LEARNER OBJECTIVES

CE Session #48
How Much Will Health Care Reform Cost?

Upon completion of this presentation, the learner will be able to:

- Learn what health care reform means for senior living providers;
- Understand the implications of new payment models; and
- Discuss how aging services organizations can demonstrate that they have embraced health reform’s emphasis on value.

PRESENTER(S):

Nancy Rehkamp, Director of Health Innovations at CliftonLarsonAllen, a leading accounting, research, and consulting firm, has over 25 years of health care experience, including long term care operations, acute care hospital administration, rehabilitation services, and home care/hospice management. She has served as President and Senior Administrator in major health care systems and free-standing senior living facilities. Nancy is a frequent speaker to state hospital and senior living association audiences.
How Much Will Health Care Reform Cost?

Florida Health Care Association

Nancy E. Rehkamp
Director of Health Innovations
August 1, 2012
The Four Perspectives:

• Buyer – Private Insurance/Self Insurance
• Consumer – The User &/or Family
• Provider – The Clinician &/or Healthcare Organization
• Product/Device Manufacturer
No Shortages of Change......

**Center for Medicare & Medicaid Innovation**
1. Health Homes
2. Community First
3. Money Follows the Person
4. Pioneer ACOs
5. ACO Shared Savings Programs
6. Community Based Care Transitions demos
7. Innovation Grants
8. Independence at Home
9. Reductions of SNF Avoidable Admissions
10. Capitated Financial Incentive Demo
11. SNF Value Based Payments

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... Get ready to dive into uncertain waters.
1. The growth in Florida population is estimated to be 5.1M between 2010 & 2030.
2. The growth in 60+ population accounts for much of the growth and is estimated to be 55.2% of the total growth.

Source: FL Dept of Economic and Demographic Research presentation 6/21/12; slide 12; accessed June, 2012 at: http://edr.state.fl.us
What We Think We Know....

1. Acute Care utilization rates have declined for all age groups, but are particularly down for the 65+. This decline in use rates are masked by population growth.

2. The estimated growth in 60+ population is expected to be strong particularly in metro areas.

3. The focus on reducing readmissions, potentially avoidable admissions and the use of Emergency Room is increasingly resulting in more care in the community.

4. The growing number of ACOs, Total Cost of Care and Value Based Contracts are creating new care models.

**Implications: The growth in 65+ will increase the demand for all long term care services, particularly post-acute care.**
Florida Medicaid Transition to 2020

Governor Scott does not support the new eligibility criteria for Medicaid due to the estimated incremental costs to Florida. The ACA calls for changes to:

1. Financial eligibility to 133% of poverty vs. 70% in 2012 for adults
2. Increased classes of individuals eligible for Medicaid
3. Higher eligibility standards for H&CBS; plus no limitation in slots or budgeted dollars under certain criteria
4. Enhanced benefits under Medicaid
5. No asset test for parents of children applying for Medicaid
6. Others
How Are We Responding?

*We are all looking for that divine intervention, but short of that:*

1. Private insurers and employers are pushing hard on providers and government to reduce health care costs.

2. Employers are shifting the costs of health care to employees through higher deductibles and new health plan designs.

3. Providers are creating new organizations, seeking new income streams and collaborating with new partners.

4. New competitors are evolving.

5. New technologies are being used to simplify and reduce costs.
How will new payment models reduce costs?

What impact will a Health Exchange have?
Payment is Transitioning to New Models

- **Shared Savings**
  - Risk based
  - Collaboration
  - Predictive modeling
  - Global budget or sub-capitation
  - Performance based

- **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

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Historical vs. Future Provider Payment Models

Current / Historical
• Fee for Volume
• Risk at Procedural Level
• Aligned System ➔ Aligned to Maximize Revenue to Providers and Costs to the Payors!!!

Future
• Fee for Value / Quality
• Gain / Loss Sharing
• Risk at Episodic Level (Bundled Payment)
• Risk at Population Level (Total Cost of Care)
• Fee for Volume ➔ but a lot less of it
• Schizophrenia System!!!
Key Financial Modeling Concepts: ACO and Risk Based Payment Arrangements

Environment
1. Care Model Impacts
2. Baseline Keepage
3. Conversion of Payor Mix to Risk Based Contracts (RBC)
4. Handling of Payors NOT in RBC
5. Timing of Impacts – Care Model vs. Revenue Model
6. Impacts of Other Providers ACO/RBC Arrangements

Performance
A. Care Model Savings
B. Global Risk Sharing Parameters
C. Keepage
D. Leakage
ACO Key Concept: Attribution and Keepage

What It Looks Like to a Multispecialty Physician Group

- Out of Network: $1,617 (4%)
- SPC: $9,676 (25%)
- All Other In Network: $27,609 (71%)

MY REVENUES: $39M

Member Results
- Total Members: 10,736
- Total Member Months: 128,830

What It Looks Like to an Integrated Health Care System

- Out of Network: $3,197 (5%)
- All Other In Network: $19,517 (30%)
- SHS: $41,786 (65%)

MY REVENUES: $65M

Member Results
- Total Members: 13,323
- Total Member Months: 142,536
CFO’s View: ACO / RBC “Baseline”
Aggressive Care Model / Limited RB Payor Contracts/Limited Capture and Keepage

### COMMERCIAL COST TRENDS

#### Operating Margin

<table>
<thead>
<tr>
<th>Year</th>
<th>Operating Margin %</th>
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<tbody>
<tr>
<td>2012</td>
<td>3.5%</td>
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<tr>
<td>2013</td>
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<td>2014</td>
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<tr>
<td>2020</td>
<td>-1.3%</td>
</tr>
<tr>
<td>2021</td>
<td>-1.6%</td>
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</table>

#### Key Financial Metrics

- **Margin w/o ACO**: 13.7% Growth
- **My Cash w/o ACO**: 25% Included in RBC

### DAYS CASH ON HAND

- **RBC**: 143, 109, 102, 92, 90, 89, 88, 84, 79
- **Non RBC**: 143, 109, 102, 92, 90, 89, 88, 84, 79
- **Baseline**: 143, 109, 102, 92, 90, 89, 88, 84, 79

### LEAKAGE (Keepage by Other Systems)

- **All Payors: 10% Net Lost**

### LEAKAGE (Keepage by Other Systems)

- **MA**: 60%
- **MC**: 60%
- **Com**: 60%
- **IP**: 0%
- **Op**: 0%

### KEPTAGE (by SiHC)

- **MA**: 60%
- **MC**: 60%
- **Com**: 60%
- **IP**: 0%
- **Op**: 0%

### CARE MODEL IMPACTS ON GLOBAL COSTS

- 100% of Baseline Growth Included in Global Target
- **CliftonLarsonAllen LLP**

### Margin Impact: Risk Based Contracts

<table>
<thead>
<tr>
<th>Year</th>
<th>Population Cost Mgmt</th>
<th>Gain (Loss) Share</th>
<th>Higher Non RBC Rates</th>
<th>Keepage</th>
<th>Leakage</th>
<th>TOTAL NET</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>$0.0M</td>
<td>$0.0M</td>
<td>$0.0M</td>
<td>$0.0M</td>
<td>$0.0M</td>
<td>$0.0M</td>
</tr>
<tr>
<td>2013</td>
<td>$0.0M</td>
<td>$0.0M</td>
<td>$0.0M</td>
<td>$0.0M</td>
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<tr>
<td>2014</td>
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<td>$0.0M</td>
<td>$0.0M</td>
<td>$0.0M</td>
<td>$0.0M</td>
<td>$(8.5M)</td>
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<tr>
<td>2015</td>
<td>$(19.9M)</td>
<td>$1.4M</td>
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<td>$0.0M</td>
<td>$0.0M</td>
<td>$(18.5M)</td>
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<td>2016</td>
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<td>$12.2M</td>
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<td>$0.0M</td>
<td>$0.0M</td>
<td>$(18.5M)</td>
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Understanding Health System Economics Is Critical
What Does Cost Shifting Really Mean Today?

If I Charge and Get Paid Like This....

- If I charge $3,000 for a particular service
  - *Variable cost of items is $800*
  - *Total fully allocated cost $1,500*

- **Medicare** Allows $1,000 for a particular service

- **Medicaid** Allows $650 to $850 for that same service

- **Self pay** pays $0 to $400 for that same service

- **Commercial Insurance** Allows $1,400 to $3,500 for that same service!

And After All That
My Health System Makes a
4%
Operating Margin
### Payer Mix Will Change – Gold Brick Theory

**Today:**

<table>
<thead>
<tr>
<th>Hospital Payer Mix</th>
<th>SNF Payer Mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>– 38% to 60% Medicare</td>
<td>– 15% to 20% Medicare</td>
</tr>
<tr>
<td>– 2% to 10% Medicaid</td>
<td>– 60% to 70% Medicaid</td>
</tr>
<tr>
<td>– 30% to 60% Private/Commercial</td>
<td>– 10% to 15% Private/Commercial</td>
</tr>
</tbody>
</table>

**Future:**

<table>
<thead>
<tr>
<th>Hospital Payer Mix</th>
<th>SNF Payer Mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>– 40% to 60% Medicare</td>
<td>– 0% to 50% Medicare</td>
</tr>
<tr>
<td>– 15% to 40% Medicaid/Exchange</td>
<td>– 35% to 90% Medicaid</td>
</tr>
<tr>
<td>– 0% to 45% Private/Commercial</td>
<td>– 10% to 15% Private/Commercial</td>
</tr>
</tbody>
</table>

The Accountable Care Act requires Medicaid physician payments be on parity with the Medicare fee schedule. There is not discussion about changing Medicaid payments for all other services ...potentially leaving significant shortfalls as millions enroll in Medicaid & the Health Exchanges.

Payment shortfalls for acute care without reimbursement reform could be devastating and if they are to collaborate with SNFs & Home care as we serve more critically ill the consequences to PAC could also be devastating..
Figure 8. Percentage of Fee-for-Service Beneficiaries Using Select Medicare Health and Post-Acute Services by Enrollment Group: Florida, 2007


Note: This analysis is based on fee-for-service claims. Medicare Advantage participation in 2007 was greater than 20% for Medicare-only beneficiaries, which impacts findings for this group.

Full Benefit enrollees tended to use select Medicare services at higher rates than Medicare-only beneficiaries. Utilization was measured by the percentage of people using the service.
What We Think We Know....

1. The move to TCOC/ACO/Bundled Payment has created new models of care and experimentation
2. Care delivery changes have changed faster than payments.
3. Clinical quality improvements are expected to reduce acute care use by about 20% over the next five to eight years.
4. Roles of palliative care and hospice are growing in the new care models

Implications:
- Care is moving to a lower cost settings that are patient-centered
- Clients served in the community are likely to be sicker and frailer and will likely be served for longer periods or more episodes
- Care delivery model changes have not seen reimbursement follow
- Patients and their families are struggling
- Care models in the home must also change to include effective technology, caregiver supports and specialty programming, frequency of interventions, greater integration, improved hand-offs, etc.
Bundled Payment Data Demonstrates

1. The post-acute diagnoses and data does not match many providers’ assumptions about care delivery.

2. The episode costs for those with a post-acute stay are expensive.

3. About 50% of home care episodes do not start with an acute care stay.

4. While the overall re-hospitalization rate for home care is higher than SNF, for many medicine MS-DRGs it is comparable.

5. The hand-offs between post-acute providers has not been a priority and will grow in importance.

6. The re-hospitalization rates in much of MN and the Twin Cities is not a significant issue for most providers and the rates have improved dramatically over last three years.

7. Most applicants for Bundled Payment in the metro area appear to be focused on the same MS-DRGs categories, orthopedic and cardiovascular. Allina is expected to focus on a limited number of cancer diagnoses.
Potential Vulnerabilities

Numbers Served

- Low Case Mix
- Rehab-only client
- Pre-episode service use

Costs

- Re-admissions
- Follow-up care

- Length of Stay
- Cost per day
- Care Variation
A New Strategic Paradigm?
Where Are You On The TCOC Quadrangle?

Volume can be defined as admissions or length of stay for SNFs

What’s Our Strategic and Operational Response to Lower the Total Cost of Care?
So, What To Do.....

- Increase data analysis capabilities
- Establish your distinctive role in the continuum
- Measure & demonstrate meaningful quality
- Redesign physicians engagement strategies
- Increase market share through relationships
- Reduce costs of care per episode
- Create a contracting strategy/Grow revenue
Potential Conclusions and Predictions.....

1. The economic impacts of not doing anything are not sustainable.

2. The economic impacts of ACA are staggering....if we understand the flow through health care business & industries.

3. Policy legislation, like ACA, is not designed to translate the concepts to operations. The CBO & others calculate the financial impact, but few have translated the impact of ACA on the provider & other health care businesses’ economics.

4. Opportunities to create a financially & operationally successful organization exist, but possibly not for all.

5. New competitors are emerging and focusing on new models of care delivery & payment.

6. The Health Care Exchanges will be one of the most important/influential outcomes of the ACA.
THANK YOU!

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For more information on health care reform, go to
CliftonLarsonAllen’s Health Care Reform Center at:
http://www.cliftonlarsonallen.com/healthreform/

Follow our blog for current discussions on health care.
www.cliftonlarsonallen.com/blog
Appendix
Innovations – One Response
Transformation at the Core

1. *Creating Opportunities* - Ascension Venture Capital Fund

2. *Leveraging Opportunities* - tapping into the Ascension Health Community

3. *Developing Opportunities* – partnering to create *Open Innovation* and targeting specific industries/vendors for engagement

4. *Identifying Opportunities* – established a system to collect and process innovative technologies, models of care and ways of applying old ideas in new ways
Nations First Virtual Care Center *

• Mercy, headquartered in Chesterfield, MO announced plans for a $90 million center that will be linked to hospitals, clinics and even patients homes.

• Mercy serves:
  – 3+ Million patients annually
  – 30 hospitals
  – 200+ outpatient facilities
  – Missouri, Arkansas, Kansas, Oklahoma

• VCC intended to be “home” to a number of telehealth initiatives and link existing programs:
  – Safewatch: ICU monitoring of 400 ICU beds in 10 hospitals over 4 state area
  – Telestroke Program: Neurologists on-call 24/7 via telemedicine from across the country

• Remote Disease Management:
  Patients connected via home based technologies to monitor weight, blood pressure, blood glucose, EKGs, and more.

Carondelet Village Community

- Started with legislative innovation grant. A three year pilot to integrate care and community.
- 14 partners – physicians, home care, health plans, health systems, home care, health researchers and community based providers.
- Serves clients on the campus and within five to seven mile radius. Requires a referral & enrollment.
- Annual report due to MN Legislature with evaluation and ability to replicate.
Using the Continuing Care Retirement Community Without Walls model – Offers a choice of coverage or programs in the home. *Offers members a predetermined set of benefits* that accrues over a period of time. Unused benefits can be utilized in the future. Program is **flexible and works if a member relocates to another part of the country.** Care coordinators are a key element to coordinate member services including:

- Care Coordination
- In-home care & services
- Emergency Response Service
- Telehealth
- Nutritional Support
- Adult Day Care
- Periodic Home Safety Review
- Travel and Social Activities
- Wellness & Prevention Services
- Home inspections
- Annual physical Exams
- Meals – in-home and central location
“Time banking” is a pattern of reciprocal service exchange that uses units of time as currency. Essentially, the "time" one spends providing services earns "time" that one can spend to receive services.” (Source: Wikipedia)

- VNS of NY manages an extensive “TimeBanking” program on behalf of their Special Needs managed care program.

- Time banking began in US with Social HMOs and were discontinued as the Social HMOs dissolved or changed funding mechanisms but is resurfacing as a tool to help support family caregivers.
Personal Health Technology System

• Integration of telehealth w/ preventative technology, self-management applications and communications with health care team
  – HealthSense
  – IPhone/IPad type applications
  – Social Networking
  – Visual communications
  – E-communications

• Business model that supports personal health technology – white coat support
Buying health technologies have not advanced as quickly as other technology markets. Based on our review of the literature the following needs to happen to expand the availability and use of personal health technology:

1. Create greater consumer knowledge about applications and devices
2. Create a “trusted advisor” to assist consumer in selection
3. Integrate the device or technology with the home &/or normal lifestyle activities
4. Develop a service component that makes use ‘simple and enjoyable’-Geeksquad; Microsoft Genius Locator, etc.
5. Assure the equipment is current and state of the art with programs for trade-out, i.e., BestBuy Buy Back for technology
6. Funding for consumer purchase is available or affordable
Center for Self-Management  (Henry Ford Health System)

- Co-located with Home Care offices, ambulatory therapies and diagnostic testing
- Managed by Home Care
- Designed for post-acute and chronic care management and those seeking a “higher” health status
- Designed to integrate technology, personal health records, patient teaching and counseling and professional consultation – virtual or in-person
- Includes wide range of health services and applications
Home Care Initiated Bundled Care

**Background:** 60%+ of Skilled Home Care begins without an acute care stay

**Opportunity:**
1. Create a home care bundled payment program w/o an acute stay
   - Reduce hospitalizations
   - Prevent health care decline or additional health cost
   - Provide linkages to appropriate health services
2. Integrate with Health Care Home & physician practices
   - Continuation of care management into community
   - Provide monitoring home health visits
3. Other care models & tools implemented

**The Approach:** Comprehensive understanding of home care episodes, the variances and alternative interventions.