Honing Your Business Acumen Skills to Partner with the Health Care Sector

January 19, 2016

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Community-Integrated Health Care Webinar Series, Part 1
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Health Reform

Impact of Target Populations on Reform

Potential Role of CDSME in Reform

Targeting your Potential Niche
Change is Here!

- Accountable Care Organizations
- Managed Medicaid
- Managed Long-term Services and Supports (MLTSS)
- Medicare Advantage changes
- Special Needs Plan
- Bundled Payment Initiatives
  - BPCI
  - CJR
- Where do CBOs fit in a changing healthcare landscape?
Impact of Change

• Changes in the reimbursement models are fundamentally changing the way that healthcare services are being delivered

• Providers are gaining an increased awareness of the impact of social determinants of health on healthcare spending

• Organizations that have particular expertise in supporting high-risk populations have greater demand for their services as providers assume more risk
Establish a business model that defines the value of your EB programs
- Target Population
- Establish a niche based on market demands
- Return on Investment (ROI)
- Price
- Reimbursement model
- Integration with the healthcare delivery system
Are all populations equal?

- Duals have significantly greater per capita costs
- Duals have higher percentages of members with two or more chronic conditions
- Duals have a higher incidence and prevalence of complications of disease
- Duals use LTSS at a much greater rate than non-duals and much higher costs of care than non-duals and even much greater per capita costs than non-dual Aged, Blind, and Disabled populations
Are traditional models impacting duals?

- According to the 2013 CBO evaluation report, initial demonstrations have shown that many of the reform models have done little to reduce the per capita costs of duals.
- Initial data shows that models of care for duals must include:
  - Inclusion of services to address social determinants of health
  - Disease self-management programs
  - Care coordination with multiple in-person encounters
Is there a role for CBOs?

- CBOs that have expertise and a proven track record in managing high-risk populations can have increasing opportunities in the changing healthcare landscape.

- In order to determine your potential role you must have a keen awareness of the following:
  - Target population – Your Niche (e.g. duals w/chronic disease)
  - Provider incentives in the current payment system
  - Impact of change on the current payment system
  - Local providers impacted by change
  - Contract models to serve the target population
What are the goals of reform

- Changes to the reimbursement models for healthcare will seek to achieve the Institute of Health Care Improvement’s Triple Aim

- Triple Aim
  - Improving the patient experience of care
  - Improving the health of populations; and
  - Reducing the per capita cost of health care
What is the impact of chronic disease on the system

• Chronic conditions significantly impact our ability to achieve the Triple Aim

• Consumers with multiple chronic conditions tremendously impact the per capita cost of health care and detract from the health of the population

• Consumers with one or more chronic conditions and social determinants of health have a greater propensity of generating higher per capita cost and experiencing worsening health outcomes
Where do you fit in Reform?

• You must understand the current payment system and the potential impact of reform initiatives
  – Who are the current payers in your market
  – Who is impacted by payment model changes
  – What population is most impacted by payment model changes

• Awareness of the current local reform implementation and planned reform initiatives

• Identifying your potential niche in the market

• Targeting services toward your niche in the market
Medicare Basics

• Medicare is a Federal Health Insurance Program
• Medicare (2016) consists of 4 parts
  – Part A
    • Inpatient hospital, SNF care, home health, hospice
  – Part B
    • Doctor services, office visits, screenings, therapies, preventive services, outpatient services, emergency care, ambulance care, medical supplies, & durable medical equipment
  – Part C
    • Medicare Advantage
      – Must cover all Part A and Part B benefits
  – Part D
    • Pharmacy benefits
Who is eligible for Medicare

- People 65 of older
- People under 65 with certain disabilities
- People of ANY age with End-Stage Renal Disease (ESRD)
  - Permanent kidney failure requiring dialysis or a kidney transplant
• The primary Public Payer for Health Care is the Centers for Medicare & Medicaid Services (CMS)

• The Centers for Medicare & Medicaid Services (CMS) is the single largest payer for health care in the United States
  – Medicare
  – Medicaid
  – State Children’s Health Insurance Program (SCHIP)

• Since CMS is the largest payer, health systems, physicians, and commercial payers generally adapt or align their programs to adhere to the requirements of CMS
What is the reach of the Medicare Program

• The Centers for Medicare & Medicaid Services is a branch off the Department of Health and Human Services (HHS)
• In 2011, Medicare covered 48.7 million people
• Total Expenditures in 2011 were $549.1 billion
How is Medicare Funded

• Medicare is paid for through 2 trust fund accounts held by the U.S. Treasury
  – Hospital Insurance (HI) Trust Fund
  – Supplementary Medical Insurance (SMI) Trust Fund

• These funds can only be used for Medicare

• Medicaid costs are paid by State and Federal funds through a match formula
What are Medicare Part A Benefits

• Medicare Part A covers the following services:
  – Inpatient hospital care
  – Skilled nursing care
  – Home health care
  – Hospice care
What are Medicare Part B Benefits

- Medicare Part B covers the following services:
  - Medically necessary outpatient services
  - Preventive health services
  - Doctor visits
  - Ambulance services
  - Supplies
  - Durable medical equipment (wheelchairs, walkers, etc.)
Medicare Part B rules

• Part B deductible and co-insurance
  – Yearly deductible of $147 (2015)
  – Once the deductible is met, beneficiary must pay a co-insurance of 20% of the Medicare-approved amount charged by providers
  – Most preventive health services require no deductible or co-insurance payments

• Duals
  – All Duals have Medicare and Medicaid pays the co-insurance for Medicare Part B
Deductible, Copay, & Coinsurance

• Deductible
  – A fixed amount that a beneficiary must pay each year towards the cost of their healthcare bills before health insurance coverage pays

• Copayment
  – A fixed amount paid whenever a particular type of healthcare service is provided
    • For example a $20 copay for brand named drugs

• Coinsurance
  – A payment that is made as a percentage of the cost of the healthcare service
Medigap market

- Medicare Part B beneficiaries can purchase a Medigap or supplemental policy to cover the 20% coinsurance requirements

- A Medigap policy defined
  - Health insurance sold by private insurance companies to fill gaps in Original Medicare coverage
    - Coinsurance, copayments, deductibles
    - If a beneficiary elects Medicare Advantage, they cannot be sold or use a Medigap policy
    - Beneficiaries with Medicaid (Duals) generally cannot buy a Medigap policy
Medigap for persons with a disability or ESRD

- Persons with Medicare, before age 65, because of a disability or ESRD
  - Are not guaranteed access to a Medigap policy
  - Federal law does not require insurance companies to sell Medigap insurance to persons under age 65
  - If the beneficiary has Medicaid, then Medicaid covers the Medicare payment gaps
What happens for Duals

- Duals are persons with both Medicare & Medicaid
- Commonly referred to as a Dual Eligible or a Medi-Medi
- Medicaid is required to pay the co-insurance and deductibles for Duals
- Provider must first bill Medicare and then bill Medicaid for the second portion
Common Medicaid Misperceptions

• My State did not accept Medicaid expansion so there are not any adults on Medicaid
• Medicaid only covers low-income women and children
• Medicaid waiver participants aren’t on regular Medicaid, it is a different program
• Adults in a Medicaid waiver program are not low-income
• Dual eligibles do not participate in value-based payment reform programs
Reform impacting Duals

- Value-Based Payment Reform
  - ACOs
  - Bundled Payment (BPCI)
  - CJR
- Medicaid Managed Care
- MLTSS
- Health Homes
- Duals Demonstrations (high opt-out rates)
- D-SNP/C-SNP/I-SNP plans
- PACE programs
Who is at Risk?

- A Dual can have 3 different payers
  - Medicare
  - Medicaid managed care plan to cover non-Medicare covered medical costs
  - MLTSS plan that only covers MLTSS risk
  - *Often the MCO for health operates under a different contract than the MLTSS plan and can be a different co.*

- Traditional healthcare systems/providers have limited knowledge or ability to navigate systems that impact social determinants of health or provide impactful self-management programs
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 vs Partial Duals

- Of the 9 million duals in 2009, the CBO reports that 7 million were full duals and 2 million were partial duals.
- Partial duals do not meet the state-level criteria for full Medicaid but they do qualify for some Medicaid covered services.
- All Duals have Medicare and have their Part B co-insurance covered by Medicaid.
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
• 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
Are providers concerned about Duals?

• Duals have diverse needs that all impact healthcare
  – Medical treatment
  – Limited disease self-management resources
  – Long-term care
  – Social determinants and requirements for social services
• More than half have one or more chronic conditions
• Social determinants of health compound the difficulty in managing the healthcare resource needs of duals
Spending on Duals

- Medicare is the primary payer for acute care services and post acute care (SNF & home healthcare)
- Medicaid is the primary payer for LTSS and some acute care costs and non-Medicare services such as dental/vision
- Most common chronic conditions:
  - Diabetes
  - COPD
  - CHF
  - Dementia
  - Osteoporosis
Chronic Disease complications

- Diabetes
  - Leading cause of ESRD
  - Leading cause of adult-onset blindness
  - Leading cause of non-traumatic lower-limb amputation

- Osteoporosis
  - Leading cause of lower-extremity joint replacement

- CHF
  - Common cause of readmissions and ambulatory-sensitive admissions
Reform Initiatives and Duals

- Value-based payment reform models include duals
  - ACOs
  - Bundled Payment
- Value-based payment models help to reduce the per capita cost of health care
- Average cost of duals $33,400 vs non-duals $8,300
  - Reducing the cost of care of duals will have the greatest immediate impact on the per capita cost of the population
  - Alignment of incentives has led many to target services to high-risk duals to get the greatest value to the system
  - Targeted CDSME programs can have great impact here
What is included in the cost numbers?

• Hospital costs
  – Inpatient admissions
  – Ambulatory Sensitive Admissions
  – Emergency Department Services
  – Readmissions

• Long-Term Services and Supports

• Complications resulting from worsening chronic disease
Skilled Nursing Facility coverage

- Medicare Part A covers SNF care under certain conditions
  - Beneficiary must have Part A
  - Must have a qualifying hospital stay prior to transfer to the SNF
    - Qualifying inpatient hospital stay is 3 days before SNF care is authorized
  - Services required for a medical condition that meets one of the following indications
    - A hospital-related medical condition
    - A condition that started while you were getting care in the skilled nursing facility for a hospital-related medical condition
Skilled Nursing Facility coverage (cont.)

- Medicare covers the cost of care for SNF care as follows
  - *Avg length of stay in a SNF is 20 days
  - SNF Readmissions likely occur between day 20 - 39

<table>
<thead>
<tr>
<th>For Days</th>
<th>Medicare Pays for Covered Services</th>
<th>Beneficiary is responsible for the following</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 20</td>
<td>Full Cost</td>
<td>Nothing</td>
</tr>
<tr>
<td>21 – 100</td>
<td>All but a daily copayment</td>
<td>Daily copayment (2014 = $152/day)</td>
</tr>
<tr>
<td>Beyond 100</td>
<td>Nothing</td>
<td>Full Cost</td>
</tr>
</tbody>
</table>

38
SNF Policy Issue

• Some hospital are using “Observation” days more frequently before formally admitting a patient to the hospital
  – Emergency dept. and observation days do not count towards the minimum 3-day hospital stay requirement for SNF coverage
  – The day of discharge doesn’t count as a inpatient day
Misalignment of payment incentives

• A dual in a nursing home bed with two chronic conditions – CHF and Diabetes
  – Medicaid is the primary payer for nursing home days
  – Medicaid pays at a lower rate than Medicare
• Consumer gets admitted to the hospital for diabetes complications
  – Consumer has a 3-day eligible stay
  – Returns to the same nursing home but now has a SNF/Medicare admission and payment increases to the higher Medicare rate for the next 20 – 100 days
Who holds the risk?

- A Dual has Medicare for their acute and post acute care costs
- ACO and bundled payment push risk to the provider, but the risk is limited to Medicare costs
- MLTSS is only at-risk for the Medicaid portion, which begins at day 21 for a SNF admission
- Since Medicare is the primary payer, the MLTSS plan often is not aware of the change until the claim is received
How Can CDSME Impact the Triple Aim for Duals

Medical Costs

LTSS

Social Determinants
Potential Target Population

- Many providers of LTSS have extensive experience with Full and Partial Duals because this population is five times more likely to require LTSS
- Duals have significantly greater expenditures
- Targeted CDSME to improve self-management with additional resources to address social determinants of health is a tremendous need
- Determine if you can fill this void and market towards your niche
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
Strategic Planning

• Market Analysis
• SWOT Analysis
• GAP Analysis
• GAP Mitigation Implementation Strategy
• Contract Capture
SWOT Analysis Elements

• SWOT should be performed for the individual agency and/or the Network

• SWOT
  – Strengths
  – Weaknesses
  – Opportunities
  – Threats
In order to prepare for completing a SWOT there are key elements that should be completed first:

- If a network will jointly complete a SWOT, then an individual agency assessment should be completed as part of the SWOT.
- Pre-SWOT should begin with a Market Analysis.
- Market Analysis can also drive the need for a Network strategy.
SWOT Goals

• Closely assess potential customers
• Identify the point of pain for the customer
• Implementation strategy to address the point of pain for the customer
• Customers have more desire to buy services that specifically address a current point of pain
  – Identify the point of pain
  – Understand how your services specifically address the customer point of pain
  – Present how you bring continual value to fix the customer point of pain
Pre-SWOT Market Analysis

- Know the current Health Reform Activity in your target area
- List each by topic area
- Define each of the entities that are engaged in these activities in your defined region
  - Medicare vs MA Population
  - Medicare Advantage Plans
  - Medicaid Managed Care initiatives
  - ACOs
  - Bundled Payment Initiatives
• Community Health Needs Assessment (CHNA)
  – Required of all 501(c)(3) Hospitals under the Affordable Care Act
  – Initial completed CHNA due by March 2012
  – Must be completed once every three years
    • Next one is due March 2015
  – Requires community engagement and assessment of needs and implementation strategy to address the identified needs
  – Publicly reported
  – Failure to complete can lead to fines and other penalties
Next Steps

- Establish a Network to address the findings of the SWOT
- Gap Analysis
- Strategic Planning
Questions and Resources

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What You Need to Know about the Medicaid Health Home Benefit

Timothy P. McNeill, RN, MPH, Independent Health Care Consultant

February 2 @ 3:00 pm - 4:30 pm

The Medicaid Health Home benefit under the Affordable Care Act provides reimbursement for comprehensive care management services to coordinate the physical, behavioral, and social services needs of individuals with two or more chronic conditions. Join us for a webinar to learn how chronic disease self-management education can be used to fulfill the requirements of the Health Home services benefit.