

NOTICEABLE IMPROVEMENT

## The Impact of Health Care Reform

April 8, 2011



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Healthcare Principal – LarsonAllen LLP




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## Topics for Today...

- Current environment
- Impacts of health care reform
- Health insurance changes
- Challenges and Opportunities you must consider
- Key trends



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## The Market – What’s on the minds of leading CEOs and Boards?



- *The number of people who need our services*
- *How consumer buying habits have changed*
- *The effects of a recessionary economy – some good, some not so good*
- *A changing work force (formal and informal care givers)*
- *Accessing capital – Financing the future of older adult services*
- *Health care reform – what are the immediate and long term implications?*
- *How will the congressional interest in home health affect us?*




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## Critical Issues Facing Our Clients...

- The effects of a new *economy* and capital planning
  - Affecting Access to *capital*
  - Addressing the issue of *Negative inflation* (shrinking margins)
- Impacts of *health care reform* and the new payment landscape
  - As an Employer
  - As a Provider
    - ◊ Accountable Care Organizations
    - ◊ Episodic, Bundled or Global Payment
- New Forms of *Relationships*
- *Technology* – new applications and reliance



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## In the short term...



... not much has changed  
But.....  
In the long term it will!!!!

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## Home Care

- Industry profits driven by Medicare – overall margins continued to be very strong during 2009
- Favorable policy environment – “RAC” audit threat is looming, but activity so far is relatively low
- M&A activity hit plateau – values high but relatively stable
- Compliance remains a high priority
- Health care payment reform and reimbursement stability is greatest concern

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## Home Care Reimbursement Updates

- PPS Refinements have driven increased profits for intermittent home health
- MedPac recommendations – Rate freeze or decline for home health agencies
- Increased scrutiny of fraud due to error rate increases in filed claims
- State budget issues causing concern
- You've already been in sessions covering short term reimbursement matters

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## Hospice Trends...

- Healthcare Reform Bill
  - Estimated \$7.8 billion in cuts to the Medicare hospice benefit (\$6.8 billion estimated by NHPCO)
  - Payment rate reduction
    - ◊ Market Basket Reduction
    - ◊ Productivity Adjustments
  - Update cost report
  - More qualitative information - Transparency
- MedPac
  - Projected 2010 Aggregate Medicare Margin
  - Recommended Payment Update

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When we look over the long term...



... things get more unsettled.

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## Medicare Payment Reform: Hospice

- **Hospice payment reforms**

- Requires HHS Secretary to collect data and information by 2011 and use it to revise payment rates on or after October 1, 2013.
  - ◊ Estimated to reduce hospice spending by \$100M over 10 years.
- Requires a hospice physician or nurse practitioner to have a **face-to-face encounter** with each patient for determining continued eligibility for recertification and attest that such visit took place. (1/1/2011)
- HHS Secretary will medically review certain patients in hospices with high percentages of long-stay patients.

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## HCBS: State Balancing Incentive Program

- **\$3 billion is appropriated to increase the Federal Medical Assistance Percentage (FMAP) paid to states as a reward for rebalancing their Medicaid LTC expenditures to be more heavily weighted toward non-institutional care by October 1, 2015**

**Non-institutional care includes:** HCBS waiver services, home health and personal care services, PACE, self-directed personal assistance

States may propose to achieve target by expanding their current HCBS state plan amendment by increasing income eligibility up to a maximum of 300% SSI

**States currently spending between 25-50% on non-institutional care**

- Must achieve 50% target for non-institutional spending to receive 2% FMAP increase

**States currently spending less than 25% on non-institutional care**

- Must achieve 25% target for non-institutional care spending to receive 5% FMAP increase

- **Requires applying states to make structural changes:**

- Must have a single entry point system
- Conflict-free case management services
- Use standardized assessment tools for HCBS eligibility determination

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## Removing Barriers to HCBS

- **Spousal Impoverishment:** Beginning January 1, 2014, requires states to apply spousal impoverishment rules to individuals who receive home and community-based services. This new requirement would apply for five years.

- **New options permit states to:**

- Provide more types of HCBS through a State plan amendment instead of a waiver to individuals up to 300% SSI
- Extend full Medicaid benefits to individuals receiving HCBS under a State plan amendment

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## Hospice Demonstration Programs

### Medicare Concurrent Care

- Three-year demonstration
- Would allow hospice-eligible patients to also receive all other Medicare covered services while receiving hospice care
- Up to 15 hospice programs -- rural and urban sites
- Independent evaluation to be conducted on its impact on patient care, quality of life, and spending in the Medicare program

### Curative and Palliative Care for Children in Medicaid and CHIP

- Allows children who are enrolled in either Medicaid or CHIP to receive hospice services without foregoing curative treatment related to a terminal illness.

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## Medicare Hospice Concurrent Care Demonstration Program

- HHS Secretary to establish a three-year demonstration program
- Demo would allow hospice-eligible patients to also receive all other Medicare covered services while receiving hospice care
- Up to 15 hospice programs in both rural and urban areas to be demo sites
- Requires an independent evaluation of its impact on patient care, quality of life, and spending in the Medicare program

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## Curative and Palliative Care for Children in Medicaid and CHIP

- Allows children who are enrolled in either Medicaid or CHIP to receive hospice services without foregoing curative treatment related to a terminal illness.

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## HCBS: Community-Based Care Transitions

Establishes five-year **community-care transitions program** to assist Medicare beneficiaries at high-risk of a hospital readmission with their transitions from inpatient to outpatient care

- Program implementation by January 1, 2011
- \$500M available to be paid to:
  - ◊ Community-based organizations that provide care transition services OR
  - ◊ Hospitals with high readmission rates that partner with such entities.
- "High-risk Medicare beneficiaries" = one or more chronic conditions and not enrolled in a Medicare Advantage program
- HHS may expand the program if the program proves to lower spending without reducing quality.

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## Health Insurance Changes – what to be aware of as an Employer and Employee



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## Employer reporting obligations

**Employers offering health insurance to their employees in 2014 will be required to report:**

- Names of FT employees on the health plan
- Employer contribution levels to employee health care coverage premiums
- Plan waiting period length
- Whether employer-sponsored plan meets "minimum essential coverage" requirements

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## Individual Mandate

- **Individual mandate to obtain health coverage:** Beginning in 2014, individuals must obtain a minimum-level of health insurance coverage or pay a penalty
- **Minimum essential coverage includes:**
  - Medicare, Medicaid, TRICARE
  - Insurance purchased through an Exchange, on the individual market
  - Employer-sponsored coverage, OR
  - Grandfathered plans
- **Penalties for failure to obtain coverage:**
  - In 2014: greater of \$95 or 1.0% of income
  - In 2015: greater of \$325 or 2.0% of income
  - In 2016: greater of \$695 or 2.5% of income
  - Includes a hardship exemption
  - Penalty is capped at three times the per person amount for a family
  - Assessed penalty for dependents is half the individual rate

**Grandfathered plans**  
= group health plans  
in existence on  
3/23/2010

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## Government assistance to help some individuals obtain coverage

- **Medicaid expansion:** Expands eligibility to individuals and families up to 133 % of the federal poverty level (FPL)
  - If cost effective, states can opt to subsidize employer-sponsored premiums for this group
  - In 2014, state can receive additional FMAP for this expansion population
- **Premium and cost share assistance:**
  - Individuals and families with household income of 133 - 400 % FPL may be eligible for sliding-scale assistance in the form of:
    - ◊ Tax credits to help pay premiums; and
    - ◊ Out-of-pocket reductions to help with cost sharing (e.g., co-payments and co-insurance)

**133% FPL**  
Individual = \$14,484  
Family of 4 = \$29,726

**400% FPL:**  
Individual = \$43,560  
Family of 4 = \$89,400

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## Cost Sharing Subsidies

- **Federal government will pay insurers to reduce the cost sharing for individuals:**
  - Enrolled in a silver-level plan through an Exchange AND
  - Whose household income is between 100-400% FPL

100-200% FPL	Two-thirds
200-300% FPL	50%
300-400% FPL	One-third

- **Reductions don't apply to benefits not included in the federal definition of "essential health benefits"**

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## State Health Insurance Exchanges

- Requires a state-based health insurance **exchange** to be created in all 50 states.
  - In 2014, open to:
    - ◊ Small employers
    - ◊ Self-employed individuals
    - ◊ Unemployed individuals
    - ◊ Large employers (2017)
- HHS to establish rules and consult the National Association of Insurance Commissioners and others.

### What is an exchange?

A marketplace for individuals and small businesses to shop for insurance.

- Offer a choice of health plans
- Standardize health plan options
- Allow consumers to compare plans based upon price (compare apples to apples)
- Intended to provide a more competitive market
- Serve as a neutral party that can offer consumers assistance in enrollment, information and determining eligibility for any subsidies

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## Exchange Plans

Types of exchange plans to be offered by insurers

- **Bronze** = 60% actuarial value
- **Silver** = 70% actuarial value
- **Gold** = 80% actuarial value
- **Platinum** = 90% actuarial value
- **Catastrophic plan**
  - ◊ Only available to individuals < 30 years old, or those exempted from the individual mandate due to unaffordability or hardship.
  - ◊ Plan must cover:
    - “minimum essential benefits”
    - a minimum of three primary care visits per year
- All exchange “metal” plans must cover essential health benefits, limit cost-sharing and have a specified actuarial value

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## Expanding Access to Health Coverage: Large Employer Role

Law does **NOT** require employers to offer health insurance

- Beginning in 2014, **employers with 50+ FTEs** must pay a **“shared responsibility” penalty** if any FT employee receives subsidized insurance through a state Exchange
  - Penalty is assessed differently depending upon whether or not employer offers affordable, **“minimum essential coverage”** to employees
- **“Minimum essential coverage”** for employer-offered plans
  - Plan with 60% actuarial value
  - Employee premium cost < 9.5% of household income

**FTE = FT employees + FT equivalents**

**FT employee** = works avg. 30 or more hours per week

**FT equivalents** = Hours worked in a month by all PT employees divided by 120

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## Employer "Shared Responsibility" Penalty

Penalty assessed only if a FT employee receives Exchange subsidies

- **Penalty for employers not offering coverage=**  
\$2000 x each full-time worker (except for first 30 workers)
- **Penalty for employers offering coverage =**
  - At least, \$3000 x # of full-time employees receiving federal assistance BUT
  - No more than, \$2000 x each full-time employee (except for first 30 full-time workers) penalty
  - No penalty for employees receiving free choice vouchers

*Employees are not eligible for the federal subsidies if their employer coverage is deemed "affordable"*

**"Affordable"** means the employee premium contribution under the employer plan is less than 9.5% of their household income

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## Free Choice Vouchers

- All employers offering and contributing to employee health coverage must offer free choice vouchers to employees if:
  - Household income < 400% FPL
  - Employee contribution toward the employer-sponsored coverage is between 8 – 9.8% of their household income, AND
  - Employee does not enroll in employer coverage.



### 400% FPL:

Individual: \$43,560  
Family of Four : \$89,400

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## Free Choice Vouchers

- Amount of "free choice vouchers" = employer's monthly contribution to the health plan premium
  - Highest % paid for any plan offered
  - Amount is tied to coverage selected (e.g., employer contribution amount for family coverage, if family coverage selected)
  - If voucher exceeds cost of plan purchased through Exchange, excess is refunded to employee and is taxable
    - ◊ Excess amounts received by employee to be included in their gross income.
- Individuals receiving vouchers are not eligible for federal subsidies for premiums or cost-sharing
- Employers do not pay the "shared responsibility" penalty for employees who receive vouchers
- Tax free for employees, deductible for employers

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### Why an Employee might choose the Exchange? Nurse Aide Example

- Annual nurse aide salary = \$18,633/yr (171% FPL) + annual premium cost via Employer = \$3388 (18.2% of HHI) = **Exchange subsidy eligible**

ANNUAL EMPLOYEE COST	EMPLOYER PLAN	SILVER EXCHANGE PLAN
Premium	\$3,388 (18.2% HHI)	\$458
Out of Pocket	\$2,000	\$1,964
<b>TOTAL</b>	<b>\$5,388</b>	<b>\$2,422</b>

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### Insights on the Potential Impact of the Exchanges

*It is irrelevant whether employers decide to maintain employer-sponsored coverage: Employees will decide the fate of the exchange!*

- Low-wage workers = biggest % increase in take home pay.
- Companies with a predominantly low-wage workers:
  - up to 90% of employees could benefit from Exchange
  - 80%+ of employees may have more take home pay by moving to the Exchange
  - Another 5-10% could move to Medicaid and eliminate insurance and out-of-pocket health care costs altogether!

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### Insights on the Potential Impacts of the Exchanges

- Even in higher-wage companies, 25%+ of employees could see increase in take home pay by purchasing insurance through the Exchange
- Don't assume employees won't be able to figure out where the best deal is for them in the Exchange!

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## Implications of the Exchanges for providers

- Health plans will be operating in a very different, more consumer driven, more price sensitive market
- Greater pressure on the providers to bend the cost curve and demonstrate value (cost/quality)
  - Unhealthy approach: focus on unit price, which is where the health plans will start
  - Healthy approach: Reform the payment system, move to value-based purchasing where providers share in savings, and change how care is delivered
- Providers need to prepare for this new environment  
...2014 is not far away

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## Health Insurance and Penalty (HIP) Calculator

HEALTH CARE REFORM  
HOW MUCH MORE WILL HEALTH REFORM COST MY BUSINESS?  
Find Out  
2011 2012 2013 2014  
[www.larsonallen.com/HIP](http://www.larsonallen.com/HIP)

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## The New Normal... for Many Americans

*It is not yet clear what the new normal resulting from the economic downturn will be, but based on historical patterns and other available information we might anticipate that:*



1. Declines in net income and wealth for older adults
2. Housing prices will remain flat
3. Unemployment will continue high
4. Lower or flat price increases for services and goods
5. Increased focus on quality
6. Increased family caregiver responsibilities

*Each of these issues will have an impact on the aging services field.*

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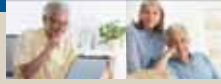
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## New Normal Operating Environment – Caregiver Focus

### Implications:

- Providers will find new ways to engage informal caregivers
  - Informal caregivers will be expected to participate in care planning and some care tasks
  - Caregivers will look to providers for a broader array of supports that are affordable and that reduce challenges & stresses
- Health care reform proposals include resources and programs to lengthen the time informal caregivers provide services in the community
- Caregivers may look to organizations that have assisted them when they need to find a more intensive care for their family member
- The growth in numbers of elders without caregivers will challenge the H&CBS system and other aging providers
- Some programs will be developed to support caregivers w/o financial eligibility requirements



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## Decreasing Role of Family Pushes up Demand for all Services

### Percentage of Family Caregiving:



#### National Ratios:

	1988	2001	2030
Caregiver Ratio	7.51	6.78	4.34
Elderly Dependency Ratio	4.75	4.61	2.76

The Caregiver Ratio is a comparison of the number of elders 85 + to women aged 45 to 64. The Elderly Dependency Ratio is the number of elders 65+ compared to workers aged 20 to 64. The lower the ratio the fewer the number of caregivers or workers.

**Each 1% drop in family care giving requires approximately \$30M in additional public funds for Minnesota.**

Source: National Caregivers Association & US Census Population Projections by Age & Sex

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## New Relationship Focus will Position for Success

**Health care is local and relies on strong relationships. Today's relationships focus on:**

- Physician/patient
- Skilled Care/family/resident
- Home care/informal caregiver/physician/client
- Skilled care/hospital social worker
- Payer/provider
- Others

**Future health care relationships will include greater reliance on:**

- Physicians/Accountable Health Organizations as the payer
- Independent care managers
- Strategic partnering with other provider organizations which start with CEO/Board relationships
- Greater reliance on volunteer/informal caregiver relationships

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## What does all this mean?



...and what do we do about it?



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## Potential Payment Reform Elements


<p><b>Key Concepts:</b></p> <ul style="list-style-type: none"> <li>• Care Coordination/Case Management</li> <li>• Disease Management</li> <li>• Medical Home</li> <li>• Patient Centered Care</li> <li>• Patient Engagement</li> <li>• Care Transitions</li> <li>• Performance Incentives</li> <li>• Comparative Effectiveness</li> <li>• Accountable Organizations</li> <li>• Increased Informal Caregiving</li> </ul>	<p><b>Payment Tools</b></p> <ul style="list-style-type: none"> <li>• Electronic Information Exchange</li> <li>• Software to Support Care Delivery</li> <li>• E-communication Tools</li> <li>• Patient Grouping Software – Diagnoses, Severity &amp; Episode</li> <li>• Performance Metrics</li> <li>• Best practice Guidelines</li> <li>• Compliance Monitoring</li> <li>• MS-DRGs/APR-DRGs/CPT Coding, etc.</li> </ul>
<p><b>Program Examples &amp; Demos:</b></p> <ul style="list-style-type: none"> <li>• Acute Care Episode Demo</li> <li>• Physician Group Practice Model</li> <li>• Prometheus Demonstrations</li> <li>• Hospital Quality Incentive Program</li> <li>• Medicare Care Management Performance</li> <li>• Medicare Hospital Gainsharing Demonstration</li> <li>• Physician Hospital Collaboration Demonstration</li> <li>• Nursing Home Value Based Purchasing Demo</li> <li>• Multipayer Advanced Primary Care Initiative</li> <li>• Physician Episodic Benchmark Report Initiative</li> <li>• Medical Home Demonstration</li> <li>• Post-acute Care Bundled Payment Research</li> </ul>	<p><b>Payment Models</b></p> <ul style="list-style-type: none"> <li>• Fee for Service</li> <li>• Capitation</li> <li>• Global Payment – Full or Partial</li> <li>• Performance Incentives</li> <li>• Value Based Payments</li> <li>• Bundled Payments for Episodes of Care</li> <li>• Prometheus</li> <li>• Blended Systems</li> </ul>

**Expected Outcomes:**

- Improved effectiveness
- Reduced growth in expenses
- Appropriate utilization
- Better patient experience



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## What Can We Expect?

**We believe the 6 emerging themes will prevail:**

1. Providers will be asked to accept greater financial risk for outcomes
2. Operational efficiency will be critical
3. Collaboration among **all providers** will be required for survival
4. Significant investments in technology will be necessary
5. Increased quality expectations, reporting and monitoring
6. Elevated regulatory risk



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## Preparing for Change...

### Key Focus for Aging Services Providers:

1. Creating an understanding of existing resident/patient care delivery patterns
2. Developing robust predictive measurement systems for utilization, quality and costs
3. Developing organizational capabilities for electronic health exchange and communications
4. Identifying and implementing best practices and strategies by diagnoses
5. Determining processes and demonstrating patient-centered care and patient engagement approaches
6. Engaging family and caregivers, particularly following Medicare Home Care episode to maintain relationships



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## Key Trends



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## Key Trends Impacting Aging Services

#1

Payment reform will focus on increasing value – higher quality and lower costs.

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### Potential Implications to Aging Services

Robust measurement systems	Automated data collecting processes
	Significant cost of care reductions
Acceptance of "gain-sharing" arrangements	Better data needed for contracting

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### Key Trends Impacting Aging Services

**#2** Referral Sources are instituting changes in preparation for different payment models (i.e. ACOs, VBPs, etc.)

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### Potential Implications to Aging Services

Hospital and physician relationships	Define and evaluate new roles
Care delivery models must be integrated	
Uniform best practice protocols across continuum	Physician participation in community and post-acute settings

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Key Trends Impacting Aging Services

**#3**

**Hospitals will experience significant financial strains over the next 5 – 7 years.**

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Potential Implications to Aging Services

More SNF and home care discharges	
Frail and clinically complex residents	Greater hospital integration
Faster response times	Preferred provider networks

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Key Trends Impacting Aging Services

**#4**

**Future customer buying practices will likely not reflect historical patterns.**

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### Potential Implications to Aging Services

More focus on quality and value	Increased vacancies and turnover
New marketing messages: choice & flexibility	
Growth of short stay residents	Aging services delivered to home

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### Key Trends Impacting Aging Services

**#5** Health Care Reform legislation will create opportunities for aging services providers.

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### Potential Implications to Aging Services

Health information exchange	Demonstrations will encourage new models
Quality and performance measurement	SNF and Home Health payment reductions
Shift to lower cost levels of care	Growth in home and community based services

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## Health Reform Will Drive Tremendous Change

Change is imminent.

Greater financial risk	Operational efficiency	Collaboration	Technology investments
Increased quality	Elevated regulatory risk	Community-based services and care	

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## Planning for the future...



... a focus on positioning




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## An Approach

Situation Analysis Phase:

Assemble facts on Environment & Operations

Conduct S.W.O.T. Analysis

Identify Priority Issues & Challenges

Where are we now?

Goal Formulation Phase:

Define Directions: Mission/Vision Goals & Objectives

Explore Alternate Ways of Dealing with Issues

Where should we be going?

Strategy Formulation Phase:

Develop Strategies to Achieve Results

Define Resource Needs for Each Strategy

Establish Budgets: Capital & Operating

How should we get there?

Evaluation & Control Phase:

Adjust Performance and/or Objectives

Ongoing Performance Evaluation of Units & Managers

Establish M.I.S. to Gather & Display Data by Objectives & Budget

Are we getting there?

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## Our Advice.....

1. **Think big, but act small**.....this can lead to greater engagement, clearer focus and higher outcomes.
2. **Go slow to go fast**.....plan the next few years out thinking about how you will create the "burning platform" for change in your organizations that will engage not only the minds but hearts of staff.
3. **Participation in the changes is not a choice**.....health care is going to change dramatically and we need to design the best transition plan for our organization and our constituents.
4. **To create better, connect more**.....connecting with referral and payer sources, wise souls and key community leaders may help identify the innovations that will lead to success.



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## Questions?

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## Thank you!

For more information on health reform,  
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