Welcome to
"The Basics of Health Care and Health Reform – Webinar #2"

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Facilitator: Magda Hageman-Apol

The webinar will begin at 3:30 p.m. Eastern Standard Time

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The Basics of Health Care and Health Reform – Webinar #2

Tim McNeill, RN, MPH

Webinar #1 Review

- Medicare Basics
- Medigap and Medicaid coverage
- Medicare coverage of hospital care
- Skilled Nursing Facility (SNF) Care
- Policy and Practical Implications of each

Key Concept Recap

- Medicare Eligibility
  - People 65 or older
  - People under 65 with certain disabilities
    - Federal Supplemental Security Income (SSI)
  - People of any age with End-Stage Renal Disease
- Duals are included in the Medicare Eligible category (Medicare + Medicaid)

Key Concept Recap (cont.)

- Four Parts of Medicare
  - Part A
    - Inpatient hospital, SNF, Home Health, Hospice
  - Part B
    - Doctor services, office visits, emergency care, ambulance services
  - Part C
    - Medicare Advantage
  - Part D
    - Prescription Benefit

Example Recap

- What is the point of pain for a typical Managed Longterm Services and Support (MLTSS) Plan serving Duals?
  - Readmissions?
  - Emergency Department Visits?
  - SNF Care?
  - Falls Prevention?
  - Meals?

Return on Investment

- Which of the two programs demonstrate a greater return on investment for the MLTSS plan?
  - Meal delivery service
    - Delivers meals to plan members and can report how many meals were delivered
  - Comprehensive Nutrition Program
    - Nutrition assessment provided quarterly
      - Program delivers appropriate meals and assesses intake of meals
    - Conducts quarterly wellness assessments and environmental safety checks – transmits data to health plan
    - Reports risks and deterioration in clinical status to the health plan on a weekly basis

What is your Value Proposition?

- A simple meal delivery service
  - Provides meals to defined members
  - Confirms that meals were delivered
- Comprehensive Nutrition Program
  - Completes regular nutrition assessments
  - Delivers appropriate meals based on assessment findings
  - Documents intake of meals
  - Prevents frailty and deterioration in status
    - Conducts safety/wellness assessments
    - Reports findings to the health plan and provider

Application of ROI

- A simple meal delivery service
  - Can provide a meal if needed
- Comprehensive Nutrition Program
  - Program prevents frailty and deterioration in status
    - Reduces overall costs of care
  - Reduces risks of SNF placement and/or shortens the duration of required skilled care
  - Reduces the need for additional HCBS resulting from deterioration in status
  - Reduces prolonged hospitalization and SNF placement
  - *Value Added provider in the continuum of care

1. Readmission Penalties
2. Value-Based Purchasing and Medicare
3. Medicare Advantage Requirements
4. Opportunities with MA Plans

ACA Mandate

- Hospital Readmissions Reduction Program
- Section 3025 of the Affordable Care Act
  - Added section 1886(q) to the Social Security Act
  - Requires Centers for Medicare Services (CMS) to reduce payments to hospitals with excess readmissions (up to 3% of total Medicare payments)
  - 2015 rules add additional conditions to the program
    - Chronic Obstructive Pulmonary Disease COPD
    - Total Hip and Knee
    - Chronic Heart Failure (CHF)
    - Acute Myocardial Infarction (MI)
    - Pneumonia

Hospital Readmission Reduction Program (cont.)

- All cause readmissions
- For penalized hospitals, CMS will reduce payment for Medicare patient admissions from October of the penalty year through Sept. of the subsequent year (Federal fiscal year)
- Penalty applies to all patients admitted to the hospital for any condition
- FY 2015 – 2,610 hospitals received a readmissions penalty

Readmissions Example

- 67 y/o Black male with CHF admitted for shortness of breath
- Diagnosed with pneumonia
- Discharged after 3 days on oral antibiotics
- Patient in the Medicare Part D doughnut hole
  - Out-of-pocket expense at Walmart = $1,500 for two week course
- Patient unable to pay for outpatient drugs, admitted 12 days later for exacerbation of pneumonia
- Penalty applied to the discharging hospital

Readmissions Penalty Example #2

- 72 y/o female admitted to the hospital for a total knee replacement
- Transferred to a SNF post discharge
- Admitted to the SNF for 20 days then discharged to home
- Readmitted to the hospital for diabetes complications
- Readmission credited to the discharging hospital

Hospital-Acquired Condition (HAC) Reduction Program

- Section 3008 of the Affordable Care Act established the Hospital Acquired Conditions (HAC) Reduction Program
  - HACs are a group of reasonably preventable conditions that patients have upon admission to a hospital, but developed during the hospital stay.
- Performance is based on a hospitals total HAC score, which ranges from 1 to 10
  - The higher the score, the worse the hospital performed
  - Beginning 2015, hospitals with the highest score receive a 1% penalty for all Medicare payments

Hospital Value-Based Purchasing

- Section 3001(a) of the Affordable Care Act
- The program attaches Value-Based Purchasing to the payment system
  - Participating hospitals are paid for inpatient care based on the quality of care, not just quantity of the services they provide
    - 2015 VBP application is 1.5%
  - The program uses the Hospital Inpatient Quality Reporting (IQR) Program authorized by Section 501(b) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 – President George W. Bush

Cummulative Penalties for hospital performance

- Readmissions Reduction Program
  - 3%
- Hospital Acquired Conditions
  - 1%
- Value-Based Purchasing
  - 1.5%
- Grand Total at-risk
  - 5.5%

Potential Penalty

- A Medicare participating hospital that scores poorly on each of the indicators, will have a total reduction in all Medicare payments up to a maximum of 5.5% (all three programs)
- A patient admitted for kidney disease complications generally may reimburse $14,000
  - The same poor performing hospital would forfeit $770
    - Interventions that prevent the penalty would need to cost less than $770 in order to have a defined ROI

Value-Based Purchasing for SNFs

- Protecting Access to Medicare Act of 2014
  - Signed into law by President Obama on April 1, 2014
  - Establishes a Value-Based Purchasing Program for Skilled Nursing Facilities (SNFs)
  - Provides a penalty for poor performers and an incentive program for high performers

SNF Value-Based Purchasing Req.

- Law requires the following
  - Requires HHS to establish an all-cause, all-condition hospital readmission performance measurement for SNFs no later than Oct 1, 2015
  - A scoring system will be put in place to rate facilities based on current performance and improvement from baseline
  - Performance will be published on the Nursing Home Compare website

Funding the SNF Value-Based Purchasing Program

- Performance measures will consider both achievement and improvement
- Facilities will be ranked based on performance
- High performers will receive a higher per diem rate for all Medicare payments
- A 2% reduction in the SNF rates will be applied beginning FY 2019 to fund the program
  - Performance bonus payment can exceed this 2% reduction

Application of the Concept

- Example – 78 y/o male w/CHF admitted to SNF for rehab
  - Planned discharge after 20 days
  - SNF and hospital are now both concerned about a readmission
    - Proposed ruling may consider both hospital readmissions and SNF readmissions for ALL-CAUSES
  - HCBS providers that can support the consumer post discharge from hospital and/or SNF can be an essential partner in addressing this issue
    - Are you a meal delivery service or a Comprehensive Nutrition Program that continually monitors safety and health status?

2015 Physician Value-Based Payment Modifier

- Beginning calendar year 2015, Medicare will apply the Value Modifier to physician payments for physicians in groups of 100 or more
- Applies to groups of 10 or more in 2016
- Applies to all physician practices, regardless of size, in 2017
  - Physicians in an Medicare Accountable Care Organization (ACO) are Exempt

Physician Value-Based Payment Modifier implications

- Allows Medicare to pay physicians based on the quality of services rendered defined by reports of clinical outcomes
- High performing physicians
  - Eligible for a 2.0% increase in payments
- Low performing physicians
  - Eligible for a 1.0% reduction in payments

Physician Value-Based Modifier Calculations

- Section 1848(p)(3) of the Affordable Care Act requires CMS to evaluate costs of the beneficiaries served by the physicians for rating
- CMS has adopted a measure to evaluate five per capita cost measures for quality
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Heart Failure
  - Coronary Artery Disease
  - Diabetes

Alignment of Initiatives

- Physician Value-Based Purchasing evaluates the following
  - COPD, Heart Failure, Coronary Artery Disease, Diabetes

- Readmissions Penalties evaluate the following conditions
  - Heart Failure, Acute MI, Pneumonia, COPD, Hip/Knee
  - Readmission program impacting SNFs will be all-cause

Value-Based Purchasing Opportunities

- Disease self-management programs that can address the cost of care, reduce readmissions, and improve outcomes address key issues facing the healthcare system
  - Improve Physician Value-based purchasing
  - Reduce Readmissions Penalties
  - Improve Hospital Value-Based Purchasing
  - Health Systems and industry will create programs to address this problem if good options are not presented
    - ROI must be clearly defined and measured

What about Medicare Advantage

- Sometimes called “Part C” or “MA Plans”
- Medicare Advantage (MA) plans are required to cover all Medicare Part A and Part B benefits
- When a beneficiary elects Medicare Part C (Medicare Advantage) they have elected to have their Part A and Part B benefits managed by a Private Health Insurance plan that is approved by CMS to operate a Medicare Advantage Plan

Part C Health Plan Premiums

- Medicare Advantage plans received a risk-adjusted capitated payment amount
- Each Medicare Advantage plan must manage their "Risk" and cover the cost of all Medicare Part A and Part B benefits required by their enrollees with the premium payments collected

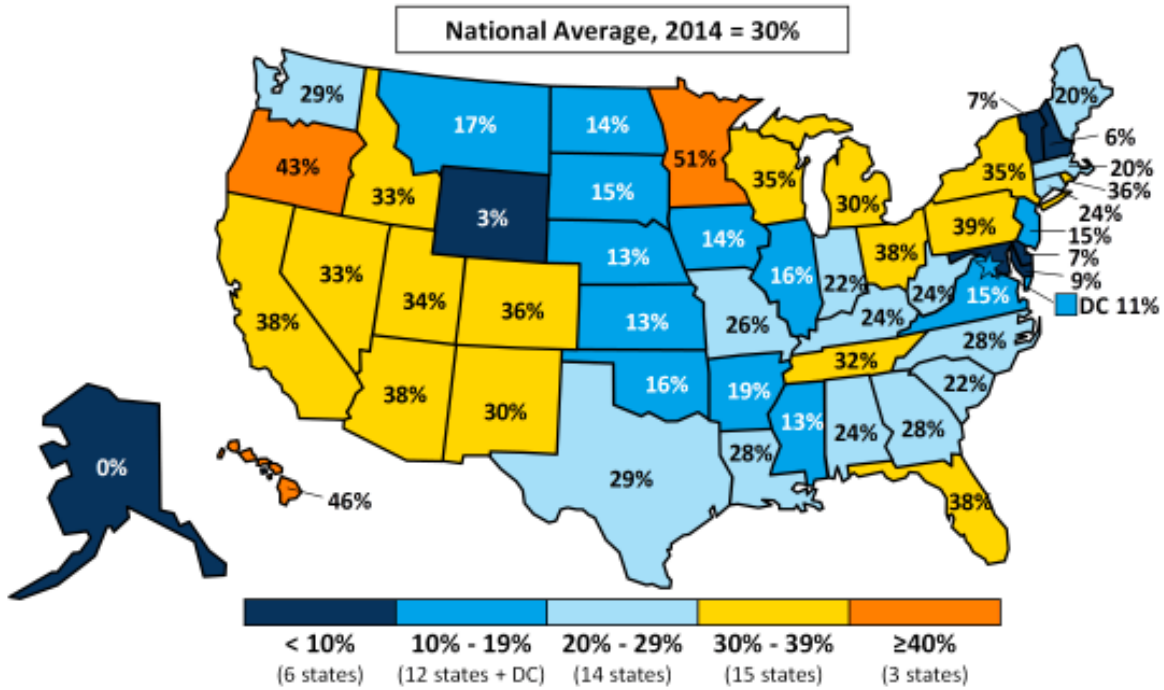
Medicare Advantage Enrollment

- Kaiser Family Foundation Report (Jan, 2015)
- In 2014, the majority of the 54 million people on Medicare are in the traditional Medicare program
- 30% are enrolled in a Medicare Advantage Plan
  - There has been consistent growth in the number of Medicare Advantage enrollees over time
  - Enrollment in Medicare Advantage varies by State and Markets within a State

MA Plan Enrollment Map

Exhibit 2

Share of Medicare Beneficiaries Enrolled in Medicare Advantage Plans, by State, 2014



NOTE: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS State/County Market Penetration Files, 2014.

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Exhibit 2. Share of Medicare Beneficiaries Enrolled in Medicare Advantage Plans, by State, 2014

Determining MA Enrollment in your area

- Administration for Community Living, Center for Disability and Aging Policy (CDAP) has two tip sheets to assist programs with determining the number of Original Medicare and Medicare Advantage enrollees in each County and some Territories in the U.S.
  - **Medicare Advantage Penetration Analysis Tip Sheet**
    - http://www.acl.gov/Programs/CDAP/OPAD/TechnicalAssistance/docs/MA_Penetration_Analysis_Tip_Sheet_Final.pdf
  - **Medicare Advantage Plan Enrollment –Top Five Plans**
    - http://www.acl.gov/Programs/CDAP/OPAD/TechnicalAssistance/docs/MA_Plan_Enrollment_Analysis_Tip_Sheet_Final.pdf

Medicare Advantage Payments

- Medicare pays Medicare Advantage plans a capitated (per enrollee) amount to provide all Part A and Part B benefits.
- Medicare makes a separate payment to plans for providing prescription drug benefits under Medicare Part D.
- Under the Balanced Budget Act (BBA) of 1997 Medicare pays 95% of average traditional Medicare costs in each county

Medical Loss Ratio (MLR)

- The Affordable Care Act requires all health insurance plans to submit data on their revenue and expenses
  - Applies to all commercial insurance plans
  - Beginning January 1, 2014, applies to all Medicare Advantage (Part C) and Part D plans

MLR Calculation

- Medical Loss Ratio (MLR) Equation Numerator: includes all health care paid claims along with any quality improvement activity (QIA).

$$\frac{\textbf{Claims + QIA}}{\textbf{Premium – Allowable Deductions}} = \textbf{MLR}$$

Quality Improvement Activities

- Can be included in the MLR Numerator calculation
- Must stand up to audit
- Designed to improve health quality
- Designed to increase the likelihood of desired health outcomes in ways that can be objectively measured and can produce verifiable results

Quality Improvement Activities Defined

- Medication Therapy Management
- Improve health outcomes, including
  - increase likelihood of desired outcomes vs. baseline
  - reduce health disparities in specified populations
- Prevent hospital readmissions
- Improve patient safety
  - reduce medical errors
  - lower infection and mortality rates
- Increase wellness and promote health activities
- Enhance use of health care data to improve quality, transparency, and outcomes

MLR Requirements

- Commercial Plans (began January 1, 2011)
  - 80% for individual and small group plans*
  - 85% for the large group market
    - * ACA defines small group plan as having 1 – 100 average total number of employees (ATNE).
- Medicare Advantage (began January 1, 2014)
  - 85% for all MA plans
- Medicare Part D (began January 1, 2014)
  - 85% for all Part D plans

Penalties for MLR Non-Compliance

- Commercial Plans
  - Must submit a pro-rated rebate to all enrollees in the amount equal to the difference between actual MLR and the required MLR per statute.
- MA's and Part D Plans
  - Starting with the 1st year of non-compliance:
    - Must send the rebate to CMS
  - Non-compliant for three (3) consecutive years:
    - Prohibition of new enrollments
  - Non-compliant for five (5) consecutive years
    - Termination of CMS contract

Medical Loss Ratio Tip Sheet

- ACL, Center for Disability and Aging Policy (CDAP) has a detailed tip sheet explaining the MLR program available at the following link:
  - http://www.acl.gov/Programs/CDAP/OPAD/TechnicalAssistance/docs/Medical_Loss_Ratio_Tip_Sheet_Final.pdf

Medicare Advantage Prevention and Health Improvement Incentives

- CY2015 Final Rule expands rewards and incentive program that focus on encouraging participation in activities that improve health, efficient use of health care resources and prevent injuries and/or illness

- Allows MA plans to pay a reward to participants as an incentive to participate in defined preventive health programs

MA Plan Rewards and Incentive Program example

- MA Plan identified all of their members with a diagnosis of diabetes
  - Notifies those beneficiaries that if they participate and complete a diabetes self-management training program, provided by a Diabetes Self Management Training (DSMT) program in the MA network
  - MA plan authorized to pay $75 to each member that completes the DSMT class
  - MA plan still obligated to pay the network DSMT provider for providing the class, based on contracted rate
  - Incentive increases participation in Evidence Based (EB) - DSMT program

Prevention and Wellness Activities

- Prevention and Wellness activities benefits for a MA plan
  - Expenses apply to the MLR
  - Preventive health activities reduce the likelihood of high-cost disease complications that increase the MLR above the 85% threshold
  - Unpredictable disease complications can dramatically raise the MLR amount far above allowable limits
  - Plans with high MLR have reduced profitability
    - Ex. MA plan with a 91% MLR increased premiums for 2015 by 40% resulting in member dis-satisfaction and member disenrollment

Medicare Risk Adjustment

- CMS risk adjusts payments made to health insurance plans
  - MA Plans
  - Program of All Inclusive Care for Elderly (PACE) organizations
  - Part D Plans
- Purpose of risk adjustment
  - Payment to plans based on the relative risk of the beneficiaries they enroll
  - Risk adjustment allows CMS to make appropriate payments based on differences in expected costs

Risk Adjustment detail

- Balanced Budget Act of 1997 (BBA) mandated that a risk adjustment payment methodology
  - Incorporates information on beneficiary health status
- CMS currently administers risk adjusted payments as follows
  - MA plans under Section 1853(a)(3) of ACA
  - PACE – 1894(d)(2) of ACA
  - Part D Plans – 1860(d) of ACA

Hierarchical Condition Category (HCC) Methodology

- CMS-HCC model includes both diseases and demographic factors
- Clinical diagnostic information must be gathered and submitted electronically to the MA plan in order for them to submit the data to CMS to obtain the appropriate risk adjustment
- Failure to properly document services and the need for additional services results in the plan and the provider obtaining less than they are owed

MA Plan Performance

- ACL, Center for Disability and Aging Policy (CDAP) has a tip sheet that provides information on how to determine how individual health plans performed on required Healthcare Effectiveness Data and Information Set (HEDIS) quality measures
  - HEDIS quality measures directly tied to STAR ratings
  - Tip Sheet link
    - http://www.acl.gov/Programs/CDAP/OPAD/TechnicalAssistance/docs/HEDIS_Performace_Tip_Sheet_Final.pdf

MA Plan Opportunity

- Providers that can support the following items bring value to a MA plan
  - Increase accuracy of HCC risk adjustment data
  - Increase access and utilization of prevention and wellness activities
  - Apply the cost of care of wellness and prevention activities to the MLR
  - Provide initiatives that reduce cost of care, such as readmission reduction programs, and electronically document and transmit the data to the health plan for a risk adjustment

Business Acumen Resources

- ACL, Center for Disability and Aging Policy (CDAP) has a treasure trove of resources to support CBOs and HCBS providers in improving business acumen

  – http://www.acl.gov/Programs/CDAP/OPAD/TechnicalAssistance/index.aspx

Key Topics to be covered

- Webinar #3
  - Accountable Care Organizations (ACOs)
  - Bundled Payment Initiatives
  - Medicaid Managed Care
  - Managed Long-term Services and Supports

Questions

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Upcoming Webinars

Stewardship that Inspires Happy, Loyal Donors

Presenter: Vanessa Chase
When: January 29, 2015
Time: 3:30 PM to 4:30 PM EST
Fee: $25
http://www.mowaa.org/webinars

Part 3: Network Development - The Need for Collaboration

Presenter: Tim McNeill
When: February 24, 2015 at 3:30 PM EST
Time: 3:30 PM to 4:30 PM EST

Part 4: Developing a Strategy and a Business Model for Your Organization

Presenter: Tim McNeill
When: February 26, 2015 at 3:30 PM EST
Time: 3:30 PM to 4:30 PM EST