

Provider-Led Responses to Managed Care & Driving Value-Based Care

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Agenda

- Value-Based & Managed Care Environment
- Opportunities in VBR & Alternative Payment Models
- Provider Owned Networks
- Provider Owned I-SNPs
- Emerging Models
- Readiness Assessment
- Questions & Next Steps

Population Health Management

Population Health Management programs aim to control health care costs by focusing on appropriate utilization of services to manage and coordinate care efficiently. There is widespread belief that the key to cost mitigation is effectively managing and preventing chronic diseases.

What is Population Health Management?

Population Health

- Health outcomes of a group of individuals
- AND
- Health factors and health outcomes within the group

Population Health Management

- Strategies and resources employed to improve the health outcomes of the population



The New Currency

Outcomes:

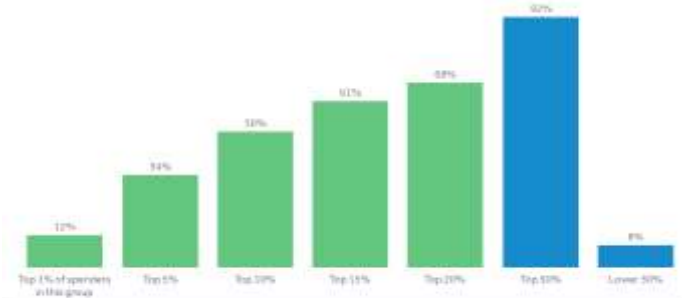
- Reduction in avoidable inpatient admissions (admits/1000)
- Reduction in avoidable emergency department visits (ED visits/1000)
- Decrease in overall inpatient cost
- Reduction in inpatient days/1000
- Decrease in cost per admit



The Value-Based World is Here

Half of
Seniors are
92% of the
Spend

Distribution of health spending among elderly population (age 66+), 2016



Source: Kaiser Family Foundation analysis of Medical Expenditure Panel Survey • Get the data.
• P98

Presented by
Health System Tracker

Trends



Volume to Value

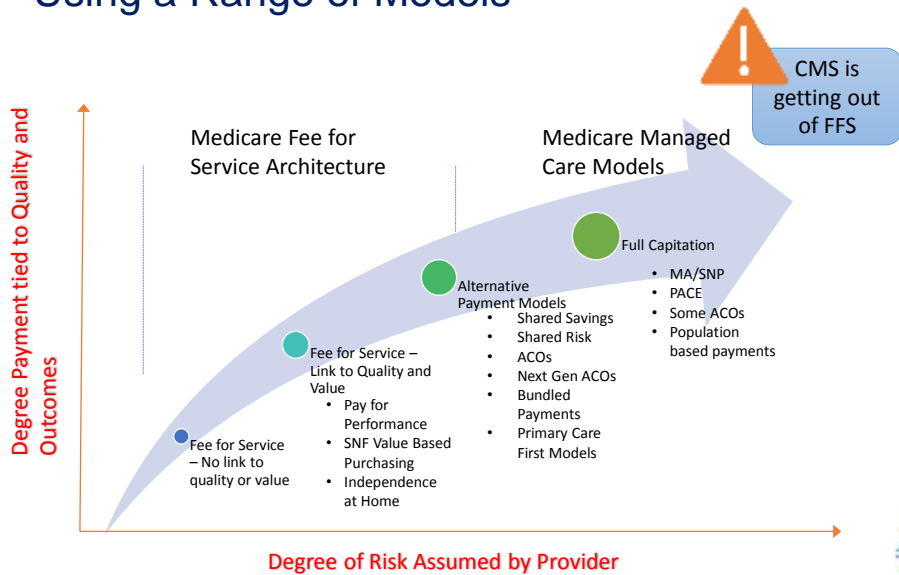


Micro to Macro View



Silos to Systems

CMS Shifting Risk From Volume to Value Using a Range of Models



Value Based Care Today



ACOs have grown five-fold since 2012, with 10% of US population covered and two-sided risk models rapidly increasing



BPCI-A participants number approximately 1,300 hospitals and physician groups almost twice BPCI Original

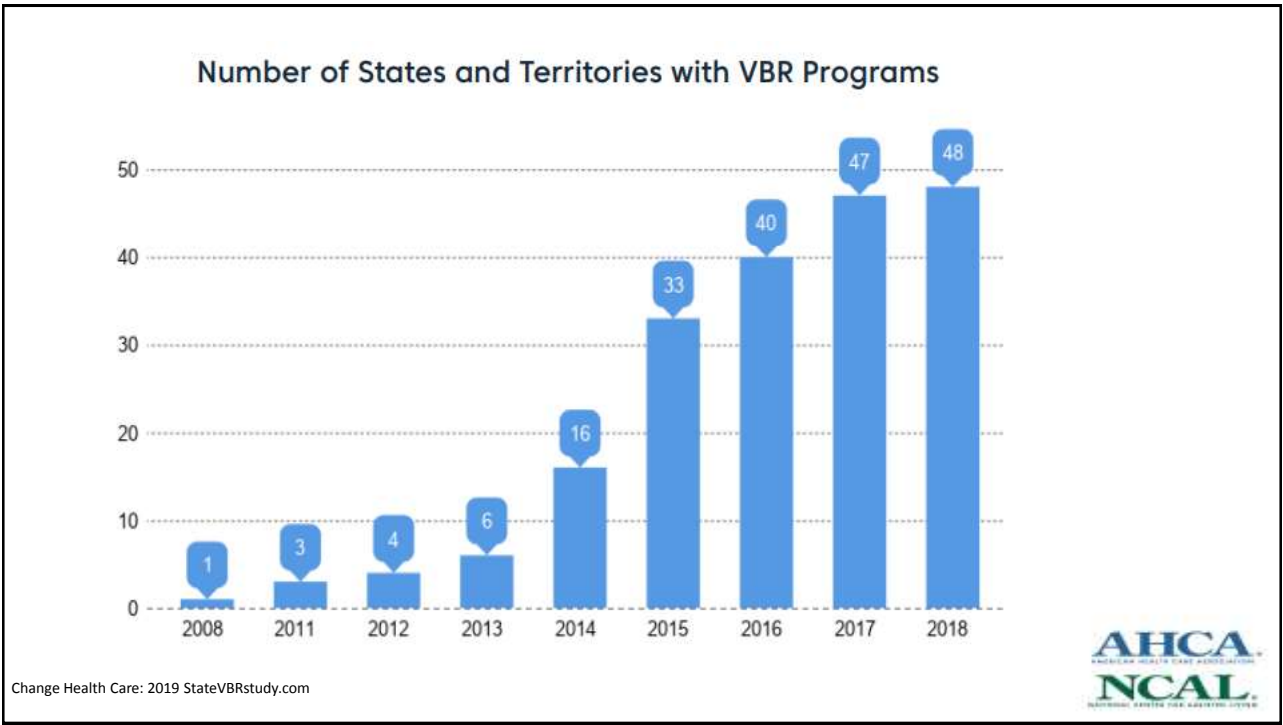
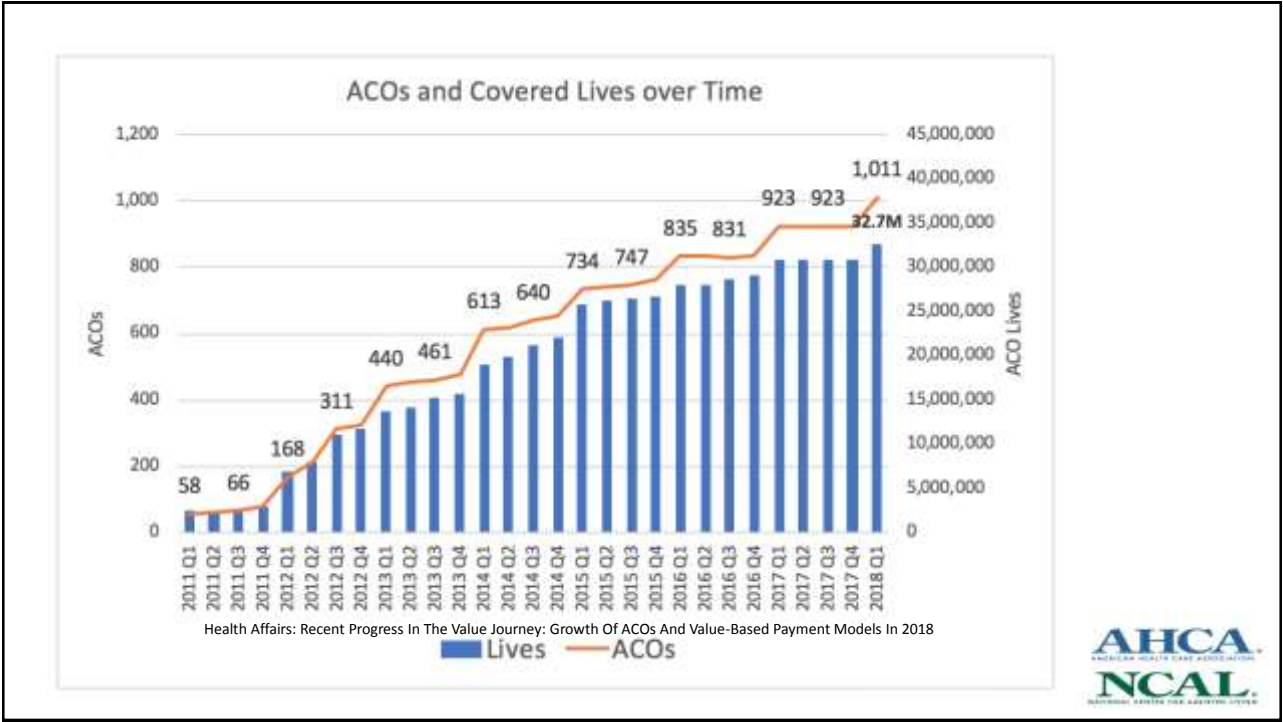


48 states use some form of value based reimbursement programs
VBP span almost every provider type

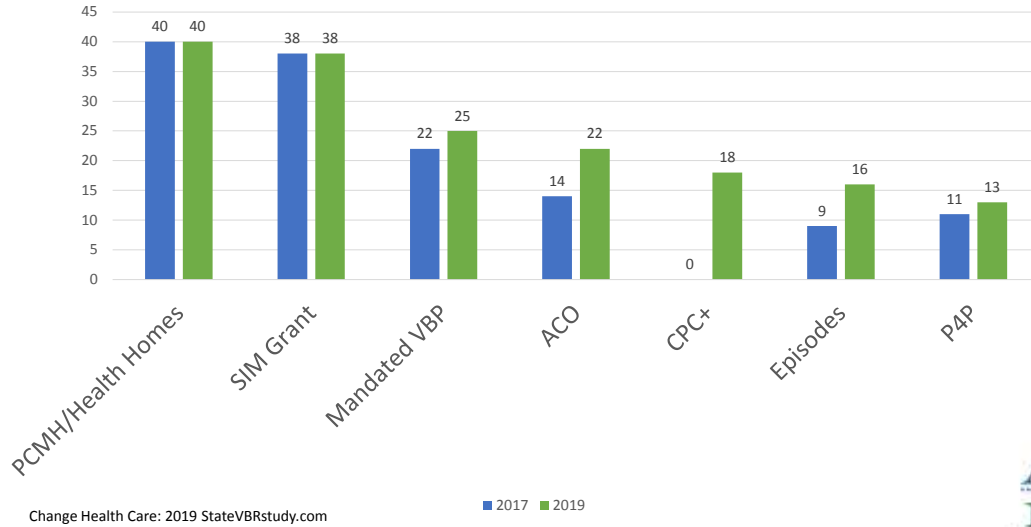


Medicare Advantage enrollment has doubled over the past decade
Benefits have also significantly expanded with additional flexibilities for those with chronic conditions

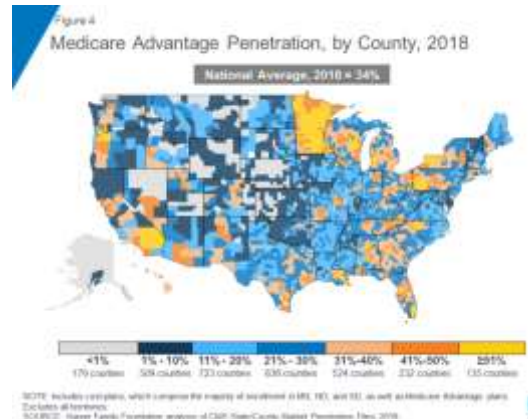
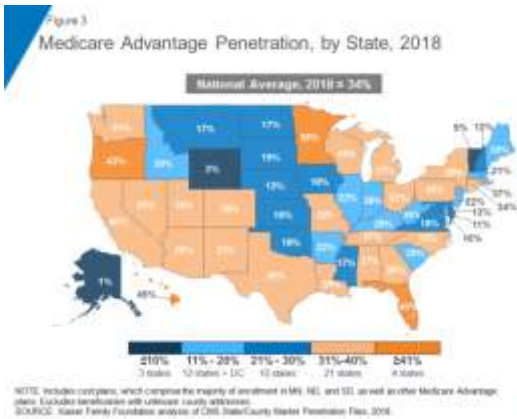




What Are States Doing?



One-third of Medicare Beneficiaries are in Medicare Advantage



Current PAC/LTC Pressure Under Managed Care

- Growing MA and MLTSS census, squeezing out FFS Medicare
- No or little negotiation of contract language and rates
- Old contracts, that haven't been touched in years
- Lack of understanding of contract terms in all levels of revenue cycle (admission to billing)
- Utilization management & lower/ing length of stay
- Payment Issues (i.e. timeliness, accuracy)
- In vs. Out of Network
- Hospital referrals

Implications

Post acute care is an opportunity for savings

SNF and Home Health margins are some of the strongest in PAC

There will be a significant shift in acuity and setting – higher acuity, lower cost setting

The emerging senior population wants value and is not afraid of managed care

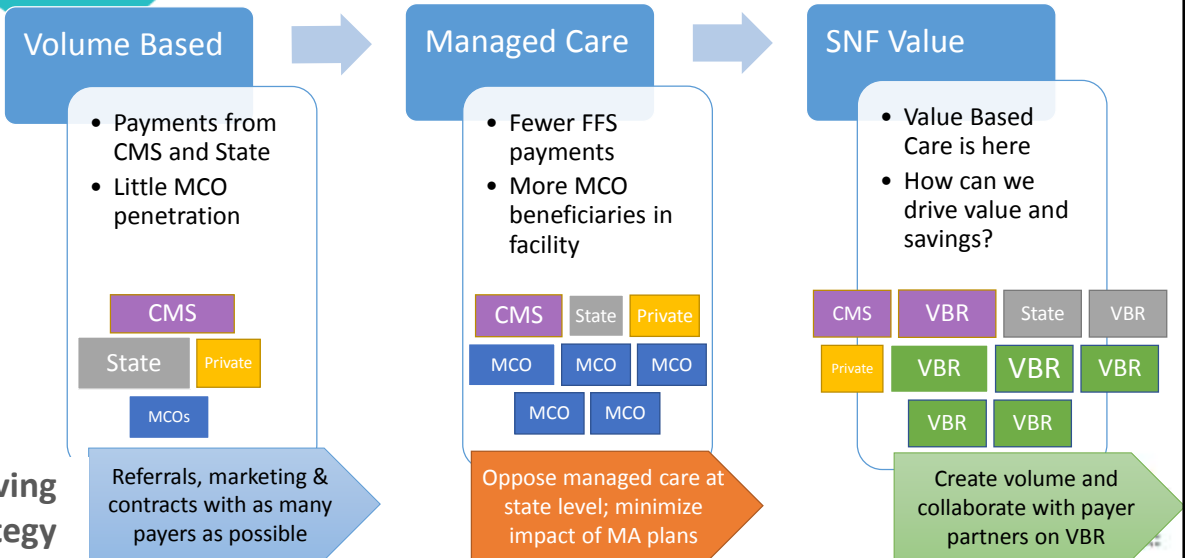
Senior preference will drive strong Medicare Advantage rates and options



Opportunities for LTC/PAC Providers

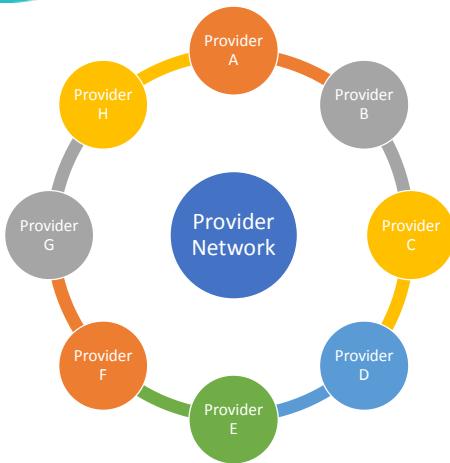


Managed Care: LTC/PAC must Shift from Opposition to Collaboration





Getting in the Game: Provider-Owned Networks

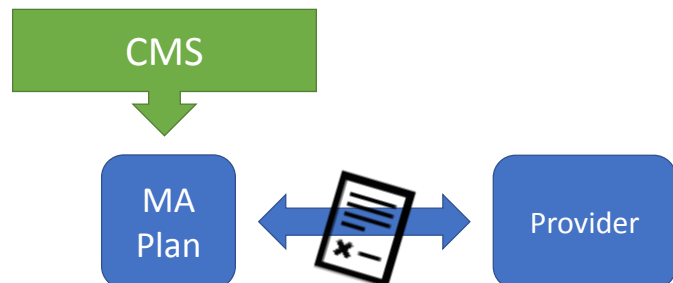


- Joint venture of independent providers
- Like an IPA (Independent Physician Association)
- Providers come together to enhance quality outcomes and value based reimbursement
- Health plans often prefer larger networks versus single facility contracts



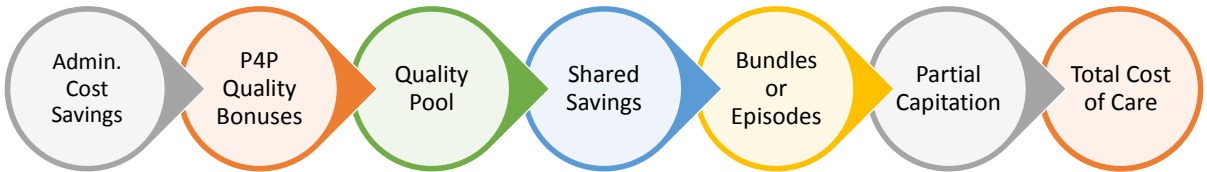
CMS Relationship with Medicare Advantage

- MA contracts are private, commercial agreements between two entities
- CMS cannot dictate the payment of provider by MA plan through its contracts
- Contracts are opportunities for payment and innovation





Contract Opportunities with Plans

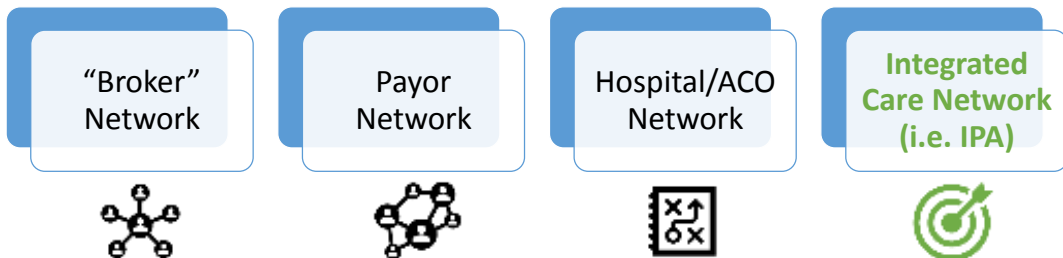


As payers identify areas for growth (\$), PAC and LTC emerges as an area to create new upside and downside Value Based Contracts. What do payers need in order to collaborate?

VOLUME



Solution: "A Network," but What Type?



Focus on Quality Measures

- Rehospitalizations/ER/Observation Stays
- 5-Star Quality Measures
 - Pressure Ulcers
 - Falls with major injury
 - Immunizations
- HEDIS Measures
 - Hospitalization Following Discharge From a SNF



Health Plan Importance



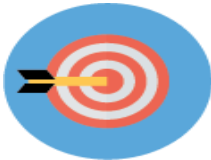
Measurable & Ability to Impact



Demonstrate Quality



Improve Quality Outcomes



OHCA Quality Partners: Provider Benefits



Access to Payors & Improved Revenue

Inclusion in more networks
Better terms due to benefit of understanding state and national payor contracting



Administrative/Credentialing

Reduces administrative costs for documentation collection and submission to multiple health plans



Value Based Reimbursement

Access to contracts that recognize quality and better outcomes that individual providers cannot be part of due to volume (Can negotiate in Clinically/Financially Integrated Model *ONLY*)



Claims, Revenue Cycle & Systemic Payor Issues

Solves systemic claims issues
Reduces cost of claim issue resolution
Contacts with payors to escalate aggregated claims issues



Strategy & Understanding

Ensures providers are able to maximize their current contracts (ex. Knowledge of drug carve outs embedded in contract language)



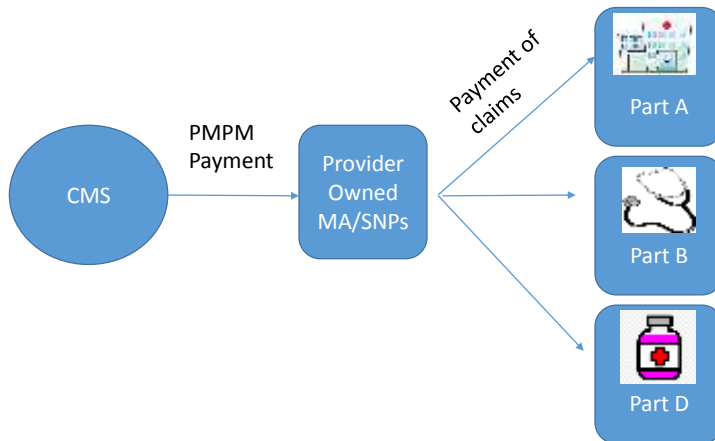
LTC Provider Owned Special Needs Plans

★ Currently operating
★ In development

- 45 products
- 17% of ISNP covered lives are enrolled in LTC provider owned plans

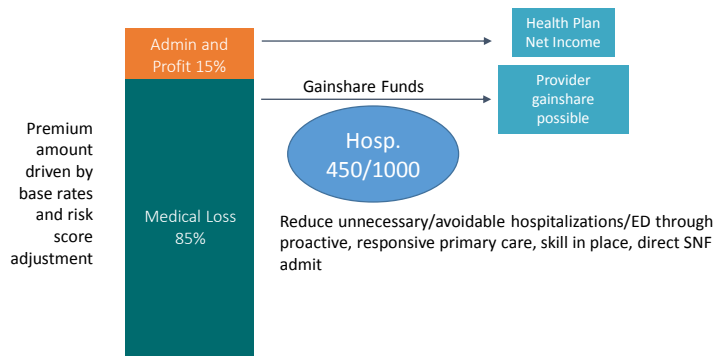


Provider Owned Special Needs Plans Position Providers Higher on the Reimbursement Food Chain





Life at The Top



Terms:

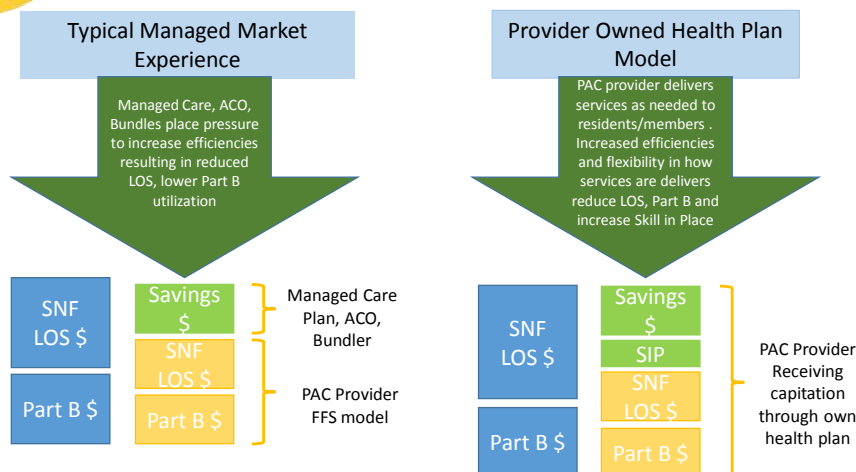
Premium – per member per month payment from CMS to Medicare Advantage plan

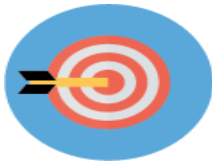
Medical Loss Ratio (MLR)– percent of every dollar that goes toward medical expenses

Administrative Loss Ratio (ALR) – percent of every dollar that goes toward administration of plan and profit



Example: How Health Plan Ownership Helps You to Capture the Value You Create





7 Steps to Successful Health Plan Development

1. Assessing feasibility and readiness
 - Enrollment potential
 - Healthcare management capabilities
 - Meeting capital requirements
2. Selecting a partner
3. Securing a state HMO license
4. The CMS application
 - General requirements
 - Network adequacy
 - Model of care requirements
5. Marketing and enrollment
6. Building your care management capabilities
7. Developing and reviewing the P&L

Health Plan Readiness/Feasibility Process

Education,
education,
education

Health Plan Implementation Process



Emerging Models

Direct Contracting

Design Approach in Brief– Global and Professional PBP

- Build off the Next Generation Accountable Care Organization Model to offer new forms of capitated population-based payments (PBPs), enhanced payment options, and flexibilities to increase the number of tools providers have to meet beneficiaries' medical and non-medical (e.g., social determinants of health) needs.
- Expand emphasis on voluntary alignment and beneficiary choice, while retaining claims-based alignment approaches.
- Reduce burden by focusing quality reporting on select measures.
- Create a more predictable, prospective spending target by capitalizing on Medicare Advantage rate calculations for various benchmarking steps.
- Focus on dually eligible, complex chronic and seriously ill patients.
- Create participation opportunities for organizations new to Medicare FFS, and for Medicaid Managed Care Organizations interested in taking accountability for Medicare cost and quality where already accountable for Medicaid spending.

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Direct Contracting

Model Goals

Goal	Examples of how Direct Contracting will achieve these goals
Transform risk-sharing arrangements	<ul style="list-style-type: none"> • Flexible cash flows • Payment that recognizes the challenges of caring for complex chronically ill populations and dual eligible beneficiaries
Empower and engage beneficiaries	<ul style="list-style-type: none"> • Enhanced voluntary alignment • Various benefit enhancements and payment rule waivers
Reduce provider burden	<ul style="list-style-type: none"> • Small set of core quality measures • Waivers to facilitate care delivery

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Direct Contracting

Direct Contracting Entities

- Generally, must have at least 5,000 aligned Medicare FFS beneficiaries.
- "On ramp" for organizations new to Medicare FFS.
- Added flexibility for organizations serving dually eligible, chronically ill populations.

DC Participants

- Core providers and suppliers.
- Used to align beneficiaries to the Direct Contracting Entity.
- Responsible for reporting quality through the Direct Contracting Entity and improving the quality of care for aligned beneficiaries.

Preferred Providers

- Not used to align beneficiaries to the Direct Contracting Entity.
- Participate in downstream arrangements, certain benefit enhancements or payment rule waivers, and contribute to Direct Contracting Entity goals.



Geographic P8P option would be open to innovative organizations, including health plans, health care technology companies, in addition to providers and supplier organizations.

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Readiness Assessment

Readiness for PHM Strategies: Governance/Leadership

- Does leadership understand the model?
- Is there a high level of leadership buy-in and commitment to model such that leadership is willing to support the culture change and the effort needed to implement and sustain the model?
- Can staff responsible for implementing the change ask for and receive the resources they need?



Readiness: Clinical/Operational

- Is performance management part of the fabric of your organization?
- Are rewards tied to specific actions and outcomes?
- Do you have processes in place to deliberately manage quality and outcomes?



Technology/Data Infrastructure

- Do you have an EHR?
- Do you have a certified EHR, EMR capable of 2-way exchange of clinical information?
- Are you able to manage a longitudinal patient record?
- Do you have the ability to manage claims data from CMS?



External environment

- Do you have established, and strong referral partnerships i.e. are you a preferred provider to hospitals, bundlers or ACOs?
- Do you have engaged hospital, health systems and physician groups?
- Do you have a positive market reputation?



Key Takeaways

Successful organizations need to be able to:

- Be flexible, pivot when there are opportunities and challenges
- Broader vision across provider types and payment systems
- Ability to reorganize, manage change and execute



AHCA/NCAL Resources



Population Health Management Council

To convene and support long term care providers engaged in population health management initiatives.



1. Representation and advocacy with policy makers and regulatory agencies.



Technical assistance to existing plans and newly interested providers.



1. Data aggregation and analysis that demonstrate the LTC provider owned value proposition




1. Forum for collaboration and best practice dissemination



AHCA/NCAL Support

- Education/Analysis
- Population Health Management Basics
- Pre-recorded webinars and support documents on PHM models
- State Led Due Diligence of Provider-Owned SNPs
- State Facilitated Provider-Owned Integrated Care Networks
- Global Managed Care Strategy Evaluations
- State Environmental Scans

Save the Date



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