TEXAS LTC
VIRTUAL SYMPOSIUM

Trends, challenges and solutions in Texas skilled nursing

SEP 15-16, 2020

SESSION 1

Population Health

New Payment Opportunities Hidden in Plain Sight

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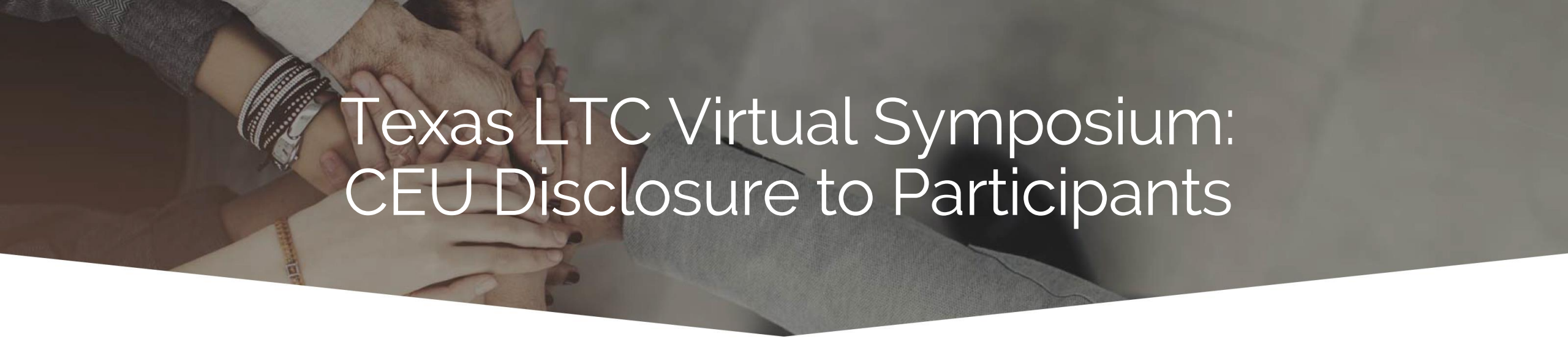

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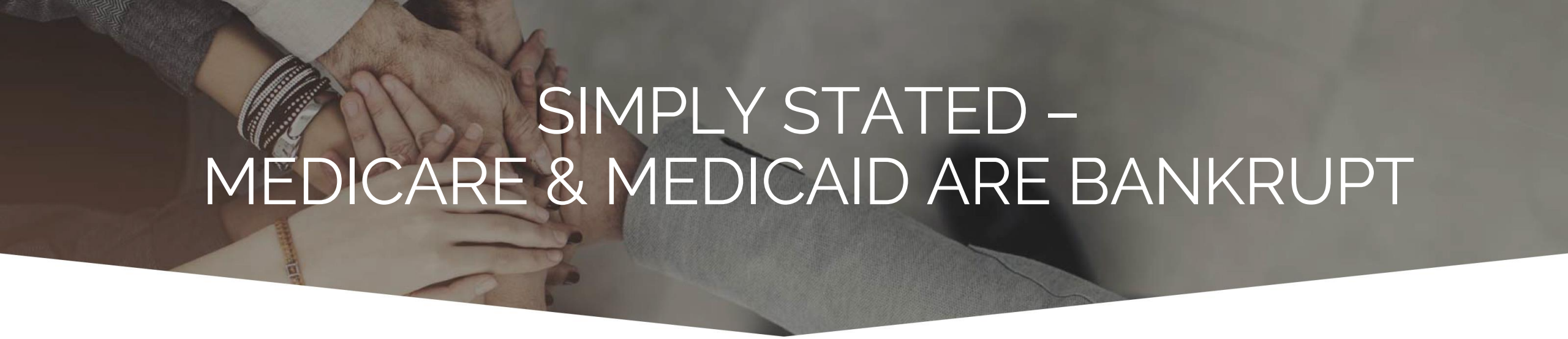
Definitions – Understanding what you read

ACO	Accountable Care Organization
CMMI	Cntr for Medcr/Mcaid Innovation
DCE	Direct Contracting Entity
FFS	Fee for Service
HEDIS	Healthcare Effectiveness Data & Info Set
I-SNP	Institutional Special Needs Pgm (MA Plan)
MA	Medicare Advantage Plan
MSSP	Medicare Shared Savings Pgm.
PCF	Primary Care First MSSP
PMPM	Per Member Per Month
RAF	Risk Adjustment Factor - HCC based
SIP	Seriously Ill Pop MSSP
MIPS	Merit Based Incentive Pmt Sys
HCC	Hierarchical Condition Category

Question #1– Will the Medicare Part A Trust Fund become insolvent? If so, when?

1. It will remain solvent under current funding
2. Between 2020 and 2025
3. Between 2026 and 2030
4. After 2031



SIMPLY STATED –
MEDICARE & MEDICAID ARE BANKRUPT

THE USA CANNOT DELIVER THE BENEFITS WE ARE PROMISED

CONGRESS EXPECTS CMS TO BE THE VILLAIN

Medicare Part A is financed through our Payroll Taxes.

Trustees of the Medicare Hospital Insurance (Part A) Trust Fund project ‘insolvency’ during Federal Fiscal Year 2026. At that time, Payroll Tax revenue will only cover 90% of projected expenditures.

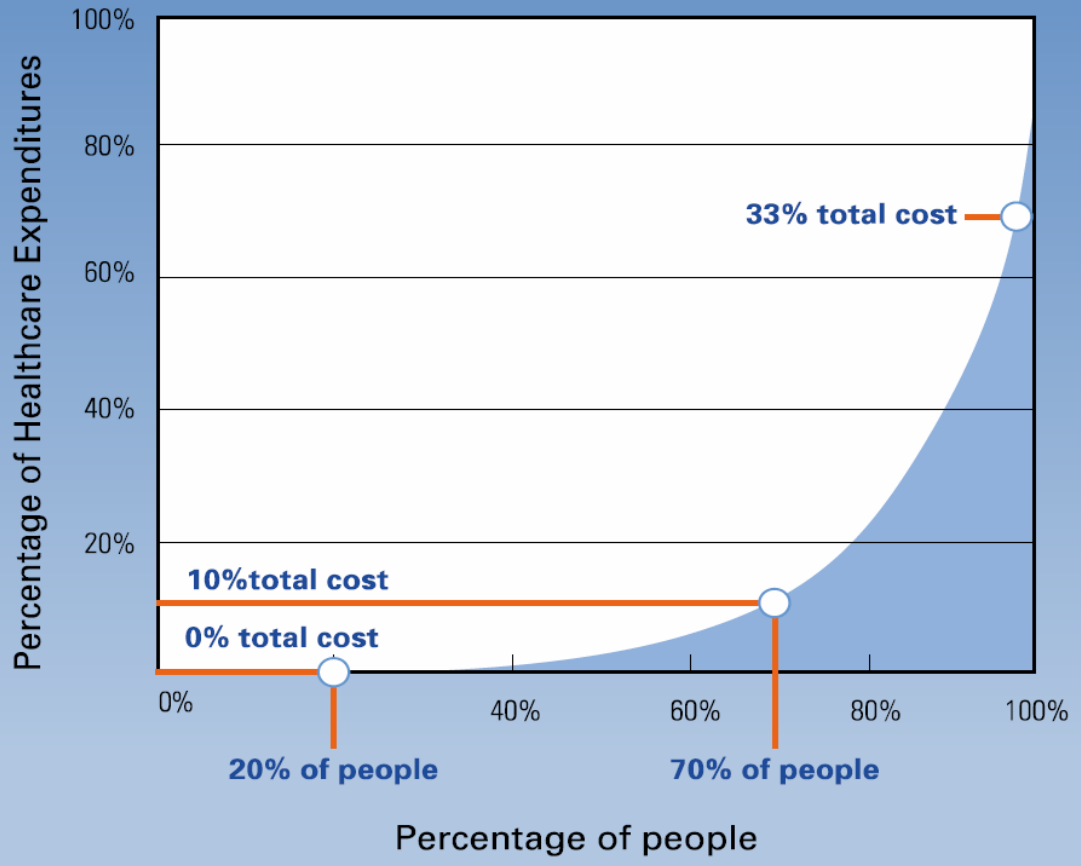
These estimates were based on projections prior to the COVID-19 Pandemic. Since the start of the Pandemic, Payroll tax revenue has dropped, and Part A expenditures are growing.

Doing the Numbers

BABY BOOMERS AND HIGH SPENDING ARE AT THE ROOT OF OUR CRISES

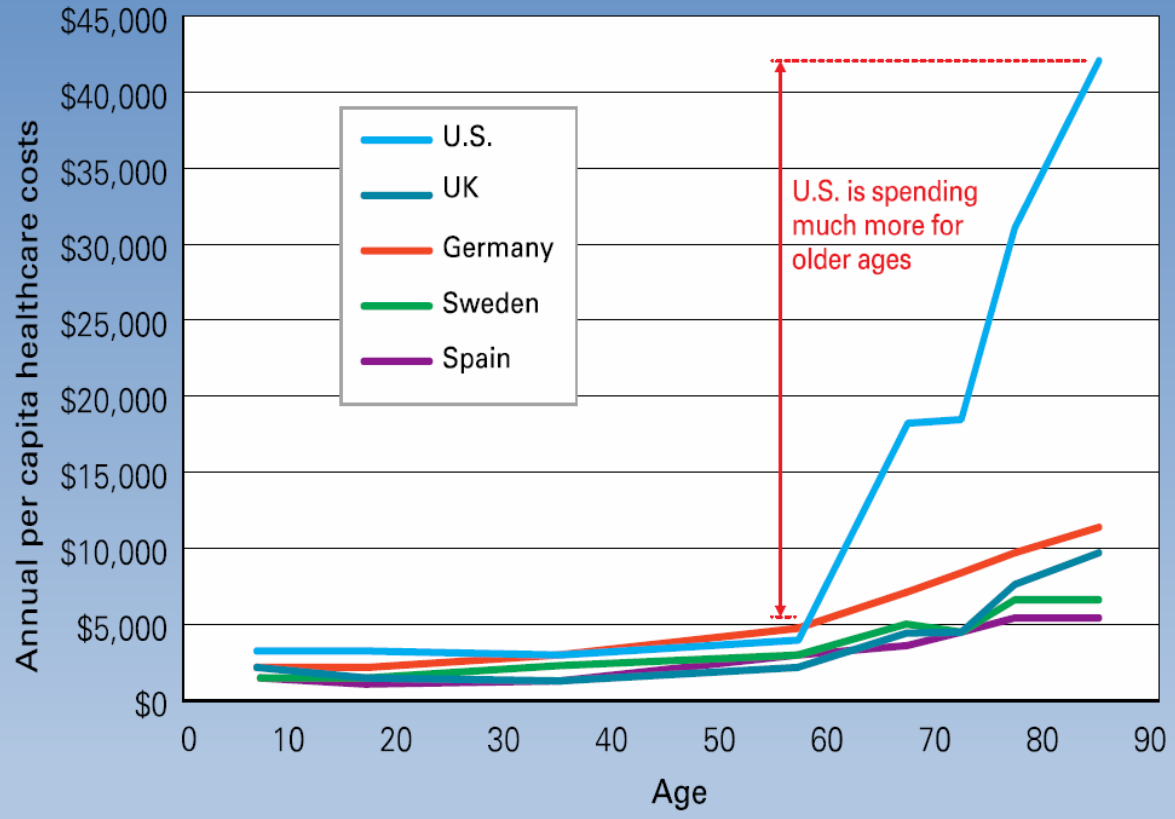
US Spending is Highly Concentrated

30% of people consumed 90% of cost



Source: Milliman USA Health Cost Guidelines— Claim Probability Distributions, Healthcare Will Not Reform Itself, George C. Halvorson, 2009.

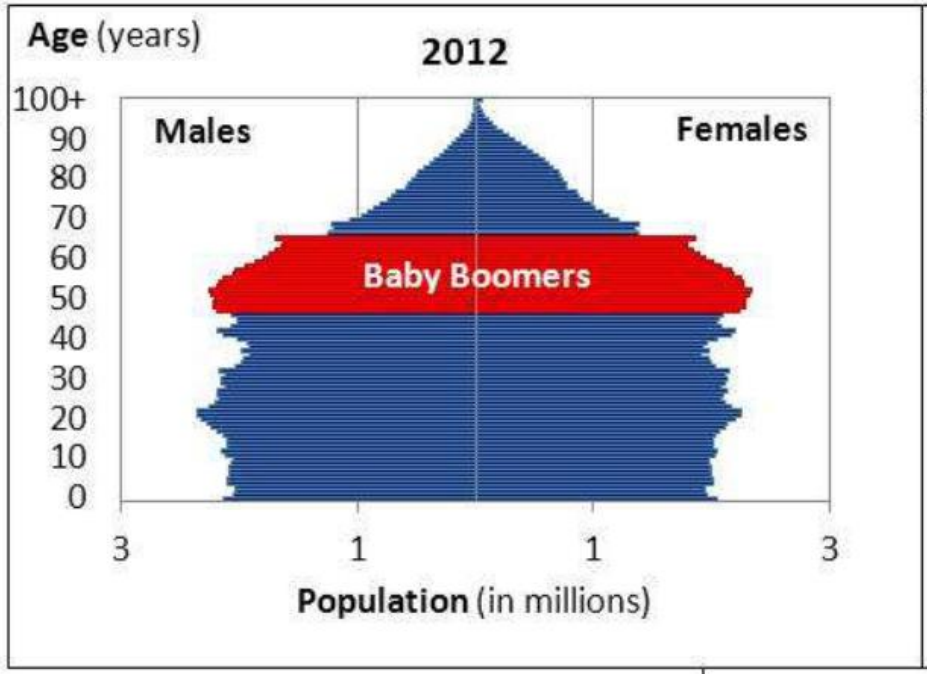
Per capita spend higher for ages 60+

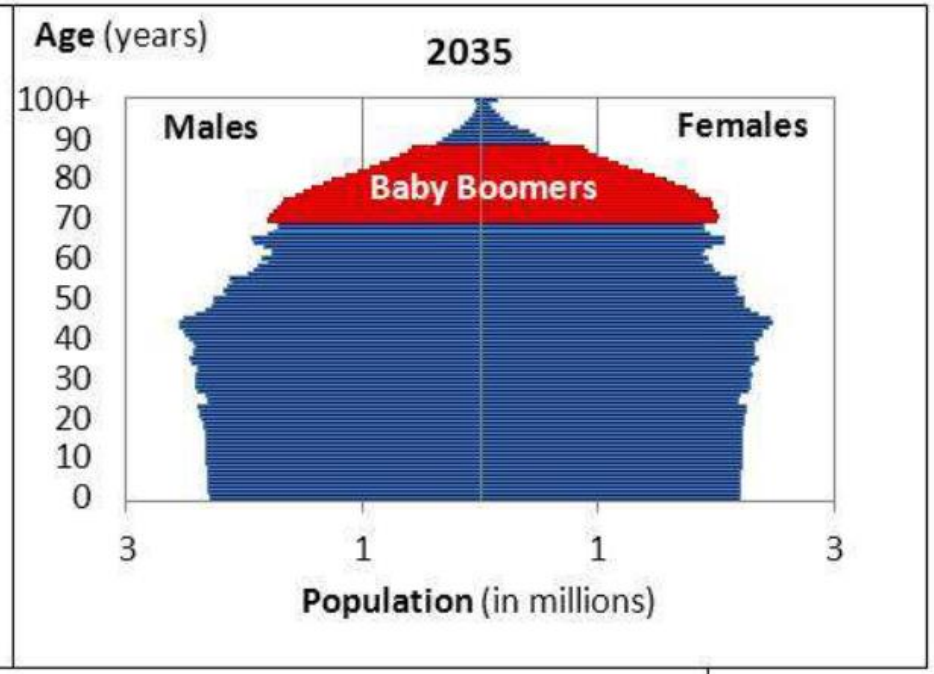


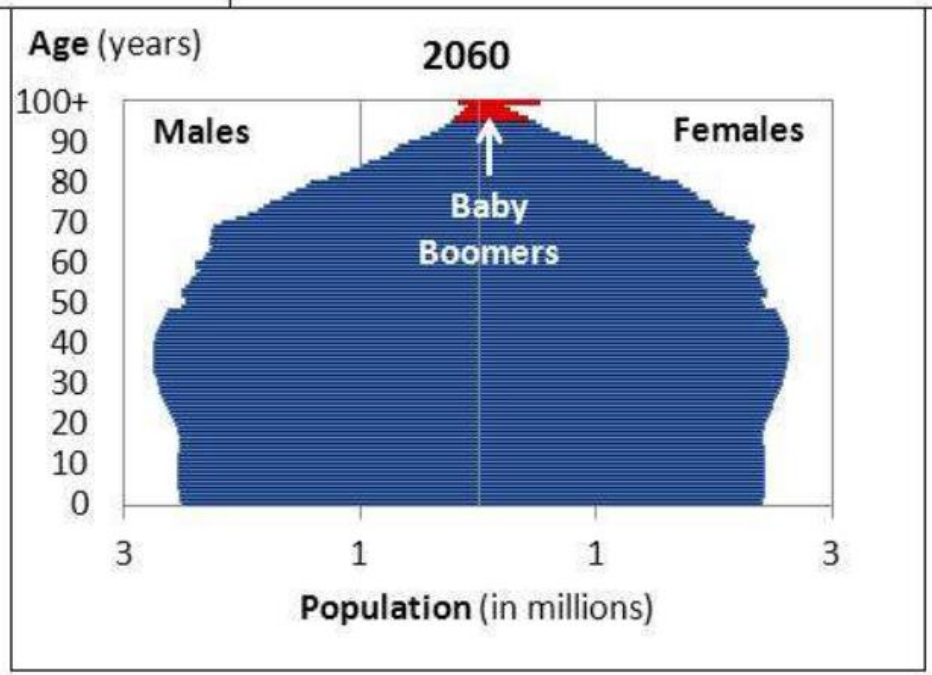
Source: Fischbec, Paul. "US-Europe Comparisons of Health Risk for Specific Gender-Age Groups." Carnegie Mellon University, September 2009.

*Source: KPMG: The Accelerating Transformation of US Healthcare: Forces, Implications, and Actions – Sept 2012

Population by Age and Sex: 2012, 2035 and 2060







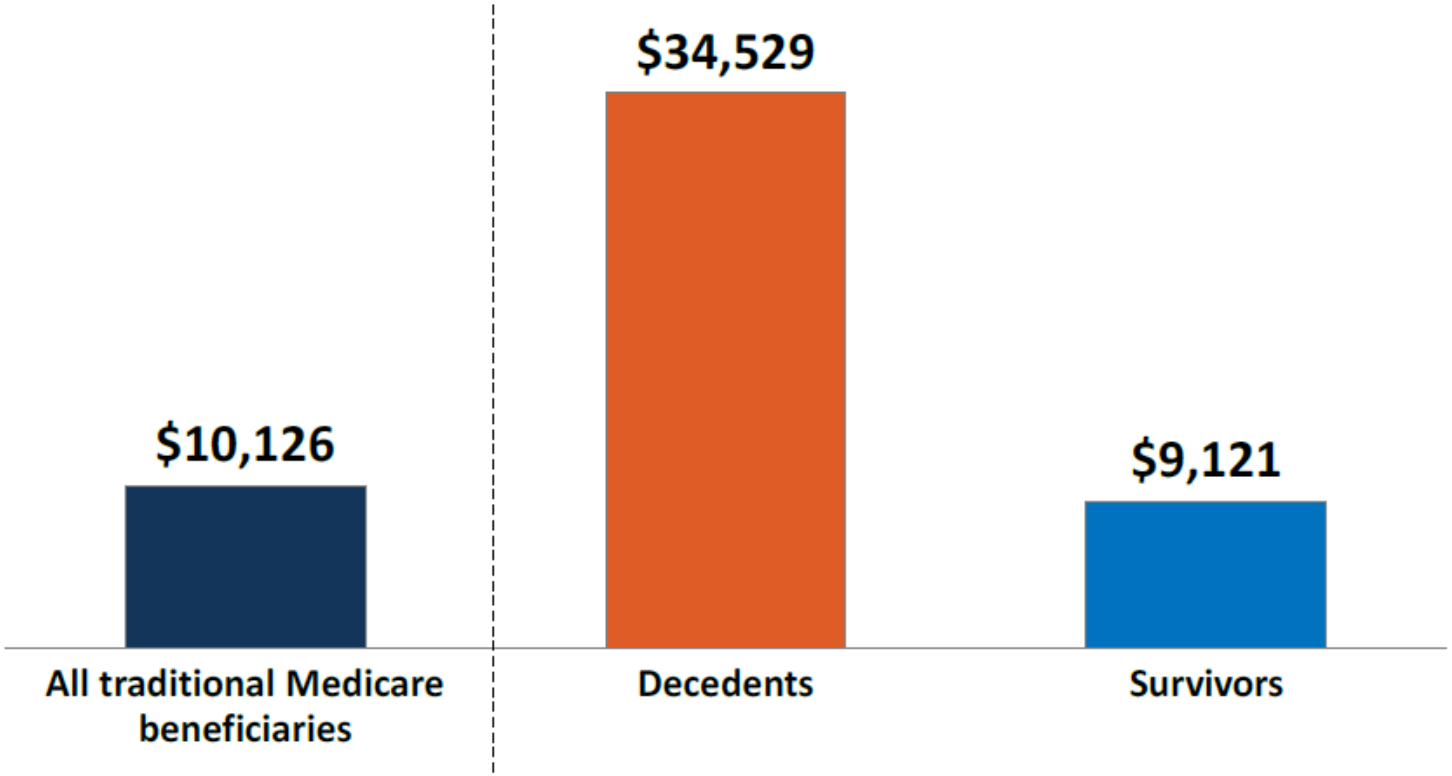
United States Census Bureau

U.S. Department of Commerce
Economics and Statistics Administration
U.S. CENSUS BUREAU

Figure 2

Medicare per capita spending was nearly four times higher for decedents than survivors in 2014

Average Medicare per capita spending for decedents and survivors in traditional Medicare, 2014



NOTE: Excludes beneficiaries in Medicare Advantage.
SOURCE: Kaiser Family Foundation analysis of a five percent sample of 2014 Medicare claims from the CMS Chronic Conditions Data Warehouse.

KAISER FAMILY FOUNDATION

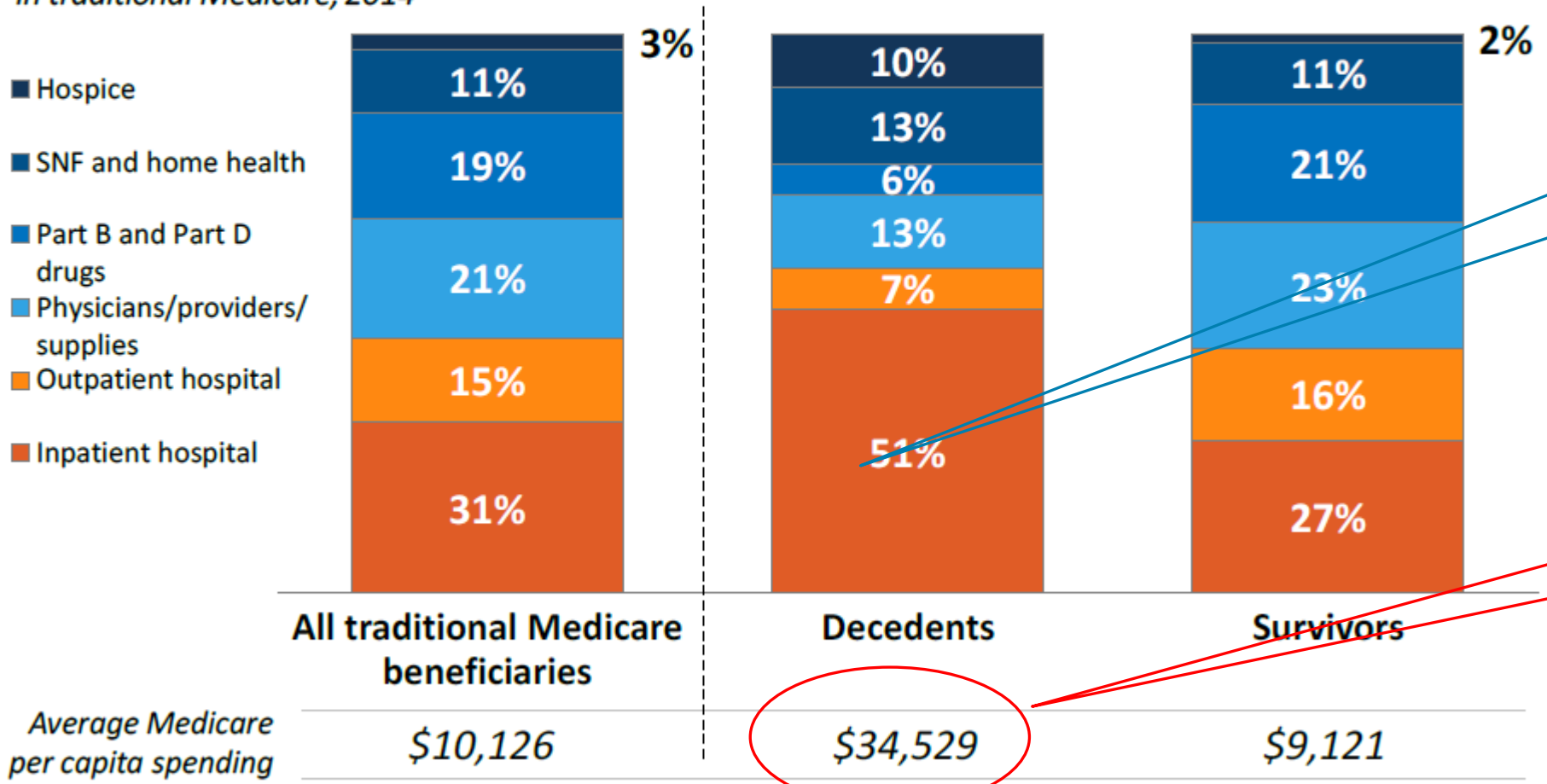
STATISTICS ARE TRICKY!

- 25% of all Medicare FFS Spending happens in the last 12 months of life.
- 13.5% of each year's spending is for decedents (those who died)
- In CY 2014 – 4% of Medicare Beneficiaries died.

Figure 6

Inpatient hospital care accounted for the largest share of per capita Medicare spending for decedents and survivors in 2014

Distribution of average Medicare per capita spending by type of service for decedents and survivors in traditional Medicare, 2014



NOTE: Excludes beneficiaries in Medicare Advantage. SNF is skilled nursing facility.

SOURCE: Kaiser Family Foundation analysis of a five percent sample of 2014 Medicare claims from the CMS Chronic Conditions Data Warehouse.

THE HENRY J. KAISER FAMILY FOUNDATION

Source of your Primary Opportunity

Can you lower this?

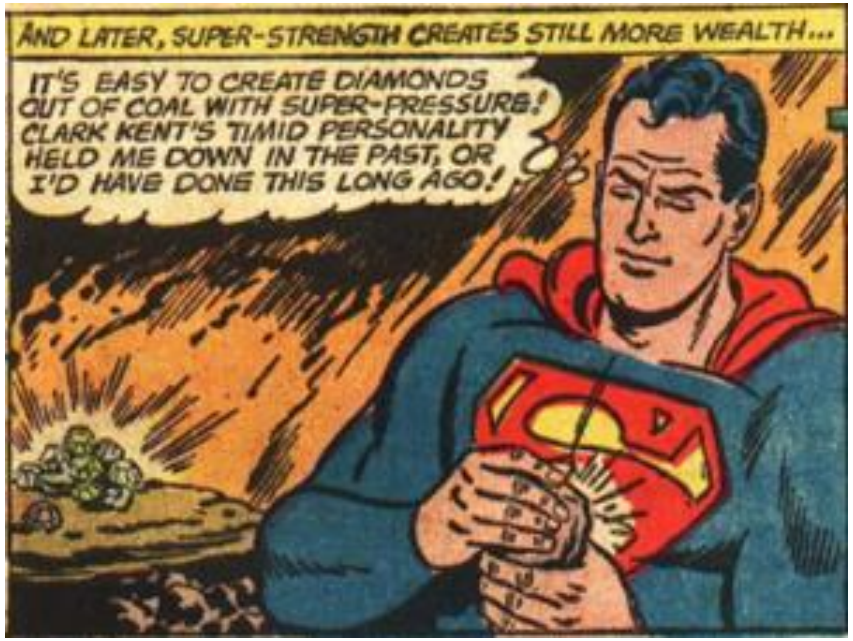
CMS will continue raising the pressure until cost per beneficiary decrease

- PDPM is budget neutral – rates will drop
- Medicaid rates for LTC are unlikely to keep up with ⬆ costs
- LTC Medical Groups face similar pressures

CMS's Goal:

Active Management of ***ALL*** Medicare Spending

Legend says high pressure turns Coal into Diamonds



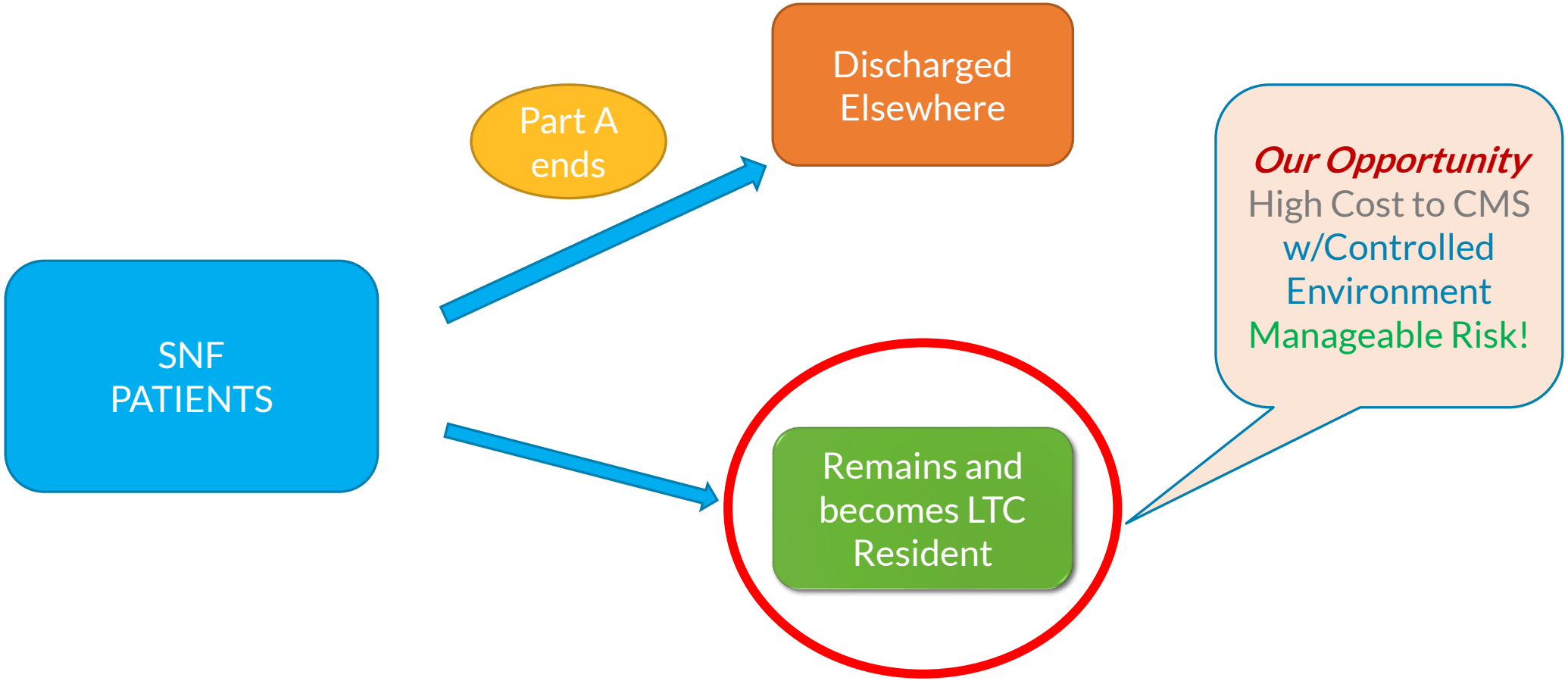
Accepting Annual Risk – the gateway to new revenues

CURRENT CHOICES

- INSTITUTIONAL SPECIAL NEEDS PROGRAMS
- ACCOUNTABLE CARE ORGANIZATIONS

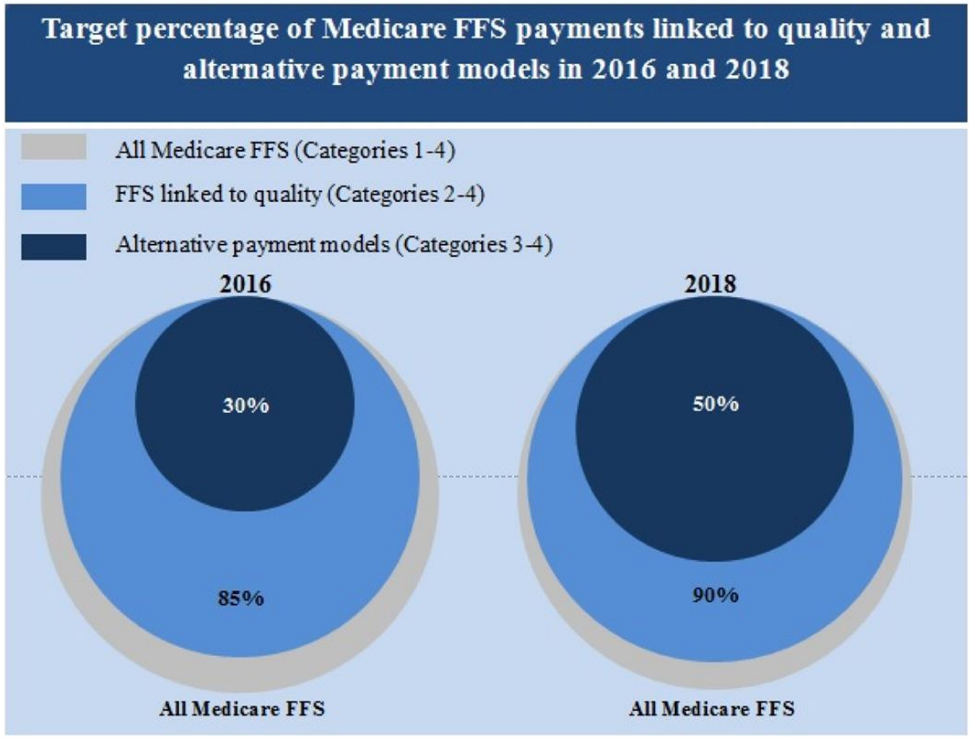
FUTURE OPTIONS?

- CMS INVITATION FOR A NEW LTC PROGRAM


SNF
PATIENTS
Part A
ends
Discharged
Elsewhere
Remains and
becomes LTC
Resident
Our Opportunity
High Cost to CMS
w/Controlled
Environment
Manageable Risk!

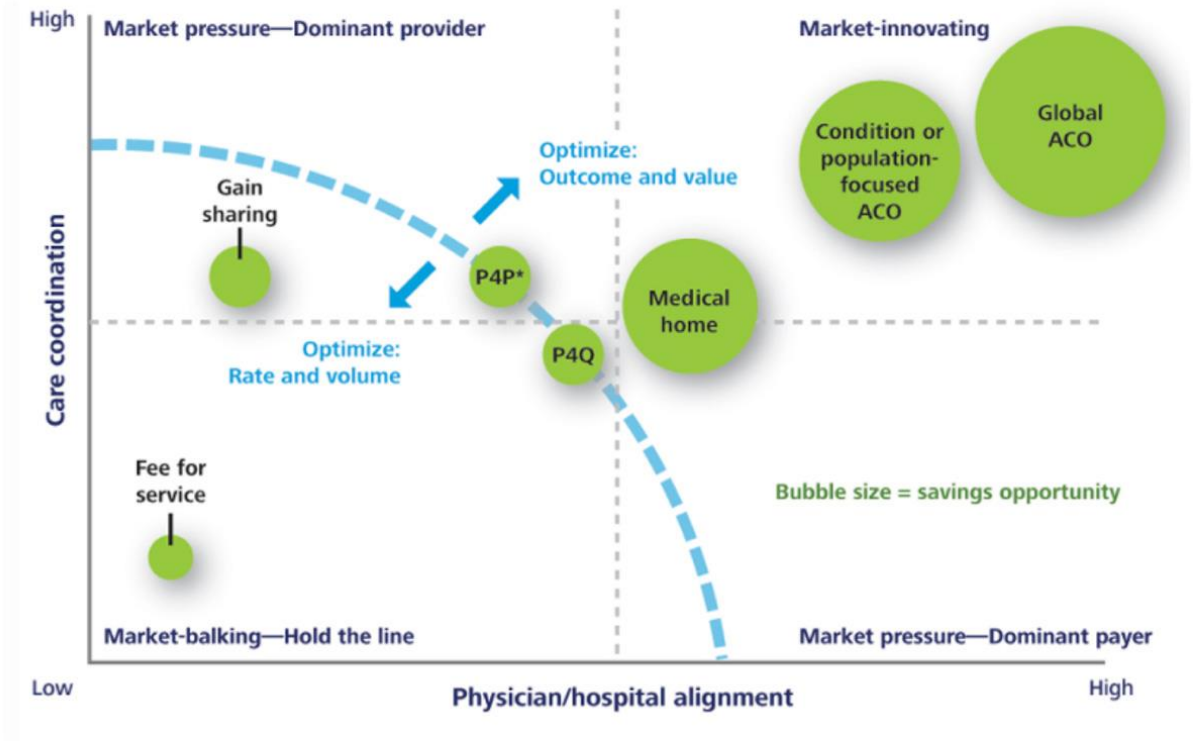
Primary Care will 'own' all patient costs
The Hospital will 'own' all inpatient/PAC $s

Figure 1 – CMS plans for shifting to value-based reimbursement



Success in Value Based Payment requires: Care Coordination, and Practitioner/Provider alignment

Figure 2 – Transitions to value-based payment models will vary by market



https://www.acc.org/membership/sections-and-councils/cardiovascular-management-section/section-updates/2018/01/18/12/07/the-transition-to-value-mostly-a-ripple-will-it-become-a-wave

Facility/Physician Partnerships create revenue and efficiency opportunities

REVENUE

- Better Coding – raises 'risk' adjusted payments
- Gainsharing on PMPM $
- Expand Part B Care Management Charges
- Greater % of all service $s paid to YOUR organizations

EFFICIENCIES

- Coordinated Coding raises payments in: PDPM, MSSP, and I-SNP
- LTC Staff can contract to provide Physician's Part B care management services.
- Teamwork lowers Hospitalization

In the LTC/ALF Settings – who is best suited to provide Care Coordination?

1. Individual and/or their Healthcare Agent
2. Case Manager Working for Insurance Co./Payor
3. Facility Nurses, Social Workers, & Therapists
4. Attending MD/DO/NP
5. All of the Above

Identifying the participants in Person Centered Care is the easy question to answer.

The most vexing question is – what does ‘Person Centered Care’ mean? LTC Settings are the ideal place to deliver person centered care using population health payment models – but it will require close collaboration between organizations which serve the same individuals, but answer to segregated regulatory schemes.

https://onlinelibrary.wiley.com/doi/10.1111/jgs.13866

What Time Frames are we discussing?

- COVID-19 *3-Day Stay* Waiver has greatly benefited some facilities
- Integrating with a Medical Group will require a year+ of effort.
- Joining a MSSP requires an enrollment – next window for 2022 opens in 2021
- If an I-SNP isn't present in your market, it takes 2+ years (and lots of $s) to get one in place.

ALL LTC RISK BASED PAYMENT MODELS REQUIRE YEARS OF PLANNING!

Proposition #1

Both Facilities and Medical Groups Gain from Partnership

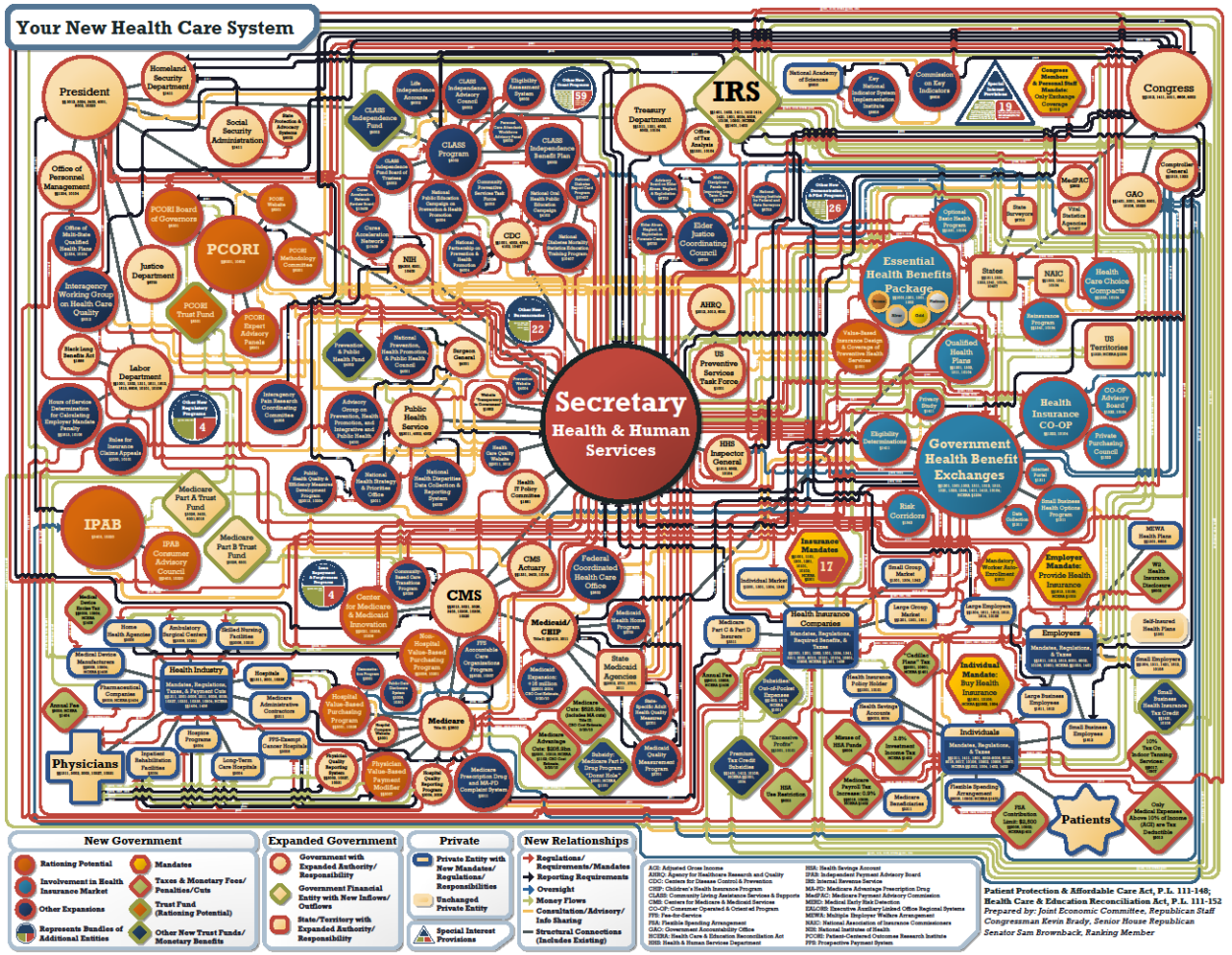
- Signed Physician Orders are a condition for all Facility Payments
- PDPM Dx require Medical Record Documentation
- D/C from SNF episode is key knowledge for Medical Group's manager
- Part B reimburses Medical Practices for (some) facility tasks
  - Care Management, wound care, advance care planning, etc.
- Facilities can provide a foundation for Physicians' assumption of Risk
- Collaboration can significantly reduce Hospitalizations

Proposition #2

A Facility/Physician Partnership starts before a Patient's Admission

- A stay's first 3 days are those with the highest risk of rehospitalizations
  - Adverse Drug Events contribute to >33% of all rehospitalizations
- PDPM is 'budget neutral' but the facilities with the best ***documented*** coding will avoid losses
- The same codes that↑PDPM rates also add value to Physicians and Medicare Advantage Plans (higher RAF)

The opportunity is buried in our System's complexity



What's More Complex than operating a SNF?

- State Licensure
- Survey & Certification
- MDS
- PDPM

Risk Based Population Health Payments are nothing more than:

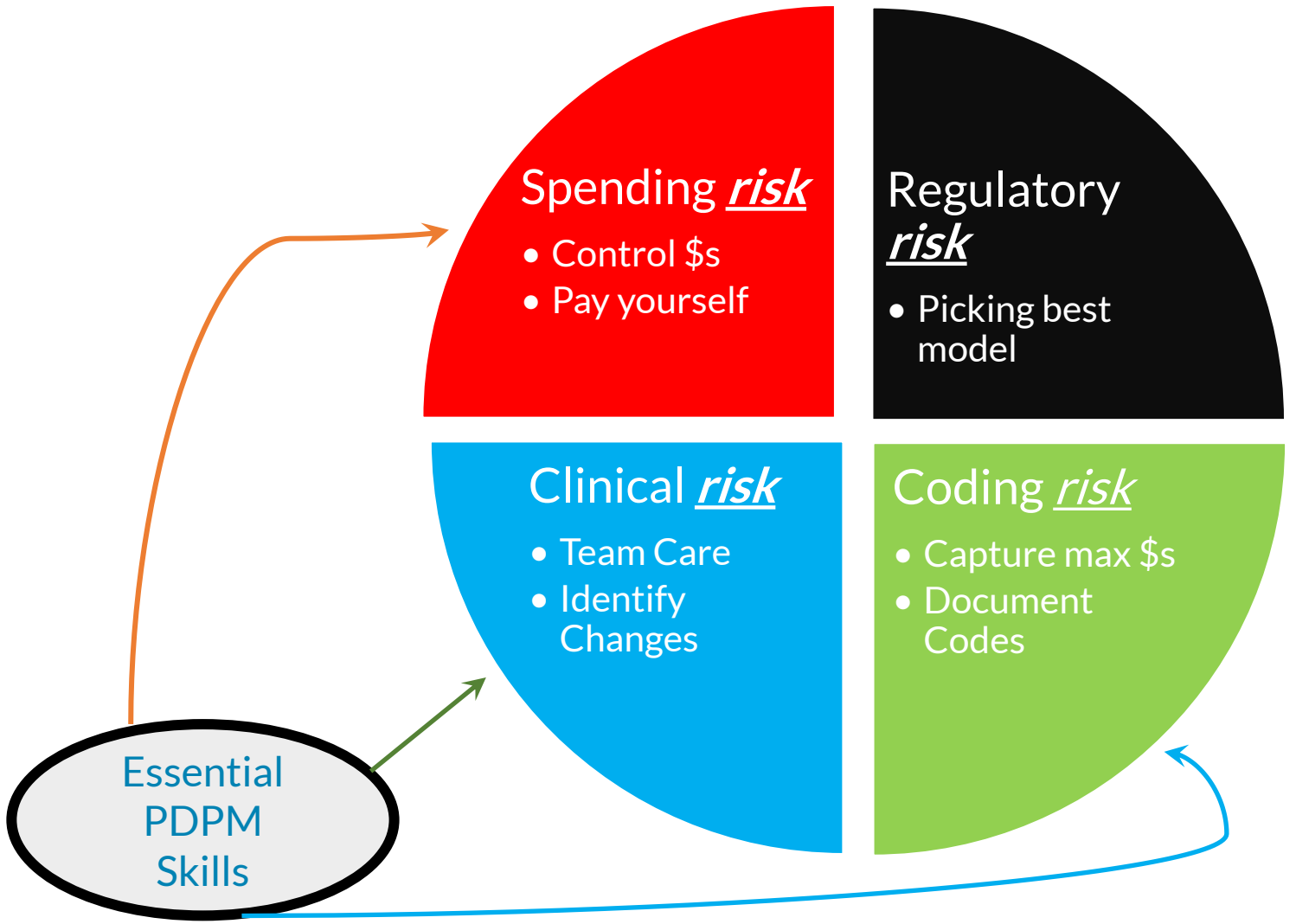
new payment schemes for residents you already treat -

using the same regulatory principals you live and breathe every day!

Why consider Population Health?

- SimpleLTC's leadership wanted to offer you new ways to think about our customer-patients.
- PDPM and Covid-19 – highly uneven effects on senior care providers
- Limited options to improve revenue/profitability in traditional Medicare/Medicaid/Self-pay.
- CMS, States, and retirees are increasing cash-strapped
- Your LTC Residents are among highest $ Medicare beneficiaries.

THE 4 ***Rs***


Spending *risk*
• Control $s
• Pay yourself
Regulatory *risk*
• Picking best model
Clinical *risk*
• Team Care
• Identify Changes
Coding *risk*
• Capture max $s
• Document Codes
Essential PDPM Skills

FACILITIES ARE NOT ALONE – PHYSICIANS ARE FACING THE SAME STORM

FFS Medicine -There are no safe harbors

In 2021, PALTC Medical Groups are facing an **<8%>** Fee Cut!

- Focused exclusively on Ambulatory Beneficiaries
- CMS is oblivious to LTC Residents
- NO Shared Savings Payment Models Designed for SNF/NF/ALF

100 Bed Nursing Facility – **Facility** POV

- 20 Skilled Beds
- Medicare A SNF payments
- 20 admits/month 30 Day ALOS
- 85% D/C to community
- 15% convert to LTC
- 80 LTC Beds
- Medicaid Per Diem @ $180
- Monthly Turnover @ 3 deaths or D/C
- Texas QIPP $s are only revenue enhancements

100 Bed Nursing Facility – **Medical** POV

- 20 Skilled Patients– POS 31
- Medicare Part B Fee for Service @ ~$200/month
  - **Role is as 'medical consultant'**
  - Minimal financial risk
- MIPS ***Quality*** Scores govern any payment ***adjustments***

- 80 LTC Patients – POS 32
- Medicare Part B FFS @~$100/month
  - **Role is Primary Care**
  - Financial Risk for Total Cost of Care
  - @ ±9% their FFS $s
  - Benchmarked against ambulatory primary care **– UGH!**

ARE THERE OPTIONS?

- Yes – but none are ideal
- Nothing is designed for LTC Population Health via the Provider/Practitioner

What do I do first?
Get advice! – this list is not exhaustive!!

Organizational Assessment	ANNE TUMLINSON INNOVATIONS, LLC	https://atiadvisory.com/
I-SNP options from the Facility POV	AHCA – VP of PopHealth Mgt	Jill Sumner - jsumner@ahca.org
National SNP Organization	SNP Alliance	https://www.snpalliance.org/
LTC Focused ACOs	LTC-ACO (formerly Genesis Phys. Serv.) Jason Feuerman jason.feuerman@ltcaco.com	CareConnectMD Tom Haithcoat tHaithcoat@careconnectmd.com
National ACO Organization	National Assn. of ACOs	https://www.naacos.com/

CURRENTLY OPERATIONAL in LTC Settings

• **I-SNP (Medicare Advantage for SNF 'eligible' LTC Residents)** ○ Capitated $ up front monthly ○ Rates based on LTC Patient Spending History ○ Defined group of beneficiaries ○ Typically part of a larger MA plan ○ Quality Scores add bonuses ○ ISNP pays all claims	• **Requires an State 'insurance' License, bonding, and new regulations** ○ Capital Intensive ○ Traditionally employs NPs (only for enrollees, not SNF) ○ Enrollment is a challenge ○ Economics requires 1,000s of Enrollees across all sites ○ Quality focused on Ambulatory (HEDIS) Measures ○ Hard to manage care based on Paid Claims
• **ACO – (Accountable Care Organization)** ○ FFS payments with retrospective settlement ○ Bills sent to Medicare A & B ○ Enrollment is easy/passive – via PCP Encounters ○ New for 2021 – Pick your own Quality Measures	• **Designed for Community Primary Care Medicine, not Facilities** ○ COVID created 'moratorium' on new ACOs for 2020 ○ Requires 5,000 lives: complicated care delivery network ○ Care Management across network is complex

NOT COVERED IN LTC – BUT WORTH EXAMINING LESS COMPLEX THAN I-SNP OR ACO

CMMI (center for medicare innovation) Alternate Payment Models	Focus in on younger/healthier populations (more years of savings)
○ PrimaryCare First/Seriously Ill Populations ▪ PCF – capture patients via 'Attribution' ▪ SIP – Capture Patients via enrollment	○ PMPM 'add-on' for primary care MD (LTC excluded) ○ Requires 100+ patients **per location** big hurdle for LTC ○ Higher PMPM 'add-on' – SIP describes LTC Population
○ Direct Contracting – Multiple Model Options ▪ Professional ▪ Primary Care Capitation ▪ Global	○ Like Medicare Advantage – but w/o an Insurance License ○ Allows DCEs (Direct Contracting Entities) ○ Capitated Payments ○ $ amounts depend on model chosen

What to do next?

1. How do you assess today's SNF/NF payment Models – are the sustainable long term?
2. If you have doubts, explore alternatives. Is risk-based LTC Population Health of interest?
3. If PopHealth is an option – what is your organizational role –
    1. Manager/Owner
    2. Partner
    3. Contractor
4. Who are your logical collaborators?
5. What service vendors (programmatic, HIT, actuarial/financial, etc.) are available?
6. Start your voyage!

Question #3
Do you see value in pursuing a LTC Population Health Strategy in your Institution(s)?

1. No Thanks – this has no interest for us.
2. We are intrigued with the options, but have a ‘wait and see’ approach’,
3. Our organization is already exploring, or has joined, a Population Payment model(s).
4. This is not applicable to my organization’s role in LTC.

Questions & Answers

PLEASE USE THE Q&A BUTTON TO
SUBMIT YOUR QUESTIONS

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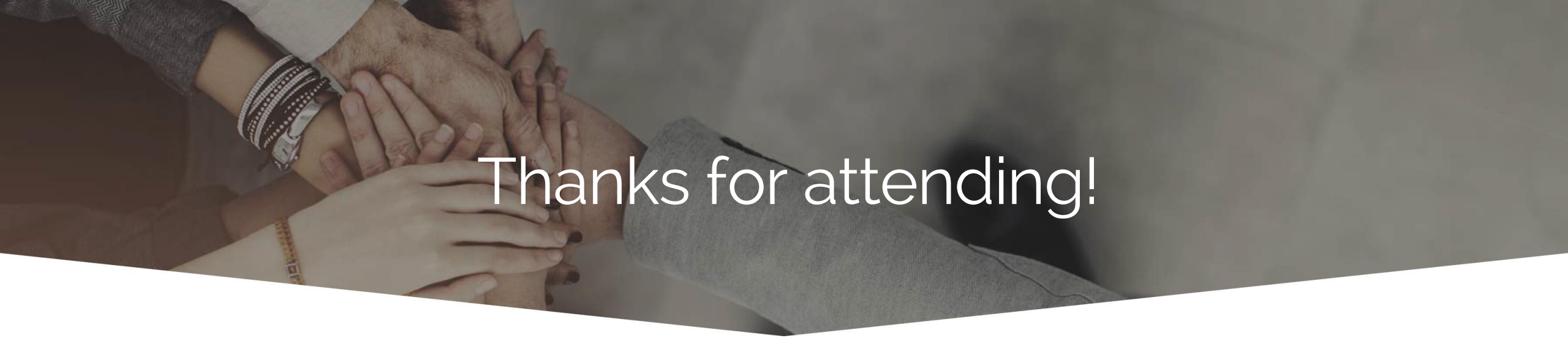
IMPORTANT! You will need to enroll as a CodeProU/Thinkific user before you can complete the evaluation. To enroll, click the purple "Enroll for free" button under the session title. Once you're enrolled, follow the steps to complete the evaluation and download your certificate. Your certificate can be downloaded as soon as the evaluation is complete.

Questions? Please contact Jill Miller at codeprou@selmanholman.com or 214-550-1477 ext 4.

Complete Session Evaluation



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