Washington-Alaska Chapter of HFMA

Spring Conference

Key Reform Strategies Facing CAHs :

An Interactive Case Study

Presented by:
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Health Care Reform
Connecting the Dots

LarsonAllen LLP
CPAs, Consultants & Advisors

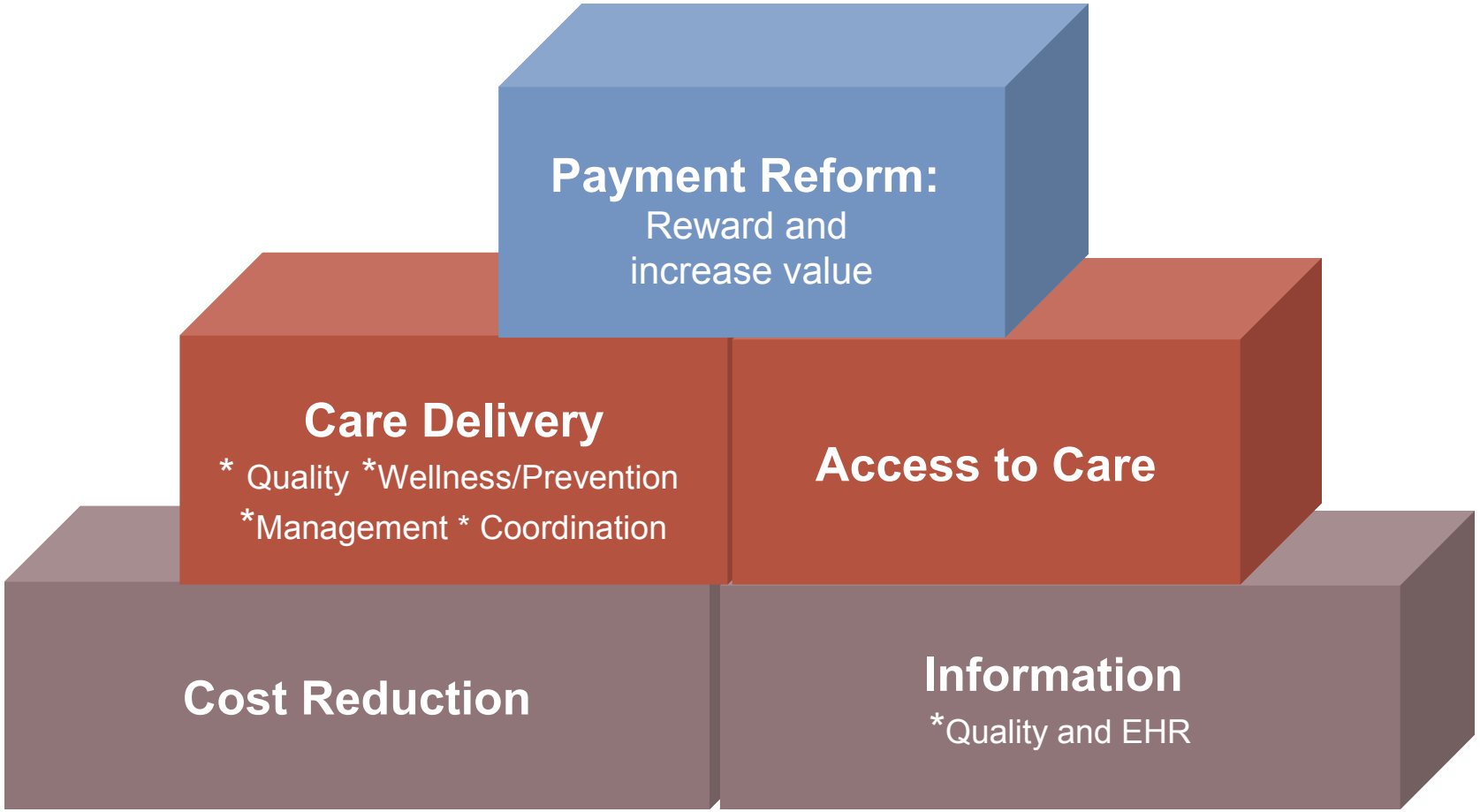
Discussion Overview

- Themes of Reform & Key Considerations
- Expansion of Coverage: An Overview of the Exchange Requirements
- Modeling the Impacts: Interactive Case Study
- Accountable Care: Substance Over Structure
- Modeling the Impacts: Interactive Case Study
- Discussion & Conclusions

Marketplace Trends: Health Care Reform – Is Reform Here to Stay?

- In the strict ACA sense of the word – Yes
- Will all relationships take the form of an ACO? – No
- Will Value Based Payment Reform happen? . . . Yes
- Should providers be developing the skill sets to be successful in a VBP environment? . . . Yes
- Will strong balance sheets, operational efficiency and high quality be critical success factors…Yes

Themes of Health Reform



Two Key Issues CAHs Should

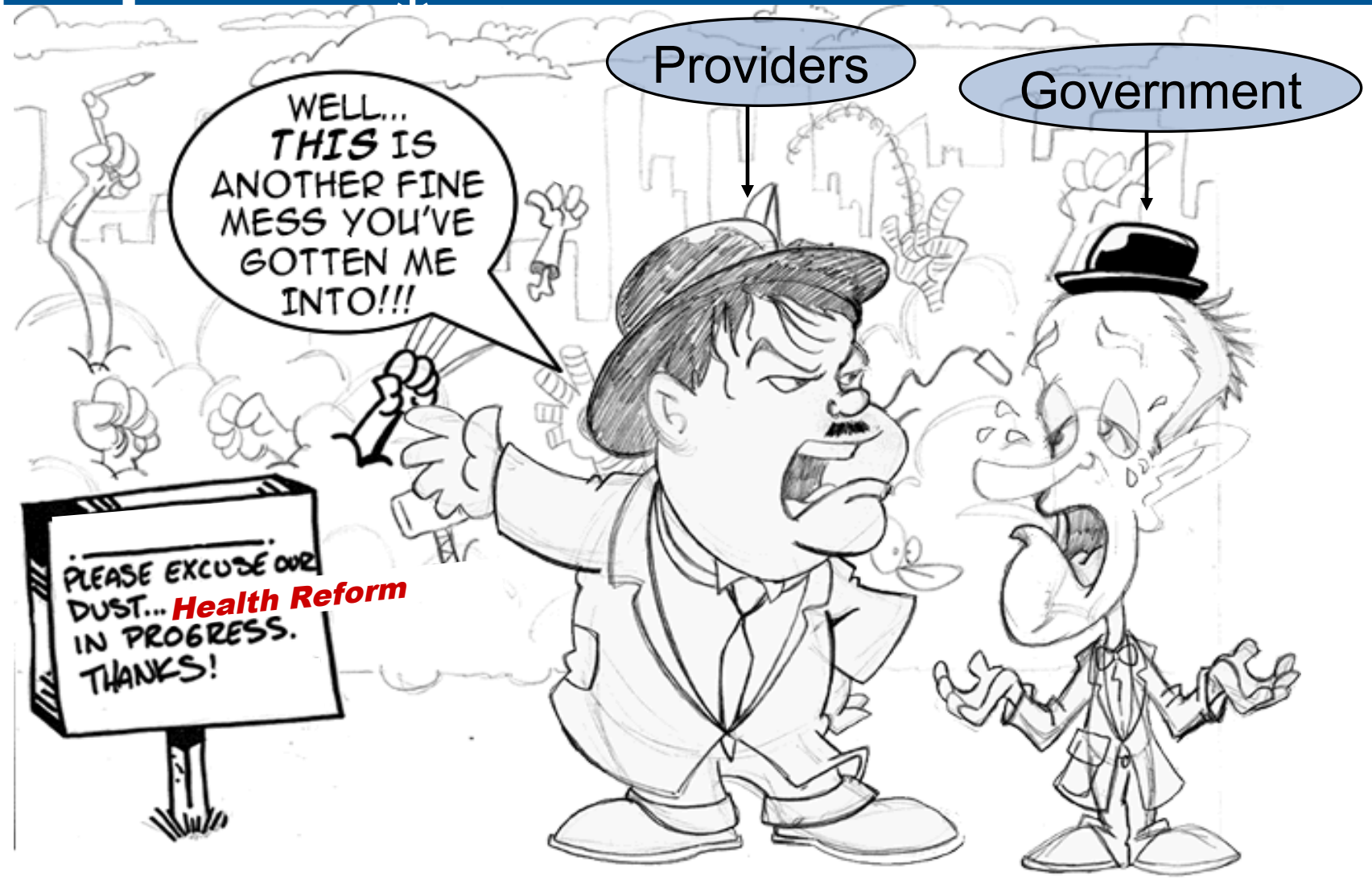
Expansion of Coverage

- Creation of Insurance Exchanges
  - ◊ Financial risk to providers of shifting payor mix
  - ◊ Who has control over the decision to switch?
- Expansion of Medicaid Eligibility
  - ◊ Is more Medicaid reimbursement a good thing?
  - ◊ Can states support expanded Medicaid populations?

Payment Reform Initiatives

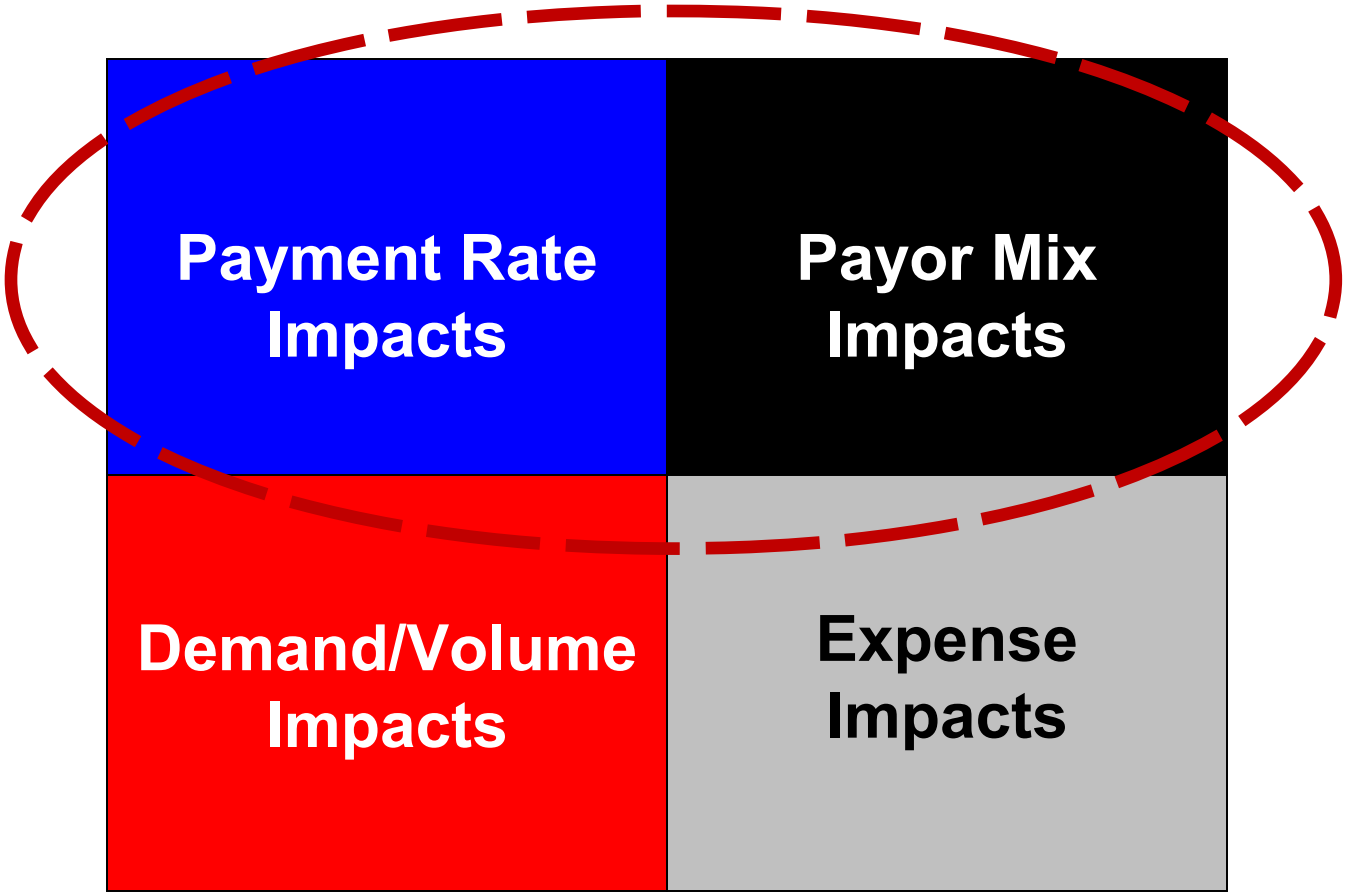
- ACOs
  - Provider Alignment
  - More than hospital & physicians
- Value Based Purchasing
  - ◊ Improving the Value of Care
- Bundled Payments
  - ◊ Financial Implications
  - ◊ Dividing the Dollars
  - ◊ What's included?
  - ◊ What's not included?

In the words of Laurel &



** Original cartoon created by Chris Flick at www.csf-graphics.blogspot.com or www.csfgraphics.com*

"Boxing" Federal Health Care



Expansion of Coverage:

An Overview of the Exchange Requirements

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Understanding Expansion of Coverage – Overview

- **Health Reform law seeks to expand access to health coverage by:**
  1) Expanding Medicaid eligibility
  2) Developing a new marketplace for purchasing insurance (“Exchange”)
  3) Mandating individuals enroll in health insurance
  4) Imposing penalties on large employers who do not offer coverage, or offer coverage that is unaffordable
  5) Subsidizing low and middle-income individuals in the Exchange
- **We believe providers need to understand the range of financial impacts as a result of this expansion?**

Greater Access: Coverage Expansion

- **Exchange Subsidies:**
  - **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)
  - **Eligibility:**
    - ◊ Individuals and families with household income between 133 - 400 % FPL
    - ◊ Unaffordable ESI > 9.5% HHI
- **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 ESI premiums for this group

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

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

What are State Health Insurance Exchanges?

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
- Intended to provide a more competitive market
- Provides consumers with a neutral party to assist with plan enrollment, information and eligibility determination for any subsidies

https://exchange.wisconsin.gov/

Who can participate?

- **In 2014, small employers** can offer an Exchange plan as their employer health plan
- **Individuals:** Includes self-employed or unemployed individuals (2014)
- In 2017, states can allow l**arge employers** to participate

- Each state must establish a health insurance exchange
- HHS Secretary to establish the rules around exchanges

Expanding access to health coverage: Employers

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 Exchange subsidies
  - Different penalties whether or not employer offers affordable, **"minimum essential coverage"** to employees
  - **Minimum essential coverage** = Plan with 60% actuarial value
  - **Affordable** = 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

Note:

* *-FT: Full time employee*

** *-PT: Part time employee*

Employer "shared responsibility" penalty

Penalty only assessed if a FT employee receives Exchange subsidies.

- **No or Inadequate Insurance Penalty**
  - $2000 x each full-time worker (after first 30 workers)
- **Unaffordable Employer Coverage Penalty**
  - At least, $3000 x # of full-time employees who receive exchange subsidies
  - Maximum penalty = $2000 x each full-time employee (except for first 30 full-time workers) penalty
  - No penalty for Medicaid eligible employees

Employees are not eligible for Exchange 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

Expanding access to health coverage: 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

- **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

HIP Calculator: Summarizing the potential impact

Impact of Employer Health Insurance Reforms		
Full-Time Employees	284	*(120 Insured / 164 Waived)*
Total Staffed	596	*(14 PT Insured/298 PT No ESI)*
2014 PPACA FTEs	439	

HEALTH REFORM KEY DRIVERS

Today's Single Coverage Employer Premium Cost

Average Single Employer Cost	$	5,090	
Employer Contribution %		*66%*	

Medicaid Eligible Employees

Total MA Enrollees		19	
Estimated Employer Cost Savings	$	223	*($000s)*

Employer Unaffordable Coverage Penalty

Subsidy Eligible Full-Time Employees		209	
Subsidy ($3,000)	$	3	
Estimated Subsidy Penalty	$	627	*($000s)*
% Total Full-Time Employees		*73.6%*	

Employer No ESI Insurance Penalty

Total Full-Time Employees		284	
Less: 30 Employees		(30)	
Adjusted Full-Time Employees		**254**	
No Insurance Penalty ($2,000)	$	2	
Estimated Subsidy Penalty	$	508	*($000s)*
2014 Pre Reform Projected HC Costs	$	*1,369*	*($000s)*
Estimated Net Savings	$	*861*	*($000s)*

HEALTH REFORM SUBSIDIES IMPACT ON HEALTH COSTS

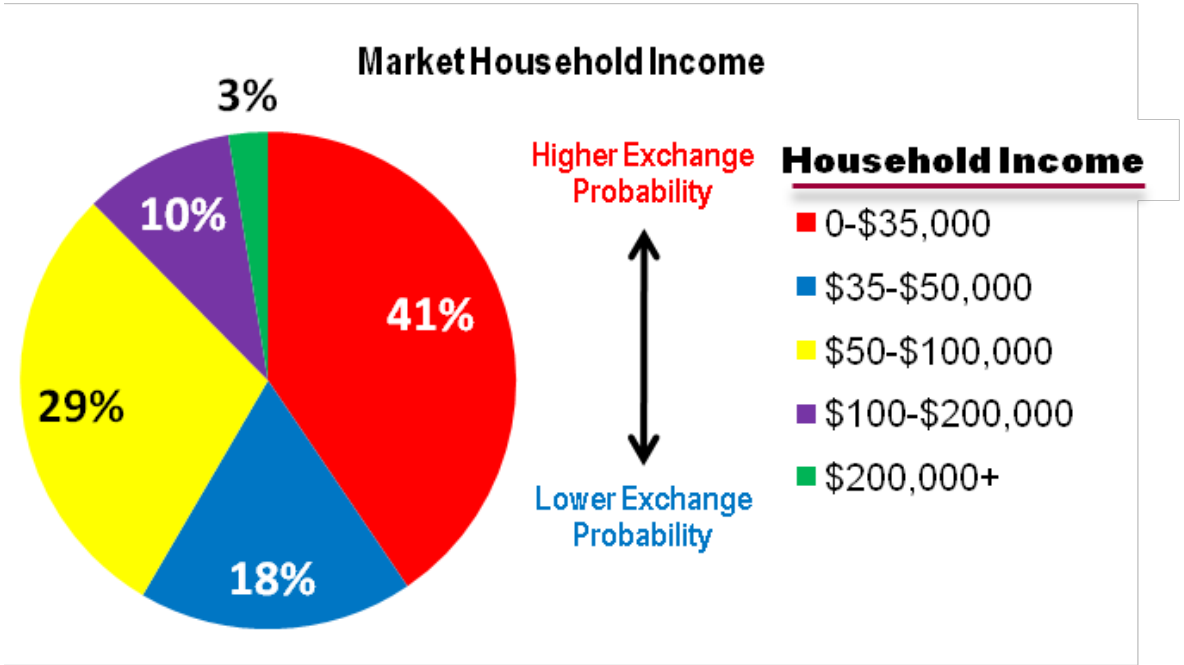
Mid Size Post Acute Provider ($000s)	Today's Cost	2014 Offer Coverage	2014 Drop/ Don't Offer
Baseline Premium Cost	$ 970	$ 970	$ 970
2011-2014 Premium Increase (9.0% / Yr)	-	399	399
Adjusted Premium Cost	970	1,369	1,369
PLUS: Additional Reform Impact			
Previously Waived FT Employees	-	1,035	-
Increased Employer Premiums	-	-	-
Penalty: Subsidy Eligibles & ESI	-	508	-
Health Reform Increased Cost	-	1,543	-
LESS: Previous Premium Liabilities			
Medicaid Employee ESI	-	(223)	-
Subsidy Eligible FT Employees ESI	-	(1,655)	-
Health Reform Decreased Cost	-	(1,878)	-
No Minimal Essential Coverage			
Less: 2014 Inflation Adjusted HC Cost	-	-	(1,369)
Plus: Subsidy Eligible Penalty	-	-	508
Health Reform No ESI Cost	-	-	(861)
Adjusted HC Costs	$ 970	$ 1,034	508
HC Cost Change to 2014 Projected		***$ (335)***	***$ (861)***
% HC Cost Change to 2014 Projected		***-24%***	***-63%***

Initial Observation Conclusions:

- The success of the exchange is more dependent on what **employees** do ➔ **employees will decide the fate of the exchange**
- Employees making less than 266% of FPL have the potential to have significantly more take home pay via the Exchange
- 5% to 10% shift to Medicaid possible in relatively low wage areas
- Even in relatively higher wage companies, 25%+ of employees who are subsidy eligible, could see more take home pay by moving to the Exchange for insurance

Exchange Market Factors:
Household Income

Displayed below is the household income distribution for a Sample County:

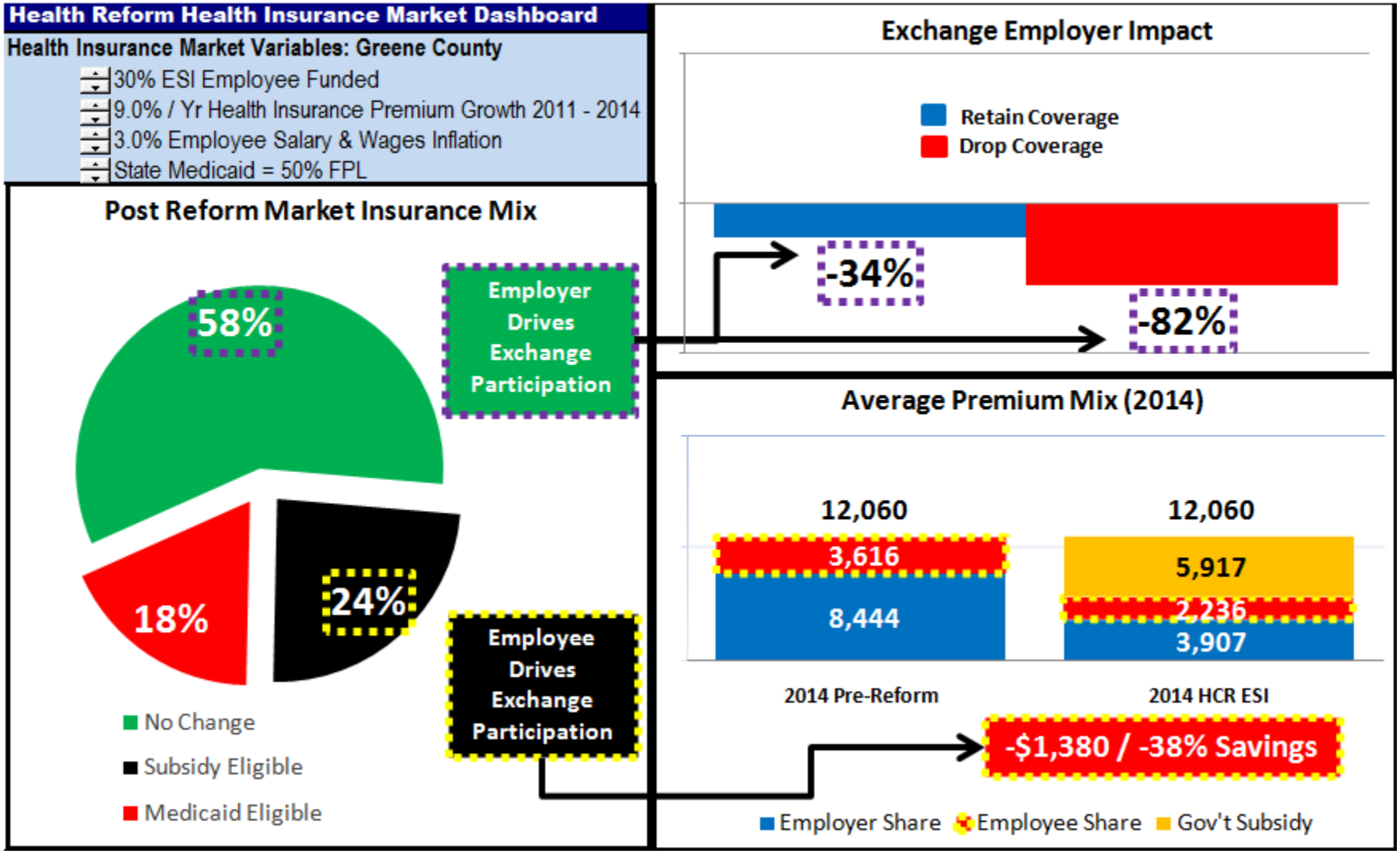


EXCHANGE IMPACT:

Exchange subsidies are largely determined based off an employee's **household income (HHI)**:

- **Single HHI**: **$10,890 - $43,560** 100-400% FPL
- **Family of 4 HHI**: **$22,350 - $88,400** 100-400%

Exchange Market Dashboard:
Initial Summary



Modeling the Impacts:

Should Providers Care?
Strategic Direction Impacts?

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Overview of "Sample Critical Access Hospital"

Financial

- $50M Operating Revenues / $70M+ Total Assets
- 5.0% Op Margin
- 170 Days Cash
- $25M Current Debt (38% Debt/Cap)

Operational

- Payor Mix: 28% MC /9% MCA/15% MA / 5% Self Pay / 43% Commercial & Managed Care
- 375 FTEs
- 26 Employed Physicians (Primary Care)

Situation Assessment - How Should We Proceed?

Where We've Been…

- **Growth:** 3% NPSR Growth *(declining admissions; flat clinic visits; declining surgical; mixed ancillary)*
- **Net Rates:** Limited Negative Spread (Commercial Cost Shifting)
- **Payor Mix:** Declining Traditional Medicare & Commercial/Increasing Medicare Advantage/Medicaid
- **Integration:** Limited Primary Care
- **Capital Investment:** No significant deferrals of capital

Discussion

Thoughts?

Accountable Care
Substance Over Structure

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ACOs: General Definition

A group of health care providers working together to manage and coordinate care for a defined patient population, that share in the accountability for the quality and total cost of that care.

ACO "Triple Aim"

- **Better Care**
  - Improve/maintain quality
  - Eliminate avoidable readmissions
- **Better Health**
  - Primary Care Driven
  - Focus on Prevention & Wellness
- **Reduce Cost**
  - Reduce/eliminate duplication
  - Improved coordination

"Medicare" Accountable Care Organizations

An Accountable Care Organization (ACO) can be:

- ACO professionals in group practice;
- Networks of individual practices;
- Partnerships and joint ventures between hospitals and ACO Professionals;
- Hospitals employing ACO professionals OR
- Other groups of providers of services approved by the HHS Secretary.

• Cannot include providers participating in other shared savings programs or demos or the Independence at Home pilot.

Possible participants:

- Hospitals
- Physicians
- Nurse Practitioners
- Physician Assistants
- Clinical Social Workers
- Dietitians/nutritionists
- Specialists
- Skilled Nursing Facilities
- Assisted Living
- Rehabilitation
- Home Health Care
- Integrated Health Systems

Proposed Medicare ACO Rules
ACO Eligibility

- **ACO Participants Defined**
  - **Eligible to Form ACO:**
    - Physician group practices
    - Networks of individual practices
    - Partnerships or joint ventures between hospitals and physicians/practitioners
    - Hospitals employing physicians/practitioners
    - CAHs billing under Method II
  - **Eligible to Participate in ACO:**
    - All other CAHs
    - FQHCs & RHCs
    - SNFs, comprehensive outpatient rehabilitation facility, home health agency, or a hospice

ACO formation will be predicated on physician and mid-level provider involvement

Modeled after the Physician Group Practice Demonstrations, which started in 2005.

Proposed Medicare ACO Rules

One-Sided vs. Two-Sided Comparison

DESIGN ELEMENT	ONE-SIDED MODEL	TWO-SIDED MODEL
Max Sharing Rate *Consists of:* *Max Quality Share* *FQHC/RHC Max Add-On*	52.5% *50.0%* *2.5%*	65.0% *60.0%* *5.0%*
MSR	2.0% to 3.9% Based on ACO assigned population	Flat 2% regardless of ACO size
Minimum Loss Rate	None	Flat 2% regardless of ACO size.
Shared Savings	Savings shared once MSR is exceeded; unless exempt, share in savings net of a 2% threshold, up to 52.5% max share rate.	Shared savings once MSR is exceeded; up to 65% of gross savings up to max share rate.
Shared Savings Cap	7.5% of benchmark, Years 1 & 2	10% of benchmark
Shared Losses	None	After 2% MLR; share in losses at rate of 1 minus quality score plus FQHC/ RHC add on up to annual caps of: Year 1: 5% of benchmark Year 2: 7.5% of benchmark Year 3: 10% of benchmark

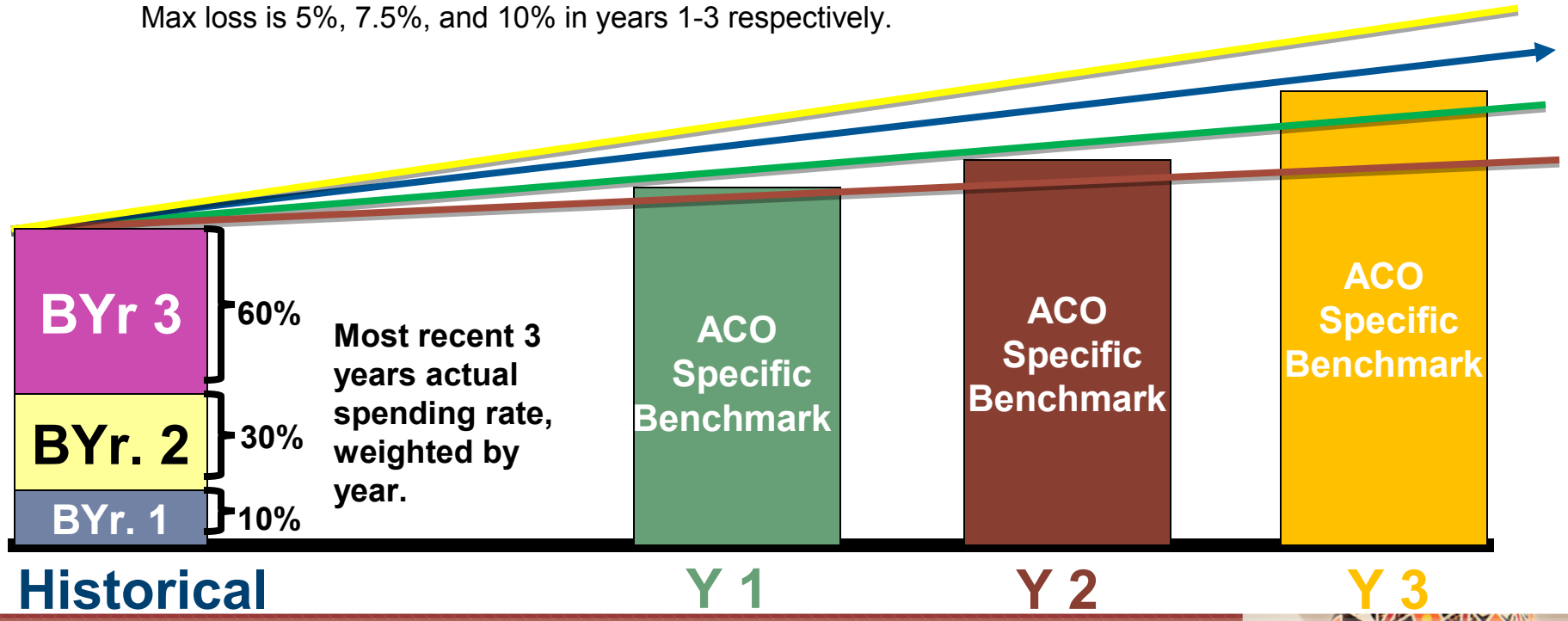
Proposed Medicare ACO Rules Determining Shared Savings

3 Year risk & growth trend adjusted expenditure per beneficiary spending rate. Projected and updated based on National FFS spending rate. Also referred to as “Benchmark”.

MSR based on ACO beneficiary population size, ranging from 3.9% to 2.0% for one-sided model; and flat 2% for two-sided model. For two sided model, savings starts at first $1 after MSR, with total savings in two-sided model capped at 10% of benchmark. One sided model must surpass add’l 2% net savings threshold to share in savings, unless exempted.

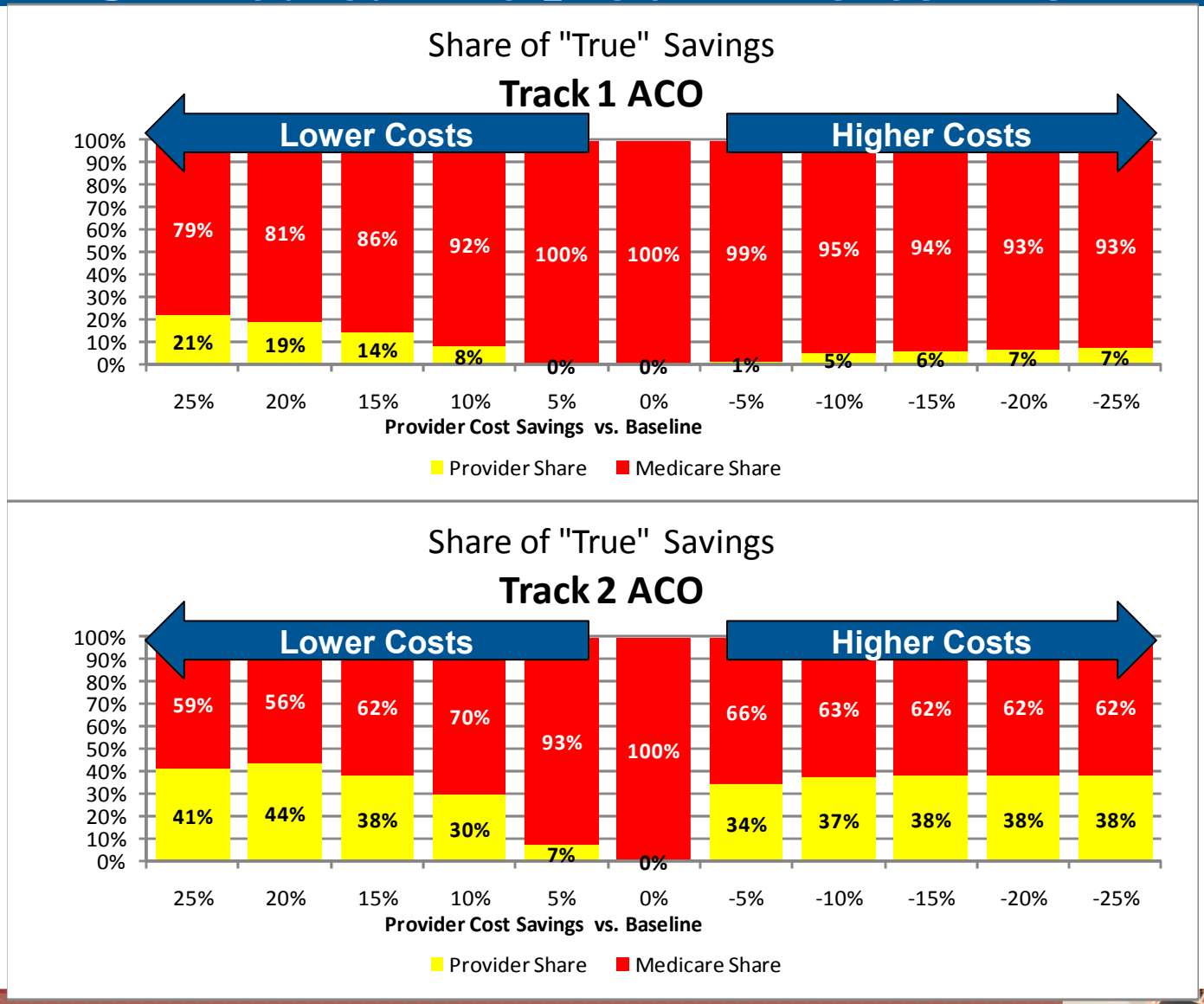
Net savings threshold, applicable to one-sided model only. First $1 savings starts after this threshold, unless certain exemptions are met. Savings for 1 sided model capped at 7.5% in Y 1 & Y 2.

MLR for two-sided model, set at 2% of per capita spending, updated for national FFS growth trends. Max loss is 5%, 7.5%, and 10% in years 1-3 respectively.

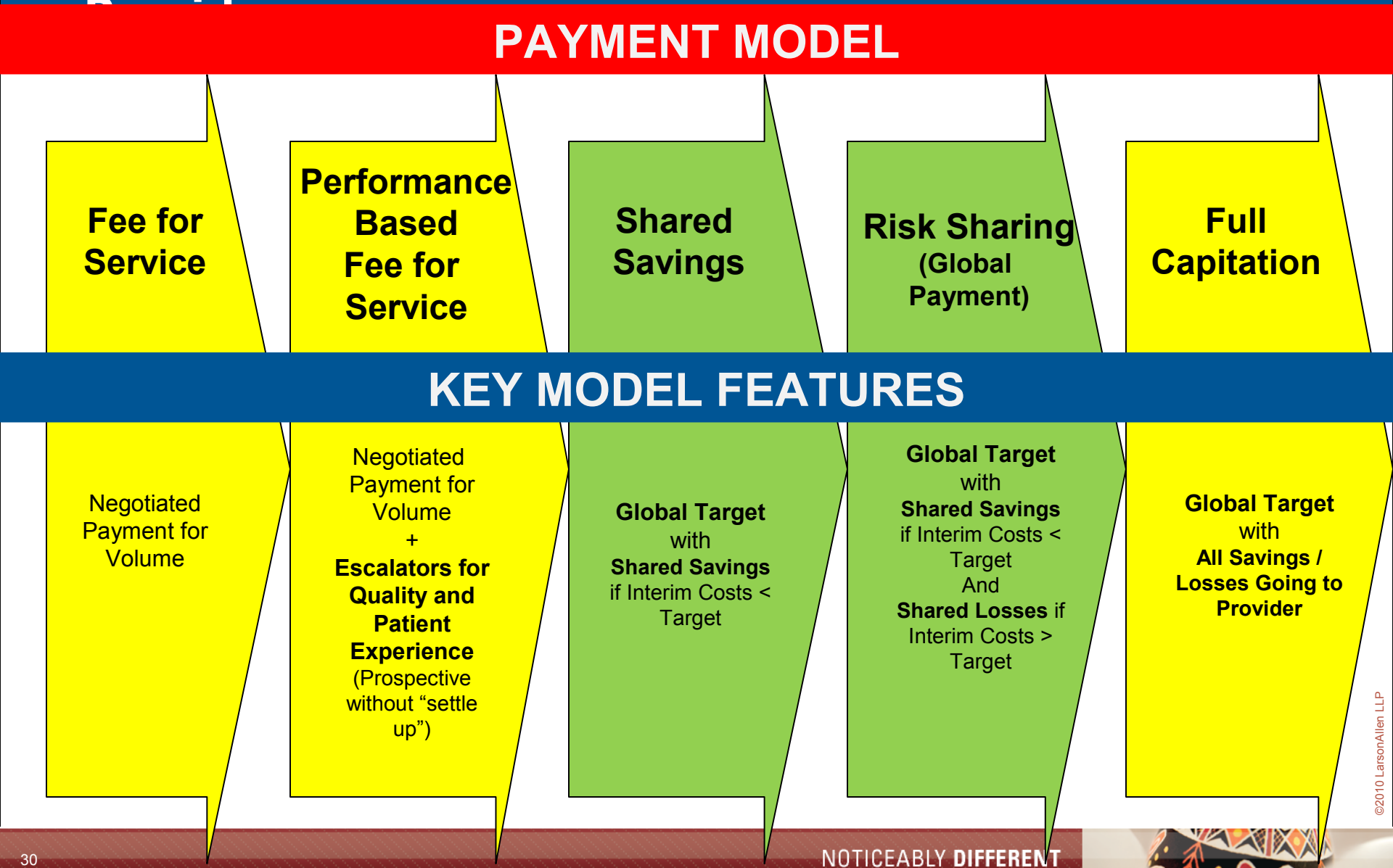


Provider vs. Medicare Share of "True" Savings

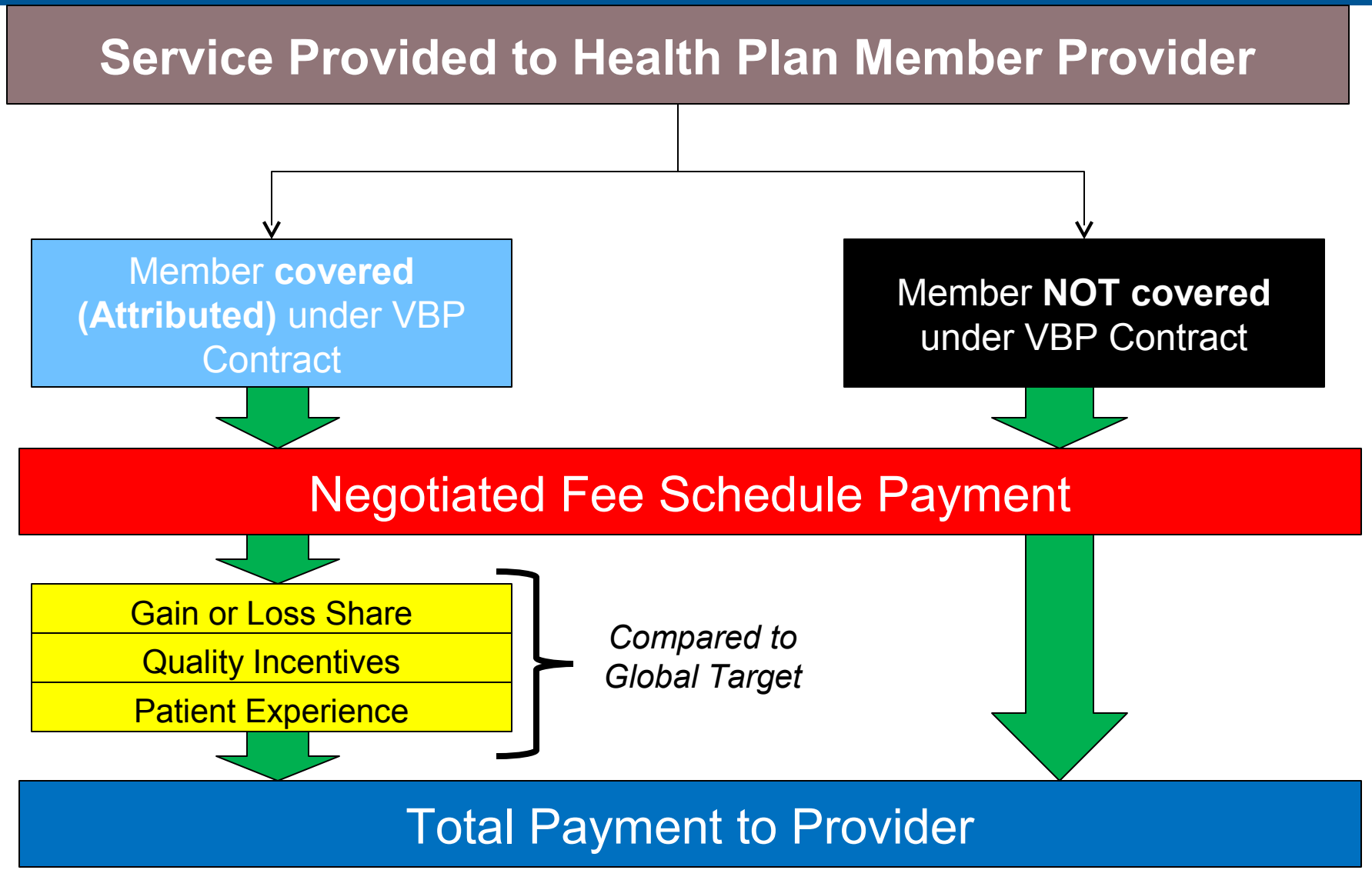
The BEST You Can Do➔ 90th + Percentile in ALL



Developing a Global Payment Model
Spectrum of Payment Models for Health Plans and



Payment Model Mechanics



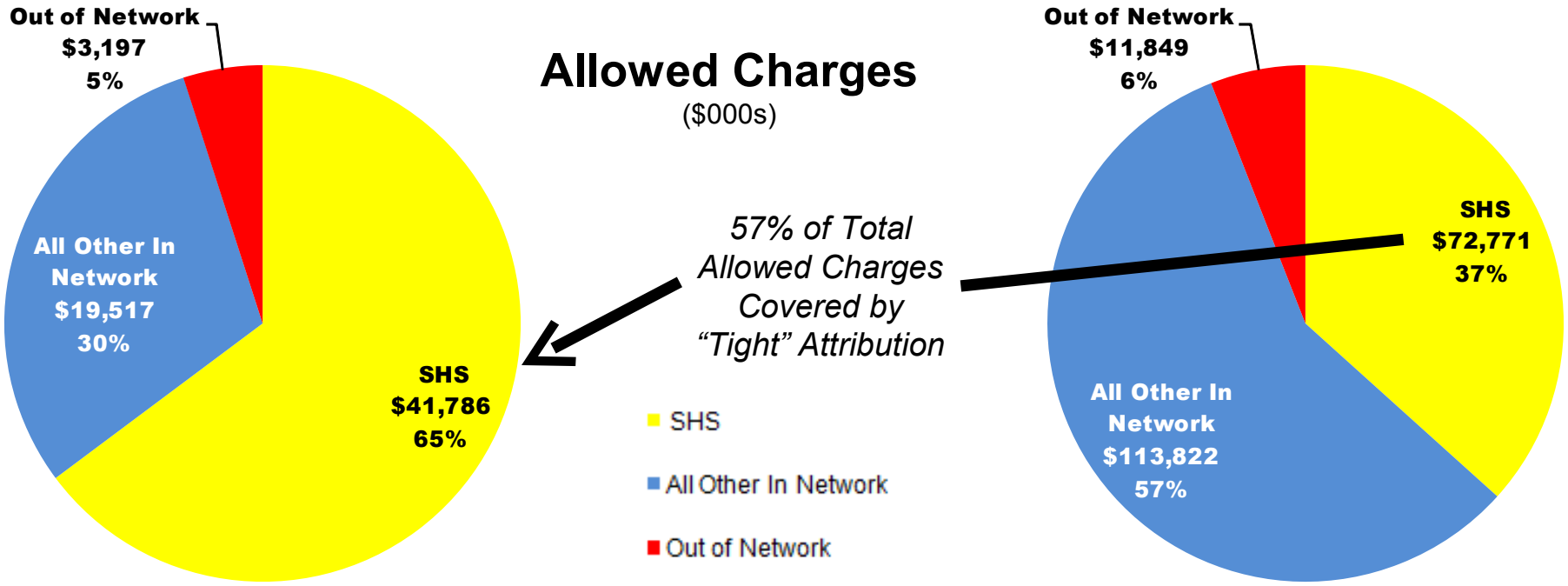
Understanding Attribution

($ in Thousands) Summary Service Groupings	Plan Allowed Charges	SHS Allowed Charges	Other In Network Allowed Charges	Out of Network Allowed Charges
ALLOWED CHARGES				
Physician				
Office Services	$9,183	$6,662	$2,410	$182
Inpatient Services	$502	$301	$158	$46
Surgical	$7,278	$5,403	$1,601	$334
Maternity	$552	$505	$51	$1
MH/AODA	$758	$123	$610	$32
Inpatient				
Inpatient Medical	$3,291	$2,338	$698	$256
Inpatient Surgical	$6,103	$4,010	$854	$1,239
Inpatient Maternity	$1,020	$935	$85	$0
Inpatient MH/AODA	$281	$73	$115	$94
Emergency Room				
Emergency Room	$2,854	$2,336	$394	$125
Outpatient / Ambulatory				
Outpatient Surgery	$4,895	$3,570	$1,169	$155
Outpatient	$5,339	$4,663	$494	$182
Hospital OP Lab/Rad	$5,203	$4,759	$297	$147
Other OP Lab/Rad	$6,994	$5,226	$1,625	$198
Therapy	$767	$540	$228	$6
Other				
Skilled Nursing	$111	$7	$103	$0
Pharmacy	$7,223	$0	$7,223	$0
Chiropractic	$1,010	$0	$903	$118
Miscellaneous	$911	$335	$501	$83
TOTAL	$64,275	$41,786	$19,517	$3,197
% of Total		**65%**	**30%**	**5%**
Members	13,323			
Member Months	142,536			

Example Global Costs – Attribution Models

- **"Tight" PPO Attribution**
  - Member or Provider Says
  - 75% E&M Costs at Provider
  - Member Affiliation
- 13,300 Members
- 142,500 Member Months

- **Full Scope of Payments to Provider**
  - Total Global Costs for any member with charges at Sample Provider
- 22,900 Members
- 275,000 Member Months



Modeling the Impacts:

The Value of Accountable Care & Shared Savings

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Accountable Care: Critical Success Factors for the

- Ability to Manage (and Reduce) Total Cost of Care
- Ability to Maintain and Improve Quality
- Member Attribution
- Gain / Loss Sharing
- Fee For Service Rates
- Quality / Patient Experience
- Maximum Limits on Contract Medical Costs
- Minimum Performance Standards
- Utilization Management Expectations
  - Contracting Providers
  - Other Providers
- “Keepage” Impacts

Focus on Substance, Not form; What Can We Expect?

We believe these 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**

CAHs Need to be Informed, Plan, & Implement

THANK YOU!

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For more information on health care reform, go to LarsonAllen's Health Care Reform Center at:

http://www.larsonallen.com/healthreform/

Follow our blog for current discussions on health care.
www.larsonallen.com/blog

Appendix:
Expansion Definitions & Mandates Overview

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Expansion Related Definitions

- **Employer-Sponsored Insurance** ("**ESI**") – represents the current health insurance coverage offered by an employer to its employees.
- **Health Insurance Exchange** ("**Exchange**") – an exchange is an insurance marketplace where individuals or certain small business employees can purchase insurance as part of a large risk pool. Each state must establish its own exchange or a federal exchange option will be provided. Four plan levels will be offered.
- **Full-Time Employee** – Working an average of 30+ hours per week, annually.
- **Waived** – A full-time employee who elects not to obtain health insurance through the employer. Future coverage decisions made by these employees will impact the employer's total health care costs.

Expansion Related Definitions (Continued)

- **Exchange Subsidy** – Individuals who meet the income and health insurance affordability criteria will be eligible for premium and cost sharing (e.g. deductibles, co-payments) subsidies in the **Exchange.**
  - **Affordable Insurance** – Employee premium cost is less than 9.5% of Household Income.
  - **Household Income (HHI)** – An employee's adjusted gross income (AGI) as reported on their annual tax return. The baseline simulation uses employee taxable wages as a proxy for AGI (EXCLUDES spousal income). Alternate scenarios can be considered. HHI will be assessed in relation to FPL to determine eligibility for **Exchange** subsidies.
  - **Federal Poverty Level (FPL)** – Government-established income thresholds used to determine eligibility for assistance through various federal programs.

Expansion Related Definitions (Continued)

- **Penalty** – Assessed on individuals who fail to obtain adequate health insurance in 2014 and beyond. Assessed on certain employers who have employees that access subsidies and purchase insurance through the Exchange in 2014 and beyond.
  - **Employer Penalty for No or Inadequate Insurance:** $2,000 x all full time employees (minus the first 30 FT employees) if no ESI provided, or ESI actuarial value is less than 60%
  - **Employer Penalty for Unaffordable Employee Insurance:** $3,000 x # of employees receiving exchange subsidies due to low income and unaffordable insurance premiums
- **Free Choice Voucher** – Employer-paid cash vouchers for eligible employees to purchase insurance through the Exchange. Cash amount is based off the ESI plan with the highest proportion paid by the employer. Eligible employees' income is less than 400% FPL and their ESI premium cost between 8-9.8% of HHI.

Expanding Access to Health Coverage:

- **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