OHIO PRESBYTERIAN RETIREMENT SERVICES

Medicaid Payment Reform from a Provider's Perspective

Presented for:

The Joint Medicaid Oversight Committee – Ohio General Assembly

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Today's presenter: **Bob Stillman**

Chief Financial Officer
Ohio Presbyterian Retirement Services

1001 Kingsmill Parkway
Columbus, Ohio 43229
614.888.7800
bstillman@oprs.org

Our Message

- Positioned our organization to provide a full array of the right services, at the right place, and at the right time for seniors.
- Committed to **Quality** and finding ways to provide patient centered population health management to improve **Quality.**
- Faith-based operational values providing the best quality senior housing and post acute health care possible, in desired settings, to as many as **feasibly possible**.
- Interested in participating and supporting value-based reimbursement programs as we have experienced and contributed to positive outcomes.
- Need **Access** and **Financial Incentive**

Our Organization

- Founded in 1922 from a gift of land in Sydney, Ohio, which became our Dorothy Love campus
- Presbyterian-based original operations but no formal ties to the Presbyterian Synod today
- Exempt from income tax
- Headquarters in Columbus, Ohio
- All operations are based throughout in Ohio
- Serve ~ 70,000 residents, patients, consumers annually
- Employ ~ 3,100

Our Organization

- **Ohio Presbyterian Retirement Services (Parent)**
  - Consolidated Revenue ~ $221,700,000
  - Total Net Assets ~ $110,000,000
- **OPRS Communities**
  - Operational Revenue ~ $172,300,000
- **Senior Independence**
  - Operational Revenue ~ $43,300,000
- **Ohio Presbyterian Retirement Services Foundation**
  - Contributions Revenue ~$6,100,000
  - Total Net Assets ~$70,000,000

OPRS Communities

- Locations = 12
  - Life Plan/Continuing Care Retirement Communities = 10
  - Skilled Nursing/Assisted Living Site = 1
  - Independent Living/Assisted Living Site = 1
- Independent Living Units = 1,750
  - Senior Affordable Housing Units = 150 (1 building)
- Assisted Living Units = 568
- Skilled Nursing Facility (SNF) Beds = 918
  - Quality Commitment: Ohio Department of Health Recent Surveys

    SNFs Citations Average: OPRS 11 Sites= 1.0; State of Ohio 5.1; Federal 6.9
- Total units/beds = 3,236
- 2015 LeadingAge Ziegler Top 100 Publication
  - Largest non-profit sector CCRC provider in Ohio
  - 14th largest non-profit sector CCRC provider in the US

OPRS Communities

Breckenridge Village
36855 Ridge Road
Willoughby, OH 44094
440.942.4342

Cape May Retirement Village
175 Cape May Drive
Wilmington, OH 45177
937.382.2995

Dorothy Love Retirement Community
3003 W. Cisco Road
Sidney, OH 45365
937.498.2391

Lake Vista of Cortland
303 N. Mecca Street
Cortland, OH 44410
330.638.2420

Park Vista of Youngstown
1216 5th Avenue
Youngstown, OH 44504
330.746.2944

Swan Creek Retirement Village
5916 Cresthaven Lane
Toledo, OH 43614
419.865.4445

Llanfair Retirement Community
1701 Llanfair Avenue
Cincinnati, OH 45224
513.681.4230

Rockynol
1150 W. Market Street
Akron, OH 44313
330.867.2150

The Vineyard on Catawba
3820 E. Vineyard Village Drive
Port Clinton, OH 43452
419.797.3100

Mount Pleasant Retirement Village
225 Britton Lane
Monroe, OH 45050
513.539.7391

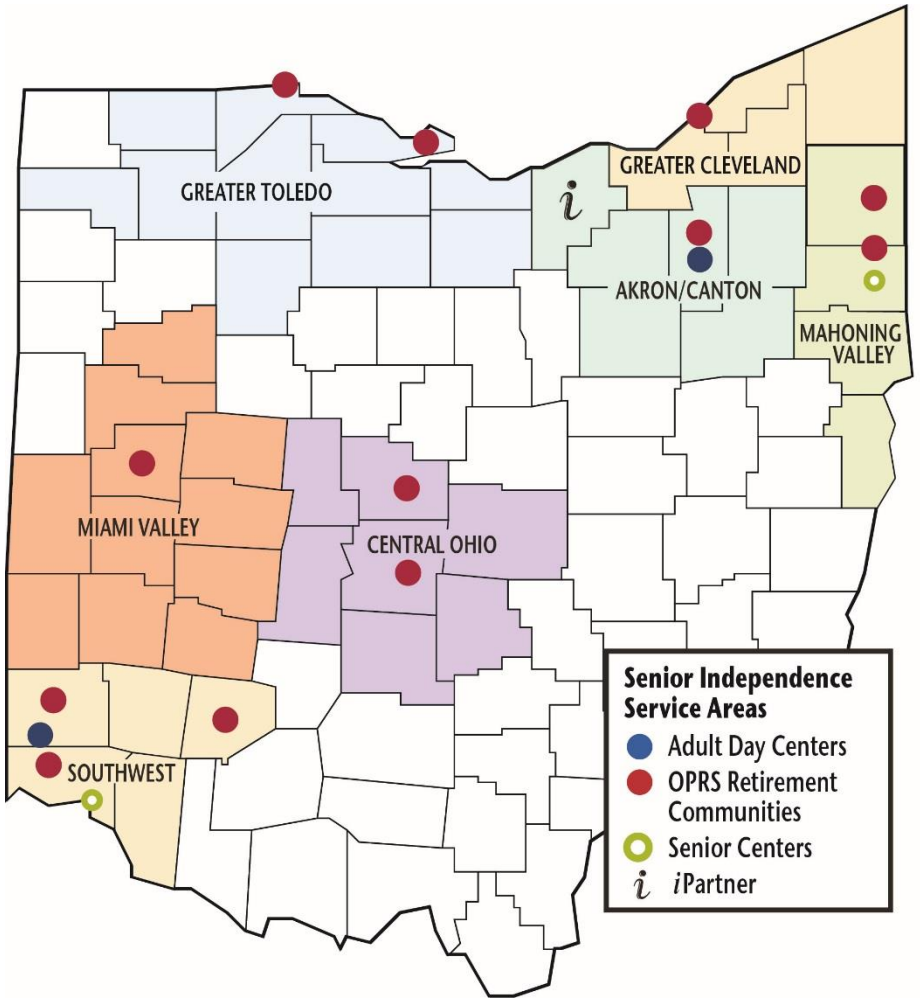
Sarah Moore Community
26 N. Union Street
Delaware, OH 43015
740.362.9641

Westminster-Thurber Community
717 Neil Avenue
Columbus, OH 43215
614.228.8888

Senior Independence

- Branch Offices = 7
- Licensed Counties = 48
- Home Health Care
  - Visits ~ 400,000
  - Revenue ~ $21,200,000
- Hospice
  - Average Daily Census ~ 297
  - Revenue ~ $18,100,000
- Home Care
  - Visits ~ 240,000
  - Revenue ~ $1,900,000
- Adult Day Care/Senior Centers/Transportation/Other
  - Revenue ~ $2,100,000

Presence in Ohio



SNF Bed Occupancy Payor Mix

Fiscal Year End	State Direct Medicaid	MyCare Medicaid	Managed Medicaid	Medicare All	Private	Total
June 30, 2016 - Trending	23.7%	14.8%	0.7%	30.4%	30.4%	100.0%
June 30, 2015 - Actual	28.8%	13.7%	0.0%	28.7%	28.8%	100.0%
June 30, 2014 - Actual	33.3%	1.7%	0.0%	34.5%	30.5%	100.0%

OPRS SNF Medicaid Days

Fiscal Year End	Days	Medicaid Rate	Estimated Gross Dollars	Dollars from Ohio
June 30, 2016 - Trending	104,242	$ 173.15	$ 18,048,950	$ 14,439,160
June 30, 2015 - Actual	106,347	$ 174.14	$ 18,519,267	$ 14,815,413
June 30, 2014 - Actual	90,566	$ 172.19	$ 15,594,107	$ 12,475,285
June 30, 2013 - Actual	90,542	$ 171.99	$ 15,589,974	$ 12,471,979
		Net of Estimated Patient Liability		80%

Senior Independence

		April 10 Months 2016	Trending Full Year 2016	Fiscal Year Ended June 30, 2015	2014	2013
Home Health						
	Starts of Care	8,861	10,633	8,454	7,359	5,606
	Trended or Actual Increase		2,179	1,095	1,753	
Hospice						
	Average Daily Census	297	297	269	269	281
	Trended or Actual Increase		28	-	(12)	

OPRS High-Level Strategy

- Acute Care Referral Source Relationship Development
  - Accountable Care Organizations (ACO)
  - Bundled Payment Care Improvement (BPCI) Initiative Participants
- Preferred Post-Acute Care Provider
- Demonstrated Quality Outcomes
- Demonstrated Efforts to Reduce Hospital Readmissions
- Single Source Provider Group for Skilled nursing, therapy and other post-acute services provided in desired setting (SNF, IL, AL, Home)

Home-to-Stay Program

- Northwest Ohio Accountable Care Organization
  - Joint venture between the Toledo Clinic, Inc. and University of Toledo Physicians, LLC
  - Represents over 12,000 covered **Medicare** lives
  - Physician owners financially incented to reduce readmissions to the Hospitals as CMS is trying to reduce the Medicare spend
  - Were not post-acute care specialists, needed help
- Exclusive agreement effective July 2013
- Provided at **No Cost** from SI to either the ACO or the Patient
- SI strategy that the relationship would:
  - Generate significantly increased Home Health starts of care, thus
  - More revenue and opportunity for enhanced financial margin performance

Home-to-Stay Program

- SI Provides Care Coordination
- Home to Stay **Transition Care Liaison** is introduced to beneficiary when nearing Hospital discharge
- SI Care Liaison develops continuing care plan
  - Determines whether skilled home care is required?
    - If yes, and if SI chosen, home health nurse visits the home within 24 hours to provide care
    - If not:
      - SI RN or LPN visit the patient at home within next 72 hours
      - Visits again 7 to 10 days after discharge
        - Conducts a thorough medication review and resolve any issues
        - Takes vital signs
        - Talks about personal emergency plans
        - Establishes personal health records
        - Teaches disease signs and symptoms
        - Confirms follow-up appointments with primary care physicians
      - Ensures transportation to those appointments
      - After in-home visits, a nurse or social worker calls the patient 3 times during the next 21 days, follows up on care and wellness

Home-to-Stay Program

Results:

- NWO-ACO Hospitals Readmissions Rates for Medicare beneficiaries decreased from ~16% to ~4%
- Patients receiving better quality care
- SI Toledo Branch Home Health volume and revenue increased significantly
- ACO Agreement was renewed for another 3 year term

Home-to-Stay Program

- Mercy Health Select ACO– also in Northwest Ohio
- Exclusive agreement effective August 2014
- Provided at **No Cost** from SI to either the Medicare ACO and all other Patients admitted to St. Vincent, St. Charles and St. Anne's and Mercy Defiance hospitals.
- **Mercy Service Requirements**:
  - Manage complex cases of patient care: no Primary Care Physician, no payor source, homeless
  - Expected Charity care support
  - Vulnerable population focus

Home-to-Stay Program

- Post Acute Transitional Care Liaison
  - Visits **ALL** patients discharged to post acute care on a weekly basis
  - Participates in patient care conferences as needed
  - Tracks and reports patient status from admission thru discharge home
  - Coordinates the transition of patient's care from post acute care to home for skilled services, DME, other.
  - Identifies ACO beneficiaries, offers Home to Stay program.
    - Re-admission rate of **2.9%** "Home to Stay" care coordination participants
    - Patients receiving better care

- Hospice Clinical Liaison
  - Coordinates with hospital palliative care team to facilitate patient admission to appropriate level of end of life care

Home-to-Stay Program

- SI Toledo Branch benefited from volume increases due to these relationships
- Revenues increased significantly from FY13 to FY16
- Positive improvements in gross margin and site net margin
  - **Medicare funding** for home health and hospice is primary driver
  - **Offsets unfunded expense** of providing the Transitional Care Liaison and Home to Stay services
- Our Provider Perspective:
  - Would like to find more of these similar relationships

What We Learned

- Need a point of **access** to the beneficiary/patient to be able to pro-actively coordinate care or provide population health management.
- Upstream referral sources must have **financial incentive** to find a post-acute care expert/specialist that is preferred.
- Upstream referral source must **acknowledge** that there are providers outside of their system that are better structured and experienced to provide home health/patient health management type services.
- Upstream referral source must be able to **direct services** to limited number of providers with proven performance record.
- Post-acute care provider does not need direct reimbursement for care coordination if has some reasonable expectation of **volume increases** from a mix of funding sources that generates **margin improvement**.

Consider Medicaid Payment Reform

- What is the Goal?
- Control Medicaid expenditures targeting custodial long term stays in SNFs?
- Identify the 'At Risk' Medicaid eligible population that:
  - Does not develop their own care monitoring process
  - Does not receive routine primary care
  - Health is beginning to fail and not identified
  - Health is rapidly failing and no action taken
  - Health declines to the point that emergency care is needed
  - Person enters SNF too frail or health condition has declined to the extent that can not return to home
- Long term care SNF stay Medicaid beneficiary
  - 365 days at $180 = $65,700
  - Significant Medicaid dollars on long term care stays

Medicaid Population Health Management

Potential Answer:

'**Home** Assessments **to** Minimize the Long Term **Stay**' Program

- Need **Access** to identify potential advance care needs and care coordination
- Doing population health management on our campus sites through 'My Independence'
    - Care Coordinator monitors IL resident
    - Facilitates physician involvement
    - Introduces home health and home care when appropriate
    - Certain percentage exhaust personal resources
        - Transition to AL Medicaid Waiver
        - Transition to SNF Medicaid
        - Average ages keep increasing in this transition

Access

- Need **Access** to the larger population
- Affordable Housing Sites
- Adult Day Care Centers
- Senior Centers
- Other Community-Based Service Providers
  - Example: Life Care Alliance – Meals on Wheels
  - In homes on frequent basis
  - Could identify issues
  - Could introduce clinical monitoring team

Access

- Need **Access** to the larger population
- Managed Care Insurance Carriers
  - Adept at managing care through case managers when at SNF or Home Health Agency
  - Limited follow-up discharged patient back to home to monitor status
    - Monitored post hospital discharge to SNF or to Home
    - Not monitored post SNF to AL or to Home
  - Could our Home to Stay model curb recurrence of future acute episode, that may possibly turn into a long term Medicaid stay in a SNF
- Patient Centered Medical Homes Model
  - Post Acute Care Clinical Liaisons coordinate the process
  - Need primary care physicians to provide the access
  - Rural settings may be more viable

Financial Incentive

- Need to align **Financial Incentives** for those involved with population health management in an effort to reduce cost associated with lengthy stays in SNFs (if that is the goal).

- Challenge for State decision makers is having confidence that there will be Medicaid savings or better expenditures control (aging population) in the future if a more proactive population health is implemented (and paid for) now.

Financial Incentive Possibilities

- Direct payment for certain access sources who interact with the 'at risk' Medicaid eligible population
  - Affordable Housing Sites: funding to pay for population health management clinicians
  - Better payment structure/support from Medicaid to operate Adult Day and Senior Centers to stay open and operational
    - Very fragmented through Passport, Senior Options, Local Levies, Meals and Transportation funding sources.
    - Need promotion to get the population to go to these public locations.
  - Funding stream for community based providers like Life Care Alliance to facilitate identification of declining health of their customers and coordinate referrals to preferred population health clinicians.

Financial Incentive Possibilities

- Interest in becoming a 'Preferred Provider' of choice/access to at risk Medicaid eligible population with anticipated volume increases for future Medicare/Managed care home health and hospice volumes.
- Interest in opportunity to earn share of Medicaid savings in some form if coordinating population health management amongst full spectrum of providers (primary care physicians, acute care, home health, SNF, DME, Pharmacy).
- Interest in the AL Medicaid Waiver funding being expanded to include health management improvement incentives. Effort to keep person in AL as opposed to declining in health to the point of needing SNF.

Value-Based Contracts

- Concept of shifting from 'Fee for Service' to 'Value Based' Funding Model.
- What would that look like as it relates to the current Ohio Nursing Facility Medicaid payment rate?
- Already reimbursed for 'Quality Points' in the SNF Medicaid rate, thus paying for Value in theory.
- No financial incentive for SNF to significantly improve the health of a long term stay Medicaid beneficiary that would enable them to return to a different, more cost effective setting (other than to make the bed available for a Private pay or Medicare beneficiary).

Thank you!

Questions?

Contact Information:

Bob Stillman
Chief Financial Officer
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