The Impact of Health Care Reform
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Topics for Today...
• Current environment
• Impacts of health care reform
• Health insurance changes
• Challenges and Opportunities you must consider
• Key trends

The Market – What’s on the minds of leading CEOs and Boards?
• The number of people who need our services
• How consumer buying habits have changed
• The effects of a recessionary economy – some good, some not so good
• A changing work force (formal and informal care givers)
• Accessing capital – Financing the future of older adult services
• Health care reform – what are the immediate and long term implications?
• How will the congressional interest in home health affect us?
Critical Issues Facing Our Clients...

- The effects of a new economy and capital planning
  - Affecting Access to capital
  - Addressing the issue of Negative inflation (shrinking margins)
- Impacts of health care reform and the new payment landscape
  - As an Employer
  - As a Provider
    - Accountable Care Organizations
    - Episodic, Bundled or Global Payment
- New Forms of Relationships
- Technology – new applications and reliance

In the short term...

... not much has changed

But........

In the long term it will!!!!

Home Care

- Industry profits driven by Medicare – overall margins continued to be very strong during 2009
- Favorable policy environment – “RAC” audit threat is looming, but activity so far is relatively low
- M&A activity hit plateau – values high but relatively stable
- Compliance remains a high priority
- Health care payment reform and reimbursement stability is greatest concern
Home Care Reimbursement Updates

- PPS Refinements have driven increased profits for intermittent home health
- MedPac recommendations – Rate freeze or decline for home health agencies
- Increased scrutiny of fraud due to error rate increases in filed claims
- State budget issues causing concern
- You’ve already been in sessions covering short term reimbursement matters

Hospice Trends...

- Healthcare Reform Bill
  - Estimated $7.8 billion in cuts to the Medicare hospice benefit ($6.8 billion estimated by NHPCO)
  - Payment rate reduction
    - Market Basket Reduction
    - Productivity Adjustments
  - Update cost report
  - More qualitative information - Transparency

- MedPac
  - Projected 2010 Aggregate Medicare Margin
  - Recommended Payment Update

When we look over the long term...

... things get more unsettled.
Forces Driving Reform...

• Growing Uninsured Population
• Exponential Growth in Expenditures
• Looming Medicare Insolvency
• Cost to Quality Comparisons

Why Reform?

• Reform is a must!
  – Cost is too high
  – Quality is too low
• The United States spends more than any other country on health care, but historically not has not received a return on its investment when compared to other countries.

What Happened?

• In March 2010, Congress passed and the President signed health reform in:
  – The Patient Protection and Affordable Care Act
    ◦ Increases access to health coverage (32 million individuals!!!)
    ◦ Aims to reduce costs via payment reductions and focus on wellness and prevention
    ◦ Seeks to reward “value-based” care delivery
• Impact of the Act:
  – Cost: $940 Billion over 10 years
  – Coverage: + 32 Million by 2019
Patient Protection & Affordable Care Act Includes...

While details are not yet clear as to what is included in the PPAC Act or how the implementation and administrative rules will be written, key provisions are as follows:

| Cost Cutting | Market basket update adjustments for productivity reduce reimbursement |
| Delivery System Reforms | Implements VBP; reduced payments for high volumes of hospital-acquired conditions and readmissions, and pilot programs to last bundled payments ACOs and medical homes |
| Independent Payment Advisory Board | Creates MedPac-like commission that has Medicare role setting authority (starts 2015). Not applicable to hospitals until 2019. |
| Medicaid | Expands Medicaid to 133% (2014) of FPL and uses revised definition of income. |
| Tax Exempt Status | Includes four new criteria hospitals must satisfy to retain not-for-profit status. |
| Mandates | Individuals must purchase insurance or pay penalty. Businesses must provide insurance (if more than 50 employees) or pay penalty if any of their employees receive federal premium or cost-sharing subsidies. |

Policy Emphasis on Home and Community Based Services

Creates new and expanded home and community-based options for seniors and individuals with disabilities:
- Offers states a new State Medicaid Option for HCBS attendant care services, Community First Choice, for individuals with disabilities. (Oct. 1, 2011)
- Removes barriers to home and community-based services (Health Reform Sec. 2402). Changes the Spousal Impoverishment rules.
- Creates the State Balancing Incentive Program to provide enhanced federal matching payments to eligible states to increase the proportion of non-institutionally-based long-term care services by October 1, 2015.
- An additional option for states includes Medicaid Home & Community Based Services State Plan Option. This option allows states to expand home & community-based services in addition to those who offer waiver services.
- Expands the Aging & Disability Resource Centers and funding available.
- Develops Independence at Home Demonstration and Community Based Care Transitions programs to coordinate care across sites of service.

Reform Summary Timeline

2011
- Establishment of high risk insurance pools
- Small business tax credits established for offering employee health insurance
- Insurers can no longer deny coverage to children
- New group & individual plans required to provide preventive services
- CMIA Innovation Center awards
- National service for reducing for quality sn. volume
- Physician compare website launched
- Increased tax assessments on HSA
- Medicare value based purchasing for hospital begins
- Medicare showed savings program begins
- CLASS Act: National voluntary payroll withhold program to assist with staying at home
- Funding for community health increased by $71 billion over 5 years
- Annual review of premium increases effective
- "Donut hole" rebates for Part D prescription drugs
- "Independence at Home" demonstration project
- Start of Medicaid demo projects for bundled payments
- Market basket reductions for certain providers

2012
- Medicaid value based purchasing for hospital begins
- Medicare showed savings program begins
- CLASS Act: National voluntary payroll withhold program to assist with staying at home
- Reductions for hospital preventable readmissions
- Productivity adjustments incorporated into market basket updates for certain providers
- "Independence at Home" demonstration project
- Start of Medicaid demo projects for bundled payments
- Reductions for hospital preventable readmissions
- Productivity adjustments incorporated into market basket updates for certain providers
**Reform Summary Timeline (cont’d)**

- Health insurers required to begin following admin simplification regulations.
- Limits placed on flexible spending accounts.
- Medicare national pilot for bundled payments begins.
- Medicaid increased payments for PC to 100% of Medicare fee schedule.
- Employer tax deduction for Part D subsidies eliminated.

**2013**

- Medicaid increased payments for PC to 100% of Medicare fee schedule.
- Employer tax deduction for Part D subsidies eliminated.

**2014**

- Independent payment advisory board report required by Congress.
- Employer coverage mandates imposed.
- Medicare hospital DSH payments reduced.
- Rebasing of Home Health payments with 4 year phase-in.

**2015 - 2018**

- Pilot projects for value-based purchasing in other care environments (2016).
- Excise tax imposed on “Cadillac” health plans (2018)

**2013**

- Beginning of Exchanges.
- Penalties imposed on individuals who fail to “share responsibility” for coverage.
- Insurance industry pays fees based on market share.
- Insurers prohibited from restricting coverage and imposing max limits.
- Medicare national pilot for bundled payments begins.
- Home Health productivity adjustments incorporated into annual updates (2015).
- Physician value-based system implemented (2015).

**2015 - 2018**

- Rebasing of Home Health payments with 4 year phase-in.
- Independent payment advisory board report required by Congress.
- Employer coverage mandates imposed.
- Medicare hospital DSH payments reduced.
- Rebasing of Home Health payments with 4 year phase-in.

**Impact of Reform on Home Health and Hospice**

- Market Basket Changes:
  - Establishes individual agency cap of 10% of revenues that may be reimbursed from outlier payments. (2011)
  - Home health payments rebasing phase in 2014-17
  - Max. reduction of 3.5% per year

- Market basket reductions begin:
  - 0.3% each year, FY2014 – 2019
  - Productivity adjustments incorporated into annual market basket adjustments, also begins FY2013 – 1% reduction

- Quality reporting required for hospice providers (2014)
  - Failure to report will result in a 2% market basket reduction.

- Revised payment beginning in October 1, 2013
  - Est. reduction of $100M over 10 years

**Medicare Payment Reductions and Rebasing**
Medicare Payment Reform: Hospice

- Hospice payment reforms
  - Requires HHS Secretary to collect data and information by 2011 and use it to revise payment rates on or after October 1, 2013.
    - Estimated to reduce hospice spending by $100M over 10 years.
  - Requires a hospice physician or nurse practitioner to have a face-to-face encounter with each patient for determining continued eligibility for recertification and attest that such visit took place. (1/1/2011)
  - HHS Secretary will medically review certain patients in hospices with high percentages of long-stay patients.

HCBS: State Balancing Incentive Program

- $3 billion is appropriated to increase the Federal Medical Assistance Percentage (FMAP) paid to states as a reward for rebalancing their Medicaid LTC expenditures to be more heavily weighted toward non-institutional care by October 1, 2015
  - Non-institutional care includes: HCBS waiver services, home health and personal care services, PACE, self-directed personal assistance
  - States currently spending between 25-50% on non-institutional care
    - Must achieve 50% target for non-institutional spending to receive 2% FMAP increase
  - States currently spending less than 25% on non-institutional care
    - Must achieve 25% target for non-institutional care spending to receive 5% FMAP increase

Removing Barriers to HCBS

- Spousal Impoverishment: Beginning January 1, 2014, requires states to apply spousal impoverishment rules to individuals who receive home and community-based services. This new requirement would apply for five years.

- New options permit states to:
  - Provide more types of HCBS through a State plan amendment instead of a waiver to individuals up to 300% SSI
  - Extend full Medicaid benefits to individuals receiving HCBS under a State plan amendment
Hospice Demonstration Programs

Medicare Concurrent Care
- Three-year demonstration
- Would allow hospice-eligible patients to also receive all other Medicare covered services while receiving hospice care
- Up to 15 hospice programs -- rural and urban sites
- Independent evaluation to be conducted on its impact on patient care, quality of life, and spending in the Medicare program

Curative and Palliative Care for Children in Medicaid and CHIP
- Allows children who are enrolled in either Medicaid or CHIP to receive hospice services without foregoing curative treatment related to a terminal illness.

Medicare Hospice Concurrent Care Demonstration Program
- HHS Secretary to establish a three-year demonstration program
- Demo would allow hospice-eligible patients to also receive all other Medicare covered services while receiving hospice care
- Up to 15 hospice programs in both rural and urban areas to be demo sites
- Requires an independent evaluation of its impact on patient care, quality of life, and spending in the Medicare program

Curative and Palliative Care for Children in Medicaid and CHIP
- Allows children who are enrolled in either Medicaid or CHIP to receive hospice services without foregoing curative treatment related to a terminal illness.
**HCBS: Community-Based Care Transitions**

Establishes five-year community-care transitions program to assist Medicare beneficiaries at high-risk of a hospital readmission with their transitions from inpatient to outpatient care

- Program implementation by January 1, 2011
- $500M available to be paid to:
  - Community-based organizations that provide care transition services OR
  - Hospitals with high readmission rates that partner with such entities.
- “High-risk Medicare beneficiaries” = one or more chronic conditions and not enrolled in a Medicare Advantage program
- HHS may expand the program if the program proves to lower spending without reducing quality.

**Health Insurance Changes – what to be aware of as an Employer and Employee**

**Employer reporting obligations**

Employers offering health insurance to their employees in 2014 will be required to report:

- Names of FT employees on the health plan
- Employer contribution levels to employee health care coverage premiums
- Plan waiting period length
- Whether employer-sponsored plan meets “minimum essential coverage” requirements
**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.

- **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

**Government assistance to help some individuals obtain coverage**

- **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 employer-sponsored premiums for this group
  - In 2014, state can receive additional FMAP for this expansion population

- **Premium and cost share assistance:**
  - Individuals and families with household income of 133% - 400% FPL may be eligible for 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)

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

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

**Cost Sharing Subsidies**

- Federal government will pay insurers to reduce the cost sharing for individuals:
  - Enrolled in a silver-level plan through an Exchange AND
  - Whose household income is between 100-400% FPL

<table>
<thead>
<tr>
<th>FPL Percentage</th>
<th>Cost Share Reduction</th>
</tr>
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<tbody>
<tr>
<td>100-200% FPL</td>
<td>Two-thirds</td>
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<tr>
<td>200-300% FPL</td>
<td>50%</td>
</tr>
<tr>
<td>300-400% FPL</td>
<td>One-third</td>
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- Reductions don’t apply to benefits not included in the federal definition of “essential health benefits”
State Health Insurance Exchanges

- Requires a state-based health insurance exchange to be created in all 50 states.
  - In 2014, open to:
    - Small employers
    - Self-employed individuals
    - Unemployed individuals
    - Large employers (2017)
- HHS to establish rules and consult the National Association of Insurance Commissioners and others.

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 (compare apples to apples)
- Intended to provide a more competitive market
- Serve as a neutral party that can offer consumers assistance in enrollment, information and determining eligibility for any subsidies

Exchange Plans

Types of exchange plans to be offered by insurers
- Bronze = 60% actuarial value
- Silver = 70% actuarial value
- Gold = 80% actuarial value
- Platinum = 90% actuarial value
- Catastrophic plan
  - Only available to individuals < 30 years old, or those exempted from the individual mandate due to unaffordability or hardship.
  - Plan must cover:
    - “minimum essential benefits”
    - A minimum of three primary care visits per year
- All exchange “metal” plans must cover essential health benefits, limit cost-sharing and have a specified actuarial value

Expanding Access to Health Coverage: Large Employer Role

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 subsidized insurance through a state Exchange
  - Penalty is assessed differently depending upon whether or not employer offers affordable, “minimum essential coverage” to employees
- “Minimum essential coverage” for employer-offered plans
  - Plan with 60% actuarial value
  - Employee premium cost < 9.5% of household income

FTE = FT employees
FTE equivalents
- FT employees = works avg. 30 or more hours per week
- FT equivalents = hours worked in a month by all PT employees divided by 120
Employer “Shared Responsibility” Penalty

<table>
<thead>
<tr>
<th>Penalty assessed only if a FT employee receives Exchange subsidies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Penalty for employers not offering coverage = $2000 x each full-time worker (except for first 30 workers)</td>
</tr>
<tr>
<td>• Penalty for employers offering coverage =</td>
</tr>
<tr>
<td>- At least $3000 x # of full-time employees receiving federal assistance BUT</td>
</tr>
<tr>
<td>- No more than $2000 x each full-time employee (except for 1st 30 full-time workers) penalty</td>
</tr>
<tr>
<td>• No penalty for employees receiving free choice vouchers</td>
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</table>

Employees are not eligible for the federal 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.

Free Choice Vouchers

• All employers offering and contributing to employee health coverage must offer free choice vouchers to employees if:
  • Household income < 400% FPL
  • Employee contribution toward the employer-sponsored coverage is between 8 – 9.8% of their household income, AND
  • Employee does not enroll in employer coverage.

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

Free Choice Vouchers

• Amount of “free choice vouchers” = employer’s monthly contribution to the health plan premium
  - Highest % paid for any plan offered
  - Amount is tied to coverage selected (e.g., employer contribution amount for family coverage, if family coverage selected)
  - If voucher exceeds cost of plan purchased through Exchange, excess is refundable to employee and is taxable
  - Excess amounts received by employee to be included in their gross income.

• Individuals receiving vouchers are not eligible for federal subsidies for premiums or cost-sharing
• Employers do not pay the “shared responsibility” penalty for employees who receive vouchers
• Tax free for employees, deductible for employers
Why an Employee might choose the Exchange?

Nurse Aide Example

- Annual nurse aide salary = $18,633/yr (171% FPL) + annual premium cost via Employer = $3388 (18.2% of HHI) = Exchange subsidy eligible

<table>
<thead>
<tr>
<th>ANNUAL EMPLOYEE COST</th>
<th>EMPLOYER PLAN Premium $3,388 (18.2% HHI)</th>
<th>SILVER EXCHANGE PLAN $458</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of Pocket</td>
<td>$2,000</td>
<td>$1,964</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$5,388</td>
<td>$2,422</td>
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Insights on the Potential Impact of the Exchanges

- It is irrelevant whether employers decide to maintain employer-sponsored coverage: Employees will decide the fate of the exchange!

- Low-wage workers = biggest % increase in take home pay.
- Companies with a predominantly low-wage workers:
  - up to 90% of employees could benefit from Exchange
  - 80%+ of employees may have more take home pay by moving to the Exchange
  - Another 5-10% could move to Medicaid and eliminate insurance and out-of-pocket health care costs altogether!

- Even in higher-wage companies, 25%+ of employees could see increase in take home pay by purchasing insurance through the Exchange
- Don’t assume employees won’t be able to figure out where the best deal is for them in the Exchange!
Implications of the Exchanges for providers

- Health plans will be operating in a very different, more consumer driven, more price sensitive market
- Greater pressure on the providers to bend the cost curve and demonstrate value (cost/quality)
  - Unhealthy approach: focus on unit price, which is where the health plans will start
  - Healthy approach: Reform the payment system, move to value-based purchasing where providers share in savings, and change how care is delivered
- Providers need to prepare for this new environment …2014 is not far away

Health Insurance and Penalty (HIP) Calculator

[Image of HIP Calculator]

www.larsonallen.com/HIP

The New Normal... for Many Americans

It is not yet clear what the new normal resulting from the economic downturn will be, but based on historical patterns and other available information we might anticipate that:
1. Declines in net income and wealth for older adults
2. Housing prices will remain flat
3. Unemployment will continue high
4. Lower or flat price increases for services and goods
5. Increased focus on quality
6. Increased family caregiver responsibilities

Each of these issues will have an impact on the aging services field.
New Normal Operating Environment – Caregiver Focus

Implications:
1. Providers will find new ways to engage informal caregivers
   - Informal caregivers will be expected to participate in care planning and some care tasks
   - Caregivers will look to providers for a broader array of supports that are affordable and that reduce challenges & stresses
2. Health care reform proposals include resources and programs to lengthen the time informal caregivers provide services in the community
3. Caregivers may look to organizations that have assisted them when they need to find a more intensive care for their family member
4. The growth in numbers of elders without caregivers will challenge the H&CBS system and other aging providers
5. Some programs will be developed to support caregivers w/o financial eligibility requirements

Decreasing Role of Family Pushes up Demand for all Services

Percentage of Family Caregiving:

<table>
<thead>
<tr>
<th>Year</th>
<th>1988</th>
<th>1995</th>
<th>2001</th>
<th>2010</th>
<th>2030</th>
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<tbody>
<tr>
<td></td>
<td>97%</td>
<td>95%</td>
<td>91%</td>
<td></td>
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National Ratios:
- Caregiver Ratio: 7.51, 6.78, 4.34
- Elderly Dependency Ratio: 4.75, 4.61, 2.76

The Caregiver Ratio is a comparison of the number of elders 85+ to women aged 45 to 64. The Elderly Dependency Ratio is the number of elders 65+ compared to workers aged 20 to 64. The lower the ratio the fewer the number of caregivers or workers.

Each 1% drop in family caregiving requires approximately $30M in additional public funds for Minnesota.

New Relationship Focus will Position for Success

Health care is local and relies on strong relationships. Today’s relationships focus on:
- Physician/patient
- Skilled Care/family/resident
- Home care/informal caregiver/physician/client
- Skilled care/hospital social worker
- Payer/provider
- Others

Future health care relationships will include greater reliance on:
- Physicians/Accountable Health Organizations as the payer
- Independent care managers
- Strategic partnering with other provider organizations which start with CEO/Board relationships
- Greater reliance on volunteer/informal caregiver relationships
What does all this mean?

...and what do we do about it?

Key Concepts:
- Payment Tools
  - Electronic Information Exchange
  - Software to Support Care Delivery
  - E-communication Tools
  - Patient/Group Software – Diagnoses, Severity & Episode
  - Performance Metrics
  - Best Practice Guidelines
  - Compliance Monitoring
  - MS-DRGs/APR-DRGs/CPT Coding, etc.
- Care Coordination/Case Management
- Disease Management
- Medical Home
- Patient Centered Care
- Patient Engagement
- Care Transitions
- Performance Incentives
- Comparative Effectiveness
- Accountable Organizations
- Increased Informal Caregiving

Potential Payment Reform Elements

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Program Examples & Demos:
- Acute Care Episode Demo
- Physician Group Practice Model
- Prometheus Demonstrations
- Hospital Quality Incentive Program
- Medicare Care Management Performance
- Medicare Hospital Bundling Demonstration
- Nursing Home Value-Based Purchasing Clinic
- McKesson Advanced Primary Care Initiative
- Physician Episodic-Benchmark Report Initiative
- Physician Hospital Collaboration Demonstration
- Post-acute Care Bundled Payment Research

Payment Models
- Fee for Service
- Capitation
- Global Payment – Full or Partial
- Performance Incentives
- Value-Based Payments
- Bundled Payments for Episodes of Care
- Prometheus
- Blended Systems

Expected Outcomes:
- Improved effectiveness
- Reduced growth in expenses
- Appropriate utilization
- Better patient experience

What Can We Expect?

We believe the 6 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
Preparation for Change

Key Focus for Aging Services Providers:
1. Creating an understanding of existing resident/patient care delivery patterns
2. Developing robust predictive measurement systems for utilization, quality and costs
3. Developing organizational capabilities for electronic health exchange and communications
4. Identifying and implementing best practices and strategies by diagnoses
5. Determining processes and demonstrating patient-centered care and patient engagement approaches
6. Engaging family and caregivers, particularly following Medicare Home Care episode to maintain relationships

Key Trends

Payment reform will focus on increasing value – higher quality and lower costs.
Potential Implications to Aging Services

- Robust measurement systems
- Automated data collecting processes
- Significant cost of care reductions
- Acceptance of “gain-sharing” arrangements
- Better data needed for contracting

Key Trends Impacting Aging Services

#2 Referral Sources are instituting changes in preparation for different payment models (i.e. ACOs, VBPs, etc.)

Potential Implications to Aging Services

- Hospital and physician relationships
- Define and evaluate new roles
- Care delivery models must be integrated
- Uniform best practice protocols across continuum
- Physician participation in community and post-acute settings
Key Trends Impacting Aging Services

#3 Hospitals will experience significant financial strains over the next 5 – 7 years.

Potential Implications to Aging Services

- More SNF and home care discharges
- Frail and clinically complex residents
- Greater hospital integration
- Faster response times
- Preferred provider networks

Key Trends Impacting Aging Services

#4 Future customer buying practices will likely not reflect historical patterns.
Potential Implications to Aging Services

- More focus on quality and value
- Increased vacancies and turnover
- New marketing messages: choice & flexibility
- Growth of short stay residents
- Aging services delivered to home

Key Trends Impacting Aging Services

- #5 Health Care Reform legislation will create opportunities for aging services providers.

Potential Implications to Aging Services

- Health information exchange
- Demonstrations will encourage new models
- Quality and performance measurement
- SNF and Home Health payment reductions
- Shift to lower cost levels of care
- Growth in home and community based services
Health Reform Will Drive Tremendous Change

Change is imminent.

- Greater financial risk
- Operational efficiency
- Collaboration
- Technology investments
- Increased quality
- Elevated regulatory risk
- Community-based services and care

Planning for the future...

... a focus on positioning

An Approach
Our Advice.....

1. **Think big, but act small**... this can lead to greater engagement, clearer focus and higher outcomes.

2. **Go slow to go fast**... plan the next few years out thinking about how you will create the “burning platform” for change in your organizations that will engage not only the minds but hearts of staff.

3. **Participation in the changes is not a choice**... health care is going to change dramatically and we need to design the best transition plan for our organization and our constituents.

4. **To create better, connect more**... connecting with referral and payer sources, wise souls and key community leaders may help identify the innovations that will lead to success.

Questions?

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Thank you!

For more information on health reform, go to LarsonAllen’s Health Care Reform Center:
www.larsonallen.com/healthreform