Leveraging CCaH Experience with CMS Databases

PART 1

Can CCaH's Build Collaborative Databases to Determine Care Management Efficacy with Objective to Enhance Funding & Marketing Opportunities

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SmithPowell Concepts for Senior Living Programs and Communities, LLC

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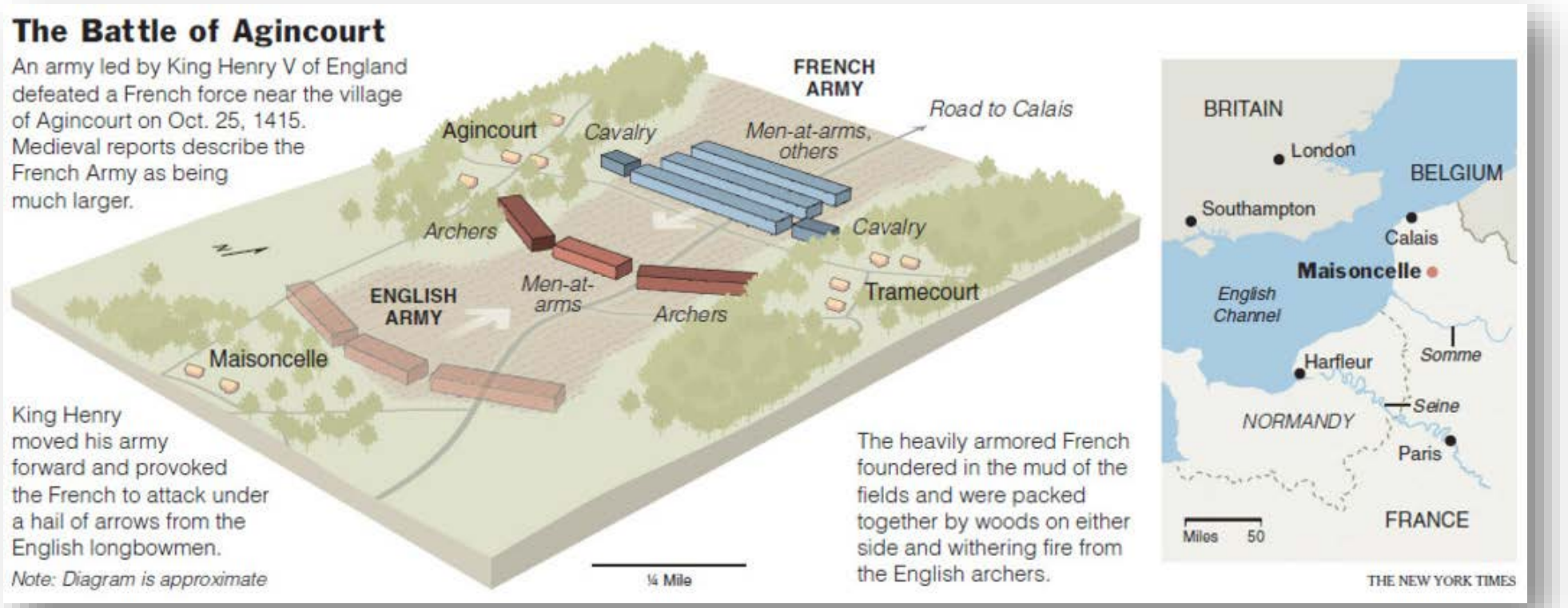
Challenges and Opportunities

1. Can CCaH collectively with other interested parties define and collect utilization data over a longitudinal period, i.e., 3 to 5 years, to evaluate whether or not CCaH care management policies are effective in changing utilization trends that that might lead cost reductions for senior long-term care?
2. Will CCaH providers assist with such an effort in regard to staff time, database sharing, and limited financial support to commission such research?
3. Are there any alternative data sources that can be used to evaluate the cost reduction premise for CCaH members, and if so, are they readily available?

Winning a Battle by Defying the Odds



30,000 French Soldiers: 8,000 English and Welsh Soldiers
10,000 French Deaths: 112 English and Welsh Deaths

Discussion

1. Understanding the Terrain
2. Adapting Tactics to the Situation
3. Superior Teamwork
4. Optimal Use of Available Tools
5. Mindful of the Treasure

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Terrain

1. Limited client base despite years in the market
2. Little or no comparative effectiveness research that demonstrates an outcome benefit for enrollees
3. Not currently seen as a component of an integrated Value-Based Population Health Management Strategy

Home Health services as preventive vs adjunctive to acute episodes of care

TABLE 9–5

Home health episodes not preceded by hospitalization or PAC stay increased at a higher rate than other episodes

	Episodes			Cumulative percent change	
	2001	2011	2016	2001–2011	2011–2016
Number of episodes preceded by a hospitalization or PAC stay (in millions)	1.9	2.2	2.2	14.8%	2.4%
Number of episodes not preceded by a hospitalization or PAC stay (in millions)	2.1	4.6	4.4	127.4	–7.7
Share of episodes not preceded by a hospitalization or PAC stay	53%	67%	66%	26	–3.3
Total (in millions)	3.9	6.8	6.6	74.0	–4.6

Note: PAC (post-acute care). "Episodes preceded by a hospitalization or PAC stay" indicates the episode occurred fewer than 15 days after a stay in a hospital (including in a long-term care hospital), skilled nursing facility, or inpatient rehabilitation facility. "Episodes not preceded by a hospitalization or PAC stay" indicates that there was no hospitalization or PAC stay in the 15 days before the episode began. Numbers may not sum to totals due to rounding.

Source: 2016 home health standard analytical file, Medicare Provider and Analysis Review file 2016, and 2016 skilled nursing facility standard analytical file.

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Tactics

Develop a data repository that comprehensively tracks enrollees Social Determinants of Health, episodes of care encounter data and cost of care data to allow the industry to monitor and manage CCaH processes and outcomes effectiveness and efficiencies

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Team

1. Need is for individuals with Clinical, Operational, Analytical and Financial expertise in managing risk in the senior services space across the continuum of care
2. Important to have individuals with skills in assessing community demographics and resources, product development, network management and marketing

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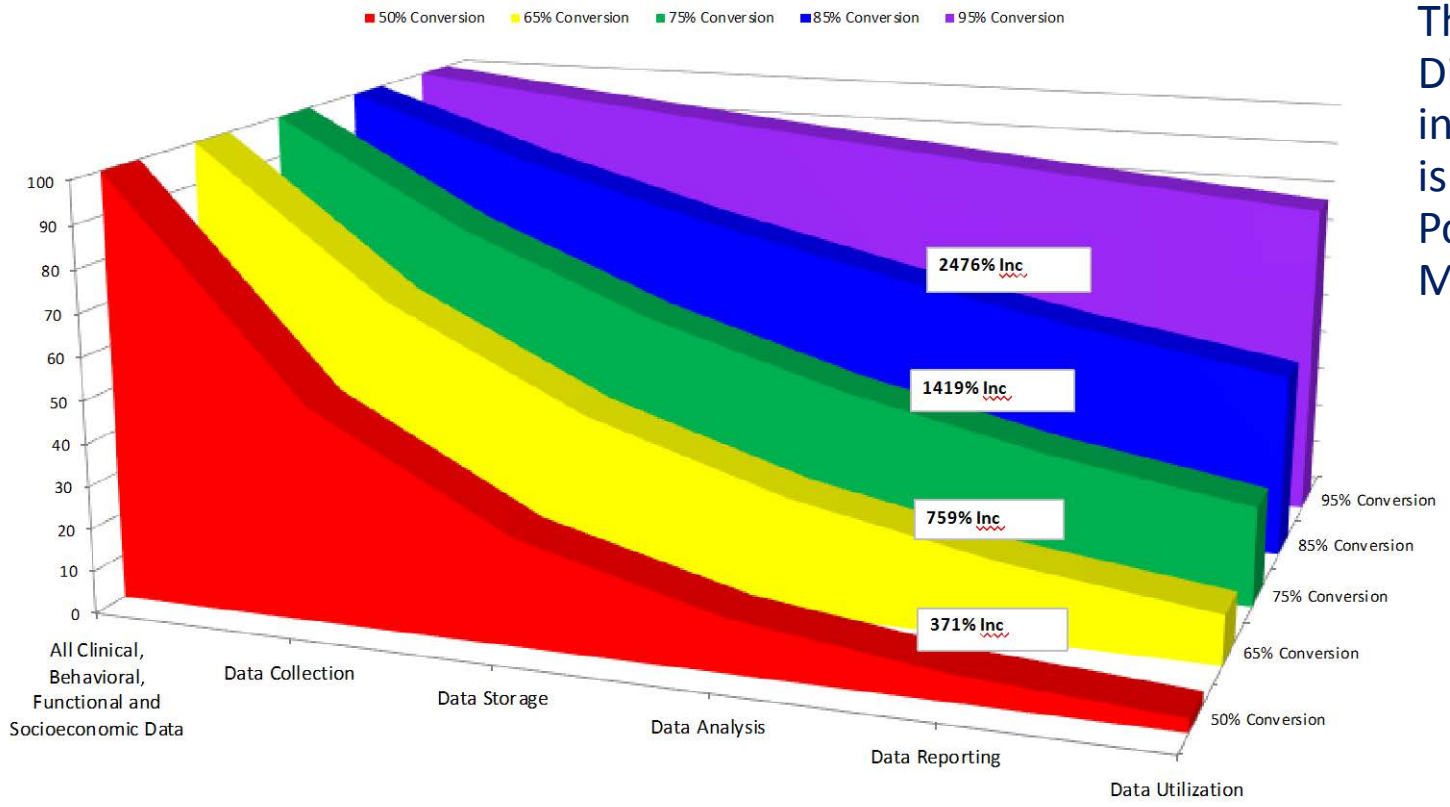
Data to Information Conversion Index (D2ICI)



The Conversion of Disparate Health Data into Valuable Information is the Alchemy of Population Health Management.

Insufficient collection, aggregation, analysis and reporting

TABLE 3-2 Summary of Data Availability for Social Risk Factor Indicators

SOCIAL RISK FACTOR	DATA AVAILABILITY			
Indicator	**1**	**2**	**3**	**4**
SEP				
Income		☐		
Education		☐		
Dual Eligibility	■			
Wealth			☐	
Race, Ethnicity, and Cultural Context				
Race and Ethnicity		☐		
Language		☐		
Nativity	■			
Acculturation				■
Gender				
Gender identity				■
Sexual orientation				■
Social Relationships				
Marital/partnership status		☐		
Living alone			☐	
Social Support			☐	
Residential and Community context				
Neighborhood deprivation		☐		
Urbanicity/Rurality	■			
Housing		☐		
Other environmental measures				■

1. Available for use now
2. Available for use now for some outcomes, but research needed for improved, future use
3. Not sufficiently available now; research needed for improved, future use
4. Research needed to better understand relationship with health care outcomes and on how to best collect data

Accounting for Social Risk Factors in Medicare Payment: Data

Demonstrating Functionally Distinguishing Value

TABLE 9–7 **Average home health agency performance on select quality measures**

	2013	2014	2015	2016
Share of beneficiaries that:				
Used emergency department care	11.7%	11.8%	12.2%	12.2%
Had to be admitted to the hospital	15.6	15.2	15.5	16.2
Share of an agency's beneficiaries with improvement in:				
Walking	58%	58%	63%	69%
Transferring	53	53	59	65

Note: All data are for fee-for-service beneficiaries only and are risk adjusted for differences in patient condition among home health patients.

Source: MedPAC analysis of data provided by the University of Colorado.

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Treasure

"If you don’t like change, you’ll like irrelevance even less.”

-Eric Shinseki, retired United States Army general, the seventh United States Secretary of Veterans Affairs (2009–2014).

Summary—Action Steps "for Discussion"

{minimum dataset} Opportunity for Disruptive Innovators

HIPAA compliant de-identified descriptors	Utilization Statistics tabulated for calendar year
1. Gender	1. Number of hospital transfers {request member permission to obtain this data from CMS}
2. Age nearest as of Jan 1st	2. Total hospital days {request member permission to obtain this data from CMS}
3. Coupled status at enrollment	3. Total home health aide hours; **when not considered ALU/MemCare/SNF eligible**
4. CCaH plan type	4. Total home health aide hours; **when considered ALU/MemCare/SNF eligible**
5. Date 1st assessed as ALU, MemCare or SNF eligible	5. Total assisted living or memory care days
6. Smoker	6. Total nursing care days

Summary

1. Health Care Delivery terrain is changing rapidly
2. Need capacity to dynamically (or quickly) adapt tactics
3. Your team must be experienced and visionary leaders
4. Success will come with developing tools that automate & accelerate data analysis
5. You will benefit with real treasure in:
   - Enhanced patient experiences and quality of care
   - If payment innovations can lead to lowering costs

About Dr. Michael Smith

Dr. Michael Vincent Smith is Regional Vice President and Medical Director of Central Region Medicare at Anthem. He oversees Medical Management, Quality Management and Population Health Management for more than 600,000 seniors in Indiana, Ohio, Wisconsin, Kentucky, Missouri, Tennessee and Georgia.

He is the former Chief Medical Officer at HealthCare Partners, IPA/MSO, an affiliate of Heritage Provider Network. He is a board-certified cardiovascular and thoracic surgeon and former Chief of Cardiovascular Surgery and Vice-Chairman of Surgery of an academic medical center in Atlanta, GA. He is a founding partner of SmithPowell.

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Leveraging CCaH Experience with CMS Programs

PART 2

Are there Synergies with Incorporating PACE in the Design of Your CCaH Program?

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Continuum Development Services

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Marketing Value of PACE in CCaH Design

1. Demonstrates ability to support members in the home even when they are frail
2. Can offer a comprehensive option, which integrates Medicare and long-term care benefit
3. Increases visibility in the broader community

Operating Value of PACE in CCaH Design

1. Provides evidence of the organization's ability to manage risk
2. Develops program infrastructure (e.g., home care, transportation, care management) from another revenue source
3. When members become eligible for costly nursing home services, member electing PACE could provide the organization a Medicare capitated payment
   - CCaH member may be at lower risk for incurring Medicare costs
   - Medicare capitation is the major source of net margin in PACE

Still Valuable Even if No One Uses Now

1. Most operation and market values exist regardless of whether PACE is a benefit elected by members
2. CCaH and PACE can become the foundation for a continuum of services for seniors regardless of economic or functional status
3. Some PACE organizations are reducing barriers to private pay as CCaH is looking for ways to broaden its market to more modest incomes, increasing the value of coordination

Future Possibilities?

1. As CCaH can become the life care benefit in a CCRC, private pay PACE may become the most efficient way to provide the benefit
2. An economic bridge may emerge as CCaH figures out how to be more attractive to modest incomes and PACE to those with greater resources through vehicles like reverse mortgages and increased technology in home
3. CMS and the states could "*truly walk through the looking glass with Alice*" and decide to fund a CCaH program to prevent Medicaid spend down for middle income seniors and a sliding scale private pay PACE optimizing Medicare dollars, if needed

Keys to Future Possibilities?

1. Collect data on CCaH members, which appropriately builds to parallel PACE information identifying best practices, government program savings, and guide operational decisions on a present value basis
2. Taking advantage of technological advances to redesign housing, support, and care models
3. Leading the way as not-for-profit senior living and healthcare organizations to create private/government partnerships to innovate new sustainable payment models meeting the needs and desires of seniors to flourish living in their communities

About Dan Gray

Dan Gray established Continuum Development Services (CDS) in 2002 and has provided consulting services for operational reviews, interim management services, and development of community-based services to more than 150 senior services organizations. Prior to starting CDS, Mr. Gray developed a continuum of services integrated with a 600-resident retirement community in the Chattanooga, Tennessee area, including PACE, Live at Home™, dementia assisted living, affordable housing and a Senior Neighbors program.

Mr. Gray is a past Board member of LeadingAge, the National PACE Association and the Catholic Health Association and he currently serves on the Board of Directors of the Caldsted Foundation.

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