



## Welcome to "Positioning Your HCBS Program in the Healthcare Market"

### Part 1: Overview of Health Reform Initiatives – How this Affects Your Organization and Terminology 101"

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*The webinar will begin at 3:30 p.m. Eastern Standard Time*



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SNF Payments and Reforms

## Got Change?



- Accountable Care Organizations
- Managed Medicaid
- Managed Longterm Services and Supports (MLTSS)
- Medicare Advantage changes
- Bundled Payment Initiatives

*If you don't have change, it is likely that change has arrived and you don't know it or that changes are on the way...*

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## Why should I care?



- Change is impacting the entire healthcare delivery system
- Some of the changes are changing the delivery of some services that were traditionally considered public social services
- In some markets, for-profit health insurers and other for-profit organizations are now delivering what had been considered social safety net services

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## Pre-Reform Example



- Dual Eligible in State A
  - Has traditional Medicare and Medicaid
  - Lives in an assisted living facility
  - Attends a social adult day program
  - Receives home delivered meals under a 1915(c) Medicaid waiver program
  - Mix of social safety net providers support the needs of this person

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## Reform Adopted



- State issues a State Plan Amendment (SPA) to CMS
- SPA accepted
- Significant changes to Medicaid program implemented

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## Social Safety Net Providers



- How does this example impact the social safety net providers?
  - Payment for HCBS now the responsibility of a managed care plan
  - Managed care plans are responsible for making decisions about the providers of services in their network
  - Decisions on the makeup of health plan network providers and cost of services determined by a health plan that has a fiduciary responsibility to control costs
  - Cost of services must begin to have a defined Return on Investment (ROI) for the payer

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## How can you prepare for these changes



- It is critical to understand how the system operated pre-reform
- Assess the planned reform changes and timeline for change in your market
- Assess how large healthcare providers and insurers are adjusting to planned changes
- Define your services, determine the ROI for your services, and prepare for change to occur

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## Step 1



- Let's begin by dissecting the system prior to the passage of the Affordable Care Act and then review how the changes are impacting the healthcare market

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## The Entire System is Changing



- System change takes time.



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## Organizational Change



- Major principles of Organizational Change must be taken into account when dealing with organizations
- Many health systems are undergoing System and Organizational change at the same time



**Did Someone  
Move Your  
Cheese?**

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## Medicare Basics



- Medicare is a Federal Health Insurance Program
- Medicare (2015) consists of 4 parts
  - **Part A**
    - Inpatient hospital, Skilled Nursing Facility (SNF) care, home health, hospice
  - **Part B**
    - Doctor services, office visits, screenings, therapies, preventive services, outpatient services, emergency care, ambulance care, medical supplies, & durable medical equipment
  - **Part C**
    - Medicare Advantage
      - Must cover all Part A and Part B benefits
  - **Part D**
    - Pharmacy benefits

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## Who is eligible for Medicare



- People 65 of older
- People under 65 with certain disabilities
- People of ANY age with End-Stage Renal Disease (ESRD)
  - Permanent kidney failure requiring dialysis or a kidney transplant

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## Affordable Care Act (ACA)



- The Patient Protection and Affordable Care Act
  - Health Reform. Commonly called the Affordable Care Act or ACA
  - Signed into law by President Obama on March 23, 2010
  - On June 28, 2012, the Supreme Court rendered a final decision to uphold the law
- ACA continues to have sweeping changes to the healthcare delivery system across the country
- Understanding the true impact of the changes imposed by ACA requires understanding how the current system evolved and the difference between where our system was and where it is going based on ACA mandates

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## The Evolution of the System



- Understanding the changes to the Health care delivery system requires understanding how the current system evolved.

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## Public Payers



- The primary Public Payer for Health Care is the Centers for Medicare & Medicaid Services (CMS)
- The Centers for Medicare & Medicaid Services (CMS) is the single largest payer for health care in the United States
  - Medicare
  - Medicaid
  - State Children's Health Insurance Program (SCHIP)
- Since CMS is the largest payer health systems, physicians, and commercial payers generally adapt or align their programs to adhere to the requirements of CMS

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## Medicare History



- The Medicare and Medicaid programs were signed into law on July 30, 1965 by President Lyndon Baines Johnson
  - Medicare enacted as Title XVIII of the Social Security Act extending health coverage to almost all Americans aged 65 or older
  - Medicaid program, authorized under Title XIX of the Social Security Act
    - Enacted to provide health care services to low-income children deprived of parental support, their caretaker relatives, the elderly, the blind, and individuals with disabilities
  - At the time of signing Older Adults were most likely to be living in poverty and about half had insurance coverage

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## Medicare Milestones



- 1972: Medicare eligibility was extended to individuals under age 65 with long-term disabilities and to individuals with end-stage renal disease (ESRD)
- 1972: Medicaid eligibility extended for elderly, blind, and disabled residents under the newly enacted Federal Supplemental Security Income Program (SSI)
- 1981: Freedom of choice waivers (1915b) and home and community-based care waivers (1915c) were established in Medicaid
- 1985: The Emergency Medical Treatment and Labor Act (EMTALA) requiring Medicare participating hospitals to provide appropriate medical screenings and stabilizing treatments

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## 1972 Amendments



- Under a risk-sharing contract, HMOs could contract with Medicare to provide interim payments compared with the Adjusted Average Per Capita Cost (AAPCC)
- AAPCC
  - An estimate of program expenses that otherwise would have been incurred for the Medicare beneficiaries enrolled in the organization
  - If the organization achieved “Savings” in relation to AAPCC, up to 20% of the savings would be split between the Government and the HMO

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## 1982: The Tax Equity and Fiscal Responsibility Act (TEFRA)



- TEFRA Made it easier for health maintenance organizations (HMOs) to contract with the Medicare program
- AAPCCs were computed for each county in the United States, with separate rates for the disabled and elderly
- HMOs were paid 95% of AAPCC on a full risk basis
  - **5%**
    - HMOs must control all of the cost for the members based on the 95 % of AAPCC

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## The Balanced Budget Act (BBA) of 1997



- Introduced Medicare Part C managed care program
- Medicare Part C was named “Medicare+Choice”
- The BBA introduced major revisions in the types of private plans that could have Medicare contracts

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## Medicare Modernization Act (MMA)



- One of the most significant changes to Medicare occurred under President George W. Bush on December 8, 2003
  - Medicare Modernization Act or MMA
- Medicare Modernization Act created the outpatient prescription drug benefit to Medicare
  - Medicare Part D program

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## MMA cont.



- The Medicare Modernization Act renamed the Medicare+Choice program “Medicare Advantage”
- For the first time, Medicare will consider beneficiary income to allow beneficiaries with incomes less than 150% of the FPL to be eligible for subsidies for the program
  - Part D program is available to beneficiaries from Private Drug Plans as well as Medicare Advantage plans

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## What is the reach of the Medicare Program



- The Centers for Medicare & Medicaid Services is a branch off the Department of Health and Human Services (HHS)
- In 2011, Medicare covered 48.7 million people.
- Total Expenditures in 2011 were \$549.1 billion

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## How is Medicare Funded



- Medicare is paid for through 2 trust fund accounts held by the U.S. Treasury.
  - Hospital Insurance (HI) Trust Fund
  - Supplementary Medical Insurance (SMI) Trust Fund
- These funds can only be used for Medicare

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## Hospital Insurance (HI) Trust Fund



- Payroll taxes paid by most employees, employers, and people who are self-employed pay into the Hospital Insurance Trust Fund
- Other sources, like income taxes paid on Social Security benefits, interest earned on trust fund investments and Medicare Part A premiums also pay into the HI Trust Fund
- HI Trust Fund pays for the following
  - Medicare Part A benefits
  - Medicare Program Administration

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## What are Medicare Part A Benefits



- Medicare Part A covers the following services:
  - Inpatient Hospital Care
  - Skilled Nursing Care
  - Home Health Care
  - Hospice Care

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## Supplementary Medical Insurance (SMI) Trust Fund



- How is it funded:
  - Funds Authorized by Congress
  - Premiums collected from people enrolled in Medicare Part B
  - Premiums collected from people enrolled in the Medicare prescription drug coverage plan (Part D)
- What does the SMI Trust Fund pay for
  - Part B benefits
  - Part D
  - Medicare program administration

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## What are Medicare Part B Benefits



- Medicare Part B covers the following services:
  - Medically Necessary Outpatient Services
  - Preventive Health Services
  - Doctor Visits
  - Ambulance Services
  - Supplies
  - Durable Medical Equipment (wheelchairs, walkers, etc.)

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## Beneficiary Costs for participation



- CMS 2015 Medicare Cost estimates
  - Part A premium
    - Most people don't pay a monthly premium for Part A
  - Part B premium
    - Most people pay \$104.90 each month
    - Total ( $\$104.90 \times 12 \text{ mo}$ ) = \$1,258.80/year
  - Part B deductible
    - \$147.00 per year (for most beneficiaries)
  - Part C and Part D premiums
    - Amount varies by plan

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## Medicare Part B rules



- Part B deductible and co-insurance
  - Yearly deductible of \$147 (2015)
  - Once the deductible is met, beneficiary must pay a co-insurance of 20% of the Medicare-approved amount charged by providers
  - Most preventive health services require no deductible or co-insurance payments
- Late enrollment penalty
  - If a person does not sign up for Part B when first eligible then they have to pay a late enrollment penalty for as long as they have Medicare

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## Policy Implications Example



- Pearl Harbor War Hero requiring a pace maker
  - Pearl Harbor War Hero aged 75
  - Did not sign up for Part B, at 65, because he thought he was promised healthcare from the military for life
  - Required a pace maker due to a heart condition
  - Could not get the pacemaker because he had to pay a late enrollment penalty equal to 10 years of non-payment into the Part B program
  - Hospital volunteered to write off expense but Surgeon could not conduct the surgery because of lack of Part B coverage

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## Ways to pay Part A & Part B premiums



- Premium amounts are commonly deducted from
  - Social Security Benefits
  - Railroad Retirement Board (RRB) Benefits
  - Civil Service Benefits
  - Direct payments

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## Deductible, Copay, & Coinsurance



- Deductible
  - A fixed amount that a beneficiary must pay each year towards the cost of their healthcare bills before health insurance coverage pays
- Copayment
  - A fixed amount paid whenever a particular type of healthcare service is provided
    - For example a \$20 copay for brand named drugs
- Coinsurance
  - A payment that is made as a percentage of the cost of the healthcare service

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## Medigap Market



- Medicare Part B beneficiaries can purchase a Medigap or supplemental policy to cover the 20% coinsurance requirements
- A Medigap policy defined
  - Health insurance sold by private insurance companies to fill gaps in Original Medicare coverage
    - Coinsurance, copayments, deductibles
    - If a beneficiary elects Medicare Advantage, they cannot be sold or use a Medigap policy
    - Beneficiaries with Medicaid (Duals) generally cannot buy a Medigap policy

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## Medigap for persons with a disability or ESRD



- Persons with Medicare, before age 65, because of a disability or ESRD
  - Are not guaranteed access to a Medigap policy
  - Federal law does not require insurance companies to sell Medigap insurance to persons under age 65
  - If the beneficiary has Medicaid, then Medicaid covers the Medicare payment gaps

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## What happens for Duals



- Duals are persons with both Medicare & Medicaid
- Commonly referred to as a Dual Eligible or a Medi-Medi
- Medicaid is required to pay the co-insurance and deductibles for Duals
- Provider must first bill Medicare and then bill Medicaid for the second portion

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## 2015 Part A hospital inpatient deductible



- Part A beneficiaries will pay the following:
  - \$1,260 deductible for each benefit period
  - Days 1-60: \$0 coinsurance for each benefit period
  - Days 61-90: \$315 coinsurance per day of each benefit period
  - Days 91 and beyond: \$630 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime)
  - Beyond lifetime reserve days: all costs

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## How are inpatient services covered



- Inpatient stay
  - Part A covers inpatient hospital services
    - Must meet medical necessity for a two day inpatient stay
  - Part B covers most of the doctor services when a beneficiary is an outpatient
- Observation of Emergency Room Care at a hospital
  - Coinsurance requirements apply to all outpatient services
  - Prescription drugs administered in an outpatient setting are not covered by Part B

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## Why would a doctor put someone in Observation status



- Medicare Part A will not cover an inpatient stay unless there is medical necessity that warrants the patient needing inpatient care for at least two (2) midnights
- For admissions on or after October 2013
  - When the inpatient admission is found to be not reasonable and necessary, CMS will allow payment of all hospital services that would be allowed as an outpatient (Part B)
  - Beneficiaries are liable for their Part B liability coinsurance

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## Medical Necessity not met



- What happens when Medical Necessity requirements are not met
  - Hospital can only obtain allowable Part B (outpatient coverage) services for the entire hospital stay
  - Routine services **are not** separately billable under Part B, when medical necessity requirements are not met for the hospital stay
    - Nursing services
    - Room and Board rate
    - IV infusions
    - Injections
    - Nebulizer treatments

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## Medical Necessity Example



- 82 y/o female living alone at home in Maryland
- Only relative is a daughter that lives in California
- Admitted for a fall, contusion to hip, no fracture
  - Difficulty walking, preparing meals, etc.
- Admitted for 4 days
  - Medical necessity not met
  - Does not qualify for SNF admission (minimum admission requirement not met)
  - Only Part B payments for all services authorized
  - Transferred to an assisted living and subsequently fell and broke her hip
    - Now eligible for SNF admission

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## Skilled Nursing Facility coverage

- Medicare Part A covers SNF care under certain conditions
  - Beneficiary must have Part A
  - Must have a qualifying hospital stay prior to transfer to the SNF
    - Qualifying inpatient hospital stay is 3 days before SNF care is authorized
  - Services required for a medical condition that meets one of the following indications
    - A hospital-related medical condition
    - A condition that started while you were getting care in the skilled nursing facility for a hospital-related medical condition

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## Skilled Nursing Facility coverage (cont.)

- Medicare covers the cost of care for SNF care as follows
  - \*Avg length of stay in a SNF is 20 days
  - SNF Readmissions likely occur between day 20 - 39

For Days	Medicare Pays for Covered Services	Beneficiary is responsible for the following
1 – 20	Full Cost	Nothing
21 – 100	All but a daily copayment	Daily copayment (2014 = \$152/day)
Beyond 100	Nothing	Full Cost

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## SNF Policy Issue



- Some hospital are using “Observation” days more frequently before formally admitting a patient to the hospital
  - Emergency dept. and observation days do not count towards the minimum 3-day hospital stay requirement for SNF coverage
  - The day of discharge doesn’t count as a inpatient day

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## SNF Admission Example



- Example
  - 70 y/o with CHF admitted to the ER for observation on January 5<sup>th</sup>
  - Transferred to an Observation bed on a Med-Surg unit on Jan 6<sup>th</sup>
  - Stays in observation until Jan 7<sup>th</sup>
  - Admitted on the 8<sup>th</sup> and discharged on the 10<sup>th</sup>
    - Total of 6 days in the hospital (January 5<sup>th</sup> – January 10<sup>th</sup>)
  - Discharged to a SNF on January 10<sup>th</sup> (3<sup>rd</sup> day of inpatient status but the 6<sup>th</sup> day at the hospital)
    - Medicare will not cover SNF stay because the beneficiary did not have a 3-day inpatient stay

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## Questions and Resources



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## Upcoming Webinars in this series

### **Part 2: Market Analysis - Determine Health Reform Initiatives in Your Market Area**

When: January 22, 2015 at 3:30 PM EST  
Time: 3:30 PM to 4:30 PM EST

### **Part 3: Network Development - The Need for Collaboration**

When: February 24, 2015 at 3:30 PM EST  
Time: 3:30 PM to 4:30 PM EST

### **Part 4: Developing a Strategy and a Business Model for Your Organization**

When: February 26, 2015 at 3:30 PM EST  
Time: 3:30 PM to 4:30 PM EST

