

The Post-Acute Healthcare Landscape for 2017

Value-Based Reimbursements
Take Center Stage

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2017 Post-Acute Healthcare Landscape

It is 2017 and we are moments into a new administration. While healthcare policy makers get ready to shake things up, value-based medical reimbursements are most likely here to stay and to be expanded. Last year our Baby Boomers celebrated another birthday and inch closer to Medicare coverage age. How can health care providers prepare for the new administration, aging America, and its unforeseen changes?



Who's old and when?

It's no secret that baby boomers are big influencers of today's American culture and economy. According to the Population Reference Bureau, Baby Boomers make up 76 million of America's people. In 2029, 20 percent of the U.S. population will be 65 or older, up from 14 percent in 2012.

As a wealthier, more active and more physically fit generation than our previous retiree groups, Baby Boomers will have a higher demand for independent living options and prescription medication choice. Assisted living facilities and home health organizations may continue to gain momentum to meet Baby Boomers' interests for aftercare. Senior health services will need to be priced in a way that suits the range of consumers' economic circumstances. It will require a different mindset, more variation and a greater focus on symptom management for patients with an array of chronic and co-morbid conditions.

Value-Based Reimbursements, Still the Focus

Obamacare and the Affordable Care Act reinforced the idea that medical care reimbursements are continuing to shift towards value-based outcomes. According to [Modern Healthcare's](#) post-election health care CEO survey, the vast majority of executives are confident the ACA-driven march to value-based care will continue. Today, outcomes are evaluated beyond patient discharge, and hospitals can be penalized for readmission if it can be traced to improper post-acute care or lack of medication compliance. Hospitals and post-acute care organizations such as rehabilitation clinics, skilled nursing homes, assisted living and home health can no longer work in silos to receive the maximum reimbursement. As the largest population of Americans ages, the frequency of health incidents will compound; are we ready to provide effective healthcare?

This white paper outlines 7 influential healthcare trends that describe the industry's continued need to collaborate to:

**Reduce Risk, Increase Reimbursements, Remain Competitive,
and Provide Quality Care To America's Residents**

1

Hospital readmission penalties to increase; post-acute care must be ready for downstream effects

As the Affordable Care Act (ACA) lurks near congress' chopping block, and individuals fear its demise, this and other legislative changes will increase the number of uninsured hospital patients. To lower Medicare and Medicaid costs and measure quality control; it is likely hospital readmission penalties will increase. According to the World Health Organization (WHO), medication non-adherence is one of the primary reasons for readmissions and emergency room visits. Hospitals will be looking for effective post-acute care to coordinate patients' medication compliance, lessen adverse interactions and manage side-effects to mitigate the risk of readmission.

As American patients take more and more prescriptions at a given time, care organizations shoulder more of the medication compliance risk over a longer period of time. Pharmacists, especially those serving the post-acute care sector, must be ready to withstand the competitive pressure and demonstrate their value along the care continuum. According to the National Community Pharmacists Association, up to 50 percent of all medications aren't taken as prescribed, and by some estimates, a third of all prescriptions are never filled; the estimated cost of medication non-compliance in the US is between \$100-\$289 billion annually. Innovative technologies like pre-packaged, customized medication delivery with pharmacy oversight are assisting the care sector in medication compliance and limiting adverse risk. Pharmacies and post-acute care sector will need to collaborate to reduce risk, cut costs, and be the preferred choice for Americans. With penalties on the rise, acute-care organizations are searching for affordable solutions to mitigate this risk.





2

Making America great again with 'A Better Way'

In June, Speaker of the House, Paul Ryan (R-WI) presented his plan "A Better Way" to reduce government costs associated with Obamacare, Medicare and Medicaid. The plan attempts to move Medicare away from the traditional, single payor program, and to provide a safety net as the ratio of employed Americans to retired individuals falls while Baby Boomers age. The overhaul would change Medicare to a privatized system. The new "premium support" Medicare would increase competition among private health care providers by allowing beneficiaries to select providers rather than rely on the government's selection. Ryan's June 22, 2016 Health Care Policy Paper states:

"The Medicare premium support payment would be adjusted so that the sick would receive higher payments if their conditions worsened; lower-income seniors would receive additional assistance to help cover out-of-pocket costs; and wealthier seniors would assume responsibility for a greater share of their premiums."

In addition, Ryan's plan focuses on changing the structure of Medicaid into block grants, run by the individual states. Block grants would give a flat amount of federal government funding to each state to spend on Medicaid as they choose. According to some studies, giving states the authority to customize their plans to align with each state's needs may better respond to coverage gaps over the federally administered current Medicaid plan.

3

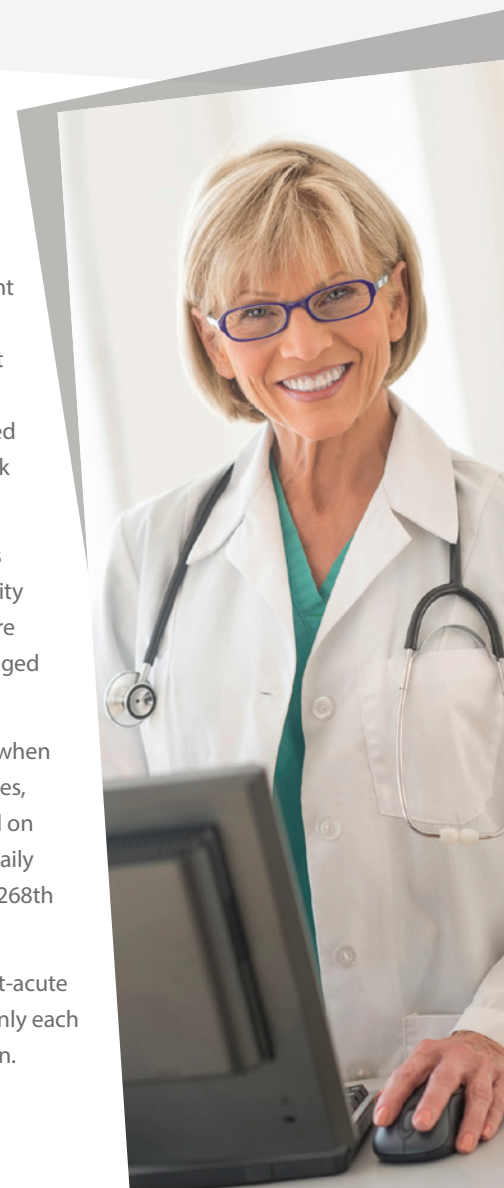
Value-based care and bundled payments encourages post-acute care and hospital coordination

The "new norm" for medical reimbursement relies on long-term health outcomes- even after a patient is discharged. The Center for Medicare & Medicaid Services (CMS) announced that by 2018 they hope half of all payments will be delivered through alternative payment models like bundles. Recent estimates predict that value based and bundled medical payments will completely overhaul the becoming traditional fee-based system in less than 15 years. Bundle payments are based on expected costs of clinically-defined episodes of care and have been proven to deliver a better value among risk reimbursement models.

CMS also announced that over 359,000 clinicians are confirmed to participate in one of four of CMS's Alternative Payment Models (APMs) in 2017. Clinicians who participate in APMs are paid for the quality of care they give to their patients. APMs are part of the Administration's effort to build a system where clinicians work together to have a full understanding of patients' needs; in turn, patients are encouraged to take a responsive role in their own care.

The shift towards medical cost containment increases the attractiveness of post-acute care services when compared to in-patient care. The cost to rehabilitate after hospital discharge in skilled nursing facilities, hospice organizations and/or any home care option is often much less than specialized clinics based on overhead and leveraged expenses. The American Association of Homecare recently found that the daily cost of oxygen for Medicare patients at home is 1/30th of the cost of a day in a nursing home and 1/268th of the cost of a single day in a hospital.

Considering the private sectors' plans to follow Medicaid's bundled payment lead, hospitals and post-acute care providers will become much more reliant upon each other for their economic survival as suddenly each procedure will be linked to its post-care outcome, medication compliance and chance of readmission.



4

Telehealth, the future of home based care

As America's population gradually shifts to one of aging Baby Boomers, many individuals will opt for long term care insurance, allowing them to remain in their homes for chronic care needs. In-home care and even hospice care can now be provided via Telehealth, especially for those in rural areas. Telehealth allows health care providers to achieve more seamless care coordination services, reducing the risk for hospital readmission. In August, Centers for Medicare & Medicaid Services (CMS) released the 2017 Medicare Physician Fee Schedule which incorporates the Telehealth reimbursement and coverage policies and added eight billable services. New policies to establish authority for non-physician practitioners to certify Medicare coverage, and creating a stand-alone Telehealth benefit for remote observation care of home-base patients, are likely to be established especially considering the recent appointment of Telehealth advocate Dr. Tom Price as Secretary of Health and Human Services.

Consistent with the momentum towards Telehealth, the increase of packaging and overnight shipping medication and information via "telepharmacies" will change the outlook of the rural America's health, most of whom do not have efficient access to acute care.



5

Patient as consumer

As long as the individual mandate for health-insurance remains, high deductible health plans will continue to be on the rise. The increased volume of out-of-pocket costs changes the patient's role to one of active consumer. As a consumer looking to evaluate one provider over another, patient satisfaction during medical acute and post-acute situations will be at the forefront. If patient satisfaction declines, care organizations are at risk of lower retention rates, coupled with risk of lower reimbursements.

With the patient now in the driver seat, care organizations are looking to guide patients through the often cumbersome path of provider selection and coordination between vendors to limit risk of adverse health outcomes.

What if the individual mandate for health insurance goes away? It will be up to Congress to introduce a way for people to be motivated to buy insurance to keep the medical market competitive.

To date, policy makers are considering the idea of allowing insurance companies to cross state borders to widen their risk pools or incentivizing health insurance policies with tax-deductions and tax-free Health Savings Accounts.

In either situation, with or without the mandate, the patient will continue to be further pressured to manage their own healthcare spending.

6

Increasing access to cross-border medication

A November poll by Kaiser Health News found that eight percent of responders, which translates to about 19 million adults based on current Census population estimates, said that they or someone in their household had imported a medication from Canada or other countries, despite this being illegal. Geographically Northern US citizens can drive over the border to Canada, and South Western US citizens can drive to Mexico. The rest of the country can use the Internet to purchase imported pharmaceuticals at prices half the cost of comparable drugs in the US.

Days after President Trump's inauguration, US Senators Susan Collins (R-ME) and Claire McCaskill (D-MO), the Chairwoman and Ranking Member of the Senate Aging Committee, respectively, released a bipartisan report on drug pricing titled, "Sudden Price Spikes in Off-Patent Prescription Drugs: The Monopoly Business Model that Harms Patients, Taxpayers, and the U.S. Health Care System." The report explores case studies of four major pharmaceutical companies and discusses potential policy solutions one of which is to consider allowing temporary prescription drug importation. Aligning with those findings, President Trump has mentioned his support in the effort of allowing international medication purchases to help moderate pricing in the US.

7

Skilled nursing homes flat-line; baby boomers have increased interest in assisted living and home health.

The number of skilled nursing homes in the United States has flat lined at about 15,000 and the National Investment Center for Seniors Housing & Care (NIC) reports that skilled nursing home occupancy experienced a significant decline to 86.8% in 2016, the lowest since 2005. The decline is more significant than in previous years, suggesting that lower occupancy is being driven a number of care delivery and reimbursement initiatives. The declines could be a result of the Affordable Care Act and the growth of Medicare Advantage, tight regulatory oversight, increasing patient acuity, labor challenges, and rising competition from home health and other senior housing and care sectors.

Even as the American Hospital Association reported that more than 37 million baby boomers will be managing more than one chronic condition by 2030; this group will want greater flexibility and programming than current skilled nursing home environments offer. It's predicated that by 2021, the number of skilled nursing homes could shrink by 20 percent.

"There is a lot going on in the skilled nursing industry," says Bill Kauffman, a senior principal at NIC. "This has a lot more nuances than just the retirement community."

The Centers for Medicare & Medicaid Services has been calling for reforms in the way that medical service providers, including nursing homes, receive reimbursements. Currently, 90 percent of skilled nursing home revenues are from Medicare and Medicaid. The proposed reform may cut costs by shortening patient stays and by bundling reimbursements for the myriad of patient services. Medicare and Medicaid are also searching for lower-cost models of geriatric health care such as home care and assisted living facilities to attain higher quality care, and more coordinated care at lower costs. As Medicaid and Medicare shift to include home and community-based settings, these two options continue to gain popularity over traditional skilled nursing home facilities, especially among the newly old.



Acute and Post-Acute Providers Need Enhanced Coordination

Welcome to 2017! This year the traditional American healthcare, Medicare and Medicaid models will be pushed further off the horizon. Healthcare providers and patients are just beginning to understand and embrace the ACA and value-based healthcare reimbursements and now both parties are bracing for more change. In the health eras of the past, health care providers worked individually, carefully providing best practices in acute or post-acute care without much thought to the patient after discharge. Those days are gone, the new healthcare landscape is fundamentally different- and payors, providers and patients need to keep adapting.

No longer will one-size-fit-all for any subgroup. Patients of all ages and conditions are picking high-deductible plans and expect effective, high outcome providers to choose from. Acute healthcare facilities must limit risk of poor evaluations and begin to align their care around patients to ensure successful delivery models. Providers must collaborate to maintain seamless care management from A to Z, from pre-op to prescription management, consultation to rehabilitation.

It's here: the patient is the consumer. Technology advances enable one patient to receive Telehealth and another to order medications from outside the US. Baby boomers keep getting older. Today, solutions exist to chaperone care organizations towards the adoption of more patient-centric delivery models. These models place partners working together to ensure compliance, increase patient satisfaction and improve health outcomes.

There is much more to be deciphered as Trump's administration gets fully underway; however, one thing is clear: acute and post-acute providers will need to coordinate care more than ever to remain focused on providing the best health outcomes possible, before, during and after medical treatment.



About TwelveStone Health Partners

TwelveStone Health Partners incorporates the objective of glorifying God into its mission by delivering a higher level of service to partners and patients. As an organization, TwelveStone supports the transition from acute to post-acute care environments and the transition from sickness to health. This is the third evolution in the company's history, beginning in 1980 when Richard Reeves and Ronald Powell created a single retail pharmacy location then called Reeves Powell Saveway Drug Store. In 1994 Shane Reeves and Rick Sain launched Reeves-Sain and over 20 years grew the organization to include seven companies. In 2015 Reeves Sain Drug Store, Inc., a retail pharmacy, and its specialty pharmacy, EntrustRx were sold to Fred's, Inc. In 2016 Shane Reeves launched TwelveStone Health Partners with the objective of continuing to pursue the highest professional, business and community goals set forth by its founders.

For more information, visit or call.
www.12stonehealth.com
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