THE HEALTH CARE SECTOR AND LTSS CBO'S

A MARKET STUDY CONDUCTED FOR THE COLORADO HEALTH FOUNDATION

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Colorado LinkageLab

NONPROFIT Impact

Your impact is our mission.

INTRODUCTION

PURPOSE

- To profile the Colorado health care market and characterize its interest, criteria, and demand for investing in relationships with LTSS CBOs

KEY QUESTIONS

- Who makes up the market?
- What drives the market?
- What is the market demand for partnerships with LTSS CBOs?
- Where should we focus?
- What's our value proposition?
- What does it take to partner successfully?

WHO MAKES UP THE MARKET?

PROVIDERS

- Hospitals / health systems
- Safety net providers
- Practices / individual providers

PAYERS

- Public – Medicaid
- Public – Medicare
- Private

HEALTH CARE PROVIDERS

HOSPITALS / HEALTH SYSTEMS

- 101 hospitals operate in Colorado
- Urban – 61; rural – 40; critical access – 27
- Consolidating market with 5 dominant health systems
  - Banner Health, Centura Health, HealthONE, SCL Health, and University of Colorado Health)

HEALTH CARE PROVIDERS

SAFETY NET PROVIDERS

- 18 nonprofit Federally Qualified Health Centers (FQHCs) operate 160+ sites
- 56 Rural Health Centers
- 500+ other safety net providers

HEALTH CARE PROVIDERS

PRACTICES / INDIVIDUAL PROVIDERS

- 13,411 licensed physicians – 6,606 primary care; 6,805 specialists
- 50% of physicians work for hospitals / healthcare systems
- Significant healthcare workforce shortages across the state (primary care, dental, mental health)

HEALTH CARE PAYERS

PUBLIC – MEDICAID

- Medicaid expansion has nearly doubled the % of citizens covered between 2010 (10.4%) – 2014 (19.5%)
- 58% of Medicaid beneficiaries (**600,000+**) were enrolled in Medicaid Accountable Care Model at end of FY 2013-14
  - Regional Care Collaborative Organizations (RCCOs) deliver this model regionally
- Two Medicaid Managed Care Organizations also serve beneficiaries

HEALTH CARE PAYERS

PUBLIC – MEDICARE

- **686,012** Medicare beneficiaries in Colorado
- 37% are covered by Medicare Advantage (MA) plans
  - 50 plans:
    - Cost plans – 19
    - Local HMOs – 22
    - Local PPOs – 7
    - Fee-for-service – 2

HEALTH CARE PAYERS

PRIVATE

- Individual and small group markets – moderately concentrated
- Large group market – highly concentrated/uncompetitive
- Three payers come up multiple times in lists of 5 largest payers by market share:
  - Kaiser Foundation (individual, small group, large group, MA)
  - Rocky Mountain Hospital & Medical (individual, small group, large group)
  - United Healthcare (small group, large group, MA)

WHAT'S DRIVING THE MARKET?

HEALTH CARE TRANSFORMATION / ACA

- Reforms to how providers deliver care:
  - Behavioral health integration
  - Care transitions
  - Health information technology
  - Patient-centered medical homes
  - Readmissions
  - Super-utilizers
- Reforms to payment models, trending (slowly and unevenly) away from fee-for-service to other models that incentivize quality, value, performance, and prevention
- Many of these efforts have been pilot projects that are now becoming more permanent

OTHER TRENDS

- Many members of the market are overwhelmed by the work of adapting to change
- Emphasis on formally measuring and improving quality is increasing across all market types
- Awareness of **the social determinants of health** and their impact on the ability of providers to meet quality and performance targets is increasing

WHAT IS THE MARKET'S DEMAND FOR PARTNERSHIPS WITH LTSS CBOs?

CURRENT DEMAND: WEAK

- Providers and payers, knee-deep in the details of health care transformation, have yet to pay concerted attention to older adults and/or LTSS
- Payment reform focuses on provider quality, areas of potentially large cost containment
- Many LTSS CBOs have too little capacity to impact cost savings

CURRENT DEMAND: WEAK

"When you look at stand-alone CBOs, how attractive are they really going to be? How much are they going to be able to move the dime and save money for a health plan with 1000's of covered lives? Even if we took all the nursing facilities that participate in Medicaid we wouldn't have critical mass to create any kind of network to attract a payer to work with us."

FUTURE DEMAND: INCREASING

- Behavioral health integration is broadening providers' definition of health and offers new partnership models—both of which provide precedents LTSS CBO's can follow
- Increasing awareness of the realities of the social determinants of health and their impact on ability to achieve outcomes in areas like hospital readmissions
- Medicare's new Hospital Value-Based Purchasing model doubles down on the readmission metrics and pushes hospitals to focus on discharge timing, destination, and execution

FUTURE DEMAND: INCREASING

"Consistent transfer of patients to more cost effective and clinically appropriate post-acute care services could result in significant hospital MSPB gains and save Medicare up to $34.7 billion in 10 years."*

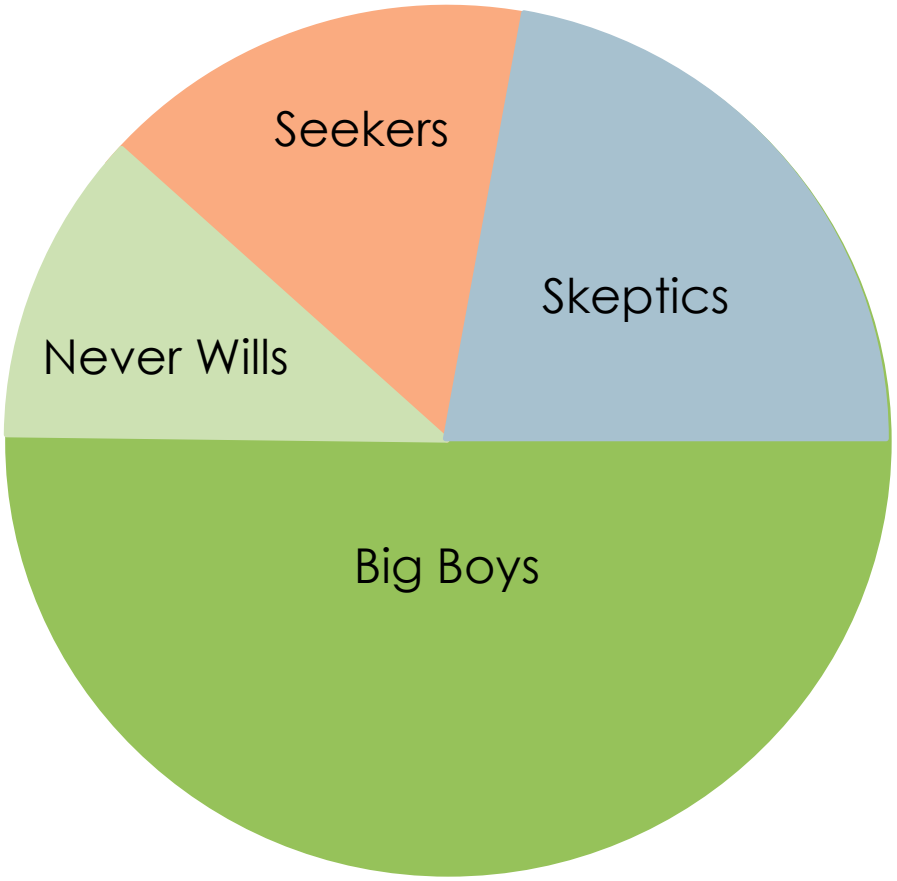
Journal of the American Medical Association; Beyond ACOs and Bundled Payments, February 19, 2014

* MSPB = Medicare spending per beneficiary

WHERE SHOULD WE FOCUS?

MARKET SEGMENTS

- Segmented by how they relate to the value of investing in partnership with LTSS CBOs



NEVER WILLS

- Will never be interested in partnering with LTSS CBOs
- Primarily providers who:
  - Share too little overlap in target population; or
  - Are so resistant to health care reform and transformation efforts that they say no to everything

BIG BOYS

- Those entities that are too big to be interested in partnering
  - Primarily payers with 1,000's or 10,000's of covered lives
  - Some larger providers (e.g., larger health care systems)
- The service delivery capacity of most LTSS CBOs is too small a drop in their bucket to make a significant population-level health or cost-savings impact
- Economies of scale may favor in-house solutions

SKEPTICS

- Think partnerships with LTSS CBOs might be useful for a variety of reasons, but have questions or concerns
  - Lack of standard quality metrics
  - Perceived competition / limited coordination amongst LTSS providers
  - Uncertainty about who to work with
  - Wondering if it would be easier / more cost effective to do it themselves, etc.

SKEPTICS: TARGET MARKETS

SELF-SUFFICIENT INNOVATORS

- Predominantly FQHCs, RHCs, other safety net providers; may include some smaller nonprofit hospitals
- In a word: scrappy!
- Identify with their patient population
- Comfortable trying new things
- Worry that new payment models may put them at a disadvantage
- Worry how increasing % of patients with Medicaid will affect their culture
- May be more likely to opt out of new collaborative efforts—they already have a lot of collaborations in place!

LINE-CROSSING CONVENERS

- RCCOs and others who blur the lines between payers and providers
- History of convening cross-sector groups to address systemic issues
- Believe that addressing LTSS gaps is important for the system
- Able to easily see the provider/patient benefits and payer/financial benefits of partnering with LTSS
- Over-achievers (if you want something done, ask a busy person) with very long to-do lists

SEEKERS

- The early-adopters and innovators
- Some who see the next wave of integration (after behavioral health) is social services
- Some who see significant potential (cost savings and/or mission-related, patient-outcome related) from working together

SEEKERS: TARGET MARKETS

TRUE BELIEVERS

- Believe in the principles of PCMH and deeply dedicated to better support and serve patients
- Often (not always) younger providers
- Welcome change; make decisions and start implementing quickly
- Some lack a deep understanding of older adult patient populations
- Can be hard to get their attention
- Likely actively engaged with RCCOs, Health Extension Service, etc.
- Technology "early adopters"
- Understand that the social determinant of health impact their patients' outcomes

STRATEGIC COLLABORATORS

- Social determinants of health is a common framework
- Aware that they cannot meet their goals without others who can attend to patients' social needs
- Nonprofit hospitals / health systems that are mission and value driven
- Starting to be on the lookout for partners or solutions to fill these gaps
- Aware that their purchasing power can impact and shape the market
- Talk "post-acute" rather than "LTSS"; "transitions" rather than "community living"
- Value consistency, reliability, quality

WHAT IS OUR VALUE PROPOSITION?

IN GENERAL

- Knowledge
- Connections/services
- Resource information
- Value added

GETTING SPECIFIC

- Depending upon your potential partner, review their quality and performance metrics and goals
- Then, explicitly connect the dots between the value you can provide and their metrics/goals
- Make sure you can measure it!

WHAT DOES IT TAKE TO PARTNER SUCCESSFULLY?

GET COORDINATED

- Get coordinated across LTSS CBOs
  - Adopt standard definitions and quality metrics
  - Band together as needed to be able to deliver sufficient reach

BE BRAVE

- Explore uncharted waters
  - Health care providers and payers aren't yet reaching out to LTSS in any significant way
  - Everyone is overwhelmed and doesn't have time or bandwidth to be proactive
  - Use a pilot project approach—not everything new will work! Set up, monitor and make mid-course corrections, evaluate results.

DO YOUR HOMEWORK

- Research your potential partner—start in the right place (discharge planning, finance, quality)
- Understand their quality measures and lead with your data

"The marketing person used to bring food to a meeting with another organization. I don't hear that anymore. Now they bring their data. That's all people care about. It's a very different approach."

DATA, DATA, DATA

- Get the data, share the data
  - Everyone needs to prove the validity of their program, so data starts to feel precious
  - Go first, be willing to share data and let a partner "look under the hood"
- Build the infrastructures you need to support new assessment and evaluation needs

QUESTIONS?