The Additional 8th Force Among The Law Of The Land For I/DD Services

by Jim Vail, April 27, 2017

Each of the 7 forces noted in Tom Schramski's recent, compelling article (Vertess; Volume 4, Issue 7) is certainly reshaping I/DD services. In our opinion, however, the following trend will roil all aspects of the I/DD landscape.

8. I/DD providers will soon be identified—primarily—as health care providers and secondarily as human services and/or LTSS organizations. The information below illustrates this impending eventuality.

As Tom notes, it appears to be an inexorable trend that MCOs will contract (as administrators and payers) with increasing numbers across state Medicaid services. There are simply too many lives to cover and too much money at stake to prevent MCOs from finding a path to success in this market.

MCOs have a core competency related to squeezing costs out of a system – primarily through tough rate negotiation and zeroing in on all areas of expense reduction. Additionally, "playing" one provider against another provider is another winning approach MCOs historically bring to the cost-cutting table. Using these tactics in the I/DD space seems to be the game plan.

Based on recent external research studies and our analysis presented to CMS, health care costs for people with I/DD are high and expanding quickly. With constant or declining LTSS rate reimbursement and health care costs likely increasing at almost double-digit annual rates, there will be a crossover point in the not-too-distant future.

For providers in states with low LTSS reimbursement rates, the crossover point—aggregate health care costs for people supported exceeding LTSS expenses—will occur in approximately three years. We expect the crossover point will occur for all states and providers within the next five to seven years. Consequently, from a cost perspective, I/DD services will squarely be in the health care business. In the eyes of funders, I/DD providers will become health care entities.

MCOs well understand that a large percentage of health care costs are due to preventable behaviors. Recent studies indicate that 13% of all early and unnecessary deaths are due to nutrition or the foods that people consume. If ongoing studies confirm that 10 – 15% of all health care costs can be forestalled (pushed into future years), or completely eliminated, via improvements to nutrition, this area of cost containment will become a laser focus for MCOs.

LTSS providers are an easily identifiable target. In most cases, these organizations are directly responsible for procuring and preparing meals for people supported. Or, the provider is responsible for helping people supported make informed and responsible choices regarding food consumption. There is recognition within the industry regarding this responsibility and opportunity to intervene; a respected I/DD provider in the Midwest notes: "Choice does not mean helping a person supported eat themselves into a poor quality of life and early death."

Value–based purchasing is already a priority for acute care hospitals because CMS and insurance companies are zeroing in on the total cost of care for patients over the long term. As a result, if a hospital provides substandard care (or care that requires unexpected follow-up and/or readmission after discharge), the hospital may not be reimbursed for all or some of the cost incurred with the readmission.

We now hear MCOs talking to I/DD providers with the same terminology – value-based purchasing. This is a straight line to health, in our opinion; in addition to runaway and unnecessary medical care costs demanding immediate attention, health and associated expenses are among the most identifiable outcomes that can be objectively assessed in LTSS settings. As such, we expect the next "shoe" to drop soon – a single capitated rate for each consumer that includes LTSS *and* health care expense. If the combination of LTSS and health care costs are below this rate for the person supported, there would be a split in the "savings" between the MCO and the provider. Conversely, if LTSS and health care costs are above this rate, providers will be on the line for some or all of this expense overage.

Based on trends, activities and our experiences in the human services industry, our conclusion can only be that the 8th force—**I/DD providers will soon be identified—primarily—as health care providers**—is a monumental shift that will necessitate bold leadership, innovation, pencils very well sharpened, and both stethoscopes and spatulas at the ready.

. . . Need more evidence that providers are morphing into, and being thought of as, health care businesses? Look at private equity/venture capital activity. Recent I/DD provider equity infusions/purchases have predominately been from health care-centric PE groups. Additionally, note the changes in the C suite within large I/DD providers, which increasingly includes executives with health insurance or direct health care experience.

About Jim . . .

James D. Vail holds his MBA from Northwestern University's Kellogg School of Management and is long experienced in both the health care and human services industries, with an impressive track record regarding critical outcomes achievement. He is president of Mainstay, Inc. and its *My*25 programs.

*My*25 resources are utilized throughout 30 states by leading providers, MCOs, state DHS, and state provider association groups, with a 99.9% subscription retention rate. Within LTSS settings, *My*25 streamlines menu planning, grocery shopping, and recipe prep to facilitate substantial and sustainable outcomes related to elevated choice, improved health for people supported, reduced expenses regarding food, labor, PRNs, acute care and prescription medications. Menus are customized for the individual (no matter how complicated) and customized regarding routines within each setting—cycling new every 35 days.

On average, 70% of people supported are moving away from a normal BMI prior to *My*25 start. 6 to 18 months after *My*25 start, 70% of people supported are at or moving toward a normal BMI, with commensurate improvement to A1c levels, blood pressure readings, waist-hips ratios, and more.

*My*25 programs additionally include robust and galvanizing engagement and educational resources for staff, consumers, and family members. Mainstay's team is comprised of: human services industry, preventive health, nutrition, disease management, culinary, business, and technology professionals.

In early 3rd quarter, 2017, *My*25 will introduce a series of resources to improve the preventive health and nutrition of people with disabilities—IDD, SPMI, TBI and behavioral challenges—within supported living and foster and home-based settings. As a result, quality of life will be enhanced for millions of individuals and invested funders and stakeholders will benefit from significantly reduced expenses.

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7 Forces Are The Law Of The Land For I/DD Services

By Tom Schramski, PhD, CMAA

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Last Friday, the first edition of Trumpcare bit the dust and Speaker of the House Paul Ryan called Obamacare the "law of the land." The truth is that neihter Obamacare nor Trumpcare rule the landscape of intellectual/developmental disabilities (I/DD). There are several unique factors in play that will shape the future and these forces will be critical in the new I/DD marketplace.

1. **Managed care organizations (MCOs) will continue to shape the I/DD marketplace**. For the last two decades, I/DD providers have largely resisted efforts to bring their services under managed care administration. Recent mandated managed care coverage in multiple states means that it is only a matter of time before most states will have their services contracted in this manner. The impact on existing providers, especially smaller organizations, will be profound.
2. **Payers will require significant IT upgrades and adoption**. I/DD providers are generally behind other healthcare providers in their technology infrastructure. This means that increased demands will be placed on I/DD organizations to upgrade their operational IT, as well as their technology interface with funding agencies that are expanding their data requirements.
3. **Providers will need to measure value-based outcomes**. Over the past four decades there has been provider resistance to embracing a quantifiable measurement of outcomes in the I/DD population. There is increasing evidence that this will not be acceptable, especially in an MCO environment. Successful providers will define their own outcomes as a step toward anticipating that outcomes will be tied to reimbursement.
4. **Service innovation will accelerate**. Many I/DD services are provided much as they were 30-40 years ago, especially in the residential support area. A younger, entrepreneurial generation of providers will offer more self-directed variations on the theme, such as host homes, and creative options to agency-focused in-home care.
5. **Service marketing will be transformed**. Today, providers rarely market directly to individuals and families, because of Medicaid restrictions. The Trumpcare era will likely lead to a relaxing of these rules and allow providers to creatively market to their potential customers. Provider websites will facilitate more direct consumer-provider interaction.
6. **Consolidation will increase**. Consolidation in the form of mergers and acquisitions will increase, especially in the nonprofit area. The evolution and requirements cited previously require that providers become more sophisticated in their operation, which means scale and financial agility, especially involving technology.
7. **I/DD executives will surf the new normal**. Successful I/DD leaders will jump in the water, explore new possibilities and convert their learning into new service opportunities. We can expect more significant change than many I/DD leaders have seen in the past half century.

If you would like to personally discuss this article, the value of your company, or how to get the best price when you sell it, you can reach Tom directly at tschramski@vertess.com or 520.975.5347.