Strategies to Align with Bundled Payment Models & Impact Your Bottom Line

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Objectives

1. Understand bundled payments as an Alternative Payment Model.

2. Learn best practices for clinical programming, data analytics, and networking to impact your bottom line.

3. Understand the SNF/therapy partnership to meet the goals of the Three-Part Aim of healthcare reform.

4. Learn how these strategies impact your 5 Star Rating, Quality Reporting Program, and Value-Based Purchasing Program.

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Let's start with some stats....

- 60 million Americans are covered by Medicare
- 10,000 become eligible for Medicare daily
- US population ages 80+ will nearly triple from 2010 to 2050
- Number of 90+ aged folks will quadruple same time period
- 72,000 aged 100+ in 2014 (>80% are women)
- 50,000 aged 100+ in 2000 (44% increase to 2014)
- 15,000 aged 100+ in 1980

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Let's start with some stats....

- By 2030 there will be 4 million PA residents over 60 y.o. (nearly 1/3 of the population)
- 699 PA Nursing Homes that care for 80,000 people
- Average resident is a widow 85+ with dementia
- Average annual cost in PA = $105,000
- 65% of residents covered by Medicaid (pays average $217/day)

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Let's start with some stats....

- 18-44 age group: 5.6% have 2 or more chronic conditions
- 45-64 age group: 31.7% have 2 or more chronic conditions
- 65+ age group: 66% have 2 or more chronic conditions
    - 23.2% have 4 or more chronic conditions
- Importance of prevention, wellness, fitness, health promotion, care coordination and management of disease and disability
- Average payment amount per SNF stay in 2013 = $10,919
- Average LOS in 2013 = 28 days

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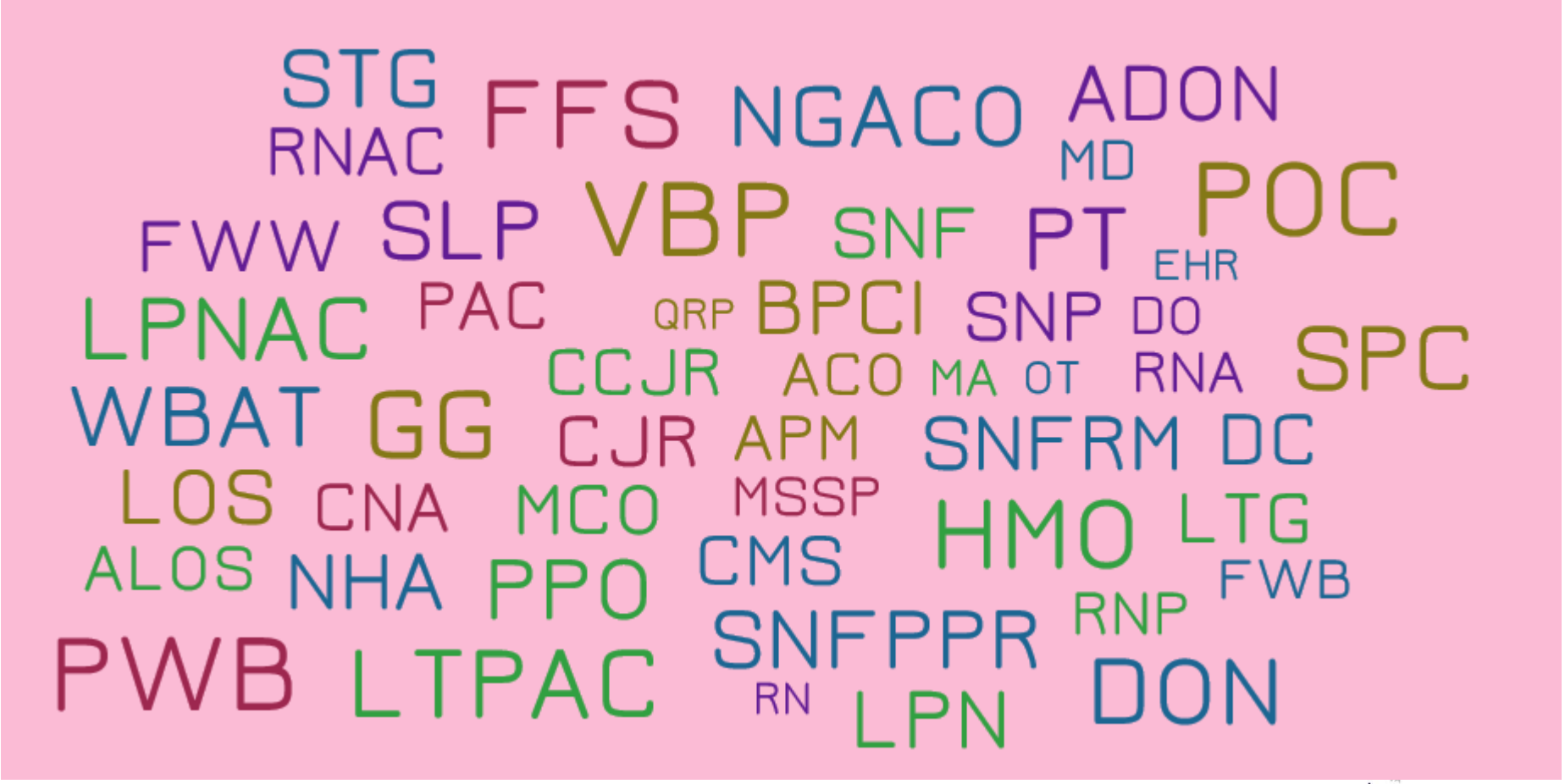
Our SNF Language



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3 Goals of Healthcare Reform
Triple Aim Goals

- Improve the individual experience (outcomes and satisfaction)
- Improve the health of populations
- Reducing the per capita cost of care for populations

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Volume → Value

- **Alternative Payment Models (APMs):**
  - **Accountable Care Organizations (ACOs)**
    - **Pioneer ACO**
    - **Medicare Shared Savings Program ACO**
    - **Next Generation ACO**
    - **Comprehensive ESRD Care Model**
  - **Bundled Payments for Care Improvement**
    - **BPCI Models 1, 2, 3, and 4**
  - **Patient-Centered Medical Homes**
    - **Coordinated care through a primary care physician**
- **Comprehensive Care for Joint Replacement**
  - **First mandatory diagnosis / DRG-specific bundled payment model**
- **Value-Based Purchasing Programs**

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Volume → Value

- 2011 – NO Medicare payments to APMs
- 2014 – 20% to APMs
- By end 2016 – 30% to APMs
- By end 2018 – 50% to APMs
- 2016 – 85% of Medicare FFS payments will be tied to value
- 2018 – 90% of Medicare FFS payments will be tied to value

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The Laws

- Affordable Care Act of 2010
- Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014
- Protecting Access to Medicare Act (PAMA) of 2014
- Medicare Access and CHIP Reauthorization Act (MACRA) of 2015

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Bundled Payments for Care Improvement

- The BPCI "initiative is comprised of four broadly defined models of care, which link payments for the multiple services beneficiaries receive during an episode of care."
- Organizations enter into payment arrangements that include financial and performance (quality) accountability for episodes of care.
- Old payment model: Medicare makes separate payments to providers for each of their services (quantity). Results in fragmented care and minimal coordination across healthcare settings.

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Bundled Payments for Care Improvement

- Episode triggered by hospitalization
- Base period target price (less 2-3% upfront CMS discount) is compared to performance period
- All providers paid through regular FFS
- Bundling is retrospective calculation
- Beneficiary must be eligible for Part A and enrolled in Part B
- Target price exclusions (unrelated conditions to bundle diagnosis, Part D drugs, hospice claims)

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Bundled Payments for Care Improvement

- Example #1:
  - Target price = $20,000 less 3% = $19,400
  - Performance FFS cost = $22,000
  - Amount paid back to CMS = $2,600
- Example #2:
  - Target price = $20,000 less 3% = $19,400
  - Performance FFS cost = $17,000
  - Amount of gain paid to bundler = $2,400
- Quarter Net Reconciliation = $200 paid back to CMS

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Bundled Payments for Care Improvement

BPCI Model 1

- Episode of care = inpatient stay in an acute care hospital
- Began in April 2013
- CMS pays the hospital a discounted amount based on IPPS and pays physicians separately (MPFS)
- All DRGs
- 1 participant (0 in PA)

BPCI Model 4

- Episode of care = **entire** inpatient stay in an acute care hospital
- Began in October 2013
- CMS pays a single, prospectively determined bundled payment to the hospital (includes physician and other practitioner services)
- 48 Clinical Episodes to choose
- 9 participants (3 in PA)

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Bundled Payments for Care Improvement

BPCI Model 2

- Episode of care = inpatient stay plus the PAC and all related services up to 90 days post hospital DC
- CMS pays a retrospective bundled payment where actual expenses are reconciled against a target price for the episode of care.
- 48 Clinical Episodes to choose
- Three-Day Hospital Stay Waiver for SNF Part A coverage
  - SNF needs 3 or more stars
- 563 participants (44 in PA)
  - Moses Taylor Hospital (Scranton), St. Luke's Hospital (Bethlehem), Geisinger Medical Center (Danville)

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Bundled Payments for Care Improvement

BPCI Model 3

- Episode of care = triggered by an acute hospital stay but begins at initiation of PAC services with a SNF, IRF, LTCH, or HHA and ends 30, 60, or 90 days after initiation
- Same retrospective bundled payment as Model 2 with a payment or recoupment amount made by Medicare comparing expenses to the target price.
- 48 Clinical Episodes to choose
- 813 participants (70 in PA)
  - Whitestone Healthcare Group (Stroudsburg), Maplewood Nsg & Rehab Center of PA (Philly), Jefferson Hills Manor (Pittsburgh), Mulberry Square Elder Care & Rehab Center (Punxsutawney)

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Bundled Payments for Care Improvement

February 2016 Kaiser Family Foundation report:

- BPCI Model 1 “was found to have lower costs than non-bundled episodes of care during the initial hospital stay”
- BPCI Model 2 “had lower spending on post-acute care than non-bundled episodes…..due in part to a decrease in the use of skilled nursing facilities….and an increase in the use of home health services.”
- BPCI Model 3 “saw no significant changes in overall spending.”
- “No differences in quality were reported between all four BPCI models and non-bundled episodes…”

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Bundled Payments for Care Improvement

Lewin Group study:

- ALOS in SNF dropped 1.3 days for BPCI orthopedic surgery patients
- Overall use of institutional PAC services for BPCI orthopedic surgery patients dropped from 64% to 57%
  - Similar pattern for cardiovascular surgery patients
- THA & TKA BPCI patients also showed reduced Medicare costs BUT not significant changes to quality of care

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Bundled Payments for Care Improvement

CMS BPCI Program Evaluation Report:

- "…modest reductions in Medicare episode payments…with isolated instances of quality declines and fewer instances of increased quality."
- Orthopedic surgery patients' costs cut by $864 per episode and reported greater improvements in mobility after 90 days compared to non-BPCI patients
- Cardiovascular surgery at hospitals in one model did not save money and quality remained the same
- Spinal surgery episode costs increased, but mortality declined

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Strategies for Success

Data Analytics / Dashboards

- MSPB report (cost per episode per diagnosis in SNF)
  - https://data.medicare.gov/Hospital-Compare/Medicare-Hospital-Spending-by-Claim/nrth-mfg3
- LOS (per diagnosis)
- Readmission rates (per diagnosis)
  - F/u after DC from SNF: 30, 60, 90 days
- Functional Outcomes
  - CARE, Fall Risk, Cognition, & other T&M
- Mortality Rates
- ED / ER visits (UTIs and handwashing)
- DC sites (per diagnosis)

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Strategies for Success

Clinical Programs

- **Outcomes tracking** (CARE item sets)
- **DC Planning Day 1**
  - Care Conference Day 2 or 3
  - Home Assessment by Day 7 (earlier if CCJR)
- Functional-based Treatment Focus
  - Establish HEP / RNP early
- Diagnosis-specific Clinical Pathways / Clinical Competencies
  - Nursing & Therapy
  - Ortho, Cardiac, Pulmonary, Diabetes
- **Medication Management / Reconciliation**
- **Acute Care Nursing Team** (Cardiac, CHF, COPD, PN, TKR/THR)
  - Know your referral sources' protocols
  - Know your referral sources' strengths and weaknesses

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Strategies for Success

Clinical Programs

- Restorative Nursing Programs paired with Therapy
- **E&T for patient, family, and caregivers**
  - Nutrition, vital signs, meds mgt, pain mgt, edema mgt, infection / DVT S&S, B&B, chronic conditions, etc.
  - Teach Back / Show Me Method
- **Chronic Disease Management**
  - Co-morbidities
  - Decrease avoidable readmissions
- Wellness Program
- Short-term Rehab wing/Rehab Recovery Suite
- **Care Transitions Management Team / Nurse Navigator**
  - RN, Therapy, HH, SS, RNAC, dietician, MD (patient / family)
- Telehealth

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Bundled Payments for Care Improvement

BPCI Stats:

- 46.6% of providers participating in BPCI are SNFs
- 27% are hospitals
- 15% of participants are testing more than 20 of the 48 Clinical Episodes
- Average number of Clinical Episodes = 9
  - Most popular: LEJR, PN, COPD, CHF
- With less voluntary participation in BPCI, CMS may create more mandatory bundled payment programs like….

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Comprehensive Care for Joint Replacement

- In 2013 more than 400,000 in-patient THRs/TKRs costing more than $7 billion for hospitalization alone
- Average Medicare expense for surgery, hospital, and recovery ranges from $16,500 to $33,000
- Goals: Acute and PAC providers work together to improve the quality of care and coordinate patient-centered care → better outcomes, better experience, fewer complications (readmissions, infections, prolonged rehab/recovery)

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CCJR

- 5 year test period – 4/1/16 through 12/31/20
- 67 geographic areas including: Reading, Harrisburg/Carlisle, and Pittsburgh MSAs in PA required to participate
- Hospital accountable for costs and quality of care from surgery to 90 days after (episode of care)
  - Hospital quality measures based on:
    - Surgical complication rates
    - HCAHPS

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CCJR

- Depending on the hospital's costs and quality performance, the hospital can earn a financial reward (winner) or be required to repay Medicare (loser) at the end of the year when compared to the "target price"
- Incentive for hospitals to work with MDs, HHAs, SNFs, and other providers to ensure coordinated care and the best outcomes and to avoid readmissions and complications

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CCJR

- Proposed rule to add hip / femur fracture to existing CCJR bundled payment model July 2017
- Proposed rule to add a new Cardiac Care Bundled Payment pilot
  - Covers 98 random MSAs
  - Covers heart attacks and bypass surgery
- Proposed rule to add a Cardiac Rehabilitation Incentive Payment model
- Humana expands TKA/THA Bundling Program in OH &TN
- 3 Year CMS experiment (28 cardiac and 9 orthopedic procedures) led to savings of $319 per patient

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CCJR

SNF Strategies for Success:

- Data Analytics
  - Cost per episode in SNF
  - ALOS
  - Hospital readmissions / complications
- Relationship building with hospitals, HHAs, AL/PCs
- Clinical pathways to provide quality care, manage costs, manage co-morbidities/complications to prevent readmissions
- Promote care transitions / smooth hand-off
- Promote Hospital QMs / Patient Surveys
- Collaborator Agreement / Sharing Arrangement

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CCJR

SNF Strategies for Success:

- Projected LOS 5-10 days
  - Therapy goals – PLOF vs. Next Level of Care
  - Functional-based treatments
- IDT communication re: care plan / DC plan
  - Care Transitions Management Team
  - DC to HHA or out-patient
- Therapy Schedule
  - 7 days / week therapy
  - Extended therapy hours / On-call
  - Consistency
- Care Conference / Family Meeting
- Home Assessments

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CCJR

SNF Strategies for Success:

- Patient-centered care -- new definition from American Geriatrics Society panel:

  "Person-centered care means that individuals' values and preferences are elicited and, once expressed, guide all aspects of their healthcare, supporting their realistic health and life goal."

- Patient-centered care wishes to be included in DC planning to help decrease hospital readmissions.

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SNF VBP Program

- PAMA of 2014 requires CMS to establish a VBP program for SNFs beginning in FY 2019
- SNF Medicare per-diem payments reduced by 2% to create a "pool" of funding
- Only 50-70% of this "pool" may be distributed back to SNFs as incentive payments
- SNFs scoring at or below the 40th percentile are "losers" and not eligible for any incentive payments = full 2% reduction

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SNF VBP Program

- Readmission Measure
  - SNF 30-day Potentially Preventable Readmission Measure (SNFPPR); proposed to replace SNFRM
  - 2015 = baseline period; 2017 = performance period
  - Excludes planned readmissions
  - Also risk-adjusted for clinical factors (co-morbidities, LOS during prior hospitalization, and ESRD status)
  - Does NOT adjust for sociodemographic factors (income or dual-eligibles)
  - Beginning 10/1/16, SNFs will receive quality feedback reports (QIES / CASPER files)

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SNF VBP Program

- It is estimated that 45% of hospitalizations among SNF residents may be prevented by targeted interventions (CMS' "Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents"):
  - Hiring staff specializing in recognition and management of conditions that cause avoidable hospitalizations
  - Improve prescription drug management
  - Facilitate resident transitions to and from inpatient hospitals

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SNF VBP Program

- University of California, San Francisco study shows that "improved discharge directions and communication between patients and providers could prevent up to 27% of hospital readmissions."
- Most common factors for readmission:
  - ER decision making
  - Premature DC
  - Lack of communication between patients and providers about post-DC appointments, contacts, and care wishes

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SNF VBP Program

- SNF strategies:
  - Track hospital readmissions (per diagnosis)
  - How to reduce unnecessary readmissions
  - Staff, physician, and family education
  - Track residents after DC from SNF
  - Assist with post-DC appointments
  - Network/build relationships with Hospitals, ALFs, PCHs, and HH agencies to smooth transitions (**Nurse Navigator**)
  - Know your hospital referral sources' protocols for CHF, acute MI, CABG, PN, COPD, LEJR and implement same in your SNF
  - Better preventive care and access to physicians and NPs in an emergency situation (Telehealth)

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SNF QRP

- IMPACT Act requires CMS establish the SNF QRP
- SNFs subject to a 2% reduction in annual payment update beginning FY 2018 if fail to meet ALL quality data submission (on 80% of MDSs submitted) and administrative requirements (2 FYs after QMs adopted in rulemaking)
- Overlap but doesn't eliminate the Nursing Home Quality Initiative (NHQI) which calculates QMs from the data on the MDS and reported on the Nursing Home Compare website (5 Star Rating)

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SNF QRP

- Required starting Oct 1, 2016 (FY 2017)
- 3 QMs calculated from the MDS:
  - Pressure Ulcers: Stage 2-4 new or worsened since a prior assessment (Admission and DC; short-stay residents)
  - Falls with Major Injury: % of SNF patients with one or more falls with major injury (short-stay residents)
  - Functional Status: Self-care, mobility, cognition, and communication items scored (CARE tool); completed at Admission and DC with at least one functional goal at Admission (Section GG on MDS 10/1/16)

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SNF QRP

3 new claims-based QMs in FY2017 Final Rule for 2018 payment determination (begin reporting 10/1/18):

- Medicare Spending Per Beneficiary – Post-Acute Care SNF QRP
- Discharge to Community – Post-Acute Care SNF QRP
- Potentially Preventable 30-Day Post-Discharge Readmission Measure – SNF QRP

1 new assessment-based QM for 2020 payment determination:

- Drug Regimen Review Conducted With Follow-Up for Identified Issues – Post-Acute Care SNF QRP

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More About Quality Measures

- 6 new QMs added to Nursing Home Compare beginning April 2016:
  1. % of short-stay residents who were successfully discharged to the community (Claims-based)
  2. % of short-stay residents who have had an outpatient emergency department visit (Claims-based)
  3. % of short-stay residents who were re-hospitalized after a nursing home admission (Claims-based)
  4. % of short-stay residents who made improvements in function (MDS-based)
  5. % of long-stay residents whose ability to move independently worsened (MDS-based)
  6. % of long-stay residents who received an antianxiety or hypnotic medication (MDS-based)

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5 Star Rating

- Essential tool for SNFs to determine how they perform as we focus on coordination of care and shift from “volume to value”
- Marketing tool for SNFs?
- ACO’s can waive 3 day hospital stay and admit directly to SNF…..The catch = SNF must be 3 Star facility
- CCJR can also waive the 3 day hospital stay (beginning in 2017) again if admitting to a 3 Star home
- Data refreshes monthly for HIs and qtly for QMs

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5 Star Rating

- Star rating calculated based on Survey Score achieved over last 3 HIs (weighted), staffing, and QMs
- Distribution:
  - 5 Star = 10%
  - 2,3,4 Star = 70% (23.33% each)
  - 1 Star = 20%
- Know your competitors ratings and HHAs ratings to develop care coordination partnerships with hospitals and other providers

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Strategies for Success

5 Star Rating

- Health Inspections / Surveys
  - Mock Surveys
- Staff patterns
  - Therapy
    - 7 days / week
    - Extended hours (BID, reverse ADLs, late admits)
  - Nursing – RN vs. LPN
- Quality Measures
  - Clinical Programming
  - Data Analytics

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Strategies for Success

Concurrent Reviews:

- Part of a utilization management program in which health care is reviewed as it is provided.
- Reviewers monitor appropriateness of the care, the setting, and the progress of discharge plans.
- The ongoing review is directed at keeping costs low while maintaining effectiveness and quality of care.
- Use of tracking tools, dashboards, benchmark data, target goals

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Strategies for Success

Misc. Ideas

- Documentation E&T / Auditing
  - Ch. 8 MBPM
- Culture Change / Mind-set Change / Philosophy Change
- Patient-centered health care philosophy
- Assist with post-DC appointments
- Post-DC follow-up (Nurse Navigator)
- Census Development Strategies – Think “Revolving Door”

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Strategies for Success

Misc. Ideas

- Preferred Provider Status (Narrowing Networks)
  - Prove the worth of a SNF stay – Outcomes
- Hospitals choose SNF based on:
  - 5 Star Rating
  - Readmission rates
  - Medical Director on staff at hospital
  - Stability of SNF management team
  - Clinical capabilities (staffing, programming, QMs)
  - Patient Satisfaction
- Future = SNF PPS Bundled Payments

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Summary

Improved Care Coordination = SUCCESS for ALL

- Improved patient-centered outcomes
- Improved patient satisfaction
- Improved community health
- Improved patient quality of life
- Decreased post-op / acute hospital complications
- Decreased re-hospitalization rates
- Decreased SNF LOS
- Decreased cost per beneficiary

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Best Practices to Align with ACOs, BPCIs & Managed Care

QUESTIONS

OR

COMMENTS??

THANK YOU!

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