Best Practices to Align with ACOs, BPCIs & Managed Care

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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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Accountable Care Organizations

ACOs are "groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high quality care to the Medicare patients they serve."

- Goals:
  - Ensure patients get the right care at the right time
  - Avoid unnecessary duplication of services
  - Prevent medical errors

Opportunity to share in the savings when an ACO meets the goals of high quality care and decreased spending.

https://innovation.cms.gov/

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Accountable Care Organizations

Pioneer ACO Model

- Designed for health care organizations and providers already experienced in coordinating care for patients across care settings.
- Currently 9 ACOs participating in this model
  - Originally 32 participants
- 33 Quality Measures
  - Patient / Caregiver Experience (8)
  - Care Coordination / Patient Safety (10)
  - Preventive Health (8)
  - At-Risk Populations (7)

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Accountable Care Organizations

Medicare Shared Savings Program ACO

- Established by the Affordable Care Act.
- Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO).
- Currently 433 participants
- 33 Quality Measures (same as Pioneer ACO model QMs)

Accountable Care Organizations

Next Generation ACO

- An initiative for ACOs that are experienced in coordinating care for populations of patients.
- Assume higher levels of financial risk and reward than Pioneer and MSSP ACO models. (64 of the total 477 ACOs are in a track that involves potential penalties – downside risk.)
- Goal is to "test whether strong financial incentives, coupled with tools to support better patient engagement and care management, can improve health outcomes and lower expenditures…"

Accountable Care Organizations

Next Generation ACO

- Benefit Enhancements
  - Telehealth Expansion Waiver
  - Post-Discharge Home Visit Waiver
  - Three-Day Skilled Nursing Facility Waiver
- Currently 18 NGACOs
- 33 Quality Measures
  - Patient / Caregiver Experience (8)
  - Care Coordination / Patient Safety (9)
  - Preventive Health (9)
  - Clinical Care for At Risk Populations (7)

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.

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)

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)

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

February 2016:

Universal Health Services (King of Prussia) reported that they may drop out and pull its 25 acute-care hospitals out of the BPCI initiative "until some of the kinks are worked out." The CFO of UHS said they struggled to get useful data from Medicare.

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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)
  - Evidence-based Practice
  - Standardized Tests and Measures
- PLOF / DC Planning checklist
  - **Day 1 DC Planning**
  - Care Conference Day 2 or 3
  - Home Assessment by Day 7 (earlier if CCJR)
- Functional-based Treatment Focus
  - Establish HEP / RNP early
- Clinical Programming (Ortho, wound care, falls, pain mgt, etc.)
- Clinical Pathways / Clinical Competencies
  - Nursing & Therapy
- **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

- Telehealth
  - Saves a trip to the physician / medical facility
  - Less disruption for the patient
  - Decrease costs (transportation)
- Restorative Nursing Programs
- **E&T for patient, family, and caregivers**
  - Nutrition, vital signs, meds mgt, pain mgt, edema mgt, infection / DVT S&S, B&B, etc.
- **Chronic Disease Management**
  - Co-morbidities
  - Decrease avoidable readmissions
- Wellness Program
- Short-term Rehab wing/Rehab Recovery Suite
  - Day 1 eval/treat, Home Assessments, DC planning, HEP, IDT communication, caregiver E&T
- **Care Transitions Management Team**
  - RN, Therapy, HH, SS, RNAC, dietician, MD (patient / family)

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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

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

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

CCJR

SNF Strategies for Success:

- Projected LOS 5-10 days
  - Therapy goals
  - Functional-based treatments
- IDT communication re: care plan / DC plan
  - Care Transitions Management Team
- 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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Managed Care Best Practices

Highmark / naviHealth (Security Blue and Freedom Blue), Geisinger, UPMC

- Goals and interventions focus on functional-based treatments
  - Early GT on stairs, ADLs, etc.
- IDT communication early and includes patient / family / caregiver
  - DC date, DC site, barriers to DC, DME needs, home support
- Functional therapy goals written considering SNF LOS projection, DC destination / next level of care (OPT, CCJR, BPCI)
- Early focus on patient / family / caregiver E&T (inc. HEP)
- Early HHA involvement / hand-off

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Managed Care Best Practices

- Provide clinically appropriate therapy care intensity to meet the patient-centered functional goals and projected outcomes (considering Managed Care guidance)
- Consider skilled maintenance vs. restorative therapy needs
- Reassess goals and interventions when patient / outcomes scores not improving
- 7 days / week therapy
- BID therapy available when appropriate
- Therapy evaluation Day 1
- Pair therapy with restorative nursing

SNF PPS: Final Rule for FY 2017

Highlights:

- Adjusted Market-basket Update = 2.4% increase = $920 million increase over FY2016
- MDS 3.0 additions
  - Part A PPS Discharge Assessment
  - Section GG
- SNF Value-based Purchasing (VBP) Program
- SNF Quality Reporting Program (QRP)

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

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)

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

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

SNF VBP Program

- University of Colorado School of Medicine study found that "mortality rates soared for patients who were readmitted to the hospital, with risk of mortality within 30 days of discharge doubling for readmitted patients."
- Most common risk factors for readmission:
  - Patients needing an invasive device (catheter, feeding tube)
  - Patients requiring advanced care (dialysis, oxygen therapy)

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, PN, COPD, LEJR and implement same in your SNF
  - Better preventive care and access to physicians and NPs in an emergency situation (Telehealth)

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)

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)

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

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)

More About Quality Measures

- In July 2016, 5 of these 6 measures will be used to calculate the facility's Five-Star Quality Rating QM ratings.
  - Antianxiety/hypnotic medication measure not used
- The readmission measure will include observation stays (but exclude planned readmissions and hospice patients)
- Improvement in function measure based on self-performance of: transfers, locomotion on unit, and walk in corridor
- Ability to move independently measure based on self-performance of locomotion on unit
- In October 2018, a new QM: Transfer of Health Information and Care Preferences required for SNFs to report

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 performance year 2) again if admitting to a 3 Star home
- Data refreshes monthly for HIs and qtly for QMs

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

Strategies for Success

5 Star Rating

- Health Inspections / Surveys
- Staff patterns
  - Therapy
    - 7 days / week
    - Extended hours (BID, reverse ADLs, late admits)
  - Nursing
- Quality Measures

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

Strategies for Success

Misc. Ideas

- Documentation E&T / Auditing
  - Ch. 8 MBPM
- Networking / Relationship building
  - Hand-off to HH, out-pt, ALF/PC, IL, etc.
  - Focus on the continuum of care
- 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"

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

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

Best Practices to Align with ACOs, BPCIs & Managed Care

QUESTIONS

OR

COMMENTS??

THANK YOU!