CCJR- Providing the First Glimpse into PAC Reimbursement for the Future

Amy Hancock, President/CEO
AdvantageCare Rehab
Advantage Home Health Services
2016
POST-ACUTE PARTNERS

Healthcare’s Transformation

• WHERE ARE WE???
  • Increasing population of aged
  • Rising Health Care Costs that are unaffordable
  • New payment mechanisms will emphasize Quality and Safety
  • Medicare will move to bundled payments, then to population based payments
  • Technology in the health care markets are changing everything
  • Increasing Regulatory Scrutiny
  • Increasing requirements for use of IT
  • Shortage of appropriately trained “person-power”
CMS will test, identify and expand alternative payment plans aggressively

- Likely focus on highest total cost procedures
- Forces parties to look for partners with systemic solutions

1. Source: innovations.cms.gov
Healthcare’s Transformation

• WHERE ARE WE GOING???

• ACO’s
• BPCI’s
• Value-Based Purchasing
• Risk Sharing
• Gain Sharing
• Navihealth
• Narrowing Networks
• Shifting from “Volume to Value”

• Evidenced by Value-Based Purchasing

• Post-Acute Population Health Models

• Quality Measures between Acute and Post Acute Providers

• Payment Reform

• Increased Scrutiny
January 26, 2015 the Department of Health and Human Services (HHS) announced an accelerated movement titled:


### Payment Taxonomy Framework

<table>
<thead>
<tr>
<th>Category 1: Fee for Service—No Link to Quality</th>
<th>Category 2: Fee for Service—Link to Quality</th>
<th>Category 3: Alternative Payment Models Built on Fee-for-Service Architecture</th>
<th>Category 4: Population-Based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Payments are based on volume of services and not linked to quality or efficiency</td>
<td>At least a portion of payments vary based on the quality or efficiency of health care delivery</td>
<td>Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Medicare FFS</th>
<th>Hospital value-based purchasing</th>
<th>Accountable care organizations</th>
<th>Eligible Pioneer accountable care organizations in years 3-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Majority of Medicare payments now are linked to quality</td>
<td>Physician Value-Based Modifier</td>
<td>Medical homes</td>
<td>Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model</td>
</tr>
<tr>
<td>Limited in Medicare fee-for-service</td>
<td>Readmissions: Hospital Acquired Condition Reduction Program</td>
<td>Bundled payments</td>
<td>Comprehensive primary care initiative</td>
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<td>Comprehensive ESRD</td>
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Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

- All Medicare FFS (Categories 1-4)
- FFS linked to quality (Categories 2-4)
- Alternative payment models (Categories 3-4)

2016:
- 30% All Medicare FFS
- 85% FFS linked to quality (Categories 2-4)

2018:
- 50% All Medicare FFS
- 90% Alternative payment models (Categories 3-4)
Alternative payment models (APM) seeking to deliver better care at lower cost share a common pathway for success:

- Calling on providers, payers, and others in the health care system
- When providers encounter new payment strategies for one payer but not others, the incentives to change are weak
- When payers align their efforts, the incentives to change are stronger and the obstacles to change are reduced
- Making operational changes will be viable and attractive only if reforms are broadly adopted by a critical mass of payers
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- The Health Care Payment Learning and Action Network:
  - Serve as a convening body to facilitate joint implementation of new models
  - Identify areas of agreement toward alternative payment models, how best to analyze data and report the findings
  - Generate evidence, share approaches, and remove barriers
  - Develop common approaches to core issues
  - Create implementation guides for payers, purchasers, providers, and consumers

H.R. 4302- Protecting Access to Medicare Act of 2013

- Included - Skilled Nursing Facility Value-Based Purchasing Program
  - Hospital readmissions reduction program
  - Projected to save Medicare over $2 billion over next 10 years

• Released March 2016, CMS’s new model aimed to reduce avoidable hospitalizations skilled nursing facilities

• The model, part of the CMS “Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents”
  o Boost payments to skilled nursing facilities
  o Physicians will receive increased payments to perform comprehensive assessments for residents in SNFs

• The new payment model will begin testing in fall 2016

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- The model will be implemented at facilities through six health systems in Alabama, Nevada, Colorado, Indiana, Missouri, New York and Pennsylvania.

- The CMS will focus on six medical conditions that together, are linked to about 80% of potentially avoidable admissions:
  - Pneumonia
  - Dehydration
  - Congestive heart failure
  - Urinary tract infections
  - Skin ulcers
  - Asthma

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COMPREHENSIVE CARE FOR JOINT REPLACEMENT MODEL
Better Care. Smarter Spending. Healthier People

“What fits your busy schedule better, exercising one hour a day or being dead 24 hours a day?”
Healthcare’s Transformation

“THE GAME CHANGER”

- COMPREHENSIVE CARE FOR JOINT REPLACEMENT MODEL
- CCJR Model is a prospective program, which includes provisions aimed at SNF performance
- Five-year pilot which mandates compliance for qualifying providers in 67 MSA’s across the country
- When it comes to frequency and expense, LEJR is the low-hanging fruit
- In 2013, Medicare paid $7 billion for more than 400,000 inpatient primary LEJR procedures
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• Exception those participating in Model 1 or Models 2 or 4 of the Bundled Payments for Care Improvement (BPCI) initiative for LEJR episodes

• The episode of care:
  • Begins with an admission to a participant hospital
  • Discharged under MS-DRG 469 or 470
  • Ends 90 days post-discharge in order to cover the complete period of recovery for beneficiaries

• Skilled nursing facilities that do business with them face a stark reality
Average Medicare Payment per CJR Episode, by Care Setting

- Initial Hospital Stay, $13,193
- Durable Medical Equipment (DME), $122
- Skilled Nursing Facility (SNF), $5,034
- Inpatient Rehabilitation Facility (IRF), $1,568
- Home Health Agency (HHA), $2,123
- Hospital Readmissions, $1,155
- Outpatient, $604
- Physician, $1,675
- Long-term Acute Care Hospital (LTACH), $91

Post-discharge spending

Total Medicare Payment per Episode = $25,565

Hospitals gain flexibility

- Utilizing PAC providers
- Patients can recover briefly in nursing homes
- SNF are significantly less expensive than hospital care
- Nursing homes that rank average or better on national quality scores will qualify for a waiver
- This will exclude 1 out of 3 nursing homes
- In some areas, as many as 80% of nursing homes will be disqualified.
High-quality SNFs in short supply

In 11 metro areas in Medicare’s mandatory bundled-payment demo, less than half of the skilled-nursing facilities have adequate quality ratings to serve joint-replacement patients.

- **33%** Carson City, Nev.
- **49%** Kansas City, Mo.-Kan.
- **37%** Harrisburg-Carlisle, Pa.
- **28%** Lubbock, Texas
- **40%** Gainesville, Ga.
- **47%** Austin-Round Rock, Texas
- **20%** Monroe, La.
- **30%** Corpus Christi, Texas
- **40%** Gainesville, Fla.
- **43%** Sebastian-Vero Beach, Fla.

Source: Modern Healthcare analysis of CMS regulations and data
• Star rating use in the CCJR is a significant expansion
• Underscores the Obama administration's eagerness to tie more Medicare spending to quality
• Accelerating the consolidation already underway among post-acute providers
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Coming together is a beginning.

Keeping together is progress.

Working together is success.

- Henry Ford

Don't find fault, find a remedy.

Henry Ford
The Factory Approach

- 20th century- the automobile was a plaything for the rich
- 21st century expensive healthcare
- 20th century- most models were complicated machines that required a chauffer conversant with its individual mechanical nuances to drive it
- 21st century- Silos of care, no collaboration of care between providers and patients
- 20th century- Henry Ford was determined to build a simple, reliable and affordable car; a car the average American worker could afford.
- 21th century- ACA determined to improve quality and reduce costs
• 20th century- Out of this determination came the Model T and the assembly line - two innovations that revolutionized American society and molded the world we live in today

• 21st century- We are tasked with becoming innovators and changing the way we deliver care

• CCJR is just the beginning of this change for SNFs

• Lets take the Ford Factory Approach to the skilled nursing homes
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• CCJR is just the beginning of this change for SNFs

• Lets take the Ford Factory Approach to the skilled nursing homes
• **Ford Factory Approach**
  - **Standard Care Pathways for specific conditions**
    - Improving efficiency
    - Reducing unwarranted variations
  - **Pathway dictates each major step in the care you deliver**
    1. Identify patient populations
    2. Create the care path
    3. Communicate the care path protocols
    4. Let staff move through the pathway without input, when appropriate
    5. Group patients with similar care together
    6. Roll out in phases

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• October 2013 Advantage Home Health designed a concept for a more coordinated surgical care model by optimizing perioperative care
  • Collaborating with Same Day Joints, LLC
• A Patient Centered Service Delivery Model based on
  • Coordinating patient care through team-based care pathways
  • Creating evidenced based practices to gain maximum patient benefits at minimum costs
Critical Success Factors

- Team-Based Protocols, designed with MD and Advantage
  - Nursing
  - Therapy
- Home Assessment Coordinator
- Patient Concierge with follow up calls
  - Day 5, 25, 55 and 75
- Comprehensive Orientation
- Data Tracking/Analytics
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**2015 Knee Visits**

<table>
<thead>
<tr>
<th></th>
<th>HHOME Same Day</th>
<th>Traditional Inpt</th>
<th>HHOME Short Stay</th>
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<tbody>
<tr>
<td>SN Visits</td>
<td>5.7</td>
<td>6.3</td>
<td>4.5</td>
</tr>
<tr>
<td>PT Visits</td>
<td>8.9</td>
<td>10.3</td>
<td>8.6</td>
</tr>
<tr>
<td>OT Visits</td>
<td>0.0</td>
<td>4.3</td>
<td>0.0</td>
</tr>
<tr>
<td>Tot Therapy</td>
<td>8.9</td>
<td>14.6</td>
<td>8.6</td>
</tr>
</tbody>
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- **HHOME Impact on Visit Patterns:**
  - 9.5% SN visit reduction
  - 13.6% PT visit reduction
  - 100% OT visit reduction

- **Estimated Financial Impact**
  - 39% reduction in overall costs to insurance carrier

*2015 Sample Size: Same Day 74, Traditional 168, Short Stay 36*
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2015 Hospital Readmissions-Knees

<table>
<thead>
<tr>
<th></th>
<th>Hospital %</th>
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<tbody>
<tr>
<td>HHOME Same Day</td>
<td>1.40%</td>
</tr>
<tr>
<td>Traditional Inpt</td>
<td>3.60%</td>
</tr>
<tr>
<td>HHOME Short Stay</td>
<td>0%</td>
</tr>
</tbody>
</table>

*2015 Sample Size: Same Day 74, Traditional 168, Short Stay 36
THREE TRANSFORMATIONAL WAVES RESHAPING HEALTHCARE

WAVE 1
PATIENT-CENTERED CARE
2010-2016

WAVE 2
CONSUMER ENGAGEMENT
2014-2020

WAVE 3
SCIENCE OF PREVENTION
2018-2025

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2010 2025
• **Innovation Is Coming**
  - Yellow Taxi vs UBER
  - Healthcare industry is ripe for the same kind of disruption the taxi industry experienced when customers gained access to other options
• Uber's message for health care is clear

• 3 choices:
  • Ignore innovators and hope for the best
  • Hope for increasing regulation to make it harder for innovators to enter the market
  • Compete on quality and efficiency, through innovative models and care paths
Post-Acute Payment Reform is Underway
- Time is of the Essence
- In Summary:
  - Payments are based on patient needs, not site of service
  - Better alignment of payments
  - Payments will shift
  - Providers need to change how PAC services are delivered
• **Virtual Nursing Homes**
  - Imagine connecting a private home to a centralized skilled nursing home control center
  - A video station, an alert link, a health vitals monitoring station, scheduled care visits, scheduled meal delivery
  - Monitoring stations capable of instant connections by voice and/or observations by video
  - Human care givers can be easily and quickly dispatched
  - Medication and packages (read: oxygen tanks e.g.) delivery for the age-at-home client can be made to the central facility
Healthcare will continue to change. Core Values remain unchanged.
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Amy Hancock, President/CEO
ahancock@feeltheadvantage.com
412-440-0126