307 Panel: Value-Driven Innovation in Post-Acute Care
Welcome

Thomas Buckingham
Executive Vice President of Strategy, Select Medical
President, Allevant Solutions
Panel Speakers

Larry Atkins
Executive Director Long-Term Quality Alliance

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Remedy Partners

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American Health Care Association

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Vice President
Post-Acute Clinical Services Trilogy
Health Services
Post-Acute Care Role in APMs

Thomas Buckingham
Current FFS Payment Model

Silos of Care

- Inpatient Hospital Acute Care
- Primary Care Physicians
- Specialty Care Physicians
- Long-Term Acute Care
- Inpatient Rehab Hospital
- Skilled Nursing Facility
- Home Health Services
CMS: Alternative Payment Models

Continuum of Care

- BPCI Models 1 & 4
- BPCI Model 2
- BPCI Model 3
- ACO's

Inpatient Hospital
Acute Care

Primary Care Physicians

Specialty Care Physicians

Long-Term Acute Care

Inpatient Rehab Hospital

Skilled Nursing Facility

Home Health Services
CMS: Alternative Payment Models

Continuum of Care

Inpatient Hospital Acute Care
Primary Care Physicians
Specialty Care Physicians
Long-Term Acute Care
Inpatient Rehab Hospital
Skilled Nursing Facility
Home Health Services

BPCI Advanced (October 1, 2018)

ACO’s
Number of U.S. Community Hospitals (STACHs) 2018

Total Number of Community Hospitals 4,840

By type:
- Nongovernment Not-for-Profit Community Hospitals 2,849
- Investor-Owned (For-Profit) Community Hospitals 1,035
- State and Local Government Community Hospitals 956

Source: 2018 AHA Hospital Statistics
Number of Medicare-Participating PAC Providers 2009 - 2017

<table>
<thead>
<tr>
<th>PAC Provider Type</th>
<th>2009</th>
<th>2011</th>
<th>2013</th>
<th>2015</th>
<th>2017</th>
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<tr>
<td>Long-Term Care Hospital</td>
<td>427</td>
<td>437</td>
<td>432</td>
<td>426</td>
<td>411</td>
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<tr>
<td>Inpatient Rehabilitation</td>
<td>1,196</td>
<td>1,165</td>
<td>1,161</td>
<td>1,182</td>
<td>1,178</td>
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<tr>
<td>Skilled Nursing Facility</td>
<td>15,062</td>
<td>15,120</td>
<td>15,163</td>
<td>15,223</td>
<td>15,277</td>
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<td>Home Health Agency</td>
<td>10,961</td>
<td>12,026</td>
<td>12,613</td>
<td>12,346</td>
<td>11,844</td>
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</table>

Source: MedPAC Health Spending Data Book, June 2014 & June 2018
## STACH Discharge Destination for Medicare FFS 2006 - 2016

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<tr>
<td>Home/Self Care</td>
<td>52.3%</td>
<td>50.1%</td>
<td>48.0%</td>
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<tr>
<td>Long-Term Care Hospital</td>
<td>0.9%</td>
<td>1.1%</td>
<td>1.2%</td>
<td>1.2%</td>
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<tr>
<td>Inpatient Rehabilitation</td>
<td>3.4%</td>
<td>3.3%</td>
<td>3.5%</td>
<td>3.9%</td>
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<tr>
<td>Skilled Nursing Facility</td>
<td>18.8%</td>
<td>19.8%</td>
<td>20.3%</td>
<td>20.2%</td>
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<tr>
<td>Home w/Home Health</td>
<td>13.8%</td>
<td>15.2%</td>
<td>15.9%</td>
<td>17.5%</td>
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<tr>
<td>Hospice</td>
<td>1.6%</td>
<td>2.1%</td>
<td>2.7%</td>
<td>3.0%</td>
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<td>IPF</td>
<td>0.4%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.4%</td>
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<tr>
<td>Other Setting</td>
<td>2.0%</td>
<td>1.6%</td>
<td>1.7%</td>
<td>2.0%</td>
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<tr>
<td>Other Acute Care Hospital</td>
<td>2.5%</td>
<td>2.2%</td>
<td>2.2%</td>
<td>1.9%</td>
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<tr>
<td>Left AMA</td>
<td>0.6%</td>
<td>0.7%</td>
<td>0.8%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Died in Hospital</td>
<td>3.8%</td>
<td>3.5%</td>
<td>3.3%</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

Source: MedPAC Health Spending Data Book, Acute Inpatient Services – June 2014 & June 2018
Initial Post-Acute Care Placement (2016)

Number of Entities

- **STACH**: 4,840
  - **LTCH**: 411
  - **IRF**: 1,178
    - **SNF**: 15,277
      - **HHA**: 11,844
        - **OPT**:
          - **Home**
42 CFR 482.43 Condition of Participation: Discharge Planning

The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.

The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services.

The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.

The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge.

The hospital must arrange for the initial implementation of the patient's discharge plan.
64% of patients discharged to PAC have “solo” stays

MedPAC March 1, 2018

First PAC Placement
Sequential Post-Acute Care Placements

36% of patients discharged to PAC have “multi-stay” sequences

MedPAC March 1, 2018
Post-Acute Care Transitions, 2014

Source: RTI September 2018

Partnering for the Future
Healthcare Payment Learning & Action Network

OCTOBER 22, 2018 | SHERATON TYSONS HOTEL | TYSONS, VA
Readmission to STACH from Post-Acute Care

First PAC Placement
Sequential PAC Placement
30-Day STACH Readmission

Avg. all sources = 17.5%

LTCH
IRF
SNF
HHA
OPT
Home

OCTOBER 22, 2018 | SHERATON TYSONS HOTEL | TYSONS, VA
Percentage of STACH Readmissions

- SNF: 27%
- HHA: 24%
- Home: 35%
- LTCH: 1%
- IRF: 2%
- All Other: 11%
Average Medicare Episode Payment By Readmission Status

Source: Dobson DaVanzo: October 2012 Pressures on LTCH and IRF under Value-Based Purchasing
Post-Acute Care Patient Flow

- **LTCH**: 1.2% 30-Day STACH Readmission
  - $40,656 26.8 days

- **IRF**: 11.2%
  - $19,714 12.7 days

- **SNF**: 3.9%
  - $19,206 25.7 days

- **HHA**: 20.2%
  - $5,677 115 days

- **OPT**: 17.5%
  - $2,075 10.8 visits

- **Home**: Avg. all sources = 17.5%
  - 13.4%

- **STACH**: 45.6%
  - 11.2%

Legend:
- **First PAC Placement**: LTCH, IRF, SNF, HHA, OPT
- **Subsequent PAC Placement**: LTCH, IRF, SNF, HHA, OPT
- **30-Day STACH Readmission**: LTCH, IRF, SNF, HHA, OPT

(avg. all sources = 17.5%)
Distribution of Medicare Spend

Data provided by Dobson DaVanzo

All data from this slide is based on 90-Day Episodes - Trimmed Spending (Risk Factor B) in 2012 Dollars. Episodes with less than 250 count are not included, but are available.
PAC Share of Average Payment For BPCI Bundles with Greatest Participation

Source: Authors’ calculations from CMS data.
POST-ACUTE CARE ACCOUNTS FOR 73% OF MEDICARE SPENDING VARIATION

Source: Institute of Medicine. Variation in Healthcare Spending: Target Decision Making, Not Geography. June 2013. Note: The individual contributors sum to >100% because of covariance.
“Financial Success” in APMs is defined by “Savings” (reduction in Medicare Part A & B payments)

- Physician Services (PFS)
- Short-term Acute Care Hospital (STACH)
- Inpatient Hospital Readmissions
- Critical Access Hospitals (CAH)
- Long-term Acute Care Hospitals (LTCH)
- Inpatient Rehabilitation Hospitals (IRF)
- Skilled Nursing Facilities (SNF)
- Home Health Agencies (HHA)
- Outpatient Rehabilitation Therapy
- Hospital-Based Outpatient Services (HOPD)
- Inpatient Psychiatric Facilities (IPF)
- Clinical Laboratory
- Imaging
- Durable Medical Equipment (DME)
- Part B Drugs and Biologicals
CMS: Alternative Payment Models

Continuum of Care

- Inpatient Hospital Acute Care
- Primary Care Physicians
- Specialty Care Physicians
- Long-Term Acute Care
- Inpatient Rehab Hospital
- Skilled Nursing Facility
- Home Health Services

BPCI Advanced (October 1, 2018)

ACO’s
Post-Acute Care
“The Low Hanging Fruit”

- assign care coordinators/navigators to the sickest patients
- extend the stay in the STACH for additional days
- discharge patients to the lowest level of care that can safely meet their clinical needs (i.e. improve 1st PAC placement)
- establish narrow networks of preferred post-acute care partners
- reduce unnecessary services (reduce the overuse the ultra-high RUGs levels)
- reduce LOS in post-acute settings (primarily SNFs)
- limit the use of the relatively higher cost IRF and LTCH settings
- address underlying issues needed to reduce PAC readmissions to STACHs
Post-acute care is the ATM of value-based health care: everyone is trying to take money out of PAC. In a new @HSR_HRET paper,
What Next?

- patient/family-caregiver involvement in collaborative decision making
- patient advisory councils
- continuous care navigation and health coaching interactions
- 90-day seamless episode-based clinical care paths
- redesigned process and tools used for care transitions
- engaged PAC providers seeking new ways to optimize the care delivery sequence, process and site of service – more rational use of PAC
- potentially... non-traditional uses of the IRF and LTCH settings
- even greater use of both home health and home chore services
- involvement of community-based services where available (transportation, food, social services)
Welcome

Michael Cheek
Senior Vice President
Reimbursement Policy and Legal Affairs
American Health Care Association
Medicare Pressure will Continue with PAC a Key Focus Area for Budget Holes

Chart source: Annual report of the Board of Trustees of the Medicare trust funds 2016.
Total $ Growth Approached Through Reductions in Per Capita $ & Price Growth

Growth in:

- People
- Service Use Per Person
- Price for Unit of Service

Per Capita Spending

Growth driver

What government can impact

Total Spending
Increases in Comorbidities Drive Up Need

Number of Over Age 85 Compared to Bed Capacity

# of SNF Beds

Year <55 55-64 65-74 75-84 85+
Costs Vary Widely Based on PAC Setting – Opportunity for Savings

Any Chronic Condition
- No Functional Impairment: $7,228
- High Functional Impairment: $17,961

5 or More Chronic Conditions
- No Functional Impairment: $11,519
- High Functional Impairment: $20,700

Source: Functional Impairment and Medical Spending, 2012
MCBS Cost and Use File, Analysis on Older Adults Receiving Help with 2+ ADLs
Value-Based Models Have Compressed PAC Provider Capacity – Closures

- **Shared Risk Models**
  - Sub/Partial Capitation
  - Bundled Payment

- **P4P (e.g., HRRP, HVBP, MIPS)**

- **Shared Savings (e.g., Track 1 MSSP, CPC+)**

- **Full Risk Models**
  - Global payment/capitation
  - MA, PACE, Some ACOs

**Level of Provider Sophistication and Collaboration**

- **Degree of Risk Managed by Provider**
- **Value-based reimbursement**

**Payment for Service or Activity**
- **Fee for service**
- **Pay for activity/coordination**

**Attain measure targets**
- **Level of Provider Sophistication and Collaboration**

**Manage event/condition**

**Manage a population**

**Partnering for the Future**

**LAN Summit**
Health Care Payment Learning & Action Network

**October 22, 2018 | Sheraton Tysons Hotel | Tysons, VA**
SNFs Are Innovating to Survive

Upstream Medicare Payment System Changes

SNF Core Capacities
- Primary Care Capabilities
- Care Integration
- Transitional Care Capabilities
- Targeted Clinical Programming

SNF Innovations
- Episodic Payment – MA & NexGen ACO
- CMS Patient Driven Payment Model
- Development of Institutional Special Needs Plans
- PAC Provider Networks
Long-Term Services and Supports

G. Lawrence Atkins, Ph.D.
Long-Term Quality Alliance

LAN Summit
October 22, 2018
Long-Term Services and Supports (LTSS)

• Provided to people with “functional limitations” who need assistance to take care of themselves – to perform basic “activities of daily living” (ADLs).

• Caused by physical, developmental, cognitive, mental health or chronic health condition expected to last for an extended period of time (e.g., 90 days +).

• Provided in institutional (nursing home, ICF, mental hospital) or home- or community-based (ALF, group home, adult day center, or home) setting.

• Services include: personal care assistance, assistive technologies, medication management, home modification, care coordination, housing assistance, employment assistance, meals, transportation.
Need for LTSS Today

- More than 70 million Americans have some activity limitation
- Over 12 million adults (18+) in need of LTSS today
- More than half (55%) age 65 plus – almost half (45%) age 18-64.
Functional Impairment Associated with High Medical Costs

Per Capita Medicare Spending, 2015

- Full Population: $10,507
- No Fi (No help or mild difficulty any ADL): $7,664
- Mild Fi (Difficulty 1+ ADLs): $16,436
- Moderate Fi (Help 1+ ADLs): $22,877
- Severe Fi (Help 2+ ADLs): $28,027

Note: Data is limited to fee-for-service Medicare beneficiaries living in the community.
Source: 2015 MCBS linked to claims
Care Received by Older Adults
2011

Receiving Personal Assistance

- Nursing Home
- 3+ Activities
- 1-2 Activities
- Minor Hshld/mobility
- No Assistance

Living in Home/Community
Type of Help Received

- Unpaid Help Only
- Unpaid + Paid Help
- Paid Help Only

Medicaid Spending is Shifting from Institutional to HCBS - 1981-2015
Movement of States to Medicaid Managed LTSS (MLTSS)

Source: NASHID survey, CMS data
11 Million Dual Eligible Beneficiaries are Covered by Both Medicare and Medicaid (2013)

- Total Medicare Beneficiaries, 2008: 54 million
- Total Medicaid Beneficiaries, 2008: 74 million

Enrollment of Dual Beneficiaries in Integrated Plans

12% of all Full Dual Beneficiaries are enrolled in integrated plans

- Unaligned D-SNP: 19%
- Aligned D-SNP/MLTSS: 2%
- FIDE-SNP: 4%
- MMP: 5%
- PACE: 1%
- FFS: 69%
Initiatives to Advance LTSS Integration

• **Financial Alignment Demonstration - ACA**
  • 13 States involved in the Demonstration – began 2013
  • Capitated model – MMPs- 3 way contract between CMS-State-MCO (11 states) – enrolled 375,000 by December 2016.

• **CHRONIC Care Act of 2018**
  • Made D-SNPs permanent
  • Encouraged states toward full integrated models (FIDE-SNPs)
  • Created new Medicare Advantage supplemental benefit for non-medical services.
# Supplemental Benefits Flexibility

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>2020: &quot;Chronic&quot;</th>
<th>2019: &quot;Targeted&quot;</th>
<th>&quot;Standard&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligibility</strong></td>
<td>&quot;Chronically ill&quot; beneficiaries (defined in statute)</td>
<td>Specific health status or disease state</td>
<td>All MA beneficiaries</td>
</tr>
<tr>
<td><strong>Benefit flexibility</strong></td>
<td>Supplemental benefit that has a reasonable expectation of improving or maintaining enrollee health or overall function</td>
<td>Benefits must (1) not be covered by original Medicare; (2) must be primarily health-related (new, more flexible definition); and (3) MA plan must incur a non-zero direct medical cost</td>
<td>The supplemental benefit is uniform across all beneficiaries</td>
</tr>
<tr>
<td><strong>Uniformity flexibility</strong></td>
<td>Ability to tailor to an individual beneficiaries' specific medical condition and needs</td>
<td>Ability to tailor to similarly situated beneficiaries</td>
<td></td>
</tr>
</tbody>
</table>
Welcome

Nick Bluhm
Senior Director Strategy and Government Policy Remedy Partners
How Should Post-Acute Providers Respond to ACOs and other risk-bearing entities?

Key Considerations

• 1. The market landscape
• 2. Your facility’s or agency’s position in the market
• 3. The business and clinical relationship between the risk-bearing entity and your traditional referral sources
• 4. What is the risk-bearing entity asking of your facility or agency?
• 5. What should my facility or agency ask of the risk-bearing entity?
How Should Post-Acute Providers Respond to ACOs and other risk-bearing entities?

Key Considerations

• 1. The market landscape
  • Appropriate substitutes (e.g. lower-cost institutional providers; home-based providers)
  • Competition within your market segment (e.g. SNF, home health)

• 2. Your facility’s or agency’s position in the market
  • Brand recognition to patients
  • Characteristics of your census (long-term vs. convalescent)
  • Clinical capabilities
How Should Post-Acute Providers Respond to ACOs and other risk-bearing entities?

Key Considerations

• 3. The business and clinical relationship between the risk-bearing entity and your traditional referral sources
  • Understand the clinical pathways from the risk-bearing entity to your facility or agency
  • What new incentives are placed on your referral sources?
Understand the clinical pathways from the risk-bearing entity to your facility or agency

1. Diagnosis
   - Select the appropriate setting for the intervention (Hospital, ASC, or Community).
   - Shared decision-making to select the most appropriate care path. Reduce unnecessary testing.

2. Intervention
   - Determine the appropriate intensity level for the recovery setting.
   - Optimize resources used (within a normal range of variation). Reduce complications.

3. Post-recovery Setting
   - Monitor the patient and coordinate with all specialties.
   - Ensure appropriate transition back to primary care physician.

4. Home
ACOs reduce SNF admissions in part by reducing IPPS admissions
ACOs reduce SNF admissions in part by reducing IPPS admissions
Average number of weekly IPPS admissions: Not dependent on the type of ACO
Hospitals in the ACO service area: Strong variation within ACO categories
How Should Post-Acute Providers Respond to ACOs and other risk-bearing entities?

Key Considerations

4. What is the risk-bearing entity asking of your facility or agency?
   - Information sharing
   - Encouraging warm hand-offs to community providers
   - Changing the patient population of the facility/agency
   - Treating the existing patient population differently

5. What should you ask of the risk-bearing entity?
   - Investments in care redesign
   - Timely sharing of information from referral sources
Visit the LAN Website for our Resources

https://hcp-lan.org/
Exit Survey

We want to know what you think!

Please take a moment to complete the exit survey so we can continue to improve and enrich the LAN. Use the link in *Guidebook* for this session to provide us your feedback.
Contact Us
We want to hear from you!

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Thank You!