Partnering for the Future

LAN SUMMIT

Health Care Payment Learning & Action Network

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

OCTOBER 22, 2018 | SHERATON TYSONS HOTEL | TYSONS, VA

Welcome

Thomas Buckingham

Executive Vice President of Strategy, Select Medical

President, Allevant Solutions

Panel Speakers

Larry Atkins

Executive Director Long-Term Quality Alliance

Michael Cheek

Senior Vice President
Reimbursement Policy and Legal Affairs
American Health Care Association

Nick Bluhm

Senior Director Strategy and Government Policy
Remedy Partners

Barbara DiMercurio

Vice President
Post-Acute Clinical Services Trilogy Health Services

Partnering for the Future

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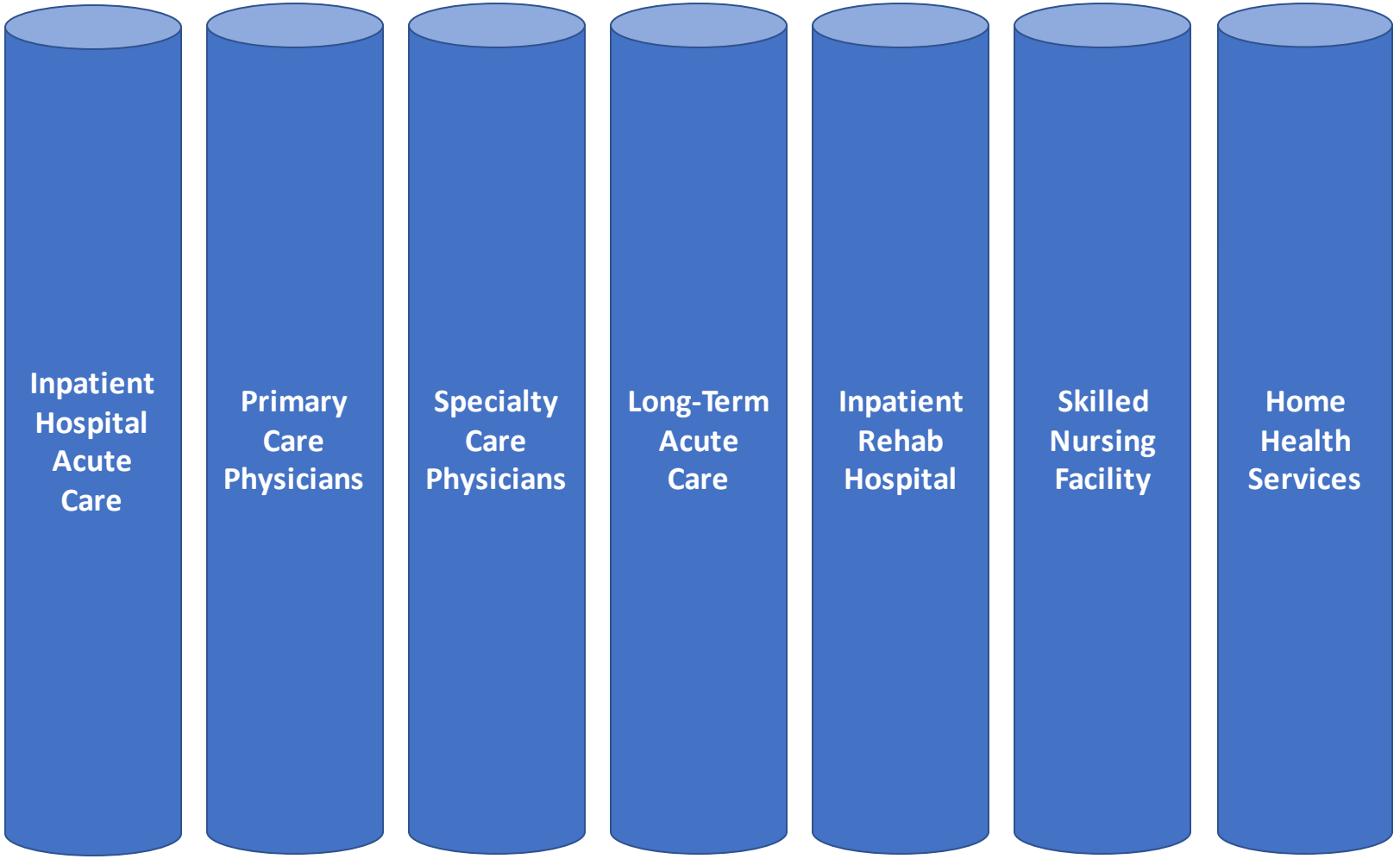
Health Care Payment Learning & Action Network

Post-Acute Care Role in APMs

Thomas Buckingham

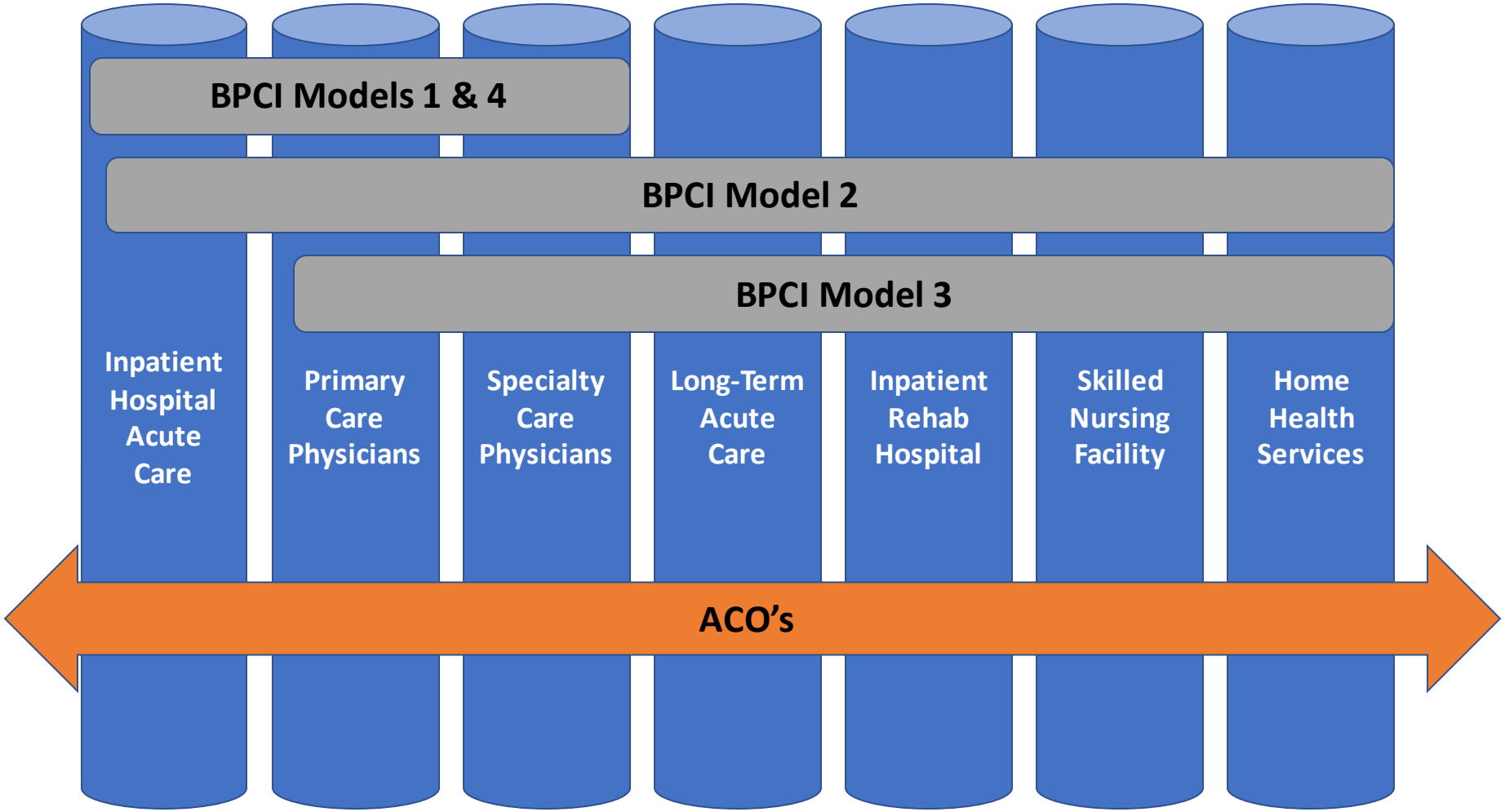
Current FFS Payment Model

Silos of Care



CMS: Alternative Payment Models

Continuum of Care



CMS: Alternative Payment Models

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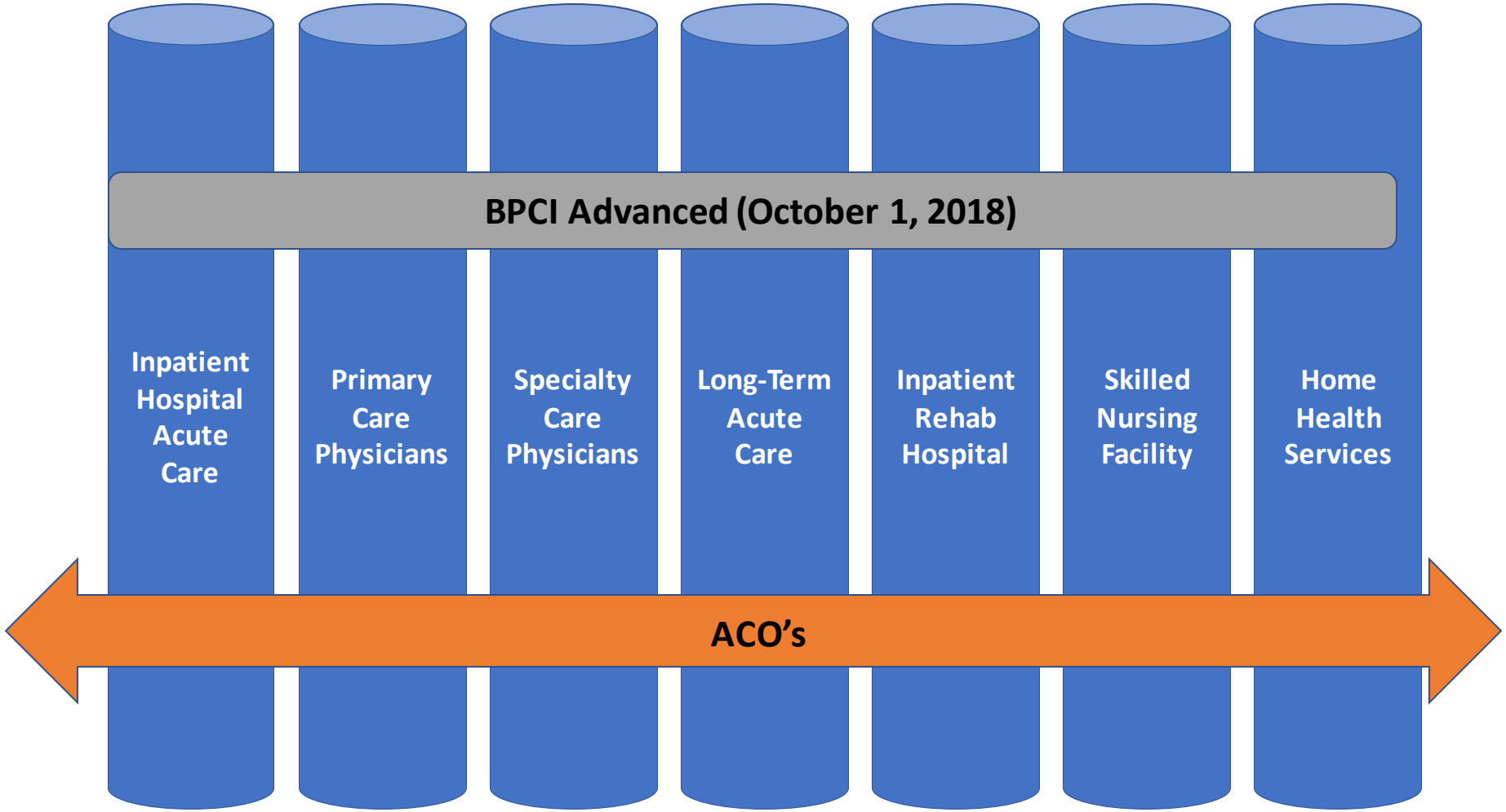


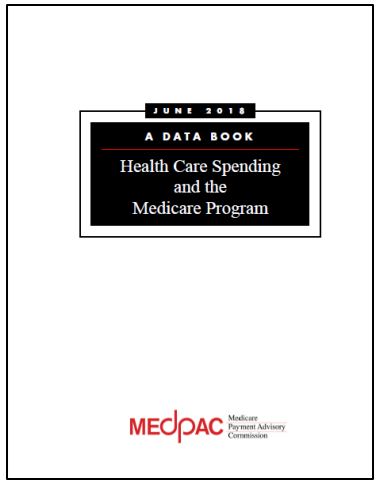
Number of U.S. Community Hospitals (STACHs) 2018

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

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



Source: MedPAC Health Spending Data Book, June 2014 & June 2018

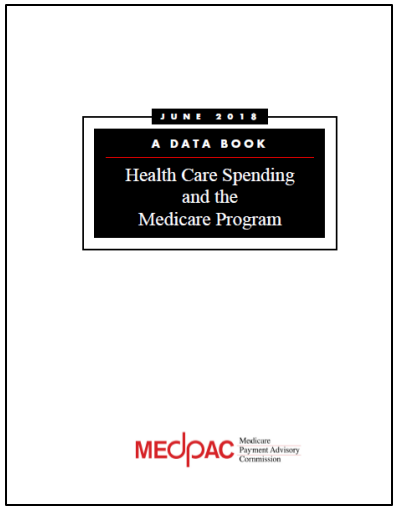
STACH Discharge Destination for Medicare FFS 2006 - 2016

Destination	2006	2009	2012	2016
Home/Self Care	52.3%	50.1%	48.0%	45.6%
Long-Term Care Hospital	0.9%	1.1%	1.2%	1.2%
Inpatient Rehabilitation	3.4%	3.3%	3.5%	3.9%
Skilled Nursing Facility	18.8%	19.8%	20.3%	20.2%
Home w/Home Health	13.8%	15.2%	15.9%	17.5%
Hospice	1.6%	2.1%	2.7%	3.0%
IPF	0.4%	0.5%	0.5%	0.4%
Other Setting	2.0%	1.6%	1.7%	2.0%
Other Acute Care Hospital	2.5%	2.2%	2.2%	1.9%
Left AMA	0.6%	0.7%	0.8%	0.9%
Died in Hospital	3.8%	3.5%	3.3%	3.3%

Source: MedPAC Health Spending Data Book, Acute Inpatient Services – June 2014 & June 2018

Initial Post-Acute Care Placement (2016)

Number of Entities



4,840
STACH

LTCH
411

IRF
1,178

SNF
15,277

HHA
11,844

OPT

Home

First PAC Placement

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

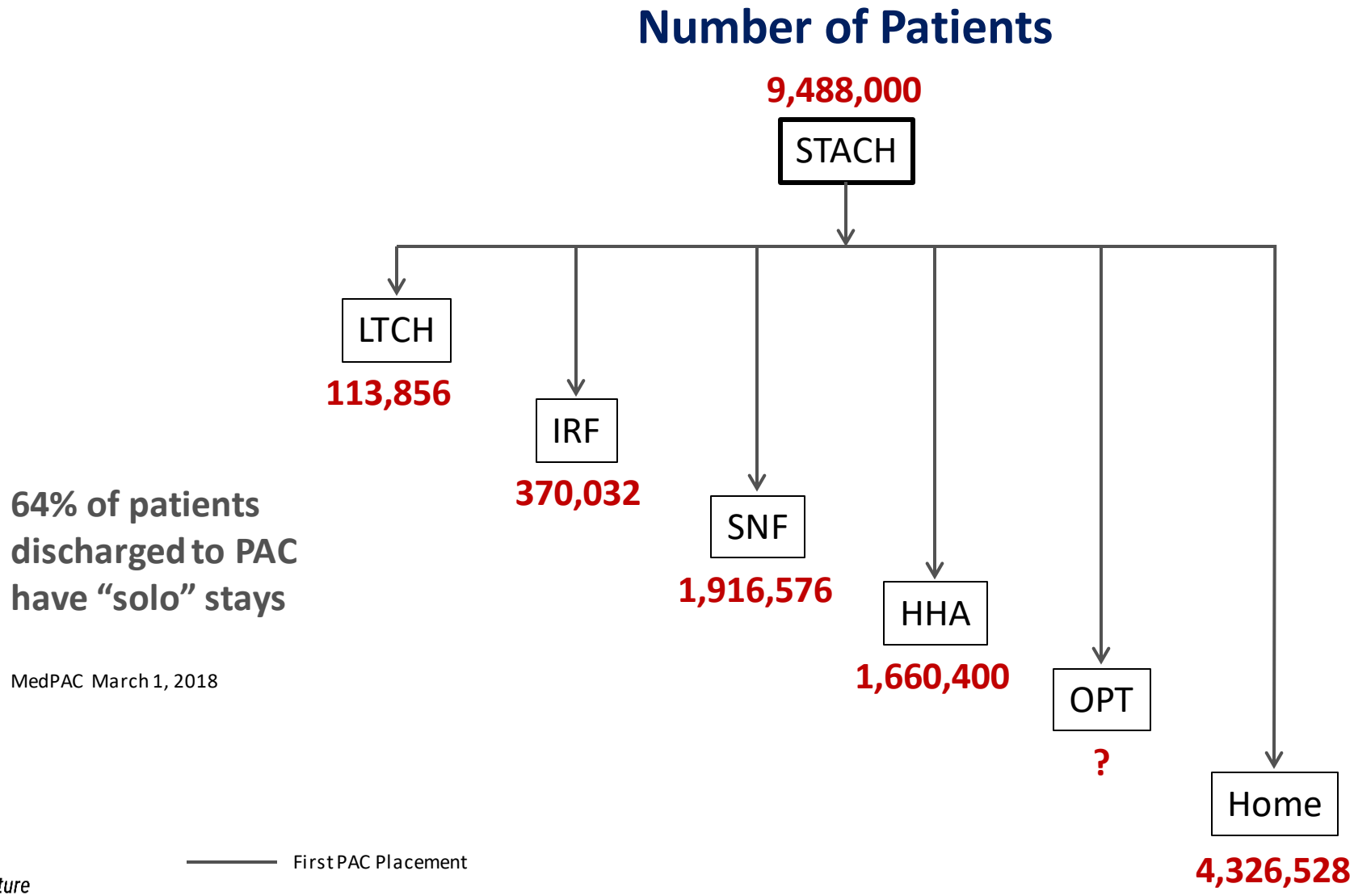
The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services

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

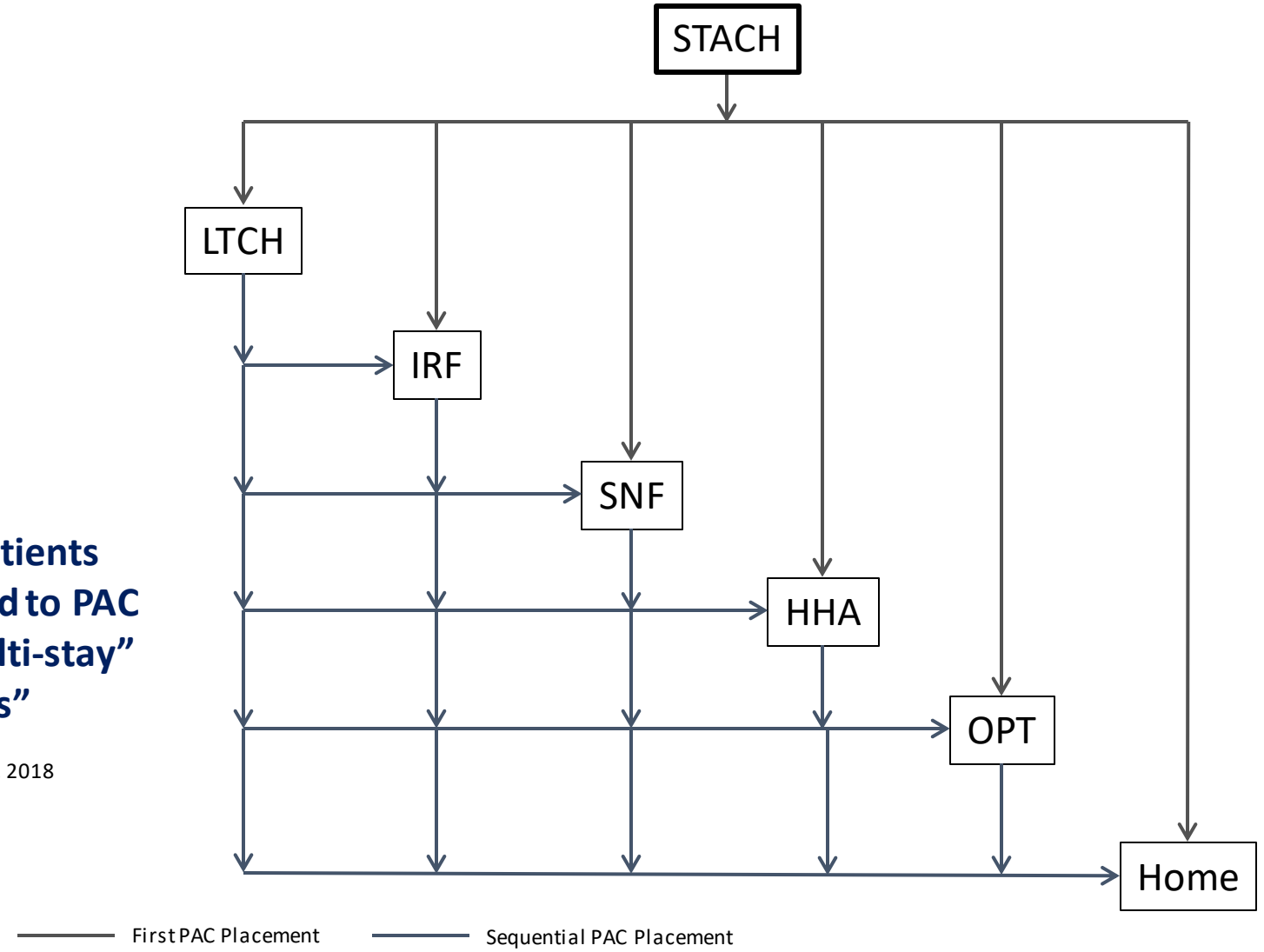
Initial Post-Acute Care Placement (2016)



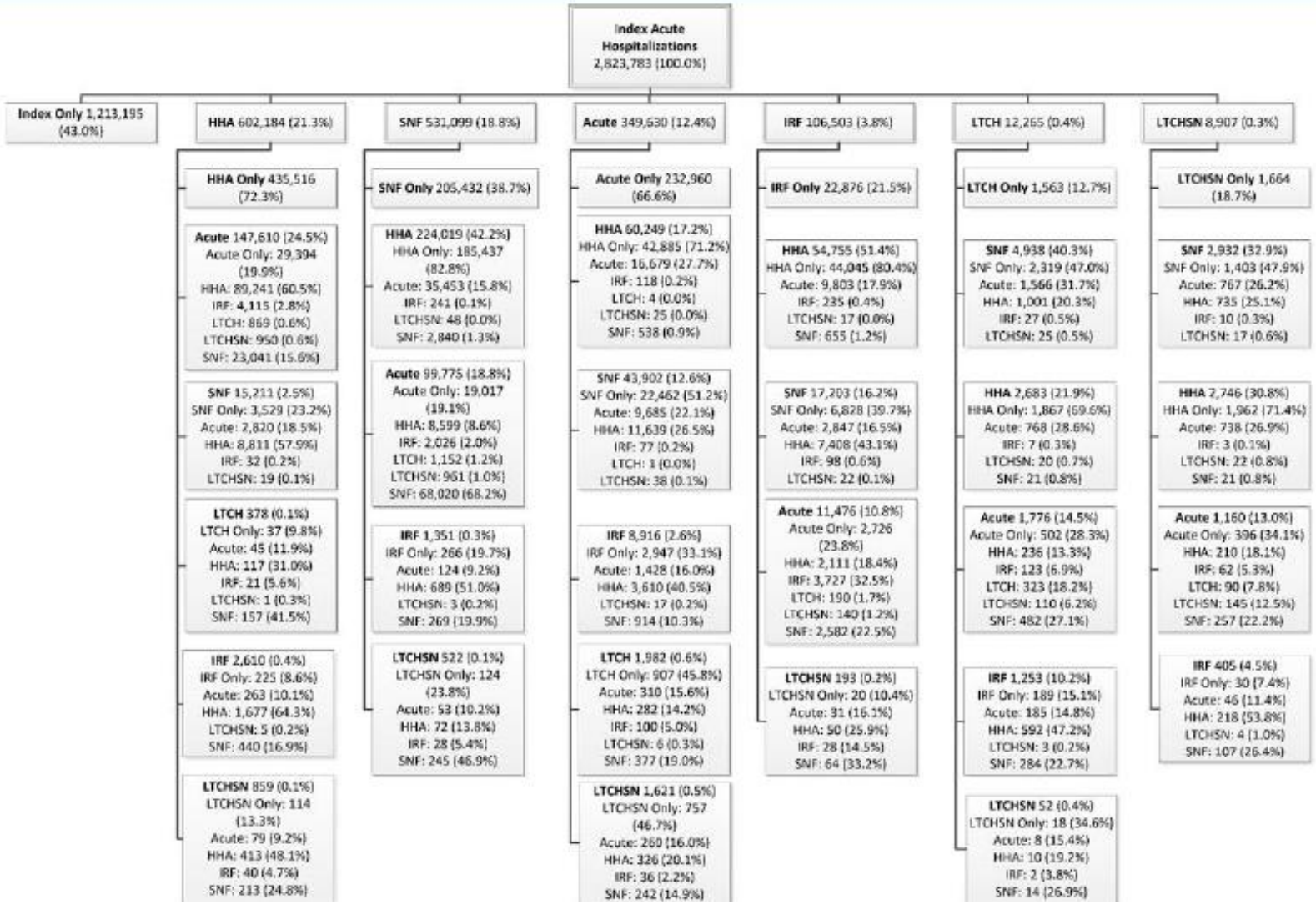
Sequential Post-Acute Care Placements

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

MedPAC March 1, 2018

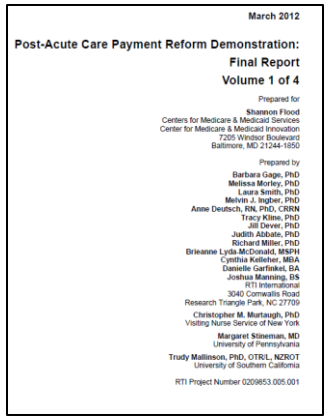


Post-Acute Care Transitions, 2014



Source: RTI September 2018

Readmission to STACH from Post-Acute Care



March 2012

Post-Acute Care Payment Reform Demonstration:
Final Report
Volume 1 of 4

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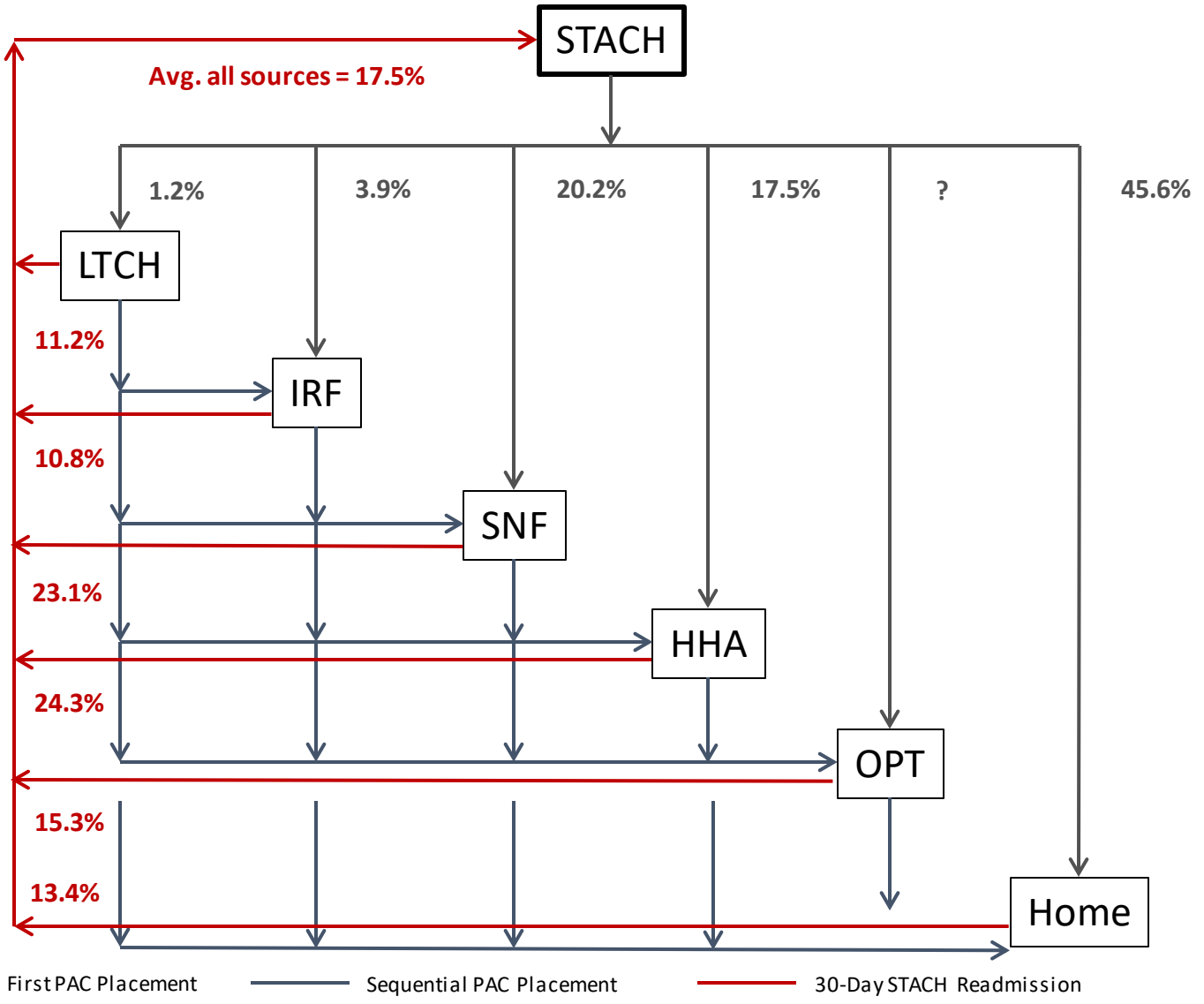
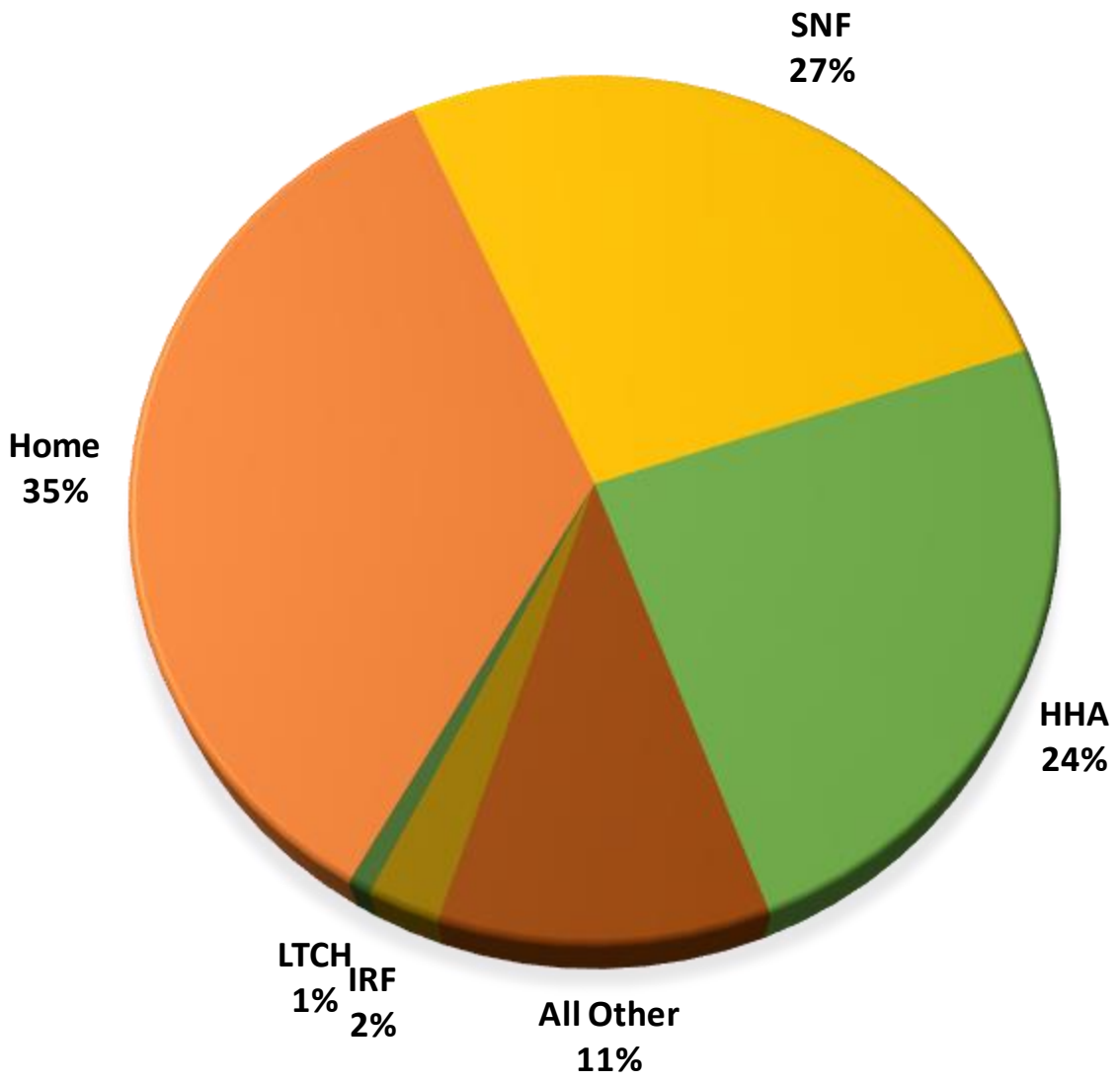
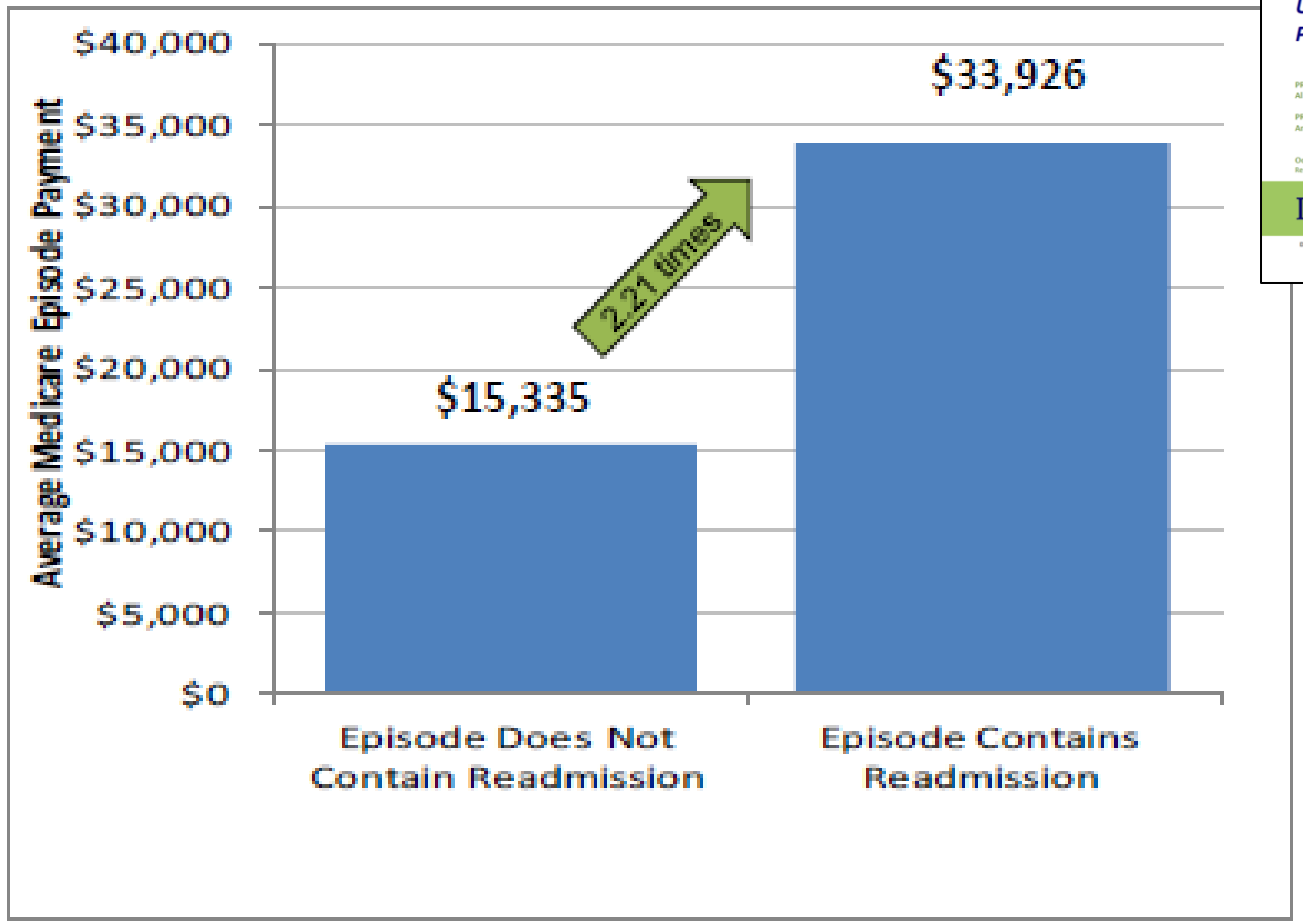
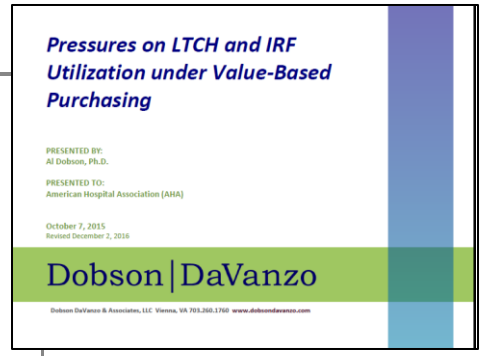


Percentage of STACH Readmissions



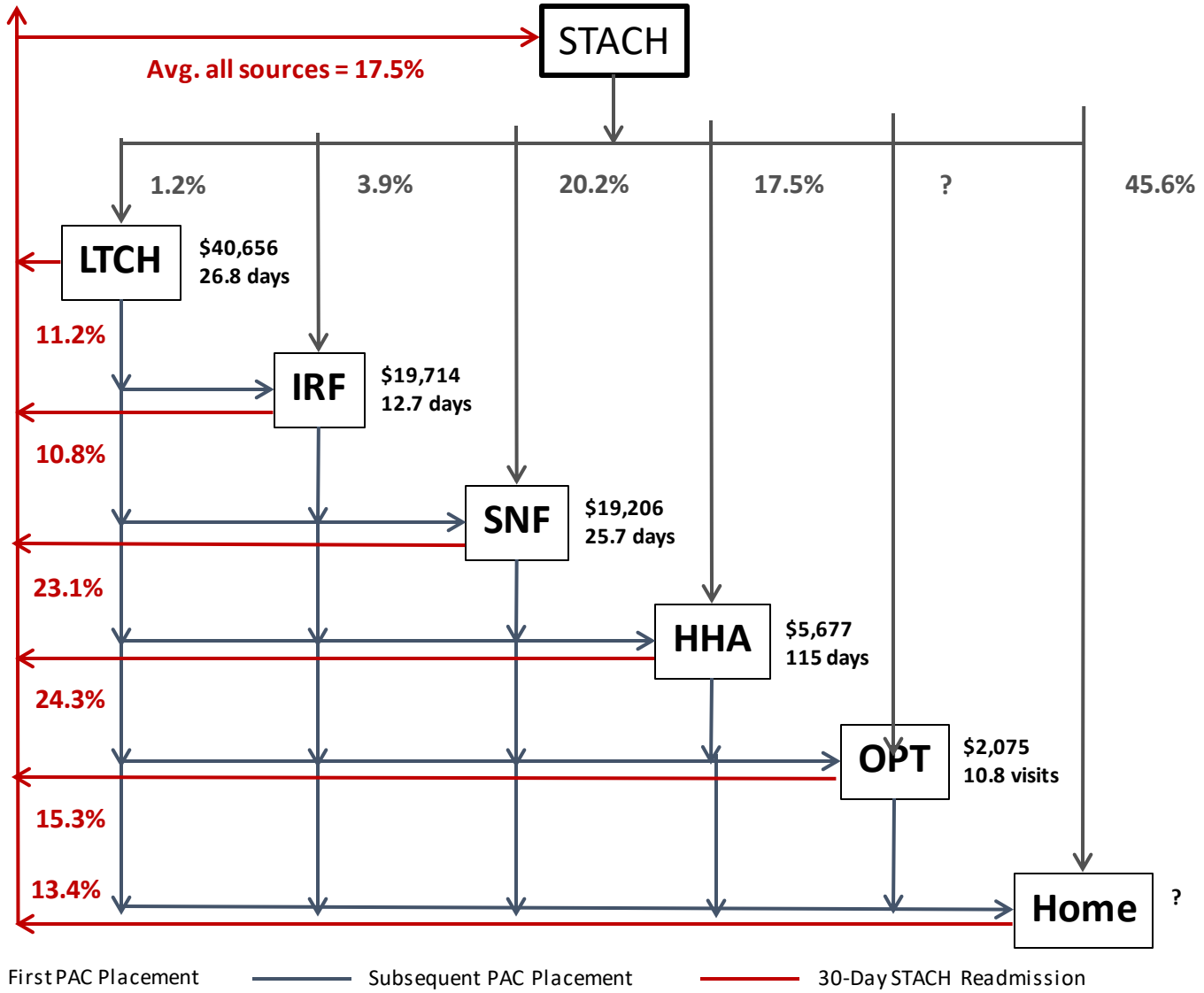
Average Medicare Episode Payment By Readmission Status



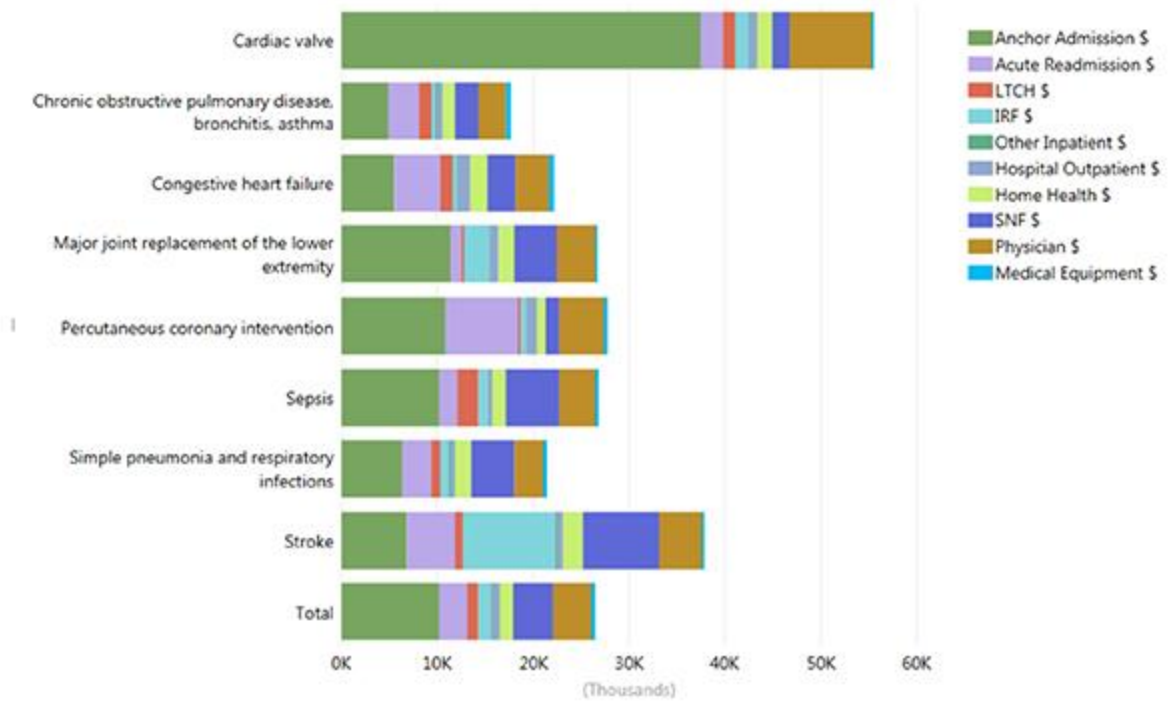


Source: Dobson DaVanzo: October 2012 Pressures on LTCH and IRF under Value-Based Purchasing

Post-Acute Care Patient Flow



Distribution of Medicare Spend



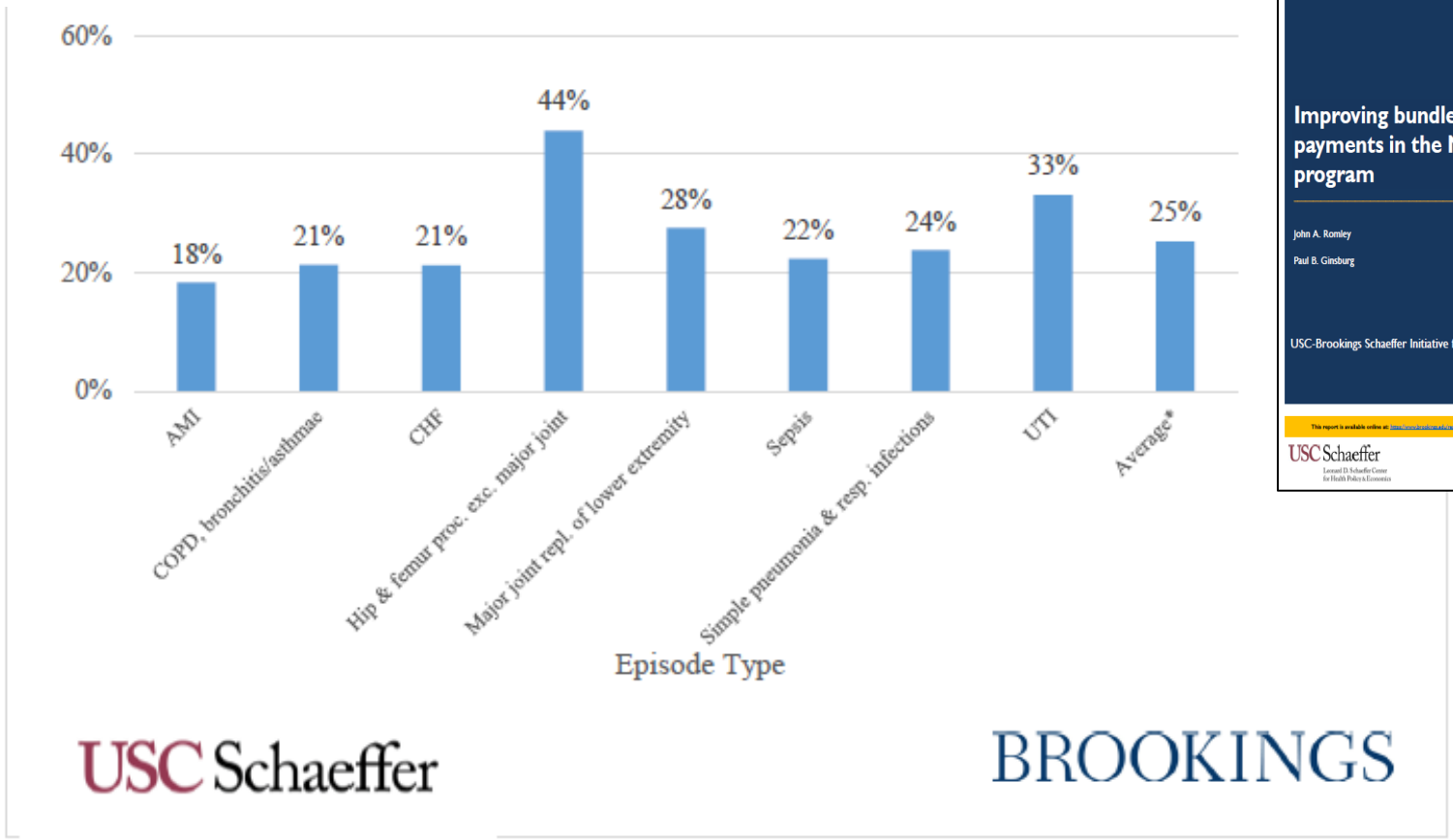
Average Episode $

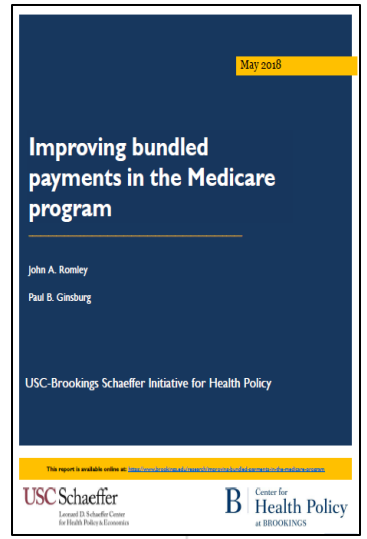
All data from this slide on is based on 90-Day Episodes - Trimmed Spending (Risk Track B) in 2012 Dollars , Episodes with less than 250 count are not included, but are available.

Data provided by Dobson DaVanzo

DHG | healthcare THE NATIONAL HEALTHCARE PRACTICE OF DIXON HUGHES GOODMAN LLP

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*

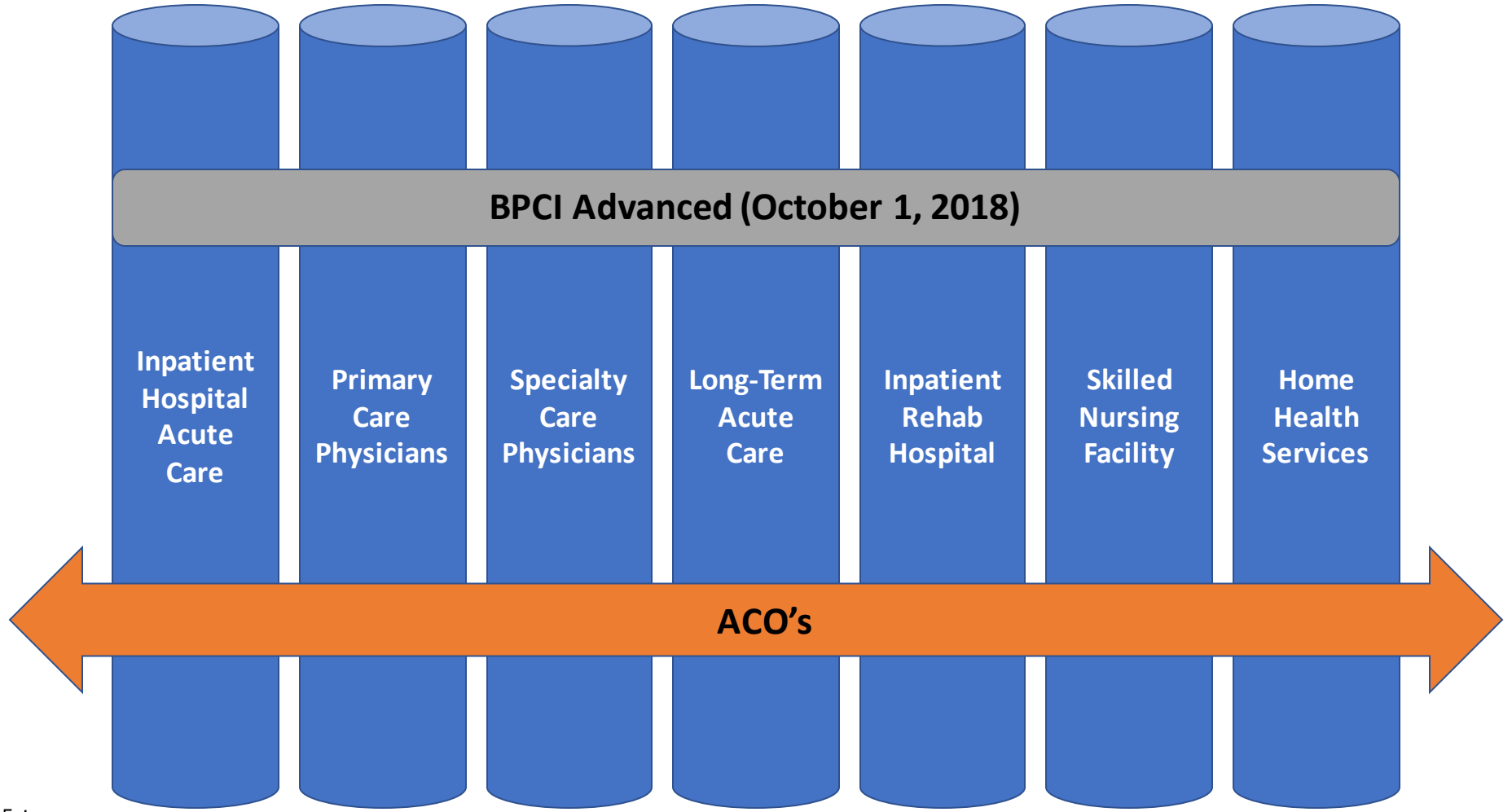
"Financial Success" in APMs is defined by "Savings"

(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

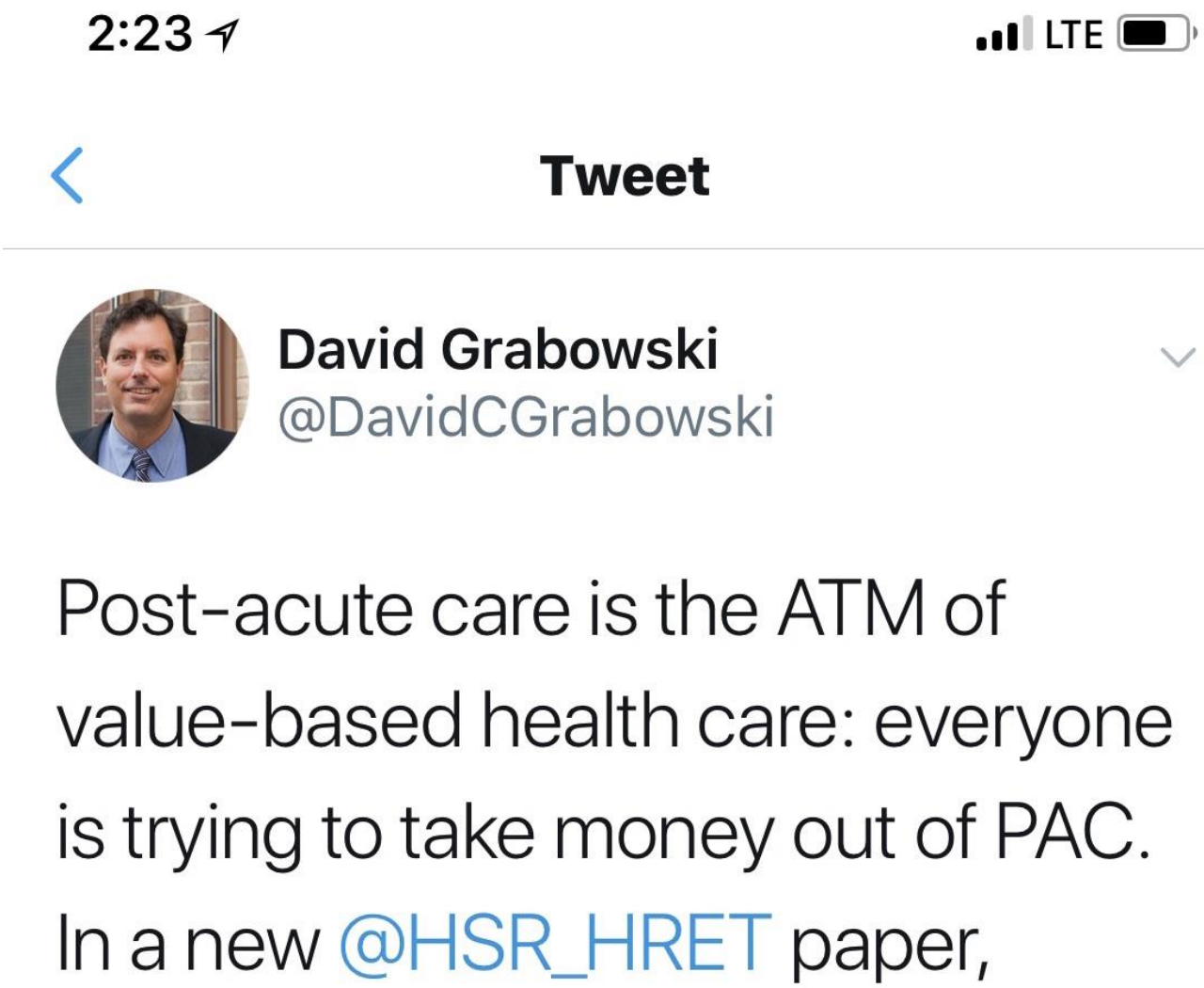
CMS: Alternative Payment Models

Continuum of Care



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



David C. Grabowski, PhD, is a professor of health care policy in the Department of Health Care Policy at Harvard Medical School and is also a member of the Medicare Payment Advisory Commission (MedPAC).

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)

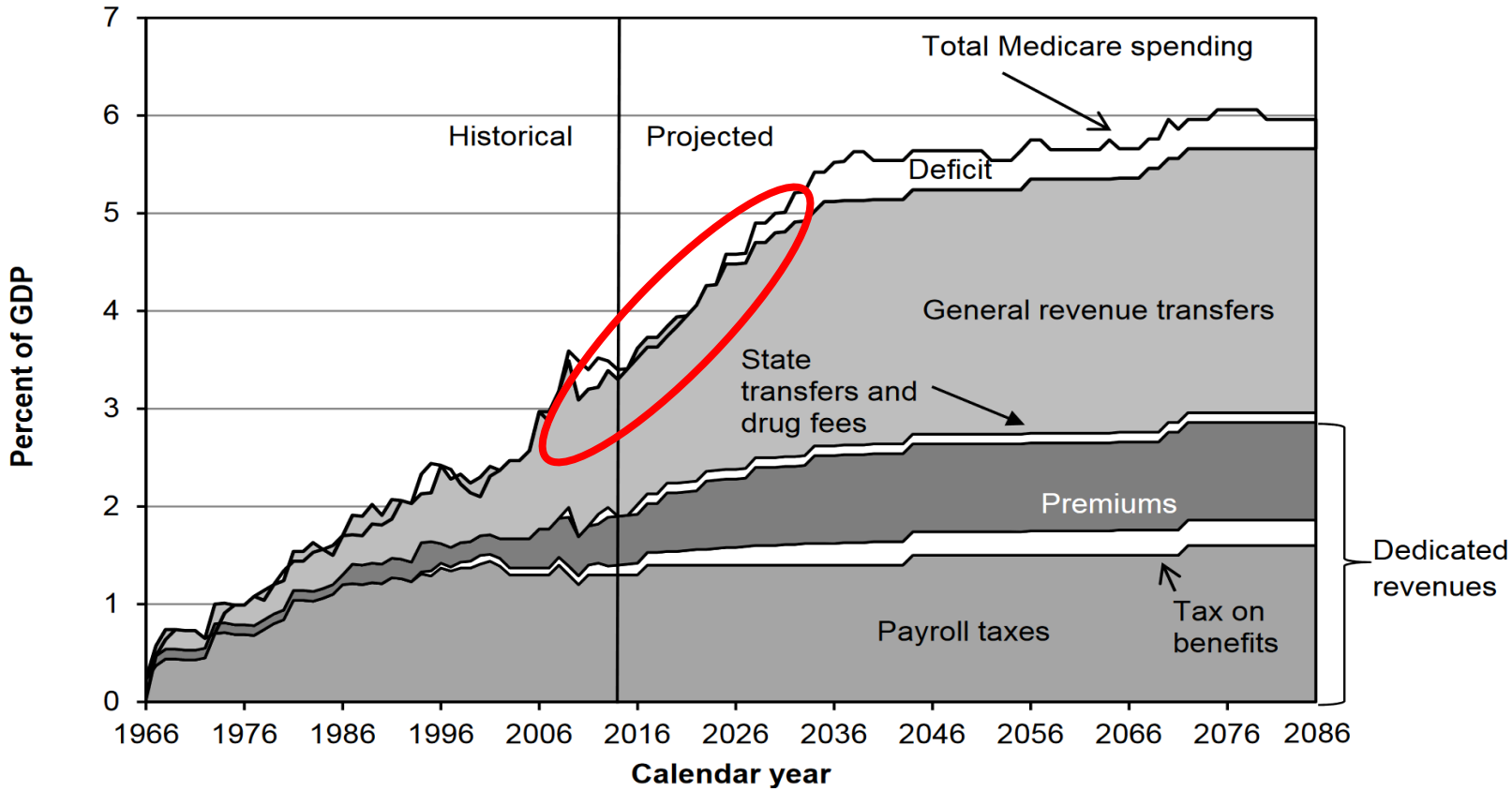
Welcome

Michael Cheek

Senior Vice President
Reimbursement Policy and Legal Affairs

American Health Care Association

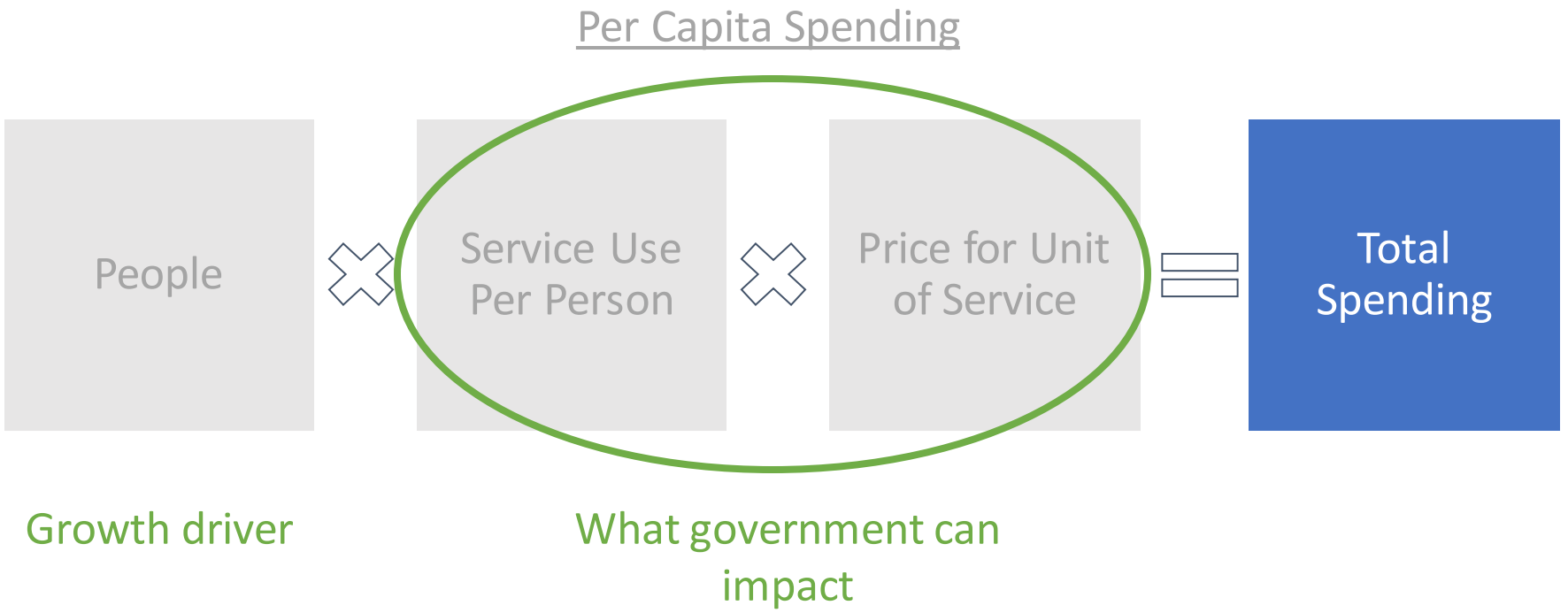
Medicare Pressure will Continue with PAC a Key Focus Area for Budget Holes



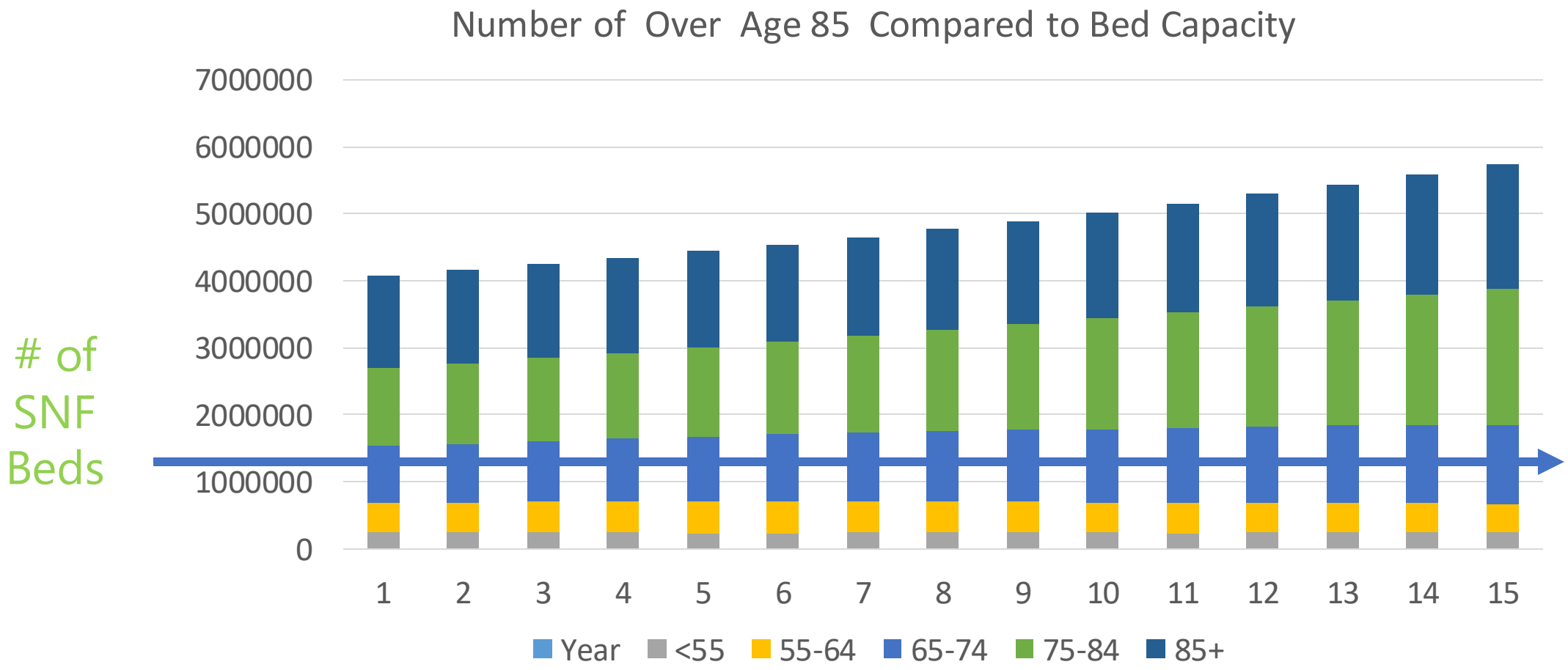
Source: MedPAC June 2017 Health Care Spending and the Medicare Program: A Data Book; Chart 1-13. June 2017.
Chart source: Annual report of the Board of Trustees of the Medicare trust funds 2016.
http://www.medpac.gov/docs/default-source/data-book/jun17_databookentirereport_sec.pdf?sfvrsn=0

Total $ Growth Approached Through Reductions in Per Capita $ & Price Growth

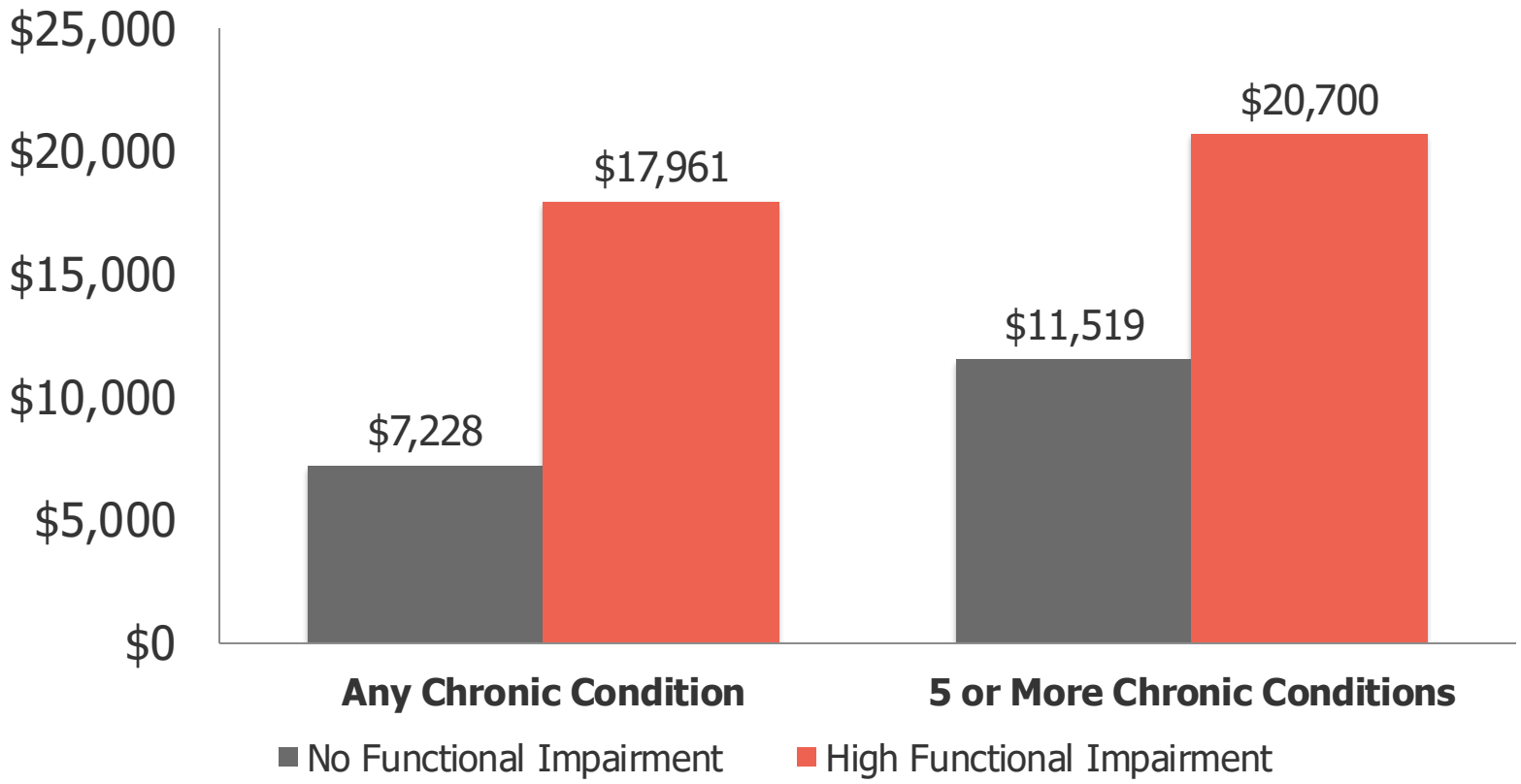
Growth in:



Increases in Comorbidities Drive Up Need

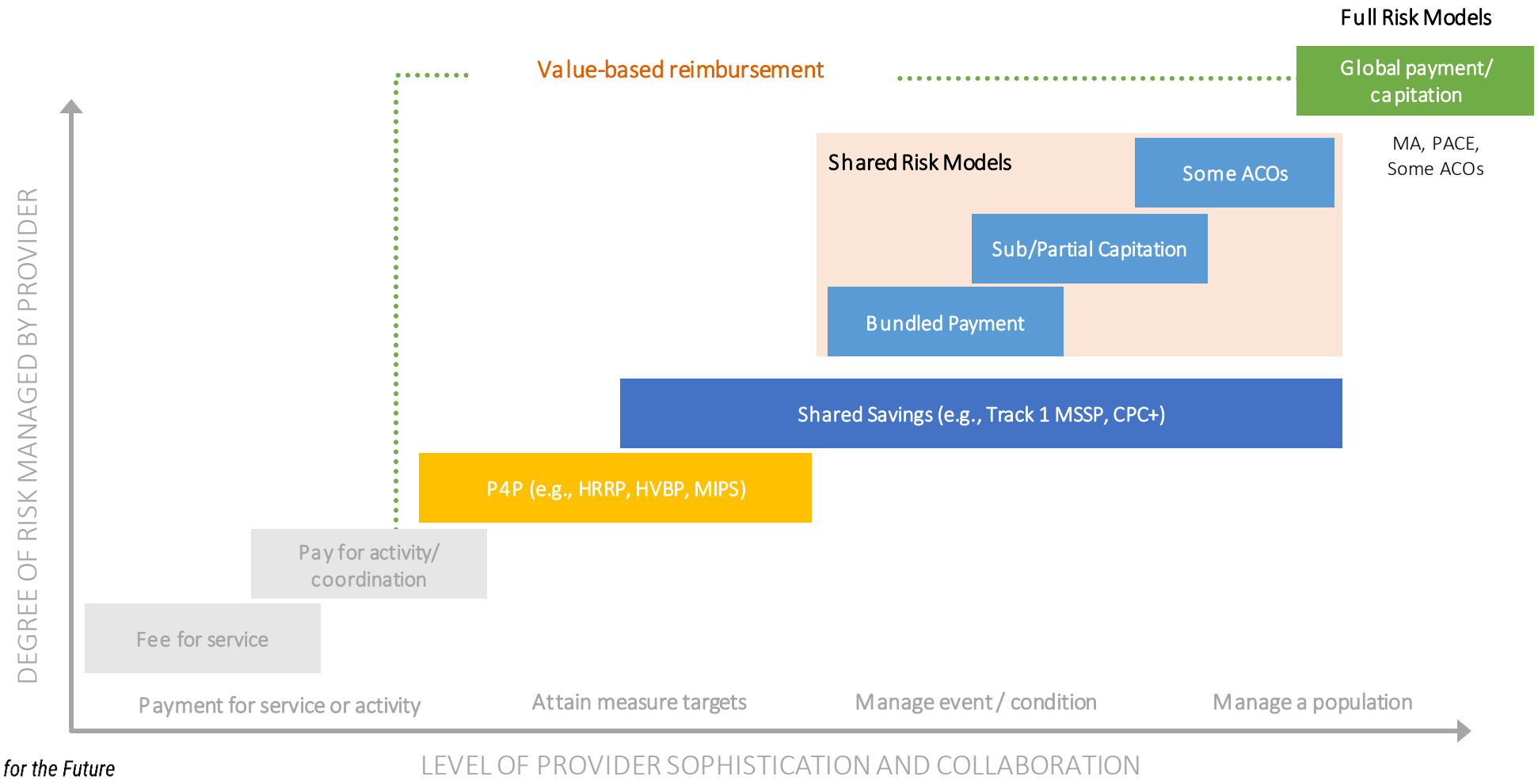


Costs Vary Widely Based on PAC Setting – Opportunity for Savings



Source: Functional Impairment and Medical Spending, 2012
MCBS Cost and Use File, Analysis on Older Adults Receiving Help with 2+ ADLs

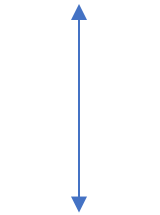
Value-Based Models Have Compressed PAC Provider Capacity – Closures



SNFs Are Innovating to Survive

Upstream Medicare Payment System Changes

Hospital



Physicians

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).

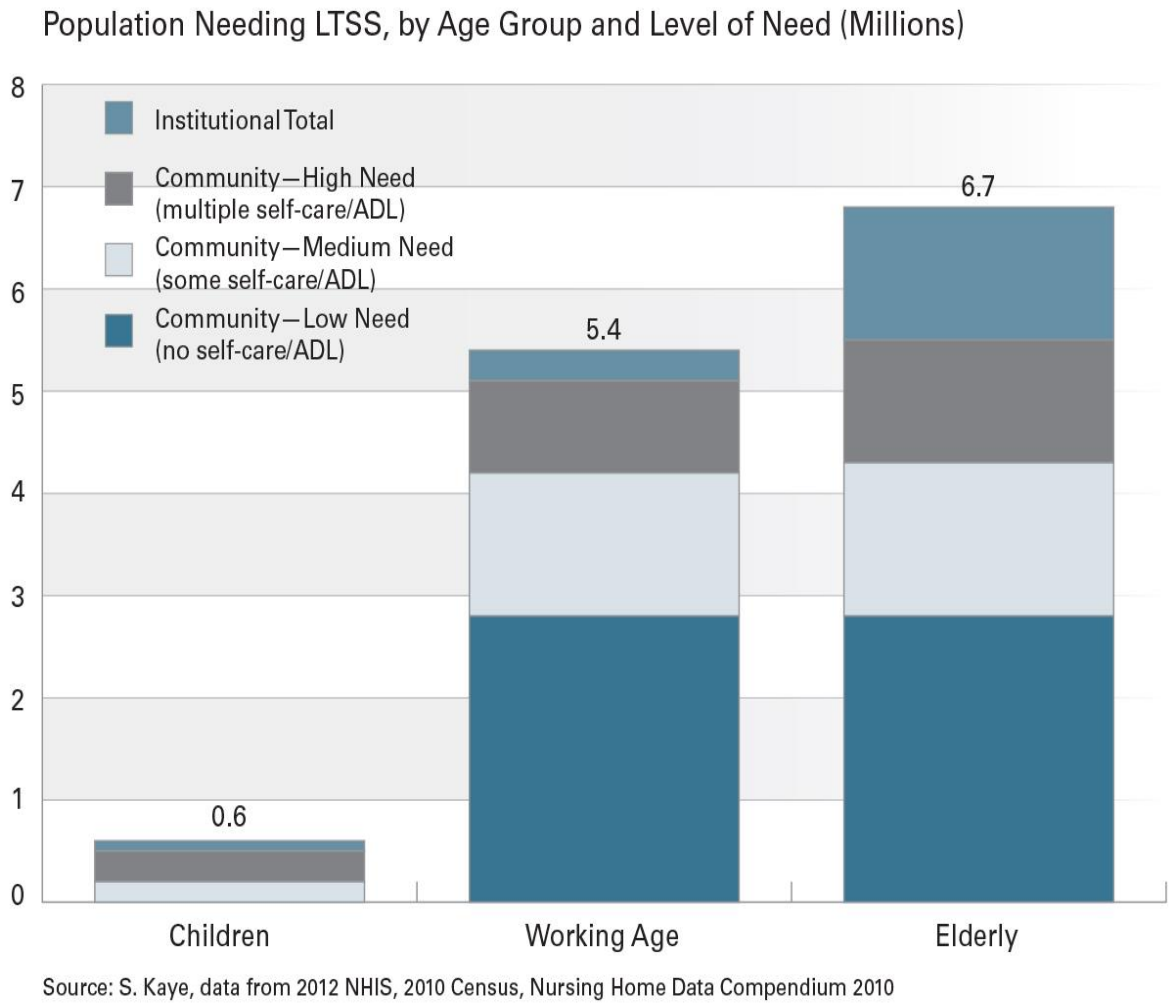
- Caused by physical, developmental, cognitive, mental health or chronic health condition expected to last for an extended period of time (e.g., 90 days +).

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

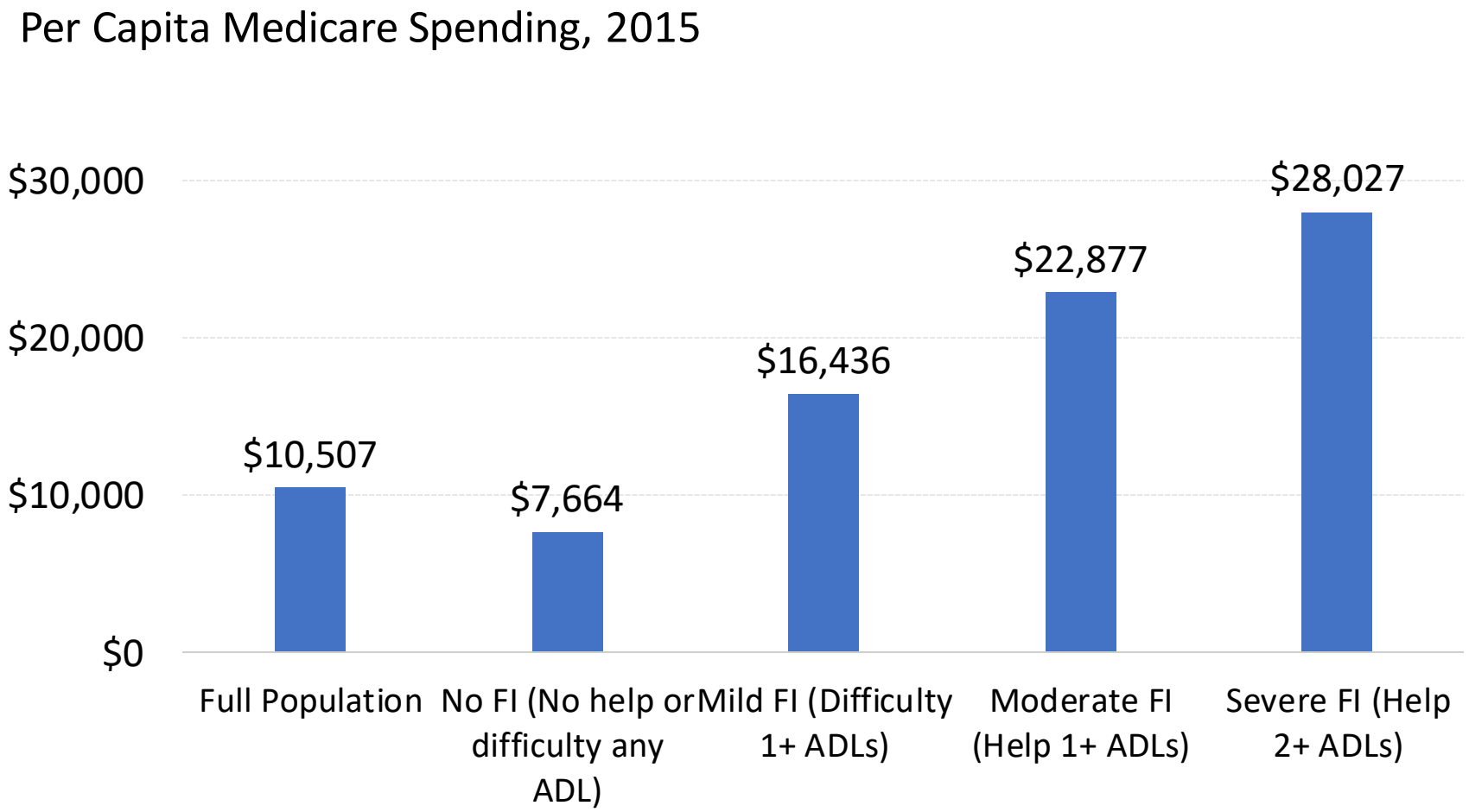
- Services include: personal care assistance, assistive technologies, medication management, home modification, care coordination, housing assistance, employment assistance, meals, transportation.

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.



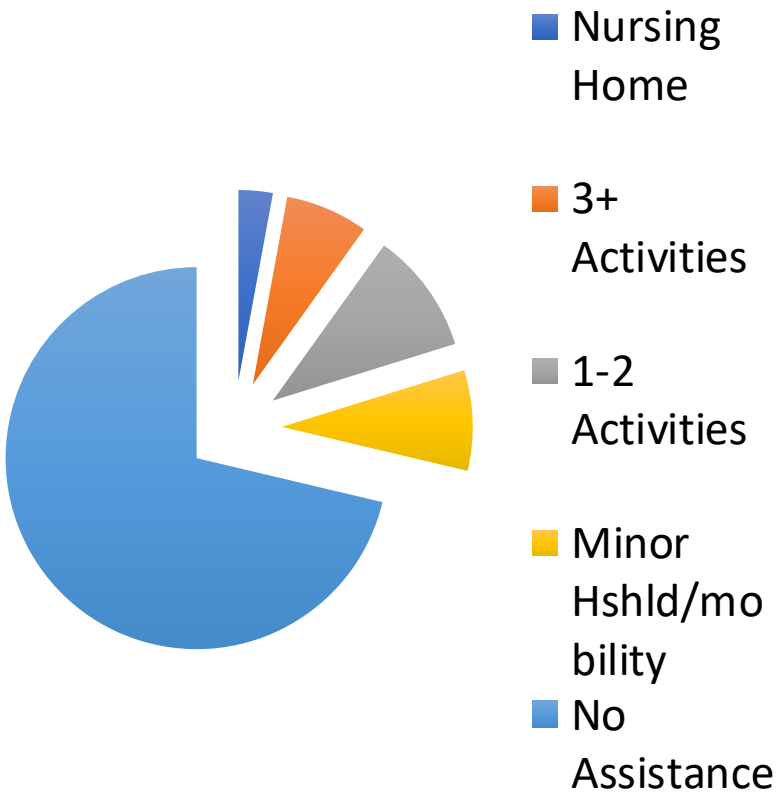
Functional Impairment Associated with High Medical Costs



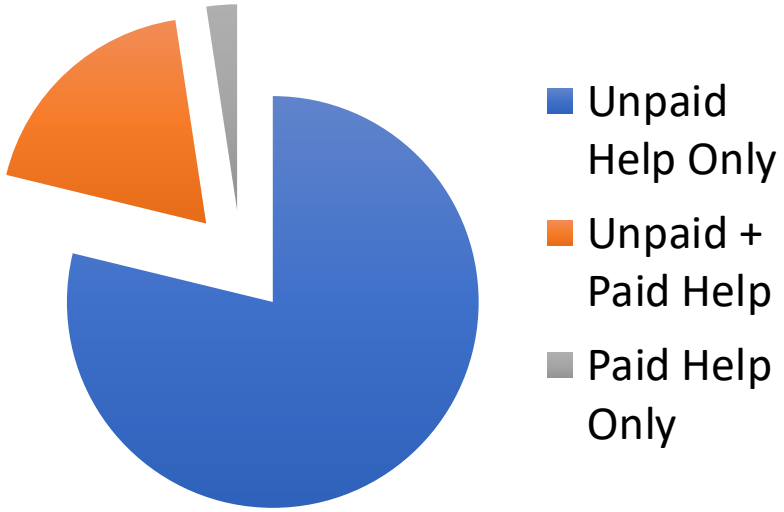
Note: Data is limited to fee-for-service Medicare beneficiaries living in the community
Source: 2015 MCBS linked to claims

Care Received by Older Adults 2011

Receiving Personal Assistance

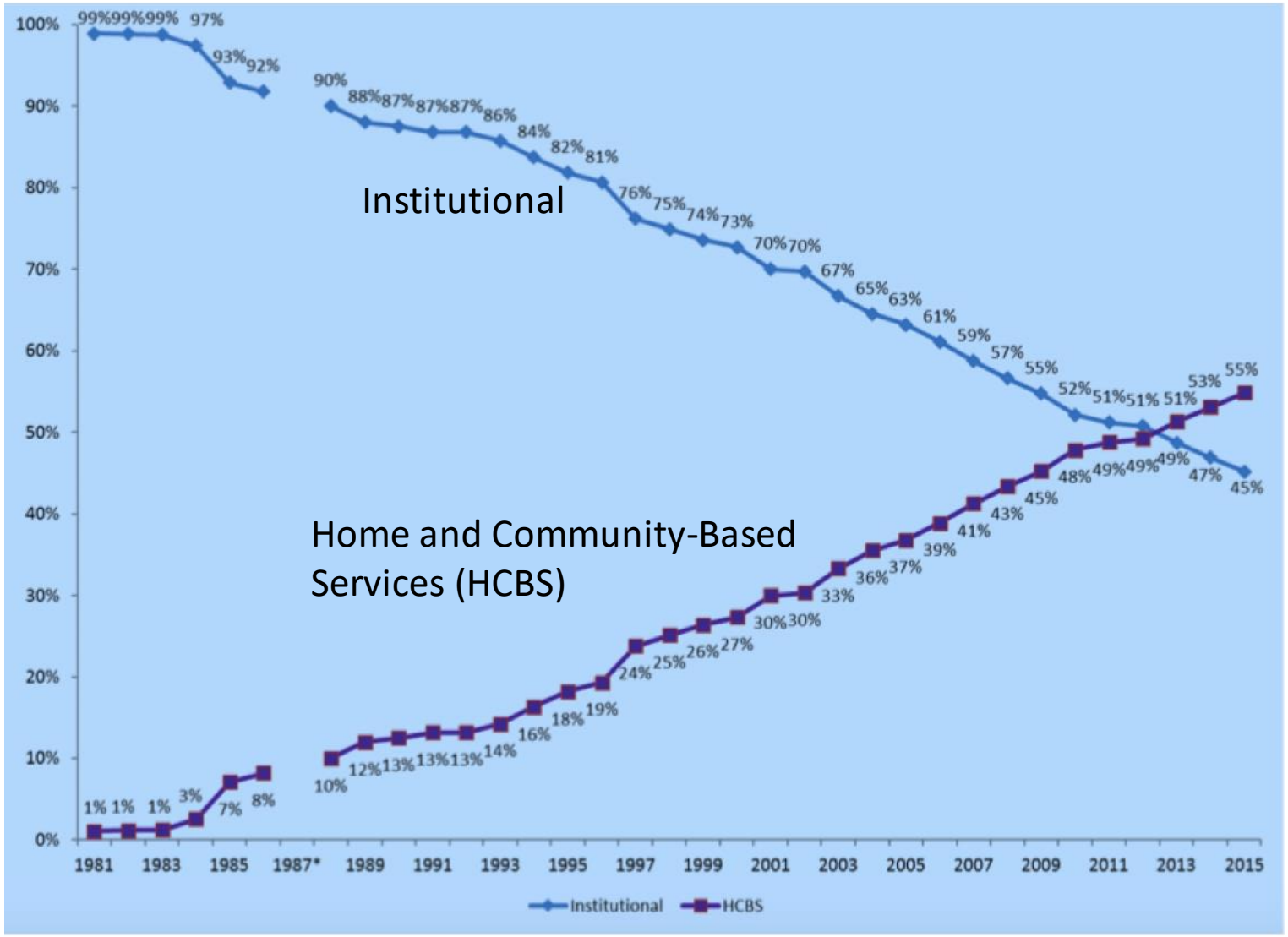


Living in Home/Community Type of Help Received

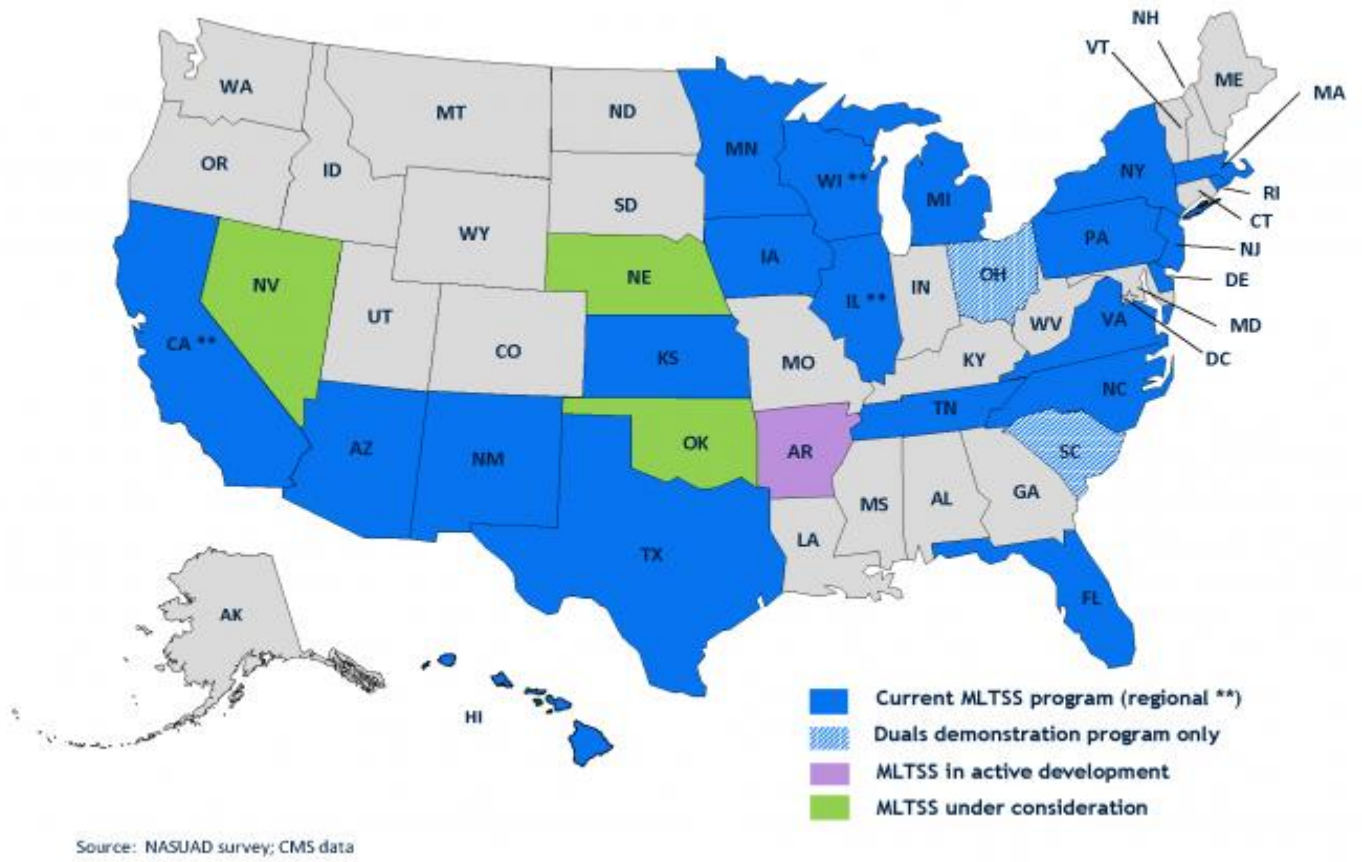


V.A. Freedman and B.C. Spillman. Disability and Care Needs of Older Americans. Milbank Quarterly. 92:3 2014

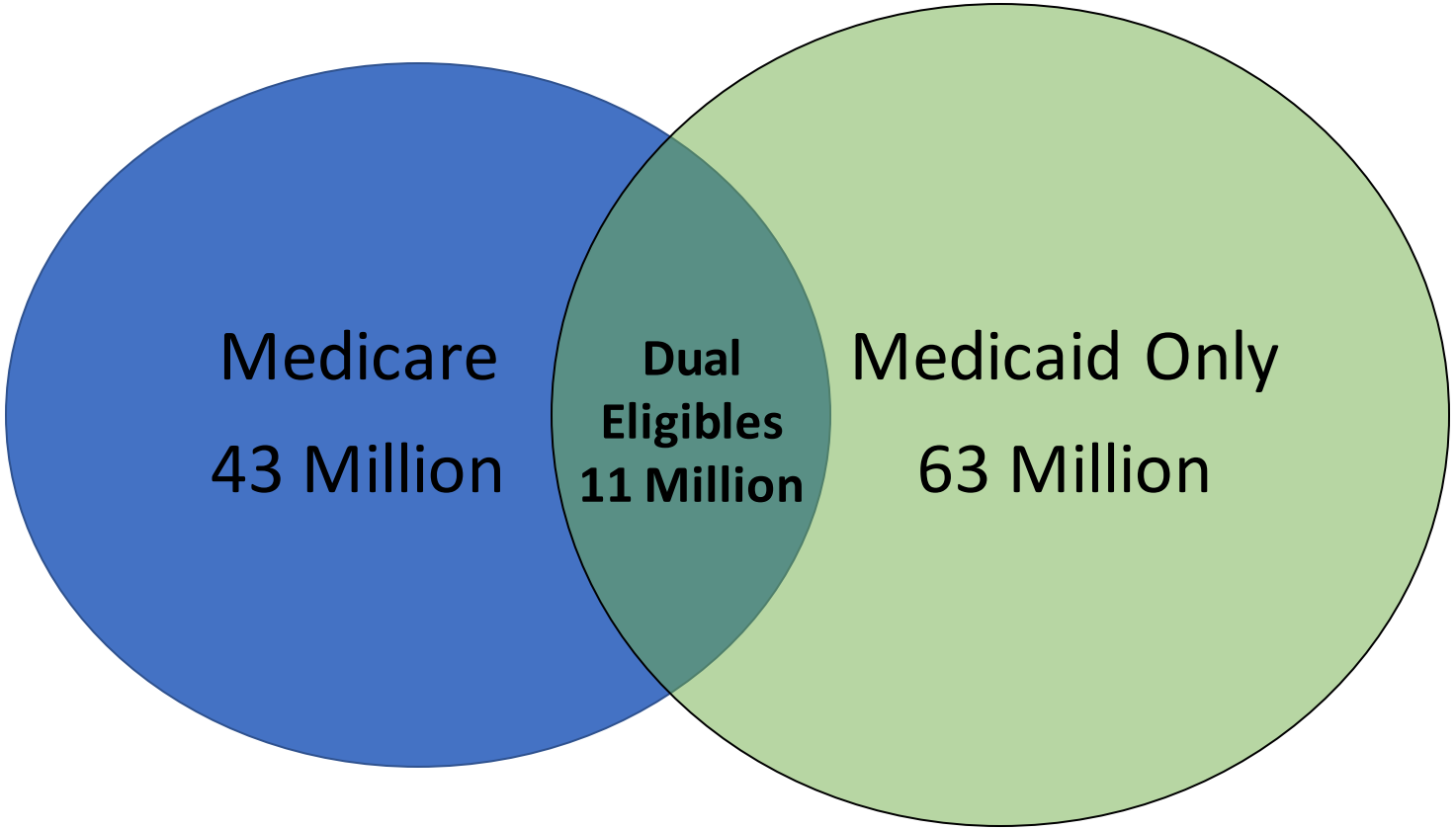
Medicaid Spending is Shifting from Institutional to HCBS - 1981-2015



Movement of States to Medicaid Managed LTSS (MLTSS)



11 Million Dual Eligible Beneficiaries are Covered by Both Medicare and Medicaid (2013)

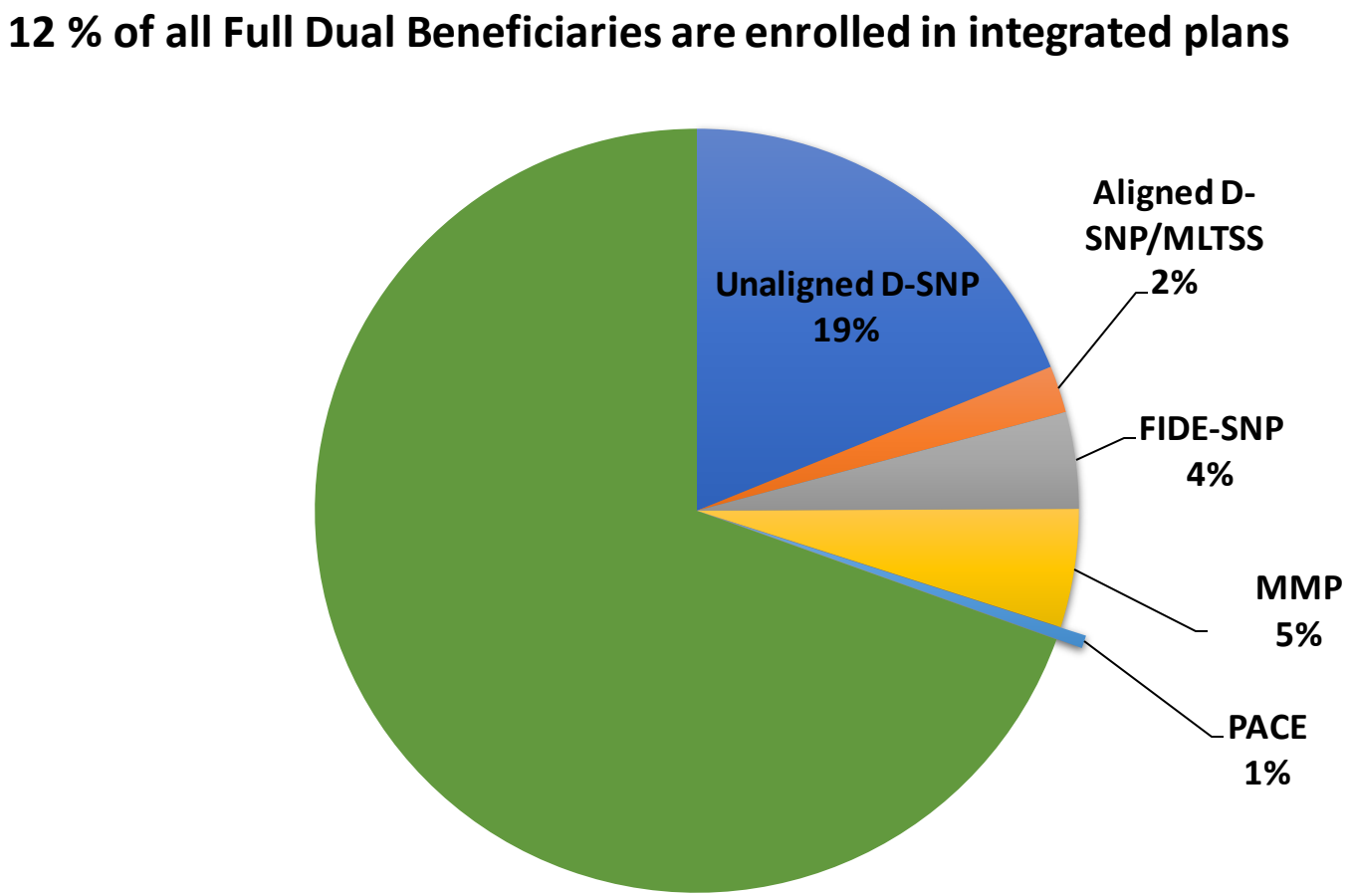


Total Medicare Beneficiaries, 2008: 54 million

Total Medicaid Beneficiaries, 2008: 74 million

- SOURCE: MEDPAC. Beneficiaries Dually Eligible for Medicare and Medicaid. Data Book. January 2018

Enrollment of Dual Beneficiaries in Integrated Plans

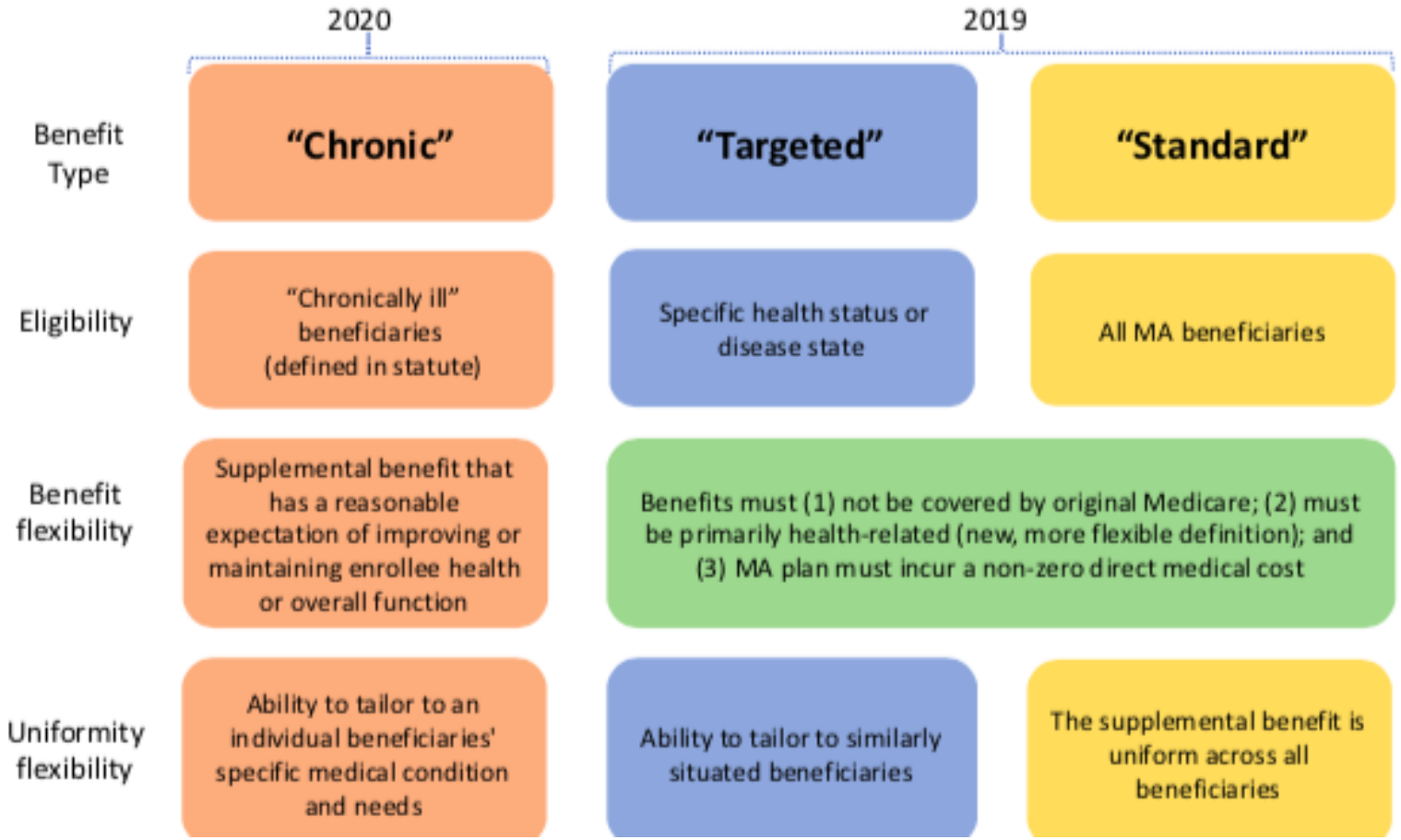


Initiatives to Advance LTSS Integration

- 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



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

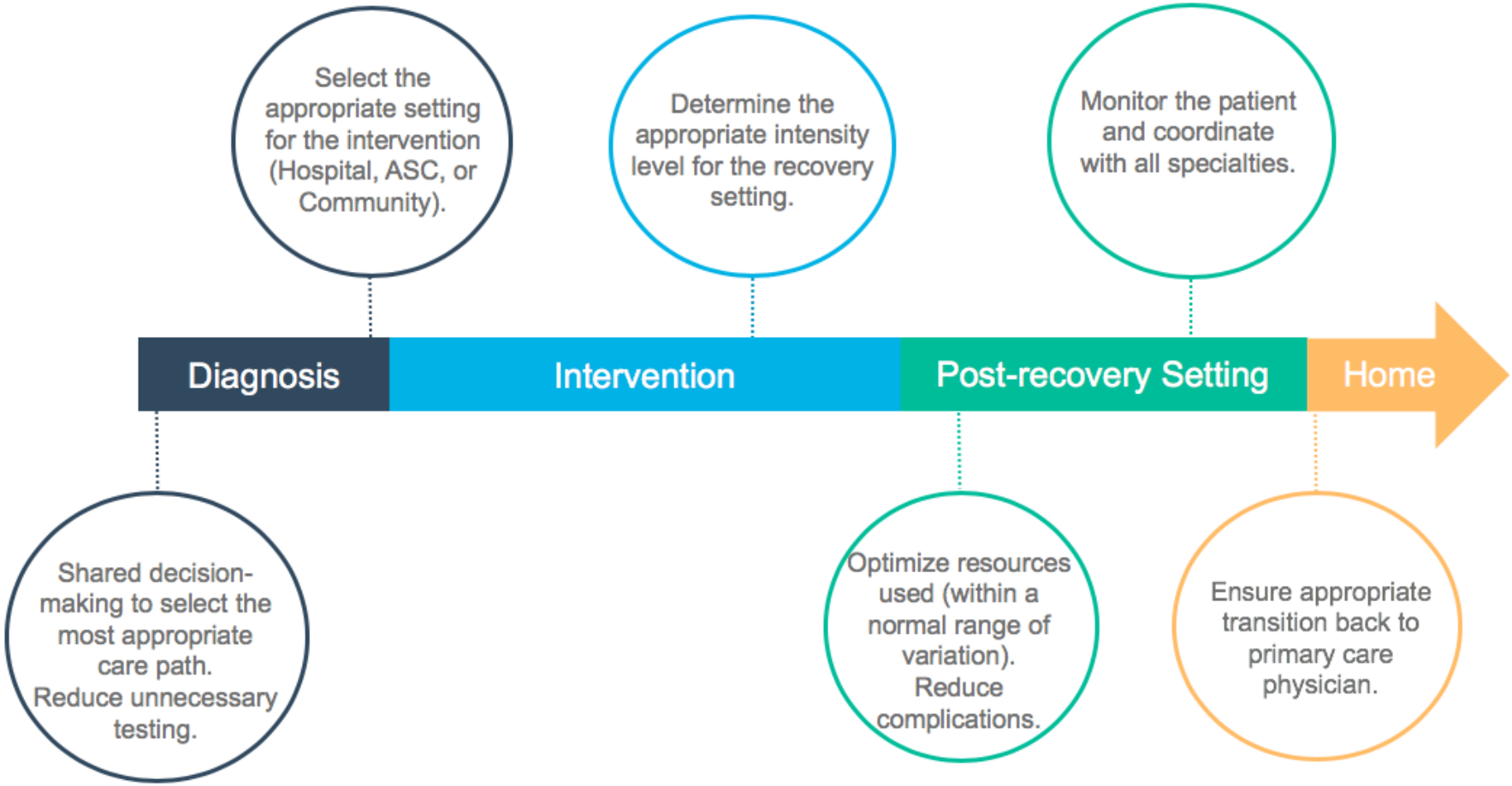
- 1. The market landscape
  - Appropriate substitutes (e.g. lower-cost institutional providers; home-based providers)
  - Competition within your market segment (e.g. SNF, home health)
- 2. Your facility's or agency's position in the market
  - Brand recognition to patients
  - Characteristics of your census (long-term vs. convalescent)
  - Clinical capabilities

How Should Post-Acute Providers Respond to ACOs and other risk-bearing entities?

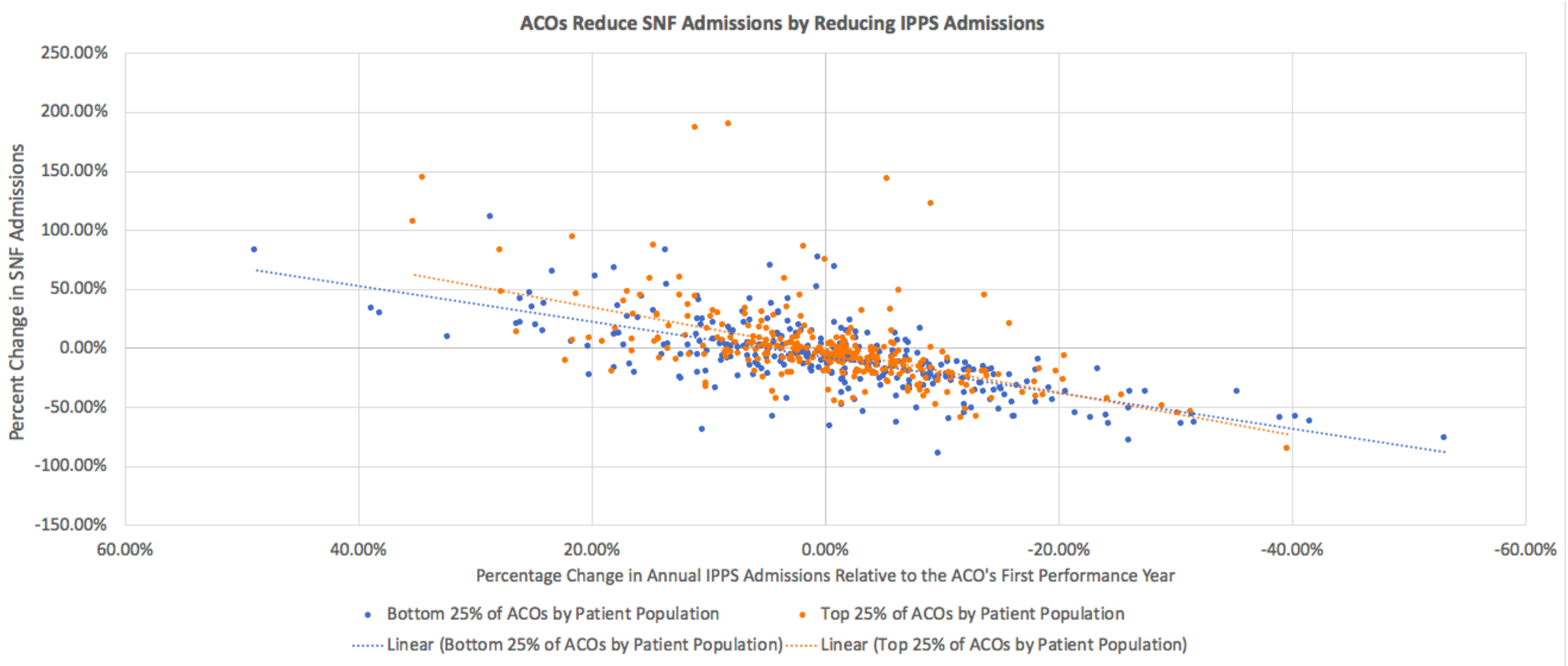
Key Considerations

- 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



ACOs reduce SNF admissions in part by reducing IPPS admissions



ACOs reduce SNF admissions in part by reducing IPPS admissions

ACCOUNTABLE CARE

By J. Michael McWilliams, Michael E. Chernew, and Bruce E. Landon

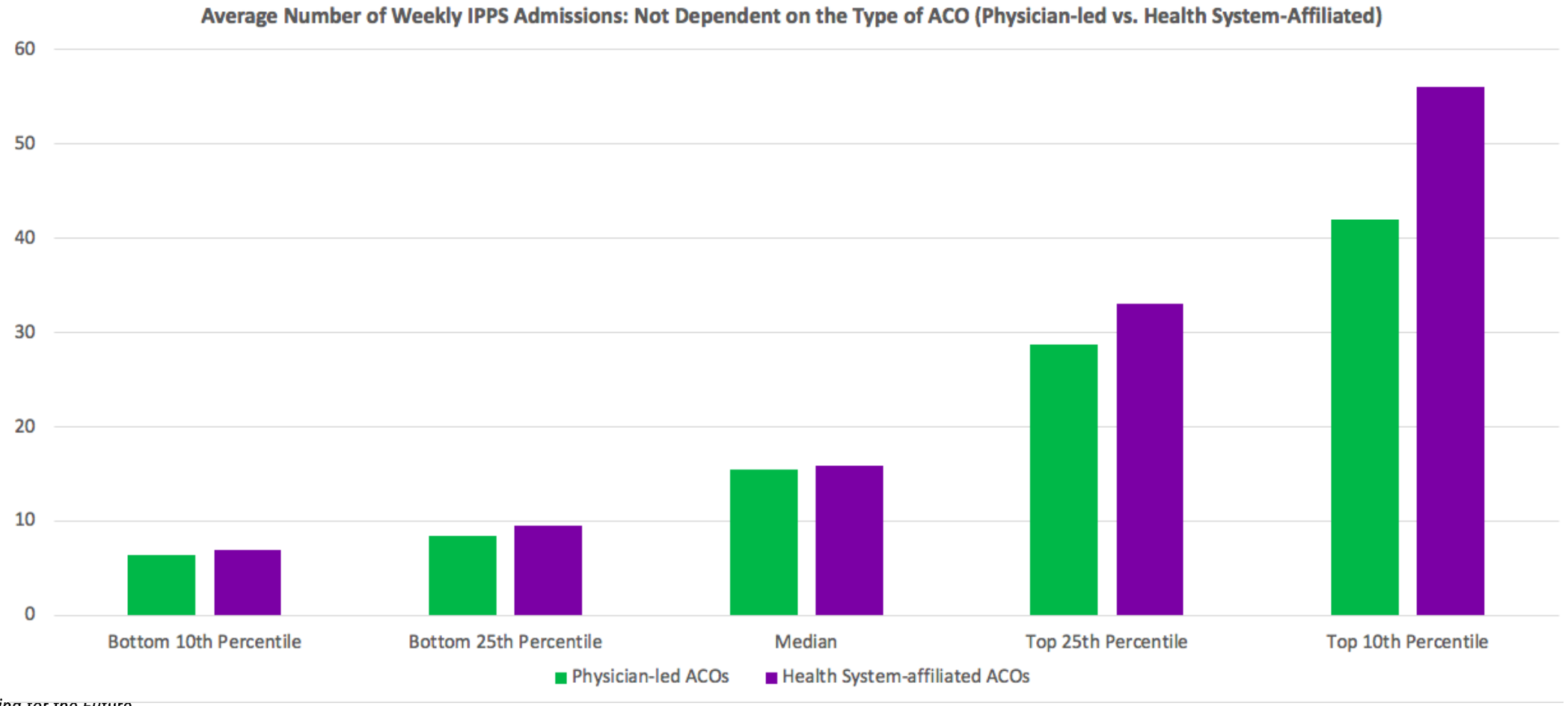
Medicare ACO Program Savings Not Tied To Preventable Hospitalizations Or Concentrated Among High-Risk Patients

JAMA Internal Medicine | Original Investigation | HEALTH CARE REFORM

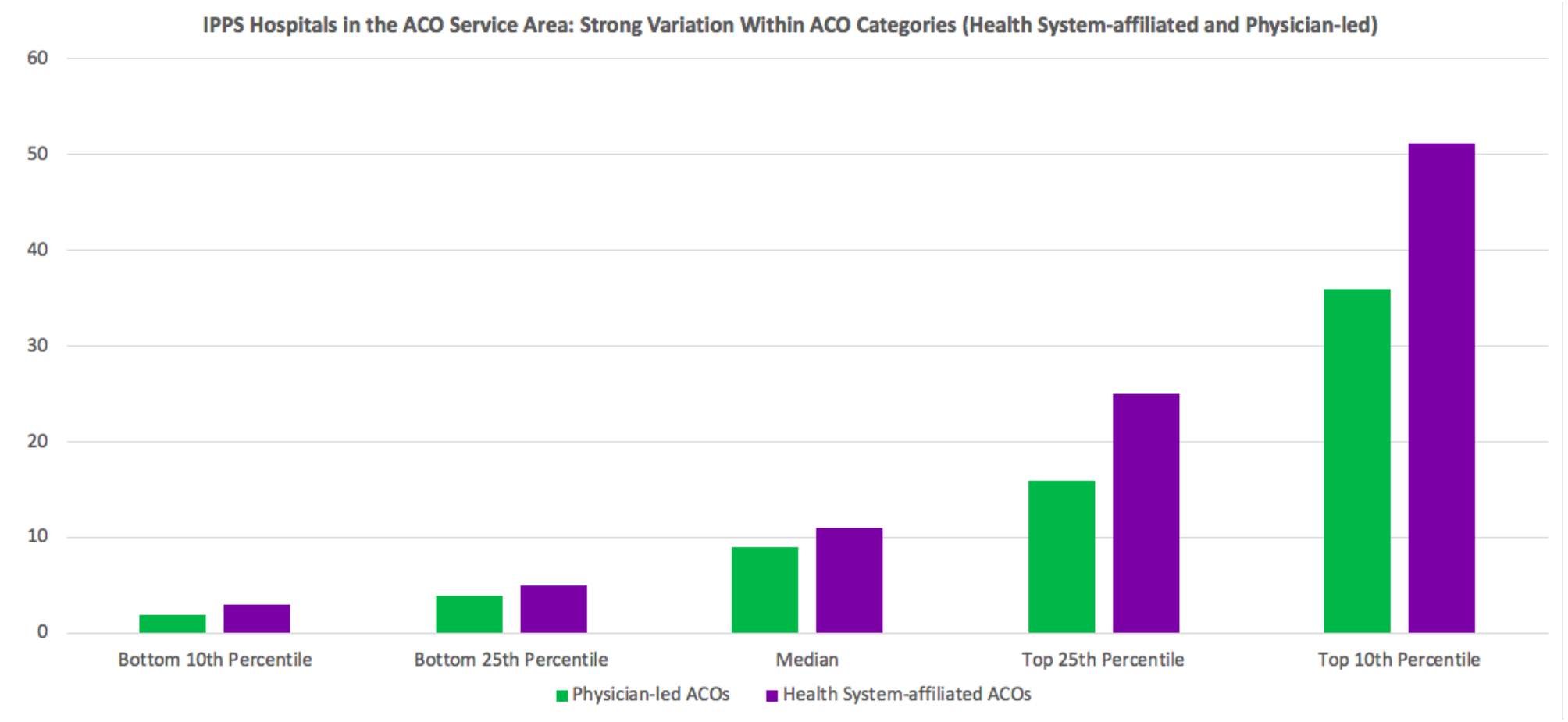
Changes in Postacute Care in the Medicare Shared Savings Program

J. Michael McWilliams, MD, PhD; Lauren G. Gilstrap, MD; David G. Stevenson, PhD; Michael E. Chernew, PhD; Haiden A. Huskamp, PhD; David C. Grabowski, PhD

Average number of weekly IPPS admissions: Not dependent on the type of ACO



Hospitals in the ACO service area: Strong variation within ACO categories



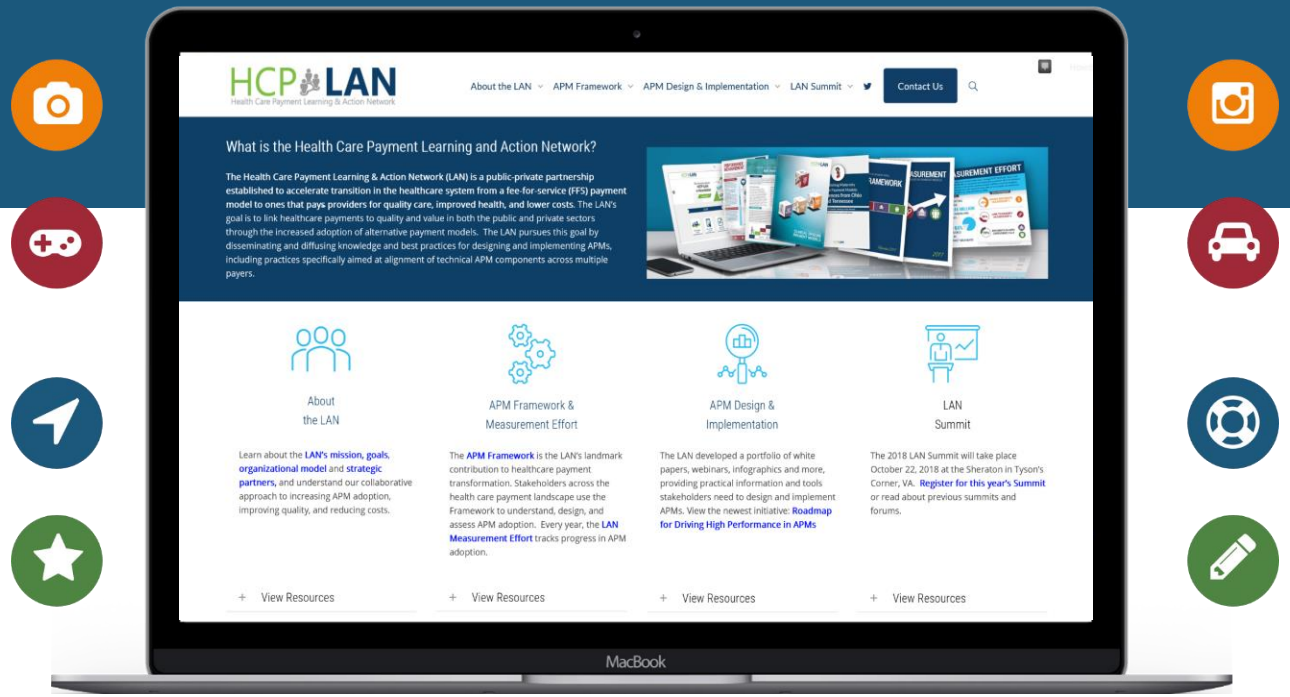
How Should Post-Acute Providers Respond to ACOs and other risk-bearing entities?

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.

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We want to hear from you!

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Thank You!