

Measuring Value

The New Challenge

*Nancy E. Rehkamp, Director of
Healthcare Innovations*

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Today's Discussion

- Defining Value Based Reimbursement in Aging Services
- How Value Based Payment Works
- Value Based Demonstration – WI, AZ & NY
- Potential Implications of VBR Models
- Other Metrics
- Preparing for VBR Models


No Shortages of Change in Health Care

Partnership for Change – reduce re-hospitalizations 20% and Hospital/SNF Acquired Conditions 40% by 2013

Bundled Payments

Center for Medicare & Medicaid Innovation

1. Health Homes
2. Community First
3. Money Follows the Person
4. **Pioneer ACOs**
5. **ACO Shared Savings Programs**
6. **Community Based Care Transitions demos**
7. **Innovation Grants**
8. Independence at Home
9. **Reductions of SNF Avoidable Admissions**
10. **Capitated Financial Incentive Demo**
11. **SNF Value Based Payments**



**Integrated
Medicare/Medicaid
Managed Care**

**PACE &
Virtual-
PACE**

Current Measurement Systems – Health Plans

1. Medicare Advantage – 50 metrics
 - Customer service on responsiveness
 - Prevention services & vaccinations
 - Health outcomes
 - Complaints, appeals and voluntary disenrollment
 - Call center patient satisfaction
 - Managing chronic care
2. Private Health Plans – Negotiated Separately
3. Managed Medicaid

Current Measurement - Hospitals

1. Hospital Compare
 - Patient Satisfaction
 - Timely & Effective Care
 - Readmissions, Complications & Deaths
 - Use of Medical Imaging
 - Medicare Payment – 3days before & 30 after
2. Accountable Care Organizations – 60+ metrics
3. Never events – 28 items
4. JCAHO, National Quality Forum, Hospital Quality Alliance, LeapFrog, etc. measures

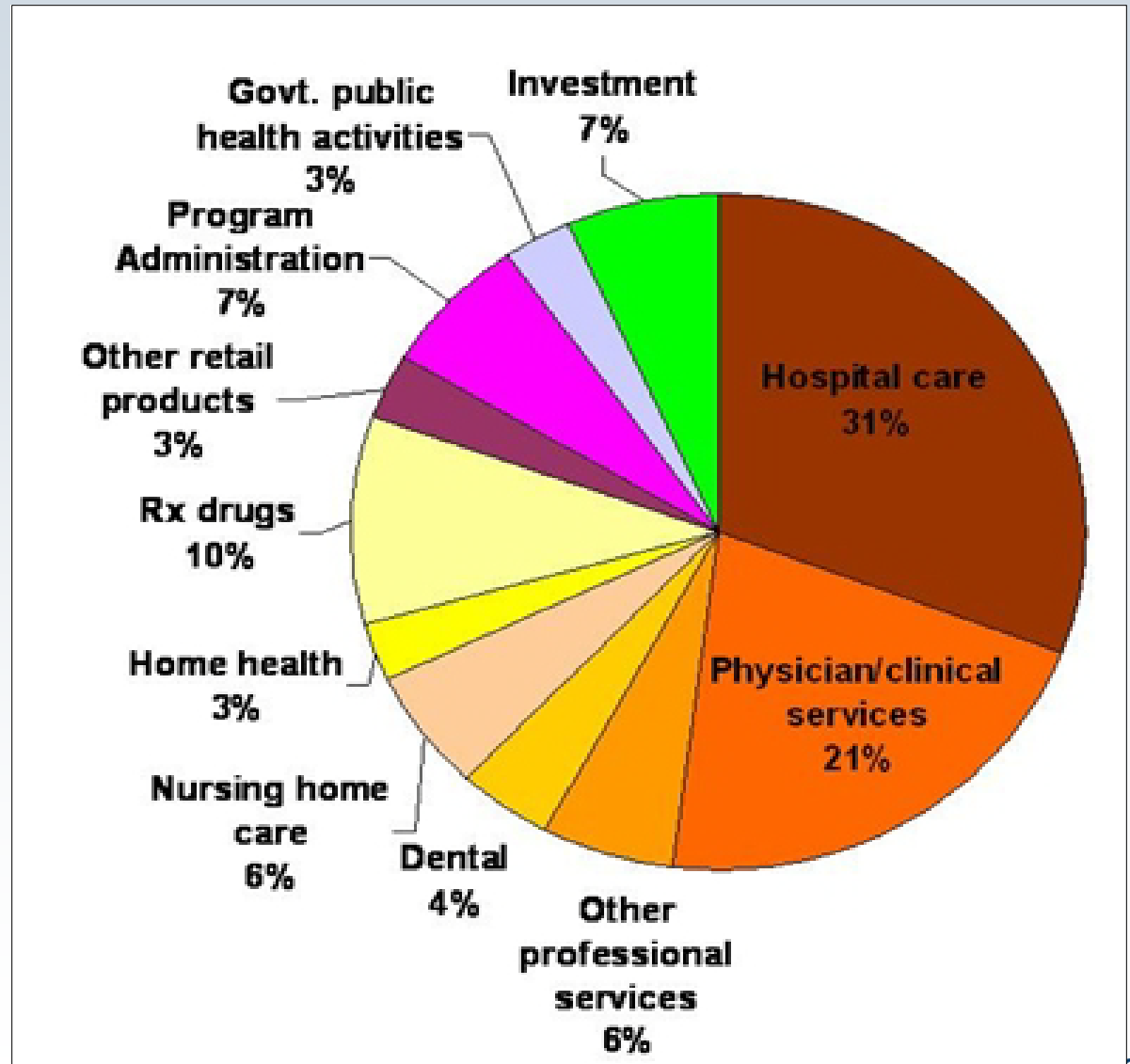
Why Isn't Post-Acute a Burning Issue?

Here's Why:

SNF care, or home health, accounts for very small fraction of the total healthcare dollar in any given market.

They'll get to us.

Will you be ready?



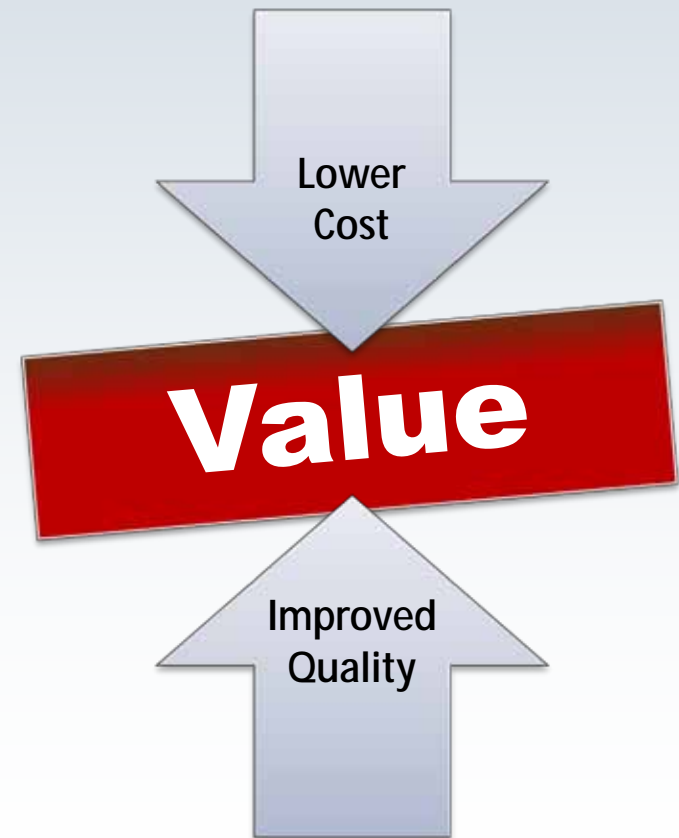
The Foundation: Moving from Volume to Value

Value Based Payment: *“a reform initiative whereby health care providers will receive payment for service based on their performance or the potential outcomes of the service”*

Tying payment to performance is perhaps the most significant aspect of health care reform.

The de facto definition of “value” in health care reform is the intersection of lower cost and improved quality.

Providers who can lower costs and deliver quality will be measured as “value-based providers”



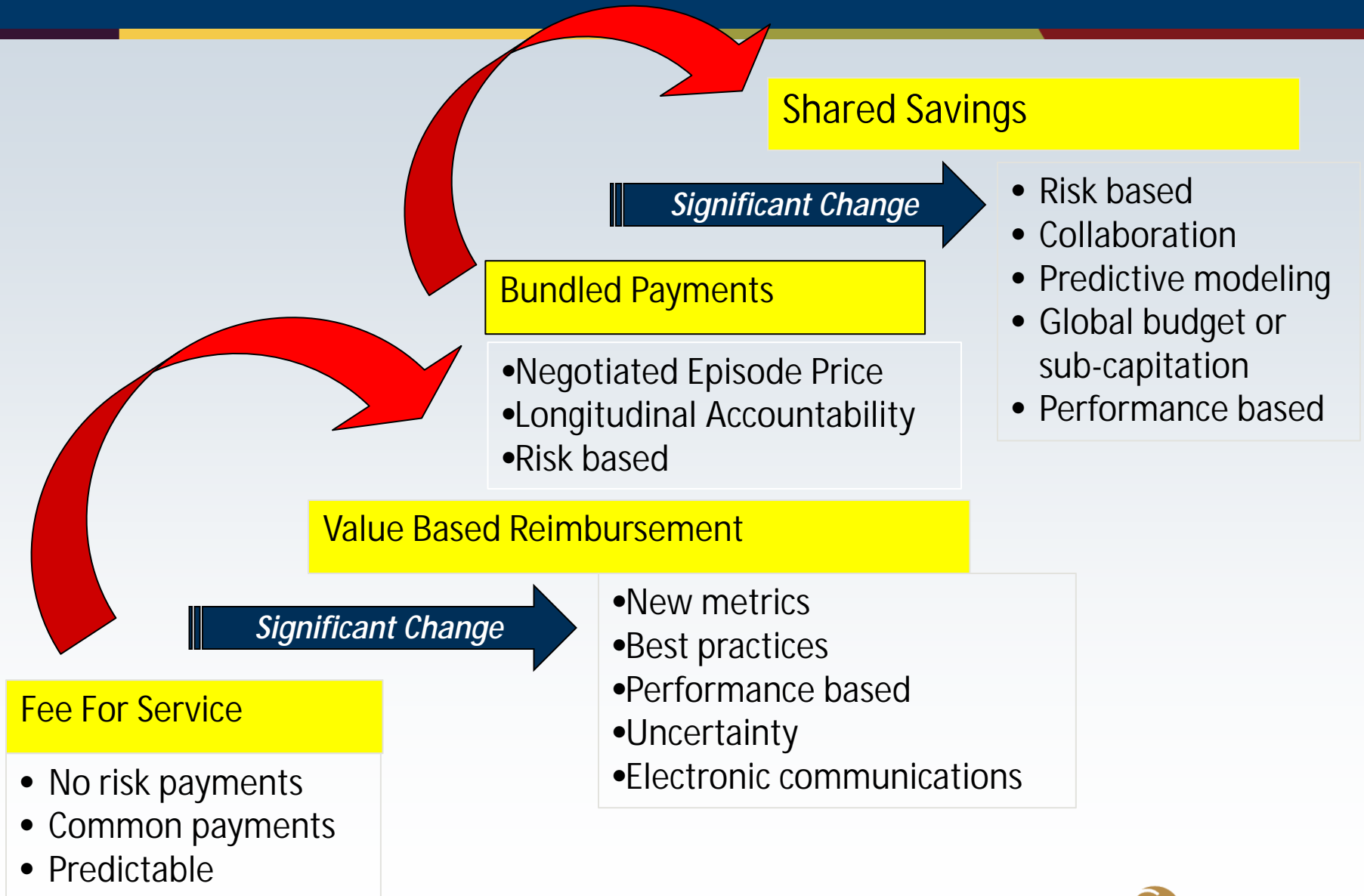
Key Goals of Value Based Reimbursement

1. Make care safer
2. Engage families and residents/customers as partners
3. Promote effective communications & coordination of care
4. Increase effective prevention & treatment practices
5. Develop and expand the use of best practices
6. Make quality care more affordable
7. Improve customer experience

How would we identify the key changes required ?

What measures demonstrate quality in these areas?

Payment is Transitioning to New Models



Home Health & SNF VBP Report To Congress

- March 2012 HHS sent plan to Congress for transitioning Medicare Home Health Agencies to Value-Based Purchasing (VBP).
- June 2012 HHS sent plan for Medicare SNF VBP to Congress
- Highlights the decision points for instituting VBP, outlines stakeholder input, outlines work to be completed and summarizes lessons learned

Payment Penalties & Incentives are Pending for....

1. Hospital/SNF Acquired Conditions
2. Patient Safety
3. Hospital Readmissions
4. Potentially Avoidable Admissions
5. Patient Satisfaction
6. Performance Goals
7. Others

Many of the performance or value-based reimbursement contracts have over 100 metrics to which provider payments are tied.

New Pilot: Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents

Four-year pilot to implement evidence-based interventions that reduce avoidable hospitalizations.

- FFS duals who are long-stay SNF residents
- Enhanced care & coordination providers eligible receive to \$5M to \$30M each
- Requirements:
 - ◇ Minimum of 15 nursing facilities with average census of 100 or more
 - ◇ Must have an on-site presence at NFs
 - ◇ Must obtain letter of support from state
 - ◇ Interventions must improve health outcomes of residents, smooth care transitions, and coordinate care

States Implementing Pilot:

1. Alabama
2. Nebraska
3. Indiana
4. Missouri
5. Pennsylvania
6. New York

More info:

- <http://www.innovations.cms.gov/initiatives/rahnfr/index.html>

Value-Based Purchasing for SNFs

What's the word on street about VBP for SNFs?

No one really knows for certain.

But scuttlebutt sounds like this:

CMS will lop 1-2% of current Medicare rates

Those providers who meet certain quality thresholds
and **outcomes** will get some of it back.

Maybe 1-2% if you're in the 50th or greater percentile.

Maybe more if you're in the 90th.

It is also beginning to look as if the program will be implemented in October
of this year with little preparation or warning for SNF operators.

Caveat Emptor

These assumptions are pure speculation.

VBP SNF Demo Metrics – WI, NY & AZ

Key Metrics:

1. Staffing levels risk adjusted (30 points)

- RN, LPN, and CNA Turnover
- RN/DON hours/resident day
- CNA hours/resident day
- Use of agency staff

2. Discharge to the community (10 points)

3. Readmission rates (30 points)

- Short stay rate and long stay rate
- Per episode and per resident day
- Includes up to 3 days post SNF
- No additional incentive for top 25%
- Heart failure
- Risk adjusted
- Respiratory infection/Pneumonia
- Electrolyte imbalance/dehydration
- Sepsis
- Urinary tract infection
- Anemia (long stay residents only)

Data Source:

Quarterly submitted payroll data
and RUGS-III data

Medicare Claims and MDS

Medicare FFS Claims database

VBP SNF Demo Metrics – WI, NY & AZ

Key Metrics:

4. State survey results (20 points)

- Based on scope and severity
- Number of revisits beyond first one
- Does not include safety deficiencies
- Includes complaint survey results

5. Quality measures (20 points)

Long Stay:

- Percent of residents whose need for help with ADL has increased
- Percent whose ability to move in and around their room got worse
- Percent high risk residents with pressure ulcers
- Percent who have had a catheter left in their bladder
- Percent physically restrained

Short Stay

- Percent with improving level of ADL functioning
- Percent who improve status on mid-loss ADL functioning
- Percent experiencing failure to improve bladder incontinence

Data Source:

State Survey Filings

MDS 3.0

VBR – SNF Incentive Payout Calculation

1. Top 10% in achievement or improvement receive 1.2 times higher than next 10%
2. Payment pool will be distributed so that those in achievement and improvement categories are equally incented
3. Payments will also be adjusted for nursing care center size
4. Payouts will be budget neutral. Size of payouts will depend on the savings generated and 20% will be retained by CMS.
 - ◇ Reduced rehospitalizations
 - ◇ Reduced avoidable hospitalizations
 - ◇ Reduced Medicare short stay SNF stays
5. Payouts cannot exceed 5% of expected savings from Part A & B
6. Savings to Medicare must be at least 2.3% (currently in the demo)
7. No payment reductions or risks in demo
8. It is anticipated that Medicaid SNF payments may increase

SNF VBP Demo: Outcomes

VBR Payouts – budget neutral; required a reduction in potentially avoidable hospitalizations for payout:



Arizona = \$27,032

- ◇ 12 of 41 nursing homes qualified for payments
- ◇ Performance Payment Range = \$802 - \$3,810
- ◇ Average performance payment received = \$2,253



New York = \$0, acute expenditures went up not down



Wisconsin = \$3.4 million

- ◇ 19 of 62 nursing homes qualified
- ◇ Performance Payment Range= \$39,281 - \$369,970
- ◇ Average payment received = \$183,371

SNF VBP Demo Outcomes: Anecdotal

Individual facilities achieved:

- Reductions in both incidence of pressure ulcers from 1.75 % of residents to 0.3%, and length of time to heal
- Reductions in physical restraint use by half within a single quarter following staff and family education and improvements in care coordination
- Hospital admission rates for Heart Failure fell from 25% to less than 5% within a year following implementation of a heart failure prevention program
- Use of agency staff was reduced significantly.

Source: Report to Congress:

Adding Value - Preferred Provider Networks

Hospitals, emerging ACOs and other payors recognize that post-acute care and aging services will play an important in pivotal role in reducing costs and managing population health.

“Policymakers and health care providers increasingly recognize that coordination between acute care hospitals and post-acute providers is essential to improving the overall quality of care and reducing health spending.”

- Rich Umbdenstock, President & CEO, AHA

But they aren't going to pick us just cuz we're pretty.

Adding Value - Preferred Provider Networks

The development of “preferred” or “select” provider networks is taking center stage in many markets around the country.

- Health Systems have stated publicly that they “work with too many nursing homes...” and will refer to a “much smaller group of facilities in the future”.
- Other organizations have already identified groupings of “select” providers and are actively working with them to develop skills, encourage measurement and improve communication.
- And a very select group of organizations have established networks, developed evaluative criteria, gone through iterations of revision and created models for others to follow.

In all of these scenarios, some degree of measurement plays a key role in determining if you are on the field or on the bench.

Adding Value - Preferred Provider Networks

- Admission policies
- Availability of therapy, pharmacy, mobile lab, x-ray and EKGs
- Size & capabilities of short stay unit
- Implementation of Interact II
 - Nursing capabilities checklist
 - SBAR communications tool
- Key performance indicators
 - Readmission rates
 - ER utilization rate
 - Staffing ratios/agency staffing
 - Customer satisfaction
 - Cost/discharge
- Specialty programs
- Physician/Nurse Practitioner engagement
- Enhanced discharge planning processes
- Other

Adding Value - Preferred Provider Networks

Hospitals and ACOs need to know what differentiates you from your competitors. How can you be their low cost, high quality value provider of post-acute services?

Mine Your Data

- 30-Day Readmission Rates
- Average time to accept patient; % admitted
- Average LOS
- Quality Measures
 - Ex., Pressure Ulcers, UTIs, Restraints
- Programmatic foci
- Chronic Disease Management Outcomes
- Resident and Family Satisfaction

Listen to their Needs

Tell Your Story

- Where do your referrals come from?
- What MS-DRGs do you serve?
- What is your admit process?
- How many MD or mid-level hours are available weekly?
- What specialty programs do you offer?
- How do you prepare patients for discharge?
- How do you monitor patients after discharge?

The Value Proposition:

Each organization in *telling their story* will define the value proposition, but it should not be limited to the value of a SNF day or a Home Care visit or episode. The value of an aging services provider can include:

1. Greater knowledge and understanding of geriatric medicine and successful older adult care delivery models
2. Ability to impact health care utilization, i.e., ER use, readmissions, etc.
3. Longitudinal relationships with customers
4. Enhanced setting for patient education
5. Ability to assess and support capabilities of informal caregivers
6. Improved transitions to the community
7. Care coordination across settings and community based
8. Large customer base who require services
9. Other

Potential Vulnerabilities

Numbers Served

- Low Case Mix
- Rehab-only client
- Pre-episode service use

- Length of Stay
- Cost per day
- Care Variation

- Re-admissions
- Follow-up care

Costs

Types of Performance Plans



Pay for Performance grant funding



Pay for Performance Incentive Pools:

- Health plans
- Health systems



Gain sharing (shared savings/risk)

Performance Plans – Key Issues

1. Create common definitions of performance metrics
2. Select metrics that are meaningful and are reasonably achievable
3. Develop baseline for measuring and rewarding improvement
4. Develop internal processes for measuring & reporting metrics that are timely, accurate and easily implemented
5. Assure partner/payer can collect and/or monitor performance measures
6. Assure partner/payer has processes & capabilities to make incentive payments accurately & on-time

What does this mean for providers?

1. ***Measurement and metrics will matter***
2. ***Tools to track and trend data will be essential***
3. ***Health care organizations will need to grow clinical and patient management skills***
4. ***Patients will need to be managed across the continuum***
5. ***Relationships are mandatory going forward***
6. ***It's not enough to just report on performance metrics, you must understand them and improve upon them***

Key Conclusions & Thoughts....

Reimbursement changes will gradually expand and clinical, operational and financial performance will matter. Some potential impacts may include:

1. Performance will determine who is "in"
2. Payers, including risk-based providers, will differentiate based on performance and costs
3. Value will be "king" – but measured differently across the continuum
4. Clients/residents will define value as ease and service
6. Integration will lower overall costs, but may increase costs for some providers
7. Redefining Medicaid payments is critical
8. Mergers & acquisitions will continue to occur
9. New competitors will evolve as the market continues to be unsettled

THANK YOU!
Nancy E. Rehkamp
nancy.rehkamp@cliftonlarsonallen.com

For more information on health care reform, go to
CliftonLarsonAllen's Health Care Reform Center at:
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