Measuring Value

The New Challenge

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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

**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

Bundled Payments
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 – 3 days 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?
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

Shared Savings

• Risk based
• Collaboration
• Predictive modeling
• Global budget or sub-capitation
• Performance based

Significant Change

Bundled Payments

• Negotiated Episode Price
• Longitudinal Accountability
• Risk based

Significant Change

Value Based Reimbursement

• New metrics
• Best practices
• Performance based
• Uncertainty
• Electronic communications

Fee For Service

• No risk payments
• Common payments
• Predictable
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:
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.
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
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
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:
Hospitals, emerging ACOs and other payors recognize that post-acute care and aging services will play an important 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
### 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

Costs

- Re-admissions
- Follow-up care

- Length of Stay
- Cost per day
- Care Variation
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
5. Integration will lower overall costs, but may increase costs for some providers
6. Redefining Medicaid payments is critical
7. Mergers & acquisitions will continue to occur
8. New competitors will evolve as the market continues to be unsettled
THANK YOU!
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