The Changing Course of Alternative Payment Models

Home Health Value Based Purchasing

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Agenda

1. Understanding the Alternative Payment Model Landscape.
Alternative Payment Model
General Overview

Major Focus

• Moving Care from FFS to Value
  → Pay for Performance Initiative
  → Alternative Models

Lower Risk ------------------------ Higher Risk
FFS  Episodic  Performance Based  Bundled  Shared Savings/Shared Risk  Capitation
Primary Goal

- **Triple AIM**
  - Improving the patient’s experience of care
  - Improving the health of the population
  - Reducing the per capita cost of care for the population

- **MedPac**
  - Better quality care while incentivizing providers to constrain cost and control spending
  - Reduce home health rates

**Medicare Money Linked to APMs**

<table>
<thead>
<tr>
<th>Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018</th>
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</thead>
<tbody>
<tr>
<td><strong>2016</strong></td>
</tr>
<tr>
<td>All Medicare FFS (Categories 1-4)</td>
</tr>
<tr>
<td>30%</td>
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<tr>
<td><strong>2018</strong></td>
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<tr>
<td>All Medicare FFS</td>
</tr>
<tr>
<td>50%</td>
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CMMI – Center for Medicare & Medicaid Innovation (the Innovation Center)

• Test various payment and service delivery models
• Goals
  → Achieve better care for patients
  → Achieve better health for our communities
  → Lower costs through improvement of our healthcare system

Risk Based Contracting Overview

• Medicare
  → ACO – Accountable Care Organizations
  → Bundled Payment initiatives
    • BPCI - Bundled Payment Care Initiatives
      – Model 1 – retrospective acute care inpatient stay
        » Inpatient Stay Initiates Episode
      – Model 2 – retrospective Bundled Payment Arrangement against Target Price
        » Inpatient Stay Initiates Episode
        » Episode ends 30, 60 or 90 Days
      – Model 3 – retrospective bundled payment with actual expenditures against target price
        » Episode triggered with hospital stay
        » Episode begins with initiation of post acute services within 30 days of discharge
        » Ends 30, 60 or 90 days
        » Note 81 HHA Participated
Risk Based Contracting Overview

• Medicare
  → Bundled Payment initiatives
  • BPCI - Bundled Payment Care Initiatives
    – Model 4 – single prospective bundled payment covering hospital, physicians, practitioners
      » Episode begins hospital stay
      » No claims submitted to Medicare
      » Related 30 day readmissions part of bundle

• CJR - Comprehensive Care for Joint Replacement and Cardiac Model
  → MACRA – Medicare Access and CHIP Reauthorization Act
  → Medicare Care Choices Model
  → Development of ACOs

Where Innovation Models Are Being Run or Tested

Legend: ■ Models run at the State level □ Health care facilities where Innovation Models are being tested
**Landscape: BPCI Model 2**

- 519 Participants (June 15, 2015)
  - Purely voluntary
  - 198 Awardees (including conveners)
    - 16 from NJ Atlanticare Regional Medical Center, Inc.: 1 episode
    - Holy Name Medical Center: 3 episodes
    - Hunterdon Medical Center: 2 episodes
    - Virtua West Jersey Health System Inc.: 1 episode
- 375 acute care hospitals
- 234 physician group practices

- 451 episodes initiators involved in care redesign

**Model 2 Early Indications**

- CMS Bundled Payments for Care Improvement (BPCI) Initiative Models 2-4: Year 1 Evaluation & Monitoring Annual Report
- Inpatient LOS decreases
- Institutional PAC decreases
  - SNF spending down
- HHA utilization stable
  - HHA LOS up slightly
  - HHA spending up
BPCI Model 3 Participation

• **717 Participants (June 15, 2017)**
  → Purely voluntary
  → Episode Initiators
    • 681 SNFs
    • 99 HHAs
    • 9 IRFs
    • 49 physician group practices
    • 1 LTCH
  → Originally 22 in NJ; none active as of today
    • SNF or Convener based

BPCI Model 3 Early Indications

• CMS Bundled Payments for Care Improvement (BPCI) Initiative Models 2-4: Year 1 Evaluation & Monitoring Annual Report
• HHA, SNF, IRF, and LTCH days of care remained the essentially the same
  → BPCI patients dropped from 16 to 15 days
• Spending increased for both BPCI participants and comparison patients
  → HHA spending up “significantly”
• Unplanned hospital readmissions up 8.5% to 9.8% (risk adjusted at 8% for both participants and comparison group)
BPCI Attributes

- **Not a “shared savings” program**
  - “Awardee” bears full risk of costs above target
  - “Awardee” gains full value of costs below target
  - Can share gains with other providers if established partnerships
  - Risk Tracks—75th, 95th, and 99th percentile
    - Bear risk up to threshold and 20% of payment above threshold.
  - Target price determined using 2009-2012 data trended to participation year plus Awardee-specific discount as proposed

- **Awardee/Awardee Convener/Facilitator Convener**
  - Awardee assumes financial responsibility for all the care of its patients
  - Awardee Convener assumes risk for its patients and all the BPPO patients w/in the episode
  - Facilitator Convener provides support and assistance to designated awardees; designated awardees assume financial responsibility

- **Conveners organize care design and manage program**

CMS Joint Replacement Bundling

- **Affects total hip and knee replacement patients (April 1, 2016)**
- **Hospital payments at risk**
  - Target spending set by CMS geographic specific data
  - Hospitals may share risk and savings with other providers
  - First year: shared savings only
  - Year 2-5: shared savings and losses
  - Covers costs through 90 days post hospital
- **67 hospital geographic areas in play**
- **Patient freedom of choice continues**
- **Providers paid at usual FFS rates**
- **Expansion/retraction/termination possible depending on results**
- **Home health impact: mixed, but mostly positive in the aggregate**
CJR BUNDLING DEMONSTRATION

• Covers approximately 23% of CJR surgeries in nearly 800 hospitals

• Mandatory participation

• Hospitals and collaborators financially at risk for entire episode of care provided to affected patients

• Hospitals have the ability to share savings and risk of repayment with downstream providers referred to as collaborators

→ May include home health agencies and others

Home Health Specific APM: Value-Based Purchasing Pilot (HHVBP)

• CMS pilots a VBP:
  – Started in 2016
    • Baseline year 2015
    • Performance year 2016
    • Payment year 2018
  – 9 states mandatory participation of all HHAs
  – 3-8% payment withhold for incentive payments
    • “greater upside benefit and downside risk”
    • Phase-in to 8%
  – Performance measures
    • Achievement and improvement
    • Process, outcomes, and patient satisfaction
  • Baseline data released in April; first HHA quarterly report in late July
Future Post-Acute Care APM?: Ways and Means PAC VBP (V. 3)

- Combined PAC VBP
- Controversial first versions
- Version 3
  - budget neutral in the aggregate
  - MSPB, Discharge to community, and preventable readmission measures
    - Optional quality measures
  - Two-track risk model
    - 2-5% at risk (high risk track)
    - 1-2% at risk (low risk w/ other VBP involvement, e.g. HHVBP)
- Reduced base rates with performance bonus opportunity
- Industry concerns
- No Senate counterpart (yet)

Health System Landscape

- Health System participation with an ACO
- Investments into technology
- Exploring the use of PAC conveners
- Narrowing the PAC network
  - Should the providers be
    - Owned
    - Contracted
    - Both
Landscape

- **Increased focus:**
  - Re-hospitalization rates
  - ED Visits
  - Patient satisfaction surveys
- **Development of Transition of Care Programs**
- **Discharge protocols focusing on the optimal discharge setting**

Landscape

- **Concerns:**
  - How do these contracts effect our overall business?
  - Prepare for the future while balancing the current reimbursement environment
  - Managing the % of Risk Based Contracts

“*We do not know what we do not know*”
Concerns

- 52% expect these contracts will lead to a decrease in operation profits
- 27% expect the decline to be 10% or more

Where does Home Health Fit?

- Consensus – Home Health plays an integral part
  - Least costly setting
  - Preferred setting for patients
  - Pre & Post Care focus
- Concerns/Challenges
  - “Is Home Care the future or a vehicle for other services”
  - Many see Home Care as a commodity
    - What services should be owned
    - What Services should be contracted out
Concerns/Challenges

• Not willing to share in Risk Based contracts
• Not sure how home care and PAC fits into the contracts
  → Alignment there but a difficult sell
  → Understanding the Actuarial Data
• Not willing to share in potential savings
  → CJR Bundle
• Do we have the technology?

ALTERNATIVE PAYMENT MODELS: WHAT IS A GOOD FIT FOR YOUR ORGANIZATION?
What Collaborators Are Looking For

- Providers focusing equally on quality and cost
- Value over volume - shift in thinking
- Post-acute providers thinking different about how they engage in the continuum of care
- Collaborators reach past the 90 day episode of care
- Data centered decisions

Hospital Goals for Collaborations

- Hospitals own the financial risk
- Hospital using claims data to see where the risks are
- Who’s the biggest spender of the hospitals $$$
- Hospital are defining ways to follow the patient through the post-acute setting
- Hospitals more involved in post-acute care planning
- Physician performance based on quality/cost
Recognize the Variety of Data and Tools Needed to Work within an APM

- Importance of Data
- Key Financial Data
- Key Clinical Data
- The Patient Experience
- Staff Performance

The Importance of Data

- Managing by exception and identifying outlier episodes
- Physician alignment
- Post-acute care collaborator identification and accountability
- Review of current discharge trends
- Establishing benchmarks and best practices
- Coding and documentation
- Predicting payments from historical data
Key Financial Data

- Readmission rates
- Discharge trends
- Providers affect on target pricing
- Reconciliation payments
- Readmission rates

Key Clinical Data

Outcomes Management
- Know which outcome measures move the needle the most
- Which measures can offer multiple benefits
- Greatest opportunity for improvement
- Certain diagnoses/conditions with poorer outcomes
- Patients with high cost & high utilization of services
- Groups of patients that frequent hospital or emergency room (chronic comorbid diagnoses)
Key Financial Data – First Discharge Location

Key Financial Data – Target Pricing
The Patient Experience

- Initiation of timely care
- Continuum of care communication
- Shared decision making
  - Plan of care oversight
  - Dialogue with hospital nurse navigator/case manager
  - Relationship with other post-acute providers
- Monitoring the cycle

Incentives for Partners

- CMS penalties – pay for performance
- Readmission rates
- Star ratings – facilities interested in quality and patient experience
- Cost savings to facility and hospitals
Elements of Collaboration

Elements outside of direct care and data:
• Education materials
• Navigator role
• Pathways/Protocols
• Active participation in quality improvement

Sample Criteria – Preferred Provider

Quantifiable Criteria to Create “Shorter List” of HHAs for Site Visits

1. Star Rating - 3 Stars or above Threshold
   • HH - Overall quality and patient experience score (CMS)
2. Readmit (overall)
   • Readmission rate lower than network average
3. Resource Utilization
   • HH average visits per episode – overall rate lower than network average
4. Geographic Coverage
   • Sufficient geographic spread and response time
5. Clinical Model
   • Staffing capacity
   • Willingness to call/triage prior to sending patients to ER for readmission
6. Willingness to Partner
   • Access – willingness to accept all patients
   • Willingness to collaborate

Sample Criteria Application: HH

Identify all sites in the defined market; limit to those that hospitals in market discharge to currently:
147 → 39 → 33 → 29
29 → 17
17 → 11
11 → 9
9 → 8
Evaluate whether major player is dropped
8 → 8
8 agencies continue to next phase of partnership development

Remaining facilities continue to next phase of PAC partnership development
How to Date a Strategic Partner

• Know your potential partners
  → Know what’s important to them (readmissions, mortality, quality, cost)
  → Know what APMs they are currently involved with, and what they are considering (see CMS map)

• Identify linkages
  → People: Board/staff/referral source cross-over
  → Ideas: Champions for change/outcomes

• Know your assets
  → Experience with other similar partners or other APMs
  → Data to demonstrate desired outcomes

• Be patient and persistent!
  → Typically takes 12-18 months to go through this process

• Develop programs that health systems view as valuable
  → Preventing ER visits
  → Discharging patients to home from ER
  → SNF bypassing and/or earlier SNF discharge

• Health system hiring of care coordinators/navigators vs. home health

• Does the APM incentives align with the agency’s?

What is Your Value Proposition?

• Share Your Agency Story!!!!
  → Ability to Manage Readmissions
  → Patient Outcomes Relative to Peers
  → Episodic Management Capabilities
  → Knowledge of Care Planning
  → Focus on Patient Centered Care
  → Scope of Service Lines and Outcomes
  → Data Sharing with Partners
**Go Slow and Learn as You Go**

- Often need to initially engage with little or no payment in order to demonstrate value prior to payment agreement
- Identify limited pilot opportunities to reduce risk for both parties, then tweak and expand
- Use QAPI processes to gather feedback and improve

**Who to Date**

- Health systems (don’t rule out those with their own home care agencies)
- Medical groups (especially those in ACOs or other APMs)
- Commercial/Managed Medicaid Health Plans
- LTC facilities (look for joint partnership opportunities)
Be Flexible and Persistent

- You may have to kiss some toads before you find the prince
- Be a true partner, view things through the partnership lens – not only your own self-interest
- Be open to doing things differently than Medicare certified services
- Balance customization for a partner with keeping a core consistency across partners

Common Challenges

- Managing volume/fluctuations
  → Physical presence/hours
  → Staffing levels
  → Response time
- Sharing data
  → Define data requirements up front as much as possible
  → Agree on how data will be shared and frequency
- The Unexpected
  → Design flexibility into arrangements
  → Have good lines of communication
RISK BASED CONTRACTING MODELS

Non-traditional Flexibility

- No standard “One Size Fits All”
- Understand the payers “Pain Points”
  → High risk patients
- Need to be creative – “Think Out Of The Box”
Potential Models

• Payment
  → Fee for Service - Claim submission to Medicare

• Incentive pools establish
  → Created by participating providers

• Incentive payment formula created for
distribution of incentive pool funds
  → Performance Targets established
    • Actual score = Quality score
  → Participation score

Potential Models - Example

• Payment
  → Fee for Service - either per visit or Episodic

• Incentive pools establish
  → Created by participating Managed Care Organization

• Payments based upon achieving certain clinical outcomes
  → Payment range from 120% to 80% of the base rate
  → Sub performing providers are eliminated from provider pool
Potential Models

• Standards/Measurements examples
  → Utilization Demographics
    • Visits per Episode
    • Case Mix
    • Length of Episodes
    • % Re-certifications
    • % of LUPAs
    • Average cost per episode

49

Potential Models

• Standards/Measurements examples
  → Quality Measures
    • Overall Star rating
    • Patient Satisfaction
    • % of Patients seen within 24-48 hrs.
    • Re-hospitalization rates
    • Transitional care

50
Potential Models

• Increased Fee for Service Model
  → Fail to achieve savings payback

• Standard Fee for Service Model
  → Bonus paid if achieved savings were realized

Things to Consider

• Establishing risk corridors
  → Minimize the downside
  → Minimize the upside

• Evolution of the contracts

Quote from an anonymous provider:

“If you focus on good quality care the rest should fall into place. It’s where it begins and where it should end.”
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