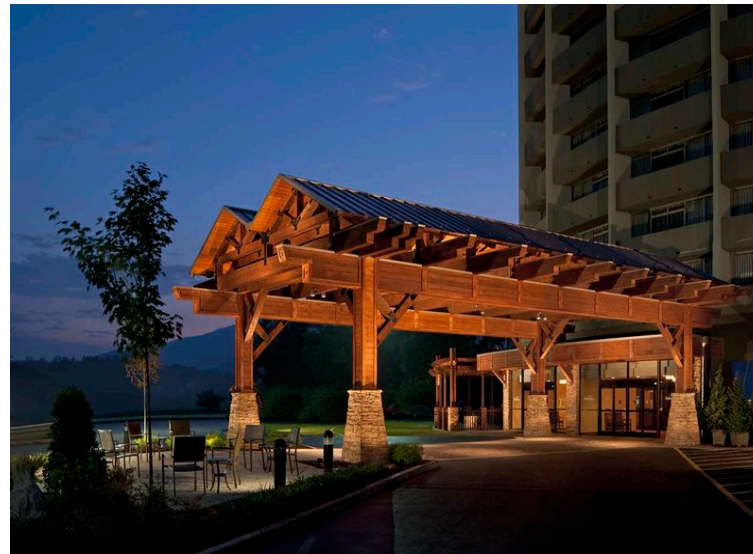


How to Keep your Long-Term Care Ship Afloat in a Sea of Accountable, Bundled and Bungled Care

Tennessee hfma Fall Institute
Park Vista Hotel
Gatlinburg , Tennessee
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1

Today's objectives

- ▶ Discuss changes in Medicare reimbursement of post-acute care services.
- ▶ Discuss how post-acute care will be impacted by the bundled care payment initiative.
- ▶ Discuss how post-acute care providers can prepare themselves for value based payment and streamlined care along the care continuum.
- ▶ Discuss changes to payment for post-acute care in Tennessee.

What Provider Types Make Up the Post-Acute Care Continuum

- ▶ Inpatient Long-term Care Hospitals (“LTCH”)
- ▶ Inpatient Rehabilitation Facilities and Units (“IRF”)
- ▶ Sub-Acute Care Units (“SAU”)
- ▶ Nursing Home Providers (“SNF”)
- ▶ Home Health Care Agencies (“HHA”)
- ▶ Hospice
- ▶ Assisted Living facilities (“ALF”)
- ▶ Continuing Care Retirement Communities (“CCRC”)

Monthly Median Cost of Post Acute Care in Tri-State Region of TN/ GA / AL

Type of care	Tennessee	Georgia	Alabama
Homemaker Service per hour	\$18	\$18	\$13
Home health aide per hour	\$18	\$18	\$17
Adult Day Care daily rate	\$62	\$60	\$36
Assisted Living per month	\$3,395	\$2,880	\$3,075
Nursing Home Semi Pvt daily	\$192	\$183	\$191
Nursing Home Pvt daily	\$207	\$195	\$209



Annual Cost in Same Tri-State Region

Type of care	Tennessee	Georgia	Alabama
Homemaker Service per hour	\$40,704	\$41,184	\$36,608
Home health aide per hour	\$41,184	\$41,184	\$37,752
Adult Day Care daily rate	\$16,120	\$15,600	\$9,425
Assisted Living per month	\$40,740	\$34,560	\$36,900
Nursing Home Semi Pvt daily	\$70,080	\$66,795	\$69,715
Nursing Home Pvt daily	\$75,555	\$71,175	\$76,267

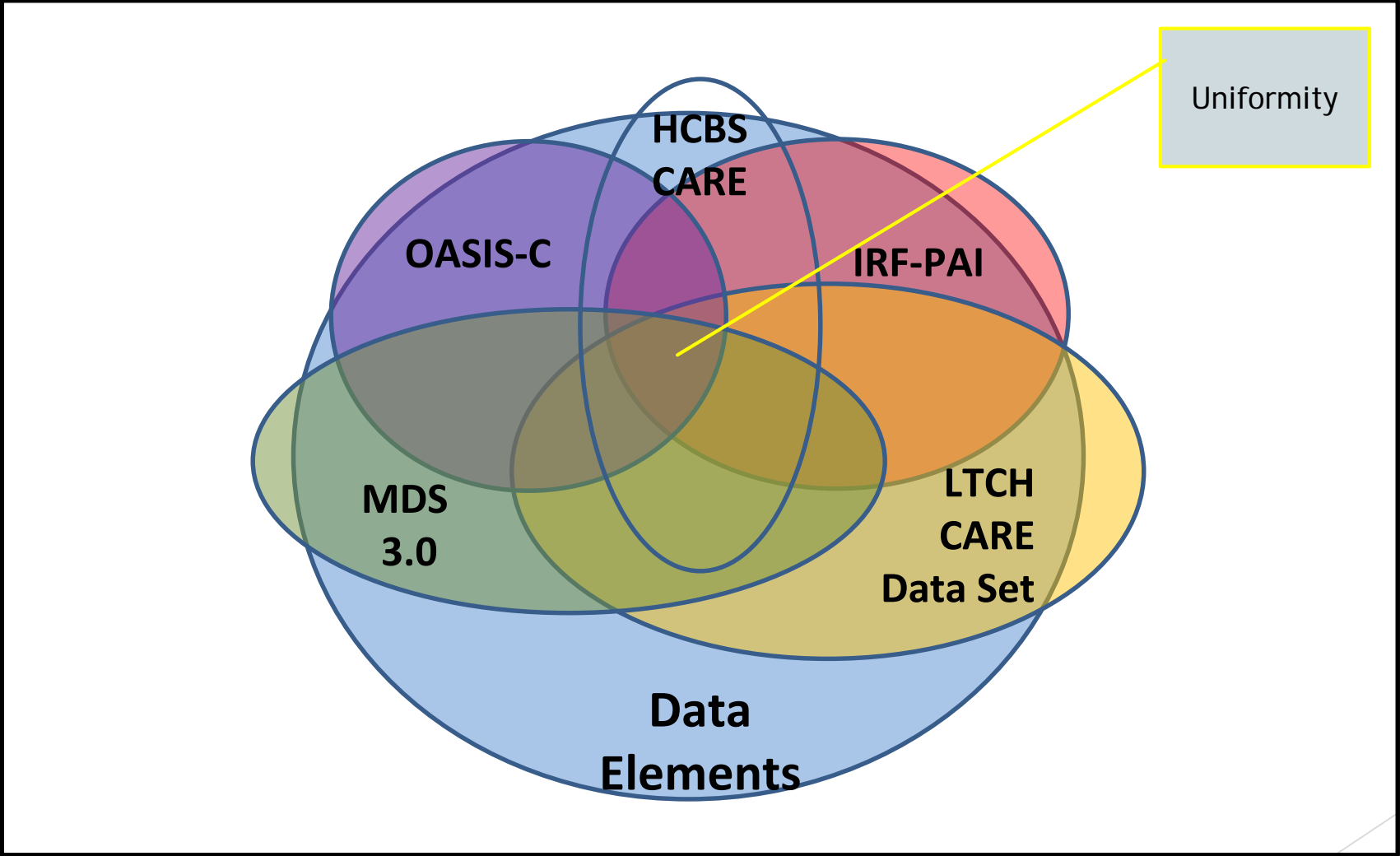


IMPACT (Improving Medicare Post Acute Care Transformation)

- ▶ Bi-partisan legislation introduced in March of 2014, passed in September 2014, and signed into law by President Obama last October.
- ▶ Requires Standardized Patient Assessment Data for:
 - ▶ Assessment and quality measures
 - ▶ Quality care and improved outcomes
 - ▶ Discharge planning
 - ▶ Interoperability
 - ▶ Care coordination

Source: Impact Act of 2014 presented by the CMS Division for Chronic and Post Acute Care

How it Works



Source: Impact Act of 2014 presented by the CMS Division for Chronic and Post Acute Care

Changes for LTCH

- ▶ Changes were part of the Interim Final Rule dated August 15, 2015 for PPS and LTCH published in the Federal Register (pp 49325-49886)
- ▶ The rule was impacted by the following legislation:
 - ▶ Affordable Care Act (“ACA”) aka ObamaCare
 - ▶ Pathway for Sustainable Growth Reform Act (“SGR”) aka Doc Fix
 - ▶ Protecting Access to Medicare Act of 2014
 - ▶ Improving Medicare Post Acute Care Transformation Act (“IMPACT”)
 - ▶ Medicare Access and CHIP Reauthorization Act of 2015.
- ▶ Primarily provides payment updates and policy changes for IPPS and LTCH hospitals
- ▶ LTCH provisions primarily are related to changing payment policy to comply with the SGR and technical correction for the moratorium on new LTCH and new or increased beds in existing facilities.

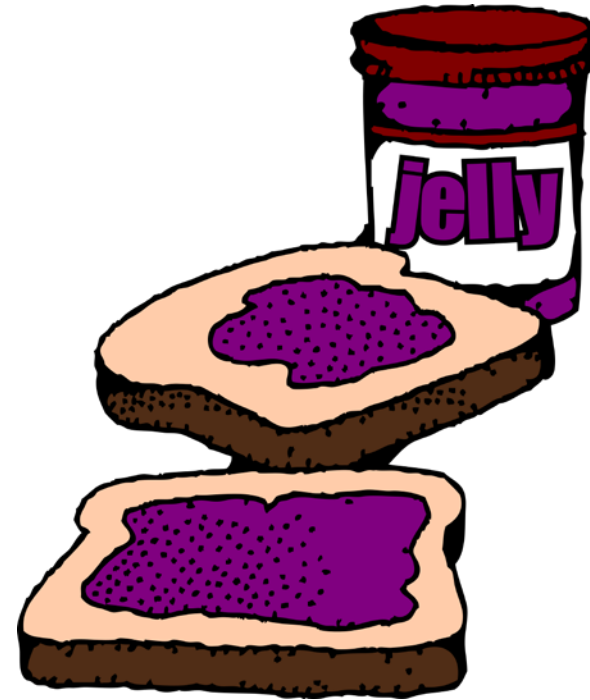
Changes for IRF

- ▶ The “usual suspects” will continue to impact IRFs
 - ▶ Site Neutral Payments
 - ▶ The 65 (75)% Rule
 - ▶ Quality Measures
 - ▶ Readmissions



Changes for SAUs and SNFs

- ▶ All Cause- All Condition Readmission measure
- ▶ SNF Value Based Purchasing measure
- ▶ Quality Reporting specified in IMPACT
- ▶ Implementation of ACA provisions
- ▶ PBJ- definitely not Peanut Butter and Jelly
- ▶ Required annual payment updates
 - ▶ Market basket Increase 2.3%
 - ▶ Reduction for forecasting error (.6%)
 - ▶ Multifactor productivity adjustment (.5%)
 - ▶ Net increase in payments of 1.2% or approximately \$430 million



All Cause- All Condition Readmission Measure

- ▶ This measure provides for a 2% withhold based on the readmission rate.
- ▶ Part of the SNF Value Based Purchasing initiative.
- ▶ It is claims based and CMS projects no additional data collection or submission burden for providers.
- ▶ The withhold can be earned back based on improvement in the readmission rate.
- ▶ This will be replaced by a risk-adjusted preventable readmission rate in future rule-making.

SNF Quality Reporting

- ▶ IMPACT requires reporting of quality measures across the following 3 domains:
 - ▶ Skin integrity and changes therein
 - ▶ Incidence of major falls
 - ▶ Function status, cognitive function and related changes
- ▶ CMS has adopted these measures to meet those requirements:
 - ▶ New or worsened pressure ulcers
 - ▶ Falls with major injury
 - ▶ Assessment and care planning for functional status

Payroll Based Staffing Reporting by SNF

- ▶ Beginning 07/01/2016 long-term Care facilities required by IMPACT and ACA to submit the following information related to direct care staffing electronically:
 - ▶ Payroll information to include:
 - ▶ Individual employee start and end dates, hours worked
 - ▶ Similar information for agency and contract personnel
- ▶ The definition of “Direct Care Staff” is Individuals, who through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practical physical, mental and psychological well-being.
- ▶ Direct care staff does not include individuals whose primary responsibility is maintenance of the physical environment.

HHA Payment Changes

- ▶ Downward adjustment of the 60 day episodic payment to reflect changes in number of visits, mix of services, average cost, intensity of services and other factors.
- ▶ Recalibration of Case Mix Weights.
- ▶ Updates to reflect case mix growth.
- ▶ Payment changes related to quality reporting.
- ▶ Submissions of OASIS assessments will become a condition for payment.
- ▶ Standardized 60-day episodic payment would be reduced by \$80.95.
- ▶ The national per visit payment will increase by 3.5%. Range of payment change is \$6.34 for Medical Social Service to \$1.79 for home health aides.
- ▶ Reduction in non-routine supply conversion factor of 2.82%.

HHA Quality Provisions

- ▶ Quality measure and value based purchasing
- ▶ The 9 measures selected based on these criteria are:
- ▶ Process Measures:
 1. Timely Initiation of Care
 2. Drug Education on all Medications Provided to Patient/Caregiver
 3. Influenza Immunization Received for Current Flu Season
- ▶ Outcome measures:
 4. Improvement in Ambulation
 5. Improvement in Bed Transferring
 6. Improvement in Bathing
 7. Improvement in Pain Interfering With Activity
 8. Improvement in Shortness of Breath
 9. Acute Care Hospitalization

Hospice Changes

- ▶ Final rule reflects CMS efforts to support beneficiary access to hospice care.
- ▶ Agencies should see increase of 1.1% in overall payments. Total tab for taxpayers is \$160 million.
- ▶ CMS is finalizing two payment rates for routine home care:
 - ▶ Rate for first 60 days of care
 - ▶ Separate rate for post 60 days
- ▶ CMS is finalizing a service intensity add-on payment.
- ▶ The policies in the two previous bullets are effective January 1, 2016.
- ▶ Memorandum on coordination between Part D and Hospice dated July 18, 2014.
- ▶ Medicare Care Choices Model.

Bundled Payment and How It Will Affect Post-Acute Care

- ▶ The Bundled Payments for Care Improvement Initiative (“BPCI”) is a pilot by CMS to determine if bundling payments across the care continuum can reduce overall cost while maintaining or improving the quality of care to beneficiaries.
- ▶ The first group of BPCI participants was announced in January 2013.
- ▶ The project includes four episode-based payment models.
- ▶ The Lewin Group and a consortium of partners are evaluating and monitoring models 2-4 and issued their first report in February 2015.

The BPCI Payment Models

	Model 1	Model 2	Model 3	Model 4
Episode	All DRGs; all acute patients	Selected DRGs; hospital plus post-acute period	Selected DRGs; post-acute period only	Selected DRGs; hospital plus readmissions
Services included in the bundle	All Part A services paid as part of the MS-DRG payment	All non-hospice Part A and B services during the initial inpatient stay, post-acute period and readmissions	All non-hospice Part A and B services during the post-acute period and readmissions	All non-hospice Part A and B services (including the hospital and physician) during initial inpatient stay and readmissions
Payment	Retrospective	Retrospective	Retrospective	Prospective

Common BPCI Terms

- ▶ Participant (Phase I)
- ▶ Awardee (Phase 2)
- ▶ Episode Initiators
- ▶ Conveners
- ▶ DiD- Difference in Difference methodology
- ▶ Anchor Hospitalization
- ▶ Implementation Protocols
- ▶ Episode of Care



Types of Participants in the BPCI

- ▶ **Awardees** are entities that assume financial liability for the clinical episode spending and have signed an Agreement with CMS.
- ▶ **Episode Initiators** are healthcare providers that trigger BPCI episodes of care; they do not bear risk directly(unless they also serve as an Awardee), but participate in the model through an agreement with a BPCI Awardee.
- ▶ **Conveners** are entities that bring together multiple health care providers. These conveners can participate as either Awardees that enter into Agreements with CMS and bear risk or Facilitator Conveners that do not enter into an Agreement with CMS and do not bear risk.

BPCI Participants by Entity Type

- ▶ Acute care hospitals (423)
- ▶ Physician Group Practices (441)
- ▶ Home Health Agencies (101)
- ▶ Inpatient Rehabilitation Facilities (9)
- ▶ Long-term care hospitals (1) and
- ▶ Skilled Nursing Facilities (1071)

BPCI Participants by Model

- ▶ Model 1 (11)
- ▶ Model 2 (741)
- ▶ Model 3 (1353)
- ▶ Model 4 (10)



The Lewin Group Report

- ▶ Looked at Models 2 through 4 .
- ▶ Eight awardees that included nine hospitals Episodic Initiators (“EI”) in Model 2.
- ▶ Six awardees in Model 3 with nine EIs.
- ▶ Only one awardee in Model 4 which had only one EI, major joint replacement of the lower extremity.
- ▶ Hospitals participating in the BPCI are in more competitive markets than non-participating hospitals.
- ▶ BPCI markets tend to:
 - ▶ Have multiple competitors
 - ▶ No dominant provider
 - ▶ Be in urban areas

Source: Lewin Group Report to CMS on Year 1 Evaluation and Monitoring of BCPI Models 2-4

The Lewin Group Report (continued)

- ▶ The report clearly states that conclusions about the results were difficult to draw due to the small sample size and short time frame.
- ▶ Used a non-experimental design
- ▶ Relied on difference-in-difference (DiD) modeling to evaluate outcomes
- ▶ Lewin used the Medicare Claims and Enrollment Database (EDB) and the Chronic Conditions Warehouse (CCW) to identify and construct BPCI episodes of care during the BPCI intervention (Q4 2013) and the baseline (Q4 2010-Q3 2013).
- ▶ Used a comparison group of non-BPCI providers similar to the BPCI Phase 2 participants to evaluate the evaluate the results
- ▶ Comparison group was similar in these areas:
 - ▶ Market
 - ▶ Available services
 - ▶ Case mix

Source: Lewin Group Report to CMS on Year 1 Evaluation and Monitoring of BCPI Models 2-4

Lewin Group Analytic Framework

CMS had three major evaluation and monitoring questions:

- 1. What are the characteristics of the program and participants at the baseline and how have they changed over the initiative?*
- 2. What is the impact of the BPCI on the costs of episodes, the Medicare program, and the quality of care for the Medicare beneficiaries?*
- 3. What program, provider, beneficiary, and environmental factors contributed to the various results of the BPCI?*

The Lewin Group Results (continued)

Model 2 Results

- ▶ In choosing to be in Model 2, awardees consulted their administrative and clinical leaders when making the decision to participate.
- ▶ An opportunity and challenge of BPCI was the establishment of relationships across provider groups to result in improved care coordination.
- ▶ The costs for surgical orthopedic patients were higher for BPCI participants than non-participants prior to intervention. (\$37,275 vs \$34,102)
- ▶ After intervention, the BPCI costs were lower but only nominally. (\$32,369 vs \$32,948)
- ▶ The average standardized allowed was lower for both groups during the intervention period but the decline for BPCI patients was greater than that of the comparison group.

Model 2 Comparison of Participants/ Non-Participants

BPCI Participants

- ▶ 89% Non-Profit entities
- ▶ 100% > 100 beds
- ▶ 61% Occupancy
- ▶ Multiple competing providers
- ▶ No dominate market provider
- ▶ Herfindahl index .30

Non-BPCI Participants

- ▶ 60% Non-Profit
- ▶ 36% > 100 beds
- ▶ 49% Occupancy
- ▶ Less competition
- ▶ Larger market share/ provider
- ▶ Herfindahl index .69

Model 2 Comparison of Participants/ Non-Participants (continued)

BPCI Participants

- ▶ Anchor hospitalization LOS for surgical orthopedic excluding spine decrease from **4.6** at the beginning of the baseline to **4.4** in the year immediately before BPCI and to **4.3** in the 1st quarter of Phase 2.
- ▶ Unadjusted avg. total Medicare standardized amount:
 - ▶ Baseline \$37,275
 - ▶ Intervention \$32,369
 - ▶ Change **\$ 4,906**

Non-BPCI Participants

- ▶ Anchor hospitalization LOS for surgical orthopedic excluding spine decrease from **4.7** at the beginning of the baseline to **4.6** in the year immediately before BPCI and to **4.5** in the 1st quarter of Phase 2.
- ▶ Unadjusted avg. total Medicare standardized amount:
 - ▶ Baseline \$34,102
 - ▶ Intervention \$32,948
 - ▶ Change **\$ 1,154**

Model 3 Comparison of Participants/ Non-Participants

BPCI Participants

- ▶ 100% Urban
- ▶ 18% Non-Profit
- ▶ Median market penetration is 7.5%
- ▶ Average Herfindahl index .08
- ▶ Lower SNF beds per population
- ▶ Median household income \$50,666
- ▶ Median PCP per 10,000 - 8.3
- ▶ Median SNF beds/10,000- 45.4

Non-BPCI Participants

- ▶ 71% Urban
- ▶ 27% Non-Profit
- ▶ Median market penetration is <1%
- ▶ Average Herfindahl .32
- ▶ Higher per capita bed ratio
- ▶ Median household income \$44,053
- ▶ Median PCP per 10,000 - 6.2
- ▶ Median SNF beds/10,000- 65.1

Model 3 Comparison of Participants/ Non-Participants (continued)

BPCI Participants

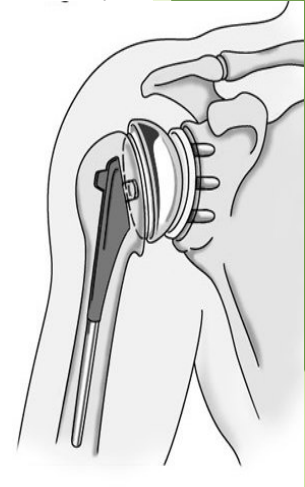
- ▶ PAC utilization post anchor hospitalization:
 - ▶ Baseline 1st eight months - 16
 - ▶ Baseline last 4 months- 15
- ▶ Change in payments:
 - ▶ 60 episode during baseline \$11,311
 - ▶ 90 episode during the risk-adjusted period \$7,465

Non-BPCI Participants

- ▶ PAC utilization post anchor hospitalization:
 - ▶ Baseline 1st eight months - 21
 - ▶ Baseline last 4 months- 20
- ▶ Change in payments:
 - ▶ 60 episode during baseline \$16,896
 - ▶ 90 episode during the risk-adjusted period \$12,082

What's Next-CCJR

- ▶ January 1, 2016, the first mandatory bundled payment model- Comprehensive Care for Joint Replacement Model
- ▶ Similar to Model 2 of BPCI
- ▶ Hospitals do not get to choose participation
- ▶ Related to anchor hospitalization for MS-DRGs 469 and 470
- ▶ 90 episode period after discharge
- ▶ For more information see John Fink's article "Mandatory Bundled Payment: Getting into Formation for Value-Based Care" beginning on p. 55 of the October issue of hfma Journal
- ▶ See also article by Deirdre Baggot and Andy Edeburn, "Mandated Bundled Payments Compel Hospitals to Rethink Post-Acute Care." on p.64 of hfma Journal.



What's Happening on the State Level- aka Bungled Payments

- ▶ Tennessee has for the last GOKW, used a simplistic and arcane system to reimburse long-term care providers.
- ▶ Governor Bredesen blessed the long-term care industry with the CHOICES ACT.
- ▶ TennCare bureau and THCA have been working for the past 8-10 years on a new reimbursement methodology. THCA and the Bureau have hired separate consultants to evaluate a new system.
- ▶ In October 2012, THCA circulated a draft of a proposed new system prepared by Eljay, LLC.
 - ▶ Consisted of an acuity-based payment model
 - ▶ Proposed revamp of the provider assessment (bed tax)
 - ▶ Separate cost components for
 - ▶ Care-related costs
 - ▶ Indirect care costs
 - ▶ Property costs based on fair rental value (FRV) similar to other states
 - ▶ Provided for meaningful incentives for facilities that met accountability standards ³²

Tennessee Long-Term Care Reform

- ▶ In the fall of 2014, the TennCare Bureau changed the assessment fee to base the amount assessed to be only calculated on non-Medicare days.
- ▶ The new assessment arrangement would have winners and losers:
 - ▶ Facilities with high Medicare patient populations would pay less tax based on the presumption that they get less pass-through.
 - ▶ Facilities with high TennCare populations would be losers but would receive more pass-through per day.
- ▶ Would enable the state to maintain payment rates and make acuity based payments.
- ▶ The system was tweaked again this fall so that the assessment will be:
 - ▶ Facilities with fewer than 50 beds as well as qualifying CCRCs: \$9.16 per non-Medicare patient day.
 - ▶ Large facilities with more than 50,000 annual Medicaid patient days: \$2,225 per licensed bed.
 - ▶ All other facilities: \$15.20 per non-Medicare patient day.



Tennessee Long-Term Care Reform (continued)

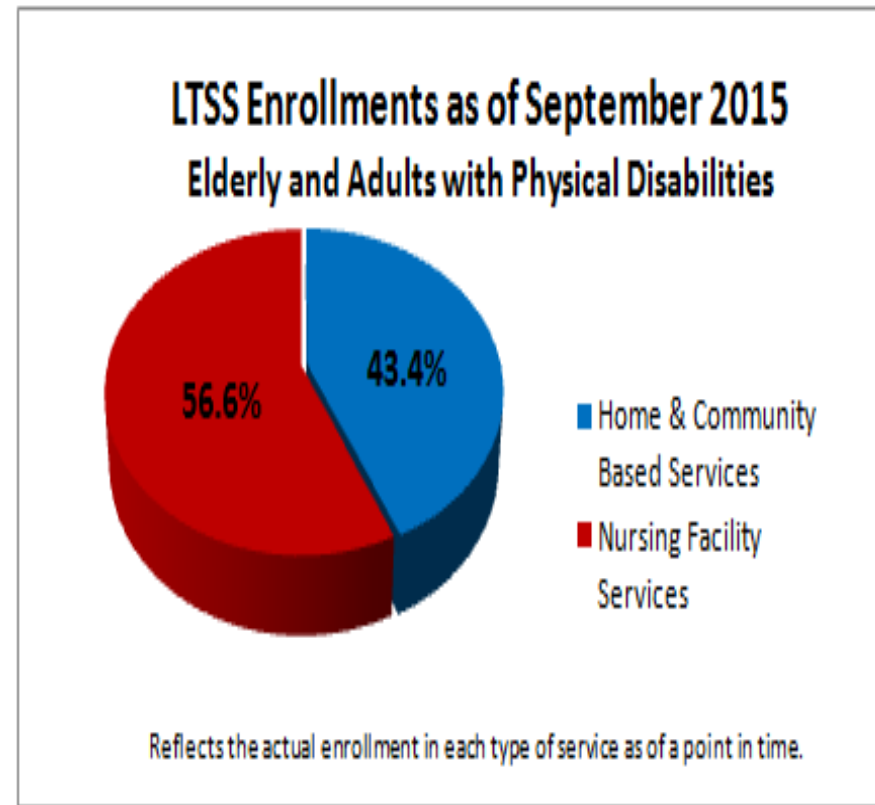
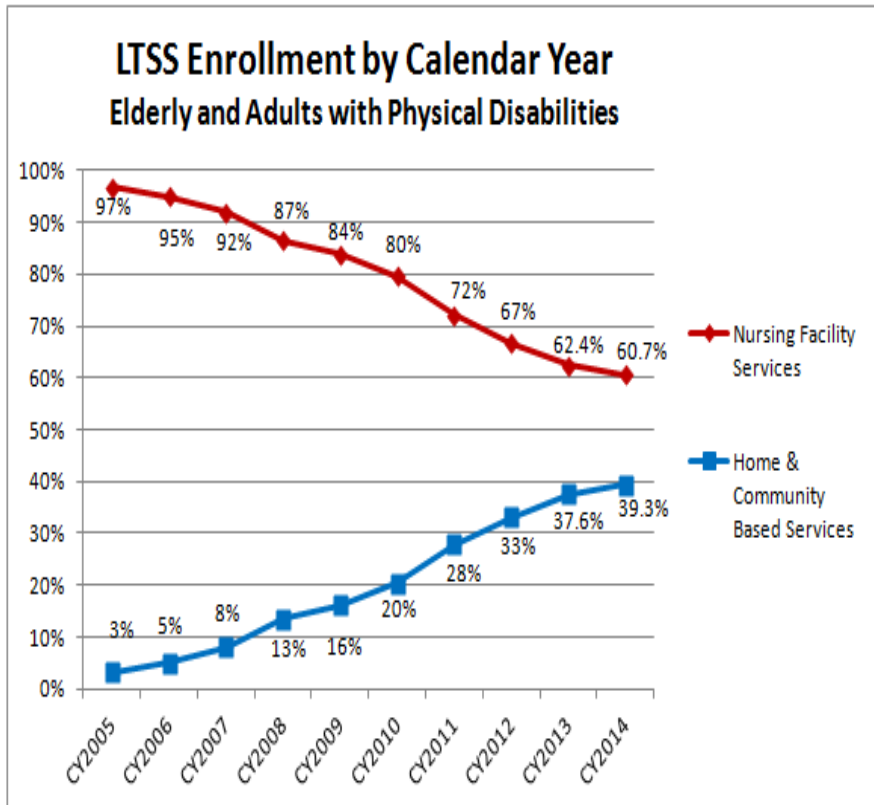
- ▶ Amount that facilities will receive in pass-through:
 - ▶ Facilities with fewer than 50 beds as well as qualifying continuing care retirement communities (CCRC): \$6.76 per patient day.
 - ▶ Large facilities with more than 50,000 annual Medicaid patient days: \$6.08 per patient day.
 - ▶ All other facilities: \$11.92 per patient day.
- ▶ The State gave TennCare providers a full increase this year with the cost limits being:
 - ▶ \$170.84 for Level 1 providers
 - ▶ \$202.88 for Level 2 providers
- ▶ Quality and acuity payments will continue in 2016.
- ▶ New worksheet in place for an all-inclusive rate for both levels of care that “piggy-backs” off the Medicare cost report via an adjustment spreadsheet. Various consultants were allowed to make comments about the spreadsheet and adjustments.

Other PAC in Tennessee

- ▶ Home and community-based care continues to grow.
- ▶ Home health payments are inadequate.
- ▶ Amendment 18 of the TennCare wavier allows Assisted Living to be added to CHOICES. (This is a major improvement)
- ▶ Choices covers these “in-home” and other services:
 - ▶ Personal care visits
 - ▶ Attendant care
 - ▶ Home-delivered meals
 - ▶ Personal Emergency Response system
 - ▶ Adult day care
 - ▶ In-Home Respite care
 - ▶ Inpatient Respite care
 - ▶ Assistive technology
 - ▶ Minor home modification
 - ▶ Community-based Residential Alternatives



CHOICES in Tennessee



Source: TennCare website

Questions



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