Succeeding in a New Era of Health Care Delivery

Building Value-Based Partnerships

LeadingAge Pennsylvania

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Your Presenter

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Discussion Topics

- Forces driving transformation of health care
- Key provisions in health care reform for post-acute and long-term care
- Why partnerships are essential and critical success factors
Forces Driving Transformation of Care
The Health Care “Tipping Point”

• Health care “tipping point” has long been predicted—it now appears we are there

• Some of the transformational drivers:
  – Unsustainable economics
  – Health care reform
Chronic Care Needs Cost Medicare Too Much

Projected Composition of Medicare Patient Population

<table>
<thead>
<tr>
<th>Year</th>
<th>Patients with 4+ Chronic Conditions</th>
<th>Patients with &lt;4 Chronic Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>21%</td>
<td>79%</td>
</tr>
<tr>
<td>2007</td>
<td>9%</td>
<td>91%</td>
</tr>
<tr>
<td>2017</td>
<td>4%</td>
<td>96%</td>
</tr>
</tbody>
</table>

Proportion of Medicare Spending by Number of Chronic Illnesses

- One to two conditions: 76.3%
- Three conditions: 7.0%
- Four conditions: 7.4%
- None: 9.2%

Source: “The Ironic Business Case for Chronic Care in the Acute Care Setting,” Health Affairs, January/February 2009; The Rise In Spending Among Medicare Beneficiaries: The Role Of Chronic Disease Prevalence And Changes In Treatment Intensity,” Health Affairs, 2006.
Where Health Care Dollars Are Spent

- Hospital care: 31%
- Physician/clinical services: 20%
- Other professional services: 7%
- Other health, residential, and personal care: 5%
- Nursing home care: 3%
- Home health care: 3%
- Retail - Rx drugs: 10%
- Retail - Other products: 3%
- Government Administration: 1%
- Net cost of health insurance: 6%
- Other health, residential, and personal care: 3%
- Investment: 6%
Business as Usual (Fee for Service) Deemed Unsustainable

CBO Baseline Projection of Medicare Trust Fund Surplus/Deficit (in billions)

<table>
<thead>
<tr>
<th>Year</th>
<th>Surplus/Deficit</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013 (E)</td>
<td>$10</td>
</tr>
<tr>
<td>2014 (E)</td>
<td>$8</td>
</tr>
<tr>
<td>2015 (E)</td>
<td>$4</td>
</tr>
<tr>
<td>2016 (E)</td>
<td>($21)</td>
</tr>
<tr>
<td>2017 (E)</td>
<td>($17)</td>
</tr>
<tr>
<td>2018 (E)</td>
<td>($15)</td>
</tr>
</tbody>
</table>

ACA Initiatives Aimed at Reducing Unnecessary Hospital Use

- Readmission penalties
- Value-based purchasing
- Shared savings program
- Episodic bundling


2011
- SNF Medicare Reductions
- Bundled Payment Initiative
- Pioneer ACOs

2012
- ACOs
- Hospital Readmission Penalties

2013
- Value-Based Purchasing Efficiency Measure
- Bundled Payment Pilot

Payment transitions from volume to value
Key Provisions in Health Care Reform for Post-Acute and Long-Term Care
Health Care Reform Implementation Timeline for Post-Acute and LTC

- **ACO Final Regulation**: Oct 2011
- **April 1 ACO Start Date**: Apr 2012
- **Readmission Penalties Value-Based Purchasing**: July 2012
- **Value-Based Purchasing Efficiency Measure (30 days after hospital discharge)**: Oct 2012
- **Bundled Episodic Payment Expansion**: Oct 2013
- **Pioneer ACOs Begin**: Jan 2012
- **Bundled Payments Initiative Applications Due April 30**: April 2012
- **July 1 ACO Start Date**: Oct 2012
- **Bundled Episodic Payments Pilot**: Jan 2013
- **Readmission Penalties Expansion**: Oct 2014
- **Applications Due April 30**: Jan 2016
Why Health Systems See Post-Acute Care as Key to Bending the Cost Curve

<table>
<thead>
<tr>
<th>PAC Setting</th>
<th>Percent Discharged from Hospital to PAC Setting</th>
<th>Percent Rehospitalized After Using PAC Setting</th>
<th>Percent Discharged to Second PAC Setting</th>
<th>Most Common Second PAC Setting Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNF</td>
<td>17.3%</td>
<td>22.0%</td>
<td>29.3%</td>
<td>Home health</td>
</tr>
<tr>
<td>Home health</td>
<td>16.0</td>
<td>18.1</td>
<td>2.3</td>
<td>Hospice</td>
</tr>
<tr>
<td>Inpatient rehab</td>
<td>3.2</td>
<td>9.4</td>
<td>56.8</td>
<td>Home health</td>
</tr>
<tr>
<td>LTC hospital</td>
<td>1.0</td>
<td>10.0</td>
<td>53.4</td>
<td>SNF</td>
</tr>
<tr>
<td>Hospice</td>
<td>2.1</td>
<td>4.5</td>
<td>2.4</td>
<td>Home health</td>
</tr>
<tr>
<td>Inpatient psych</td>
<td>0.5</td>
<td>8.7</td>
<td>25.4</td>
<td>SNF</td>
</tr>
<tr>
<td>Total</td>
<td>40.0</td>
<td>18.0</td>
<td>19.8</td>
<td>Home health</td>
</tr>
</tbody>
</table>


Large volume of Medicare discharges to post-acute settings and frequent readmissions of chronically ill from post-acute have captured attention of hospitals and payers.
Health Care Reform Provisions to Reduce Medicare Costs

Hospital readmission penalties

Value-based purchasing

Bundled Medicare payment

Accountable care organizations (ACOs)
30-Day Rehospitalizations High, and Most are Avoidable

### Table 1. Rehospitalizations and Deaths after Discharge from the Hospital among Patients in Medicare Fee-for-Service Programs.

<table>
<thead>
<tr>
<th>Interval after Discharge</th>
<th>Patients at Risk at Beginning of Period</th>
<th>Cumulative Rehospitalizations by End of Period</th>
<th>Cumulative Deaths without Rehospitalization by End of Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>number (percent)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All discharges</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–30 days</td>
<td>2,961,460 (100.0)</td>
<td>579,903 (19.6)</td>
<td>103,741 (3.5)</td>
</tr>
<tr>
<td>31–60 days</td>
<td>2,277,816 (76.9)</td>
<td>834,369 (28.2)</td>
<td>134,697 (4.5)</td>
</tr>
<tr>
<td>61–90 days</td>
<td>1,992,394 (67.3)</td>
<td>1,006,762 (34.0)</td>
<td>151,901 (5.1)</td>
</tr>
<tr>
<td>91–180 days</td>
<td>1,802,797 (60.9)</td>
<td>1,325,645 (44.8)</td>
<td>177,234 (6.0)</td>
</tr>
<tr>
<td>181–365 days</td>
<td>1,458,581 (49.3)</td>
<td>1,661,396 (56.1)</td>
<td>200,852 (6.8)</td>
</tr>
<tr>
<td>&gt;365 days</td>
<td>1,099,212 (37.1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharges after hospitalization for medical condition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–30 days</td>
<td>2,154,926 (100.0)</td>
<td>453,993 (21.1)</td>
<td>87,736 (4.1)</td>
</tr>
<tr>
<td>31–60 days</td>
<td>1,613,197 (74.9)</td>
<td>653,998 (30.3)</td>
<td>113,188 (5.3)</td>
</tr>
<tr>
<td>61–90 days</td>
<td>1,387,740 (64.4)</td>
<td>788,535 (36.6)</td>
<td>127,274 (5.9)</td>
</tr>
<tr>
<td>91–180 days</td>
<td>1,239,117 (57.5)</td>
<td>1,032,141 (47.9)</td>
<td>147,851 (6.9)</td>
</tr>
<tr>
<td>181–365 days</td>
<td>974,934 (45.2)</td>
<td>1,280,579 (59.4)</td>
<td>166,561 (7.7)</td>
</tr>
<tr>
<td>&gt;365 days</td>
<td>707,786 (32.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharges after hospitalization for surgical procedure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–30 days</td>
<td>806,534 (100.0)</td>
<td>125,910 (15.6)</td>
<td>16,005 (2.0)</td>
</tr>
<tr>
<td>31–60 days</td>
<td>664,619 (82.4)</td>
<td>180,371 (22.4)</td>
<td>21,509 (2.7)</td>
</tr>
<tr>
<td>61–90 days</td>
<td>604,654 (75.0)</td>
<td>218,227 (27.1)</td>
<td>24,627 (3.1)</td>
</tr>
<tr>
<td>91–180 days</td>
<td>563,680 (69.9)</td>
<td>293,504 (36.4)</td>
<td>29,383 (3.6)</td>
</tr>
<tr>
<td>181–365 days</td>
<td>483,647 (60.0)</td>
<td>380,817 (47.2)</td>
<td>34,291 (4.3)</td>
</tr>
<tr>
<td>&gt;365 days</td>
<td>391,426 (48.5)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


19.6% of Medicare patients are readmitted within 30 days and 28.2% within 60 days; only 10% of these readmissions are “planned”
30-Day Readmissions: Opportunity for Improvement in Many States

Readmission Penalties Launched October 1, 2012

• CMS will rank hospitals based on 30-day readmission rate for **heart attack, heart failure, and pneumonia:**
  – Not limited to preventable, avoidable readmissions
  – Applies even if readmitted to another hospital
• In 2015, the program will expand to include **COPD, CABG, PTCA, and other vascular conditions** for total of seven conditions: secretary authorized to expand policy to additional conditions beyond these seven
• Requires secretary to publish patient hospital readmission rates for certain conditions
• Does not apply to critical access hospitals
Readmission Penalties Launched
October 1, 2012 (continued)

• Beginning October 1, 2012, rate of excess readmissions for these three conditions translates into as much as 1% reduction in FY 2013, increasing to 3% in October 2014 for all Medicare admissions.

• Progressive post-acute providers are targeting health system partnership approach by customizing value proposition based on hospitals’ specific readmission problems:
  – Creating COPD, CHF, and pneumonia programs designed to help hospitals avoid penalties.
  – Hospital readmissions data available at www.hospitalcompare.hhs.gov.
Fear Factor: Readmission Penalty Risk for Typical Community Hospital

- Implementation is imminent: begins October 1, 2012
- Risk assessment is simple to calculate and substantial

<table>
<thead>
<tr>
<th>Before Penalty</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Revenue</td>
<td>$ 250,000,000</td>
</tr>
<tr>
<td>Operating Margin</td>
<td>3.00%</td>
</tr>
<tr>
<td>Income from Operations</td>
<td>$ 7,500,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Penalty at 1%</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>% Medicare</td>
<td>40.00%</td>
</tr>
<tr>
<td>Medicare Revenue</td>
<td>$ 100,000,000</td>
</tr>
<tr>
<td>Penalty %</td>
<td>1.00%</td>
</tr>
<tr>
<td>Penalty</td>
<td>$ 1,000,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1% Penalty Impact</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Income from Operations Before Penalty</td>
<td>$ 7,500,000</td>
</tr>
<tr>
<td>1% Penalty</td>
<td>$ 1,000,000</td>
</tr>
<tr>
<td>Income from Operations After 1% Penalty</td>
<td>$ 6,500,000</td>
</tr>
</tbody>
</table>

% Income Reduction: 1% Penalty: -13.33%
% Income Reduction: 2% Penalty: -26.67%
% Income Reduction: 3% Penalty: -40.00%
Value-Based Purchasing (VBP)

• **Hospitals**: 1% reduction in Medicare payments and $850,000,000 to reward best performers:
  – FY 2013 starts with patient quality care and satisfaction
  – FY 2014 proposed “efficiency” measure for amount of Medicare payments for acute episode + 30 days after hospital discharge
  – Creates incentive for hospitals to build low-cost, high-quality PAC network

• **SNFs and home health**: HHS secretary must submit plan to congress by FY 2012 for transitioning skilled nursing facilities and home health agencies to VBP system

• **Hospice**: HHS secretary authorized to establish pilot program no later than January 1, 2016, to test VBP for hospice providers
Medicare Pilot Per ACA

- Payment to a single provider entity of one amount for the full range of care
- Episode from 3 days prior to a hospitalization to 30 days after a hospitalization
- Includes acute, post-acute, rehospitalization, ER use
- Initial focus on one or more of eight conditions
Bundled Payment Initiative: 8/23/11

Bundling Options

- Acute: 2%–3% discount
- Acute + post-acute: 2%–3% discount
- Post-acute only: Subject to bids with no set discount; profit potential but also downside risk (payback)

CMMI Bundling

Hospitalization

- 3 days prior
- Hospital
- 30 days post

Models:
- Model 1
- Model 2
- Model 3
- Model 4
CHF Example: Success Hinged on Ability to Reduce Readmissions

$23,000 = 30 days

<table>
<thead>
<tr>
<th>Service</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>$9,000</td>
</tr>
<tr>
<td>Hospitalist</td>
<td>$1,200</td>
</tr>
<tr>
<td>Cardiologist</td>
<td>$500</td>
</tr>
<tr>
<td>Subacute</td>
<td>$7,500</td>
</tr>
<tr>
<td>PCP</td>
<td>$300</td>
</tr>
<tr>
<td>Home Care</td>
<td>$2,500</td>
</tr>
<tr>
<td>Shared Savings (providers and perhaps beneficiary), or…</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

Typical Medicare Total Payment = $25,000 for Hospital + 30 Days

...Readmission at $9,000 will kill the bundle
Orthopedics Example: Bundling Changes Use of Acute and Post-Acute

Shared savings: 45% Physicians
45% Hospital
10% Visiting Nurse

payment bundled at $24,600
Implications for Post-Acute Providers Not Participating in Bundling Initiative

• Even without directly participating, all post-acute providers impacted by bundled payment programs

• Widespread and rapid adoption will fast-track development of preferred provider networks, favoring post-acute organizations with:
  – Demonstrated improvement in readmission rates
  – High RN to patient ratios and robust primary care coverage
  – Patient and family education and engagement procedures
Care Delivery System Changes

Care Shifts from Procedures for Sickness to Population-Based Health
Foundation of New Delivery Systems: Triple Aim

- Better patient care and experience
- Better population health
- Lower costs
Accountable Care Organizations: 32 Pioneers and 50–270 ACOs

- Shared savings program for hospitals and physicians for Medicare Part A and B services for “attributed lives”
- 32 Pioneers in December 2011; 50–270 ACOs between 2012–2015
  - One Pennsylvania Pioneer: Renaissance Medical Management Company, Wayne, a practice association with over 200 physicians
- **Objective**: reduce overall Medicare costs

- **Incentive**: ACOs share in cost savings versus “normal” market-based payment for Medicare beneficiaries
- Savings through:
  - Easy access to primary care
  - Prevention, care management, chronic disease management
  - Avoid hospitalization
  - Use selected contract providers for non-physician/non-hospital services (e.g., SNFs, home health agencies, assisted living)
How Shared Savings Works

- Current average per-capita spending for Medicare patients in market area determined from claims for past three years
- Spending target is determined by CMS
- If actual spending lower than target, savings are shared
- IF 33 quality targets are also achieved

Shared savings…
...to be distributed among ACO participants, but not necessarily contractors unless also share risk

Adapted from Brookings Institute
ACOs Not Limited to Medicare – Some Have Shared Savings Agreements with Insurers

- Some insurers own or are acquiring physician clinics (and health system) and may compete with health system ACOs:
  - Blue Cross
  - Aetna
  - UnitedHealth Group
  - Cigna
Why Partnerships are Essential and Critical Success Factors
Partnerships Requirements

• SNF/home health/senior housing-hospital-physician-payor partnerships required to…
  – Develop an integrated delivery model
  – Provide coordinated care
  – Improve quality outcomes
  – Drive out cost
Health Systems’ Priorities and Post-Acute and Long-Term Care

- EMR

- Physician alignment—adequate PCPs for desired attributable Medicare beneficiaries (and insurers with at-risk contracts)

- Assure existing post-acute assets are meeting system needs:
  - Admission, effective management of existing patients
  - Integration with primary care: subacute and LTC
  - Management of cost, patient outcomes: 30 days

- Extend existing post-acute assets:
  - Acquire venues: straight acquisition or JV
  - Preferred provider network

- Continuum care pathways and PCP extension to home
Critical Success Factors in Partnering

Partnerships must be value-based: what do you bring?

- Hospital readmission reduction
- Capability to manage medically complex, not just rehab
- Embedding primary care in SNF
- Cost management for patient episode of care
- Care coordination across the continuum
- Chronic care management to reduce ED visits and hospitalizations
- Electronic information exchange
- Ability to share payment risk based on outcomes
What’s the Quid Pro Quo?

• Financial Viability:
  – Continued, increased flow of Medicare FFS or Medicare Advantage patients into subacute SNF or HHA (not all will qualify as health system/ACO partner)
  – Downstream ability to share savings under bundled payment or with an ACO

• Quality Care:
  – Improved ability to manage higher acuity patients in your post-acute settings
  – Improved access for your residents to care management, care navigation, and primary care

• Multiple Relationships You Select:
  – Not limited to one health system or ACO—you choose your partners just as they choose you

• Learning:
  – Readiness for capitated payment and population health management
Questions on Today’s Webinar?
Assignment for On-site Session Participants

- Complete ACO readiness tool
- Complete at least some of the recommended readings
- June 26 – Health Care Reform Update and Best Practices for Building Partnerships, Hershey, PA
- September 12 – Organization Business Planning for Creating Partnerships, Harrisburg, PA Location TBD
HOSPITALITY
STEWARDSHIP
INTEGRITY
RESPECT
HUMOR