Managing in a Managed Care World
February 2016

Objectives
• Describe the current state of Managed Care penetration in the Post-Acute Care (PAC) space
• Summarize the sources of data available to PAC providers that are of interest to payers
• Demonstrate strategies for effective communication between providers and payers
• Apply data and analytics to ensure effective and appropriate care delivery in a managed care environment
Managed Care Arrangements - State of the State(s)

- Traditional Medicare Fee for service reimbursement declining for post-acute care delivery

- Trend toward managed care contracts and/or alternative payment model reimbursement (aka risk-sharing) increasing for PAC providers

- Difficult to survive in changing climate if PAC providers remain FFS

Managed Care Arrangements - State of the State(s)

- Medicare payments to be linked to quality and value based payment models (Bundles, ACOs, Medical Homes)

- HHS goal = shift 30% of Medicare payments to alternate forms by end of 2016

- HHS goal = shift 50% of Medicare payments to alternate forms (ACOs/bundles) by 2018

- Prior 2011 –Medicare FFS payments reimbursed for ↑census/volume, ↑LOS

1www.CMS.gov
Managed Care Arrangements - State of the State(s)

• Today reimbursement now shifting to payments for ↑ quality/performance, ↓ LOS, ↓ readmission, and successful care transition

• Seeing increase in Managed Care enrollment for Medicare/Medicaid eligible beneficiaries

• Current Medicare Advantage enrollment up by 1 million beneficiaries since 2014

Managed Care Arrangements - State of the State(s)

• In 2015, 1 of every 3 Medicare beneficiaries was enrolled in a Medicare Advantage (MA) plan

• Many states converting traditional Medicaid beneficiaries to Managed Care Organizations (MCOs)
  – as of 2016 there are 39 + DC

• Medicaid MCOs may include managed long-term services and supports (MLTSS)
Managed Care Arrangements - State of the State(s)

As of 2016, Medicaid MCOs in 28 states include MLTSS with several pending implementation\(^2\)

Special Needs plans – Dual SNP & Institutional SNP increasing

Alignment of D-SNP and MLTSS providers occurring in some states

\(^2\)Kaiser Family Foundation – www.kff.org

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Alternative Payment Models: Driving Care Alignment

- Can provide additional revenue resources through gain sharing for upstream downstream partners
- May provide additional revenue through risk sharing for care resources not covered by traditional FFS e.g. telehealth, NPs, SNFists
- May include PAC providers in “select” network determined by Awardee
- For patients participating in risk sharing arrangements (via bundles or qualifying ACOs) the CMS 3 day hospital stay rule may be waived
Alternative Payment Models: Driving Care Alignment

• ACOs – participate in shared savings contracts with CMS and MCOs
  – Share savings (or losses) determined by ACOs quality outcomes for performance based risk tracks 1, 2, or 3
  – Encourage collaboration of care and decreased spending for ACOs patient population
• Bundled payment models
  – global payments covering specific set of services associated with a diagnosis or procedure (MS-DRG)
  – Encourage improvement of care outcome, collaboration, quality, and cost for the episode of care being managed

Bundled Payments

• Described as “middle ground" between FFS and capitation
• Proposed in ACA as strategy for reducing health care costs
• Initiated by CMS, MCOs
• CMS bundled payment arrangements = voluntary or mandatory
  – Voluntary bundles: Awardees contract with CMS to participate in bundled program may be Medicare provider (hospital, ACO), or convener
  – Mandatory bundles: hip and knee replacement – CJR
**Bundled Payments: Awardees and Episode Initiators**

Awardees are organizations contracting (with CMS or MCO) for the bundled agreement
- Awardees may be Hospitals, MCOs, ACOs, Conveners

Episode Initiators (EIs) – are sites where a bundled payment event is triggered for one of the qualifying MS-DRGs and the episode of care begins
- physician group practices, acute care hospitals, ACOs

A bundled episode is defined at contract for an agreed upon duration of care for a qualifying MS-DRG
- may include acute hospital stay, post acute care, or combination of both

**Bundled Payments: Reimbursement**

- Reimburse providers on the basis of expected costs for clinical episodes of care
  - Retrospective:
    - FFS billed then reconciled upon cessation of episode of care
    - Awardee must carefully manage care across continuum
    - Bonuses awarded or penalties collected based on outcomes
  - Prospective:
    - Payment upfront - covers cost of all services agreed upon in bundle (acute hospital stay, post-acute care: SNF, HHA)
    - Awardee must carefully manage care across continuum
Bundled Payments: CMS

- Center of CMS Innovation promoting two major bundled payment program demonstrations:
  - Comprehensive Care for Joint Replacement (CJR)
    - mandated in effect 4/1/16
  - Bundled Payments for Care Improvement (BPCI)
    - voluntary in progress

Comprehensive Care for Joint Replacement (CJR)

7/9/15 – CMS announced program to mandate bundled payments for joint replacement surgery paid by Medicare

Mandate requires hospitals in 67 geographic areas to participate in a 5 year demo of bundled payments for hip/knee replacements

Bundled payments cover all services provided during the hospitalization and 90 days of post discharge care
Bundled Payments for Care Improvement (BPCI)

• Designed to test if bundled payments can reduce costs while maintaining/improving quality of care
• Three-year initiative (which may be extended) links payments for services related to an episode of care triggered by a hospitalization
• Under BPCI CMS is testing four models of bundled payments:
  – Model 1 Awardees participate in all MS-DRGs
  – Models 2, 3, and 4, Awardees have 48 clinical episodes they are able to choose from
  – **Models 2 and 3 include post-acute care providers**

Bundles and PAC

• Model 2
  – Episode Initiators = hospitals or physician group practices
  – includes inpatient hospital plus post-acute care and related services up to 90 days after hospital discharge
  – FFS with retrospective bundled payment (actual expenditures are reconciled against a target price for an episode of care)
• Model 3
  – Event is triggered by hospital stay - begins at initiation of post-acute care services with SNF, IRF, LTAC, or HHA
  – FFS with retrospective bundled payment (actual expenditures are reconciled against a target price for an episode of care)
Questions for Providers to Ponder

What are the needs of my partners?
MAO, ACO, Bundle

What is my center good at?
Rehab, Specialty care

What’s in it for me?
Benefits of meeting the requirements of Managed Care arrangements

How Do You Measure Up?

• Payers are interested in
  – Five-Star Overall rating
  – Rehospitalization rates
  – Clinical data e.g. QMs/other quality outcomes

• What data can payers access to measure your performance?
  – Nursing Home Compare
    • Five-Star/Survey/QMs/Staffing
  – Claims data
    • Not timely
  – But that doesn’t tell the whole story...you need to fill in the gaps
**Share the Inside Story**

- Data that are not publicly available will need to be shared by you
  - Rehospitalization rates
    - How is it being measured?
  - Length of Stay (overall/by diagnosis)
  - Resident/Family Satisfaction
- Other reports-as requested
  - Safety (incident/accident reporting-aggregate only)
  - Medication Reconciliation
- Transparency more important than “looking good”

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**Understanding Your Strengths**

<table>
<thead>
<tr>
<th>Risk adjusted 30 day Rehospitalization rates</th>
<th>Quality Measures</th>
<th>What’s your specialty? Use your data to tell your story</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Focus on diagnoses with best performance for referrals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Identify best practices to share with partners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Collaborate on standard care protocols</td>
<td></td>
<td></td>
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<tr>
<td>• Identify areas of excellent performance compared to peers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• If QMs have been a focus of QAPI, show improvement</td>
<td></td>
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<tr>
<td>• Successful discharge to community, improved rates of pain, healed pressure ulcers</td>
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</tbody>
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What’s In It For Me?

- Payers and providers want to control costs. How do you do this?
- Risk assessment and care planning to mitigate risk lead to:
  - Preventing accidents/injury
    - Avoiding associated costs (x-rays, ambulance transfers)
  - Improved rehospitalization rates
    - Bed holds, staffing for discharge and readmission
  - Improved clinical outcomes
    - Decreased cost of care (medications, treatments)

Get Your Partners On Board

- Demonstrate risk assessment/management processes using valid, consistent data
  - MDS, other standard assessment formats
- Share results with Care Managers/NPs for immediate intervention
  - High risk residents
    - Falls, Pressure Ulcers, Mortality, Hospitalization
  - Worsening condition
    - ADLs, Cognition, Mood, Pain
Risk Management Pays Off

Very high percentage of residents who are high risk for pressure ulcers

Risk Management Pays Off (continued)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Num</th>
<th>Denom</th>
<th>%</th>
<th>Adj %</th>
<th>Natl Avg</th>
<th>Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short Stay New or Worsened Pressure Ulcers</td>
<td>0</td>
<td>233</td>
<td>0</td>
<td>0</td>
<td>1.2</td>
<td>0</td>
</tr>
<tr>
<td>Long Stay Pressure Ulcers (High-Risk Residents)</td>
<td>4</td>
<td>128</td>
<td>3.1</td>
<td></td>
<td>6.2</td>
<td>31</td>
</tr>
</tbody>
</table>

Quality Measures show excellent risk management in both Short Stay and Long Stay populations
Get the Picture!

Pain (SS)
November 2015 to January 2016

Significant improvement in Short Stay Pain QM over last 12 months

Rehospitalization By Diagnosis

Overall Rehospitalization rates better than national average
Best performance with CHF and CVA
Communication Is Key

- The payer doesn’t see the resident every day but **YOU** do
- Communicate on a regular basis (i.e. weekly)
  - Unplanned discharges
  - Other changes in condition
  - Let them know ahead of time if the resident changes payer
    - Saves time and money in the long run

How to Respond: Payer Priorities

- Quality and performance measures will be key
  - May go beyond CMS 5-star ratings – push for that!
  - Share your clinical data – MDS, OASIS
- Payers will focus on ↓ overall cost of post acute care and providing more value to patients by:
  - Decreasing LOS by improving quality of care
  - Selecting quality PAC network partners
  - Increasing community support services
  - Promoting communication, data transfer, transparency for patients transition through care continuum
How to Respond: Internalize the Process

• Determine who is the paying for PAC services
• Take an active lead in becoming a network partner with contracting payers
• Be adept with payer contracting - dedicate managed care staff member to oversee contracting/billing
• Be on top of contracting exclusions and different plan/contract requirements
• MCOs, Alternative payment models may pay slower than traditional Medicare – plan accordingly
• Communicate contract specifications to key staff: Administrators, Therapy Directors, Billing etc.

How to Respond: Demonstrate through Data

Measure your quality and performance - use validated data analytics to back up quality/performance metrics

Use analytics to demonstrate your excellence in care delivery based on acuity/volume/outcomes

Use analytics to drive partnership agreements/contract negotiations

Demonstrate key differentiators in market place using data: e.g. rehospitalization rates, lower falls, best practice by diagnosis

Share data with MCO/payer partners - utilize same analytics for measuring scales/solutions/benchmarks
How to Respond: Aligning versus Maligning Relationships with Payer Partners

• Understand your role
• Define expectations when working/contracting with payers and convener partners:
  – What programs do you want to participate in?
    • How are you lobbying for a place at the table?
  – How with this add to present workflows/administrative overhead?
  – What benchmarks will be used to define quality/success?
    • How will benchmarks be measured?
  – What benefits will be recognized?
    • Increased revenue - gain sharing, other quality bonuses
    • Patient referrals

How to Respond: Aligning versus Maligning Relationships with Payer Partners

• Focus on upstream and downstream networks
  – What resources do you have or need to add to manage?
  – Address any interoperability for communicating information
  – Who will be your downstream partners?
• Share MDS data with partners
  – Assists payers/providers in identifying/closing gaps in care
  – Encourage uniformity in reporting/tracking systems
• Establish regular meetings to communicate progress, changes, challenges
• Deliver on deliverables
Discharges to Community

• Under bundled payment, the SNF’s responsibility doesn’t end on discharge
  — Episode of care of up to 90 days can extend beyond SNF stay, so a rehospitalization from home care still counts against the bundle
  — SNF needs to work collaboratively with payer/other providers to ensure successful care transitions

• Keep in touch with patients after discharge
  — Scheduled follow-up calls
  — Option to return to SNF instead of back to hospital (3-day waiver)
  — Other alternatives—outpatient therapy, wellness clinics etc.

PointRight (PAC & LTC Data Intermediary)
Conclusion

- Payers are your partners
  - Communication and teamwork lead to success
  - Differentiate yourself with valid data
- Manage change-don’t let change manage you!
  - Managed care in the Post-Acute space will continue to evolve
  - Focus on the benefits of efficiency and delivery of care

For More Information

- Kaiser Family Foundation: Medicare Advantage Statistics
- CMS Fact Sheet on Payment Models
- CMS Web Page on bundled Payment Models
  - [https://innovation.cms.gov/initiatives/bundled-payments/](https://innovation.cms.gov/initiatives/bundled-payments/)
Questions?

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