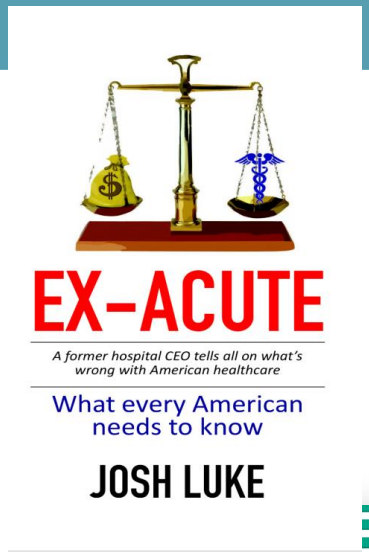
NBPC
National Bundled Payment Collaborative

Teaching Hospitals & Health Systems to **Own the Continuum**

The Health System of the Future:

Lead. Follow. Or get out of the way.



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University of Southern California, Sol *Price School of Public Policy*

Founder, National Readmission Prevention Collaborative (2013)

Founder, National Bundled Payment Collaborative (2015)

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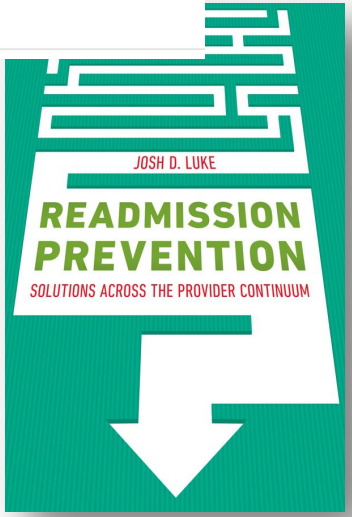


Josh Luke, PhD, FACHE

- SNF Administrator/AL Executive Director
  - Kindred, Windsor/SNF Management, Life Care Centers of America
- Hospital CEO
  - Memorial Hospital, Western Medical Center Anaheim, Anaheim General
- CEO for Acute Rehab
  - HealthSouth Las Vegas Rehab Hospital
- Vice President Post Acute Services
  - Torrance Memorial Health System
  - Home Health and Hospice

Part One: My Story

Why I Became a Patient Advocate

1998 - It Was a Very Good Year

1998 — It Was a Very Good Year

The Fee For Service "Free For All"

Grandma Belva: 1920 - 2002	
Home	$0
Hemet Valley Medical Center	$48,000
LTACH	$52,000
Nursing Home	$12,000
Home with Home Health	$4,000
Hemet Valley Medical Center*	$36,000
Nursing Home	$18,000
Assisted Living with Home Health	$4,000
Hemet Valley Medical Center*	$42,000
Nursing Home	$24,000
Hemet Valley Medical Center*	$58,000
	$298,000

Provider and physician got paid at every stop:
Episode- based reimbursement

Career Change

- My grandmother was ill and being juggled through the system
- Entered AIT program for Life Care Centers of America
  - The best leadership lessons of my career
  - Discovering empathy: a heart for caring
- Became a hospital CEO two years later

Part Two:
The Fee for Service Free-For-All

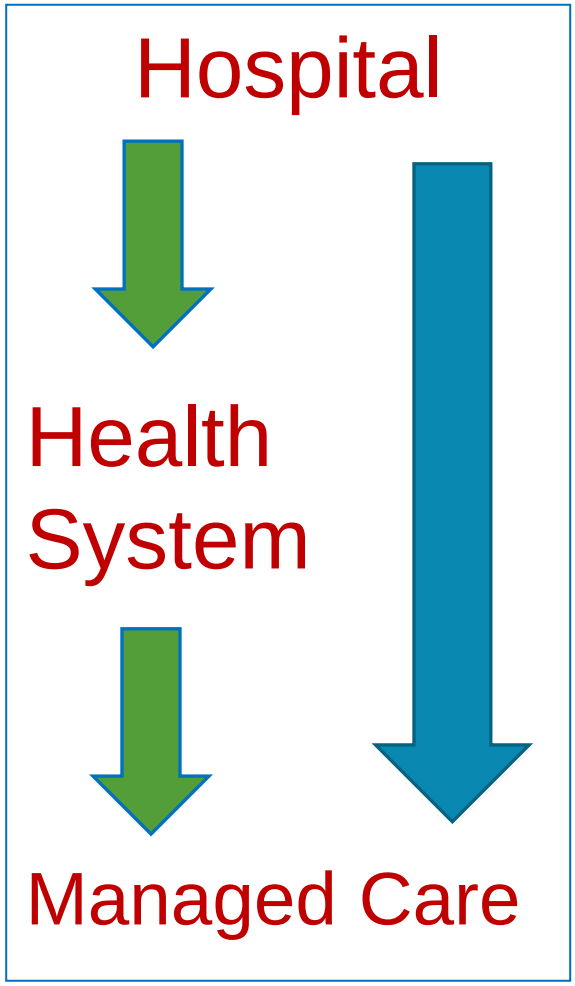
From Volume to value:

How we got here and where we go from here

The Transformation of the Acute Hospital: The C-suite Must Take Action

Coordinating care for improved outcomes:

- Hospitals must act like health systems
- Health systems must act like managed care organization
- Thus, the hospital must act like a managed care organization as well
- Mandated post acute care plans – *October 2015*



Too much regulation?

These are just the ones that I have shared reimbursement strategy with: There are more!

- Center for Medicare/Medicaid Services
- Center for Medicare/Medicaid Innovation
- Office of the Inspector General
- Department of Health Services
- Health Care Learning and Action Network
- US Congressman
- Department of Justice
- Post Acute Care Center for Research
- Medicare Payment Advisory Commission
- AHA, AHCA/NCAL, Leading Age, NTOCC

Obama, Alaska
Hypothetical New City

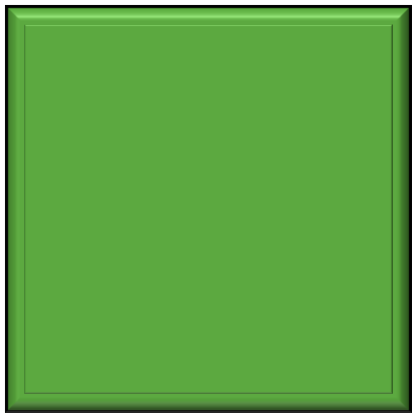
Health System of the Future

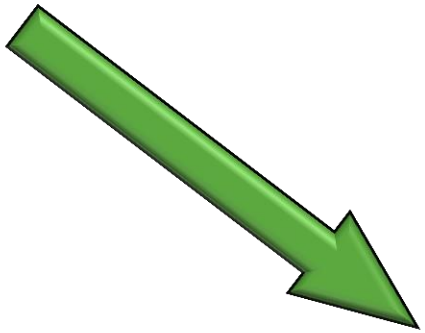
- Home
- Doctor's office
- Wellness clinic/gym
- OP/Ancillary services
- Assisted living
- SNF
- Hospital

Obama, Alaska

The System of Old—The Fee-for-Service Free-for-All

Hospital





- Home
- Doctor's office
- Wellness clinic/gym
- OP/Ancillary services
- Assisted living
- SNF

Insert Hospital Here!

Tommy Olmstead v Lois Curtis

U.S. Supreme Court Decision, June 1999

"Patients in an acute hospital have the right to be discharged to the least restrictive environment."

"Continued institutionalization of patients who may be placed in less restrictive environments often constitutes discrimination."

"Operationally, this means that both physicians and hospital case managers must first rule out the least restrictive environment as a safe discharge before considering institutionalizing a patient for post acute services."

Financial Incentives to Avoid Unnecessary Hospitalization

Welcome to the world of…Admission Prevention

- RAC Audits
- Hospital readmission penalty program
- Accountable Care Organizations
- Bundled Payments
- Medicare Spending Per Beneficiary penalty
- Better, smarter, healthier: In January 2015, HHS announced goal for 30% of Medicare spending in ACO/Bundle by 2016 and 50% by 2018
- Proposed Medicare Spending Per Beneficiary post-acute penalty

What Does This Mean for You?

Hospitals = Last resort

SNF = Second-to-last resort; increase capability to handle medical-surgical level patients

Home health = Networks will be narrowed

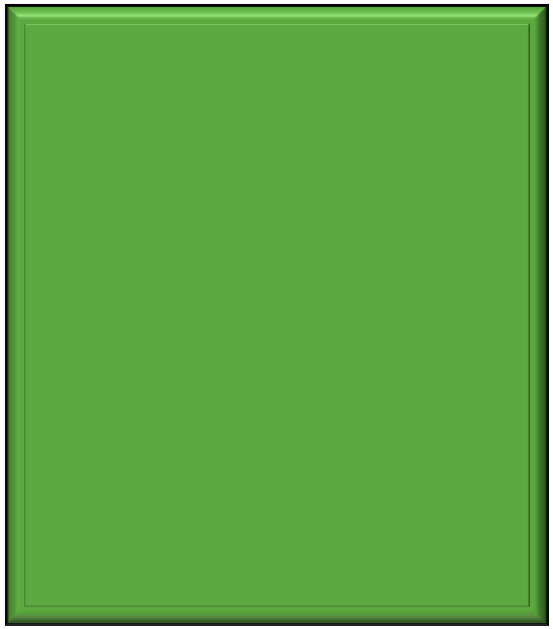
Winners = Home care, private duty, and assisted living

Story Time

Once Upon a Time…

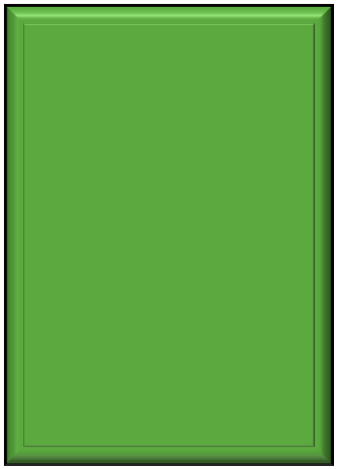
Hospital Bed Capacity

Old Hospital = 290 beds



The Fee-for-Service Free-for-All Era

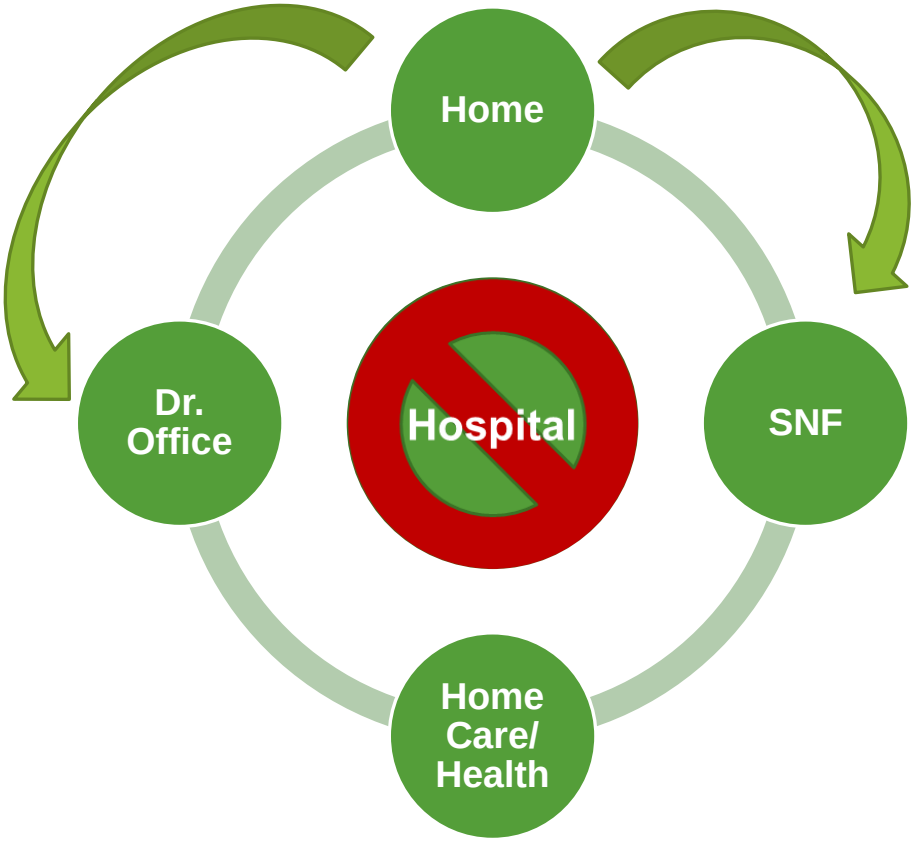
New Hospital = 249 beds



Post-ACA Era

Part Three:
Strategies to Succeed in the New Era

Understanding Alternative Payment Models



Options for Direct Transfer from Emergency Department

Patients with a Medicare benefit can be transferred directly from the Emergency Department to the following levels of care

Alternative Level of Care	Pre-Authorization Required?	Doctor's Order Required?	Notes
Observation Floor	No	Yes	High Cost to Hospital; should be last resort
Physician Office/Urgent Care	No	No	
Long Term Acute Care **(Alt Acute)**	No	Yes	New admission criteria makes this process more challenging but still an option if patient meets STACH criteria
Acute Rehab	No	Yes	Easiest
Skilled Nursing/Sub-Acute	No**	Yes	** Patients discharged from a hospital or SNF within last 30 calendar days
Assisted Living/Board & Care	No	No	Cash pay; not a covered benefit; discharge delay
Home Health	No	Yes	
Home Care	No	No	Patient pays; not a Medicare covered benefit but no caps or limits on service
Hospice or Palliative	No	Yes	
Acute Psychiatric Hospital	Yes	Yes	Can vary based state to state

Luke, Josh, 2016: www.joshluke.org; www.NationalBundledPaymentCollaborative.com

Emerging Trends For Health System Revenue Enhancement

Health Systems Revenue Streams

1. Health system owned or managed home care services (cash pay)

2. Health system owned or managed home health services (Medicare reimbursed but services capped)

3. Provide Chronic care management services to discharged patients

    - $35 to $45 per month; averaging $42 monthly per patient (code 99490)

4. Provide transitional care management services to all patients

    – Range from $135 to $350 depending on potentially additional services provided on site (codes 99495 and 99496)

Post-Acute Opportunities & Expectations

1. SNF's MUST align with hospital based home health and home care
   - Align with health system owned home health and home care
   - Align with top 1-3 home health providers of referral source

2. SNF's should be skipping home health upon SNF discharge and offering the patient non-medical home care
   - Medicare Spending Per Beneficiary (Referral Source)
   - Post Acute Medicare Spending Per Beneficiary (Recommended)

3. Outreach to all referral sources with data and consistently on the 15th each month

4. Prep for disappearance of the 3 midnight rule and criteria/performance-based payment

5. Tools to Implement in facility:
   - POLST (Advanced Directive for Care)
   - SBAR & Stop and watch
   - Return to acute log (emergency department) & root cause analysis

Bundled Payment: Competing for the Post Acute Dollar

Hip Replacement Case

$40,000 for episode (hypothetical for illustration)

Acute Stay = $20,000 or 75%

$18,000	$10,000	$2,000
Hospital	Surgeon	Anesthesia

Built in Margin For Initiator/Convener = $4,000 or 10%

Post Acute Care (All encompassing) = $6,000 or 15%

Includes LTACH, IRF, SNF, Home Health, *home care, *assisted living, palliative and *other

In 2015 app. 42% of joints were discharged from acute to SNF. Projected to be only 20% by 2018.

That leaves 80% for home based providers!

** Not required to be a Medicare participant if application states service*

All Bundled Payment Models Impacted by ED Admissions

	Model 1	Model 2	Model 3	Model 4
Episode	All acute patients; all DRGs	Selected DRG's, hospital plus post acute period	Selected DRG's, post acute period only	Selected DRG's, hospital plus **readmissions**
Services included in Bundle	All Part A services paid as part of the MS-DRG payment	All non-hospice Part A & B services during the initial inpatient stay, post acute period & **readmissions**	All non-hospice Part A & B services during the post acute period & **readmissions**	All non-hospice Part A & B services (including the hospital & physician) during initial inpatient stay & **readmissions**
Payment	Retrospective	Retrospective	Retrospective	**Prospective**
Severity of Financial Impact of avoidable Hospitalization	Medium	**High** *Note: CCJR most closely resembles Model 2.*	**High**	**Severe** *(reduction in initial episode payment; impacts health systems immediate cash flow)*

Source: HIN Reducing Readmission Survey, November 2009

Why Hospitals and ACO's are Engaging No-cost Community Providers to Manage Post Acute Spending and Episodes

8 PROGRAMS & 20 REASONS HOSPITALS ARE FI

Program/Initiative	Revenue Opportunity	Cost Savings	Penalty Exposure
ACO Shared Savings	**Yes - $**	↓	**Yes - $**
Bundled Payments	**Yes - $**	↓	**Yes - $**
Value Based Initiatives	**Yes - $**	↓	**Yes - $**
Readmission Penalty	No	↓	**Yes - $**
Medicare Spending Per Beneficiary	No	↓	**Yes - $**
Better. Smarter Healthier. (30% in an APM by 2016; 50% in an APM by 2018)	**Yes - $**	↓	**Yes - $**
Care Plan Act	No	↓	**Yes - $**
SB 675* (California Only)	No	↓	**Yes - $**

Part Four:
Challenges to Transformation

Case managers. Discharge planners. Care Managers…

Should I stay or should I go?

Challenge for Health Systems and Post Acute Providers: Will hospital and post acute discharge planners transform?

Re-program discharge planning within the hospital

- Required by Care Management Act
- First option for all patients is to go home if possible
  - What services and resources are needed if the patient goes home
- Every post acute dollar spent can financially impact the hospital (Insurance model)
- Discharge planners must provide only what is necessary
- Discharge planners can no longer assume patients are unwilling to pay; many services are capped

The Discharge Planners New Role: Adopt a Home-First Mentality

The Discharge with Dignity Model

	LTACH	Acute Rehab	SNF	Home Health	Home Care	Assisted Living	Transit-ional Care Visit	Chronic Care Man.	Hospice Palliative
Degree of Financial and Quality Penalty to Discharging Hospital	**Severe**	**Severe**	**Moderate**	**Nominal**	**None**	**None**	**Negligible (its less than 10% of the cost of home health – and it covers 30 of 60 days)**	**Negligible**	**None NA**
Discharge Level	**A**	**A**	**LR**	**NR**	**FO**	**FOADH**	**AHD**	**ADWCD**	**NA**
Patient Financial Responsibility	**Varies**	**Varies**	**20% after 20 days**	**Nominal**	**$**	**$$**	**Nominal**	**Nominal**	**NA**

A – Avoid,
LR – Last Resort (if patient is unsafe to go home with resources)
FO – First Option and consideration for all patients
NR – Only if the patient has No Resources to pay for Home Care,
AHD – Order for All Home Discharges
ADWCD – Order for All Discharges with Chronic Diseases
FOAHD – First Option After Discharge Home; Assisted Living can cause delays in hospital discharge; engage AL before discharge

My Legacy: *Going Purple for My Mom*

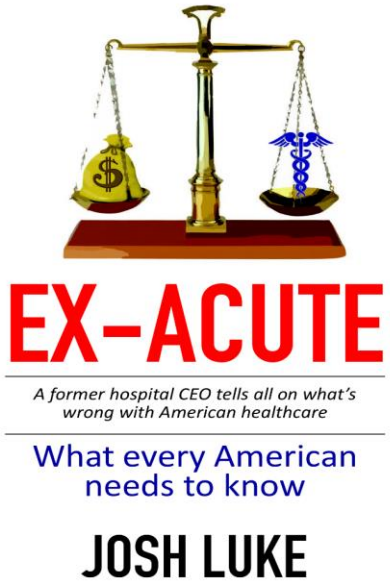
Raising $20,000 in 2016 to Fight Alzheimer's Disease!

Values

- *Passion*
- *Empathy*
- *Fight*
- *Use your gifts*
- *Legacy*

Thank you!

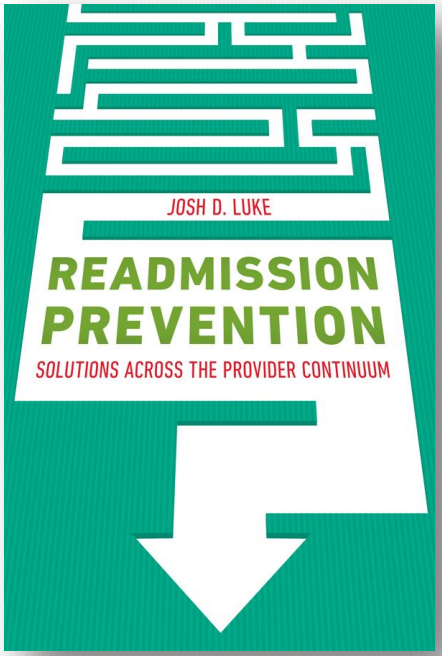
Contact me: lukej@usc.edu



Available at Amazon.com

May 2016

www.JoshLuke.org



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