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Survival Strategies in a Future of Accountable Care Organizations and Medicare Bundled Post-Acute Payments

Presentation by:
Scott Plumb, Senior Vice President
Massachusetts Senior Care Association

What is the Problem with the Current System?

What Are the New Models of Care?

- Accountable Care Organizations
- Bundled Payment Pilots
- Patient Centered Medical Homes

What is the Role of SNFs in the New World of ACOs?

- Threat or Opportunity?
  - It all depends on your point of view: organizational structure, access to capital, geographic coverage and extent of diversification.

Reducing Hospitalizations

- STARR
- INTERACT

Policy Issues with ACOs and Bundled Payment Pilots

- Information Technology
- Regulatory Hurdles
- Workforce Challenges

The Five Major Challenges Facing Nursing Facility Providers

- Protecting and preserving quality nursing home care
- Maintaining Financial Viability
- Handling sophisticated patient classification and payment systems
- Preparing for the new world of ACOs
- Facing our manpower challenges

Current and Future Strategic Directions

The Case for Payment and Delivery Reform

The Problem:

- Fragmented Care
- Uneven, Unsafe Practices
- Unsustainable Costs

"Our fee-for-service system, doling out separate payments for everything and everyone involved in a patient's care, has all the wrong incentives: it rewards doing more over doing right, it increases paperwork and duplication of efforts, and it discourages clinicians from working together for the best possible results."

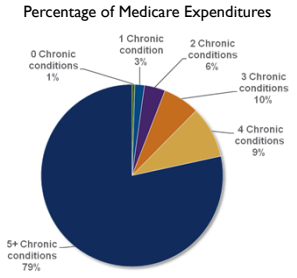
-- Atul Gawande, MD, "Testing, Testing," The New Yorker, 12/14/09

Source: Doug Hastings, "Constructing Accountable Care Organizations: Observations at the Nexus of Policy, Business and Law", Health Insights, 10/14/2010

5

Two-Thirds of Medicare Spending Is for People With Five or More Chronic Conditions

- Ninety-nine percent of Medicare expenditures are for beneficiaries with at least one chronic condition.
- Ninety-eight percent of Medicare expenditures involve individuals with multiple chronic conditions.



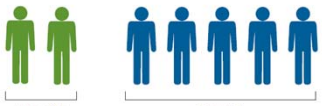
Source: Medicare Standard Analytic File, 2007, RWJ Foundation

10

Coordination of Care

Medicare patients see a multitude of physicians.

Chart 1: Average Number of Physicians Medicare Beneficiaries Visit Annually



Source: Pham, H, Schrag, D., et al. (2007). Care Patterns in Medicare and Their Implications for Pay for Performance. *The New England Journal of Medicine*, 356: 1130-1139.

A study of Medicare claims from 2000-2002 found that each year the typical Medicare beneficiary saw a median of two primary care physicians and five specialists, collectively working in four different practice settings.

Source: AHA TrendWatch, Clinical Integration – The Key to Real Reform, February 2010

11

Reform Payment Models

Multiple Providers	ACO	Primary Care Team	PCMH	Aligning Risks and Rewards	Bundled Payments

- Aligning payments with outcome and resource utilization
- Joint contracting across provider settings
- Team approach to care coordination
- Paying for value and sharing savings

" To end the current fragmentation, waste and complexity, physicians and other care providers should be rewarded, through financial and nonfinancial incentives, to band together into traditional or virtual organizations that can provide the support they need to practice 21st century health care."The Commonwealth Fund, "A High Performance Health System for the United States" (November 2007)

12

Aligning Incentives with Coordination

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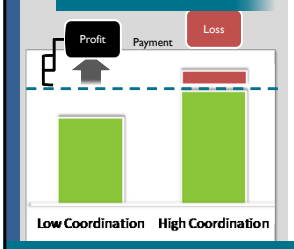
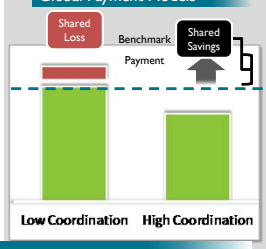
Fee-for-Service Model



Global Payment Models



Coordination does not pay in a FFS model

What is an ACO?

MASSACHUSETTS SENIOR CARE ASSOCIATION

An ACO is a group of "**providers of services and suppliers**" who agree to become accountable for the coordination and care of a patient population.

Accountability for a population of Medicare beneficiaries

Improve coordination of fee for service items and services

CMS

Encourage investment in infrastructure and care processes to ensure high quality and efficient care

Incentivize high quality care

14

Clinical Integration and Accountable Care

MASSACHUSETTS SENIOR CARE ASSOCIATION

A Stepwise Approach to Accountable Care Organizations

"An ACO assumes responsibility for improving healthcare quality and slowing the growth of healthcare costs. Assuming accountability may or may not involve the assumption of financial risk for organizational participants."
~American Hospital Association

Clinical Integration is "the extent to which patient care services are coordinated across people, functions, activities, processes, and operating units so as to maximize the value of services delivered." ~Stephen M. Shortell

15

Elements of the ACO Model

Local Accountability & Clinical Integration

- Can foster provider accountability for the cost and quality of care delivered to the patient population
- Providers come together in "real" or "virtual" networks capable of managing and providing the full continuum of patient care

Shared Savings

- Concept underlying the Medicare PGP Demonstration success
- Rewards increased value rather than volume/intensity by sharing savings
- Encourages collaboration and shared responsibility amongst providers

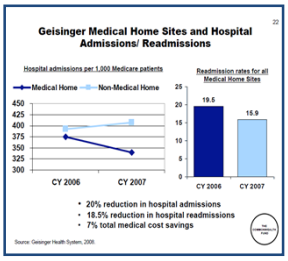
Performance Measurement

- Increased accountability from providers requires greater transparency and measurement
- Provides increased information to consumers
- Ensures cost savings are not resulting from withholding appropriate care

Patient-Centered Medical Homes

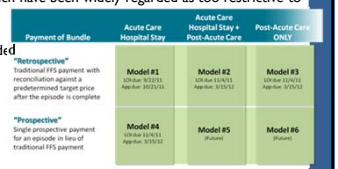
The patient-centered medical home (PCMH) is a **way of organizing primary care** so that patients receive care that is coordinated by a primary care physician (PCP), supported by information technologies for self-care management, delivered by a multi-disciplinary team of allied health professionals and adherent to evidence-based practice guidelines. The **goal of the PCMH is to deliver continuous, accessible, high-quality, patient-oriented primary care.**

Source: Medical Home 2.0: *The Present, the Future, Deloitte Center for Health Solutions.*



Bundled Payments for Care Improvement Initiative

- ACA Initiative to Lower Costs, Help Doctors and Hospitals Coordinate Care
- Align payments for services delivered across an episode of care, such as heart bypass or hip replacement, etc.
- Organizations interested must submit a Letter of Intent (LOI) no later than September 22, 2011 for Model 1 and November 4, 2011 for Models 2, 3, and 4
- Unlike the ACO regulations which have been widely regarded as too restrictive to support participation, the guidelines (which were not as regulations, but instead included in the "Request for Application) are very broad and allow considerable flexibility to the proposing organizations.



http://innovations.cms.gov/areas-of-focus/patient-care-models/bundled-payments-for-care-improvement.html

ACOs and Bundled Payment Models: The Differences

	ACO	Bundled Payment Model
Emphasis	Organizational structure reform – voluntary	Payment Reform – voluntary: HHS can make mandatory if successful
Time Focus	Measures savings and quality over 3 year period	Limited episode of care such as days as acute care patient plus a period of post-acute care
Structure	Required to be separate legal entities. Large healthcare systems subcontracting with other providers	Less prescriptive. Existing organization or network of organizations.
Services	Broad. Primary, acute, preventive, and post-acute. Medicare A & B. Minimum of 5,000 participants. Pioneer ACO = 15,000 participants.	More limited. Successful applicant can choose the diagnostic category and length of the episode of care (e.g. one month post-acute cardiac rehab.)

19

ACOs and Bundled Payment Models: The Differences

	ACO	Bundled Payment Model
Eligible Participants	Physicians in group practice arrangements, networks of individual practitioners, hospital with physician networks	Physician group practice, acute care hospital, health systems, physician-hospital organization, post-acute provider including SNFs, LTCHs, IRFs, home health agencies
Treatment of Shared Savings	Shared savings (and losses) between the ACO and the Medicare program.	Retrospective or Prospective – 6 models. -Target Price for episode = discount from FFS - Interim FFS payments -Reconciliation and shared savings with applicant and contractors
Timing	Rolling basis: 2012, 2013, 2014 MA – 5, NH -1. (Pioneer ACO)	LOIs already due. Applications by March, 2012
Role of SNFs	Incentive payment models (reduction in hospitalization rates, quality metrics, etc.	Applicants? Partners with equity interest. Subcontractors: FFS initially but shared savings possibilities.

20

Hospital Readmission Rates

- Frequent
  - 17.6% of all Medicare hospitalizations are day *rehospitalizations*
- Costly
  - $12B in Medicare spending; est. $25B payers annually
- Actionable for improvement
  - 76% potentially avoidable
  - Heart Failure, Pneumonia, COPD, lead the medical conditions
  - CABG, PTCA, other vascular procedures lead the surgical conditions
- Performance highly variable
  - Medicare 30-day rehospitalization rate varies 13-24% across states
  - ***Variation greater intra-state***

Source: MedPAC Report to Congress, Promoting Greater Efficiency in Medicare. June 2007
Mark Taylor, The Billion Dollar U-Turn, *Hospitals and Health Networks*, May 2008
Commonwealth Fund State Scorecard on Health System Performance. June 2009

21

Improving Geriatric Care by Reducing Potentially Avoidable Hospitalizations

How Much Can Be Saved to Reinvest in Quality?

Assume:

- Among 1.5 million NH residents in the U.S., ~1/3 will be hospitalized in one year
  = 450,000 hospitalizations
- The cost of each hospitalization is ~ $6,500 for a hospital DRG payment, plus a 30 day SNF stay for 1/3 of those hospitalized at $350/day
  = $10,000 per hospitalization

Total cost: $ 4.5 billion

Source: Joseph G. Ouslander, MD, Florida Atlantic University

22

Improving Geriatric Care by Reducing Potentially Avoidable Hospitalizations

INTERACT
Interventions to Reduce Acute Care Transfers

A Toolkit to Improve Nursing Home Care by Reducing Avoidable Acute Care Transfers and Hospitalizations

Developed based on interviews and ratings of avoidability, and Expert Panel ratings of importance and feasibility

- Care Paths
- Communication Tools
- Advance Care Planning Tools

23

State Action on Avoidable Rehospitalizations (STAAR Initiative)

Purpose
- Demonstrate improved quality, patient experience, and reduced avoidable utilization through a multi-stakeholder initiative to reduce rehospitalizations.

Methods
- Engage state-level leadership and state-wide action to improve communication and coordination with patients and between providers at times of transitions.

Aims
- Improve patient/family satisfaction with care transitions.
- Reduce all-cause 30-day rehospitalization rates by 30 percent.

Settings
- Massachusetts, Michigan, Washington.

THE COMMONWEALTH FUND

INSTITUTE FOR HEALTHCARE IMPROVEMENT

24

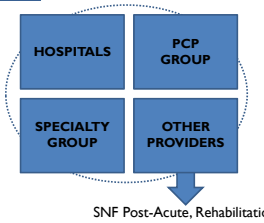
Initiatives in Massachusetts

Policy Issues

- IT Development
  - Investment in expertise, resources
- Legislative/Regulatory Opportunities
  - ✓ Elimination of Medicare 3-day stay
  - ✓ SNF Post-Acute, Rehabilitation, Hospital Prevention Services Unit
- Workforce Development
- Active Engagement in Process

What is the Role of SNFs in the New World of ACOs?

Illustrative ACO



SNF Post-Acute, Rehabilitation, Hospital Prevention Services:
- Orthopedic Rehabilitation
- Cardiac Care and Rehabilitation
- Pulmonary Care and Rehabilitation
- Diabetes Care
- Hypertension

Value- Based Opportunities

Long Term Nursing Facility Custodial 24-hour Care and End of Life

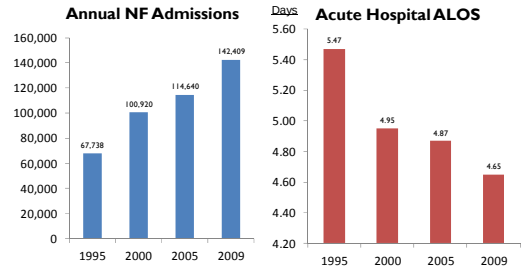
Nursing Facilities Offer the System Savings

Nursing facility short-term rehabilitation services can save the health care system significant dollars in four areas:

1. Decreasing hospital length of stay
2. Decreasing the percentage of hospital readmissions
3. Returning patients safely to the community
4. Serving as a high quality, low cost alternative for the treatment of certain medical conditions

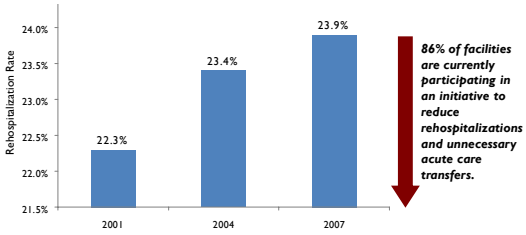
Decreasing Hospital Length of Stay

During the period 1995 – 2009, NF admissions skyrocket as facilities increasingly provide short term rehab care to allow acute hospital patients to more quickly return home.



Source: DHCFP Nursing Facility Cost Reports and Hospital Discharge Reports

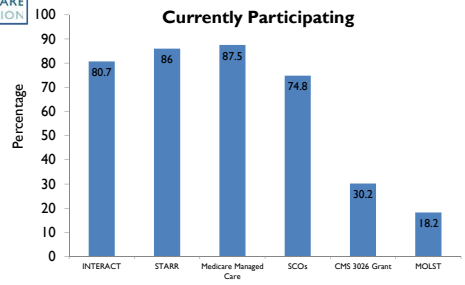
Working to Decrease Rehospitalizations



86% of facilities are currently participating in an initiative to reduce rehospitalizations and unnecessary acute care transfers.

Source: American Health Care Association, based on CMS Nursing Facility Data
Mass Senior Care Member Survey, October 2011

Nursing Facility Rehospitalization Reduction Initiatives



Source: Mass Senior Member Survey, October 2011

Returning Patients Safely to the Community

Each year more than 100,000 patients are admitted from a hospital to a skilled nursing facility for short-term rehabilitation services following an acute illness or surgery and nearly 60% return safely home within a few weeks with the necessary coordinated support services.

Discharging hundreds of patients a day, nursing facility staff provide high quality, safe and successful patient care transitions by effectively coordinating care across the continuum.

High Quality, Low Cost Alternative

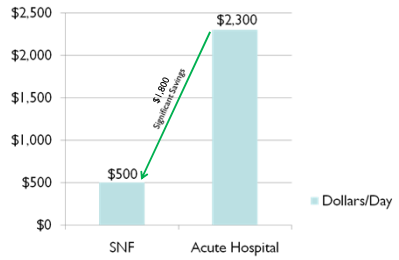
Ambulatory-Care Sensitive Admissions

- UTI
- Dehydration
- Pneumonia
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive heart failure (CHF)
- Diabetes: long-term and short-term complications and uncontrolled
- Hypertension

Source: Milliman Research Report, Ambulatory-Care Sensitive Admission Rates: A Key Metric in Evaluating Health Plan Medical-Management Effectiveness, January 2009)

Low Cost, High Quality Alternative to Acute Care

Massachusetts SNF Medicare Payment Per Day vs. Acute Hospital Cost Per Day



Source: (1) Nursing home cost reports and (2) Kaiser Family Foundation State Health Facts

MSCA's Legislative Proposals

- SNFs may participate in ACOs
- Equity of Payment
- Elimination of Medicare 3-day rule
- Patient Transfer
- EHR Grants

The Five Major Challenges for Nursing Facility Providers

Protecting and Preserving Quality Nursing Home Care

- Outcomes Are King
- Patient Satisfaction Rules
- Surveys Are Necessary Evil

37

Maintaining Financial Viability

- Closing the Medicaid Funding Gap: $30/day
- Managing Medicare, Both Fee-For-Service and Managed Care
- Attracting Private Resources

38

Handling Sophisticated Patient Classification and Payment Systems

- MDS 3.0
- RUG-IV
- P4P

39

Preparing for the New World of ACOs

- Proving Our Worth
- Taking Control of the Patient
- Horizontal and Vertical Integration

40

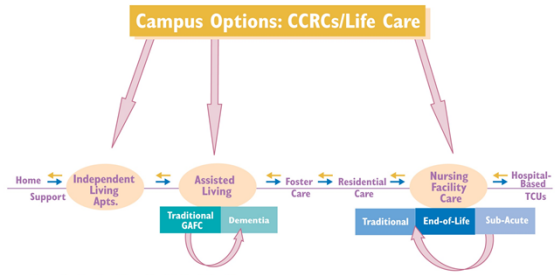
Facing Our Manpower Challenges

- "Growing" Our Own
- Maintaining Competitive Wages and Benefits
- Reducing Turnover

41

Current and Future Strategic Directions

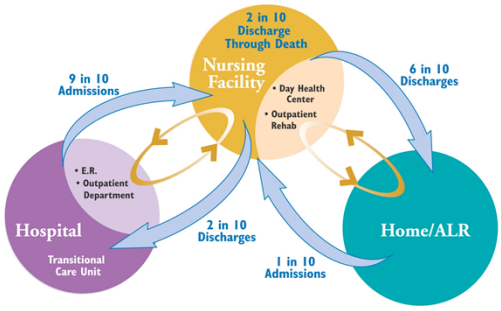
The Long-Term Care Continuum:



- From the Residential to the Medical Model
- Increasing Acuity and Intensity of Nursing/Medical Services
- Increasing Level of Regulation & Oversight
- Interdependence and Movement in both Directions

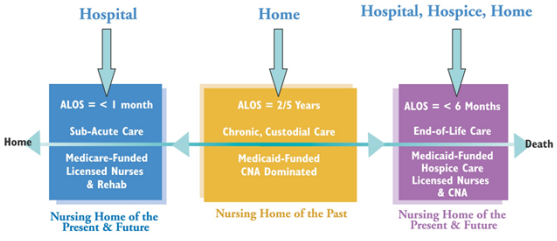
43

The Hospital, Nursing Facility, Home Connection



44

The Changing Nature of Nursing Facility Care:
Out to the Ends and Away From the Middle



45