Financial Managers:
Strike the Right Balance

Strategic Long-Term Partnerships

Versus

Financial Stability

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Leading Age New York     I         August 2016

Learning Objectives

• To understand how to – in light of recent industry changes -- evaluate opportunity, assess risk, and successfully align with rigorous requirements of value-based programs -- while still also remaining financially viable.

• To examine important key drivers of success including care redesign, interdisciplinary coordination, project management, clinical programming, outcome tracking, strategic decision-making, etc.

• Case studies to illustrate how critical performance measures (such as ALOS, hospital readmission rate, census, etc.) have a remarkable impact on the financial bottom line.
When did healthcare become like NASCAR?

The Statistics
Tell the Story of Post-Acute Reform

HISTORICALLY:
52% of ACOs in MSSP did not keep costs below benchmarks in the first performance year

TODAY:
1 in 10 Medicare FFS beneficiaries are attributed to an ACO

By 2018:
50% of all payments will be via VBP program;
90% of FFS MCA $ linked to quality or value

Post-acute services accounts for ~73% of regional variations in cost /beneficiary

Healthcare Reform: “A Brave New World”

- Expansion of voluntary & mandatory programs
- Who will ultimately control $$$
- How / when to terminate FFS?
- Regional bundle pricing
- Adjustments based on risk, acuity
- Define/share outcomes

CMS

Healthcare Reform: Striking a Financial Balance

- Alternative Payment Model: 35%
- Fee For Service: 32%
- MA: 33%
“So, what’s new?”

Critical Healthcare Reform Updates

- BPCI and newly proposed EPMs
- Mandatory bundle expansions
  - hip and femur fractures add to current CJR
- Final rule 2017 and 2018
- New and expanding Quality Measures
- MDS changes and clarifications
- APMs
- MACRA and MIPS
- Advancements in the Impact Act
- Expanding risk arrangements
- Narrowing networks

New Mandatory Cardiac Bundles

- Include patients treated for AMI (MS-DRGs 280-282; MS-DRGs 246-251) and undergoing CABG (MS-DRGs 231-236).
- Launch in July 2017 in 98 MSAs randomly selected; comments accepted thru September 23.
- Emphasis on Cardiac Rehab Services and test impact of incentive payments ($25 for first 11 services; subsequent services reimbursed at $175)
- Hospitals incentivized to choose “preferred SNF providers” based on:
  - Hospital readmissions reduction initiatives;
  - Sophisticated discharge planning;
  - Strategies to improve patient adherence to cardiac rehab;
  - Star Ratings;
  - Qualitative measures (e.g.: willingness to collaborate, ease of communicating, transparency in sharing performance data, etc.)
SNF Final Rule 2017

• SNF aggregate payments will increase by 2.4%, or $920M

• Additional Quality Measures adopted:
  • Three claims-based measures
    • Discharges to community
    • Medicare spending per beneficiary
    • Preventable 30-day post-discharge readmission measure
  • One assessment-based measure
    • Medication reconciliation

Note: Any SNF that fails to submit required quality data to be subject to 2% point reduction in FY 2108 annual market basket adjustment

• SNF Value Based Purchasing Program beginning in FY 2019
  Note: the baseline year for data collection is October 1- December 31, 2016

Quality Measures

Potentially Preventable Readmission Measure (PPRM)
  • All-cause readmission rate to SNF 30-day
  • Baseline year 2015; performance period 2016; rates affected 2019
  • Risk-adjusted using full year of data & funded by a 2% withhold
  • To use improvement versus attainment awards

Medicare Spending per Beneficiary Measure (MSPB)
  • Utilizes calculation similar to Model 3 bundling
  • Episode starts day of SNF admission
  • Includes all treatment services, all Part B and DME through discharge date from SNF
  • Includes inpatient, outpatient, post acute, Part B, DME, hospice through 30 days post discharge
### Common Network RFI Inquiries

- Dedicated bed numbers and specialty services offered?
- Advanced clinical capabilities profile
- Medical and APRN coverage / Employed or contracted? / Use of telemedicine?
- Vendor status for ancillary services / Timeliness?
- Rehab Services: Coverage? / Service model?
- Current partners in provision of care across the continuum / Quality of home health, hospice, etc.
- Internal and external care transitions process
- Integration of EMR / Data collection procedures?
- Is there a key contact person for care coordination?
- Episodic cost

### What is Your Total Quality Score?

**Ready for RISK**

- Five Star Rating (Quality Measures)
- All-cause readmission rate and formula
- 90 day statistics: readmissions & episodic costs
- Functional outcomes measures
- Patient experience scores
- Episodic cost total and by diagnosis
- Cost per resident per diagnosis
The Five Star Rating

Clinical Programs

Quality Measures
• Short Term
• Long Term
• New Measures

5 Star Rating
• Staffing
• Quality Measures
• Health Inspection

Documentation

Have you looked?
Six New QMs on Nursing Home Compare

Since April 2016, CMS reporting on the percentage of short-stay residents who:
• Were successfully discharged to community (claims-based)
• Had an outpatient emergency department visit (claims-based)
• Were re-hospitalized after a nursing home admission (claims-based)
• Made improvements in function (MDS-based)

Also, on the percentage of long-term stay residents who:
• Ability to move independently worsened (MDS-based)
• Received an antianxiety or hypnotic medication (MDS-based)

As of July 2016, five measures now factor into the calculation of Five-Star Quality Rating QM ratings at 50%.
Antianxiety/hypnotic medication measure will not be used in Five-Star due to concerns about its specificity and appropriate thresholds for star ratings.
Know Where You Stand…

Final Rank Among SNFs  
11 out of 13  
265 of Max Score 300  
53.85%

<table>
<thead>
<tr>
<th>Measure</th>
<th>ABC Facility</th>
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</thead>
<tbody>
<tr>
<td>Patient Volume (2014)</td>
<td>12</td>
</tr>
<tr>
<td>Rehospitalization Rate (2014)</td>
<td>1.5%</td>
</tr>
<tr>
<td>Average Length of Stay (2014)</td>
<td>31.65 days</td>
</tr>
<tr>
<td>Nursing Home Compare Measures (May 2014)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Network Average</td>
</tr>
<tr>
<td>Health Inspections Star Rating</td>
<td>5 stars</td>
</tr>
<tr>
<td>Nurse staffing star rating</td>
<td>3 stars</td>
</tr>
<tr>
<td>Clinical Team Rating</td>
<td>4 stars</td>
</tr>
<tr>
<td>Average LOS by payer</td>
<td>5 stars</td>
</tr>
</tbody>
</table>

Your Rating

“What do you need?”

Outcomes!

Outcome measures
- Re-hospitalization rates by diagnosis;
- Percent of patients discharged home; with home care/OP referrals

Organizational capability measures
- Clinical Capabilities profile
- Care coordination measures
- Patient engagement measures

Efficiency measures
- Average response time to referrals
- Average LOS by payer/program/diagnosis

Performance Measures
- Therapy intensity (minutes/week)
- Functional Status Changes (*CARE Tool)/LOS
- Cost/episode by diagnostic group

Internal Scorecards
- Quality Measures- sepsis/UTI, falls, cognition, etc.
- 5-Star Ratings- listed by criteria
- Control group/peer benchmarking/hospital & national standards
Financial Risk: Critical Areas Defined

- Demands of networks, hospitals and payers
  - Earning your seat at the table
  - Cost of meeting the “preferred network” demands
- Balance of occupancy and lower LOS demands
  - Clinical support of LOS and variations
  - Impact of outliers
- Re-hospitalization mitigation
  - Realistic, competitive but stretch goals
  - Engage / align incentives with physicians
  - Internal accountability and non-biased root cause analysis
- Payer mix
  - Balance of variations and churn
  - Cost containment strategies and process efficiencies
  - Shared savings or steerage- might not be able to have both
- Vendor relationships impacts and expectations

Project Management:
Create Two Work Groups &
Designate a Project Manager (potentially a Finance Officer?)

Clinical Work Group to:
- Develop risk & acuity tools;
- Identify & track QMs / outcomes;
- Trend critical scorecard metrics;
- Develop root cause analyses;
- Hold departments accountable to implement plans /gather outcomes
- Include internal & partner experts.

Financial Work Group to:
- Apply financial oversight;
- Create data models;
- Verify metrics;
- Review contracts;
- Identify opportunities for growth / cost-savings.

--- Transition to next level of care; not PLOF
-- Select performance criteria, preferred partners
-- Create/share pathways

-- QAPI joint task force
-- Maximize PAC network collaboration
Key Drivers that Impact Success

- Staff education/“buy in”
- Interdisciplinary involvement
- Transparency & data sharing
- Accountability to outcomes
- Willingness to modify plan

Roadblocks exist, but avoid or mitigate these pitfalls with a strategic, innovative approach

- Staff resistance to change
- Lack of MD involvement
- Incomplete or partial plan
- Unrealistic timelines

Case Study #1

Holy Family Manor (Bethlehem, PA)

- 208 dually certified beds
  - Short term: 60 beds,
  - Assisted living: 52 beds
  - Independent living: 115 units
- June 2015: Change from primary LTC to STR focus
- Marketplace: Highly competitive; two large hospital networks; significant managed care penetration
- Strategic Plan: Prioritize care redesign for post acute population
- Project Management via: CEO/CFO
- August 2015: Implemented clinical pathway interdisciplinary taskforce

Holy Family Manor is now:
The #1 provider-of-choice for St. Luke’s Bethlehem (BPCI, Model 2)
- The #2 state-ranked provider for Highmark Managed Care
Case Study #1

Key Elements of Redesign

Review of current systems:
- MD credentialing
- Hospital affiliations
- MD expectations/guidelines for post acute care patient visits, documentation, etc.

Revisions of interdisciplinary process:
- Focus/timelines to ID high risk areas
- BOOST risk assessment form - The Eight P’s
- Early care planning, (e.g.: 72 hr patient/caregiver meetings upon admission & DC)
- Weekly patient risk reviews

Seven multidisciplinary pathways developed by taskforce:
- In collaboration with Remedy Partners & St. Luke’s Bethlehem
- COPD, CHF, Sepsis, Diabetes, pneumonia, THA, TKA, Pain

Communication with HH
- Updates, barriers, transitions back to SNF vs. back to acute care
- Completed selection of internal preferred network
- Performance outcomes reviewed

Case Study #1

Redesign Outcomes

Significant performance improvements:
Readmission rates as well as overall LOS
Case Study #2
The Result: “Preferred Provider” Status

Van Dyk Manor
- Chosen as a “Preferred Provider” in ACO & BPCI networks
- Impact on census and workloads

Case Study #3
Financial Implications for Reducing ALOS

By reducing ALOS, Happy Valley Nursing Home* to lose + $1.1 million (annualized revenue) without a mitigation strategy.
(Note: HVNH has~368 annual admissions)

Historical ALOS = 23.42 days
(8,619 days / year)

New, Improved Reduced ALOS = 17.53 days
(only 6,451 days / year)

* Name changed to maintain privacy
Case Study #2: Financial Implications for Reducing ALOS

Only by increasing census 30%, HVNH to backfill financial shortcoming due to ALOS reduction

<table>
<thead>
<tr>
<th>368 Historical Admissions with 23.42 ALOS</th>
<th>368 Historical Admissions with 17.53 ALOS</th>
<th>430 Projected Admissions with 17.53 ALOS</th>
<th>Additional 62 Admissions to make up for ALOS decrease to 17.53</th>
</tr>
</thead>
<tbody>
<tr>
<td>$4,528,000 annualized revenue</td>
<td>$3,387,000 annualized revenue</td>
<td>$3,957,000 annualized revenue</td>
<td>$4,528,000 annualized revenue</td>
</tr>
</tbody>
</table>

Case Study #3: Financial Implications for Reducing Readmissions Rates

Facility Profile:
- 125-bed SNF in Connecticut that admits ~476 STR residents annually
- Under new ownership, challenged by previous reputation
- Implementing new clinical programs & protocols
- Goals: (1) to be included in regional “Preferred Provider” network; (2) to mitigate loss in revenue due to unnecessary readmissions

In 2015:
- 94 residents returned to hospital (20% readmissions rate)
  - ALOS of residents readmitted: **10.5 days**
- 382 residents NOT returned to hospital
  - The ALOS of residents not readmitted: **15.2 days**

Lost days/revenue: 4.7 days @ $600/day (*94 residents) = **$265,080 annual loss**
Case Study #3: Financial Implications for Reducing Readmissions Rates

**In 2016:**
- Facility is on tract to reduce the readmit rate from 20% to 10%
  - Projection: only 47 residents to return to hospital

Lost days/revenue: 4.7 days @ $600/day (*47 residents) =
only $132,540 projected annual loss

- Plan is to leverage this change in readmission rate with referral sources, sharing details related to new interventions, programs, resources

Implications of Shift in Payer Sources

- Enhanced communication especially with Case Managers
- Tighter Billing, auditing, reconciliation procedures
- Focus on Cost Containment
- Declining Revenue
- Change!
Lost Revenue: 
Due to Payer Shift Mix

Two year financial impact is $905K based on the payer mix.

Financial Challenge: 
Inadequate, Unrealistic Volumes

A recent study by CMS revealed:

Many Medicare patients could and perhaps should be placed in a lower cost setting

In fact, ~20% of current SNF patients could and perhaps should being managed via home health or outpatient services.
The 90-Day Landscape

30 day
- Hospital Stay
  - Care transition
- 30 day rehospitalization penalty risk
- PAC inpatient stay – if applicable
  - Care transition
- Initiation of Home health services
- Hospital satisfaction process
- PAC follow up calls 48-72 hours post discharge
- Follow up MD visit

60 day
- Completion of the home health episode
  - Care transition
- Possible follow up outpatient therapy services
  - Care transition
- Initiation of community services- if applicable
- Risk for readmission continues
  - Risk for SNF readmission penalty??

90 day
- Risk for readmission continues
- Follow up MD appointments?
- Community services?
- Case management follow up?

Who is accountable for patient Follow-ups during this time?

Expectations for Vendor Partnerships
Expectations for Downstream Partners

- 1. Customer Experience
  - Nurse liaison contact with patient/caregiver pre-discharge
  - Coordination of care plan based on risk
  - Follow-up satisfaction survey post-discharge

- 2. Improve Population Health
  - Review of health literacy materials
  - Joint completion of discharge packet contents
  - Use of telehealth or house calls program for post-discharge

- 3. Reduce Expense
  - Start of care for nursing and therapy with 24-48 hours
  - Weekly sharing of updates and planned discharges
  - Notify SNF of readmission within 24 hours
  - Share monthly scorecards with performance metric trending

Expected coordination of care with downstream providers

Expectations must be well-defined

Case Study #5
Community Transitional Care Model

Van Dyk Healthcare identified a unique niche opportunity to better serve post acute patients by partnering with Valley Home Care (a non-affiliated home health agency)

- **Strategic Plan:**
  - Best meet patients’ needs as they transition thru post acute continuum
  - To create focused care transitions, clinical pathways and joint outcome measures

- **Therapists follow patient from SNF to community based HH resulting in:**
  - Improved transitional communication
  - Reduced redundancy of services
  - Improved efficiency of start of service delivery in all settings
  - Improved patient / caregiver satisfaction
  - Created continuity of patient care / preserved functional gains
  - Completed pre-discharge assessment in hospital or SNF before return to home
Case Study #6
Financial Implications “On the Sidelines”

Metro New York PAC community remained on the sidelines during a critical time when relationships/collaborations were taking shape.
On the Healthcare Reform Horizon:
Future Considerations

- The impact of the new Quality Measures will be significant;
- Network narrowing will continue;
- The benchmarks become more competitive, and only organizations with experience / systems in place will make the cut; other PAC communities will be challenged and may not endure the evolution;
- Implementation of CARETool across PAC settings;
- Programs will include multiple payers;
- LTC patients will also be included in ACOs & VBPs;
- 2017 Proposed Rule adds more focus to cardiac domain;
- The fun will continue…………..

For those who survive:
The Good News !

There will be a significant population enhancements for those that navigate the current changing environment !
In Summary:
Pursue Meaningful Collaborations & Choose Strategic Partners

Contact HealthPRO® with questions/feedback or to learn about therapy management and/or consultative services:

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