FR18- Coming Soon to Your Town: Post-Acute Networks and APMs

Friday, March 23
1:30 PM- 3:00 PM

Session Description
This session will discuss the importance of Post-Acute Network formation, the processes involved in selection and maintenance and the impact it will have on post-acute care providers. The importance of networks to the value-based payment (VBP) concept will be reviewed, along with suggestions as to how to assist with positioning your facilities for participation. An integral part of these changes will be advanced alternative practice models (Advanced APMs), which are designed to move clinicians away from fee-for-service to value-based payment. Advanced APMs are APMs where providers must bear more than “nominal financial risk” for monetary losses and ensure quality, in addition to other criteria. Currently there are no specific PA/LTC APMs, but there are some that will involve these settings. There is a significant opportunity for the Society to not only participate effectively in pertinent APMs, but more importantly to create new models specific for the populations we serve.

Learning Objectives
Discuss Why Post-Acute Networks are being formed, and how participating Facilities are chosen.
Compare the merits of MIPS and Advanced APMs.
Review current Advanced APMs that include PA/LTC care sites.
Describe the potential advantages of a PA/LTC specific Advanced APMs.

Presenter(s): Charles Crecelius, MD, PhD, CMD; Kerry Weiner, MD, MPH; Robert Reynolds, MD; Rajeev Kumar, MD, CMD

Presenter(s) Disclosures: All speakers have reported they have no relevant financial relationships to disclose.
Learning Objectives
By the end of the session, participants will be able to:

• Discuss Why Post-Acute Networks are being formed, and how participating Facilities are chosen
• Compare the merits of MIPS and Advanced APMs
• Review current Advanced APMs that include PA/LTC care sites
• Describe the potential advantages of a PA/LTC specific Advanced APMs

Post Acute Networking

National Focus on Post Acute Networking

From MEDPAC meeting September 2017:

• "A MedPAC study looked at whether beneficiaries discharged had access to a better-quality PAC provider, and most did, particularly in urban areas. Medicare could expand efforts to encourage higher-quality PAC use that would benefit patients and the program by requiring the use of quality measures in the discharge planning process. Specifically, by allowing hospitals to recommend PAC providers, require discharge planners to use quality measures of PAC providers in the development of the discharge plan, and require hospitals to provide beneficiaries seeking a PAC provider with quality data.”

Translation: Networks

• Develop committed working relationships with higher performing partners
• Optimize patient management within Episode of Care
• Impact Value Based Purchasing goals:
  Best Outcomes at Lowest Cost
• Improve communications and continuum planning
• Develop improved transitional communication protocols
• Improve avoidable readmission rates
### Who Forms (or will be forming) Networks?
- Acute Care Hospitals
- Payers
- Conveners
- Clinician Practice Groups
- SNFs
- HHAs
- Any Risk Bearing Entity or Combinations of Entities

### How? Post Acute Network Implementation: One Approach to Creating SNF Networks
**Joint Effort between:**
- Acute Health System
- BPCI Convener
- Clinician Practice Group

### How? Post Acute Network Implementation: One Approach to Creating SNF Networks
- Detailed review of 3 years Market SNF claims data by Bundle
- "Town Hall" meeting of all Market Post Acute entities, explaining the concept and presentation of their historical performance data
- Field visits to market SNFs, focusing on:
  - Commitment to quality, cost, availability, communications
  - Issues impacting STAR Ratings, and plans for improvement

### How? Evaluate SNF Performance – Data Driven
- Length of Stay
- Readmissions
- Cost per Episode
- Medicare Star Rating
- "Partnership Rating"

### How? Evaluate SNF Performance – Data Driven
**Tour/Survey of top Performers:**
- Strengths/Weaknesses?
- Utilization of Expected LOS Guidelines?
- Root Cause Analysis of Readmissions?
- Use of Discharge Protocols?
- Staff Turnover Rate?
- Communication Protocols/Information Sharing with Upstream/Downstream Partners?
- Bed Availability?
- Involvement of Facility Medical Director?

### How? Implementation
- Choose and Publish the Performance Network
- Quarterly Partner/Network data driven meetings
- Annual re-evaluation of all Market entity performance and possible revision of Network
  - Town Hall Presentation of performance data
  - Revision of the published Performance Network
How? Evaluate SNF Performance – Medical Director Impact*

• Length of Stay*
• Readmissions*
• Cost per Episode*
• Medicare Star Rating*

Tour/Survey of top Performers:
Strengths/Weaknesses?
Utilization of Expected LOS Guidelines?
Root Cause Analysis of Readmissions?
Use of Discharge Protocols?
Staff Turnover Rate? +/-
Communication Protocols/Information Sharing with Upstream/Downstream Partners?
Bed Availability? +/-


Post Acute Networks are Only the Tip of the…

Guide to Successful MACRAmony

Or
How to Succeed in MACRA Without Really Trying
(To Hard)
Kerry Weiner, M.D., MPH,

MIPS vs Alternative Payment Models

• How are MIPS and APMs evolving for PALTC?
• What are your best options?
• Will there be new PALTC APMs?

Solemn Facts About MIPS 2018

• Base year for +/- 5% adjustment to 2020 Medicare
• Default option for 600,000 physicians
• 2017 MIPS scores will be public including a 5 star rating
• Thresholds remain low but treadmill slated to speed up in 2019
• Medical care cost becomes a factor
Make Sure You Qualify for MIPS

- Do you meet minimum qualifying thresholds?
  - $90k part B charges or 200 beneficiaries
- Are you in an APM?
  - Advanced or MIPS
- Did you enroll in Medicare for the first time in 2018?

MIPS 2018: Palatability Attempts

- Thresholds to avoid penalty remain low.
- Cost factor is small (10%) in scoring.
- “Handicaps” for sicker patients and small PGP.
- Exemption for natural disasters
- Virtual group option for MIPS reporting
- CEHRT Relaxation

MIPS Is In a State of Change

2019-2020

- Flexibility to set MIPS performance thresholds
- Current Quality Score TH 2019: Must be based on 2018 average scores
- Current cost component 2019: Increases from 10% to 30% in score
- 2019 Baseline year: 2021 +/- 7% adjustment to fees
- Limit reimbursement penalties to Part B Provider services

Patient Relationship Categories Testing a New Concept in 2018

- Provider’s role in care of a patient
- Attribute appropriate cost to a provider (resource use)
- 5 HCPCS II Modifiers
- Voluntary participation, will not influence payment or QPP

Participate in MIPS APMs?

MSSP, NGACO, CPC+, ABPCI (Not BPCI), CJR-T1

<table>
<thead>
<tr>
<th>ADVANTAGES</th>
<th>DISADVANTAGES</th>
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<tbody>
<tr>
<td>Low threshold to qualify</td>
<td>Group Score</td>
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<tr>
<td>On participation list/1 claim</td>
<td>Irrelevant QM</td>
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<tr>
<td>Preferential Scoring</td>
<td>No Option out for ACI</td>
</tr>
<tr>
<td>100% IA</td>
<td>Possible payback issues</td>
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<tr>
<td>Use APM Q metric score</td>
<td>NF Patients are high cost</td>
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<tr>
<td>Alleviates individual reporting</td>
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<tr>
<td>No individual reporting on Physician Compare</td>
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<tr>
<td>Limit reimbursement penalties to Part B Provider services</td>
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Participate in Advanced APM?

MSSP 1+, 2, 3, NGACO, ABPCI

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<thead>
<tr>
<th>ADVANTAGES</th>
<th>DISADVANTAGES</th>
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<tr>
<td>5% ↑ Medicare B payments</td>
<td>Group Score; ACI reporting</td>
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<tr>
<td>Excluded from MIPS</td>
<td>High threshold to qualify as QP (25%/$20%B)</td>
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<tr>
<td>AAPMS are also MIPS APMs</td>
<td>Limited models</td>
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<tr>
<td>No individual reporting on Physician Compare</td>
<td>High Cost NH patients</td>
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<tr>
<td>Possible upside gainsharing</td>
<td>Possible downside risk sharing</td>
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<tr>
<th>PCP</th>
<th>Specialist</th>
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<tr>
<td>X1</td>
<td>Continuous care</td>
</tr>
<tr>
<td>X2</td>
<td>Continuous focused</td>
</tr>
<tr>
<td>X3</td>
<td>Episodic broad care</td>
</tr>
<tr>
<td>X4</td>
<td>Episode focused</td>
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<tr>
<td>X5</td>
<td>Care at request of another provider</td>
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If you can, choose…

MIPS
AAPM
MIPS APM

Do ACOs need you?

- High cost of PAC/LTC & Benchmarking/SNF performance/LOS
- Hospice, HCC adjustments

Cost
- Cost Attribution: patients
- Cost Attribution: patients

Quality
- SNF readmissions, admissions
- Fall risk, BMI
- ACI hardship exclusion
- Disease management: cancer screening, tobacco, Htn, DM, HF, depression, vascular disease

Does Advanced BPCI need you?

32 Clinical episodes: 29 Hospital, 3 outpatient anchored. 90 day episodes

Many episodes commonly involve PAC
- Ortho: ULR, LJR, Spine
- UTI
- Cardiac: MI, CHF, CABG
- Stroke
- PN & Lung Infections

QM: 30d readmission, 30d mortality, ACP

Cost: Admissions, LOS

Future CMMI APM for PALTC?

MSSP ACO for LTC (Genesis Model)
- Institutionalized LTC beneficiaries

2024 Unified PAC Pay System APM
- NH, HHA, IRF, LTACH

Physician-Focused Payment Model Technical Advisory Committee (PTAC)

- Comment and recommend to HHS promising proposals submitted by stakeholders.
- 22 Models under consideration
- 3 proposals recommended for limited testing
  - ACS – Brandeis AAPM
  - Project Sonar
  - Oncology Bundle Using CAN- Guided Care
- 3 PAC relevant models deemed “promising”.

PTAC: Three PAC Proposed Models

- Am Academy of Hospice & Palliative Care Medicine
  - Patient and Caregiver Support for Serious Illness (PACSSI).

- Coalition to Transform Advanced Care
  - Advanced Care Model

- Avera Health
  - Intensive Care Management in SNF
New APMS for PALTC

End of Life Care

- Serious illness electing palliative care
- PNPM for palliative services
- Shared risk on total cost

Coalition to Transform Advanced Care

Advanced Care Model
- Patients with advanced illness, last year of life
- PNPM for all team visits
- Shared risk on total cost

Comparing PTAC Models

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<tr>
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<th>ACM</th>
<th>PACSSI</th>
<th>ICNMF</th>
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<td>Beneficiaries</td>
<td>Palliative, 1 yr EOL</td>
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<td>All residents</td>
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<td>ANA site</td>
<td>NF</td>
<td>NF</td>
<td>UF, NF</td>
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<td>Unit D, hospital</td>
<td>NH LOS X-1st 2 AC</td>
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<td>PCT</td>
<td>Geriatrician</td>
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<td>Pt. Attribution</td>
<td>Sign up</td>
<td>Sign up</td>
<td>Automatic</td>
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<td>Clinical, efficiency</td>
<td>Existing metrics NF, Hospice</td>
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<td>$400, $650</td>
<td>$213 H&amp;P, $55</td>
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<td>Incentive</td>
<td>+</td>
<td>+</td>
<td>+</td>
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<tr>
<td>Pt. access to providers</td>
<td>F2F + Flexibility</td>
<td>F2F + Flexibility</td>
<td>Telemedicine</td>
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Advanced APM for PAC

- Avera’s model covers both SNF and NF
- Shortage / availability of geriatricians may limit
- SNF is increasingly crowded with ACO, bundles, MCP
- Current dismissal of Model 3 BPCI not encouraging for engaging PA sites as “master of their destiny”
- Who would the convener be?

Advanced APM for PA/LTC

- PA/LTC is really two different populations
- SNF – invaded by ACO, advanced BPCI
- NF – some ACO, I-SNP – mainly untouched
- An APM will probably be more successful if it deals with one or the other

PAC Specific Advanced APM

- PTAC has shown less interest in site specific models especially if other models cover disease specific
- Patients heterogeneous
- Room for more specific condition bundles?
- Case mix, risk adjustment critical
- However - much of cost variation in networks is in post acute care, and improved performance is critical to success
Advantages of LTC Specific Advanced APM

• Current models do not address this population well
• More homogenous population
• Better cost basis
• Better risk adjustment
• Better benchmark
• Chance for better QMs
• Available to all interested
• May advance QI more rapidly
• Own your own network

Disadvantages of LTC APM

• More than one population served
• Dementia, medically complex, psychiatric, end of life
• Risk of gaming system
• Preferential selection of better clients if risk adjustment, benchmarking not done correctly
• May not be appropriate for all NF persons
• Dementia APM
• Anyone up for combined psychiatric/medically ill APM?

LTC APM Hurdles

• Cost of development, testing, CMS approval
• Grants may be available under MACRA
• Need to coordinate with other societies / stakeholders
• Site specific vs. condition specific
• Heterogeneity of population
• Procedural & time limited / specific disease APM easier
• Need to coordinate with facility and other providers
• Facility, ER, hospital, vendors, other physician specialties
• Need to be approved

Physician-Focused Payment Model Technical Advisory Committee (PTAC)

• Physician Focused Payment Models = APM Approval Agency
• PTAC makes comments / recommendations to the Secretary DHSS on proposals for PFPMs submitted by individuals & stakeholder entities
• Make recommendations regarding the proposed model including limited-scale testing, implementation, implementation with a high priority, or not recommend
• Our Society is investigating various potential models and collaborations

Is LTC APM the best direction for you?

• Where is a patient best served?
  • LTC APM
  • Palliative APM
  • MCO
  • Part of a current ACO
  • I-SNP

And now for something completely different

I-SNP (Institutional Special Needs Plans)

• SNPs that restrict enrollment to MA eligible individuals who, for 90 days or longer, have had or are expected to need the level of services provided in a long-term care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), a SNF/NF, an intermediate care facility for individuals with intellectual disabilities (ICF/IDD), or an inpatient psychiatric facility
• Independent evaluation for enrollment needed
• Model of Care required
I-SNP Pros and Cons

**Advantages**
- Basically a site specific MA plan
- Network controlled
- Relatively local
- No MIPS
- Historically have been profitable

**Disadvantages**
- MA application needed, upside cost considerable
- Need to include drug coverage
- Same risk adjustment methodology as MA

Commonalities of all Value Based Medicine

- Best Care at Lowest Cost
- Best Care not possible without best doctors and nurse practitioners
- Lowest Cost not possible without controlling post acute cost
- Best care and lowest cost invokes forming networks of physicians and practitioners who can partner with the facility to improve care and cost

Discussion with Panel

The Need for Integrating PA/LTC into Models

- Are good physicians and NP/PA being driven out of the market due to the goal of an integrated system?
- Are there opportunities for physicians/NP/PA to market their expertise?
- How would you set up an optimal physician/NP/PA network?

Is the Selection Process for Networks Ideal?

- Value of 5 star rating
- How do you factor more LOS / cost with lower overall 30 day readmission rate?
- Is home health care being involved well in the overall process?
- How do you rate partnership?

To join or not to join?

- Advantages / disadvantages of being in a corporate network
- Advantages / disadvantages of being independent
Strategies for Success in VBM / Networks
- Clinical expertise
- Medication management
- Advance directives, palliative care, hospice
- Communication
- Facility interaction
- Transitions
- Understanding local environment

Strategies for success in advanced BPCI
- Disease state expertise
- Communication
- Facility interactions
- Transitions

Managed Care Strategies
- Differences between ACO, AdvBPCI, APM, MCO
- Future directions in AP/LTC