TH1- Basics of Value-Based Practice (VBP), Program Models, and Clinical Strategies for Success

Thursday, March 22
8:00 AM- 11:30 AM

Session Description

In this session, readmissions, length of stay (LOS), advance care planning, and patient/family education will be presented with strategies for positive individual clinician and group practice outcomes/performance. The speakers will discuss provider actions that “influence a good discharge” and the concept of “discharge planning beginning on admission.” This session will explore use of facility resources and home health nursing and provider/practice behaviors that influence positive partnerships with facilities and partners.

Learning Objectives

Describe general concepts of Value Based Purchasing Models and alterations in clinical practice and workflow to ensure success in participation.

Explain the concepts of risk-bearing within VBP models, as well as metrics utilized, data collection, and reporting options.

Discuss the role and Management of Readmission Rates, Advance Directives, and Length of Stay in VBP strategies.

Recognize the importance of Medication Optimization, Facility Partnering, and use of Available Resources in VBP Strategies.

Presenter(s): Michelle Benedict, MS, APN-C, RN-C; Robert Reynolds, MD; Charles Crecelius, MD, PhD, 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 general concepts of Value Based Purchasing Models and alterations in clinical practice and workflow to ensure success in participation.
- Explain the concepts of risk-bearing within VBP models, as well as metrics utilized, data collection, and reporting options.
- Understand the role and Management of Readmission Rates, Advance Directives, and Length of Stay in VBP strategies.
- Recognize the importance of Medication Optimization, Facility Partnering, and use of Available Resources in VBP Strategies.

Affordable Care Act

ACA Origins:

- Health Care Spending is Growing at an Unsustainable Rate

- U.S. health care expenditures to reach 20% of GDP by 2021
- Costs per patient averages more than twice ($8,860) the average of other developed countries
- The high level of spending has not led to proportionally superior population health

ACA and Post Acute......

For a typical 90-day episode, Medicare typically spends more on a patient’s post-acute care than their initial hospitalization.
CMS Prioritizes Post-Acute Cost Control

- Post-Acute Care (PAC) spending increased from $27B to $59B 2001-11
- In 2015, CMS began implementation of Readmission Penalties, Value-Based Purchasing Programs, and Quality Reporting Mandates for Post-Acute Care Providers.

**MAIN DRIVERS:**
- Decrease in Hospital LOS
- Throughput pressures
- Reflex PAC facility referral

**What is VBP?**

\[ V = \frac{Q}{C} \]

**VALUE = QUALITY / COST**

Examples of Value Based Programs

- **MIPS:** Merit-based Incentive Payment System
- **BPCI:** Bundled Payment of Care Initiative
- **ACOs:** Accountable Care Organizations
- **ISNP:** Institutional Special Needs Programs
- **MSSP:** Medicare Shared Savings Programs
- **CPC+:** Comprehensive Primary Care Plus
- **Medical Home Models**
- **All APMs:** Advanced Payment Models

Who Takes Risk in Each Model?

- Hospitals, Medical Practice Groups, Post Acute Facilities, 3rd Party Payers (Insurance Companies), others
- Risk is both positive and negative; Gains or Losses
- Medicare Payments to the Risk-Bearing Entity may be Proactive or Retroactive
- Important to know in order to negotiate and contract for Provider payment, or

**Gain-Sharing** (Bonus +/−)

Your Basic Fee for Service Reimbursement Model Changes Under:

**MACRA**

Medicare Access and CHIP Reauthorization Act

Repealed the SGR formula, which linked Medicare Annual Provider payment adjustment to GDP

- Two sections which address new methods of payment for eligible professionals:
  - MIPS (Merit-Based Incentive Payment System)
  - APMs (Alternative Payment Models)

Goal of MACRA 90% of all Provider payments tied to quality and value by 2018.

**MIPS – Merit Based Incentive Payment System**

- Evaluates individual Providers using a composite score which incorporates Cost (Resource Use), Quality Metrics, Clinical Practice Improvement Activities and Advancement of Care Information
- This score is attached to the Provider regardless of employer or place of practice, and follows the Provider to future practice sites
MedPAC urges repeal of MIPS

A Medicare pay model meant to encourage doctors to improve the quality of patient care should be junked as it's too burdensome and poses no benefit, according to an influential congressional advisory group.

Quality Measures (QMs)

- QM system does not reward high quality, it rewards high quality reporting skills

MIPS Cost Allocation for Post Acute Practices

You Lose!

So How Do I Get Paid ???

- The two basic programs are MIPS and APMs
- APMs can be regular APMs or advanced APMs
- Advanced APMs take more financial risk
- Accountable Care Organizations (ACOs) are a type of APM
- You will automatically be in the Merit-based Incentive Payment System (MIPS) unless you take certain steps
- Your employer decides on MIPS versus APM
- If you are in MIPS and do not participate / don’t submit data you will take the maximum penalty
- Cost and quality are determined through your individual Quality and Resource Use Report (QRUR). You or your employer receive this.
MIPS is based on Performance Category Weights

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
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<tbody>
<tr>
<td>Quality</td>
<td>50%</td>
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<tr>
<td>Cost</td>
<td>10%</td>
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<tr>
<td>Improvement</td>
<td>15%</td>
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<tr>
<td>Advancing Care Information</td>
<td>25%</td>
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Transition Year Weights

<table>
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<tr>
<th>Year</th>
<th>Quality</th>
<th>Cost</th>
<th>Improvement</th>
<th>Advancing Care Information</th>
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<tbody>
<tr>
<td>2019</td>
<td>50%</td>
<td>10%</td>
<td>15%</td>
<td>25%</td>
</tr>
<tr>
<td>2020</td>
<td>50%</td>
<td>10%</td>
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<tr>
<td>2021</td>
<td>50%</td>
<td>10%</td>
<td>15%</td>
<td>25%</td>
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<tr>
<td>2022 onwards</td>
<td>50%</td>
<td>10%</td>
<td>15%</td>
<td>25%</td>
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How much can MIPS adjust payments?

Based on a MIPS Composite Performance Score, clinicians will receive +/- or neutral adjustments up to the percentages below.

-4%  -5%  -7%  -9%  +4%  +5%  +7%  +9%  

2019  2020  2021  2022 onwards

The potential maximum adjustment % will increase each year from 2019 to 2022.

Who is excluded from MIPS?

Clinicians who are:

- Newly enrolled in Medicare
  - Enrolled in Medicare for the first time during the performance period (average until following performance year)
- Below low-volume threshold
  - Medicare Part B allowed charges less than or equal to $50,000 a year
  - See 200 or fewer Medicare Part B patients a year
- Significantly participating in Advanced APMs
  - Receive 25% of Medicare payments
  - See 20% of your Medicare patients in an Advanced APM

Note: There are no exclusions based on place of service.

CMS Changes to MIPS 2018 Affecting PA/LTC

- Cost of care counts 10%
- Virtual groups allowed
- More bonus points
  - Small groups – 5 points for reporting one performance measure
  - 5 points for treating complex patients (HCC)
- Hardship exemptions for those affected by hurricanes Harvey, Irma and Maria
- Low volume threshold increased
  - ≤30,000 /100 patients to $90,000 / 200 patients

Advanced Alternative Payment Models

Advanced Alternative Payment Models (Advanced APMs) enable clinicians and practices to earn greater rewards for taking on some risk related to their patients’ outcomes.

**REQUIREMENTS**

- APM requires participants to use certified EHR
- APM bases payment on quality measures comparable to those in the MIPS quality performance category.
- The APM either: (1) requires APM Entities to bear more than nominal financial risk for monetary losses; OR (2) is a Medical Home Model expanded under CMMI authority

**Advanced APMs**

- 5% lump sum incentive
MACRA provides additional rewards for participating in APMs

**Potential financial rewards**

<table>
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<tr>
<th>Not in APM</th>
<th>In APM</th>
<th>In eligible APM</th>
</tr>
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<tr>
<td>MIPS adjustments</td>
<td>+ APM-specific rewards</td>
<td>+ 5% lump sum bonus</td>
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If you are a qualifying APM participant (QP)

**How do I become a qualifying APM participant (QP)?**

- Eligible APM
- QP
- You must have a certain % of your patients or payments through an eligible APM
- Be excluded from MIPS
- Receive a 5% lump sum bonusoting that will receive higher fee schedule update starting in 2026

**Advanced APMs in 2018**

For the 2018 performance year, the following models are Advanced APMs:

- BPCI Advanced
- ACO – Shared Savings Program Track 1
- ACO – Shared Savings Program Track 2
- Next Generation ACO Model
- Comprehensive Primary Care Plus (PCP+1)
- Oncology Care Model (Two-sided Risk Arrangement)

**Most practitioners will start in MIPS**

- Subject to MIPS
- Not in APM
- In APM
- In eligible APM

- Not in APM
- In non-eligible APM
- In eligible APM, but not a QP
- QP in eligible APM

Some people maybe in eligible-APMs and but not have enough payments or patients through the eligible APM to be QP.

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**What Types of APMs are there?**

- Accountable Care Organizations
- Network of doctors, hospitals, and other health care providers that share responsibility for coordinating care and meeting health care costs and quality metrics for a defined patient population – Medicare Shared Savings Program (MSSP)
- The most common type of APM and the most applicable to managing large segments of populations (such as NF patients)
- Bundled Payment Models (BPCI Advanced)
- Deal with managing an episode of care through a single payment over a defined period of time (typically 90 days) – Now CMS Bundled Payment for Care Improvement - Advanced (BPCI - Advanced)
- APM Specialty Specific
- Condition +/- Care Episode +/- Population based
- Patient Centered Medical Home
- Total care coordination through primary care physician, not SNF/NF applicable

**Medicare Shared Savings a Slow Transition to Risk**

Majority of ACO Participants Still Not Bearing Much Risk

**Continuum of Medicare Risk Models**

- MSSP Track 1
- MSSP Track 2
- MSSP Track 3
- BPCI Track 1
- BPCI Track 2
- BPCI Track 3
- Next Gen ACO

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Patient Access to SNF Care With and Without 3-Day Stay Waiver
868 SNFs Now Participating in SNF Waiver 2018

With hospital LOS under 3 days, patient is nonetheless appropriate for SNF care

Without 3-Day Stay Waiver
- SNF’s unwilling to admit patient
- CMS-approved SNF accepts patient
- SNF receives reimbursement

With 3-Day Stay Waiver
- If admitted, SNF is not reimbursed
- Medicare Advantage beneficiaries exempt from 3-day stay rule

SNF Waiver Program for 3 Day Stay
- Medicare Fee for Service Beneficiary Eligible for the Waiver
  - Prospectively assigned to ACO
  - Approved for SNF admission by ACO
  - Not a NF resident
- SNF Eligible for Waiver
  - Must have overall 3 star rating
  - Must have partnered with ACO by signing an affiliate agreement
  - Selection process variable, usually includes LOS, 30 day readmission rate, adjusted cost/day, proximity

BPCI Advanced Bundled Payment for Care Improvement Advanced
- Voluntary Model
- A single retrospective bundled payment and one risk track, with a 90-day Clinical Episode duration
- 29 Inpatient Clinical Episodes
- 3 Outpatient Clinical Episodes
- Qualifies as an Advanced APM
- Payment is tied to performance on quality measures
- Preliminary Target Prices provided in advance of the first Performance Period of each Model Year

More BCPI
- Conveners can only be
  - Acute Care Hospitals (ACH)
  - Physician Group Practices (PGP)
- NQ Model 3: Retrospective Post Acute Care Only
- Can waive 3 day stay, geographic telehealth requirements
- Starts October 1, 2018 with Downside risk from start
- Target 3% discount, historic fee for service, case-mix, retrospective
- Can also participate in ACO, medical home

Bundles
- Liver disorders excluding malignancy, cirrhosis, alcoholic hepatitis
- Acute myocardial infarction
- Back & neck except spinal fusion
- Cardiac arrhythmia
- Cardiac defibrillator
- Cardiac valve
- Cellulitis
- Cervical spinal fusion
- COPD, bronchitis, asthma
- Combined anterior posterior spinal fusion
- Congestive heart failure
- Coronary artery bypass graft
- Double joint replacement of the lower extremity
- Fractures of the femur and hip or pelvis
- Gastrointestinal hemorrhage
- Gastrointestinal obstruction
- Hip & femur procedures except major joint
- Lower extremity/humerus procedures except hip, foot, femur
- Major bowel procedure
- Major joint replacement of the lower extremity
- Major joint replacement of the upper extremity
- Pacemaker
- Percutaneous coronary intervention
- Renal failure
- Sepsis
- Simple pneumonia and respiratory infections
- Spinal fusion (non-cervical)
- Stroke
- Urinary tract infection

APMs – Specialty Specific Models
- APM can be designed by specialty & approved by CMS (PTAC)
- Should be based on
  - Specific clinical condition
  - A care episode
  - A population
- Site specific not preferred at this time
- AMDA (and others) are considering such models
  - Dementia care
  - Neurologic disease care
  - Acute illness models
  - Population based (separate SNF & NF population)
Opportunity for Significant Medicare Cost Savings

- **Low Direct Participation in Value-Based Models**
  - SNFs have not pursued development of ACOs, despite the opportunity it presents, due to:
    - Absence of a scalable physician services organization and related Medicare billing that allows for clean attribution of LTC members
    - Inability to meet MSSP requirement for a minimum 5,000 attributable members
    - Reluctance to move away from traditional FFS billing strategies and concern about potential reductions in Medicare stays
    - Lack of value-based program management tools, including claims data analysis, quality data collection and reporting, etc.

- **Opportunity for Significant Medicare Cost Savings**
  - 6 conditions drive 80% of potentially avoidable hospitalizations for LTC residents
    - CHF, COPD, Pneumonia, UTI, Dehydration, UTI, Skin Conditions
  - Admissions are eminently preventable, or able to be treated in place
    - Hospital admissions average $12,000 per occurrence, then a Medicare A SNF stays
    - Unmanaged: 1,100 admissions per thousand [APK]
    - Optum/Evercare: 180 APK (Genesis experience)

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Is it time for PA/LTC Chronic Care Codes?

**Medicare Offers Payment for Clinician-led Care Coordination**

<table>
<thead>
<tr>
<th>New Medicare Billing Option</th>
<th>Care Coordinator Responsibilities</th>
</tr>
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<tbody>
<tr>
<td>Medicare now covers clinician-led care coordination services in PA/LTC</td>
<td>Arrange smooth transitions from hospital to home or nursing home</td>
</tr>
<tr>
<td>Two levels of intervention</td>
<td>Assess patients’ medical, psychological and social needs</td>
</tr>
<tr>
<td>Payment for Coordination (PMPM)</td>
<td>Craft and execute care management plan</td>
</tr>
<tr>
<td>$42 Chronic Care Management</td>
<td>Monitor care provision from other providers</td>
</tr>
<tr>
<td>$93 Complex Chronic Care Management</td>
<td>Improve medication adherence</td>
</tr>
</tbody>
</table>

The real question is whether the cost of increased physician services via these codes results in savings compared to conventional billing.

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PA/LTC Specific APM - ACO Possibilities

- Appropriate metrics being developed to reflect our population
- Hospitalizations would be a key metric
- Cost measures historically based
- PA/LTC has a large potential for cost savings compared to other sites
- Population based
- NF - Frail elders defined by both dependency and specific diseases
- Attribution very easy
- Services more easily controlled
- SNF – similar to bundles
- Requires management services beyond what most facilities and practitioners can currently provide

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APM Development Hurdles

- Cost of development, testing, CMS approval
- Need to coordinate with other societies
- Time, effort, navigating through processes
- Approval through Physician-Focused Payment Model Technical Advisory Committee (PTAC)
- While population based, appears site specific
  - Would pertinent AL and Home Care patients need to be included?
  - Heterogeneity of population
  - Procedural & time limited disease APM easier
- Need to coordinate with facility and other providers
- Facility, ER, hospital, vendors, other physician specialties

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And one last entity of note – I-SNP

- Institutional Special Need Plan
  - 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
  - Institutional LOC determined by state assessment tool
  - Independent, impartial party administers assessment
  - I-SNP have same cost and quality considerations
Challenges to the PA/LTC Practitioner

- Risk based contracting
- Preferred Provider Networks
- Hospitalists/ SNFists/ APN teams employed by Health systems
- Network refinement
- Lack of Adequate Risk Stratification
- Lack of accurate benchmarking
- Outcomes matter beyond care episodes
- Shrinking LOS and Increasing acuity

Value Based Practice

- Better Quality and Outcomes at lower cost
- Future Reimbursement will be directly tied to Quality and Metrics Achieved
- Clinical/Practice Strategies that Optimize Patient Stays & Outcomes

Clinical/Practice Strategies

- Managing Readmissions
- Appropriate LOS
- Advance Care Planning
- Medication Management Strategies
- Effective Discharge Planning
- Partnering with Facility
- Setting Expectations with Patient & Caregivers

Skilled Nursing Facility Readmission Measure (SNFRM March 2015)

- 1 out of every 4 Medicare hospital admissions discharged to SNF were readmitted within 30 days
- Data indicates a large proportion were preventable
- Very expensive, 2010 Avoidable re-hospitalizations cost excess of 3.39 billion dollars
- 78% of re-hospitalizations deemed avoidable of the total 4.34 Billion
- Increase risk for complication

Managing Readmissions

Clinician/Practice Influence on readmission rates:

- Scheduled Presence
  - Continuity with clinician coverage
  - Coverage reflects acuity and volume
  - Improves communication
- Structure of Call coverage
- Medical Decision making with inadequate Patient Information

Managing Readmissions

High Risk Patients

- Top 1% = 23% of Total Health Care Spending
- Top 5% = 50% spending with patients ≥65 with chronic conditions.
- Burden of chronic illness – goals of care discussion

Easy Identification of High Risk Patients

- 3 Hospital Admissions past year
- 2 Hospital Admissions past 5 months
- Previous SNF Placement
Managing Readmissions

Facility Process for Acute Change in Patient
- Process in place i.e. INTERACT
  - Success and use of current process
- Clinician notification of change

Evaluating & Learning from Unplanned Discharges
- Team Approach with Facility – Root Cause Analysis
- Schedule review with appropriate facility personal
- Have medical records available
- Assess facility related factors:
  - Staffing issues, Assessment Skills, Communication, Advanced Directives
- Assess Clinician related factors:
  - Awareness of services, medications and in house treatment available 24/7, Advanced Directives, Facility & Call Coverage

Managing Readmissions

Length of Stay
- Communication – patient, family, goals of care discussion
- Communication with facility and group partners
- Pain control
- Monitor progress in therapies
- Medication Management
- Clinician schedule impact on management of chronic and acute illness
- Expected LOS – based on DRG

Advance Care Planning
- Patient Centered Care – goals of care discussion
- Awareness of facility protocols, forms and state requirements
- Hospice/Palliative consult
- Use of the ACP codes
- Impact on readmission rates
- CMS using as quality measure

Medication Management Strategies

- United States ER visits for outpatient ADE’s 2013-2014
- One out of every 250 visits are due to ADE’s
  - Persons >65 y/o accounted for 35% of ER visits for ADE’s
  - 3 drug classes were implicated in 60% of these visits:
    - Anticoagulants
    - Diabetes agents
    - Opioid

- Did you know:
  - 1 in 6 hospital admissions of older adults is due to adverse drug event (ADE)
  - Hospital admissions in persons >75 due to ADE increases to 1 in 3.
  - After 5 prescribed medications the % of patients with ADE nearly doubles
  - CMS Survey 2004 – implemented quality indicator measure that targeted patients on 9 or more meds due to prevalence of polypharmacy.
Medication Management Strategies

• Focus of management should be the therapeutic benefits of each medication and consider:
  • quality of life for an individual resident
  • goals of care
  • current health status.

Diagnosis for every medication prescribed

Discharge Planning

• Begins on Admission
• Medication Reconciliation and Ability to get RX
• Home Health Nursing, Nursing Assistant, PT/OT
• Community Resources (Meal on Wheels etc.)
• DME and Home Environment
• F/U with PCP and specialists
• Assessment of support care and caregivers
• Documentation in Discharge Summary if resident at risk for readmission.

Partnering with Facilities

• Communication
• Engagement as Medical Director and/or Corporate roles
• Understanding facility resources
• Working through issues as true partners
• Educating and updating on issues pertaining to clinicians (MIPS, BPCI)
• Assisting with education of facility staff
• Support and professionalism
• Developing initiatives for quality metrics together (Scorecard etc.)

PA/LTC ACO Requires Transforming the Quality and Efficiency of Long Term Care Delivery

KEY TACTICS

Strategic Priorities
• Hospitalization avoidance
• Evidence based medicine
• Advanced care planning
• Narrowed physician panels
• Clinical Decision Support embedded in EHR at the point of care
• Rewarding value over volume
• Robust analytics and benchmarking of provider performance
• Aligned incentives across the care team and with center operators
• Heightened expectations of medical director leadership

All know that the drop merges into the ocean, but few know that the ocean merges into the drop. Kabir