

**NARA**
The National Association of
Rehabilitation Providers and Agencies

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Metrics of Value: The World of Value Based Reimbursement

Tuesday, May 5, 2020

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NARA Pre-Conference: Metrics of Value: The World of Value Based Reimbursement

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Today's Agenda

- Welcome
- Objectives Review
- Value Based Care: Past & Future
- **Casamba Sponsored Break**
- Building Your Contract for Value Based Reimbursement
- **MedBridge Sponsored Break**
- Panel: Our Experience with Value Based Reimbursement

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Objectives

- Identify the key areas of Value Based Reimbursement for Rehab Providers
- Identify potential issues to address for contract therapy
- Develop a plan to assess focus areas of impact to the attendee's business
- Develop a plan to facilitate collection of data to share with customers and payers

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Session 3: Speaker Introductions



Chris Carlin, OTR/L, MBA
Hartford HealthCare Rehab Network

Speaker Disclosure: Financial: Mr. Carlin has no relevant financial relationship. Nonfinancial: He is a member of NARA.



Dawn Greaves, PT, DPT
Aegis Home Health Services

Speaker Disclosure: Financial: Ms. Greaves has no relevant financial relationship. Nonfinancial: She is a member of NARA.



Martha Schram, PT
Aegis Therapies

Speaker Disclosure: Financial: Ms. Schram has no relevant financial relationship. Nonfinancial: She is a member of NARA.





Stephen Hunter, PT, DPT, OCS
Intermountain Healthcare

Speaker Disclosure: Financial: Mr. Hunter has no relevant financial relationship. Nonfinancial: He is a member of NARA.

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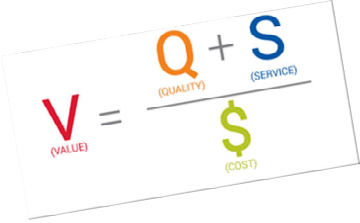
Hartford HealthCare Value Based Reimbursement

Chris Carlin, OTR/L, MBA
Vice President, Rehabilitation

Hartford HealthCare
Rehabilitation Network

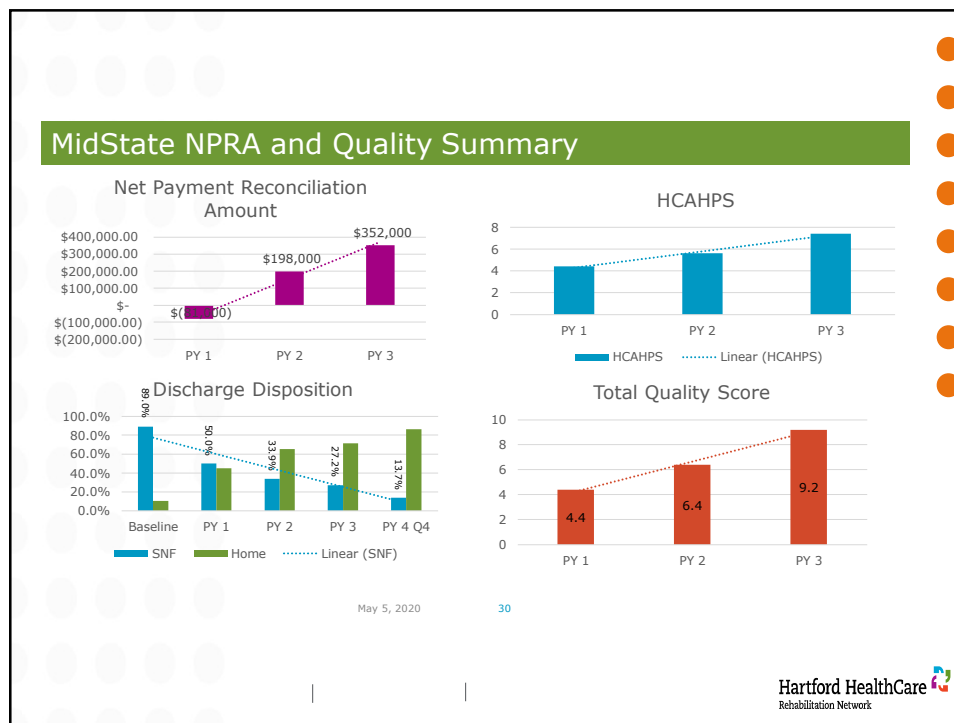
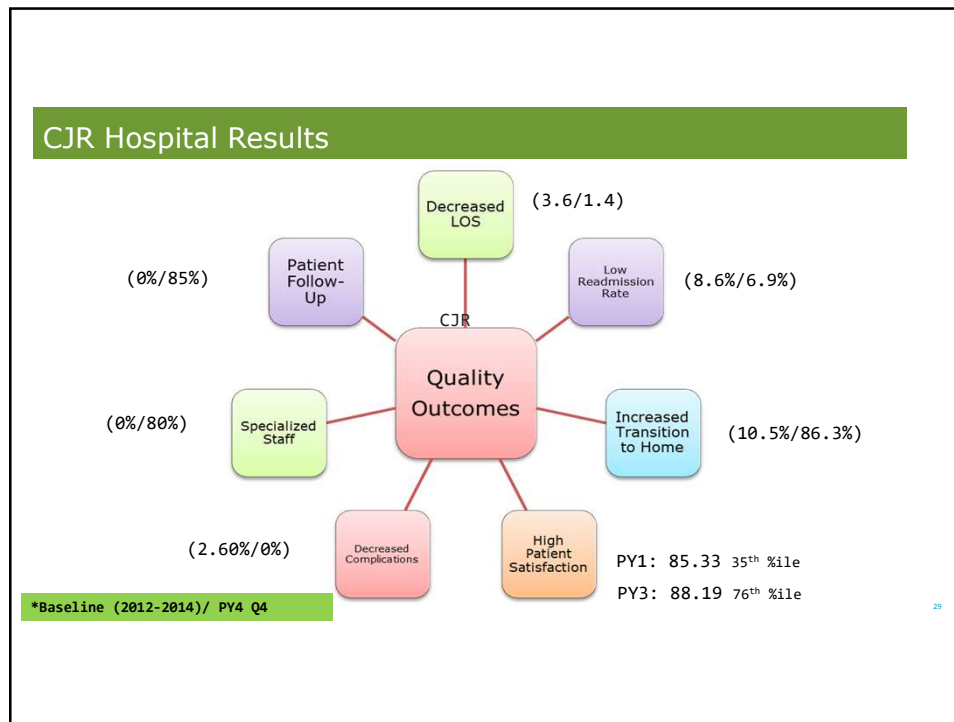
Value Based Focus

- **Enhance Outcomes**
 - Evidence Based
 - Standardization of Care
- **Improve Customer Experience**
 - Patient
 - Payer
- **Manage Costs**
 - Transitions of care through the continuum
 - Post-acute care utilization



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Clinical Care Pathway

Reduce Visits all Settings



- **Care Coordination** Across Continuum
 - Single electronic medical record
 - Access to care for specialists and services
 - Care pathways
 - Wellness aspects

- Hartford HealthCare**
Rehabilitation Network

Demonstrating Therapy Value in Spine Care

Care Coordination

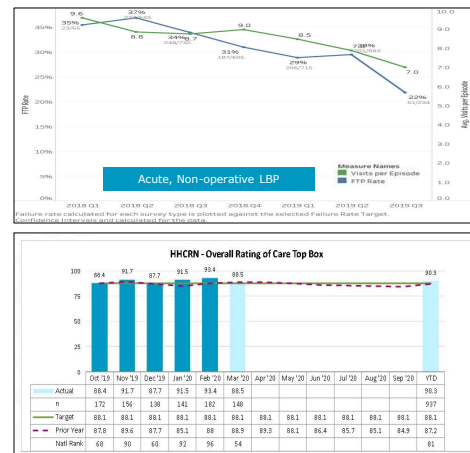
- Immediate Access
- Care Pathways

Measure results

- Patient Reported Outcomes
- Patient Experience
- Cost/Utilization

Collaborative approach

May 5, 2020



Learning From Our Journey

Successes

- HHC Operating Model
 - Continuous improvement
 - Visibility of drivers and results
- Data analysis evolution
- Standardization/care pathways
- Post acute-care utilization
- Risk mitigation
- Win, Win
 - Higher quality, improved experience
 - Lower cost = shared savings


Challenges

- Achieving/maintaining alignment
- Change management
- Ability to tell your value based story
- Obtaining and assessing data
- Risk stratification and mitigations
- Readiness for risk sharing

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The image shows a caregiver in a blue polo shirt assisting an elderly man in a white shirt and blue jeans as he descends a staircase. The caregiver is holding the man's arm for support. The background is a bright, modern interior with white walls and a wooden railing.

@home
WITH AEGIS

Value-Based Reimbursement

May 5th, 2020

Outline

- HHVBP
- Transitions of care in a preferred provider relationship
- A different perspective - PDGM

What Is Home Health Value Based Purchasing?

- Ties a percentage of reimbursement to outcomes over a period of 5 years
- 8 states (MA, MD, NC, FL, WA, AZ, IA, NE, TN)
- First payment year 2018, Last year to be 2022
- Adjustments move from max of 3% in 2018 to 8% in 2022, up or down
- Metrics measured
 - Clinical Quality (Ambulation, Bed Transfers, Bathing, Dyspnea)*
 - Outcome and Efficiency (D/C home, Care management, Acute Care Hosp, ED use, Prevention of pressure ulcers, Pain interfering with activity, Management of oral meds, fall assessment and PLOF)
 - HHCAPS score (Care of patients, communication, care issues, overall rating, willingness to recommend agency)

*In 2019, the individual mobility items were combined into two composite measures

How Can You Help Your Agencies

- Help ensure the patients are properly base-lined through appropriate OASIS scoring and therapy evaluations
- Ensure provision of evidenced based treatment interventions that drive improvement in functional progress and improved performance for the patient
- Care plans that address risk – avoidable hospitalizations, prevention of pressure ulcers, med management
- Customer service that exceeds patients' expectations

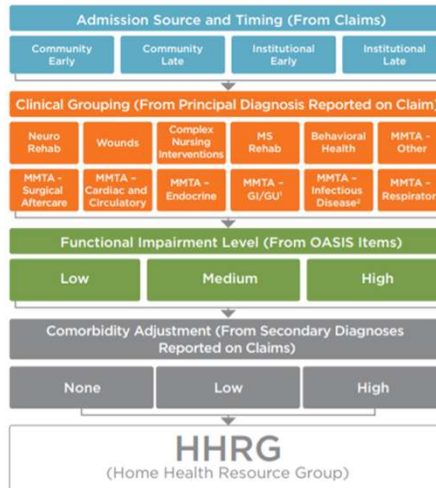
Preferred Provider and the Continuum of Care

- CCRC campus with Home Health Agency
- Aegis provided all therapy (SNF, OP and HH) and Wellness
- Preferred provider relationship with local hospital specific to joint patients
- Transitional Care focus developed across the campus and HH including a transitional care notebook, risk stratification for patients discharging home and cross setting care coordination meetings including AL/IL, SNF and HH
- Concepts applied to all patients, not just those in the preferred provider group
- Results
 - SNF** - LOS decreased from 25.6 to 18 days, improvement in gains, all patient rehospitalization for short stay decreased from 17% to 8%
 - HH** - re-hospitalization from 14.6 to 9.19, quality scores improved, episodes increased from an average of 350 to 845
 - Antidotally** – quality of referrals increased, discipline engagement within setting and across setting improved as did collaboration across campus

A Different Perspective - PDGM

- As a contract therapy provider, we have not directly participated in the upside or downside of a quality initiative such as HHVBP, while we can support the agencies success in these initiatives
- CMS focus with PDGM is moving from volume to value
- So where are the areas you can bring value to your agency?

Bringing Value to Your Agency Partners - PDGM



Numbers to Know Under PDGM

- MMTA other, 12 visit per episode – Revenue per visit comparison

Admission Source and Timing	Clinical Group and Functional Level	Comorbidity	HIPPS Code	Weight	Revenue	Visit Threshold	Therapy Visits	Revenue per Visit
Early - Community	MMTA - Other - Low	1	1AA21	1.0631	\$ 1,981.65	4	12	\$ 165.14
Early - Community	MMTA - Other - Low	1	1AA21	1.0631	\$ 1,981.65	4	11	\$ 180.15
Late - Community	MMTA - Other - Low	1	3AA21	0.6570	\$ 1,224.67	2	1	\$ 160.00
					\$ 2,206.32		12	\$ 178.47
Early - Community	MMTA - Other - Low	1	1AA21	1.0631	\$ 1,981.65	4	10	\$ 198.17
Late - Community	MMTA - Other - Low	1	3AA21	0.6570	\$ 1,224.67	2	2	\$ 612.33
					\$ 3,206.32		12	\$ 267.19

- Same scenario except medium functional impairment

Admission Source and Timing	Clinical Group and Functional Level	Comorbidity	HIPPS Code	Weight	Revenue	Visit Threshold	Therapy Visits	Revenue per Visit
Early - Community	MMTA - Other - Medium	1	1AB21	1.1962	\$ 2,229.75	5	12	\$ 185.81
Early - Community	MMTA - Other - Medium	1	1AB21	1.1962	\$ 2,229.75	5	11	\$ 202.70
Late - Community	MMTA - Other - Medium	1	3AB21	0.7901	\$ 1,472.77	2	1	\$ 160.00
					\$ 3,702.52		12	\$ 199.15
Early - Community	MMTA - Other - Medium	1	1AB21	1.1962	\$ 2,229.75	5	10	\$ 222.98
Late - Community	MMTA - Other - Medium	1	3AB21	0.7901	\$ 1,472.77	2	2	\$ 736.39
					\$ 3,702.52		12	\$ 308.54

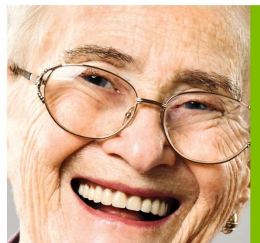
Note: Care plans must be patient specific and delivered based on individual clinical presentation and need. Examples for illustrative purposes only

Bringing Value to Your Agency Partners - PDGM

- OASIS scoring - complete and accurate
- Collaboration around primary DX and primary patient need
- Collaboration around care planning – the right discipline at the right frequency and duration at the right time
- Pay attention to the 30 days not just Medicare regulatory week
- Interventions with an increased focus on patient health literacy, condition management, progression of nonskilled care to patient or caregiver, and durability of response – Decrease avoidable hospitalizations
- Explore options for non visit follow up with patients to optimize outcomes while controlling costs

Therapy Intersection with Value Based Reimbursement

Presenter: Martha Schram



Value

- “Consider (someone or something) to be important or beneficial, have a high opinion of”
- “The worth of something compared to the price paid for or asked for it”
- Defined by the person or entity purchasing or reimbursing for the service or provider



Therapy Intersection with Value Based Reimbursement

- CMS-VBP
- Managed Care/ISNPs
- ACOs/Hospital Systems
- Clients/Customers

I-SNP

Institutional Special Needs Plans, or I-SNPs, are Medicare Advantage plans 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.

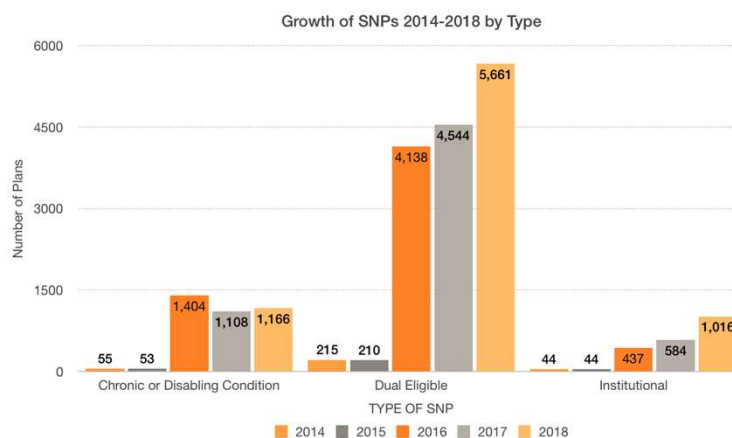
CMS may allow an I-SNP that operates in either single or multiple facilities to establish a county-based service area as long as it has at least one long-term care facility that can accept enrollment and is accessible to the county residents.

As with all MA plans, CMS will monitor the plan's marketing/enrollment practices and long-term care facility contracts to confirm that there is no discriminatory impact.



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Growth of SNPs



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Therapy Impact

- Since Special Needs Plans are Managed Care programs, care may be managed by the plan through Prior Authorizations or other care management elements
- Participation in a SNP will include a provider network where a provider/facility contracts with the Managed Care company for a set rate(s) to provide care and agree to follow the plan's rules/benefit limits
- For I-SNPs specifically a SNF will contract with the I-SNP and typically will have a Flat Rate (Per Diem or Monthly Cap) that will be paid for the provision of care (all Part A/Part B/Part C and D services). In this case the facility will need to be efficient and manage the care delivery to that "budget" rate AND still achieve quality outcomes.
 - This may cause the SNF and/or Plan to "limit" the amount of delivery to achieve good outcomes in less time – thus reducing expense for Part B or Part A services
 - Shorter length of stays in SNF are typical of a managed care patient as are limited visits to provide therapy under Part B

Driving Value Based Reimbursement Success

- **Impacting Rehospitalization Rates and ER Visits**
 - CMS, ISNP/managed care, ACOs, clients
- **Reducing Cost**
 - ISNP/managed care, ACOs, clients, CMS (predicted)
- **Maintaining or Improving Outcomes**
 - All payors

Core Strategies to Consider

- **Transitional Model of Rehabilitative Care**
- **Targeted Clinical Programming and Execution**

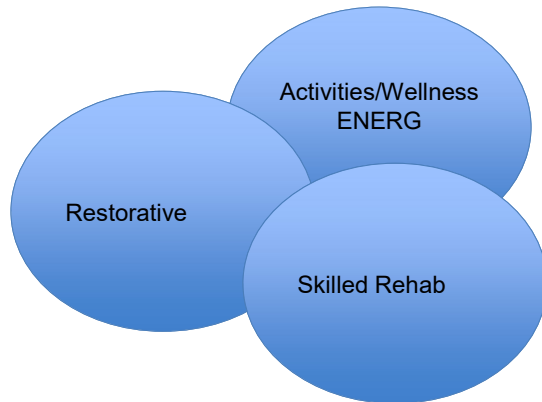
Transitional Care Model

Goal: Address fragmented care experienced by patients (residents) to improve health outcomes, reduce avoidable rehospitalizations and ED visits

Applications

- **Internal (SNF/CCRC)**
- **Across Post Acute Settings – SNF → HH → Outpatient**
- **Critical Core Concepts**
 - Expand transitional care model to connect environments of care and closing gaps that bring risk to residents
 - Standardized, evidenced based programming with consistent knowledge of staff and program execution
 - Improved communication resulting in more effective addressing of challenges and provision of just in time support
 - Develop behaviors and processes focusing on continued effort to keep people “well” rather than initiate treatment/support when they are injured or sick

Transitional Care Model in SNFs



Impacting Rehospitalization Through Targeted Programming and Execution

- Identifying those at higher risk for re-hospitalization and focusing on care delivery differently is key
- Example: Aegis Complex Disease Management Program
- N = 14,712 patients with multiple co-morbidities identified that impact course of therapy

Period	Rehospitalization Rate*
Q1 2019	24.3%
Q2 2019	21.2%
Q3 2019	20.3%
Q4 2019	21.0%
Q1 2020	19.2%
April 2020	16.6%

* Based on discharge disposition at time of discharge from therapy

A Case Study

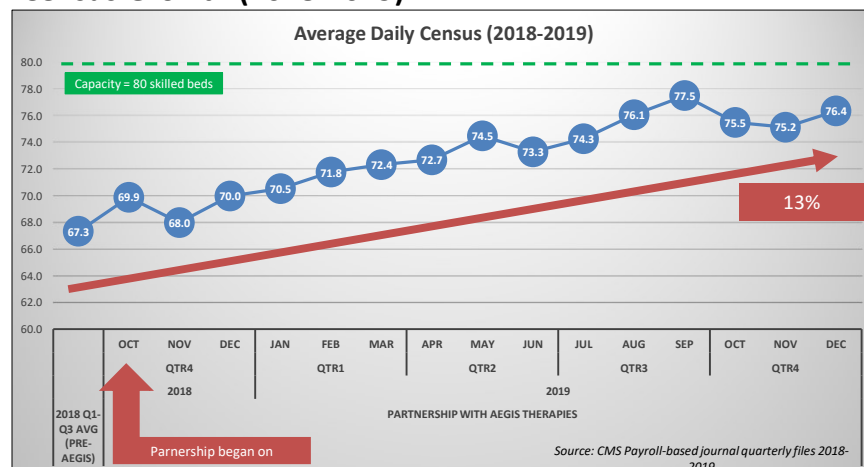
- Successful implementation of transitional care model
- Clinical programming – risk tiered
- Consistent competencies and standardization of programming
- Maintained or improved outcomes
- Aligning financial and clinical success



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Impact Value Based Purchasing Alignment

Census Growth (2018-2019)



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Impact

Medicare Part A Claims

Time Period	Part A Volume	ALOS
2017 Q4 – 2018 Q3 (Before Aegis Partnership)	185	30.0
2018 Q4 – 2019 Q3 (After Aegis Partnership)	244	27.8
Totals	32% increase	7% decrease

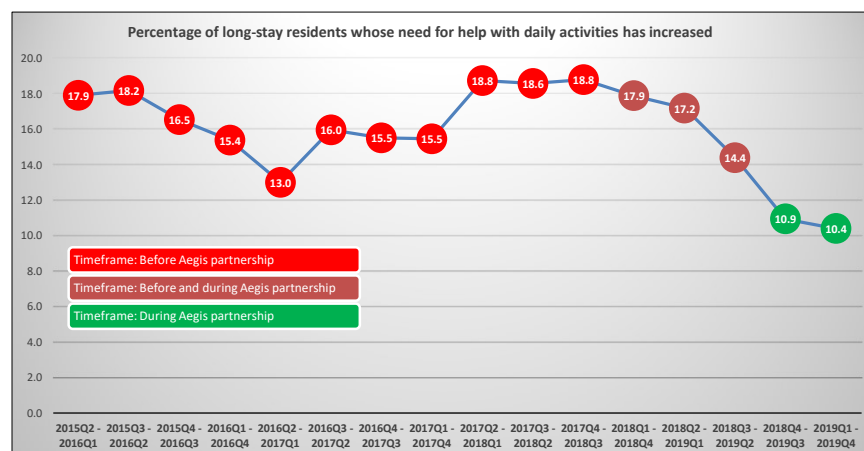
- Aegis partnership began on 10/1/2018
 - More patients
 - Decreased length of stay
 - Increased Part A revenue



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Impact

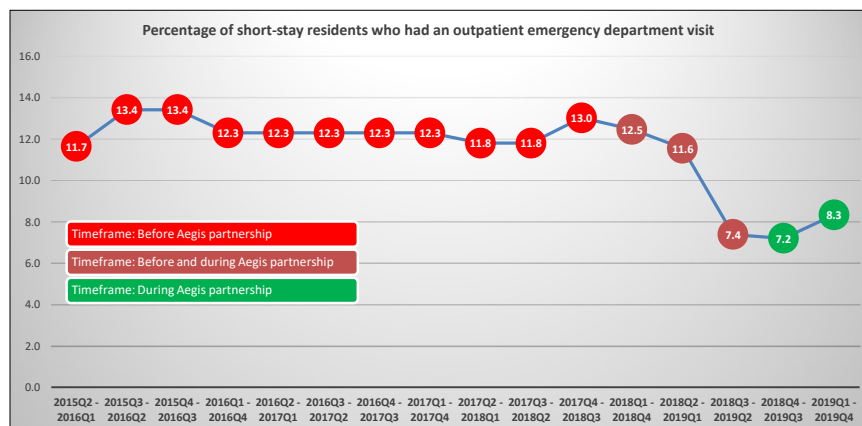
QM 1 – ADLs



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Impact

QM 2 – Outpatient ER Visits



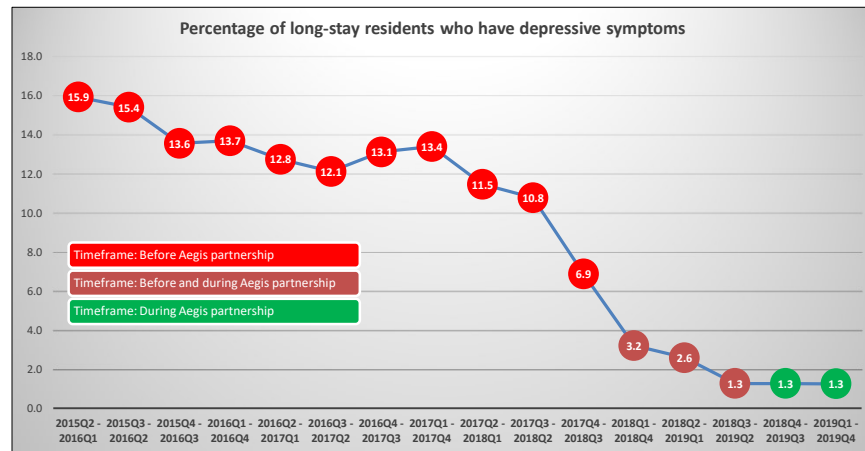
Impact

QM 3 – Bowel and Bladder



Impact

QM 4 – Depression



Clinician Experience and Change Management

- **Paradigm Shift**
 - “Top of license”
 - Goals focused on transition to next level of care (restorative and wellness/activities)
 - Concurrent, integrated intervention
- **Increased competency expectations and aligned competency across model**
- **Increased standardization/evidence based practice expectations**
- **Manage the patient’s journey vs. therapy program**

Value Based Payment- An Incentive Program based on Outcomes

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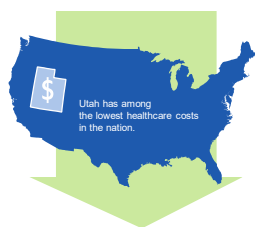
Stephen Hunter PT, DPT, OCS

REHABILITATION SERVICES
INTERMOUNTAIN HEALTHCARE



Intermountain Healthcare

Not-for-Profit Integrated System Based in Salt Lake City, Utah



PREVENTION & WELLNESS

88,000 Healthy Plates sold in hospital cafes
12,000 Utah students participating in Live Well assemblies
58 Schools in Step Express program
57,000 Healthy Living participants



HOSPITALS & CLINICS

23 Hospitals
2,700 Beds
185 Intermountain Clinics



750,000 Members



OUR TEAM

5000 Affiliated Physicians
1,400 Employed Medical Group doctors & advanced practice clinicians
36,000 Employees
3,000 Volunteers
470 Volunteer Trustees



Outline

- What changes payer's behavior
- Pay for quality program
- Thoughts about the future



What matters most to payers



Large Commercial CFO Quote:

*"We don't care about quality,
what most employers want:
LOWER PREMIUMS"*



The Intermountain Journey



- Years of expecting to be rewarded for lower utilization
- Payers listen to data...especially cost data
- Be transparent, admit faults
- Establishing a relationship of trust can pay off
- Include physician support



The “Game Changer” publication



Physical Therapy for Acute Low Back Pain Associations With Subsequent Healthcare Costs

Julie M. Fritz, PhD, PT, ATC,*† Joshua A. Cleland, PhD, DPT, FAAOMPT,‡
Matthew Speckman,§ Gerard P. Brennan, PhD, PT,* and Stephen J. Hunter, MS, PT, OCS*

SPINE 2008 Vol 33, 16, pp 1800-1805



Study Results:

- PT care was not consistently adherent to evidence based guidelines
- Adherent care was associated with better clinical outcomes for PT episode.
- Adherent care was associated with lower utilization of:
 - Prescription medications (37%)
 - Imaging (56%)
 - Injection procedures (58%)
- Average cost savings per case was \$1400 (n=493) **\$700K**



Pay for Quality Program

- Payer pays participating therapists personally up to \$2500 per year
- Payment based on goals met at the clinic level
- Minimum requirement to participate
 - Data collection at 80%
 - Clinical quality at 90%
 - Regular self evaluation



Program Details

- Goal agreement
- Process for measurement
- Chart review process
- Business plan document
- Contract
- Therapist eligibility
- Consistent with fair pay practices
- Administration, HR & Legal approval



Goal Example (Total Knee Arthroplasty)

*“Therapists **must achieve a ninety percent (90%) rate of compliance** with the recommended care process for TKA. Compliance will be verified by chart review...Compliance rates will be measured for accountability...”*



Goal Example (Low Back Pain)

*“Each Provider clinic must achieve a 75th percentile rank or greater for achieving a reduced proportion of Members that “fail to progress” when compared to the percentile ranking of all other Provider clinics.
The 75th percentile Goal is 20.0% failure to improve.
If a Provider clinic hits or exceeds a lower percentile threshold... (they) will be deemed to have met the LBP Stretch Level Goal”.*



The Future Will Change

“Healthcare delivery is likely to change in ways that will make the last decade’s adoption of Obamacare look trivial.... It may be hard to see now, but the seeds of the next great growth industries are taking root now”

-Harvard Business Review April 17, 2020

- Can we justify rehabilitation is an essential service?
- Can we justify a continuation of telehealth reimbursement?
- What is the appropriate patient selection for remote care?
- What is the value of integrating care across the continuum?
- Will this new transparency with payers continue?
- Will value based payment accelerate?



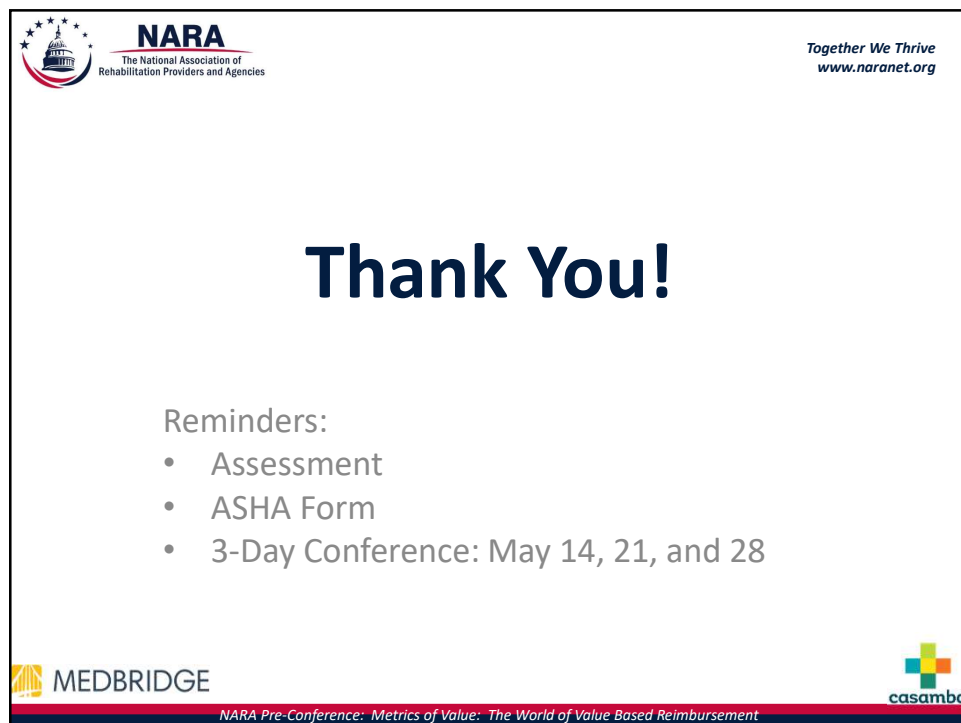


Questions

Discussion

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Intermountain
Healthcare
Partnering for Life



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Thank You!

Reminders:

- Assessment
- ASHA Form
- 3-Day Conference: May 14, 21, and 28

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