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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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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 1: Speaker Introductions

Mary Van de Kamp, MS/CCC-SLP
RehabCare

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

Ron Scharff, PT
Kindred Healthcare

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

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Value Based Care : Past and Future
May 5, 2020
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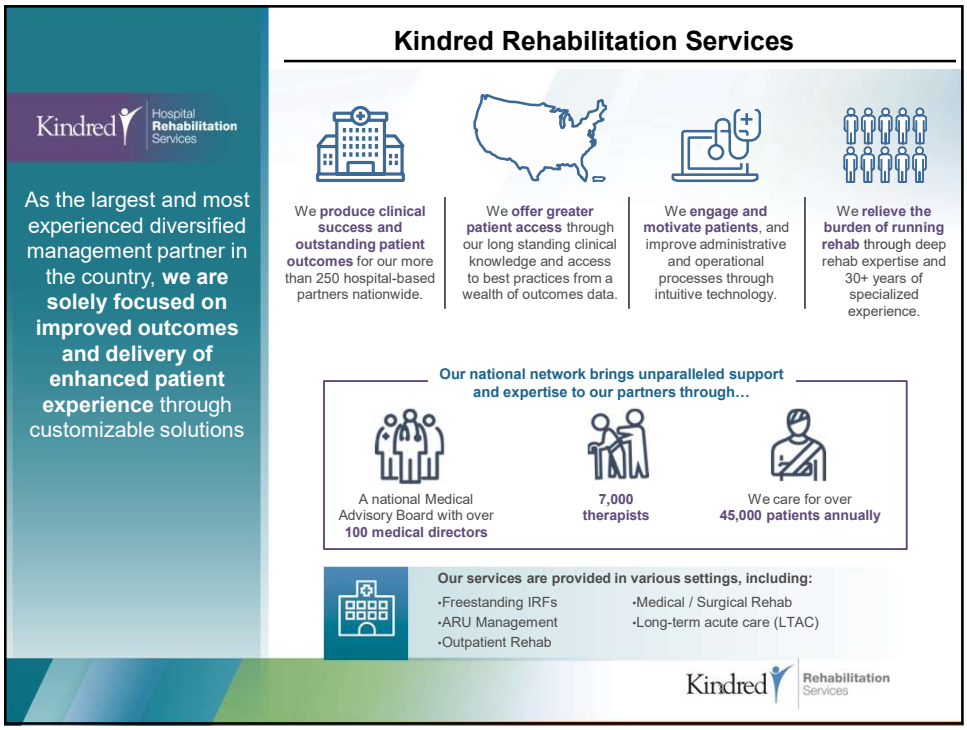
Kindred Hospital Rehabilitation Services
As the largest and most experienced diversified management partner in the country, we are solely focused on improved outcomes and delivery of enhanced patient experience through customizable solutions
Kindred Rehabilitation Services
We produce clinical success and outstanding patient outcomes for our more than 250 hospital-based partners nationwide.
We offer greater patient access through our long standing clinical knowledge and access to best practices from a wealth of outcomes data.
We engage and motivate patients, and improve administrative and operational processes through intuitive technology.
We relieve the burden of running rehab through deep rehab expertise and 30+ years of specialized experience.
Our national network brings unparalleled support and expertise to our partners through…
A national Medical Advisory Board with over 100 medical directors
7,000 therapists
We care for over 45,000 patients annually
Our services are provided in various settings, including:
•Freestanding IRFs
•ARU Management
•Outpatient Rehab
•Medical / Surgical Rehab
•Long-term acute care (LTAC)
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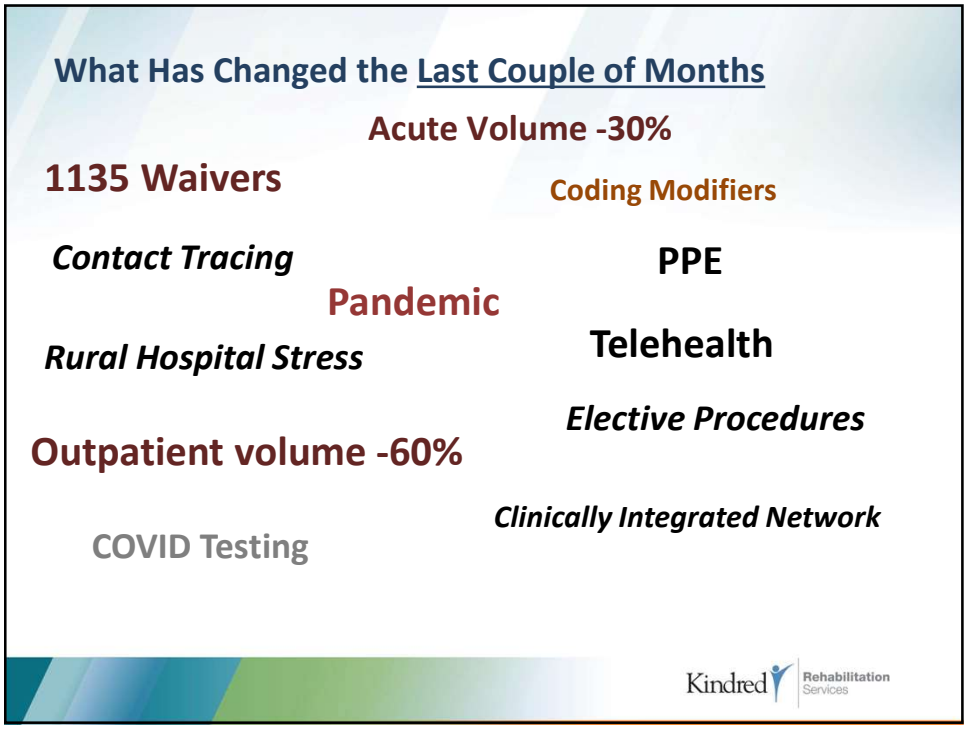
What Has Changed the Last Couple of Months
Acute Volume -30%
1135 Waivers
Coding Modifiers
Contact Tracing
PPE
Pandemic
Telehealth
Rural Hospital Stress
Elective Procedures
Outpatient volume -60%
Clinically Integrated Network
COVID Testing
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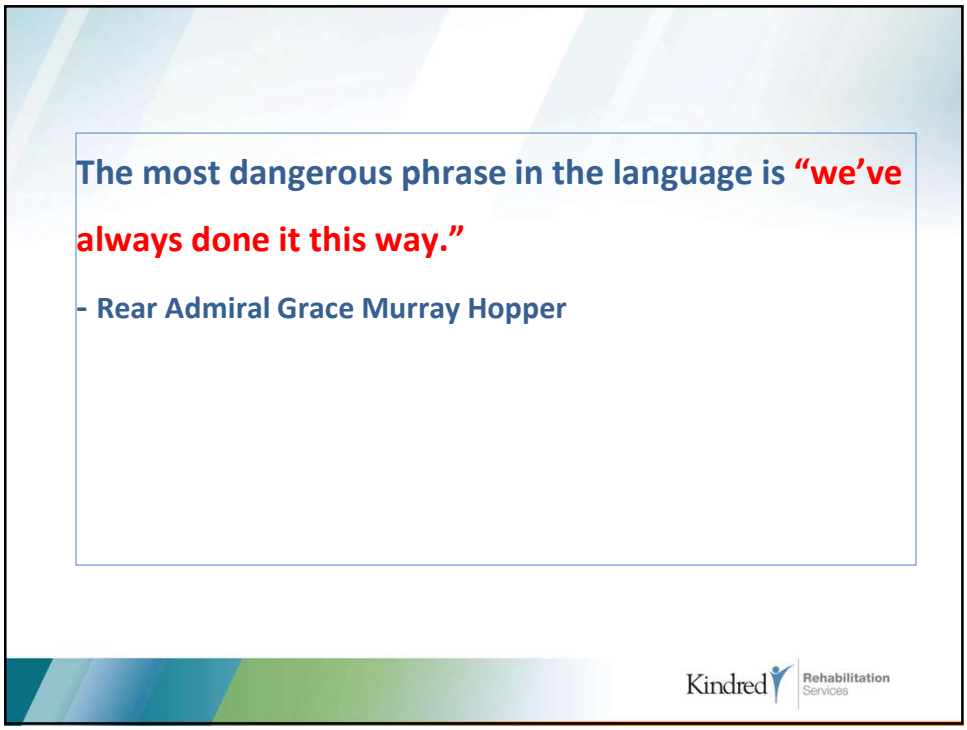
The most dangerous phrase in the language is "we've always done it this way."
- Rear Admiral Grace Murray Hopper
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What is Value Based Care

- Intentional movement from fee-for-service reimbursement to models based on the measured, positive value of the services
- Value measured has been predominantly operational rather than patient-centric
- Volume lever is replaced by but controlling costs downstream, often by accumulating the costs by the episode of care (30-, 60-, 90-days)
- 'The Game" becomes long term cost curve rather than a one time savings opportunity
- CMS and payors must address episode and capitation
- Referral selectively is essential to control costs by focusing on downstream volume and length of stay /visits, as well as the performance of providers
- Relationships and measured outcomes become all the more data driven

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What Has Changed the Last Couple of Years

Medicare Spend per Beneficiary

Managed Care Contracting

Value Based Payment

Alternate Payment Model

Medicare Therapy Caps

Modifiers

Bundle Payment Care Initiative - Advanced

MACRA/ MiPs

HCAPHs

Population Health

Preferred Provider Network

Convener

Uncompensated care

Accountable Care Organization

Medicaid Waiver

Telehealth

Clinically Integrated Network

High deductible health plan

NextGen ACO

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What Has Changed the Last Couple of Years (1)

CMMI Innovation Models marching toward downside risk:

- Medicare Advantage
- MSSP ACOs – Tracks with downside risk
- Next Generation ACOs
- Primary Care First
- CPC+ Groups
- Specialty Care Models
- Bundle Payment Care Initiative, and
- Direct Contracting Enterprise (January 2021)

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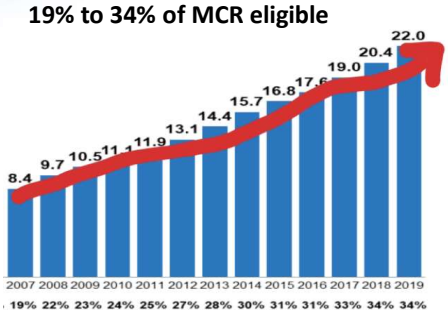
What Has Changed the Last Couple of Years (2)

CMS marching toward Advantage Plans:

MA enrollment has grown from 19% to 34% of MCR eligible



- CMS publicly praises MA and gives special benefits
- CMS references MA as an alternative to provider-based models
- Patients voluntarily choose to be in MA plans

Result:

- MA proves a cost-effective model
- MA plans become increasingly expenditure constraint vehicles rather than benefit coverage models
- MA moves more risk downstream to physicians, posing a financial choice to physicians & providers
- Will CMS make MA ultimately Medicare's capped/ privatized future?

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Participation Decision Points MAP vs. MSSP

Factor	MAP	MSSP
Patient profile		Older, higher HCC
Attribution Method	Variety of models	Pro- or retrospective per track
Referrals & Network	Patients forced to use PCP	PCP as quarterback
Payment mechanism	Risk score estimates expected expenditure; when risk score fluctuates, so too expenditure. Earn savings when below expected value.	Benchmark estimate does not fluctuate with actual experience.
Assessing Pop Risk		Benchmark does not account for acuity over time.
Quality metric aligned	Variable based on negotiated contract	Metrics are the same for all. May change year to year
PAC Management	Short SNF LOS; payer provide resources to manage PAC & population	Short SNF LOS; CMS provides no resources for management

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Rehab Providers Must Appeal to Different Stakeholders

Executive/ Stakeholder	Strategies or Tactics
Physician Association (Alliance)	MD engagement, MACRA/MiPS participation, Alternative Payment Model participation
Chief Financial Officer (Hospital Cost Control)	Medicare Spend, MSSP arrangement, Managed Care, Clinically Integrated Network, Brand Management
Population Health Management	Chronic condition control, PAC alignment and performance, Quality outcomes (ER utilization, Readmissions)
CMO, CNO (HRRP and HCAPHs)	Medicare Spend Per Beneficiary, Patient Satisfaction Surveys, PAC Performance
Managed Care, CIN, or ACO Director	New Contracts, Preferred Provider or Clinically Integrated Networks

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KRS' VBC observations and experiences

Hospitals & health systems chose VBC models:

- Revenue opportunities and expense management
- Capitalize on existing services
- Align services that equal the broader mission of service and sustainability
- Replicable across the enterprise

Different models were undertaken to meet enterprise goals:

- Medicare savings,
- clinical alignment,
- physician engagement (MACRA),
- PAC narrow network and control wide variation in quality and utilization,
- develop bench-strength for managed care contracting, and
- Develop direct-to-employer contracting

KRS partners and clients in BPCI Models :

- IRFs experienced -10% to -37% impact on admissions,
- SNFs experienced declining volume and days without reward for goal achievement.

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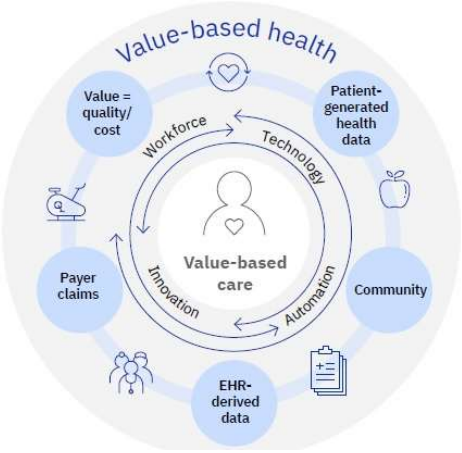
VBC Implementation Strategies - Ideal

- Consult the consumer
- Embrace empathetic automation
- Build support for analytics
- Focus on time to value
- Overcome innovation barriers
- Optimize the "value" equation – value = quality/cost
- Quality = operational and patient-centric measures



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Opportunities and Challenges for VBC Success

Clinical Variation reduction

- Clinical standardization
- Reduce inpatient waste

Care Transformation tactics

- Physician engagement/ control
- Care redesign activities
- Care management & coordination tactics (telehealth)
- Post acute operational changes
  - ✓ Readmission reduction
  - ✓ Limitation of volume and days (visits)
  - ✓ Medical condition segmentation
- Patent engagement and education
- Community-based social services alignment
  - ✓ Housing & food
  - ✓ Transportation
  - ✓ Mental health

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Opportunities and Challenges for VBC Success (2)

How providers may be successful under new models:

- Be low cost and high quality from outset
- Be in a low cost market area
- Influence both cost and quality for specific patient cohorts
- Demonstrate genuine senior management commitment
- Dedicate resources (available capital, equipment, professional skills)
- Provide strong clinical leadership and buy-in
- Adapt prior payment model or population management experience

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Rehab Services' best role is to actively support VBC models:

- Participation on the organizing committees
- Access educational materials for Case Management and clinicians:
  - Patient identification and assessment
  - Acute tracking tools
  - PAC placement protocol
  - Post-acute tracking tools
- Mutually share operational data and benchmarking practices
- Protocol for identification, assessment, and recommendation (placement)?
- Formalize systems to determine placement options: HHS, SNF, IRF, LTACH?
- Risk stratification and/or predictive risk assessment?
- Why do some networks perform better than others:
  - Patient assessment and preparation
  - Standardized perioperative care
  - Development of PAC services and partnerships

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Considerations for the VBC Conference and "New Normal"

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