Metrics of Value: The World of Value Based Reimbursement

Tuesday, May 5, 2020

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
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

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.
Value Based Care: Past and Future

May 5, 2020

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.

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)
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

The most dangerous phrase in the language is “we’ve always done it this way.”

- Rear Admiral Grace Murray Hopper
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

What Has Changed the Last Couple of Years

Medicare Spend per Beneficiary
Managed Care Contracting
Alternate Payment Model
Value Based Payment
Medicare Therapy Caps
Modifiers
Bundle Payment Care Initiative - Advanced
MACRA/ MiPs
HCAPHs
Convener
Population Health
Preferred Provider Network
Uncompensated care
Accountable Care Organization
Medicaid Waiver
Telehealth
Clinically Integrated Network
High deductible health plan
NextGen ACO
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)

What Has Changed the Last Couple of Years (2)

CMS marching toward Advantage Plans:
- 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?
### Participation Decision Points MAP vs. MSSP

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

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

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
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
- Patient engagement and education
- Community-based social services alignment
  - Housing & food
  - Transportation
  - Mental health

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
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

Considerations for the VBC Conference and “New Normal”