Disclosure of Commercial Interests

I have commercial interests in the following organization(s): (or I consult for the following organizations)

President
DeRousse Healthcare Consulting, LLC
DeRousse Healthcare Consulting,, LLC specializes in post-care care, bundled payment initiatives, survey readiness, accreditation preparation, as well as program and process improvement.

Achieving Success in a Bundled Payment World

ACHCA 2017 Fall Forum
November 18, 2017

Presenter Rebecca D. DeRousse, MBA, MHA, CNHA, RHIA (retired)

Rebecca DeRousse has been a licensed nursing home administrator for over 30 years. She has also served a rehabilitation hospital administrator.

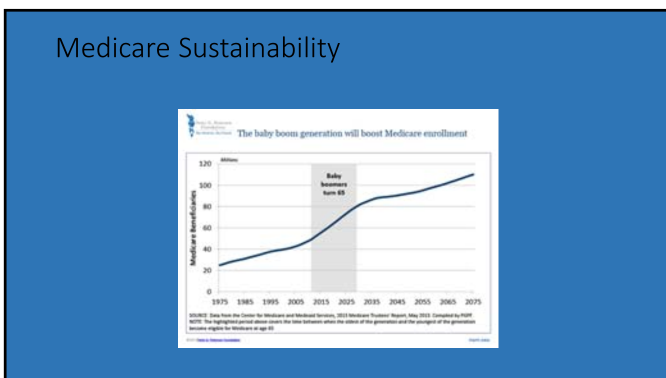
She has been working as a BPCI consultant since April, 2015.

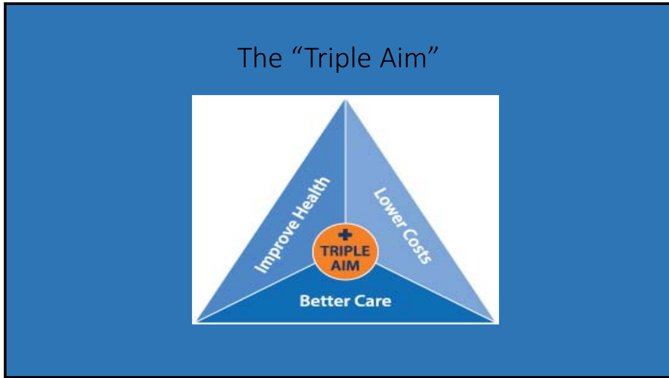
She is President of DeRousse Healthcare Consulting, LLC, which specializes in post-acute care.

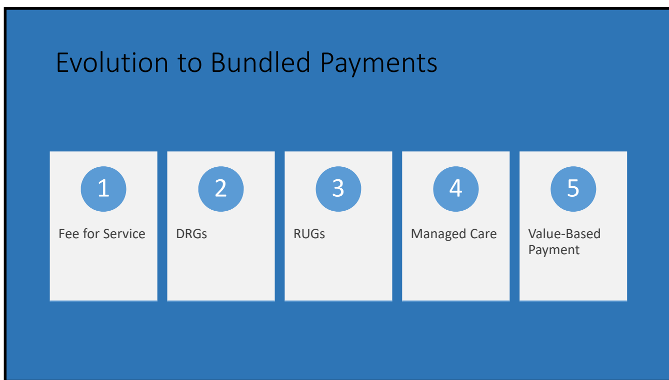
Why Bundled Payments are Here

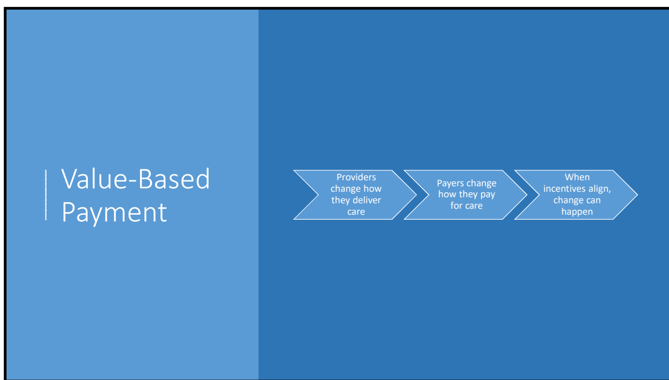
- Need to preserve Medicare funding beyond 2028
- Healthcare costs continue to rise at exorbitant rates
- Healthcare insurance premiums continue to rise –
  - Family of four - $22,030
    - Employer portion - $12,886
    - Employee portion - $ 9,144 – Increase of 6.5% over last year

    (Forbes.com)




The "Triple Aim"
Improve Health
Lower Costs
TRIPLE AIM
Better Care


Evolution to Bundled Payments
1
Fee for Service
2
DRGs
3
RUGs
4
Managed Care
5
Value-Based Payment


Value-Based Payment
Providers change how they deliver care
Payers change how they pay for care
When incentives align, change can happen

What is a Bundled Payment

- Providers – most appropriate, lowest cost setting at the right time – Largest opportunity for savings/risk methodology in which payments to a variety of healthcare providers are linked into one payment by a predetermined grouping of health care costs
- Single target price for full continuum of care
  - Hospital
  - Physician
  - Post-Acute Care

Post-Acute Care Providers

- Inpatient Rehabilitation Facilities (IRF)
- Long-Term Acute Care (LTAC)
- Skilled Nursing Facilities (SNF)
- Home Health
- Outpatient Therapy
- Part B
  - DME
  - Lab
  - Drugs

Types of Bundles BPCI – Model 2

- CMS Pilot Program (CMMI/ACA) through September 30, 2018
- Voluntary program
- Certain orthopedic DRGS may be selected for inclusion – TKA, THA, TSA, revisions, Hemiarthroplasty/bipolar for hip fx's, spinal fusions
- Managed by orthopedic surgeons
- Medicare Part A and B patients, Railroad
- Episode of Care Begins at Hospital Admission
- Episode of Care Ends 90 days after Hospital Discharge
- All procedures, acute and post-acute services are included during this time, regardless if it relates to diagnosis

Types of Bundles
BPCI – Model 2

- Waiver of 3-day hospital stay
- Bill to Medicare in same mechanism as with all patients

- BPCI Advanced – Set to start October 1, 2018
  - Details not available yet

Types of Bundles
BPCI – Model 3

- Retrospective Post-Acute Care Only
- Post-acute provider or physician group practice triggers episode of care
- Primary participants in Phase 2 are SNFs
- Extends through September 30, 2018

Episode Payment Models
Mandatory – Medicare
Proposed Changes and Cancellations – August 15, 2017

- Managed by hospitals
- Shift Medicare payments from rewarding quantity to rewarding quality by creating strong incentives for hospitals to deliver better care to patients at a lower cost
- Target price established – Hospital to receive additional payment from Medicare or be required to repay Medicare for a portion of the episode spending, dependent upon actual spend
- Goals:
  - Avoid complications
  - Prevent hospital readmissions
  - Speed recovery

Episode Payment Models - Orthopedic

- Comprehensive Care for Joint Replacement (CJR)
  - Proposed Changes
- Surgical Hip and Femur Fracture Treatment (SHFFT)
  - Proposed Cancellation

Types of Bundles
CJR

- CMS Pilot – (CMMI/ACA) – effective April 1, 2016 – Risk sharing to be added January 1, 2018
- Mandatory for hospitals in 67 Metropolitan Statistical Areas (MSA)
- Proposed Changes to scale back to 34 MSAs for mandatory participation
  - Greater potential to demonstrate significant changes in episode spending
- Participation would be voluntary for remaining 33 MSAs, as well as for low-volume and rural hospitals
  - One time opt-out – Voluntary election period January 1-31, 2018
- If physician in BPCI, his patients will continue under BPCI
- Medicare Part A and B
- DRG Diagnoses – Lower extremity total joints, Hemiarthroplasties for hip fx's – DRGs 469 and 470
- Episode begins with hospital admission
- Episode ends 90 days after hospital discharge
- All procedures, acute and post-acute care related to LE joint procedures only

Surgical Hip and Femur Fracture Treatment (SHFFT)
Proposed Cancellation August 15, 2017

- Mandatory for Hospitals in 67 Metropolitan Statistical Areas – same as CJR
- First performance period began July 1, 2017
- Start date January 1, 2018
- To end on or about December 31, 2021
- Episode begins with hospital admission
- Episode ends 90 days after hospital discharge
- DRG Diagnoses not covered under BPCI
  - DRG 480 – Hip and femur procedures except major joint with major complication or comorbidity
  - DRG 481 – Hip and femur procedures except major joint with complication or comorbidity
  - DRG 482 – Hip and femur procedures except major joint without complication or comorbidity

Episode Payment Models – Cardiac
Proposed Cancellation – August 15, 2017

- Acute Myocardial Infarction (AMI)
- Coronary Artery Bypass Graft (CABG)
- Cardiac Rehabilitation (CR) Incentive

Episode Payment Models – Cardiac
Proposed Cancellation – August 15, 2017

- First performance period began July 1, 2017
- Start date is January 1, 2018
- To end on or about December 31, 2021
- Episode begins with hospital admission
- Episode ends with 90 days after hospital discharge
- Mandatory for Hospitals in 98 geographic areas

Acute Myocardial Infarction (AMI)
Proposed Cancellation – August 15, 2017

- DRG Diagnoses:
  - DRGs 280 to 282 – AMI , discharged alive with MCC, CC, without CC/MCC
  - DRGs 246 to 251 – Percutaneous cardiovascular procedures with drug-eluting stent, non-drug-eluting stent, or without coronary artery stent

Coronary Artery Bypass Graft (CABG)
Proposed Cancellation – August 15, 2017

- DRGs:
  - DRG 231 – Coronary bypass with percutaneous transluminal coronary angioplasty (PTCA) with MCC
  - DRG 232 – Coronary bypass with PTCA with MCC
  - DRG 233 – Coronary bypass with cardiac catheterization with MCC
  - DRG 234 – Coronary bypass with cardiac catheterization without MCC
  - DRG 235 – Coronary bypass without cardiac catherization with MCC
  - DRG 236 – Coronary bypass without cardiac catherization without MCC

Acute Myocardial Infarction (AMI)
Coronary Artery Bypass Graft (CABG) –
Proposed Cancellation – August 15, 2017

- Target pricing based on blend of provider specific and regional pricing
- Quality and Pay-for-Performance Methodology
  - Achieve minimum level of quality when spend is below target price
  - Incentivizes to avoid expensive and harmful events
  - Provide hospitals with data/waivers to encourage flexibility/sharing best practices
  - Composite quality score
    - 30-day mortality rate
    - Excess LOS in acute care
    - HCAHPS

Cardiac Rehabilitation (CR) Incentive
Proposed Cancellation – August 15, 2017

- Initial payment - $25 per cardiac rehabilitation service for each of first 11 services paid for by Medicare during the care period for an AMI or CABG care episode
- After 11 services are paid by Medicare – Payment would increase to $175 per service paid for by Medicare
- Services limited to maximum of two one-hour sessions per day for up to 36 sessions over up to 36 weeks – Option for additional 36 sessions over extended time period if approved
- Intensive cardiac rehab program – limited to 72 one-hour sessions, up to 6 sessions per day, over a period of up to 18 weeks

Resources for Medicare Bundles

- https://innovation.cms.gov/initiatives
- www.federalregister.gov/agencies/centers-for-medicare-Medicaid-services
- Department of Health and Human Services – Centers for Medicare and Medicaid Services – 42 CFR Parts 510 and 512

Possible Actions to Replace Mandatory Medicare Bundles

- Change mandatory bundles to voluntary bundles
- Considered altering design for voluntary bundles for EOM but not enough time for hospitals to prepare by January 1
- Originally proposed mandatory bundles might reemerge as voluntary, perhaps under BPCI Advanced (October, 2018)

State Initiatives

- States have their own forms of bundled payment initiatives
  - Commercial
  - Medicaid
  - Multiple procedures and conditions

Important to know what is available in your state

Why Strive to Become a Preferred Provider

- Bundled Payments are here to stay
  - Increasing in number
  - Increasing in payers utilizing bundled payments
- Alignments crucial with hospital systems to maintain census
- Key strategy to financial viability

Becoming a Preferred Provider

Quality	Improve Quality
Cost	**Reduce Cost of Patient Stay**
Data/ Outcomes	**Be Data Driven/Outcomes Focused**

Improve Quality

- Differentiate your facility through your quality in order to become a preferred provider
  - Utilize your Facility Assessment to help you determine in what areas you excel – Niche
- Three star or above rating – Recommended to be a preferred provider

Improve Quality

- Low hospital readmission rate
- Low infection rate
- Low occurrence of acquired or worsened pressure ulcers
- Low occurrence of falls with major injury
- High percentage of discharge to community
- High increase in functional improvement
- Standardized care pathways for evidence-based practice

Reduce Cost

LOS	**Reduce length of stay**
Discharge	**Goal must be to get patient home as quickly as possible in a safe manner**
Efficiency	**Provide efficiencies in operations**
Eliminate	**Eliminate redundancies**

Reduce LOS

- Impact to census – occupancy issue for facility
- Important to be in a preferred provider network in order to keep referrals coming to replace patients as they discharge earlier to the community
- Reduced LOS is the right thing to do for the patient
- Assure discharge is safe with reduced LOS – do not want patient to experience a readmission to the hospital

Be Data Driven – Outcomes Focused

What gets measured, gets improved.

Peter Drucker

Be Data Driven-Outcomes Focused

- Establish metrics – many established for you and provided in MDS data
- Be able to share your data with potential partners in simple graph format to demonstrate your good work
- Be able to filter your data for a particular diagnosis/population
- Hospital readmissions - key as hospitals are penalized for readmissions
- Be thoughtful in the development of your performance indicators for your QAPI program
- Include Patient Satisfaction in your metrics

What Providers Expect of SNFs

- Seven day/week admissions and discharges – 24 hours/day
- Seven day/week therapy
- Nursing competency to provide care to reduce hospital readmissions
- Open dialogue during the post-acute care stay on patient progress and estimated length of stay

What Providers Expect of SNFs

- Coordination for discharge planning
- LOS – 7 to 10 days average
- Follow protocols
- Multidisciplinary team approach to care
- Embrace bundle culture

Determine Alignment of Provider Network

- **Based on**
  - **Culture**
  - **Mission, vision, values**
  - **Integrity**
  - **Patient Centered Care**
  - **Safety**
  - **Positive contribution to value**

Be Proactive in Establishing Relationships

- Network
- Relationships
- Communication
- Data
- Gainsharing

Network

- Start conversations with all potential partners
  - Hospitals
  - Physicians

Providers are narrowing their networks in order to have the right care for their patients.

Relationships

- Develop Relationships within the organizations of potential partners
  - Start at the top
  - Work with relationships already established (hospital case managers)

Establish trust

Communication

- Maintain open communication between your facility and potential partners
  - Establish regular meetings
  - Be available and respond promptly for any patient needs

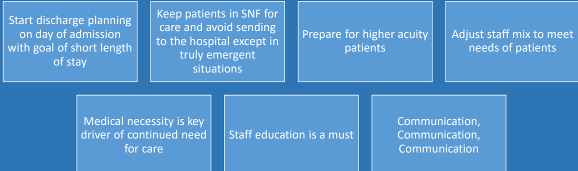
Provide Data/Outcomes Information

- **Be transparent**
- **Filter according to need of population mutually serving**
- **Assure information provided meets potential provider needs**
- **Graphs when possible to show trends**

Gainsharing

- **Discuss opportunities for gainsharing**
  - **More engagement/buy-in by each organization if incentives and risk-sharing are a part of the preferred provider agreement**
  - **Available in CJR for SNFs**

Success Requires Culture Change



Summary

- New world order – Expect expansion of voluntary bundled payment programs
- Change is inevitable
- Must keep up with the times in order to survive
- While change can be scary, it can also be exciting.
- Strategically plan for your organization to be viable into the future
- Prepare to be a preferred provider in the right networks for your facility

Questions?

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