Peace, Love & Understanding the Post-Acute Environment to Prepare for Advanced Payment Models

Chris Murphy, CPA|Partner
BKD, LLP; Tulsa, OK

cmurphy@bkd.com
@PACchrismurphy
HHS goal of 30% of traditional FFS Medicare payments through Advanced Payment Models (APMs) by the end of 2016 and 50% by the end of 2018
Key concept: episode of care
Payment Drives Culture

FFS
- Drive Frequency & Intensity
- Cross-Continuum Competition

APM
- Drive Efficiency
- Patient Experience
- Cross-Continuum Cooperation
Are We Drawing the Right Conclusions from Historical Information?

Medicare has already established the Regional Average Payment for DRG 470 at $25,989, which will be combined with Hospital's historical payments to create target prices. Overlaying Hospital's historical claims with the regional average is a good indicator of risk and opportunity. In some episodes, clinical intervention may curb high payments driven by post-acute providers or readmissions—or both.
Putting the Pieces Together

- 5-Star Ratings
- Use of UPL Payments
- Staffing levels, stability
- Value as a Collaborator
- Scorecard?
- Quality Indicators & Trend
- Financial Impact of Changes
- Discharge Frequency by Site
- Clinical Competencies, Competitive Advantage

Scorecard?
A Collaborator’s View

- Readmits & Cost
- Anecdotal “Evidence”
- Provider Compare

Desirability of Collaboration
## Is SNF PPS a PAC Competitive Disadvantage?

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Payment Methodology</th>
<th>Behavior Incentivized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled nursing</td>
<td>Per-diem, driven by resource utilization</td>
<td><strong>Increase LOS; increase service intensity</strong></td>
</tr>
<tr>
<td>Home health</td>
<td>Per 60-day episode of care, higher for greater rehab visits</td>
<td><strong>Lower frequency of visits</strong>, hit rehab visit thresholds</td>
</tr>
<tr>
<td>Inpatient rehab</td>
<td>Per-discharge, driven by case-mix</td>
<td><strong>Manage LOS</strong></td>
</tr>
<tr>
<td>CAH swing bed SNF</td>
<td>Medicare share of cost + 1% (less sequestration)</td>
<td>Increase swing-bed utilization to increase Medicare coverage of overhead costs</td>
</tr>
<tr>
<td>Long-term acute care hospital</td>
<td>Per-discharge, driven by diagnosis, complications &amp; comorbidities</td>
<td>Admissions in the right categories (vent, ST ICU stays, burns, wounds), <strong>manage LOS</strong></td>
</tr>
</tbody>
</table>
### ...Or a Strategic Advantage?

<table>
<thead>
<tr>
<th>Patient Description</th>
<th>Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Active 70-year old patient</strong></td>
<td>7 days @ RUB ($590)</td>
</tr>
<tr>
<td></td>
<td>$4,130 per episode</td>
</tr>
<tr>
<td><strong>80-year old patient, COPD</strong></td>
<td>14 days @ RMB ($365)</td>
</tr>
<tr>
<td></td>
<td>$5,110 for the episode</td>
</tr>
<tr>
<td><strong>ICF Patient</strong></td>
<td>14 days @ RMB ($365), 16 days at RLA ($240)</td>
</tr>
<tr>
<td></td>
<td>$8,950 for the episode</td>
</tr>
</tbody>
</table>
Collaborator Expectations of PACs

• Open communication about individual patient status

• Track & report readmissions

• Targeted LOS based on patient characteristics and care needs

• Physical therapy initiated timely

• Consistent quality staffing throughout the week
Build A Scorecard That Tracks What Matters?

Nursing home or home health compare
- Survey results vs. staffing vs. quality measures

Staff information
- Stability in key positions (administrator, nursing leadership, etc.)
- Turnover rates
- Staffing mix during key periods (i.e. heavy admission/transition days)

Financial information
- Medicare payments for high-frequency cases
- Factors affecting payments

Patient discharge disposition, sliced & diced
Preferred Providers

- Hospitals have flexibility to recommend “preferred providers” from the post-acute setting per CMS.
  - Patients will still maintain right to choose
Math? You didn’t say there’d be math?
5-Star Calculations Simplified

<table>
<thead>
<tr>
<th>Step</th>
<th>Discussion</th>
<th>Illustrative Rating</th>
<th>Adjusted Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health inspection rating</td>
<td>3-year composite, weighted 1/2, 1/3, 1/6</td>
<td>2.00</td>
<td>★★★</td>
</tr>
<tr>
<td>Adjust for staffing</td>
<td>Add 1 if 4-5 stars, &gt; inspection score; Subtract 1 if 1 star</td>
<td>4.00</td>
<td>★★★★</td>
</tr>
<tr>
<td>Adjust for quality measures</td>
<td>Add 1 if 5 stars; subtract 1 if 1 star</td>
<td>4.00</td>
<td>★★★★</td>
</tr>
</tbody>
</table>

**Note:** If health inspection rating is 1 star, overall rating cannot be more than 2 stars.
5-Star Staffing Metrics

• Overall rating
  • Starts with overall, then adjusted for RN
  • Low overall score?
    • Insufficient staffing?
    • Low turnover?
    • Bad CMS-671?

• Reported v. Expected
  • Based on MDS & STRIVE studies
  • RN hours expected > reported
    • Readmission risk
    • Quality of nursing care
# Quality Metrics that Reflect Care – Skilled Nursing

<table>
<thead>
<tr>
<th>Metric</th>
<th>What it Says about the Facility</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of short-stay residents who self-report moderate to severe pain</td>
<td>Patient experience? Pain management program?</td>
<td>15%</td>
</tr>
<tr>
<td>% of short-stay residents with new or worsened pressure ulcers</td>
<td>Facility sanitation? Clinical competence? Patient engagement?</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>% of short-stay residents with improved function</td>
<td>Effectiveness of short-term treatment programs? What specialty?</td>
<td>65%</td>
</tr>
<tr>
<td>% of short-stay residents rehospitalized after nursing facility admission</td>
<td>Quality of staff? RN staffing? Need for assistance with physicians?</td>
<td>21%</td>
</tr>
<tr>
<td>% of short-stay residents with an outpatient ER visit</td>
<td>Quality of staff? RN staffing? Need for assistance with physicians?</td>
<td>11%</td>
</tr>
<tr>
<td>% of short-stay residents successfully discharged to community</td>
<td>Effectiveness of skilled services</td>
<td>56%</td>
</tr>
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</table>
Success in Post-Acute Care

• Know partners’ capabilities and strengths

• Place patients in the right PAC setting the first time

• Avoid acute readmissions

• Seamless patient transitions

• Address PAC expectations up front with patient and family
Case Management Done Right!

• Current focus: clear the bed by any means possible

• Future focus:
  • Clear the bed within the anticipated LOS
  • With as little transitional stress to the patient as possible
  • To the PAC setting and provider that provides the best value

• Requires
  • Educated/knowledgeable case managers
  • Onsite interaction with post-acute care admission coordinators
  • Hard look at our processes & relationships
“For the hospital CEO or CFO out there who says, ‘I’m doing really well in fee-for-service, so I’m just going to stick with it and it’s going to be OK’, eventually it will not be OK, and I actually predict it will not be OK in a much shorter time frame than they imagine.”

Patrick Conway, MD
Deputy Administrator, CMMI
Chris Murphy, CPA|Partner
cmurphy@bkd.com
918.584.2900
@PACChrisMurphy