Health Care Reform and Person-Centered Care? Are Our Elders Getting the Rehabilitation Services They Need?

Presented by: Cindy Gensamer, LNHA
Vice President Absolute Rehabilitation & Consulting

Today's Discussion

- Med A-Innovative payment models
- The growth of ACOs
- MSPB (Medicare Spend and Value Based Purchasing)
- Companies managing the post acute benefit
- CMS Final Rule Summary
- Medicare Part B Therapy Update
- How we can still deliver therapy services with a focus on person centered care

Why Reform?

EXHIBIT ES-1. OVERALL RANKING

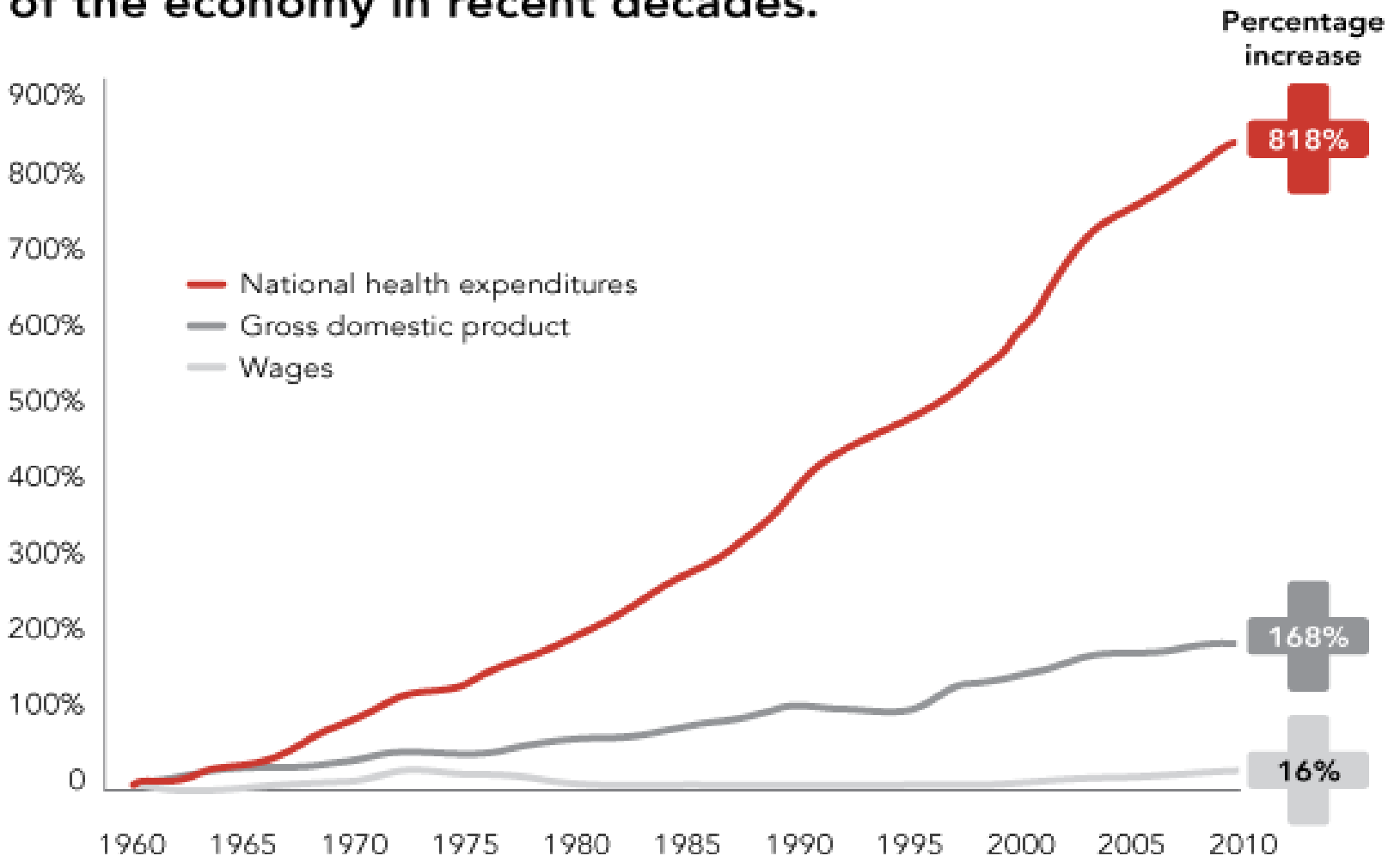
COUNTRY RANKINGS

Top 2*
Middle
Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011*; World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

Health care spending has grown much faster than the rest of the economy in recent decades.



Sources: McKinsey, "Accounting for the Cost of U.S. Health Care" (2011), Center for American Progess

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Despite high spending, Americans don't go to the doctor very frequently.

Notes: Data is from 2011 or nearest year.
Source: OECD Health Data 2013

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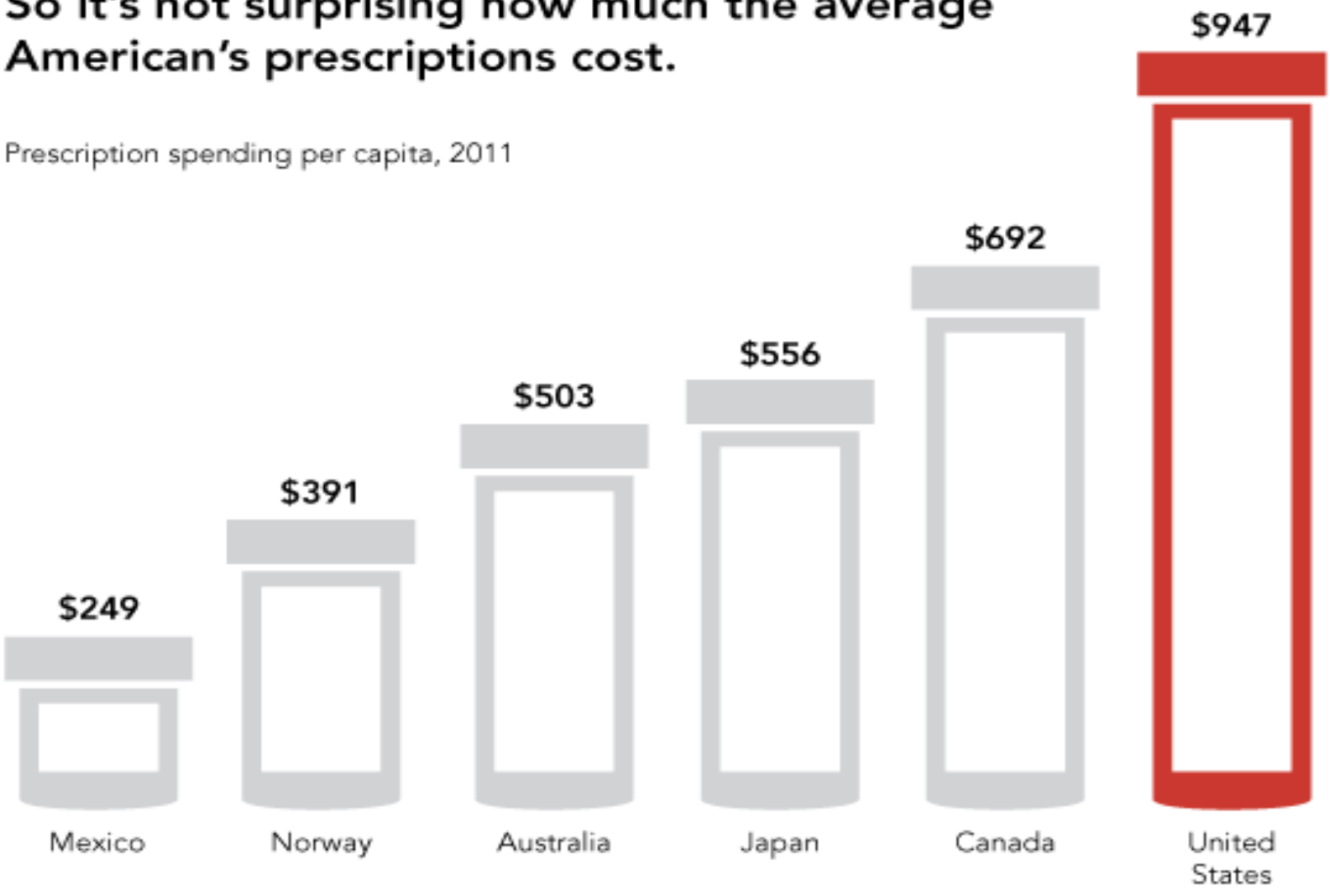
So it's not surprising how much the average American's prescriptions cost.



Notes: Numbers from Mexico and Norway cannot be separated and include medical non-durables. Data is from 2011 or nearest year.
Source: OECD Health Data 2011

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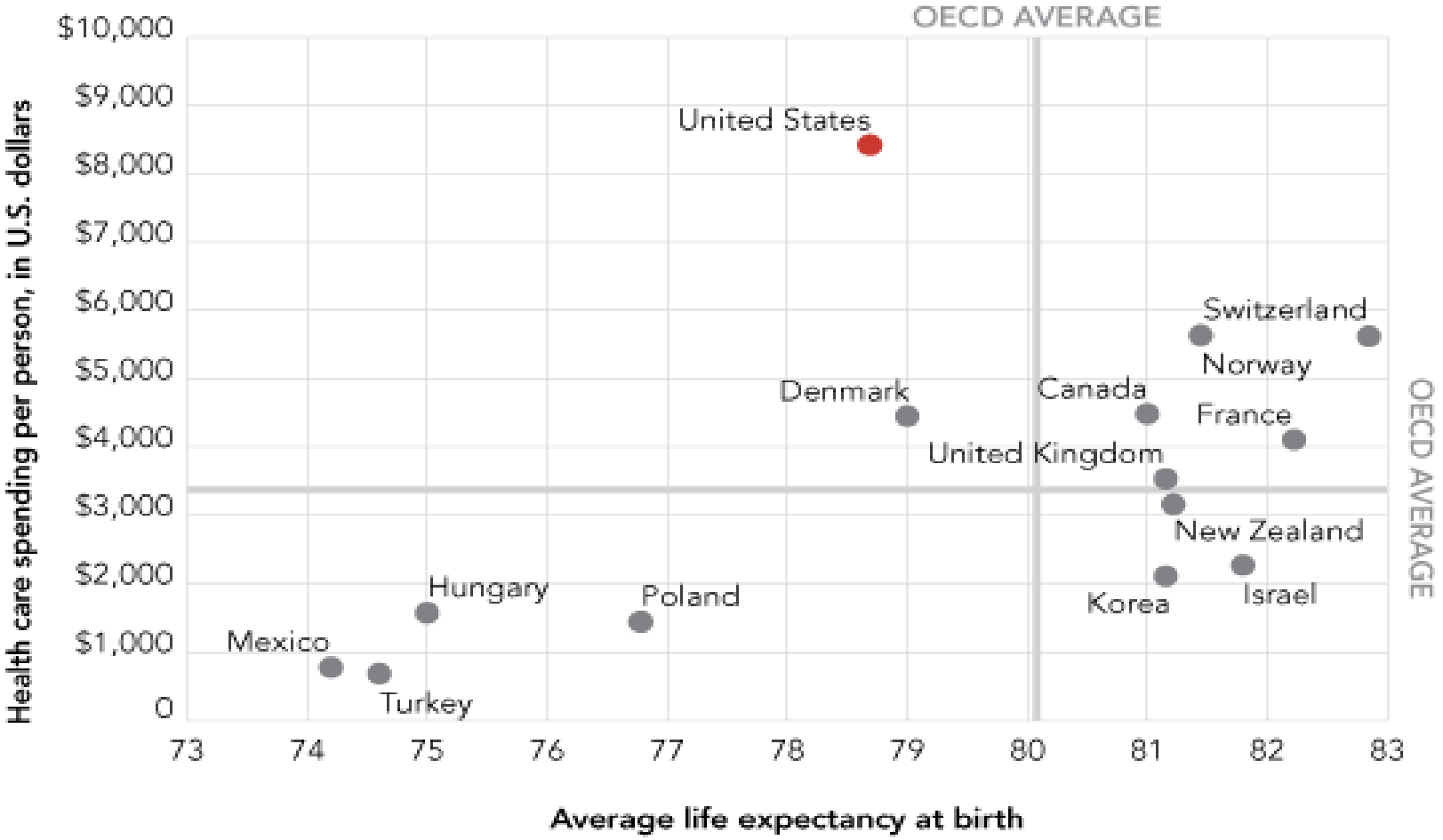
Americans don't live longer than people in countries that spend much less on health care.



Notes: Data is from 2011 or nearest year. New Zealand numbers exclude investments. Not all OECD countires are inlcuded.
Source: OECD Health Data 2013

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JANUARY 2015

THE NEED TO REFORM MEDICARE'S PAYMENTS TO SKILLED NURSING FACILITIES IS AS STRONG AS EVER

A report jointly produced by the Medicare Payment Advisory Commission and the Urban Institute

MEDPAC Medicare Payment Advisory Commission

URBAN INSTITUTE

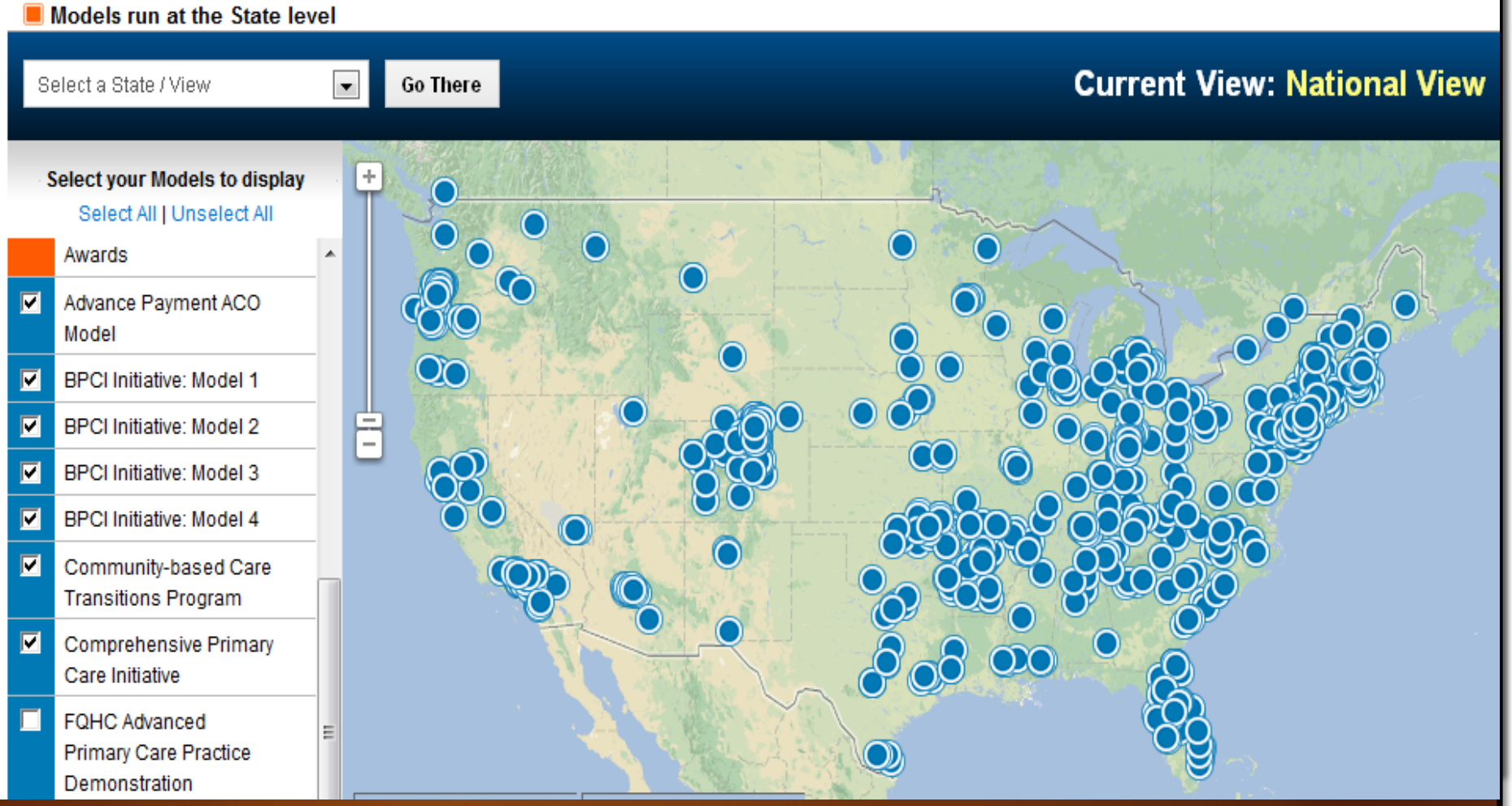
The need to reform Medicare's payments to skilled nursing facilities is as strong as ever

Executive summary

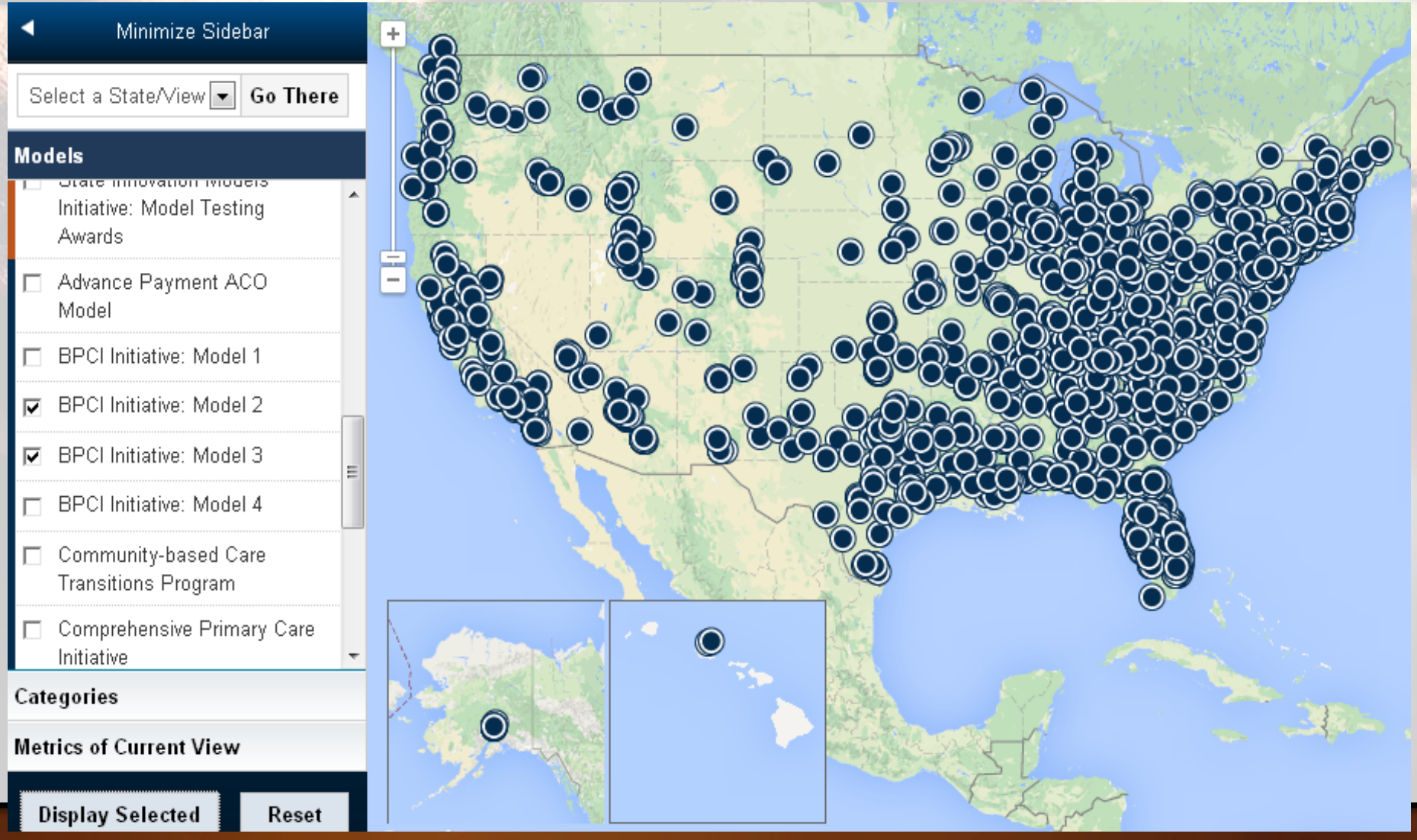
Well-documented shortcomings in the design of Medicare's payment system for skilled nursing facilities (SNFs) have prompted CMS to make many revisions to it, including shifting payments from therapy care towards nursing care. Payments for therapy services are tied to the amount of therapy provided rather than patient need and generally overpay facilities for the costs of those services. Payments for nontherapy ancillary (NTA) services do not vary with these services' costs or a patient's need for the services. As a result, SNFs face incentives to shift their patient mix toward intensive therapy case-mix groups by providing unnecessary therapy services.

2013 Innovative Initiatives 7 models

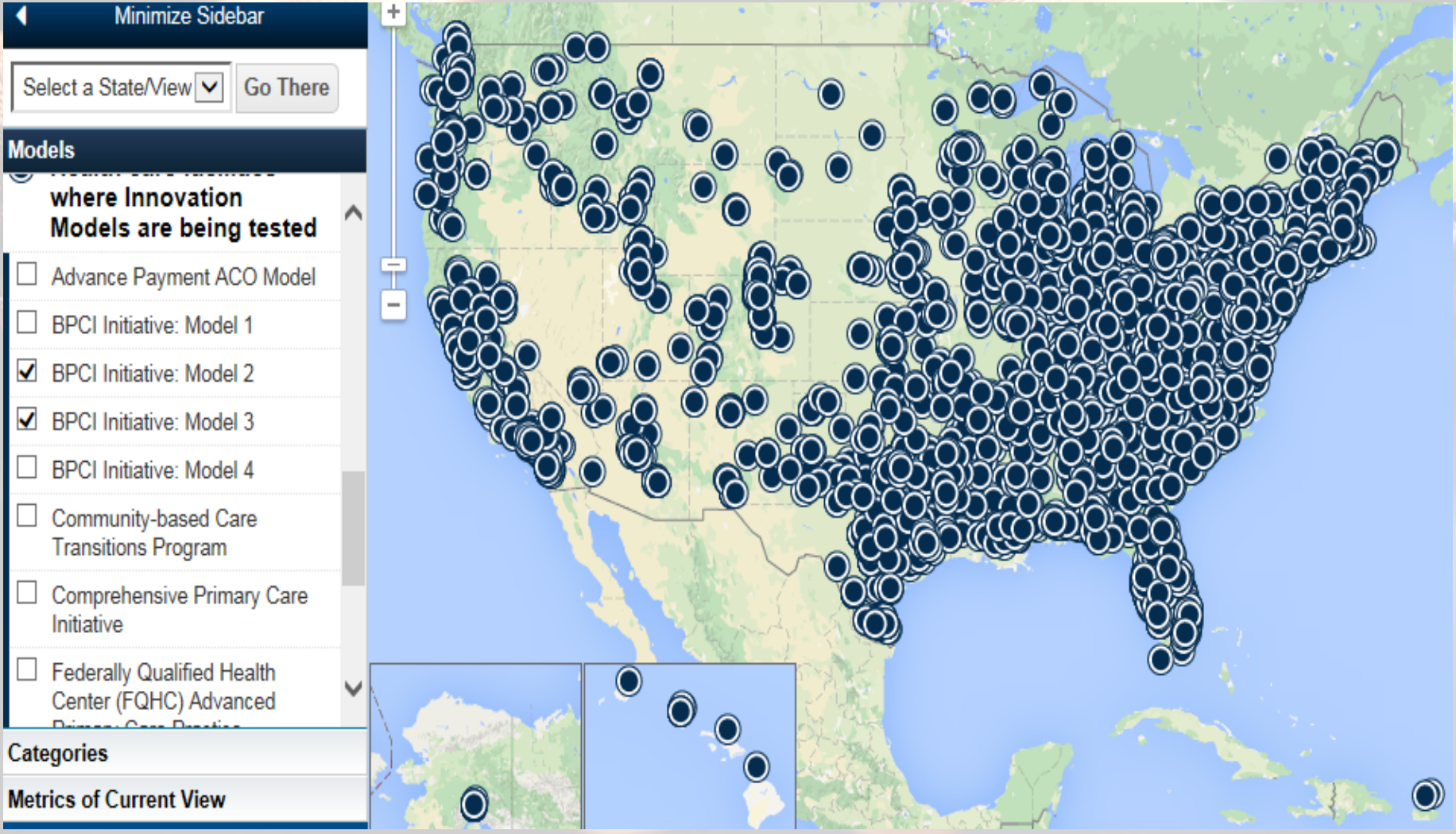
How to use this map: This map shows the Innovation Models run at the State level (in orange) as well as the health care facilities where Innovation Models are being tested (in blue). In the default view of this map, all States and health care facilities of all Models are displayed. To create a filtered view, use the check-boxes to select the desired Models to display, and/or use the drop-down to go directly to a particular state or to zoom back out to the national view.



2014 Bundling Model 2 & 3 Only



2015 Bundling Model 2 & 3 Only



AHCA Bundling Workgroup

"The train has left the station," with respect to bundling. We have reached a tipping point in the level of interest in moving toward bundled payments, and it would be virtually impossible to slow down or to stop it."

AHCA Bundling Workgroup

"Congress is sparing no time in moving forward with a tangible bundled payment proposal that would pose numerous challenges for the skilled nursing profession."

BPCI Model 2: Hospital Holder

BPCI Model 2: Retrospective Acute & Post Acute Care Episode

Share

The Bundled Payments for Care Improvement initiative is comprised of four broadly defined models of care, which link payments for multiple services beneficiaries receive during an episode of care. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality and more coordinated care at a lower cost to Medicare. For more information on the background of this initiative, various types of models, or details on episodes of care, visit BPCI Initiative: General Information.

In Model 2, the episode of care includes the inpatient stay in the acute care hospital and all related services during the episode. The episode ends either 30, 60, or 90 days after hospital discharge. Participants select up to 48 different clinical condition episodes. For more information on the other models, visit the BPCI Initiative: Model 1 web page, BPCI Initiative: Model 3 web page, or BPCI Initiative: Model 4 web page.

How does it work?

- Payor is the same (Medicare Part A)
- Payor rules must be adhered to
- After the bundle time period is over, a reconciliation will be performed by Medicare, if the hospital does better than their target average, they are refunded money, if they do worse, they pay back.

BPCI Model 3: Nursing Home Holder

BPCI Model 3: Retrospective Post Acute Care Only

Share

The Bundled Payments for Care Improvement initiative is comprised of four broadly defined models of care, which link payments for multiple services beneficiaries receive during an episode of care. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality and more coordinated care at a lower cost to Medicare. For more information on the background of this initiative, various types of models, or details on episodes of care, visit BPCI Initiative: General Information.

In Model 3, the episode of care is triggered by an acute care hospital stay and begins at initiation of post-acute care services with a participating skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency. The post-acute care services included in the episode must begin within 30 days of discharge from the inpatient stay and end 30, 60, or 90 days after the initiation of the episode. Participants can select up to 48 different clinical condition episodes. For more information on the other models, visit the BPCI Initiative: Model 1 web page, BPCI Initiative: Model 2 web page, or BPCI Initiative: Model 4 web page.

How does it work?

- Payor is the same (Medicare Part A)
- Payor rules must be adhered to
- After the bundle time period is over, a reconciliation will be performed by Medicare, if the nursing home does better than their target average, they are refunded money, if they do worse, they pay back.

Demonstration ACOs

Accountable Care Organizations (ACO)

Accountable Care Organizations (ACO)

What's an ACO?

Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.

The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will **share in the savings** it achieves for the Medicare program.

Medicare offers several ACO programs:

- Medicare Shared Savings Program—a program that helps a Medicare fee-for-service program providers become an ACO. Apply Now.
- Advance Payment ACO Model—a supplementary incentive program for selected participants in the Shared Savings Program.
- Pioneer ACO Model—a program designed for early adopters of coordinated care. No longer accepting applications.

Organizations across the country have already transformed the way they deliver care, in ways similar to the ACOs that Medicare supports.

Growth of ACOs in US, 2011-Present

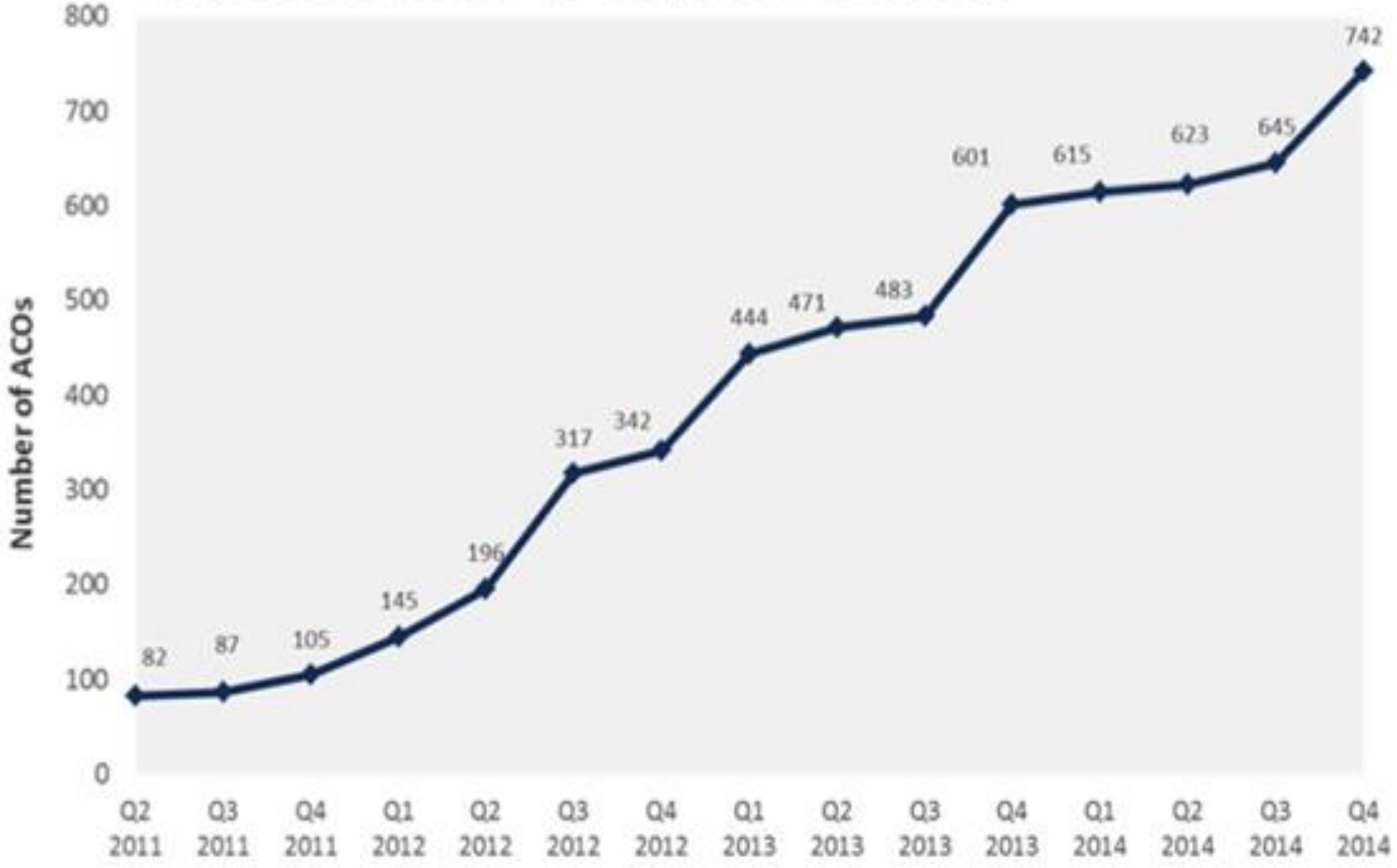
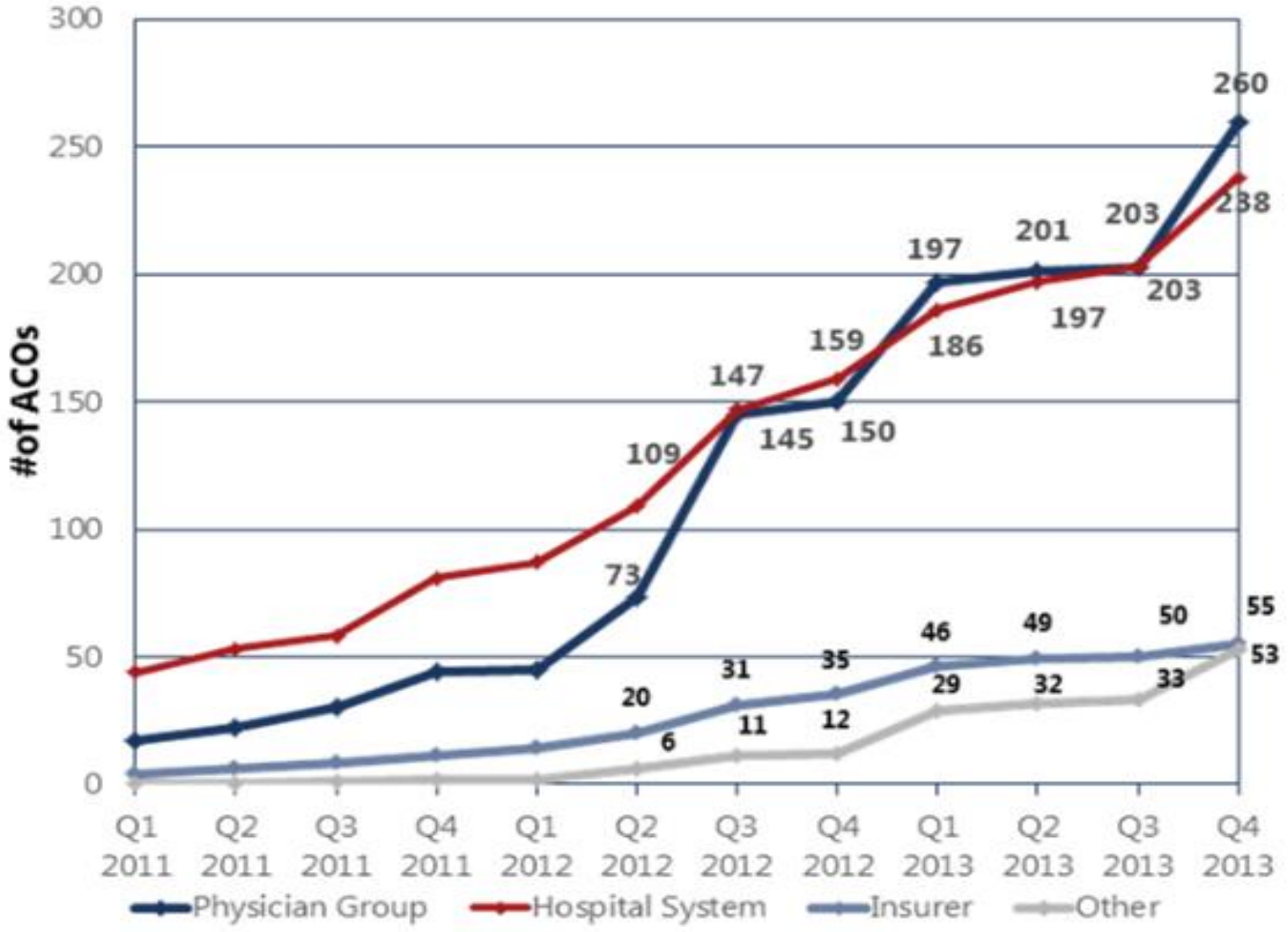
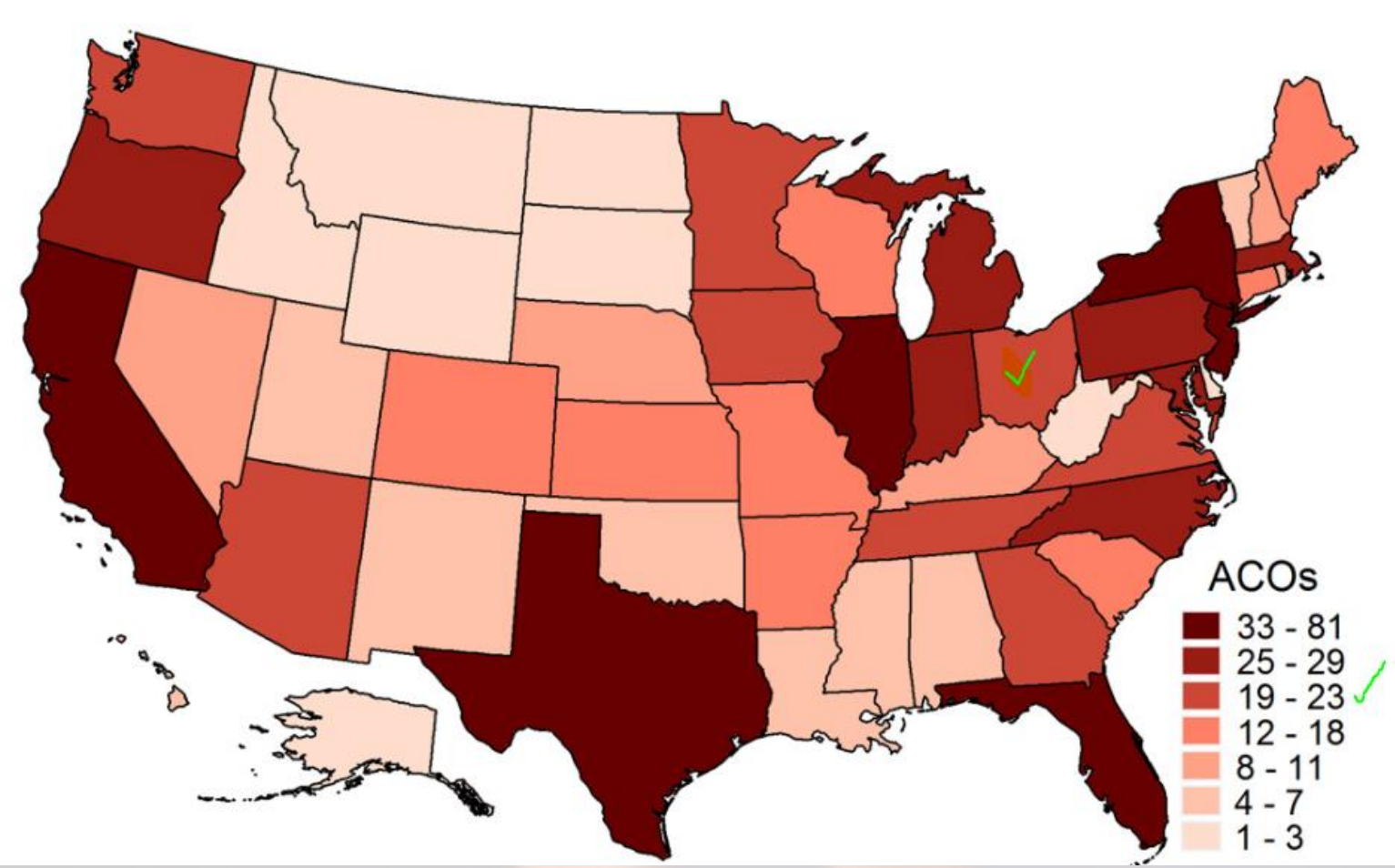


Chart 2: Total Accountable Care Organizations by Sponsoring Entity; Source: Leavitt Partners Center for Accountable Care Intelligence



Number of ACOs by State
January 2015



Source: Leavitt Partners Center for Accountable Care Intelligence

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Fact sheets

Return to Newsroom Center

Fact sheets: Medicare ACOs continue to succeed in improving care, lowering cost growth

Date	2014-09-16
Title	Medicare ACOs continue to succeed in improving care, lowering cost growth
For Immediate Release	Tuesday, September 16, 2014
Contact	press@cms.hhs.gov

Medicare ACOs continue to succeed in improving care, lowering cost growth ***(Updated November 7, 2014)***

Impact Act

The Improving Medicare Post-Acute Care Transformation Act of 2014
"IMPACT Act of 2014"

Section-By-Section

Section 1: Short Title

Section 2: Standardization of Post-Acute Data

Requirement for Standardized Assessment Data. Amends title XVIII of the Social Security Act (SSA) to add a new section 1899B. Requires post-acute care (PAC) providers to report standardized patient assessment data and requires PAC providers to report standardized quality measures and resource use measures. Requires the Secretary to modify PAC assessment instruments to allow for submission of standardized patient

IMPACT ACT

Improving Medicare Post Acute Care Transformation Act of 2014

- Fast track for payment reform
- Post-acute providers will begin submitting standardized assessment data in 2019
  - Items on the Care Tool

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

News Release

U.S. Department of Health & Human Services
News Division

202-690-6343
media@hhs.gov
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FOR IMMEDIATE RELEASE
Monday, January 26, 2015

Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value

FOR IMMEDIATE RELEASE
January 26, 2015

Contact: HHS Press Office
202-690-6343

Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value

Alternative Payment Models:

By 2016 30% of all payments

By 2018 50% of all payments

Payment Linked to Outcomes:

85% by the end of 2016

90% by the end of 2018

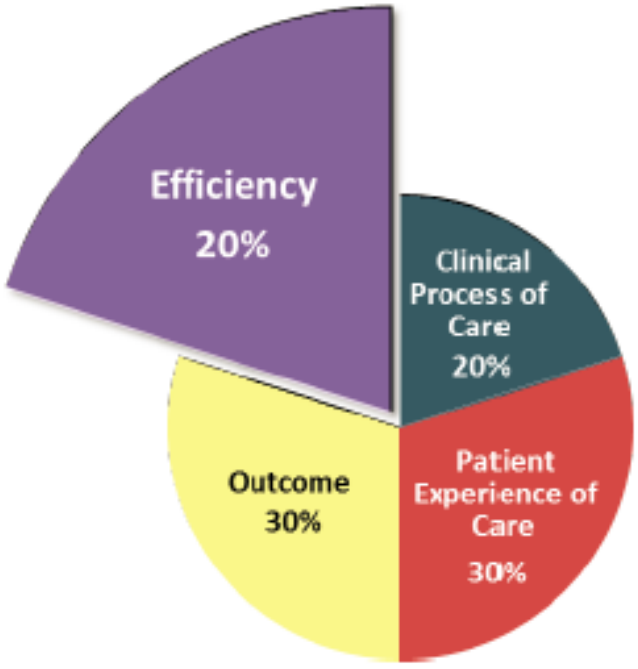
Value Based Purchasing

SNF Value-Based Purchasing Program

Included in this 12-month doc fix is a "skilled nursing facility value-based purchasing program," which would establish a SNF readmissions reduction program to save an estimated $2 billion over the next 10 years. The program is based heavily on AHCA's rehospitalization proposal, and we are working closely with Congress to ensure that if the legislation proceeds, that the final program is manageable for our members. Here's what we know so far:

- **Skilled nursing care centers do not experience any financial ramifications for 4 years.**
  - This includes giving CMS requisite time to create an optimal risk-adjusted readmissions tool. The National Quality Forum is expected to ratify and select the mechanism for the Secretary.
- **Beginning in FY 2019 (October 1, 2018), the Secretary will withhold 2% of payments to skilled nursing.**
  - Of the 2% withheld, 50-70% will be used for value-based incentives returned to skilled nursing providers.
  - That means that higher-performing providers could in fact see no cut, but rather increases to their reimbursements based on reduced rehospitalizations.
- **The skilled nursing profession is credited for improving readmissions.**
  - Only 30-50% of the payments withheld would be retained as savings to the program (approx. $1 billion over 10 years). The remaining $1 billion will be credited to providers for reducing hospital readmissions.

Efficiency Measure for FY 2015: Medicare Spending Per Beneficiary



Efficiency Measure for FY 2015
★ 1. MSPB-1 Medicare spending per beneficiary

★ Represents a new measure that was not in the FY 2013 and FY 2014 programs.

Medicare Spending Per Beneficiary (MSPB) Measure

Efficiency Measure for FY 2015
1. **MSPB-1 Medicare spending per beneficiary**

- **MSPB is:**
  - A measure in the new Efficiency Domain
  - A claims-based measure that include risk-adjusted and price-standardized payments for all Part A and Part B services provided from 3 days prior to a hospital admission (index admission) through 30 days after the hospital discharge

naviHealth™
Navigating Post-Acute Care

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What We Do

naviHealth partners with health plans, health systems and post-acute facilities to manage the entire PAC continuum.

Health Plans: We offer delegated management of PAC services, guaranteeing significant savings below a health plan's current PAC spend. We provide plan members with the coordination and education needed to navigate the PAC experience.

Healthcare Providers: In the post-reform environment, hospital systems, physician groups, and PAC providers are increasingly taking risk to manage patient spend through such vehicles as ACOs, bundled payments and insurance capitation

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remedy partners™

THE EPISODES OF CARE COMPANY

Remedy is facilitating the evolution from fee-for-service to value-based payment for health care services. We leverage big data, proven care redesign, practical technology and experience to assure success in rolling out bundled payment programs.

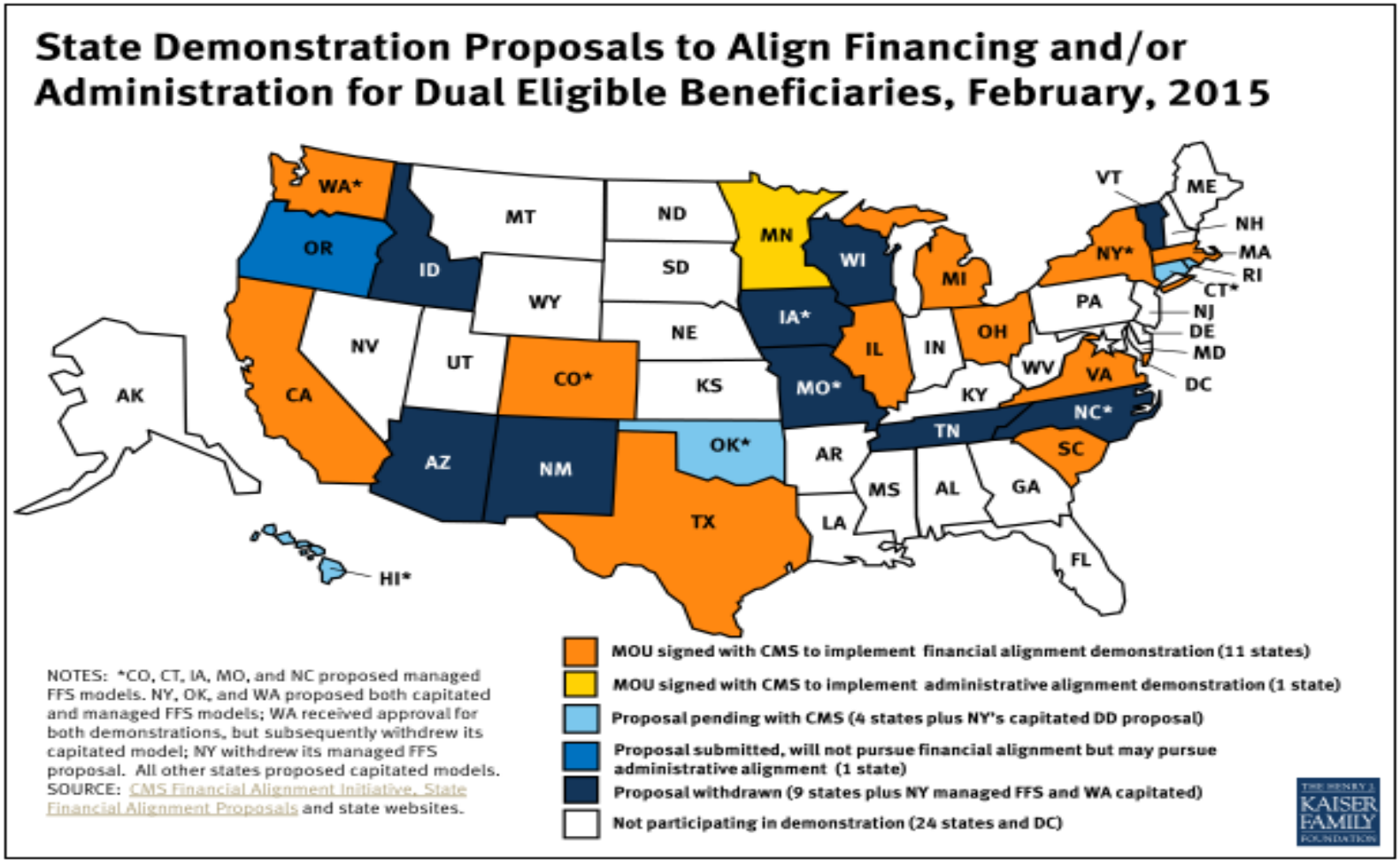
Welcome.

BUNDLED PAYMENTS - in which a fixed price is paid for a wide range of health care services over a specified period of time known as an 'episode of care' - represent one of the primary

Example in Ohio: Dual Eligible Demonstration

Dual Eligible Demonstrations

Feb 06, 2015
Updated: Feb 06, 2015



Major Differences in 2015 Final Rule and 2016 Proposed Rule!

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 488

[CMS-1605-F]

RIN 0938-AS07

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2015

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 483

CMS-1622-P

RIN 0938-AS44

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNFs) for FY 2016, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and Staffing Data Collection

2015/2016 Final and Proposed Rule Therapy Issues

2015

- SNF Therapy Research Project
- Find alternatives to pay for therapy in SNFs
- Identified three alternatives and implementing studies to find the most appropriate
- Therapy in the hot seat

2016

Nothing! Nada! Therapy is a non-factor.

CMS Proposed Rule FY 2016
October 2016

Some topics in proposed rule:

- Payroll verification of staffing levels
- Rehospitalization measure for SNFs
- IT road map for exchange of clinical information across the continuum
- Three measures for quality/payment
  - Skin, falls, function/cognitive status declines

Medicare Part B Therapy
What is the Future?

One Theory/Proposal that has been discussed:

49 Current CPT codes (97000 codes) will be collapsed into a per visit/episode code structure

- PT/OT will have 4 evaluation codes (3 eval and one re-eval)
- One bundled code (ther ex, neuro re-ed, ther act, manual therapy, gt training) described in five levels depending on acuity
- Levels will be reported based on complexity and intensity of therapist work

Medicare Part B

Therapy Cap 2015 $1,940

Exception Process- until 2017

TITLE II—MEDICARE AND OTHER HEALTH EXTENDERS

Subtitle A—Medicare Extenders

SEC. 201. EXTENSION OF WORK GPCI FLOOR.

Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(E)) is amended by striking "April 1, 2015" and inserting "January 1, 2018".

SEC. 202. EXTENSION OF THERAPY CAP EXCEPTIONS PROCESS.

(a) IN GENERAL.—Section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) is amended—

Medicare Access and CHIP Reauthorization Act of 2015 & Threshold

Effective 90 days after enactment
Target high denial ratings
Target outlier billing patterns
New providers
Certain medical conditions and certain group practices
Takes RAC auditors out of the review process
Limits funding to conduct audits giving relief to providers

graph.

"(E)(i) In place of the manual medical review process under subparagraph (C)(i), the Secretary shall implement a process for medical review under this subparagraph under which the Secretary shall identify and conduct medical review for services described in subparagraph (C)(i) furnished by a provider of services or supplier (in this subparagraph referred to as a 'therapy provider') using such factors as the Secretary determines to be appropriate.

"(ii) Such factors may include the following:

"(I) The therapy provider has had a high claims denial percentage for therapy services under this part or is less compliant with applicable requirements under this title.

"(II) The therapy provider has a pattern of billing for therapy services under this part that is aberrant compared to peers or otherwise has questionable billing practices for such services, such as billing medically unlikely units of services in a day.

"(III) The therapy provider is newly enrolled under this title or has not previously furnished therapy services under this part.

"(IV) The services are furnished to treat a type of medical condition.

"(V) The therapy provider is part of group that includes another therapy provider identified using the factors determined under this subparagraph.

"(iii) For purposes of carrying out this subparagraph, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $5,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for fiscal years 2015 and 2016, to remain available until expended. Such funds may not be used by a contractor under section 1893(h) for medical reviews under this subparagraph.

"(iv) The targeted review process under this subparagraph shall not apply to services for which expenses are incurred beyond the period for which the exceptions process under subparagraph (A) is implemented.".

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to requests described in section 1833(g)(5)(C)(i) of the Social Security Act (42 U.S.C. 1395l(g)(5)(C)(i)) with respect to which the Secretary of Health and Human Services has not conducted medical review under such section by a date (not later than 90 days after the date of the enactment of this Act) specified by the Secretary.

The Reality:

Less funded time to accomplish therapy goals

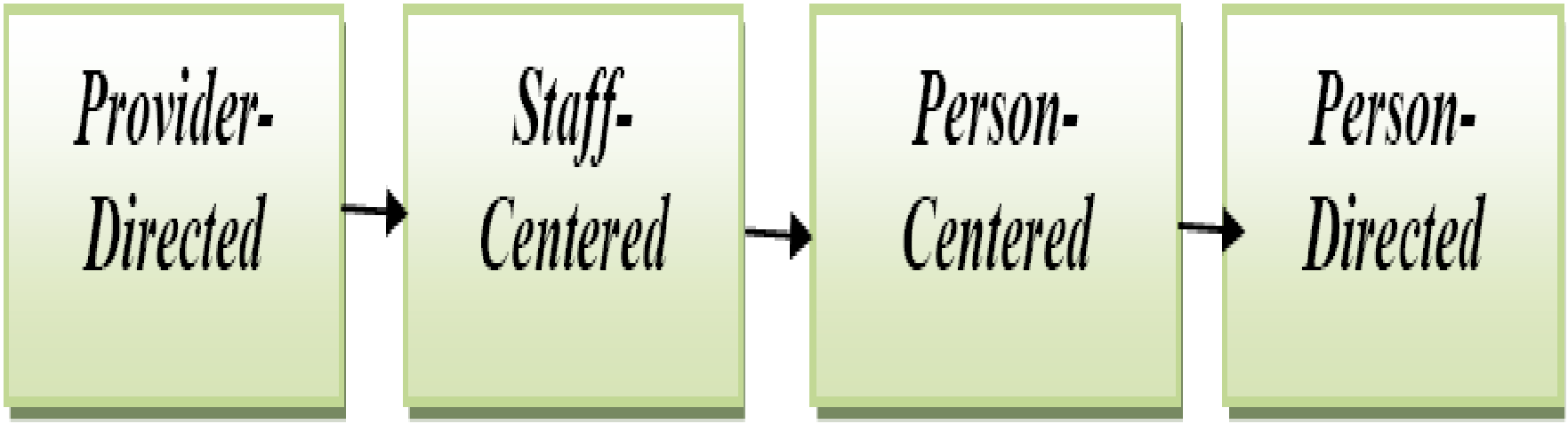
How can we continue to provide quality therapy to our patients with decreased funding in less time?

Person Centered Therapy

- Is it possible with less time and reimbursement?
  - Yes!

Culture Change

Continuum of Person-Directedness (Pioneer Network, 2010)



Culture Change

"Nothing about ***me*** without ***me***."

-Pioneer Network

Therapy and Person Centered Care

- Clinical professionals funded for one on one care
- Focus is to attain goals to get patient to prior level of function
- Focus should be on the personal goals of the patient

    Patient discharging

    Patient staying long term

How can Person Centered Care continue to be the focus?

Tips

1. Thoroughly interview the patient upon evaluation, isolate the patient's top goals
2. Start discharge planning early
3. Make every clinical treatment functional
4. Make patient education and carry over a priority
5. Start educating care givers early in the therapy regimen

How can Person Centered Care continue to be the focus?

Tips

6. Work with nursing to control pain prior to therapy session
7. Encourage patients to participate and help them enjoy therapy sessions
8. Share clinical data showing improvement with the patient
9. Listen and interact with the patient during treatment times
10. Observe preferred times for activities (waking up, etc.)
11. Assign a consistent therapist to each patient
12. Advocate for the patient for re-certifications if necessary

How can Person Centered Care continue to be the focus?

Tips

13. Staff identifies self each therapy session
14. Include patient clinical decisions and conferences
15. Include patient in goal setting
16. Encourage feedback about progress, barriers, etc.

Quality Starts With Effective Treatments

Therapists' goals should be to provide effective, individualized, detailed and motivating treatments evidenced by documentation of skilled interventions.

How can we start to make sure therapy embraces person center care?

Getting Started with Person-Directed Care

Understanding the Culture Change Process

The Process of "Getting Ready"

The getting-ready phase is a time for **Learning**, **Self-Reflection**, **Adopting New Beliefs**, **Organizational Assessment**, and **Planning**. There is much to be accomplished during this time, all of which is critical to the success of the change process.

-Pioneer Network website

Class Exercise

Actionable ways to implement person centered care into rehab within the confines of funded care.

Questions?

Cindy Gensamer, LNHA, CCAC

Absolute
REHABILITATION
& CONSULTING SERVICES, INC.

Vice President

Absolute Rehabilitation & Consulting

339 East Maple St.

North Canton, Ohio 44720

330-498-8204 • cgensamer@abstherapy.com