The Long Term Care Conundrum; Quality, Cost and Demand

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Medical Director, Kindred at Home, Boston Integrated Market
Objectives

- Clinical Integration and Population Health, in the context of Post Acute Care
- CMS’s solutions, to date
- The case for Care Management
- Creating effective Care Management programs
The Key: Co-Evolution

Delivery System Redesign and Alternative Payment Models must support each other and evolve in parallel.

Non-Risk → Risk
Payment Methodology

FFS → Shared Savings → Single Payment

Delivery System
Fragmented Care → Coordinated Care

Quality & Efficient Care
Clinical Integration: The High Value Network
‘Shared’ Savings programs

- One of many value based purchasing initiative (e.g. hospital inpatient VBP)
- Promotes Accountability for care
- Coordinates items and services under Medicare Part A and Part B
- Encourages infrastructure investment and redesigned care processes for high quality and efficient delivery
- Intent is to promote accountability for a population of Medicare beneficiaries
- As an incentive, Medicare can share a percentage of the savings with the ACO
- This only occurs if the quality performance standards are met and sharable savings are generated
Quality Care Measures (33)

- CAHPS Measures (7)
- Care Coordination (6)
- Preventative Health (8)
- At Risk Populations (12)

Each group counts equally
The Affordable Care Act at 5 Years

Hamel, Mary Beth, M.D., M.P.H. Editor, Blumenthal, David, M.D., M.P.P. Abrams, Melinda, M.S. Nuzum, Rachel, M.P.H.

NEJM 5-15

Figure 4. Ten-Year Medicare Spending Projections, January 2010 through March 2015.
Adapted from the Congressional Budget Office.26,27
ACO and $$$$ 

Yr1

32 ACO-Gross losses from $92M to Savings of $23M
13 shared savings of $23M, ranging from $1m to $14M
18 ACO owed CMS $$, one enough to write a check.

23 remaining ACO, losses from $6M to $24M gain
11 qualified for $$ ranging from $1M to $13M
9 ACO owed $$, 3 enough to write a check

Brookings Brief 2105

<table>
<thead>
<tr>
<th>Measure</th>
<th>Mean in the ACO Group</th>
<th>Difference in ACO Group vs. Control Group in Precontract Period</th>
<th>P Value</th>
<th>Differential Change in Postcontract Period for ACO vs. Control Group</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total quarterly per-beneficiary spending ($)</td>
<td>2,455.8</td>
<td>-18.7</td>
<td>0.37</td>
<td>-29.2</td>
<td>0.007</td>
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<td>Quarterly per-beneficiary spending according to type of service and care setting ($)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Total acute inpatient care</td>
<td>911.2</td>
<td>3.9</td>
<td>0.71</td>
<td>-13.5</td>
<td>0.04</td>
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<tr>
<td>Facility</td>
<td>792.9</td>
<td>3.4</td>
<td>0.71</td>
<td>-12.2</td>
<td>0.04</td>
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<tr>
<td>Professional services</td>
<td>118.3</td>
<td>0.5</td>
<td>0.75</td>
<td>-1.3</td>
<td>0.13</td>
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<tr>
<td>Total outpatient care</td>
<td>793.4</td>
<td>-14.1</td>
<td>0.17</td>
<td>-6.9</td>
<td>0.24</td>
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<tr>
<td>Office</td>
<td>405.0</td>
<td>-24.6</td>
<td>0.01</td>
<td>7.3</td>
<td>0.02</td>
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<tr>
<td>Hospital outpatient department</td>
<td>388.4</td>
<td>10.5</td>
<td>0.44</td>
<td>-1.2</td>
<td>&lt;0.001</td>
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<tr>
<td>Total post-acute care</td>
<td>270.6</td>
<td>-0.4</td>
<td>0.93</td>
<td>-8.7</td>
<td>0.003</td>
</tr>
<tr>
<td>Facility</td>
<td>256.7</td>
<td>-0.4</td>
<td>0.91</td>
<td>-8.5</td>
<td>0.003</td>
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<tr>
<td>Skilled nursing facility</td>
<td>204.7</td>
<td>-1.2</td>
<td>0.77</td>
<td>-6.5</td>
<td>0.01</td>
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<td>Rehabilitation facility</td>
<td>52.0</td>
<td>0.8</td>
<td>0.52</td>
<td>-2.0</td>
<td>0.23</td>
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<tr>
<td>Professional services</td>
<td>13.9</td>
<td>0.0</td>
<td>0.93</td>
<td>-0.2</td>
<td>0.47</td>
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<tr>
<td>Home health care</td>
<td>150.8</td>
<td>5.5</td>
<td>0.18</td>
<td>0.9</td>
<td>0.66</td>
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<td>Durable medical equipment</td>
<td>80.2</td>
<td>0.7</td>
<td>0.74</td>
<td>-1.6</td>
<td>0.10</td>
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<td>Hospice</td>
<td>50.9</td>
<td>-1.8</td>
<td>0.24</td>
<td>0.0</td>
<td>0.97</td>
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<td>Annual quality measure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>30-day readmissions (no.)</td>
<td>0.26</td>
<td>-0.02</td>
<td>0.73</td>
<td>0.0</td>
<td>0.78</td>
</tr>
</tbody>
</table>

Performance Differences in Year 1 of Pioneer Accountable Care Organizations
J. Michael McWilliams, M.D., Ph.D., et al
On line April 15, 2015, at NEJM.org.
Medicare Shared Savings ACO’s

- 400 ACO’s participated
- 7 million Medicare beneficiaries enrolled
- Year 1--58 ACO’s yielded $700 million in savings
- $ to ACO’s = $234 million
- Avg/ACO = <$400,000
- Cost of starting/operating an ACO $1-3 million
  + Plus lack of expertise, IT systems
- CMS new model:
  + Defer going at risk if generate savings in first 3 yrs
  + Must generate 2-3.9%* savings in order to share savings
    + depends on # of beneficiaries enrolled

Source: Commonwealth Fund ‘Medicare Shared Savings Program: Keeping Savings in Sight’: Tuesday, March 3, 2015
## Bundled Payment

### Types of Services by Model

<table>
<thead>
<tr>
<th>Type of Services Included in Bundle</th>
<th>Model 1: Acute Hospital Stay Only</th>
<th>Model 2: Acute Hospital Stay + Post-Acute Care</th>
<th>Model 3: Post-Acute Care Only</th>
<th>Model 4: Acute Hospital Stay + Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital and physician services</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Related post-acute care services</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-acute care services</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Related readmissions</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Other services defined in bundle (Part A &amp; Part B)</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

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CMS Bundled Payment

EXHIBIT 3

Components Of Thirty-Day Spending For Major Joint Replacement And Congestive Heart Failure, By Phase, 2011

“Finally, our findings suggest that if the BPCI hospitals wish to find opportunities for savings, they would do well to look at post acute care services such as those provided by skilled nursing facilities, rehabilitation facilities, or home health agencies.”
## CMS Penalty Matrix

<table>
<thead>
<tr>
<th>Program</th>
<th>FY 2014</th>
<th>FY 2015</th>
<th>FY 2016</th>
<th>FY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital VBP Program</td>
<td>±1.25%</td>
<td>±1.50%</td>
<td>±1.75%</td>
<td>±2.00%</td>
</tr>
<tr>
<td>Readmissions Reduction Program</td>
<td>-1.0%</td>
<td>-2.0%</td>
<td>-3.0%</td>
<td>-3.0%</td>
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<tr>
<td>HAC Program</td>
<td>-1.0%</td>
<td>-1.0%</td>
<td>-1.0%</td>
<td>-1.0%</td>
</tr>
<tr>
<td>Hospital IQR Program</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>-2.0%</td>
</tr>
<tr>
<td><strong>Max Penalty:</strong></td>
<td>4.25%</td>
<td>6.5%</td>
<td>7.75%</td>
<td><strong>8.0%</strong></td>
</tr>
</tbody>
</table>
Unsustainable Traditional Model

- Hospital Stay: $14,200
  - (373/day x 30 days)
- Rehab/LTC Stay: $11,190
- Home Care: 1-6 Visits $870
- 2-10 Docs
- ER Visit $1,516

Total: $27,776
• Recovering from acute illness
  • “perturbed physiologic systems”

• Stress
  • Sleep deprivation
  • Disruption of normal circadian rhythms
  • Poorly nourished
  • Have pain and discomfort
  • “…confront a baffling array of mentally challenging situations”
  • Receive medications that can alter cognition and physical function
  • Can become deconditioned by bed rest or inactivity

• Lead to impairments in the early recovery period
  • Inability to fend off disease
  • Susceptibility to mental error
An estimated 70% of Americans ages 65 and older are projected to experience some level of need for long-term services and supports. (1)

Those who survive to age sixty-five have a 46% chance of spending time in a nursing home. (2)

‘29% of the sample who lived alone, were in the worst health and had the highest prevalence of activity limitations of any group in the sample’

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2. New estimates of lifetime nursing home use: have patterns of use changed- Med Care. 2002;40(10)
### Tremendous Opportunities Exist to Better Manage Patient Care for Patients Discharged From Acute Care Hospitals

Currently there are 47.6 million Medicare beneficiaries with an estimated 10,100 individuals added to the program each day.\(^{(1)}\)

35% of Medicare Beneficiaries Discharged from Acute Hospitals Need Post-Acute Care \(^{(2)}\)

### Medicare Patients’ Use of Post-Acute Services Throughout an “Episode of Care”

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Higher (Intensity of Service)</th>
<th>Lower (Intensity of Service)</th>
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</thead>
<tbody>
<tr>
<td>Short-Term Acute Care Hospitals</td>
<td>2%</td>
<td>37%</td>
</tr>
<tr>
<td>Long-Term Acute Care Hospitals</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Inpatient Rehabilitation</td>
<td>11%</td>
<td>21%</td>
</tr>
<tr>
<td>Skilled Nursing Facilities</td>
<td>52%</td>
<td>9%</td>
</tr>
<tr>
<td>Outpatient Rehabilitation</td>
<td>41%</td>
<td>9%</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>61%</td>
<td>9%</td>
</tr>
</tbody>
</table>

\(^{(1)}\) Kaiser Family Foundation, 2011 statehealthfacts.org and AARP 2011 projections

\(^{(2)}\) Source: RTI, 2009: Examining Post Acute Care Relationships in an Integrated Hospital System
Trends in the percentage of patients discharged home or to PAC facilities are shown. Each year is compared with 1996 values to calculate a relative percentage change.
Part of The Problem

- MedPAC reported that between 2002 and 2012, the share of SNF days that were classified into “rehabilitation case-mix groups increased from 78 percent to 93 percent,” while the share of “intensive therapy days as a share of total rose from 29 percent to 77 percent.”

- “the increase in the most intensive therapy days (18 percent) far outpaces the changes in patient characteristics,”
Proportion of Medicare Patients Placed in an Avoidably High-Cost Setting

*Study Findings by Post-Acute Setting*

Adapted from: Advisory Board; Post-acute collaborative
Post-Acute Options

- Remain in hospital; AKA- long stay
  - Guardianship
  - One on one
  - High level of need
- LTACH
  - Long Stay
  - Vent patients
- Inpatient rehabilitation hospital
  - Generally younger patients
  - Ability to tolerate 3 hrs of rehab daily
- SNF
  - Voltage drop in MD attention, access to testing, specialists, level of nursing care variable
- Home
  - Home health
Requirement to Qualify for LTCH PPS Payment

Patient spends either:

1. at least three days in an intensive care unit of a short-term acute care hospital (STACH) immediately prior to being admitted to an LTACH.
2. 96 hours on a ventilator in an LTACH and had an STACH stay immediately prior to being admitted to an LTACH.
   - The LTACH discharge cannot have a principal psychiatric or rehabilitation diagnosis.
   - By 2020 if <50% of admissions are not LTACH level, all future payments will be at site neutral rate.
   - The 25% rule will be suspended, not eliminated.
Site-Neutral Payment Rate

- The lower of either the IPPS comparable per-diem payment rate including any short-stay outlier payments.
- Or 100 percent of the estimated costs for services.
- This new payment policy will become effective for LTACHs with cost reporting periods beginning on or after Oct. 1, 2015.
- For fiscal years 2016 and 2017, a blended site-neutral payment rate will apply (half the site-neutral payment rate and half of the payment rate that otherwise would be applicable).
- Beginning fiscal year 2018, only the site-neutral payment rate will apply.
- Site neutral payments or payment by MA plans would be excluded from the calculations to determine whether the average length of stay of an LTACH exceeds 25 days.
DYING IN AMERICA
Improving Quality and
Honoring Individual Preferences
Near the End of Life

Key Findings and Recommendations

Committee on Approaching Death:
Addressing Key End-of-Life Issues

Philip A. Pizzo (Co-Chair)
Stanford University, CA

David M. Walker (Co-Chair)
Former U.S. Comptroller
General, Bridgeport, CT

Patricia Bomba
Excellus BlueCrossBlueShield,
Rochester, NY

Eduardo Bruera
University of Texas MD Anderson Cancer Center, Houston

Charles J. Fathery
Fordham University and Milbank Memorial Fund, Syracuse, NY

Pamela S. Hinds
Children’s National Health System and The George Washington University, Washington, DC

Kara F. C. Holloway
Duke University, Durham, NC

Naomi Karp
Consumer Financial Protection Bureau, Washington, DC

Jean S. Kutner
University of Colorado School of Medicine and University of Colorado Hospital, Aurora

Bernard Lo
Greenwall Foundation, New York, NY

Salimah H. Meghani
University of Pennsylvania School of Nursing, Philadelphia

Diane E. Meier
Center to Advance Palliative Care and the Icahn School of Medicine at Mount Sinai, New York, NY

William D. Novelli
Georgetown University, Washington, DC

Stephen G. Pauker
Tufts University School of Medicine and Tufts Medical Center, Boston, MA

Judith A. Perl
Chevy Chase, MD

Leonard D. Schaeffer
University of Southern California, Santa Monica

W. June Simmons
Partners in Care Foundation, San Fernando, CA

Christian T. Sinclair
Gentiva Hospice, Overland Park, KS

Joan M. Teno
Brown University, Providence, RI

Fernando Torres-Gil
University of California, Los Angeles

James A. Tulsky
Duke University Medical Center, Durham, NC
Misaligned Incentives

- Medicare Part A
  - FFS
    - Churning
  - Hospital DRG
    - Push out patients
  - SNF
    - Can’t bill for both usual care and hospice care
      - Overuse of rehab services at EOL
  - Hospice
    - Benefit designed for home bound patients
      - Does not take into account acuity and resource needs
      - Not a fit for SNF due to costs of room and board
      - 6 mo designation deters patients

- Medicare Part B
  - Promotes over-testing and treatment.
Gaps in the ACA

- Does not address the needs of EOL care
  - No metrics
  - No $
- Does not address financing the LTC system to better match the ageing population
- Managed Medicare may have to carry expenses of Hospice per MedPAC
- Home based Palliative Care is not covered
- No reimbursement for EOL conferences/planning*
  * Medicare considering new code
“...there is little reason to expect that nonspecific incentives to “have a discussion” or “complete a form” will do much good.”

“If the major barrier to engaging patients about end-of-life care is physicians' perceived lack of capacity to engage in these conversations, money is unlikely to be the right catalyst.”

“Physician payments should be geared more toward time spent thinking about and interacting with patients and families than doing things to them.”
Variability Among US Intensive Care Units in Managing the Care of Patients Admitted With Preexisting Limits on Life-Sustaining Therapies

Joanna L. Hart, MD, MSHP; et al

JAMA Internal Medicine Published online March 30, 2015

Figure 2. Variability Among Intensive Care Units (ICUs) in the Management of Patients With Preexisting Limits on Advanced Therapies

A] Receipt of cardiopulmonary resuscitation

B] Provision of new forms of life support

C] Enactment of further limits on care among survivors

D] Reversal of treatment limits among survivors

All plots represent point estimates and 95% CIs for each included ICU. A, Among 109 ICUs. B, Among 137 ICUs. C, Among 117 ICUs including only survivors of their hospitalization. D, Among 128 ICUs including only survivors of their hospitalization.
TRIAD VI: How Well Do Emergency Physicians Understand POLST Forms?
TRIAD VII: Do Pre-hospital Providers Understand POLST Documents?

Ferdinando L. Mirarchi, DO, FAAEM, et al
J. Patient Safety Volume 11, Number 1, March 2015

<table>
<thead>
<tr>
<th>Information Presented</th>
<th>POLST Document Notation</th>
<th>Code Status</th>
<th>Care</th>
<th>Intervention?</th>
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<tr>
<td></td>
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<td>DNR</td>
<td>FC</td>
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<td>POLST document</td>
<td>DNR/full treatment</td>
<td>58% (616)</td>
<td>15% (159)</td>
<td>27% (284)</td>
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<td>Meaning of DNR</td>
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<td>N/A</td>
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<tr>
<td>Scenario A</td>
<td>DNR/full treatment</td>
<td>64% (599)</td>
<td>22% (209)</td>
<td>14% (126)</td>
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<tr>
<td>Scenario B</td>
<td>DNR/limited treatment</td>
<td>74% (657)</td>
<td>16% (140)</td>
<td>10% (83)</td>
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<tr>
<td>Scenario C</td>
<td>DNR/full treatment</td>
<td>50% (414)</td>
<td>40% (328)</td>
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<td>Scenario D</td>
<td>DNR/full treatment</td>
<td>67% (538)</td>
<td>24% (190)</td>
<td>9% (77)</td>
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<tr>
<td>Scenario E</td>
<td>DNR/CMO</td>
<td>83% (654)</td>
<td>12% (91)</td>
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<td>Scenario F</td>
<td>CPR/full treatment</td>
<td>5% (20)</td>
<td>95% (737)</td>
<td>2% (19)</td>
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</tbody>
</table>

Values in bold denote consensus decisions

**TABLE 3. Overall Responses**

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<thead>
<tr>
<th>Information Presented</th>
<th>POLST Document Notation</th>
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<th>Resuscitation Consensus?*</th>
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<tbody>
<tr>
<td>POLST document</td>
<td>DNR/full treatment</td>
<td>59% (128)</td>
<td>14% (31)</td>
<td>27% (58)</td>
<td>N/A</td>
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<tr>
<td>Meaning of DNR</td>
<td>—</td>
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<td>N/A</td>
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<tr>
<td>Scenario A</td>
<td>DNR/full treatment</td>
<td>62% (117)</td>
<td>22% (42)</td>
<td>16% (31)</td>
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<tr>
<td>Scenario B</td>
<td>DNR/limited treatment</td>
<td>84% (155)</td>
<td>8% (14)</td>
<td>5% (9)</td>
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<td>N/A</td>
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<tr>
<td>Scenario C</td>
<td>DNR/full treatment</td>
<td>59% (106)</td>
<td>25% (45)</td>
<td>17% (30)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Scenario D</td>
<td>DNR/full treatment</td>
<td>65% (113)</td>
<td>16% (27)</td>
<td>20% (34)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Scenario E</td>
<td>DNR/CMO</td>
<td>90% (153)</td>
<td>6% (10)</td>
<td>4% (8)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Scenario F</td>
<td>CPR/full treatment</td>
<td>5% (9)</td>
<td>94% (159)</td>
<td>1% (2)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Based on a 59% response rate—see Methods for explanation.
CMO, comfort measures only; N/A, not applicable.
CMS To The Rescue
Nursing home results

414 nursing homes in Massachusetts.

Choose up to 3 nursing homes to compare. So far you have none selected.

Compare Now

Nursing Home Search Results

Viewing 1 - 20 of 414 results

<table>
<thead>
<tr>
<th>Nursing home information</th>
<th>Overall rating</th>
<th>Health inspections</th>
<th>Staffing</th>
<th>Quality measures</th>
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<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ABBOTT HOUSE NURSING HOME</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
28 ESSEX STREET
LYNN, MA 01902
(781) 596-5600

Much Above Average
Much Above Average
Above Average
Above Average

Update Results
Home Health Star Rating
Provider Preview Report

Based on completed quality episodes with end-of-care OASIS assessment dates from January 1, 2014 through December 31, 2014 and claims data with through dates from October 1, 2013 through September 30, 2014

| Rating for Jack Walker Blues Home Health Agency (999999) Baton Rouge, Louisiana |
|----------------------------------------|-----------------------------|
| Overall Star Rating                   | ★ ★ ★ (3.0 stars)          |

The Overall Star Rating will be displayed on Home Health Compare (HHC) in July 2015.

How the Ratings are Calculated

The HHC Star Rating is calculated using 9 of the quality measures currently reported on HHC. To have a star rating computed on HHC, HHAs must have reported data on HHC for at least 5 of the 9 measures used in the ratings.¹ The 9 measures used in the HHC Star Ratings are:

Process Measures:
1. Timely Initiation of Care
2. Drug Education on all Medications Provided to Patient/Caregiver
3. Influenza Immunization Received for Current Flu Season

Outcome Measures:²
4. Improvement in Ambulation
5. Improvement in Bed Transferring
6. Improvement in Bathing
7. Improvement in Pain Interfering With Activity
8. Improvement in Shortness of Breath
9. Acute Care Hospitalization
Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

In October 2014, the bipartisan Improving Medicare Post-Acute Care Transformation (IMPACT) Act became law. This legislation is an important step forward in improving the quality of health care for millions of Americans, providing consumers and government critical information regarding outcomes and cost. IMPACT will standardize assessments for critical care issues across the spectrum of post-acute care (PAC) providers and builds a bridge to ensure that patient care is delivered based on what the patient needs, eliminating the silo focused approach to quality measurement and resource utilization.

How it Works

The IMPACT Act has five parts:

I. Incorporate standardized assessment, including components of the CARE tool, into existing assessment tools across PAC providers: skilled nursing facilities (SNF), long term care hospitals (LTCH), inpatient rehabilitation facilities (LTC), and home health agencies (HHA). This tool will measure quality based on a variety of metrics: pressure ulcers, functional status, cognitive status, and special services.
   - Data will be collected at admission and discharge.
   - Implementation begins October 2018 (fiscal year 2019).

II. Development and public reporting of quality measures across settings, including hospitalizations, rehospitalizations, rehospitalizations after discharge from PAC provider, discharge to community, pressure ulcers, medication reconciliation, incidence of major falls, patient preferences, and average total Medicare cost per beneficiary.
   - Any measures must be approved by National Quality Forum or through notice and comment rulemaking.

III. Hospitals and PAC providers are required to provide quality measures to consumers when transitioning to a PAC provider. Conditions of participation are modified to incorporate Quality Measures (QMs) into the discharge planning process.
   - There is a market basket payment penalty of 2% for failure to effectively collect and report data.

IV. Requires HHS and MedPAC to conduct studies and reports to link payment to quality. HHS and MedPAC must develop a plan to link Medicare PAC payment to quality of care, review current risk adjustment methodologies, and study the effect of beneficiaries’ socioeconomic status on quality, resource use, and other measures.

V. Adds $11M in funding for CMS to use payroll data to measure staffing in SNF setting.
Data Elements: Standardization

- Uniformity
- OASIS-C
- HCBS CARE
- MDS 3.0
- LTCH CARE Data Set
- IRF-PAI

Data Elements
Care Tool Going Forward

- **Measure Domains to be standardized:**
  - Skin integrity and changes in skin integrity;
  - Functional status, cognitive function, and changes in function and cognitive function;
  - Medication reconciliation;
  - Incidence of major falls;
  - Transfer of health information and care preferences when an individual transitions;
  - Resource use measures, including total estimated Medicare spending per beneficiary;
  - Discharge to community; and
  - All-condition risk-adjusted potentially preventable hospital readmissions rates.

Source-CMS
Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional, may include:

- Communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care
- Communication with home health agencies and other community services utilized by the patient
- Patient and/or family/caretaker education to support self-management, independent living, and activities of daily living,
- Assessment and support for treatment regimen adherence and medication management,
- Identification of available community and health resources,
- Facilitating access to care and services needed by the patient and/or family
AND...

- Non-face-to-face services provided by the physician or other qualified health care provider may include:
  - obtaining and reviewing the discharge information (e.g., discharge summary, as available, or continuity of care documents);
  - reviewing need for or follow-up on pending diagnostic tests and treatments;
  - interaction with other qualified health care professionals who will assume or reassume care of the patient’s system-specific problems;
  - education of patient, family, guardian, and/or caregiver;
  - establishment or reestablishment of referrals and arranging for needed community resources
  - assistance in scheduling any required follow-up with community providers and services.
AND

- TCM requires a face-to-face visit, initial patient contact, and medication reconciliation within specified timeframes. The first face-to-face visit is part of the TCM service and not reported separately.
- Additional E/M services after the first face-to-face visit may be reported separately. TCM requires an interactive contact with the patient or caregiver, as appropriate, within two business days of discharge. The contact may be direct (face-to-face), telephonic or by electronic means. Medication reconciliation and management must occur no later than the date of the face-to-face visit.
- These services address any needed coordination of care performed by multiple disciplines and community service agencies.
- The reporting individual provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs and activity of daily living support by providing first contact and continuous access.
CMS Chronic Care Management Payment Program

- Planned for CY 2015
- $40/pmpm
- $480/yr
- 200 qualified patients = $96,000/yr
- 20% co-insurance for patient = $100/yr if no supplemental insurance
- Minimum of 20 min devoted to care planning/month

Adapted from: Edwards and Landon NEJM 371;22 Nov 2014
To Do’s

- 24/7 Access to CCM services and a linked provider
- Primary provider with easy access
- Care Plan*
  - Physical, mental, social, functional and environmental assessments and actions.
  - Inventory of supports and resources
  - Patient document aimed at choice and values
- Chronic disease management
  - Systems based plan
  - Prevention
  - Medication management
    - Reconciliation
    - Compliance
  - Regular updates of plan with respect to physical, mental and social
- Care transitions management
- Coordination of home, HH and community based providers with plan
- e-Highway for patients and caregivers to communicate with team
*Care Plan Components*

- Problem list
- Expected outcomes and prognosis
- Measurable treatment goals
- Planned interventions
- Symptom management
- Medication management plan
- List of community and social services ordered
- Plan for directing and coordinating outside services
- List of responsible people for each intervention
- Requirements and schedule for plan reviews and updates
More To Do’s

● Authorizations
  ● Regarding program and written agreement
  ● To share PCHIS

● Documentation
  ● That program fully explained
  ● Accept or decline
  ● Written care plan given to patient
  ● Right to terminate
  ● Explanation of benefit, in terms of sole provider overseeing and receiving payment
Care Management

A comprehensive strategy for high quality, patient centered, cost effective care, aimed at restoration of function and independence.

- And a word on ‘post acute care’
Why Do We Need Care Management?

Cost of Care Increases Dramatically with # of Chronic Conditions

TABLE 1-5 Average Medicare Expenditures per Fee-for-Service Beneficiary, by Number of Chronic Conditions, 2010

<table>
<thead>
<tr>
<th>Number of Chronic Conditions</th>
<th>Average Expenditure ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1</td>
<td>2,025</td>
</tr>
<tr>
<td>2-3</td>
<td>5,698</td>
</tr>
<tr>
<td>4-5</td>
<td>12,174</td>
</tr>
<tr>
<td>6 or more</td>
<td>32,658</td>
</tr>
</tbody>
</table>

NOTE: The 15 chronic conditions included in this analysis are high blood pressure, high cholesterol, ischemic heart disease, arthritis, diabetes, heart failure, chronic kidney disease, depression, chronic obstructive pulmonary disease, Alzheimer’s disease, atrial fibrillation, cancer, osteoporosis, asthma, and stroke.

The Exploding Home-Limited Elderly Population
Cost & Case Management Tiering Of Medicare Chronic Disease Patients

Tier 3A: 5% (half) of Tier 3 pts. 50% of total costs

Tier 3: 10% of pts. 64% of total costs

Tier 2: 40% of patients 31% of total costs

Tier 1: 50% of patients 5% of total costs

May 2015 GAO- Medicaid: A Small Share of Enrollees Consistently Accounted for a Large Share of Expenditures
Table 1: Percentage of High-Expenditure and All Medicaid-Only Enrollees with Certain Conditions or Services, Fiscal Years 2009 through 2011

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>Asthma</th>
<th>Diabetes</th>
<th>HIV/AIDS</th>
<th>Mental health conditions</th>
<th>Substance abuse</th>
<th>Delivery or childbirth</th>
<th>Long-term care residence</th>
<th>None of these conditions or services</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>14.20</td>
<td>18.79</td>
<td>3.10</td>
<td>52.64</td>
<td>19.87</td>
<td>9.95</td>
<td></td>
<td>8.35</td>
</tr>
<tr>
<td>2010</td>
<td>14.42</td>
<td>18.50</td>
<td>3.27</td>
<td>51.13</td>
<td>19.21</td>
<td>10.45</td>
<td></td>
<td>8.15</td>
</tr>
<tr>
<td>2009</td>
<td>14.08</td>
<td>18.13</td>
<td>3.24</td>
<td>50.13</td>
<td>18.48</td>
<td>10.79</td>
<td></td>
<td>8.48</td>
</tr>
</tbody>
</table>

Percentage of all Medicaid-only enrollees:

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>Asthma</th>
<th>Diabetes</th>
<th>HIV/AIDS</th>
<th>Mental health conditions</th>
<th>Substance abuse</th>
<th>Delivery or childbirth</th>
<th>Long-term care residence</th>
<th>None of these conditions or services</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>5.74</td>
<td>2.98</td>
<td>0.27</td>
<td>13.61</td>
<td>4.02</td>
<td>6.16</td>
<td></td>
<td>1.01</td>
</tr>
<tr>
<td>2010</td>
<td>5.88</td>
<td>2.86</td>
<td>0.29</td>
<td>12.72</td>
<td>3.72</td>
<td>6.26</td>
<td></td>
<td>0.86</td>
</tr>
<tr>
<td>2009</td>
<td>5.41</td>
<td>2.81</td>
<td>0.29</td>
<td>12.00</td>
<td>3.50</td>
<td>6.52</td>
<td></td>
<td>1.07</td>
</tr>
</tbody>
</table>

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-15-460
High Level Care Management Flow

HOME Residence/ALF/SNF
- Med Mngmnt-Healthy
- Behavior-Activation-Communication
- Communication

Home Health
- Med Mngmnt-Healthy
- Behavior-Activation-Communication

SNF
- Communication/IDT/Care Plan and Goals/Med Mngmnt/DC Plan

MD Office/Urg Care-Health Maint/Illness
- Med Mngmnt-Healthy
- Behavior-Activation-Communication

IRF
- Communication/IDT/Care Plan and Goals/Med Mngmnt/DC Plan

TCH
- Communication
- IDT/Care Plan and Goals/Med Mngmnt/DCPlan

ED/Hospital/Day Surgery/Surgictr
- Communication

CM Transition

Case Management CL
Recent Negative Studies

  - “Perhaps most of the social risk factors that we identified are not useful for improving the prediction of stroke readmission, and other variables—such as living alone or social support which were unavailable for this analysis—are more important.”

- A Comprehensive Hospital-Based Intervention to Reduce Readmissions for Chronically Ill Patients: A Randomized Controlled Trial *Am J Managed Care.* 2014;20(10)
  - “we were not able to include—home visits and ambulatory follow-up care—were essential”

  - “there was no significant impact of the nurse telephone calls on 30-day readmission rates”

- Effect of a Post-discharge Virtual Ward on Readmission or Death for High-Risk Patients A Randomized Clinical Trial *JAMA* 312 (13) Oct 2014
  - “There are several potential reasons the virtual ward model of care we implemented did not reduce readmissions. First, it was difficult for virtual ward team members to communicate with many patients’ primary care physicians. Many primary care physicians were not easily available by telephone or e-mail, which made collaborative care difficult. Second, the multiplicity of different information technology systems available made it difficult for virtual ward team members to know what care had previously been provided to a patient”

- A Multidisciplinary Intervention for Reducing Readmissions Among Older Adults in a Patient Centered Medical Home *Am J Managed Care Feb 2015: 21(2)*
  - 572 patients with ED visit, unanticipated hospitalization or SNF stay. Pharmacist call within 2-4 day post d/c. Geriatric clinic visit within 1 wk. 21% readmit rate in intervention, 17% matched control group. Medication burden and HRDS correlated best. (21% success with both call and visit)
Recent Positive Studies

- Impact of an Integrated Transition Management Program in Primary Care on Hospital Readmissions  JHQ Vol. 37 No. 1 January/February 2015
  - "Our TM program had several key features... Care Managers ..contacted by telephone to arrange timely outpatient follow-up."

- Medical Home Network announced today the results of a data review of its model of care program for Illinois Medicaid patients CHICAGO, Dec. 11, 2014
  - “One of the key strategies was creating a policy which made patients discharged from the hospital a top priority for scheduling follow-up appointments. By working together, in our first year we were able to achieve an average timely follow up rate of 47.2 percent with rates as high as 58.3 percent in some months."
“...high intensity transitional care interventions were associated with reduced readmissions in the short, intermediate, and long terms.”
Home-Based Primary Care Model

- Comprehensive, longitudinal primary care
- Patients are visited monthly, more often as medically necessary
- **Team-Based approach**: Physicians collaborate with NPs/Pas; nurse clinical coordinators support team
- Model has been associated with strong quality and financial outcomes (cost savings)
HBPC: Quality and Cost Outcomes

Keeping Readmissions Low…

30-Day Readmission Rates:

Mean Medicare 30-Day Rehosp. Rate

2010 2011 2012 2013 2014

Kindred HBPC: 5.7%
Approx General Medicare Population: 25%

While Reducing Costs

Percent of Deaths at Home:

Kindred HBPC: 86%
Approx General Medicare Population: 25%

30-Day Readmission Rates:

Mean Medicare 30-Day Rehosp. Rate

2010 2011 2012 2013 2014

Kindred HBPC: 5.7%
VA: 89%
JAGS 2014: 83%
Prelim IAH: 75%
Prelim KND: 33%

Empowering Seniors with End of Life Decisions…

While Reducing Costs
# Key Elements of A Care Transitions Program

<table>
<thead>
<tr>
<th>Identify Patients At High Risk for Readmission</th>
<th>Deploy Care Transitions Managers to ensure smooth transition</th>
<th>Coordinate Patient Access to PCP/Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Assessment Tool</td>
<td>Patient Choice</td>
<td>Schedules follow up appointment within 7 days of transition home</td>
</tr>
<tr>
<td>External Referrals</td>
<td>Assesses patient for transition readiness (Teach Back)</td>
<td>Attends appointment(s) when indicated</td>
</tr>
<tr>
<td>Internal Referrals</td>
<td>Present on the day of transition -ensures thorough handoff</td>
<td>Review Medications/Treatment Plan pre and post PCP visit</td>
</tr>
<tr>
<td>Interdisciplinary Collaboration</td>
<td>Transitional Care Pharmacist Referral</td>
<td>Ensures additional follow up appointments are made and kept</td>
</tr>
<tr>
<td>Internal Data Trigger Reports</td>
<td>Transitional Care Rehab Specialist Referral</td>
<td>Obtains new provider for patients without a PCP</td>
</tr>
</tbody>
</table>
Care Transitions Program Data 2014 YTD

- Readmission rate 30 days post discharge from a Kindred site of care = 6.1%
- Patient Satisfaction with Transition score = 3.6 (1-4 scale)
- PCPs were notified of admission and transition 97% of the time
- 98% of patients kept their scheduled PCP appointment within 7 days of discharge to home
- 98% of medications were administered as scheduled on the day of transition
- 98% of patients did not miss a meal on the day of transition
## Key Elements of ‘Tier 2’ Program

<table>
<thead>
<tr>
<th>Identify Patients At High Risk for Readmission</th>
<th>Deploy Home Health Nurse to ensure smooth transition</th>
<th>Coordinate Patient Access to PCP/Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Assessment Tool</td>
<td>Early Visits</td>
<td>Schedules follow up appointment within 7 days of transition home</td>
</tr>
<tr>
<td>External Referrals</td>
<td>Medication Reconciliation</td>
<td>Make sure patient attends visit</td>
</tr>
<tr>
<td>Internal Referrals</td>
<td>Environment Prepared DME, Meals, Support, etc</td>
<td>Review Medications/Treatment Plan pre and post PCP visit</td>
</tr>
<tr>
<td>Interdisciplinary Collaboration</td>
<td>Education and activation</td>
<td>Ensures additional follow up appointments are made and kept</td>
</tr>
<tr>
<td>Internal Data Trigger Reports</td>
<td>Rehab Specialist Referral</td>
<td>Obtains new provider for patients without a PCP</td>
</tr>
</tbody>
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Objectives

- Clinical Integration and Population Health, in the context of Post Acute Care
- CMS’s solutions, to date
- The case for Care Management
- Creating effective Care Management programs