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"Post-Acute Care Costs: Overcoming a Roadblock on the Path to Shared Savings"

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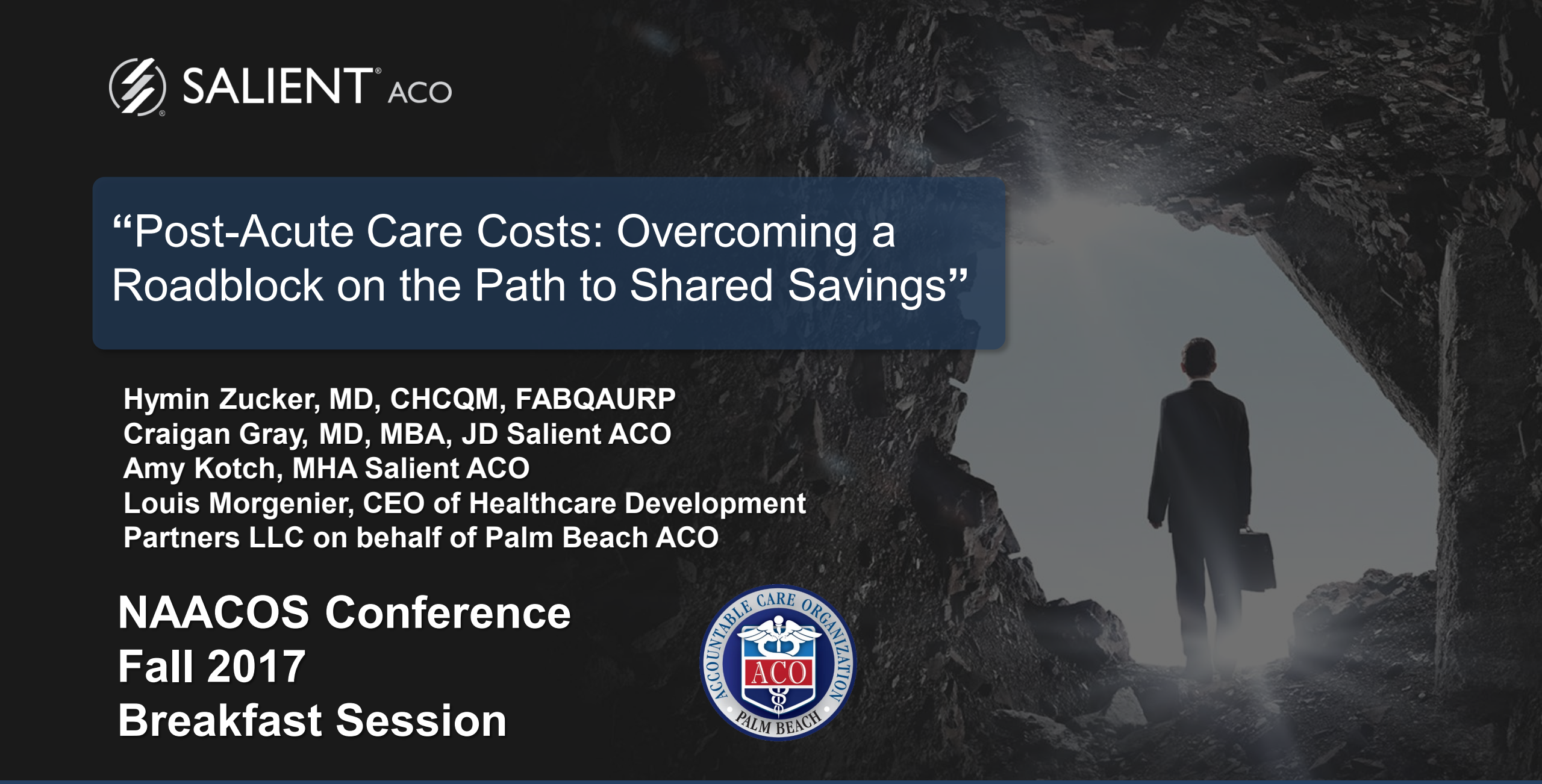
NAACOS Conference
Fall 2017
Breakfast Session



October 5, 2017

Salient-ACO.com

A Mother's Tale

- **84 y/o female with**
  - PMH, ASHD, s/p 3x vessel bypass 1992
  - CHF nl EF
  - Pul HTN RV systolic pressure 70
  - Bronchiectasis/COPD
  - CKD stage 3b
  - Chronic Anemia hgb avg 10
  - Hyponatremia
  - DM type 2

OP Cardiac Cath.
at Hospital A

7 Days Post Cath.
Admission CHF/Resp. failure at
Hospital B

- 3 days ICU on Ventilator
- 11 day total admission
- d/c to home with HHA and oxygen therapy
- **Total cost $108,000**

8 Days Post d/c
readmission SOB/CHF/hyponatremia at
Hospital C

- LOS 8 days
- d/c to home with HHA, cardiology, pulmonology, and nephrology visits
- **Total cost $48,000**

45 days Post d/c
admitted with hypotension/syncope/ARF s/p start of Pul HTN meds
Hospital B

- LOS 8 days
- **Total cost $21,000**

Total Cost of Care: $171,000
LOS: 27d
# of transition visits = 1

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Intro

- **What we know about post-acute care (PAC)**
  - Consumes about 11% of total Medicare spend
    - which is more than $62 Billion (in 2012) for those suffering from acute illnesses
  - Fastest growing category of spend in Medicare
  - For those suffering from chronic conditions
    - post-acute care and readmissions in the first 30 days = initial hospital admission
  - Extreme variation-73% of variation is due to rendered PAC services
    - Example: in 2008, beneficiary with CHF:
      - $2,500 HHA vs$ 10,700 with SNF vs $15,000 inpatient rehab

References:
-Newhouse JP, Garber AM. Geographic variation in Medicare services. N Engl J Med 2013;368:1465-8
-Chandra A, Dalton MA, Holmes J. Large increases in spending on postacute care in Medicare point to the potential for cost savings in these settings. Health Aff (Milwood)2013;32:864-72
-Mechanic R. Postacute care-The next frontier for controlling Medicare spending. N Engl J Med 2014;370:692-4

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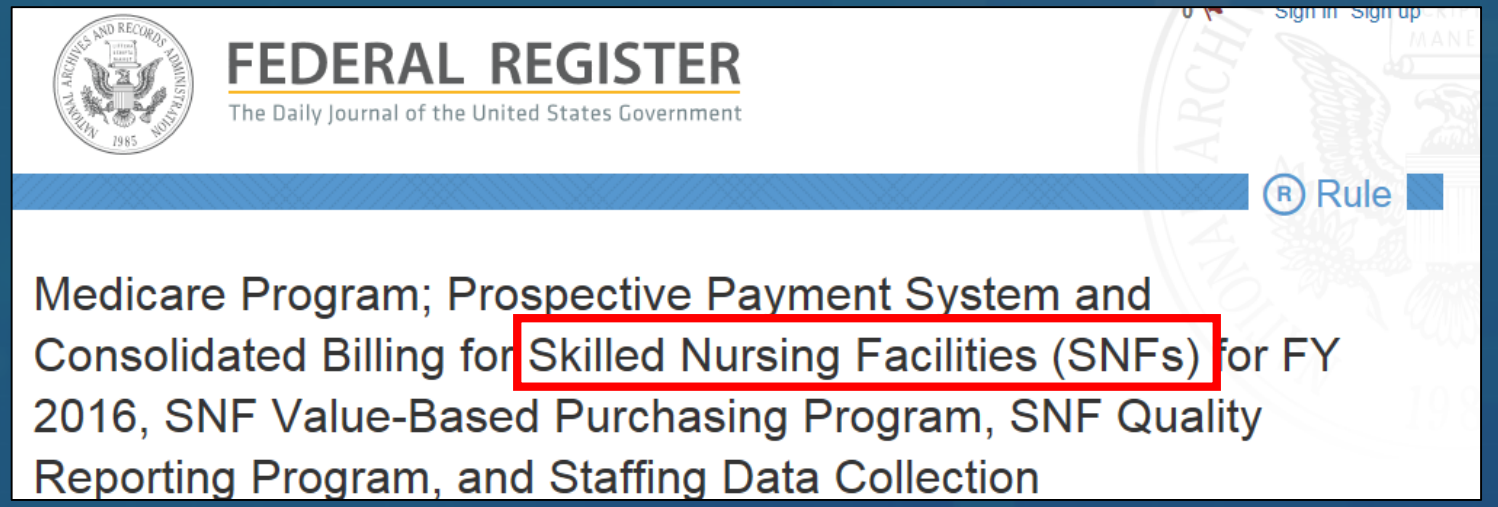
Readmission Penalties

Readmissions Reduction Program (HRRP)

Background

Section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.150 through §412.154).

https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html



https://www.federalregister.gov/documents/2017/05/04/2017-08521/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities

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Quality Resource Use Report (QRUR)

Per Capita and Per Episode Costs of Care for Specific Services

Exhibits 11 and 12 show the dollar difference between your per capita and per episode costs and the mean among TINs with at least 20 eligible cases for the measure (benchmark), by category of service. Detailed cost of services breakdowns for these measures are available via the CMS Portal in downloadable supplementary exhibits (see the "About the Data in this Report" section).

Exhibit 11. Differences between Your TIN's Per Capita Costs and Mean Per Capita Costs among TINs with these Measures, by Category of Service: Per Capita Costs for All Attributed Beneficiaries and Beneficiaries with Specific Conditions

Service Category	Amount by Which Your TIN's Costs Were Higher/(Lower) than Benchmark:Per Capita Costs for All Attributed Beneficiaries	Amount by Which Your TIN's Costs Were Higher/(Lower) than Benchmark:Per Capita Costs for Beneficiaries with Diabetes	Amount by Which Your TIN's Costs Were Higher/(Lower) than	Amount by Which Your TIN's Costs Were	Amount by Which Your TIN's Costs
Evaluation & Management Services Billed by Eligible Professionals in Your TIN*	$0	—			
Evaluation & Management Services Billed by Eligible Professionals in Other TINs*	$0	—			
Major Procedures Billed by Eligible Professionals in Your TIN*	$0	—			
Major Procedures Billed by Eligible Professionals in Other TINs*	$0	—			
Ambulatory/Minor Procedures Billed by Eligible Professionals in Your TIN*	$0	—			
Ambulatory/Minor Procedures Billed by Eligible Professionals in Other TINs*	$0	—			
Ancillary Services	$0	—			
Hospital Inpatient Services	$0	—			
Emergency Services Not Included in a Hospital Admission	$0	—			
Post-Acute Services	$0	—			
Hospice	$0	—			
All Other Services**	$0	—			

Exhibit 6-CCC-B. Communication and Care Coordination Domain Quality Indicator Performance (CMS-Calculated Outcome Measures)

Performance Category	Measure Reference	Measure Name	Your TIN's Eligible Cases	Your TIN's Performance Rate	Benchmark	Benchmark −1 Standard Deviation	Benchmark +1 Standard Deviation	Standardized Score	Included In Domain Score?
Hospitalization Rate per 1,000 Beneficiaries for Ambulatory Care-Sensitive Conditions	CMS-1	Acute Conditions Composite	0	0.00	0.00	0.00	0.00	0.00	Yes
	-	Bacterial Pneumonia	0	0.00	0.00	0.00	0.00	0.00	No
		Urinary Tract Infection	0	0.00	0.00	0.00	0.00	0.00	No
		Dehydration	0	0.00	0.00	0.00	0.00	0.00	No
	CMS-2	Chronic Conditions Composite	0	0.00	0.00	0.00	0.00	0.00	No
	-	Diabetes (composite of 4 indicators)	0	0.00	0.00	0.00	0.00	0.00	No
		Chronic Obstructive Pulmonary Disease (COPD) or Asthma	0	0.00	0.00	0.00	0.00	0.00	No
		Heart Failure	0	0.00	0.00	0.00	0.00	0.00	No
Hospital Readmissions	CMS-3	All-Cause Hospital Readmissions	0	0.00%	0.00%	0.00%	0.00%	0.00	No

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2014-Sample-Annual-QRUR.pdf

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All Other Services**	$0	—			

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	-	Bacterial Pneumonia	0	0.00	0.00	0.00	0.00	0.00	No
	-	Urinary Tract Infection	0	0.00	0.00	0.00	0.00	0.00	No
	-	Dehydration	0	0.00	0.00	0.00	0.00	0.00	No
	CMS-2	Chronic Conditions Composite	0	0.00	0.00	0.00	0.00	0.00	No
	-	Diabetes (composite of 4 indicators)	0	0.00	0.00	0.00	0.00	0.00	No
	-	Chronic Obstructive Pulmonary Disease	0	0.00	0.00	0.00	0.00	0.00	No
Hospital Readmissions	CMS-3	All-Cause Hospital Readmissions	0	0.00%	0.00%	0.00%	0.00%	0.00	No

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2014-Sample-Annual-QRUR.pdf

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Bundled Payments

Bundled Payments for Care Improvement (BPCI) Initiative: General Information

Share

The Bundled Payments for Care Improvement (BPCI) initiative is comprised of four broadly defined models of care, which link payments for the 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.

https://innovation.cms.gov/initiatives/bundled-payments/

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Post-Acute Care Quality Reporting Program

Coming Attraction

Post-Acute Care Quality Reporting Program Final Rules Published

The Centers for Medicare & Medicaid Services (CMS) published the following final rules:

Long Term Acute Care Hospital Quality Reporting Program:

- Fiscal Year 2018 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Final Rule
- View the Long-Term Care Hospital (LTCH) Quality Reporting (QRP) webpage for more information about the quality reporting program.

Inpatient Rehabilitation Quality Reporting Program:

- Fiscal Year 2018 Inpatient Rehabilitation Facility Prospective Payment System Final Rule
- View the Inpatient Rehabilitation Facilities (IRF) Quality Reporting Program (QRP) webpage for more information about the quality reporting program.

Skilled Nursing Facility Quality Reporting Program:

- Fiscal Year 2018 Skilled Nursing Facility Prospective Payment System Final Rule
- View the Skilled Nursing Facility (SNF) QRP webpage for more information about the quality reporting program.

Hospice Quality Reporting Program:

- Fiscal Year 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements Final Rule
- View the Hospice QRP webpage for more information about the quality reporting program.

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-08-02.html

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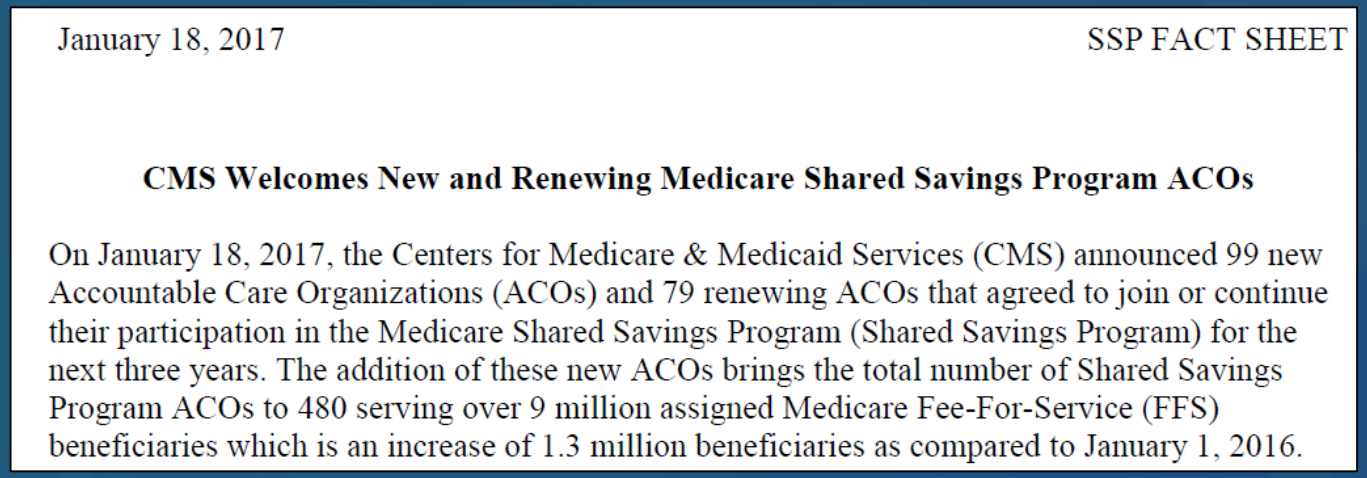
Medicare Efforts Continued…

- ACOs!!!
  - Next generation and Track 1+ ⟶ movement to risk
  - SNF waivers (SNF spend accounts for half of PAC spending)
  - Other meaningful partnerships
  - Other ACO tactics i.e., have an ACO provider round at a SNF and take on only ACO beneficiaries



January 18, 2017 SSP FACT SHEET

CMS Welcomes New and Renewing Medicare Shared Savings Program ACOs

On January 18, 2017, the Centers for Medicare & Medicaid Services (CMS) announced 99 new Accountable Care Organizations (ACOs) and 79 renewing ACOs that agreed to join or continue their participation in the Medicare Shared Savings Program (Shared Savings Program) for the next three years. The addition of these new ACOs brings the total number of Shared Savings Program ACOs to 480 serving over 9 million assigned Medicare Fee-For-Service (FFS) beneficiaries which is an increase of 1.3 million beneficiaries as compared to January 1, 2016.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/news.html

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Primary Care Can Do It!

- **As ACOs, we know that the best way to control costs is by placing the PCP in the forefront of care**
  - We need to prove it!

How does the PCP gain patient trust and make shared decisions?

How does the PCP set up the office to accommodate for transitions?

What should the transition entail?

How do we prove the PCP intervention is the answer to increasing value and satisfaction while decreasing costs?

Med rec, care plan adjustment, utilize narrow network, check necessity of HHA

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The Hypotheses

1. If there is a Primary Care Intervention:

then the costs within 90 days post discharge will be less than those who do not have the intervention

2. If there is a Primary Care Intervention:

then the number of readmissions will decrease compared to those who do not have the intervention

Primary care intervention: TCM (99495 and 99496)- a transition visit within 1-2 weeks post inpatient/obs/SNF
Possible TCM: a PCP eval & treat visit within 1-2 weeks post discharge

Readmissions: any cause admission following an initial admission as set by the dates of analyses in the 90 day window

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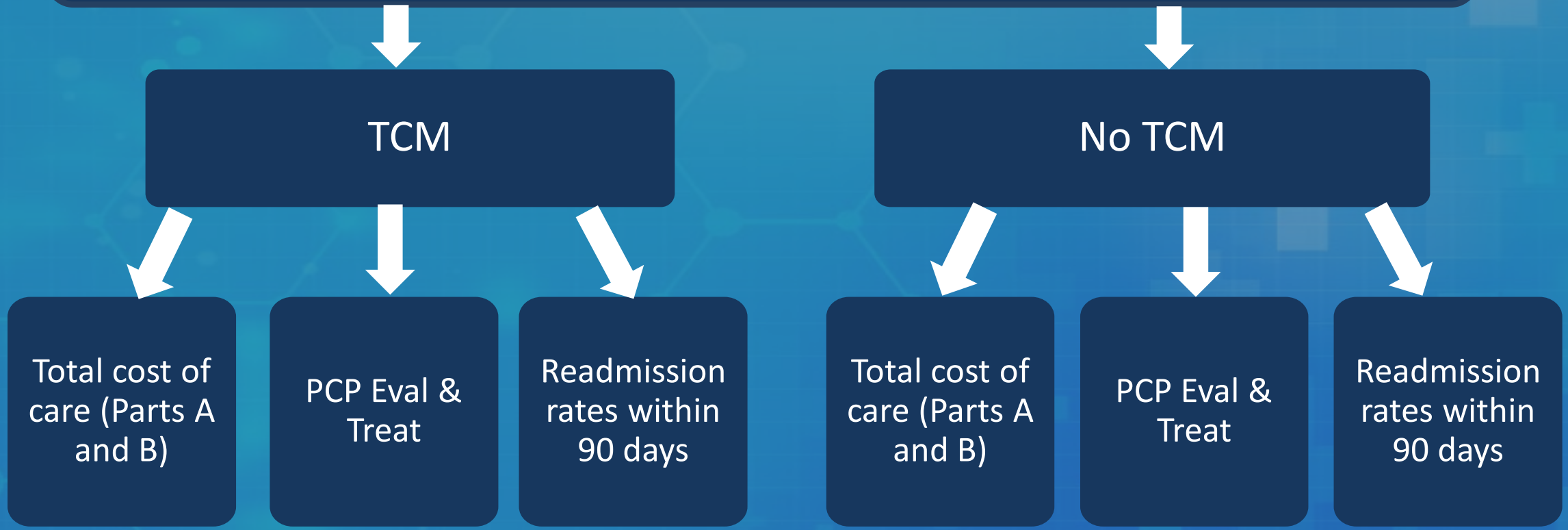
The Study

Any discharges in 2016 from: SNF, inpatient acute care, inpatient psych hospital, long term care hospital, inpatient rehab facility, hospital observation and community mental health centers

Any Discharges in 2016 to: home and home with HHA



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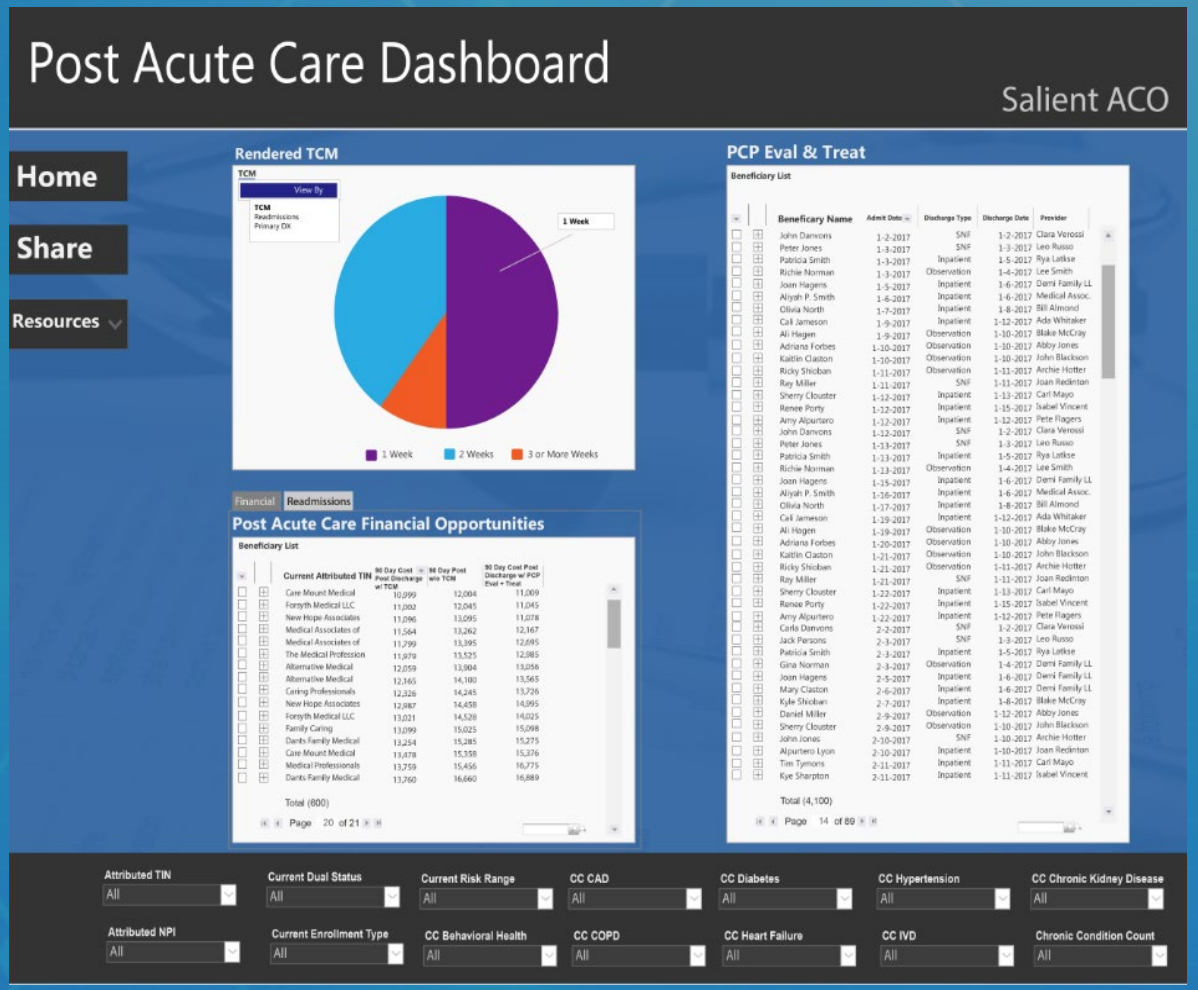
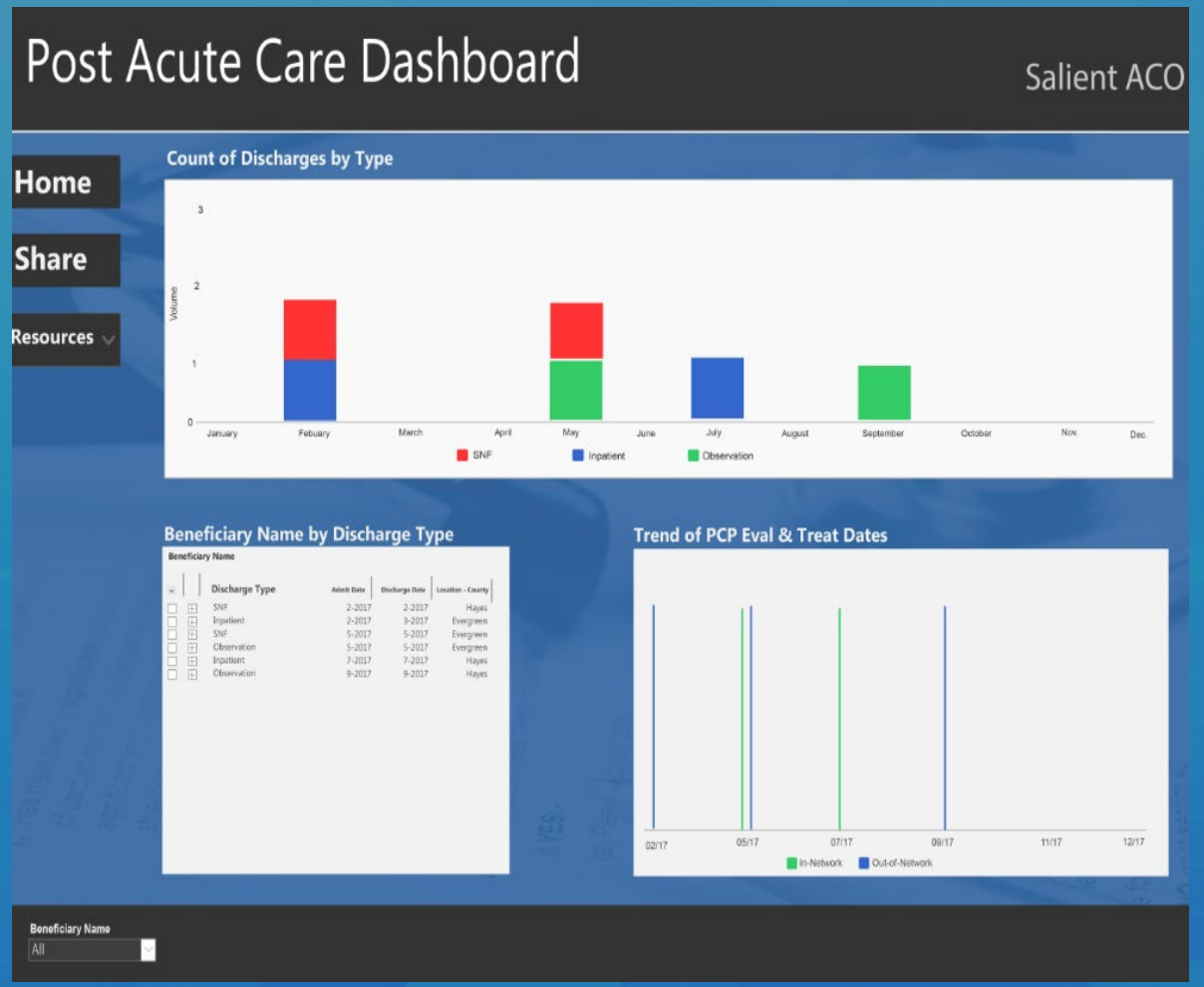
TCM Visualized in the Salient ACO Dashboards





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Keep in Mind

- **Time frame selection**
  - Whole year of 2016, which excludes any true initial IP admissions at the end of 2015 or earlier
- **Deceased beneficiaries**
  - Those who pass within 7 and 14 days are no longer capable of receiving a TCM
- **D/C IP to home & SNF**
  - Difficult to capture TCM when patient is in SNF
- **The “n” in each category**
  - some are significant compared to others, but we left the data raw

The Findings-Service Opportunity

- **Out of the total possible instances where a TCM could be rendered (73,097), 10% (7353) were captured within 1-2 weeks post discharge**
  - Of TCMs captured:
    - 72% within 1 week
    - 28% within 2 weeks
- **Possible TCMs (PCP Eval & Treat)- any PCP visit except AWVs or CCMs that fell within 1 or 2 weeks**
  - Out of total possible instances where a PCP could see the beneficiary post discharge (73,097), 69% (50,322) were seen as a subsequent visit
  - Of all PCP Eval and Treat Visits:
    - 80% within 1 week
    - 20% within 2 weeks

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The Findings-Financial Opportunity

- **Total spend in ACO 2016: $819,535,618**
- **Part A spend on IP: $459,919,873**
- **Part A spend on SNF: $44,149,845**
- **Average total spend 90d post discharge: $13,339**
  - If any TCM is captured, the average savings are $1,882
    - Within 1 week, average savings are $2,092
    - Within 2 weeks, average savings are $1,338
  - If TCM is captured post discharge from IP, the savings are $3,149
    - Within 1 week, average savings are $3,427
  - If TCM is captured post discharge from Obs, the savings are $3,158
    - Within 1 week, average savings are $3,330

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The Findings-Readmission Opportunity

- Total discharges: 73,097
- Total readmissions: 20,773 or a rate of 28% within 90 days post discharge
- Slight differences are seen across all discharge types, however the largest difference is seen with a TCM within 1 week from an IP discharge, which lowers the rate 12% from 40% to 28%

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The Findings-Conclusion

- PBACO is capturing TCMs at 10% but when TCMs are added to PCP Eval and Treat visits, they are seeing patients within 1-2 weeks post discharge at a 79% rate
- Huge savings are seen across all discharge types when a TCM is captured
- Opportunity is to capture more TCMs in both billing aspect as well as getting the beneficiaries in between 0-14 days
- If PBACO increased TCMs within 1 week by 10% more, they would save an additional $30,583,784 on average

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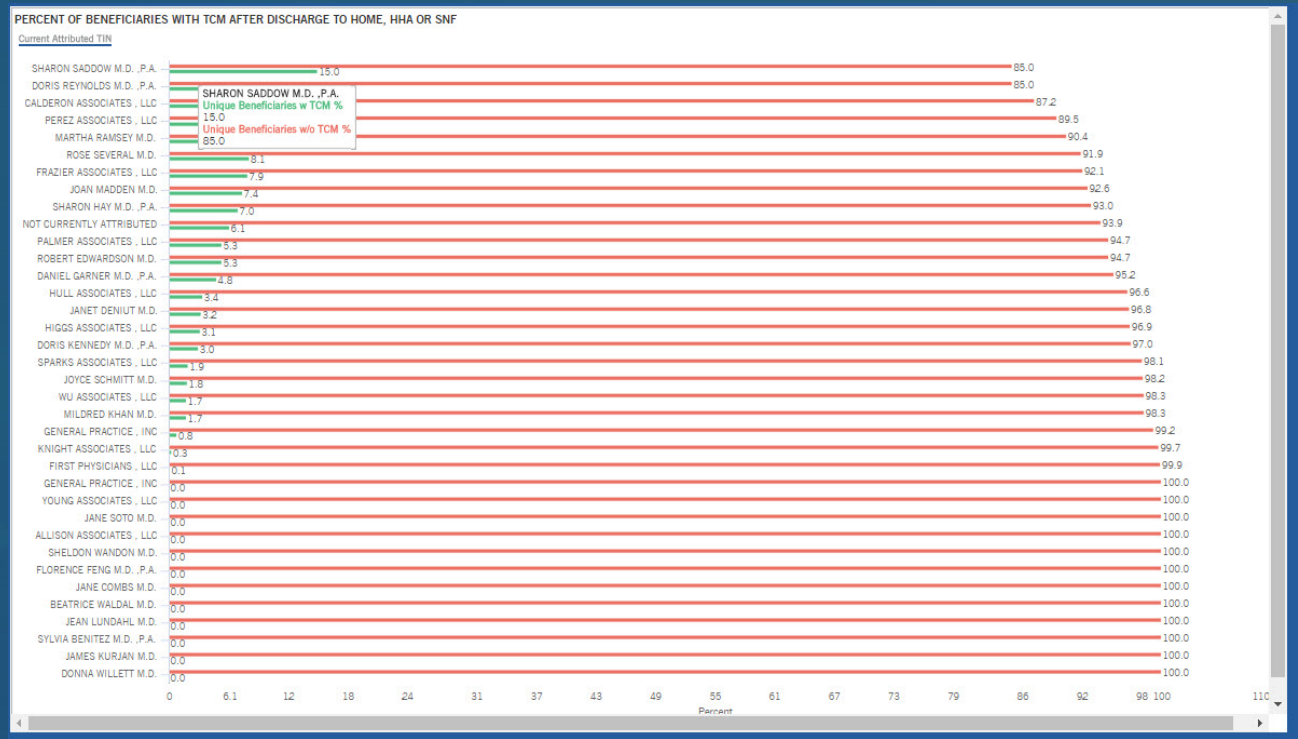
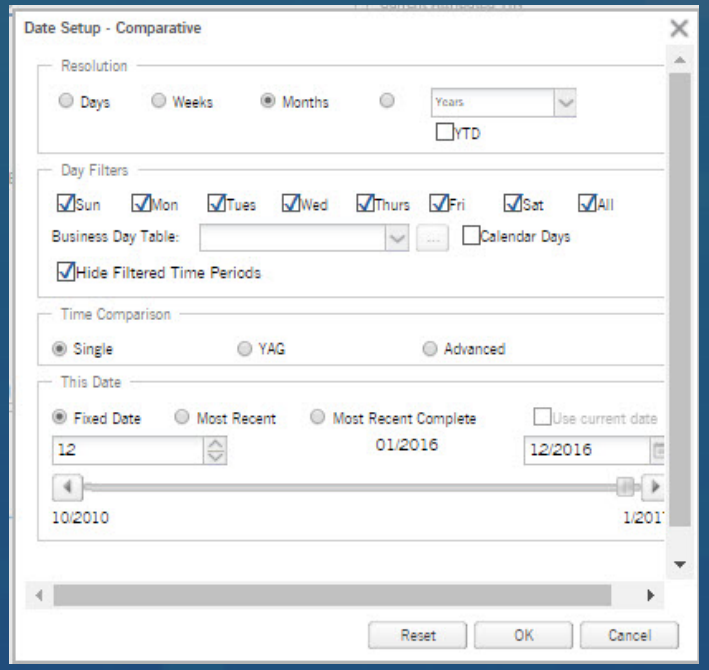
Where We're Goin', Come and Join Us!

Is the rendering TIN/NPI the attributed TIN/NPI



What does a time series look like?



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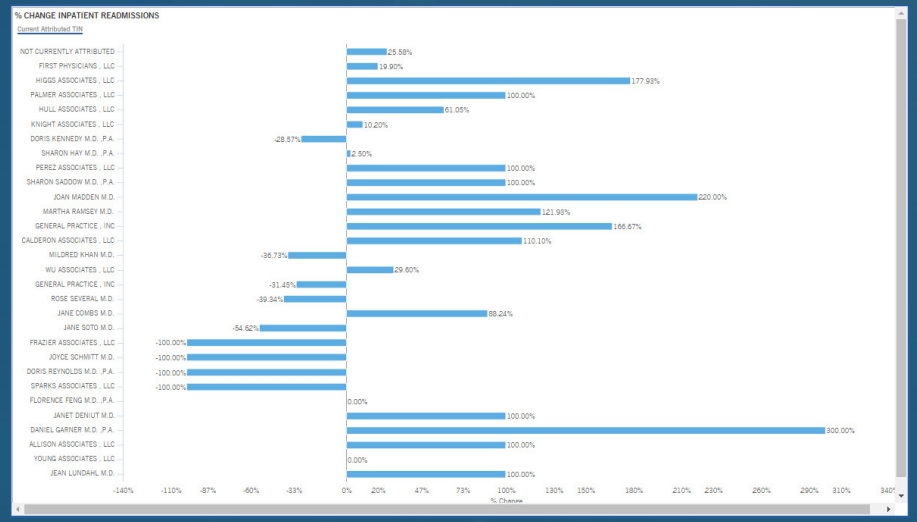
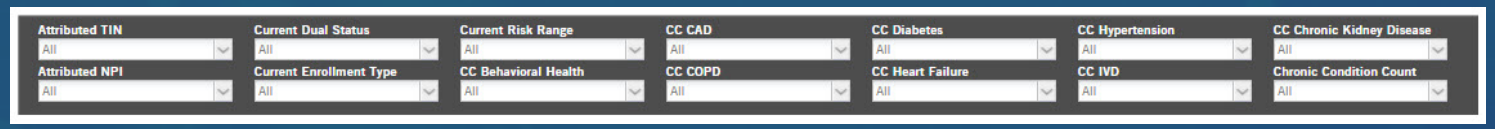
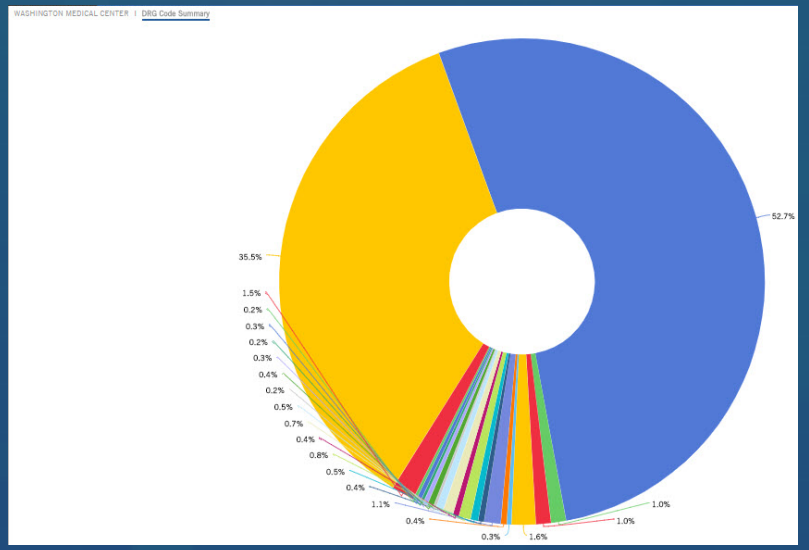
Where We're Goin', Come and Join Us!

TIN/NPI comparison of TCM compared to costs and readmission rates



Utilize filters for chronic condition and DRG procedures





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What can ACOs do with this information?

- Create relationships with hospitals in bundled payment structures and use information for leverage
- Create relationships with hospitals
- Create relationships with SNFs
- Increase PCP engagement
- Increase patient engagement

Continuous Process Improvement!

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Conclusion & Questions

Drawing Amazon Echo 2

See a Live Demo at Booth B13

Learn more at Salient-ACO.com

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