



# Healthcare Reform & Medicare: Is Your Organization Positioned for Success?

OHCA/OCAL/OCDD Winter Leadership Conference

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# Topics

- ◆ Status of Healthcare Reform, February 2010
- ◆ Biggest Challenges for LTC 2010–15
  - ◆ Medicare cuts
  - ◆ Bundling
- ◆ What Keeps Hospital Leaders Up at Night
- ◆ Strategies for Success for Post-Acute Providers
  - ◆ Address hospitals' biggest concerns through customized programs and 24/7 physician/NP management
  - ◆ Enhance your post-acute care continuum through ownership or partnerships
  - ◆ Create a cluster-care continuum, market by market; and cement hospital relationships

# Healthcare Reform: Medicare

- ◆ Still alive, but doubtful that massive bill will be passed
- ◆ Likely Medicare payment-related events with or without bill:
  - ◆ Reduced annual *market basket* (MB) increases
  - ◆ Value-based purchasing
  - ◆ Avoidable readmission penalties for hospitals
  - ◆ Demonstrations/pilots (new or additional) for medical home, accountable care organization (ACO), episodic bundling, care transitions, chronic care management
    - If they bend the cost curve for Medicare, will convert to regulations

# Healthcare Reform: Other

- ◆ Questionable:
  - ◆ Massive changes in health insurance
  - ◆ Public option for health insurance
  - ◆ Increase in Medicaid eligibles

# Post-Acute Providers' Greatest Challenges 2010–15: Medicare Cuts

- ◆ Annual Medicare reductions: SNFs and home health
  - ◆ Market basket reductions (or eliminations)
  - ◆ Productivity adjustments
  - ◆ Value-based purchasing
- ◆ Additional potential revenue reductions and adjustments
  - ◆ Medicaid shortfalls (more for Medicare payments to offset)
  - ◆ More dollars to HCBS-NF transitions (occupancy)
  - ◆ Possible realignment of SNF Medicare payment (more dollars to medical, less to rehab)
  - ◆ Possible revision of home health payment (reduced HHRG rates based on updated data)

# Annual Medicare Reductions

## ◆ **Market Basket Reductions**

- ◆ MedPAC recommendation = 0% MB increase FY 2011 for SNFs and HHAs
- ◆ Productivity adjustments
  - Net cut to MB rate in both Senate and House bills
  - Possible additional -.2% reductions FY 2014–19 in Senate bill

## ◆ **Value-Based Purchasing**

- ◆ Payment based on achieving certain thresholds for quality measures: HHAs in 2011; SNFs in 2012 (Senate bill)
- ◆ Would be easy for CMS to implement for HHAs as already penalized if do not report quality indicators

# Potential Adjustments in Medicare Payment

- ◆ **Home Health: Rebase (both bills)**

- ◆ Senate bill more specific: rebase 2014–17, no more than 3.5% annual reduction
- ◆ Case mix adjustments in FY 2010 and FY 2011



- ◆ **Skilled Nursing: Payment Revision (House bill)**

- ◆ Payment for non-therapy ancillaries (NTAs) increase by 10% and therapy case mix component decrease by 5.5%
  - Government then to analyze NTAs to ensure accuracy of payment so that *a new budget neutral classification system can be implemented*
- ◆ Future Medicare payments to SNFs may be reduced by 2% to provide dollars for high-cost outliers for therapies and non-therapy ancillaries

# Post-Acute Providers' Greatest Challenges 2010–15: Bundled Payment via ACOs

- ◆ Accountable Care Organizations
  - ◆ Integration of physicians, hospitals, post-acute providers, outpatient
  - ◆ Responsible for all care for more than 5,000 Medicare beneficiaries
  - ◆ *Objective*: reduce overall Medicare costs
  - ◆ *Incentive*: ACOs share in cost savings versus “normal” market-based payment for Medicare beneficiaries
- ◆ Many large health care systems preparing now—even if just demonstration; employing physicians as first step

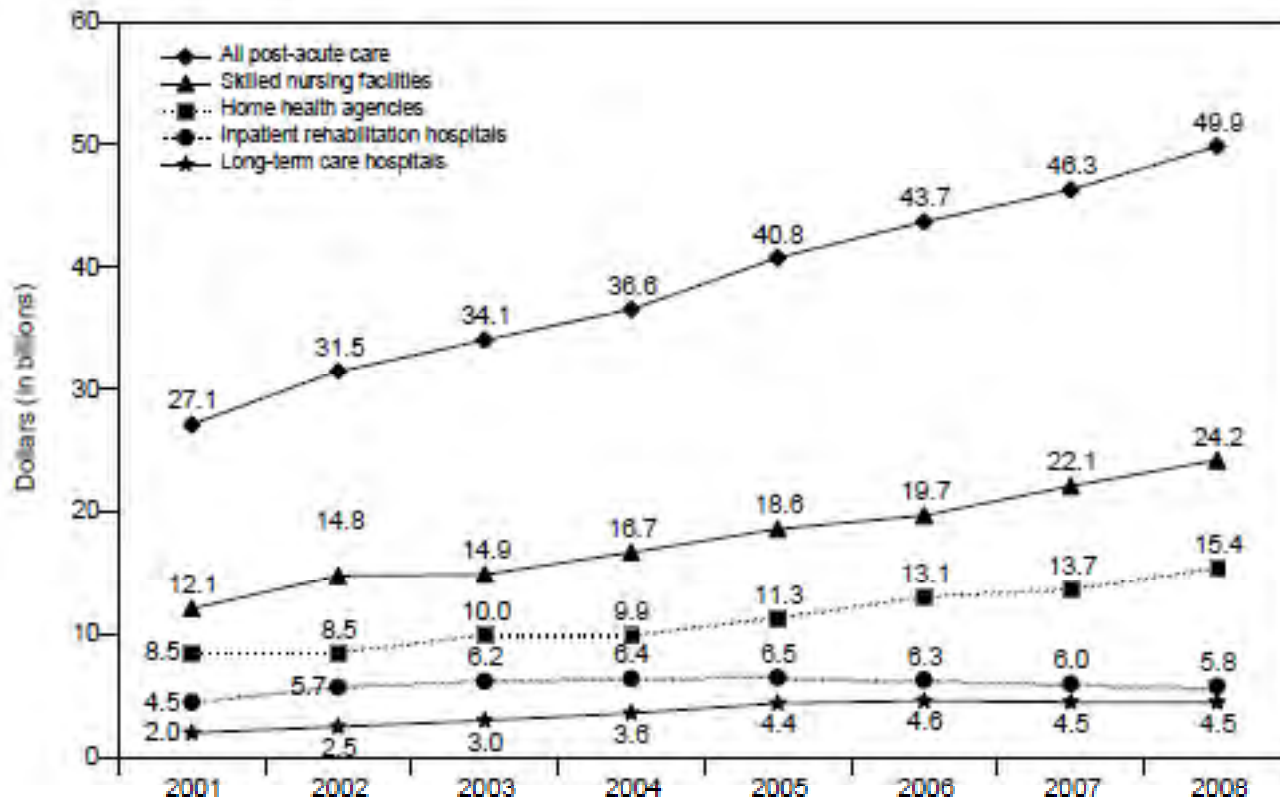
*SNFs and HHAs will be in or out—  
not everyone will play in Medicare space*

# Post-Acute Providers' Greatest Challenges 2010–15: Bundled Episodic Payment

- ◆ Bundling = payment to a single provider entity one amount for the full range of care during a hospitalization episode
  - ◆ Episodic payment related to acute hospitalization: -3 through +30 days
  - ◆ Hospitalization, re-hospitalization, post-acute care, outpatient, physicians
- ◆ In both bills, beginning 2011 or 2013, but could start with demonstrations

# Why Post-Acute Targeted for Medicare Cuts: Spending

## MedPAC (2009): Medicare Post-Acute Spending Increases Fueled by SNFs and HHAs



# Why Post-Acute Targeted for Medicare Cuts: Use and Re-hospitalizations

PAC Setting	Percent Discharged from Hospital to PAC Setting	Percent Rehospitalized After Using PAC Setting	Percent Died in PAC Setting	Percent Discharged to a Second PAC Setting	Most Common Second PAC Setting Used
SNF	17.3%	22.0%	5.4%	29.3%	Home health
Home Health	15.0	18.1	0.8	2.3	Hospice
Inpatient Rehabilitation	3.2	9.4	0.4	56.8	Home health
Hospice	2.1	4.5	82.2	2.4	Home health
Long-term Care Hospital	1.0	10.0	15.5	53.4	SNF
Inpatient Psychiatric	0.5	8.7	0.4	25.4	SNF
<b>TOTAL</b>	<b>40.0%</b>	<b>18.0%</b>	<b>6.2%</b>	<b>19.8%</b>	

# What Keeps Hospital Leaders Up at Night

## ◆ **Penalties for Avoidable Re-admission**

- ◆ Hospitals report re-admissions for heart attack, heart failure, and pneumonia—likely the first “conditions”
- ◆ Penalties in both bills, but could be regulated by CMS
- ◆ Probable penalty: reduction in all Medicare payments if exceed threshold for avoidable re-admissions for the three conditions



## ◆ **Value-Based Purchasing**

- ◆ Link Medicare payments to performance: withhold on Medicare payments to all hospitals; extra payment to hospitals that meet performance thresholds

# Strategies for Success in a New Health Care Delivery System

- ◆ Become your hospitals' preferred or only partner in the care continuum
- ◆ Diversify your revenue base by extending your care continuum
  - ◆ *Yesterday*: Adding companies to serve your multi-state SNFs
  - ◆ *Today*: Owning the post-acute continuum in your targeted market
- ◆ Achieve scale within your targeted markets by deepening and extending your care continuum—the cluster continuum



*In the new healthcare delivery system, skilled nursing providers who are lone rangers in the institutional long-term care business will be—  
in the Medicaid business*

# The Post-Acute Providers' Strategy for the Future

## ◆ Three strategic imperatives

Address hospitals' biggest concerns through customized programs and 24/7 physician/NP management

- ◆ Length of stay (LOS)
- ◆ Pending re-admission penalties

Enhance your post-acute care continuum through ownership or partnerships

Create a cluster care continuum, market by market; and cement hospital relationships

# Address Hospitals' LOS and Re-admission Concerns: Point 1

- ◆ Customize subacute programs and solutions to hospital partners by using hospital data
- ◆ Obtain data from the potential hospital partner, WebMD or state hospital association



- ◆ Identify the biggest LOS and readmission problems by hospital

# Example Hospital Data Set

MS-DRG	MS-DRG Description	SNF Discharges	Acute Hospital Days	CMS GMLOS Days	ALOS at Hospital	CMS GMLOS	Total Excess Hospital Days	LOS Over (Under) GMLOS
480	Hip and femur procedure except major joint w/mcc	50	400	380	8.0	7.6	20.0	0.40
193	Simple pneumonia and pleurisy w/mcc	40	245	212	6.1	5.3	33.0	0.83
286	Circ disorder except ami, w/card cath w/mcc	35	180	175	5.1	5.0	5.0	0.14
291	Heart failure and shock w/mcc	30	135	150	4.5	5.0	(15.0)	(0.50)
640	Nutritional and miscellaneous metabolic disorders w/mcc	28	124	104	4.4	3.7	20.4	0.73
<b>Total</b>		<b>183</b>	<b>1,084</b>	<b>1,021</b>	<b>5.9</b>	<b>5.6</b>	<b>63.4</b>	<b>0.35</b>



30-Day Re-admission Rate		
Type	Hospital Percent	National Percent
Heart Attack	19.4%	19.9%
Heart Failure	25.8%	24.5%
Pneumonia	19.6%	18.2%



# Address Hospitals' LOS and Re-admission Concerns: Point 2

- ◆ Upgrade physician-NP coverage
  - ◆ Train attending physicians on coding, documentation “musts” and reimbursement; provide cheat-sheets
  - ◆ Train nurse managers to round with physicians/NPs/PAs on Medicare patients and coach on coding
  - ◆ Implement procedures to simplify reporting to physicians' billers to mitigate risk of noncompliance and assure that attendings and consultants receive proper Medicare payment



# Example NP SNF Patient Visits Payment January–February 2010

Code	Total 2010 RVUs	2010 Payment Rate (CF=28.4061)	Total 2009 RVUs	2009 Payment Rate	Percentage Change 2009–10	Ohio
99304	2.33	\$66.19	2.22	\$80.07	-17.34%	\$65.73
99305	3.27	\$92.89	3.1	\$111.81	-16.92%	\$92.24
99306	4.17	\$118.45	3.98	\$143.55	-17.48%	\$117.62
99307	1.13	\$32.10	1.1	\$39.67	-19.09%	\$31.88
99308	1.74	\$49.43	1.68	\$60.59	-18.42%	\$49.08
99309	2.3	\$65.33	2.23	\$80.43	-18.77%	\$64.87
99310	3.4	\$96.58	3.29	\$118.66	-18.61%	\$95.90
99315	1.65	\$46.87	1.61	\$58.07	-19.29%	\$46.54
99316	2.16	\$61.36	2.1	\$75.74	-18.99%	\$60.93
99318	2.42	\$68.74	2.32	\$83.67	-17.84%	\$68.26

Source: [www.amda.com/advocacy/feeschedule.cfm](http://www.amda.com/advocacy/feeschedule.cfm) and CMS

As of February 8, 2010, Senator Max Baucus has submitted a bill to increase physician payment rates and to delete therapy caps

# Address Hospitals' LOS and Re-admission Concerns: Point 3, Part 1

- ◆ *Customize* your post-acute programs for key referring hospitals; create venues that attract hospital discharges
  - ◆ Create TRABHs and mini-TRABHs (Transitional Rehab All but Hospitals): completely separate unit or new facility, dedicated staff, high-tech nursing, dedicated therapy area; ALOS <20 days
  - ◆ *Look like, feel like a rehab hospital in a Marriott hotel*



- ◆ Protocols and programs for most important referring hospitals' needs

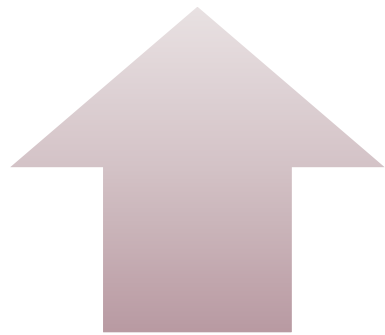
# Address Hospitals' LOS and Re-admission Concerns: Point 3, Part 2

- ◆ Assure that your clinical staff is able to reduce avoidable readmissions
  - ◆ Upgrade nursing clinical skills, integration
    - IV starts, trach management, isolation, assessments, acute care or acute rehab protocols
    - Establish *functional rehabilitation* programs
  - ◆ Track re-admissions, time, nurse, physician, reason; analyze and implement procedures to reduce
    - Enhanced NP coverage
    - Most qualified nurses at night
    - Clinical protocols for key conditions

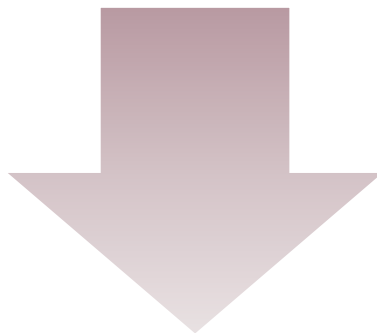


# Extend Your Post-Acute Continuum

- ◆ Extend post-acute continuum, through integrated SNF-home health-hospice continuum
  - ◆ *Why?* SNF and HHA discharges account for 88% of Medicare post-acute admissions



Average Medicare  
post acute episode  
cost =  $> \$30,000$



SNF-HHA  
combination cost =  
 $\$12,000 - \$15,000$

# Why Home Health?

- ◆ New revenue stream in today's payment system
  - ◆ EBITDA = >10% even with pending Medicare reductions
- ◆ Cost management for ACOs & episodic bundling
  - ◆ Avalere Health (2009) studied diabetes, COPD, & CHF
  - ◆ Early home health use without other PAC use
    - Reduced odds of hospital readmissions versus other PAC use
    - Lowered costs versus other PAC users—the higher patient severity, the greater cost savings
      - Diabetes (\$6,120–\$9,441)
      - COPD (\$5,453–\$10,725)
      - CHF (\$4,588–\$8,010)

# LTACH and IRF Partnerships: Subacute as Alternative Post-Acute Venue & HHA Referrals

- ◆ Consider partnering with LTACHs and inpatient rehab facilities (IRFs) for post-acute continuum
  - ◆ Keep your perspective
    - 400 LTACHs
    - 1,230 IRFs; more than 1,000 are hospital units, not freestanding
    - 16,000 SNFs
    - 10,700 HHAs
  - ◆ Freestanding IRFs and all LTACHs typically have sophisticated, aggressive referral development functions ... and many restrictions on patient types for admission ... and often discharge to home health

# Cluster Care Continuum and Cement Hospital Relationships

- ◆ Assess your hospitals' ability to become partners (number of SNF discharges, drive to become ACO); pick most likely partners
- ◆ Message your specific solutions to the targeted hospital C-suite and physicians
- ◆ Provide value-added benefits, e.g.,
  - ◆ Care transitions intervention (evidence-based NQF approved program)
  - ◆ Physician support for documentation and coding
  - ◆ Best outcomes at least cost
- ◆ Build your continuum around key healthcare systems

# Care Transitions Intervention

- ◆ Care transitions coordinator facilitates patients' readiness for hospital discharge (your nurse liaison, for example)
- ◆ One SNF/home visit to assist in developing personal health responsibility/record; medication management; understanding of red flags for condition, and what to do when they occur; follow-up visit to PCP
- ◆ Same process for discharge from SNF to home
- ◆ Four weeks of telephonic coaching



# Cement Hospital Relationships

- ◆ Seek opportunities for shared risk
  - ◆ Joint ventures
  - ◆ Medicare Advantage episodic payment
  - ◆ CMS pilots



# A Final Thought



***If everything seems under control,  
you're just not going fast enough.***

Mario Andretti

# Thank You

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