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The Big 4 Health Care Reform Models: What It Means to Home Care

Jane Gorwin, Senior Home Care Consultant

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Topics for Presentation and Discussion

- Reforming health care through payment reform or bending the Medicare cost curve:
  - Hospital readmission penalties.
  - Value-based purchasing.
  - Accountable care organizations (ACOs).
  - Bundled payment.

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What Is On Our Health Care Reform Radar?

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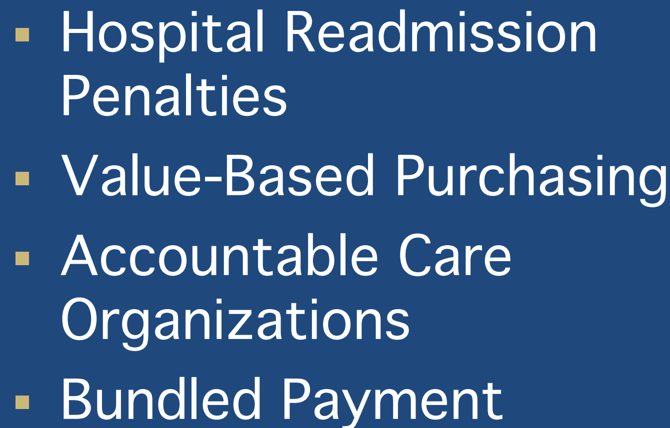

- Hospital Readmission Penalties
- Value-Based Purchasing
- Accountable Care Organizations
- Bundled Payment

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Hospital Readmission Penalties

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Hospital Readmissions: What's the Problem?

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- Percentage of Medicare beneficiaries readmitted within:
  - 30 days of initial discharge=19.6%
  - 90 days of initial discharge=34%
  - 12 months of initial discharge=56.1%[1]
- Unplanned readmissions cost Medicare $17.4B (2004).[1]
- Average Medicare payment for potentially preventable readmission=$7,200 (2005).[2]
  - Only $1,400 less than payment for original stay
- Lowest readmission rate in the U.S.=Idaho, 13.3%.[1]

Sources: 1. "Rehospitalizations among Patients in the Medicare Fee-for-Service Program, "New England Journal of Medicine, April 2, 2009, 360:14; 2. MedPAC 2007 Report to Congress.

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Top Five Conditions Requiring Readmissions

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- Medical:
  - Heart failure
  - Pneumonia
  - COPD
  - Psychoses
  - Gastrointestinal problems
- Surgical:
  - Cardiac stent placement
  - Major hip or knee surgery
  - Vascular surgery
  - Major bowel surgery
  - Other hip or femur surgery

Source: "Rehospitalizations among Patients in the Medicare Fee-for-Service Program," New England Journal of Medicine, April 2, 2009, 360:14

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Health Reform: Reducing Hospital Readmissions (October 1, 2012)

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- Based on 30-day readmission rates, CMS will rank hospitals for heart attack, heart failure, and pneumonia:
  - May not be limited to preventable, avoidable readmissions.
  - Applies even if readmitted to another hospital.
- In 2015, the program will expand to include **COPD, CABG, PTCA, and other vascular conditions** for a total of seven conditions; the secretary authorized expansion of the policy to additional conditions beyond these seven.
- Requires the secretary to publish patient hospital readmission rates for certain conditions.
- Does not apply to critical access hospitals.

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Penalty for Excess Hospital Readmissions

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- Poor performing hospitals will have all Medicare payments reduced by an amount equal to the value of payments for excess readmissions:
  - Those in bottom quartile (nationally) from prior year will have a percentage of **total** Medicare payments withheld.
  - All 30-day readmissions counted except two:
    - AMI with planned readmission for stent or CAB.
    - If to another hospital.
- Hospitals can lose up to 3% of all Medicare payments in 2015

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Why Post-Acute Is Key to Managing 30-Day Readmissions

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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
TOTAL	40.0%	18.0%	6.2%	19.8%	

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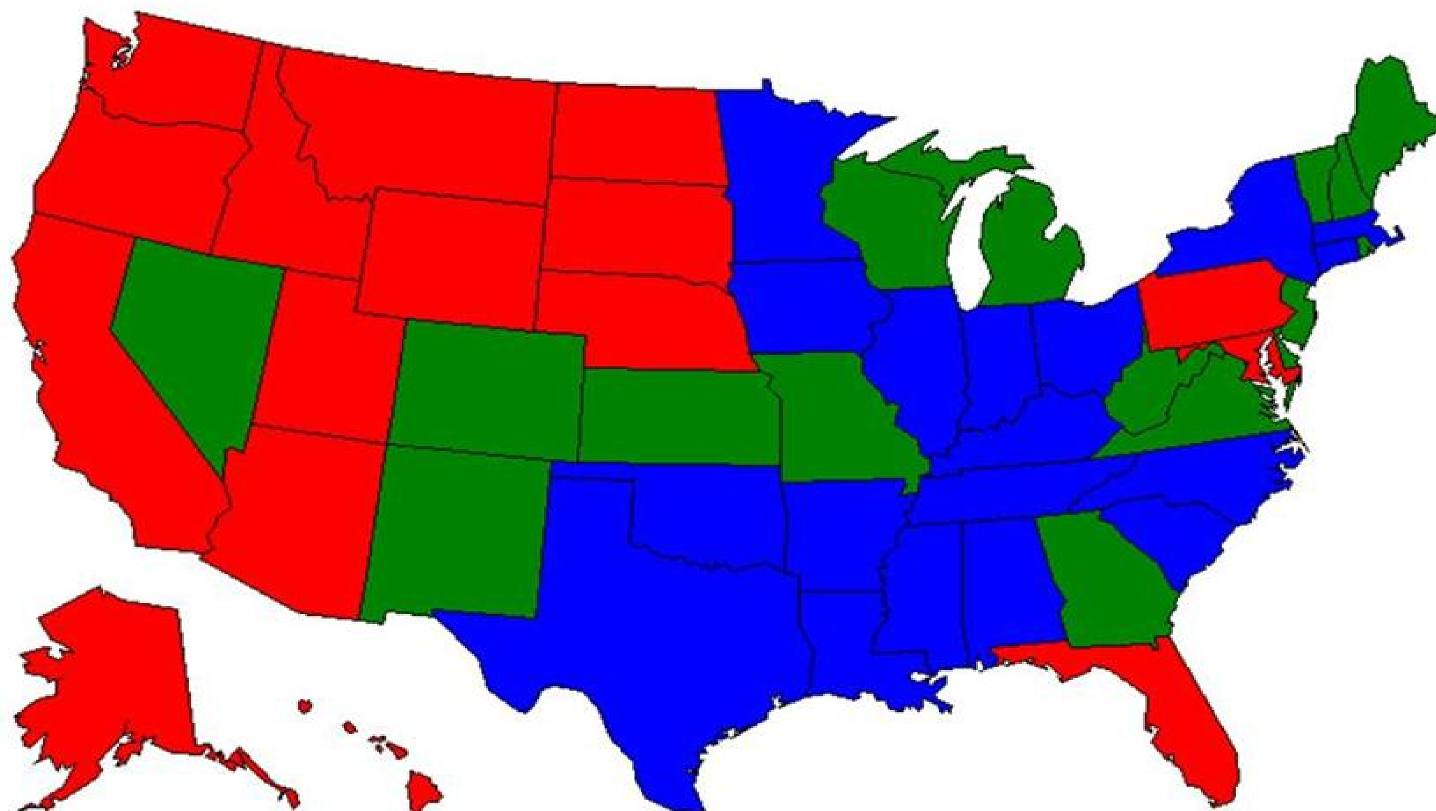
Home Health Readmissions by State



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Value-Based Purchasing

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Value-Based Performance Payment

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Value-Based Performance Payment is a generic term for payments that:
“improve beneficiary health outcomes and experience of care by using payment incentives and transparency to encourage higher quality, more efficient professional services.”

Key objectives:

1. Encourage the use of evidence-based medicine.
2. Reduce fragmentation, duplication, and inappropriate use of services.
3. Encourage effective management of chronic disease.
4. Accelerate the adoption of health information exchange.
5. Empower and engage consumers.

Source: Development of a Plan to Transition to a Medicare Value-Based Purchasing Program for Physicians and Other Professionals, Issue Paper, Public Listening Session, December 9, 2008; CMS

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Key Assumptions

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1. Performance-based payments will drive change.
2. Different practice arrangements will be accommodated.
3. Multidisciplinary team members will be recognized.
4. Accountability will be across multiple levels and sites of services.

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Value-Based Purchasing Programs

- **For hospitals** (FY2012):
  - Ties percentage of hospital payment to performance on quality measures for common, high-cost conditions but **does not include a readmissions measure.**
  - Includes critical access or low-volume hospitals.
  - Funded by a 1% decrease in Medicare payments beginning in FY2013, rising to 2% in FY2017.

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Value-Based Purchasing Programs
(continued)

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- **For home health and skilled nursing facilities:** HHS secretary must submit a plan to congress by FY2012 for transitioning home health agencies and SNFs to a value-based payment (VBP) system.
- **For hospice:** HHS secretary is authorized to establish a pilot program to test VBP for hospice providers no later than January 1, 2016.
- **For physicians:** By 2015, CMS will phase in over two years a budget-neutral payment system that adjusts Medicare payments based on the quality and cost of delivered care.

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Accountable Care Organizations

Accountable Care Organizations (ACOs)

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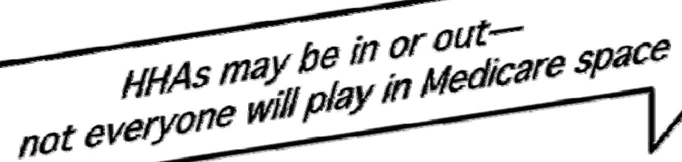
- New shared savings program begins January 1, 2012.
- Integration of physicians, hospitals, post-acute providers, outpatient, and ancillaries.
- Responsible for **all Part A and Part B care**; more than 5,000 Medicare beneficiaries; three-year contracts with CMS.
- *Objective*: reduce overall Medicare costs.
- *Incentive*: ACOs share in cost savings versus "normal" market-based payment for Medicare beneficiaries.
- Many large health care systems preparing; employing physicians as first step.



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ACO Model

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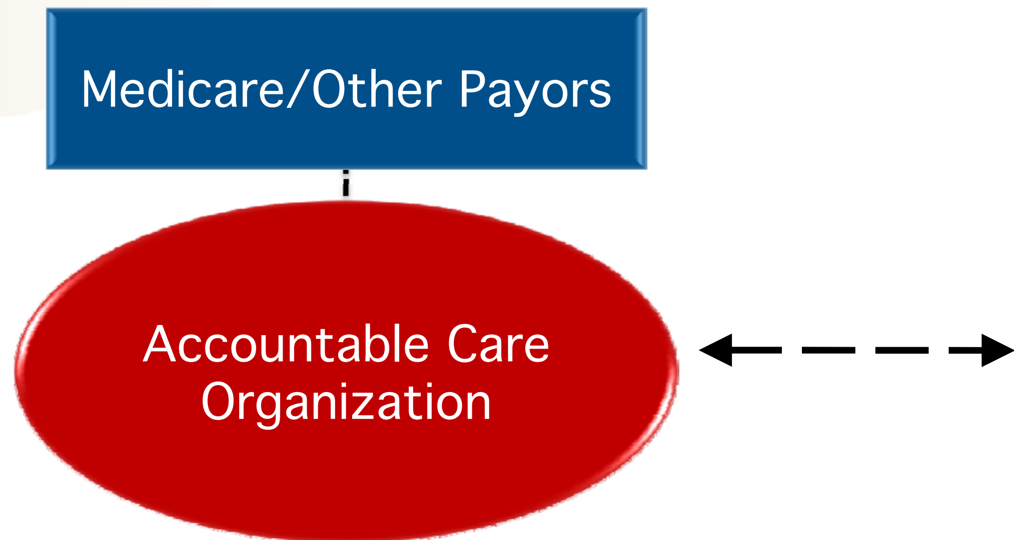

- 5,000+ Medicare fee-for-service beneficiaries
- Accountable for all Medicare Part A and Part B Service
- Requires robust and integrated provider network; successful chronic care management methods; comprehensive home-based services
- EHR across settings

Physician Network:
- Medical Group(s)
- Community MDs
- Medical Home

Hospitals:
- Hospitals
- Other Regional Hospitals

Continuum of Care:
- Outpatient services
- Skilled nursing
- **Home health**
- **Hospice**
- Geriatric care management
- Non-institutional home-based services
- Prevention and wellness programs
- Private Duty – Non medical

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How Will Post-Acute Be Paid by ACOs?

- Bundled payment example:

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

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

- Capitation PMPY: $ to manage post-acute and long-term care (home or SNF) for ACO members based on actuarial analysis of population of members.

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Bundled Payment

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Bundled Episodic Payment

- **Bundling:** payment to a single provider entity of one amount for the full range of care during a hospitalization episode:
  - Episodic payment related to acute hospitalization: -3 through +30 days.
  - Hospitalization, rehospitalization, post-acute care, and outpatient hospital services including ED, physicians.
- Pilot begins January 1, 2013; if spending reductions, expand at least by January 1, 2016.
- Initial focus on one or more of eight conditions.
- Payment either single bundle or via bids.

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Why Bundling is Key to Bending the Medicare Projected Cost Curve

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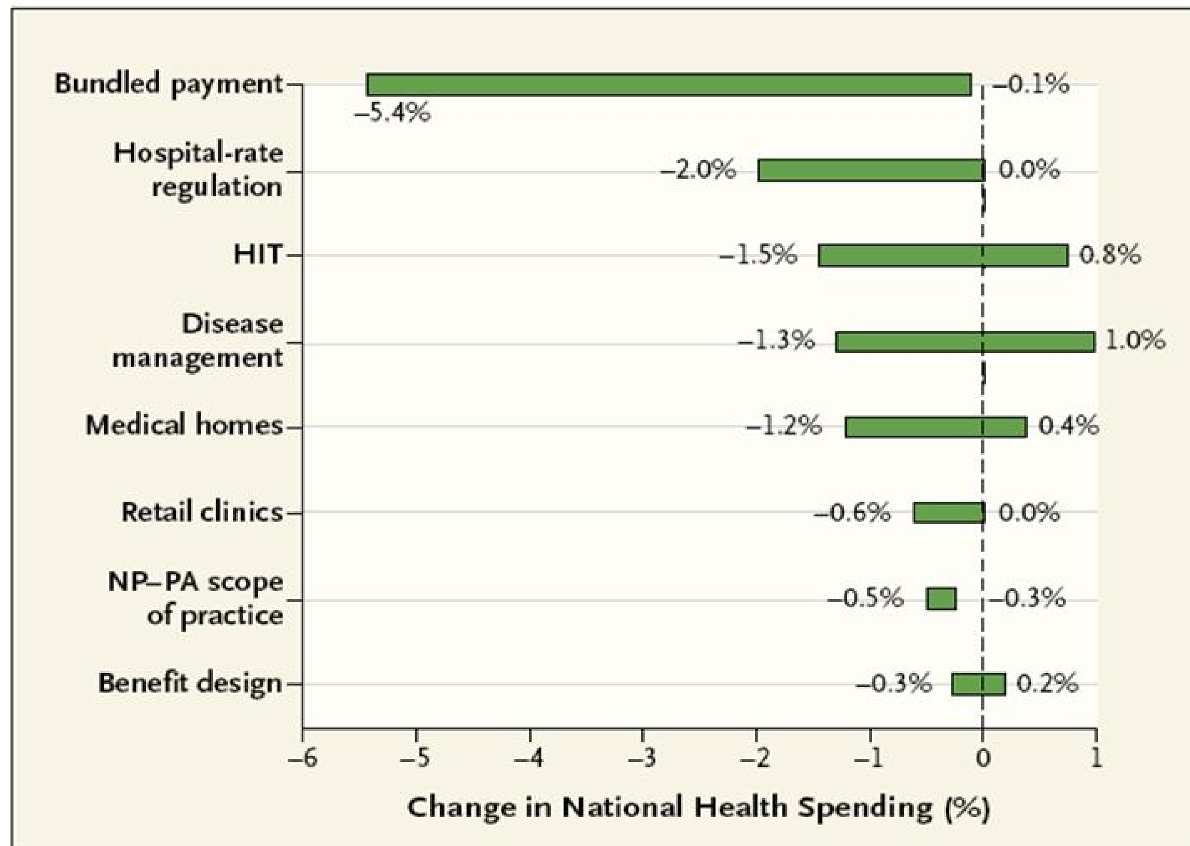

Estimated Cumulative Percentage Changes in National Health Care Expenditures, 2010 through 2019, Given Implementation of Possible Approaches to Spending Reform.

Source: Perspectives: Controlling US Health Care Spending – Separating Promising from Unpromising Approaches, Hussey, Peter, Ph.D., et. al., NEJM, 11/09.

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CMS Acute Care Episode (ACE) Bundled Payment Pilot

- “Bundle” includes all services related to the inpatient stay; five hospitals in pilot.
- 28 cardiovascular and 9 orthopedic DRGs.
- Demonstration length: 2009–2011.
- Medicare fee-for-service beneficiaries.
- Competitive bidding.
- Gain sharing with physicians.
- Shared savings with beneficiaries.
- Planned expansion to 200–300 new sites in 2011; at least one pilot including post-acute care.

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Medicare Acute Care Episode Demonstration
Shared Savings Payment
TFS Group, Inc.
P.O. Box 1001, McLean, VA 22102
ph: 877-402-3693

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CHECK

Name
Street Address
City, State ZIP

Dear________:

Medicare is conducting a number of projects designed to improve the quality of health care for people with Medicare and reducing the costs of care. In one of our current projects, the Acute Care Episode Demonstration, some hospitals and their doctors are charging Medicare discounted fees for certain surgical procedures. Under this project, hospitals must provide detailed reports on the quality of care related to these surgical procedures. **To encourage people with Medicare to use these hospitals, Medicare is sharing up to half of its savings with patients who undergo one of these procedures.**

The attached check for $________ represents your share of what Medicare saved on your recent stay at _____(hospital)________________, which ended on ___(discharge date)_______________. You are responsible for paying any Federal, state, and other taxes that may be owed on this amount. At the end of the calendar year, you will receive an IRS Form 1099 reflecting this amount as taxable income.

Please contact Medicare's contractor, TFS Group, Inc., at 1-877-402-3693 if you have any questions regarding this check. If you have any questions regarding this project or your hospital stay, please contact _________(hospital)________________ at ________(hospital's demo information number)______________.

Thank you for being a part of this important project.

Sincerely,

Cynthia Mason
Project Officer
Acute Care Episode Demonstration
Office of Research, Development, and Information

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Summary of Starting Dates in Affordable Care Act (ACA)

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ACA Provision	Start Date
Hospital 30-day readmission penalties	October 1, 2012
Hospital value-based purchasing	October 1, 2012
Plan for SNF and HHA value-based purchasing (starting date unknown)	October 1, 2011
Accountable care organizations (ACOs)	January 1, 2012
Bundled payment pilot	January 1, 2013

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Planning for 2012–2015

Payment and Delivery System Changes	Implications for Home Care
Reductions in hospital readmission rates and penalties	• Increased care coordination. • Data-driven PAC decisions. • More home health technology. • More effective use of hospice and palliative care. • Non-medical personal and functional support.
ACOs and bundled payment	• Hospital-physician-post-acute partnerships essential. • Greater home health-hospice electronic information and connectivity. • Evidence-based care protocols. • Fewer home health visits and more use of home technology. • Bundled PAC payment, financial risk/gain sharing, capitated payments. • Risk/gain sharing with suppliers, manufacturers, physicians. • Home care will have leading role.

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What Are Strategies and Solutions Home Care Can Offer to an ACO?

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So.....Where is the Detail for Home Care Strategies under the ACA?

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- Visit the breakout session

  and/or

- Slides available on the association Web site.

Faculty Contact Information

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