34A - Building a High Value Post-Acute Network

October 29, 2017
Building a High Value Post-Acute Network

PAC Network Market Evolution

Jade Gong, RN, MBA
Principal, Jade Gong & Associates

Ken Burkholder
Director, Network Management
HM Home & Community Services

A Partnership Model

Paul Winkler, President and CEO,
Presbyterian SeniorCare Network

Provider Success Strategies
PAC NETWORK MARKET EVOLUTION

SNF 1.0
Hospital/ACO/Sponsor developing SNF network as key to a value based strategy; initial focus on SNF; beginning to consider key data to collect on providers in network

PAC 1.0
Hospital/ACO/Sponsor narrowing SNF network with performance expectations; may be developing separate HHA or LTACH network or hospital may require post-SNF referral to hospital-sponsored HHA; reduction in LTACH and IRF admissions

PAC 2.0
Hospital/ACO/Sponsor creating high value/high performance SNF networks; adding LTACH and HHA networks; may also add IRF network if not available within system; significant reduction in LTACH & IRF admissions; some reduction in SNF admissions; increase in hospital to HHA admissions

PAC 3.0
High value/high performance SNF networks become PAC networks where patients are managed across settings; network management may remain with hospital/ACO or be transferred to PAC benefits manager

PAC 4.0

<table>
<thead>
<tr>
<th>PAC NETWORK MARKET EVOLUTION</th>
<th>SNF Network 1.0</th>
<th>PAC Network 2.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>Hospital/ACO/Sponsor developing SNF network as key to a value based strategy; initial focus on SNF; beginning to consider key data to collect on providers in network</td>
<td>Hospital/ACO/Sponsor narrowing SNF network with performance expectations; may be developing separate HHA or LTACH network or hospital may require post-SNF referral to hospital-sponsored HHA; reduction in LTACH and IRF admissions</td>
</tr>
<tr>
<td>Clinical Services and Care Redesign</td>
<td>Early internal hospital/ACO/sponsor discussion</td>
<td>Begin acute/PAC working groups for evidence-based care pathways and care redesign</td>
</tr>
<tr>
<td>Integration</td>
<td>Initiating working relationship with SNFs, general meeting(s) with SNFs</td>
<td>Starting hospital/ACO-related MD/NP coverage in SNFs, may initiate warm handoffs; monthly or quarterly discussions with PAC venues regarding metrics</td>
</tr>
<tr>
<td>Metrics</td>
<td>Developing network selection criteria with a focus on coverage, historical relationships and star ratings; may be starting simple monthly reporting by SNFs</td>
<td>Enhancing metrics for PAC venues reporting; providing feedback to PAC venues on performance on select metrics</td>
</tr>
<tr>
<td>Data Exchange and Reporting</td>
<td>Requiring SNF reporting on selected metrics, mainly hospital readmissions and federal quality reporting including nurse staffing</td>
<td>Migrating from manual to automated data exchange and quality reporting</td>
</tr>
<tr>
<td>Value Based Relationship for SNF/PAC providers</td>
<td>No share of savings or increase in SNF volumes</td>
<td>Discussion of outcomes based payment; narrowing network + shorter SNF stays + “Skip the SNF” stabilizes Medicare volumes in SNFs</td>
</tr>
</tbody>
</table>
## PAC Network Market Evolution

<table>
<thead>
<tr>
<th></th>
<th>PAC Network 3.0</th>
<th>PAC Network 4.0</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall</strong></td>
<td>Hospital/ACO/Sponsor creating high value/high performance SNF networks; adding LTACH and HHA networks; may also add IRF network if not available within system; significant reduction in LTACH &amp; IRF admissions; some reduction in SNF admissions; increase in hospital to HHA admissions</td>
<td>High value/high performance SNF networks become PAC networks where patients are managed across settings; network management may remain with hospital/ACO or be transferred to PAC benefits manager</td>
</tr>
<tr>
<td><strong>Clinical Services and Care Redesign</strong></td>
<td>Beginning to extend standardized, condition specific, evidence based care pathways from acute through PAC; may select certain SNFs, HHAs for specific medical or post-surgical conditions</td>
<td>Applying risk stratification and predictive analytics to determining best site of PAC care</td>
</tr>
<tr>
<td><strong>Integration</strong></td>
<td>Focus on coordinating transitions between settings of care, often using hospital/ACO care navigators; integrating SNF MD/NP with office-based PCPs</td>
<td>De facto integrating of acute and PAC venues within narrow networks across the continuum</td>
</tr>
<tr>
<td><strong>Metrics</strong></td>
<td>Raising achievement thresholds for PAC metrics and including multiple efficiency measures; beginning to eliminate PAC providers that do not achieve metrics targets</td>
<td>Continuing attention to quality metrics, but notably more emphasis on Medicare spend/PAC episodic cost</td>
</tr>
<tr>
<td><strong>Data Exchange and reporting</strong></td>
<td>Requiring electronic exchange of information between PAC venues and hospital/ACO</td>
<td>Transitioning to automated bi-directional information exchange; may be using an HIE</td>
</tr>
<tr>
<td><strong>Value Based Relationship for SNF/PAC providers</strong></td>
<td>Implement outcomes based payment (P4P); little change in Medicare SNF volumes due to lower use and shorter stays</td>
<td>PAC providers can share in gain and loss; SNFs may assume episodic risk and use owned HHAs or create narrow network of HHAs to control Medicare spend</td>
</tr>
</tbody>
</table>

### Estimated Savings

**Estimated savings in spending per episode of post acute care if FFS Medicare patients used Medicare Advantage levels of post discharge care**

- **Heart Failure**: $526.30
- **Joint Replacement**: $108.50
- **Stroke**: $369.60
- **Hospital Readmission**: $628.00

**Source:** "Less Intense Postacute Care, Better Outcomes for Enrollees in Medicare Advantage than Those in Fee-For-Service, Peter J. Huckfeldt et al, Health Affairs, January 2017"
STATUS OF ACO EFFORTS ON POST-ACUTE INTEGRATION

Exhibit 7: Most Implemented Population Health Management Activities

PAC INTEGRATION IS ACO PRIORITY!

Exhibit 14: Top Focus Areas For 2017 (ACOs Asked To Select Three)

VALUE BASED PAYMENT IS HERE TO STAY

09/20/2017

Centers for Medicare & Medicaid Services (CMS) Innovation Center New Direction Request for Information (RFI) Announced

• Medicare Advantage Continues to Grow
• Expanded opportunities to join Advanced APMs
• Value based payment driven by 2014 Protecting Access to Medicare Act (PAMA) and the 2015 Improving Medicare Post acute Transformation Act (IMPACT) including Site Neutral Payment

MEDICARE ADVANTAGE WILL KEEP GROWING


NEW PHYSICIAN PAYMENT 2019

MACRA
A new Medicare reimbursement system goes into effect in 2017


ADVANCED APMS PAY OFF WITH A 5 % BONUS

MACRA of 2015 ("Physician Fix") provides automatic 5% lump sum bonus to physicians (starting 2019) who receive **significant portion of their revenue from alternative payment models** (such as bundled payment or ACOs). OR... rewards or penalizes physicians by up to +/- 9% depending on their Merit-based Incentive Payment System (MIPS) score

**Intent is drive physicians to value-based behavior through multiple pathways**
PHYSICIANS SEARCH FOR AN ADVANCED APM AND MAKE MOTIVATED PARTNERS FOR SNFS AND HHAS

Models that could qualify now or in future:
- MSSP ACO Tracks 2 or 3
- Next Generation ACO
- Track 1+ ACO (2018)
- Comprehensive Primary Care Plus (as medical home)
- Comprehensive ESRD Care
- Oncology Care Model (two-sided track)

Models that do not qualify in 2017 (but future voluntary BPCI model likely to qualify)
- MSSP Track 1 (has upside risk only)
- Bundled Payments for Care Initiative (BCPI)
- Comprehensive Care for Joint Replacement (CJR)

2014 PAMA ACT AND 2015 IMPACT ACT DRIVING PAC SITE-NEUTRAL PAYMENT

CMS Required to Make Interoperable:
- Standardized patient assessments
- Quality measures data
- Data on resource use
- Other measures
To allow for the exchange of data among PAC* and other providers to facilitate coordinated care and improved outcomes

Anticipated Result = PAC Site-Neutral Payment Likely Earlier Than We Thought

Note: *Post-Acute Care (PAC) includes Long-Term Care Hospitals, Inpatient Rehab Facilities, Skilled Nursing Facilities, Home Health Agencies
Source: Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014
YOUR FUTURE SUCCESS WILL BE DEPENDENT UPON NETWORK PARTICIPATION

- Evidence is mounting that reducing post acute utilization does not negatively impact quality
  - Managed care
  - Bundling
  - ACOs
- High value networks are demonstrating many advantages to payors and patients
- Regulatory barriers to “steering” patients while maintaining choice are declining

QUESTIONS TO CONSIDER:

- Does my organization perform at the highest quality level (beyond STAR ratings)?
- What is the stage of PAC network development in my market?
- Is my organization a part of the networks of our key referral sources?
- How does my organization become a preferred PAC network partner and share in the gain?
Building a High Value Post-Acute Network
A Partnership Model

Ken Burkholder
Director, Network Management
HM Home and Community Services

What did we notice that led us down this path?

Increased cost pressures and high variation in post-acute spending
Managed care organizations are increasingly offloading risk to providers through value-based reimbursement strategies
Early stage bundles demonstrated the effect post-acute can have on overall spend

Control costs and improve quality by implementing high performing PAC networks
Our approach is purposefully phased

<table>
<thead>
<tr>
<th>Opportunity Area</th>
<th>Solving</th>
<th>Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Design</td>
<td></td>
<td>Broad</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Micro-Market</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Product Specific</td>
</tr>
<tr>
<td>Reimbursement</td>
<td></td>
<td>FFS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Upside Value-Based</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Episodic w/ Downside</td>
</tr>
<tr>
<td>Care Design</td>
<td></td>
<td>Small Pilots</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Broaden Scope</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Evolve</td>
</tr>
<tr>
<td>Utilization Management</td>
<td></td>
<td>Utilization Review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Utilization Management</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Care Management</td>
</tr>
</tbody>
</table>

As an IDFS, we know a partnership model is most effective

1. Leverage both carrots and sticks
2. Drive volume to higher performing providers while optimizing network design
3. Incentivize providers to consider the entire care continuum
4. Alignment with acute/physician pay-for-value programs
5. Evolution to micro-market based, consumer and delivery system driven demand model
Data transparency and insight is a key first step

Our team has been deployed to treat providers as customers
We have also recently designed a SNF pay-for-value program

**Guiding Principles**

1. Reward quality care
2. Align financial incentives
3. Learn together
4. Prepare for more advanced VBR programs
5. Align to scorecards
6. Impact readmissions

**Description**

<table>
<thead>
<tr>
<th>Performance Improvement</th>
<th>Superior Performance</th>
<th>Readmission Rate Definition</th>
<th>Benchmark Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Entities that reduce readmission rate Performance Period-over-Baseline Period</td>
<td>• Entities with Readmission Rate less than or equal to a Benchmark during the Performance Period</td>
<td>• NCQA HEDIS definition of 30 day All Cause Readmission Rate, readmission inclusion and exclusion criteria</td>
<td>• Readmission Rate at the 90th percentile of the Baseline Readmission Rates for all SNFs eligible to participate in the program</td>
</tr>
<tr>
<td>• between 2-6% earn $25.00 per MA admission</td>
<td>• ≤7% Benchmark Readmission Rate: $50.00 per MA admission</td>
<td>• Readmission Rates will be risk-adjusted by a market average readmission rate for the Baseline Period (accounts for case-mix index differences between network partners)</td>
<td></td>
</tr>
<tr>
<td>• ≥6% earn $40.00 per MA admission</td>
<td>• Monthly report to display values of X, Y and Benchmark</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Deploying external partners has added value but also has needed to evolve over time

- PAC UM partner brought on to ensure most appropriate use of SNF, IRF, and LTACH
- Market communication was not optimal
- Significant LOS and RUG acuity level decrease
- Introduction of HCS to partner with PAC networks
- Network performance team members and PAC UM partner provided more transparency
- LOS and RUG acuity optimized
- Partnership focus on optimizing physician practice patterns and patient choice and value transparency

The transition from prescription to partnership has hinged on ensuring that the network has the opportunity to understand how PAC UM fits into the bigger picture.
Together, we have driven very positive early results

Network Engagement

Participation from the network in HCS hosted education sessions has exceeded expectations.

Outcomes

Cumulative improvement of 19% on MA SNF cost per stay, which includes fewer inpatient transfers.

Cumulative improvement of 11% on MA SNF 60 day cost, which includes fewer readmissions to the hospital.

So what should PAC providers be thinking about to prepare to succeed in a value-based world?

1. QUALITY, QUALITY, QUALITY
   - High value networks will be built with partners that provide the highest quality outcomes

2. Vertical integration and partnership
   - Payors will begin aligning the continuum of care through reimbursement designs
   - Build, buy, or partner?

3. Enhancement of cross-continuum clinical capabilities
   - Clinical alignment and transitions at the disease state level will drive results to get to the top of the pack

4. Alignment with health plans and hospitals
   - Proactively build capabilities that stand out from the crowd, and showcase outcomes
   - It doesn’t matter if it’s an MCO or ACO – what the partner needs will be the same

5. Decide if and when you’re willing to take a level of risk
   - There is a higher reward but readiness is critical
   - Likely will be a phased approach

6. And lastly, QUALITY
   - Providers that drive better outcomes will always win in a value-based world
Building a High Value Post-Acute Network

Provider Success Strategies

Paul M. Winkler
President and CEO
Presbyterian SeniorCare Network

PROVIDER SUCCESS STRATEGIES

Who is Presbyterian SeniorCare Network?

- Southwestern PA
  - 54 communities/services
  - 45 locations
  - 10 western PA counties
- Serving more than 6,500 annually
- Over 2,200 employees
- First in Pennsylvania and third in the U.S. to earn accreditation by CARF as a Aging Services Network in 2006 and 2011.
- Awarded five-year accreditation in six areas in 2016.
PROVIDER SUCCESS STRATEGIES

Leveraging Our Core Values

**Benevolence**
- Serve people of all faiths / no faith affiliation
- Serve people of all income levels
- Benevolent Care program – SeniorCARE Fund

**Innovation**
- Create products / services people want / need
- Create future of aging services

**Collaboration**
- Partner with peers
- Partner across the continuum (hospitals, physicians, etc.)

---

**PROVIDER SUCCESS STRATEGIES**

Our Care Management Journey

1. Affordable Housing
2. Community Life (PACE)
3. SeniorCare BLUE
4. Bundled Payment Program
5. Longwood at Oakmont
6. Longwood at Home
7. Care Pathways
8. Presbyterian SeniorCare at Home
9. Alzheimer’s / Dementia Care Management
PROVIDER SUCCESS STRATEGIES

Our Strategic Plan Thematic Goal

**2015 / 2016**

Hardwire the key elements of operational excellence to be a model partner in an evolving healthcare environment.

**2017 / 2018**

Strengthen Presbyterian SeniorCare Network’s position as the essential partner, uniquely different employer and provider of choice.

---

PROVIDER SUCCESS STRATEGIES

To be the essential partner we must have...

**Data-Driven Quality Systems**
- Standardization of evidence-based practices and outcomes
- Focus on hospital readmissions and unnecessary transfers
- Align with hospital partners’ goals and areas of focus

**New Care / Care Management Models**
- On-site medical management
- Build clinical nursing/therapy programs
- Hardwire care management and home health care across our Network

**Infrastructure**
- Fully implement an integrated Information Systems/Electronic Health Record for Health Information Exchange
- Embrace technology (e.g., telemedicine)
- Strengthen culture of Process Improvement

**Mindset**
- Integration of the Network (Population Health Management)
- Think total cost of care
- Be willing to take on risk
- Be flexible and nimble!
PROVIDER SUCCESS STRATEGIES

Clinical Capabilities:
Bundled Payment for Care Improvement (Model 3 Post-Acute Program)

- Clinical Episodes
  - Hip and Femur Procedures Except Major Joint
  - Major Joint Replacement of the Lower Extremity

- Care Redesign
  - Care Pathways and Protocols
  - Medication Reconciliation
  - Discharge Planning

- Our Outcomes
  - Some of our communities achieved care delivery at or below the “target price” within 2 quarters/6 months
  - All of our communities achieved care delivery at or below the “target price” within one year.

PROVIDER SUCCESS STRATEGIES

Implementation -
Identify Vulnerabilities in the Post-Acute Process

HOSPITAL TO SNF
- Incomplete orthopedic orders; leading to incorrect precautions or weight bearing status.

SNF TO HOME HEALTH
- Medications not reconciled on discharge; leading to negative interactions.

HOME HEALTH TO HOME
- Care managers did not coordinate follow up phone call; leading to missed PCP appointment.
PROVIDER SUCCESS STRATEGIES

What Did This Tell Us?

Data Analysis
- SNF length of stay is too long
- Too much therapy was provided from the Home Health Agencies when outpatient therapy is just as effective, less expensive and better for the patient
- Hospital readmissions aren’t necessarily the biggest expense; don’t increase length of stay with the intent of avoiding a readmission
- Rehab is no longer a revenue center; it’s a cost center to be managed

PROVIDER SUCCESS STRATEGIES

Lessons Learned through Collaboration with Highmark Health / Allegheny Health Network
- Shift from “vendor” mentality to “partner” approach in quality.
- Don’t be resistant to change, commit to collaborate building trust and don’t be afraid to discuss your concerns about the care experience.
- Understand your clinical competencies and partners’ needs/expectations.
- Understand your data and the data that matters to your partners.
- Build something together with your partners (e.g. clinical pathways, protocol for root cause analysis, new care programs).
“The man on top of the mountain didn’t fall there.”

- Vince Lombardi

QUESTIONS AND DIALOGUE:

Jade Gong
Jade Gong Associates
jade@jadegong.com
703-243-7391
www.jadegong.com

Paul Winkler
President and CEO
Presbyterian SeniorCare Network
pwinkler@srcare.org
412-826-6525
www.SrCare.org

Ken Burkholder
Director, Network Management
HM Home & Community Services
ken.burkholder@hmhcs.com
412-544-1635
www.highmarkhealth.org