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Post-Acute Care: Payment Reform and Alternative Payment Models

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Moderated by:
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POST-ACUTE CARE: PAYMENT REFORM AND ALTERNATIVE PAYMENT MODELS

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Tuesday November 14th 2017; 3 pm EST

Learning Objectives

After this course, participants will be able to:

- Describe current alternative payment models (APM) structures.
- Explain the impacts of moving from reimbursement based on volume to reimbursement based on the value and outcomes of skilled care.
- Define the role of a speech language pathologist in APMs, including methods to show value for the services we provide.

Course Description

- Alternative Payment Models known as APMs are alternatives to traditional fee-for-service reimbursement. This course will explore current payment reform structures and the impacts on moving from volume based fee for service models to outcomes based reimbursement which will impact post acute care.

What is an APM?

- APMs are alternatives to traditional fee-for-service reimbursement.
- In APMs, providers receive reimbursement from third-party payers (health insurers, Medicare and Medicaid, for example) based on the quality and/or efficiency of the services they deliver to patients.
- Shift from fee-for-service plans provide reimbursement based on the volume of services.
- Public and private health insurers are moving toward APMs in an effort to reduce costs and improve the quality of patient care. Under APMs, all health care providers—including audiologists and speech-language pathologists—are held accountable for the increased quality and lower costs of the care they provide.

◦ Source: Grooms, D. December 2016, Vol. 21, 30-31. doi:10.1044/leader.BML.21122016.30

Improving Medicare Post-Acute Care Transformation (IMPACT) Act

- **Requires standardized patient assessment data**
 - Quality care and improved outcomes across post-acute care (PAC) settings
 - Comparison of quality and data across PAC settings
 - Improved discharge planning, especially from hospital
 - Exchangeability of data across PAC settings
 - Coordinated care across PAC settings

CMS Triple Aim with APMs

- **Better Care**
 - Better care for patients through more coordinated, higher quality care during and after select episodes or care periods
- **Smarter Spending**
 - Smarter spending of health care dollars by holding hospitals accountable for total episode spending, not just inpatient costs, and incentivizing use of high value services during care periods
- **Healthier People and Communities**
 - Healthier people and communities by improving coordination in health care and by connecting care across hospitals, physicians, and other health care providers

Affordable Care Act (ACA)

- The ACA, which became law in 2010, created a number of new payment models that move away from paying clinicians **for quantity of care (fee-for-service) towards quality of care (value)**.
- The ACA provided funding and a mandate to the Centers for Medicare and Medicaid Services (CMS) to determine what other sorts of models might work.
- CMS formed the Center for Medicare and Medicaid Innovation (CMMI) to develop and test various payment and delivery models.

Center for Medicare and Medicaid Innovation

- The Innovation Center develops new payment and service delivery models in accordance with the requirements of section 1115A of the Social Security Act. Additionally, Congress has defined – both through the Affordable Care Act and previous legislation – a number of specific demonstrations to be conducted by CMS.

CMMI and MACRA

- The Innovation Center also plays a critical role in implementing the Quality Payment Program, which Congress created as part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to replace Medicare's Sustainable Growth Rate formula to pay for physicians' and other providers' services.
- In this new program, clinicians may earn incentive payments by participating to a sufficient extent in Advanced Alternative Payment Models (APMs). In Advanced APMs clinicians accept some risk for their patients' **quality** and cost outcomes and meet other specified criteria.
- The Innovation Center is working in consultation with clinicians to increase the number and variety of models available to ensure that a wide range of clinicians, including those in small practices and rural areas, have the option to participate.

CMMI Categories

- **Accountable Care**
 - Accountable Care Organizations and similar care models are designed to incentivize health care providers to become accountable for a patient population and to invest in infrastructure and redesigned care processes that provide for coordinated care, high quality and efficient service delivery.
- **Episode-based Payment Initiatives**
 - Under these models, health care providers are held accountable for the cost and quality of care beneficiaries receive during an episode of care, which usually begins with a triggering health care event (such as a hospitalization or chemotherapy administration) and extends for a limited period of time thereafter.
- **Primary Care Transformation**
 - Primary care providers are a key point of contact for patients' health care needs. Strengthening and increasing access to primary care is critical to promoting health and reducing overall health care costs. Advanced primary care practices – also called "medical homes" – utilize a team-based approach, while emphasizing prevention, health information technology, care coordination, and shared decision making among patients and their providers.

CMMI Categories

- **Initiatives Focused on the Medicaid and CHIP Population**
- Medicaid and the Children's Health Insurance Program (CHIP) are administered by the states but are jointly funded by the federal government and states. Initiatives in this category are administered by the participating states.
- **Initiatives Focused on the Medicare-Medicaid Enrollees**
- The Medicare and Medicaid programs were designed with distinct purposes. Individuals enrolled in both Medicare and Medicaid (the "dual eligibles") account for a disproportionate share of the programs' expenditures. A fully integrated, person-centered system of care that ensures that all their needs are met could better serve this population in a high quality, cost effective manner.

CMMI Categories

- **Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models**
- Many innovations necessary to improve the health care system will come from local communities and health care leaders from across the entire country. By partnering with these local and regional stakeholders, CMS can help accelerate the testing of models today that may be the next breakthrough tomorrow.
- **Initiatives to Speed the Adoption of Best Practices**
- Recent studies indicate that it takes nearly 17 years on average before best practices - backed by research - are incorporated into widespread clinical practice—and even then the application of the knowledge is very uneven. The Innovation Center is partnering with a broad range of health care providers, federal agencies professional societies and other experts and stakeholders to test new models for disseminating evidence-based best practices and significantly increasing the speed of adoption.

Percent of Payments Tied to APMs

- Department of Health and Human Services' **goal of having 50 percent** of Medicare payments tied to **APMs by the end of 2018**.
- Currently, more than 30 percent of Medicare Part A and B payments are tied to APMs.

What are types of Alternative Payment Models?

- **Accountable care organizations (ACOs)**
- **Bundled payments**
- **Patient-centered medical homes (PCMHs)**

Accountable Care Organizations

- **Accountable care organizations (ACOs).** Providers form a network that assumes accountability for the entire cost and quality of care for its patients. ACOs manage all the patient's health care needs by coordinating the services its providers deliver in various settings. The network receives reimbursement based on targeted cost and quality metrics.

Payment Centered Medical Homes

- **Patient-centered medical homes (PCMHs).** This model uses a traditional care-delivery model, enhanced by care coordination and communication between the primary care physician and other treating providers, to improve the patient's health outcomes. The goal is to minimize fragmentation of information among providers. According to information from the National Academy for State Health Policy, Medicaid programs in 24 states use the PCMH model.

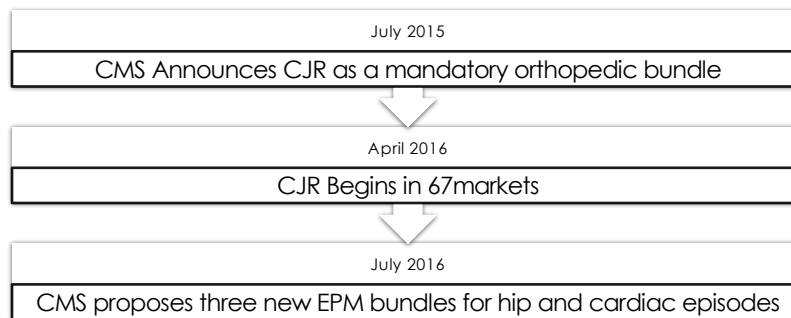
Bundled Payments

- **Bundled payments.** Health insurers pay a provider—a hospital, for example—a single fixed payment for an “episode of care.” An episode of care refers to all the services provided to a patient with an identified condition (stroke, for example) within a specific time period across a continuum of care.

What services are covered in bundles?

- Physicians' services
- Inpatient hospital services (including hospital readmissions)
- Inpatient psychiatric facility (IPF) services
- Long-term care hospital (LTCH) services
- Inpatient rehabilitation facility (IRF) services
- Skilled nursing facility (SNF) services
- Home health agency (HHA) services
- Hospital outpatient services
- Outpatient therapy services
- Clinical laboratory services
- Durable medical equipment (DME)
- Part B drugs; hospice
- Some per beneficiary per month (PBPM) care management payments under models tested under Section 1115A of the Social Security Act

Timeline for Episodic Models



Comprehensive Joint Replacement

- What can we learn from Medicare's first bundled payment model?
- CJR is a bundled episodic payment model
- The current demonstration project runs in 67 geographic areas from April 1, 2016, through Dec. 31, 2020.
- The "episode of care" **begins** when an eligible Medicare beneficiary is admitted to an acute-care hospital with either of two diagnosis codes (major joint replacement or reattachment of lower extremity, with or without complications) and **ends** 90 days after discharge from that hospital.
- Participation is mandatory and providers cannot opt out.

CJR, Where is the Risk?

- In CJR the hospital assumes all of the financial risk associated with providing all needed services to the patient, from surgery to post-hospitalization rehabilitation.
- Goal= To encourage hospitals, post-acute-care facilities and other providers to work together to improve the quality and coordination of the patient's care.

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Cardiac Rehabilitation Incentive Payment Mode

- **Cardiac Rehabilitation Incentive Payment Model** Aim (12.20.16):
 - Encourage coordinated care, improve the quality of care and decrease costs for heart attack patients
 - Released by Centers for Medicare and Medicaid Services (CMS) in the final rule for Advancing Care Coordination Through Episode Payment Models (EPMs)
 - Changes the Comprehensive Care for Joint Replacement Model that finalized bundled payment models for certain cardiac conditions and procedures in select geographic areas.
- The final regulation introduces a new cardiac rehabilitation (rehab) model and a pathway that helps physicians who are heavily involved in bundled payment models to qualify for incentives as part of the Advanced Alternative Payment Model (APM) track beginning in performance year 2019, as part of the downside risk parameters under the Quality Payment Program (QPP), part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

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Cardiac Rehabilitation Incentive Payment Mode

- Created new mandatory EPMs for the **Acute Myocardial Infarction (AMI)** Model and the **Coronary Artery Bypass Graft (CABG)** Model.
- Mandates the **first performance period for the new episode payment models will begin on July 1, 2017** with the duration through December 31, 2021, which gives eligible clinicians, including physicians and non-physician practitioners, the opportunity to qualify as participating in Advanced APMs through EPMs as part of the QPP.
- These EPMs are one of a select few Advanced APM options for specialists and the only option specifically for cardiologists.
- Introduces a cardiac rehab incentive payment to increase utilization of cardiac rehab services for heart attack and bypass surgery Medicare beneficiaries referred to as the **Cardiac Rehab Incentive Payment Model** with the same duration as the EPMs.

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AMI and CABG Model and Quality

Quality Measure	Definition
30- Day Mortality (AMI and CABG)	30- day all cause risk-standardized mortality rate following a hospitalization
Excess Days (AMI)	Excess days in acute care, including emergency department, observation, and inpatient re-admission days following a hospitalization for AMI
HCAHPS Survey (AMI and CABG)	Patient experience composite measure which reflects elements of care such as communication, pain management, discharge information, cleanliness and quietness
Hybrid AMI Mortality Voluntary Data	30-day, risk-standardized AMI mortality rate, using claims and EHR data

August 2017- CMS Changes

- August of 2017 CMS issued a proposal to cancel its Episode Payment and Cardiac Rehabilitation bundled payment models, citing a need for "greater flexibility" in designing new models.
- "These changes ... give CMS maximum flexibility to test other episode-based models that will bring about innovation and provide better care for Medicare beneficiaries," CMS Administrator Seema Verma said.

CMS Requirements for Participation

- Background: Revised Medicare and Medicaid requirements for participation for Long Term Care (LTC) facilities (42 CFR part 483, subpart B) were released on September 28, 2016 and became effective as of November 28, 2016, with a three-part phase-in of implementation dates over the next three years:
 - **Phase 1: Nov. 28, 2016**
 - **Phase 2: Nov. 28, 2017**
 - **Phase 3: Nov. 29, 2019**

CMS Phase II Requirements of Participation

- IMPLEMENTATION DATE NOVEMBER 28th 2017
- The regulation reform implements a number of pieces of legislation from the Affordable Care Act (ACA) and the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, including the following:
 - **Quality** Assurance and Performance Improvement (QAPI)

Implementation Date	Type of Change	Details of Change
Phase 1: November 28, 2016 (Implemented)	Nursing Home Requirements for Participation	New Regulatory Language was uploaded to the Automated Survey Processing Environment (ASPEN) under current F Tags
Phase 2: November 28, 2017	F Tag numbering Interpretive Guidance (IG) Implement new survey process	New F Tags Updated IG Begin surveying with the new survey process
Phase 3: November 28, 2019	Requirements that need more time to implement	Requirements that need more time to implement

Phase II: Person Centered Care

- Person-centered care:
 - For purposes of this subpart, person- centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.
 - The right to participate in the development and implementation of his or her **person centered plan of care**, including but not limited to:
 - The right to **participate in the planning process**, including the right to **identify individuals or roles to be included in the planning process**, the right to **request meetings** and the right to **request revisions** to the person- centered plan of care.

Changes to Prospective Payment System

- Resident Classification System, Version I (RCS-I), changing from volume to value in Post Acute Care SNF
- Currently, therapy payments under the SNF PPS are based primarily on the amount of therapy provided to a patient, regardless of the specific patient characteristics and care needs.
- Current CMS initiatives have moved towards paying providers based on resident characteristics and assessing value rather than paying directly for input use.
- Move from payment based on volume to payment based on patient characteristics

Questions?