Presentation Goals

• Set the stage of why readmissions are important
• Understand the calculation of basic readmission rate
• Understand why a hospital may be using a different calculation
• Understand how one hospital is focusing on post-acute providers

SETTING THE STAGE
**Medicare Trends**

Estimated Medicare payments to SNFs are expected to increase by $750 million during FY 2015.

**Value Based Purchasing Models**

We will focus on P4P, Shared Savings and Bundled Payments.

**Changes in the Reimbursement Model**

- Traditional Payment – Fee for service (FFS)
  - Viewed as insufficient at containing costs
  - Volume was rewarded
  - Limited shared risk
- Where are we headed (CMS Goal over 85% by 2016)
  - Value-based purchasing
  - Direct link between payment and outcome (pay for performance)
  - Bundled payments
  - Greater focus on care coordination and prevention
Reform Initiatives

Mandatory
• Readmission Reduction Program – Nursing Homes (2018)
• Hospital Acquired Conditions
• Value Based Payment Modifier

Voluntary
• Medicare Shared Savings Program
• Bundled Payment for Care Improvement
• Comprehensive Primary Care Initiative
• Community Based Care Transitions Programs

Other Initiatives In Process

Reimbursement Models

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments based on volume of services</td>
<td>85% by 2016 and 50% by 2018 of this category</td>
<td>30% by end of 2016 &amp; 50% by end of 2018 of this category</td>
<td>Providers are paid and responsible for the care of a beneficiary for a period of time</td>
<td></td>
</tr>
<tr>
<td>Examples</td>
<td>RUGs</td>
<td>Hospital value-based purchasing</td>
<td>Readmissions</td>
<td>Quality Metrics</td>
</tr>
</tbody>
</table>

The Future of Healthcare

• A significant decline in hospitalization will occur
• Consumerism will increase quality and reduce prices
• Consolidation / partnerships of all types of health, wellness, and insurance entities will continue
• Insurers and hospitals will look to narrow networks to help control cost
• Quality and value will drive market share
• Providers will need to increasingly assume financial risk
Reform Impact on Post Acute

• Payers will begin to narrow networks of post acute providers
• Hospitals will build post acute networks that are committed to help manage the post acute care spend and manage readmissions
• Increase in operating cost as post acute providers:
  • build out care management resources
  • IT to be able to track and report performance back to referral sources
  • Reduced admissions and lengths of stay

Reliance on Medicare Referrals

• Partnerships will become important for survival / financial stability
  • Where would you be if your leading referral hospital began steering volume to another facility?
• Post acute providers need to realize revenue pressures in acute care
• The better we all realize the hospital’s position – the better the other post acute providers can prove their value to the hospital and develop effective and efficient partnerships

READMISSIONS
CMS Definition of Readmission

- An admission to a hospital within 30 days of a discharge from the same or another hospital
  - Per 2012 inpatient prospective payment system (IPPS) final rule

Readmission Statistics

Cost of Hospitalization

<table>
<thead>
<tr>
<th>Reason for Hospitalization</th>
<th>Total Cost</th>
<th>$ / Hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Septis</td>
<td>$9 billion</td>
<td>$7,240</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>$800 million</td>
<td>$9,000</td>
</tr>
<tr>
<td>CHF</td>
<td>$640 million</td>
<td>$8,760</td>
</tr>
<tr>
<td>Aspiration Pneumonia</td>
<td>$612 million</td>
<td>$12,290</td>
</tr>
<tr>
<td>Complications</td>
<td>$450 million</td>
<td>$14,660</td>
</tr>
</tbody>
</table>

Hospital Readmission Reduction Program

- ACA initiative to reduce hospital readmissions
- CMS reducing overall Medicare payments to hospitals with excess readmissions
- Current Diagnosis (DRGs):
  1. Heart Failure – since 2013
  2. Pneumonia – since 2013
  3. Acute Myocardial Infarction – since 2013
  4. Elective Total Hip and Total Knee – new for 2015
  5. Chronic Obstructive Pulmonary Disease (COPD) – new for 2015
Hospital Medicare Revenue (At Risks)

<table>
<thead>
<tr>
<th>OCTOBER 1ST OF:</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission Program (a)</td>
<td>1.0%</td>
<td>2.0%</td>
<td>3.0%</td>
<td>3.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Value Based Purchasing (b)</td>
<td>1.0%</td>
<td>1.25%</td>
<td>1.5%</td>
<td>1.75%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Hospital Acquired Conditions (a)</td>
<td>1.0%</td>
<td>1.0%</td>
<td>1.0%</td>
<td>1.0%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Total Potential Rates at Risk</td>
<td>2.0%</td>
<td>3.25%</td>
<td>5.5%</td>
<td>5.75%</td>
<td>6.0%</td>
</tr>
</tbody>
</table>

* Based on past three years of results

a: Represents a worst case scenario and a ceiling of the maximum penalties
b: Represents a withhold of payment that can be earned back based on quality metrics

Readmissions Measurement

- 79% of all Florida hospitals paying a penalty
- Calculate Excess Readmission Ratio

Facility Predicted Value

Over 1.0 = Bad

Facility Expected Value

Under 1.0 = Good

Predicted = Actual readmissions for the facility
Expected = Governmental assigned assumption based on demographics of population

Readmission Reduction Program

- 9% of Current / Future Medicare Reimbursement at Risk
  - 3% penalty of Medicare at risk each program year
  - Measured Populations 30 days from DISCHARGE
- Performance Periods: 3 Year Rolling Program
  - FY’17: July 1, 2012 – June 30, 2015 – 3%
  - FY’18: July 1, 2013 – June 30, 2016 – 3%
  - FY’19: July 1, 2014 – June 30, 2017 – 3%
- Payment adjustments applied to all discharges and not just those measured

Currently participating in 3 performance periods simultaneously
Know Your Hospital(s)

- Hospital Compare: [www.medicare.gov/hospitalcompare/search.html](http://www.medicare.gov/hospitalcompare/search.html)
  - General information
  - Survey of patient experiences
  - Timely and effective care
  - Readmissions, complications, and deaths
  - Medicare payment (Medicare Spending per Beneficiary)

Why Track Hospital Admissions and Readmissions?

- If you don’t track them, how are you going to minimize them?
- PDSA - Plan, Do, Study, Act
- Effectively managing resident care **REQUIRES** tracking hospital readmissions
- Allows you to find and fix problematic patterns
Why Track Hospital Admissions and Readmissions? (Cont.)

- ACA mandates that each facility have a Quality Assurance and Performance Improvement program ("QAPI")
- Improving management of acute change in condition and reducing unnecessary hospital transfers is one potential focus of your QAPI
- Tracking hospital admissions/readmissions allows nursing homes to find and address problematic patterns

SNF READMISSIONS

Focus on Post Acute

- VARIATION
  - Post acute responsible for over 40% of total spend variation
  - Due to provider patterns of patient placement, geographic supply of post acute AND readmission patterns.

- STUDY
  - CMS believes 45% of readmissions avoidable
  - Cost to Medicare is DOUBLE when a readmission occurs within 60 days

STUDY
Medicare and Medicare Advantage

- Both Medicare and Medicare Advantage payors are focusing on episodes
- Post Acute medical spend exploding over last 10 years

<table>
<thead>
<tr>
<th>% Change</th>
<th>Compound Annual Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>19%</td>
</tr>
<tr>
<td></td>
<td>2%</td>
</tr>
<tr>
<td>Post Acute</td>
<td>68%</td>
</tr>
<tr>
<td></td>
<td>6%</td>
</tr>
</tbody>
</table>

- Largest variance in Medicare episode spend is in post acute component of an episode.
- 4 in every 10 Medicare discharges need post acute

Readmission Statistics

1 in 4 patients admitted to an SNF are re-admitted to the hospital within 30 days at a cost of $4.3 billion

SNF Readmissions: Focus of Ongoing Research

Effect of Hospital-SNF Referral Linkages on Rehospitalization
Rahman et al, December 2013 (HSR Health Services Research)

- “Stronger hospital-SNF linkages were found to reduce readmission rates”
- “The greater the concentration of discharges a hospital sends to a single SNF, the lower the rate of readmission”
- Specifically lower rates of immediate bounce-backs (days 0-3)

TIMELINE
Incentive pool created by Medicare rate reduction of 2%.
Only 50-70% of pool may be distributed back to SNFs.
High performance levels = receive incentive; low performing = penalty

SNF Value Based Purchasing
- Strong chance you are already in a measurement period (or soon will be)
- Two required metrics
  - “All cause” readmissions
  - “Preventable” readmissions
- Same formula as hospital readmissions penalty
  - Hence will in part be based on an expected value

Readmission Calculation SNF

Figure 1 Risk Window for the SNF Readmission Measure

Reduction in 30-day readmission or SNF

Readmission is counted as long as it occurs within 30 days of discharge from the prior residential hospital. The readmission is counted regardless of whether the patient is discharged back to the SNF.
Readmission Strategies

- Review readmissions when they happen
- Track & monitor readmissions from your service
- Improve “admissions” into your care
  - Identify key information you need from hospitals & articulate that
  - Improved medication review & clarification procedures
  - Consistent discussions about care preferences

Readmission Strategies

- Specify reasons to escalate issues to responding providers
- Communicate your capabilities to hospital
- Improve communication with hospital
- How can you help this specific hospital prepare for a more broad interpretation of readmission penalties by focusing on readmissions for significant MS DRG groupings that represent significant clinical specialties

BUNDLED PAYMENT
Measure of Efficiency (MSPB)

- Medicare Spending Per Beneficiary (MSPB)
- Bundles total dollars spent for an episode of care across the continuum of care
  - a hospital stay, bundling hospital sources (Part A)
  - post acute care (Part B)
  - 3 days prior to admission and 30 days post discharge
  - Indexed by the discharging hospital regardless of who provides services in the 3 days prior and 30 days post

MSPB Results – 2013 Data

<table>
<thead>
<tr>
<th>Total Spending</th>
<th>Florida Average</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Days Prior To Admission</td>
<td>1.3%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Admission</td>
<td>56.3%</td>
<td>55.1%</td>
</tr>
<tr>
<td>30 Days After Hospital Discharge</td>
<td>42.4%</td>
<td>43.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3 Largest Areas of Spending</th>
<th>Florida Average</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient During Admission</td>
<td>46.5%</td>
<td>45.2%</td>
</tr>
<tr>
<td>Skilled Nursing After Discharge</td>
<td>16.8%</td>
<td>16.4%</td>
</tr>
<tr>
<td>Inpatient After Discharge</td>
<td>12.2%</td>
<td>13.6%</td>
</tr>
</tbody>
</table>

Home health and hospice in Florida were 4.2% and 0.5%, respectively.

Bundled Payment Care Initiatives (BP) Overview

- New voluntary incentive programs for Medicare
- Base payments on performance to incentivize providers to collaborate on patient care (requires risk sharing)
- Four current models allowed
  - #1 - Retrospective Acute Care Hospital Stay Only
  - #2 - Retrospective Acute Care Hospital Stay plus Post Acute Care
  - #3 - Retrospective Post-Acute Care Only
  - #4 - Acute Care Hospital Stay Only
- 48 Separate episodes including 181 separate DRG’s
Care Continuum (BP)

<table>
<thead>
<tr>
<th>3 Days Pre-Acute</th>
<th>Hospital Inpatient Stay</th>
<th>Inpatient MD Services</th>
<th>Post-Acute Facility Services</th>
<th>Post-Acute MD Services</th>
<th>Related Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: participation allows access to unique data for any selected episodes

BP Participants Today

Source: Centers for Medicare & Medicaid Services

Common Episodes Selected

<table>
<thead>
<tr>
<th>Episode Family</th>
<th>Phase 2 Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>National</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>57%</td>
</tr>
<tr>
<td>Major joint replacement of the lower extremity</td>
<td>51%</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease, bronchitis, asthma</td>
<td>41%</td>
</tr>
<tr>
<td>Simple pneumonia and respiratory infections</td>
<td>42%</td>
</tr>
<tr>
<td>Coronary artery bypass graft</td>
<td>14%</td>
</tr>
<tr>
<td>Acute myocardial infarction</td>
<td>32%</td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td>31%</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>29%</td>
</tr>
<tr>
<td>Other respiratory</td>
<td>29%</td>
</tr>
<tr>
<td>Stroke</td>
<td>29%</td>
</tr>
</tbody>
</table>

* Participation not included in the Top 5 National Episode Families

- Fractures of the femur and hip or knee: 26% 37%
- Fracture of the hip or knee: 15% 57%
- Hip & lower procedures except major joint: 14% 57%
- Double joint replacement of the lower extremity: 10% 71%
- Spinal fusion (low cervical): 10% 29%
Model Comparison

<table>
<thead>
<tr>
<th>Included Services</th>
<th>Model 2: Hospital and Physician Inpatient and Post-Discharge Services</th>
<th>Model 3: Post-Discharge Services Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expected Discount</td>
<td>Minimum of 3% for 30-89 days post-discharge services; minimum 2% for 90+ days post-discharge</td>
<td>Proposed by applicant (no set minimum)</td>
</tr>
<tr>
<td>Inpatient hospital and physician services; related post-acute care and readmissions</td>
<td>Post-acute care; Related readmissions</td>
<td></td>
</tr>
<tr>
<td>Clinical Conditions</td>
<td>Select inpatient DRGs proposed by applicants</td>
<td></td>
</tr>
</tbody>
</table>

BP Model 2: Retrospective Acute Care Hospital Stay plus Post Acute Care

- **Episode of Care**
  - Inpatient stay in the acute care hospital
  - All related services during the episode
  - Ends either 30, 60, or 90 days after discharge

- **Participants**
  - Hospitals or Physician Group Practices
  - 2013: 60 Awardees – 142 Providers
  - 2014: 364 Awardees – 2,038 Providers

- **Payments and Incentives**
  - Physicians and Facilities paid separate
  - Physician Fee Schedule
  - Inpatient Prospective Payment System
  - Reconciliation post episode (bonus or repayment)

Example BP Model #2

- 200 Average Patients Per Anchor Episode
- Average 90-day cost per episode is $20,000 ($4M total)
- CMS applies a 2% discount = $400 to average cost
- Average Target Price of $19,600
- Initiatives designed to be below average target price
- If the average episode cost is $19,000, then Participant will be paid by Medicare $120,000 ($600 X 200) for that particular episode
- Net result – Hospital gets paid its normal DRG plus its portion of shared savings.
BP Model 3: Retrospective Post-Acute Care Only

**Episode of Care**
- Post acute care services
- Begins before 30 days after discharge
- Ends either 30, 60, or 90 days after initiation

**Participants**
- Skilled Nursing Facilities, Inpatient Rehab, Long Term Care, or Home Health Agency
- 2013: 20 Awarded – 81 Providers
  - 2014: 240 Awarded – 4,646 Providers
- Providers paid separate
  - Physician Fee Schedule
  - Inpatient Prospective Payment System
  - Reconciliation post episode (bonus or repayment)

**Payments and Incentives**
- Episodes of Care
- Skilled Nursing Facilities, Inpatient Rehab, Long Term Care, or Home Health Agency
- 2013: 20 Awardees – 81 Providers
  - 2014: 240 Awardees – 4,646 Providers
- Participants
- Providers paid separate
  - Physician Fee Schedule
  - Inpatient Prospective Payment System
  - Reconciliation post episode (bonus or repayment)

**HOSPITAL EXAMPLE**

**Parrish Episode Benchmark Comparison**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Parrish Medical Center</th>
<th>Orlando FL</th>
<th>US Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD</td>
<td>13,865</td>
<td>15,020</td>
<td>14,091</td>
</tr>
<tr>
<td>Cardiac</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>arrhythmia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MJR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>failure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sepsis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHF</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UTI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Avg. Total Payment per 90-Day Episode

Parrish's spending on MJR is 20% higher than national

MOORE STEPHENS LOVELACE CIPS & ADVISORS
### Episode Payment Variation – Major Joint Replacement

- Impatient paid by DRG (relatively fixed). The variation in total cost is due to post discharge.
- 63% of Parrish MJRs utilized SNF as first post-anchor setting compared to 40% nationally.

### Episode Payment Variation – Congestive Heart Failure

- 36% of Parrish CHF episodes were readmitted at least once in the 90 days following anchor admission, costing an average of $10,864 in additional episode payments.

### Skilled Nursing Discharges for Parrish

**Average Payment per SNF Claim**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Average Payment (in $)</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD</td>
<td>$18,580</td>
</tr>
<tr>
<td>PN</td>
<td>$19,426</td>
</tr>
<tr>
<td>Cardiac</td>
<td>$18,515</td>
</tr>
<tr>
<td>MI</td>
<td>$19,426</td>
</tr>
<tr>
<td>Sepsis</td>
<td>$18,515</td>
</tr>
<tr>
<td>CHF</td>
<td>$18,515</td>
</tr>
<tr>
<td>UTI</td>
<td>$19,426</td>
</tr>
<tr>
<td>Stroke</td>
<td>$18,515</td>
</tr>
<tr>
<td>Hip &amp; Femur</td>
<td>$18,515</td>
</tr>
</tbody>
</table>

**Medicare spend in SNF was 20% higher than national average.**
SKILLED NURsing Versus Home Health

Average Episode Cost by First Post-Anchor Setting

- COPD: $26,814
- Sepsis: $23,408
- PNEU: $21,908
- CHF: $20,404
- MJR: $19,906
- Renal failure: $18,413
- Cardiac arrhythmia: $17,906

Shifting just six cases from SNF to HHA would save 3%

**FINAL THOUGHTS**

**SNF Benchmarking - Process**

1. Identify what is to be benchmarked
2. Identify comparable companies, groups, states
3. Identify benchmarking source
   a. Cost reports
   b. 5 star rating, surveys
   c. Pepper, LeadingAge reports
   d. Length of stay, readmissions
4. Determine current performance
5. Project future performance
6. Develop action plans
Negotiating Collaborating With Hospitals and Health Plans

- Physical Attractiveness
  - Private rooms, amenities, rehab
- Reputation and Character
  - Clinical competencies
  - Quality Measures (5 star)
  - Regulatory performance
  - Outcomes measurements
- Earning Potential
  - Manage and reduce lengths of stay
  - Minimize readmissions
  - Do you have niche in hard to place residents

Facility Data

- Does your data support your ability to do it better?
- Are you tracking and trending?
  - What is your re-hospitalization rate?
  - What is your hospitalization rate?
  - What is your ER utilization?
  - What is your average length of stay?
- What are you doing to improve your quality measures?
  - Quality metrics accurate?
  - Driving care priorities?

Conclusions

- Traditional Fee for Service models will dwindle over time but will still be a valid payment method
- The payment landscape will not be dominated by a single VBP model
- Providers will have to handle a variety of payment types
- Financial risk to providers will increase
- Sophisticated IT and clinical integration will be required
- Providers must be willing to collaborate with their local hospital(s)
- Data analytics and reporting will be key to successfully implementing value based purchasing models