Value-Based Purchasing 101

Matt McGarvey, MBA, VP of Business Development
Harmony Healthcare International (HHI)

About Matt

As Vice President of Business Development for Harmony Healthcare International (HHI), a nationally recognized, premier Healthcare Consulting firm specializing in C.A.R.E. (Compliance, Audits and Analysis, Reimbursement and Regulatory, Education and Efficiency), Matt is responsible for growing and maintaining customer relationships, having added new relationships in 20 different states including New York, Connecticut, Vermont, Pennsylvania, California and more. Matt is passionate about improving the delivery of healthcare and specializes in the areas of 3rd party reimbursement, compliance, revenue cycle, electronic medical record software, and managed care.

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Learning Objectives

- The learner will be able to identify the key strategies to prepare the SNF for the Value-Based Purchasing reimbursement system
- The learner will describe two strategies to proactively negotiate payment contracts for managed care and hospitals
- The learner will state three clinical and operational strategies to excel in an episodic reimbursement system
Today’s Topic

DEATH BY POWERPOINT

Today’s Agenda

1. Impact of the Election
2. Definitions: Value-Based Purchasing System
3. Impact of VBP on Clinical and Financial Operations
4. Re-hospitalizations
5. Clinically Anticipated Stay
6. Payment Models
7. Therapy Operations
8. Quality Measures/Five-Star Rating
9. Managed Care Contracts
10. Partnering with your Partners

Impact of the Election
Impact of the Election

- Certainly the result of the election was surprising
- Strong likelihood that Republicans will control the federal government for the next 4 years (only need to defend 8 Senate seats in 2018)
- New Administration attempting to be business-friendly and looking to reduce regulations
- Congressman Tom Price has been nominated to Chair the Department of Health and Human Services
  - has been an outspoken critic of the Affordable Care Act
  - Also has aggressively opposed additional post acute bundles

Impact of the Election

- AHCA sees an opportunity to seek relief from regulatory requirements, aggressive tactics of survey teams, IJs and CMPs for relatively minor infractions

Impact of the Election

- Among the issues AHCA will be advocating for:
  - Clean Medicare Payment Rule for FY 2018
  - Relief related to delivery of therapy
  - Recognizing Observation stays as counting for the 3-day stay
  - Survey/Regulatory/CMP relief
  - Stop Additional Bundles
  - Repeal of the Requirements of Participation (RoP)
  - Repeal of the employer mandate (return to mini-med plans)
Impact of the Election

• Sounds good so far.......... 

Impact of the Election

• Riskiest area by far is Medicaid
  – Republicans have long wanted to fundamentally change Medicaid
  – With complete control now at hand, Medicaid reform is now at hand
  – Will come in the form of Block Grants
  – This could put Post-Acute Care at risk
Impact of the Election

- Riskiest area by far is Medicaid
  - Under the Republican Proposal, the federal contribution would fundamentally change dividing the contribution amongst 5 categories
  - Aged, Disabled, Children, Medicaid Expansion, other adults
  - Limits tied to increases in CMI
  - States with Governors who support LTC are likely to do be in better position than others

Hang on, This Gets Better

Here Comes RCS-1
Resident Classification System, Version 1  
RCS-1  
(CMS Proposed)

Summary

- CMS (Centers for Medicare and Medicaid Services) made available details of the proposed payment system in a document called the Advanced Notice of Proposed Rulemaking.
- The document defines the proposed revisions to the currently used Case-Mix Methodology with time for public feedback and opinions on the possibility of replacing the SNF PPS existing Case-Mix Classification Model, Resource Utilization Groups, (RUG-IV) Case Mix Classification Model with the Resident Classification System, Version I (RCS-I).
- Comments must be received no later than 5 p.m. on June 26, 2017.

Summary

- The revised model, the Resident Classification System, Version I (RCS-I), will case-mix adjust and be grouped into four major cost categories:
  1. Physical Therapy (PT) / Occupational Therapy (OT)
  2. Speech Language Pathology (SLP) Services
  3. Nursing Services
  4. Non-Therapy Ancillaries (NTAS)
The Top 14 Salient Points

3. The PT/OT and SLP components will be determined based on Resident Characteristics, not Therapy Days and Minutes.

4. Nursing Classification will align with Current Nursing RUG Levels.

5. MDS Diagnosis Coding Accuracy is critical.

6. Proposed System will base reimbursement on the 5-Day MDS Assessment Only and all other PPS assessments eliminated.

7. Reclassification for a Significant Change in Status will occur with completion of a Significant Change in Status Assessment

8. The Resident Classification covers the entire Medicare stay unless a Significant Change in Status Assessment is performed

9. Reimbursement rate will be adjusted throughout the Medicare Covered Stay with decreasing rate accounting for utilization of fewer resources as the stay extends

10. A patient re-hospitalized for greater than 3 days will have a new 5-Day MDS Assessment completed to reclassify

11. A re-hospitalization of less than 3 days will be considered a continued stay and a new 3-Day PPS MDS will not be completed. The existing Resident Classification will continue upon return.

12. The SNF PPS Discharge Assessment requirement will not change

13. Activities of Daily Living (ADL) Scoring will be modified and Bed Mobility will be eliminated from the ADL Calculation

14. The below grid depicts the Proposed MDS Assessment, ARD and Payment Days

<table>
<thead>
<tr>
<th>Medicare MDS Assessment Sustained Type</th>
<th>Assessment Reference Date</th>
<th>Applicable Standard Medicare Payment Days</th>
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<tbody>
<tr>
<td>5-Day Scheduled PPS Assessment</td>
<td></td>
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</tr>
<tr>
<td>Significant Change in Status Assessment (SCS)</td>
<td>To see if 14 days have passed since change in status</td>
<td></td>
</tr>
<tr>
<td>PPS Change Assessment</td>
<td></td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>
Let’s Get Back to Value-Based Purchasing

Key Definitions

- **Bundled payment**: Known as episode-based payment, case rate, evidence-based case rate, package pricing. Reimbursement of health care providers on the basis of expected costs.
- **Bundled Payments for Care Improvement (BPCI)**: Made up of four models of care that link payments for multiple services beneficiaries receive during an episode of care. Organizations enter into payment arrangements that include financial and performance accountability for episodes of care.
- **CCJR**: Comprehensive Care for Joint Replacement. Part A and Part B payment model which acute care hospitals in certain selected geographic areas will receive retrospective bundled payments for episodes of care. All related care within 90 days from admission is included in the episode.
Essence of Value Based Purchasing

- Beginning on October 1, 2018, all SNF Medicare Part A rates will be cut by 2 percent to fund an incentive payment pool.
- At that time CMS, will adjust payments and return SOME based on how well they do managing hospital readmissions.

Key Definitions

- **DRG**: Diagnosis related group. Used to classify patients by diagnosis, average length of hospital stay and therapy received.
- **Episode**: All services provided to a patient with a medical problem within a specific period of time across a continuum of care in an integrated system.

IMPACT Act

- Improving Medicare Post Acute Care Transformation Act of 2014 (IMPACT Act) puts in place new and streamlined quality measures for nursing homes, home health agencies, and other post-acute care providers participating in Medicare.
- Expand and strengthen Medicare's widely-used 5-Star Quality Rating System for Nursing Homes, also known as Nursing Home Compare.
IMPACT Act

- Bipartisan bill passed on September 18, 2014 and signed into law by President Obama on October 6, 2014

IMPACT Act Intent

- Quality care provision will now be directly linked to financial success
- Quality versus Quantity of Care

IMPACT Act Intent

- Strengthens patient rights
- Improves communication
- Focuses on patient well-being
Impact of Value-Based Purchasing on Clinical and Financial Operations

SNF Industry Concerns About Value-Based Purchasing

• Being left out in the cold – excluded from the network by acute-care organizations who are trying to narrow their networks:
  – Post-acute providers are striking deals with hospital systems and payors to become part of preferred networks, realizing the narrow network trend can work to their favor as CMS provides incentives for quality improvements across the network
• Pressure to reduce re-hospitalizations

SNF Industry Concerns About Value-Based Purchasing

• Pressure to reduce costs
• Payment Reform seems to be in direct conflict with admitting more medically complex patients
• More and more admissions and discharges
• If it’s anything like managed care.........
Traditional SNF Payment Arrangements

- Medicaid:
  - Most of our volume
  - Payment doesn’t cover costs
  - Goes a long way toward paying the bills
  - Provides regular cash flow
- Private Pay & Medicare Part A:
  - Provides profit margin
  - Depends on volume
  - The more volume, the better
  - Fill the beds!

MedPAC’s observation include:
- Increase in SNF admissions by 3.2%
- Decrease in LOS of 4% between 2013 and 2015
- Payments driven by the amount of therapy delivered, not patient characteristics

Among MedPAC’s recommendations:
- More bundles
- Eliminate future PPS updates

New Arrangements Under Payment Reform

- ACOs were a precursor to a quality-based/risk sharing reimbursement system
- Bundled Payment for Care Improvement (BCPI) programs such as Comprehensive Care for Joint Replacement (CCJR) are the second wave
- Payments by the episode (Episodic Care) are the future
- Let’s, not forget the RCS-1 “at the time of publication”
Essence of Value-Based Purchasing

- Measure
- Report
- Reward

Value-Based Purchasing

- Measure:
  - Gauge performance by showing if care is:
    - Safe
    - Timely
    - Efficient
    - Effective
    - Equitable
    - Patient-Centered

Value-Based Purchasing

- Report
  - The performance measure needs to be transparent and public for purchasers, payers and consumers to make informed decisions
Value-Based Purchasing

• Reward
  – When provider is successful in meeting the performance measure, they are rewarded with:
    • Improved reputations because of the public reporting
    • Enhanced payments
    • Increased market share

VBP in Skilled Nursing Facilities

Measure
(SNF RM) Skilled Nursing Facility Re-admission Measure:

1. Re-hospitalizations during a 30 day window from admission to the SNF during and after the SNF stay (if discharged home prior to 30 days)
2. The current National Average for hospital readmissions is 21.1%
3. The Better of Achievement Score (Ranking) or Improvement Score
   • The Achievement Score based on SNF’s ranking on their rate
   • Performance period based on Calendar Year (Jan 2017 to Dec 2017)
4. The Improvement score based on SNFs improvement over 2 years
5. Compares re-hospitalization rates Calendar Year 2015 to Calendar Year 2017

VBP in Skilled Nursing Facilities

• CMS proposed "potentially preventable re-hospitalization" measures
• Counts re-hospitalizations with a diagnosis on hospital claims that is considered potentially preventable
• Including COPD, CHF, etc.
VBP in Skilled Nursing Facilities

• Report
  – Provide confidential feedback reports quarterly via QIES (Quality Improvement and Evaluation System) system starting October 2016
  – Information will be public in 2018
  – This measurement will be different than the Five-Star

Reward

• The government is using a "withhold approach"
• The amount of money impacted is 2% of total Medicare Revenue. This amount will be "withheld" and given back to the facility if they meet the measure.
• If your hospital readmission rate is above 20% hospital readmission level, there is a high likelihood you will lose the 2%
• The 2% withhold of SNF Part A payments is effective October 1, 2018 (based on performance calendar year 2017)

Potential Impact of VBP

Nursing and Rehab
Revenue Analysis 2016 & 2017

<table>
<thead>
<tr>
<th>Month</th>
<th>Part A Revenue</th>
<th>Part A Rate</th>
<th>Total Revenue</th>
<th>Total Revenue %</th>
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<tbody>
<tr>
<td>Jul 16</td>
<td>$627.99</td>
<td>91.9%</td>
<td>$706,485.33</td>
<td>94.5%</td>
</tr>
<tr>
<td>Aug 16</td>
<td>$643.47</td>
<td>92.9%</td>
<td>$810,775.57</td>
<td>94.9%</td>
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<tr>
<td>Sep 16</td>
<td>$648.02</td>
<td>93.2%</td>
<td>$843,726.14</td>
<td>94.7%</td>
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<tr>
<td>Oct 16</td>
<td>$666.22</td>
<td>92.4%</td>
<td>$781,475.96</td>
<td>94.7%</td>
</tr>
<tr>
<td>Nov 16</td>
<td>$652.26</td>
<td>93.4%</td>
<td>$816,551.31</td>
<td>95.3%</td>
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<tr>
<td>Total</td>
<td></td>
<td></td>
<td>$4,014,930.28</td>
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Estimated Timeline for SNF VBP Implementation

- Oct 2015: SNF comments
- Oct 2016: Post-withhold in Proposed Rule
- Oct 2017: Analyze Data
- Oct 2018: Collect Data
- Oct 2019: Withhold Starts

Re-hospitalizations

CMS SNF RM Measure

- Includes only Medicare FFS Part A Beneficiaries:
  - Used data from Part A Medicare Claims
- All cause readmission
- Counts re-hospitalizations during 30 day window from admission to the SNF:
  - During & after SNF stay (if discharged home prior to 30 days)
- Excludes:
  - Elective admits
  - Observations stays
- Risk adjusted:
  - \[(Actual \div Predicted) \times \text{National average}\]
SNF Re-hospitalization Rates

• Takeaway #1 -- Know your Re-hospitalization rate compared to the national average

SNF Re-hospitalization Rates

National Average 21.1%

SNF Readmissions Program

• Included in the Protecting Access to Medicare Act of 2014 signed into law on April 1, 2014
• Establishes 2% withhold from which 50-70% will be used as an incentive pool for bonus payments to providers who perform well on 30-day readmissions
SNF Re-hospitalizations

Value-Based Purchasing

- This program establishes a hospital readmissions reduction program for these providers, encouraging SNFs to address potentially avoidable readmissions by establishing an incentive pool for high performers
- The program is budgeted to save Medicare $2 billion over the next 10 years

Value-Based Purchasing

- In order to fund the incentive payment pool, CMS will withhold 2% of SNF Medicare payments starting October 1, 2018
- CMS will redistribute 50-70% of the withheld payments back into the profession by way of incentive payments to SNFs
- CMS will retain the remaining 30-50% of funds as programmatic savings to Medicare
- The program also requires the Secretary to publicly report the performance on the readmission measure for each SNF on Nursing Home Compare beginning on October 1, 2017
Clinically Anticipated Stay

- Understanding Clinically Anticipated Stay (CAS) has always been a bit of a moving target
- In order to succeed under Value-Based Purchasing, we must understand CAS by Diagnosis!
- It is a MUST in order to achieve financial & clinical success
- Takeaway #2 – Start collection your CAS by diagnosis

Top 10 Questions to Ask About Data

1. Why are you collecting the data?
2. What type of data is collected?
3. How is data collected?
4. How is data normalized?
5. What does the data mean?
6. How is data presented?
7. How is the data beneficial?
8. How are you going to use the data?
9. Are you going to be transparent with your data?
10. What was your starting point data?
Performance By Diagnosis

Percent Patients & CAS By Diagnosis

Home CAS By Categories
## Home CAS By Diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>% Patients</th>
<th>CAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PNA</td>
<td>8.4%</td>
<td>19.2 Days</td>
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<tr>
<td>CHF</td>
<td>5.7%</td>
<td>19.1 Days</td>
</tr>
<tr>
<td>UTI</td>
<td>5.2%</td>
<td>20.2 Days</td>
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## Re-hospitalization CAS By Diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>% Patients</th>
<th>CAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PNA</td>
<td>6.6%</td>
<td>11.8 Days</td>
</tr>
<tr>
<td>UTI</td>
<td>5.9%</td>
<td>12.4 Days</td>
</tr>
<tr>
<td>CHF</td>
<td>5.7%</td>
<td>14.1 Days</td>
</tr>
</tbody>
</table>

## Payment Models
Payment Models

- Today’s Model:
  - Paid by the RUG by the day
  - The more “resources” used, the higher the payment
- Bundled Payment Model:
  - Lump sum payment by condition/diagnosis
  - Regardless of Clinically Anticipated Stay
  - Measure thy outcomes!

Payment Models

- Takeaway #3 – Its time to work double time on Clinical Reimbursement. Accurate and appropriate reimbursement in the PPS / RUGS System. Prepare for VBP simultaneously

What Do Episodic Payments Look Like?
What Do Episodic Payments Look Like?

- Establishment of a bundled payment for an episode of care (i.e., by diagnosis)
- It becomes a de facto “Target Price”
- Hospitals have done it for years
- Financial success will come from 2 areas:
  - Know the relationship between clinical outcomes and target price
  - Reduce readmissions
  - Deliver clinically appropriate care in order to produce successful discharges

Payment Models

- What Constitutes a “Good” Bundle?
- Need to Know Three Critical Statistics:
  1. CAS by Diagnosis
  2. Average Medicare Rate
  3. Outcomes by diagnosis/re-hospitalization Rate

  - Recent article in McKnights showed that from 2008 – 2015 payments for CCIR episodes saved 20% or $5,500 per beneficiary. Almost half for the join itself.

Payment Model

- Example #1:
  - Facility A is has an average Medicare Rate of $500 per day. A COPD CHF patient typically stays 25 days, receiving an RU level of therapy with 9/10 successful discharges to the community.
  - If the referring hospital wants to pay you $15,000, is that a good bundle?
Payment Model

• Example #2:
  – Facility A is has an average Medicare Rate of $450 per day. A Pneumonia patient typically stays 20 days, receiving an RU level of therapy with 8/10 successful discharges to the community.
  – If the referring hospital wants to pay you $5,500, is that a good bundle?

Payment Models

• Now you have a starting point!
• Until you know this information, you run the risk of being out-negotiated!
Therapy Operations

- Takeaway #4 – Look long and hard at therapy operations

Future of Therapy

Therapy Reimbursement to be linked to improvement
Treatment Environment Considerations

- Containing costs:
  - Expenditures appropriate
  - Predictable
- Consider: What are the costs of the individual components of care?
  - What are the costs of the episode across the continuum of care?
  - Which clinical processes have the greatest cost variation?
- Reducing this variation will improve the cost structure

Value-Based Treatment Goals

- Avoid surgeries
- Heal wounds faster
- Prevent adverse medical events
- Successful and sustained discharge
- Reducing pain to avoid interruption of task completion and sleep

Treatment Environment

- Individual sessions?
- Groups
- Concurrent
- Co-Treatment
- Student Programs
- Rehab Aides
- Clinical Practice Acts
- State Regulations still supersede
Therapy for Quality Measures

- Interdisciplinary Team to focus on:
  - Falls reduction
  - Preventing and improving Pressure Ulcers
  - Prevent re-hospitalization
- Are you part of the team?
- How can we help?
- Are we providing therapy in a Silo?

Discharge Planning

- What are the patient’s individualized clinical goals?
- What are the patient’s individualized physical/functional goals?
- What are barriers to safe discharge home?
  - What are we doing about it!!
- Work together as a team
- Develop and use Rehabilitation programs

Rehabilitation Program Development

- Interdisciplinary Discharge Planning
- Identify and Care Plan barriers to achieving clinical, rehab and Discharge goals
- Communicate patient changes to prevent adverse events
- Clinical Program Development:
  - Interdisciplinary Team
  - Nursing and Rehab Program liaisons
Program Development

• The goals are:
  – To provide quality care
  – To ensure that all patients that have the potential to benefit from skilled therapy intervention receive access to services
  – To support the facility in meeting all regulatory requirements
  – Improve patient outcomes

Program Development

• Educate nursing on appropriate patient referrals
• Therapy to initiate routine review of key facility reports to address resident needs in a timely fashion (e.g., falls, weight loss, skin, etc.):
  – Quality Measures
  – Risk Reports
• Utilize the MDS

Patient Identification

• 30-day window of wellness, annual, and significant change in status screens:
  – Screening determines only if an Evaluation is warranted. No recommendations should be made without an evaluation.
  – Previous therapy service dates or documentation for most recent services or reviews
  – ADL flow sheets for previous three months
  – Review nursing documentation and MDS to identify any red flag areas (falls, skin issues, positioning issues, incontinence, pain, feeding issues)
  – MD orders for 1-2 months for med/diet change orders and recent acute diagnosis that may indicate a therapy evaluation is needed
Program Development
Systems for Resident Identification

- 24-hour report review
- Nursing referral checklist for Care Plan meetings
- Effective communication at daily stand-up and weekly Medicare meeting
- Develop specialty programs and perform monthly or quarterly rounds
- Interview direct care staff for patients with a functional decline in mobility, ADLs or communicating
- Review patients at RISK for skin issues, weight, pain, behavior, restraint, incontinence and fall risks
- Review Quality Measure data

Program Development
Specialty Programs

- Pain management
- Seating and positioning
- Contracture management
- Wound care
- Dementia rounds
- Dementia intervention (mobility, communication, safety and behavior)
- Dining rounds
- Activity rounds
- Therapy Integration with RNA
- Continence Program
- Rehab Dining
- Dysphagia Management (Altered consistencies)
- Fall and Balance Program
- Comprehensive use of modalities and other treatment areas

Program Development

- Create a Clinical Leader Program partnering rehab and nursing staff for program development
- Lunch and Learn program in-servicing
- Create STOP Program: See, Tell, Observe and Referral Program
Program Development
Falls and Balance

• Reason for Referral:
  – Fall
  – Patient has unsteady gait while ambulating from room to dining room and has had 2 episodes of loss of balance in the past week
  – Patient able to ambulate 35 feet with rolling walker with min assist x 1, however requiring increase verbal cues for safety
  – Patient requires verbal cues for hand placement to push up to stand and unable to bear weight onto left leg due to sore on heel

Program Development
Falls and Balance

• Assessment Tools to consider:
  – Tinneti’s Test, Berg Test, Functional Reach test, Chair Stand test, and 6-Minute Walk test
• Prior Level of Function:
  – Patient was able to ambulate 100 feet with rolling walker with supervision for safety
  – Patient required mod A x 1 to roll to left side to get from side-lying to edge of bed

Program Development
Falls and Balance

• Clinical Partnership:
  – Clinical Nurse Leader: Risk Manager, Safety/Quality Assurance Nurse
  – Clinical Rehab Leader: Falls and Balance Specialist
Program Development
Falls and Balance

• Strategies to implement a Falls and Balance Program:
  – Review Risk Meeting note and review falls reports and data
  – Daily Risk Meeting note and review falls reports and data
  – Interview staff to identify who requires more assistance, who requires frequent redirecting on transfer and mobility. Identify patients that have increase difficulty with bearing weight, transferring, ambulating, has changes in vision, or altered muscle tone.

Program Development
Falls and Balance

• Examples of Goals:
  – Patient will decrease left knee pain to 2/10 and build gross LE strength to 4/5 to focus on stand pivot transfers
  – Patient will increase static standing for 3 minutes with ability to right self with min assist in order to perform standing ADL tasks
  – Patient will ambulate 75 feet with CTG with rolling walker with minimal SOB on exertion and >90% O2 saturation on 1L via nasal cannula

Program Development
Falls and Balance

• Treatment Activities:
  – PREs, Strengthening and balance programming, analyze gait patterns over various surfaces, ongoing graded cueing to improve deviation in weight shift during swing phase of gait. Functional reach activities and obstacle course or walk test programming.
Five-Star Rating & Quality Measures

Sweet 16 Quality Measures
Short-Stay
1. Improvements in Function (Short-Stay)- New
2. Successful Community Discharge (Short-Stay)- New
3. Re-Hospitalized Following Nursing Home Admission (Short-Stay)- New
4. Outpatient Emergency Room Visits (Short-Stay)- New
5. New or Worsening Pressure Ulcers (Short-Stay)
6. New Antipsychotic Medications (Short-Stay)
7. Moderate to Severe Pain (Short-Stay)

Sweet 16 Quality Measures
Long-Stay
8. Residents Whose Ability to Move Independently Worsened (Long-Stay)- New
9. Moderate to Severe Pain (Long-Stay)
10. High Risk Pressure Ulcers (Long-Stay)
11. Antipsychotic Medications (Long-Stay)
12. Injurious Falls (Long-Stay)
13. Urinary Tract Infection (Long-Stay)
14. Catheter (Long-Stay)
15. Physical Restraints (Long-Stay)
16. ADL Decline (Long-Stay)
New Quality Measures

- **Three** of the new measures are on Medicare claims and include events that occur after discharge from the **SNF**:
  1. Re-hospitalization
  2. Emergency Room Use
  3. Discharge to Community

Data Preview

- Data will be available for SNFs to preview before it is posted on Nursing Home Compare
- Rates on the 6 measures can be previewed on QIES (Quality Improvement and Evaluation System)

Quality Measures

- **Takeaway #5** – Start looking at Quality Measures more often
  - Used to be a once-a-quarter thing, now every week is not too often
Analyze Your Data

Five-Star July 2016

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Five-Star Composite Rating Calculator

2016

<table>
<thead>
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<td>Health Inspection</td>
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<tr>
<td>Staffing Stars</td>
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<tr>
<td>Quality Measure</td>
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<tr>
<td>Overall Score</td>
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Quality Measures/Five-Star

- Takeaway #6 - “What do I do if my Five-Star rating is below average?”
  1. Survey star carries the most weight
  2. Quality Measure star is most dynamic
  3. Focus on your strengths during conversations with partners & negotiations
  4. Launch a QAPI program for continuous lasting results

- Wait a minute... What about Geography??
Managed Care Contracting

1. Do your homework
2. Know the players in your geographic area
3. Will they be good business partners?
4. Identify those with whom you want to contract?
5. Begin to establish a relationship
6. Use your data as a your strongest negotiating tool

Successful Managed Care Contracting

$6,000
$100,000

Thanks to compromise they were moving closer.
Tools for Successful Managed Care Contracting

• Takeaway #7 – Sharpen your negotiating tools

Tools for Successful Managed Care Contracting

• Put yourself in their shoes: What do they want in a partner?
  • Low cost
  • High quality
  • Successful outcomes
  • If that is YOU, then TELL THEM!
  • SING YOUR PRAISES!!
Managed Care Contracting

• Low Cost:
  – One night in the hospital costs them more than a week in a SNF. Don't let anyone tell you otherwise.

• High Quality:
  – Five-Star Rating and MDS-Based QMs

• Successful Outcomes:
  – Outcomes based Quality Measures (above average successful discharges, below average re-hospitalizations)

Managed Care Contracting

• Negotiating the Plan:
  – Payment rates & terms: Levels, RUGs, or Bundles???
  – Exclusions
  – Consolidated Billing: Out of the ordinary billing rules?
  – Concurrent Clinical Review
  – Rules of Traditional Medicare (Prior Level of Function/Highest State of Well Being)

Managed Care Contracting

• Recently saw some examples of some very poor Managed Care billing practices
  – Poor ICD-10 Diagnosis coding
  – Ancillaries (Lab, Pharmacy, Radiology) missing
  – Concurrent review processes with very poor vernacular
Managed Care Contracting

• Vocabulary and vernacular in speaking with medical reviewers:
  – “Skilled Observation and Assessment”
  – “Ensuring Medical Safety”
  – “Promoting Recovery”
  – “Stable” – Don’t Say It!!!!!!
• Appeal Rights:
  – What are your appeal rights?
  – Know them in advance

Partnering with Your Partners

Looking for Solutions?

Answers
NEXT EXIT
Looking for Solutions?

- We have been living in a Medicare world where it’s all about volume
- Now we are transitioning into a world of preferred post-acute providers where hospitals are narrowing their networks to high performing SNF providers
- Define what makes you successful
- WORK DOUBLE-TIME!
- Must work on both simultaneously

What is on the Minds of the Hospital Systems?

- Reducing readmissions are Numero-Uno in their world
- The best way for them to gain control over reducing readmission rates is to narrow their networks
- It’s too difficult to manage if hospitals are discharging to 100 different SNFs
- If in that network are high performers (Five-Star and QMs), readmissions are more likely to be reduced
What if Hospitals and Physicians Want to Bypass the SNFs?

- We have to expect that outcomes will eventually catch up to them
- QUALITY and OUTCOMES!
- We know it really isn’t as cost effective as one would lead you to believe
- Transition Nurses in facilities will play a vital role in order to deal with shorter LOS
- Sing your praises! Show them your outcomes and quality. Sell your strengths.

How to Succeed in VBP

- Develop effective, quality, utilization, risk and infection management programs
- Implement reliable performance improvement tools and measures – TECHNOLOGY
- Implement effective admission, discharge and transfer protocols
- Improve performance in reducing conditions and complications that will lead to readmissions
- Build solid relationships… DO NOT wait!
Key References

• IMPACT Act
• Final Rule FY 2016
• Final Rule FY 2017

Thank You