The Value-Based Perspective: Positioning Aging Services to Thrive in the Future

LeadingAge Iowa
Fall Leadership Conference
14 September 2017
Are We Having Fun Yet?
What’s Keeping Us Up At Night?

- Two Words: Block Grants
- Volume: SNF census keeps softening and payment systems keep shifting
- Growth: Are we big enough? How big is big?
- When does this “partnering” thing start getting real?
- How do we stay relevant or essential in our markets?
- What are hospitals thinking?

I used to sleep at night.
SNFs Sliding into Irrelevance?

Three stars will be the new one star

Nursing home operators call it low occupancy. Medicare insiders call it a declining census. Economists call it excess capacity.

Already, occupancy has slipped to a five-year low, 82.2%, in the second quarter of this year, according to the National Investment Center for Seniors Housing & Care.

Kindred is exiting the skilled-nursing home business

By Dave Barkholz | November 8, 2016

Kindred Healthcare is exiting the skilled-nursing home business to focus on its better-performing home health, rehabilitation and long-term acute-care hospital units, the company announced Monday.
Or Just Consolidating and Transforming...

Kindred replacing physical nursing homes with 'virtual portfolio'

The first of those partners was announced Tuesday. Nursing home giant Genesis HealthCare has entered into "strategic clinical collaboration" with Kindred to improve quality, outcomes and patient transitions between the two systems, Kindred and Genesis announced.

CommuniCare Health Services acquires healthcare centers in Baltimore, Towson

Ensign Group Completes Acquisition of Legend Healthcare

Centers Health purchases Beth Abraham

Post Acute Partners to buy 126-bed NY nursing home

Nursing Home Care Industry Is A Solid Investment
The Wave...
+10k boomers per day
$13 trillion by 2032
“The health care system is going to undergo a lot of change, and change is good for companies looking for opportunities.”

Helena Foulkes, CEO, CVS Pharmacy
Where Are We Going?
“Nobody knew health care could be so complicated.”
That Didn’t Go As Expected...

Repeal and Replace?

More like
Tread Water, Play Nice and
Hope it All Works Out
<table>
<thead>
<tr>
<th></th>
<th>Political Realities and Economic Incentives</th>
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<tbody>
<tr>
<td>1</td>
<td>There is bipartisan support to move from fee-for-service to value, which will continue.</td>
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<td>2</td>
<td>Reform involves using Medicare (and Medicaid) to incentivize change, but the pace of change will be market dependent.</td>
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<td>3</td>
<td>Providers, not payers, will increasingly be accountable for cost and outcomes.</td>
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<td>Commercial payers and managed care organizations being incented to follow Medicare’s payment and quality models</td>
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<td>5</td>
<td>Increasing alignment between physicians and health systems, as well as community resources and “non-traditional” partners</td>
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<td>6</td>
<td>Data insights, analytics, exchange and innovation are keys to future success and relevance</td>
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MACRA: Medicare Access and CHIP Reauthorization Act of 2015

Created in 1997, the SGR capped Medicare physician spending per beneficiary at the growth in GDP

The formula does not incentivize high-quality, high-value care

Since 2003, Congress has passed 17 laws to override SGR cuts

SGR creates uncertainty and disruption for physicians and other providers

Most of $170B in ‘patches’ financed by health systems

On 3/26/15, the House passed H.R. 2 by 392-37 vote.

On 4/14/15, the Senate passed the House bill by a vote of 92-8, and the President signed the bill.
MIPS Overview

**Quality** — PQRS Measures, PQIs (Acute & Chronic), Readmissions

**Cost** — MSPB, Total Per Capita Cost, Episode Payment

**Advancing care information** — Modified Meaningful Use Objectives & Measures

**Improvement activities** — Expanded access, population management, care coordination, beneficiary engagement, patient safety, social and community involvement, health equity, emergency preparedness, behavioral and mental health integration and Alternative payment models.

- Sets performance targets in advance, when feasible
- Sets performance threshold at 3; median or mean in later years.
- Improvement scores in later years

**Merit-Based Incentive Payment System (MIPS) adjustments**

<table>
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<th>Year</th>
<th>Adjustment</th>
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<tr>
<td>2019</td>
<td>+/-4%</td>
</tr>
<tr>
<td>2020</td>
<td>+/- 5%</td>
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<tr>
<td>2021</td>
<td>+/- 7%</td>
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<td>2022 &amp; beyond</td>
<td>+/- 9%</td>
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MIPS exceptional performance adjustment; ≤ 10% Medicare payment (2019-2024)
As a nation, we are pushing towards population health

“the health outcomes of a group of individuals, including the distribution of such outcomes within the group”

- Focused on growing beyond individual levels of health or medical practices to address the mass in total – via consistent strategies and application of evidence-driven practice

- “Social determinants” are key to PH – economic and social conditions that drive health choices and options

- PH does not imply a “disease-free” state – alternatively, it seeks to empower individuals to adapt or respond to health challenges

The Challenge: Chronic Disease in America

Incurable illnesses or conditions that are often preventable and frequently manageable via early detection, pharmaceutical interventions, and lifestyle factors

- Leading cause of death in America
- 45% of the population has at least one chronic disease
- Account for 81% of hospital admissions; 76% of physician visits
- Spending for chronic disease related conditions accounts for 99% of Medicare spending
- By 2025, chronic disease will affect an estimated 164 million Americans – nearly half the population
Shifting Focus: Populations & Resources

Population Stratification

- **5%**
  - Poly-chronic
  - Frail elders
  - End of life

- **25%**
  - At risk for major intervention

- **70%**
  - Healthy, minor issues

Resource Consumption

- **45%–50%**
  - ED visits
  - Avoidable events
  - Readmissions

- **30%–35%**
  - Higher acuity episodes than required
  - Complications and readmissions

- **15%**
  - Unmanaged and unengaged

- **Most uniformly agree that our healthcare system must shift the focus of health management “down pyramid”, including chronic persons at risk for a major intervention.**

- **There are 4 to 5 chronic individuals for each frail individual – should the chronic population go left unmanaged, the inevitable impact to a system designed to address frail individuals will be catastrophic.**

Source: HFMS National Institute 2013: Blended MarketScan Commercial, Medicare 5% LDS, and representative payor Medicare data
% of Medicare Beneficiaries with Diabetes

Map created by the Office of Senator Ron Wyden
http://www.wyden.senate.gov/chroniccare

References: U.S. Census 2010 and CMS.gov 2011
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<th>Top Areas of Focus: Premier Pop Health Organizations</th>
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<tr>
<td>Effective management of post-acute care / SNF utilization</td>
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<tr>
<td>Refining care management techniques to more effectively manage chronically ill / top 5%</td>
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<tr>
<td>Scaling population health tactics and learnings across populations</td>
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<tr>
<td>Best practices for integrating data from disparate EHRs</td>
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<tr>
<td>Increasing appropriate EOL care and palliative care hospice usage</td>
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<tr>
<td>Reducing avoidable admissions for CHF and COPD patients</td>
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<tr>
<td>Decreasing ED utilization and avoidable admissions through the ED</td>
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<td>Shifting culture away from FFS / “heads in beds”</td>
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43% of Medicare Beneficiaries are Discharged from Acute Hospitals to Post-Acute Care

<table>
<thead>
<tr>
<th>Intensity of Service</th>
<th>Short-Term Acute Care Hospital</th>
<th>Long-Term Acute Care Hospital</th>
<th>Inpatient Rehab</th>
<th>Skilled Nursing Facility</th>
<th>Home Health Care</th>
<th>Outpatient Rehab</th>
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<tbody>
<tr>
<td>High</td>
<td>First site of discharge after acute hospital stay</td>
<td>2%</td>
<td>10%</td>
<td>41%</td>
<td>37%</td>
<td>9%</td>
</tr>
<tr>
<td>Low</td>
<td>Patient’s use of site during 90-day episode</td>
<td>2%</td>
<td>11%</td>
<td>52%</td>
<td>61%</td>
<td>21%</td>
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Hospitals often have limited control of costs and outcomes sent to non-affiliated post-acute settings

Source: MedPAC June 2013; MedPAC Post Acute Care Reforms Congressional Testimony
MS-DRG 470
MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC

Home > Home Health
Home > OT or No Order

MS-DRG 469
MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W MCC

Home > SNF
Home > Home Health
The Increasing Slide of Acuity Pushdown

Traditional Patient Dynamic

Acute Stepdown

Home → Home Health → SNF → IRF → LTACH

Home Health → Assisted Living

SNF → LTACH

LTACH
The Future of Home Health

The Alliance for Home Health Quality & Innovation’s “Future of Home Health Care Project” cites three key value components of home health in a PH future.

**Improving Patient Outcomes**
- Medicare HH patients more likely to improve self-care after acute discharge
- HH typically drives improved outcomes in terms of wound improvement and healing, breathing, bathing, and reduced pain

**Efficient and Least Costly**
- Among PAC, HH is generally the least costly option
- MC FFS expenditures for patients in home health as first setting after acute discharge are nearly 30% less than patients across all settings

**Patient Preferred**
- Patients prefer in-home service over institutional settings, like a nursing home
- When it comes 24-hour care, nearly 3 out of 4 persons with disabilities prefer service at home
Medicare Advantage: Opportunity or Terror?

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Actual and projected enrollment (in millions)


Actual

Projected

CBO

OACT

NOTE: CBO is Congressional Budget Office; OACT is CMS Office of the Actuary.
Site Neutral Payment Marches Forward

- The IMPACT act required MedPAC to create a site-neutral payment system by 2018 for deployment by 2023

**Payment Model Features**

- Common unit of service (i.e., a stay or episode) with a patient characteristic risk-adjustment system
- Payment adjustment to reflect lower costs in HHA settings.
- Separate payments for routine and therapy services and for non-therapy ancillary services such as drugs
- Outlier policies for unusually high-cost stays and unusually short stays.

*Site-neutral is essentially DRGs for post-acute care – an episodic model that will demand service need evaluation upon admission, proactive LOS management, and aggressive quality/performance management*
Paradigm Shift:
Fundamental change in an individual's or a society's view of how things work in the world.
The Opportunity for Aging Services
Where Things Are Going & Why This Is Important

New Care Delivery Options
Immediate Answers
Mobile Care
Remote Monitoring
Acute Care Clinics

Evolving Workforce
Multi-Disciplinary Teams
Extenders
Care Coordination

Value-Based Payment
Per Patient Payment Goals
Guaranteeing Quality
Embracing Risk

Three New Competencies Needed Over the Next 15 Years

Keeping the healthy out of trouble
Helping people manage their risk factors and chronic conditions
Better managing the sickest 5-10% of patients so they don’t need frequent ED visits and hospitalizations and don’t consume excessive resources

Source: HFMA Leadership Bulletin, April 2015
• Many health systems, ACOs and payers are only beginning to grapple with social determinants as the critical element of population health success.

• Roughly 80% of health outcomes are derived from issues and settings outside traditional “control”.

• These big players will depend on allied organizations to be successful for their populations and their risk.
Acuity Stepdown Drives Need for Care Management

- As financial pressures mount, the system is pushing care and service “down” to lower cost settings. Ensuring successful (i.e., quality) delivery between these multiple settings and improving communication will require enhanced care management.
### Evolving PAC Networks Will Only Increase Expectations

#### KEY FUNCTIONS

<table>
<thead>
<tr>
<th>PACN 1.0</th>
<th>PACN 2.0</th>
<th>PACN 3.0</th>
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| - Understanding sponsor challenges and needs  
- Developing selection process  
- Engaging in discussion and selecting – initial agreements  
- Identifying basic quality measures  
- Starting initial work together – transfers, clinical education, manual data sharing, MD/NP coverage  
- Stumbling but learning from the bumps | - Working towards greater integration – clinical redesign, evidence-based pathways  
- Expanding quality measures  
- Deploying care mgmt. oversight  
- MD/NP integration with PAC  
- Migrating from manual to automated data exchange and quality reporting  
- 1st generation data-driven QAPI platform  
- Anticipating the bumps | - Increasing clinical intensity for complex populations and concurrent quality measures  
- Consistently stepping down PAC use to lower levels: LTACH > SNF  
- Employing gain-sharing or other alternative payment arrangements  
- Bi-directional data and quality availability; predictive functionality  
- Eliminating the bumps |

#### Decreasing Utilization/Readmission/Cost

- **storming**
- **norming**
- **performing**
Primary Care: The “Health Home”
MDs/NPs/PAs | PCMH | Integrated EHR | Patient Accountability

Wellness (Prevent)
- Health risk assessments
- Labs and Diagnostics
- Weight loss programs
- Personal wellness coaches
- Fitness and exercise
- Senior Centers
- Smoking cessation programs
- Local fitness centers
- Community clinics
- Independent senior housing
- Adult day programs
- Social networking groups

Chronic Care (Manage)
- Home-delivered care (HHA)
- HCBS | PACE | MMLTC
- Assisted Living
- Care Management
- Hospital
- Physician office
- Group visits
- Self management
- Nurse/Health Coaches
- Telehealth/Behavioral monitoring

Avoid at all costs

Acute
- Inpatient Acute Care
- Long-Term SNF
- LTACH | IRF
- Emergency Room

Avoid at all costs

Aging Services Thinking in a New Landscape
Alignment Healthcare – Care Management

- Care manages patients and risk across the continuum, using an advanced clinical model, IT and enablement systems, risk experience, and capital by integrating with hospitals, physician groups, health plans, and employers
- **An advanced clinical model, IT and enablement, risk experience and capital** to tackle challenges of population health across multiple settings and site of care
- **Accepts financial risk** through full-risk, joint venture, and care-as-a-service arrangements with hospitals, physicians and health plans
Landmark – In-Home Primary Care & Management

- House Call program provides home-based medical care to individuals with multiple chronic conditions to ensure continuity of primary care services.
- Conducts scheduled and urgent house calls 24/7 through a team of physicians and nurse practitioners.
- Collaborates to deliver comprehensive care in the home using a team of physicians, nurse practitioners, behavioral health specialists, pharmacists, dietitians, and social workers.
What Should We Be Doing?
“HOPE IS NOT A STRATEGY.”

USAF Special Ops pilot
Risk

Reward and volatility
Diversified Payor Mix Will Demand More Rugged Infrastructure and Skills
Success Hinges on Consistency and “Stickiness”

- **STANDARDIZATION!**
  - Developing evidence-based clinical pathways to support common patient diagnoses and deploying evidence-based protocol and tools to manage high-acuity patients
  - Evaluating cost structures, expense relationships, consistent supply chain management, and getting as lean as possible
  - Being smart about managed care contracts, bundled payment arrangements and preferred provider agreements
  - Re-engineering intake processes for “churn and burn”
  - Centralizing contract management, authorizations and service determinations to inform practice and track costs
  - Growing beyond EHR to informatics to predict and drive CQI, rather than retrospective QA
Making Housing More than Shelter Is Key!

Senior customers will want more than just a space. Forward-looking providers must:

• Integrate aspects of population health and chronic disease management into a proactive model of senior housing service.

• Abandon any notion of “levels of care” tied to a physical location.

• Integrate technology across the continuum to monitor clients, deliver medications, foster independence and know WHEN to intervene.

• Recognize that you don’t have to own everything but there is value in leading the collaboration.

Senior housing’s future role in the at-risk and value-based space is only beginning to emerge in many markets
Leverage Your Investment in HIT

• Maximize your use of the functionality inherent in your existing systems – everyone becomes a superuser!
• Use available data, measures and outputs to inform quality and performance improvement on a daily basis
• Seek out the opportunities to participate in emerging HIEs and RHIOs – think towards interoperability
• Migrate outstanding paper-based practices into your HIT systems:
  - Admissions/Intake
  - Service planning and management
  - Patient education
  - Discharge planning
  - Contract management
Understanding the Intersection…

The Partnership Development Matrix

What You Know About Yourself: Your OUTCOMES Your VALUE

What You Know About Others and Their CHALLENGES

HELLO my name is Opportunity
The $4 Billion Threshold

If you’re not big enough on your own, you’re going to need someone else to survive.

Industry pundits say $4-6 billion for a health system.

How much for a post-acute organization?
Isn’t He Done Yet?
Don’t fixate on where you were...
IF YOU DON'T HAVE A PLAN FOR YOURSELF, YOU'LL BE A PART OF SOMEONE ELSE'S.
Questions?
Thank You!

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