Monday, October 14, 2019  11:30 AM

305  Laying the Foundation to Alternative Payment Models
Laying the Foundation To APMs

Introductions

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Payment Reform

Alternative Payment Models
- PDGM

Managed Medicaid

New Technology Requirements
- ACOs
- Advanced APMs

Payment Reform

Chronic Care Management
- CCBHC

Providers Assuming Risk
- Hospice Carve-In Under Medicare Advantage Plans
- BPC
- Bundles
- CCJR

Managed Medicare

Payment that Covers Cost of Service

Risk Continuum

Move Sequentially Through Different Forms of Payments, Each Built Upon the Last

RISK

Complexity

Fee-for-Service
- One service
- One payment

Pay for Performance
- "Upside only"
- Process measures

Case Rate
- Group of services
- Unified payment
- Periodic payment

Bundled Payment
- Bundle of services
- Unified payment
- Quality targets
- Episode-based payment

Capitation
- Full risk
- Population target
- Disease specific/
  All in

Total Health Outcomes
- Shared risk on total
  member experience
### Post-acute Care Integration will be Critical in most Value-Based Care Reimbursement Models

<table>
<thead>
<tr>
<th>Level of Risk Bearing</th>
<th>Pay-for-performance</th>
<th>Bundled Payments</th>
<th>Shared-savings models</th>
<th>Shared-risk models</th>
<th>Full risk models</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital value-based payments</td>
<td>BCPI initiative</td>
<td>Medicare shared-savings program (MSSP) Track 1 (savings only, no downside risk)</td>
<td>MSSP Track 2 (60% sharing)</td>
<td>Next Generation ACO (full risk model)</td>
<td></td>
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<tr>
<td>Hospital readmission penalties</td>
<td>Comprehensive joint replacement (CJR)</td>
<td>Medicare Track 3 (up to 75% sharing)</td>
<td>Medicare advantage (MA)</td>
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<tr>
<td>Hospital-acquired infection program</td>
<td>Cardiac bundles</td>
<td>Next Generation ACO (80-85% sharing option)</td>
<td>Managed Medicaid</td>
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<tr>
<td>Merit-based incentive payments</td>
<td>Movement toward 50% bundled payments</td>
<td>Managed Medicaid</td>
<td>Exchange-based plans</td>
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<tr>
<td>Post-acute readmission penalties</td>
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Note: Risk models highlighted by these boxes indicate post-acute care will be a key focus.

Source: The Advisory Board Company and William Blair

### MIPS/APMS/ Advanced APMS differences

**MIPS**
- Merit Based Incentive Payment
  - Links fee-for-service to quality and value
  - Consolidates Meaningful Use, Physician Quality Reporting System (PQRS), and the Value-Based Payment Modifier into a single composite scoring system

**A-APMs**
- Advanced Alternative Payment Models
  - Value-based incentive models that incentivize providers for quality, outcome and cost containment
  - Includes Accountable Care Organizations (ACOs), Bundles, Medical Homes
Solidify Preferred Partner Position

- Creating Value Through Efficiencies

Connecting Electronically to Referring Health System

- Reduction in acceptance times of 50 to 75%
- Increase in census up to 5 to 10%
- Analyze and report outcome/referral data back referral partners
- Only 7% of SNFs can send, receive, find, and integrate data electronically
- With Carequality, providers are connected to 50% of healthcare, enabling a competitive advantage and expanding referral footprint

Definitions & Evolving Perspectives

Advanced Illness Management

_Palliative Care_: Specialized medical care for people with serious illness. The goal is to improve quality of life for both the patient and family. It is appropriate at any stage of a serious illness and is not tied to prognosis. Palliative care can be offered alongside curative care.

_Serious or Advanced Illness_: One or more severe medical conditions and/or functional decline requiring assistance with activities of daily living, typically leading to at least one hospitalization in the prior 12 months.

Source: Hope Health Care (image); Center to Advance Palliative Care & the Coalition to Transform Advanced Care (definitions).
Taking the Steps Towards Integrated Care

- EHR Vendor Ability
  - Technology Capable To Fit Payors Needs
    - Clinical Design & Workflow
    - Claims specifications
    - Coding Needs

- Internal Facilitator:
  - Hire new / Use Existing Associate
  - Infrastructure Possible from financial perspective
  - Manage Payor Relationship

- Right Model Of Care For Your organization
  - Evolving Perceptions of Care
  - Core Competencies
  - Financial Feasibility

The Opportunity of Palliative Care

- **Increased** quality outcomes
- **Increased** family and caregiver satisfaction and quality of life
- **Improved** communication and adherence to care goals
- **Reduced** overall healthcare utilization (e.g.; ED and IP settings)

*Impact to total cost of care ranges from reductions to cost neutral*

See overview of evidence in appendix
Replicate What Works for High Performance

Once you have established a relationship with one health system, leverage the same concept with other health systems in your area.

Failing to partner with high-value post-acute care providers could result in a length of stay over 34 days versus 24 days at a top performing facility, equating to a $4,000 per-admission cost difference.

<table>
<thead>
<tr>
<th>Length of Stay</th>
<th>Readmission Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>34 days</td>
<td>23%</td>
</tr>
<tr>
<td>24 days</td>
<td>&lt;15%</td>
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</tbody>
</table>

$4,000 differential

High Performers
Low Performers

NAH Core Competencies

- Providing care to patients wherever they call home
- Connecting patients with needed resources
- Serving the whole person and their caregivers
- Coordinating patients’ care to prevent unnecessary utilization of acute care services
- Effective pain and symptom management to ensure better quality of life
- Leveraging technology to connect and monitor patients
Patient Identification & Care Needs

Criteria would be tailored to meet the needs of payors managed care population in Nevada, leading to three potential care model approaches.

Care Model Approaches

**Advanced/Serious Illness Model**

- Advanced illness diagnosis and evidence of active decline, which may include:
  - 2 admits/ED visits in the last 6 months;
  - Progressive and significant decline in last 3 months (measured by ADL limitations or proxy measures such as DME use); and/or
  - Nutritional decline (i.e. weight loss)
- Emphasizes traditional palliative care approach for serious illness with services adapted to address social determinants of health and other conditions
Pt ID & Enrollment (Wk 1)

1. Patient ID & Referral
   - From Payer Palliative Care Case Manager

2. Initial Evaluation Appointment
   - *Intake Staff
   - RN Care Manager

3. Eligibility Screening & Discussion of Program

4. Initial Assessment and Develop POC
   - RN Care Manager

5. Address urgent Medical issues w/providers(s); Refer to pharmacy as needed
   - Provider 1st visit

6. Address urgent psychosocial issues and offer resources for housing, food, mental health issues
   - Provider 1st visit

7. IDT Review and Weekly Case Conference
   - Team

8. Address urgent needs & provide resources housing, food, mental health services
   - SW Care Manager prn

9. Team

Intensive Support (Wk 2-7)

1. RN follow up every wk, alternating between home and telephonic visits in order to:
   - Establish pt centered goals and POC
   - Explore end-of-life care beliefs/preferences
   - Coordinate services to meet basic medical needs

2. IDT Review at Weekly Case Conference
   - Team

3. Address urgent needs & provide resources housing, food, mental health services

4. SW Care Manager prn

5. Team

6. Continue to update PCO, establish relationship, build expectations for patient to call Team when in need

7. Advanced care planning

8. Symptom management; Provider f/u at Week 4 on complex medical management needs & to coordinate with RN Care Manager with all providers on patient’s preferences

9. Review milestones & new issues at weekly case conferences
   - Team
Follow-Up (M 3-10)

• RN follow up every 2 wks, alternating between home and telephonic prn to monitor symptoms & coping status:
  • Provider to stabilize emerging new issues via routine follow up every 6 wks;
  • SW visit prn to revisit advance care planning, Team continues to support patient physically, emotionally, and spiritually

The Team

• Who is involved in advanced illness management?
  – Office Staff
    • Admission Assistant
    • Coordinator
    • Office Manager
  – Clinical Staff
    • Chaplains
    • RN Navigators
    • Social Workers
    • Nurse Practitioner
    • Medical Director
  – Interdisciplinary Team (IDT) Meetings
    • Weekly internally
    • Bi-weekly externally
Support Services Offered

- 24/7 telephone support from the Trusted Partners team
- Coordination of care with outside healthcare providers for everyday needs, including routine wound care
- Regularly scheduled home and telephone visits
- Plan of care focusing on quality of life
- Completion of Advanced Directives
- Health education specific to your illness
- Emotional support for you and your family
- Medication management
- Coordination of resources you need to remain in your home

Acute/Transitional Care

- Notify PCP/Specialist/Oncologist Team

- Initial home visit within 48 hours of referral notification
  - 72 hours for weekend/holiday

  RN Case Manager
Discharge

Death, Hospice or Early Discharge

Early Discharge Process at IDT Case Conference
Scenarios: Pt is actively engaged at clinic or patient no longer benefits from services SW to assist with transition to hospice as needed

Team

RN monitoring to aid in warm handoff to hospice as needed
RN Care Manager

Data and Metrics
From December 2018 to may 2019
Accountability for Outcomes

MEASURING OUTCOMES IS IMPORTANT
The process for selecting metrics involves a collaborative effort to align existing provider and payer federal and state quality measures with program goals.

POTENTIAL METRICS: A Starting Point

<table>
<thead>
<tr>
<th>Process Measures</th>
<th>Outcomes and Utilization Measures</th>
<th>Patient Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Percent of patients for whom all items were done on Comprehensive Assessment Item Set</td>
<td></td>
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<tr>
<td>• Documentation of surrogate decision maker and preferences for life-sustaining treatment (CP, other life supports and hospitalization)</td>
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<tr>
<td>• Documentation of a functional assessment</td>
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<tr>
<td>• Percent of patients with a home visit within 7 days of hospital discharge</td>
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<tr>
<td>• Estimated impact of model to total cost of care</td>
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<tr>
<td>• Risk-adjusted hospitalizations/1000 pts</td>
<td></td>
<td></td>
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<tr>
<td>• Risk-adjusted ED visits/1000 pts</td>
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<td></td>
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<tr>
<td>• Overall satisfaction/willingness to recommend</td>
<td></td>
<td></td>
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<tr>
<td>• Timeliness of care</td>
<td></td>
<td></td>
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<tr>
<td>• Care respectful of values</td>
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POTENTIAL OPERATIONAL MEASURES

<table>
<thead>
<tr>
<th>Market Penetration</th>
<th>Staffing Levels</th>
<th>Partner/Provider</th>
<th>Financial Sustainability</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Number of patients served</td>
<td></td>
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<tr>
<td>• Geographic footprint</td>
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<tr>
<td>• Caseload</td>
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<tr>
<td>• Referral patterns</td>
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<td></td>
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</tr>
<tr>
<td>• Net revenue or loss</td>
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<td></td>
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<tr>
<td>• Donations or investments</td>
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Referrals & Admissions

- **29** Referrals
- **23** Admissions
- **ALOS:** 53.8 days
- Average # of days from referral to admission: **5**
Diagnosis

- 87% of admissions had a CANCER diagnosis

![Diagnosis Chart]

Metrics - Advanced Care Planning

- 14 of 23 admissions completed a POLST form (60.9%)
- 0% patients who died admitted to hospice for less than 3 days
Readmission Rates

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital at least once</td>
<td>21.7%</td>
</tr>
<tr>
<td>Visited the ER without admission to hospital</td>
<td>4.8%</td>
</tr>
<tr>
<td>Readmitted more than once</td>
<td>80%</td>
</tr>
</tbody>
</table>

*Table is based on home admission patients

Question & Answers

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Appendix

Overall effectiveness of palliative care is well-established

<table>
<thead>
<tr>
<th>Measured Outcomes</th>
<th>Evidence</th>
</tr>
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<tbody>
<tr>
<td>Health outcomes positively impacted, including: decreased patient symptoms and pain, increased quality of life, improved physical health, functional/performance status, functional autonomy, psychosocial health, addressed existential or spiritual concerns, created positive health behavior change, and increased death at home and disease control.</td>
<td>Sampson et al., 2005; Finlay et al., 2002; Gomes et al., 2015; Higginson et al., 2016; Kavaleratos et al., 2016; Singer et al., 2016; Zimmerman et al., 2000; Bainbridge et al., 2016</td>
</tr>
<tr>
<td>Quality of care outcomes positively impacted, including: improved quality of care, care planned, clinical adherence to evidence-based guidelines, process quality measures, patient-physician communication, physician-to-physician communication, hospital to home quality, home-based quality and increased rate of advanced directive completion, ACP and DNR.</td>
<td>Finlay et al., 2002; Kavaleratos et al., 2016; Murphy et al., 2016; Stall et al., 2014</td>
</tr>
<tr>
<td>Patient, family caregiver and physician experience improved as well, including: improved experiences and satisfaction of patients, caregivers and physicians and caregiver quality of life. Caregiver burden was also found to be decreased.</td>
<td>Dy et al., 2013; Finlay et al., 2002; Kavaleratos et al., 2016; Totten et al., 2016; Singer et al., 2016</td>
</tr>
<tr>
<td>Utilization and costs decreased: the number and bed days/LOS of hospital admissions, readmissions, ED use, overall health care costs, primary care costs, use of chemotherapy were found to decrease.</td>
<td>Higginson et al., 2010; Totten et al., 2010; Singer et al., 2016; Stall et al., 2016; Stuck et al., 2002; Zimmerman et al., 2000</td>
</tr>
</tbody>
</table>
Opportunities exist for more cost-effective care through Palliative CARE & Complex care management. The table below lists key studies and review articles that examine the impact of palliative care on overall patient costs. While results vary, the addition of palliative care typically either reduces overall costs or is cost neutral.

<table>
<thead>
<tr>
<th>Study</th>
<th>Effect of adding palliative care (per patient)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudat et al 2017 Paliat Med</td>
<td>Final month expenditures were reduced by $4824 ($3379, $6238) and inpatient payments by $6127 ($4874, $7682)</td>
</tr>
<tr>
<td>Sweeney et al 2007 Am J Manag Care</td>
<td>The gross savings in utilizations was more than three times the cost of providing care. Overall costs decreased by 26.1%.</td>
</tr>
<tr>
<td>Lustbader, Mudra et al 2016 Paliat Med</td>
<td>Cost per patient during the final three months of life was $12,000 lower with a Home-Based Palliative Care Program in an ACO than with usual care in the ACO ($20,420 vs. $32,420; p=0.0002)</td>
</tr>
<tr>
<td>Cassel et al 2016 JAGS</td>
<td>Net savings (with program costs), the net savings per participant per month were $4,258 for cancer, $4,017 for COPD, $3447 for HF, and $2,690 for dementia</td>
</tr>
<tr>
<td>Healthcare Transformation Task Force 2016</td>
<td>Wilmington- 18% reduction in admissions, 22% reduction inpatient spending, 9% reduction in total medical spending; Greenville- 25% decrease inpatient utilization, 33% decrease in ED use, 20% decrease in 30-day readmissions, increased discharge satisfaction and transitional care satisfaction; Aetna- Compassionate Care- 3x hospice election rate, 2x hospice LOS, 82% reduction inpatient days, 86% reduction ICU days, 77% reduction ED visits; Blue Shield- $325 million cost savings, 13% reduction in admissions, 27% reduction in hospital days; PBG- Improved PHQ scores 3.1%, 4.2% increase in mental functioning, 3.3% increase in physical functioning</td>
</tr>
<tr>
<td>Kerr 2014 Paliat Med</td>
<td>Cost savings in the last three months of life—$6,804 per member per month (PMPM) cost for palliative care participants versus $10,712 for usual care</td>
</tr>
<tr>
<td>Colaberdine 2016 Paliat Med</td>
<td>Specific to Medicare Advantage members, a telephonic advance care planning program demonstrated cost savings of $13,956 per decedent in the final six months of life compared to control</td>
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</tbody>
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