Post-Acute Care Work Group

January 30, 2017

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Agenda

9:00 - Call to Order and Roll Call – Greg Banaszynski, Chair

9:05 - Welcoming Remarks – Eric Borgerding

9:15 - Work Group Member Introductions – All Work Group Members

9:25 - Background on Post-Acute Care – Laura Rose

10:15 - Post-Acute Care Survey Results – Laura Leitch

10:30 - Identification of Issues – All Work Group Members

11:30 - Next Steps; Plans for Future Meetings – Greg Banaszynski

11:45 - Adjournment

Lunch – Immediately following adjournment

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Work Group Purpose and Goal

- **Purpose**: To explore how WHA can help hospitals and health systems address their post-discharge challenges and opportunities.

- **Goal**: To develop a package of achievable policy initiatives aimed at improving the ability of hospitals and health systems to provide or locate post-acute care for their patients.

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Post-Acute Care and Hospitals

- Medicare reimbursement for P-AC is trending away from site of service, each with their own reimbursement formula, and towards reimbursement based on patient characteristics.
- Use of common patient assessment data across P-AC providers may help with appropriate P-AC placement. (IMPACT Act)
- Greater integration of providers is essential as alternative payment models become more prevalent; hospitals increasingly responsible for outcomes over an episode of care.
- Discharge planning rule - proposed rule issued 11/2015. Not finalized yet.

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Post-Acute Provider Types

- **Long-term care hospitals (LTCH):** A hospital that furnishes extended medical and rehabilitative care to individuals with clinically complex problems, such as multiple acute or chronic conditions, that need hospital-level care for relatively extended periods. To qualify as an LTCH for Medicare payment, a facility must meet Medicare's conditions of participation for acute care hospitals and have an average inpatient length of stay greater than 25 days. Medicare recognized 436 LTCHs in 2011.

- **Inpatient Rehabilitation Facilities (IRF):** Freestanding rehabilitation hospitals and rehabilitation units in acute care hospitals. They provide an intensive rehabilitation program and patients who are admitted must be able to tolerate three hours of intense rehabilitation services per day. IRFs are paid under Medicare's IRF Prospective Payment System (PPS) which went into effect 1/1/2002.

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Post-Acute Provider Types

- **Skilled Nursing Facility (SNF):** An institution that is primarily engaged in providing:
  - Skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and is not primarily for the care and treatment of mental diseases;
  - Has in effect a transfer agreement with a hospital. (Medicare will reimburse for SNF stays following hospital discharge only if the patient had at least a 3 day stay in the hospital.)
  - Meets the requirements for a skilled nursing facility described in 42 U.S.C. 1395i–3.

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Post-Acute Provider Types

- **Home health agency (HHA)**: An agency that:
  - Is primarily engaged in providing skilled nursing and other therapeutic services;
  - Has policies established by a professional group including at least one physician and at least one registered nurse to govern services, and provides for supervision of these services by a physician or a registered nurse; and
  - Maintains clinical records on all patients

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Post-Acute Provider Types

Swing bed hospital: A hospital or critical access hospital (CAH) participating in Medicare that CMS approves to provide post-hospital SNF care and meets the SNF requirements set out in federal regulations.

CAHs that offer swing bed services are exempt from the SNF PPS. These CAHs are paid for their SNF-level services based on 101 percent of the reasonable cost of the services. Non-CAH hospitals offering swing bed services are paid for their SNF-level services under the SNF PPS.

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Numbers of P-AC Providers, Wisconsin

- LTCH: 5 hospitals; 255 beds
- IRF: 3 facilities; 121 beds
- SNF: 372 facilities; 32,854 beds
- HHA: Approx. 154 agencies
- Swing bed hospitals: 58 hospitals

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Post-Acute Care Discharges

- In 2013, 22.3% of all inpatient hospital discharges (7.96 million) were to a post-acute setting.
- Patients whose payer is Medicare have, by far, the greatest percentage of discharges to post-acute care:
  - Medicare: 41.7% of discharges are to P-AC
  - Private insurance: 11.7%
  - Medicaid: 8.1%
  - Uninsured: 4.8%

*AHRQ Healthcare Cost and Utilization Project, Statistical Brief #205, *An All-Payer View of Hospital Discharge to Post-Acute Care*, 2013, May 2016

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Medicare Spending on Post-Acute Care

- P-AC is fastest growing major Medicare spending category.
- P-AC Medicare spending grew from $29 billion in 2001 to $59 billion in 2013.

*MedPAC, Report to the Congress: Medicare Payment Policy, Ch. 7; 3/2015

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Medicaid Spending on Long-term Care, Wisconsin, 2015

- FY 2015 expenditures, Medicaid FFS, all funds,
  - Nursing homes: $608,800,000*
  - Home health AND personal care: $966,312,508**

Source: *Wisconsin Legislative Fiscal Bureau, Informational Paper #41, *Medical Assistance and Related Programs*, January 2017.

**Kaiser Family Foundation, State Health Facts: Distribution of Fee-for-Service Medicaid Spending on Long Term Care, published 12/2106.

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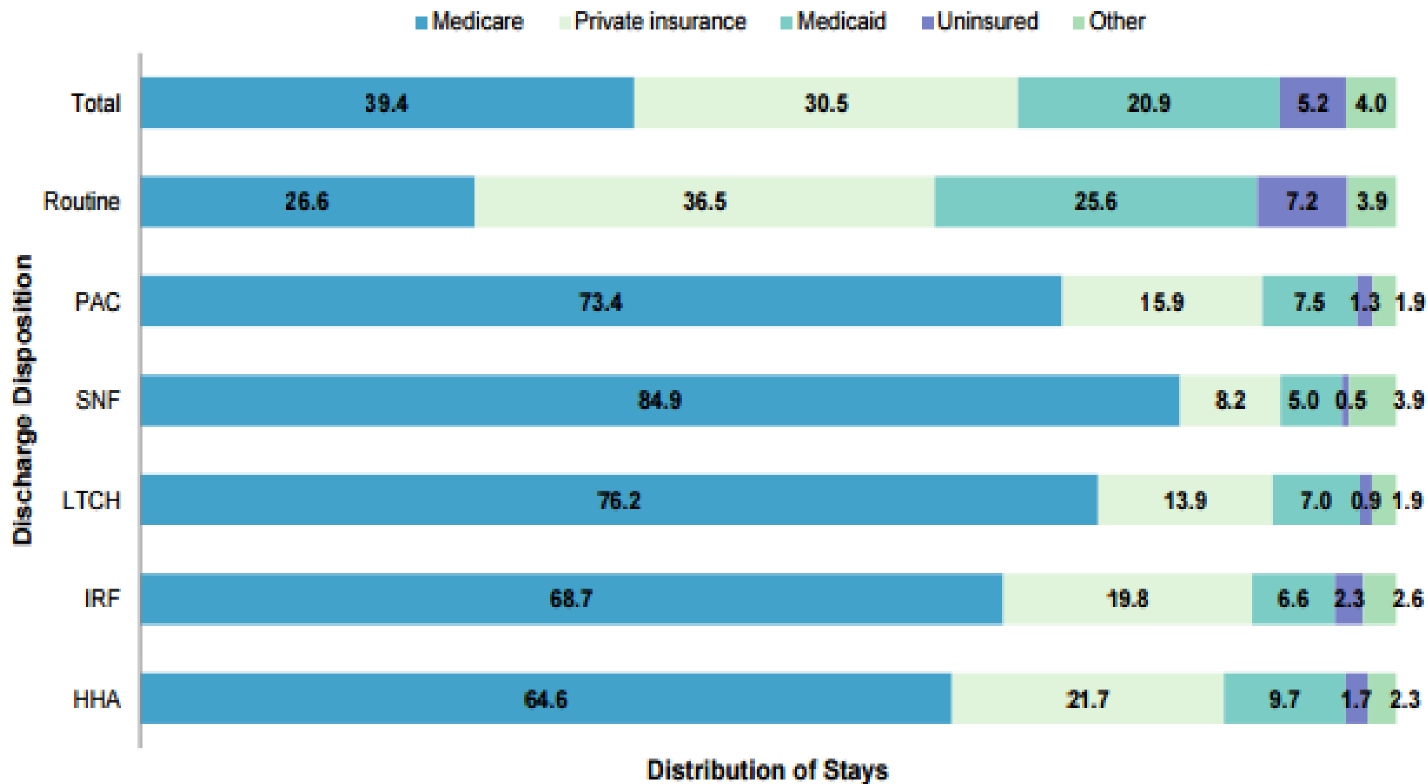
Payer Mix by Discharge Disposition



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Medicare Payment Policies: LTCHs

- To qualify as an LTCH for Medicare payment, a facility must meet Medicare's conditions of participation for acute care hospitals and have an average length of stay greater than 25 days for certain Medicare patients.

- The "25% Rule": Only 25% of an LTCH's patients may be admitted to the LTCH from a single referring acute care hospital during a cost-reporting period without being subject to a negative payment adjustment.

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Medicare Payment Policies: IRFs

- To qualify as an IRF, a facility must meet Medicare's conditions of participation for acute care hospitals.
- In addition, the facility must be primarily focused (e.g., no less than 60% of the IRF's patient population) on treating one of 13 conditions that typically require intensive rehabilitation therapy.

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Medicare Payment Policies: SNFs

- Beneficiaries who need short-term skilled care (nursing or rehabilitation services) on an inpatient basis following a hospital stay of at least three days are eligible to receive covered services in skilled nursing facilities(SNFs). Medicare covers up to 100 days of SNF care per spell of illness. A spell of illness begins with the first day of a hospital or SNF stay and ends when there has been 60 consecutive days during which a patient was not in a hospital or a SNF.

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Medicare Payment Policies: HHAs

- CMS has a prospective payment system (PPS) that pays HHAs a predetermined rate for each 60-day episode of home health care, on patients' conditions and service use, and adjusted to reflect the level of market input prices in the geographical service area. The patient must be homebound.

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Regulatory Issues

- Key Medicare regulations :
  - LTCHs: 25 day average length of stay rule; reduced payment for certain patients transferred to an LTCH from a particular general acute care hospital.
  - IRFs: 3 hours of therapy/5 days a week minimum; 60% rule
  - SNFs: SNF 3 day stay requirement .
  - HHAs: Requirement that patients be homebound in order to qualify for services

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MedPAC Observations on Post-Acute Care

- Medicare payments to P-AC providers are too generous.
- System encourages providers to increase payments by making certain patient care decisions.
- Biases in payments systems make certain patients and services provided to them more profitable than others.
- Despite increased costs, quality of care had not improved.
- The need for P-AC is not well defined.
- Medicare per capita spending on P-AC varies more than any other covered services. High Medicare margins relative to other settings.

MedPAC Report to Congress, March 2015, ch. 7.

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Value-Based Purchasing

- Important for P-AC because payments are tied to value rather than volume; measures in VBP initiatives include episodes of care that extend beyond the hospitalization period into the P-AC setting.
- VBP refers to a broad set of performance-based payment strategies that link financial incentives to a provider's performance on a set of defined measures in an effort to achieve better value by driving improvements in quality and slowing the growth in health care spending.
- Hospital value based purchasing ties a small % of a hospital's payments to quality metrics (75%) and Medicare spending per episode (25%).

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VBP, P-AC, and Hospitals

Guide beneficiaries to high-value PAC providers

- Hospitals are at risk for PAC care but lack clarity on what they are allowed to do to guide beneficiary decisions
- Explore options to allow "soft steering"
- Need to ensure
  - Beneficiary choice
  - Physician input
  - PAC networks are adequate and include high-value providers

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VBP Initiatives Affecting Post-Acute Care Landscape

- Bundled Payments (such as Comprehensive Care for Joint Replacement; Bundled Payments for Care Improvement)
- ACOs
- Hospital Readmission Reduction Program
- IMPACT Act

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Bundled Payments Initiatives

- Important for P-AC because the expressed goals of bundled approaches to payment are to improve coordination across the providers engaged in caring for a patient during an episode of care and, in turn, improve cost efficiencies or savings.
- Important for P-AC because payment to providers is based on predetermined expected costs for a group of related health care services, including P-AC.
- Medicare goal: 30 % of all Medicare fee-for-service payments should be made via alternative payment models by 2016 and 50 % by 2018.

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Comprehensive Joint Replacement (CJR) Initiative

- CJR tests bundled payment and quality measurement for an episode of care associated with hip and knee replacements (the most common surgeries for Medicare beneficiaries) to encourage hospitals, physicians, and post-acute care providers to work together to improve the quality and coordination of care from the initial hospitalization through recovery.
- CMS has implemented the CJR model in 67 geographic areas across the U.S.
- Wisconsin mandatory participants (except for certain BPCI participants):
  - Madison, WI: Columbia, Dane, Green, Iowa Counties
  - Milwaukee-Waukesha-West Allis, WI: Milwaukee, Ozaukee, Washington, Waukesha Counties

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Bundled Payments for Care Improvement (BPCI) Initiative

- The three-year initiative (which may be extended by up to two years) links payments for services related to an episode of care that is triggered by a hospitalization. BPCI participants may benefit financially from providing services in the bundle more efficiently and are at risk if their costs for the bundle are higher than a historical benchmark.
- Conditions tested:
  - Acute Myocardial Infarction (AMI) Model;
  - Coronary Artery Bypass Graft (CABG) Model;
  - Surgical Hip and Femur Fracture Treatment (SHFFT) Model; and
  - Cardiac Rehabilitation (CR) Incentive Payment Model

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Accountable Care Organizations

- Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to the Medicare patients they serve.
- When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it shares in the savings it achieves for the Medicare program.
- 4 MSSP ACOs in Wisconsin.
- Important for P-AC because ACOs hold providers financially responsible for the total cost of care and a set of quality measures, which may potentially incentivize post-acute care management.

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Hospital Readmission Reduction Program

- Requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012.
- One in 5 Medicare patients admitted to skilled nursing facilities from hospitals is readmitted to the hospital within 30 days,
- Important for P-AC because hospitals (except CAHs) may be penalized for readmissions that happen 30 days post-discharge for certain conditions.
- Hospitals activities that may lower readmission rate include: clarifying patient discharge instructions; coordinating with post-acute care providers and patients' primary care physicians; and reducing medical complications during patients' initial hospital stays.

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Literature Review and Recent Study

- RAND Corporation, *Measuring Success in Health Care Value-Based Purchasing Programs,* 2016
- Recent JAMA Study:
  - During a time period in which Medicare payments for joint replacement episodes increased by 5%, bundled payment for procedures at a 5 hospital system in Texas was associated with substantial hospital savings and reduced Medicare payments.
  - Decreases in P-AC spending occurred only when it was included in the bundle.

Source: January 03, 2017: *Cost of Joint Replacement Using Bundled Payment Models* (JAMA Intern Med. doi:10.1001/jamainternmed.2016.8263)

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IMPACT* Act of 2014

- Attempts to implement standardized assessment data across all P-AC settings, rather than the current system.
- PAC providers must submit patient assessment data using uniform tool beginning in 2018; HHS Secretary must recommend a uniform payment system for P-AC based on two years of uniform patient assessment data; probably not until 2023.

* Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014.

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Selected State Policies Affecting Post-Acute Care

- Post-acute provider Medicaid reimbursement rates.
- Other Medicaid policies.
- Potentially Preventable Readmissions (PPR).
- SNF statewide bed limit; construction moratorium.
- Workforce issues.

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Medicaid Pay-for-Performance (P4P)

- Currently: Potential for recoupment of payment if the external quality review organization determines a discharge from a hospital was medically inappropriate and patient needed to be readmitted.
- Readmission within 30 days used as a measure for FFS P4P.

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Potentially Preventable Readmissions

- New PPR policy will replace the current FFS P4P program; PPR output will provide actionable data for providers to drive improvement.
- In CY 2017, DHS will evaluate the PPR model results in collaboration with WHA and report to hospitals and HMO plans.

Medicaid Reimbursement of Post-Acute Providers

- IRFs: Rehabilitation hospitals are reimbursed for inpatient services on a per diem basis. The rate is set at 85% of the average daily cost of serving Medicaid patients.
- SNFs: Nursing homes are reimbursed on a daily rate for care provided to Medicaid recipients according to a prospective payment system that DHS must update annually. Rate incorporates case-mix and consideration of 5 cost centers.

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Medicaid Reimbursement of Post-Acute Providers

- HHAs: DHS establishes maximum allowable fees for all covered home health services provided to Wisconsin Medicaid members.
- Providers are required to bill their usual and customary charges for services provided.
- For each covered service, the DHS shall pay the lesser of a provider's usual and customary charge or the maximum allowable fees established by the DHS (is almost always the latter).

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Medicaid Certification Requirements

- In addition to federal Medicaid regulations, providers must meet additional state-level regulations for Medicaid certification:
  - Rehabilitation hospitals: approved as a general hospital under s. 50.35, Stats., and ch. DHS 124, including the requirements for rehabilitation services under s. DHS 124.21.
  - Nursing homes: licensed pursuant to s. 50.03, Stats., and ch. DHS 132.
  - Home health agencies: licensed under DHS 133, and meet additional requirements in DHS 105.16.

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Requirements for Prior Authorization or Physician's Order

- Prior authorization, generally: DHS 107.02(3)
- Prior authorization, Home health agencies: DHS 107.11(3)
- Services requiring a physician's order or prescription: Skilled nursing services in a SNF; Home health agencies services: 107.02(2m)

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SNF bed availability

- SNFs are a primary location for post-acute care, but:
  - The number of skilled nursing home beds in Wisconsin has declined between July 2003 and July 2013 by 6,577 beds, or 16 percent.
  - A moratorium on nursing home bed construction has existed since 1981.

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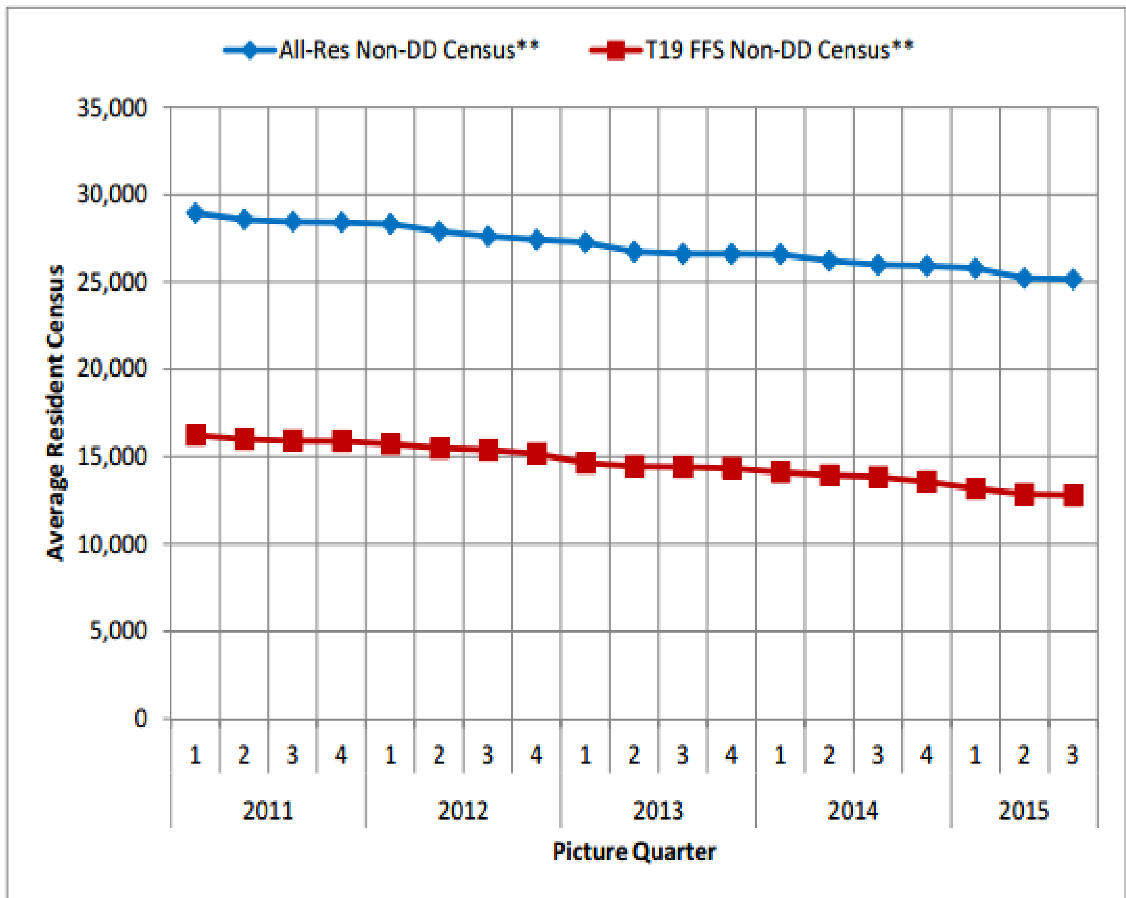
Nursing Home Census Trends

Wisconsin Nursing Home Census Trend*

Year	Quarter	All-Res Non-DD Census**	T19 FFS Non-DD Census**
2011	1	28,957	16,231
	2	28,574	15,996
	3	28,453	15,900
	4	28,416	15,881
2012	1	28,319	15,719
	2	27,889	15,497
	3	27,625	15,389
	4	27,415	15,164
2013	1	27,265	14,649
	2	26,732	14,441
	3	26,609	14,409
	4	26,613	14,339
2014	1	26,585	14,107
	2	26,217	13,941
	3	25,989	13,828
	4	25,922	13,554
2015	1	25,784	13,172
	2	25,215	12,847
	3	25,153	12,797



Post-Acute Provider Workforce Issues

- The median hourly starting wage for personal caregivers is $10.75, compared to $12.00 for local, non-health care employers seeking unskilled, entry-level workers.
- Nursing facilities vacancy rates, 2016:
  - 12.6% for registered nurses (RN),
  - 12.1% for licensed practical nurses (LPN),
  - 14% for certified nurse aides (CNA), the primary caregivers in nursing facilities.

Source: LeadingAge, WHCA, RSA and WALA; The Long Term Care Workforce Crisis; 2016.

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Post-Acute Provider Workforce Issues: Nurses

Age 55 & over by work setting	55 and over	55 and over %	Average Age
Academic education	778	45.8%	52
Ambulatory care	3,666	30.1%	46
Home health	1,221	33.6%	48
Hospital *	7,496	21.9%	42
Nursing home/extended care	2,061	33.8%	47
Public/community health	1,076	41.5%	50
Other	2,178	43.8%	51

*Data from the 2016 RN re-licensure survey reveals that registered nurses working in hospitals are on average the youngest group in the state

Creation of Preferred Post-Acute Networks : Preferred Criteria

- Easy access for hospital patient discharges:
  - Geographic access for all patients.
  - Admissions allowed 24/7.
  - Start of home care within 24 hours of hospital discharge.

Source: AHA Trendwatch, December 2016

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Preferred Criteria

- Compliance with federal and state regulations.
- Lower than average survey deficiencies:
  - For SNFs: at least a 3 start quality rating
  - Separate unit for P-AC patients with ACO or health system physician serving in the SNF
  - 24/7 RN care provider and 1:15 RN/P-AC patient ratio.
  - Use of INTERACT 3.0 tools

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Preferred Criteria

- Common outcomes measures that may be collected monthly, and may be aggregated for comparison purposes:
  - 30 day hospital readmission rates.
  - Patient/family satisfaction ratings.
  - ED visits, especially within 3 days of admission to P-AC venue.

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WHA Post-Acute Care Survey Results

Fall, 2016

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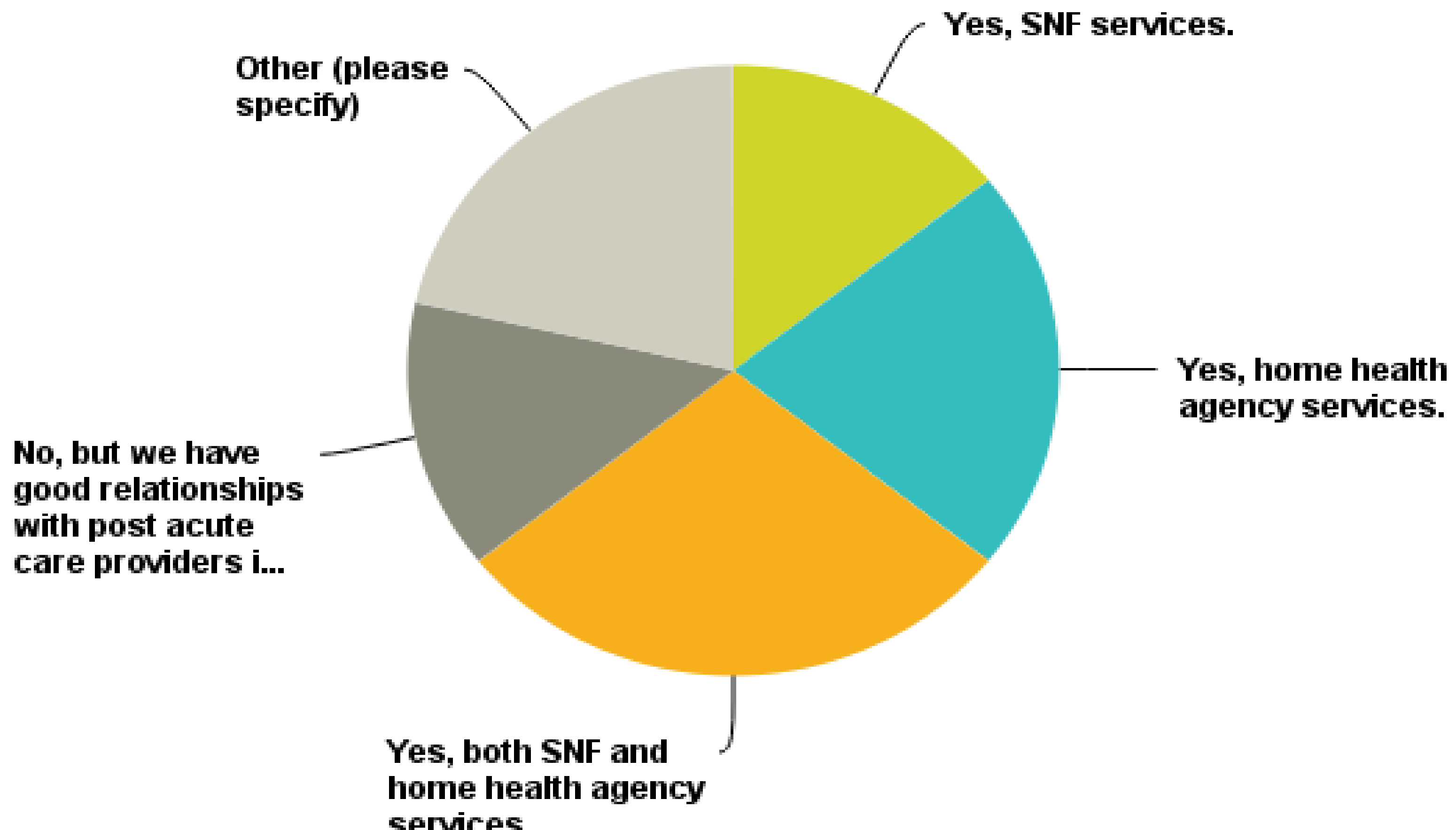
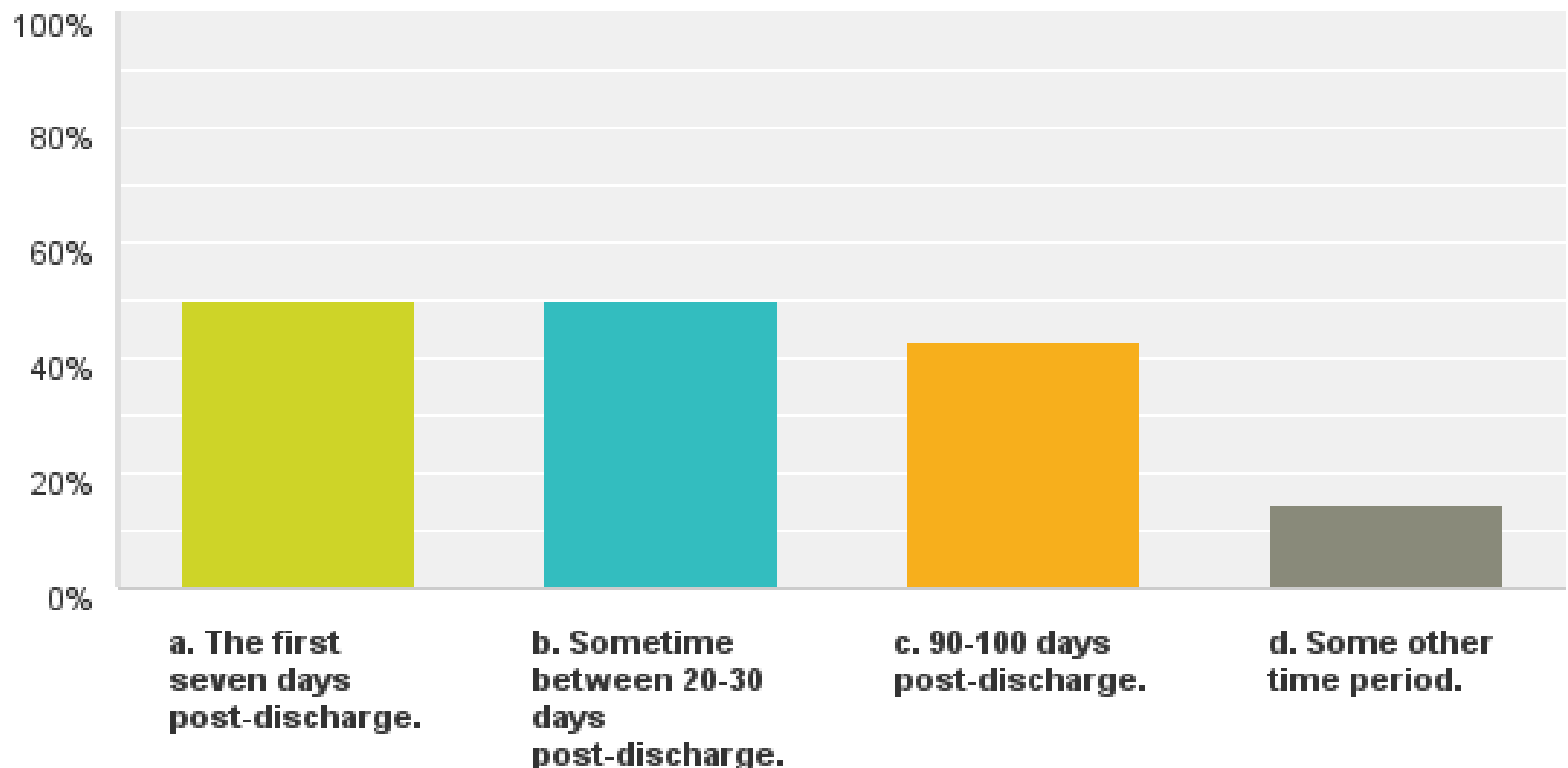
Q2 Does your organization provide post acute care services?

Answered: 14 Skipped: 0



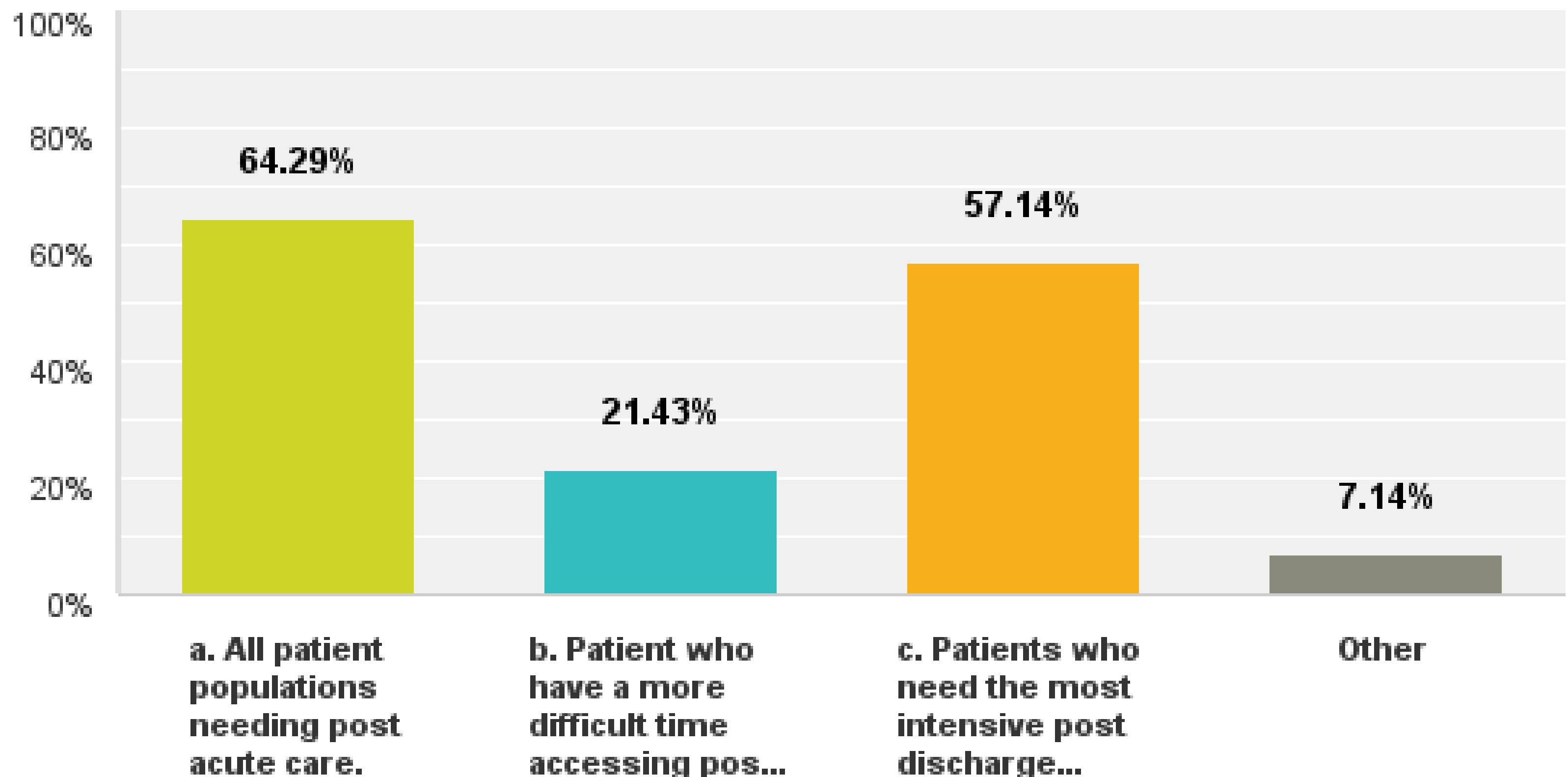
Q3 Please complete the following sentence: WHA's post acute care agenda should focus on the following time period (you may enter more than one answer):

Answered: 14 Skipped: 0



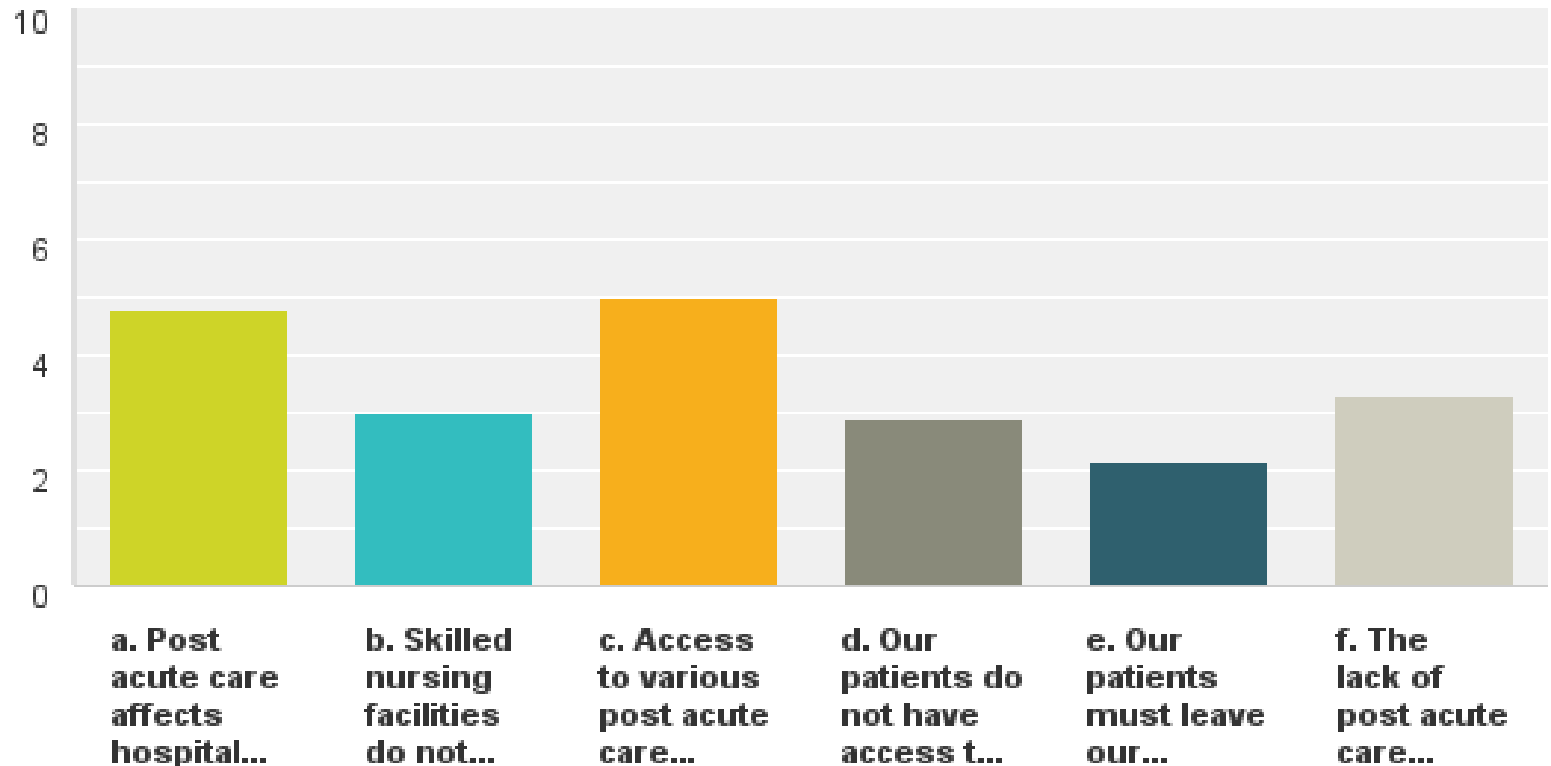
Q4 Which populations should be the focus of the post acute care agenda? (you may choose more than one response)

Answered: 14 Skipped: 0



Q5 Why is it important for the hospital/system community to work on post-acute care issues? Please rank the following from most (#1) to least important.

Answered: 14 Skipped: 0



Why is it important?

5. Access to various P-AC options is key to our discharge planning.

4.79. Post acute care affects hospital reimbursement through bundled payments, penalties and incentives.

3.29 The lack of P-AC options results in people overusing inpatient and outpatient hospital services.

Why is it important?

3. SNFs do not necessarily provide the level or frequency of services patients need post-discharge.

2.92 Our patients do not have access to PAC that allows them to stay in their home even when home care should be an option.

2.5 Our patients must leave our community to receive care in a SNF.

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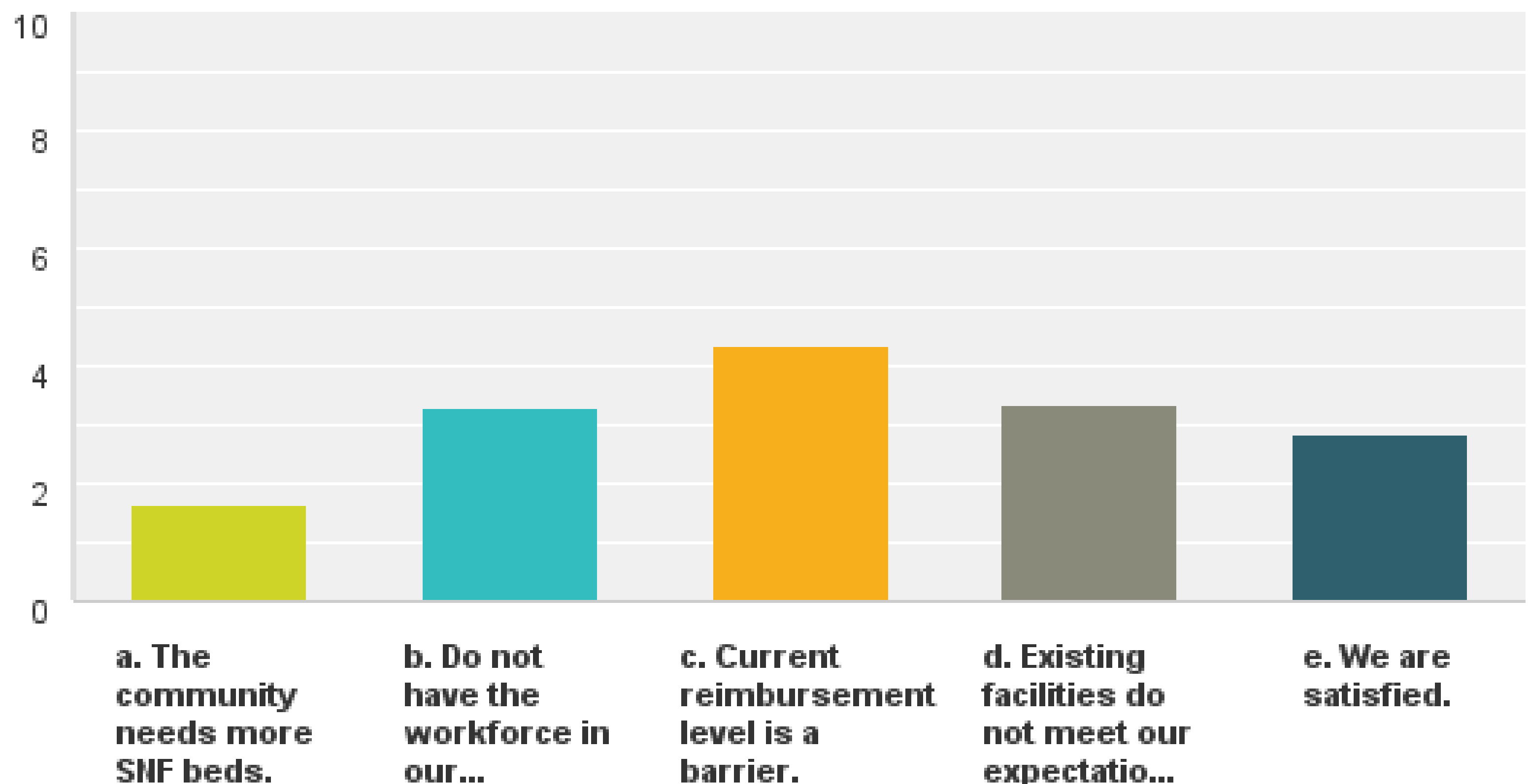
Q7 What are some of the impediments to organizations providing needed post acute care in your community? Please rank the following from most (#1) to least important.

Answered: 14   Skipped: 0



Other barriers

- Volume of regulations across settings.
- Lack of understanding of cost effectiveness of P-AC.
- EHR connectivity.
- Better incentives for SNFs to work with hospitals.
- Physicians don't understand or lack familiarity with P-AC services.

Challenges next 5 years

- Providing appropriate care for difficult populations.
- Reimbursement and staffing.
- Regulatory environment. Mega rule.
- Home care not available or affordable.
- Align hospital and SNF incentives.
- Management structure to manage bundled payments.

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