paccr
Post-Acute Care Center for Research

[Become a PACCR Member!]

TRANSLATING POLICY TO PRACTICE

MARCH 2015, ISSUE 6

See Us In Action!

Upcoming Events

Mar 19-20: CASA California Summit of Corporate ASC Leaders

Mar 26: ASA Aging in America Conference, Potential and Strategies for Care Coordination in a "Post-Acute Care" World Symposium

Apr 21: National CRT Leadership and Advocacy Conference

Previous Engagements

Feb 24: Health Dimensions Group, The National Summit: The Pursuit of Value

Mar 5: Our Aging Market: Why Businesses Need to Respond

Mar 18: The Vision Group: The Evolving PAC Landscape

Happenings at paccr

The spring-like weather here in Washington, D.C. must mean it is time for another SGR debate. While the speculations continue about a patch versus a longer-term fix, the current patch will expire on March 31, 2015, leaving just days for a solution to be agreed upon. Because of the rapidly evolving discussions, we will use Twitter (@PAC_CR) to provide relevant and confirmed updates.

Aside from the SGR debate, organizations are contemplating the new, "Next Generation ACO" model and preparing to launch the BPCI initiative on April 1st. We are excited to see just how many providers and systems actually move forward into Phase 2, the risk-bearing portion of the initiative. Currently, there are over 2,000 organizations in Phase 1 for Model 2 while Model 3 has over 4,500 organizations in Phase 1. Organizations can also move into Phase 2 in July. Stay tuned- we will provide analysis on the participation within BPCI and among the 48 episodes.

And just this week, (Monday, March 16th) the House unanimously passed the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act. The Act (H.R. 876) requires hospitals to verbally and in writing notify beneficiaries within 36 hours of their observation status. Under observation status, beneficiaries are not eligible for SNF coverage. The Act is a stepping stone in the right direction to the promotion of patient engagement. This bill is now set to move to the Senate.

Faculty Spotlight

We are thrilled to focus this month on Dr. Margaret (Peg) Terry, the Vice President of Quality and Innovation at the VNAA, and the leader in the development of the Blueprint for Excellence. The Blueprint for Excellence for Home Health Transitions of Care and Hospice and Palliative End of Life Care provides research and current evidence-based practices to guide workforce development and performance improvement. Dr. Terry is working with researchers, clinical experts and VNAA member agencies across the country to build on the Home Health Transitions of Care work with a new Clinical Conditions Workgroup. This group is developing best practices for clinical conditions in home health including HF, Diabetes, COPD and Hips and Knees. A second group is developing evidence-based practices for remote patient monitoring. She also oversees the development of the only Clinical Procedure Manual for home health and hospice.

April Webinar Announcement

Trying to identify high value home health providers in your local market? Come learn how the national home health experts define high quality care. Margaret (Peg) Terry (Ph.D., R.N.), of the Visiting Nurse Associations of America (VNAA) and leader in the development of the Blueprint, will speak about the national Blueprint for effective home health, hospice, and palliative care. For ACOs, home health, hospice and palliative care providers, the VNAA Blueprint for Excellence provides a training curriculum to promote best practices. For patients, these tools are a mechanism to identify exceptional care. This national blueprint can help you achieve the Triple Aim and decrease health care costs by improving overall health and care delivery. Tune in to PACCR's "VNAA Blueprint for Excellence" webinar, on Tuesday, April 28th, at 12:00 pm EST. Register now!

MedPAC March 2015 Report to Congress

On Friday, March 13th, MedPAC released its March 2015 Report on Medicare Payment Policy. Chapter 7: Medicare's post-acute care: Trends and ways to rationalize payments, opened with the unanimous recommendation that "The Congress should direct the Secretary of Health and Human Services to eliminate the differences in payment rates between inpatient rehabilitation facilities (IRFs) and skilled nursing facilities for selected conditions. The reductions to IRF payments should be phased in over three years. IRFs should receive relief from regulations specifying the intensity and mix of services for site-neutral conditions."

A few other notable takeaways from Chapter 7 include:

- Medicare's payments to the more than 29,000 PAC providers totaled $59 billion in 2013, more than doubling since 2001.
- Medicare paid for 9.6 million PAC encounters (IRF and LTCH discharges, home health episodes, and SNF stays) in 2013.
- About 42 percent of all beneficiaries enrolled in fee-for-service (FFS) Medicare and discharged from an acute care hospital in 2013, went on to post-acute care: 20 percent were discharged to a SNF, 17 percent were discharged to an HHA, 4 percent were discharged to an IRF, and 1 percent were discharged to an LTCH.
- The most notable trend in the PAC program spending was the high and sustained level of Medicare margins (a measure that compares program payments with the costs to treat its beneficiaries) relative to other settings. For example, Medicare margins for HH and SNFs have been above 10 percent every year since 2001.

How PACCR webinars fit into broader research agenda

Come join us to learn about current issues in Medicare PAC payments, quality, and access to care. PACCR's webinar series provides the latest thinking from national leaders in each of these areas. Data standardization underlies all these issues, including payment equity, quality/outcomes, cost-effective treatments, appropriate discharge placements. Send us your requests for future webinars.

Bundled Payments for Care Improvement: Year 1 Evaluation

On February 27th, the Lewin Group released the Year 1 Evaluation and Monitoring Annual Report for BPCI Models 2-4. The three CMS evaluation and monitoring questions establish the framework for annual report:

1. What are the characteristics of the program and participants at baseline and how have they changed during the course of the initiative?
2. What is the impact of the BPCI initiative on the costs of episodes, the Medicare program and the quality of care for Medicare beneficiaries?
3. What program, provider, beneficiary, and environmental factors contributed to the various results of the BPCI initiative?

This first year report is largely descriptive as the small sample sizes proved difficult to draw any statistically significant findings. There were 8 active Awardees with nine hospital Episode Initiators in Model 2 of the BPCI initiative in Q4 2013 that participated in 34 of the 48 clinical episodes. There were six Model 3 Awardees with nine Episode Initiators in Q4 2013, participating in six clinical episodes and only one active Awardee in Model 4 with one clinical episode. Despite the lack of statistically significant findings, there are still interesting points to be garnered from the report and a summary of the Model 2 and Model 3 report, along with the URL for the complete report can be found on our website.

MedPAC March 2015 Report to Congress (cont'd.)

- The Commission's analysis indicates that, if some portion of site-neutral cases shifted to SNFs, the SNF industry would have the capacity to treat these cases. In 2012, although the average SNF occupancy rate was high (82 percent), the additional volume associated with movement of site-neutral conditions from IRFs to SNFs would be small relative to total SNF volume. Furthermore, one-quarter of SNFs had occupancy rates at or below 76 percent, indicating capacity to treat additional cases.
- The Commission's review of private sector practices suggests that further efforts to improve the management of PAC services in FFS are possible. A refined referral process, one that better supports beneficiary choice by providing beneficiaries with better information about available providers, could encourage the use of higher quality providers. These approaches could be particularly appropriate for ACOs or other models of delivery reform where hospitals and other providers are at risk for the cost of care and quality indicators. Other changes may include aligning incentives for referring physicians and beneficiaries.

MedPAC made several other recommendations, including;

- A 3.25% update to inpatient and outpatient hospital payment rates for 2016, concurrent with changes to the outpatient payment system.
- A reduction or eliminating differences in payment rates between outpatient departments and physician offices for selected ambulatory payment classifications.
- Reducing payment for LTCH services furnished to patients whose illness is not characterized as chronically critically ill (CCI) to the same rate that an acute care hospital would be paid for such care under the IPPS.
- Eliminate the SNF market basket update and the 2016 update for LTCHs, hospices, and outpatient dialysis services.
- Eliminate the Ambulatory Surgical center payment update for 2016 and require submission of cost data.
- Eliminate the home health market basket update for 2016, rebase rates, and revise the home health case-mix system to rely on patient characteristics to set payment for therapy and non-therapy services, and expand medical review activities and exercise program integrity authorities.

CMS Observations: ACO Activity

As you have heard by now, the CMS announced a new ACO model. But, what does this mean? The new, "Next Generation ACO Model" is intended to provide an avenue for risk-hungry organizations to continue to adopt value based models. The Model offers organizations a choice between two arrangements; one with increased shared risk for Part A and B, and one with full risk for Part A and B. The Next Generation Model offers several waivers as well- increased access to home visits, broader adoption of telehealth services, patient incentives, and increased coordination between the ACO and CMS. The majority of Medicare beneficiaries won't participate under this ACO model, given CMS is intending for only a handful of organizations to have the capabilities to succeed- under this model. The Model will kick-off on January 1, 2016 with LOI's due by May 1, 2015. This model joins the other five CMS ACO models; Medicare Shared Savings Program, Pioneer ACO, Advance Payment ACO, ACO Investment Model and ESRD Care Initiative. And, if there was a question about whether ACO's are here to stay, the six models from CMS alone, suggest ACO's might be here to stay after all.

Subscribe to our mailing list!

Need more information?
Visit us at PACCR.org or contact us at PACCR@PACCR.org
Follow us on Twitter! @PAC_CR