

## **Innovations in Post-Acute Care: A National Perspective**

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I appreciate the opportunity to share my experience in the evolving national discussion of how to control cost, improve patient centered services, and improve quality of care in the post-acute care space. Post-acute care appears to be the next frontier for exploration seeking opportunities to slow the growth in the cost of health care. I'm sure you are well aware of the forces driving the threats to state and national economies of growing health care costs:

- Demographics, fastest growth in the “old-old” population,
- Rapidly evolving new technology and drugs that are highly targeted, and generally very expensive—science driven super specialty practice
- Concentration of cost in those with multiple chronic diseases
- Uncounted costs of care-giving
- Dementia & serious mental illness

I'm not sure as to the scope of work for this committee, but I would like to start with some perspective on the boundaries of post-acute care. Most policy makers have some period of time in mind following discharge from the hospital when thinking about post-acute care. Sometimes, post-acute episodes of care are defined to include the “index” hospitalization. However, that approach to defining a post-acute episode, includes re-hospitalization, and it is a bit difficult to sort out a chain of hospitalizations. The rate of re-hospitalization is generally the policy target for saving money, the assumption being that some proportion of hospitalizations could be averted. This view of post-acute care tends to focus attention on hospitals, skilled nursing and home health providers and cost. The decisions about which services are used, however are generally made by patients, their families, and their physicians. So the challenge to changing the landscape in post-acute care really begins outside the provider settings.

I note that you had a presentation earlier today by a transitional care organization. “Transitional care” is a concept and service continuum with deep roots in organizations that have coordinated care for elderly and disabled people for decades, mostly outside the framework of national policy and funding. There is currently a demonstration project launched by CMS to test transitional care models. In 2012, the American Medical Association approved a CPT® code to allow physicians to be paid for non-face-to-face services to coordinate care for patients transitioning from the hospital or skilled nursing facility to home with Medicare payments for these services beginning in 2013. Insurance companies have long used case managers to coordinate care for high cost cases. Area Agencies on Aging have long provided information and referral services to help families and others obtain information to coordinate care, and some have offered coordination services, largely limited by lack of funding. Sectarian and other non-profit organizations offering social services have provided some forms of transitional care and care coordination for individuals and families seeking their assistance. And county adult protection agencies have provided some services to vulnerable elderly, mentally ill, and disabled adults in need of assistance, though these agencies have been starved of the funding they need to maintain reasonably sized case loads. Some charitable foundations provide grant funding to organizations that provide some types of transitional care service, though not necessarily only for hospital or SNF transitions: some of

these target particular underserved groups or communities. Federally funded community and rural health centers have a long tradition of offering some outreach and social services, again subject to very limited funding. So there is a long tradition of providing pieces of transitional care and care coordination services through a patchwork of federal, state, and local funding.

Based on my own experience of documenting model programs for Federal agencies and charitable foundations in the 1990s, there is no lack of highly effective and low cost models for delivering these services. They have simply not been the focus of national policy, and have lacked a sound funding source. There is also no obvious system to connect individuals and families to these coordinating services where they exist, although recently internet and telephone based services have begun advertising to the public that they can provide some of these services. Most of these services are not regulated, monitored for quality, or subject to scrutiny for standards of practice.

In 2014, Medicare began paying for physician services to coordinate care for individuals with multiple chronic diseases. In 2016, in American Medical Association meetings, agenda indicate that a broader batch of new codes are in development to pay physicians for other services that involve different elements in coordination of care. The product of this work could emerge by 2018 or so. Once the AMA approves new codes, and develops payment levels for Medicare, other payers often adopt and provide payment for these new activities. So Federal policy is just beginning to validate the role of physicians in providing care coordination services to smooth gaps in care when patients transition from one provider to another, or when patients receive care simultaneously from multiple providers. However, these physician delivered services are still not linked to services provided in the voluntary sector, through insurance case managers, or by demonstration projects. There remains no national policy with a focus on coordination of care that preserves the role of the patient, family, and physicians in decisions about care delivery.

What appears to be the focus of national policy in the post-acute space, is a series of regulatory innovations and new payment mechanisms. So let's review these. In many cases, an innovation is tested in one corner of the health care system and then rolled out across the different legacy and fractionated parts of the health care system, and then embedded in any new alternative payment systems or demonstrations.

- **Value Based Payment:** So, for example, the first value based purchasing program where quality was used as the basis for payment system penalties, was implemented in the End Stage Renal Disease payment system in 2012, then rolled out using different structures into the inpatient hospital prospective payment system the next year, introduced to physician payment in 2015, and currently with a time schedule to encompass post-acute providers (SNF, HH, IRF, LTCH) by 2018-2019. Meantime, the physician payment system was redefined by the federal legislation (MACRA) that eliminated the sustainable growth rate (the infamous SGR) that had projected annual cuts to physician payment, to base all increases in physician payment in future years on value based measures or a high rate of participation in alternative payment systems (APMs) like two-sided risk bearing Accountable Care Organizations (ACOs) and similar innovations. This week CMS and others announced that major insurance organizations have reached a consensus with federal programs on a reduced set of quality measures that everyone will begin to implement. Meantime, CMS has indicated physicians, hospitals, APMs and demonstrations will also incorporate some sort of resource use (efficiency) measures, separate from the "quality" measures, into value based payment. Resource use currently counts for 50% of physician value

based scoring which can lead to payment penalties or incentive payments based on performance, and will decrease to a minimum of 30% of the score with the implementation of the new payment system in 2019.

- **Episode of Care Bundled Payment:** The Bundled Payment for Care Improvement (BPCI) demonstration for Fee-for-service Medicare launched by the Innovation Center within CMS in 2011 with a second round initiated in 2014, has been testing post-acute episode of care payment for 60 and 90 day post hospital discharge periods of time. Most of these demonstrations are hospital-controlled and include the costs of the index hospitalization. Participation by post-acute providers in taking risk has been lower, but some SNF and HH organizations are participating as bundled holders in the model that excludes the index hospitalization. The focus of these demonstrations is on saving money, largely by minimizing re-hospitalizations, shortening SNF length of stay and payments, and some measure of better care coordination, though the latter function remains in its infancy. In 2016, a spin-off of this demonstration is being launched with recent rule-making in 2015, as a new payment system for major joint replacement episodes of care. All of these models involve some level of discount off of historical average payments to save money, and the assumption of risk for the entity that holds the bundle. This payment system names the hospital as the entity that holds the bundle, leaving post-acute providers to find their way into partnerships or relationships with the participating hospitals. This program is being launched in a limited number of geographic areas, but could be expanded nationwide under CMS's authority. Similarly, new episodes of care could be added in the future.
- **Episode of Care Concepts in Value Based Payment:** Under MACRA, the new Medicare physician payment system, a regulatory cycle takes off this spring to define condition based episodes of care that will be used in value based payment: that is physicians managing particular episodes (like hospitalization for heart failure) will be compared to physicians managing the same episodes for quality measurement. These episodes can be acute (short or related to hospitalization or a treatment intervention) or they can be annual for chronic conditions (e.g., diabetes, rheumatoid arthritis).
- **Providing Information on Cost to Physicians:** In 2014, CMS started sending physicians quarterly reports showing all the services and payments for services for Medicare fee-for-service (FFS) patients "attributed" to their practice. Prior to this time, physicians would generally have had no idea what other providers were being seen by their patients, nor would they know the payments made for services, including some of the services they themselves might order (like drugs or diagnostic tests). While individual physicians may have difficulty using these data, physicians are increasingly either becoming part of larger physician or hospital owned organizations, or are contracting with practice management groups, where managers will be learning how to use these data to influence physician practice, particularly as penalties and incentive payment possibilities get larger in the 2020's. Early intelligence from practice managers and larger practices suggest that this information and the potential for payment penalties are leading to cautious attention to cost, with a particular focus on hospitalization, the largest target for cost fluctuations. With more experience, this attention will likely turn to expensive drugs and biologics, skilled nursing, and high cost tests.
- **Providing Information on Cost to ACOs and APMs:** With the implementation of alternative payment models that are expected to assume risk, CMS is also providing updated real time data on cost of all Medicare services for FFS beneficiaries. These initiatives will evolve methods

similar to those long used in commercial and public program managed care organizations to monitor spending and per-capita cost. This will also likely lead to the provision of guidelines and other pressures for participating providers. It is already having significant market influence on decisions about preferred post-acute providers. While hospitals are prohibited by law from requiring patients to use their preferred post-acute providers, “soft steering” practices are reported (encouraging patients to choose preferred providers by the selective presentation of information, or interaction with staff in the hospital). Post-acute providers are also reporting being asked for information about their length of stay, cost, and various other sources of information. Star ratings and other report-card data sources –Nursing Home Compare Website—are also being used to rank potential post-acute providers. “Freedom of Choice”, the hallmark of fee-for-service Medicare and some insurance programs, is increasingly challenged when differences in cost are evident—these freedoms have been foregone in managed care plans.

- **All-Payer Demonstrations:** The Federal government is increasingly attempting to engage commercial payers and Medicaid in consensus around payment policy. The dual eligible demonstrations in a dozen states are attempting to merge/compromise the different rules in Medicare and Medicaid to coordinate care to eligible populations. Other provisions to encourage the development of alternative payment models will likely weight any provisions that can be accepted by both commercial and government payers. Some states are also experimenting with all or multiple payer initiatives. All of these efforts are driven first by cost control, and reference quality, but motives and priorities are clearly about cost. I would expect increased consensus to very gradually emerge around devices like prior authorization, step therapies, and other criteria for the use of high cost care. Coordination of care mechanisms that cross payers are much less evident, and much harder to put into place.
- **Medical Homes:** Both Federal and commercial payers are experimenting with medical home concepts and demonstrations, in which monthly payments are made to physician practices or other medical providers (e.g., community health centers) who assume medical home responsibilities which can include electronic medical records, and increased access to contact with the physician or care team. These initiatives are evolving rapidly in many different forms, and there are, as yet not shared standards or quality measures that are distinctly assigned to “medical homes”. The heart of the medical home concept is to have coordinated care run out of the medical home. With new payments for physician practices for some of these services, this coordination may become more hardwired. At present it is difficult to see any standards for coordinated care emerging.
- **Longer Term Post-Acute Payment:** An integrated post-acute payment system is on the horizon for Medicare FFS beneficiaries, but still a long way off. Plans for such a payment system are assigned to the Medicare Payment Advisory Commission in the early 2020’s, and there is no clear consensus on what such a system should look like. Post-acute providers, are, however, concerned that this payment system will give post-acute funds to hospitals to control, without their having a real stake in transforming the higher cost parts of the post-acute care system in which they operate. Note that about 60% of Medicare beneficiaries discharged from hospitals go home without any of the hospital, SNF, or home health services, so hospitals are not presently heavily invested or experienced with post-acute care planning or management.

There are some clear challenges to advancing post-acute payment that protects patient rights and quality of care. Some of the concerns you should have in mind include:

- **The “Pot of Gold” Syndrome:** Some entrepreneurs and venture capitalists view the post-acute space as a target for short term profits. Third party organizations have “swooped” into the Federal demonstration arena to offer to take all or some of the risk for participating post-acute providers, in exchange for a variety of trade-offs. Entrepreneurs are offering hospitals and post-acute providers new tools, products and services. Some are offering “big data” solutions (most of which are not sensitive to local health care system characteristics or variations). Some are offering soft-ware and other sorts of information system tools to monitor or choose preferred post-acute providers, or to sort through the cost data to suggest targets for influencing provider behavior. Some offer streamlined telephone care management services. Some may have excellent capabilities, but others have no relevant experience, and offer slick materials and promises that eventually prove impossible to live up to.
- **Local Resources May be Neglected:** In many communities, the voluntary and public sector have long offered some of the services needed to coordinate post-acute care. Often these services are time tested and include experienced professionals, but similarly they are often limited to small segments of a community and have limited or vulnerable funding. Attention to the established medical provider community of hospitals, nursing homes, home health agencies, and others may by-pass or duplicate the value offered by these local resources.
- **Financial interests of Risk Bearing Entities need to be Balanced with Patient Rights and Quality of Care:** Most of the attention to post-acute payment policy involves an implicit conflict of interest between the risk-bearing entity and the decisions about care for the patient. Federal policy makers have leverage with the providers who are subject to risk and so tend to allow them to increase the “soft steering” element in patient selection of provider. Managed care and other full risk programs also tend to penalize patient choice when it does not conform to preferred provider agreements. At the same time, “strings” can be included in preferred provider agreements that mitigate various forms of free choice by the patient, family, and physician. Theoretically, quality measurement and value based payment policies are supposed to balance these conflicts. However, the state-of-the art in quality measurement and value based payment remains crude, and there are not, at present, good surveillance systems to monitor for bad actors. Feedback loops and whistle blowers in the context of federal demonstrations have identified some of the risks associated with these conflicts of interest, garnering some attention by demonstration leaders, but there is, as yet, no clear policy that separates, or negotiates risk bearing interests in savings from patient decisions and interests. Further, crude measures of performance like the STARS ratings or length of stay data, which are not sensitive to clinical complexity, case mix, or specialized clinical practice, may result in business decisions that adversely impact some providers and deny appropriate services to some patients.
- **The Focus of Federal Policy is Only Tangentially Sensitive to Evolving Challenges Associated with the Aging Population in Dementia and Mental Health Care:** Dementia can be demonstrated to increase many costs of care relative to those without dementia. The health care system generally fails to support families and individuals with dementia, as there are few or no treatments that change the course of the disease. Until such treatments are available, many of the impacts of dementia on medical care are not studied or understood, and most family resources remain in the Medicaid and voluntary sector where they are seriously underfunded.

The stress on families and family care-giving impinges on the health of aging care-givers in ways that may exacerbate ill health and erode quality of life contributing to increased health care costs in the long run. Some long term care policy is attempting to address some of these needs, but in general the medical system is not paying attention. In our research we can demonstrate, for example, that dementia is strongly implicated in higher costs of post-acute care whenever any rehabilitation is part of that care. While we have pointed this out to CMS in many areas, dementia is not being used to risk adjust or payment adjust care, so incentives remain for providers at risk to avoid patients with dementia. Similar problems exist for the aging mentally ill, and for mentally ill disabled patients depended on the Medicare, Medicaid, and VA programs for services. For a sub-population of Medicare beneficiaries with mental illness diagnoses, our research shows two or more hospitalizations per year, for both psychiatric and medical reasons, most of which could have been avoided with appropriate psychiatric medication management and primary care, neither of which are provided on any regular basis for this population. For both populations with dementia and severe mental illness, extremely high costs of care could be avoided by appropriately designed medical home programs, and care-giver supports. While there are a limited number of demonstrations targeting these populations, they don't get mentioned in the larger debate about post-acute care.

So, to summarize, there is a lot of innovation going on in Medicare payment policy designed to influence all payers and provider behavior. While a great deal of investment is going on in quality, the quality work is not targeting the risks of payment policy innovation associated with the real complexities and vulnerabilities of patients. It is relatively easy for payment policy to create inadvertent incentives to avoid high cost or un-attractive patients, leaving many of the most costly and vulnerable patients and their families underserved or inappropriately served, with unacceptable human cost.

There is also a lot of similar innovation going on in commercial programs and in some states. No independent broker is funded to look across the nation at innovations to identify which hold promise, or to identify the inadvertent problems that emerge. Hence, there is no coordination across all this innovation. Insufficient information in the market of health care innovation makes it difficult to place investments where they will have the most payoff on long term improvements in the health of the US population.

At the state level, you may be able to take a statewide view of what is unfolding for your citizens, and perhaps begin to target your resources to fill gaps, strengthen existing resources in your communities, address conflicts of interest, and protect your citizens against inadvertent bias.

I would be happy to take any questions.