THE IMPACT OF VALUE BASED MEDICINE ON POST ACUTE AND LONG TERM CARE MEDICINE

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Subjects

• What is Value Based Medicine (VBM)?
• Traditional Medicare trends and issues
• Newer models that pay for Quality and Fiscal Responsibility
• Eventually new payment models for care post-acute and long term care (PA/LTC)
What is Value Based Medicine

• VBM is the practice of medicine based upon the objective value (improvement in length-of-life and/quality-of-life) conferred by healthcare interventions as determined by utilizing a set of standardized parameters commonly used to evaluate value and cost-effectiveness.

• Medical care that emphasizes both evidence based medicine and cost-effective care
  • Best: High quality, low cost
  • Worse: Low quality, high cost
Problems with Current Fee for Service (FFS) Medicine

• Encourages overutilization to maximize profit
• Good and bad doctors paid the same
• No quality determination
• Total cost of care per episode illness not considered
• No allowance for any coordination of care, telephone calls, or other non-face to face time crucial to good care coordination
CMS Attempts to Improve FFS Codes

Current Codes
- Annual Wellness Exams
- Transition of Care Management

New Code 2015
- Chronic Care Management

Proposed Code
- Advance Care Planning
Transitional Care Management Services Codes (99495 and -96)

- As of January 1, 2013, Medicare pays for combined face to face and non-face to face physician and staff service of complex patients recently discharged from hospital, LTAC, or skilled nursing facility.
- Medicare will pay between $164 and $231, depending on the complexity of the patient, for care during the 29 days after the discharge date.
Transitional Care Management Services Codes (99495 and -96)

- Non-face-to-face services that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his/her direction:
  - Staff services: medication adherence, education of patients / caregivers e.g. self-management, HHA communication, facilitating access to care.
  - Physician services: discharge information review, diagnostic test follow up, community resources referrals, educating patients / families, interaction with other health professionals
Transitional Care Management Services Code 99495

- 99495 - Moderate complexity patients
  - Requires physician / staff to make direct contact, by phone or electronically, with the patient or caregiver within 2 business days of discharge.
  - A face-to-face visit with the patient is required within 14 calendar days of discharge.
Transitional Care Management Services Code 99496

• 99496 - High-complexity patients
  • Requires direct contact with the patient or caregiver within 2 business day
  • Face-to-face visit within 7 calendar days

• Both codes billable by only one party (PCP or specialist) in the outpatient setting
• Requires medication reconciliation and any needed coordination of care
Chronic Care Management (CCM) Code

- CMS finalizing details, will pay in 2015

- Pays for services (physician and staff) furnished to patients with multiple complex chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation / decompensation or functional decline
CCM Requirements

- Services include regular development and revision of a plan of care, communication with other treating health professionals, and medication management
- Two or more chronic conditions
- Services available on a 24/7 basis
- EHR capabilities
- Prior discussed requirement for NP/PA, Medical Home dropped
- Accepting suggestions for further requirements
- Twenty minutes of more time per month required
- Pays $41.92 per month per qualified patient
Proposed Advance Care Planning Code

• Not approved by CMS
• Not fully valuated
• No plans for implementation 2105
• Would pay for $1/2$ hour a year for more difficult cases of advance care planning (e.g. code status, discussion and finalizing advance directive) in face to face manner
• Difficult “sell” with “death squad mentality”
Problems with New Codes

- Will add to total expenses of patient care
  - Will theoretically lower payment of other codes
- Not proven to be of value in practice
  - Does it improve transitions of care
  - Does it decrease re-hospitalizations / Part A&B costs?
  - What is the value to the patient?
- May be under utilized / not accomplish goals
Problems with the Status Quo: SNF/NF Costs and Quality 2000-2010

• Avoidable Re-hospitalization rates unchanged
  • CHF, Respiratory infection, UTI, Sepsis, Fluid/Electrolyte Imbalance
  • 18.4 % to 18.7%

• Community discharges unchanged 2000-2010
  • 24.6% to 24.8%

• Expenditures higher
  • 27% more with minimal change in covered days
Outpatient vs. Inpatient Expenditures

June 2013 Healthcare Spending and the Medicare Program, MedPac
Home health care and skilled nursing facilities fuel growth in Medicare’s PAC expenditures
Physician Services – Utilization Growth of MFS Services All Sites

2013 RUC Database
## Summary, Nursing Facility Family E/M Services 2009-2014

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2011</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Services</strong></td>
<td>22,740,267</td>
<td>24,873,607</td>
<td>26,244,294</td>
</tr>
<tr>
<td><strong>Charges</strong></td>
<td>1,587,498,025</td>
<td>1,905,820,590</td>
<td>2,193,727,594</td>
</tr>
<tr>
<td><strong>Increase</strong></td>
<td><strong>9.4%</strong></td>
<td><strong>20%</strong></td>
<td><strong>15.4%</strong></td>
</tr>
</tbody>
</table>

Source: CMS Website: Research and Statistics, Medicare Part B Utilization,
Other Fiscal Facts Affecting PA/LTC

• Practitioner visit types changing 2009-2012
  • Number of IM / FP visits flat
  • NP / PA / PMR visits up about 45%
  • NP/PA visits constitute 25% of all PA/LTC visits
• Number of SNF and Volume little changed
• SNF Medicare margins have increased
  • 2005 – 13.1%
  • 2010 – 18.5%
### Post-Acute Care – A Large $$ Component of Average Beneficiary Expenditure

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Yearly Costs</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Services</td>
<td>10,520</td>
<td>3117</td>
</tr>
<tr>
<td>E/M</td>
<td>1,090</td>
<td>319</td>
</tr>
<tr>
<td>Procedures</td>
<td>768</td>
<td>259</td>
</tr>
<tr>
<td>Hospital</td>
<td>2566</td>
<td>1025</td>
</tr>
<tr>
<td>Outpt Service</td>
<td>2595</td>
<td>1252</td>
</tr>
<tr>
<td>ER</td>
<td>260</td>
<td>93</td>
</tr>
<tr>
<td>All Ancillary</td>
<td>972</td>
<td>301</td>
</tr>
<tr>
<td>Post Acute</td>
<td>1,634</td>
<td>1555</td>
</tr>
<tr>
<td>Other</td>
<td>636</td>
<td>636</td>
</tr>
</tbody>
</table>

*2012 QRUR Report*
So What Does This Mean for the PA/LTC Physician?

- CMS is unsure of the value obtained from increased use of SNF and HHC services compared to decreased hospitalization.
- CMS is unsure of the value of increased prescriber services in PA / LTC.
- Current systems are not addressing quality and cost concerns in LTC and should be fixed.
- Paying for quality and controlling costs (ACA and HiTech acts) are seen as solutions.
“Measures are the New Currency”

3 Goals of Healthcare Reform:
1. Improve Quality
2. Improve Population Health
3. Decrease Cost of Care

6 National Priorities
- Safer Care
- Engage Patients and Families in their Care
- Communication and Coordination of Care
- Promote Best Practices
- Population Health
- Make Quality Care Affordable (spread new delivery models)
A Physician’s New Reality

- PQRS
- EHR
- eRX
- Pay for Performance
- Meaningful Use
- ACOs
- VBM or VBP
- Care Coordination
CMS NH Programs to Improve Quality

- Physician Quality Reporting System (PQRS)
- Value-Based Modifier
- Quality Assurance & Performance Improvement (QAPI)
- Partnership to Improve Dementia Care
- ACOs
- Bundled Payment for Care Improvement Initiative
EHR Incentive Program (Meaningful Use)

- MU Incentive per Eligible Providers (EP) varies from $4,000 to $21,500 a year depending on Medicare or Medicaid program and on years of participation - ends in 2014.

- EPs who are eligible for both PQRS and the EHR meaningful use (MU) program may participate in both programs and earn incentives for both.

MU Hardship Exemptions

Had to apply for hardship exceptions by July 1, 2014:

1. **Infrastructure** EPs are in an area without sufficient internet access or face insurmountable barriers to obtaining infrastructure.

2. **New EPs** Newly practicing EPs who would not have had time to become meaningful users.

3. **Unforeseen Circumstances** Examples may include a natural disaster or other unforeseeable barrier.

4. **EPs meet the following criteria:**
   - Lack of face-to-face or telemedicine interaction with patients
   - Lack of follow-up need with patients

5. **EPs who practice at multiple locations must demonstrate that they:**
   - Are unable to control the availability of CEHRT for more than 50% of patient encounters
PQRS for PA/LTC Practitioner

- PQRS is happening NOW
  - 2% penalty in 2016 for those not reporting in 2014
- 284 measures currently available
  - 39 individual measures apply to the nursing home setting covering 5 national quality domains
  - 7 Measures Groups apply to the nursing home setting

- For 2014 must report on minimum of 9 measures across 3 national quality domains on 50% of all Medicare Part B patients OR
- Report on 1 measures group and report on at least 20 patients most of which should be Medicare Part B FFS patients
Value-Based Payment Modifier (VBM)

- VBM assess both quality of care furnished and the cost of that care under the Medicare Physician Fee Schedule.
  - CMS is mandated to begin phase-in of VBM in 2015, complete by 2017
  - CMS is proposing implementation of the VBM to be based on participation in PQRS.
  - CY 2015 VBM will apply only to groups of 100+
  - For CY 2016, proposes to apply to groups of 10+ but only groups of 100+ could get payment adjustment up to 2%
Use domains to combine each quality measure into a quality composite and each cost measure into a cost composite.

- Clinical care
- Patient experience
- Population/Community Health
- Patient safety
- Care Coordination
- Efficiency
- Total per capita costs (plus MSPB)
- Total per capita costs for beneficiaries with specific conditions

Quality of Care Composite Score

Cost Composite Score

VALUE MODIFIER AMOUNT
Quality Tiering Approach

- Two composite scores based on the group’s **standardized performance** (e.g. how far away from the national mean).
- Group cost adjusted for group specialty composition

<table>
<thead>
<tr>
<th>Quality/cost</th>
<th>Low quality</th>
<th>Average quality</th>
<th>High quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low cost</td>
<td>0.0x</td>
<td>+2.0x*</td>
<td>+4.0%*</td>
</tr>
<tr>
<td>Average cost</td>
<td>-2.0x</td>
<td>0.0%</td>
<td>+2.0%*</td>
</tr>
<tr>
<td>High Cost</td>
<td>-4.0%</td>
<td>-2.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Eligible for an additional +1.0x if average beneficiary risk score in the top 25 percent.
# 2012 Quality Tiering Results

Percent All Physicians in Each Group

<table>
<thead>
<tr>
<th>Quality / Cost</th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Cost</td>
<td>0.3</td>
<td>3.4</td>
<td>0.8</td>
</tr>
<tr>
<td>Average Cost</td>
<td>3.3</td>
<td>80.6</td>
<td>3.9</td>
</tr>
<tr>
<td>High Cost</td>
<td>3.7</td>
<td>3.9</td>
<td>0.2</td>
</tr>
</tbody>
</table>
# Quality and Practice Make-up

<table>
<thead>
<tr>
<th>Group</th>
<th>Low</th>
<th>Average</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9% PCP</td>
<td>5%</td>
<td>76%</td>
<td>14%</td>
</tr>
<tr>
<td>10-49% PCP</td>
<td>7%</td>
<td>88%</td>
<td>3%</td>
</tr>
<tr>
<td>50-79%</td>
<td>7%</td>
<td>88%</td>
<td>2%</td>
</tr>
<tr>
<td>80-100% PCP</td>
<td>25%</td>
<td>68%</td>
<td>2%</td>
</tr>
<tr>
<td>≥ 80% Same Specialty</td>
<td>10%</td>
<td>63%</td>
<td>22%</td>
</tr>
</tbody>
</table>

*FY2012 QRUR Experience Report*
## Cost and Practice Make-up

<table>
<thead>
<tr>
<th>Group</th>
<th>Low</th>
<th>Average</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9% PCP</td>
<td>10%</td>
<td>75%</td>
<td>8%</td>
</tr>
<tr>
<td>10-49% PCP</td>
<td>3%</td>
<td>89%</td>
<td>6%</td>
</tr>
<tr>
<td>50-79% PCP</td>
<td>1%</td>
<td>87%</td>
<td>10%</td>
</tr>
<tr>
<td>80-100% PCP</td>
<td>1%</td>
<td>60%</td>
<td>36%</td>
</tr>
<tr>
<td>≥ 80% Same Specialty</td>
<td>15%</td>
<td>57%</td>
<td>16%</td>
</tr>
</tbody>
</table>

FY2012 QRUR Experience Report
### Costs and Risk, Age

<table>
<thead>
<tr>
<th>Quality Tier</th>
<th>Low</th>
<th>Average</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost ($) 2012</td>
<td>5,775</td>
<td>10,013</td>
<td>21,621</td>
</tr>
<tr>
<td>Risk (Average HCC)</td>
<td>0.88</td>
<td>1.06</td>
<td>1.74</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>65-74</th>
<th>75-84</th>
<th>85-94</th>
<th>≥ 95</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost ($) 2005</td>
<td>6078</td>
<td>8608</td>
<td>10,935</td>
<td>11,515</td>
</tr>
</tbody>
</table>

FY2012 QRUR Experience Report

Evaluation of the CMS-HCC Risk Adjustment Model March 2011
Problems with VBM & PA/LTC

- PA/LTC patients are among the sickest and highest cost patients (top 5%) — problem in cost and utilization comparison under VBM score
- Highly variable care goals between care settings
  - Must have Quality Measure and Value Based System that account for these factors
  - Site of service must be considered as a factor in calculating VBM scores
Alternatives to VBM Quality Tiering

• Alternative Practice Models
  • Accountable Care Organizations (ACO) most common
  • Specialty Specific Models
  • All must take risk

• OR - Don’t participate, accept penalties, no potential increases, retire early
Accountable Care Organizations

• As of March 2013: There are 3.2 million Medicare beneficiaries are receiving care from providers in shared savings initiatives in 47 states.

• Even if you are not part of such a network, NHs and Medical Directors really must be familiar with these payment models – otherwise you risk being merely a “contracted vendor”

• Still being analyzed as to their overall benefit – cost savings, care improvement
Accountable Care Organizations

MSSP and Pioneer ACO Counts by County
(counties with more than 1 percent of an ACO’s assignees)
ACOs and LTC

- Applicability and models for LTC still not well developed
- Models of risk sharing not well developed
  - Bundled within or outside of episode of illness
- Still working with CMS on beneficiary assignment and exclusivity issues
  - PCP designation – can only belong to one ACO
  - Specialist – can serve more than one ACO
ACO Effect on LTC

- ACOs generally review parameters suggesting success
  - Rehospitalizations
  - Length of stay
  - Quality measures
  - Star rating
  - Special programs, capacity
  - Proximity
- Most will downsize the numbers of home used
### Key to ACO Success

#### Annual Hospitalization Rate in FY 2011

<table>
<thead>
<tr>
<th>Annual Hospitalization Rate</th>
<th>% Homes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Above 50 percent</td>
<td>0.6</td>
</tr>
<tr>
<td>40 to 49.9 percent</td>
<td>6.2</td>
</tr>
<tr>
<td>30 to 39.9 percent</td>
<td>22.1</td>
</tr>
<tr>
<td>20 to 29.9 percent</td>
<td>39.9</td>
</tr>
<tr>
<td>10 to 19.9 percent</td>
<td>26.9</td>
</tr>
<tr>
<td>Less 19.9 percent</td>
<td>4.3</td>
</tr>
</tbody>
</table>

20.4% SNF patients are re-hospitalized within 30 days
Key to ACO Success
Avoidable NH Hospitalizations

• Medicare spent $14.3 billion on NH resident hospitalizations in 2011
• Between 40- 60% of all hospitalizations may be avoidable
• 72% of all avoidable hospitalizations are due to 4 common conditions:
  • Pneumonia (30.5%)
  • Congestive heart failure (16.8%)
  • Dehydration (12.9%)
  • UTI (11.7%)
Accountable Care Organizations

LTC Issues - Attribution

- ACOs assign each patient / data to one physician – done through a process called “attribution”
- Attribution = Whoever makes plurality of visits per year
- Primary care physicians can only belong to one ACO, so attribution = must belong to that ACO
- Nursing home codes are included in family of PCP codes
- SNF patients in particular will be a problem if receiving patients from multiple systems – theoretically will need a doctor for each system served
- AMDA has proposed separating out NH codes OR SNF-POS as a non-primary care code (or making SNFist specialists)
Accountable Care Organizations
LTC Issues - Exclusivity

• Theoretically regulations allow non-primary care physicians to practice in multiple ACOs – however with time CMS is applying exclusivity more broadly than it had indicated in the final rule effectively precluding any practice that performs E&M services from full-fledged participation in more than one ACO regardless of specialty.

• AMDA has proposed CMS consider site of service in determining which E/M codes are counted as primary care – NF = exclusivity but SNF= no exclusivity

• CMS has yet to officially address the issue in any rulemaking.
Specialty Specific Models

- Alternative Practice Models that are designed and approved by CMS
- Usually disease and time limited
- AMDA is considering such models
  - Dementia care
  - Hip Fracture care
  - Pneumonia / infection models
  - CHF / dehydration models
Problems with Quality Metrics and PA / LTC

• No metrics require use of an EHR – BUT all are designed with presumption of EHR use (reward the compliant)
• Movement of PQRS program into eCQMs (electronic clinical quality measures)
  • eCQMs run in ‘background’ – like NSA surveillance
• Current measures not LTC friendly
• Lack of adequate PA/LTC – Pharmacy interface hampers quality metric development
PA/LTC Medication Management Issues in VBM

- Counts in your Quality Score
  - All our Part D prescriptions are tracked
    - Beers List counts against you
  - CMS will soon get SNF Rx history, too.
  - EHR QMs also track use of High Risk Meds

- LTC Physicians need better tools to manage medication use –
  - Requires Pharmacy & Facility Partnership
  - Exchange of electronic med lists
Current Status of PQRS / eCQM & PA/LTC

- Limited number of PQRS measures which may be appropriate for PA/LTC (46/284)
- Some current eCQM may be contrary to best PA/LTC practices
- AMDA has a Quality Measures Group to define measures that will work for PA/LTC population
- AMDA meeting with CMS officials to discuss concerns (measures development expensive)
- Will concentrate on eCQMs
Current Examples of CQMs Appropriate for PA/LTC

- Advance Care Planning
- Influenza
- Wound Care – Use of Surface Culture
- Wound Care – Use of Wet to Dry Dressings
- Fall Risk Assessment
- Falls: Plan of Care
- Atrial Fibrillation/Flutter and Chronic anticoagulation
Current Examples of CQMs Appropriate for PA/LTC

- Diabetes HgbA1C goal
- CAD and antiplatelet use
- Left Ventricular Function Assessment
- CAD and beta blocker therapy
- LVEF < 40% and ACE/ARB Use
- Heart Failure and ACE/ARB use
- Heart Failure and Beta Blocker use
- CAD and symptom management
Current Examples of “Group File” CQMs Appropriate for PA/LTC

- Dementia Group
- Hypertension Group
- Coronary Artery Disease Group
- Parkinsons Group
- Heart Failure Group
- CKD Group
- Diabetes Group
So what are appropriate eCQMs?

- No low lying fruit – if everyone can easily do it, it doesn’t measure quality
- Should be consistent with evidence based medicine
- Should fit an identified gap / need
- Needs to be measurable
- Improvement should be achievable
Nursing Home Value Based Purchasing

• Protecting Access to Medicare Act 2014 (PAMA)
• Puts a value based system into place for SNF

Deadlines

• October 2016
  All Cause Readmission Rate developed
• October 2017
  Publically reported on Nursing Home Compare
• October 2018
  Reimbursement partially dependent on metric
  2 % withhold on all SNF payments
  50-70% returned to the higher performing SNF
  CMS keeps the other 30-50%
  40% of SNF will not get full return of 2% payment
Main Issues for PA/LTC Professionals

- Need to ensure PA/LTC physician fit value-based quality initiatives
- Need appropriate quality measures written for the PA/LTC population
- Need to align physician quality measures with nursing home quality priorities
- Adequate measure risk adjustment to account for PA/LTC population
- Cost and resource use comparison groups need to account for PA/LTC population differences
- Need to ensure PA/LTC physician have an appropriate peer comparison group
Main Issues for PA/LTC Professionals

• Incentivize PA/LTC to adopt meaningful HIT use
• For now - exclude PA/LTC professionals from penalties that they have no control over (i.e. meeting current EHR Incentive Program requirements)
• Ensure seamless integration with pharmacy
• Advocate for appropriate measures in new systems (eCQM)
• Consider treating PA/LTC physicians as a specialty
• Determine if PA/LTC would benefit by fitting into an APM models
Hope This is Clearer

If Not – Take Two Tylenol and Call Me in the Morning

PQRS
EHR
eRX
Pay for Performance
Meaningful Use
ACOs
VBM or VBP
Care Coordination