Best Care Practices in the Geriatrics Continuum 2016

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PA/LTC Payment Reform: Making Sense of Value Based Medicine

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Speaker Disclosures

Dr. Crecelius has no relevant disclosures
At the conclusion of this program, attendees should be able to:

- Discuss the forces that make the transition to value-based medicine a necessity
- Understand the different forms value-based medicine will take and the impact it will have on the PA/LTC practitioner
- Relate the impact value-based medicine has on the practitioner to others in the PA/LTC spectrum
- Analyze the purpose of value-based medicine on patient outcomes and care
Problems with Current Fee for Service (FFS) Medicine

• Encourages overutilization to maximize profit
• Good and bad doctors paid the same
• Poor quality determination
• Unable to compare efficiency, costs of care
• Have not kept up with the shift from inpatient to outpatient care
• Newer codes (AWE, TCM, CCM, ACP and upcoming CCCM/others) not proven to be of value
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
Post-Acute Care – A Large Component of Average Beneficiary Expenditures

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Yearly Costs</th>
<th>Variance</th>
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<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>
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<tr>
<td>Hospital</td>
<td>2566</td>
<td>1025</td>
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<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>
Nursing Facilities Fuel Growth in Medicare’s PAC Expenditures

Dollars (in billions)

- All PAC
- SNF
- HHC
- InptRehab
- LTCH

June 2013 Healthcare Spending and the Medicare Program, MedPac
Physician Services – Utilization
Growth of MFS Services All Sites

2013 RUC Database
# Summary, Nursing Facility Family

## E/M Services 2009-2015

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2011</th>
<th>2013</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number Visits</td>
<td>22,740,267</td>
<td>24,873,607</td>
<td>26,294,294</td>
<td>27,558238</td>
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<tr>
<td>Increase</td>
<td>9.4%</td>
<td>15.4%</td>
<td>21.2%</td>
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</tr>
</tbody>
</table>

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

• Practitioner visit types changing 2009-2015
  o Number of IM / FP visits flat
  o NP / PA / PMR visits up about 45%
  o NP/PA visits constitute 30% of all PA/LTC visits
• Number of SNF and Volume little changed
• SNF Medicare margins have increased
  o 2005 – 13.1%
  o 2010 – 18.5%
• About 42% of Medicaid are in managed care
So What Does This Mean for the PA/LTC Physician?

- CMS is unsure of the value re: increased use of SNF, HHC, and prescriber services
- Current systems don’t address quality & cost
- Alternative models are seen as solutions
  - Value Based Model (VBM)
  - Merit Incentive Performance System (MIPS)
  - Alternative Practice Models (APM)
  - Accountable Care Organizations (ACO)
  - Bundled Payments for Care Improvement (BCPI)
  - Managed Care Organizations (MCO)
“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 (new delivery models)
Value Based Medicine = Quality and Cost

• Physician Quality Reporting System (PQRS) is the cornerstone of measuring quality for most systems
  o QM are developed by the National Quality Forum (NQF)
  o eCQM will be new method (surveillance of records)

• Costs are actuarially based
  o Pharmacy costs, DME not always included
PQRS for PA/LTC Practitioner

• PQRS is happening NOW and will continue to be a part of VBM
• 284 measures currently available
  o 39 individual measures apply to the nursing home setting covering 5 national quality domains
  o 7 Measures Groups apply to the NH setting
  o Overall current measures need to be expanded to reflect actual quality in PA/LTC
• Number of measures to be reported changing under VBM and will change under future iterations
So what are “best practice” QMs?

QMs will be important in any model

• CMS encourages development of QMs
• No low lying fruit – if everyone can easily do it, it doesn’t measure quality
• Consistent with evidence based medicine
• Should fit an identified gap / need
• Needs to be measurable
• Improvement should be achievable
• QM will be retired as they are less relevant
New Measures AMDA is Working On

• Group measures
  o Changing Dementia Measures Group to better align with PA/LTC needs
  o Adding Multiple Chronic Measures Group

• Individual Measures
  o Cognitive impairment assessment
  o Depression remission
  o Health proxy for the cognitively impaired
  o Osteoporosis Mgt. for Women with history of fracture (NQF 0053)
  o Unnecessary screening colonoscopies- age >85
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
Say Goodbye to Current Quality & Cost Tiering Approach

- Quality and Cost “tiered” into three groups each
- Group cost adjusted for group specialty composition
- Retired with MIPS which uses continuous scoring

<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.
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a bipartisan legislation signed into law on April 16, 2015

- Repeals the Sustainable Growth Rate Formula
- Changes the way that Medicare rewards clinicians for value over volume
- Streamlines multiple quality programs under the new Merit-Based Incentive Payments System (MIPS)
- Provides bonus payments for participation in eligible alternative payment models (APMs)
MACRA: starting in 2017*, physicians will choose from or land in one of two paths: MIPS or APMs?

* Decisions in 2017 affect payment in 2019
MACRA changes how Medicare pays clinicians.

The current system:

- Services provided
- Medicare Fee Schedule
  - Adjustments
- Final payment to clinician
- Physician Quality Reporting Program (PQRS)
- Value-Based Payment Modifier
- Medicare EHR Incentive Program
MIPS Combines Current Pay-for-Reporting Programs

MACRA gets rid of previous incentive programs
- Physician Quality Reporting System (PQRS)
- Value Based Modifier
- Medicare EHR Incentive

And streamlines it into a new program:
Merit-Based Incentive Payment System (MIPS)
- Quality Measures
- Resource Use
- Meaningful Use Certified EHR
- Clinical Improvement Activities

The Secretary must specify clinical practice improvement activities. Some subcategories are specified in the statute:

**Expanded Practice Access**
- Same day urgent appointments, after hour clinician advice

**Population Management**
- Monitoring conditions, timely intervention; QDR

**Care Coordination**
- Timely communication test results, exchange clinical information, remote monitoring, telehealth

**Beneficiary Engagement**
- Complex patient care plans, shared decision making, self management / training
## MIPS Payment Adjustments

<table>
<thead>
<tr>
<th>Year</th>
<th>Quality Measures</th>
<th>Resource Use</th>
<th>Clinical Improve Activities</th>
<th>Meaningful Use cEHR Technology</th>
<th>MIPS Adjust. Factor (+/-)</th>
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</thead>
<tbody>
<tr>
<td>2019</td>
<td>50%</td>
<td>10%</td>
<td>15%</td>
<td>25%</td>
<td>+/- 4%</td>
</tr>
<tr>
<td>2020</td>
<td>45%</td>
<td>15%</td>
<td>15%</td>
<td>25%</td>
<td>+/- 5%</td>
</tr>
<tr>
<td>2021</td>
<td>30%</td>
<td>30%</td>
<td>15%</td>
<td>25%</td>
<td>+/- 7%</td>
</tr>
<tr>
<td>2022 and beyond</td>
<td>30%</td>
<td>30%</td>
<td>15%</td>
<td>25%</td>
<td>+/- 9%</td>
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</table>

Statute establishes formula for calculating payment adjustment factors relative to performance threshold and established “applicable percent” amounts. EPs receive a positive adjustment factor if score is above the performance threshold and a negative adjustment factor if score is below threshold.
Hold on a minute! CMS now offers a “Pick your Pace Program” for 2017

Due to many concerns about the wide diversity of physician practices and their readiness, CMS is offering four ways to participate in MIPS and avoid any penalties reflected in associated 2019 payments.

• **First Option: Test the Quality Payment Program**
  Submitting some data avoids negative penalty

• **Second Option: Participate for part of calendar year**
  Submit Quality Payment Program information for a reduced number of days – on / after January 1- and receive a small positive payment adjustment.
More MIPS

“Pick Your Pace” Options

• Third Option: Participate for the full calendar year
   Submit Quality Payment Program information for a full calendar year -beginning on January 1, 2017 – and could qualify for a modest positive payment adjustment. CMS expects many will be ready to do so.

• Fourth Option: Participate in an Advanced APM
   If enough of your Medicare payments or your Medicare patients are through the Advanced APM (e.g. MSSP track 3) in 2017, then you would qualify for a 5 percent incentive payment in 2019 and bypass MIPS.
Alternative Payment Models

APMs are new approaches to paying for medical care through CMS that incentivize quality and value.

According to MACRA law, APMs include:

- CMS Innovation Center model (under section 1115A, other than a Health Care Innovation Award)
- MSSP (Medicare Shared Savings Program)
- Demonstration under the Health Care Quality Demonstration Program
- Demonstration required by Federal Law

- MACRA doesn’t change how APMs rewards value.
- APM participants who are not “QPs” will receive favorable scoring under MIPS.
- Only some of these APMs will be eligible APMs.
Most APM physicians / practitioners will be subject to MIPS and will receive favorable scoring under MIPS clinical practice improvement activities performance category. Those in the most advanced APMs may be determined to be qualifying APM participants ("QPs"). QPs:
1. Are not subject to MIPS
2. Receive 5% lump sum bonus payments for years 2019-2024
3. Receive a higher fee schedule update for 2026 and onward

MACRA Provides Rewards for APMs and More Rewards for APM - QP

Potential financial rewards

<table>
<thead>
<tr>
<th>Not in APM</th>
<th>In APM</th>
<th>In eligible APM</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIPS adjustments</td>
<td>MIPS adjustments</td>
<td>APM-specific rewards</td>
</tr>
</tbody>
</table>

If you are a qualifying APM participant (QP)

5% lump sum bonus
How do I become a qualifying APM participant (QP)?

You must have a certain % of your patients or payments through an eligible APM:
- 25% in 2019 & 2020

QPs will:
- Be excluded from MIPS
- Receive a 5% lump sum bonus

Bonus applies in 2019-2024; higher fee schedule update starting in 2025
Note: Most practitioners will be subject to MIPS.

Some people may be in eligible APMs and but not have enough payments or patients through the eligible APM to be a QP.
Target Percent Payments Linked to Quality and APMs 2014-2018

- Alternative payment models (Categories 3-4)
- FFS linked to quality (Categories 2-4)
- All Medicare FFS (Categories 1-4)

<table>
<thead>
<tr>
<th>Year</th>
<th>Historical Performance</th>
<th>Goals</th>
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</thead>
<tbody>
<tr>
<td>2011</td>
<td>0% 0%</td>
<td>0%</td>
</tr>
<tr>
<td>2014</td>
<td>68% 22%</td>
<td>50%</td>
</tr>
<tr>
<td>2016</td>
<td>85% 30%</td>
<td>90%</td>
</tr>
<tr>
<td>2018</td>
<td>85% 50%</td>
<td>90%</td>
</tr>
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</table>
Physician Fee Schedule Update

- PFS 0.5% update CY 2016 - 2019
- PFS 0.0% update CY 2020-2025
- MIPS & APMs will drive payment 2019 onward
- Beginning with CY 2026 - 0.75% APM update
- Beginning with CY 2026 - 0.25% update for other PFS services
Accountable Care Organizations

- January 2016: 838 ACOs in 50 states
  - 8.3 million Medicare
  - 2.9 million Medicaid (8.9% of all lives in ACOs)
  - 17.2 million commercial
- 12.6% increase in number of ACOs last year
- ¾ ACOs have continued since inception
  - Turnover lowest in commercial plans
  - Variable success in plans
  - Still being analyzed as to their overall benefit – cost savings, care improvement
ACO Types

• Pioneer Program
  o a program for early coordinated care adopters. No longer accepting applications.

• Medicare Shared Savings Program (MSSP)
  o a program that helps a Medicare fee-for-service program providers become an ACO
  o Different stages depending on up/down side risk

• Advance Payment ACO Model
  o a MSSP incentive program, rural / physician based ACOs, early payment for infrastructure investment

• Next Generation Program
Accountable Care Organizations

LTC Issues - Attribution

- ACOs assign each patient to one physician
  - Done through a process called “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 were considered PCP codes
- SNF is now being taken out of the PCP pool for MIPS - anticipate this will occur in the ACO world too, so only NF patients will stay in the attribution process
- Unclear how expenses will be allocated in SNF
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 rule making.
Next Generation ACO

• Announced March 10, 2015 – more risk & benefit
• Geared towards elite health care systems
• Allows ACO to operate more like MA plan
• Prospectively assign beneficiaries to ACOs
• Confirms care relationships through voluntary alignment - supersede claims-based attributions.
• Lifts restrictions on how ACOs use nursing homes, home health services and telehealth
• Ultimately transitions away from an ACO's recent expenditures when setting / updating benchmark
Key to ACO (& any VB Program) Success
Reduce Your Hospitalization Rate

<table>
<thead>
<tr>
<th>Annual Hospitalization Rate 2011</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 Success (any Value Program)

Improve Key Quality Measures

• Main metrics
  o Re-hospitalizations, Length of Stay (LOS)
  o Star rating, % return to the community

• Quality Measures
  o Pain, pressure ulcers, antipsychotics, ADL loss, high risk PU, incontinence, restraints, catheters, falls with injuries

• Others
  o Capacity, proximity, special programs, adequate QAPI process, physician services
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:
  o Pneumonia (30.5%)
  o Congestive heart failure (16.8%)
  o Dehydration (12.9%)
  o UTI (11.7%)
Key to Value Program Success
Specialized Programs

• Consider specializing in key areas
• CHF – COPD – Orthopedic Programs
  o These three most common
  o Need to integrate hospital programs
  o Involve specialists
  o Adequate nurse training
  o Adequate practitioner expertise / coverage
    • Should hospitalist, specialty NPs round?


Alternative to ACO – Specialty Specific Models

- Alternative Practice Models (APM) are designed by specialty / approved by CMS
- Usually disease and time limited
  - “Specialty Bundled Care”
  - Not site specific
- AMDA is considering such models
  - Dementia care
  - Neurologic disease care
  - Acute illness models
- CMS & AMA interested in combined psychiatric – medical model
APM Hurdles

• Cost of development, testing, CMS approval
  o Grants will be available under MACRA
• Site specific vs. condition specific
• Heterogeneity of population
  o Procedural & time limited disease APM easier
• Need to coordinate with facility and other providers
  o Facility, ER, hospital, vendors, other physician specialties
Bundled Payments for Care Improvement Initiative

- Under the initiative, organizations will enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality, more coordinated care at a lower cost to Medicare.
Bundled Payments for Care Improvement Initiative

• The 4 Models
  o Model 1: Retrospective Acute Care Hospital Stay Only
  o Model 2: Retrospective Acute Care Hospital Stay plus Post-Acute Care
  o Model 3: Retrospective Post-Acute Care Only
  o Model 4: Acute Care Hospital Stay Only

• 48 episodes participants were able to choose from including UTI, stroke, heart failure, and diabetes.
• Several phases – still ongoing
• http://www.innovations.cms.gov/initiatives/bundled-payments/index.html
Bundling Payment Models for Post-Acute Care

**Model 2**
- Selected DRGs, hospital plus post acute period
- All non-hospice Part A and B services during the initial inpatient stay, post-acute and readmissions
- Payment is traditional FFS - reconciliation with target pricing (retrospective)

**Model 3**
- Selected DRGs, post-acute period only
- All non-hospice Post acute services during the post-acute period and readmissions
- Payment is traditional FFS - reconciliation with target pricing (retrospective)
Basis of CMS Bundled Model Payments

- Historical performance based target payment set
- A small percent (2%-3%) is deducted for savings
- During bundle period CMS pays customary FFS rates for services - then reconciles the actual cost with the target price
- If the care is delivered below the target price, participants keep the difference
- If higher, they are responsible for the excess cost
- Quality metrics involved – if not met, penalties or participants withdrawn
Bundles

- Comprehensive Care for Joint Replacement
- **Acute MI / CABS and CHF** - upcoming
- Stroke – TIA - Syncope
- Cervical fusion – spinal surgery
- COPD – bronchitis – asthma – pneumonia
- Sepsis – cellulitis - UTI
- GI Obstruction - hemorrhage – bowel surgery
- Peripheral vascular disorders - amputation
Conveners, Initiators, Awardees & Bundles

• Conveners – those that do the actuarial analysis, logistics, planning, interfacing with CMS for a group of health providers
• Initiators – the professional organization that cares for the patient – usually a hospital system or large physician group
• Awardee – those getting the award – convener, initiator
• Risk taking requires large organizations with many beneficiaries and assets
• Initiators can subcontract with others for services and fiscal risk taking
BPC Key Factors for Success

• Well managed initial care (hospital)
• Ensuring post-hospital care is done in the most cost effective site
• Limiting LOS in post-institutional care
• Avoiding rehospitalizations
• Controlling DME, HHC, test and provider use
• Meeting quality metrics to ensure safe and effective care delivery
• Excellence in communication
BPC and Quality

- General and Diagnosis Specific Measures
- General Examples
  - Readmissions
  - Avoidable complications
  - Adverse events
  - SCIP Core Measures Set
  - Care coordination with PCP
  - Patient education
  - Patient satisfaction
Succeeding in BPC

- Organizational commitment
- Adapt PPS to more cost effective models
- IT / tracking tools / timely data
- Standardized assessments
- Benchmarking performance
- Care managers
- De-fragmenting care / communication
- QAPI
- Account for heterogeneity of patients
Special Bundles for PA/LTC?

- Second phase of CMMI NH Hospitalization Project starting October 2016
  - Six sites currently involved for 4 years
  - New phase pays facility for six defined serious illness (e.g. pneumonia, CHF exacerbations) – about an additional $218/day for 7 days
  - Physician receives level 3 hospital initial visit and can bill one care plan meeting
  - Typical hospitalized NH patient with pneumonia costs $10-15 K. Tremendous savings potential, improved care, support for the physician and home
Managed Care Organization (MCO)

• Often referred to as Managed Long Term Services and Supports (MLTSS)
• Refers to Medicaid (and soon duals)
• 16 states currently offer MLTSS
  o Most cover all Medicaid eligible (Texas 72,000)
  o Some cover special needs (PENN – 90 – autistic adults)
• New CMS plan will align Medicaid MCO regulations with existing commercial, marketplace, and Medicare Advantage regulations
Medicaid MCO Issues

- Many difficulties and successes, overall results are not consistently conclusive
  - Most savings come from reducing hospitalizations and institutionalization
  - Predicting, containing costs difficult
  - MCOs can enter and leave market, disrupting services
  - Adequacy of providers and capitation rates
  - Best methods of measuring quality underdeveloped
  - Best practices are poorly researched
  - Upfront costs not fully appreciated
Medicare-Medicaid Financial Alignment Initiative

• New CMS initiative - enables states to use capitated managed care model and/or enhanced fee-for-service model, or both, for Medicare-Medicaid dual eligibles

• Capitation model – must provide necessary continuity of care, ensure access to providers, & fully meet diverse needs of duals population

• FFS model - state benefit from savings resulting from initiatives that improve quality & reduce costs for both Medicare and Medicaid
Nursing Home Value Based Purchasing (NHVBP)

• Protecting Access to Medicare Act 2014 (PAMA)
• Puts a value based system into place for SNF
• Deadlines
  o October 2016   All Cause Readmission Rate
  o October 2017   Publically reported NH Compare
  o 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
NHVBP Measures

• Cost
  o SNF, Hospital, Outpt, Physician, Hospice
    • NH stay + 3 days if discharged
    • HHC, DME excluded
  o Long term and Short term separated
    • Short < 90 days, Long > 90 days

• Quality Measures
  o Skin integrity – PU
  o Incidence of major falls
  o Functional status / cognitive function
NHVBP Measures con’t

• Potentially avoidable hospitalizations
  o CHF, electrolyte imbalance, respiratory disease, sepsis, UTI and anemia
• Survey results
  o Weighted by scope and severity
• Staffing data
  o RN, LPN, CNA
Nursing Home and Practitioner Metrics

• Should practitioner metrics mirror the NH for best resident outcomes?

• What NH metrics can the practitioner “own”?
  o CMS interested in hospitalizations – antipsychotics
  o Others to follow
  o Some chains investigating others already

• Should joint metrics and payment be static based, improvement based or both?

• Medical Director Role?
Main Issues for PA/LTC Professionals

• Need to ensure PA/LTC physician fit general value-based quality initiatives
• Need “best practices” quality measures written for the PA/LTC population
• Adequate measure risk adjustment to account for PA/LTC population
• Need to align physician quality measures with nursing home quality priorities
• Cost and resource use comparison groups need to account for PA/LTC population differences
• Need to ensure PA/LTC physician are compared to appropriate peer group
More Issues for PA/LTC Physicians

• Make QAPI work – critically self examine
• Determine strengths and weaknesses under VBM / MIPS, MCO, ACOs & bundled payments
• Consider if you should provide specialty care
• As medical director be part of a team effort
• Ensure person centered care in a population health world
Selected References

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