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Business Intelligence to Accelerate Profitability and Growth

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PREPARING FOR CHANGE IN 2020

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TO THE POINT

By **LISA REMINGTON**

Preparing for change in 2020. The best vision is insight.

The lines are being blurred. We are seeing the possibility of value-based reimbursement with a possible 5% withhold for home health agencies, and PDGM beginning in January 2020. On October 1st, skilled nursing facilities began readmission penalties. Payers are providing higher acuity care in the home, and expanded policy for Medicare and Medicare Advantage are blurring the lines between acute care, physicians, payers and post-acute providers.

Policy and emerging payment is unraveling fee-for-service in an abrupt way. The announcements and news impact every provider. Why? Because a change to one side of the industry now demands change for other stakeholders.

In addition to *The Remington Report* magazine, we are keeping your organization informed of changes through our weekly **FutureFocus** e-newsletter at:

- https://remingtonreport.com/intelligence-resources/futurefocus/ and, **MarketWatch** at:
- https://remingtonreport.com/marketwatch/

Our three resources are comprehensive and a one-stop resource for the latest news, and growth opportunities.

We are tracking multiple market dynamics because the changes are happening more rapidly and at a higher speed than we have seen before. For example, recent announcements about physician reimbursement are expanding chronic care and care management into the home. New Stark Law reform creates new value-based arrangements for both physicians and post-acute providers. These are not just headlines to read and click to the next headline. Deeper analysis and insight can help your organization see more clearly the new challenges and opportunities backed by law, policy and reimbursement.

The slower pace of reform that we have seen in the past is no longer the environment. All providers have a lot more at stake. The best vision is insight.

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Business Intelligence to Accelerate Profitability and Growth

November/December 2019
VOLUME 27 ■ ISSUE 6

PREPARING FOR CHANGE IN 2020

Predictive Insight & Business Intelligence Driving Change

Data Points

Traveling?

Which airlines have the cleanest water?

PAGE 3

In Every Issue

Making Travel Plans Soon?

You might want to pay attention to the water quality!

A recent study ranks the water served on major and regional US airlines.

As part of a national investigation, the 2019 Airline Water Study from Hunter College in New York has ranked several U.S. airlines on the safety of the water used to prepare hot beverages.

Drink up if you're on an Alaska Airlines or Allegiant Air flight. Those two airlines tied for first place in the rankings in the study, from the **Hunter College New York City Food Policy Center** at the City University of New York and the website **DietDetective.com**.

The airlines were given "water health scores" ranging from a 5 (the highest score) to a 0 (the lowest).

TO BE EXTRA SAFE:

- NEVER drink any water onboard that isn't in a sealed bottle,
- Do not drink coffee or tea onboard,
- Do not wash your hands in the bathroom; bring hand-sanitizer with you instead.

The major airlines, and their rankings are:

Alaska Airlines	✈✈✈✈
Allegiant Air	✈✈✈✈
Hawaiian Airlines	✈✈✈✈
Frontier Airlines	✈✈✈
Southwest Airlines	✈✈✈
Delta Air Lines	✈✈
American Airlines	✈✈
United Airlines	✈✈
JetBlue	✈
Spirit Airlines	✈

A score of 3.0 or better indicates that the airline has relatively safe, clean water, the study says.

INSIGHTS TO WHY

Medicare Advantage (MA) plans offer limited supplemental benefits

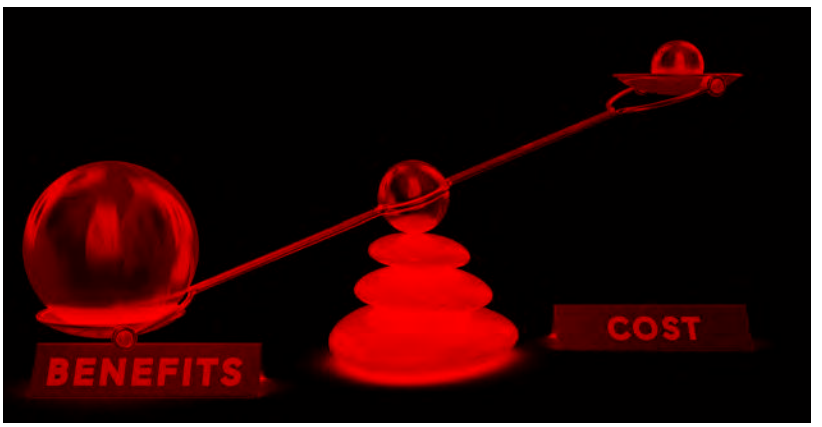
By **LISA REMINGTON**

As of March 2019, Medicare Advantage (MA) plans covered over one-third of Medicare beneficiaries, or 22 million Americans.

It's all about rebates. Medicare Advantage plans are required to use a part of the rebate they receive for bidding lower than benchmark amounts to provide supplemental benefits. The catch is rebates amount to about $107 per member per month in 2019. But, the amount varies considerably between states. In 2015, the average rebate in Florida was $159 a month per member in contrast to North Dakota, where the average rebate that same year was just $2.

HOW THE REBATE PROGRAM WORKS

The MA program allows Medicare beneficiaries to receive their Parts A and B benefits through private plans, and most also receive integrated Part D prescription drug coverage.



To participate in the program, private plans submit a bid to the Centers for Medicare & Medicaid Services (CMS) equal to the expected cost, including administrative costs and profits, of providing Medicare Parts A and B benefits to an average-risk Medicare enrollee in a county.

This bid is compared with a predetermined county-level benchmark set by CMS, which is based on traditional Medicare spending in each county, with adjustments for counties with particularly high or low traditional Medicare spending, and therefore varies widely across the country. Plans bidding below the benchmark receive a portion of the difference between the benchmark and their bid as a rebate, which must be used to provide lower cost sharing or supplemental health care benefits, like dental and vision coverage, to enrollees. Before the 2019 plan year, supplemental benefits funded by rebates had to be items or services not covered by Medicare, were primarily health related, and incurred a direct medical cost for the MA plan.

For plan year 2019, CMS expanded the acceptable uses of rebate dollars by reinterpreting supplemental benefits to include those that "are used to diagnose, prevent, or treat an illness or injury, compensate for physical impairments, try to make better the functional/ psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization."

In 2019, CMS began allowing MA plans to target supplemental benefits to enrollees by health condition. The 2018 Bipartisan Budget Act expanded allowable uses of supplemental benefits to include any item or service that could reasonably improve or maintain health or function for enrollees with certain chronic conditions (called Special Supplemental Benefits for the Chronically Ill or SSBCI). Initial research on MA plan supplemental benefits for 2019 indicated that some plans used the new flexibility to provide or expand transportation benefits, home-delivered meals, and personal care services, but it has been limited.

HOW HAVE SUPPLEMENTAL BENEFITS BEEN DISTRIBUTED?

The Urban Institute and the Robert Wood Johnson Foundation interviewed five major Medicare Advantage insurers representing about 38% of the Medicare Advantage market. In 2019, limited supplemental benefits were offered due to no new funding.

Research on MA plan supplemental benefits for 2019 indicated that some plans used the new flexibility to provide or expand transportation benefits, home-delivered meals, and personal care services, but that take-up of the new flexibility was limited.

Four out of five insurers did report adding new benefits or expanding existing benefits in 2019 in response to CMS's guidance. These additions included both benefits to address social needs and long-term services and supports (LTSS), like in-home personal care.

The most commonly added or expanded benefit was meal delivery, reported by three insurers and noted by industry experts as being of great interest to insurers. The next most commonly added benefits (added by two insurers each) were adult day care, improvements to home safety, personal home helpers, and telephone navigator support. One insurer reported expanding transportation in response to CMS's guidance in 2019, and another insurer added acupuncture and massage therapy.

Though all five insurers covered meal delivery and transportation for at least some members before 2019, they rarely offered the other benefits. All insurers that added or expanded benefits said they offered these benefits in a few markets based on the cost of the benefits, the rebate dollars available for that plan, and/or service providers' availability.

In addition, MA insurers often noted that new benefits focused on SNP enrollees, rather than enrollees in general MA plans, because SNP enrollees have higher health care costs and are more likely to have health-related social needs. One insurer added multiple benefits as a menu of newly available services and has employed social workers to help beneficiaries select one benefit from the menu, and then provides referrals to additional services as it discovers the members' needs.

Additional details on each reported benefit type are described below:

Meals. All five insurers offered home-delivered meals in some plans before 2019, and three reported expanding their existing meal delivery benefit in response to CMS's new interpretation of what supplemental benefits are primarily health related. Of the insurers who expanded the benefit, one removed the requirement that meal delivery could only be provided after a hospital discharge. Because CMS specified the benefit must be directly tied to chronic conditions and clinical care, this insurer now provides meals per event for four events per year (64 meals).

An "event" can either be a discharge or a determination by a physician that a food issue is contributing to a beneficiary's clinical condition. In addition, two insurers reported expanding meal delivery from a benefit in SNP plans to some of their general Medicare Advantage plans. One insurer used clinical criteria to target enrollees with two of the following three diseases: congestive heart failure, chronic obstructive pulmonary disease, and diabetes. The insurer reportedly selected these to target the benefit, which allows two weeks of meals following a discharge, to its most frail and high-cost patients. The other limited its expansion to one county "to see if it was an attractor for sales." In plans from this insurer, beneficiaries work with a care navigator to determine how many meals are needed after each hospitalization, totaling up to 30 days of meal delivery per patient per year.

Adult day care. Two insurers reported adding an adult day care benefit in response to CMS's guidance. Though adult day care

"If you really want to be impactful, then you should let your plans use these (benefits) and target these not based on the fact that somebody has diabetes or congestive heart failure, but rather that maybe they're a frequent flyer at the (hospital emergency department)," one interviewee said.

generally provides respite for caregivers, these insurers felt it could also help address social isolation. For example, one insurer is providing access to an adult day U.S. Health Reform – Monitoring and Impact center for up to one day a week in some plans. Another insurer provided a weekly credit for adult day care in some plans.

Home safety improvements. Two insurers reported adding benefits intended to improve home safety in some plans. In one example, for any member requesting the benefit, an occupational therapist evaluates the member's home environment for risks or hazards that could cause falls. This insurer then reviews findings with the member and connects him or her with community resources that can install the recommended equipment. Another insurer added a $500 credit members can use to purchase assistive devices, such as sticky mats for the shower floor, add-ons to toilet seats, and ramps and handrails that do not require mounting. The benefit "stopped short of putting holes in people's walls" out of concerns that more significant renovation would open the plan to legal liability issues.

Personal home helpers. Two insurers reported adding this benefit to some plans. For example, one insurer provides up to four hours of light housework per day for up to 31 days per year to help keep the home safe and help the individual remain independent. To qualify for the benefit, beneficiaries must have two limitations to activities of daily living, which the insurer says they included to adhere to CMS's requirement that benefits remain as clinically relevant as possible. Another insurer made this benefit available after a hospital stay, with the members working with a navigator to determine how much in-home help is needed.

Telephone navigator support for enrollees and caregivers. Two insurers reported adding this benefit. One reported the benefit is available to enrollees who proactively reach out to the call center, and it is intended to provide both facilitation and emotional support, helping members and their caregivers navigate issues ranging from legal or financial support to handyman services. Another insurer reported making this benefit available as a component of its in-home assessment to help ensure member needs are met, such as by connecting the member with community-based organizations that can provide help.

Transportation. All insurers provided some transportation benefits before 2019. Only one insurer reported expanding this benefit in response to CMS's guidance. This insurer reported using the new flexibility to allow members of some plans to use the benefit beyond transportation to a health care visit, for example to access the pharmacy or their gym benefit. In the interviewee's words, "The line we drew was if you need transportation to get to any one of your filed benefits, then you can use it for that." This insurer also increased the number of covered rides per beneficiary to allow for these new uses of the benefit. Another insurer reported they considered adding transportation for non-medical purposes but have not yet done so out of concern that a member may use the limited number of covered rides for non-medical activities then have none left when they need to go to the doctor.

Acupuncture and massage therapy. One insurer reported adding this benefit to provide culturally relevant care to its members. Industry experts said they expect to see more use of the MA benefit flexibility in 2020, including scaling up the geographic reach of some benefits introduced in 2019 as insurers gain more experience. The five insurers interviewed reported planning to add benefits in 2020, though they could share few details because the benefits were still being developed. Many described the potential for scaling up recently added benefits to more geographic areas. Benefits planned or considered for 2020 included pest control, programs to reduce social isolation, palliative care, and dental care for people with certain diseases. However, there remained some reported uncertainty around what CMS would include in the final call letter defining the new SSBCI benefits because these interviews were conducted before the letter had been released. This uncertainty caused some hesitation because, reportedly, after CMS released its guidance on the supplemental benefits, they rejected some plans' proposals focused more on social determinants of health. Therefore, some insurers wanted more clarity on the SSBCI benefits before submitting new social needs–focused proposals.

"… In 2019, CMS began allowing MA plans to target supplemental benefits to enrollees by health condition."

– LISA REMINGTON, PRESIDENT, REMINGTON HEALTH STRATEGY GROUP
PUBLISHER, THE REMINGTON REPORT

Challenges and Barriers of Offering Supplemental Benefits

Although interviewees generally viewed the new supplemental benefit flexibility as a positive step, industry experts reported that plans added few new benefits to address social needs using the new flexibility in 2019.

1. Interviewees largely attributed the lack of uptake in 2019 to the short time plans had to respond to CMS's new regulations.

2. Interviewees expressed more long-term concerns regarding the lack of additional funding for new benefits, MA plans' lack of experience addressing social needs, and plans' concerns about investing in benefits that reach a small number of enrollees and therefore have limited appeal to a broad group of beneficiaries One interviewee noted, "You don't want to design benefits that speak to 1 percent of your population; you try to cover as many [enrollees] as you can." These sentiments were consistent across our interviews with MA insurers.

3. Available providers. Another consideration mentioned was community-based organizations' capacity to provide these new benefits under contract with MA insurers. One interviewee felt it is easier to implement LTSS benefits because LTSS providers typically have experience working with Medicaid-managed care and therefore are adept at submitting claims and working with insurance companies. Conversely, because they are typically grant funded, community-based organizations working to address social needs are less likely to have established relationships with insurance companies or the infrastructure to quickly ramp up providing new benefits to the MA population.

4. CMS limits on targeting. Several interviewees noted that CMS only allows these benefits to be targeted based on clinical criteria, rather than social needs.

MA insurers generally reported that the new benefit flexibilities do not sufficiently allow plans to target where social needs are greatest and new benefits could have the biggest impact.

SOURCE: Urban Institute

Four out of five insurers did report adding new benefits or expanding existing benefits in 2019 in response to CMS's guidance.

Johns Hopkins nurse practitioner wins 24th Heinz Award for pioneering approach to help older adults

Community Aging in Place Advancing Better Living for Elders (CAPABLE) provides low-income seniors with home repair services along with in-home nursing and occupational therapy to help them age in place and decrease health care costs.

Developed at the Johns Hopkins School of Nursing, CAPABLE works from the foundational belief that home is where health is. CAPABLE teams work collaboratively toward the goal of enabling patients to carry out everyday tasks, achieve greater independence, and stay in their homes.

The program prioritizes the goals that patients themselves identify as important to making their lives more fulfilling and meaningful, such as cooking or walking to the library. Team members use motivational interviewing techniques – including active listening, follow-up responses, and using the person's own words – to determine how barriers to independent living can be overcome.

While making house calls as a nurse practitioner to homebound, low-income, older patients in Baltimore, Dr. Szanton noticed the challenges her patients faced caring for themselves and moving around in their homes were impacting their overall mental and physical health as much as or more than their medical needs, and were often a determining factor in their ability to remain in their homes.

In response, along with colleagues, she designed CAPABLE, a program that addresses the barriers older adults face in carrying out everyday tasks such as bathing, dressing, and preparing meals, while also helping them manage their medical issues.

CAPABLE programs operate in 28 locations in 14 states, and the list is growing. Recent studies show that an investment of roughly $3,000 in CAPABLE is associated with more than $20,000 in medical savings from reduced inpatient and outpatient expenditures. Difficulties in day-to-day functioning fell by half, accompanied by improvements in depression and medication management.

At a time when healthcare costs are skyrocketing, Dr. Szanton's insightful, practical approach that protects what is essential to health as we age should be a model and inspiration for all those caring for older adults.

Dr. Sarah Szanton PhD, ANP, FAAN, nurse researcher, pioneered a care approach to provide low-income older adults with handyman services alongside in-home nursing visits and occupational therapy to help them live more independently.

Established by Teresa Heinz to honor the memory of her late husband, U.S. Senator John Heinz, the Heinz Awards celebrates his accomplishments and spirit by recognizing the extraordinary contributions of individuals in the areas of greatest importance to him.

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CARE MANAGEMENT CHALLENGES AND BARRIERS ACOs AND MANAGED CARE ORGANIZATION FACE FOR HIGH COST MEDICAID BENEFICIARIES

By **LISA REMINGTON**

A recent GAO Report explored the efforts to identify, predict, or manage high-expenditure beneficiaries. Five percent of high-cost Medicaid beneficiaries account for nearly half of the expenditures for all beneficiaries.

Examining beneficiaries who were enrolled only in Medicaid, the GAO found the most expensive 5 percent of beneficiaries were much more likely to have certain conditions – such as asthma, diabetes, and behavioral health conditions – than all other beneficiaries enrolled only in Medicaid. The GAO when examining 2009 data, found that about 65 percent of the total expenditures for high-expenditure beneficiaries enrolled only in Medicaid were for hospital services and long-term services and supports, with the remaining 35 percent of expenditures for drugs, payments to managed care organizations and premium assistance, and non-hospital acute care.

CARE MANAGEMENT STRATEGIES

Care management programs can be used as efforts to manage the cost and quality of health care services delivered to high-expenditure Medicaid populations, with the aim of improving outcomes and achieving cost savings. Care management programs seek to assist consumers manage physical and mental health conditions more effectively, for example, by assessing patient needs and coordinating care across different providers.

The GAO found seven selected states to explore strategies for managing high-expenditure beneficiaries. To manage costs and ensure quality of care for high-expenditure beneficiaries, the seven selected states used care management and other strategies.

Care management. All the selected states provided care management – providing various types of assistance such as coordinating care across different providers to manage physical and mental health conditions more effectively – for beneficiaries in their fee-for-service delivery systems. Five of the states also contracted with managed care organizations (MCO) to deliver services for a fixed payment and required the MCOs to ensure the provision of care management services to high-expenditure beneficiaries.

Other strategies. Some of the seven selected states used additional strategies to manage care for high-expenditure beneficiaries. For example, Indiana officials described a program to restrict, or "lock in," a beneficiary who has demonstrated a pattern of high utilization to a single primary care provider, hospital, and pharmacy.

5 APPROACHES TO PREDICT HIGH-EXPENDITURE BENEFICIARIES

Through interviews with officials all seven selected states, five MCOs, and the ACO took at least one approach to identify or predict high-expenditure beneficiaries, and some took more than one approach. State officials said they used these approaches to identify or predict high-expenditure beneficiaries among different segments of their Medicaid populations, such as beneficiaries in fee-for-service delivery systems or those with certain chronic conditions.

The approaches were as follows:

1. Using high-risk scores. Officials from most state agencies, MCOs, and the ACO said they used risk scores to identify or predict high-expenditure beneficiaries. Officials from four of the seven selected states, four MCOs, and the ACO said they used software or hired vendors who computed beneficiaries' risk scores based on Medicaid service utilization data.

Washington state officials said that in addition to Medicaid service utilization data,

they used utilization data from Medicare Parts A, B, and D to compute risk scores for their dual-eligible population. In contrast, officials from an MCO in Nevada said they considered risk scores alongside other contextual information, such as the recent diagnosis of a chronic condition, to predict whether the beneficiary would likely generate high expenditures in the future and should be assigned care management services. Officials from three states, an MCO in South Carolina, and the ACO interviewed said their software or vendors identified or predicted high-expenditure beneficiaries by using the risk scores they computed to stratify beneficiaries into risk tiers, such as low, medium, and high risk.

2. Utilization. Officials from South Carolina's state Medicaid agency and two MCOs from Pennsylvania and Washington said they identified high-expenditure beneficiaries by examining service utilization data to identify statistical outliers or trends.

Officials from the two MCOs said they looked for statistical outliers for various types of service utilization, such as emergency department visits, inpatient stays, and pharmacy use. Officials from South Carolina said they built internal software tools to help them easily examine service utilization for various subsets of beneficiaries and services. These officials said they looked for beneficiaries whose utilization appeared to be significantly higher or lower compared with other beneficiaries with similar characteristics, such as among children with Type 1 diabetes or among children in foster care.

The officials also said that after they identified those outliers, they examined the reasons for those beneficiaries' utilization patterns to better understand why those beneficiaries were outliers and to take corrective action if appropriate. The officials explained that they did not simply focus on a discrete list of beneficiaries with the highest overall expenditures, because many of those beneficiaries have medical needs that are inherently expensive and cannot be meaningfully improved through intervention.

3. Diagnosis. Officials from three of the seven state Medicaid agencies and four MCOs said they identified high-expenditure beneficiaries based on diagnoses or other group categorization. Officials commonly said they used chronic conditions, such as end-stage renal disease, the human immunodeficiency virus or acquired immune deficiency syndrome, chronic obstructive pulmonary disease, diabetes, or Hepatitis C. Pennsylvania officials said their list was developed based on clinical experience. Officials from South Carolina said their list of diagnoses was based on a review of conditions associated with high expenditures.

4. Service Utilization and Claims Expenditures. Officials from two state Medicaid agencies – Indiana and Nevada – and all five MCOs said they identified high-expenditure beneficiaries as beneficiaries who exceed certain service utilization or claims expenditure thresholds.

Indiana officials said they used service utilization thresholds, such as visiting the emergency room six or more times in the past 6 months. Nevada officials said one of their programs identified high-expenditure beneficiaries as those whose treatment costs exceeded $100,000 over a 12-month period.

"Care management programs seek to assist consumers manage physical and mental health conditions more effectively."

– LISA REMINGTON, PRESIDENT, REMINGTO/N HEALTH STRATEGY GROUP PUBLISHER, THE REMINGTON REPORT

Officials from the five MCOs offered varying thresholds, such as claims exceeding $100,000 over a 6-month period; claims exceeding $40,000 during a state fiscal year; or stays in a neonatal intensive care unit exceeding 15 days.

5. Clinical Judgment. Officials from two state Medicaid agencies – Nevada and Pennsylvania – four MCOs, and the ACO said they relied on clinical judgment to decide whether a beneficiary was likely to be high expenditure. Officials from one MCO in Washington said the MCO conducted health assessments of new members to obtain a baseline understanding of their clinical states, which were then used to stratify beneficiaries and identify appropriate staff to address their needs.

Similarly, officials from Pennsylvania and three MCOs said clinical reviews of beneficiaries' needs or histories were triggered by providers, caregivers, or self-referrals for care management or other services. Officials from the ACO said that while risk scores made initial predictions about beneficiaries' risk for generating high expenditures, those predictions could be overridden by clinical judgment. >>

WHAT ARE THE FIVE BARRIERS TO CARE MANAGEMENT?

The report sites five barriers to care management. Officials from the selected states, MCOs, and the ACO identified barriers to implementing care management for some high-expenditure Medicaid beneficiaries, including the inability to contact beneficiaries, the lack of social supports – that are part of what is referred to as "social determinants of health" – and shortages of providers or care management staff in rural areas.

1/ Difficulties Contacting Beneficiaries

The lack of valid contact information can result from missing or outdated information, transiency and homelessness, and beneficiary reliance on cell phones with limited minutes. Officials described efforts they had taken to address this barrier, including asking pharmacies to confirm and get updated information when beneficiaries pick up prescriptions; using email, which officials stated is more consistent than physical addresses; and conducting direct outreach in emergency rooms.

2/ Social Determinants of Health

The effectiveness of care management in addressing the health needs of high-expenditure beneficiaries can be hindered by the lack of social supports. Officials said that in order to help beneficiaries manage their medical needs, care managers sometimes needed to address these social determinants of health, such as lack of transportation to medical appointments, lack of stable housing, and inconsistent access to food and other basic resources.

At the same time, states and MCOs can face challenges to addressing social determinants of health, such as lack of data on social determinants of health and a lack of understanding about the effect of social determinants of health on health care utilization, which if available could help bolster program investments in those areas.

3/ Staff Shortages in Rural Areas

Efforts to provide care management and medical services can be hindered by staff shortages in rural areas. Officials with one state Medicaid agency's health home program said there was a shortage of individuals in rural areas willing to provide care management to high-expenditure beneficiaries. MCO officials in another state said their ability to care for beneficiaries in rural areas was also affected by a shortage of care managers.

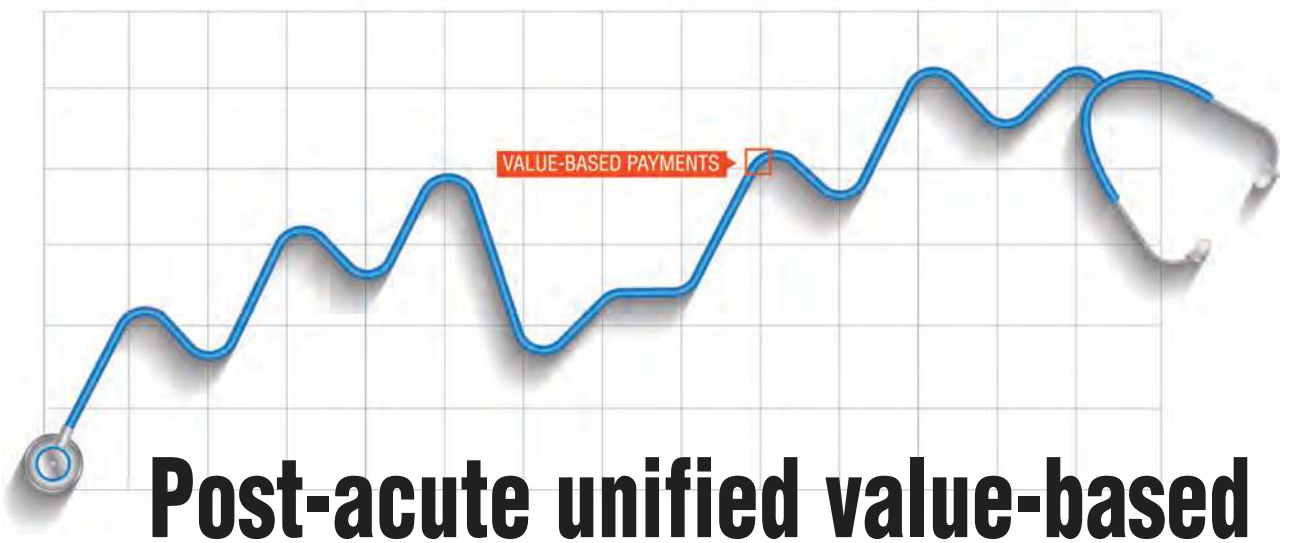
4/ Coverage Policy Changes

South Carolina Medicaid officials said that in certain cases they reviewed their coverage policy to see if changes could reduce costs and improve health outcomes for high-expenditure beneficiaries. For example, according to officials, the state had a small number of high-expenditure beneficiaries with Type 1 diabetes that officials thought could benefit from continuous glucose monitoring, which was not covered by their state Medicaid program. The officials said that they wrote a proposal into their state budget and drafted state plan amendment language to address this, though they noted that the proposal had not been implemented as of January 2019.

5/ Payment Incentives

Medicaid officials in Nevada and Pennsylvania described efforts to use payment incentives to manage costs for high-expenditure beneficiaries. for example: Nevada officials told us that the state's arrangement with its care management organization for high-expenditure beneficiaries included payment incentives related to reductions in cost, as well as performance on certain quality measures, such as immunization rates and treatments for specific conditions such as asthma, coronary artery disease, and heart failure. However, state officials said that they faced difficulties measuring these outcomes.

Although CMS has programs such as the Health Home State Plan Option, the Financial Alignment Initiative, the Medicaid Innovation Accelerator Program, a State Data Resource Center, and the Medicare-Medicaid Data Integration Initiative, additional resources will be needed to reduce the expenditures of high-expenditure beneficiaries.



Post-acute unified value-based incentive program

How Close Is It?

By **LISA REMINGTON**

A unified value-based incentive program for post-acute care providers is recommended with a possible 5% withhold. MedPAC, the Committee that advises Congress on Medicare, is building on their previous work of the unified prospective payment system across four post-acute settings.

The unified value-based incentive program would tie quality to payments for skilled nursing facilities, home health services, inpatient rehabilitation facilities and long-term care hospitals.

The proposed incentive program includes a number of risk-adjusted claims-based measures including all-condition hospitalization within the post-acute care stay, successful discharge to the community and Medicare spending per beneficiary.

The incentive program also accounts for social risk factors by comparing providers with similar shares of dual-eligible beneficiaries. A 5% withhold would fund the incentive payments. But, the Commission said that the number might change based on feedback from its members.

The program would establish a unified value-based incentive program to evaluate providers across a standardized set of measures, including:

- Risk-adjusted, claims-based measures such as Medicare spending per beneficiary.
- Uniform performance targets that account for social-risk factors.

The value-based incentive encourages increased focus on quality measures, the patient experience, and social-risk factors that might impact performance payments. Recommendations are expected to be finalized next year.

How the Unified Value-Based Incentive Ties Back to the IMPACT Act

Growing concerns over the rapid growth and wide variation in Medicare's PAC spending and the lack of uniform patient assessments to gauge quality prompted the enactment of the Improving Medicare Post-Acute Care Transformation Act of 2014.

On October 6, 2014, the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act) was signed into law.

IMPACT ACT

IMPACT Act Domain	MPACT Act Measure	PAC Setting Adopted
Skin Integrity and Changes in Skin Integrity	Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) replaced with Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	IRF, LTCH, SNF, HH
Functional Status, Cognitive Function, and Changes in Function and Cognitive Function	• Application of Percent of LTCH Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function • Percent of LTCH Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function • Change in Self-Care Score for Medical Rehabilitation Patients • Change in Mobility Score for Medical Rehabilitation Patients • Change in Discharge Self-Care Score for Medical Rehabilitation Patients • Change in Discharge Mobility Score for Medical Rehabilitation Patients	IRF, LTCH, SNF, HH LTCH IRF, SNF IRF, SNF IRF, SNF IRF, SNF
Medication Reconciliation	Drug Regimen Review	IRF, LTCH, SNF, HH
Incidence of Major Falls	Application of the Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	IRF, LTCH, SNF, HH
Transfer of Health Information and Care Preferences when an Individual Transitions	Under Development	IRF, LTCH, SNF, HH
Resource Use Measures, including Total Estimated Medicare Spending Per Beneficiary	Medicare Spending Per Beneficiary	IRF, LTCH, SNF, HH
Discharge to Community	Discharge to Community	IRF, LTCH, SNF, HH
All-Condition Risk-Adjusted Potentially Preventable Hospital Readmissions Rates	Potentially Preventable 30-Day Post-Discharge Readmission	IRF, LTCH, SNF, HH

FOR MORE INSIGHT

See the details for MedPAC's rationale for a uniform value-based incentive program for post-acute care

http://www.medpac.gov/docs/default-source/default-document-library/pac-vip-sept-2019-final.pdf?sfvrsn=0

"… Growing concerns over the rapid growth and wide variation in Medicare's PAC spending and the lack of uniform patient assessments to gauge quality prompted the enactment of the Improving Medicare Post-Acute Care Transformation Act of 2014."

– LISA REMINGTON, PRESIDENT, REMINGTON HEALTH STRATEGY GROUP
PUBLISHER, THE REMINGTON REPORT

The Act requires the submission of standardized data by Long-Term Care Hospitals (LTCHs), Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs) and Inpatient Rehabilitation Facilities (IRFs). Standardized data are to be collected by the commonly used assessment instruments: The Long-Term Care Hospital CARE Data Set (LCDS) for LTCHs, the Minimum Data Set (MDS) for SNFs, the Outcome and Assessment Information Set (OASIS) for HHAs, and the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF PAI) for IRFs.

The law mandated that in June 2016, the Medicare Payment Advisory Commission (MedPAC) recommend features of a unified payment system that would replace the four individual payment systems that Medicare currently uses. Later, the Act also requires the Secretary of Health and Human Services and MedPAC – using two years of data that began collection in October 2018 – to design a prototype PPS and to make recommendations for implementation of a unified system. These reports are expected in 2022 and 2023.

A unified payment system for post-acute care would better match payments to costs based on patient characteristics, and greatly reduce undesirable incentives to treat some types of patients or provide certain services over others.

A unified PPS would represent a major change in payments for PAC and would result in large shifts in payments across types of stays and providers. Payments would be redistributed from therapy care to medically complex care and from higher-cost settings and providers to lower-cost settings and providers. Payments would shift from higher-profit stays to lower-profit stays, resulting in more uniform profitability across them. As a result, providers would have less incentive to selectively admit certain types of patients.

Work to meet the intent of the IMPACT Act supports the CMS initiative "Meaningful Measures". This initiative identifies the high priorities for quality measurement and improvement. It demonstrates how improved outcomes for beneficiaries are being achieved through focusing on quality measures and core issues that are the most critical to providing high-quality care.

The Meaningful Measure priority areas are:

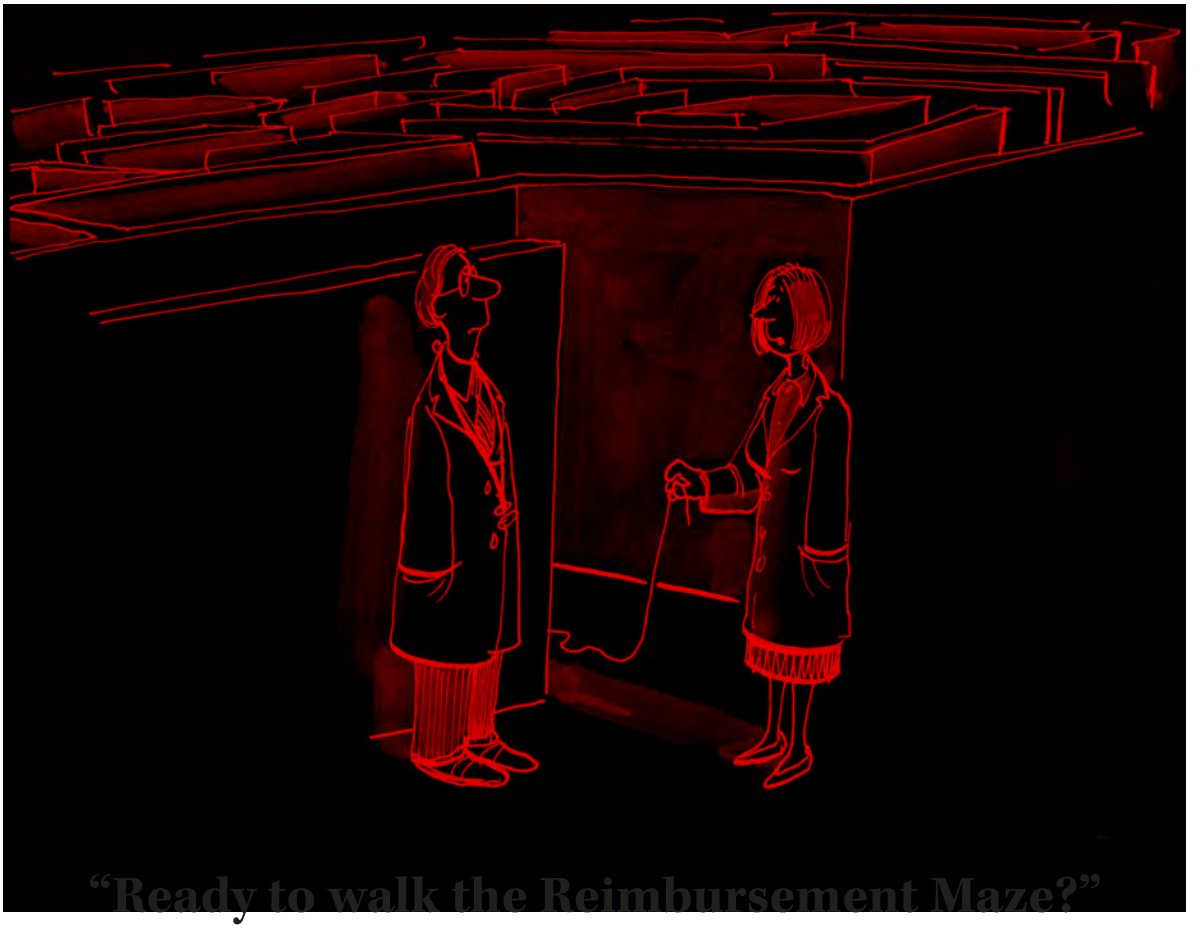
- **Promote effective communication and coordination of care.**
- **Promote effective prevention and treatment of chronic disease.**
- **Work with communities to promote best practices of healthy living.**
- **Make care affordable.**
- **Make care safer by reducing harm, cost in the delivery of care.**
- **Strengthen person and family engagement as partners in their care.**

Physicians

Insight and analysis of physician reimbursement changes 2020 and beyond

What post-acute providers need to know

By **LISA REMINGTON,** PRESIDENT, REMINGTON HEALTH STRATEGY GROUP, PUBLISHER, THE REMINGTON REPORT



On July 29, 2019, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that includes proposals to update payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2020.

BACKGROUND ON THE PHYSICIAN FEE SCHEDULE (PFS)

Payment is made under the PFS for services furnished by physicians and other practitioners in all sites of service. These services include, but are not limited to, visits, surgical procedures, diagnostic tests, therapy services, and specified preventive services.

In addition to physicians, payment is made under the PFS to a variety of practitioners and entities, including nurse practitioners, physician assistants, and physical therapists, as well as radiation therapy centers and independent diagnostic testing facilities.

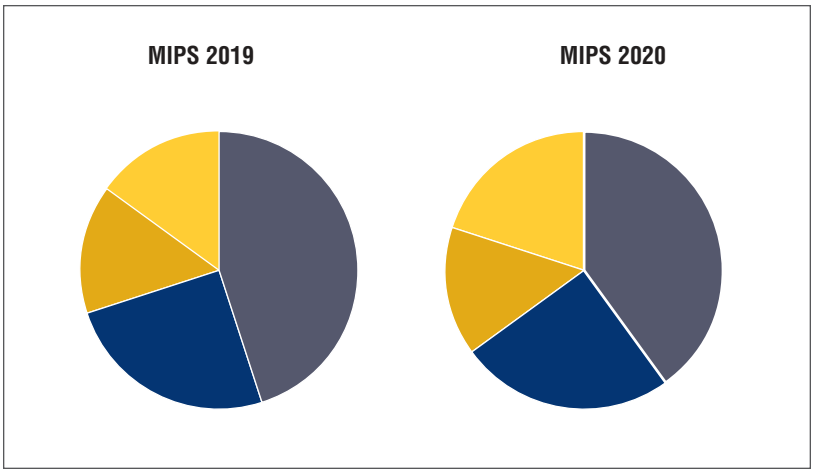
Payments are based on the relative resources typically used to furnish the service. Relative Value Units (RVUs) are applied to each service for physician work, practice expense, and malpractice. These RVUs become payment rates through the application of a conversion factor. Payment rates are calculated to include an overall payment update specified by statute.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Moving to MIPS Value Pathways (MVPs)

At the core of the proposed physician policy changes, CMS is seeking to improve the Quality Payment Program (QPP) under MACRA (the Medicare Access and CHIP Reauthorization Act of 2015) by streamlining the program's requirements. The proposal calls for an easier way for clinicians to participate in CMS' pay-for-performance program, the Merit-based Incentive Payment System (MIPS), which is one of two payment tracks within the QPP.

This new framework, called the MIPS Value Pathways (MVPs), beginning in the 2021 performance period, would move MIPS from its current state, which requires clinicians to report on many measures across the multiple performance categories, such as Quality, Cost, Promoting Interoperability and Improvement Activities, to a system in which clinicians will report much less.



Under MVPs, clinicians would report on a smaller set of measures that are specialty-specific, outcome-based, and more closely aligned to Alternative Payment Models (APMs). MVPs will connect activities and measures from the four existing MIPS performance categories that are relevant to the population they are caring for a specialty or medical condition, according to CMS.

Per the proposal, "MVPs would utilize sets of measures and activities that incorporate a foundation of promoting interoperability and administrative claims-based population health measures and layered with specialty/condition specific clinical quality measures to create both more uniformity and simplicity in measure reporting. The MVP framework will also connect quality, cost, and improvement activities performance categories to drive toward value; integrate the voice of patients; and reduce clinician barriers to movement into Advanced APMs."

2020 BILLING AND CODING CHANGES

Evaluation and Management Codes

For 2019, CMS finalized changes to simplify billing and coding requirements for certain office-based visits known as evaluation and management (E/M) services, respond to longstanding criticism that they were burdensome and overly complicated. Changes, the first to the E/M framework in more than 20 years, aim to give clinicians new flexibility

Proposed Weights by MIPS Performance Category for the 2022 through 2024 MIPS Payment Years

Performance Category	2022 MIPS Payment Year (Proposed)	2023 MIPS Payment Year (Proposed)	2024 MIPS Payment Year (Proposed)
Quality	40%	35%	30%
Cost	20%	25%	30%
Improvement Activities	15%	15%	15%
Promoting Interoperability	25%	25%	25%

In all, the proposals to the PFS, QPP, and other Medicare Part B payment policies for calendar year 2020 make up a 1,704-page document.

The Merit based Incentive Payment System (MIPS), established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), came into effect on January 1, 2017. It is a major catalyst towards transforming the healthcare industry from fee-for-service to pay-for-value.

to consider time with the patient or medical decision-making in how they code an E/M visit, so they could focus more closely on what is clinically relevant and medically necessary for the patient.

The proposed changes for 2020 would build on these policies by paying clinicians across all specialties for the time they spend treating the growing number of patients with greater needs and multiple medical conditions, through increasing the value of E/M codes for office/outpatient visits and providing enhanced payments for certain types of visits. "This is especially important to certain specialists that spend significant time managing patients with multiple co-morbidities, such as diabetes and heart disease," the agency stated.

Chronic Care Management

CMS is proposing to take steps to help clinicians better manage chronically ill patients, particularly during their transition from hospital to home. The proposed rule would increase payments to practitioners for time spent on care management after a patient leaves the hospital ensuring proper follow-up and continuity of care for patients.

And, for the first time, CMS is proposing to pay for care management services for patients with a single, high-risk chronic condition such as diabetes or high blood pressure. CMS is also proposing to pay clinicians more for additional time spent on care management activities for patients suffering from multiple chronic conditions.

Opioid Treatment

The proposed rule also calls for expanded Medicare coverage to pay opioid treatment programs (OTPs) for delivering Medication-Assisted Treatment (MAT) to people with Medicare suffering from opioid use disorder (OUD). Opioid Treatment Programs (OTPs) are programs or providers that provide a range of services to people with opioid use disorder, including medication-assisted treatment and counseling. OTPs must be accredited by the Substance Abuse and Mental Health Services Administration (SAMHSA), and CMS is also proposing to make a new monthly bundled payment to practitioners for management and counseling involving MAT for patients with opioid use disorder.

2020 PROPOSED PAYMENT PROVISIONS: WHAT POST-ACUTE ORGANIZATIONS SHOULD KNOW

Medicare Telehealth Services

For CY 2020, the proposal adds the following codes to the list of telehealth services: HCPCS codes GYYY1, GYYY2, and GYYY3, which describe a bundled episode of care for treatment of opioid use disorders.

Chronic Care

CMS is proposing to consolidate the Medicare-specific add-on code for office/outpatient E/M visits for primary care and non-procedural specialty care finalized in the CY 2019 PFS final rule for implementation in CY 2021 into a single code describing the work associated with visits that are part of ongoing, comprehensive primary care and/or visits that are part of ongoing care related to a patient's single, serious, or complex chronic condition.

Physician Supervision Requirements for Physician Assistants (PAs)

CMS is proposing to modify regulation on physician supervision of PAs to give PAs greater flexibility to practice more broadly in the current health care system in accordance

with state law and state scope of practice. In the absence of State law governing physician supervision of PA services, the physician supervision required by Medicare for PA services would be evidenced by documentation in the medical record of the PA's approach to working with physicians in furnishing their services.

Care Management Services

CMS is proposing to increase payment for Transitional Care Management (TCM), which is a care management service provided to beneficiaries after discharge from an inpatient stay or certain outpatient stays.

The proposal has a set of Medicare-developed HCPCS G codes for certain Chronic Care Management (CCM) services. CCM is a service for providing care coordination and management services to beneficiaries with multiple chronic conditions over a calendar month service period. The proposal replaces a number of the CCM codes with Medicare-specific codes to allow clinicians to bill incrementally to reflect additional time and resources required in certain cases and better distinguish complexity of illness as measured by time. The proposal also adjusts certain billing requirements and elements of the care planning services. These changes would also reduce burden associated with billing the complex CCM codes.

Recognizing that clinicians across all specialties manage the care of beneficiaries with chronic conditions, the proposal creates new coding for Principal Care Management (PCM) services, which would pay clinicians for providing care management for patients with a single serious and high risk condition.

Bundled Payment Concept Under the PFS

CMS is seeking comment on opportunities to expand the concept of bundling to improve payment for services under the PFS and more broadly align PFS payment with the broader CMS goal of improving accountability and increasing efficiency in paying for the health care of Medicare beneficiaries. CMS says that the statute, while requiring CMS to pay for services on the basis of the resources required to furnish the service, allows considerable flexibility for improving the efficiency of health service delivery within the PFS.

The Focus on Chronic Care Management Under MIPs

1. READMISSION REDUCTION

Hospital costs account for 1/3 of spending in U.S. healthcare. Two best practices have emerged to reduce unnecessary use of the hospital: chronic care management (CCM) and transitional care management (TCM).

2. CHRONIC CARE MANAGEMENT (CCM)

Chronic care management (CCM) prevents hospital admissions. The purpose of CCM is to empower patients to better understand and better control their condition(s).

3. TRANSITIONAL CARE MANAGEMENT (TCM)

Transitional Care Management (TCM) prevents readmissions. The purpose of TCM is to prevent gaps in care as patients transition from the inpatient to the outpatient setting. Medicare's TCM guidelines include: 1) interactive contact within 2 days of discharge, 2) a face-to-face visit within 7 or 14 days, and 3) other non-face-to-face services that you would expect. Two of six non-face-to-face services include:

- Obtaining and reviewing discharge information
- Identifying and following up on outstanding orders

4. PREVENTING UNNECESSARY USE OF THE EMERGENCY DEPARTMENT (ED)

Approximately 30% of all ED visits in the U.S. are for non-emergent causes. Treatment from an ED costs 10x as much as similar care provided in less expensive setting.

5. 24/7 NURSE AVAILABILITY

Immediate access to a clinical team prevents patients from using unnecessary services or necessary services from unnecessary settings like an ED. Patients that can call a nurse line first can reduce ED visits when appropriate.

Bundled Payments Under the PFS for Substance Use Disorders

In the CY 2019 PFS proposed rule, CMS sought comment on creating a bundled episode of care for management and counseling treatment for substance use disorders. In response to comments received, CMS is proposing to create new coding and payment for a bundled episode of care for management and counseling for Opioid Use Disorder (OUD).

The new proposed codes describe a monthly bundle of services for the treatment of OUD that includes overall management, care coordination, individual and group psychotherapy, and substance use counseling. One code describes the initial month of treatment, which would include administering assessments and developing a treatment plan; another code describes subsequent months of treatment; and an add-on code describes additional counseling.

"CMS is proposing to increase payment for Transitional Care Management (TCM), which is a care management service provided to beneficiaries after discharge from an inpatient stay or certain outpatient stays."

– SEEMA VERMA, AMERICAN HEALTH POLICY CONSULTANT AND CURRENT ADMINISTRATOR OF THE CENTERS FOR MEDICARE AND MEDICAID SERVICES

CMS is proposing that the individual psychotherapy, group psychotherapy, and substance use counseling included in these codes could be furnished as Medicare telehealth services using communication technology as clinically appropriate. CMS is also seeking comment on bundles describing services for other Substance Use Disorders (SUDs) and on the use of Medication-Assisted Treatment (MAT) in the emergency department setting, including initiation of MAT and the potential for either referral or follow-up care, as well as the potential for administration of long-acting Medication-Assisted Treatment (MAT) agents in this setting, to help inform whether we should consider proposing to make separate payment for such services in future rulemaking.

Therapy Services

In the CY 2019 PFS final rule, in accordance with amendments to the Medicare law, modifiers were established to identify therapy services that are furnished in whole or in part by physical therapy (PT) and occupational therapy (OT) assistants. The proposal also established that the statutory reduced payment rate for therapy assistant services, effective beginning for services furnished in CY 2022, does not apply to services furnished by critical access hospitals because they are not paid for therapy services at PFS rates.

Medicare Shared Savings Program

CMS is soliciting comment on how to potentially align the Medicare Shared Savings Program quality performance scoring methodology more closely with the Merit-based Incentive Payment System (MIPS) quality performance scoring methodology. CMS recognizes that accountable care organizations (ACOs) and their participating providers and suppliers dedicate resources to performing well on quality metrics.

CMS believes that aligning quality metrics across programs will reduce burden and will allow ACOs to more effectively target their resources toward improving care.

Stark Advisory Opinion Process

CMS issues written advisory opinions on a case-by-case basis about whether a physician referral for certain health services is prohibited under Section 1877 of the Social Security Act (the "Stark Law"). Last year, CMS issued a Request for Information (RFI) to gather public input on how to address unnecessary burden created by the physician self-referral law, focusing in part on how it may impede care coordination, a key aspect of value-based healthcare.

In response to the RFI, many health systems and provider groups urged CMS to update the regulations governing its advisory opinion process on physician referrals to reduce provider burden and uncertainty around compliance with the Stark Law.

For updates to Stark Law Reform see October 16, 2019 FutureFocus at: https://remingtonreport.com/intelligence-resources/futurefocus/

2019 MIPS APMs

MIPS APM	Overview
Bundled Payments for Care Improvement Advanced Model (BPCI Advanced)	The Bundled Payments for Care Improvement (BPCI) initiative is a model of care, which links payments for the multiple services beneficiaries receive during a clinical episode of care.
Comprehensive ESRD Care (CEC) Model (LDO arrangement)	The Comprehensive ESRD Care (CEC) Model is designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with End-Stage Renal Disease (ESRD).
Comprehensive ESRD Care (CEC) Model (non-LDO two-sided risk arrangement)	The Comprehensive ESRD Care (CEC) Model is designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with End-Stage Renal Disease (ESRD).
Comprehensive ESRD Care (CEC) Model (non-LDO one-sided risk arrangement)	The Comprehensive ESRD Care (CEC) Model is designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with End-Stage Renal Disease (ESRD).
Comprehensive Primary Care Plus (CPC+) Model	Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation.
Medicare Accountable Care Organization (ACO) Track 1+ Model	The Medicare ACO Track 1+ is a time-limited model for Track 1 Medicare Shared Savings Program (Shared Savings Program) ACOs. The Shared Savings Program is a voluntary program that encourages groups of doctors, hospitals, and other health care providers to come together as an ACO to provide coordinated, high-quality care to their Medicare patients. Track 1+ Model ACOs assume limited downside risk (less than Track 2 or Track 3).
Medicare Shared Savings Program Accountable Care Organizations – Track 1, 2, 3	The Shared Savings Program is a voluntary program that encourages groups of doctors, hospitals, and other health care providers to come together as an ACO to provide coordinated, high-quality care to their Medicare patients. ACOs may participate in the Shared Savings Program under Tracks 1, 2, or 3. Each track varies by their financial risk and portion of savings.

2019 MIPS APMs

MIPS APM	Overview
Next Generation ACO Model	Building upon experience from the Pioneer ACO Model and the Shared Savings Program, the Next Generation ACO Model offers a new opportunity in accountable care – one that sets predictable financial targets, enables providers and beneficiaries greater opportunities to coordinate care, and aims to attain the highest quality standards of care.
Oncology Care Model (OCM) (one-sided Risk Arrangement)	Under the Oncology Care Model (OCM), physician practices have entered into payment arrangements that include financial and performance accountability for episodes of care surrounding chemotherapy administration to cancer patients.
Oncology Care Model (OCM) (two-sided Risk Arrangement)	Under the Oncology Care Model (OCM), physician practices have entered into payment arrangements that include financial and performance accountability for episodes of care surrounding chemotherapy administration to cancer patients.
Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)	The Vermont All-Payer Accountable Care Organization (ACO) Model is the Centers for Medicare & Medicaid Services' (CMS) new test of an alternative payment model in which the most significant payers throughout the entire state – Medicare, Medicaid, and commercial health care payers – incentivize health care value and quality, with a focus on health outcomes, under the same payment structure for the majority of providers throughout the state's care delivery system and transform health care for the entire state and its population.
Maryland Primary Care Program	The Centers for Medicare & Medicaid Services (CMS) and the state of Maryland are partnering to test the Maryland Total Cost of Care (TCOC) Model, which sets a per capita limit on Medicare total cost of care in Maryland. The TCOC Model is the first Center for Medicare and Medicaid Innovation (Innovation Center) model to hold a state fully at risk for the total cost of care for Medicare beneficiaries. The TCOC Model builds upon the Innovation Center's current Maryland All-Payer Model, which had set a limit on per capita hospital expenditures in the State.
Independence at Home Demonstration	The Independence at Home Demonstration provides chronically ill patients with a complete range of primary care services in the home setting. This focus on timely and appropriate care is designed to improve overall quality of care and quality of life for patients served, while lowering health care costs by forestalling the need for care in institutional settings.

Payers

How to improve quality measures and performance to align with payers

By **CHRISTY JOHNSTON, MPH**

This is the third article in a series to discuss how to promote the growth of in-home community-based organizations and accelerate relationships with payers.

The first article published in the Remington Report's July/August issue, pages 4-8, focused on the home health aide workforce:

- **"How Real Time Actionable Data Leverages New Value For Home Health Aides and Stakeholders."**
- **The second article appeared in the September/October issue, pages 16-19 titled: "How Leadership and the Value of Home Health Aides Can Secure Positive Payer Outcomes."**

How payers measure success may vary with attention paid to prevention services and screenings, timeliness of services, functional and clinical stability in the home, or satisfaction with service providers.

In today's healthcare landscape, the concept of paying for value over volume is ubiquitous. The shift away from fee for service reimbursement to value based payment is moving rapidly and touching all healthcare providers and services. As such, it almost goes without saying that in order to succeed in this value-based healthcare world, it is critical to understand how payers are measuring value.

Regardless of the Alternative Payment Models (APM) home care providers have secured or are seeking (value based payment, bundled reimbursement, shared savings, quality bonus programs) the common denominator for all APMs is quality. Knowing the quality measures by which an organization will be judged is essential for success in a value over volume healthcare world.

QUALITY MEASURES – WHY?

Quality measures in healthcare define a common standard against which payer and provider performance is measured. There are different types of quality measures – process, outcome, satisfaction – but all require the collection and analysis of standardized data. Utilizing the data collected, the quality of health care services can be evaluated and rated. Providers and payers are then able to see their quality outcomes and performance over time and in comparison to others delivering the same services.

Quality measures for payers have a direct impact on the bottom line. The development of premiums or assignment of penalties include aspects of quality measure performance and funding is more favorable when quality is higher. Payer Star Ratings, which are linked to quality measure outcomes, are also made public and consumers are adept at reviewing these scores to determine which payer (plan, hospital, physician, home care) will receive their business.

For home care providers, the stakes are similar. Meeting and improving on quality measures will be reflected in how eager payers are to contract for a provider's services and may result in: higher payment, preferred

A six web-based Signature Education series provided by The Remington Report and Premier Home Health Care Services is being offered to support company-wide training in the areas of:

- **The Changing Healthcare Landscape: The New Role of the Home Health Aides**
- **How to Expand Payer Partnerships and Meet Their Goals**
- **How to Expand the Role of Aides to be Part of an Interdisciplinary Team Member**
- **How to Target Interventions to Improve Outcome**
- **How to Size-up Your Organization for Cultural Change**
- **How to Boost Quality Scores and Performance Improvement**

See details: (pgs. 26-27)

provider designations and referrals, and opportunities for quality incentive programs, shared savings or other VBP arrangements.

And importantly, the primary reason to understand and strive to improve quality outcomes is the client. Moving to value over volume is ultimately meant to benefit the client and improve the outcomes they experience when receiving home care services. Home care providers have the ability to keep people healthier at home for longer, and this is especially true when providers are focused on improving outcomes and meeting quality measures.

QUALITY MEASURES – WHAT?

Strange as it may sound, identifying the quality measures a payer uses to evaluate performance is very exciting, because these are the clues that show us what measures are important to the payer and how funding for quality services flows. This information also is critical to help align service delivery strategies to improve quality measures, client outcomes, and meet payer objectives.

Quality measures vary among payers and services and data is captured through client assessments, satisfaction surveys, grievance reports, or other mechanisms. How payers measure success may also vary with attention paid to prevention services and screenings, timeliness of services, functional and clinical stability in the home, or satisfaction with service providers. While measures differ, there are some quality measures that are linked frequently to in-home, long term care services including:

- Falls prevention
- Chronic disease management – COPD, CHF, Diabetes
- Flu and pneumococcal immunizations
- Avoiding hospitalizations and emergency department visits
- Medication management
- Perceived involvement in decision making – person-centered planning
- Quality of and satisfaction with in-home aide
- Timeliness of service delivery

QUALITY MEASURES – HOW?

Like other home care providers, quality has always been a key part of the culture at Premier Home Health Care Services, Inc. As the healthcare system began to shift away from traditional fee for service to managed long term care, our efforts to look beyond our own quality initiatives and identify payers' quality measures increased. Initially, the focus was on identifying quality measures that impacted managed care plan risk scores and premiums, so that we were able to align our service delivery approaches to focus on measures important to payers.

While there are countless ways to approach quality improvement, as VBP arrangements became the focus, Premier has used a multi-pronged approach that places an emphasis on education, data collection, and involvement of the entire interdisciplinary team (IDT) that contributes to service delivery. Targeted education is developed and refined for each quality measure tied to payer contracts and the IDT receives training on the role they play in improving client outcomes.

The home care aides then play invaluable roles. First, because they are a direct caregiver for the client and utilize the enhanced training on quality measures to impact outcomes in the home, and also because they are the eyes and ears in the home and collect and transmit data to others on the IDT who facilitate necessary interventions to improve outcomes.

Regardless of an organization's approach to working on quality measures, the collection of data to inform the process is fundamental. Internal data collection, working collaboratively with payers to access data, or identifying other creative methods all work, but the key is to secure the data necessary to track what is happening with clients and target interventions to improve outcomes.

QUALITY MEASURES – WHERE?

When working to develop an approach to improving quality measures and payer alignment, finding all relevant quality measures that are important to payers and ultimately providers is an important place to start and there a number of ways to track down the information you need.

If you are researching and preparing for

payer relationships, start by going to the policy or payer sources:

Government: State and Federal regulators typically establish quality/performance measures for services that are offered through government payment systems. Get familiar with government agencies that oversee Medicaid Programs at the state level and CMS for Medicare Advantage and other Medicare services, including Accountable Care Organizations (ACOs), and monitor websites and meetings for information.

Quality Organizations: National Commission on Quality Assurance (NCQA), National Quality Forum (NQF), Agency for Healthcare Quality and Research (AHQR), academic institutions, and other independent organizations focus on quality measures in healthcare and are used by payers and government programs for support in the development, review, and selection of quality measures.

Payers: Many payers have information about their quality initiatives on their websites. Information also can be found under provider information or by contacting a provider representative.

Home care providers that have already partnered with payers or others, should be looking at communications from and with these partners to identify quality measure expectations.

Typically this detail can be found in:

Contracts: Provider contracts or agreements with payers, especially value based payment arrangements with upside and/or downside risk, will contain detail on the quality/performance measures and targets you will be measured against. If this information is not included, ask for what you need to know.

Quality Incentive Programs: Payers may have incentive programs that will reward providers for positive performance against select quality measures. Sometimes detailed outlines of the programs and expectations are made available and other times providers must ask for the detail.

Quality and performance measures also change over time so it is important to keep track of adjustments. This could include the addition or removal of measures, increases in quality measure targets, or changes in the weight/value placed on a certain measure.

As home care providers assume greater risk, seek additional funding, and strive for positive client outcomes, it is important to know the quality measures to which we are being held to in order to build service delivery strategies around the specific measures.

The delivery of in-home aide services as part of Managed Long Term Services and Supports (MLTSS), Medicare Advantage plans, and ACOs is increasing and the recognition of the overall role home care plays in providing quality care continues to grow. Along with this comes a greater responsibility to focus on outcomes and adapt approaches to continue to deliver quality services. With the focus on data, it is easier for payers to recognize the home care providers that are investing in efforts to improve their quality measures and client outcomes.

"While there are countless ways to approach quality improvement, as VBP arrangements became the focus, Premier has used a multi-pronged approach that places an emphasis on education, data collection, and involvement of the entire interdisciplinary team (IDT) that contributes to service delivery."

– CHRISTY JOHNSTON, MPH IS VP OF GOVERNMENTAL & MANAGED CARE SERVICES FOR PREMIER HOME HEALTH CARE SERVICES, INC.

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About Premier Home Health Care Services

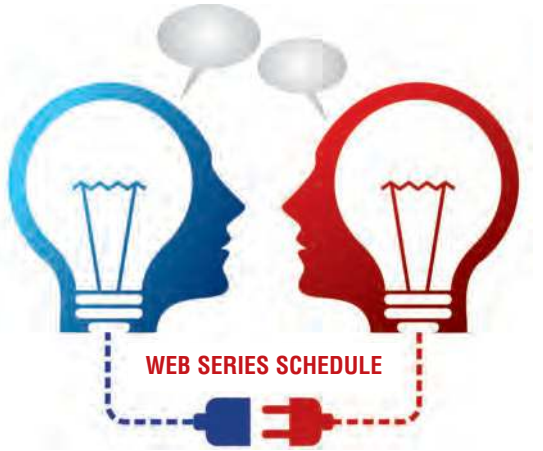
Established in 1992, Premier maintains its Corporate Headquarters in New York State and operates in seven states – New York, New Jersey, Connecticut, Massachusetts, Illinois, North Carolina, and Florida. Led by a management team with decades of experience in community-based home care, managed care, and care management services, Premier has trained over 10,000 aides and provides personal care and care management services to approximately 34,000 long-term care members on a monthly basis through both traditional and Value Based Payment (VBP) risk contracts with health plans and other payers.

REMINGTON HEALTH STRATEGY GROUP

About the Remington Health Strategy Group

The Remington Health Strategy Group has been partnering with healthcare organizations to accelerate profitability and growth for nearly three decades. We work closely with organizations to increase revenues, identify new and existing growth opportunities, and leverage strategic partnerships across the continuum. The Remington Health Strategy Group and The Remington Report has provided education to over 6,000 C-suite healthcare executives through a variety of platforms, including think tanks, executive leadership and clinical summits, board retreats, and peer-to-peer networking groups.

FOR ADDITIONAL INFORMATION https://remingtonhealthstrategygroup.com/consulting/customized-solutions-and-education/



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SERIES 1: November 20, 2019

The Changing Healthcare Landscape: The New Role of the Home Health Aides

Learning Objectives:

- Identify new regulations and policy changes.
- Explore why the payer landscape is changing.
- Discover how the competitive environment is impacting organizations.
- Explore why the role of the home health aide is changing.

SERIES 2: December 10, 2019

How to Expand Payer Partnerships and Meet Their Goals

Learning Objectives:

- Identify critical payer quality measures.
- Discover how to align payer quality measures to service delivery approaches.
- Identify what data collection is important to payers.
- Explore how to maximize the role of the home health aide.

SERIES 3: January 14, 2020

How to Expand the Role of Aides to be Part of an Interdisciplinary Team Member

Learning Objectives:

- Team-based quality measure improvement.
- Focusing on decreasing potentially avoidable hospitalization.
- Addressing social determinants of health.
- Strategies for behavioral health and chronic disease management.

SERIES 4: February 11, 2020

Targeting Interventions to Improve Outcomes

Learning Objectives:

- Tailoring interventions to improve health outcomes.
- Disease-state interventions.
- Social determinant interventions.
- Managing medication adherence.
- Meeting person-centered care plans goals.

SERIES 5: March 26, 2020

How to Size-up Your Organization for Cultural Change

Learning Objectives:

- How to get buy-in.
- The importance of an interdisciplinary team approach.
- The value of a retention/recruitment model.
- Understand the challenges and opportunities that comes with organizational change.

SERIES 6: April 23, 2020

Boosting Quality Scores and Performance Improvement

Learning Objectives:

- Explore how to analyze your resources and desired outcomes to develop manageable workflows.
- Discover how constant reevaluation of data informs change and improves quality.
- Measure and report your value.

Business

News Report

By **PETE LEWIS**

MERGERS & ACQUISITIONS

Addus Buys Hospice Partners of America: Addus HomeCare Corp. purchased Hospice Partners of America LLC, a Birmingham, Alabama-based provider of hospice services. Hospice Partners of America serves an average daily census of approximately 1,000 patients through 21 locations in Idaho, Kansas, Missouri, Oregon, Texas and Virginia, with annualized revenue of approximately $55 million.

This is the fourth acquisition that Addus has closed in 2019. On August 1, Addus acquired Alliance Home Health Care, LLC and its affiliate, House Calls of New Mexico, LLC, both located in New Mexico. On the same day, Addus acquired the operating assets of Foremost Home Care, Inc., a personal care provider based in New York City. The aggregate purchase price for Foremost and Alliance was approximately $24 million. Addus also added another hospice component to its service model at the end of August, announcing a $130 million cash deal for Hospice Partners of America, LLC, a multi-state hospice services provider based in Birmingham, Alabama. Earlier in the summer, on June 1, Addus completed its acquisition of VIP Health Care Services, another New York City-based personal care services provider. That deal was announced in November 2018, with a price of $28 million.

PETE LEWIS IS A CONTRIBUTING WRITER FOR THE REMINGTON REPORT®

Option Care and BioScrip Combine to Create Option Care Health: Option Care Enterprises Inc. and BioScrip Inc. completed their merger to form Option Care Health Inc, the largest independent provider of home and alternative infusions services in the country. The company is headquartered in Bannockburn, Illinois and is listed on the Nasdaq Global Select Market under the ticker symbol BIOS. Option Care Health is led by CEO John Rademacher. Mike Shapiro is Chief Financial Officer and Harry Kraemer, former chairman and CEO of Baxter International Inc., will serve as Chairman of the Board.

LHC Buys VNA Home Health of Maryland: LHC Group Inc. purchased a home health and home and community based services (HCBS) provider in Baltimore from VNA of Maryland and Elite Home Care Services. Home health services will continue to operate under the current name of VNA of Maryland. HCBS services will operate under the name of Maryland Private Care. The company provides in-home healthcare to patients in Baltimore and the licensed service area.

To date in 2019, LHC Group has acquired or agreed to acquire 12 home health, five hospice, and one HCBS locations in four states and the District of Columbia.

Ensign Acquires Idaho Skilled Nursing Facility: The Ensign Group Inc., the parent company of the Ensign™ group of skilled nursing, rehabilitative care services, home health care, hospice care, medical transportation, and assisted living companies, acquired the real estate and operations of Temple View Transitional Care Center, a 119-bed skilled nursing facility located in Rexburg, Idaho. This acquisition brings Ensign's portfolio to 202 skilled nursing operations, 27 of which also include assisted living operations, 57 assisted and independent living operations, 26 home health agencies, 28 hospice agencies and nine home care businesses across sixteen states. Ensign owns the real estate at 80 of its 259 healthcare operations.

PARTNERSHIPS & AGREEMENTS

LHC Partners with Norton Healthcare: Lafayette, La.-based LHC Group Inc. and Norton Healthcare in Louisville, Ky. finalized a joint venture (JV) agreement to share ownership of Caregivers Health Network, a home health provider in Louisville and surrounding region. Under the terms of the agreement, Norton Healthcare purchased a minority interest in the agency, which will be renamed Norton Home Health. The agency will be integrated in accordance with LHC Group's current JV processes and procedures.

Norton Healthcare is a hospital and health care system that serves adult and pediatric patients from Greater Louisville, Southern Indiana and the

commonwealth of Kentucky. The Louisville-based not-for-profit system includes five Louisville hospitals with 1,837 licensed beds; seven outpatient centers; 14 Norton Immediate Care Centers; more than 15,000 employees; more than 1,000 employed medical providers; and approximately 2,000 total physicians on its medical staff. LHC Group has JV partnership agreements with 350 hospitals across the United States.

CORPORATE MANEUVERS

Ensign to Spinoff Home Health and Hospice Businesses: The Ensign Group spun off its home health hospice and senior living business lines from its skilled nursing operations. The new separate entity, The Pennant Group, will trade on the Nasdaq exchange under the ticker symbol PNTG. Danial Walker, the former president and CEO of Cornerstone Healthcare, Ensign's home health and hospice arm, was named Pennant's president and CEO. The Ensign Group Inc. will continue to include transitional and skilled services, healthcare campuses, post-acute-related new business ventures and real estate investments.

Capital Senior Living Names Ribar COO: Dallas-based Capital Senior Living appointed Brandon M. Ribar chief operating officer. Ribar previously held several operational-focused roles at Golden Living, a $3 billion post-acute healthcare provider. His most recent role was senior vice president, operations, responsible for overseeing operations of 305 skilled nursing and assisted living centers across 21 states, encompassing 20,000 employees. While at Golden Living, Ribar also served as senior vice president, operational finance and strategy.

Capital Senior Living Corp. is one of the nation's largest operators of independent living, assisted living and memory care communities for senior adults. The company's 128 communities are home to nearly 12,000 residents in 23 states.

Stalmack Joins Providence Service Corp. and LogistiCare as SVP, General Counsel and Corp. Secretary: The Providence Service Corp. appointed Kathryn Stalmack as senior vice president, general counsel and corporate secretary of Providence and its subsidiary, LogistiCare Solutions. Stalmack will be responsible for all legal matters relevant to the company including contracting, litigation, corporate governance and regulatory compliance. She succeeds M. Chinta Gaston, who is retiring and previously served SVP, general counsel and secretary of Providence since January 2019 and as LogistiCare's general counsel since 2003. Stalmack recently served as SVP, general counsel and corporate secretary of BioScrip Inc. She was a shareholder within the Healthcare Practice group at Polsinelli, PC and as a healthcare litigator at Donohue Brown Mathewson & Smith and Cassiday Schade & Gloor. Stalmack holds a Bachelor of Science degree from Miami University in Oxford, Ohio, and Juris Doctor from Loyola University Chicago School of Law.

The Providence Service Corp., through its fully-owned subsidiary LogistiCare Solutions, is the nation's largest manager of non-emergency medical transportation programs for state governments and managed care organizations. Its range of services includes call center management, network credentialing, vendor payment management and non-emergency medical transport management. The company also holds a minority interest in Matrix Medical Network a provider of assessment and care management services to individuals that improve health outcomes and health plan financial performance.

Ensign Names Freeman Chief Financial Officer of Pennant Group: The Ensign Group Inc., the parent company of the Ensign™ group of skilled nursing, rehabilitative care services, home health care, hospice care and assisted living companies, appointed Jennifer L. Freeman as chief financial officer (CFO) of The Pennant Group Inc., the holding company of all of Ensign's home health and hospice agencies and substantially all of Ensign's senior living businesses. Freeman has been serving as CFO of Cornerstone Healthcare, Ensign's home health and hospice portfolio company, since she joined the organization earlier

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this year. She joined Ensign with more than 15 years in the healthcare industry and more than 25 years of experience leading financial teams and departments.

NON-PROFITS & ASSOCIATIONS

Johnson Named New COO at NHPCO: Suzi K. Johnson, MPH, RN, joined the National Hospice and Palliative Care Organization as its new chief operating officer. Johnson previously served as the vice president of Sharp Hospice and Palliative Care, a program of Sharp HealthCare in San Diego. She joined Sharp HospiceCare in 1986 and brings her 33 years of experience to her new position at NHPCO. Johnson is a nationally recognized leader in the field of palliative care and hospice, lecturing throughout the country on topics such as leadership, organizational innovation, and program development in palliative and end-of-life care. In 2016, she was awarded the inaugural Doris A. Howell, MD Award for Advancing Palliative Care.

Home Health Foundation Names Farraher-Smith Chief Clinical Integration Officer: Diane Farraher-Smith joined the Home Health Foundation (HHF) as chief clinical integration officer. In this newly developed position, Farraher-Smith is responsible for the integration of home health and hospice services within the Wellforce System. She also is responsible for the delivery of home-based services across the care continuum including traditional home health and hospice care, services for patients with advanced illness, care utilizing technology extenders such as remote patient monitoring and non-traditional population management provisions while partnering with Wellforce system hospitals, physician groups, and the Wellforce Care Plan. Farraher-Smith is the former president of Hallmark Health VNA & Hospice System, VP of Melrose Wakefield Healthcare and former interim executive director of Circle Home.

Home Health Foundation, which is comprised of Home Health VNA and Merrimack Valley Hospice, has joined forces with Circle Home and Hallmark Health VNA to develop a new, regional, home health and hospice post-acute continuum with a focus on transform - ing home-based care. Together, the agencies serve 124 cities and towns throughout Northeastern Massachusetts and Southern New Hampshire with six offices and a 21-suite hospice house that provide care to more than 16,000 patients annually. Additionally, Merrimack Valley Hospice serves the Southern Maine region as York Hospital Hospice in partnership with York Hospital.

Markiewicz Named Chief Business Development Offices for Catholic Health: Joyce Markiewicz moves into a new position as Chief Development Officer for Buffalo, NY-based Catholic Health. Markiewicz was the President and CEO of Home and Community Based Care at Catholic Health. President and CEO of Catholic Health, Mark Sullivan called Markiewicz "the ideal person" for the job, citing her experience developing strategic partner - ships and new business initiatives.

Gleason Named Senior Vice President of Home and Community Based Care for Catholic Health: Tom Gleason who served as chief operating officer for Home and Community Based Care for Buffalo, NY-based Catholic Health has been promoted to senior vice president of Home and Community Based Care. Gleason will oversee Catholic Health's skilled nursing facilities and home care agencies.

KUDOS

Homewatch CareGivers Among Top Franchises for Women: Homewatch CareGivers was named to *Franchise Business Review's* annual list of top franchises for women. Greenwood Village, Colo.-based Homewatch Care-Givers provides a variety of at-home services including elder care, care for individuals with developmental and physical conditions, after-surgery care and dementia care. The company has more than 200 franchised units in 34 states. The team at *Franchise Business Review* surveyed nearly 9,000 female franchise owners from over 260 leading franchises before compiling its "Top 50 Franchises for Women in 2019" list.

Capital Senior Living Chosen to Participate in Apprenticeship Grant: Capital Senior Living was selected to participate in a $12 million apprentice-ship grant through the Dallas County Community College District from the U.S. Department of Labor. The grant will promote work-based training and serve as a model for strengthening the local Dallas workforce through the appoint-ment of trained, credentialed workers. Capital Senior Living is one of 12 Dallas-based healthcare companies chosen to participate. The company expects to offer 400 apprenticeships, helping workers earn Certified Nursing Assistant (CNA), Licensed Practical/Vocational Nurse (LPN/LVN) and Registered Nurse (RN) certifications. The overall $12 million grant will support training for 7,500 apprentices in approximately 50 critical health care occupations for health care providers, locally and nationally. Of the 7,500 apprentices, it is projected there will be nearly 3,700 women, more than 2,500 people of color, and over 1,100 transitioning service members, military spouses and veterans.

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5 Ways To Partner With Physicians Under MIPs

PAGE 16

The new framework, called the MIPS Value Pathways (MVPs), beginning in the 2021 performance period, would move MIPS from its current state, which requires clinicians to report on many measures across the multiple performance categories, such as Quality, Cost, Promoting Interoperability and Improvement Activities, to a system in which clinicians will report much less. MIPS focuses on chronic care payments to:

1. Reduce Readmissions
2. Implement Chronic Care Management Models
3. Develop Transitional Care Management
4. Reduce ED Visits
5. Provide a 24/7 Nurse Line

– LISA REMINGTON, PRESIDENT, REMINGTON HEALTH STRATEGY GROUP, PUBLISHER, **THE REMINGTON REPORT**

Post-Acute Unified Value-Based Incentives: PAGE 13

How Close is it?

Learn why the biggest Medicare Advantage Payers limited supplemental benefits PAGE 4

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