All Payer Solutions for Post Acute Care Providers

A White Paper by DART Chart

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INTRODUCTION

The healthcare industry is experiencing dramatic changes in reimbursement, moving away from traditional PPS and fee-for-service to capitated and incentive-based systems. CMS’s expansion of mandatory bundled payment models drive provider communities to re-evaluate their strategies for maintaining a high quality of care while decreasing cost. This capitated payment model pressures provider communities to operate within a set target price. As innovations from CMS and the commercial sector often feed off one another, experts agree that capitated payments are not going away. Providers will need to adopt new strategies in this changing reimbursement landscape.

Skilled nursing organizations are rethinking financial strategies due to quickly changing Post-Acute Care (PAC) reimbursement. Traditional Skilled Nursing Facility (SNF) business models are under more pressure than ever with Managed Medicaid, Accountable Care Organizations, Medicare Advantage Plans, new CMS Bundled Payments for Care Improvement (BPCI), and the first required bundled payment model for comprehensive joint replacements. Various, complex payment models have changed the game quickly by reducing revenue opportunities and squeezing SNF margins. Some market reports show bleak results for the SNF market, yet opposing reports argue that SNFs have a survivor mentality and the ability to leverage legislation and changing payment models to their advantage.

To remain relevant and competitive, SNFs must respond now to integrate managed care, bundled payment, and value-based models into their existing systems. SNFs will need to make significant technology investments and process improvements to integrate with healthcare systems, hospitals and other specialties.
As bundled payments and value based reimbursement models increase, hospitals begin to narrow their list of SNF referral partners. They are focusing on providers with the lowest readmission rates, shortest stays, highest star ratings, best outcomes/measures, and lowest cost of care. With CMS’s preliminary data from bundled payment and value-based reimbursement models showing remarkable results, this trend is only expected to pick up speed. It is becoming critical for SNFs to be able to show their hospital partners new metrics that are crucial to the ensuring success in the continuously expanding alternative payment market.

Hospitals are pressured to develop a comprehensive, integrated continuum for risk and will continue to analyze their post-acute strategic model to determine the best in class performers who can demonstrate quality, low cost results through data capture.

**RECENTLY INTRODUCED PAYER MODELS**

According to a McKesson state of the industry’s transition study from volume (fee-for-service) to value (value-based care), 90% of payers in 2014 offered a mix of fee-for-service and other reimbursement models, and only 3% offer fee-for-service only.

When projecting into the near future, payers expect the proportion of fee-for-service payments to decrease significantly, from 56% today to 32% five years from now. With the remainder of payments being made in capitation, pay-for-performance, bundled payment, episode of care and global payment.

The most recent models affecting SNFs are detailed below:

**Pioneer ACO Model:** The Pioneer ACO Model was designed for organizations with experience in offering coordinated, patient-centered care. The payment models tested in the first two years of the Pioneer ACO Model are a shared savings payment policy with generally higher levels of shared savings and risk for Pioneer ACOs than levels currently proposed in the Medicare Shared Savings Program. The future holds higher levels of rewards in shared savings but with higher risk attached.

In the first program year, all Pioneer ACOs reported improvements in quality and approximately half reported lower costs. While a few participants that did not produce savings switched back to the original Shared Savings Program, very few left the program entirely.

A total of 250 organizations participate in the Pioneer ACO Model and the Medicare Shared Savings Program (with more joining annually) / 4 million Medicare beneficiaries served.
**Next Generation Value-Based ACO Model:** The Next Generation ACO Model is an initiative for ACOs that are experienced in coordinating care for populations of patients. It allows provider groups to assume higher levels of financial risk and reward than are available under the current ACO Pioneer Model. The goal of the new model is to test whether strong financial incentives for ACOs, coupled with tools to support better patient engagement and care management, can improve health outcomes and lower expenditures for FFS beneficiaries.

This model provides benefit enhancements or waivers of certain Medicare service rules and initiatives intended to assist Next Generation ACOs in improving care for and engagement of their beneficiaries. Rules/waivers positively impacted may include telehealth, post-discharge home visits regardless of homebound status, and the three-day qualifying stay rule.

**ACO Investment Model:** The ACO Investment Model was developed in response to stakeholder concerns and available research suggesting that some providers, specifically in rural and/or medically underserved areas, lack adequate access to capital needed to invest in infrastructure necessary to successfully implement population care management. CMS provides financial support to these ACOs to make infrastructure investments and develop new ways to improve care for Medicare beneficiaries in medically underserved areas. ACOs receive both payments based on number of assigned beneficiaries as well as fixed payments.

**Bundled Payments for Care Improvement (BPCI) Model:** CMS has been working in partnership with providers since 2011 to develop models for bundling payments through the BPCI initiative. Under BPCI, CMS links payments for multiple services patients receive during an episode of care. For example, instead of a surgical procedure generating multiple claims from multiple providers, the entire team is compensated with a “bundled” payment that provides incentives to deliver health care services more efficiently while maintaining or improving quality. CMS has identified 48 conditions that can be reimbursed on a bundled care basis. Participants choose which conditions to include, from 1 to 48.

There are four different models of the BPCI initiative:
- Model 1: Retrospective Acute Care Hospital Stay Only
- Model 2: Retrospective Acute Care Hospital Stay PLUS Post-Acute Care
- Model 3: Retrospective Post-Acute Care Only
- Model 4: Acute Care Hospital Stay Only

**Comprehensive Care for Joint Replacement (CJR) Model:** The Comprehensive Joint Replacements model differs from other Innovation Center models in several major aspects. First, unlike the ACO & BPCI models, it is not voluntary. Participant hospitals are located in 67 metropolitan statistical areas (MSAs) and are all acute care hospitals paid under the inpatient prospective payment system (IPPS) that are not concurrently participating in Models 1, 2, or 4 of the BPCI initiative for lower extremity joint replacement (LEJR) episodes. The participating hospitals will be paid in accordance with an episodic rate calculated by CMS. There are exceptions for patients covered under Medicare Advantage plans. Second, providers cannot choose which services to include in the CJR bundle. The specific conditions apply to every hospital within the selected geographic areas. Third, the payment model presently applies solely to hip/knee replacement and hip surgery, the most common inpatient surgical conditions for Medicare beneficiaries.

In 2014, there were more than 400,000 hip/knee replacement procedures, costing more than $7 billion for hospitalizations alone.
ACTION NEEDED TO ADDRESS NEW CHALLENGES

With the most recent payer model changes, there's more than a change in the methods of payment. For a SNF to be successful in any new bundled care structure, each entity caring for the patient will need to break old habits and ways of providing care. In effect, establishing a true bundled payment partnership is a form of "culture change" with successful management of patient care and improved outcomes tied to payment much more directly than ever before. For example, if a hospital fails to give a SNF a detailed discharge summary, the admitting SNF may not be able to prepare its care plan within 24 hours— a delay that increases the risk of expensive readmission. If a physician is unaware of recent tests / services and orders duplicate tests, these extra costs decrease the amount of shared savings available to the partners at the end of each year. Even worse, if the partners continue to operate just as they always have, the bundled payment partnership may find that their reimbursement does not fully cover their costs. They may even owe CMS money for failing to meet cost and quality targets.

The winners will be those SNFs who act and collaborate decisively in response to these changes. But good decisions require timely and accurate information. There is a strong need to benchmark and monitor the pace of change in the multi-payer landscape, understand how key hospital referral partners are structured, and understand how they are reacting to new models of care reimbursement. This knowledge is critical to the long-term success of SNFs, improving care quality for patients, and reducing healthcare costs.

PRIMARY OBSTACLES FOR SNFS

As the healthcare industry continues to transition from volume to value reimbursement, SNFs will have to continue to be inventive in their efforts to improve the quality of care, while at the same time reducing their costs. The most recent changes in reimbursement have demanded innovation at a rapid-fire pace. But many reimbursement models and ideas put forth, although promising, are unproven and untested, and require technologies that are themselves untested on a larger scale.

Many SNFs believe that alternative reimbursement models will have a negative financial impact on them as they have already seen the pressure to reduce cost. Revenue capture and clinical outcomes have become the main area of focus around continued success in the payment models.

While most SNFs realize that pay for performance will be a critical part of their future reimbursement, many of them have not made the necessary changes in technology solutions to successfully implement these value based models. The only way to scale for the inevitable mixed reimbursement models is to understand and use new technology. By doing so, SNFs can automate the complexity out of the human and organizational experience, and engineer better decisions across the board—all for better health of the organization and the patients.

The primary obstacles SNFs urgently need to address to enable new bundled payment practices are technology related. This is led by the need to expand internal data collection, access, and analytics to survive in the changing landscape - all while taking action to reduce administrative burdens and costs to remain financially sound.
HOW CAN DART CHART HELP?

DART Chart understands the challenges SNFs face in the transition to alternative payment models. The company has been providing effective solutions to the SNF market since 1997, and has recently invested in expanding their existing Map & Track technology to enable this important all payer transformation. The expanded features allow SNFs to focus on complex financial models, drive down costs and improve quality.

All payer enhancements found in DART Chart’s new ACO and BPCI release are key to the competitive edge that SNFs need in the new reimbursement landscape.

Expanded features of Map & Track with Quick Map that propel the value of SNFs to referring hospitals include:

- Short stay management tracking to assist in lowering average length of stay.
- Metrics management that illustrates outcomes to enhance star ratings.
- Readmission workflow tracking that allows tracking outcomes of alternative options and redirection to other facilities outside of the hospitals.
- Bundled payment cost tracking that focuses on the large volume of simple and complex hip and knee replacement costs to drive revenue within the newly released bundled payments.

On the heels of newly proposed federal regulations to carry out CMS’s modernized reimbursement, DART Chart’s latest Map & Track release, called Map & Track ACO and BPCI, delivers the solution to reduce readmission, LOS, and costs. The current Map & Track solution already helps SNFs manage preadmission financials, daily care management, reconcile billing, and track pharmacy, therapy, and skilled care costs. The addition of the all payer enhancements found in the ACO and BPCI release to the product are key to the competitive edge that SNFs need in the new reimbursement landscape.

Some market reports show bleak results for the SNF market, but DART Chart is changing that dynamic by allowing SNFs to leverage technology as a competitive advantage. Through its ongoing Map & Track product releases, DART Chart is committed to help SNF practices thrive so they can continue to put patients first. By advancing initiatives that enhance practice efficiency, professional satisfaction, and the delivery of care, DART Chart strives to stay ahead of regulatory reimbursement changes and build solutions that help SNFs navigate and succeed in a continually evolving health care environment.

For more information on DART Chart’s newest Map & Track release (ACO and BPCI), go to www.dartchart.com.
GLOSSARY OF ACRONYMS

SNF – Skilled Nursing Facility

ACO – Accountable Care Organizations

CJR - Comprehensive Care for Joint Replacement model aims to support better and more efficient care for beneficiaries undergoing the most common inpatient surgeries for Medicare beneficiaries: hip and knee.

LEJR – Lower Extremity Joint Replacements is another term for CJR related to knee and hip replacements in Medicare.

BPCI - The Bundled Payments for Care Improvement initiative is comprised of four broadly defined models of care, which link payments for multiple services beneficiaries receive during an episode of care. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care with a goal of higher quality and more coordinated care at a lower cost to Medicare.

FFS – Fee For Service is a payment model where services are reimbursed separately.

ABOUT DART CHART

DART Chart provides payment integrity and managed care compliance software solutions focused on the long term care industry. We service long term care post acute providers, state government agencies and vendors. Our unique solutions identify and recover uncaptured revenue.

Discover the Power of a DART Chart Partnership

DART Chart is paving the way for innovative managed care solutions. To learn more about our company, our services and our commitment to eliminating burden and risk of managed care for the long-term care organizations visit our website at www.dartchart.com, or call 888.210.3200.