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VALUE-BASED PURCHASING:
A Practical Approach

Educational Objectives

1. Outline the evolution of Value Based Payment (VBP) in the marketplace and current pilots & models
2. Understand the value proposition of various VBP models
3. Appreciate the resources required to implement a VBP approach to care
4. Outline steps to optimize Revenue Cycle processes to support VBP investment

Content Outline

I. VBP: Evolution & Overview
   • Why VBP? Historical Perspective
   • VBP Models: Voluntary to Mandatory
   • Strengths & Limitations of Selected Models

II. The Value Proposition: Quality & Cost = Value
   • Partnership & Payor Considerations
   • BPCI-Drivers of Cost
   • ACO-Population Management
   • CMS/Pay for Performance & Quality Focus
I. VBP: Evolution & Overview

- Why VBP? Historical Perspective
- VBP Models: Voluntary to Mandatory
- Strengths & Limitations of Selected Models

Let's Start Here

Medicare Health Care Quality Demonstration

- The Medicare Modernization Act (MMA), enacted in 2003, produced the largest overhaul of Medicare in the public health program’s 38-year history. Section 646 of the act mandated a 5 year demonstration Program under CMS to test the use of modifications to the traditional Medicare benefits and alternative payment systems for services provided to Medicare beneficiaries with broad goals to:
  - Improve patient safety
  - Enhance quality
  - Increase efficiencies
  - Reduce scientific uncertainty and unwarranted variation in medical practice that results in both lower quality and higher costs
Projected Medicare Spending

![Projected Medicare Spending Chart]

Source: CBO (Congressional Budget Office)

Source: 2014 Annual Report of Boards of Trustees of Medicare trust funds and CBO report The 2014 Long-Term Budget Outlook

Affordable Care Act (ACA) 2010

Patient Protection & Affordable Care Act, or Affordable Care Act (ACA) or Obamacare is a US federal statute enacted by President Obama on March 23, 2010.

- The most significant regulatory change to our healthcare system since 1965 and the passage of Medicare & Medicaid
- The intent of ACA was to improve quality, affordability & availability of health care for all Americans while expanding coverage & reducing costs
- The Act allowed the creation of Accountable Care Organizations (ACO’s) for Medicare patients, the CMS Innovation Center, and the Bundled Payments for Care Initiative

https://innovation.cms.gov/initiatives/index.html#views=models

Value-Based Payments (VBP): An Overview

- VBP is a payment methodology that rewards quality of care through payment incentives and transparency
- Value is broadly considered to be a function of quality, efficiency, safety and cost
- Under VBP, providers are held accountable for the quality and cost of the services they provide through a system of rewards and consequences and are conditional upon achieving pre-specified performance measures
- Incentives are structured to discourage inappropriate, unnecessary and costly care
VBP: The CMS Strategic Evolution

- CMS has been paving a strategic path to position VBP as the basis for an evolution in healthcare reimbursement.
- The goal is to reward providers who deliver value & care coordination rather than volume & care duplication.
- Department of Health & Human Services (HHS) adopted a framework that categorizes healthcare payment according to how providers receive payment to provide care:
  - Category 1: Fee-for-service (FFS) with no link of payment to quality
  - Category 2: FFS with a link of payment to quality
  - Category 3: Alternative payment models built on FFS architecture
  - Category 4: Population-based payment

CMS Payment Models

Moving Healthcare from FFS to VBP

To reward high quality and cost-effective care Alternate Payment Models (APM) need to address seven principles:

1. Change in financial incentives alone is insufficient to achieve person centered care. Patients must be empowered to be partners in healthcare transformation.
2. The goal of payment reform is to shift healthcare spending towards population-based payments.
3. Value-based incentives should reach the providers that deliver care.
4. Payment models that do not take quality into account should not be considered as APMs.
5. Value-based incentives should be intense enough to motivate providers to invest in and adopt new approaches to care delivery.
6. APMs will be classified according to the dominant form of payment when more than one type of payment is used.
7. Centers of excellence, accountable care organizations, and patient-centered medical homes are examples, not categories because they are delivery systems that can be applied to and supported by a variety of payment models.
II. The Value Proposition = Quality + Cost

- Partnership & Payor Considerations
  - CMS/Pay for Performance & Quality Focus
    - CMMI
    - Home Health VBP
  - BPCI-Cost Drivers
    - Comprehensive Care for joint Replacement (CJR)
    - Episode Payment Models (EPM)
  - ACO-Population Management

Evidence that Quality + Cost = Value

- Hospitals now have a business case to support efforts to improve care coordination with community partners
  - Readmission penalties
  - Bundled payments
- Study published in Home Health Care Management & Practice, 2016, 28 (4). * demonstrated that health care communities with higher performing nursing homes and home health agencies were more likely to have a lower 30-day risk-standardized readmission rates.
  - Improvement efforts require system changes
  - When HH agencies improved their performance ratings, readmission rates were also reduced
- Nearly two thirds of providers in some type of integrated employment model (Integrated health networks, physician hospital organizations, ACOs and large medical groups) are primarily based through alternative payment models.*

* http://www.volumetovaluestudy.com
VBP: Providers Perspective Post Election

- Anticipate that the concept of VBP will continue to be realized as both federal, state and private payers adopt models to a variety of conditions and providers.
- Policymakers appear to be continuing broad bi-partisan support for models that move from “FFS” to “Pay for Quality” improvement & cost controls.
- The Medicare Quality Payment Program, which ties all Medicare physician reimbursement to performance, is likely to move forward as planned.
- Providers will be encouraged to adopt advanced alternative payment models (APMs) and thus enact changes in care delivery to facilitate improved outcomes.
- In the 2016 SNF PPS final rule, CMS adopted the SNF 30 day readmission measure as the first measure for the SNF-VBP program.
- In February 2016, per executive order of President Trump, new Medicare regulations will be delayed by 60 days.

Categories of Innovation Center Models

Accountable Care
- Accountable Care Organizations and similar care models are designed to incentivize health care providers to become accountable for a patient population and to invest in infrastructure and redesigned care processes that provide for coordinated care, high quality and efficient service delivery.

Episode-based Payment Initiatives
- Under these models, health care providers are held accountable for the cost and quality of care beneficiaries receive during an episode of care, which usually begins with a triggering health care event (such as a hospitalization or chemotherapy administration) and extends for a limited period of time thereafter.

Primary Care Transformation
- Primary care providers are a key point of contact for patients’ health care needs. Strengthening and increasing access to primary care is critical to promoting health and reducing overall health care costs. Advanced primary care practices – also called “medical homes” – utilize a team-based approach, while emphasizing prevention, health information technology, care coordination, and shared decision-making among patients and their providers.

Categories of Innovation Center Models

Initiatives Focused on the Medicaid and CHIP Population
- Medicaid and the Children’s Health Insurance Program (CHIP) are administered by the states but are jointly funded by the federal government and states. Initiatives in this category are administered by the participating states.

Initiatives Focused on the Medicare-Medicaid Enrollees
- The Medicare and Medicaid programs were designed with distinct purposes. Individuals enrolled in both Medicare and Medicaid (the “dual-eligibles”) account for a disproportionate share of the programs’ expenditures. A fully integrated, person-centered system of care that ensures that all their needs are met could better serve this population in a high quality, cost effective manner.
Categories of Innovation Center Models

Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models

- Many innovations necessary to improve the health care system will come from local communities and health care leaders from across the entire country. By partnering with these local and regional stakeholders, CMS can help accelerate the testing of models today that may be the next breakthrough tomorrow.

Initiatives to Speed the Adoption of Best Practices

- Recent studies indicate that it takes nearly 17 years on average before best practices - backed by research - are incorporated into widespread clinical practice—and even then the application of the knowledge is very uneven. The Innovation Center is partnering with a broad range of health care providers, federal agencies, professional societies, and other experts and stakeholders to test new models for disseminating evidence-based best practices and significantly increasing the speed of adoption.

CMS: Home Health VBP

- The Home Health Value Based Payment Pilot was first established as part of CMS 2016 HH PPS Update, CMS-1625-F November 5, 2015, Federal Register
- Initially impacts all Medicare certified agencies in nine VBP states
- Align “payment with quality”
- Baseline performance year of 2015 for 2016 measures
- Performance measurement begins January 2016
- Two Measurement Groups
  - Smaller Volume Cohorts (exempt from HHCAHPS)
  - Larger Volume Groups (participating in HHCAHPS)

CMS HHVBP

Figure 5: CMS Framework for Measurement Mapped to the Six National/Quality Strategy Domains

- Clinical Quality of Care
- Care on Demand
- Patient and Family Engagement
- Population Health
- Organizational and Technical Efficiency
- Value Creation

Innovation should be measured in the following areas:
- Innovation should be measured in the following areas:
  - In areas that are consistent with innovation.
  - In a way that considers the scale of a innovation.
Bundled Payments for Care Initiatives (BPCI)

The Bundled Payments for Care Improvement (BPCI) initiative was developed to test innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid, or Children’s Health Insurance Program (CHIP) expenditures while preserving or enhancing the quality of care for beneficiaries. Over the course of the initiative, CMS has worked with participating organizations to assess whether the models being tested result in improved patient care and lower costs to Medicare.

Under these models, health care providers are held accountable for the cost and quality of care beneficiaries receive during an episode of care, which usually begins with a triggering health care event (such as a hospitalization or chemotherapy administration) and extends for a limited period of time thereafter.

- 70-75% of Medicare patients are in the unmanaged fee-for-service program.
- For the past two decades, there has been a continuing trend of moving Medicare payments away from fee for service reimbursement.
- Paying a fixed price for all services in a patient’s “episode of care” has proven to be an attractive risk-based payment system.

Bundled Payments for Care Initiatives (BPCI)

- BPCI is the largest voluntary payment innovation program.
- Revenue cycle management remains unchanged—all providers are paid under their typical arrangements, i.e., DRG, RUGS, PPS or FFS.
- Infrastructure and organizational investment is the responsibility of the general contractor.
- Episode Initiators accept performance risk for a 90 day period, not insurance risk.
- Episode Initiators may participate with a limited number of bundles, add bundles, drop bundles or exit the program entirely with a 60 day notice.
- Gain sharing payments are restricted to physicians and other providers who have entered into formal agreements that comply with CMS requirements.

Bundled Payments for Care Initiatives (BPCI)

- Bundles are comprised of a variety of diagnostic categories across 179 DRGs.
- Four Models:
  - Model 1: Retrospective acute care stay only.
  - Model 2: Retrospective acute and post acute care episode.
  - Model 3: Retrospective post acute care only.
  - Model 4: Prospective acute care hospital stay.
- Medicare beneficiaries are automatically enrolled to the program if one exists at a participating hospital or if a participating physician is listed as the operating or attending physician for the inpatient stay.
- Bundles supersede ACO enrollment. Physician bundles supersede hospital bundles.
- Expected cost of care is derived for Medicare claims data across the continuum.
- CMS takes at least a 2% discount. Savings achieved are shared between BPCI general contractor, episode initiator (hospital, SNF, HHA, or physician) and other providers depending on the contractual arrangement.
Major Areas of Spending in a 90 day Bundle

Sources of Savings in an Episode of Care

Performance Illustration for a Single Bundle
### Strategic Considerations for Home Health Care in Value Based Model Participation

<table>
<thead>
<tr>
<th>Total Hip Replacement</th>
<th>SNF Replacement</th>
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<td><strong>Expected Episode Cost</strong></td>
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<td>Acute Anchor Admission</td>
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<td>OP and Other Part B</td>
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<td>Physician (PCP &amp; Specialist)</td>
<td>$3,300</td>
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<tr>
<td>Total Episode Cost</td>
<td>$24,800</td>
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### Comprehensive Care for Joint Replacement: CJR

- CMS finalized regulations for the Comprehensive Care for Joint Replacement (CJR) Model, formerly CCJR, on November 16, 2015.
- CJR aims to support better and more efficient care for beneficiaries undergoing the most common inpatient surgeries for Medicare beneficiaries: hip and knee replacements (also called lower extremity joint replacements or LEJR).
- In 2014, there were more than 400,000 procedures, costing more than $7 billion for the hospitalizations alone.
- Quality and cost of care for these hip and knee replacement surgeries still vary greatly among providers.
- Infections, implant failures, and readmissions.
- The average Medicare expenditure for surgery, hospitalization, and recovery ranges from $16,000 to $33,000 across geographic areas.

### Comprehensive Care for Joint Replacement: CJR

- Episode of care begins with an admission to a participant hospital of a beneficiary who is ultimately discharged under MS-DRG 469 (Major joint replacement or reattachment of lower extremity with major complications or comorbidities) or 470 (Major joint replacement or reattachment of lower extremity without major complications or comorbidities) and ends 90 days post-discharge in order to cover the complete period of recovery for beneficiaries.
- The episode includes all related items and services paid under Medicare Part A and Part B for all Medicare fee-for-service beneficiaries, with the exception of certain exclusions.
- Retrospective bundled payment model.
- All related care within 90 days of hospital discharge will be included in the episode.
- Hope was for this model to contribute to the Medicare goal of having 30 percent of all Medicare fee-for-service payments made via alternative payment models by 2016 and 50 percent by 2018.
- CJR was implemented in 76 MSA’s, including approximately 800 hospitals.
CMS: Episode Payment Models (EPM)

- On December 20, 2016, the Centers for Medicare & Medicaid Services (CMS) finalized new Innovation Center models that continue the Administration’s progress to shift Medicare payments from rewarding quantity to rewarding quality by creating strong incentives for hospitals to deliver better care to patients at a lower cost.

- These models will reward hospitals that work together with physicians and other providers to avoid complications, prevent hospital readmissions, and speed recovery.

EPM Impact on Quality

- These models have the potential to improve quality in four ways:
  - **First**, the model adopts a quality-first principle where hospitals must achieve a minimum level of episode quality before receiving reconciliation payments when episode spending is below the target price.
  - **Second**, higher episode quality, considering both performance and improvement, may lead a hospital to receive quality incentive payments based on the hospital’s composite quality score, a score that reflects hospital performance and improvement on the following two measures:
    - Hospital 30-day, All-cause, Risk-Standardized Mortality Rate (RSMR) following Co-Surgery (NQF #2558) and
    - Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey (NQF #0166)
  - **Third**, in addition to quality performance requirements, the model incentivizes hospitals to avoid expensive and harmful events, which increase episode spending and reduce the opportunity for reconciliation payments.
  - **Fourth**, CMS provides additional tools to improve the effectiveness of care coordination by participant hospitals in selected MSAs. These tools include: 1) providing hospitals with relevant spending and utilization data; 2) waiving certain Medicare requirements to encourage flexibility in the delivery of care; and 3) facilitating the sharing of best practices between participant hospitals through a learning and diffusion program.

CMS: Episode Payment Models (EPM)

- 5-year project begins July 1, 2017-December 31, 2021*

- Includes the cost of all Medicare A & B item & services

- Hospitals may develop provider collaborative agreements to share in risk that includes HHA’s

- All providers and suppliers will be continue to be paid their usual Medicare reimbursement

- Hospitals are financially accountable for the quality and cost of an episode of care:
  - Increased incentive for care coordination
  - 90-Day Episode triggered by a hospital admission

*In Feb 2017, via executive order, President Trump delayed start dates for new Medicare regulations for all sites.
Advancing Care Coordination through EPM

- **Cardiac Care Coordination**
  - The Acute Myocardial Infarction (AMI) Model
  - The Coronary Artery Bypass Graph (CABG) Model
  - The Cardiac Rehabilitation (CR) Incentive Payment Model

- **Orthopedic Care Model** adds to CJR bundle that went into effect April 1, 2016
  - Surgical hip/femur fracture treatments (SHFFT)

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### EPM: Michigan MSA’s

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<thead>
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<th>MSA Title</th>
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**Accountable Care Organizations (ACOs)**

The term Accountable Care Organization was first used in 2006 by Elliott Fisher, MD, Director of the Center for Health Policy Research at the Dartmouth Medical School.

Accountable Care Organizations and similar care models are designed to incentivize health care providers to become accountable for a patient population and to invest in infrastructure and redesigned care processes that provide for coordinated care, high quality and efficient service delivery.

- Health care providers voluntarily come together to deliver high quality, cost effective care
- CMS initiatives are focused on traditional Medicare beneficiaries but commercial insurers have adopted as a strategy to improve quality, control costs and share risk
Accountable Care Organizations (ACOs)

- Requires a minimum of 5,000 Medicare beneficiaries for three years
- Responsible for care across the continuum for a defined period of time
- Primary care driven, commercial insurer partnerships common
- Variety of incentive structures, but the ACO concept includes acceptance of insurance risk
- Savings are shared with CMS or insurer
- Requires significant infrastructure and organizational investment

Outcomes Management

Overlaps in Care, Incentives and Measures

Each sector is dependent on the others to deliver quality, cost effective care.
Risk Pathway to Evolving Payment & Delivery System Models

Where Do You Fit?

Partners and payers need to know how your agency can help them succeed under their VBP arrangements:

- **Bundled Payment Initiatives/EPMs**
  - Substitute for rehab stay
  - Reduce readmissions

- **Medicare and Commercial ACOs**
  - Reduce readmissions
  - Develop programs to manage chronic disease patients with high utilization.
  - Hospice and Palliative Care

- **Patient Centered Medical Homes/Physician Practices**
  - Develop partnership with physician practices
  - Facilitating “coordination of care visit” for PCPs
  - Assist in the management of chronic disease and frequent fliers
  - End of life care

III. Challenges, Approach & Critical Resources

- Identify Key Areas for Consideration in your Strategic Planning
- Identify Resources Required as a Provider and Valued Partner in your Marketplace
- Identify Best Practice Models of Care to Meet Patient, Payor and Community Needs
- Develop Analytic Approaches to Data Mining & Reporting
Strategic Considerations for Home Health Care in Value Based Model Participation

- Post-acute care is the largest driver of geographic variation in Medicare spending (IOM)
- Treat patients in the most cost-effective and clinically appropriate setting
  - Right Care-Right Setting-Right Time
- Under BPCI, health systems have financial incentives to NOT refer patients to high intensity care settings that they don’t need
- Financial responsibility for readmissions and quality outcomes diminish concerns for limits to medically necessary care
- Population management/risk stratification & care planning
- Readmission reduction
- Hospitals, SNF’s and Physician providers want post acute partners who help them improve care transitions and care coordination

Strategic Considerations for Home Health Care in Value Based Model Participation

Align with hospitals, physicians and post acute providers to increase referral volume

- Willingness to actively collaborate on quality improvement & care coordination with community partners
- Identify technology to support care coordination, data collection and regular performance reporting
- Develop service offerings that target areas of potential savings/lower costs
- Develop services that substitute for all or part of SNF stays
- Expansion of patient support services paid for by program savings
- Demonstrate ability to reduce readmissions
- Maximize PPS reimbursement for selected bundles

Strategic Considerations for Home Health Care in Value Based Model Participation

- Home Health can provide the critical success factor in VBP
  - Care delivery
  - Care coordination for physician practices, health departments, insurers
  - Community care management for assisted living and independent clients
- Innovations in Mobile Technology/Digital Health
  - Partnerships or new business lines
- Connect with patients in more convenient and cost-effective ways
  - Web based coaching
  - Cloud based self management tools
  - Tele-Health programs for chronic disease monitoring, management & real-time interventions
  - Medication minders
- Enhanced patient engagement, patient & care-giver experience
Strategic Considerations for Home Health Care in Value Based Model Participation

- Home Health must be prepared to substitute for some or all of the post acute services traditionally delivered in an IP setting
  - Ability to care for patients with complex needs
    - Bilateral knees
    - Lack of caregiver support in home
    - Co-morbid conditions
  - Provide a discharge day visit
  - Daily coordinated visits for first 7-14 days
  - Enhanced Interdisciplinary Teams: Community Pharmacists, APRN’s
  - Palliative Care
- Ability to provide high-quality care efficiently
- Willingness to collaborate in care coordination

Can Your Software Support Strategic Goals?

- The ability to collect, measure, management and share data will be essential in the VBP environment of care
- Utilize data to:
  - Identify high risk patients
  - Determine individual patient care needs
  - Optimize patient placement/LOC across continuum
  - Communicate across the provider continuum
  - Support changes in care delivery
  - Care management
  - Report quality outcomes
  - Utilize results in marketing and contracting
  - Track, trend, & optimize patient satisfaction
  - Real-time monitoring of outcomes at a staff level to facilitate trending & accountability
  - Educate staff, patient and community
- TELL YOUR STORY!!

What Can You Offer?

<table>
<thead>
<tr>
<th>Physician Value Modifier</th>
<th>BPCI</th>
<th>CJR</th>
<th>VBP</th>
<th>ACOs</th>
<th>VBP</th>
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IV. Roadmap to Revenue Cycle Best

• Redefining Outcomes Data to Meet Payor Requirements
• Technology Support
• Managing Internal Variance
• Revenue Cycle Best Practice
• Revenue Cycle Analysis
• Key Metrics

How to Look at Your Data Strategically

• Identify your data sources
  - EMR
  - External vendors
• Invest in internal resources to produce and refine data—technology and analytics
• Identify measures that align with VBP measures
• Identify and manage variance

Admits
Discharges

Timely Initiation of Care

Also includes:
• By Diagnosis
• By Care Type
• By Admission Coordinator

Caregiver Optimization
Revenue Cycle Strategies for VBP

- Revenue cycle optimization is key in supporting infrastructure development for value based payment
- Improve billing velocity and cash flow
- Data to support decision making and conversations with partners and payors
- Data source to project impact of VBP models on your own financials
- Identify break in process, costly work arounds, system configuration issues
- Timeliness of cash and data
RCM Optimization

- Build a continuous revenue cycle, get rid of “billing week”
  - Improves cash flow
  - Reduces errors
- Establish protocols for error turn around and measure compliance.
- Minimize “hand offs”
- Build a revenue cycle team composed of clinical and financial staff.
  - Identify bottlenecks, work arounds, workflow and technical issues.
- Revisit your EMR setup
  - Are payors, codes and rates configured correctly?
  - What are the available edits and which ones do you have turned on?
  - Are you billing every possible payor electronically?
  - Have you optimized your knowledge and use of clearinghouse functionality?

How Close Are You to 40?

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<th>Best Practice Benchmark</th>
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<td>Non-Medicare days in AR</td>
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<tr>
<td>Medicare Write Offs</td>
<td>1% or less</td>
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Why Days in Accounts Receivable (AR or DSO) Matter

Days in Accounts Receivable (DSO)—the length of time it takes to receive money for the services sold.

Money is tied up and can’t be used to pay bills.

The older it gets the less likely it will be collected.

(Accounts Receivable/Revenue) X Number of Days in the Period=DSO

Example: ($10,000,000/$50,000,000) X 365=73

What happens if you reduce DSO by 10 days?

($8,650,000/$50,000,000) X 365= 63

$10,000,000-$8,600,000=$1,350,000 more cash in the bank!
**AR Aging**

- Includes patient/invoice level drilldown

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**Know Your Agency Capabilities & Goals**

- Where do you go from here?
- How do you pay for it?

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**HH Medicare Unbilled**

- Also includes:
  - Client drilldown
  - Unbilled/EOE summary
  - Detailed development available for In-House Per Diem
What Are Your Strategic Goals?

<table>
<thead>
<tr>
<th>Physician Value Modifier</th>
<th>BPCI</th>
<th>CJR</th>
<th>VBP</th>
<th>ACOs</th>
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Thank You

Q&A

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Resources

- https://innovation.cms.gov/initiatives/Medicare-Health-Care-Quality
- https://innovation.cms.gov/initiatives/CJR

2017 Healthcare Industry Outlook: Navigate the Landscape; 2017 Avalere Health, LLC

Bundled Payments for Care Improvement (BPCI) Initiative: General Information. https://innovation.cms.gov/initiatives/bundled-payments/


Community-Level Association Between Home Health and Nursing Home Performance on Quality and Hospital 30-Day Readmissions for Medicare Patients. Home Health Care Management & Practice 2016, Vol.28(4):201-208


https://innovation.cms.gov/initiatives/index.html#views=models


Resources

2017 Healthcare Industry Outlook: Navigate the Landscape: 2017 Avalere Health, LLC
Avalere Health info@avalere.com; January 17, 2017


APM FPT Alternative Payment Model (APM) Framework: Final White Paper, 1/12/2016; Health Care Learning and Action Network

Measuring Success in Health Care Value-Based Purchasing Programs, Summary and Recommendations; Rand Corporation, Cheryl Damberg, et al 2014

Handouts

The Basic D&I Reports That Every Home Health Agency Should be Looking at: Data Collection, Data Interpretation, and Data Analysis; 12/4/2017

[Handout content redacted]
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