Health Reform 101

Presentation Compiled by the ASHA StAMP Network
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Disclaimer

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OVERVIEW AND OBJECTIVES

- Upon completion of this session, participants will be able to:
- Identify government requirements, payer parameters and standards of care impacting clinical services.
- Explain the development, structure and implementation of alternative payment models.
- Identify resources for additional information and clarification.

CHANGE IS CONSTANT

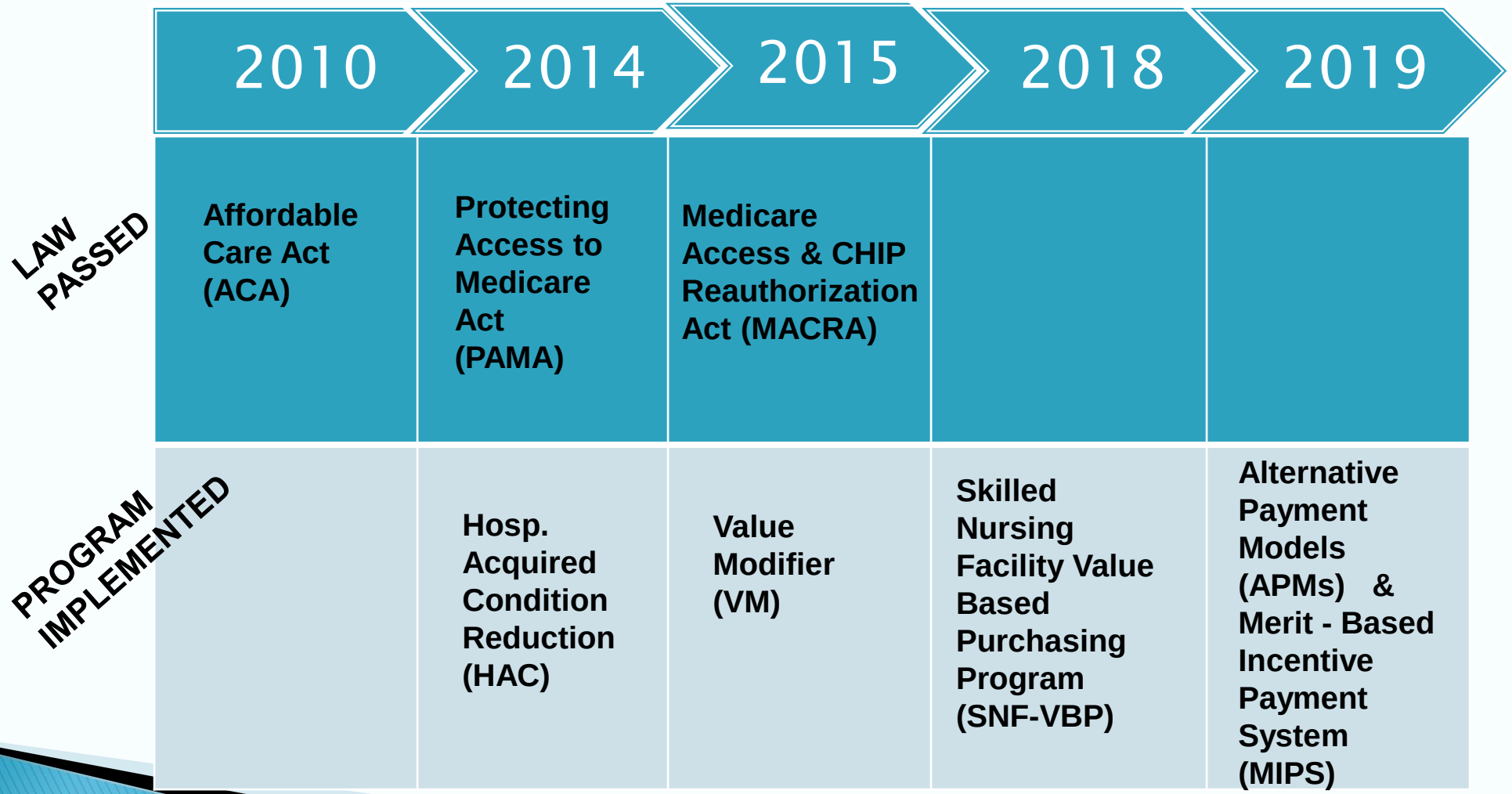
- Federal Laws & Regulations
  - Annual “Revised Final” Rules
  - Fee Schedules
  - Annual Medicare Advantage Updates
- State Surveys
  - Irregular schedules, OSHA, AAAASF
- Medicare Regulations and Policy
  - Service Model Changes
  - Payment Model Proposals
  - Medicare Learning Network “Newsletter”
  - CMS Open Door Forums with verbal revisions
- State Practice Acts
  - Frequent and significant changes

HEALTHCARE SERVICE AND DELIVERY IS TRANSFORMING

- Fee-for-service = payment for *quantity* of care
- Value-based = payment for *quality* of care
- The trend is moving toward value-based
  - (As a result of the Affordable Care Act in 2010)

Value: Improved quality at reduced cost

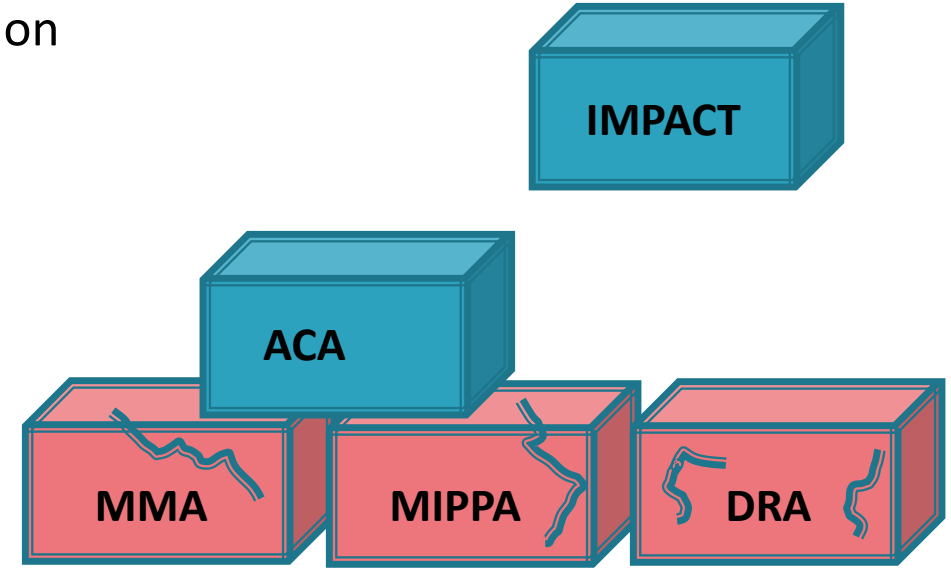
FEDERAL LAWS & VALUE-BASED PROGRAMS



THE GAME CHANGER: DATA COLLECTION AND REPORTING

Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

- Data Collection
- Standardized Assessment
- Interoperable Information



QUALITY REPORTING

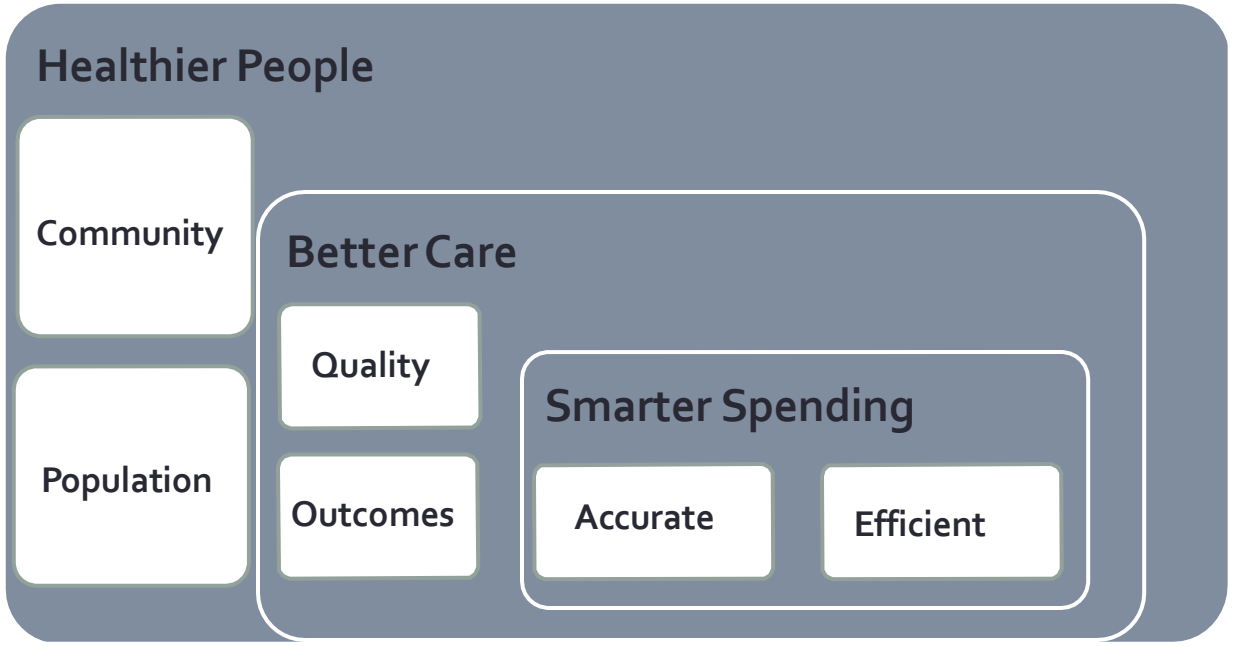
- IMPACT Act
  - Quality Measures
    - Incorporated into each setting
    - Cross-setting requirements to report on cognitive function, functional status, skin integrity, falls, medications and resource use
  - Requirements for standardized assessment
    - Across all settings facilitates information being uniform throughout the progression of care
  - Interoperability requirements
    - Enhance the ability to share patient-centered information
  - SLPs have a responsibility to participate in the collection and reporting of quality results through various programs

HAS ACA GONE AWAY??

- No. It's important to remember….
- ACA includes language on alternative payment models and delivery reform
- Established law requires the legal process to be used to make changes.
- What we know today, could be changed BUT only through the legal process.

- Background Information-
- http://www.healthdatamanagement.com/news/repeal-of-obamacare-could-cut-accountable-care-organizations

CMS TRIPLE AIM: THE MASTER PLAN



CMS INITIATIVES & SLP PRACTICE

- Survey & Certification
  - Target Surveys
  - Performance – QA/QI
- Value Based Purchasing
- Alternative Payment Models (APMs)
  - Hospital VBP
  - Skilled Nursing Facilities
  - Home Health
  - Ambulatory Surgical Facilities
- Accountable Care Organizations (ACOs)
- Community Based Transitions
  - Medical Home
  - Home Health
- Quality & Public Reporting
  - Hospital & SNFs
  - LTCHs & IRFs
  - HHAs

SLP & RELATED SERVICES

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CMS INITIATIVES & AUD. PRACTICE

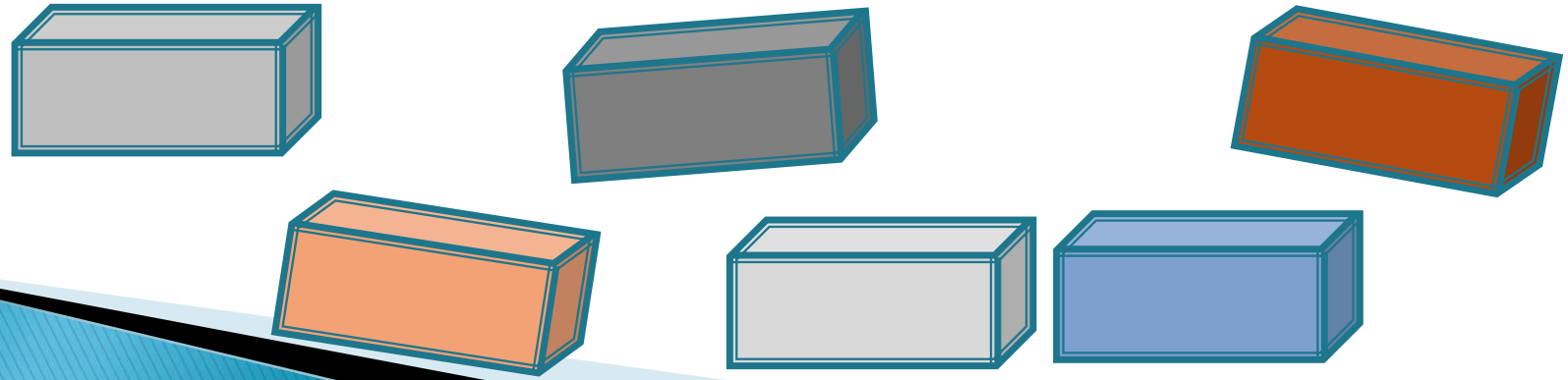
- Diagnostic Bundling
  - CMMI
    - ACOs
    - Care Model Demos
  - Quality & Public Reporting
    - Outpatient clinics
    - Private practice
    - Hospital & SNFs
  - Value Based Purchasing
    - Hospital VBP
    - Diagnostic Facilities

VALUE BASED CARE

WHERE ARE WE TODAY?

Value Based Programs

- Achievement & Improvement Measures
  - Quality Measures – some are
    - Implemented
    - Being revised
    - Remain in development
  - Ranked Performance Scores – most providers
- Withhold % of Payment to Fund Incentive Payments



VALUE BASED CARE: DEVELOPMENT, IMPLEMENTATION, EVOLUTION 2016 -2020

- Skilled Nursing Homes
  - Implemented Quality Measures – revisions and development continue
  - VBP implemented – payment incentive program initiated 10/1/18
  - Alternative Payment Model: Patient Driven Payment Model (PDPM) – implementation 10/1/2019
- Schools and Clinics
  - Medicaid Expansion – 36 states and the District of Columbia

VALUE BASED CARE:
DEVELOPMENT, IMPLEMENTATION, EVOLUTION 2016 -2020

- SNF, IRF, LTCH, HH - IMPACT Act (implementation is ongoing)
  - Standardized Assessment – portions integrated into SNF MDS, IRF-PAI, HH OASIS, LTCH – FIMS
  - Interoperability – initiated but far from completion

VALUE BASED CARE: DEVELOPMENT, IMPLEMENTATION, EVOLUTION 2016 -2020

- Home Health
  - OASIS revisions – 2018
  - Alternative Payment Model – Patient Driven Groupings Model (PDGM)– implementation 1/1/2020
- Private Practice, Rehab Agency, Group Practice (Physician Fee Schedule)
  - New Rehab (PT & OT) evaluation codes
  - Reduced Fee Schedule Rates
  - Ongoing and proposed re-weighting of "mis-valued" codes
  - Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Merit Based Incentive Payment System (MIPs)

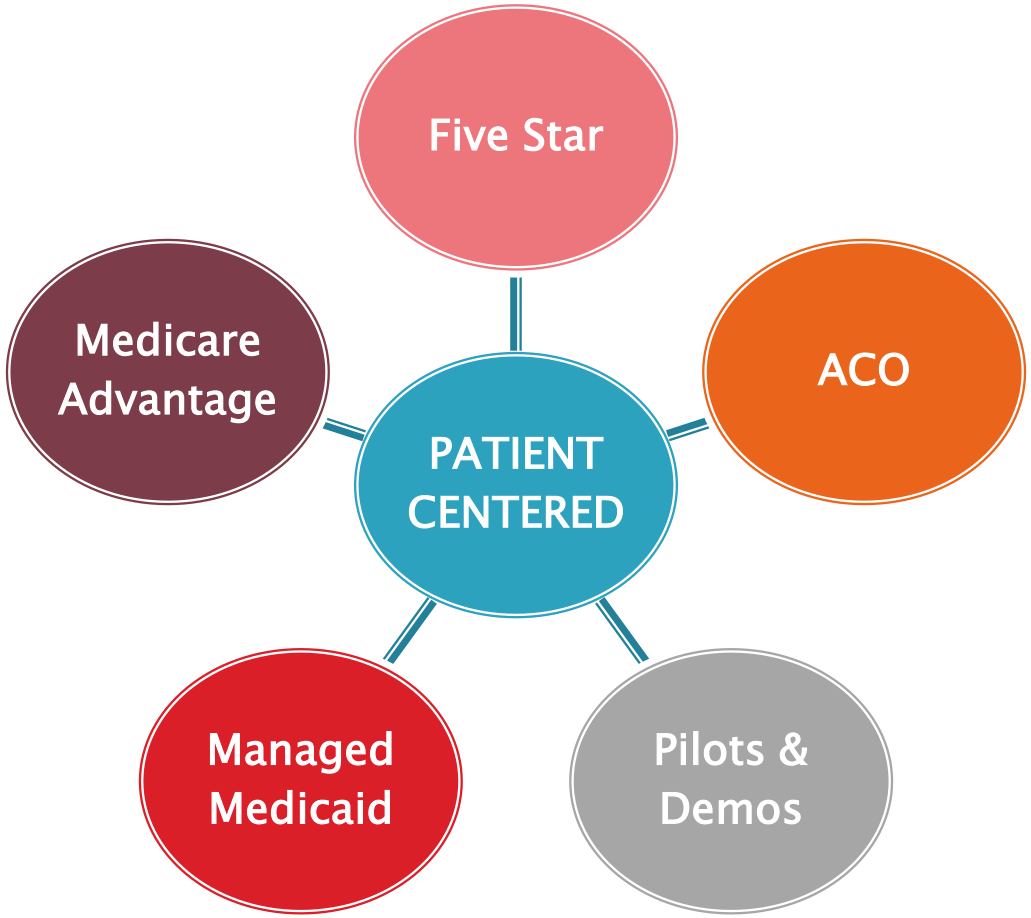
MORE TO COME FOR ALL PRACTICE SETTINGS

- Alternative Payment Models
  - Skilled Nursing Facilities Patient Driven Payment Model (PDPM) – implementation 10/1/2019
  - Home Health Care Patient Groupings Payment Model (PDGM) – implementation 1/1/2020
  - Private Practice Medicare Incentive Payment System (MIPS) – data collection underway for 2021 payment adjustments

MORE TO COME FOR ALL PRACTICE SETTINGS

- Quality Measures
  - SNF, HH, IRF, LTCH, Private Practice, Rehab Agencies, Clinics – Medicare Spending Per Beneficiary– Post Acute Care (MSPB–PAC) – data collection implemented in 2017
- Clinical Care and Service Models
  - SNF/Long Term Care Revised Rules Of Participation
  - Agencies, Clinics, Private Practice – New Code Values and/or "Mis-valued" code revisions

VALUE BASED CARE IS EVERYWHERE…



ALTERNATIVE PAYMENT MODELS

ALTERNATIVE PAYMENT MODELS

What is an Alternative Payment Model (APM)?

- An APM is a reimbursement system that incorporates quality and the total cost of care rather than paying providers a set fee for a particular service.
- APMs may be government run or operated by a private insurance entity.
- APMs may require the provider to give evidence of the expected patient outcome that is based on the patient's classification/diagnosis and historic resource utilization.

APMs & Quality Measures: What To Do

Encourage efficient, high quality service systems

- Look for innovative opportunities……
  - Reimbursement is dependent on:
    - Quality Measures ***AND*** Shared Savings
  - Payment is impacted by:
    - Re-hospitalization ***AND*** Functional Outcomes

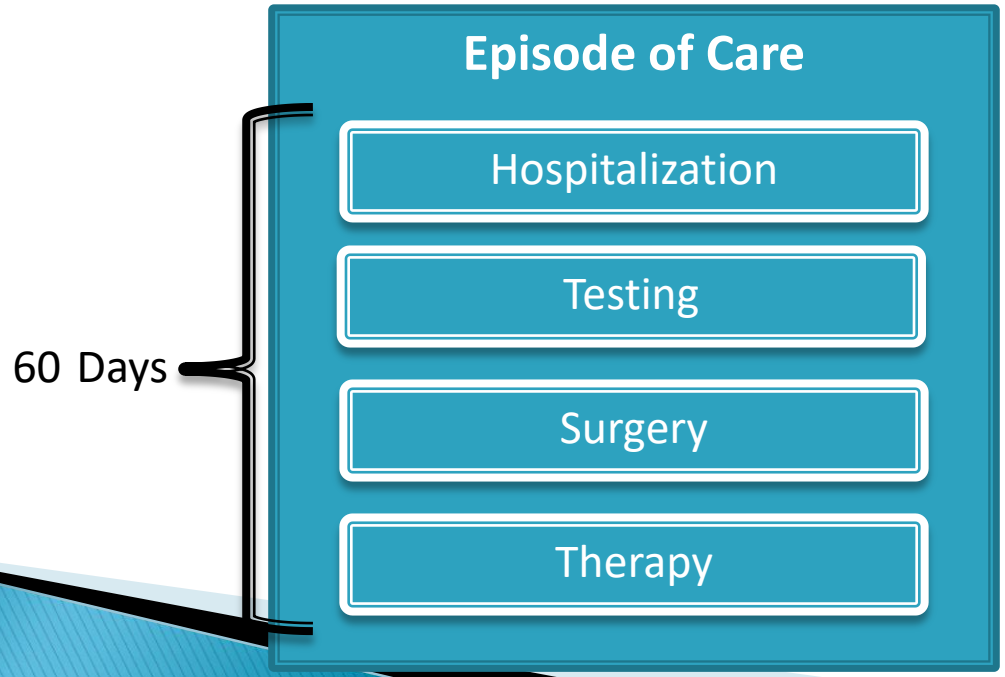
Participate in personal contact to educate & collaborate

- Strategically plan for what is
- Structure systems & processes for what will come

EPISODE OF CARE

Encompasses all services provided to a patient with an identified condition within a specific period of time across a continuum of care in an integrated healthcare system (e.g., Stroke).

Example: Home Health Patient with diagnosis of CVA (stroke)



- Did services improve outcome?
- Was spending reduced?
- Was treatment completed within the required timeframe?

BUNDLED PAYMENT

- Episodes of care are typically used to inform a bundled payment.
- Represents a single fixed payment for an identified condition.
- Better coordination of care for patients.
- Works really well for procedures/services with a discrete stop/end time.
- Can also be implemented for chronic conditions.

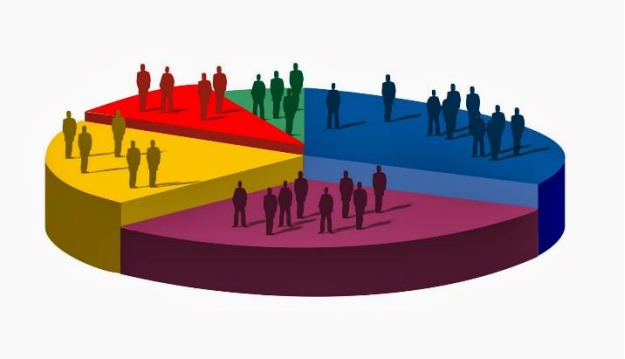
ACCOUNTABLE CARE ORGANIZATIONS(ACOs)

- Assume accountability for the cost and quality of care for a defined population of patients.
- Coordinate the services of its providers in various healthcare settings to manage patients' needs.
- Health information technology is integral.
- Can be hospital-driven or hospital/provider arrangements
- Medicare and private sector ACOs exist.

- Background Information….
  - http://www.beckershospitalreview.com/lists/100-accountable-care-organizations-to-know-2015.html

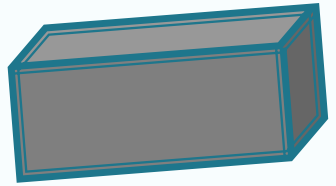
MEDICARE AND ACOs

- MedPAC defined an ACO as a group of physicians (possibly including a hospital) that assumes responsibility for annual Medicare spending for a defined patient population.
- ACOs would be compensated through an arrangement that combines traditional fee-for-service payments with financial incentives to reduce costs, improve quality, and achieve greater information transparency.



ACCOUNTABLE CARE ORGANIZATIONS

- Quality and cost savings
- Enhancing care coordination and integration
- Efficiency
- Use of performance-based incentives and bundled payments



ACO

(Accountable Care Organizations and Payment Reform: Setting a Course for Success
Bard & Nugent – www.navigant.com)

ACCORDING TO THE AFFORDABLE CARE ACT

Accountable Care Organizations must:

1. Be willing to become accountable for the quality, cost, and overall care of a defined population of Medicare fee-for-service beneficiaries;
2. Agree to participate in the program for at least three years;
3. Have a formal legal structure allowing it to receive and distribute payments for shared savings;
4. Have in place leadership and management structures that include clinical and administrative oversight systems;

ACCORDING TO THE AFFORDABLE CARE ACT

5. Accountable Care Organizations must:
6. Have a network of providers that includes enough primary care professionals to cover the Medicare beneficiaries assigned to it;
7. Demonstrate to the Secretary of HHS that it meets patient-centeredness criteria for these beneficiaries; and
8. Define processes to promote evidence-based medicine and patient engagement.

PAYMENT TO ACOs

- Providers participating in ACOs can continue to receive payments under the original Medicare fee-for-service program Parts A and B
  - These providers are eligible to receive additional payments for shared savings if the ACO meets the quality performance standard.
- If the ACO's annual expenditures are far enough below the benchmark, and the ACO meets the quality performance standard..
  - The ACO shall be eligible to receive payment for a portion of the savings it has brought to the Medicare program.

PATIENT-CENTERED MEDICAL HOME (PCMH)

- Patient-Centered Medical Home
- A model, not a “home”.
- The PCP coordinates care with other providers (“gatekeeper”).
- Enhanced care coordination and communication, particularly useful for chronic conditions.
- Intended to minimize fragmentation of information between providers.
- Can be integrated into ACOs.

PATIENT DRIVEN PAYMENT MODEL (PDPM): SLP CLASSIFICATION CRITERIA

- Implementation Date : October 1, 2019
- With regard to the presence of an acute neurologic condition, this criteria solely depends on if the patient is classified into the Acute Neurologic clinical category.
  - If the patient is not classified into this clinical category, then they would not qualify for this aspect of the SLP component classification criteria.
- For the presence of a cognitive impairment, any level of cognitive impairment (mild or above) is sufficient to qualify the patient for this aspect of the SLP component classification criteria.

PATIENT DRIVEN PAYMENT MODEL (PDPM): SLP CLASSIFICATION CRITERIA

- With regard to the presence of an SLP-related comorbidity, CMS identified twelve comorbidities that were directly correlated with increased SLP costs.
  - Rather than separately accounting for each of these twelve conditions, the presence of any one of these conditions is sufficient to qualify the patient under this aspect of the SLP component classification criteria.
- Reference (emphasis added): https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

PATIENT DRIVEN PAYMENT MODEL: SLP-RELATED COMORBIDITIES

Aphasia	**Laryngeal Cancer**
CVA, TIA or Stroke	**Apraxia**
Hemiplegia or Hemiparesis	**Dysphagia**
Traumatic Brain Injury	**ALS**
Tracheostomy Care (while a resident)	**Oral Cancers**
Ventilator or Respirator (while a resident)	**Speech and Language Deficits**

PATIENT DRIVEN GROUPINGS MODEL (PDGM): HOME HEALTH CLASSIFICATIONS

- Implementation Date: January 1, 2020
- Under the PDGM, each 30-day period is grouped into one of twelve clinical groups based on the patient's principal diagnosis.
  - The reported principal diagnosis provides information to describe the primary reason for which patients are receiving home health services under the Medicare home health benefit.
- The PDGM includes a comorbidity adjustment category based on the presence of secondary diagnoses….Home health 30-day periods of care can receive a comorbidity adjustment under the following circumstances:
  - Low comorbidity adjustment: There is a reported secondary diagnosis that is associated with higher resource use, or; ·
  - High comorbidity adjustment: There are two or more secondary diagnoses that are associated with higher resource use when both are reported together compared to if they were reported separately. That is, the two diagnoses may interact with one another, resulting in higher resource use
- Reference: https://www.cms.gov/center/provider-type/home-health-agency-hha-center.html

EVOLUTION OF DIAGNOSTIC PRACTICE

- The focus is on EFFICIENCY
  - The diagnosis must be accurate and substantiated.
- We must focus on the CLINICAL QUESTIONS
  - Reason for referral
  - Impact on function
  - Determining the problem
  - Recommending the solution
- PATIENTS are the CENTER
  - What do they want/need to know?
  - What do they want/need to do?
- Interprofessional COLLABORATION is required
  - Differential diagnosis needs to consider the whole person.
- Reporting DATA is not an option.

WHAT DOES EVOLING PRACTICE LOOK LIKE?

- Our clinical decisions are questioned and must be substantiated.
  - Evidence based practice is expected
- Interprofessional Collaborative Practice is the expected standard
  - Collaboration
  - Communication
  - Community
- Clinical predictions/assumptions for length of service are challenged
  - Lengths of service are to align with historic clinical evidence .

MANAGING EVOLVING PRACTICE

- Comprehensive evaluations are expected on “Day One” of service
  - Completion within 24-48 hours of admission
- Treatment must focus on FUNCTION, FUNCTION, FUNCTION.
  - International Classification of Function (ICF) is the foundation for most value-based rules
- Quality Measurement criteria must be known
  - Patient outcome must reflect quality care and respect patient preferences

MANAGING EVOLVING PRACTICE

- As clinically appropriate, Interprofessional Collaboration requires us to insert ourselves into the care of the patient, regardless of the “admission diagnosis”
  - Are there swallow or cognitive issues post-surgery?
  - Does the patient have the ability to follow directions and problem solve?
- SNF Facility “short stay” patient care is still comprehensive
  - Treatment must be individualized for each admission
  - Care is based on the patient’s discharge plans and destination.

KEYS TO SUCCESS

- Collect your performance data to share it with “upstream” and “downstream” care partners/providers.
- Be able to answer these questions:
  - What are the provider’s rehospitalization rates?
  - What are the provider’s successful “Discharge to Community” rates?
  - What is your patient’s average length of service?
  - Do you have Guest/Patient/Family Satisfaction Scores?
  - What are you contributing to Quality Measurements for the hospital/SNF/IRF/LTCH/Agency/Clinic, etc.?
  - What Functional Outcome Information can you report about your patients?

KEYS TO SUCCESS

- The goal for the new Value Based/APMs/bundled plans is the next level of care
  - Prior Level of Function (PLOF) is no longer the deciding factor for medical necessity
- Re-design nursing and therapy processes to increase prompt and complete communication.
- Discharge management is from day of admission.
  - Essential to have SLP active participation
- Involvement from the caregiver/family is now required.
- Establish good partnerships with HHA and other community resources.
  - Strive for increased transparency with all provider partners.

Working Well & Moving in the Right Direction

- Inter-professional collaboration: Improving & expanding
- Teaming & Leadership opportunities
- Family/Caregiver interaction & participation in care
- CPT Coding Expansions – 4 new ST evaluation codes
- Job market remains strong
- Telepractice
- Versatility of the profession

The Challenges

- Reimbursement Issues, Paperwork burden
- Rules – hard to keep up with frequent changes & differences across payers
- Productivity expectations – time for what??
- Work at top of professions – what does this mean & can we do it???
- Evidence Based Practice
- Customer / Patient anxiety and discontent due to economy and pressures of economy (e.g. high deductible plans, feeling rushed at appointments)
- Medical providers' understanding of what SLP's can do
- Poor understanding of healthcare economics

Reframing the Professions to Become Indispensable

- First…….Understand the Healthcare Landscape
- Then……..Embrace Change!

Healthcare Perspectives

- Triple Aim from two divergent populations serving inpatient and outpatient populations
  - Children in clinical settings
  - Adults in the medical, home, and community environments

The Adult Healthcare Setting

- Influencing the Patient Experience
  - Short term rehab, Long term stay, HOME AND COMMUNITY SERVICES
  - Managing expectations of the patient and his/her family members
  - Managing other caregivers
  - Educating family and caregivers about SLP services
  - Functional Outcomes

Children's Hospital IP & OP

- Influencing the Patient Experience
  - Outcome Measures – need to be able to demonstrate outcomes & life impact
  - Service Delivery Models – increasing access to care
    - Individual, Group – what we know
    - Telepractice – continue to develop
    - Consultative, Intensive, Episodic – need to get better at knowing when appropriate & using these models!
  - Family Education & Training – developing overviews, patient experience… Computer Based Trainings, could be in multiple languages

Population Health

- Medical scholars David Kindig, M.D., and Greg Stoddart, M.D., defined population health in 2003 as, "the health outcomes of a group of individuals, including the distribution of such outcomes within the group."
- Daniel Hyman, M.D., M.M.M., Chief Quality and Patient Safety Officer at Children's Hospital Colorado, further qualifies this definition, stating that population health is about improving the health outcomes of the entire population AND reducing or eliminating disparities between groups.

Population Health Management

- Population health management is the attempt to affect health outcomes within a group of individuals by studying why some people within that group are healthy and why some are not, then implementing policies and interventions to decrease disparity and raise the level of health outcomes of the entire group.

The ADULT HEALTH CARE Environment

- Education, Education, Education
  - the Experience—what has changed in 30 years since OBRA
  - Dementia management
  - The Medical Profession re: SLP treatment
  - The General Public/Consumers
  - SLP Scope of Practice

The SNF Environment

- Public Service Announcements and Stroke Response times
  - F: Face Drooping
  - A: Arms Drifting Down
  - S: Speech Difficulties
  - T: Time to call 911!

Children's Hospital IP & OP

- Education & Outreach
  - providers & consumers of SLP's scope of services
  - Sponsored Silence and other public awareness campaigns
- Improving Access to our services
- Implementing EBP!
- Improving our communication & collaboration with community providers & colleagues
- Helping families provide support at home & in the community

Our Role in Reducing Healthcare Costs

Understanding the Economics of Our Services

- Financial awareness/education
  - AUDs & SLPs need to understand health care economics and be accountable for their contributions to costs and cost savings
  - We need to be able to discuss financially sound services and delivery models that meet the needs of our patients with hospital leadership

Stretching our Healthcare Dollar

- Professional Time – our main expense!
  - Work at the Top of Your License – How? What does this mean for us?
  - Adequately Scheduled Work Day – What does this look like for your setting?
  - Developing workflow efficiencies
- Outcomes – our main cost savings!
  - How can we: help reduce LOS, increase independence, reduce resources needed/services utilized…
  - EBP – ensuring effectiveness
- Reimbursement – how we get paid!

Professional Time

- Work at Top of our Profession (more than one answer)
  - SLPA – identify where they can be used & how (when extra set of "skilled" hands are needed – e.g. group therapy)
  - SLP as educator/trainer – for nursing, nursing aids; need to ensure that SLPs are trained in training professionals & para-professionals
  - Service Delivery Models – Consultative – develop clinical competence

Skilled vs. UnSkilled

- When the patient has achieved all their goals and your primary role is observation to maintain their gains, you are no longer providing skilled services.
- CMS does not reimburse us to observe or maintain
- Our plan must include caregiver training so carryover and maintenance is achieved

Professional Time

- Developing workflow efficiencies
- Streamlined Paperwork (advocate for, develop)
- Electronic Medical Record – Be a key team member in documentation and process flow development for our service
- Point of Service Documentation
  - A lap top enables you to document when you are with a patient.
  - Most patients enjoy participating in writing up their “report card”.
- Working with a therapy aide
  - Room set up, materials preparation, cleaning

Professional Time

- Productivity – expectations, understanding
  - What is an adequately scheduled work day for your setting?
  - What to do if your agency requires an unreasonable level? How to discuss this with your leadership team.
  - Billable vs. non-billable activity

Outcomes

- Search for and know EBP for your services
  - Critically appraise the research, determine the clinical bottom line, be able to discuss
- Service Delivery Models
  - Not one size fits all, be able to use & discuss with patients & families, providers & 3rd party payors
- Measure your program effectiveness
  - Not just goals met, but life impact (increased independence, reduced services/resources needed)
  - Overall cost of care impact? help reduce LOS, services needed while in hospital (did you reduce the need for a 1:1 assistant??)

Understanding Reimbursement

- KNOW YOUR PAYOR SOURCE!!
  - Medicare Part A
  - Medicare Part B
  - Managed Care A and B
  - Commercial Insurance
  - Private Pay
  - Medicaid

How is Speech Reimbursed?

- Bundled services vs. per unit charges
  - Defining a service-based visit (ST) vs. a time-based unit (PT & OT)
  - Comparing cost to reimbursement
  - The importance of time per visit
- Screening vs. Evaluating

CMS Guidelines

- What is medical necessity?
  - You must be able to say that the services you are providing is at the level of complexity that it could ONLY be provided by a licensed SLP.
- The only insight into your treatment to determine medical necessity that CMS has is your documentation!!

What is Billable?

- All patient interactions that include:
  - Direct patient care
  - Care Conferences in which the patient participates
  - Point of service documentation, in which the patient is present and participates
  - Evaluations, Re-Evaluations, Assessments to update the plan of care