

MHCC Issue Brief Nursing Home-Hospital Collaboration

Maryland Developments:

Maryland initiated a new all-payer model for regulation of hospital charges in 2014. It transitioned the 40-year old system of regulation from a Medicare inpatient per admission test to an all-payer total hospital payment model, with spending growth limitations and Medicare savings targets. This model has met the objectives agreed to by Maryland and the Centers for Medicare and Medicaid Services (CMS) to date and, in 2020, is planned to enter a second phase model expanded to address the total cost of care, across the continuum of primary care, outpatient diagnosis and treatment, inpatient care, and post-acute and long-term care. The spending limitations and savings targets that will be adopted for this second phase model will reinforce the Phase One emphasis on reducing hospital admissions and readmissions, broadening the scope to post-acute care, and incentivizing reductions in Medicare skilled nursing facility admissions and length of stay.

According to the *Maryland All-Payer Model Progression Plan*, a key element going forward will be to develop initiatives focused on post-acute and long-term care. The report acknowledges that “currently, there is little comprehensive care coordination between settings that address the needs of these patients who have higher rates of potentially avoidable [hospital] utilization.” The goals are to coordinate and optimize the use of acute care hospital services with post-acute and nursing home services. Options that may be considered include bundled payments and controlled relaxation of the three-day rule which requires a three day hospital stay prior to nursing home admission for Medicare patients.¹

Developing preferred provider networks with hospitals would provide nursing homes with a ready source of post-acute Medicare patients. Such networks might also be a source of marketing to promote the nursing home as a provider offering special benefits.

There are also CMS incentives. Nursing homes are now being held accountable for hospital readmissions. CMS has started publicly reporting the rates at which nursing home residents return to the hospital within a month of admission. Starting in October 2018, facilities with high hospital readmission rates will be penalized, with CMS withholding two percent of Medicare reimbursements and redirecting some of those funds to higher performing facilities.²

National Models on Reducing Hospital Utilization:

While Maryland’s form of hospital rate regulation is unique, the following information provides background on federal initiatives that are likely to have some relevance for the collaborative efforts to develop alternative approaches to paying for post-acute care. There are several national models that encourage the collaboration between hospitals and post-acute providers necessary to reduce hospital readmissions.

¹ *Medicare All-Payer Model Progression Plan*, December 16, 2016.

² Chedekel, Lisa, “New Strain on State Nursing Homes: Keep Patients out of Hospitals,” *Hartford Courant*, January 16, 2018.

IMPACT Act

CMS was concerned about post-acute spending which between 2001 and 2013 grew at an annual rate of 6.1 percent and doubled to \$59.4 billion. Payments to hospitals grew at an annual rate of 1.7 percent during the same time period. The intended solution to this issue of accelerated post-acute spending was the passage of the IMPACT Act of 2014 legislation.³

“The Improving Post-Acute Care Transformation (IMPACT) Act of 2014 mandates the Health and Human Services (HHS) secretary to measure how often certain services should be used in post-acute settings based on the risk of a provider’s population. The CMS also proposes evaluating a provider’s efficiency by tracking per-beneficiary spending.”⁴ Field testing for measures began in July, 2016. After testing, the use of standardized assessment data is due no later than the following: SNF, Inpatient Rehabilitation Facilities (IRF), Long Term Care Hospitals (LTCH) (October 1, 2018); HHA (January 1, 2019). The March, 2017 MedPAC report recommended changes in reimbursement for all post-acute payer types. They recommend transitioning to a unified post-acute prospective payment system (PPS) beginning as early as 2021. Until then, they recommend that CMS move forward with revisions to SNF and home health PPS.⁵ The goal is to reimburse based on care needs, rather than the setting of care.

Next Generation ACOs:

In January, 2016 CMS and the CMS Innovation Center launched an accountable care organization (ACO) model called the Next Generation ACO Model. During the first year (2016) 18 ACOs participated and in 2017 28 ACOs are joining. The Accountable Care Coalition of the Chesapeake, LLC serves the District of Columbia, Maryland and Virginia. The Next Generation ACO Model’s Core Principles include:

- Protect Medicare fee-for-service beneficiaries’ freedom to seek covered items and services from the Medicare-enrolled providers and suppliers of their choice;
- Engage beneficiaries in their care through benefit enhancements designed to improve the patient experience and reward seeking appropriate care from providers and suppliers participating in ACOs;
- Create a financial model with long-term sustainability;
- Utilize a prospectively-set benchmark that: (1) rewards quality; (2) rewards both improvement in and attainment of efficiency; and (3) ultimately transitions away from using an ACO’s recent expenditures for purposes of setting and updating the benchmark;
- Mitigate fluctuations in aligned beneficiary populations and respect beneficiary preferences by supplementing a prospective claims-based alignment process with a voluntary process; and

³ Dickson, V. Providers Balk at Post-Acute Measures. *Modern Healthcare*. January 21, 2016

⁴ Ibid.

⁵ Report to Congress. Medicare Payment Policy. MedPAC. March, 2017.

- Smooth ACO cash flow and support investment in care improvement capabilities through alternative payment mechanisms.⁶

Bundled Payment:

One component of the IMPACT Act is the development of a demonstration model for bundled payment. The first one planned was for joint (hip and knee) replacement. Under this model, acute care hospitals in certain selected geographic areas would assume quality and payment responsibility for retrospectively calculated bundled payments for joint replacement episodes. The payment program would make hospitals financially accountable for the cost and quality of all medical services related to lower-joint replacements during a patient's hospital stay and for 90 days after. This program would waive the 3-day hospital requirement prior to a nursing home admission; however, the nursing home used for placement must have at least 3 stars on the CMS' Nursing Home Compare website.⁷

It is expected that such programs would encourage collaboration between hospitals and nursing homes since there will be a shared financial incentive to ensure the best care throughout the continuum of care. As of March, 2017 CMS has delayed the expansion of the bundled payment for comprehensive care for joint replacement and cardiac care. In November, 2017 CMS indicated that it wanted to focus on voluntary models. On January 9, 2018, CMS introduced a test program for bundled payment for 32 clinical episodes; however, this model only includes hospitals and physicians and excludes post-acute providers such as nursing homes and home health agencies.⁸

Incorporation into the State Health Plan:

The State Health Plan, which is used to guide decisions on the supply and distribution of nursing homes and nursing home beds, can be a tool for facilitating the payment model changes under way in Maryland, by promoting development of nursing home resources by persons who appear most able to deliver the more cost effective post-acute care required. Docketing rules could include exceptions for risk sharing contracts between hospitals and nursing homes. For example, if establishment or expansion of a nursing home is proposed as part of an arrangement between a hospital and a nursing home that is designed to reduce Medicare SNF length stay and unnecessary hospital admissions, SHP rules could allow for such projects to be docketed and reviewed even if the SHP's bed need projections would not be consistent with the proposed project. Such rules could also be used as preference rules in comparative reviews.

⁶ Next Generation ACO Model Fact Sheet; CMS. <https://innovation.cms.gov/Files/fact-sheet/nextgenaco-fs.pdf>

⁷ Evans, Melanie. Bundled Payment Demo has Nursing Homes Seeing Stars. *Modern Healthcare*, November 21, 2015.

⁸ Reid, Jon. "Post-Acute Care Providers Upset Over Being Left Out of Bundled-Payment Test Program." *Morning Consult*, January 23, 2018.

Questions for Discussion:

- What are the major issues nursing homes face in admitting certain patients from hospitals? Do specific categories of patients pose particular challenges?
- What are the risks and benefits for nursing homes in working with hospitals under risk sharing arrangements? What risks should hospitals/nursing homes be willing to assume?
- How are nursing homes working with HSCRC to develop post-acute networks?
- Are there standards for how such contracts between hospitals and nursing homes should be structured?
- Are there specific clinical conditions that lend themselves to such arrangements?
- What specific examples exist in Maryland for risk sharing arrangements?