Regulatory & Policy Landscape

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Speaker Disclosures

- Alex Bardakh has no relevant financial disclosures.
Political Update 2018
Key Issues Before Mid-Terms

- Politics
  - Midterms for the party not in power: historical trends; presidential popularity
    - Will Congress flip? 24 needed in House; Senate more difficult
  - State Elections/Redistricting

- The Economy: key trends include lower unemployment, wage increases, continued job insecurity and a volatile stock market.
Administration’s Regulatory Goals

- Patients over Paperwork Campaign
  - Reduce Admin Burden
  - Less time spent on things like EHR and Documentation
- Meaningful Measures
  - Too many measures across programs
  - Confusing and meaningless in terms of patient outcomes
  - Streamline measures and measure reporting
- Complete overhaul of Meaningful Use/ACI (latest: ACI/MU renamed to promoting interoperability)
- My HealthEData Initiative – (latest: hospital COP to require sharing data with patients?)
- Overhaul of E&M Guidelines
Society on the Hill

- Workforce – Geriatric Workforce Enhancement Program (GWEP)
- PA/LTC Role in Value-Based Medicine
- Advance Care Planning
- Telehealth in SNF
Legislative Victories

- Permanent Repeal Therapy Caps – only 20+ years in the making
- Signed into Law: Recognize, Assist, Include, Support and Engage (RAISE) Family Caregivers Act (S. 1028), requires the development of a national strategy that would identify specific actions that government, communities, providers, employers, and others can take to recognize and support family caregivers.
- Passed out of committee: Good Samaritan Health Professional Act of 2017, a bill that protects health care professionals from being held liable for harm caused by providing health care services during a national or public health emergency, or a major disaster.
- Physician Payment Changes – reduction in MACRA penalty liability; physician payment protections
So How Are Things in DC?
MACRA

MIPS / APMs
## Payment Adjustment Timeline

<table>
<thead>
<tr>
<th>Payment Year</th>
<th>2015-2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
<th>2024</th>
<th>2025</th>
<th>2026</th>
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<tbody>
<tr>
<td><strong>Physician Conversion Factor</strong></td>
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<tr>
<td><strong>Annual Update</strong></td>
<td>0.5%</td>
<td>0.25%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>QPs = 0.75%</td>
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<td>All other physicians: 0.25%</td>
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<td><strong>MIPS</strong></td>
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<tr>
<td><strong>Payment Adjustment</strong></td>
<td>+/-4%</td>
<td>+/-5%</td>
<td>+/-7%</td>
<td>+/- 9%</td>
<td></td>
<td>(2022 &amp; beyond)</td>
<td></td>
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</tr>
<tr>
<td><strong>Exceptional Performance Adjustment Applies (Top 25%)</strong></td>
<td>Applies to Top 25% of Performers (2019-2024)</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
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<tr>
<td><strong>Advanced Alternative Payment Models (APMs)</strong></td>
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<tr>
<td><strong>Incentive Payment</strong></td>
<td>5% Incentive Payment (2019-2024)</td>
<td>N/A</td>
<td>N/A</td>
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</tbody>
</table>

✓ 2019 CF update was reduced to 0.25 percent from the 0.50 authorized by MACRA as a result of a provision in the BBA of 2018
✓ Beginning in 2020 a period of 0% updates begins, which could potentially result in negative updates due to the application of other scalers, such as the RVU budget neutrality adjustment

*Note that the MACRA statute included additional bonus potential due to application of a scaling factor, not reflected here.
Reminder – MACRA’s Two Pathways

MIPS

AAPM
MIPS APM
Important MIPS Changes for Year 2

- Low-volume threshold
- Who is excluded?
- Cost category is back but SNF (POS 31) patients excluded!
  - 10% for 2018 Reporting Year
  - Minimum performance threshold has changed!
    - Now need to report on more than one measure
MIPS Eligibility Year 2

- Change to the Low-Volume Threshold for 2018. Include MIPS eligible clinicians billing more than $90,000 a year in Medicare Part B allowed charges AND providing care for more than 200 Medicare patients a year.

Transition Year 1 (2017) Final
BILLING >$30,000 AND >100

Year 2 (2018) Final
BILLING >$90,000 AND >200
MIPS Performance Categories Year 2

- Comprised of four performance categories in 2018.
- **So what?** *The points from each performance category are added together to give you a MIPS Final Score.*
- The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a positive, negative, or neutral payment adjustment.
- Minimum threshold to avoid penalty – 15
- Exceptional performance – 70 points
- **Reminder** – SNF (POS 31 only) encounters do not count for cost category attribution!
MIPS – Should I stay or should I go?

- MedPAC, President’s Budget and Health Affairs articles have all called for repeal of MIPS
- Specialty societies are so far not on board with the idea – continue work on simplification of reporting and scoring
- Something to monitor but continue to participate – MIPS is likely to be with us for the foreseeable future!
Changes Proposed in Year 3

- SNF specialty set of measures – win for AMDA advocacy!
- Facility-based scoring – currently available for hospitalists, CMS is looking for ideas on how to do this for PAC
- New patient reported outcome measures
- Deleting 10 measures from “library”
- Changes to category weights – cost at 15 points!
  - Additional cost measures and refinement of current ones
Alternative Payment Models

MIPS / APMs
Recap of Advanced APM requirements to become eligible for 5% bonus payment

- Qualifying Model Type
- Quality Measures Comparable to MIPS
- Use of CEHRT
- More than nominal financial risk or qualifying medical home
Qualifying Model Types in 2018

- Bundled Payments for Care Improvement Advanced (BPCI Advanced)
- Comprehensive ESRD Care (CEC) Two Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Medicare Accountable Care Organization (ACO) Track 1+
- Next Generation ACO Model
- Shared Savings Program ACOS Tracks 2 and 3
- Oncology Care Model (OCM) Two Sided Risk
- Comprehensive Care for Joint Replacement Payment Model, Track 1
- CEHRT
Advanced APMs in PA/LTC

- No available Advanced APMs for exclusive PA/LTC clinicians
- MIPS APMs available
  - IAH
  - I-SNIP
- Could success of Initiative to Reduce Rehospitalizations Among Nursing Home Residents be scalable to Advanced APMs?
- PTAC has approved two new models
  - End-of Life Model – Submitted by AAHPM (working with CMMI)
  - Telehealth Model in SNF – Submitted by Avera Health (rejected by Secretary)
- RFI issues on how PTAC operates
  - No mention of PTAC in proposed rule
Quality: The Other Side of “Value”

- Measures are “reportable” but are not benchmarked for PA/LTC based clinicians
- CMS funding announcement for specialty societies to develop measures – focus on patient reported outcome measures
- Society submitted a MACRA funding application for physician measure development
  - Focus is on UTIs but others will need to be developed later
  - Did not receive grant but will focus on other opportunities
Society Advocacy

- Simplify MIPS!
  - Get credit in multiple categories
  - Easier reporting options
  - Flexibility in reweighing categories
  - Create a “facility-based” eligible clinician definition
  - Specialty Designation for better comparison!

- Improve Risk Adjustment in Cost Measures
  - I-SNP
  - Johns Hopkins Model
  - Others
Your Foundation
The Foundation for PA/LTC Medicine

- Separately incorporated 501(c)(3) organization formed in 1996 to advance the quality of life for persons in post-acute & long-term care (PA/LTC) through inspiring, recognizing and educating future and current health care professionals.

- In 2016, AMDA-The Society’s Board of Directors mandated the Foundation to be the fundraising vehicle for all the Society entities. In addition to changing its name to align with the Society, the Foundation Board restructured and created the Development Committee. Under the guidance of the Board, the committee is directly responsible for raising funds for its programs to support not only the Foundation’s mission but that of the Society and ABPLM.

- Proposals from all Society entities were solicited to determine funding priorities. The Board of Directors established the following priorities for fundraising:
  - Development of the PA/LTC workforce
  - Quality measures development
  - Professional impact research that demonstrates the value of our members in this continuum

- In addition to fundraising, the Foundation will continue it’s successful awards programs to recognize and educate health care practitioners.
The Foundation for PA/LTC Medicine

- The Foundation Futures Program:
  - In order to address the workforce issue in PA/LTC in 2001 the Foundation created an intensive learning experience designed to expose residents, fellows and advanced practitioner to career opportunities in PA/LTC Medicine.

- Quality Improvement Awards:
  - To encourage the development of innovative projects to make a direct impact on the quality of long-term care.
  - The program has awarded more than $300,000 in research funding.

- Quality Improvement & Health Outcome Awards:
  - For “Improving the Quality of Life for Persons Living in Nursing Homes”
  - Three facilities are awarded $1,000 each for programs developed by the team that demonstrated improved quality of life for their residents.

- Visit our website at [www.paltcfoundation.org](http://www.paltcfoundation.org) and learn how to support YOUR Foundation.
Billing/Coding Update
All Those New Codes

- Advance Care Planning codes 99497/99498 - reimbursed since January 1, 2016 (billable in SNF/NF)
- Chronic Care Management Codes 99490 – reimbursed since January 1, 2016 (billable in SNF/NF)
- G0506 – add-on code to the CCM initiating visit
- Complex Chronic Care Management Codes 99487/99489 – reimbursed since January 1, 2017 (billable in SNF/NF)
- Transitional Care Management – 99495/99496 – reimbursed since January 1, 2015 – (NOT billable in SNF/NF)
- Cognitive Assessment and Care Planning 99483 (old G0505) (not billable in SNF/NF* clarifying for NF with CMS)
- Non-Face-to-Face Prolonged Service 99358/99359 – reimbursed since January 1, 2017 (billable in SNF/NF)
All Those New Codes

- Behavioral Health Integrated Services **99492, 99493, 99494** (old G0502/G0503/G0504) – reimbursed since January 1, 2017 (billable in SNF/NF)
- General Behavioral Assessment **99484** (old G0507) – reimbursed since January 1, 2017 (billable in SNF/NF)
- Functional Assessment **99483** (old G0505) – reimbursed since January 1, 2017 (not billable in SNF/NF)
- More coming next year!

Guide to PA/LTC has been revised to include information on all new codes! Available now! [https://tinyurl.com/ycgx6nak](https://tinyurl.com/ycgx6nak)
New ACP Series

Proposed Changes in E&M Coding

- First major revision since the 1997 E&M Guidelines!
- Comments on the rule due Sept 10
- Office CPT codes only ... for now!

- Documentation
  - Document visits using medical decision-making or time instead of applying the current the highly complex 1995 or 1997 E/M documentation guidelines

- CMS is proposing a new, single blended payment rate for new and established patients for office/outpatient E/M level 2 through 5 visits (new patient $134; established patient $92) and an add-on code to reflect resources involved in furnishing primary care reported with GPC1X ($5 additional) and for visits reported by certain specialties that often report higher level E/M visits reported with GCG0X ($14 additional)

- Concerns:
  - What is the actual admin burden reduction?
  - Do physician specialties treating complex patients lose?
  - Are we taking money out of the physician payment pool?
  - Will physician groups like RUC/CPT have input into value of codes?
Practice Management Section

- New section established through affiliation with a group of PA/LTC practices
  - Will pursue advocacy, education, membership goals for attending physicians, APRNs and PAs
- **Practice Group Network** – new benefit structure established to serve the practice’s needs, distinct from individual clinician needs
- Quarterly conference calls, e-news, online Forum established to provide networking
- Focused track at Annual Meeting
Understanding the CMS ROPs
Three-Phase Implementation

- **Phase 1:**
  - Upon the effective date of the final rule (Nov 28, 2016)

- **Phase 2:**
  - 1 year following the effective date of the final rule (Nov 28, 2017)

- **Phase 3:**
  - 3 years following the effective date of the final rule (Nov 28, 2019)
F-tag Renumbering

- The image above is the F Tag Crosswalk showing:
  - The original regulatory grouping and the new associated grouping
  - The original regulation number and the new associated regulation number
  - The original F Tag and the associated new F Tag


**PDF List of F Tags:** [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/List-of-Revised-FTags.pdf](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/List-of-Revised-FTags.pdf)
Topics Covered in Phase 2

- Share of information on transfer/discharge
- Care plan developed within 48 hours
- Policies and procedures for reporting suspicion of crimes
- Pharmacy Services – limits on use of psychotropic drugs
- Dental Services
- QAPI Plan
- Facility assessment/staff “competency”
- Smoking policy
- Behavioral Health
- Antibiotic stewardship program
Temporary Changes Around Phase 2

- Star rating kept constant from Nov. 2017-2019
- CMP not being assessed for deficiencies in some of new Phase 2 regs
- Advocacy groups upset that nursing homes not being ‘punished’ appropriately
What does this mean for me?

- A time of transition – within your centers (and for surveyors too)
- A time to reflect, self-assess, and prioritize your efforts
- A marathon, not a sprint
Society Updated Synopsis of Federal Regs!

- Updated with all new F-Tags and Recommendations for Medical Directors and Clinicians!
  - https://paltc.org/synopsis-federal-regulations
- Thank you to Steve Levenson, Vicky Walker, Gaby Geise and the entire Clinical Issues Subcommittee!
IMPACT Act

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

- Bipartisan bill passed on September 18, 2014, and signed into law October 6, 2014
- The Act requires the submission of standardized patient assessment data elements by:
  - Long-Term Care Hospitals (LTCHs): LCDS
  - Skilled Nursing Facilities (SNFs): MDS
  - Home Health Agencies (HHAs): OASIS
  - Inpatient Rehabilitation Facilities (IRFs): IRF-PAI
- The Act specifies that data “… be standardized and interoperable so as to allow for the exchange of such data among such post-acute care providers and other providers and the use by such providers of such data that has been so exchanged, including by using common standards and definitions in order to provide access to longitudinal information for such providers to facilitate coordinated care and improved Medicare beneficiary outcomes…”.
- Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014
## IMPACT Act: Quality Measures

<table>
<thead>
<tr>
<th>Measure Domain</th>
<th>HHA</th>
<th>SNF</th>
<th>IRF</th>
<th>LTCH</th>
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</thead>
<tbody>
<tr>
<td>Functional status</td>
<td>1/1/2019**</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2018</td>
</tr>
<tr>
<td>Skin integrity</td>
<td>1/1/2017</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
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<tr>
<td>Medication reconciliation</td>
<td>1/1/2017</td>
<td>10/1/2018*</td>
<td>10/1/2018*</td>
<td>10/1/2018*</td>
</tr>
<tr>
<td>Incidence major falls</td>
<td>1/1/2019**</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
</tr>
<tr>
<td>Transfer of Health Information</td>
<td>1/1/2019**</td>
<td>10/1/2018**</td>
<td>10/1/2018**</td>
<td>10/1/2018**</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Resource Use &amp; Other Measures Domain</th>
<th>HHA</th>
<th>SNF</th>
<th>IRF</th>
<th>LTCH</th>
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<tr>
<td>Medicare Spending Per Beneficiary</td>
<td>1/1/2017</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
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</tr>
<tr>
<td>Discharge to Community</td>
<td>1/1/2017</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
</tr>
<tr>
<td>Potentially Preventable Hospital Readmissions</td>
<td>1/1/2017</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
</tr>
</tbody>
</table>

* = Implemented, but data collection has not begun  
** = Not implemented yet
# IMPACT Act Measure Domains

<table>
<thead>
<tr>
<th>Measure Domain</th>
<th>Measure Name</th>
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<tbody>
<tr>
<td>Functional status</td>
<td>Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)</td>
</tr>
<tr>
<td>Skin integrity</td>
<td>Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) (NQF #0678)</td>
</tr>
<tr>
<td>Medication reconciliation</td>
<td>Drug Regimen Review Conducted with Follow-Up for Identified Issues Post Acute Care (PAC)</td>
</tr>
<tr>
<td>Incidence major falls</td>
<td>Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)</td>
</tr>
<tr>
<td>Transfer of Health Information</td>
<td>Transfer of Information at Post-Acute Care Admission, Start or Resumption of Care from Other Providers/ Settings Transfer of Information at Post-Acute Care Discharge to Other Providers/Settings</td>
</tr>
<tr>
<td>Medicare Spending Per Beneficiary</td>
<td>Medicare Spending Per Beneficiary-Post Acute Care (PAC)</td>
</tr>
<tr>
<td>Discharge to Community</td>
<td>Discharge to Community-Post Acute Care (PAC)</td>
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<tr>
<td>Potentially Preventable Hospital Readmissions</td>
<td>Potentially Preventable 30-Day Post-Discharge Readmission Measure</td>
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</table>
Data Element Standardization

- Achieving Standardization (i.e., Alignment) of Clinically Relevant Data Elements to Improve Care and Communication for Individuals Across the Continuum
  - Enables shared understanding and use of clinical information;
  - Enables the re-use of data elements (e.g., for transitions of care, care planning, referrals, decision support, quality measurement, payment reform, etc.);
  - Supports the exchange of patient assessment data across providers;
  - Influences and supports CMS and industry efforts to advance interoperable health information exchange (HIE) and care coordination in disparate settings.
A NEW WAY?
PDPM – A Patient-Driven Payment Model
RCS1 – Resident Classification System
Patient Driven Payment Model

- SNF Prospective Payment System in Place Since 1998 – Criticized Over Time
- CMS hired Acumen to develop a new payment system with 3 goals in mind
  - More accurately compensate SNFs
  - Reduce incentives for SNFs to deliver therapy based on financial considerations, rather than resident need
  - Maintain simplicity, to the extent possible
- CMS Held Expert Panels – AMDA was represented
- Would replace the current RUG based system (RUG-IV)
- SNF Payment Rule released recently begins to implement “money follows the patient approach”
- PDPM is a switch from RCS-1
BREAKING NEWS: CMS gives skilled nursing 2.4% Medicare pay raise, unveils another new resident classification system

In a flurry of activity late Friday, the Centers for Medicare & Medicaid Services announced an $850 million pay raise for skilled nursing facilities for fiscal 2019 that comes along with major simplifications to a previously pitched resident classification system.

The proposed Patient-Driven Payment Model (PDPM), a switch from last spring’s originally pitched RCS-1, will replace the Resource Utilization Group system, or RUG-IV, used to categorize Part A residents into various payment groups based on their level of need.

In its announcement, CMS said the new model would reduce the number of payment group combinations by 80%, use more standardized items for payment calculations and “greatly simplify” providers’ paperwork.
PDPM Details

- **Scheduled for implementation October 2019!**
- Categorize residents across five categories, including two nursing case mixes (nursing and non-therapy ancillary) and one each for PT, OT, and speech language pathology
- Regardless of therapy type, resident rated in that category to create an aggregate mix and determine the corresponding reimbursement rate
- MDS plays a key role
- ICD-10 coding important
Advocacy Efforts

- Coalition of Stakeholders worked together to develop and submit comments, concerns
- Meetings with CMS
- Coalition response to SNF PPS rule
  - PDPM is a new payment system requiring SNFs to adapt to significant changes in payment policy and operations including but not limited to: a) a shift away from therapy minutes as a key factor for payment to patient characteristics; b) collection of medical information defining patient characteristic in more detail than required in past; and c) use of the Minimum Data Set (MDS) assessment both as a care planning tool as well as now serving as the basis for payment. Regarding the latter point, MDS items and clinical information imputed on the MDS classify patients into component case-mix groups which, in turn assign payment rates, is a major change which will require substantial education to prevent access to care challenges and payment error rates.
  - Request a CMS workgroup with all stakeholders
SNF Value-Based Programs
SNF VBP

- 2017 first year of data collection
- Skilled Nursing Facility 30-Day All-Cause Readmission Measure
- The Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) is used in the SNF VBP Program. The SNFRM estimates the risk-standardized rate of unplanned readmissions within 30 days for:
  - People with fee-for-service Medicare who were inpatients at PPS, critical access, or psychiatric hospitals.
  - Any cause of condition
- SNFs will earn a SNF VBP Performance score (0 to 100) and ranking which is calculated based on that SNF’s performance on the measure. The SNF VBP performance score is equal to the higher of the achievement score and improvement score.
- SNFs will be awarded points for achievement on a 0-100-point scale and improvement on a 0-90-point scale, based on how their performance compares to national benchmarks and thresholds.
PA/LTC As a Specialty
PA/LTC Specialty?

- More research by Joan Teno and colleagues showing increased number of physicians practicing exclusively in SNF/NF setting. Estimated around 15k physicians/nearly 50k unique SNF/NF billing encounters

- SNF/NF based physicians lose in value-based purchasing programs due to cost comparison with colleagues in IM/FM

- No way to define physicians practicing in this space

- Submitted an application to CMS for a self-selected specialty code

- ABMS has a new “focused practice designation” under their umbrella
SNF Staffing
‘It’s Almost Like a Ghost Town.’ Most Nursing Homes Overstated Staffing for Years

By Jordan Kau

July 7, 2018

ITHACA, N.Y. — Most nursing homes had fewer nurses and caretaking staff than they had reported to the government for years, according to
PBJ – Payroll Based Journaling

- Section 6106 of ACA requires facilities to electronically submit direct care staffing data (including agency and contract staff) based on payroll and other auditable data.

- Reported in Nursing Home Compare.

- Medical director hours include both on site and off site work (AMDA advocacy win).

- Latest: Nursing homes under fire in press for under-reporting staffing levels leading to questions of appropriate staffing ratios etc..
Health IT
State of Health IT in PA/LTC

- AMDA Foundation completed a study in conjunction with HIMSS
  - 2 major companies MatrixCare, PointClickCare control the market share
  - Majority of nursing homes are adopting HIT
- Interoperability
  - Remains a big issue
  - Market is driving change
  - Administration focus on interoperability
- RFI on Interoperability
  - Joint comments with LTPAC HIT Collaborative
  - Need latest information in clear and concise form to make decisions
- Physician office EHR integration into system in PA/LTC still an oversight
- No – we are not getting any more $$$
Telehealth

- Growing in use in PA/LTC
- Studies showing positive impact on patient care, readmission reduction etc...
- CMS rejected AMDA request to remove once a month requirement for telehealth of subsequent care codes – AMDA will comment
- RUSH Act – emergency medicine in SNF
  - AMDA and others have many concerns but working in coalition to address bigger issue
- AMDA workgroup developing educational materials, best practices
Future Outlook
Looking into the future

- Think big picture
- Role of Preferred Provider Networks (are you seeing this in your market??)
- Predictive Analytics – PointRight; NaviHealth etc, have platforms to help with SNF selection
- Health IT – do you have a strategy for billing; reporting; and tracking performance?
  - Foundation for PA/LTC partnered with HIMSS conduct a major PA/LTC IT readiness study. More to come!
- How do you leverage your clinical expertise in PA/LTC population in value-based environment when others don’t understand what you do?
If they can do it

So can we!
Thank You!  

Questions?  

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