Topics of Today’s Presentation

• Value-Based Environment
• Post-Acute Policy Changes
• Medicare Case Study: BPCI
• Succeeding in a Value-Based World
Value-Based Environment

MACRA Driving Growth in Bundling, ACOs, and Downside Risk
Defining Terminology: Value-Based Payments & APMs

Value-based payments (VBP) refers to a broad set of performance-based payment strategies that link financial incentives to providers’ performance on a set of defined measures.

Often referred to as alternative payment models (APMs)
42% of Hospitalized Medicare FFS Beneficiaries Use at Least 1 PAC Provider

1 in 5 Medicare FFS beneficiaries admitted to acute hospital each year

Medicare Fee-for-Service (FFS) Acute Hospital Discharges

42% Sent to Post-Acute Care (PAC)

SNF 20%
Home Health 17%
Acute Rehab 4%
LTACH 1%

Medicare Continues to March Towards Its Goals

APM Goals for Medicare Fee-for-Service Program

Better Care, Smarter Spending, Healthier People

Source: Centers for Medicare and Medicaid Services (CMS)
Medicare Is Not Alone in Moving to VBP!

In 2017, 34% of U.S. health care payments, representing approximately 226 million Americans and 77% of the covered population, flowed through Categories 3 & 4 models.

Percentages of Categories 3 & 4 Payments in Each Market

- **Commercial**: 28.3%
- **Medicare Advantage**: 49.5%
- **Medicare FFS**: 38.3%
- **Medicaid**: 25%

Category 3: Alternative Payment Methods Built on FFS Architecture
Category 4: Population-Based Health

Source: Health Care Learning Action Network, October 2018
Physician Payment Law (MACRA): Important Driver of “Advanced APMs”

**Door 1**
Possible 5% bonus if physician has significant participation in Advanced APMs

**Door 2**
Possible +/- 9% rate change based on Merit-based Incentive Payment System (MIPS)

Either way, intent is to drive physicians to value-based behavior.
What Are “Advanced APMs?”

Advanced APMs

• Link payment to quality measures
• Require use of electronic medical records
• Require bearing more than nominal financial risk for monetary losses

They Matter Because

• Imposing more than nominal risk drives behavior change
• Physician payment rules will become the platform for widespread adoption of Advanced APMs, including by other payors

MACRA’s impact is designed to grow over time
Medicare Payments to Hospitals Have Contained Readmission Penalties for Years

Hospitals face up to 3% reimbursement penalties based on 30-day readmission rates for 6 diagnostic categories.

Now SNF Value-Based Purchasing Program Also Focuses on Readmissions

• As of October 1, 2018, Medicare SNF rates adjusted based on performance on 30-day All-Cause Readmission Measure (eventually potentially preventable)

• Higher of improvement or achievement determines degree of recovery of a 2% withhold (or possible bonus), with performance graded on a curve

• Approximate range for calculating improvement or achievement thresholds have been specified:
  – Achievement Threshold: 20%
  – Performance Benchmark: 16%

• Readmissions measure risk-adjusted to give credit for risks associated with higher acuity patients
Bundled Payment on the Rise: Retrospective Two-sided Risk

- **Episode Initiation**
- **Target Price**
  - Reconciliation of target prices to spending occurs after episode is over

- **Episode Spending (less exclusions)**
  - **Gain**
  - **Loss**
Comprehensive Care for Joint Replacement (CJR) has Driven More Care to Home

Five-Year Program Went Live April 1, 2016

Mandatory & Voluntary Program

- Mandatory demonstration, originally requiring participation from all inpatient PPS hospitals in 67 metro regions (subsequently made optional for 33 in 2018)

Hospitals Bear Financial Risk

- Hospitals must bear risk for hospital care and 90 days post-discharge for all related costs to major joint replacement of the lower extremity

Shared Savings Directly Tied to Quality Measures

- To qualify for realized savings, hospitals must meet specified quality measure performance targets

Source: https://innovation.cms.gov/initiatives/cjr
### Typical Results from a Mature Joint Replacement Bundling Program

**Cleveland Clinic’s Experience Under Model 2 BPCI for Major Joint Lower Extremity**

<table>
<thead>
<tr>
<th>Year</th>
<th>Baseline Data</th>
<th>Euclid Hospital Results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013</td>
<td>2013</td>
</tr>
<tr>
<td>Quarter</td>
<td>Q1</td>
<td>Q4</td>
</tr>
<tr>
<td>Medicare A/B Patients* †</td>
<td>72*</td>
<td>65†</td>
</tr>
<tr>
<td>Cauti Rate*</td>
<td>5.2</td>
<td>0</td>
</tr>
<tr>
<td>LOS*</td>
<td>3.40</td>
<td>2.90</td>
</tr>
<tr>
<td>Readmission*</td>
<td>5.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Discharge Disposition Home/HHC*</td>
<td>39%</td>
<td>71%</td>
</tr>
<tr>
<td>Discharge Disposition SNF*</td>
<td>56%</td>
<td>28%</td>
</tr>
<tr>
<td>HCAHPS Overall Rating*</td>
<td>73%</td>
<td>88%</td>
</tr>
</tbody>
</table>

Sources: * Cleveland Clinic; † 2014 Q3 CMS Reconciliation Report 2058-002
California Hospitals Results Under CJR

Performance Year 1 (last nine months of 2016)
• 248 hospitals participating, upside-only risk
• 52 hospitals had $4 million in gains, or $1,276 per episode

Performance Year 2 (CY 2017) – initial reconciliation
• 124 hospitals, first year of two-sided risk
• 77 hospitals had $12.4 million in gains, or $1,262 per episode
• 35 hospitals had $1.4 million in losses, or $1,277 per episode

Performance Year 3
• 78 hospitals currently participating
Medicare FFS Landscape Will Be Affected by Recent Policy Changes

Bundled Payments for Care Improvement Advanced (BPCI-A)
- Started October 1, 2018, for 1,300 hospitals and physician groups
- Six-month no-risk trial period ends March 2019, after which full risk is expected; Round 2 RFP coming in spring

Pathways to Success Reforms of Medicare Shared Savings Program (MSSP)
- Starts July 1, 2019
- Puts new and existing Medicare ACOs on quicker path to behavior-changing downside risk
- Opportunities include access to 3-day waiver

Participants in both programs face important decisions
Next Wave of Episodic Payment: BPCI Advanced

The Centers for Medicare & Medicaid Services (CMS) is requesting applications for a new voluntary episode payment model that will qualify as an Advanced Alternative Payment Model (Advanced APM) under the Quality Payment Program.

Who Can Participate? There are two categories of Participants under BPCI Advanced: Non-Convener Participants and Convener Participants. Acute Care Hospitals (ACHs) and Physician Group Practices (PGPs) may participate as either a Non-Convener Participant or a Convener Participant. Eligible entities that are providers or suppliers—either Medicare-enrolled or not Medicare-enrolled—may participate in BPCI Advanced as a Convener Participant.

Source: https://innovation.cms.gov/Files/x/bpci-advanced-timeline.pdf
Next Wave of Episodic Payment: BPCI Advanced (cont.)

Start:
- Request for Applications Released 1/9/2018
- Application Portal Opens 1/11/2018
- Application Portal Closes 3/12/2018
- CMS screens Applicants March – August 2018

Signed Participation Agreements and selection of EIs and Clinical Episodes due to CMS August 8, 2018 - new date

CMS distributes Participation Agreements for review July 2018
CMS distributes Data and Target Prices to Applicants June 2018

Deliverables due to CMS Sept. 14, 2018 new date
Selection of Participants announced by CMS Sept. 2018
First Cohort Starts 10/1/18
First date for QP determination March 31, 2019
Next Application Period Spring 2019
Second Cohort Starts 1/1/20

Until 12/31/23

Source: https://innovation.cms.gov/Files/x/bpci-advanced-timeline.pdf
## Key Features of BPCI Advanced

<table>
<thead>
<tr>
<th>Domain</th>
<th>BPCI Advanced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation</td>
<td>Voluntary, with initial 15-month lock-in requirement (one-time 6-month opt-out)</td>
</tr>
<tr>
<td>Episode Initiators</td>
<td>Hospitals and Physician Group Practices only</td>
</tr>
<tr>
<td>Scope</td>
<td>Up to 29 Clinical Episode Groups anchored by hospitalization; 3 triggered by outpatient care</td>
</tr>
<tr>
<td>Length of Bundle</td>
<td>90 days</td>
</tr>
<tr>
<td>Target Price</td>
<td>Own historical data (2013–2016) with 3% discount, trended forward and subject to retro adjustment based on final patient mix</td>
</tr>
<tr>
<td>Reconciliation</td>
<td>Semi-annual</td>
</tr>
<tr>
<td>Quality Linkage</td>
<td>Positive and negative reconciliations subject to further adjustment by composite quality score</td>
</tr>
<tr>
<td>Hospice</td>
<td>Included in bundle</td>
</tr>
<tr>
<td>Waivers</td>
<td>3-day stay for SNF, home visits, telemedicine, and gainsharing</td>
</tr>
</tbody>
</table>
## BPCI Advanced Participants in California

<table>
<thead>
<tr>
<th>Type</th>
<th>Number</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Group Practices</td>
<td>62</td>
<td>Non-Convener</td>
</tr>
<tr>
<td>Acute Care Hospitals</td>
<td>14</td>
<td>Non-Convener</td>
</tr>
<tr>
<td>Acute Care Hospitals</td>
<td>2</td>
<td>Convener</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>Convener</td>
</tr>
</tbody>
</table>

Source: Centers for Medicare and Medicaid Services
Medicare ACOs Are Growing

- ACOs incentivized to manage cost and quality for population of at least 5,000 Medicare FFS lives attributed to/aligned with the ACO based on physician visits
- Three main Medicare ACO types:
  - Medicare Shared Savings Program (MSSP)
  - Next Generation
  - Pioneer

MSSP ACOs are predominant type of Medicare ACO
Medicare ACOs by Type for 2017–2018: 80%+ Are Still at Upside-Only Risk

Note: N/A = not applicable; ESCO = ESRD seamless core organization

* 58 NextGen ACOs at start of 2018, but reports indicate that 7 left the program, leaving 51 ACOs

The ACO participating in the Vermont All-Payer Model is included in the NextGen count

Source: CMS data (data are preliminary and subject to change; Long-term issues confronting Medicare Accountable Care Organizations (ACOs); Glass, D., S. McClendon, J Stensland; MedPAC; April 6, 2018
California Medicare ACOs

• 28 Medicare Shared Savings Programs
  – 19 in track 1 (upside-only)
  – 9 in track 2 (up and downside risk)

• 7 Next Generation ACOs
  – Increased risk/reward
  – Increased flexibility on waivers
    • Telemedicine
    • 3-day prior stay SNF

<table>
<thead>
<tr>
<th>Next Generation ACO</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>National ACO, LLC</td>
<td>Beverly Hills</td>
</tr>
<tr>
<td>Prospect ACO Northeast, LLC</td>
<td>Los Angeles</td>
</tr>
<tr>
<td>Regal Medical Group dba Heritage California ACO</td>
<td>Northridge</td>
</tr>
<tr>
<td>HCP ACO California, LLC</td>
<td>El Segundo</td>
</tr>
<tr>
<td>Torrance Memorial Integrated Physicians, LLC</td>
<td>Torrance</td>
</tr>
<tr>
<td>Hill Physicians Medical Group</td>
<td>San Ramon</td>
</tr>
<tr>
<td>APA ACO, Inc.</td>
<td>Glendale</td>
</tr>
</tbody>
</table>
ACO Performance Still in Early Stages of Achieving Results—CMS Wants Better

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only 31%</td>
<td>• of Medicare Shared Savings Plan (MSSP) ACOs earned shared savings; payments totaled $700 million</td>
</tr>
<tr>
<td>Another 25%</td>
<td>• of MSSP ACOs generated savings, but did not meet threshold needed to share those savings</td>
</tr>
<tr>
<td>Only 18%</td>
<td>• of MSSP two-sided risk ACOs were responsible for repaying losses</td>
</tr>
<tr>
<td>41%</td>
<td>• of physician-only MSSP ACOs earned shared savings, compared to 23% of ACOs with hospitals</td>
</tr>
<tr>
<td>Pathways for Success</td>
<td>• Finalized December 2018 to take effect July 1, 2019; forcing ACOs quicker to behavior-changing downside risk</td>
</tr>
</tbody>
</table>
Medicare ACOs and Post-Acute Care: A Tale of Two Cities…

According to a recent study, more than 70% of ACOs would leave the program if they are forced to accept risk.
Close Working Relationship with Post-Acute Care is a Key to Success

CONCLUSIONS AND RELEVANCE:

- Participation in the MSSP has been associated with significant reductions in post-acute spending without ostensible deterioration in quality of care.
- Spending reductions were more consistent with clinicians working within hospitals and SNFs to influence care for ACO patients than with hospital-wide initiatives by ACOs or use of preferred SNFs.

Medicare Managed Care Penetration Is Growing in California and U.S.

Source: Centers for Medicare and Medicaid Services
Medicare Advantage Trends

- Supplemental benefits
- Value-Based Insurance Design (VBID)
- Rise of Special Needs Plans (SNPs)
- Discussion about carving-in hospice
Obtaining Critical Mass in Managed Care Is a Challenge for Health Plans & Post-Acute

Suppose there are 5 plans contracting with 10 providers for PAC care representing, in total, 10% of each plan’s spend...

Plan 1 = 20%
Plan 2 = 20%
Plan 3 = 20%
Plan 4 = 20%
Plan 5 = 20%

Provider 1 (10%)
Provider 2 (10%)
Provider 3 (10%)
Provider 4 (10%)
Provider 5 (10%)
Provider 6 (10%)
Provider 7 (10%)
Provider 8 (10%)
Provider 9 (10%)
Provider 10 (10%)

In this example, each PAC represents only 0.2% of each plan’s spending.
Challenges in PAC Medicare Advantage Contracting

• Wide variation in key metrics observed
• Existing payment methods generally discourage medically complex admissions
• By far, the biggest problem is…

Fragmentation at plan and provider level makes it difficult to achieve critical mass
In Recent Years, Firms Have Sprung Up to Manage Post-Acute Care (PAC)
Typical Trajectory of Post-Acute Management Contracts

- Manage Authorizations
- Narrow Network
- Take (and Share) Risk
Preferred Networks Are an Option, But Freedom of Choice Must Be Maintained

From FAQs on BPCI Advanced:

Q12: Are preferred networks for SNFs and Home Health providers encouraged as long as beneficiaries are informed that they have a choice of any provider?

A12: Participants can create and/or recommend preferred Post-Acute Care networks; however, a beneficiary’s freedom of choice of provider cannot be affected. Therefore, Participants must notify beneficiaries of their participation in the Model and require their downstream Participating Practitioners and Episode Initiators to do the same.

Source: CMS BPCI Advanced website; FAQs
Emerging Evidence Shows That Post-Acute Can Be Managed When Critical Mass Is Obtained

*Example: Advocate Health System*

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of SNFs</th>
<th>Patient Volume</th>
<th>30-Day Readmission Rate</th>
<th>SNF ALOS</th>
<th>Home Care Capture Rate at DC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>-</td>
<td>-</td>
<td>20.0%</td>
<td>30+</td>
<td>-</td>
</tr>
<tr>
<td>2012</td>
<td>12</td>
<td>1,918</td>
<td>13.7%</td>
<td>19.6</td>
<td>65.4%</td>
</tr>
<tr>
<td>2013</td>
<td>29</td>
<td>6,180</td>
<td>14.8%</td>
<td>18.3</td>
<td>75.4%</td>
</tr>
<tr>
<td>2014</td>
<td>37</td>
<td>9,290</td>
<td>14.6%</td>
<td>17.1</td>
<td>80.5%</td>
</tr>
<tr>
<td>2015</td>
<td>39</td>
<td>8,669*</td>
<td>13.5%</td>
<td>15.7</td>
<td>82.4%</td>
</tr>
</tbody>
</table>

- Each day of SNF ALOS represents $4.5 million in annual Medicare spending
- Each percentage point of readmissions rate worth $1.3 million in annual Medicare spending

Example 2: Banner Health System Has Integrated Network at Risk

After a preferred network was formed, banner implemented P4P model based on LOS and readmissions

Source: Lisa Frank, Banner Health System, Developing a Post-Acute Network, November 2015
PAC Providers Achieving Scale By Forming: Clinically Integrated Networks and Independent Provider Associations

- Managed Care Contracting
- Multiple Providers
- Vendor or Risk Taker in Bundling or ACOs
Post-Acute Providers Are Also Moving Into Risk

• Program for All-inclusive Care for the Elderly (PACE) growing integrated care option for frail dual eligibles
  – National PACE Association created PACE 2.0
  – Goal of increasing participant enrollment from nearly 50,000 nationally this year to 200,000 by 2028 through increased penetration and continued increase in programs

• Enrollment in Medicare Special Needs Plans (SNPs) has increased by 18% over last 5 years
  – Increasing opportunities for participation by LTC providers
Companies Are Emerging to Address Readmissions in Real-Time

**REAL-TIME CARE**

Call9 embeds highly-skilled first-responders (known as Clinical Care Specialists or CCSs) on-site, in nursing homes and rehab centers, giving patients 24/7 real-time access to emergency care. Via the CCS and Call9’s technology, doctors are able to see, diagnose and treat patients in their nursing home beds, avoiding unnecessary trips to the Emergency Department and subsequent hospitalizations.

**LEARN ABOUT CALL9’s CARE MODEL >**

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**Filling the Care Gap Across the Post-acute Sector**

TripleCare is a provider of telemedicine-enabled healthcare services to facilities throughout the country engaged in the delivery of post-acute care. Our dedicated medical team, in partnership with facility medical staff, brings consistent, quality care to the residents under their care.

The Company fills a void by bringing skilled physicians to patients’ bedsides, during times when staff clinicians are not typically on site, such as overnight, weekends and holidays.

Using advanced technology, in collaboration with on-site skilled nursing facilities’ (SNFs) nurses, TripleCare’s physicians treat in place, providing timely clinical interventions when a change of condition occurs, in an attempt to avoid hospitalization or readmissions. TripleCare’s virtual services make it possible for its physicians to evaluate patients and differentiate between those who can be treated in place and those who require a hospital transfer.

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Post-Acute Policy Changes

IMPACT Act

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

Bipartisan statute requires:

• Core set of assessment items across settings
• Development of uniform quality & resource measures
• Detailed timelines and objectives

IMPACT Act intended to facilitate:

• Interoperable, reusable core data set
• Creation of site-neutral payment policies
• Value-based payment approaches
• Improved care transitions & hospital discharge planning
Timeline of Major Deliverables in IMPACT Act of 2014

- **2014–2016**: Standardized quality & resource use measure reporting for PAC providers begins
- **2017**: Use of quality data to inform discharge planning
- **2018**: Standardized assessment data required for PAC providers begins
- **2019**: CMS & MedPAC reports on PAC prospective payment
- **2020**: Study on hospital assessment data
- **2021**
Medicare Spending Per Beneficiary Episodic View of Care & Associated Services

IMPACT Act Key to Large-Scale VBP: Standardized, Interoperable, Reusable Data

Source: CMS, Understanding the IMPACT Act, Special Open Door Forum, February 2, 2016
IMPACT Act Goal: Unified Prospective Payment System (PPS) Across Post-Acute Care (PAC)

Design feature:
• A common unit of service (e.g., institutional stay or home health stay)
• A common method of risk adjustment that relies on administrative data on patient characteristics and incorporates functional status as these data become available
• Two payment models (one for routine and therapy services, another one for non-therapy ancillary services) to reflect differences in benefits across settings; sum of the two payments establish the total payment amount for the stay
• Adjustment of payments for home health stays to prevent considerable overpayment
• A high-cost outlier policy to protect providers from incurring large losses and help ensure beneficiary access to care
• A short-stay outlier policy to prevent large overpayments for unusually short stays
• Uniform application of any payment adjusters across all providers

Source: Medicare Payment Advisory Commission 2016
Medicare FFS Payment Reform:
SNF and HHA Payments Set to Change Next Year

• On July 31, 2018, CMS finalized a rule to replace RUGs-IV with Patient-Driven Payment Model (PDPM), effective October 1, 2019
  – Six payment categories (5 case-mix adjusted) and length of stay (LOS) adjustment
• On October 28, 2018, CMS finalized released proposal to replace Home Health Resource Groups with Patient-Driven Grouping Model (PDGM)
  – 30-day episode and removes emphasis on therapy visits

Source: Advanced Notice of Proposed Rulemaking, 5/4/17; CMS-1686
New Post-Acute Payment Systems Present Opportunities for Providers, but Come with Challenges

<table>
<thead>
<tr>
<th>Opportunities</th>
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</thead>
<tbody>
<tr>
<td>• Greater ability to manage costs—particularly therapy</td>
</tr>
<tr>
<td>• Opportunity to expand into new service lines</td>
</tr>
<tr>
<td>• Potential for alignment with value-based payors</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Mastering operational complexities and addressing staffing needs</td>
</tr>
<tr>
<td>• Complete, accurate coding at necessary time points</td>
</tr>
<tr>
<td>• Understanding how revenues &amp; costs can/will shift as payment changes unfold</td>
</tr>
</tbody>
</table>

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Why Is CMS Doing This? Highest Level of Therapy Grew by 30+% in Three Years

SNF Medicare Part A Payment No Longer Tied to Minutes of Therapy Provided

RUG-IV
Number of PT, OT, and SLP therapy treatment minutes are combined for total number of treatment minutes used to classify a given patient into a given therapy RUG

PDPM
Patient characteristics will be used to predict therapy costs associated with a given patient, rather than rely on service use

Patient Characteristics Now Drives SNF Payment

- 5-day assessment initially drives patient classification into PDPM categories
- Payment rates can then be modified by Interim Payment Assessment or Interrupted Stay
- Length of stay also affects PT, OT & NTA components
Current Medicare SNF Payment System Compared to Proposed PDPM

Current PPS consists of 3 components

- Therapy
- Nursing
- Non-Case Mix

New payment method consists of 6 components

- PT
- OT
- SLP
- NTA
- Nursing
- Non-Case Mix

Source: Final Rule, Federal Register, August 8, 2018
Two Different Patients: Same RUG, Different PDPM Rate

<table>
<thead>
<tr>
<th>Patient Characteristics</th>
<th>Patient A</th>
<th>Patient B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation Received</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Therapy Minutes</td>
<td>730</td>
<td>730</td>
</tr>
<tr>
<td>Extensive Services</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>ADL Score</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Clinical Category</td>
<td>Acute Neurologic</td>
<td>Major Joint Replacement</td>
</tr>
<tr>
<td>PT &amp; OT Functional Score</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Nursing Function Score</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Cognitive Impairment</td>
<td>Moderate</td>
<td>Intact</td>
</tr>
<tr>
<td>Swallowing Disorder</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Mechanically Altered Diet</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>SLP Comorbidity</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Comorbidities</td>
<td>IV Medication &amp; Diabetes</td>
<td>Chronic Pancreatitis</td>
</tr>
<tr>
<td>Other Conditions</td>
<td>Dialysis</td>
<td>Septicemia</td>
</tr>
<tr>
<td>Depression</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

- RUGs: Both patients paid at Rehab Ultra = $616
- PDPM: Patient A = $708; Patient B = $534

Source: CMS presentation on PDPM December 11, 2018
Payment Improves for Nursing Cases

*Nursing Case Study With Long LOS*

- **60-day** length of stay
- 75-year-old male
- Stage 4 pressure ulcer, wound is infected
- Oral antibiotics
- Diabetic, daily insulin
- Obese
- Colostomy

RUGs: <$20,000
PDPM: >$30,000
Basic Structure of Patient-Driven Groupings Model (PDGM) Will Drive Change for Home Health

- Effective January 1, 2020
- Removes effect of therapy visits on payment changes
- Replaces 60-day episode with 30-day episodes
- Increases payment for medically complex admissions
Markets Will Evolve Under New Medicare Payment Models

**Current**
- Ortho Patient: Hospital → SNF → Home
- Complex Patient: Hospital → Delay → SNF → Home

**Future**
- Ortho Patient: Hospital → SNF → Home
- Complex Patient: Hospital → SNF → Home
Payment System Changes Will Help Alignment with Value-Based Payors

- Payment model changes likely to incentivize better access for medically complex patients, of interest to population health managers
- LOS adjustment in PDPM and 30-day episode in PDGM rewards shorter stays, which is of interest to bundlers and ACOs
- Medicare Advantage plans may take a close look at these systems and adopt them in whole or in part
Medicare VBP Case Study

Model 3 of Bundled Payments for Care Improvement
Bundled Payments for Care Improvement (BPCI): Large-Scale Demonstration Ended in 2018

Source: CMS BPCI Website, October 2017

Episode Initiators by Provider Type

- 550 SNFs
- 306 Hospitals
- 218 Physician Groups
- 60 HHAs
- 9 IRFs

Source: CMS BPCI Website, October 2017
BPCI Reduced Costs and Had Little Effect on Quality

From the Fifth Annual BPCI Evaluation Report (analysis through 2016):

“Under the BPCI initiative, Medicare payments declined for most clinical episodes and over half of the relative payment reductions were statistically significant. The declines were primarily due to relative reductions in the use of PAC. The Medicare payment reductions occurred under Model 2 and 3 and across participant types as well as a range of surgical, acute, and chronic clinical episodes. Quality of care, measured as emergency department visits, mortality, and readmissions, was not affected in the vast majority of clinical episodes.”

However, total net spending by the Medicare program increased under BPCI due to the elimination of hold harmless policies for various reasons.
Gainsharing in BPCI Did Not Generally Focus on Post-Acute Care

- Of 113 participants in BPCI from 2013 to 2015:
  - 66% engaged in gainsharing
  - 15% shared gains with institutional PAC
  - 10% shared with home health

- BPCI evaluation report states that gainsharing was often used to increase provider engagement and influence specific behaviors

Source: CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 3 Evaluation & Monitoring Annual Report, Prepared for CMS, October 2017
### Lessons Learned from Model 3 BPCI: Medically Complex Clinical Episode Groups Can Be Managed

<table>
<thead>
<tr>
<th>Episode Group</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac arrhythmia</td>
<td></td>
</tr>
<tr>
<td>Sepsis</td>
<td></td>
</tr>
<tr>
<td>Fractures of the femur and hip or pelvis</td>
<td></td>
</tr>
<tr>
<td>Hip &amp; femur procedures except major joint</td>
<td></td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td></td>
</tr>
<tr>
<td>Medical non-infectious orthopedic</td>
<td></td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease, bronchitis, asthma</td>
<td></td>
</tr>
<tr>
<td>Lower extremity &amp; humerus procedure except hip, foot, femur</td>
<td></td>
</tr>
<tr>
<td>Simple pneumonia and respiratory infections</td>
<td></td>
</tr>
</tbody>
</table>
Hip & Femur Procedures Except Major Joint: Example of Strong Use of Post-Acute Care

**Average Episode Spending by Discharge Destination**

- Total
- Other
- IRF
- SNF
- HHA
- Home

**Distribution of Episodes by Discharge Destination**

- HHA: 12%
- Home: 10%
- IRF: 20%
- Other: 1%
- SNF: 57%

Source: Dobson DaVanzo analysis of 2015 and 2016 Medicare FFS claims
BPCI Advanced Provides Roadmap for Sharing Risk

NPRA Sharing Partner: A Participating Practitioner; clinician employed by a hospital or PGP participant; or Episode Initiator, ACO, or post-acute provider, that:

1. is participating in BPCI Advanced activities;
2. is identified as NPRA Sharing Partner on financial arrangement screening list; and
3. has entered into written NPRA Sharing Agreement that satisfies all applicable requirements of BPCI Advanced Model Participation Agreement

NPRA = Net Payment Reconciliation Amount
Why Hospitals & Post-Acute Care Should Share Risk

Risk-Taking Hospital

- **Achieve gains** by effectively managing hospital discharge decision and through its designated share of PAC savings
- **Safely take on more risk** during lock-in periods
- **Reduce hospital LOS** for otherwise hard-to-place patients
- **Reduce administrative costs** by delegating post-discharge case management to PAC

Post-Acute Care

- **Achieve gains** through contractually guaranteed funding mechanism, instead of vague promise of more referrals
- **Improve quality of care**
- **Increase alignment with hospital**
Quality of Care Opportunities Presented by Risk Sharing with PAC

- Reducing readmissions
- Improving access for medically complex persons
- Increasing use of telehealth
- Promoting palliative care and hospice
Additional Benefits of Risk Sharing

• Expand scope of Advanced APMs, allowing more physicians to qualify for MACRA increases
• Reduce readmission penalties
• Address Medicare Spending Per Beneficiary (MSPB)
• Reduce unnecessary inpatient bed days
Succeeding in a Value-Based World

Hospital-PAC Integration

Driving Care Redesign
Post-Acute Patient Touch Points

- Primary care
- Orthopedic specialist
- Hospital
- Skilled nursing
- Lab
- Imaging
- Post-acute medicine

- Home health
- Durable medical equipment
- Transportation
- Pharmacy
- Oxygen
- Senior housing
What Does PAC Want from Hospitals?

- Referrals
  - Acute care is best revenue source for most SNFs
- Clinical support
- Streamlined ancillary services
- Thorough referral information
- Timely, well-planned discharge processes
- Shared risk for hard-to-care-for residents
What Do Hospitals Want from PAC?

• Swift admission approval
• Strong clinical outcomes
• Lower readmission rates
• Shorter lengths of stay
• Use of ancillary services
• Shared risk for hard-to-place patients
## Hospital or Health System 1 Owns Post-Acute Care

### Benefits
- Full control of patient experience
- Revenue opportunities
- Management of hard-to-place patients
- Clinical integration
- Value-based payment advantages

### Risks and Challenges
- Operating risks of post-acute industry
- Changing care models
- Capital needs
- Need for in-house post-acute care expertise

### Opportunities
- Operational efficiencies
- Accurate financial reporting
- Clinical pathway development
### Hospital or Health System 2 Formally Partners with PAC

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Risks and Challenges</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Minimizes financial risk</td>
<td>• Changing ownership of post-acute assets</td>
<td>• At-risk partnerships</td>
</tr>
<tr>
<td>• Low or no capital needed</td>
<td>• Less control of experience and outcomes at post-acute venue</td>
<td>• Advancement of clinical integration</td>
</tr>
<tr>
<td>• Post-acute care expertise is not needed in-house</td>
<td>• Downstream provider variance</td>
<td>• Preferred network development</td>
</tr>
<tr>
<td>• Ancillary service revenue</td>
<td>• Uniformity of PAC management</td>
<td>• Downstream provider selection</td>
</tr>
<tr>
<td>• Clinical integration</td>
<td></td>
<td>• Value-based payment models</td>
</tr>
</tbody>
</table>
## Hospital or Health System 3 Relies on Community for PAC

### Benefits
- Fewer resources
- Less initial financial risk

### Risks and Challenges
- No control of patient experience
- Varied clinical outcomes by provider
- Less revenue from ancillary services
- Value-based payment models

### Opportunities
- Formalized top provider relationships
- Preferred provider network development
- Discharge planning processes improvement
- Evaluation of clinical outcomes and opportunities
Patient Loyalty

• All care is episodic
• Leakage
• Referrals
• Experience
Revenue Opportunities

• Hospitals have evolved to have other business lines to which senior services and post-acute care can drive revenue
• Value- and risk-based payment models
• Market share and referrals
## VBP Capabilities Today

<table>
<thead>
<tr>
<th>Capability</th>
<th>Not Capable</th>
<th>Somewhat Capable</th>
<th>Highly Capable</th>
<th>Extremely Capable</th>
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</thead>
<tbody>
<tr>
<td>Post-Discharge Follow-Up</td>
<td>4%</td>
<td>52%</td>
<td>37%</td>
<td>6%</td>
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<tr>
<td>Chronic Care Management</td>
<td>11%</td>
<td>57%</td>
<td>25%</td>
<td>7%</td>
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<tr>
<td>Assessing ROI</td>
<td>23%</td>
<td>46%</td>
<td>29%</td>
<td>3%</td>
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<tr>
<td>Care Standardization</td>
<td>8%</td>
<td>59%</td>
<td>31%</td>
<td>2%</td>
</tr>
<tr>
<td>Real-Time Data Access</td>
<td>10%</td>
<td>54%</td>
<td>30%</td>
<td>5%</td>
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<tr>
<td>Business Intelligence</td>
<td>5%</td>
<td>51%</td>
<td>39%</td>
<td>4%</td>
</tr>
<tr>
<td>External Interoperability</td>
<td>24%</td>
<td>59%</td>
<td>15%</td>
<td>3%</td>
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<tr>
<td>Interoperability</td>
<td>2%</td>
<td>57%</td>
<td>33%</td>
<td>8%</td>
</tr>
<tr>
<td>Eligibility Verification</td>
<td>1%</td>
<td>28%</td>
<td>63%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Importance in Three Years

Key Elements of Care Redesign Under VBP

• Transitions management:
  – Between acute, post-acute, and community settings
  – Coordination with primary and specialty care
• Readmissions prevention
• Risk stratification
• Patient activation, teaching, and self-care

• Medication reconciliation
• Primary care engagement
• Utilization of telehealth
Systematically Identify Value-Based Payors in Your Market and Move Towards Risk-based Contracting

- Careful thought on benchmarks and quality metrics
- Ensure that payment rewards medically complex admissions
- Align with FFS quality and payment systems when possible
- Think creatively about waivers and payment models
- Achieve critical mass
The secret is paddling faster and harder than the current around you!
Questions?

Raise your hand or submit questions at www.menti.com and enter code 36 75 60
For More Information

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