Evolving Payment and Service Models: Blessing or a Curse?

NAHC Annual Conference
October 20, 2014

Objectives

• Understand structure of ACOs and bundled payment demonstration projects
• Anticipate future trends around new payment models and provider partnerships
• Recognize key relationship and financial management components involved
• Identify how to evaluate your agency’s readiness for new payment structures
• Determine elements of successful non-traditional payment contracts and management strategies
May you live in interesting times.
- Chinese proverb

Transforming the Care Continuum

Today's Spectrum of Services

Want Driven
Need Driven

Preventative
Long-term care
Hospital

Long-term
care

Source: Adapted from previous Greystone and CliftonLarsonAllen LLP presentations
Reformed Health System – Service Delivery

• Home care
• SNF
• Assisted Living
• Hospital
• Physician office
• Group visits
• Self management
• RN, Care Coach
• Online/social networking (e.g. diabetes group)
• Telehealth monitoring

• Health risk assessment
• Independent senior housing
• Adult day programs
• Community clinic for vaccines
• Local fitness center
• Smoking cessation program
• Weight loss program
• Personal wellness coach
• Senior Center
• Online social networking groups/tools
• Labs, diagnostics

Key ACA Initiatives

1. Value Based Payment
   • Foundation of all programs
   • Will Impact all Markets

2. Medical Home
   • Four different demos

3. Bundled Payment
   • Four models
   • 48 possible episodes
   • Target Price based upon provider cost history
   • Started October 2013 and January 2014

4. Accountable Care Organizations
   • Pioneers
   • Shared Savings
   • Advanced Payment

5. Financial Alignment Initiatives
   • Focus is on dual eligibles
Making the Transition to Performance Based Payment

Shared Savings

Significant Change
- Risk based
- Collaboration
- Predictive modeling
- Global budget or sub-capitation

Bundled Payments

Significant Change
- Negotiated Episode Price
- Longitudinal Accountability
- Risk based

Value Based Reimbursement

Significant Change
- New metrics
- Best practices
- Performance based
- Uncertainty
- Electronic communications

Fee For Service
- No risk payments
- Common payments
- Predictable

New Responsibilities of Accountable Care

Categorization of Risk-Based Payment Models

<table>
<thead>
<tr>
<th>Performance Risk</th>
<th>Utilization Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of Care</td>
<td>Quality of Care</td>
</tr>
<tr>
<td>Volume of Care</td>
<td></td>
</tr>
</tbody>
</table>

- Bundled Pricing
  - Bundled Payments for Care Improvement program
  - Commercial bundled contracts

- Pay-for-Performance
  - Value-Based Purchasing
  - Readmissions penalties
  - Quality-based commercial contracts

- Shared Savings
  - Medicare Shared Savings Program
  - Pioneer ACO Program
  - Commercial ACO contracts

Source: Health Care Advisory Board interviews and analysis.
Bundled Payments for Care Improvement Initiative

- First bundled payment initiative announced by the Center for Medicare and Medicaid Innovation in 2011.

- Tests four models of bundled payment related to an inpatient hospital stay
  - Choose from 48 episodes for which to accept a bundled payment for 30, 60 or 90 days
    ◊ Target price based upon individual provider’s cost history.
    ◊ Participants’ bundle price is a discount off current cost
  - Allows gainsharing to align provider incentives

- Participants were announced January 31, 2013

- **New round:** 2014 Winter Open Period, application due April 18, 2014

Bundled Payment Models

**Timeline**

- **Phase 1:** No-risk prep period.
  - 1/1/2013 – Phase 2 start date

- **Phase 2:** Risk Bearing Implementation Period
  - Starts either 10/1/2013 or 1/1/2014

2014 Winter Open Period:
Additional organizations can apply to participate in BPCI and current participants can expand their activities

- **Model 1 – Acute Care Hospital Stay Only (Retrospective):** 3 participants representing 32 organizations

- **Model 2 – Acute Care Hospital Stay + Post Acute Care Episode (Retrospective):** 55 participants representing 192 organizations.

- **Model 3 – Post Acute Care Only (Retrospective):** 14 participants representing 165 organizations

- **Model 4 – Acute Care Hospital Stay Only (Prospective):** 37 participants representing 75 organizations

** Participants as of 2013

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Bundled Payment for Care Improvement

Model 2: Acute + Post-Acute
- **Episode** is triggered by an inpatient stay in acute care hospital and includes all related services during episode

- **Target price**
  - Discount:
    ◦ 3% for a 30 or 60 day episode
    ◦ 2% for 90 day episode

Model 3: Post-Acute Only
- **Episode** triggered by AC hospital stay and begins at initiation of PAC services with SNF, inpatient rehab facility, long-term care hospital or home health agency

- **Target price**
  - Discount: standard 3% for all episode lengths (e.g., 30, 60, or 90 day)

Medicare’s Largest Payment Innovation Program

BPCI\(^1\) Participation by State

More than 450 Providers Participating in BPCI\(^1\)

450+
Total Number BPCI Participants as of February 2013
BCPI Participants Favoring Episodes with PAC Services

<table>
<thead>
<tr>
<th>Model Type</th>
<th>Participation by Model Type</th>
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<tbody>
<tr>
<td>Hospital Inpatient Services</td>
<td>41%</td>
</tr>
<tr>
<td>Hospital and Physician Inpatient and Post-Discharge Services</td>
<td>36%</td>
</tr>
<tr>
<td>Post-Discharge Services</td>
<td>16%</td>
</tr>
<tr>
<td>Hospital and Physician Inpatient Services</td>
<td>7%</td>
</tr>
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</table>

Source: Centers for Medicare and Medicaid Services; Health Care Advisory Board interviews and analysis.

CMS Bundled Payments Initiatives: What is Being Bundled?

Number of Bundles Selected per Provider

- 1-5 Bundles: 47%
- 6-47 Bundles: 18%
- All 48 Bundles: 34%

Top Ten Clinical Conditions for Bundling

- Major joint replacement of lower extremity: 70%
- Congestive heart failure: 68%
- Coronary artery bypass graft: 51%
- COPD, bronchitis/asthma: 49%
- Percutaneous coronary intervention: 48%
- Cardiac valve: 47%
- Simple pneumonia or respiratory infections: 47%
- Cardiac ablation: 46%
- Revision of the hip or knee: 44%
- Double replacement of the lower extremity: 43%

Source: The Advisory Board: “What are BPCI participants bundling?” by Rob Lazerow dated February 1, 2013
Bundled Payments: Understanding Bundle Characteristics

<table>
<thead>
<tr>
<th>Service</th>
<th>Indexed Total</th>
<th>Indexed Total</th>
<th>Indexed Total</th>
<th>Indexed Total</th>
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<tbody>
<tr>
<td></td>
<td>Avg Cost</td>
<td>Cost</td>
<td>Avg Cost</td>
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<tr>
<td>Hospital</td>
<td>$ 12,040</td>
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<td>SNF</td>
<td>3,134</td>
<td>3,133,676</td>
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<td>2,169</td>
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<td>MD</td>
<td>3,535</td>
<td>3,535,248</td>
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<tr>
<td>All Other</td>
<td>654</td>
<td>653,696</td>
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<tr>
<td>Total Costs</td>
<td>$ 21,531</td>
<td>$ 21,531,488</td>
<td>$ 10,637</td>
<td>$ 10,637,156</td>
</tr>
</tbody>
</table>

**Bundle Risk: Approximately 51% of total bundle costs occurred post-discharge!**

Source: Example based on CMS data

Commercial Bundled Payment

Commercial Bundled Payment Adoption Tracker

- Cardiovascular
- Orthopedic
- Spine
- Other
- View All

Contract type:
- Commercial Insurer
- Employer
Commercial Insurance BPI Activity: Large Employers Cardiovascular & Spine Services Bundles

- **Payer: Walmart**
  - Six Participating Providers:
    - Virginia Mason Medical Center, Seattle, WA
    - Mayo Clinic, Scottsdale, AZ, Rochester, MN & Jacksonville, FL
    - Scott & White Memorial Hospital, Temple, TX
    - Mercy Hospital, Springfield, MO
    - Cleveland Clinic, Cleveland, OH
    - Geisinger, Danville, PA
  - Description: Beginning January 2013 1.1 million employees eligible for consultation and care for certain cardiac & Spine procedures at no additional cost. Walmart will cover cost of travel, lodging, and food for patient and one caregiver.

- **Payer: PepsiCo**
  - Participating Providers: John Hopkins, Baltimore, MD
  - Description: Starting 12/11 began waiving deductibles & co-insurance for employees who receive cardiac and complex joint replacement surgery at John Hopkins.

- **Payer: Lowes**
  - Participating Providers: Cleveland Clinic, Cleveland, OH
  - Description: Contract for heart surgery program; will waive $500 deductible, out-of-pocket costs, airfare, hotel and living expenses.


Health Care Delivery: ACO Network

- ACO Providers: Bonus-Eligible
- Non-ACO Preferred Providers
- Non-Preferred Providers
- Primary Care Practitioners
- “Value” Providers
- Low Quality, High Cost Providers

Medicare ACO Programs

**Pioneer ACO Program started 1/1/12 (23)**
- Originally 32 participants, 9 exited or transitioned to MSSP in 2013
- New entrants RFP anticipated to be released in 2014
- Eligible organizations had prior ACO-like experience
- 15,000 Medicare beneficiaries minimum
- Must enter into outcomes-based contracts with multiple payers.
- Model transitions to greater financial accountability (risk) faster.

**Medicare Shared Savings Program (MSSP) (351 ACOs)**
- Program requires the participating providers to form an ACO
- 5,000 Medicare beneficiary minimum for participation
- Two approaches: Savings only, Savings/Losses
- MSSP start dates: 4/1/2012, 7/1/2012, 1/1/2013

**Advanced Payment Initiative (35)**
- Must apply to be an MSSP ACO first
- Only smaller physician only practices OR rural health clinics or CAHs are eligible to participate
- Receive advance payment on their projected shared savings
Where the ACOs Are
23 Pioneer and 351 Shared Savings Program ACOs as of January 2014

Geographic Distribution of MSSP ACO Assigned Patient Population (includes 2012-14 starters)

Source: CMS 04-08-2014
Early Findings from 32 Pioneer ACOs

- Total covered Medicare beneficiaries in ACOs was about 670K
- **Total Medicare Savings** = $156M of which $76M was shared with 13 ACOs
- **Shared Losses**: 14 Pioneer ACOs had losses but only two were required to “share” in those losses ($4M) because of the financial models they chose
- **2012 Medicare beneficiary cost growth**: Pioneer ACOs = 0.3% vs. Other Medicare beneficiaries = 0.8%
- Average savings PMPY = $209
- All Pioneer ACOs met their quality reporting and many of the quality performance targets
- Two Pioneer ACOs withdrew from the program and 7 others moved to Shared Savings ACOs (less risk)
- 70,000 hospital readmissions avoided; 25 of 32 Pioneer ACOs generated lower risk-adjusted readmission rates

ACO Results to Date *

- **Pioneer ACO First Year Results:**
  - Cost Reduction/Shared Savings:
    ◦ Cost growth rate for 669,000 beneficiaries .3% vs .8%
    ◦ 13 participants generated gross savings of $87.6 million
    ◦ 2 participants generated losses of approximately $4 million
  - Quality Metrics
    ◦ 100% successfully reported quality measures
    ◦ Overall performed better for all 15 clinical quality measures
      - 25 of 32 generated lower risk-adjusted readmissions rates
      - Median rate for blood pressure control for beneficiaries with diabetes was 69% vs. 55%
      - Median rate for LDL cholesterol control for patients with diabetes was 57% vs. 48%
- **CMS expects MSSP results later in year**

* Source: CMS “Pioneer Accountable Care Organizations succeed in improving care, lowering costs” July 16, 2013
9 Pioneer ACOs exited the Program

- **Prime Care Medical Network Inc.**: San Bernardino and Riverside counties, CA
- **University of Michigan Faculty Group Practice**: southeastern Michigan
- **Physician Health Partners LLC**: Denver, CO
- **Seton Health Alliance**: Austin, TX and surrounding counties
- **Plus**: North Texas Specialty Physicians and Texas Health Resources
- **Healthcare Partners Nevada ACO LLC**: Clark and Nye counties
- **Healthcare Partners California ACO LLC**: Los Angeles and Orange counties
- **JSA Care Partners LLC**: Orlando, Tampa Bay and surrounding south Florida
- **Presbyterian Healthcare Services**: central New Mexico

- Seven who achieved no savings are transitioning instead to the Medicare Shared Savings program.
- Two are opting to exit the Medicare ACO model altogether.
- At least one struggled to attain enough attributed beneficiaries without a widely expanded geography that couldn’t be supported.

The Opportunities: Preferred Provider Network Development

Many of the ACOs have begun developing a preferred provider network. Key elements on the selection criteria:

1. Customer preferences & feedback/Brand recognition
2. CMS quality metrics on nursinghomecompare.gov
3. Current discharge referral relationships & numbers
4. Admission policies
5. Physician/Nurse Practitioner coverage & availability
6. Willingness to contract for services – Medical Director, Lab, Imaging
7. Ease of doing business – number of denials, types of denials, supportive of ACO providers/staff, time to admit
8. Willingness to engage/perception of leadership capabilities
Post Acute Care Cost: ACO Perspective

In this sample market, for every $1 of an ACO’s Total Cost of Care, post acute care (30 Days post discharge) accounts for $0.13 of the total spend.

- All Other Costs (IP, OP, MD, Rx)
- Post Acute - SNF
- Post Acute - HHA
- All Other Post Acute Services
- Other HHA

Per $1 of Total Cost of Care

$0.805

$0.076 (Post Acute SNF and Home Care $0.11 of Spend)

$0.026

$0.031

$0.062

Totals may not equal $1 due to rounding

Potential Care Model Touch Points for Change

Numbers Served

- Comorbidities
- Chronic Diseases
- Pre-episode service use

Costs

- Emergency Room
- Pain Management
- Re-admissions
  ✓ Post-surgical Infections
- Post-acute care
  ✓ Physician Follow-up
  ✓ Outpatient
  ✓ Homecare
  ✓ SNF

Goal: Reducing Variation & Improving Care

- Length of stay
- Cost per day
- Care variation
- Surgical care
- Best practices

Numbers Served

- Physician Follow-up
- Outpatient
- Homecare
- SNF

Goal: Reducing Variation & Improving Care
The health care transformation process we are currently in is:

“a long trip on a road that is not yet paved”

Culture and Mindset

- How open to change is your organization?
- How innovative is your organization?
- Are you open to adopting a new model of care that may be required in a reforming health care environment?

Key Themes from Interviews with Health Systems

- Opportunities/Strategies for post-acute providers:
  - Geographic in underserved markets (hospitals are looking at zip codes with higher readmissions)
  - Collaborative mindset is important to hospitals
  - Enhance clinical capabilities
  - Hospitals are open to feedback from post-acute providers
  - Service diversification is important to some, not as much to others

- What health systems are focusing on:
  - Developing their preferred network (narrowing their referral base)
  - Understanding their patient base (attributed patients)
  - Figuring out how care is going to be coordinated
    - Developing care coordinators and liaisons
Key Themes from Interviews with Health Systems  (Continued)

- **Health systems are reaching into the community:**
  - Looking to embed Advance Practice Registered Nurses (APRN’s) in nursing facilities
  - Hosting clinics in several post-acute providers
  - Sending liaisons into independent living facilities
  - Evaluating whether they could develop urgent care centers in concert with post acute providers

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Health Care Reform: A trip around the U.S. in 40 minutes

**National Snapshot of Bundled Payment Initiatives**

- 2638 participants in all four BPCI Initiatives
  - Top National Convening Organizations: Remedy Partners, Signature Medical Group, Amedisys Holdings, Optum, PA Holdings

**National Snapshot ACOs**

- Medicare ACOs
  - 23 Pioneer ACOs
  - 351 MSSP ACOs
  - 35 Advanced Payment Initiative
**Central**

- BPCI Model 1: 1 participant in KS

**Bundled Knee-Replacement**
IL: AdvocateCare

Northwest
OR: Coordinated Care Organizations

WA: Boeing ACO for employees & retirees
Southwest & California

AZ: Walgreens – Heritage Provider: Population Health

“Coordinated care programs are vitally important to help ensure patients have access to the quality care they need, especially in today’s healthcare environment”

- Jeffrey Kang, MD, senior vice president of health and wellness services and solutions, Walgreens
South

TX: STAR+PLUS Expansion
Consolidation/Market Activity
A Wave of Hospital Mergers*


Change, like sunshine, can be a friend or a foe, a blessing or a curse, a dawn or a dusk.

- William Arthur Ward
Federal Government Perspective:

**Administration/President’s Budget**
- Move payment towards value
- Encouraging multi-payer approaches
- Bundled Payments for Post-Acute Providers beginning FY2019
- Budget neutral value-based purchasing for several additional providers: skilled nursing facilities, home health agencies, ambulatory surgical centers, and hospital outpatient departments,
- Site neutral or equalized payments for certain conditions treated in IRFs and SNFs

**Congress**
- “Better Care, Lower Cost Act”
- Bi-Partisan Proposal: IMPACT Act of 2014

Provider Perspective:

**Timing of Transition to Risk-Based Payment**

**TODAY**
- Value-oriented payment = about 10% of all payments
  - 7% of hospital Medicare payments are at-risk
- 61% of providers receive more than 80% of revenue from FFS
- 2x as many providers have risk-based contracts in 2013 vs. 2011
- More providers seeking risk-based arrangements with Commercial payers rather than Medicare

**In next five years**
- 75% of providers who don’t currently have a Total Cost of Care Contract expect to
  - Pursuing to gain experience for future and align financial incentives
- 80% expect to have a Bundled Payment contract
  - Seeking to increase volume, gain experience

Source: 2013 Accountable Payment Survey: The State of Risk-Based Payment – and How Industry Leaders Expect to Transition, The Advisory Board
The “Next New” Challenge

1. The Era of No Excuses – clinical integration, publicly reported performance data, integrated health communications, the capabilities of big data and greater risks will reduce the acceptance of excuses.

2. Focus on Reducing Variation – ACOs, BPCI, MedicareAdvantage plans, VBPs – all are focused on reducing variation and creating best practice compliance. The recent IOM Report on Geographic Variation will keep the spotlight on reducing variation particularly in Post-Acute Care.

3. Disrupted and altered revenue streams – movement toward population health, managed Medicaid and other risk-based payment models will change utilization patterns, patient’s access to providers and ultimately disrupt and alter the revenue streams providers have grown accustomed to.

The “Next New” Challenge (Continued)

4. Evolving Role and Influence of Payers – United Health Group’s OptumHealth, Aetna’s ACO division, growth in MedicareAdvantage and Medicaid managed care, etc., will change how the payers participate in care delivery and revenue generation

5. Performance Excellence – publicly reported and transparent data will be more pervasive and ultimately, determine who is in & who is not

6. Patient engagement strategies – separating successful care systems from potentially higher risk care systems

7. New Market Entrants with new innovations and technologies, i.e., Walgreens, CVS, Wal-Mart, Apple, Target, Kroger Foods, etc.
Evolving Service & Payment Models

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Director, Financial Planning
Visiting Nurse Service of New York

Rose Madden-Baer
DNP, RN, MHSA BC-PHCNs
Senior Vice President, Population Health Management

October 20, 2014

The Visiting Nurse Service of New York

VNSNY: Who We Are

Founded in 1893 by Lillian D. Wald, VNSNY is the largest non-profit community-based healthcare agency in the U.S.

Two Business Lines

• Provider – CHHA and Hospice
• Health Plan – Medicaid & Medicare
VNSNY Offers a Wide Range of Services & Integrates Care Across Settings

- Charitable Care
- Traditional Home Health Care
- Hospice & Palliative Care
- Private Pay Services
- Children & Family Services
- Congregate Care
- Community Mental Health
- Health Plan

- MLTC
- MA
- HIV - SNP

The Healthcare World is in Flux & Change is Imminent

- Value-Based Purchasing
- Consolidation
- Declining Reimbursement
- Shared Risk
- More Patients at Risk
- Increased Competition
- Evolving Models of Care
- Greater Application of Technology
- Cross-Continuum Partnerships
- Health Reform (ACA)
- Integrate Care for Duals
Population Health

VNSNY and Emerging Care Model Innovations

- External Drivers
  - Patient Safety
  - Affordable Care Act
  - Triple Aim: Cost, Quality, Access
  - Value Based Purchasing
  - Medicaid Redesign (DSRIP)
  - Request for Partnerships (DSRIP, National Health Plans)

- VNSNY Comprehensive Approach
  - Population Health/Care Transitions Innovations
  - Partnerships: Evolution of role of Hospital Clinical Intake Liaisons & Handoff
  - Care Coordination and Community Health Competencies
A Dual Imperative for Home Health Providers

Traditional Home Care Under Medicare/Managed Care Fee-for-Service

Care Coordination and Management Outside Core Patient Population

Ensuring a financially-viable model for traditional home care services in a declining reimbursement environment

Opportunities and share in value by providing population health management services for broader range of patients

Patients and Care Transitions

RWJF Care About Your Care initiative along with Dartmouth Atlas Project (2013) reveals:

- Nine million Medicare beneficiaries are discharged from hospitals annually
- 1 out of 5 of these patients will have a readmission within 30 days and more are seen in the Emergency Department
- More than 1 in 3 is back within 90 days
- Annual cost of readmissions of 26 billion to Medicare with 17 billion in avoidable cost
Transitional Care: The Evidence

Decades of research highlight:

• Elderly patients are at increased risk for poor outcomes in the transition from hospital to home

• Re-hospitalization rates are high and one quarter to one-third of these re-hospitalization rates are avoidable—Mary Naylor (2004)

• Under the Affordable Care Act of 2010, a variety of transitional care programs and services have been established to improve quality and reduce costs.

Population Care Management

- Patient: Interactions: face-to-face, telephonic, and electronic
- Financial and Clinical Outcomes & Reporting
- Predictive Analytics & Risk Stratification
- Collaborations with Primary Care and Other Providers
- Person Centered Goals and Care Plan
- EB Tools, Engagement & Motivational Interviewing
- Health Coaching and Support
- Assessment & Care Coordination by RN
The VNSNY Population Care Coordination team, anchored by the RN Population Care Coordinator

PATIENT AND FAMILY

VNSNY Population Care Coordination Team

- Hospital-based RN liaison/TCC
- Social Worker
- Health Coach
- Nurse Practitioner
- Psych NP
- Pharmacist

OTHER PROVIDERS

- Referring MD
- Home Care Nurse
- Home Care Therapist
- Primary Care Physician
- Post-acute facilities
- Specialist Physicians
- Other Care Managers
- Community-based orgs
- Paraprofessional Svcs

Population Health at VNSNY: Applications

- 2 Medicare-sanctioned bundled payment demonstrations
- Delegated disease-specific care management for health plans
- Post-hospitalization transitional care for ACOs and health plans
- Ongoing population health management for vulnerable communities
- Remote and embedded care coordination for emerging provider systems as part of NY State Medicaid Delivery System Reform (DSRIP)
- Care coordination for largest Managed Long Term Care Plan in NY State
### Success Factors and Challenges

<table>
<thead>
<tr>
<th>Success Factors</th>
<th>Challenges</th>
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<tbody>
<tr>
<td>• Use of evidence-based tools</td>
<td>• Clear and established reimbursement model</td>
</tr>
<tr>
<td>• Partnership with leading-edge academic institution on training curriculum</td>
<td>• Changing perception of VNSNY as a traditional home care provider</td>
</tr>
<tr>
<td>• Standardized approach across all applications of model</td>
<td>• Internal culture change</td>
</tr>
<tr>
<td>• Stratification-driven, dosed mix of interventions</td>
<td>• Data capture</td>
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### VNSNY Innovative Care Models: Future Implications

- Replicate programs at additional sites to ensure best practice for vulnerable patients
- Working with partners to address the ongoing needs based on the changing climate
- Creative planning and innovation to achieve the demands of the External Drivers
- Scaling – additional transitional care programs and patients
- Define the evolving role of post-acute organizations: DSRIP; Care Coordination Partners
- Disseminating best practices nationally and internationally
Payment Models

New Models of Payments

Risk Based Payments

Per Case Payments

Who is Paying?

- Hospitals
- ACOs
- Managed Care Companies
Risk Based Models: What You Need To Do

Financial Model Development Process

Evaluate Data and Identify Potential Opportunities
- Evaluate baseline claims data by diagnosis group
- Identify population, episodes by service type
- Determine rate of hospitalization/re-hospitalization
- Complete at Diagnoses level
- Factor Sample Size

Develop Financial Analysis and Clinical model
Factors to Review:
- Potential costs as risk?
- Total population volume /costs and unit cost
- Where can we make an impact?
  - Baseline re-admission data at the disease specific level vs. benchmarks
  - Calculate opportunity: Cost Savings per Day of Costs to Reduce for potential impact
  - Develop tailored clinical intervention model

Develop Risk Sharing Agreement
- Components of risk sharing:
  - Sharing with payer (CMS, Managed Care)
  - Sharing with Awardee Convener
  - Partial Risk vs. Full
  - Partial Gain-sharing/ Loss-sharing
  - Full Case rate/ Capitated Payment
  - Pilot approach

Monitor Outcomes/ Calculate Savings
- Monitor to targets
- CMS: Quarterly review of claims data
- Other Payers: monthly, quarterly look back
- Reevaluate contract and ability to manage risk with more experience

Risk Based Payments:
Bundled Payments
Medicare’s Bundled Payment For Care Improvement Program (BPCI): 4 Models

Models with VNSNY Participation

Overview of two models with VNSNY participation

<table>
<thead>
<tr>
<th>Model 2- AMC Hospital at Anchor</th>
<th>Model 3- VNSNY as Anchor Provider</th>
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</thead>
<tbody>
<tr>
<td><strong>Scope</strong></td>
<td></td>
</tr>
<tr>
<td>Any service beginning 72 hours prior to inpatient admission through 90 days of post-acute care</td>
<td>Any service beginning with home care admission (post-hospitalization) for 90 days of post-acute care</td>
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<tr>
<td><strong>Covered services</strong></td>
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<tr>
<td>All Part A and B services</td>
<td>All Part A and B services</td>
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<td><strong>DRGs in scope</strong></td>
<td></td>
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<tr>
<td>• Total Joint Replacement</td>
<td>Subset of 48 episodes that encompass 180 DRGs</td>
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<tr>
<td>• Spine Surgery</td>
<td>• CHF</td>
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<tr>
<td>• Cardiac Valve Replacement</td>
<td>• Exploring additional diagnoses (e.g., COPD)</td>
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<td><strong>Expected volume</strong></td>
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<tr>
<td>~600-800 cases per year</td>
<td>~ currently 1,000 cases/year, up to ~13,000</td>
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<tr>
<td><strong>Sources of savings</strong></td>
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<tr>
<td>Reduced readmissions, lower cost site of service, coordinated post-acute care</td>
<td>Reduced readmissions, coordinated post-acute care</td>
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<tr>
<td><strong>Minimum required savings to CMS before gain sharing</strong></td>
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<tr>
<td>2% for 90 day episode</td>
<td>3% for all episode lengths</td>
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<td><strong>Financial arrangements</strong></td>
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<tr>
<td>• Hospital shares full Medicare Part A and B risk with CMS.</td>
<td>Upside to VNSNY: 2/3 of the savings, after CMS’ 3% savings requirement and management overhead paid to Awardee Convener Organization</td>
</tr>
<tr>
<td>• Finalizing risk-sharing agreement between VNSNY and hospital</td>
<td>Downside to VNSNY: 1/3 of the losses</td>
</tr>
<tr>
<td><strong>Partners</strong></td>
<td></td>
</tr>
<tr>
<td>We are one for 11 post-acute partners (4 home care organizations)</td>
<td>We are the only post-acute partner in our service areas</td>
</tr>
</tbody>
</table>
Payment Innovation

EPISODE OF CARE MODEL
Healthcare services provided for a specific illness during a set time period

- **Definition**
  - Description
  - Included Services
  - Excluded Services
  - Hardware, etc.

- **Participating Providers Network**
- **Compensation Model**

**Episode Components**

- **Starting Point**
  - e.g. 30 days prior to the Date of Surgery

- **Trigger Point**
  - Decision to initiate an Episode

- **Stopping Point**
  - e.g. 39 days following the Date of Surgery

**Episode Timing**

- **Diagnostic**
  - 30 days

- **Event**
  - 2-5 days

- **Follow-up Care**
  - 90 days

BUNDLED PAYMENT
Reimbursement to healthcare providers on the basis of expected costs for clinically-defined episodes.

Under the Bundled Program

**VNSNY at risk for all Medicare Part A/B costs for 90 days after admission to home care**

- **Initial Hospitalization:** Categorized into 45 Episode Types
  - For example: CHF, Total joint, UTI, Stroke, CABG

- **Days 1-45**
  - Admission to VNSNY Home Care

- **Days 45-90**
  - Discharge from VNSNY Home Care
  - (Median LOS: 45 days)

  - **Avg $/episode**
  - ~$3,500/episode VNSNY CHHA Episode
  - ~$3,000/episode Physician visits, DME, outpatient diagnostics, etc.
  - ~$6,500/episode Rehospitalization (+ any post-discharge sub-acute admission)
  - 60% Days 1-45, 40% Days 45-90

  - **Medicare Costs at Risk: All Part A & B**
  - ~$13,000/episode

  - **Primary opportunity for VNSNY to improve quality/care and achieve savings = reduction in rehospitalization**

How Care has been Redesigned Under Model 3: Leveraging Population Health

<table>
<thead>
<tr>
<th>Triggering Hospitalization</th>
<th>Traditional CHHA episode (~45 days)</th>
<th>Remainder of 90-day episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>• VNSNY RN onsite hospital liaisons (~40 facilities): shift from intake processing to transitional care</td>
<td>• Additional focus on transitional care &amp; CHF home care protocols</td>
<td>• Introduction of VNSNY CO-CARE 90 model, anchored by a Nurse Population Care Coordinator who delivers/manages care with other providers beyond traditional Home Care period of service</td>
</tr>
<tr>
<td></td>
<td>• Calculation of acuity score using enhanced risk stratification algorithm (low, rising, high risk)</td>
<td>• Stratification-driven mix of face-to-face, telehealth, telephonic communication; emphasis on goal-setting via motivational interviewing and behavior activation</td>
</tr>
<tr>
<td></td>
<td>• Ongoing internal tracking of key outcome metrics, with frequent feedback loop to core clinical operation teams</td>
<td>• Partnership with community resources to tailor care plans and interventions to cultural/demographic needs</td>
</tr>
</tbody>
</table>

Goal: Reduced 90-day rehospitalization rates and improved coordination of post-acute care

Bundled Payment Example: Model 3
Financial Scenario Analysis: CHF, COPD, Other Respiratory

Risk Sharing Assumptions

Global Assumptions
- CMS Savings: 3%
- Admin: 2%

Gainsharing Assumptions
- Admin: 33%
- VNSNY: 67%

Loss-sharing Assumptions
- Admin: 67%
- VNSNY: 33%
### Financial Scenario Analysis: CHF, COPD, Other Respiratory

#### Episodes at Risk

<table>
<thead>
<tr>
<th>Episode Category</th>
<th>Annual Episodes</th>
<th>Baseline Cost/Episode</th>
<th>Total Baseline Cost</th>
<th>Baseline Readmission Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHF</td>
<td>969</td>
<td>$16,899</td>
<td>$16M</td>
<td>$8M</td>
</tr>
<tr>
<td>COPD, bronchitis/asthma</td>
<td>856</td>
<td>$14,402</td>
<td>$12M</td>
<td>$5M</td>
</tr>
<tr>
<td>Other respiratory</td>
<td>299</td>
<td>$17,841</td>
<td>$5M</td>
<td>$2M</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,123</strong></td>
<td><strong>$16,025</strong></td>
<td><strong>$34M</strong></td>
<td><strong>$16M</strong></td>
</tr>
</tbody>
</table>

#### Scenario Analysis

<table>
<thead>
<tr>
<th>Scenario #</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Cost Reduction/Increase</td>
<td>10%</td>
<td>7%</td>
<td>5%</td>
<td>3%</td>
<td>0%</td>
<td>-3%</td>
</tr>
<tr>
<td>Reduction as % of Readmit Costs</td>
<td>21%</td>
<td>15%</td>
<td>10%</td>
<td>6%</td>
<td>0%</td>
<td>-6%</td>
</tr>
<tr>
<td>Actual Cost</td>
<td>$30.6M</td>
<td>$31.6M</td>
<td>$32.3M</td>
<td>$33.0M</td>
<td>$34.0M</td>
<td>$35M</td>
</tr>
<tr>
<td>Savings from Baseline</td>
<td>$3.4M</td>
<td>$2.4M</td>
<td>$1.7M</td>
<td>$1.0M</td>
<td>$ -</td>
<td>($1M)</td>
</tr>
<tr>
<td>CMS Share</td>
<td>$1.0M</td>
<td>$1.0M</td>
<td>$1.0M</td>
<td>$1.0M</td>
<td>$1.0M</td>
<td>($1M)</td>
</tr>
<tr>
<td>Savings before Admin</td>
<td>$2.4M</td>
<td>$1.4M</td>
<td>$0.7M</td>
<td>$ -</td>
<td>($1M)</td>
<td>($2M)</td>
</tr>
<tr>
<td>Admin</td>
<td>$0.7M</td>
<td>$0.7M</td>
<td>$0.7M</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
</tr>
<tr>
<td>Net Savings</td>
<td>$1.7M</td>
<td>$0.7M</td>
<td>$ -</td>
<td>$ -</td>
<td>($1M)</td>
<td>($2M)</td>
</tr>
<tr>
<td>Risk Sharing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner</td>
<td>$0.6M</td>
<td>$0.2M</td>
<td>$ -</td>
<td>$ -</td>
<td>$ (0.7M)</td>
<td>($1M)</td>
</tr>
<tr>
<td>VNSNY</td>
<td>$1.1M</td>
<td>$0.5M</td>
<td>$ -</td>
<td>$ -</td>
<td>$ (0.3M)</td>
<td></td>
</tr>
</tbody>
</table>
Risk Based Payments: Bundled Payments – Model 2

VNSNY-Hospital Model 2
Bundled Payment Partnership

• Conditions currently under the bundle:
  1. Total joint replacement
  2. Non-cervical spinal fusion
  3. Cardiac valve procedures

• Redesigned 'Standard' and 'High-risk/Enhanced' post-acute pathways defined for each condition

• Enhanced Communication and Data sharing between VNSNY and Hospital
  • Regular communication between hospital care coordination RNs and VNSNY bundled payment liaisons
  • Automated two-way data exchange with hospital with detailed clinical progress data (including VNSNY visit notes and hospital discharge plan) viewable to both organizations and updated on a weekly basis
  • Quarterly quality reports prepared by VNSNY outcomes group
Risk Sharing Structure

VNSNY and Hospital will share in upside and downside risk vs. the baseline cost target according to a graduated schedule that places bounds around the shared risk.

<table>
<thead>
<tr>
<th>Risk Tier</th>
<th>Definition</th>
<th>VNSNY Risk Share</th>
<th>Hospital Risk Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Above 15%</td>
<td>Dollars over 15% of target</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>10 to 15%</td>
<td>Dollars between 10% and 15% above target</td>
<td>25%</td>
<td>75%</td>
</tr>
<tr>
<td>0 to 10%</td>
<td>Dollars between target and 10% above target</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>0% to - 10%</td>
<td>Dollars between target and 10% below target</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>-10% to - 15%</td>
<td>Dollars between 10% and 15% below target</td>
<td>25%</td>
<td>75%</td>
</tr>
<tr>
<td>Below - 15%</td>
<td>Dollars below 15% of target</td>
<td>0%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Risk Sharing Structure

As an example, under this arrangement, if the target price is $1,000, and the actual experience during a particular period resulted in average spend of $800, the distribution of the $200 in savings would follow this schedule:

| Risk Tier          | Savings Dollars | VNSNY Share | Hospital Share |
|--------------------|-----------------|-------------|               |
| 0% to - 10%        | $100            | $50         | $50           |
| - 10% to - 15%     | $50             | $12.50      | $37.50        |
| Below - 15%        | $50             | $0          | $50           |
| Total              | $200            | $72.50      | $137.50       |

Risk Sharing with Managed Care Payors
Managed Care
Readmission Avoidance Program Goals

Major Objectives Include:

- Identification and engagement of members at risk for hospital readmission and coordination with their primary care provider.
- Increase in patient activation and self-management.
- Medication reconciliation between hospital and home.
- Follow-up visit with the primary care provider within 14 days of hospital discharge.
- Reduction in potentially preventable re-admissions (PPR) for members that might occur within 30 days of discharge from the acute inpatient setting.
- Promotion of collaboration among network hospitals regarding readmission avoidance initiatives thereby enhancing current discharge planning activities.

Performance Goals and Rates

<table>
<thead>
<tr>
<th>Performance</th>
<th>New Hospital Readmission Rate</th>
<th>Portion of Fee Charged</th>
<th>In-Hospital Assessment Fee</th>
<th>Fee per Enrolled Case</th>
<th>Reduction in Hospital Costs*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Achieved</td>
<td>11.2%</td>
<td>100.0%</td>
<td>$135.00</td>
<td>$620</td>
<td>$1,280,000</td>
</tr>
<tr>
<td>75% of Target Achieved</td>
<td>11.2%</td>
<td>87.5%</td>
<td>$118.13</td>
<td>$543</td>
<td></td>
</tr>
<tr>
<td>50% of Target Achieved</td>
<td>12.6%</td>
<td>75.0%</td>
<td>$101.25</td>
<td>$465</td>
<td></td>
</tr>
<tr>
<td>25% of Target Achieved</td>
<td>13.3%</td>
<td>62.5%</td>
<td>$84.38</td>
<td>$388</td>
<td></td>
</tr>
<tr>
<td>0% of Target Achieved</td>
<td>14%</td>
<td>50%</td>
<td>$67.50</td>
<td>$310</td>
<td></td>
</tr>
</tbody>
</table>

*Reduction in Hospital Cost is based on $16,000 Cost per Hospitalization
Case Rate

- Initial RN 1st visit: $147
- 30 Day Case Rate: $1,164
- Every additional 30 days: $745