Evolving Payment and Service Models: Blessing or a Curse?

NAHC Financial Management Conference
July 14, 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

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

Primary Care

- 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

Chronic Care

Acute Care

Wellness

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**
  - Risk based
  - Collaboration
  - Predictive modeling
  - Global budget or sub-capitation

- **Bundled Payments**
  - Negotiated Episode Price
  - Longitudinal Accountability
  - Risk based

- **Value Based Reimbursement**
  - 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>Quality of Care</td>
<td>Volume of Care</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
**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]

[^1]: BPCI refers to Bundled Payment for Care Improvement.
BCPI Participants Favoring Episodes with PAC Services

Participation by Model Type

- **Model 1**: Hospital Inpatient Services, 7%
- **Model 2**: Hospital and Physician Inpatient and Post-Discharge Services, 41%
- **Model 3**: Post-Discharge Services, 36%
- **Model 4**: Hospital and Physician Inpatient Services, 16%

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**: 47%
- **All 48 Bundles**: 18%

Top Ten Clinical Conditions for Bundling

- Major joint replacement of lower extremity: 78%
- Congestive heart failure: 69%
- Coronary artery bypass graft: 51%
- COPD, bronchiectasis: 49%
- Percutaneous coronary intervention: 48%
- Cardiac valve: 47%
- Simple pneumonia and respiratory infections: 47%
- Cardiac ablation: 46%
- Revision of the hip or knee: 41%
- Double replacement of the lower extremity: 41%

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>Total Indexed Admissions</th>
<th>Indexed Total Indexed Avg Cost</th>
<th>Total Cost</th>
<th>Indexed Total Indexed Avg Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>1,000</td>
<td>12,040</td>
<td>12,040,359</td>
<td>8,662</td>
<td>8,661,981</td>
</tr>
<tr>
<td>SNF</td>
<td>3,134</td>
<td>3,133,676</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>HHA</td>
<td>2,169</td>
<td>2,168,509</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>MD</td>
<td>3,535</td>
<td>3,535,248</td>
<td>1,975</td>
<td>1,975,175</td>
<td>-</td>
</tr>
<tr>
<td>All Other</td>
<td>654</td>
<td>653,696</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total Costs</td>
<td>21,531</td>
<td>21,531,488</td>
<td>10,637</td>
<td>10,637,156</td>
<td></td>
</tr>
</tbody>
</table>

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

Source: Example based on CMS Data

Commercial Bundled Payment

[Map and Adoption Tracker Diagram]

Contract types:
- Commercial Insurer
- Employer
- Other
- View All
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.


“All of care is going to move down this path [value-based care], and it has to. Medical homes are doing it; the very best ACOs are going to figure out how to do it”

Health Care Delivery: ACO Network

ACO Network

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

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

Totals may not equal $1 due to rounding

Potential Care Model Touch Points for Change

Numbers Served
- Comorbidities
- Chronic Diseases
- Pre-episode service use
- Length of stay
- Cost per day
- Care variation
- Surgical care
- Best practices

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

Goal: Reducing Variation & Improving Care
Case Studies and Lessons Learned

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

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

Partnerships: Banner Health & U of AZ
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

Northeast

BPCI Model 1: 24 out of 25 participants located in NJ
M & A - Consolidation

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, Medicare Advantage 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.

Transform your business model
Re-Design Your Operating Infrastructure

Evolving Payment Models

Sam Heller
Senior Vice President & CFO
Visiting Nurse Service of New York

July 14, 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
- Private Pay Services
- Congregate Care
- Health Plan
- Community Mental Health
- Children & Family Services
- Hospice & Palliative Care

- MLTC
- MA
- HIV - SNP
The Healthcare World is in Flux & Change is Imminent

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

New Models of Payments

- Per Case Payments
- Risk Based Payments

Who is Paying?

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

<table>
<thead>
<tr>
<th>Data</th>
<th>Financial Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>What was the rate of hospitalization</td>
<td>Cost saving for each day</td>
</tr>
<tr>
<td>Number in sample</td>
<td>Cost to reduce</td>
</tr>
<tr>
<td>Diagnoses</td>
<td></td>
</tr>
</tbody>
</table>

Bundled Payments
Overview of two models with VNSNY participation

<table>
<thead>
<tr>
<th>Scope</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered services</td>
<td>All Part A and B services</td>
<td>All Part A and B services</td>
</tr>
</tbody>
</table>
| DRGs in scope | • Total Joint Replacement  
• Spine Surgery  
• Cardiac Valve Replacement | Subset of 48 episodes that encompass 180 DRGs (to be finalized) |
| Expected volume | ~600-800 cases per year | ~Up to 13,000 cases per year, reflecting total Part A/B Medicare costs at risk of ~$175MM |
| Sources of savings | Reduced readmissions, lower cost site of service, coordinated post-acute care | Reduced readmissions, coordinated post-acute care |
| Minimum required savings to CMS before gain sharing | 2% for 90 day episodes | 3% for all episode lengths |
| Financial arrangements | Currently, NYU bears all upside and downside risk; however, gain sharing negotiations are in process | Upside to VNSNY: 2/3 of the savings, after CMS’ 3% savings requirement and management overhead paid to Remedy  
Downside to VNSNY: 1/3 of the losses |
| Partners | We are one of 11 post acute partners (4 home care organizations) | We are the only post-acute partner in our service area |

Payment Innovation

**Episode of Care Model**

- **Definition**: Healthcare services provided for a specific illness during a set time period
- **Participating Providers Network**
- **Compensation Model**
- **Starting Point**: e.g., 30 days prior to the Date of Surgery
- **Trigger Point**: Decision to initiate an Episode
- **Stopping Point**: e.g., 90 days following the Date of Surgery
- **Diagnostic**: 30 days
- **Event**: 2-5 days
- **Follow-up Care**: 90 days

**Bundled Payment**

Reimbursement to health care providers on the basis of expected costs for clinically-defined episodes.
VNSNY’s Model 3 Program: Bundle Mechanics

- CMS has defined 48 potential episode categories for the bundle payment program based on the DRG associated with the initial hospitalization.
- These include episode types such as CHF, Total Joint, UTI, Stroke, CABG, each of which represents a handful of specific DRGs; for example, the ‘CHF’ category includes patients hospitalized under one of the following DRGs:
  - 291 heart failure and shock with major complication or comorbidity
  - 292 heart failure and shock with complication or comorbidity
  - 293 heart failure and shock without complication or comorbidity
- Even though financial risk ‘clock’ for the Model 3 program begins upon admission to home care, the existence of the episode is triggered by the initial hospitalization, and the episode type is defined by the hospitalization DRG (not the home care diagnosis).
- The scope of VNSNY’s Model 3 program cannot be limited to specific referring hospitals or geographies—any Medicare beneficiary admitted to VNSNY after being hospitalized for an included DRG would be part of our bundle.
- Savings are calculated by CMS by comparing actual costs to a target price on a quarterly basis:

**Bundled Pricing Mechanics**

Historical baseline average 90-day cost / patient for each episode, based on CMS analysis of 2009-2012 claims data for VNSNY patients.

- minus 3% savings to CMS = Target Price
  - if actual costs < target price, savings go to the awardee
  - if actual costs > target price, difference is owed to CMS
  - agrees to bear 2/3 of the downside risk and share 1/3 of the upside risk
  - admin costs (max 2%) are subtracted from upside savings pool

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 48 Episode Types
  - CHF, Total joint, UTI, Stroke, CABG

- Days 1-45
  - Admission to VNSNY Home Care
  - Avg $/episode

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

**Medicare Costs at Risk: All Part A & B**

- ~25% ~$3,500/episode VNSNY CHHA Episode
- ~25% ~$3,000/episode Physician visits, DME, outpatient diagnostics, etc.
- ~50% ~$6,500/episode Rehospitalization (+ any post-discharge sub-acute admission)
- 100% ~$13,000/episode Primary opportunity for VNSNY to improve quality/care and achieve savings = reduction in rehospitalization
Our clinical workgroup has proposed a set of clinical interventions to introduce/expand as part of Bundled Program.

### Initial Hospitalization:
Categorized into 48 Episode Types
- CHF, Total Joint, UTI, Stroke, CABG

### Medicare Costs at Risk
- Rehospitalization (+ post-discharge sub-acute admission)

### Proposed VNSNY Interventions
- Enhance CHHA fidelity to existing guidelines/protocols designed to reduce rehospitalization, eg.
- Consider expansion of NP-led Transitional Care and Palliative Care programs, or RN-led TCC role where appropriate and cost-effective
- Transitional Care Nurse Navigator role to provide telephonic and/or visit-based care management
- Patients can be risk stratified based on recalculation of rehospitalization risk score after discharge OASIS
- Can be staffed through Assessment Unit

### Financial Scenario Analysis:
**CHF, COPD, Other Respiratory**

#### Assumptions
- **Global Assumptions**
  - CMS Savings: 3%
- **Gainsharing Assumptions**
  - Partner: 33%
  - VNSNY: 67%
- **Loss-sharing Assumptions**
  - Partner: 67%
  - VNSNY: 33%

#### 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 Re admission Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHF</td>
<td>969</td>
<td>$16,899</td>
<td>$16,370,193</td>
<td>$8,451,599</td>
</tr>
<tr>
<td>COPD, bronchitis/asthma</td>
<td>856</td>
<td>$14,402</td>
<td>$12,323,016</td>
<td>$5,412,459</td>
</tr>
<tr>
<td>Other respiratory</td>
<td>299</td>
<td>$17,841</td>
<td>$5,326,451</td>
<td>$2,488,980</td>
</tr>
</tbody>
</table>

| Total | 2,123 | $16,025 | $34,019,660 | $16,353,038 |

#### 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>$30,617,694</td>
<td>$31,638,284</td>
<td>$32,318,677</td>
<td>$32,999,070</td>
<td>$34,019,660</td>
<td>$35,040,250</td>
</tr>
<tr>
<td>Savings from Baseline</td>
<td>$3,401,966</td>
<td>$2,381,376</td>
<td>$1,700,983</td>
<td>$1,020,590</td>
<td>$1,020,590</td>
<td>$1,020,590</td>
</tr>
<tr>
<td>CMS Share</td>
<td>$1,020,590</td>
<td>$1,020,590</td>
<td>$1,020,590</td>
<td>$1,020,590</td>
<td>$1,020,590</td>
<td>$1,020,590</td>
</tr>
<tr>
<td>Savings before Admin</td>
<td>$2,381,376</td>
<td>$1,360,786</td>
<td>$680,739</td>
<td>-</td>
<td>$1,020,590</td>
<td>$12,041,185</td>
</tr>
<tr>
<td>Admin</td>
<td>$680,393</td>
<td>$680,393</td>
<td>$680,393</td>
<td>$680,393</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net Savings</td>
<td>$1,700,983</td>
<td>$680,393</td>
<td>-</td>
<td>-</td>
<td>$1,020,590</td>
<td>$12,041,185</td>
</tr>
</tbody>
</table>

#### Risk Sharing
- Partner: 566,994
- VNSNY: 1,133,989

---

67
VNSNY Bundled Payment Risk Sharing

<table>
<thead>
<tr>
<th></th>
<th>First site of discharge</th>
<th>Annual volume</th>
<th>Target 90-day post-acute price (based on Q1/Q2'13 claims)</th>
<th>Total post-acute target cost</th>
<th>Portion of cost due to Rehospitalization</th>
<th>% of cost due to rehospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Joint</td>
<td>Homecare</td>
<td>258</td>
<td>$5,102.00</td>
<td>$1,316,316.00</td>
<td>$295,410.00</td>
<td>22%</td>
</tr>
<tr>
<td></td>
<td>SNF then HC</td>
<td>60</td>
<td>$18,000.00</td>
<td>$1,080,000.00</td>
<td>$141,420.00</td>
<td>13%</td>
</tr>
<tr>
<td>Spine Procedures*</td>
<td>Homecare</td>
<td>48</td>
<td>$2,568.00</td>
<td>$123,264.00</td>
<td>$10,656.00</td>
<td>9%</td>
</tr>
<tr>
<td>Valve Procedures*</td>
<td>Homecare</td>
<td>66</td>
<td>$4,656.00</td>
<td>$307,296.00</td>
<td>$111,078.00</td>
<td>36%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>432</td>
<td>$6,544.00</td>
<td>$2,826,876.00</td>
<td>$558,564.00</td>
<td>20%</td>
</tr>
</tbody>
</table>
### VNSNY Bundled Payment Risk Sharing

#### Post-acute cost reduction scenarios

<table>
<thead>
<tr>
<th></th>
<th>-5%</th>
<th>-10%</th>
<th>-15%</th>
<th>-20%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Joint</strong></td>
<td>$ (65,816.00)</td>
<td>$ (131,632.00)</td>
<td>$ (197,447.00)</td>
<td>$ (263,263.00)</td>
</tr>
<tr>
<td><strong>Total Joint</strong></td>
<td>$ (54,000.00)</td>
<td>$ (108,000.00)</td>
<td>$ (162,000.00)</td>
<td>$ (216,000.00)</td>
</tr>
<tr>
<td><strong>Spine Procedures</strong></td>
<td>$ (6,163.00)</td>
<td>$ (12,326.00)</td>
<td>$ (18,490.00)</td>
<td>$ (24,653.00)</td>
</tr>
<tr>
<td><strong>Valve Procedures</strong></td>
<td>$ (15,365.00)</td>
<td>$ (30,730.00)</td>
<td>$ (46,094.00)</td>
<td>$ (61,459.00)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$ (141,344.00)</td>
<td>$ (282,688.00)</td>
<td>$ (424,031.00)</td>
<td>$ (565,375.00)</td>
</tr>
</tbody>
</table>

#### Proposed Risksharing

<table>
<thead>
<tr>
<th>Cost savings/overage vs target</th>
<th>VNSNY %</th>
<th>VNSNY Partner</th>
<th>Max upside/downside</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5%</td>
<td>50%</td>
<td>50%</td>
<td>$ (70,672.00)</td>
</tr>
<tr>
<td>5-10%</td>
<td>50%</td>
<td>50%</td>
<td>$ (70,672.00)</td>
</tr>
<tr>
<td>10-15%</td>
<td>25%</td>
<td>75%</td>
<td>$ (35,336.00)</td>
</tr>
<tr>
<td>15% +</td>
<td>0%</td>
<td>100%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$ (176,680.00)</td>
</tr>
</tbody>
</table>

*note: insufficient volumes for spine/valve patients discharged to SNF as first site of care to set a target price*
## Managed Care Risk Sharing

### Managed Care Readmission Avoidance Program

<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>11.9%</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 Hospitalisation
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.

Who is on the Team?

- RNs
- Social Workers
- Health Coaches
- Nurse Practitioners – when required
Case Rate

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

Presented by:

**Samuel Heller**  
Senior Vice President and Chief Financial Officer  
Visiting Nurse Service of New York  
Office: 212-609-5701  
Samuel.Heller@vnsny.org

**John Richter**  
Chief Strategy Officer  
704-998-5220  
John.Richter@CLAconnect.com

**Michael Slavik**  
Chief Industry Officer – Health Care  
617-984-8150  
Michael.Slavik@CLAconnect.com