Risk-Sharing in Medicare: Can it Work for You?

Overview: Does the path to risk-based payment lead to a cliff?
Key ACA Initiatives

- Bundled Payment
- ACOs

- Medical Home
- Financial Alignment Initiative
- Community-Based Care Transitions

Value-based Payment

Increasing risk

Making the Transition to Risk-Based Payment

Shared Savings/Total Cost of Care

Significant Change

Bundled Payments

- Negotiated Episode Price
- Longitudinal Accountability
- Risk based

Significant Change

Value Based Reimbursement

Significant Change

Fee For Service

- No risk payments
- Common payments
- Predictable

Shared Savings/Total Cost of Care

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

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

Medicare Value-Based Payment Goals

Today, 20% of Medicare FFS dollars are under an alternative payment model such as Shared Savings, Bundled Payment, etc.

2016 Goals
• 85% of all Medicare Fee-For-Service dollars to be tied to quality or value
  – 30% tied to alternative payment models (this is part of the above number)

2018 Goals
• 90% of all Medicare Fee-For-Service dollars to be tied to quality or value
  • 50% in alternative payment
Value-Based Payment: Overview

**How Paid:** Providers receive a financial reward (or penalty) for achieving or exceeding an established outcome for pre-defined measures.

**Types of Performance Measures**
- Cost of care
- Process of care
- Outcomes of care
- Structural
- Patient satisfaction

Examples of Payment shifting from Volume to Value

- **Providers Currently Covered:** hospitals, physicians
  - Medicare Hospital VBP = 2% withhold for quality
  - Readmission penalties = Up to 3% readmission penalties FY2015
  - Health Care Acquired Infections and Conditions = 1%

- **Skilled Nursing Facilities and Home Health Agency demos completed**

- **SNF VBP program just passed into law – FY2019**

- **IMPACT Act of 2014:** Standardized assessments, metrics, and evaluation of site neutral payments
### VBP Results to Date: Hospitals FFY 2014

- Withholds 1.25% of all hospitals Medicare payments.
- 24 quality measurements in three domains:
  - Clinical Process of Care (45%); Experience of Care (30%); Outcomes of Care (25%)
- 1,231 of 3,000 hospitals received payment incentives/bonuses
  - Average bonus = 0.24%; largest bonus = 0.88%
  - Even with bonus, hospitals are paid less under this program.
- Average penalty is higher than in FFY2013

**Lessons Learned to Date**
- Most winners stay winners, losers stay losers

**On the horizon**
- % of Medicare revenue at-risk increases
- New VBP for health acquired infections = 1%


### SNF Value-Based Program for Readmissions (FY2019)

- Passed as part of the Medicare Protection Act of 2014 (a.k.a. the SGR or “doc” fix bill)
  - Calls for a 2% Medicare withhold
    - SNFs in Top 60% to receive some of it back: Only 50-70% of the total amount set aside will be redistributed to the SNFs in the top 60%
    - SNFs in the bottom 40% will not receive any of these dollars back.
  - All-cause, all-condition readmission measures to be established by 10/1/2015 and risk adjusted by 10/1/2016
  - Measures to be included in Nursing Home Compare by 10/1/2017
  - Incentive payments to begin on or after 10/1/2018
Bi-Partisan Proposal: IMPACT Act of 2014

- Introduced March 18, 2014, and passed by Congress on September 26, 2014 called, “Improving Medicare Post-Acute Care Transformation” (IMPACT) Act of 2014
  - Standardized patient assessment metrics across PAC providers
  - Required reporting of Standardized Patient Assessment Data and Quality Measures.
  - Public reporting of new metrics and develop reports to provider
  - New quality metrics including: skin integrity, medication reconciliation, major falls, accurate communication during care transitions.
  - New efficiency measures: total beneficiary costs, discharge to community rate and hospitalization rate
  - Studies of alternative payment models including site-neutral payment, etc.

IMPACT Act: Quality Reporting Implementation Timelines

<table>
<thead>
<tr>
<th>Measure</th>
<th>Skilled Nursing Facility</th>
<th>Inpatient Rehabilitation Facility</th>
<th>Long-Term Care Hospitals</th>
<th>Home Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional Status, cognitive function</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2018</td>
<td>1/1/2019</td>
</tr>
<tr>
<td>Skin integrity &amp; changes</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>1/1/2017</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
<td>10/1/2018</td>
<td>10/1/2018</td>
<td>10/1/2018</td>
<td>1/1/2017</td>
</tr>
<tr>
<td>Major Falls</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>1/1/2019</td>
</tr>
<tr>
<td>Accurate communication during care transitions</td>
<td>10/1/2018</td>
<td>10/1/2018</td>
<td>10/1/2018</td>
<td>1/1/2019</td>
</tr>
</tbody>
</table>
Value-Based Payment

- **Capabilities Needed**
  - Internal processes for identification, definition and tracking of various performance metrics
  - Dashboards to identify trends, areas to target for improvement
  - Root-cause analysis
  - Predictive modeling
  - Best practice protocols development, training and accountability
  - Encourages adoption and use of electronic health record.

Risk considerations

- **Payment arrangements can take different forms**
  - Withhold of percentage of payments that are earned back
  - Bonus payment over and above standard reimbursement
  - Shared Savings earned only with achieved performance

- **Earning based upon Performance metrics**
  - All or none
  - Prorated Earned reward can be tied to the percentage of metrics where benchmark met or exceeded

- **Benchmarks**
  - Peer comparison
  - Year over year improvement
  - Set by payer based upon some goal
Bundled Payment: An Overview

• **Definition:** Bundled payment is a single payment to providers or health care facilities (or jointly to both) for all services to treat a given condition or provide a given treatment. Providers assume financial risk for the cost of services for a particular treatment or condition, as well as costs associated with preventable complications. (Health Affairs, Jan 2015)

• **What can be bundled?** Bundled payment can be triggered by a hospitalization (e.g., CMS Bundled Payment for Care Improvement initiative) or by a diagnoses (e.g., CHF, diabetes, etc.)

Bundled Payment: An Overview (continued)

• **How paid:**
  – Prospective – provide set amount to providers once trigger pulled -- or
  – Retrospective – set a target price, continue to pay providers fee-for-service and evaluate if total services paid were over/under target price. If over, then providers must pay back payer. If under, then providers share dollars left on the table.

• **Capabilities Needed**
  – Negotiated episode price and duration
    ◊ Understand costs
    ◊ Pricing a bundle and determining which services should/not be included
  – Contracting
  – Identification of desirable clinical pathways by diagnoses
  – Longitudinal accountability and coordination, communication
  – Managing costs in a risk-based environment
Medicare Bundled Payment for Care Improvement Model Timelines

• **Phase 1:** No-risk prep period.
  - Started June 2014 for 2014 Open Period awardees

• **Phase 2:** Risk Bearing Implementation Period
  - Original awardees started either 10/1/2013 or 1/1/2014
  - 2014 Open Period Awardees to start January 2015

**2014 Winter Open Period:** Additional organizations were able to apply to participate in BPCI and current participants could expand their activities by applying to CMS through April 18, 2014.

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Over 6000 Providers Participating in Bundle Payments for Care Improvement

BPCI Participation by State

*August 2014*

- **50-100 providers**
- **100-200 providers**
- **200-300 providers**
- **>300 providers**

Source: Centers for Medicare and Medicaid Services, Health Care Payments Bundled Interventions and Analysis.
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)
CMS Bundled Payments Initiatives: What is Being Bundled?

Number of Bundles Selected per Provider

<table>
<thead>
<tr>
<th>Number of Bundles</th>
<th>Percentage of Model 2-4 Applicants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5 Bundles</td>
<td>47%</td>
</tr>
<tr>
<td>6-47 Bundles</td>
<td>34%</td>
</tr>
<tr>
<td>All 48 Bundles</td>
<td>18%</td>
</tr>
</tbody>
</table>

Top Ten Clinical Conditions for Bundling

<table>
<thead>
<tr>
<th>Clinical Condition</th>
<th>Percentage of Model 2-4 Applicants Selecting Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major joint replacement of lower extremity</td>
<td>78%</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>60%</td>
</tr>
<tr>
<td>Coronary artery bypass graft</td>
<td>61%</td>
</tr>
<tr>
<td>COPD, emphysema/asthma</td>
<td>49%</td>
</tr>
<tr>
<td>Percutaneous coronary intervention</td>
<td>48%</td>
</tr>
<tr>
<td>Cardiac valve</td>
<td>47%</td>
</tr>
<tr>
<td>Simple pneumonia and respiratory infections</td>
<td>47%</td>
</tr>
<tr>
<td>Cardiac defibrillator</td>
<td>46%</td>
</tr>
<tr>
<td>Revision of the hip or knee</td>
<td>44%</td>
</tr>
<tr>
<td>Double replacement of the lower extremity</td>
<td>43%</td>
</tr>
</tbody>
</table>

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

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.

Risk Considerations

- How much risk and what risk are you taking on?
  - Number of days after discharge – 30, 60, 90
  - # of episodes for which will accept a bundled payment
  - Is this a high volume episode for you? Is so, competing against yourself? If not, how will you generate more volume from referral sources?

- Partner or go it alone?
  - If Model 3 – PAC only, Model 2 by the hospital trumps.

- How are savings and losses distributed among partners? Who shares in the gains and what is the split? Is this appropriate given the amount of risk you are taking? How are the losses divided?

- How will you generate savings: If have to achieve a 3% reduction (or 5% reduction due to additional admin costs of 2%) to break even, how much do you have to reduce to reap the rewards? How will you do this? (e.g., reducing readmissions, care protocols, care transitions, follow up upon completion of HH episode?)
  - Readmissions
  - Care coordination
  - Care Protocols

Accountable Care Organizations

General Definition

A group of health care providers working together to manage and coordinate care for a defined population, that share in the risk and reward relative to the total cost of care and patient outcomes.

Medicare ACO Programs

- Medicare Shared Savings Program
- Pioneer ACOs
- Advanced Payment Initiative
- Next Generation
- Investment Model
Medicare ACO Programs

Pioneer ACO Program started 1/1/12 (19)
- Originally 32 participants, 13 exited or transitioned to MSSP
- Eligible organizations had prior ACO-like experience
- 15,000 Medicare beneficiaries minimum
- Must enter into outcomes-based contracts with multiple payers.
- This model transitions to greater risk faster.

Medicare Shared Savings Program (MSSP) (405 ACOs)
- Program requires the participating providers to form an ACO
- 5,000 Medicare beneficiary minimum for participation
- Two Tracks: Savings only, Savings/Losses

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

ACO Network

ACO Network: “A Team of Rivals”

ACO Providers: Bonus-Eligible
- Primary Care Practitioners
- Hospitals

Non-ACO Preferred Providers
- “Value” Providers

Non-Preferred Providers
- Low Quality, High Cost Providers
### Original Medicare ACO Rules Determining Shared Savings

#### Shared Savings Formula

- **Benchmark:** Three-year risk & growth trend adjusted per beneficiary spending rate. Projected and updated based on National FFS spending rate.

- **Minimum Savings Rate (MSR):** Use **One-sided model** = 2.0 to 3.9%, based upon # of assigned Medicare beneficiaries. Max savings = 10% of benchmark. **Two-sided model** = 2%. Max savings = 15% of benchmark.

- **Maximum Loss Rate (MLR):** For two-sided model, set at 2% of per capita spending, updated for national FFS growth trends. Max loss is 5%, 7.5%, and 10% in years 1-3 respectively.

#### Track 1 (One-sided Model)

- **BYr 3:** 60%
- **BYr 2:** 40%
- **BYr 1:** 20%

#### Track 2 (Two-sided Model – Proposed)

- **BYr 3:** 70%
- **BYr 2:** 50%
- **BYr 1:** 30%

#### Track 3 (Two-sided/higher risk/reward)

- **BYr 3:** 80%
- **BYr 2:** 60%
- **BYr 1:** 40%

#### Historical Spending Rate

- **Y 1:** 10%
- **Y 2:** 30%
- **Y 3:** 60%

### Final 2015 Medicare ACO Rules:

Comparing the Three MSSP Payment Models

<table>
<thead>
<tr>
<th></th>
<th>TRACK 1 (One-sided Model)</th>
<th>TRACK 2 (Two-sided Model – Proposed)</th>
<th>TRACK 3 (Two-sided/higher risk/reward)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Max. Sharing Rate</strong></td>
<td></td>
<td>60%</td>
<td>75%</td>
</tr>
<tr>
<td><strong>Minimum Savings Rate (MSR)</strong></td>
<td>2.0 - 3.9%</td>
<td>2.0 - 3.9%</td>
<td>2.0%</td>
</tr>
<tr>
<td><strong>Shared Savings Cap</strong></td>
<td>10%</td>
<td>15%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Shared Loss Threshold</strong></td>
<td>Not applicable</td>
<td>2.0 - 3.9%</td>
<td>Fixed 2.0%</td>
</tr>
<tr>
<td><strong>Loss Sharing Limit</strong></td>
<td>Not applicable</td>
<td>Year 1: 5%</td>
<td>Year 2: 7.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Year 3+: 10%</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Beneficiary Assignment</strong></td>
<td>Preliminary prospective for reports; retrospective for financial reconciliation</td>
<td>Prospective for both</td>
<td></td>
</tr>
</tbody>
</table>
Shared Savings Formula

Final Shared Savings =

ACO achieved savings

\[ \times \left( \left( \frac{\text{Maximum Shared Savings} \%}{100} \right) \times \left( \text{Quality Score} \% \right) \right) \]

Example:

ACO savings $800,000

Maximum under Model I \times 50\%

ACO-specific Quality Score \times 87\%

\[ = \frac{348,000}{87\%} \]

Notes

- CMS withholds 25% of earned Shared Savings until end of agreement to offset potential losses.
- Failure to complete full three years = withhold forfeited
- Must be 90% or above on all quality metrics in order to achieve maximum savings rate.

Final Rule – Key components

- Track III model of MSSP adopted
- Current Track I ACOs can continue in Track I without a reduction in the savings rate (proposed 10% reduction not adopted)
- Contract-renewing ACOs that achieved savings, CMS to adjust the financial benchmark (“to preserve the sweetness of the pot”) – according to Health Leaders newsletter
- Additional adjustments to the MSSP financial benchmark to be made later in 2015 to strengthen incentives (separate rule to come)
- Waivers 3-day hospital stay before PAC SNF, use of telehealth in rural areas, and home health without an admission
### Pioneer ACO Payment Models

<table>
<thead>
<tr>
<th>Year</th>
<th>Core</th>
<th>Option A</th>
<th>Option B</th>
<th>Alternative 1</th>
<th>Alternative 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>60% - two-sided 10% sharing cap 10% loss cap, 1% MSR</td>
<td>50% - two-sided 5% sharing cap 8% loss cap, 1% MSR</td>
<td>70% - two-sided 15% sharing cap 16% loss cap, 1% MSR</td>
<td>50% - one-sided 5% sharing cap 2-2.7% MSR (depends upon # of beneficiaries)</td>
<td>60% - two-sided 10% sharing cap 10% loss cap, 1% MSR</td>
</tr>
<tr>
<td>Year 2</td>
<td>70% - two-sided 15% sharing cap 15% loss cap, 1% MSR</td>
<td>60% - two-sided 10% sharing cap 10% loss cap, 1% MSR</td>
<td>75% - two-sided 15% sharing cap 15% loss cap, 1% MSR</td>
<td>70% - two-sided 15% sharing cap 15% loss cap, 1% MSR</td>
<td>70% - two-sided 15% sharing cap 15% loss cap, 1% MSR</td>
</tr>
<tr>
<td>Year 3</td>
<td>Population-based pynt of up to 50% of expected Part A &amp; B revenue Risk: 70% - two-sided 15% sharing cap 16% loss cap, 1% MSR</td>
<td>Population-based pynt of up to 50% of expected Part A &amp; B revenue Risk: 70% - two-sided 15% sharing cap 16% loss cap, 1% MSR</td>
<td>Population-based pynt of up to 50% of expected Part A &amp; B revenue Risk: 70% - two-sided 15% sharing cap 16% loss cap, 1% MSR</td>
<td>Population-based pynt of up to 100% of expected Part B revenue, less 3% discount Risk: Full risk for all Part B w/3-6% discount (depending upon quality scores) and shared risk for Part A (same as Yr 2)</td>
<td>Population-based pynt of up to 100% of expected Part A &amp; B revenue, less 3% discount Risk: Full risk for all Part A &amp; B w/3-6% discount (depending upon quality scores)</td>
</tr>
<tr>
<td>Year 5</td>
<td>Same as above.</td>
<td>Same as above.</td>
<td>Same as above.</td>
<td>Same as above.</td>
<td>Same as above.</td>
</tr>
</tbody>
</table>

### Timeline: Next Generation ACO

- **May 1, 2015**: Letter of Intent Due for 2016
- **June 1, 2015**: Application for 2016 start
- **January 1, 2016**: Next Generation ACO Model begins
Overview

- CMS anticipates 15-20 participants in new model
  - Two application rounds: 6/1/2015 and 6/1/2016
  - Start dates: 1/1/2016 and 1/1/2017
  - Seek diversity in geographic and provider types
- Beneficiary choice remains, voluntary selection
  - Benefit enhancements -- financial reward for beneficiaries
- Prospective financial benchmarks that reward quality, and attainment of and improvement in efficiency
- More flexibility: Graduate from FFS to capitation via multiple alternative payment mechanisms

Benefit Enhancements (waivers)

- No 3-day hospital stay requirement for PAC SNF eligibility
- Permit telehealth without geographic limitations in specified facilities and in the beneficiaries’ home
- Post Discharge Home Visits for non-homebound aligned beneficiaries following inpatient facility stay
Next Generation ACO Relationships with non-ACO Providers/Suppliers

NextGen Risk

A: Increased Shared Risk
Parts A and B Shared Risk
- 80% sharing rate (PY 1 -3)
- 85% share rate (PY 4-5)
- 15% savings/losses cap
- Discount (0.5% - 4.5%)

B. Full Performance Risk
- 100% Risk for Part A and B
  - 15% savings/losses cap
  - Discount (0.5% - 4.5%)

** Outlier protection embedded in both Risk Arrangements = cap of individual beneficiary expenditures at 99th percentile

2017 Full Capitation becomes an option
NextGen Benchmark Setting – Year One

Benchmark set prospectively and is same for all NextGen regardless of selected payment mechanism

Step 1: Baseline
- Use one-year of historical baseline expenditures
- Calculate regional FFS baseline

Step 2: Trend
- Project baseline forward using regional projected trend

Step 3: Risk Adjustment
- Uses full Hierarchical Condition Category (HCC) risk score
- Cap = 3% + or -

Step 4: Discount
- Quality Score + Regional efficiency + National efficiency
- Range = 0.5% to 4.5%

Payment mechanisms

1. **Normal FFS Payment** = no change from original Medicare
2. **Normal FFS + Monthly Infrastructure payment** = Providers paid FFS and ACO receives a per beneficiary per month payment (max $6 PBPM), requires higher reserves
3. **Population-Based Payments** = Providers agree on a discount off FFS; this amount is distributed to the ACO in monthly PBPM amounts. Providers are paid by CMS at FFS discounted rates and receive additional payment from ACO per the ACO contract terms
4. **Capitation** = PBPM amount distributed based upon annual estimate beneficiary expenditures minus withhold for non-ACO providers. ACO pays provider/suppliers + capitation affiliates
ACO Results: Year 2 – Pioneer + MSSP

- 2012 ACOs (approximately 250 ACOs) to date have reduced Medicare spending by $871M
  - Provider-retained savings to date total = $445M
- Pioneer ACOs = $68M in shared savings earned
  - 11 of the 23 Pioneers earned shared savings (fewer than Yr 1 results)
  - 3 of 23 faced penalties for increased spending
  - Quality improved on 28 of 33 metrics
- Medicare Shared Savings Program = $300 M earned
  - 53 of 204 ACOs received shared savings totaling $300M
  - Dean Clinic & St. Mary’s Hospital ACO is only MSSP to face a $4M penalty or shared losses for increased spending
  - Insurer Universal American has backed out of several of its ACOs (they are the largest player in the MSSP)

Risk Considerations

- Performance risk
- Contracting risk
  - What metrics are you judged on? How are they defined? Does this favor you or the ACO?
  - Do you understand the terms?
- Utilization risk
- Risk of not being a preferred provider = lower volumes
- Upside risk
  - Capitation = great if you can successfully manage costs and quality
  - Preferred provider = increased volumes/larger market share
  - Preferred provider/capitation affiliates = waiver options -> paid for more services than today
Emerging models and trends

- Medicare Advantage contracts being renegotiated to no longer pay for Ultra High RUGs in SNFs - *how would this translate to home health?*
- Bundled Payments – *may increase % of discharges going to home health vs. SNF*
- Pay for improving function so patients can move to next lower cost setting not to restore function
- Discharges to home without services is also increasing - *worrying trend*

Back to the Future

Reimbursement Today

- More episodes
- More services
- Reactive services – treat when ill

Value-Based or Total Cost of Care Rewards

- Prevention/Wellness
- Avoidance of unnecessary care
- High quality outcomes
- Lower cost/spending
- Chronic Care Management
- Substitutions of care
Evaluating the Opportunity

JUST OUTSIDE THE BOX

Zorba the Lensman

Current State Example:
Medicare Post Acute Spending (SNF, HHA, IRF, LTACH)

EXAMPLE CURRENT MARKET STATE

60 Day Cost Per Episode
10,000 Indexed Admissions

Index Admit $9,448
1.73 CMI

52% $20,003 Avg Cost
SNF 1.67 Acute CMI
30% Readmit %

38% $10,268 Avg Cost
HHA 1.33 Acute CMI
28% Readmit %

5% $34,508 Avg Cost
IRF 2.37 Acute CMI
28% Readmit %

5% $46,639 Avg Cost
LTACH 3.66 Acute CMI
38% Readmit %

$183.5M Post Acute Costs
POTENTIAL FUTURE STATE SPENDING
Medicare Post Acute Spending (SNF, HHA, IRF, LTACH)

Consider: What if....

• There were 40% Reductions in IRF and LTACH utilization
• Target Home Health for 55% to 65% of post acute discharges

Are You Prepared for this Potential New Reality?

Example: 10,000 Discharges to Post Acute Setting

<table>
<thead>
<tr>
<th>Post Acute Setting</th>
<th>Current State</th>
<th>Potential Future State??</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNF</td>
<td>413 ADC</td>
<td>271 ADC</td>
<td>-34%</td>
</tr>
<tr>
<td>IRF</td>
<td>27 ADC</td>
<td>16 ADC</td>
<td>-40%</td>
</tr>
<tr>
<td>LTACH</td>
<td>34 ADC</td>
<td>20 ADC</td>
<td>-40%</td>
</tr>
<tr>
<td>Total Institutional</td>
<td>473 ADC</td>
<td>307 ADC</td>
<td>-35%</td>
</tr>
<tr>
<td>HHA</td>
<td>3,812 Episodes</td>
<td>6,000 Episodes</td>
<td>57%</td>
</tr>
<tr>
<td>TOTAL &quot;COST&quot;**</td>
<td>$183.5M</td>
<td>$154.0M</td>
<td>-16%</td>
</tr>
</tbody>
</table>

* Cost to Medicare = Provider Revenues!!
Understanding the Financial Drivers in a Bundled Payment Arrangement

VNSNY Bundled Payment Example
Overview of two models with VNSNY participation

<table>
<thead>
<tr>
<th></th>
<th>Model 2- AMC Hospital at Anchor</th>
<th>Model 3- VNSNY as Anchor Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scope</strong></td>
<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>
</tr>
<tr>
<td><strong>Covered services</strong></td>
<td>All Part A and B services</td>
<td>All Part A and B services</td>
</tr>
<tr>
<td><strong>DRGs in scope</strong></td>
<td>• Total Joint Replacement</td>
<td>Subset of 48 episodes that encompass 180 DRGs</td>
</tr>
<tr>
<td></td>
<td>• Spine Surgery</td>
<td>• CHF</td>
</tr>
<tr>
<td></td>
<td>• Cardiac Valve Replacement</td>
<td>• Exploring additional diagnoses (eg, COPD)</td>
</tr>
<tr>
<td><strong>Expected volume</strong></td>
<td>~600-800 cases per year</td>
<td>~ currently 1,000 cases/year, up to ~13,000</td>
</tr>
<tr>
<td><strong>Sources of savings</strong></td>
<td>Reduced readmissions, lower cost site of service, coordinated post-acute care</td>
<td>Reduced readmissions, coordinated post-acute care</td>
</tr>
<tr>
<td><strong>Minimum required savings to CMS before gain sharing</strong></td>
<td>2% for 90 day episode</td>
<td>3% for all episode lengths</td>
</tr>
<tr>
<td><strong>Financial arrangements</strong></td>
<td>• Hospital shares full Medicare Part A and B risk with CMS. • Finalizing risk-sharing agreement between VNSNY and hospital</td>
<td>Upside to VNSNY: 2/3 of the savings, after CMS’ 3% savings requirement and management overhead paid to Awardee Convener Organization Downside to VNSNY: 1/3 of the losses</td>
</tr>
<tr>
<td><strong>Partners</strong></td>
<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>
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
For example:
- CHF, Total joint, UTI, Stroke, CAD

Days 1-45
Admission to VNSNY Home Care

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

Financial Scenario Analysis:
CHF, COPD, Other Respiratory

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>
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</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>
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<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>
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<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>
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<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>
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<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>
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<tr>
<td>Savings before Admin</td>
<td>$2.4M</td>
<td>$1.4M</td>
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<td>Admin</td>
<td>$0.7M</td>
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<td>Net Savings</td>
<td>$1.7M</td>
<td>$0.7M</td>
<td>$ -</td>
<td>$ -</td>
<td>($1M)</td>
<td>($2M)</td>
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<td>Risk Sharing</td>
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<tr>
<td>Partner</td>
<td>$0.6M</td>
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<td>VNSNY</td>
<td>$1.1M</td>
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<td>$ -</td>
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Case Study: Post-Acute Network and Providers Take on Bundled Payments

Background

• Three senior service organizations founded a Post Acute Network – two CCRCs and a home health agency
• Interested in testing the idea of developing a PAC network that would offer ACOs/Hospitals/Health Systems and Payers a single-entry point to PAC services
• Seeking to maximize total cost of care payments under new alternative payment models – Bundled Payment, Managed Medicaid LTC, and ACOs - to share in savings.
Development Timeline

• Four years from idea to network formation and expansion to bundled payment
  - Examine Medicare 1st round of Bundled Payments for Care Improvement = poor data, took a pass
  - Initiate joint effort to begin evaluating the opportunity to form a network and understand critical components to success
  - Educate Board and Management team – early and often
  - Internal, joint staff work groups to evaluate network components – technology, clinical processes, financials, etc.
  - Develop business cases and identify investment to be made
  - Initiate clinical protocols across participants
  - Outreach to payers and referral sources
  - Outreach and expansion of network to establish 30% market share
  - Hire an Executive Director to run network and business development
  - Apply/Implement Medicare bundled payment
  - Revisit and expand clinical best practice protocols
  - Renew conversations with payers and referral sources

Clinical processes: The secret sauce

• Nine protocols vetted and agreed to by a joint clinical committee.
  - Founders have been using protocols for 1.5 years and new bundled payment providers just starting.
  - Reductions in readmissions and average length of stay, early modifications.
  - Care Transition protocol: one of three founders being reimbursed for service to date – “getting ahead of the curve” and positioning for future

• Show me the money: First three years uphill battle to get hospitals/systems interested. They were distracted by their ACO starts and physician integration strategies
### Scenario 1: Clinical Impacts Only

#### Financial Performance Dashboard

**Performance Drivers**
- Member Fee (%) SDF: 6.90% MHA: 4.60%
- Our ACO Gain Share (%) 10%
- No Adjustment to Baseline Costs

**Total Cost of Post Acute Care Impacts**
- 10% Reduction in Member SDF ALLOS
- 30% Reduction in Readmissions
- 5% Decrease Costs @ Target

**Market Share Growth Impacts**
- +10% SDF in Channel (102.7%)
- -10% MHA - SDF Channel (102.0%)
- No Impact from Global Channeling

**Global Channel Mix**
- 60% SDF 40% MHA

**SNF ADC**
- 31 29 31 29 29

**Year 1**
- 31 29 31 29 29

**5 Year NVP Returns at 8.0%**

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<th>Income Stream Only</th>
<th>Income Capital</th>
<th>ROE</th>
<th>ACO</th>
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</table>

### Scenario 2: Network Success

#### Financial Performance Dashboard

**Performance Drivers**
- Member Fee (%) SDF: 6.90% MHA: 4.60%
- Our ACO Gain Share (%) 10%
- No Adjustment to Baseline Costs

**Total Cost of Post Acute Care Impacts**
- 10% Reduction in Member SDF ALLOS
- 30% Reduction in Readmissions
- 5% Decrease Costs @ Target

**Market Share Growth Impacts**
- +10% SDF in Channel (102.7%)
- -10% MHA - SDF Channel (102.0%)
- No Impact from Global Channeling

**Global Channel Mix**
- 60% SDF 40% MHA

**SNF ADC**
- 31 46 60 63 63

**Year 1**
- 31 29 34 34 34

**5 Year NVP Returns at 8.0%**

<table>
<thead>
<tr>
<th>Year</th>
<th>Income Stream Only</th>
<th>Income Capital</th>
<th>ROE</th>
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</table>
Critical Success Factors for Bundled Payment

• Must be willing to do hard work, dedicate time, money and staff resources to effort
• Don’t forget to bring along your board and staff
  – Significant, early and on-going education about the impacts and expectations of reform, new risk-based payment models, and the corresponding terminology
  – Helps clinical staff understand the context for the changes that will be expected – while they may not like it, more likely to commit to it because alternate future
• Design clinical systems and processes to achieve a different result
  – Requires resource investment of staff and money
• Reserves – retention fund

Questions?

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612-376-4843

Thank you!

For more information on health reform: CLAconnect.com/healthreform