Risk Based & Contracting Overview

Medicare

• ACO – Accountable Care Organizations
• BPCI - Bundled Payment Care Initiatives - Voluntary
• BPCI – Bundled Payment Care Initiatives - Mandatory
  ✓ CJR – Comprehensive Care for Joint Replacement
  ✓ EPM – Episodic Care Model - Cardiac Conditions
• MACRA - Medicare Access and CHIP Reauthorization Act
• IMPACT – Improving Medicare Performance Transformation Act
• Next Gen ACO - continued evolution

Commercial Contracting, and

Managed Medicare Coverage

• Contracting
• Care navigation
Objectives

Attendees will learn:

1. Bundling because you must and with caution
2. Medicare Reality = why new payment models & reforms
3. Medicare Advantage = penetration growing = GOP’s intention
4. Current PAC experience in 2016-17 bundling arrangements
5. How you prepare for new payment models
6. New engagements, collaborations, and networks
Why PAC Providers Must Consider Bundling

- Elevate facility network performance and alliances
  - Restructure physician network to meet twin mandates of population health and consumerism
  - Re-engineer provider relationships, and therapy/nursing expectations

- Build physician and consumer loyalty platform
  - Prioritize consumer loyalty strategy to build durable patient relationships

- Radically reduce cost PAC structure
  - Reduce cost structure to enable pricing flexibility
  - Diversify revenue programs

- Establish a reliable Medicare Risk strategy
  - Carefully pace transition to Medicare risk to capture returns from care management

The Value Based Post Acute Network

Building the Seamless Post-Acute Network
- What partnerships, mergers or affiliations will align the right set of offerings?
- Who builds a continuum PAC and senior care management infrastructure?

Creating a PAC-Specific Value Proposition
- Is there a role for each PAC sector in a value-based delivery system?
- What populations will be prioritized for specialty program development?
- What services and clinical factors elevate survivors from competitors?

Forging Strong Acute/Post-Acute Partnerships
- What trends do we see in post-acute network development?
- How are PAC scorecards developed and utilized?
- How will Care Managers be directed to ensure patients are discharged to PPN?

Developing Meaningful Clinical Capabilities
- What clinical competencies necessarily meet emerging market demands?
- How will nursing and therapy re-engineer to meet key clinical priorities?
- What quality tracking and IT investments are required infrastructure?
Why PAC Providers Must Consider Bundling with Caution

- Conveners do not have any obligation to PAC providers
  - No substitute volume (cases or days) may be promised (Kick Back Laws)
  - None will be delivered

- There is no easy barrier between the protocols and treatments adopted for “bundled patients” versus the rest of the patients
  - Advantage: overall reduced readmission
  - Advantage: uniform patient care experience
  - Disadvantage: total days for all patient populations decline over time

- Prepare for increasing number of Medicare Managed patients

- Republican healthcare strategy includes structural changes to traditional Medicare by pushing enrollment in Medicare Advantage Plans (MAPs)
  - Subsidies to MAPs in order to reduce premiums & offer new benefits
  - Year-round enrollment option
  - Increased co-payments in traditional Medicare

Bundling Is Here to Stay – with Changes*

- New EPM rule, even though delayed, indicates CMS’ belief in bundles.
- BPCI may be replaced in 2018 with a new voluntary program (version).
- CMS has indicated current mandatory and future voluntary bundled payment models will have options to qualify for the MACRA Advanced APM track.
- Quality metrics requirements incentivize hospitals to monitor performance.
- Episode savings creates opportunities for alignment with providers through gainsharing and other mechanisms.
- Hospitals must get past the point of discharge, post acute is essential. Not just bundles (savings).

*Consensus opinion: Deloitte, BKD, Truven Health, ECG, LeadingAge MO, MI, IL, etc.
Medicare Reality

Why This Matters to YOU

Tax Payer, Family Member, and Future Medicare Beneficiary
Unsustainable Expenditure Growth

Projected Growth GDP, National Health Expenditures (NHE), Medicare, Medicaid
2009-2019

6.1% Federal Health Expenditures as percentage of GDP, 2008
8.1% Projected Federal Health Expenditures as percentage of GDP, 2018

7.5% Medicaid Average Annual Growth Rate
6.0% Medicare Average Annual Growth Rate
6.1% NHE Average Annual Growth Rate
4.4% GDP Average Annual Growth Rate

NOTE: *Consists of Medicare benefit spending on hospice, durable medical equipment, Part B drugs, outpatient dialysis, ambulance, lab services, and other Part B services; also includes the effect of sequestration on spending for Medicare benefits and amounts paid to providers and vendors.

SOURCE: Congressional Budget Office, 2016 Medicare Baseline (March 2016).
Age Groups by Year, Population

Medicare Trust Fund Projected Depletion Varies with Economy & Policy Affects on Revenue & Spending

NOTES: BBA is Balanced Budget Act of 1997. ACA is Affordable Care Act.
SOURCE: Annual Reports of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, various years.
AHCA Tax Repeal for Highest-Income Earners Will Deplete the Trust Fund 3 Years Faster Than ACA

Trust Fund Depletion Date:

<table>
<thead>
<tr>
<th>Years to Trust Fund Depletion</th>
<th>2016 Trustees Report</th>
<th>Under AHCA</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>2028</td>
<td>2025</td>
</tr>
</tbody>
</table>


Why This Matters to YOU

Targeting Post-Acute Services
PAC Placement in “Avoidably High Cost Setting”

ACA Initiatives
Center For Medicare & Medicaid Innovation
Alternate or Episode Payment Models

- Medicare Shared Savings Plans (3,100)
- Bundled Payment Care Initiative (2,000+)
- Accountable Care Organization (400+)
- Value Based Purchasing (3,100)
- MACRA
- Population Health Management
- Managed Care Contracts

Power of Purpose

Accountable Care Organization (ACO) Models

- Medicare Shared Savings Program (MSSP)
- Pioneer ACOs
- Advanced Payments ACOs

SOURCE: Map data downloaded October 7, 2016 from CMS: [https://innovation.cms.gov/initiatives/map/index.html](https://innovation.cms.gov/initiatives/map/index.html) and [https://www.cms.gov/Medicare/Medicare-fee-for-Service-Payment/Shared-SavingsPrograms/ACOs-to-Your-State.html](https://www.cms.gov/Medicare/Medicare-fee-for-Service-Payment/Shared-SavingsPrograms/ACOs-to-Your-State.html). Participant counts in this dataset are updated periodically. See Table 3 for official counts in most recently-available CMS documents and websites.
Bundle Payments for Care Improvement (BPCI) Models

2016 National Bundled Payments’ Landscape, ~ 1,500 Organizations
Power of Purpose

Comprehensive Care for Joint Replacement Model

Several Key Changes in the Final Rule to Know

CJR Final Rule Highlights

- Mandatory for hospitals in 67 markets, not for physicians, PACs or BPCI
- 90 day episode covering hips & knees (DRGs 468 and 470) with risk adjustment for hip fracture
- Pricing based on mix of hospital and regional benchmarks, shifting to 100% regional by 2019
- No downside until Year 2 (2017), max downside commences in year 3
- Composite quality scoring methodology determines discount level applied
- Phase in risk and reward: Maximum upside “stop gain” and downside “stop loss” amounts modified from proposal
- Benchmarks set annually in advance, reimbursed on FFS basis with reconciliation at EOY

CJR by the Numbers

- 5 Years the program will cover, 2016-2020
- 788 Expected number of participant hospitals
- 23% Percent of national LEXJR episodes in the program
- $343m Estimate of episodic savings over 5 years

Early Observations of Success in Premier’s BPC

CJR – Utilization Decreases Example

Anchor Hospitalization:
Inpatient length of stay ↓ 14%

Post-acute Utilization:
IRF Utilization ↓ 46%
SNF Utilization ↓ 15%
SNF LOS ↓ 25%
Avera – St Luke’s Hospital: Total Joint Replacements (CJR)
Physician champion, multi-disciplinary team, oversight structure, and 1 FTE nurse navigator.
Results:
• 40% reductions in PAC spend within 1 year.
• Physicians feel they have a better handle on the health of their patients.
• Focus has shifted from acute operations to a comprehensive PAC strategy.

Southwest General Univ Hospitals: Congestive Heart Failure
Aligned people, processes and technology to establish process for PCs and Specialists to receive notifications when a bundle patient arrived and received support from the population health team. Transparent with SNF utilizations and PAC spend data.
Results:
• 15% in 30-day readmissions
• 17% reduction in 90-day readmissions
• 9% reduction in unnecessary consults/associated costs

Signature Health: Total Joint Replacement
Convener for >100 voluntary bundles across the US. Nurse navigators aligned patients and post acute continuum services
Results:
• 40% reduction in post acute facility admissions (IRF & SNF)
• 21% reduction in total Medicare expenditure for the 90-day episode of care
Medicare Advantage Plans

Medicare Managed Care Penetration, 2016

Source: HHS, CMS 12/15; 67% MCR MC is highest in US (MN Counties)
GOP Proposed Changes to Medicare to Address Healthcare Spending Challenges

- raising the Medicare eligibility age;
- restructuring Medicare benefits and cost sharing;
- shifting Medicare from a defined benefit structure to a “premium support” system;
- eliminating “first-dollar” Medigap coverage;
- further increasing Medicare premiums for beneficiaries with relatively high incomes (from 1.4% to 1.8%); and
- accelerating the CMS’ delivery system reforms
**ACA’s Mandated Health Coverage Benefits**

- **Ambulatory patient services** - outpatient care
- **Emergency Services** - trips to the emergency room
- **Hospitalization** - treatment in the hospital for inpatient care
- **Laboratory services**
- **Maternity and newborn care**
- **Mental health services and addiction treatment** - inpatient and outpatient care
- **Pediatric services** - care of infants and children, including well-child visits, recommended vaccines and immunizations, dental, and vision care to children <19yo.
- **Prescription drugs** - medications that are prescribed by a doctor to treat an illness or condition.
- **Preventive services, wellness services, and chronic disease treatment** - includes counseling, preventive care, such as physicals, immunizations, and screenings, like cancer screenings, designed to prevent or detect certain medical conditions. Also, care for chronic conditions, such as asthma and diabetes.
- **Rehabilitative services and devices** - plans must provide 30 visits each year for either physical or occupational therapy, chiropractor, speech therapy, as well as cardiac or pulmonary rehab.

---

**Reimbursement Forecast – Timeline Unknown**

- **Fee For Service**
- **Future Payor Mix**
  - **FFS**
  - **ACO/bundle**
  - **Other**

- **Payment Centered**
- **Patient Centered**
  - **Shared Incentives**

*Bill Frist, MD, former Senate Majority leader, calls for “eliminating stand-alone fee-for-service payment by the end of the decade.”* - NEJM 2013.
Growth of Critical Access Hospitals

STAC Hs’ Perspective of PACs?

Save Money. Full Speed Ahead!
**Medicare Spend per Beneficiary, 2015-16**

Source: CMS, Standard Analytic File, Q3’15 – Q2’16

**Medicare Spend per Beneficiary, 2016 Components**

Source: CMS, Standard Analytic File, Q3’15 – Q2’16
### SNF and HHA MCR Expenditure, Q3’15 – Q2’16

<table>
<thead>
<tr>
<th>Provider</th>
<th>Type</th>
<th>Cases</th>
<th>LOS Visits</th>
<th>Pay/ Day</th>
<th>Pay/ Stay</th>
<th>Pay Total</th>
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</thead>
<tbody>
<tr>
<td>Silver Tree Nsg And Rehab - Schertz</td>
<td>SNF</td>
<td>370</td>
<td>25.2</td>
<td>$412</td>
<td>$10,375</td>
<td>$3,838,679</td>
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<tr>
<td>Kirkwood Manor - New Braunfels</td>
<td>SNF</td>
<td>341</td>
<td>28.9</td>
<td>$404</td>
<td>$10,829</td>
<td>$3,709,785</td>
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<tr>
<td>Eden Home Inc - New Braunfels</td>
<td>SNF</td>
<td>244</td>
<td>25.0</td>
<td>$372</td>
<td>$9,311</td>
<td>$2,271,807</td>
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<tr>
<td>Sundance Inn HC - New Braunfels</td>
<td>SNF</td>
<td>215</td>
<td>25.7</td>
<td>$411</td>
<td>$10,565</td>
<td>$2,271,575</td>
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<tr>
<td>Remarkable Healthcare - Seguin</td>
<td>SNF</td>
<td>208</td>
<td>32.5</td>
<td>$394</td>
<td>$12,795</td>
<td>$2,661,372</td>
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<tr>
<td>Legend Oaks &amp; Rehab - New Braunfels</td>
<td>SNF</td>
<td>134</td>
<td>24.8</td>
<td>$405</td>
<td>$10,061</td>
<td>$1,348,171</td>
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<tr>
<td>Colonial Manor CC - New Braunfels</td>
<td>SNF</td>
<td>115</td>
<td>35.4</td>
<td>$354</td>
<td>$11,517</td>
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<td>Guadalupe Valley Nrsng Ctr - Seguin</td>
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<td>103</td>
<td>24.7</td>
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<td>$9,370</td>
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<td>Windsor Nursing And Rehab Ctr - Seguin</td>
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<td>102</td>
<td>33.0</td>
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<td>$12,028</td>
<td>$1,226,861</td>
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<td>Nesbit Living &amp; Recovery Ctr - Seguin</td>
<td>SNF</td>
<td>69</td>
<td>35.2</td>
<td>$364</td>
<td>$12,820</td>
<td>$884,563</td>
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<td>Hacienda Oaks Nsg &amp; Rehab - Seguin</td>
<td>SNF</td>
<td>65</td>
<td>23.4</td>
<td>$374</td>
<td>$8,747</td>
<td>$568,552</td>
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<tr>
<td>Autumn Winds Living &amp; Rehab - Schertz</td>
<td>SNF</td>
<td>36</td>
<td>35.7</td>
<td>$365</td>
<td>$13,019</td>
<td>$468,696</td>
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<tr>
<td>Carter Healthcare - New Braunfels</td>
<td>HHA</td>
<td>1664</td>
<td>15.8</td>
<td>$269</td>
<td>$4,254</td>
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<tr>
<td>Advanced Home HHS - Sequin</td>
<td>HHA</td>
<td>1365</td>
<td>28.6</td>
<td>$184</td>
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<tr>
<td>Hill Country HH - New Braunfels</td>
<td>HHA</td>
<td>473</td>
<td>12.9</td>
<td>$235</td>
<td>$3,023</td>
<td>$1,429,698</td>
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<td>Christus Homecare - New Braunfels</td>
<td>HHA</td>
<td>323</td>
<td>16.4</td>
<td>$173</td>
<td>$2,827</td>
<td>$913,107</td>
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<td>Legend HHA - New Braunfels</td>
<td>HHA</td>
<td>33</td>
<td>25.5</td>
<td>$170</td>
<td>$4,343</td>
<td>$143,312</td>
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</table>

### Managed Care Organizations

<table>
<thead>
<tr>
<th>MCO</th>
<th>Total Lives</th>
<th>Medicare Total</th>
<th>Commercial Total</th>
<th>Medicaid HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealth Group</td>
<td>37,659</td>
<td>5,368 4,531 837</td>
<td>32,250</td>
<td>41</td>
</tr>
<tr>
<td>Humana</td>
<td>25,978</td>
<td>5,186 2,010 1,277 1,049</td>
<td>20,792</td>
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<tr>
<td>Aetna</td>
<td>28,994</td>
<td>1,777 27 1,550</td>
<td>25,539</td>
<td>1,678</td>
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<tr>
<td>Anthem</td>
<td>1,425</td>
<td>13 13  0 0 0 0 1 0</td>
<td>0</td>
<td>1,412</td>
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<tr>
<td>Health Care Service Corp</td>
<td>44,759</td>
<td>0 0 0 0 0 0 0 0</td>
<td>44,734</td>
<td>25</td>
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<tr>
<td>Cigna</td>
<td>7,495</td>
<td>0 0 0 0 0 0 7,490</td>
<td>513</td>
<td>7,947</td>
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<tr>
<td>Assurant</td>
<td>1,626</td>
<td>0 0 0 0 0 1,626</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Centene</td>
<td>8,460</td>
<td>0 0 0 0 0 513</td>
<td>0</td>
<td>7,947</td>
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<tr>
<td>Government Employees Hlth</td>
<td>392</td>
<td>0 0 0 0 0 392</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Premera Blue Cross</td>
<td>359</td>
<td>0 0 0 0 0 359</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>BlueCross BlueShield Tennessee</td>
<td>311</td>
<td>0 0 0 0 0 311</td>
<td>0</td>
<td>0</td>
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<tr>
<td>University Health System (TX)</td>
<td>12,184</td>
<td>0 0 0 0 0 0</td>
<td>12,184</td>
<td>0</td>
</tr>
<tr>
<td>Molina Healthcare</td>
<td>490</td>
<td>0 0 0 0 0 0</td>
<td>0</td>
<td>490</td>
</tr>
<tr>
<td>Grand Total</td>
<td>170,348</td>
<td>12,355 6,781 4,525 1,049</td>
<td>134,160</td>
<td>23,833</td>
</tr>
</tbody>
</table>

**Power of Purpose**
### Consultants Rushed to Develop BPCI and CIN

- NaviHealth
- Remedy Partners
- Navigant
- Navvis
- MedSolutions
- Marshall Steel
- Health Dimensions Group
- Reliant Healthcare
- Signature Health

### Remedy Partner’s SNF Expected LOS, 2015

<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>Lo</th>
<th>Hi</th>
<th>Surgical Procedures</th>
<th>Lo</th>
<th>Hi</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Myocardial Infarction **</td>
<td>12</td>
<td>15</td>
<td>Amputation (BKA/AKA)</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>12</td>
<td>14</td>
<td>Coronary Artery Bypass Graft</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Congestive Heart Failure **</td>
<td>13</td>
<td>15</td>
<td>Major Cardiovascular Procedure</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>COPD, Bronchitis Asthma **</td>
<td>10</td>
<td>13</td>
<td>Cervical Spinal Fusion</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Fractures of the Femur, Hip or Pelvis</td>
<td>18</td>
<td>20</td>
<td>Combined Anterior Posterior Spinal Fusion</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Gastrointestinal Obstruction</td>
<td>11</td>
<td>14</td>
<td>Complex Non-Cervical Spinal Fusion</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Medical Peripheral Vascular Disorders</td>
<td>13</td>
<td>19</td>
<td>Major Joint Replacement Lower Extremity**</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Renal Failure</td>
<td>14</td>
<td>17</td>
<td>Major Joint Replacement Upper Extremity</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Sepsis</td>
<td>12</td>
<td>15</td>
<td>Double Joint Replacement Lower Extremity **</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Simple Pneumonia and Resp Infections **</td>
<td>12</td>
<td>14</td>
<td>Revision of the Hip or Knee</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Stroke</td>
<td>15</td>
<td>19</td>
<td>Spinal Fusion (non-cervical)</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Transient Ischemia</td>
<td>13</td>
<td>16</td>
<td>Removal of Orthopaedic Devices</td>
<td>13</td>
<td>16</td>
</tr>
<tr>
<td>Urinary Tract Infection</td>
<td>14</td>
<td>17</td>
<td>Other Vascular Surgery</td>
<td>11</td>
<td>14</td>
</tr>
</tbody>
</table>

** Range Lo to Hi: 13 to 16

** Items included in HRRP
### STACH Narrow Network Examples – Kansas to Pennsylvania

- **Ohio** – 5 hospitals –
  - Selected 39 / 111 SNFs to track 2,300 patients/year

- **Tennessee** – 50 orthopedic physician practice
  - Selected 6 / 28 SNFs to track 1,400 CJR patients/year

- **Pennsylvania** – largest regional hospital
  - Selected 8 / 36 SNFs to track 1,700 patients/year

- **Kansas** – ACO (3 hospitals) and 2 independent physician groups
  - Selecting ?? SNFs and HHAs for >20 bundled conditions including CJR

### STACH’s Expectations (Requirements) of PACs

- Reduced PAC LOS and HHS visits
- Limited readmission
- Reduced PAC LOS and HHS visits
- Physician appointment <7 days after SNF discharge
- Telephonic follow up: Days 2, 10, and 30
- Partnership with Home Health, Outpatient, and community support services
- Reduced PAC LOS and HHS visits
**Acute to Post Acute Determinants**

**Before 2016:**
- Complex medical factors
- Patient history
- Severity of signs & symptoms
- Con-current medical needs
- Risk of adverse medical events
- Patient potential for rehab and physical recovery
- Family/caregiver involvement

**Today:**
- Diagnosis
- Procedure Code
- Navigator
- Physician choice
- Preferred Provider
- “CMS adequate services”
- Pre-determined days & visits

---

**Placement Options**

**Hospitals may**
- Include objective data (e.g. Nursing Home Compare) on facility lists distributed at discharge
- List providers with shared financial interests, so long as patients are made aware of ties
- Point out a facility’s high quality performance without explicitly recommending patient go there

**Hospitals may not**
- Explicitly recommend a facility
- Omit facilities from list that fall within patient’s chosen geographic area and are of appropriate level of care
Friends and Families Need to Know What YOU know

- Traditional Medicare benefits remain intact
  - Bundle and MAP financial preference do NOT take precedence over your rightful benefits
- “We will keep you for Observation” is not a “Hospital Admission”
  - Observation status places financial responsibility on patient rather than Medicare
- Never spend the night alone in a hospital
  - Medical and procedure errors are much too rampant
- Discharge planning includes the patient and family/caregivers
- Patient Care Laws remain intact
  - Right to make care and placement choices remain with the patient
- Always have a designated family/caregiver for medical communications
- Create a list of questions and ask them of all your doctors, nurses and therapists

Where Goes Quality?

**Operational Outcomes vs. Functional Measures**
### CMS' CJR Final Rule: Quality Metrics, 2016

<table>
<thead>
<tr>
<th>Reporting Requirement</th>
<th>Measure Source</th>
<th>Measure Weights for Quality Composite Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital-level risk standardized complication rate following elective lower extremity joint replacement</td>
<td>Mandatory</td>
<td>Claims-based (NOF #1550) 50%</td>
</tr>
<tr>
<td>Patient Experience (not specific to joint patients)</td>
<td>Mandatory</td>
<td>HCAHPS 40%</td>
</tr>
<tr>
<td>Hospital-level patient reported outcomes following electives lower extremity joint replacement</td>
<td>Voluntary</td>
<td>Under development 10%</td>
</tr>
</tbody>
</table>

### CMS’ Cardiac Final Rule: Quality Metrics, 2017

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Definition</th>
<th>Weight in Composite Quality Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-Day Mortality</td>
<td>30-day, all cause, risk-standardized mortality rate following a hospitalization for AMI</td>
<td>60%</td>
</tr>
<tr>
<td>AMI Excess Days</td>
<td>Excess days in acute care, including emergency department, observation, and inpatient readmission days following a hospitalization for AMI for 30 days</td>
<td>20%</td>
</tr>
<tr>
<td>Hybrid AMI Mortality Voluntary Data</td>
<td>30-day, risk-standardized AMI mortality rate, using a combination of claims data and EHR data submitted by hospitals (age, heart rate, systolic blood pressure, troponin, creatinine)</td>
<td>10%</td>
</tr>
<tr>
<td>HCAHPS Survey</td>
<td>Patient experience composite measure not specific to DRGs</td>
<td>20%</td>
</tr>
</tbody>
</table>
Hospitals’ Strategic Options

“Ostrich” or Align/Bundle

Hospitals Must Understand Their Post-Acute Challenges and Opportunities

• Determine what and where post-acute venues will be needed in the future? Build, buy or partner?

• Must assure access to the right post-acute venues to be able to effectively manage patients over an episode of care?

• Use post-acute care to drive down costs, share information, and report meaningful metrics?

• Select and incentivize non-affiliated post-acute providers, and then effectively manage cost, quality, and patient outcomes across the continuum?

• Effect clinical integration, care transitions, and evidence-based care delivery in disparate post-acute venues?
Where Does Post Acute Fit?

Consensus – Post Acute Providers play an integral part

• Least costly setting
• Preferred setting for patients
• Pre Acute & Post Care focus

Hospital - Concerns / Challenges

• What services does the hospital own vs. affiliate?
• How to develop a post acute network
• What services should hospital contract?
• How to value quality vs. financial performance?
• How will hospital share in Risk Based contracts, up & down side?
  • Alignment versus affiliation versus contracted
  • Understanding the Actuarial Data

Hospital & PAC – how to develop & invest in necessary technology?

PAC Importance to Hospitals

Penalties

• Reduced readmissions help avoid hospital financial penalties under CMS readmissions penalties
• Reduced downstream costs help avoid hospital financial penalties under VBP1 efficiency domain
• PAC performance impacts shared savings opportunity under BPCI2 and in ACOs3

Prevention and financial goals

• Holistic and proven benefits of smooth care transitions
• PACs assigned responsibilities for patient tracking relieve hospital staff and investments
• Increased count of community days during episode of care

Brand management

• Positive PAC experience raises patient satisfaction scores for the entire care episode care
Hospitals Know Processes to Control in PAC Network

**Patient Placement**
Inappropriate placement for acuity and clinical services

**In-Setting Utilization**
PAC provider delivers more or higher-cost services than clinically necessary

**Readmissions**
Patient accrues avoidable costs associated with additional hospitalization
Clinical Red Flags = CHF, Sepsis, UTI, Respiratory conditions
Poly-pharmacy
Chronic conditions
Social Red Flags = multiple admissions & ER visits, social support, caregiver burden

**End-of-Life Care**
Patient does not access cost-saving hospice benefits

**Information Exchange**
Building, sharing, care improvement teams

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**Power of Purpose**

**Acute to Post Acute Pathway: ex. Orthopedic Surgical**

**Pre Operation**
- Surgical Office
- Pre Anesthetic Assessment and Joint Class

**Hospital to Home or SNF**
- Surgeon/ Nursing/ Hospitalist
- Therapists
- Case Management/ Discharge Planner

**Home Care Pathway**
- Nursing/ Therapy Visits 1 to 2
- Nursing / Therapies Visits 1 to 4, or Visits 5 to 10
- Case Management/ Discharge Planner

**SNF Pathway per Day periods: 1 to 5, 5 to 9, 10 to 11**
- Nursing/ Therapies Patient education and instruction
- Patient Demonstration Patient verbalize safety instructions
Care Navigation Planning

- Transition from Acute IP to SNF
- SNF Admission Process & BPCI
- Care Transition Coordination (Hospital & SNF)
- Transition to Home

Patient identification
Medication reconciliation
Clinical methodologies depending upon CJR, BPCI, MCR Adv patient
Standardized administrative metrics through the episode of care
Focus on patient care experience

The Care Variation Reduction Model

Capabilities to Accelerate Clinical and Operational Improvement at Scale

Build an Integrated System-Level Care Variation Reduction Organization
Align Physicians and Clinical Stakeholders on the Care Reliability Ambition
Design New Care Standards and Pathways that Clinicians Trust
Measure Adherence and Outcomes to Surface Variation and Track Impact
Embed Standards at the Point of Care with EHR Enablement and Training
Sustain Continuous Improvement through Systems and Values Promoting Engagement, Collaboration and Organizational Learning
Advisory Board Endorsed a JOC Approach in 2013
3-4 Month Start Up

Basic JOC Membership Model

<table>
<thead>
<tr>
<th>Post-Acute Care Representatives</th>
<th>Acute Care Hospital Representatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Director</td>
<td>Physician Chair</td>
</tr>
<tr>
<td>Clinical Leadership</td>
<td>PAC Strategic Planning Administrators</td>
</tr>
<tr>
<td>Clinical Integration Director</td>
<td>Quality Director</td>
</tr>
<tr>
<td>IT Support</td>
<td>IT Support</td>
</tr>
<tr>
<td>Clinical Liaison(s)</td>
<td>Care Management Directors</td>
</tr>
</tbody>
</table>

Next-Level Components

- Additional Participants
  - Chief Medical Officer
  - Hospital Director of Nursing
  - Ancillary service representatives

Basic Operation

- Committee meets monthly to review clinical outcome metrics
- Focuses on clinical quality tracking and improvement

Care Navigation and Coordination Discussion

- How do we improve the care delivery model we've used for more than 25 years?
- What methods do we currently use that cost more than required to provide care?
- How do we create care production and delivery processes that will address care reforms and evolve to better value over time?
- How do we eliminate waste and unwanted variation, improve communication, focus on outcomes and prevention?
- How may we change care focus from volume-based platform to a collaborative, value centric model?
What are the top two benefits to having a preferred post-acute network? (NEJM, 2016 survey)

- Appropriately decreased readmissions to emergency department or hospital: 55%
- Able to improve quality metrics outcomes: 38%
- Appropriately decreased inpatient length of stay (LOS): 29%
- Improved patient experience: 26%
- Improved triage of patients to home versus facility: 17%
- Appropriately decreased post-acute LOS: 15%
- Not applicable: 6%

Source: NEJM Catalyst, MA Medical Society; n= 375

How coordinated is your patients’ care experience acute-post acute-home? (NEJM, 2016 survey)

- Fully coordinated: 7%
- Mostly coordinated: 30%
- Somewhat coordinated: 53%
- Not coordinated: 10%

Source: NEJM Catalyst, MA Medical Society; n= 375
What opportunities exist for improving transitions between inpatient-post acute-home settings?

<table>
<thead>
<tr>
<th>Opportunity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved real-time communication between hospital, post-acute, and primary</td>
<td>71%</td>
</tr>
<tr>
<td>care/outpatient providers</td>
<td></td>
</tr>
<tr>
<td>Shared electronic medical records/data exchange</td>
<td>66%</td>
</tr>
<tr>
<td>Embedded roundsers (such as physicians, nurse practitioners, or case</td>
<td>53%</td>
</tr>
<tr>
<td>managers)</td>
<td></td>
</tr>
<tr>
<td>Specific quality metrics focused on care coordination tied to</td>
<td>47%</td>
</tr>
<tr>
<td>reimbursement</td>
<td></td>
</tr>
<tr>
<td>Retrospective cross-continuum team meetings among key stakeholders</td>
<td>36%</td>
</tr>
</tbody>
</table>

Source: NEJM Catalyst, MA Medical Society; n= 375

PACs’ Strategic Options

Boldly tread new ground!
Assess

Internal Performance and Attributes
External Networks
Competitor Services and Performance

Establish Engagement Plan

Network leaders (systems, payers, physicians)
Executive leaders
Physician and clinical leaders

Build collaboration across networks, formal & informal

Power of Purpose

Network Must Point to Strategic Centers

Executive Leadership

Strategies
- Acute
- Ambulatory
- Health System
- Post Acute Care (PAC)

Clinical Leadership

Physician Hospital Organization
Clinically Integrated Network
- Outcomes
- Alignment
- Bonuses

Case Management/ Social Work

Post Acute Care Providers (PAC)
Power of Purpose

The PAC Mantra - 8 Essential Talking Points

a) Admissions from ________ Hospital (residents vs. non-residents)
b) Clinical mix (diagnoses): 1) ______ , 2) ______ , 3) ______
c) Unplanned Readmissions to ________ Hospital
d) Clinical mix (diagnoses): 1) ______ , 2) ______ , 3) ______
e) Readmission prevention process (ability to track patient status change, common issues or trends observed past 2-3 months, improvement process to limit readmits)
f) Overall tracking/reporting capability (KIT, etc.)
g) ALOS overall
h) DC Disp % to community
i) Goal: Joint Operating Committee

Power of Purpose

Functional Recovery - Service Line Example

<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>Cases</th>
<th>ALOS</th>
<th>FOM Eval</th>
<th>FOM DC</th>
<th>FOM Gain</th>
<th>Min/ Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>21</td>
<td>19.7</td>
<td>3.4</td>
<td>4.3</td>
<td>0.9</td>
<td>91.8</td>
</tr>
<tr>
<td>Cardio</td>
<td>310</td>
<td>23.0</td>
<td>3.6</td>
<td>5.1</td>
<td>1.5</td>
<td>95.8</td>
</tr>
<tr>
<td>Cognitive DysFunx</td>
<td>19</td>
<td>32.1</td>
<td>2.9</td>
<td>3.9</td>
<td>1.0</td>
<td>89.4</td>
</tr>
<tr>
<td>Gen Med</td>
<td>378</td>
<td>26.4</td>
<td>3.4</td>
<td>4.6</td>
<td>1.3</td>
<td>91.3</td>
</tr>
<tr>
<td>Neuro</td>
<td>258</td>
<td>32.6</td>
<td>3.0</td>
<td>4.2</td>
<td>1.2</td>
<td>96.5</td>
</tr>
<tr>
<td>Ortho</td>
<td>1,079</td>
<td>27.7</td>
<td>3.3</td>
<td>4.9</td>
<td>1.7</td>
<td>94.0</td>
</tr>
<tr>
<td>Pulm</td>
<td>296</td>
<td>25.4</td>
<td>3.4</td>
<td>4.7</td>
<td>1.3</td>
<td>94.4</td>
</tr>
<tr>
<td>Grand Total</td>
<td>2,361</td>
<td>27.1</td>
<td><strong>3.3</strong></td>
<td><strong>4.8</strong></td>
<td><strong>1.5</strong></td>
<td><strong>94.1</strong></td>
</tr>
</tbody>
</table>

PATIENT FUNCTIONAL OUTCOME MEASURE and DISCHARGE IMPACT

<table>
<thead>
<tr>
<th>1.0 Complete Dependence 100%</th>
<th>1.7 Near Total Dependence 90%</th>
<th>2.0 Maximum 75-90%</th>
<th>2.5 Moderate 50-75%</th>
<th>3.0 Low 40-50%</th>
<th>3.5 Mod/Min 25-40%</th>
<th>4.0 Minimum &lt;25%</th>
<th>4.5 Contact Guard contact</th>
<th>5.0 Stand By Assistance</th>
<th>6.0 Mod-Independent</th>
<th>7.0 Independent</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH RISK READMISSION</td>
<td>HIGH RISK READMISSION</td>
<td>MODERATE RISK READMISSION</td>
<td>LOW RISK READMISSION</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Functional Recovery - Readmission Condition Example**

<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>Cases</th>
<th>ALOS</th>
<th>FOM Eval</th>
<th>FOM DC</th>
<th>FOM Gain</th>
<th>Min/Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardio AMI</td>
<td>31</td>
<td>24.0</td>
<td>3.5</td>
<td>4.6</td>
<td>1.1</td>
<td>95.2</td>
</tr>
<tr>
<td>Cardio CHF</td>
<td>79</td>
<td>24.1</td>
<td>3.6</td>
<td>4.8</td>
<td>1.3</td>
<td>96.0</td>
</tr>
<tr>
<td>Cardio Sx</td>
<td>92</td>
<td>21.7</td>
<td>3.7</td>
<td>5.5</td>
<td>1.8</td>
<td>97.2</td>
</tr>
<tr>
<td>Gen Med Sepsis</td>
<td>75</td>
<td>27.1</td>
<td>3.3</td>
<td>4.8</td>
<td>1.4</td>
<td>88.8</td>
</tr>
<tr>
<td>Gen Med UTI</td>
<td>46</td>
<td>25.3</td>
<td>3.3</td>
<td>4.6</td>
<td>1.2</td>
<td>97.8</td>
</tr>
<tr>
<td>Pulm COPD</td>
<td>55</td>
<td>23.1</td>
<td>3.6</td>
<td>4.9</td>
<td>1.3</td>
<td>90.6</td>
</tr>
<tr>
<td>Pulm Pneu</td>
<td>140</td>
<td>25.7</td>
<td>3.4</td>
<td>4.8</td>
<td>1.3</td>
<td>95.2</td>
</tr>
<tr>
<td>Grand Total</td>
<td>518</td>
<td>24.1</td>
<td>3.3</td>
<td>4.8</td>
<td>1.5</td>
<td>94.1</td>
</tr>
</tbody>
</table>

**Power of Purpose**

**Clinical Assets versus Clinical Services**

**Clinical Assets**
- Clinical staffing
- Home Health Care
- Primary Care
- Rehab Therapy
- Wellness Program
- Recreational Therapy
- Memory Care Programs

**Clinical Services**
- Care Planning
- Dietary Support
- Health Status Monitoring
- Medication Management
- Social Interaction
- Transportation
Network Assessment

1. Due diligence – data and process analyses -
   a) patient referral origin
   b) patient admission trends (hospitals, payors, diagnoses)
   c) reporting and process standards
2. Identify priority network contacts
3. Set meeting date, participant list, and expectations
4. **Establish an ongoing work group (Joint Operating Committee)**
   a) Identify complementary PACs
   b) Establish initial quality measures
   c) Organize PACs by disease states or other characteristics
   d) Establish DRG guidelines as appropriate
   e) Integrate PAC into transition process

Enhanced and New Strategic SNF Imperatives

- Strategic messaging
- MD Sales
- Hospital Partner
- Network Marketing
- Network Sales
- Branding
- Lead Management Program
- Web Design and Tracking
- Digital Marketing
- Managed Care Contracting
- Managed Care Sales
PAC Collaboration - Progressive Agenda

• Current experiences within the BPCI
  ✓ Problems experienced
  ✓ Measurement (quantifiable metrics)
  ✓ Solutions to recommend
• Community updates
  ✓ Hospital/health system news
  ✓ Physician realignments
  ✓ Post acute provider news
• Coordinated effort to discuss clinical care network with hospitals
  ✓ Targeted executive and clinical leaders
  ✓ Shared message and goals
• Establish mutually agreeable measurement definitions
  ✓ LOS, co-morbidities, functional outcomes, discharge dispositions
• Research & Analytic Support
  ✓ Measurement & reporting resources (tools and analytic support)
  ✓ Clinical continuum network expertise
  ✓ Clinical program library (best practice, documentation, implementation)
I. How to prepare for BPCI interview and tour?

II. I’ve been selected to participate; how do I get started?

III. Beyond Phase 2, what data must I collect and analyze in order to stay ahead?

IV. I’m not included in the BPCI, how do I make myself important?

Self Assessment

• 5-Star status
• Internal data metrics and performance
• Case and Payor mix
• Referral patterns past 18 months
• Analyze all factors above within the context of the facility AND external market demands

• External, Market Assessment
  • Hospital(s)
  • SNFs
  • HHAs
  • IRFs
  • Hospice
  • LTACHs
• Identify the SNF providers most like your facility: culture, clinical and IT competence
II. I’ve been selected to participate; how do I get started?

- Understand the data definitions and match them to data collection
- Understand the data collection and reporting requirements
  - What may I automate and what must I manually manage?
- 5 Star status maintenance or improvement
- Establish practice to make certain each patient has a PGP appointment within 10 days of SNF DC
- Measure patient care experience scores
- Develop appointment setting, patient scores and outcomes into physician communication whether in the BPCI or not
- Become expert at readmission reduction: MUST implement tools like Interact, Red, Boost or the like.
- Having identified SNFs most like you, find best ways to collaborate on data metrics. [developing trust through data will prove essential in later Phases of BPCI and hospital relationships]

III. Beyond Phase 2, What must do in order to stay ahead?

- 5 Star status maintenance or improvement
- Improve metric collection and analytics for process improvement
- Establish patient specific functional performance scores in regular reporting with physicians, payors, patients & families
- Establish 30-Day or greater post discharge patient tracking process
- Begin tracking Medicare Spend Per Beneficiary [SNF Performance Score in 2018]
- With SNF collaborators, share performance data for:
  - Best practice
  - Establish community marketing plan with your measured performance as gold standard
  - Create tracking mechanism for patient variance within your established treatment protocols
IV. I am not included in BPCI, how do I earn participation?

- 5 Star status maintenance or improvement
- Find the key point of contact with political strength to make your case for participation
- Develop argument for inclusion based on geographic demand
- Develop argument(s) for fitness to perform within the BPCI
  - Measure non-bundle outcomes, and work to make them meet or exceed facilities in the BPCI

Discussion and Questions