Shift Away from Traditional FFS from 2010 to 2015, Continued but Slower Growth in Alternative Payment Going Forward

Sources: CMS Office of the Actuary for spending and enrollment. Avalere analysis for alternative payment model projections.

2010
- Traditional Fee-for-Service: 75%
- Medicare Advantage: 25%
- N = 47.7 million

2015E
- Traditional Fee-for-Service: 54%
- ACOs: 14%
- Medicare Advantage: 31%
- N = 55.8 million

2020E
- Traditional Fee-for-Service: 49%
- ACOs: 16%
- Medicare Advantage: 34%
- N = 64.5 million
What Are the Risks?

- Managed Care
- ACOs
- Bundling
- Conveners
- Narrow Networks
- Length of Stays
- Doing nothing
What Worked for Me

✓ Acquired insurance companies

✓ Developed Medicare Advantage Special Needs Plan - the “Ultimate” Bundle

✓ Added nursing center based products
Why Take on the Risks?

We ARE at risk already
What You Can Do

- Know your data
- Join a Quality Network
- Expand services up and down the continuum
- Explore niche services
- Become a bundler of services
NCAL Update
Chris Mason
NCAL Chair
President & CEO, Senior Housing Managers, LLC
Overview

- **Significant Shift in Payment and Delivery Models**
- Implications for Skilled Nursing Facilities
- Critical Capabilities
**Dramatic Shift in Coverage and Payment over the Past Five Years**

<table>
<thead>
<tr>
<th>ACO: Accountable Care Organization; APM: Alternative Payment Model; BPCI: Bundled Payments for Care Improvement Initiative</th>
<th>2009</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicare Advantage</strong></td>
<td>~24% of enrollees</td>
<td>~30% of enrollees and <strong>growing</strong></td>
</tr>
<tr>
<td><strong>Medicare ACOs</strong></td>
<td>None</td>
<td>350+</td>
</tr>
<tr>
<td><strong>Bundled Payments</strong></td>
<td>None</td>
<td>1,500+ organizations in BPCI</td>
</tr>
<tr>
<td></td>
<td></td>
<td>850+ Hospitals in CCJR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4+ states implementing bundles</td>
</tr>
<tr>
<td><strong>Patient Centered Medical Homes</strong></td>
<td>Limited</td>
<td>8000+ NCQA accredited PCMHs</td>
</tr>
<tr>
<td><strong>Commercial ACOs</strong></td>
<td>Limited</td>
<td>262</td>
</tr>
<tr>
<td><strong>Medicaid ACOs</strong></td>
<td>Limited</td>
<td>62</td>
</tr>
<tr>
<td><strong>Duals Demonstrations</strong></td>
<td>None</td>
<td>15 States participating in Financial Alignment Initiative</td>
</tr>
</tbody>
</table>

Sources:
- Congressional Budget Office’s March 2015 Medicare baseline. CBO report. Mar 9, 2015;
- Shared savings program. CMS website. Accessed Jul 7, 2015;
Overview

- Significant Shift in Payment and Delivery Models
- Implications for Skilled Nursing Facilities
- Critical Capabilities
Implications of Value-Based Care for Nursing Facilities and Other Post-Acute Care Providers

GREATER MA, APMs, AND VALUE-BASED PURCHASING WILL DRIVE:

- Fewer FFS Patients
- Shorter LOS
- Fewer Readmissions
- Less Use of Costly Settings

Payers, Providers, and Patients will Have Higher Expectations for Quality and Value

APM: Alternative Payment Model; FFS: Fee-for-Service; LOS: Length of Stay; MA: Medicare Advantage
Decrease in Medicare-Covered Hospital Stays 2007 to 2013

DECREASE APPARENT ACROSS THE TOP AND BOTTOM THREE HRRs WITH REGARD TO PER-CAPITA MEDICARE SPENDING

Figure includes top and bottom three markets based on 2013 standardized risk-adjusted per capita Medicare costs. Hospital stays include inpatient acute care hospitals paid under the PPS, CAHs, IPFs, and cancer hospitals.

Source: Avalere Analysis of CMS Geographic Variation Public Use Files. Available at:
Reduction in SNF Admissions and Covered Days

LOS SLIGHTLY HIGHER IN RECENT YEARS; MIGHT BE DUE TO HIGHER ACUITY PATIENT POPULATION

<table>
<thead>
<tr>
<th>Year</th>
<th>Covered Admissions per 1,000 FFS Beneficiaries</th>
<th>Covered Days (per 1,000 FFS Beneficiaries)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>71.2</td>
<td>1,935</td>
</tr>
<tr>
<td>2012</td>
<td>68.0</td>
<td>1,861</td>
</tr>
<tr>
<td>2013</td>
<td>67.0</td>
<td>1,835</td>
</tr>
</tbody>
</table>

Admissions declined more rapidly than covered days declined resulting in a small increase in covered days per admission, or average length of stay.

ACO & BPCI Participants Selecting Preferred SNFs: Expectations for Lower LOS

Banner Health (ACO, BPCI): Limit recommended SNFs to 34 out of nearly 100 in Phoenix area; LOS 5-7 days shorter among preferred SNFs

Catholic Health Initiatives (BPCI): Requiring SNFs to submit applications with quality data; selecting less than 1/3rd of SNFs in market as preferred

Cleveland Clinic (ACO, BPCI): Uses infection rates, LOS, and hospital readmissions rates to select preferred SNFs in region

Franciscan Alliance (ACO): Reduced SNF network from 30 to 9; LOS dropped by more than 14 days (from 42 to 28 days)

LVHN (ACO): Refined SNF network, choosing 5 of 20 SNFs as “Tier 1”

Atrius Health (ACO): Selects 35 SNFs out of 100 applicants as preferred facilities; LOS 6 days shorter among preferred SNFs

Partners Healthcare (ACO): Limited recommended SNFs to 47 out of 140 applicants

In 2012, OSF HealthCare, a Pioneer ACO, leveraged its 51 accredited medical home sites and EHR system to create a network of 17 preferred skilled nursing facilities with daily visits to facilities to ensure smooth transitions and coordination.

**Results:** SNF readmissions decreased from 27% in 2012 to 11% in 2013 and ED visits decreased by more than 50%.

A Leavitt Partners analysis found that a majority of MSSP ACOs' most significant decrease in total spending was attributed to SNF expenditures.

18 of the 33 quality measures in MSSP ACOs are impacted by PAC providers.
Overview

- Significant Shift in Payment and Delivery Models
- Implications for Skilled Nursing Facilities
- **Critical Capabilities**
Shift to Medicare Advantage and Alternative Payment Models Is Transforming Relationships between Acute and Post-Acute Providers

- **Narrowing Networks/Integration with Acute:** Preferred partners selected based on quality performance and expectations.

- **Gainsharing Among Providers:** Providers sharing gains (and losses) based on performance against quality and spending targets with upstream and downstream providers.

- **PAC Providers Pushing Value & Risk Upstream:** PAC providers are bearing risk with hospitals, payers, and physician groups to manage quality and cost of PAC.

- **Demand of Meeting Quality Expectations:** Meeting expectations for quality performance increasingly tied to referral volume and/or payment levels by many partners.

- **New Players Emerging:** Emerging integrators and conveners bring together providers to share risk/reward under new payment models.
Providers Need Key Capabilities to Succeed

- Network Development
- Data Sharing/HIT
- Business Operations
- Patient Engagement
- Clinical Operations
Business Operations and Key Capabilities

VARIETY OF BUSINESS CAPABILITIES NEEDED TO ENTER INTO CREATIVE CONTRACTING, MONITOR PARTNERSHIPS, AND EVALUATE PARTNERS

Showcase Assets
- Scorecards
- Performance reports

Financial Planning
- Forecasting
- Finance tracking

Data Analytics
- Financial performance

Business Agreements
- Upstream referral

Key Business Capabilities
- Assets
- Planning
- Analytics
- Agreements
PAC Must Focus on Up- and Downstream Network Development

**Past Provider Networks:**
Linear, Hospital-Centric

**Present & Future Provider Networks:**
Dynamic, Multiple Owners
Improving Physician Engagement in PAC

5 WAYS PAC CAN PROMOTE STRONGER RELATIONSHIPS WITH PHYSICIANS

Increase Clinical Presence in PAC
- Recruit and Employ physicians and physician extenders
- Share clinicians with at-risk PGPs/Hospitals

Enhance Internal Communication
- Identify high-risk patients daily
- Secure buy-in for new protocols

Enhance communication with physicians
- Adopt communication tools
- Grant remote access to EHRs

Build Clinical Protocols and Capabilities
- Define robust clinical protocols
- Evaluate needs of patient populations
- Form specialist care units

Measure, Evaluate, and Share Results of Quality Outcomes
- Set benchmarks
- Conduct root cause analyses
- Meet regularly with partners
HIT Underpins the Drive to Value-Based Care

HIT CONNECTS PROVIDERS ACROSS THE CONTINUUM OF CARE

Cross-Provider Information-Sharing Enabled by HIT
Data Capture, Aggregation, and Analytics Enable More Effective Risk-Management

- Partner Assessment
- Benchmarking
- Opportunity Analysis and Goal Setting

Retrospective

- Active Patient Management (Tracking and Monitoring)
- Clinical Protocols Implementation and Performance

Real-Time

- Financial Planning
- Actuarial Solvency
- Risk Contract Negotiation/ Gainsharing Negotiation

Prospective
Patient Engagement Tactics Must Educate, Motivate to Drive Better Outcomes, Lower Costs

Sample Patient Engagement Tactics

- Provide relevant education throughout care delivery
- Host peer groups for patients with chronic conditions
- Engage patients through motivational interviewing and “teach back” tools

Cultural differences, literacy limitations, and cognitive issues impede optimal provider-patient interactions. Even the most thoughtful care plans can be ignored and result in poor outcomes if patients are not educated and/or motivated.

Care Management and Care Transitions are Critical Under Every Alternative Payment Model

eINTERACT, CARE TRANSITIONS INTERVENTION (CTI), AND OTHER PROGRAMS HELP TO FACILITATE THE MANAGEMENT OF PATIENTS

Many of these programs are still focused on one encounter and one handoff rather than on the management of patients over longer periods of time.

Shifting Rules under Alternative Payment Models Allow for Increased Clinical Care Management

**PROGRAM DESIGN ELEMENTS AND WAIVERS PROVIDE ADDITIONAL OPPORTUNITIES FOR COLLABORATING ACROSS THE CONTINUUM**

<table>
<thead>
<tr>
<th>Data availability and sharing</th>
<th>SNF three-day stay waiver</th>
<th>Increased telehealth coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiary-level Medicare claims data provide a more accurate, current perspective on providers’ performance/episode performance</td>
<td>Waiver: Enables hospitals to reduce length of stay and transition patients to a lower cost setting earlier in the episode of care</td>
<td>Waiver: Permits providers to offer telehealth services to a broader patient population who otherwise would not have been eligible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gain-sharing &amp; risk-sharing</th>
<th>Beneficiary incentives</th>
<th>Home health visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waivers: Provide organizations with the opportunity to enter into formal gain-/risk-sharing arrangements to redesign care and offer innovative and financial incentives to partners</td>
<td>Waiver: Allows organizations to provide beneficiary incentives to improve the provision and continuity of care and motivate patients to be more engaged in their care management</td>
<td>Waiver: Providers may conduct home visits throughout the episode to reduce hospital readmissions and admissions to higher-cost settings</td>
</tr>
</tbody>
</table>
Building Clinical Protocols and Capabilities

1. **Analyze Market Trends and PAC Needs**
   - Identify specialty care needs by evaluating market trends related to the PAC needs and reach out to local hospitals to help assess the volume of patients with conditions that commonly require PAC.

2. **Form Specialty Care Units**
   - Develop sophisticated, specialized care units that provide a highly clinical environment in which physicians can treat patients and can meet the care needs of area hospitals.

3. **Define Robust Clinical Protocols**
   - Build core clinician teams and strong clinical protocols to increase trust in provider capabilities and more effectively manage patients over longer timeframes.
Key Takeaways

SNFs will need to be responsive to the hospital and physician market needs and financial risk. Single cross-market strategy difficult.

- Aggressive
  - SNFs must address quality, LOS
  - Identify opportunities for pro-active engagement
  - Push toward clinical partnership

- Passive
  - Proactive identification of opportunities
  - Identify barriers to hospital success and market-specific interventions
  - Evaluate and proactively engage hospitals on what they need to succeed
The ACA Has Accelerated Payment and Delivery Reform

- **Hospital Readmissions Reduction Program**
- **MSSP First and Second Cohorts**
- **BPCI Participants Announced**
- **MSSP Fourth Cohort**
- **MSSP Fifth Cohort Begins Operation**
- **Round 1 Health Care Innovation Awards Announced**
- **Round 1 State Innovation Model Awardees**
- **Physician Value-Based Modifier**
- **Initial Round 2 Health Care Innovation Awards Announced**
- **Hospital Acquired Condition Penalty Begins Implementation**
- **Hospital Readmission Penalties expand to COPD and THA/TKA**
- **SGR Repeal and Passage of MACRA**
- **Initial Round 1 State Innovation Model Awardees**
- **Hospital Value-Based Purchasing**
- **MSSP Third Cohort**
- **Hospital Acquired Condition Penalties begin**
- **Hospital Readmission Penalties expand COPD and THA/TKA**
- **MSSP Third Cohort**
- **Initial Round 2 Health Care Innovation Awards Announced**
- **Hospital Acquired Condition Penalty Begins Implementation**
- **Hospital Readmission Penalties expand to COPD and THA/TKA**
- **SGR Repeal and Passage of MACRA**

**Key:**
- **BPCI – Bundled Payments for Care Improvement**
- **MSSP – Medicare Shared Savings Program**

**Timeline:**
- 2010: Passage of Affordable Care Act
- 2011:
  - Pioneer First Cohort
  - Hospital Readmissions Reduction Program
  - BPCI Program Announced
  - MSSP First and Second Cohorts
- 2012:
  - MSSP Third Cohort
  - Hospital Value-Based Purchasing
  - Initial Round 2 Health Care Innovation Awards Announced
  - Hospital Acquired Condition Penalty Begins Implementation
- 2013:
  - BPCI Participants Announced
  - MSSP Fourth Cohort
  - Hospital Acquired Condition Penalties begin
- 2014:
  - MSSP Fifth Cohort Begins Operation
  - Hospital Readmission Penalties expand COPD and THA/TKA
  - SGR Repeal and Passage of MACRA
- 2015:
  - Hospital Readmission Penalties expand COPD and THA/TKA
  - SGR Repeal and Passage of MACRA

**CMMI Innovation Initiatives**
- **VBP Programs**
Providers Face Increasing Payment Penalties Under Mandatory Programs

EHR: Electronic Health Record; MU: Meaningful Use; DRG: Diagnosis-Related Group
Note: MU penalty is percentage of annual market basket update. All other hospital quality programs apply penalty to DRG payments. Physician payment adjustments based on Medicare Physician Fee Schedule. In 2015, for hospitals, MU penalties equal to 1/3 reduction on 3/4 market-basket update. In the chart example, a 3% market basket increase would be reduced by 0.75%. In 2016, penalties increase to 2/3 reduction or 1.5% on 3/4 market-basket update (assuming a 3% market basket increase). In 2017, penalties increase to 3/4 market-basket reduction or 2.25% assuming a 3% market basket increase. The Physician Value-Based Payment Modifier applies to increasingly larger eligible physician group practices during the first two years, before being applied broadly.

FY 2015 Hospital Penalties*
$2.2 Billion
*excludes MU penalties

FY 2015 Physician Penalties
$211 Million
Hospitals Are Evaluated Against Increasingly Outcomes-Based Measures to Yield a Total Performance Score

Measure Domains

1. Clinical Care:
   - **Process** (e.g., discharge instructions)
   - **Outcomes** (e.g., heart failure mortality rate)**

2. Patient & Caregiver-Centered Experience of Care/Care Coordination
   (Composite of HCAHPS survey questions)

3. Efficiency & Cost Reduction
   (Medicare Spending per Beneficiary)

4. Safety
   (e.g., surgical site infections)

Total Performance Score (TPS)

For each domain, CMS sums the weighted score based on achievement (compared to a national benchmark) or improvement (compared to a hospital's performance over time), whichever of the two values is better. CMS then converts the TPS to a bonus payment or payment adjustment.

Domain Weights and Number of Measures by Fiscal Year*

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Clinical Care</th>
<th>Clinical Care - Outcomes</th>
<th>Patient &amp; Caregiver-Centered Experience of Care/Care Coordination</th>
<th>Efficiency &amp; Cost Reduction</th>
<th>Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>2018</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

*The values in the bars are the number of measures for each domain

**Beginning in 2018, Clinical Care – Process domain will be removed and Clinical Care – Outcomes will be renamed “Clinical Care”

Note: For FY2017, CMS restructured the domain names to align with the National Quality Strategy domains. For clarity, we have utilized the new domain names throughout.

Source: FY 2016 Inpatient Prospective Payment System Final Rule
With efficiency measures, CMS evaluates total Part A and B spending for services related to the underlying condition* for three days prior to admission through 30-days afterwards:

**Measure Timeline**

- **Inpatient stay** (variable based on LOS)
- **30-days post-inpatient stay**
- 3 days pre-inpatient stay

**CMS Moving Towards Episode-based* Efficiency Measures**

<table>
<thead>
<tr>
<th>Measures Addressing Medical Episodes</th>
<th>Measures Addressing Surgical Episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Cellulitis</td>
<td></td>
</tr>
</tbody>
</table>

LOS: Length of Stay; AMI: Acute Myocardial Infarction; HF: Heart failure

*Currently, HVBP has a single efficiency measure, Medicare Spending per Beneficiary, which is not condition-specific. These measures will be part of the Hospital Inpatient Quality Reporting program starting in fiscal year 2019.

Source: FY 2016 Inpatient Prospective Payment System Final Rule
Questions?

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202.459.6263