ACO/Bundle/Managed Care - Environmental Factors

Environmental Demand Factors:

- ↑ Population
- ↑ Aging population
- ↓ Current utilization patterns
- ↓ Medical enhancements
- ↓ Disease management
- ↑ Medicaid expansion
- ↔ Exchanges, Public & Private
- ↔ Alternate payment models
- ↔ Dual eligible programs

Clinical Utilization Affects:

- ↑ Acute length of stay
- ↑ Case complexity
- ↔ PAC venue selection
- ↑ Care transition programming
- ↑ Telehealth monitoring
- ↑ Family education & training
- ↑ Outcomes tracking

Bundling Is Here to Stay – with Changes*

*Consensus opinion: Deloitte, BKD, Truven Health, ECG, LeadingAge, etc.

- 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).

BPCI : Lewin Group 3rd Annual Report, Oct'17

- Providers for CMS were starting to reap the benefits of BPCI, but it's still unclear whether the savings and improved quality actually stemmed from the program.
- Participants can withdraw from the experiment at any time. 27 BPCI hospitals had exited the initiative by Q3' 2015. Many cited administrative burdens as the reason for their departure.
- Most participants surveyed had engaged in BPCI for three quarters, which Lewin said isn't enough time to see results on payments and quality from care redesign.
- "The lack of consistent or significant results may be partly due to the short average tenure of participants in the initiative."
- BPCI data from late 2013 to fall 2015, and found that Medicare payments decreased:
- TJR : $1,273, or 4.5%, per case
- CHF : $970 , or 3.6% per case
- However, BPCI providers often participated in multiple value-based pay initiatives, so researchers couldn't tell whether BPCI led to the savings.
- "Because we are measuring multiple outcomes across the range of model, participant, and episode combinations, by chance alone some results will appear significant, although in reality, they are not true effects of the initiative."

	Medicare Claims	MDS assessments	OASIS assessments	IRF-PAI assessments	Beneficiary Assessment
Unplanned readmission rate	X				
Emergency department use without hospitalization	X				
All-cause mortality rate	X				
SNF PAC setting					
improve status or remain independent in long-form ADL function		X			
improve status or remain independent in early-loss ADL function		X			
improve status or remain independent in mid-loss ADL function		X			
HHA PAC setting					
improve status or remain independent in bathing			X		
improve status or remain independent in upper body dressing			X		
improve status or remain independent in lower body dressing			X		
improve status or remain independent in ambulation/locomotion			X		
improve status or remain independent in bed transferring			X		
IRF PAC setting					
Average change in self-care score				X	
Average change in mobility score				X	
Self Report Improvement					
bathing, dressing, using the toilet, or eatinge					X
walking without rest					X
use of mobility device (i.e., less frequent) e					X
using stairs					X
planning regular tasks					X
improvement in physical/emotional problems limiting activities					X
improvement in pain limiting regular activities					X

RehabCare Because Outcomes Matter — The RIGHT PATH Reducing Rehospitalization Program

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

RehabCare Because Outcomes Matter — The RIGHT PATH Reducing Rehospitalization Program

Risk Based & Contracting Vocabulary

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

RehabCare The RIGHT PATH Reducing Rehospitalization Program

Hospitals' Reality = Medicare Reality

Why This Matters to YOU

Tax Payer, Family Member,
and
Future Medicare Beneficiary

Kindred Rehabilitation Services

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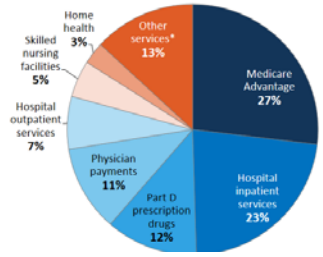
Medicare Benefit Payments by Type of Service, 2015



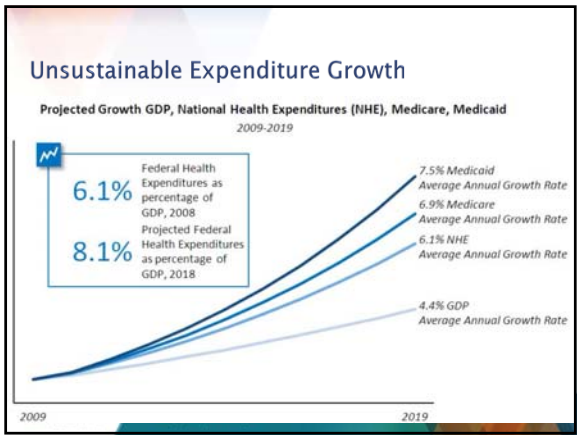
1975
$15.6 B

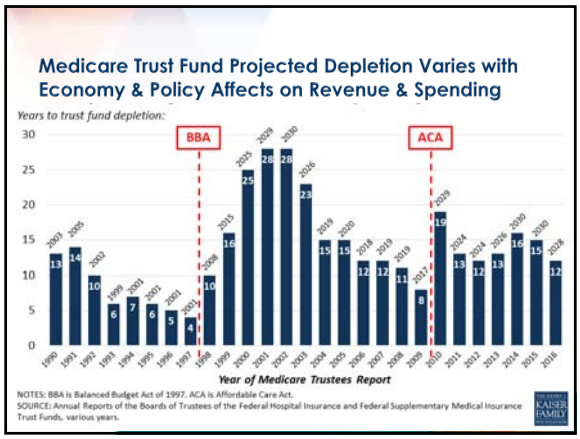
1995
$183B

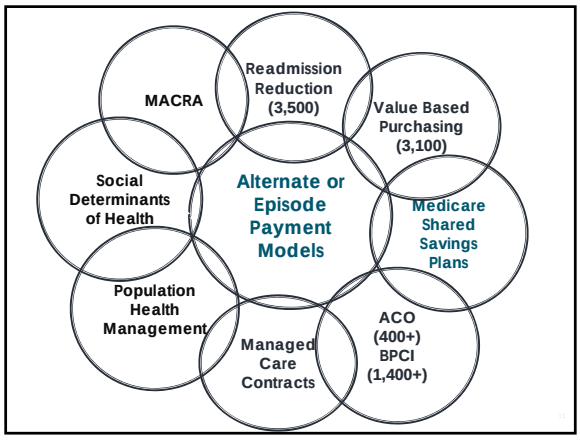
2015
$632B

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 recovered.
SOURCE: Congressional Budget Office, 2016 Medicare Baseline (March 2016).

KAISER FAMILY FOUNDATION


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
6.9% Medicare Average Annual Growth Rate
6.1% NHE Average Annual Growth Rate
4.4% GDP Average Annual Growth Rate
2009
2019


Medicare Trust Fund Projected Depletion Varies with Economy & Policy Affects on Revenue & Spending
Years to trust fund depletion:
BBA
ACA
Year of Medicare Trustees Report
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.


MACRA
Readmission Reduction (3,500)
Value Based Purchasing (3,100)
Social Determinants of Health
Alternate or Episode Payment Models
Medicare Shared Savings Plans
Population Health Management
Managed Care Contracts
ACO (400+) BPCI (1,400+)

CMMI Quality Evaluation Programs

QOC: clinicians, hospitals, ASCs, ESRD facilities, health plans, & LTC facilities.

- Ambulatory Surgical Center Quality Reporting (ASCQR),
- End Stage Renal Disease (ESRD) Quality Incentive Program,
- Home Health Quality Initiative,
- Hospice Quality Reporting,
- Hospital Acquired Condition (HAC) Reduction Program,
- Hospital Inpatient Quality Reporting (IQR),
- Hospital Outpatient Quality Reporting (OQR),
- Inpatient Psychiatric Facility Quality Reporting (IPFQR),
- Inpatient Rehabilitation Facility (IRF) Quality Reporting,
- Long-Term Care Hospital (LTCH) Quality Reporting Program,
- Medicare Advantage Star Rating Program,
- Medicare and Medicaid EHR Incentive Program for Eligible Professionals,
- Medicare and Medicaid EHR Incentive Program for Hospitals and CAHs,
- Nursing Home Quality Initiative,
- Physician Quality Reporting System (PQRS),
- Prospective Payment System (PPS) - Exempt CA Hospital Quality Reporting (PCHQR)
- Value-Based Payment Modifier (VBPM) Program Calendar Year (CY).

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Inovalon Policy Experts' Recommendations for Systems and Plans

1. Apply ACA strategies to market segments
2. Invest in state engagement plan that includes proactive and reactive strategies
3. Prepare for commercial style benefits in Medicaid
    a) How to engage beneficiaries for desirable outcomes
4. Shape outcome based contracts driven by public payers
5. Focus on MACRA/MIPs effect on physician behavior and needs
6. Use data to shape your competitive edge
    a) Credibility
    b) Outcomes – clinical, operational, and financial
    c) Community alignments

WHY is Post Acute Targeted?

Kindred

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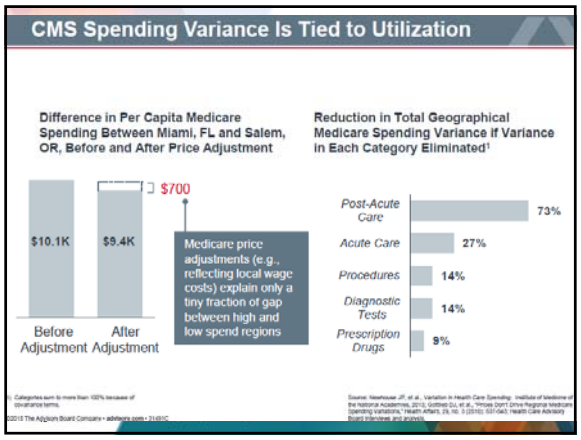
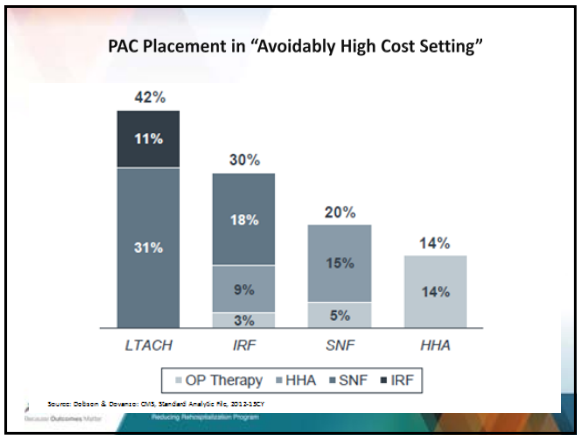
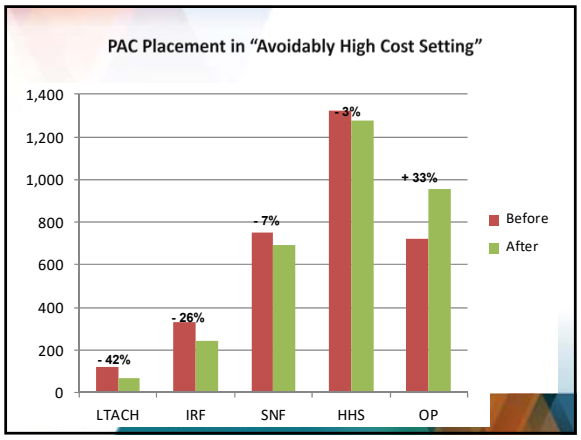
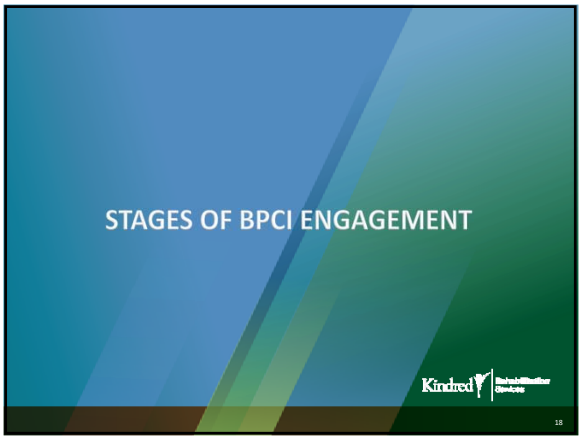

CMS Spending Variance Is Tied to Utilization
Difference in Per Capita Medicare Spending Between Miami, FL and Salem, OR, Before and After Price Adjustment
$10.1K
$9.4K
$700
Before Adjustment
After Adjustment
Medicare price adjustments (e.g., reflecting local wage costs) explain only a tiny fraction of gap between high and low spend regions
Reduction in Total Geographical Medicare Spending Variance if Variance in Each Category Eliminated[1]
Post-Acute Care
73%
Acute Care
27%
Procedures
14%
Diagnostic Tests
14%
Prescription Drugs
9%


PAC Placement in "Avoidably High Cost Setting"
42%
11%
31%
30%
18%
9%
3%
20%
15%
5%
14%
14%
LTACH
IRF
SNF
HHA
OP Therapy
HHA
SNF
IRF


PAC Placement in "Avoidably High Cost Setting"
1,400
1,200
1,000
800
600
400
200
0
- 42%
- 26%
- 7%
- 3%
+ 33%
LTACH
IRF
SNF
HHS
OP
Before
After



Stages of SNF BPCI Engagement

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?

Promise of Bundling

Scope of services to be bundled. Part A and Part B outpatient services need to be made part of the post-acute bundle to avoid cost shifting from Part A to Part B.

Duration. The 30-60-90 day period needs to vary somewhat with the type of medical condition

Method of patient assessment. The assessment is needed for post-acute placement, clinical management, outcome measurement, and case-mix adjustment for both payment and outcome.

Method of payment and gain sharing. The payment system must 1) adjust for patient case-mix to avoid cherry picking, and 2) include a significant pay-for-performance (P4P)

Selection of bundler or accountable entity. A bundled payment system implies that there is an overarching entity that 1) will be accountable for payment and outcome and 2) is prepared to share gains and losses with all provider stakeholders

Choice of quality and outcome metrics. Quality and outcome metrics (mortality, patient function, infection rates, medical complications, readmissions, discharge destination, and health-related quality of life) must be appropriate to the intervention and types of patients.

Use of case-mix adjustment. It is needed for both payment and outcome as well as to create a level playing field and avert "gaming" by payers and

PACs Adaptations to Managed & Bundled Scenarios

- Adapt to 14 to 21 ALOS depending on diagnoses (Remedy, Kaiser, Navihealth)
- Meet patient and family in acute setting prior to transfer to SNF
- Provide therapy evaluation same day as transfer (first next morning)
- Hold bedside round with family/caregiver present
- Establish DC plan from initial evaluation and communicate expectations to patient/caregiver
- Prior to SNF discharge
  - establish home compliance routine (medications, exercise, etc)
  - introduce patient/family to home health agency
  - set a primary care physician appointment for patient within 10 days
- After SNF DC,
  - Communicate with patient within 24 hours, Day 10, and Day 30
  - Follow up communication with other PAC providers (when handed off)

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PAC Strategic Response to Current Initiatives

- Bundled payment, mandatory and voluntary
- Managed care penetration
  - National trends 2017
  - GOP policy initiatives
- IMPACT ACT 2018
  - SNF readmission penalty
  - MCR expenditure 90-days post SNF
  - SNF LOS reduction
  - SNF QAPI data submission (and penalty)
- Marketing RHB Client Report metrics
  - Quality metrics become Patient/Family Education, Marketing materials & Social media opportunities
- Hospital LOS tracking initiative
- Hospital Avoidable Days Reduction strategy
  - Service line and medical condition strategies

CMS INITIATIVES

CENTER for MEDICARE & MEDICAID INNOVATION

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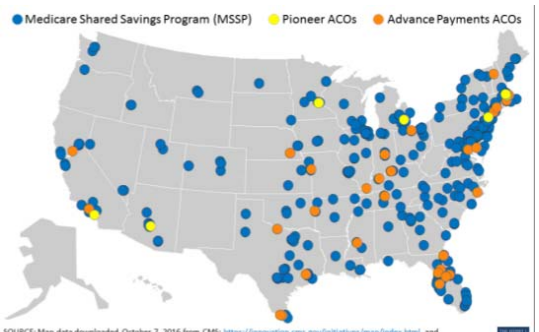
Accountable Care Organization (ACO) Models



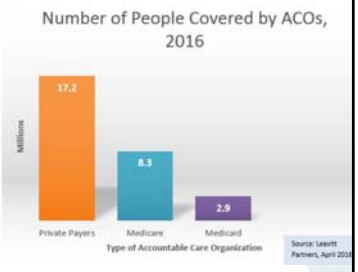
SOURCE: Map data downloaded October 7, 2016 from CMS: https://innovation.cms.gov/initiatives/map/index.html and https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/ACOs-In-Your-State.html. Participant counts in this dataset are updated periodically. See Table 3 for official counts in most recently-available CMS documents and webpages.

	Pioneer ACOs	Shared Savings Program (MSSP)	Next Generation ACO Model	Private ACOs
Summary	Medicare pilot group of advanced risk-taking organizations.	Payers and providers contractually united with Medicare to form an ACO	Medicare group with ACO experience using stronger financial incentives	Agreements between providers and private payers. Conditions vary.
Potential Participants	Advanced Risk Hospitals, Medicare	Hospitals, Physicians, Medicare	Providers with ACO experience, Medicare	Hospitals, Physicians, Private Insurers
Approx. # of ACOs	9	434	21	>200
Beneficiary Requirements	Minimum 15,000 Medicare Beneficiaries	Minimum 5,000 Medicare Beneficiaries	Minimum 10,000 Medicare beneficiaries; 7,500 for Rural ACOs	Private Insurance Beneficiaries
Financial Risk	High	Varies	Very high	Varies

Payment Reform

ACOs are being used widely by commercial payers

- Commercial ACOs cover some 17.2 million beneficiaries, more than twice as many as Medicare ACOs.[1]
- The total number of ACOs in the US is estimated at 200-300
- Seven of the ten largest ACOs in the US are commercial ACOs.[2]



1 Muhlstein D and McClellan M; "Accountable Care Organizations in 2016. Health Affairs blog April 21, 2016
2 SK&A "Top 30 ACOs" SK&A Market Insight Report 2014.

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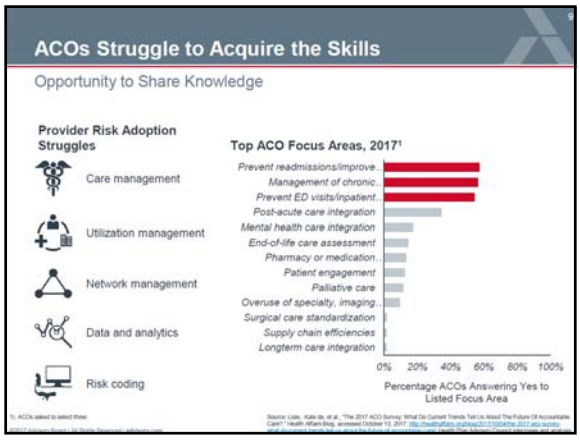
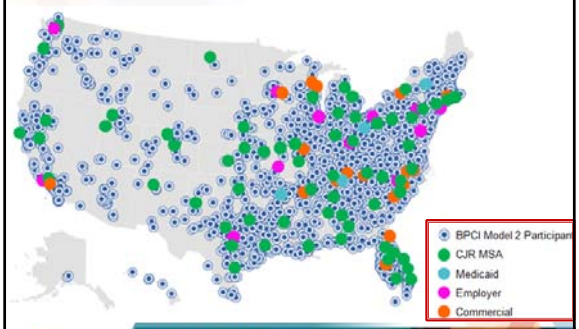


BPCI Model 2, 3 & 4

https://innovation.cms.gov/initiatives/map/index.html#model=

BPCI Model	Organization Name	City	Episodes	Notes
2	ECC Hospitalist Services	Dalton	39	Remedy Partners BPCI
2	Hospital Physician Svcs - SE Professional Corp	Tifton	1	Remedy Partners BPCI
2	Orthoatlanta, LLC	Atlanta	1	Signature
2	Peachtree Orthopaedic Clinic	Atlanta	1	Signature
2	Resurgens Orthopaedics, Professional Corp	Atlanta	3	United Surgical Partners
2	St. Mary's Health Care System	Athens	6	Remedy Partners BPCI
3	Island Health Care	Savannah	11	THA Group
3	Island Health Care	Savannah	11	THA Group
3	Lp Atlanta, LLC (dba Signature Healthcare)	Atlanta	2	Signature
3	Lp Marietta, LLC (dba Signature Healthcare)	Marietta	5	Signature
3	Tucker Investments & Associates	Tucker	3	Remedy Partners BPCI

2016 National Bundled Payments' Landscape, ~ 1,500 Organizations



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 469 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[1] episodes in the program

$343m
Estimate of episodic savings over 5 years

[1] Lower extremity joint replacement

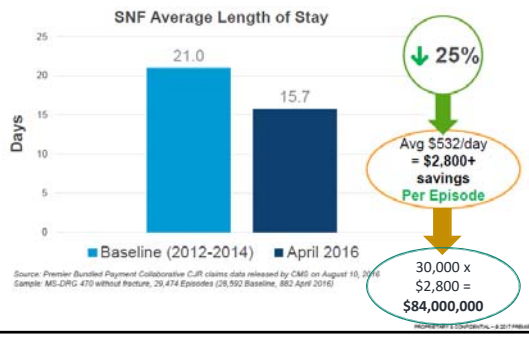
Early Observations of Success in Premier's BPC

CJR – Utilization Decreases Example

Anchor Hospitalization:
Inpatient length of stay ↓ **14%**

Post-acute Utilization:
IRF Utilization ↓ **46%**
SNF Utilization ↓ **15%**
SNF LOS ↓ **25%**

Post-Acute Length of Stay



Source: Premier Bundled Payment Collaborative CJR claims data released by CMS on August 10, 2016
Sample: MS-DRG 470 without fracture, 29,474 Episodes (28,592 Baseline, 882 April 2016)

Medicare Expenditure as Measuring Stick

- Medicare 90-day expenditures for CVA, CJR, & Hip/Femur Fracture reflect IRF cost > than SNF & HH
- Financial comparison does not reflect patient acuity or outcomes

CVA

	Total Spend	IRF	SNF	HHA	LTACH	Readmission	Physician	OP	Hospice	Other IP	DME
IRF	$39,120	$23,195	$5,637	$2,065	$168	$2,808	$3,766	$1,037	$246	$60	$137
SNF	$29,222	$688	$19,379	$1,491	$104	$3,276	$2,971	$914	$169	$150	$80
HHA	$10,692	$269	$781	$3,330	$137	$1,940	$2,083	$1,398	$599	$4	$151
LTACH	$52,416	$3,158	$11,815	$1,559	$27,370	$1,696	$4,959	$775	$835	$119	$130

CJR

	Total Spend	IRF	SNF	HHA	LTACH	Readmission	Physician	OP	Hospice	Other IP	DME
IRF	$31,860	$17,410	$3,081	$2,390	$511	$3,125	$3,917	$1,188	$37	$39	$163
SNF	$22,094	$142	$13,565	$1,757	$199	$2,373	$2,728	$1,085	$116	$31	$98
HHA	$8,512	$247	$229	$3,181	$10	$1,630	$1,594	$1,376	$37	$3	$206
LTACH	$56,031	$0	$7,903	$1,921	$36,948	$2,226	$6,358	$222	$143	$0	$309

Source: Avalere: CMS, Standard Analytic File, 2013–14 CY

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Medicare Part A Cost and Outcomes Comparing IRF vs. SNF

- 2013-2014CY PA County Medicare expenditures for 370 residents whose first PAC site was IRF or SNF
- IRF as 1st Site of Care : lower LOS than SNF (17 d vs. 27 d) with same readm rate
- IRF as 1st Site of Care over the clinical episode (90-days) : lower Readmission and Mortality Rate, longer # of days living in the community and fewer Emergency Department visits

First Post Acute Site of Care	Avg MCR Spend/ PAC Episode	First PAC Payment	Initial PAC Days	First PAC Stay Readmission	90-Day Readmit Rate	Mortality Rate	Avg Community Days	Episodes with ED Visits
IRF Average	$39,000	$21,000	17	6%	23%	3%	53	27%
SNF Average	$23,000	$13,000	27	6%	26%	24%	48	41%

=(26-23)/26
Actually a 12% advantage or gain, or 12/100 patients

Source: Dobson & Dovanzo: CMS, SAF File, 2013–14 CY

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CJR Changes and EPM Cancellation*

*Comment Period until 09/30/17

- CJR markets revised into 34 Mandatory (Memphis) and 33 Voluntary (Nashville) markets
- Non-participating market hospitals may opt-in this year
- Cancelled inclusion of femoral fractures
- Cardiac Episode Model cancelled in full
  - No program for CABG or AMI
  - No increased funding for cardiac rehabilitation services
- Total Knee Arthroplasty will become Hospital Outpatient, then Ambulatory Surgery Center eligible
  - Per case change from $12,400 to $9,900
- TKA change will reduce CJR cases as well as increase competition for post acute care providers

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Several BPCI Examples

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

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

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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

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MEDICARE ADVANTAGE

Kindred Rehabilitation Services

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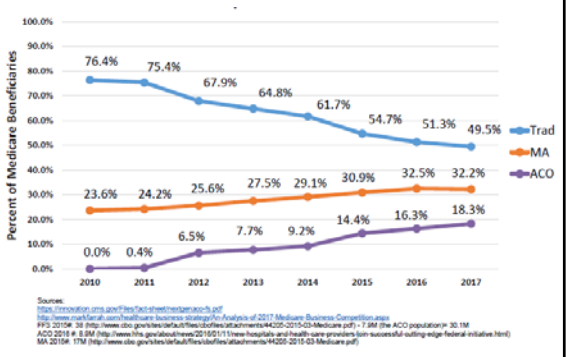
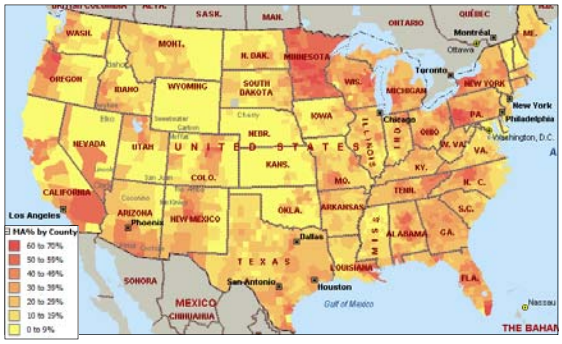
Medicare Enrollment: FFS, MAP, ACO

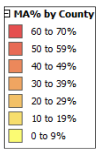


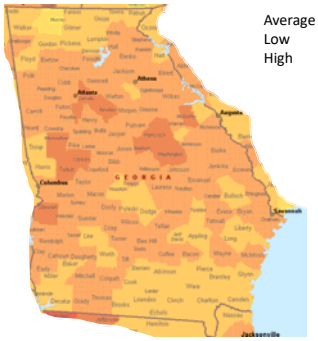
Sources:
https://innovation.cms.gov/Files/fact-sheet/medpac-ch.pdf
http://www.markfarrah.com/healthcare-business-strategy/An-Analysis-of-2017-Medicare-Business-Competition.aspx
FFS 2015E: 36 (http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205-2015-03-Medicare.pdf) - 7.9M (the ACO population)= 30.1M
ACO 2016 #: 8.8M (http://www.hhs.gov/about/news/2016/01/11/new-hospitals-and-health-care-providers-join-successful-cutting-edge-federal-initiative.html)
MA 2015E: 17M (http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205-2015-03-Medicare.pdf)

Medicare Advantage Penetration per County



Medicare Advantage Penetration per GA County





Average	33%
Low	17%
High	46%

Managed Care in GA 2017

	Total Lives	**6,912,115**
Medicare	Total	**558,143**
	HMO / POS	165,227
	PPO / PFFS	392,916
	Dual	0
Commercial	Total	**4,964,717**
	HMO / POS	2,013,603
	PPO	2,173,353
	Exchange	418,491
	Indemnity	25,127
	Tricare	334,143
Medicaid	Total	**1,389,255**
	Dual	67

Medicare Managed Care in GA 2017 CY

	Medicare		
MCO	**Total**	**HMO / POS**	**PPO / PFFS**
Grand	**507,455**	**160,952**	**346,430**
UnitedHealth Group	225,604	14,961	210,643
Humana	105,498	43,413	62,085
Aetna	72,569	3,510	69,059
WellCare	42,905	42,905	0
Kaiser Permanente	27,359	27,359	0
Cigna	25,048	25,048	0
Anthem	6,380	3,019	3,361
BlueCross BlueShield MI	782	0	782
Centene	410	410	0
UNICO Premier	226	226	0
Horizon Blue Cross Blue Shield	214	0	214
Blue Cross and Blue Shield AL	212	0	212
Eon Health	101	101	0
Health Care Service Corporation	47	0	47
Molina Healthcare	45	0	0
AmeriHealth Caritas Family	28	0	0

Managed Care in GA 2017 CY

	Commercial						Medicaid	
MCO	**Total**	**HMO / POS**	**PPO**	**Exchange**	**Indemnity**	**Tricare**	**Total**	**Dual**
Grand Total	**4,779,260**	**1,936,616**	**2,088,494**	**396,308**	**23,871**	**333,971**	**1,277,830**	**67**
Anthem	1,669,795	799,745	697,800	172,250	0	0	347,897	0
UnitedHealth Group	674,502	604,079	60,654	0	9,769	0	0	0
Aetna	617,300	93,226	514,879	0	9,195	0	0	0
Humana	536,858	184,202	13,305	5,380	0	333,971	0	0
Cigna	515,505	4,349	508,095	0	3,061	0	0	0
Kaiser Permanente	288,704	247,197	46	41,443	18	0	0	0
Centene	152,978	0	0	152,978	0	0	394,406	0
Health Care Service Corporation	143,588	11	141,814	0	1,763	0	0	0
BlueCross BlueShield SC	33,906	2,735	25,390	5,781	0	0	1,879	0
BlueCross BlueShield TN	32,611	0	32,606	5	0	0	0	0
Alliant Health	26,338	0	9,423	16,915	0	0	0	0
Government Employees Health	24,474	0	24,474	0	0	0	0	0
Premera Blue Cross	14,097	0	14,097	0	0	0	0	0
BlueCross BlueShield MA	11,516	0	11,516	0	0	0	0	0
Blue Cross and Blue Shield AL	7,554	74	5,920	1,551	9	0	0	0
APWU Health	7,523	0	7,523	0	0	0	0	0
BlueShield California	6,561	10	6,547	4	0	0	0	0
NALC Health Benefit	6,522	0	6,522	0	0	0	0	0
HealthPartners (MN)	2068	5	2063	0	0	0	0	0
SAMBA Health Benefit	1313	0	1313	0	0	0	0	0
Harvard Pilgrim Health Care	1130	26	1103	1	0	0	0	0

GOP Proposed Changes: Increase Medicare Advantage Enrollment

- 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

Cassidy – Graham Bill

Content:

- the bill gives states virtually unlimited control over federal dollars that are currently spent on marketplace subsidies and MCD expansion.
- It eliminates federal premium subsidies and by making pulls back MCD expansion. Federal monies become block grants with a per-capita limit for each enrollee.
- States will not be able to give premium subsidies to those who become eligible for such subsidies if their economic conditions change.
- Block grant funding will grow slower than the rate of healthcare cost increases.
- Grant funding growth will leave states with 34% to 50% less funding by 2026.
- States may waive certain ACA essential health benefits, thus no longer providing protections for those with preexisting conditions.

Analyst:

- LA Secretary of Health: "in its current form, the harm to Louisiana from this bill far outweighs any benefit, especially the MCD cuts."

CMS Benefit and Payment Parameters 10/17

- The Centers for Medicare and Medicaid Services (CMS) released the Notice of Benefit and Payment Parameters for 2019 proposed rule.
- CMS proposes standards for issuers and Exchanges, generally for plan years beginning on or after January 1, 2019.
- The rule is intended to increase flexibility in the individual market, improve program integrity, and reduce regulatory burdens associated with the Patient Protection and Affordable Care Act in the individual and small group markets.
- Implications:
  - "Skinny" insurance plans
  - Benefit waivers
  - Cross state issuance

GOP Proposed Changes: Mandatory Benefits Waiver (Cruz Amendment)

Ambulatory patient services - outpatient care

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.

Pediatric services - care of infants and children, including well-child visits, recommended vaccines and immunizations, dental, and vision care to children <19yo.

Maternity and newborn care

Prescription drugs - medications that are prescribed by a doctor to treat an illness.

Laboratory services

Emergency Services - trips to the emergency room

Hospitalization - treatment in the hospital for inpatient care

Mental health services and addiction treatment - inpatient and outpatient care

Rehabilitative services and devices - plans must provide 30 visits each year for PT, OT, SLP, DC, cardiac or pulmonary rehab.

STACHs' Perspective of PACs?

Save Money. Full Speed Ahead!

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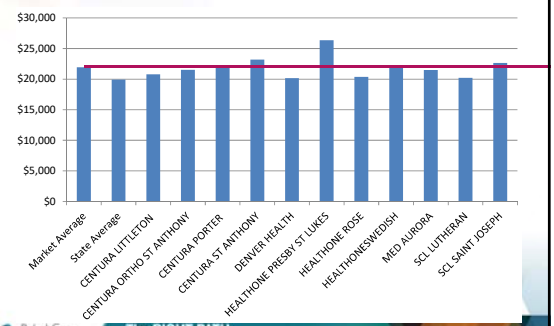
Medicare Spend per Beneficiary, 2015-16



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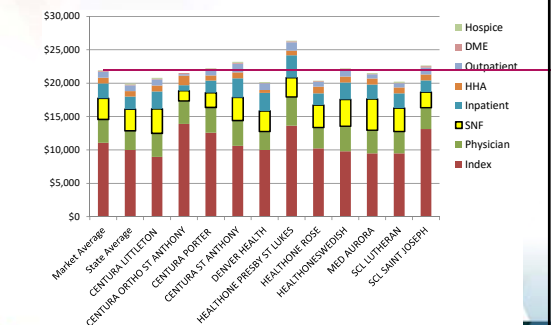
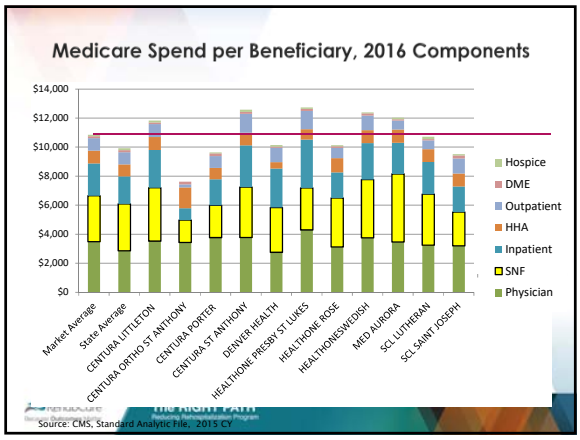
Source: CMS, Standard Analytic File, 2015 CY

Medicare Spend per Beneficiary, 2016 Components



RehabCare The RIGHT PATH

Source: CMS, Standard Analytic File, 2015 CY



SNF MCR Expenditure, Q3'15 – Q2'16

Provider	Cases	Share	ALOS	Pay/ Day or Visit	Pay/ Episode	Pay Annual
FOREST HILLS CARE CENTER	401	3%	25.0	$474	$11,840	$4,747,770
COVENANT VILLAGE OF GREEN TOWNSHIP	372	3%	25.7	$451	$11,567	$4,302,906
CHESTERWOOD VILLAGE	362	3%	21.6	$406	$8,755	$3,169,148
EASTGATE HEALTH CARE CENTER	330	2%	23.1	$438	$10,102	$3,333,738
CEDAR VILLAGE	329	2%	23.9	$434	$10,384	$3,416,307
HILLANDALE HEALTH CARE	326	2%	17.9	$425	$7,597	$2,476,670
ATLANTES THE	299	2%	21.8	$468	$10,209	$3,052,606
DRAKE CENTER INC	290	2%	15.6	$395	$6,157	$1,785,434
TRIPLE CREEK RETIREMENT COMMUNITY	280	2%	22.0	$427	$9,394	$2,630,354
WELLSPRING HEALTH CENTER	267	2%	24.8	$383	$9,499	$2,536,350
SHAWNEESPRING HEALTH CARE CENTER	261	2%	21.2	$444	$9,435	$2,462,483
OTTERBEIN LEBANON RETIREMENT COMMUNITY	259	2%	25.1	$435	$10,913	$2,826,423
HERITAGESPRING HCC WEST CHESTER	257	2%	25.3	$440	$11,143	$2,863,688
BERKELEY SQUARE RETIREMENT CEN	250	2%	24.0	$393	$9,427	$2,356,668
WESTOVER RETIREMENT COMMUNITY	241	2%	27.2	$396	$10,769	$2,595,370
HILLSPRING HEALTH CARE & REHAB	234	2%	24.8	$453	$11,243	$2,630,795
INDIANSPRING OF OAKLEY	234	2%	23.6	$440	$10,364	$2,425,174
BROOKWOOD RETIREMENT COMMUNITY	229	2%	22.1	$443	$9,769	$2,237,001
MARJORIE P LEE RETIREMENT COMMUNITY	229	2%	15.6	$411	$6,420	$1,470,290
TWIN LAKES	223	2%	16.7	$465	$7,745	$1,727,090
COURTYARD AT SEASONS	221	2%	19.2	$409	$7,869	$1,739,087
SANCTUARY POINTE NURSING & REHAB CENTER	218	2%	22.2	$441	$9,772	$2,130,195
HILLEBRAND NURSING AND REHAB CENTER	217	2%	24.8	$441	$10,918	$2,369,307
MOUNT PLEASANT RETIREMENT VILLAGE	217	2%	25.6	$388	$9,924	$2,153,597
MCV HEALTH CARE FACILITIES	197	1%	22.6	$411	$9,279	$1,828,021

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, 2016

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

Range Lo to Hi 13 16 **Range Lo to Hi 9 11**

** Items included in HRRP

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

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"You'll be discharged quickly after surgery and placed in our mobile recovery unit: a taxi home."

Discharge Placement Options: CJR Final Rule

Hospitals may

- Include objective data (e.g. Nursing Home Compare) on facility lists distributed a 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

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Friends and Families Need to Know What YOU Know

- Never spend the night alone in a hospital
  - Medical and procedure errors are much too rampant
- Always have a designated family/caregiver for medical communications
  - Create a list of questions and ask them of all your doctors, nurses and therapists. You constantly ask, "What is recovery course from this point?"
- "We will keep you for Observation" is not the same as "Hospital Admission"
  - "Observation" status places places the patient in a less intensely focused status and places more financial responsibility on patient than Medicare
- Traditional Medicare benefits remain intact
  - Patient Care Laws remain intact
  - Right to make care and placement choices remain with the patient
  - Discharge planning includes the patient and family/caregivers
  - Bundle and MAP financial preferences do NOT take precedence over the Medicare beneficiaries rightful benefits
- Maximize coordination with clinical pharmacists to reconcile medications and avoid polypharmacy confusion

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PACs' Strategic Options

Boldly tread new ground!

Kindred

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Successful Post Acute Providers MUST:

- Become partners not vendors for referral sources (payers, physicians, hospitals)
- Partner with other providers to control the 90-day period: financially, clinically, and patient care experience
- Connect in new data driven communication with referral sources, patients and caregivers
- Re-engineer therapy services for efficiency, effectiveness, and cost reduction
- Build data metrics for accuracy, transparency, and meaningfulness in communications, social and financial

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PACs Must:

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

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Successful Post Acute Providers MUST:

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Partnership Not Vendor

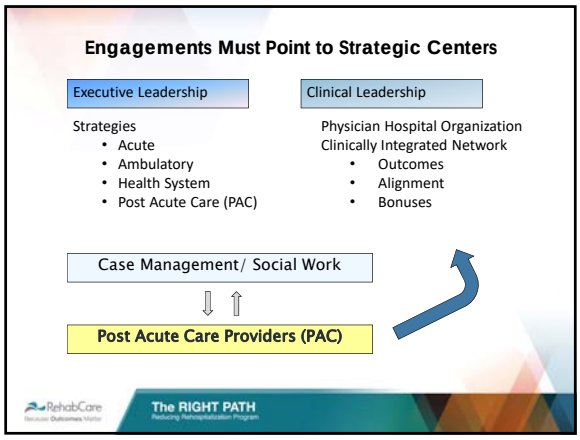
- Shift the control from hospital to physicians and post acute partners
- Based on capabilities and culture
- Emphasize quality metrics in the market
  - Patient-centric versus operational measures
  - Prefer: patient recovery, satisfaction, and caregiver safety
  - Not forgetting: readmission, LOS, ER visits, or
- Control spending!
  - Medicare FFS spend
  - Medicare Advantage and Commercial contracting
- Confidence for the positive impact on patients and families
- Survivability

PACs MUST Plan for IMPACT, Managed & Bundled Scenarios

- Adapt to 14 to 21 ALOS depending on diagnoses (Remedy, Kaiser, Navihealth)
- Meet patient and family in acute setting prior to transfer to SNF
- Provide therapy evaluation same day as transfer (first next morning)
- Hold bedside round with family/caregiver present
- Establish DC plan from initial evaluation and communicate expectations to patient/caregiver
- Prior to SNF discharge
  - establish home compliance routine (medications, exercise, etc)
  - introduce patient/family to home health agency
  - set a primary care physician appointment for patient within 10 days
- After SNF DC,
  - Communicate with patient within 24 hours, Day 10, and Day 30
  - Follow up communication with other PAC providers (when handed off)

PACs Must Gain Expertise & Efficiency Providing:

- **Readmission reduction**
  - Collaborative discharge process
  - Care transition programs
  - Protocols and guidance for PAC sequence and outcomes tracking
  - Increase focus on optimal return to home or lowest cost setting
- **PAC collaboration**
  - Continuum collaboration: SNF, IRF, LTACH, HHS, ALF-ILF, Hospice & palliative
  - Prepare for Joint Operating Committee (Acute and PAC Collaboration)
  - Enhanced physician education & focus (attentiveness)
- **Accepting clinical and financial management of patient risk as part of the hospital's acute AND post acute care (PAC) strategy**
- **Shifting focus from Acute dominance to PAC shared responsibility**
  - PAC risk assessment
  - Reduce PAC loss risk



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

FUNCTIONAL MEASURE and DISCHARGE IMPACT					
01 Dependent	02 Substantial/ Maximal Assistance >50%	03 Partial/Moderate Assistance <50%	04 Supervision or Touching Assistance	05 Set-Up or Clean Up Assistance	06 Independent
Advised Caregiver Support: Full time skilled nursing care	Advised Caregiver Support: Full Time caregiver; providing physical assistance with all BADL's		Advised Caregiver Support: Partial caregiver; supervision or oversight with most BADL's		Advised Caregiver Support: Home alone; occasional assistance with IADL's
HIGH RISK READMISSION	HIGH RISK READMISSION		MODERATE RISK READMISSION		LOW RISK READMISSION
Discharge to Facility	*Remain in Skilled Facility or Discharge home dependently with Home Health Care*		*Discharge home with Home Health Care*		*Discharge home with Outpatient Therapy*

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Functional Recovery – Readmission Conditions

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

01 Dependent	02 Substantial/ Maximal Assistance >50%	03 Partial/Moderate Assistance <50%	04 Supervision or Touching Assistance	05 Set-Up or Clean Up Assistance	06 Independent

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Referral Sources and Acute ALOS, 12 months

	Adam	Baker	Charles	Daniel	Edward	Frank	George	Harry	Total
Total	**86**	**29**	**50**	**62**	**41**	**202**	**82**	**60**	**612**
Olathe Medical	48	5	36	22	10	31	5	7	163
Via Christi St Francis					19	91			110
Wesley MC						74			74
Mosaic		5						48	53
Shawnee Mission							38		38
SNF	5		10	19					34
KUMC	5	2		5			10	2	24
Lawrence Memorial	19						2		22
Ransom Memorial	2			14					17
Hiawatha Hospital		12							12
Overland Park Rgnl	2						10		12
Home	2			2			2	2	10
12 OTHER	26	17	5	17	12	5	29	2	113

	Adam	Baker	Charles	Daniel	Edward	Frank	George	Harry	Total
Total	**18.1**	**25.9**	**21.2**	**18.5**	**29.3**	**19.4**	**18.4**	**25.6**	**20.7**
Olathe Medical	16.8	21.0	23.7	15.2	27.0	14.3	15.0	28.3	18.2
Via Christi St Francis					28.6	21.3			22.6
Wesley MC						18.5			18.5
Mosaic		22.5						27.0	26.6
Shawnee Mission							18.7		18.7
SNF	6.5		20.3	19.3					17.7
KUMC	38.0	55.0		17.5			16.8	1.0	23.4
Lawrence Memorial	20.9						24.0		21.2
Ransom Memorial	19.0			20.7					20.4
Hiawatha Hospital		20.8							20.8
Overland Park Rgnl	18.0						18.5		18.4
Home	15.0			30.0			17.0	15.0	19.3
12 Other	19.2	29.8	22.0	20.5	27.8	18.0	18.3	17.8	20.5

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

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PAC Collaboration – Progressive Agenda

- Current experiences within the BPCI
  - ✓ Problems experienced
  - ✓ Measurement (quantifiable metrics)
  - ✓ Solutions to recommend
- Community updates
  - ✓ Post Acute Provider AND Hospital/health system news
  - ✓ Physician realignments 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, program library (best practice, documentation, implementation)

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Episodic Accountability

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Post Discharge Telephone Contacts

The IMPACT ACT's January 2018 requirement for SNFs to be all the more responsible for readmission to avoid penalty reductions.

SNFs across the country may benefit by access to a call protocol or call center. SNF will want at least three post-discharge contacts in a 30 day period.

The calls may be easily scripted:

- Prior to D'C inform the patient and family about the purpose, process and script.
- Day 2-3: general check-in that patient remains home, prescriptions filled, exercise regime and safety precautions practiced, contact made with home health, and primary, health provider appointment remains scheduled.
- Day 7-10: confirming all is well AND that patient kept appointment with primary health care professional
- Day 29-30: confirming all is well, and patient has not experienced ER visits or hospital readmissions

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2 Ways to Extend Accountability

Leverage the Preoperative Period and Inpatient Stay

- Clinical interventions
- Psychosocial interventions
- Education
- Engagement

Develop Community-Based Programs and Partnerships for Vulnerable Patients

- Chronic disease and multiple comorbidities
- Frail and elderly
- Unstable housing
- Low income
- Complex behavior health issues

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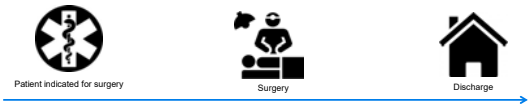

Clinical Interventions

Identify and work to mitigate clinical risks factors prior to surgery.

Psychosocial Interventions

Proactively prepare the post-discharge setting and preempt post-discharge needs before and during the inpatient stay.

Education

Provide educational materials and training for patients and caregivers during the preoperative period, for use throughout the inpatient stay and post-discharge.

Engagement

Activate and empower patients to confidently manage their own health and access additional resources and support as needed, through the inpatient setting and beyond.

Develop Community Based Programs for the Vulnerable

Chronic Disease and Multiple Comorbidities

Unstable Housing

Frail Elderly

Complex Behavioral Health Issues

Low-Income

Telehealth and Social Media (Online)

- Texas Mulls Telemedicine Coverage for Worker Compensation
- New Rules will give VA Physicians National Telehealth Privileges
- Telehealth as a Means of Health Care Delivery for Physical Therapist Practice (APTA 2012)
- How Can PTs Use Telehealth? (WebPT 2017)

Why engage:

- Boost therapy online reviews
- Improve therapies' online reputation
- Offer more patient and caregiver communication options
- Provide better patient and caregiver education options
- Engage patients and caregivers through social media

For Your Sunday Consideration

"Good News Section"

Institute for Healthcare Improvement
Alliance Leadership

We share generously with one another, confident that by sharing and learning together, we can individually and collectively get better, faster.

Michigan ACHCA / Webinar Series

Michigan Chapter of ACHCA

July 20, 2017- 11am - 12 pm

Care Re-Design: Opportunity, Reward, Risk

- Attendees will recognize opportunities to deliver quality care through development of **innovative partnerships along the care continuum**, and understand **the benefits of such collaborations** for patients they serve.
- Innovators will be challenged to "think outside the box", consider the changes in reimbursement, and appreciate how **active participation in care re-design** will support key performance metrics to build/sustain market share.
- Participants will identify the principle risks associated with operational/regulatory compliance concerns, as well as the key areas of recent OIG/DOJ anticipated actions.

The Beatitudes from Book of Matthew

He said:
3 "Blessed are the poor in spirit,
for theirs is the kingdom of heaven.
4 Blessed are those who mourn,
for they will be comforted.
5 Blessed are the meek,
for they will inherit the earth.
6 Blessed are those who hunger and thirst for righteousness,
for they will be filled.
7 Blessed are the merciful,
for they will be shown mercy.
8 Blessed are the pure in heart,
for they will see God.
9 Blessed are the peacemakers,
for they will be called children of God.
10 Blessed are those who are persecuted because of righteousness,
for theirs is the kingdom of heaven.

Common Book of Prayer

Standing on the parted shores of history
we will believe what we were taught
before ever we stood at Sinai's foot;

that wherever we go, it is eternally Egypt
that there is a better place, a promised land;
that the winding way to that promise
passes through the wilderness.

That there is no way to get from here to there
except by joining hands, marching
together.