CMS'S NEW EPISODE PAYMENT MODELS

UNDERSTANDING THE POLICY, OPERATIONAL AND FINANCIAL OPPORTUNITIES

James Muller, Senior Director of Research, AHCA
Marinela Shqina, CFO, Manchester Manor and Vernon Manor

AHCA
AMERICAN HEALTH CARE ASSOCIATION

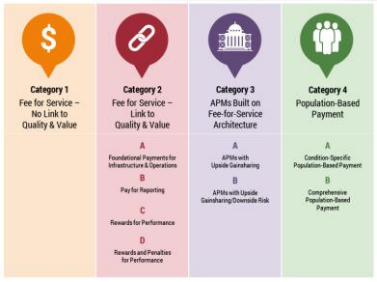
Today's presentation

- Structure:
  - Part 1: The policy, and care/cost patterns
  - Part 2: Prescribed business strategy & opportunities
- Questions to ask ourselves as we go through this training:
  - What is the post-acute comparative advantage for SNFs, and hence the best approach for your organizational positioning?

Part 1: The policy, and care/cost patterns

What is CMS doing?

- CMS's strategic direction for Medicare payments



What is CMS doing?

- BPCI extends to CJR…
  - Which expands to another orthopedic bundle
  - And a heart attack bundle
  - And a bypass surgery bundle
- And very likely a second round of BPCI
  - Unless superseded by something sexier
- And *certainly* a full move to episode models in the future

What is CMS doing?

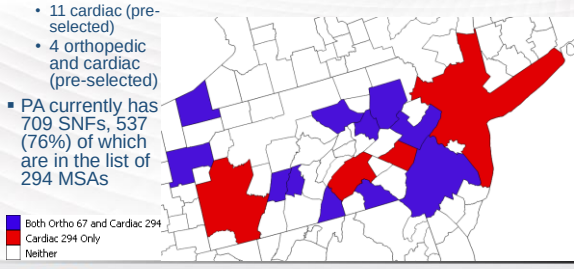
- All of these are intermediate steps
  - To set the stage for a later complete transition to population health models (i.e., a capitated system)
- At Federal HHS level, this has *full* dedicated staff support
  - A philosophical movement exceedingly unlikely to pivot
- Which means the SNF sector has a new evolutionary dynamic
  - Natural selection based on organizational approach

What is CMS doing?

- Added CJR (hip/knee replacements) in April 2016
- In July 2017
  - Adding SHFFT (hip/femur fractures w/o joint replacement) to traditional CJR in the original 67 markets
  - Adding new bundles, AMI (heart attacks) and CABG (bypass surgery) in one third (98) of 294 proposed markets

What is CMS doing – specific to PA?

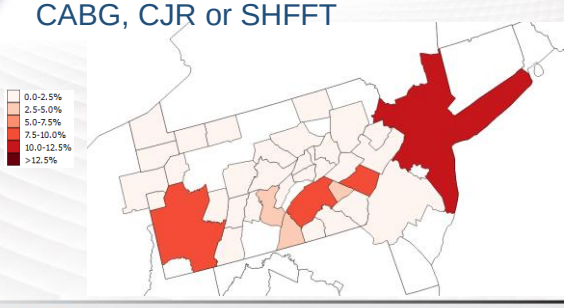
- Of PA's 36 CBSAs:
  - 11 cardiac (pre-selected)
  - 4 orthopedic and cardiac (pre-selected)
- PA currently has 709 SNFs, 537 (76%) of which are in the list of 294 MSAs



How will CJR/EPMs impact PA SNFs?

- If you receive a CJR, SHFFT, AMI or CABG case
  - from a hospital in one of these markets,
    - you are in the policy.
      - ✓ *Even if you're not in one of the markets yourself*
      - ✓ *Means the hospital "sees" you in this new light anyway*
- Many PA markets in the policy
  - Many SNFs outside the markets receive patients from hospitals in the markets
- >25% of PA SNFs likely have revenue "exposed" to the policy
- **Bigger factor is:**
  - **Hospital behavior is converging to controlling costs of post-discharge episodic payments**

PA's SNF total FY2014 Medicare A revenue within the EPMs: AMI, CABG, CJR or SHFFT



PA SNFs' most exposed markets (≥1% of FY2014 SNF-PPS revenue)

		Total FY2014 SNF Revenue Exposed to EPMs				
Market	Inclusion	Total	CJR	SHFFT	AMI	CABG
New York-Newark-Jersey City, NY-NJ-PA Metro Area	Both	10.8%	4.9%	4.5%	1.1%	0.3%
Pittsburgh, PA Metro Area	Both	9.8%	4.2%	4.1%	1.4%	0.2%
Harrisburg-Carlisle, PA Metro Area	Both	9.3%	5.0%	3.1%	1.1%	0.1%
Reading, PA Metro Area	Both	9.2%	4.2%	3.5%	1.0%	0.5%
Chambersburg-Waynesboro, PA Metro Area	Cardiac 294	4.0%	0.4%	0.9%	2.7%	0.1%
Huntingdon, PA Micro Area	Neither	3.8%	0.1%	0.4%	3.2%	0.0%
Lebanon, PA Metro Area	Neither	3.6%	1.4%	1.8%	0.4%	0.0%
Somerset, PA Micro Area	Neither	2.4%	0.0%	0.0%	1.8%	0.5%
Youngstown-Warren-Boardman, OH-PA Metro Area	Cardiac 294	2.2%	0.3%	0.2%	1.6%	0.1%
Erie, PA Metro Area	Cardiac 294	2.2%	0.1%	0.0%	1.7%	0.3%
Altoona, PA Metro Area	Cardiac 294	2.1%	0.1%	0.0%	1.8%	0.2%
Pottsville, PA Micro Area	Neither	2.1%	0.5%	0.6%	1.0%	0.0%
Johnstown, PA Metro Area	Cardiac 294	1.9%	0.1%	0.0%	1.5%	0.3%
Gettysburg, PA Metro Area	Neither	1.8%	0.2%	0.0%	1.0%	0.5%
Rural PA	Neither	1.6%	0.4%	0.6%	0.4%	0.2%
Oil City, PA Micro Area	Neither	1.6%	0.2%	0.0%	1.0%	0.4%
Scranton--Wilkes-Barre--Hazleton, PA Metro Area	Cardiac 294	1.5%	0.0%	0.0%	1.2%	0.2%
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD Metro Area	Cardiac 294	1.5%	0.0%	0.1%	1.1%	0.3%
Indiana, PA Micro Area	Neither	1.4%	0.6%	0.0%	0.8%	0.0%
York-Hanover, PA Metro Area	Cardiac 294	1.3%	0.0%	0.1%	1.1%	0.2%
Williamsport, PA Metro Area	Cardiac 294	1.2%	0.0%	0.0%	1.2%	0.1%
Bloomsburg-Berwick, PA Metro Area	Cardiac 294	1.2%	0.0%	0.0%	1.0%	0.1%
Allentown-Bethlehem-Easton, PA-NJ Metro Area	Cardiac 294	1.1%	0.0%	0.1%	0.8%	0.2%

Exactly how do EPMs work?

- Two orthopedic episodes, and two cardiac episodes
  - Lower extremity replacement (CJR), w/o replacement (SHFFT)
  - Heart attacks (AMI), and bypass surgery (CABG)
- CMS has chosen
  - 67 markets for orthopedic, and
  - will choose 98 of 294 markets cardiac
- Mandatory participation for hospitals within these markets,
  - Except if they are BPCI participants in a conflicting BPCI model

Exactly how do EPMs work?

- Medicare Part A acute hospitalization in chosen markets for CJR/SHFFT/AMI/CABG
  - All services during the "anchor hospitalization" and the 90 days post-discharge are included
- "Target prices" are then calculated based on historical Medicare claims
  - Different target prices by DRG and other factors
  - Target prices decreased ("discounted") based on quality
  - Savings below target price paid back to hospital; costs above owed back to CMS

Exactly how do EPMs work?

- Hospitals can waive 3-day stay requirement if they send patient to SNF ≥ 3 stars for 7 of last 12 months
  - Being < 3 Stars puts SNFs at a disadvantage to maintain higher occupancy
- SNFs will still get reimbursed on Fee-for-Service, however, not meeting the hospital's cost requirements under episodic payments will deny patient referral to the facility
  - Main business lever for hospitals is *referral networks*
  - That is, *your access to their discharges*

Timelines and parameters? CJR

		Stop Loss/Gain Limits			CY2016				CY2017				CY2018				CY2019				CY2020				CY2021				CY2022			
		Loss		Gain	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Program Life	Risk	Most	Rural*	All																											
1st Performance Period	**Upside**	**0%**	**0%**	**5%**																											
1st reconciliation																															
2nd reconciliation																															
2nd Performance Year	**2-sided**	**5%**	**3%**	**5%**																											
1st reconciliation																															
2nd reconciliation																															
3rd Performance Year	**2-sided**	**10%**	**5%**	**10%**																											
1st reconciliation																															
2nd reconciliation																															
4th Performance Year	**2-sided**	**20%**	**5%**	**20%**																											
1st reconciliation																															
2nd reconciliation																															
5th Performance Year	**2-sided**	**20%**	**5%**	**20%**																											
1st reconciliation																															
2nd reconciliation																															

** Includes rural hospitals, sole community hospitals, Medicare-dependent hospitals and rural referral centers*

Timelines and parameters? New EPMs

Program Life	Risk	Discount Percentage: Worst	Discount Percentage: Best	Stop Loss/Gain Limits: Loss: Most	Stop Loss/Gain Limits: Loss: Rural*	Stop Loss/Gain Limits: Gain: All	Benchmark Data: Hspl	Benchmark Data: Region	CY2017 Q1 Q2 Q3 Q4	CY2018 Q1 Q2 Q3 Q4	CY2019 Q1 Q2 Q3 Q4	CY2020 Q1 Q2 Q3 Q4	CY2021 Q1 Q2 Q3 Q4	CY2022 Q1 Q2 Q3 Q4	CY2023 Q1 Q2 Q3 Q4
1st Performance Period	**Upside**	Not Applied		**0%**	**0%**	**5%**	**66%**	**33%**							
1st reconciliation															
2nd reconciliation															
2nd Performance Year	**2-sided**	2.0%	0.5%	**5%**	**3%**	**5%**	**66%**	**33%**							
1st reconciliation															
2nd reconciliation															
3rd Performance Year	**2-sided**	2.0%	0.5%	**10%**	**5%**	**10%**	**33%**	**66%**							
1st reconciliation															
2nd reconciliation															
4th Performance Year	**2-sided**	3.0%	1.5%	**20%**	**5%**	**20%**	**0%**	**100%**							
1st reconciliation															
2nd reconciliation															
5th Performance Year	**2-sided**	3.0%	1.5%	**20%**	**5%**	**20%**	**0%**	**100%**							
1st reconciliation															
2nd reconciliation															

** Includes rural hospitals, sole community hospitals, Medicare-dependent hospitals and rural referral centers*

Total episode cost progression as complexity increases

	Not Transfer Case			Transfer Case		
	w/o CC/MCC	w/CC	w/MCC	w/o CC/MCC	w/CC	w/MCC
AMI/PCI episodes						
AMI, discharged alive	$ 16,489	$ 22,701	$ 33,439	$ 42,346	$ 45,717	$ 63,720
PCI w/ drug-eluting stent	$ 22,477	n/a	$ 37,368	$ 35,595	n/a	$ 63,066
PCI w/ non-drug-eluting stent	$ 23,688	n/a	$ 39,116	$ 41,927	n/a	$ 68,779
PCI w/o stent	$ 25,260	n/a	$ 39,360	*	n/a	*
AMI transferring to CABG w/ PTCA	n/a	n/a	n/a	*	n/a	*
AMI transferring to CABG w/ cardiac catheter	n/a	n/a	n/a	*	n/a	*
AMI transferring to CABG w/o cardiac catheter	n/a	n/a	n/a	*	n/a	*
CABG Episodes						
CABG w/ PTCA	$ 56,141	n/a	$ 81,222	n/a	n/a	n/a
CABG w/ cardiac catheter	$ 47,253	n/a	$ 73,243	n/a	n/a	n/a
CABG w/o cardiac catheter	$ 39,410	n/a	$ 62,849	n/a	n/a	n/a
CJR Episodes						
LEJR w/ hip fracture	$ 61,427	n/a	$ 46,814	n/a	n/a	n/a
LEJR w/o hip fracture	$ 43,562	n/a	$ 26,187	n/a	n/a	n/a
SHFT Episodes						
Hip/Femur fracture w/o replacement	$ 41,049	$ 49,184	$ 62,244	n/a	n/a	n/a

SNF cost behavior as complexity increases

	Not Transfer Case			Transfer Case		
	w/o CC/MCC	w/CC	w/MCC	w/o CC/MCC	w/CC	w/MCC
AMI/PCI episodes						
AMI, discharged alive	$ 1,737	$ 3,634	$ 6,170	$ 2,853	$ 4,853	$ 6,853
PCI w/ drug-eluting stent	$ 560	n/a	$ 2,300	$ 1,890	n/a	$ 4,550
PCI w/ non-drug-eluting stent	$ 1,102	n/a	$ 3,554	$ 3,645	n/a	$ 5,031
PCI w/o stent	$ 1,113	n/a	$ 2,933	$ 2,448	n/a	$ 5,847
AMI transferring to CABG w/ PTCA	n/a	n/a	n/a	$ 4,438	n/a	$ 5,675
AMI transferring to CABG w/ cardiac catheter	n/a	n/a	n/a	$ 2,641	n/a	$ 8,053
AMI transferring to CABG w/o cardiac catheter	n/a	n/a	n/a	$ 3,165	n/a	$ 6,038
CABG Episodes						
CABG w/ PTCA	$ 1,947	n/a	$ 3,978	n/a	n/a	n/a
CABG w/ cardiac catheter	$ 2,059	n/a	$ 4,323	n/a	n/a	n/a
CABG w/o cardiac catheter	$ 1,546	n/a	$ 3,636	n/a	n/a	n/a
CJR Episodes						
LEJR w/ hip fracture	$ 8,063	n/a	$ 20,726	n/a	n/a	n/a
LEJR w/o hip fracture	$ 3,672	n/a	$ 16,517	n/a	n/a	n/a
SHFT Episodes						
Hip/Femur fracture w/o replacement	$ 15,966	$ 20,520	$ 23,569	n/a	n/a	n/a

What will hospitals read into the data?

- You need to know and understand your data
  - Measure and perform
- Some hospitals will analyze your data and make anything of it
  - Some hospitals will be informed and have good intelligence about the dynamics and reasoning behind SNFs' higher cost
  - Some will look at aggregate patterns of cost and misperceive:
    - ✓ A highly complicated referral that contributed to very high cost overall
    - ✓ Rather than a deliberate choice of hospitals sending patients to SNFs for complex care
- **Your job is to become familiar with your data so you can articulate to the hospitals how you bring value to the post acute partnership**

SNF % of total episode costs with episode complexity

	Not Transfer Case			Transfer Case		
	w/o CC/MCC	w/CC	w/MCC	w/o CC/MCC	w/CC	w/MCC
AMI/PCI episodes						
AMI, discharged alive	11%	16%	18%	7%	11%	11%
PCI w/ drug-eluting stent	2%	n/a	6%	5%	n/a	7%
PCI w/ non-drug-eluting stent	5%	n/a	9%	9%	n/a	7%
PCI w/o stent	4%	n/a	7%	*	n/a	*
AMI transferring to CABG w/ PTCA	n/a	n/a	n/a	*	n/a	*
AMI transferring to CABG w/ cardiac catheter	n/a	n/a	n/a	*	n/a	*
AMI transferring to CABG w/o cardiac catheter	n/a	n/a	n/a	*	n/a	*
CABG Episodes						
CABG w/ PTCA	3%	n/a	5%	n/a	n/a	n/a
CABG w/ cardiac catheter	4%	n/a	6%	n/a	n/a	n/a
CABG w/o cardiac catheter	4%	n/a	6%	n/a	n/a	n/a
CJR Episodes						
LEJR w/ hip fracture	13%	n/a	44%	n/a	n/a	n/a
LEJR w/o hip fracture	8%	n/a	63%	n/a	n/a	n/a
SHFT Episodes						
Hip/Femur fracture w/o replacement	39%	42%	38%	n/a	n/a	n/a

Percent of episodes first referred to SNFs

- And how did hospitals historically refer to SNFs for different complexities of case?

	Not Transfer Case			Transfer Case		
	w/o CC/MCC	w/CC	w/MCC	w/o CC/MCC	w/CC	w/MCC
AMI/PCI episodes						
AMI, discharged alive	8%	15%	28%	14%	19%	27%
PCI w/ drug-eluting stent	3%	n/a	12%	8%	n/a	18%
PCI w/ non-drug-eluting stent	6%	n/a	19%	13%	n/a	18%
PCI w/o stent	5%	n/a	15%	12%	n/a	21%
AMI transferring to CABG w/ PTCA	n/a	n/a	n/a	*	n/a	*
AMI transferring to CABG w/ cardiac catheter	n/a	n/a	n/a	24%	n/a	46%
AMI transferring to CABG w/o cardiac catheter	n/a	n/a	n/a	24%	n/a	35%
CABG Episodes						
CABG w/ PTCA	15%	n/a	26%	n/a	n/a	n/a
CABG w/ cardiac catheter	17%	n/a	27%	n/a	n/a	n/a
CABG w/o cardiac catheter	14%	n/a	23%	n/a	n/a	n/a
CJR Episodes						
LEJR w/ hip fracture	66%	n/a	70%	n/a	n/a	n/a
LEJR w/o hip fracture	33%	n/a	49%	n/a	n/a	n/a
SHFT Episodes						
Hip/Femur fracture w/o replacement	60%	69%	72%	n/a	n/a	n/a

Percent of episodes first referred to SNFs

- Traditional business lines: orthopedic rehabilitation
- But also increasing focus on complex rehab of cardiac recovery cases
- Now to conclude with the HHA episodic referrals…

Episodes referred to home health…

- Do you see how the Home Health referral patterns from the episodes differ?

	Not Transfer Case			Transfer Case		
	w/o CC/MCC	w/CC	w/MCC	w/o CC/MCC	w/CC	w/MCC
AMI/PCI episodes						
AMI, discharged alive	13%	17%	23%	23%	28%	34%
PCI w/ drug-eluting stent	8%	n/a	18%	16%	n/a	32%
PCI w/ non-drug-eluting stent	11%	n/a	20%	23%	n/a	38%
PCI w/o stent	9%	n/a	20%	23%	n/a	38%
AMI transferring to CABG w/ PTCA	n/a	n/a	n/a	*	n/a	
AMI transferring to CABG w/ cardiac catheter	n/a	n/a	n/a	52%	n/a	37%
AMI transferring to CABG w/o cardiac catheter	n/a	n/a	n/a	45%	n/a	42%
CABG Episodes						
CABG w/ PTCA	44%	n/a	30%	n/a	n/a	n/a
CABG w/ cardiac catheter	41%	n/a	34%	n/a	n/a	n/a
CABG w/o cardiac catheter	40%	n/a	35%	n/a	n/a	n/a
CJR Episodes						
LEJR w/ hip fracture	7%	n/a	4%	n/a	n/a	n/a
LEJR w/o hip fracture	44%	n/a	25%	n/a	n/a	n/a
SHFFT Episodes						
Hip/Femur fracture w/o replacement	12%	6%	4%	n/a	n/a	n/a

- For everybody except heart attack and PCI patients without transfers or later bypass surgery…
  - As complexity increases, SNFs take over and HHAs step back.
- This *is speciation of SNFs for more complex medical needs*, and HHAs for straight forward cases.

Part 2: Prescribed business strategy & opportunities

Financially broke, time for something new

- CJR, EPMs, BPCI, ACOs, all forms of Alternative Payments (APMs) attempt to:
  - Decrease Medicare spending while increasing quality
    - Which can be achieved by paying providers for performance or penalizing for underperformance
      - ✓ Which can lead to aggressive competition in the healthcare market as we scramble to define quality
        - And real competition requires real change

"What if we don't change at all ... and something magical just happens."

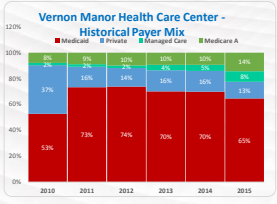
Preparing for change

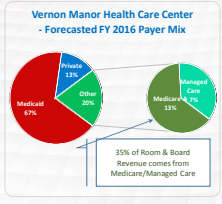
- In order for hospitals to be in an upside gain position under CJR/EPMs, they need to reduce costs while improving quality
  - Which can be achieved through careful selection of downstream providers
    - Whose performance will be measured through the following key metrics
      - ✓ Post Acute or Medicare LOS
      - ✓ Readmission Rate (beyond 30 days)
      - ✓ 5-Star

Our incentives to change

- Increased volume of admissions through Preferred Provider Networks (PPN) partnerships as well as 3-day stay waiver
  - Some hospitals may carve out special PPN shortlists for CJR/EPM
  - Others will look at total PAC population metrics in making PPN selections
- Opportunity to receive gain sharing incentives from acute care providers

Why We Need Post Acute Referrals…





How You Do It: Portfolio of Strategies

- Six key elements in the portfolio:
  - SNF length of stay
  - SNF rehospitalization rate
  - Keep your Five Star rating ≥3 stars for 7 of last 12 months
  - Manage the hospital's CJR/EPM quality measures
  - Be the competent care coordinator
  - Leverage participation in Model 3 BPCI

Element #1
Manage hospital requirements for shorter LOS

- Educate Hospital to stop telling patients SNF will get patient back to baseline level of functioning as this should be the task of the HHA
- SNF gets patients to a functional status which permits safe discharge. HHA can get patients back to prior level of functioning

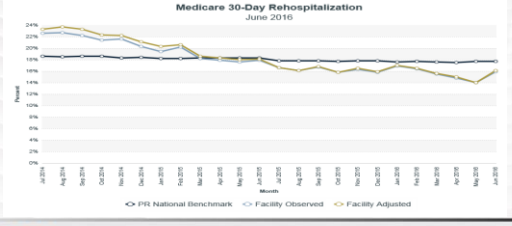
Acute Myocardial Infarction

The DRGs	Goal ELOS
Acute Myocardial Infarction, Disease/Discharged Alive w/ MCC (280), Acute Myocardial Infarction, Disease/Discharged Alive w/ CC (281), Acute Myocardial Infarction, Disease/Discharged Alive w/o CC/MCC (282)	12 – 15 Days*

Discharge Planning Goals	Functional Goals
Home Health Evaluation	PT Evaluation
Social Work Referral	Patient will be able to ambulate and transfer without Chest Pain or Shortness of Breath

Element #2
Minimize Your Rehospitalization Rates

- Rehospitalizations is seen as the main measure of cost paired with quality
- Concrete example: Manchester Manor PointRight® Pro 30™:



Element #3
Manage Your Five Star Rating

- Use the strategy of practicing the survey process continually through the year, before you are surveyed
  - E.g., Abaqis, etc.
- Work towards RN and overall direct care staffing rating ≥4 stars
- Work towards quality rating at 5 stars
  - Comprehensive QA/PI

Element #4
Manage the Hospital's Quality Measures

- Hospital target prices are higher for better quality and almost all of them can be affected by a SNF stay

Program and Quality Measure	Reference Period	SNF Opportunity
CJR		
Complications following elective hip/knee replacement:		
1) Mechanical complications - 90 days	90 days post-hospitalization	Yes
2) Wound infection/Periprosthetic joint infection (PJI) - 90 days	90 days post-hospitalization	Yes
3) Surgical site bleeding - 30 days	30 days post-hospitalization	Yes
4) Pulmonary embolism - 30 days	30 days post-hospitalization	Yes
5) Death - 30 days	30 days post-hospitalization	Yes
6) AMI - 7 days	7 days post-hospitalization	Yes
7) Pneumonia - 7 days	7 days post-hospitalization	Yes
8) Sepsis/septicemia/shock - 7days	7 days post-hospitalization	Yes
Customer satisfaction about hospital stay (all discharges)	Hospitalization	No
SHFFT		
Same as CJR plus…		
Hip/knee replacement patient reported outcomes	9-12 months post-hospitalization	Yes
AMI		
Mortality rate (AMI only)	30 days post-hospitalization	Yes
Excess days in ED, readmissions, and observations (AMI only)	30 days post-hospitalization	Yes
Customer satisfaction about hospital stay (all discharges)	Hospitalization	No
CABG		
Mortality rate (CABG only)	30 days post-hospitalization	Yes
Customer satisfaction about hospital stay (all discharges)	Hospitalization	No

Element #5
Be the Competent Care Coordinator

- Manage the patient within the SNF stay (traditional model of care), and post SNF discharge (new model of care)

Element #6
Leverage participation in Model 3 BPCI

- BPCI Models 2 and 3 take precedence over CJR and EPMs
  - Creating a strategic opportunity for SNF providers participating in BPCI
    - When hospital refer a CJR/EPM patient to SNFs participating in BPCI, the SNF becomes the risk bearing entity for that patient, relieving the hospitals from the burden of assuming risk in a mandatory program
      - ✓ This is true through the December 31 2016, when the awardees conclude their participation

Don't just change, *drive* change

- Take relentless aggressive action to preserving and increasing post acute admissions
- Don't wait for the hospital to come see you, you go to the hospital and demonstrate how you can bring value to their financial success with CJR
- Make CJR/EPMs work for you

AHCA IMPROVING LIVES by DELIVERING SOLUTIONS for QUALITY CARE

AHCA
AMERICAN HEALTH CARE ASSOCIATION

IMPROVING LIVES by DELIVERING SOLUTIONS for QUALITY CARE

WWW.AHCA.ORG