Bundled Payments and the Progression of Episodic Care
To be covered

CHANGE UNDERWAY - Payor & Market Forces Affecting SHC’s Move Into Bundled Payments

FRAMEWORK - SHC’s Critical Thinking & Key Methods Related to Entering BPCI

HOW IMPLEMENTED - Systems and Tools Developed to Effectively Manage Risked-Based, Episodic Care

EARLY REVIEWS - Perspectives on Current and Future State of Episodic Care
Signature HealthCARE (SHC) is a post-acute care provider offering a broad continuum of services, at 144 locations in 11 states with approximately 20,000 employees:

- Alabama
- Florida
- Georgia
- Indiana
- Kentucky
- Maryland
- North Carolina
- Ohio
- Tennessee
- Virginia
- Pennsylvania
Provider sponsored health insurance (ISNP)

Telehealth solutions for rural markets
1. Traditional and fundamental relationships in healthcare are changing: provider/payor, provider/beneficiary, provider/retail/technology, independent provider/system-based provider/network consortiums

2. The volume to value shift is real and being operationalized in many markets & understanding the type and pace of the change is critical: markets are now seeking preferred providers, standards for preferred status are evolving, network/provider relationships are evolving, first generation risk-sharing model are underway and expanding rapidly

3. Healthcare systems are focusing on creating agile care networks across a broad spectrum of services: isolation to integration w/shared governance, programs/services, coordination, HIE, incentives/risks

4. Dominant Hospital Systems are rapidly assembling proprietary care networks to successfully manage episodes of care: acquiring core components, partnering for non-core components, establishing governance & management structures
5. PAC providers must shift from a “facility operator” to a collaborative “post-acute services solution” orientation

6. The future success (survival) of PAC providers will depend on securing alignments with the markets’ dominant health systems as a highly-valued, deeply-engaged, innovative collaborator

7. The federal government has “upped the ante” by committing to have $\geq 50\%$ of the total Medicare provider spend in alternative, risk-based payment models by 2018, AND as of July, 2015 mandating the bundle payment method for hip and knee replacements effective 04/01/16, for all hospitals, in 67 markets
Post Acute Cost is Attracting Significant Attention

1. Efficient placement into PAC is a persistent challenge

2. Variability in the cost of care and the comparative growth in episode spending is unusually extreme in PAC
Skilled Nursing Properties Among Lower Cost Alternatives for Post-Acute Care

Higher Average Cost  Lower Average Cost

Acute Care  Post-Acute Care Continuum

$1,819/day  $1,450/day  $1,314/day  $432/day

Hospital  Long-Term Care Hospital  Inpatient Rehab Facility  Skilled Nursing Property

$190/day  $121/day

Home w/ Home Health Care  Assisted Living

What We Are Doing
Initiating creative JVs and payment arrangements, including actively participating in the CMS Bundled Payment for Care Improvement (BPCI) Initiative, which we believe will be one of the dominant episodic care models by 2020.

Why We Are Doing It
1. Learn to Value & Optimize Data
2. Accelerate Organizational Reform Toward Episodic Care
3. Enhance Market Position - NOW
What is BPCI?

The Bundled Payments for Care Improvement initiative proposes to test models that align hospital, physician, and, where appropriate, post-acute provider payment incentives, by allowing providers to enter into payment arrangements that include financial and performance accountability for episodes of care and share with each other gains accrued from more cost-effective care. It is anticipated that the use of these models may lead to higher quality, more coordinated care at lower cost to Medicare.

(CMS, Bundled Payments for Care Improvement Initiative Request for Application, 8/22/2011, Pg. 5)
the episode of care begins at discharge from the inpatient stay and ends either 30, 60, or 90 days after discharge (SHC chooses)

the bundle would include physicians’ services, care by SHC and other post-acute providers, related hospital readmissions and other services during the period of time SHC chooses

Medicare’s minimum discount = 3% from usual FFS services (target price)

the total actual (undiscounted) Medicare payments for the episode will be reconciled against the target price

any reduction in expenditures beyond the target price will be paid to SHC, any costs in excess of the target price is covered by SHC
Framework for change

48 clinical conditions from which to choose, episode of care begins at discharge from the inpatient stay and ends either 30, 60 or 90 days after discharge (SHC chooses)

**NOTE:** SHC selects markets, facilities, episodes of care and lengths of PAC
SHC’s Critical Thinking & Key Methods Related to Entering Risk-Based, Episodic Care

SHC’s Initial BPCI Markets & Facilities

- 10 markets, 39 facilities, 48 clinical conditions from which to choose, episode of care begins at discharge from the inpatient stay and ends either 30, 60 or 90 days after discharge (SHC chooses), varying choices for risk tracks, gain sharing, payment periods, elements at facility or market level, etc.
SHC’s Critical Thinking & Key Methods Related to Entering Risk-Based, Episodic Care

- Risk Tolerance  
  (Limiting risk while learning & implementing keys to success.)
- Volume  
  (Do we have enough volume to impact results?)
- CMS Target Price  
  (Is the initial rate reasonable w/ genuine room for improvement?)
- RTH Rates  
  (Is our RTH improving, are we able to improve near-term?)
- Hospital Activity  
  (Are local hospitals participating, and if so, impact on us?)
- Operational Readiness  
  (Leadership and clinical stability, tolerance of change.)
SHC’s Critical Thinking & Key Methods Related to Entering Risk-Based, Episodic Care

- Risk Period (30/60/90 day risk period?)
- Facilities in each market to include (Affects target price for that market.)
- Risk Track (3 options that vary by upper & lower limits in episode costs – by percentiles.)
- Reconciliation Payment Cycle (Reconcile & pay / get paid quarterly or longer.)
## SHC’s Critical Thinking & Key Methods Related to Entering Risk-Based, Episodic Care

<table>
<thead>
<tr>
<th>Strategy Analytic Gates 1-3</th>
<th>48 BPCI Clinical Conditions</th>
<th>39 SHC Facilities in Phase 1</th>
<th>1,872 possible conditions between all facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gate 1</strong></td>
<td>Minimum volume of 15 conditions at market level</td>
<td>179 conditions between 27 facilities</td>
<td></td>
</tr>
<tr>
<td><strong>Gate 2</strong></td>
<td>Individual condition analysis per facility to identify outliers and abnormalities (broad variations in case costs, etc)</td>
<td>48 conditions between 19 facilities</td>
<td></td>
</tr>
<tr>
<td><strong>Gate 3</strong></td>
<td>Minimum savings of $20,000 per condition per facility to receive “Yes”</td>
<td>44 conditions between the remaining facilities = “Yes”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Minimum savings between $0 and $19,999 to receive “Maybe”</td>
<td>4 conditions between the remaining facilities = “Maybe”</td>
<td></td>
</tr>
</tbody>
</table>
## Operational and Clinical Readiness

| Gate 4 | 48 BPCI Clinical Conditions | 39 SHC Facilities in Phase 1 | Operational Readiness: CEO Ranking 1-5  
Op Readiness H, M, L  
Clinical Readiness: DON ranking 1-5  
Clin Readiness H, M, L | Op and Clinical Readiness:  
High (green): Ready now  
Med (yellow): Ready 4/1/15  
Low (red): Not ready by 4/1/15  
Considerations Included:  
Clinical competencies (ortho, cardio, pulm), RTH, TransitionalCare Program status, NP/PA presence, etc. |
|---|---|---|---|
| Gate 5 Considerations | Market Positioning SHC Continuum of Care  
(HomeNow, Silver Angels)  
ACO and BPCI Market Activity | Gathered from research and operations team |
Summary of Conditions at Risk

**SHC is at risk for 20 conditions in 11 facilities**
- 65% Orthopedic
- 20% Pulmonary
- 15% CHF and UTI

**SHC is at risk for 7 unique conditions**
- Major joint replacement of the lower extremity
- Hip & femur procedures except major joint
- Medical non-infectious orthopedic
- Simple pneumonia and respiratory infections
- Other respiratory
- Congestive heart failure
- Urinary tract infection
### SHC’s Critical Thinking & Key Methods Related to Entering Risk-Based, Episodic Care

473 episodes with total target price of $14.3M

<table>
<thead>
<tr>
<th>CONDITION</th>
<th># EPISODES</th>
<th>TARGET PRICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Joint Lower Extremity</td>
<td>121</td>
<td>$3.0M</td>
</tr>
<tr>
<td>Hip &amp; Femur</td>
<td>104</td>
<td>$3.4M</td>
</tr>
<tr>
<td>Non-Infectious Ortho</td>
<td>95</td>
<td>$3.2M</td>
</tr>
<tr>
<td>Simple Pneumonia</td>
<td>56</td>
<td>$1.7M</td>
</tr>
<tr>
<td>CHF</td>
<td>48</td>
<td>$1.4M</td>
</tr>
<tr>
<td>UTI</td>
<td>37</td>
<td>$1.2M</td>
</tr>
<tr>
<td>Other Respiratory</td>
<td>11</td>
<td>$0.4M</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Major Joint Lower Extremity</th>
<th>Hip &amp; Femur</th>
<th>Non-Infectious Ortho</th>
<th>CHF</th>
<th>Other Respiratory</th>
<th>Simple Pneumonia</th>
<th>UTI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heritage Park</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
</tr>
<tr>
<td>Peninsula</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buckhead</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Georgetown</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marietta</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Chautauqua</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Fountain Circle</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Courtyard</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>19</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Cherokee Park</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waterford</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
How implemented

Systems and Tools Developed to Effectively Manage Risk-Based, Episodic Care
How implemented

Systems and Tools Developed to Effectively Manage Risk-Based, Episodic Care
Comprehensive Care for Joint Replacement

An aggressive move by CMS to accelerate the shift to value-based payments

1. **Mandatory Program**
   This is the first mandatory CMMI demonstration, requiring participation from all hospitals located in 67 MSAs

2. **Hospitals Bear Financial Risk for Post-Discharge Care**
   Hospitals will have a target payment for hospital care and 90 days post-discharge for MS-DRGs 469 and 470

3. **Eligibility for Savings Directly Tied to Quality Measures**
   Hospitals will receive a composite quality score which will determine their eligibility for reconciliation payments and effective discount rate
Proposed Episode Payment Models (EPMs)

CMS has proposed three new episodic payment models similar to CJR effective 07-01-2017

- Acute Myocardial Infarction (AMI)
- Coronary Artery Bypass Graft (CABG)
- Surgical Hip/Femur Fracture Treatment (SHFFT)

✓ Hospital participation in cardiovascular bundles will be mandatory in 98 random MSAs.

✓ Hip fracture bundle will be overlaid on top of existing CJR MSAs and participants.
Bundled Payments: Mixed Results So Far

- 11 out of 15 clinical episode groups analyzed showed potential savings to Medicare.

- Orthopedic surgery under BPCI Model 2 showed statistically significant savings of $864 per episode while showing improved quality as measured by beneficiary surveys.

- Cardiovascular surgery episodes under BPCI Model 2 did not show savings yet, but quality of care was preserved.

- Consensus – EPM data for analysis is limited, yet CMS is aggressively expanding EPMs.

- Provider community is taking the position that CMS needs to slow down the aggressive expansion.
1. Initial reasons for entering are proving to be intensely valid.

2. A serious investment in data management / analytics / decision support is needed.

3. Episodic care requires genuine organizational reform that will take years to implement.

4. Networks are ready to experiment with innovative ventures and payment models: JVs to better manage the continuum, BPCI, patient scholarships, etc.

5. Third party intermediaries, providing network build and control, can be both valuable and counter-productive.

6. Health systems are committing tremendous resources and redesigning their structures to succeed within an episodic care environment – a profound shift.
Bundled Payments and the Progression of Episodic Care