In Pursuit of Value: Challenges in a Changing Health Care Environment

May 24, 2016
Agenda

- Macro Trends & Driving Forces
  - Why Post Acute Care
  - PAC Providers in the New World: Challenges & Opportunities
  - Key Capabilities & Early Lessons Learned
# Predictions on the Health Care Landscape in 2021: Implications for Hospitals and PAC Providers

## Payors
- More than 50% of CMS payments tied to APMs
- 2-3 active prospective bundled payment programs
- 4 dominant payors
- MA plans delegate risk to health systems and patients
- The shift to VBC will continue to highlight the importance of PAC management
- Success within increased provider financial risk will require aligned incentives and accountability for quality and costs across the continuum
- Hospitals will likely be the holder of episodic financial risk on behalf of providers
- Hospitals will increasingly desire to build the capabilities themselves and maintain some downstream control
- Scale will require operational efficiency in care coordination which will result in working with fewer downstream partners
- National networks may emerge among larger players
- Winners and losers will emerge and impacts are likely to be felt via volume and possibly gainsharing/financial upside by PAC providers

## Hospitals / Health Systems
- More than 75% of hospitals are taking risk with commercial payors
- More than 1,000 Medicare ACOs
- More fully-integrated hospital networks
- Massive consolidation
- Epic is in nearly half of hospitals
- Hospitals will likely be the holder of episodic financial risk on behalf of providers
- Hospitals will increasingly desire to build the capabilities themselves and maintain some downstream control
- Scale will require operational efficiency in care coordination which will result in working with fewer downstream partners
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## Post-Acute Care
- Fewer but higher quality providers (through consolidation and closings)
- Providers compete to be part of hospital networks
- PAC providers own the entire PAC continuum
- Pilots for unified PAC PPS (site neutral payment system)
- More & higher acuity care received at home
- National networks may emerge among larger players
- Winners and losers will emerge and impacts are likely to be felt via volume and possibly gainsharing/financial upside by PAC providers
Value-Based Care (VBC) requires a transition from payer to provider assumed risk

- **Payer takes full financial risk**
  - Traditional fee for service: Medicare, Medicaid, commercial plans, etc.
  - Pay for performance: Value-Based Purchasing, Hospital Readmissions Reduction Program

- **Risk**
  - One sided shared savings: MSSP ACOs (Track 1)
  - Bundled / episode payments: BPCI, CJR
  - Two sided shared savings: MSSP ACOs (Track 2 & 3)
  - Partial capitation: Pioneer ACOs
  - Global capitation: Next Gen ACOs

- **Provider takes full financial risk**

**Increased provider risk = Increased need for care coordination**
Market impacts are just beginning as hospitals are very early in this VBC transition

Hospitals transitioning to value-based care must:

- Assume ownership for patients before, during, and after inpatient stay
- Hardwire seamless patient transitions
- Select, navigate, and monitor the patient through their post-acute care plan
- Drive clinical standardization
- Control and monitor post-discharge spend and quality of care
- Digest and analyze large amounts of data
- Facilitate and manage at-risk arrangements with payors, physicians and post-acute care providers

80% of health systems are evaluating VBC efforts
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Payors Spend Considerably on PAC, and there is Significant Variance in Cost and Quality

$60+ Billion in Post-Acute Spending

Spend growing >6% annually

Eliminating PAC spend variation eliminates 73% of Medicare spend variation

Readmissions cost the healthcare system $30-40B annually

Sources: CDC, NCAL, AARP, HealthAffairs, MedPac, The Advisory Board Company, AHRQ, L.E.K. analysis
Referring to the Appropriate Post-Acute Site is a Critical Element of Success Under Value-Based Care

43% of Medicare patients utilize post acute care (PAC) after discharge and there is wide variation in costs across each setting.

Why PAC?

Hospital Discharges

- Home without Assistance
  - 49%
  - Average Cost per Episode: $2,700
- Home Health Agency (HHA)
  - 16%
  - Average Cost per Episode: $19,000
- Skilled Nursing Facility (SNF)
  - 22%
  - Average Cost per Episode: $18,000
- Inpatient Rehab Facility (IRF)
  - 4%
  - Average Cost per Episode: $40,000
- Long Term Acute Care Hospital (LTACH)
  - 1%
- Hospice
  - 3%
- Other
  - 5%

~14 million annual Medicare discharges

1) Other inpatient facilities (acute and psychiatric) and death
2) Represents average cost to Medicare per case, or discharge in 2013 (Source: MedPAC June 2015 Data Book)
Health Systems Can Impact PAC

**Effective management of post-acute care is critical as value-based care models continue to proliferate**

1. **1st PAC Setting**
   - Determine most appropriate level of post-acute care upon discharge from acute facility (i.e., home health vs. skilled nursing)

2. **Preferred Provider Network**
   - Create a high-performance post-acute referral network that can meet quality, efficiency and cost standards

3. **Optimal PAC Length-of-Stay**
   - Keep patients for the right length of time required to optimize patient’s recovery

4. **Appropriate Billing Level**
   - Provide the right amount and severity of therapy needed per episode of care
Post-Acute as Substitute for Acute Care

The vertical line at 1984 represents the start of the inpatient prospective payment system. The increase in SNF utilization in 1989 corresponds to a one-year waiver of a Medicare requirement that patients be hospitalized for three days before qualifying for a skilled nursing facility benefit.
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The winners will capitalize on the tailwinds and mitigate the headwinds; the losers will maintain the status quo

- Care delivery model changes with bias to least costly setting & low LOS
- Operating multiple business & care models with margin pressures across the board
- Key investments required to transform
- Market battles for “preferred provider” status
- Paralysis by the unknown and/or the overwhelming

- Role & importance of non-acute settings
- Demographic growth of 65+
- Uniquely positioned to manage patients in post-acute and HCBS settings
- Opportunity to create new revenue streams under value-based care

Key question: When do you push the gas pedal along the road to value-based care?
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New Care Models Require New Capabilities

- Workflow reengineering
- Patient & Caregiver engagement
- Data analytics & reporting
- Patient Monitoring Across Continuum & HCBS
- Social & Community Support
- Dedicated Physician Model with High-Risk Case Management
- Risk & Need Stratification
- High Performing Downstream Provider Network
- Assessment & Care Plan Development
- Technology & Telehealth Solutions
- Evidence-Based clinical decision support
- Information sharing across continuum

IMPACT
Reduce cost
Improve outcomes
# A Growing Trend: Narrowing of PAC Provider Networks as a key enabler of success

## Key Factors

<table>
<thead>
<tr>
<th>Process</th>
<th>Selection Criteria</th>
<th>Metrics &amp; Expectations</th>
<th>Results &amp; Market Impacts</th>
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</thead>
<tbody>
<tr>
<td>Little hospital involvement PAC provider informed “after the fact”</td>
<td>Volume 5-Star Rating</td>
<td>High performance on pre-set quality metrics Attendance at hospital meetings</td>
<td>Little/no volume shifts Modest improvement in key quality metrics</td>
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<tr>
<td>Cross-departmental hospital involvement, including medical staff leadership PAC providers kept informed through multiple interactions</td>
<td>30-Day readmit rate Publicly available quality data RFP data request</td>
<td>Joint protocols (INTERACT, assessments, etc.) Medical model integration with medical staff Engagement in clinical service line initiatives</td>
<td>85% volume to in-network providers Top 10% quality metrics performance Targeted clinical &amp; performance improvement projects New specialized services offerings</td>
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<tr>
<td>Onsite clinical &amp; admin survey(s) Severity-adjusted performance Denial rates analysis</td>
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## Level of Network Integration
Early Lessons Learned

1. There is no “one model”

2. Different payment models incentivize different care management priorities

3. Financial incentives may not be aligned or strong enough to encourage investments and partnerships

4. Internal ability and willingness to engage in a value-driven way varies across providers

5. Human behavior sits at the core of required change