Preparing Post-Acute Providers for Accountable Payment

In Partnership with the American Health Care Association
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Use the blue and white square to maximize the presentation area.
Preparing Post-Acute Providers for Accountable Payment

In Partnership with the American Health Care Association

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The Advisory Board is Uniquely Positioned to Help

Research and Relationships at the Intersection of a Dynamic Industry

The Advisory Board Difference

We are …
- Willing to challenge conventional wisdom
- Devoted to exceeding member expectations at every turn

And we offer …
- Unique visibility into provider CXOs’ world – challenges, priorities, vendor perceptions
- Direct access to over 500 in-house health care experts

2,300+
Hospitals and Health Systems

200+
Independent Physician Practices

500+
Post-Acute Care Facilities and Agencies

200+
Health Care Product and Service Companies

5,000+
CXO Relationships Across the Care Continuum
A Multi-Pronged Value Proposition

Three Pillars of Post-Acute Care Collaborate Memberships

1. Refining Members’ Health Reform Strategy
   - Responding to shifting customer priorities
   - Understanding post-acute demand drivers
   - Analyzing market readmission vulnerabilities
   - Preparing for bundled payments

2. Elevating Members’ Operational Performance
   - Reducing pressure ulcers and falls
   - Monitoring patients post-discharge
   - Enhancing employee engagement
   - Improving behavioral-based interviewing

3. Fortifying Members’ Relationships With Acute Care Providers
   - Achieving preferred provider status
   - Maximizing referrals
   - Understanding hospital customer needs
   - Aligning with physicians
   - Articulating a clear “quality” message
Additional AHCA-Advisory Board Collaboration

View Additional Advisory Board Research on Targeted Issues

Upcoming Webconference

Next-Generation Partnership Strategy

- May 8, 2013 – 1:00 PM
- Original Advisory Board Company webconference featuring best practice research and case studies
- 15 tactics for acute/post-acute partnership development focused on:
  - Easing Care Transitions
  - Collaborating on Clinical Quality
  - Migrating Towards Shared Accountability

AHCA Convention Presentation

Building the Integrated Post-Acute Enterprise

- October 6-9, 2013 – Phoenix, AZ
- Convention presentation to highlight recently completed best practice research connecting post-acute and long-term care providers with the following entities:
  - Physician-led ACOs
  - Patient-centered medical homes
  - Community-based services
  - Other PAC providers
Road Map

1. The Inexorable March of Costs

2. Toward Accountable Care

3. Charting the Path Forward
Unbridled Cost Growth Taking Its Toll

Projected Health Care Spending

Average Annual Growth Rate

- 6.1% Federal health expenditures as percentage of GDP, 2008
- 8.1% Projected federal health expenditures as percentage of GDP, 2018

- 7.5% Medicaid
- 6.9% Medicare
- 6.1% NHE
- 4.4% GDP


1) National Health Expenditure.
From Pilot to Policy?

CMS Timeline for Accountable Payment Rollout

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>Medicaid Capitation Pilot Operation Eval.</td>
</tr>
<tr>
<td>2011</td>
<td>Medicaid Capitation Pilot Operation National Rollout</td>
</tr>
<tr>
<td>2012</td>
<td>Medicaid Capitation Pilot Operation Eval.</td>
</tr>
<tr>
<td>2013</td>
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<tr>
<td>2018</td>
<td>Medicaid Capitation Pilot Operation Eval.</td>
</tr>
<tr>
<td>2019</td>
<td>Medicaid Capitation Pilot Operation National Rollout</td>
</tr>
<tr>
<td>2020</td>
<td>Medicaid Capitation Pilot Operation Eval.</td>
</tr>
</tbody>
</table>

1) Value-Based Purchasing.
2) Accountable Care Organization.

Source: Centers for Medicare and Medicaid Services; Health Care Advisory Board interviews and analysis.
### Seeking to Change Provider Incentives

#### Overview of Accountable Payment Models

<table>
<thead>
<tr>
<th>Key Attributes</th>
<th>Value-Based Purchasing</th>
<th>Bundled Payments</th>
<th>Accountable Care Organizations (ACOs)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>Pay-for-performance program differentially rewards or punishes hospitals (and likely ASCs and physicians in coming years) based on performance against predefined process and outcomes performance measures</td>
<td>Purchaser disburses single payment to cover certain combination of hospital, physician, post-acute, or other services performed during an inpatient stay or across an episode of care; providers propose discounts, can gainshare on any money saved</td>
<td>Network of providers collectively accountable for the total cost and quality of care for a population of patients; ACOs are reimbursed through total cost payment structures, such as the shared savings model or capitation</td>
</tr>
<tr>
<td><strong>Purpose</strong></td>
<td>Create material link between reimbursement and clinical quality, patient satisfaction scores</td>
<td>Incent multiple types of providers to coordinate care, reduce expenses associated with care episodes</td>
<td>Reward providers for reducing total cost of care for patients through prevention, disease management, coordination</td>
</tr>
<tr>
<td><strong>Advisory Board Assessment</strong></td>
<td>Withhold-earnback model will put significant dollars at risk for all providers, force immediate focus on quality and experience metrics</td>
<td>Increases accountability for cost and quality within episodes of care without removing FFS volume incentive; new lever for financial alignment between independent specialists and hospitals</td>
<td>Long-range goal of CMS to migrate to risk contracting; will spark industry-wide investment in primary care infrastructure to establish narrower networks</td>
</tr>
<tr>
<td><strong>Role of CMMI</strong></td>
<td>Dedicating $500M to Partnership for Patients, targeting hospital-acquired infections, readmissions</td>
<td>Accepting providers’ proposals to test four different bundled payment models, including one without inpatient care</td>
<td>Accepting providers’ proposals to test various payment systems, including both shared savings and partial capitation</td>
</tr>
</tbody>
</table>

1) Center for Medicare and Medicaid Innovation.

Source: Health Care Advisory Board interviews and analysis.
New Responsibilities of Accountable Care

Emerging Payment Models Calling Old Imperatives Into Question

Accountable Payment Models

<table>
<thead>
<tr>
<th>Performance Risk</th>
<th>Utilization Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of Care</td>
<td>Quality of Care</td>
</tr>
<tr>
<td>Volume of Care</td>
<td></td>
</tr>
</tbody>
</table>

Bundled Pricing
- Bundled Payments for Care Improvement program
- Commercial bundled contracts

Pay-for-Performance
- Value-Based Purchasing
- Readmissions penalties
- Quality-based commercial contracts

Shared Savings
- Medicare Shared Savings Program
- Pioneer ACO Program
- Commercial ACO contracts

Source: Health Care Advisory Board interviews and analysis.
Road Map

1. The Inexorable March of Costs

2. Toward Accountable Care

3. Charting the Path Forward
Medicare Evolution Necessary—but Which Direction?

Unable to Remain Stuck in the Middle

Medicare Benefits Spectrum

“Embracing Defined Contribution”

“Optimizing Defined Benefit”

Potential Medicare Spending

Medicare Involvement in Financing Care Delivery

- Pure Voucher System
- Hybrid Voucher System
- Medicare Advantage
- Means Testing
- Fee-for-Service
- Prior Authorization
- Rate Cuts
- Global Spending Caps
- Accountable Payment Models

Source: Advisory Board interviews and analysis.
Migrating to Total Cost Accountability

Charting the Path of Payment Reform

Continuum of Payment Models

Episodic Cost Accountability

- Traditional Fee-for-Service
- Pay-for-Performance
- Bundled Payments

Total Cost Accountability

- Shared Savings
- Partial Capitation
- Full Capitation

Provider Risk

Minimal

Provider Risk

Substantial

Source: Advisory Board interviews and analysis.
Full Steam Ahead

Delivery System Reforms Well Underway

Multitude of Initiatives Already Taking Place

April 1, 2012
Start of first performance period for 27 organizations selected to participate in the Medicare Shared Savings Program

June 11, 2012
CMS announced new round of MSSP applications for January 1, 2013 start

June 15, 2012
Final batch of Health Care Innovation Award recipients announced; 107 organizations to receive total of $895 M in grants

June 28, 2012
Application deadline for Bundled Payments models 2-4

CMS Innovation Center Demonstrations in Progress

• Five Advance Payment ACO participants selected; more to be announced July 1, 2012
• 15 states selected to receive up to $1 M to participate in Medicare/Medicaid State Demonstrations
• Seven localities selected to implement Comprehensive Primary Care Initiative
• FQHC Advanced Primary Care Practice Demonstration expected to improve care for up to 195,000 Medicare beneficiaries

Future Payments Depend on Performance
Upside Opportunity Available, But Downside Risk Prevails

Prominent Pay-for-Performance Programs

<table>
<thead>
<tr>
<th>Payment Driver</th>
<th>Description</th>
<th>Payment Reduction Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Value-Based Purchasing Program</strong></td>
<td>• Mandatory pay-for-performance program</td>
<td>• Withholds begin at 1% in 2013, grow to 2% by 2017</td>
</tr>
<tr>
<td></td>
<td>• Percentage of hospital inpatient payments withheld, earned back based on quality performance</td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Readmissions Reduction Program</strong></td>
<td>• Hospitals with greater than expected readmission rate subject to financial penalty</td>
<td>• Penalties capped at 1% of total DRG(^1) payments in 2013, 2% in 2014, and not to exceed 3% in 2015 and beyond</td>
</tr>
<tr>
<td></td>
<td>• Performance based on 30-day readmission metrics for three conditions in 2013, expanding in 2015 to include four others</td>
<td></td>
</tr>
<tr>
<td><strong>Hospital-Acquired Condition (HAC) Penalty</strong></td>
<td>• Hospitals in top quartile of national, risk-adjusted HAC rates subject to financial penalty</td>
<td>• 1% penalty deducted from DRG payment starting in 2015</td>
</tr>
</tbody>
</table>


\(^{1}\) Diagnosis-Related Group.
P4P Shifting to the Post-Acute Environment

Transforming From Passive Payer to Active Purchaser

**Skilled Nursing**
- **ACA Mandate:** Develop a SNF value-based purchasing Medicare program that rewards care quality, efficiency, and improvement based upon Skilled Nursing VBP Demonstration Project
- **MedPAC Recommendation:** Revise and rebase rates, reduce payments to SNFs with high risk-adjusted rates of re-hospitalizations

**Home Health**
- **ACA Mandate:** Implement HH value-based purchasing Medicare program that rewards better value, outcomes, and patient-focused care building upon Home Health Pay-for-Performance Demonstration
- **MedPAC Recommendation:** Revise and rebase home health rates, expand fraud and abuse oversight

**Hospice**
- **ACA Mandate:** Institute a quality reporting program; failure to submit required data will result in a 2% reduction to market basket increase starting in FY 2014
- **MedPAC Recommendation:** Increase provider accountability standards, improve data collection and accuracy, reform payment

**LTACHs/IRFs**
- **ACA Mandate:** Establish a quality reporting program; failure to submit required data will result in a 2% reduction to the market basket increase starting in FY 2014
- **MedPAC Recommendation:** Eliminate update to payment rates for long-term care hospitals for FY 2013

Medicaid Enters Pay-for-Performance Arena

Amid Budget Crisis, States Implement VBP for Nursing Homes

Rewarding Quality Nursing Home Care

- Direct Care Staffing Levels
- High Medicaid Occupancy
- Quality of Life
- Quality of Clinical Care

Structure  Process  Outcomes

- Regulatory Compliance
- Special Licensure
- Staff Training and Development
- Culture Change (Patient-Centered Care)
- Employee Satisfaction and Retention

Case in Brief: Medicaid Nursing Home P4P Programs

- Value-Based Purchasing is an active component in Medicaid reimbursement based upon a range of quality indicators in ten states, with five additional states pending implementation
- These programs would impact over 40 percent of nursing homes nationwide if implemented in all fifteen states
- Early indicators suggest higher nursing home customer and staff satisfaction between P4P and non-P4P states, although quality and efficiency gains are inconclusive

Source: My InnerView, “Value Based Purchasing in Skilled Nursing: A Discussion of Current Trends and Initiatives”, 2011; Advisory Board interviews and analysis.
Redefining the Acute Care Episode

Bundled Payments Drive Delivery System Integration

Bundled Payment Framework

Lump Sum Payments Drive Integration Through Shared Accountability

Program in Brief: Medicare’s Bundled Payments for Care Improvement

- Program seeking voluntary participation in four bundled payment models
- Models 1-3 provide retrospective reimbursement; Models 2 and 3 include post-episode reconciliation; Model 4 offers single prospective payment
- Acute care hospitals, physician groups, health systems eligible for all models; post-acute facilities may participate without hospitals in Model 3
- Physicians eligible for gainsharing bonuses up to 50 percent of traditional fee schedule
- For all models, applicants must propose quality measures, which CMS will use to develop set of standardized metrics

Source: Centers for Medicare and Medicaid Services; Health Care Advisory Board interviews and analysis.
Post-Acute Care Contributing to Cost Variation

Average Risk-Adjusted Hospital Spending

*Total Episode of Care*

<table>
<thead>
<tr>
<th>Condition</th>
<th>Low-Cost Hospitals</th>
<th>Average-Cost Hospitals</th>
<th>High-Cost Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>$4,408</td>
<td>$4,414</td>
<td>$4,406</td>
</tr>
<tr>
<td>Default</td>
<td>$671</td>
<td>$998</td>
<td>$1,780</td>
</tr>
<tr>
<td>Post-Acute</td>
<td>$1,543</td>
<td>$916</td>
<td>$1,012</td>
</tr>
<tr>
<td>High-Cost Heart Failure</td>
<td>$2,550</td>
<td>$1,986</td>
<td>$2,965</td>
</tr>
<tr>
<td>Default</td>
<td>$1,102</td>
<td>$842</td>
<td>$2,041</td>
</tr>
<tr>
<td>Physician and Ancillaries</td>
<td>$4,837</td>
<td>$1,378</td>
<td>$1,189</td>
</tr>
<tr>
<td>Hospital</td>
<td>$4,826</td>
<td>$1,088</td>
<td>$4,824</td>
</tr>
</tbody>
</table>

1) Spending reflects national standardized payment rates for Medicare and does not reflect differences in the cost to the facility of providing services. Low-cost hospitals are in the bottom quartile of risk-adjusted episode spending, and high-cost hospitals are in the top quartile of risk-adjusted hospital spending.

## Elevating Accountability for Episodes of Care

### Comparing the Four Models

<table>
<thead>
<tr>
<th>Model 1: Hospital Inpatient Services for All DRGs</th>
<th>Model 2: Hospital and Physician Inpatient and Post-Acute Services</th>
<th>Model 3: Post-Acute Services Only</th>
<th>Model 4: Hospital and Physician Inpatient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligible Participants</strong></td>
<td>Model 1 participants plus post-acute care providers</td>
<td>Model 1 participants plus post-acute care providers, long-term care hospitals, inpatient rehab facilities, home health agencies</td>
<td>Model 1 participants</td>
</tr>
<tr>
<td>Physician groups, acute care hospitals reimbursed under IPPS, health systems, PHOs, conveners of participating providers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Conditions</strong></td>
<td>Select inpatient DRGs, proposed by applicants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Medicare DRGs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Included Services</strong></td>
<td>Inpatient hospital and physician services; related post-acute care and readmissions</td>
<td>Post-acute care; related readmissions</td>
<td>Inpatient hospital and physician services; related readmissions</td>
</tr>
<tr>
<td>Inpatient hospital services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Expected Discount</strong></td>
<td>Minimum increases from 0% for first six months to 2% in year 3</td>
<td>Minimum of 3% for 30-89 days post-discharge services; minimum 2% for 90+ days post-discharge</td>
<td>Minimum 3% discount (larger for DRGs in ACE Demonstration)</td>
</tr>
<tr>
<td>Minimum increases from 0% for first six months to 2% in year 3</td>
<td>Minimum of 3% for 30-89 days post-discharge services; minimum 2% for 90+ days post-discharge</td>
<td>Proposed by applicant (no set minimum)</td>
<td></td>
</tr>
<tr>
<td><strong>Provider Payments</strong></td>
<td>IPPS payment less discount for Part A services; physicians reimbursed on traditional fee schedule</td>
<td>Traditional fee-for-service payment, subject to reconciliation with target price</td>
<td>Prospectively established payment; hospitals distribute payment to clinicians</td>
</tr>
<tr>
<td>IPPS payment less discount for Part A services; physicians reimbursed on traditional fee schedule</td>
<td>Traditional fee-for-service payment, subject to reconciliation with target price</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Quality Measures</strong></td>
<td>Proposed by applicants, with CMS ultimately establishing a standardized set of metrics aligned with measures in other CMS programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Hospital IQR measures, plus additional measures proposed by applicants</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

1) Inpatient Payment System.  
2) Acute Care Episode.  
3) Inpatient Quality Reporting.
Not Just a Medicare Mandate

Private Sector Bundling Pilots Emerging Nationwide

1) Coronary Artery Bypass Graft.

Source: Health Care Advisory Board interviews and analysis.
Model #3: Shared Savings Model

Mechanics of Shared Savings

Applying Total Cost Accountability to Fee-for-Service Payments

Program in Brief: Medicare Shared Savings Program

- Cohorts launched April 2012, July 2012, and January 2013; contracts to last minimum of three years
- Physician groups and hospitals eligible to participate, but primary care physicians must be included in any ACO group
- Participating ACOs must serve at least 5,000 Medicare beneficiaries
- Bonus potential depends on Medicare cost savings, quality metrics
- Two payment models available: one with no downside risk, the second with downside risk in all three years

Shared Savings Payment Cycle

1. Assignment
   Patients assigned to ACO based on terms of contract

2. Billing
   Providers bill normally, receive standard fee-for-service payments

3. Comparison
   Total cost of care for assigned population compared to risk-adjusted target expenditures

4. Shared Savings Payment
   Bonuses or penalties levied based on variance of expenditures from target

5. Distribution
   ACO responsible for dividing bonus payments among stakeholders

Source: Health Care Advisory Board interviews and analysis.
Medicare ACOs Off and Running

32 Pioneer and 221 Shared Savings Program ACOs as of January 2013

Source: Centers for Medicare and Medicaid Services; Health Care Advisory Board interviews and analysis.
ACOs Constructing Continuum of Care

Renewed Interest in Post-Acute Sphere to Improve Coordination, Quality

Recent Investments and Post-Acute Services

**Partners HealthCare**
- Building state-of-the-art Spaulding Rehabilitation Hospital (Opening in 2013)
- Expanding existing service offerings, including inpatient and outpatient rehab, skilled nursing, and therapy
- Operating region's largest non-profit home care provider, Partners HealthCare At Home

**Steward Health Care**
- Acquired New England Sinai, a 212-bed Long-Term Care Hospital and rehab facility (2012)
- Signed letter of intent to purchase VNA Home Health Hospice, Mercy Hospital
- Offering nursing and geriatric care management through Steward Home Care Clinical Services

Case in Brief: Steward Health Care System and Partners HealthCare

- Steward Health Care is a for-profit health system with ten community hospitals in the Boston region, home care, and range of service offerings
- Partners HealthCare is a not-for-profit organization with eight community and specialty hospitals, physician network, home care and other post-acute providers
- As main competitors, the health systems have contested for market share through investments to assemble the core components of a continuum of care, including key post-acute entities

Health Systems Continue to Divest PAC Services

Providers Focusing on Core Competencies

Percentage of Hospitals Offering Select Post-Acute Services¹

<table>
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<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health</td>
<td>76%</td>
<td>60%</td>
<td>53%</td>
<td>49%</td>
<td>37%</td>
<td>37%</td>
</tr>
<tr>
<td>SNF</td>
<td>60%</td>
<td>53%</td>
<td>49%</td>
<td>49%</td>
<td>37%</td>
<td>37%</td>
</tr>
</tbody>
</table>

“I want to keep our post-acute facilities; I know that in the future they’ll be good for us. But I’m afraid we’ve just run out of time.”

CEO
Large Health System in the East

¹ As part of hospital, health system, network or joint venture.

Source: American Hospital Association Chartbook, Chart 2.8, available at: www.aha.org; Advisory Board interviews and analysis.
The Future of ACO Partnerships?

Post-Acute Providers Enter Accountable Care Arena

Case in Brief: Hospice of Michigan

- Hospice of Michigan serves nearly 900 patients in 56 counties throughout the state and is one of the largest hospices in the country
- Formed three-year contract with Detroit Medical Center and Michigan Pioneer ACO to supply customized care to terminally ill patients through Hospice of Michigan's @HOMe Support™ Program
- Hospice shares in a portion of savings generated from cost reductions associated with declining inpatient utilization within Michigan Pioneer ACO

Hospice of Michigan’s Role

1. Identifies high-risk patients with end-stage illness for Personalized Care at Home program

2. Provides advanced disease management through an interdisciplinary care team, patient and family education, counseling, and comprehensive around-the-clock support

3. Fosters health system navigation across the care continuum, improved quality-of-life to avoid unnecessary ED visits, hospitalizations

Cost savings in pilot group of @HOMe Support™ patients¹


¹ Pilot study funded by Blue Cross Blue Shield of Michigan Foundation in collaboration with Wayne State University (2012).
Referral Networks Narrowing Fast

Degree of Clinical Alignment to Determine Future Referral Patterns

Acute/Post-Acute Affiliation Agreements

- Formalizes written agreement between hospital and PAC organization to develop and meet quality standards
- Creates joint infrastructure for future quality improvement collaboration, review of relationship performance
- Tracks clinical outcomes, patient satisfaction to inform referrals toward a narrowed, quality-oriented PAC network

“"You’re really going to have some **winners and losers**. And those progressive organizations that can set up the capabilities [to collaborate] effectively are going to be the winners, and then the others are really going to struggle in the future.”

*Director, Health System Senior Services*

“I don’t expect them to hit every one of these expectations on day one, but if we’re sitting here six months from now and there’s been no forward movement, then we will look if we can **take our business elsewhere**.”

*ACO Development Executive*

Source: Advisory Board interviews and analysis.
Scrutiny Intensifying for Referrals

Hospitals Solidifying PAC Performance Criteria

Home Health Scorecard

Scorecard Creation Methodology

- Geriatrics leaders researched clinical literature, comparable health care organization practices to determine metrics
- Vetted performance metrics with case managers, social workers, PAC leaders in community
- Target measurements to remain in HHA network currently under review

<table>
<thead>
<tr>
<th>Performance Metrics</th>
<th>Target vs. Result</th>
<th>Scores by Payer Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission Rate by Location</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Number of Visits, CHF, Pneumonia, AMI, COPD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression, Influenza, Pneumococcal Screening</td>
<td></td>
<td></td>
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<tr>
<td>Fall Rates, Infection Rates, Wound Management</td>
<td></td>
<td></td>
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<tr>
<td>Medication Review</td>
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<tr>
<td>Patient Satisfaction</td>
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<td>Staff and Patient Education</td>
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<td>PCP Communication</td>
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<tr>
<td>Joint Commission Certification</td>
<td></td>
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</tr>
</tbody>
</table>

Source: Scorecard metrics created by Aaron Senich, The Christ Hospital; Advisory Board interviews and analysis.

For complete HHA and SNF scorecards please email landisj@advisory.com
Road Map

1. The Inexorable March of Costs

2. Toward Accountable Care

3. Charting the Path Forward
Strategy Drives Participation Decisions

Two Viable Care Management Ambitions

**Care Management Goals**

<table>
<thead>
<tr>
<th>Efficient Acute Care Provider</th>
<th>Population Health Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of Care</td>
<td>Quality of Care</td>
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<td>Volume of Care</td>
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**Bundled Pricing**
- Bundled Payments for Care Improvement program
- Commercial bundled contracts

**Pay-for-Performance**
- Value-Based Purchasing
- Readmissions penalties
- Quality-based commercial contracts

**Shared Savings**
- Medicare Shared Savings Program
- Pioneer ACO Program
- Commercial ACO contracts

Source: Health Care Advisory Board interviews and analysis.
At the Nexus of Accountable Care Strategy

Assessing the Dynamics of External Forces, Internal Capabilities

Accountable Care Market Strategy

Market Readiness

High

Low

Build Fast

Ensure Advantageous Terms

Create Option Value

Pursue Alternative Distribution

Strategic Options

• Engage payers in incentive redesign discussions
• Secure alignment with physician “principals”
• Accelerate IT investments

Strategic Options

• Establish payment transition road map with payers
• Ensure preference with employers, patients
• Invest in patient activation initiatives

Strategic Options

• Seek arbitrage opportunities in payment innovations
• Develop advanced primary care strategy
• Maximize specialty care efficiency, reliability

Strategic Options

• Deploy accountable care capabilities in pilot with own self-funded benefits plan
• Direct contract with employers
• Market own insurance product

Institutional Readiness

Low

High

Source: Health Care Advisory Board interviews and analysis.
Defining a Value-Based Business Model

Three Key Strategic Considerations

Designing a Value-Based Business Model

Which populations are we targeting for value-based contracts?
- Medicare
- Medicaid
- Commercial payers
- Employers
- Individuals

What types of value-based contracts should we sign?
- Shared savings
- Delegated risk
- Full risk

How will we manage patients to thrive under our contracts?
- Partner engagement
- Care management
- Plan management

Source: Health Care Advisory Board interviews and analysis.
Establishing the Medical Perimeter

Extensive Ambulatory Care Network Addresses Medical Demand

Medical Management Investments

- Patient Activation
- Post-Acute Alignment
- Medical Home Infrastructure
- Primary Care Access
- Electronic Medical Records
- Health Information Exchanges
- Disease Management Programs
- Population Health Analytics

Source: Health Care Advisory Board interviews and analysis.
Navigating Divergent Payment Models

Incentive Disconnect Complicating Transition

Evolution to Accountable Payment Models

Revenue Generated Through Incentive Model

100%

0%

Total Cost Accountability

Fee for Service

Time

Assessing our Charge

“Navigating this migration is our central management challenge for the next decade. Transitions are always messy, and we’re in a transition period. You can’t have one foot in two boats forever.”

Chief Executive Officer
10-Hospital Health System

Source: Health Care Advisory Board interviews and analysis.
The Path to Accountable Care

Financing, Care Delivery Must Evolve Together

The Efficient Delivery System Transformation

Ampere Health¹
- PGP demonstration participant
- Inadequate physician alignment, high-cost patient pathways, poor analytics hinder success
- No bonus earned

“In Over Our Head”

Weber Hospital¹
- Reengineered care delivery to lower unnecessary utilization
- Only secured performance-based reimbursement from one payer
- “Improvements” undermine revenues from non-accountable contracts

“Too Far, Too Fast”

¹ Pseudonym.

Source: Health Care Advisory Board interviews and analysis.
Next-Generation Partnership Strategy

May 8, 2013 at 1:00 PM ET

15 Tactics for Partnership Development

I. **Easing Care Transitions**
1. Create a Central Intake Infrastructure
2. Cultivate an Admissions Culture Based on “Yes”
3. Embed Clinically-Oriented Liaisons
4. Forge Relationships for Institution-Specific Initiatives

II. **Collaborating on Quality**
5. Hardwire Performance Evaluation Forums
6. Facilitate Patient Information Exchange
7. Jointly Upskill Clinicians in Areas of Need
8. Establish Shared Medical Leadership
9. Develop Cross-Continuum Evidence-Based Pathways
10. Implement Real-Time Care Plan Adjustment Mechanisms

III. **Migrating Toward Shared Accountability**
11. Ensure Cost-Appropriate Care Setting
12. Mitigate Case-Specific Financial Challenges
13. Demonstrate Risk Management Capabilities
14. Serve as Senior Care Navigator
15. Co-Develop Accountable Care Infrastructure

Source: Advisory Board research and analysis.
Inaugural National Meeting Series Across 2012-2013

Presentation Topics

*Post-Acute and Long-Term Care State of the Union*
- Navigating Delivery System Uncertainties
- Responding to Market Realities
- Preparing for the Future

*Partnership Strategy*
- Easing Care Transitions
- Collaborating on Clinical Quality
- Migrating Towards Shared Accountability

*Perfecting the Patient and Family Experience*
- Hardwiring for Service Excellence
- Creating a Patient-First Culture
- Learning Through Family and Resident Feedback

Meeting in Brief: Post-Acute Care Collaborative National Meeting

- In response to member interest and demand, the Post-Acute Care Collaborative will host the first National Meeting exclusively for members
- Single day session to feature original best practice research on topics determined through a survey of the membership
- Remaining meeting dates scheduled:
  - Washington, DC, June 3rd, 2013
Questions About Today’s Session?

For Additional Information on How the Advisory Board Supports Post-Acute and Long-Term Care Providers

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- Lead Consultant for Post-Acute Care Collaborative
- 6+ years experience within the Advisory Board’s Strategic Research Division working across the Philanthropy Leadership Council, Technology Insights, and the Marketing and Planning Leadership Council
- Areas of research specialty include: post-acute and long-term care trends, provider relationship building, referral strategy, and business planning