Post-Acute Networks
Why Are Health Systems Developing Them?

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Innovation and Excellence in Advanced Illness at End of Life
42nd Annual Hospice & Palliative Care Conference - September 2018 - Charlotte, NC

Agenda

• Rationale for post-acute networks
• Creation and management of post-acute networks
• Strategies for hospice & palliative care providers to engage health systems
Who We Are Today

Size and Scope

- 65,000+ employees*
- 28+ urgent care locations*
- 47 hospitals across three states*
- 16,000+ nurses*
- 25+ cancer care locations*
- 7,400+ licensed beds*
- 350+ primary care practices*
- 47 hospitals across three states*
- $9.77 billion net operating revenue*
- 25+ cancer care locations*
- 65,000+ employees*
- 350+ primary care practices*
- 35 emergency departments, including freestanding*
- 7,400+ licensed beds*
- 16,000+ nurses*
- 350+ primary care practices*
- 35 emergency departments, including freestanding*
- $9.77 billion net operating revenue*

* denotes enterprise-wide data or PE plus some regional data

Who We Are Today

16,000+ Nurses*
$1.87 billion in community benefit and uncompensated care in 2016
$5.1 million In uncompensated care and community benefit every day

Continuing Care Scope of Services

- An integrated network and full continuum solution for post acute service needs
- Services provided at 73 locations
- Average Daily Census > 14,000
- > 125,000 outpatient visits
- > 70,000 Unduplicated Patients
- > 2,600 teammates

Value - The Why

- Government, commercial payers & employers are transferring risk to providers, and demanding accountability
- Payment for quality & cost effectiveness outcomes
- Current trajectory is unsustainable – economically & politically not viable
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National Landscape

1. Aging Population

2. Chronic Conditions

Market Pressures

1. Aging Population

2. Chronic Conditions

15.5%
16.0%
16.5%
17.0%
17.5%
18.0%
18.5%
19.0%
19.5%
20.0%
20.5%

$0
$2,000
$4,000
$6,000
$8,000
$10,000
$12,000
$14,000
$16,000
$18,000

2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025

National Health Expenditures, per capita

3. Significant Spend Increases

4. Not Fiscally Sustainable

Value-based Care

ACOs

BPCI

MACRA

CMS Quality Reporting Programs

Medicare Advantage

CMS Payment Penalty Programs

Commercial Payor Risk Contracts

Self-insured Employers

BPCI-A

Value-based purchasing

CMS Payment Penalty Programs
Patient Protection and Affordable Care Act (ACA)
Enacted March 23, 2010

Goals of the ACA
- Make affordable health insurance available to more citizens through the creation of subsidies.
- Expand the Medicaid Program to cover adults with an income below 138% of the federal poverty level.
- Support innovated medical care delivery methods designed to lower costs of health care generally.

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Shift to Focus on Incentivizing Quality & Efficiency

ACOs and Covered Lives

ACOs and Covered Lives

ACOs and Covered Lives
ACO Types

- Pioneer ACO
- Medicare shared savings programs
- Next generation ACO
- ACO Investment Model
- Advanced Payment ACO Model
- Comprehensive ESRD Care Initiative
- Oncology Care Model
- Comprehensive Primary Care (CPC+) Model

What is an Accountable Care Organization?

**MSSP Definition:**
- “...a legal entity that is recognized and authorized under applicable State, Federal, or Tribal law, is identified by a [TIN], and is formed by one or more ACO participant(s) that is (are) defined at § 425.102(a) and may also include any other ACO participants described at § 425.102(b).” 42 CFR § 425.20.

**Functional/Operational Definition:**
- Partnerships among health care providers to coordinate and deliver high-quality, cost efficient health care services to defined populations
- **Purpose:**
  - Promote accountability for Medicare FFS beneficiary population
  - Improve the coordination of FFS items and services
  - Encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery
  - Promote higher value care

ACO Value Proposition

<table>
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<tr>
<th>Who to Persuade</th>
<th>How to Persuade</th>
<th>Value to Health Systems</th>
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<tbody>
<tr>
<td>Alliance with the ACO brand and strategy</td>
<td>Redefine provider relationship from combative to collaborative</td>
<td>Align independent practices and physicians</td>
</tr>
<tr>
<td>A more powerful voice in health plan relationships</td>
<td>Expand, stabilize and improve network for products</td>
<td>Spread health system reach (and risk) across broader population and geography</td>
</tr>
<tr>
<td>Demonstrate, improve, and be rewarded for clinical quality</td>
<td>Collaborate to improve value for beneficiaries, members and customers</td>
<td>Communicate value with independent &quot;affiliates&quot;</td>
</tr>
<tr>
<td>ACO governance, leadership and input</td>
<td>Transition from FFS payment; address cost and quality</td>
<td>Demonstrate value to payers, businesses, and community</td>
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Participation in development of:
- Value-based compensation models
- Evidence-based guidelines
- Work resource from medical management to other areas (benefit design, etc.)

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How to Share in Savings

- Meet the Minimum Savings Rate for Assigned Beneficiaries (2.3-3.9%) - Meet the Quality Performance Standards for Assigned Beneficiaries - Maintain Compliance and Eligibility within the MSSP ACO Program

If all requirements are met within the MSSP, the ACO will share in savings with a rate of up to 50%.

BPCI Advanced

- Voluntary bundled payment model that ties physician & hospital payments to quality and cost of services provided under a 90-day clinical episode ("bundle")
- Actual FFS spend vs. target price determines gainsharing
- Multiple waivers of fraud and abuse and anti-kickback laws

BPCI-A

- 29 Inpatient episodes
  - Ortho
  - Cardiac
  - Pulmonary
  - CVA
  - GI
  - Renal
  - Infection

- 3 Outpatient episodes
  - PCI
  - Defibrillator implantation
  - Back & neck

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Continuing Care

One in Five Acute Patients Discharged to Post-Acute

What is Continuing Care?

Why is Continuing Care Performance Important?

Post Acute Spending Represents 20-25% of all Medicare Expenditures

Regional Variation in Spending

Medicare Would Save $20 Billion Annually if Patients used the Appropriate Post-Acute Setting
What Challenges Exist Today?

Home Health?

“Post acute looks like an archipelago of little islands with no bridges. Consumers are at a loss about which island to approach, with poor transportation and communication options.”

- Physician Interview, Deloitte

Decreased Payments to PAC

- SNF – patient driven payment model (PDPM) - October 2019
- Home health – Patient-driven groupings model (PDGM) – January 2020
- Post-acute site neutral payments – 2021
- Hospice – future cuts???

Continuing Care Networks
The Continuum of Care – Rethinking Post Acute

The diagram illustrates the different components of care across the continuum, including Acute Care, Home Health, SNF, and Rehabilitation. Each component serves a unique role in achieving the goal of returning to health.

Key Components of Strategic Management:

1. Risk Stratification
2. Cross-Continuum Care Management
3. Network Management
4. Post Acute Service Evolution

1. Risk Stratification
- Begins with discharge planning and assessment: Right Place, Right Time, Right Cost
- Data-driven process
- Requires elevating communication, coordination, and navigation across settings
- Goal is to manage higher risk patients to proactively intervene prior to readmission or ED visit
  - e.g., flags for missed appointments, blood pressure, etc.

Key Factors:
- Socioeconomic
- Complex Chronic
2. Cross Continuum Care Management

- Multi-Disciplinary Team
- Triage
- Plan
- Track/ Monitor
- Manage

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<th>Multi-Disciplinary Team</th>
<th>Care Continuum Management</th>
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<tr>
<td>Identify</td>
<td>Attribution (Medicaid, ACO, BPCI, MA)</td>
</tr>
<tr>
<td></td>
<td>Risk Stratification</td>
</tr>
<tr>
<td></td>
<td>Care Pathways (Projected)</td>
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<tr>
<td></td>
<td>Advanced Discharge Planning</td>
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<tr>
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<td>Optimal Post-Acute Placement/De-ICU</td>
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<td></td>
<td>Discharge to Highest Value Network</td>
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<tr>
<td></td>
<td>Via Population Health Platform</td>
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<td>Via Virtual Monitoring/Exception/Trend</td>
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<tr>
<td></td>
<td>Care Management interventions</td>
</tr>
<tr>
<td></td>
<td>Hospice and Palliative Care Involvement</td>
</tr>
<tr>
<td></td>
<td>Active SNF Patient Management (LOS)</td>
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<tr>
<td></td>
<td>Connecting back: PCP/Complex Chronic</td>
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3. Network Management

- Education and Best Practice Sharing
- SNF Collaborative, Home Health Collaborative
- Medical Directorships
- Focus on Readmissions and ED Visits

- Options For Discharge
- Network for Value

- Identify and Select the Right Partners using Data
- Preferred Network
- Continuous Engagement of Physicians and ACPs in Quality Improvement
- Focus on Episodic Cost, Quality and Experience = Value

4. Post Acute Service Evolution

- Challenges
  - Aging and sicker populations
  - Higher and Health Systems taking on Risk
  - Current PAC settings can be high cost
  - Aging Patients have different expectations

- Solutions
  - Alternative to Hospital Care
  - Innovative PAC Options
  - Alternative Care Settings
  - Sharing Risk with PAC Partners

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Atrium Health SNF Network

To improve outcomes and overall Medicare spend
To establish the largest, best network
To focus on partnership and shared accountability
To proactively address opportunities for improvement

We want to partner with facilities that share a Vision and Commitment to Quality

SNF Preferred Network Design

SNF Network Performance Metrics

<table>
<thead>
<tr>
<th>Metric</th>
<th>Source</th>
<th>Weight</th>
<th>Top Performer</th>
<th>Acceptable</th>
<th>Needs Improvement</th>
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<tbody>
<tr>
<td>Readmission Rate Q3/Q4</td>
<td>Premier</td>
<td>40%</td>
<td>&lt; 0.9</td>
<td>&lt; 1.1</td>
<td>&gt; 1.1</td>
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<td>% Medicare/MA Placements</td>
<td>CHS 2017</td>
<td>20%</td>
<td>&lt; 80.0%</td>
<td>&lt; 90%</td>
<td>&gt; 90.0%</td>
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<td>Market Payment Ratio</td>
<td>CMS (2016)</td>
<td>30%</td>
<td>&lt; 1 SD Below Market Average</td>
<td>&gt; 1 SD Higher than Market Average</td>
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<tr>
<td>Weighted Score</td>
<td>30.0 – 50.0</td>
<td>20.0 – 29.9</td>
<td>0.0 – 19.9</td>
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<td></td>
</tr>
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</table>
SC Health Company

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Are You Committed?

“No, thanks,” said the pig. “I’d be committed. You’d only be involved.”

Integrated Post-Acute Network

1. Build a post-acute care network through coordination and collaboration that allows the patient to maintain the highest level of independence.
2. Manage the network to building the right team and resources that supports the patient’s needs.
3. Support the patient through enhanced care coordination and close management of patients across the journey.

Source: The Chartis Group
Network Priorities

- Develop strategic partnerships
- Leverage learnings to prepare for value based care
- Evaluate processes and transitions across the care continuum
- Analyze and share data transparently

Health System Network Analysis

- Criteria for selecting a network participant:
  - Geographic Location
  - Financial/Quality Performance
  - Diversity of Services
  - Financial Stability

GHS Clinical Priorities

- Enhance Experience
- Improve Health Status
- Reduce Variations in Care
- Eliminate Disparities
- Data Driven Decisions
- Care Model Transformation
- Highly Reliable Organization
- Value Based Care
Care Model

INTEGRATED CARE MODEL

Integrated, standardized workflow management & monitoring

Seamless Patient Experience Across the Continuum

MyHFN Preferred Partners

- 30 Skilled Nursing Facilities
- 8 Home Care Facilities with multiple locations
- 16 Hospice providers with multiple locations
- 4 Inpatient Hospice Houses

Quality Monitoring and Reporting

- Site specific metrics
- Quality reporting to Quality & Care Model Committee
- Improvement ActionPlans

Care Management Engagement

- Dedicated Care Manager
- Ongoing rounding with patient and staff
- Care Transitions between care settings
- Education & Training (i.e. Sepsis, COPD, etc.)

GHS in MSSP

SUCCESS IN MSSP YEAR 1

59,996
ASSIGNED BENEFICIARIES

$17.3M
TOTAL SAVINGS

$8.997
PER CAPITA SAVINGS

$9,299
PEOPLE SAVINGS

$8.47M
PERFORMANCE PAYMENT
Network “Value”

- Hospitals/ACOs are “new buyers” of service to:
  - Improve hospital mortality rates
  - Improve hospital length of stay
  - Reduce overall Medicare spend

Data Considerations

- Medicare Shared Savings Program (Track 1 – 2016 & 2017 performance years)
- Assigned MSSP beneficiaries
- Source: Claims and Claim Line Feeds (CCLFs)

Definitions:

- Allowed $ per Service/Stay – Allowed amount per continual service period/stay
- Average Visits/ALOS – Average number of continual visits in service period or days
- 30 Day Readmit Rate – Number of qualified readmissions within 30 days of discharge divided by total number of discharges
- Case Mix Index – hospital relative resource use index
- Quality Score – average of 7 hospice compare quality measures
- Service Count – Number of continual service periods/stays
GHS Post-Acute Care Utilization

- Home Health: 15.3%
- Hospice: 1.4%
- SNF: 2.3%
- IRF: 25.3%
- Home Community: 56.1%

40% of Medicare Patients Use Post-Acute Services

Current Performance

Not adjusted for patient expiring in PAC setting

GHS Post-Acute Care Spend

- Home Health: $2,797
- Hospice: $7,720
- IRF: $19,413
- SNF: $9,439
- Home Community: $7,804

System Average

Not adjusted for patient expiring in PAC setting

GHS Post-Acute Care ALOS

- Home Health: 10.1
- Hospice: 16.3
- IRF: 14.7
- SNF: 22.9
- Home Community: 18.1

Current Performance

Not adjusted for patient expiring in PAC setting
### Hospice Performance

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<td>116</td>
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### Hospice High Performer

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Diagnosis Grouping

Visit Distribution

Data Interaction
Data Interaction with Quality

- X-axis: 30-day Readmit Rate
- Y-axis: Average Quality Score
- Color: Allowed $ per Service/Stay
- Size: Average Visits/ALOS

*Quality scores based on latest Hospice Compare data from data.medicare.gov

Future Analytics

Strategic Approaches for Hospice & PC Providers

DATA → KNOWLEDGE → ACTION
Data Sources

- Understand the health system’s problems to solve
  - Corporate goals including focused populations
- Resources
  - www.hospitalcompare.hhs.gov
  - http://www.leapfroggroup.org/compare-hospitals
  - https://www.ibm.com/watson-health/services/100-top-hospitals
  - Statewide health data organizations
  - State and regional coalitions
  - Private/proprietary data for purchase

Data Sources

- Evaluate your data/impact by potential “solutions”
  - Diagnosis
  - Provider
  - Site of care
  - Cost
  - Mortality
  - Readmissions

Knowledge

- Know the literature
  - What has approaches have proven effective in patients with advanced illness?
    - ACP
    - Home-based palliative care
    - Care management
  - Health systems may or may not know this information
Action

- Health systems/ACOs not looking for a sales pitch – need solutions
- Engage wherever you can
- Create targeted outcomes with leadership
  - Hospice LOS by provider group
  - Number of ACP conversations
- Think scale – not looking for “one-off” solutions

Questions

- What do you know about your health system partners including their employed physicians?
- What do you know about your own organization and performance?
- What do you know about non-health system PAC partners? SNFs/HH/IRF/LTACH?
- Who can you start a dialogue with?
- Do you have business model beyond days of care?