“Stars” and “Bundles”: Latest Buzzwords or Real Change

May 13, 2016
DRIVING THE FUTURE OF HEALTHCARE

We help clients redefine their strategies, operations, and processes based on both patient-centric demands and rigorous best practices - responding to the industry’s new market disrupters, cost pressures, and outcome-based reimbursement models.

Our Team:

- Healthcare Executives
- Clinical Practitioners
- Valuation Professionals
- Turnaround / Restructuring Advisors
- Investment Bankers
- Economists & Statisticians
- Auditors
- IT Specialists / Data Analysts
- Forensic Technologists
- Regulatory Specialists
- Tax Accountants
- Real Estate Planners & Advisors
Agenda

1. Overview

2. Embracing care model redesign

3. Modeling success through data-informed network decisions
Bundled Payments Overview

- In January 2015 CMS announced their Better, Smarter, Healthier campaign, shifting more than $300 Billion away from Fee-for-Service into Alternative Payment models by 2018.
- Bundled payments are starting to gain traction through an attractive care and risk management option
  - Designed specifically for specialists, acute and post-acute care providers
  - Focus care coordination responsibilities and opportunities on the best provider to treat ‘targeted’ patient populations
- BDO believes bundled payment models are the best way to maximize clinical outcomes, minimize expense and drive value based purchasing.

We predict bundled payments will become dominant in US $3T Healthcare spend and represent the overwhelming part of this shift.
Seismic Change in Reimbursement, Pricing and Valuation . . .
Focused on CLINICAL OUTCOMES and VALUE BASED

- CMS deploying an array of voluntary and mandatory payment innovation models to accelerate transition to accountable payments

- Payment programs
  - Change Accelerators
  - Pay-for Performance
  - Total Cost of Care
  - Bundled Payments

**CMS Payment Goals:**

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternate Payment Models</td>
<td>20%</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>Quality or Value</td>
<td>80%</td>
<td>85%</td>
<td>90%</td>
</tr>
</tbody>
</table>
From: Current Payment and Care Model

Silos today: separate functions, separate billing, separate payment
To: Bundled Payment and Care Model

Bundles align services and payments . . . crossing all traditional lines

Index Admission
- Hospital and readmit
- SNF, IRF
- Home Health, Rehab
- Enabling Services
- Physician Services
- Diagnostic Services

Post-Acute Care

Risk Stratification, Care Transition, Care Coordination, Enabling Services
Bundled Payment Impact on Providers

• Consolidating supply chains

• Pushing the point of care outside the hospital

• Providers aggregating risk and managing payments outside their system
The Comprehensive Joint Replacement Program
An Immediate Future State
Market and Timing

- Mandatory program—all hospitals in the total joint business in these MSAs are included
- 794 Hospitals in 67 MSAs (107,037 episodes in our data cohort)
- Five “performance years” started 1 April 2016
Major Joint Replacement Cost Variance

Significant Variance in Cost Unrelated to Quality - $10,000 to $80,000.

Source: Centers for Medicare and Medicaid Services; 2013 data
DRG Cost Variance Across SNFs

Hospitals and CMS are shifting their focus to more consistent, lower cost facilities creating narrow networks.

Source: Centers for Medicare and Medicaid Services; 2013 data
New Care Model: “End-to-End” Systems Manage Inside and Outside the Hospital Walls

Develop an “end-to-end” clinical system

Internal (hospital processes)
- Standardize the “upstream” supply chain
- Understand, quantify, and manage inbound risk

External (person-centric care system)
- Understand, quantify, and manage “downstream” risk
- Develop and operate a post-acute care system
- Proactively manage care transitions
- Monitor post acute care workflow
- Create non-institutional contact points
Timely Data Required to Focus on the Risks and Opportunities Across a Bundle

Joint Replacement (CCJR) Readiness Assessment

DRG: 469
Major Joint Replacement or Reattachment of Lower Extremity w MCC

DRG: 470
Major Joint Replacement or Reattachment of Lower Extremity w/o MCC

Episode Cost 90 Days After Admission

Target Price: $24,705

- Part A: $12k
- Part B: $4.2k
- Readmission: $1.8k
- SNF: $9.1k
- HH: $1.1k
- Other: $483
- Total: $28.6k (Unfavorable Cost)

Represents a single episode of care for illustrative purposes only
Comparative SNF Performance in Market

Hospitals are analyzing partners across the complete episode of care as bundled payments drive narrow network formation.

Costs and quality are being assessed to identify best options for SNFs partners going forward.

<table>
<thead>
<tr>
<th>SNF Provider</th>
<th>Episodes to SNF</th>
<th>Payments to SNF</th>
<th>Readmissions</th>
<th>ALOS</th>
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<tbody>
<tr>
<td></td>
<td>Total</td>
<td>% to Total</td>
<td>Avg</td>
<td>% of Total</td>
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<tr>
<td>National Benchmark</td>
<td></td>
<td></td>
<td>$15,294</td>
<td>16.6 %</td>
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<tr>
<td>State Benchmark</td>
<td></td>
<td></td>
<td>$17,700</td>
<td>16.6 %</td>
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<tr>
<td>SNF 1</td>
<td>158</td>
<td>11.2%</td>
<td>$20,737</td>
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<tr>
<td>SNF 2</td>
<td>154</td>
<td>10.9%</td>
<td>$20,309</td>
<td>12.0%</td>
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<tr>
<td>SNF 3</td>
<td>109</td>
<td>7.7%</td>
<td>$13,483</td>
<td>5.6%</td>
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<td>SNF 4</td>
<td>85</td>
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<td>$17,223</td>
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<td>SNF 5</td>
<td>78</td>
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<td>$16,693</td>
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<td>SNF 6</td>
<td>74</td>
<td>5.2%</td>
<td>$15,841</td>
<td>4.5%</td>
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<td>SNF 7</td>
<td>71</td>
<td>5.0%</td>
<td>$18,540</td>
<td>5.1%</td>
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<tr>
<td>All Other Average</td>
<td>684</td>
<td>48.4%</td>
<td>$18,849</td>
<td>49.5%</td>
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<tr>
<td>Total when SNF is 1st PAC</td>
<td>1,331</td>
<td></td>
<td>$19,550</td>
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</table>

Source: Centers for Medicare and Medicaid Services; 2013 data
Five Star Rating System

Tool created by CMS in 2008 to help consumers select and compare skilled nursing care centers. Uses information from Health Care Surveys (standard, focus and complaint), Quality Measures, and Staffing.

CMS intends to move to a five star rating system for all of its "Compare" sites, "with a goal of full transition to star ratings by 2016,"

- This will include hospitals.
High Quality, Low Cost SNFs are a Must

<table>
<thead>
<tr>
<th></th>
<th>1 Star</th>
<th>2 Star</th>
<th>3 Star</th>
<th>4 Star</th>
<th>5 Star</th>
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<tr>
<td>National</td>
<td>14.9%</td>
<td>19.8%</td>
<td>18.9%</td>
<td>23.5%</td>
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<tr>
<td>N=15446</td>
<td>2307</td>
<td>3057</td>
<td>2926</td>
<td>3267</td>
<td>3529</td>
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<tr>
<td>LA</td>
<td>10.3%</td>
<td>20%</td>
<td>19.1%</td>
<td>23.7%</td>
<td>26.8%</td>
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<td>N=560</td>
<td>58</td>
<td>122</td>
<td>107</td>
<td>133</td>
<td>150</td>
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<tr>
<td>OC</td>
<td>6.5%</td>
<td>25%</td>
<td>19.7%</td>
<td>28.9%</td>
<td>23.6%</td>
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<tr>
<td>N = 76</td>
<td>5</td>
<td>19</td>
<td>15</td>
<td>22</td>
<td>18</td>
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<tr>
<td>MSA</td>
<td>10%</td>
<td>20.5%</td>
<td>19.2%</td>
<td>24.4%</td>
<td>26.4%</td>
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<tr>
<td>N=636</td>
<td>63</td>
<td>131</td>
<td>122</td>
<td>155</td>
<td>168*</td>
</tr>
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</table>

How do you find them?
About 55% are 3-Star rated or lower.
Quality scores impact your ability to collaborate with every SNF in the market.
You need to be highly selective about your partners in this program.

*Source: BDO analysis of CMS data
Making Data-Driven Care Decisions Across the Bundle—Access to Timely Data is a Must

Access to timely data is necessary to analyze performance across a bundle
- CMS program data is not shipped in ready to use format and requires competent assembly
- Delivery has been delayed in the past

Need to develop supplemental and timely data sources that can be analyzed in advance of and parallel to the CMS data set

Analyzing more timely data facilitates:
- Stratifying episodes into high, medium, and low opportunities
- Reducing readmission rates
- Increasing patient satisfaction
- Lowering unnecessary costs
- Driving care improvements
- Providing pointed insights to drive bundled payments performance
Making Data-Driven Care Decisions
Across the Bundle—Access to Timely Data is a Must

Timely inputs:
• Analyze raw claims as they arrive and gain instant updates on how individual episodes are performing
• Gain insights on the optimal way to help patients get better as fast as possible for the lowest cost and drive quality care improvements along the way

Post care delivery:
Quantify gains and exposure levels, what worked and what didn’t
• View performance relative to goals and quality metrics
• Identify opportunities to create quality improvements, optimize the network and institutionalize behaviors and patterns that led to the success
Example of Monitoring and Optimizing a Network

National average 90-day readmission rates across discharge destinations
Line colors are driven by comparison to national averages:

- Improvement relative to average 90d readmission rates
- Under-performance relative to average 90d readmission rates

- Market avg. indicates 90-day readmission rates for the selected clinical conditions for patients discharged to SNFs within a 25mi radius from the facilities
- Dark blue dots are SNFs, pale blue dots are clinical conditions or service lines
- Thicker lines => larger case count, thinner lines indicate fewer cases
SNF Readmission Rates by Service Line

- 3 Star Rating
- Above average for Ortho, Other Medical and Neurology
- Opportunities for improvement:
  - Cardiology
  - Respiratory
  - Sepsis
  - Digestive
  - Vascular

20% or better improvement relative to average 90d readmission rates

SNF 1

>20% under-performance relative to average 90d readmission rates
Why are Readmissions Important?

• 30-day readmission penalties: Hospitals are subject to penalties for excessive rates of patients readmitting 30 days following a hospitalization

• With bundled payment programs, hospitals are assuming financial risk for longer time periods - 60 and 90 days following a hospitalization
  – Hospitals narrowing networks, directing patients to centers of excellence in post acute care to reduce readmissions and PAC LOS and ultimately, overall utilization

• SNF cost load is increased by cost of readmissions following SNF stay:
  – In a typical Medicare AMI bundle costing $23K, SNF costs amount to $3.6K. However, 90-day readmission costs tack on another $5.5K in costs!

• CMS now includes a re-hospitalization measure into Nursing Home Compare
  – Percentage of short-stay residents who were re-hospitalized after a nursing home admission
Going “inside the numbers” reveals risk in primary total joint cases

10% BELOW national avg

20% BETTER than national avg
**Curating the Care Process**

1. **Data**
   - Receive, process, analyze data...build cost models

2. **Care Model**
   - Identify required process change, care model redesign

3. **Clinical System**
   - Secure collaborators, "manage outside the walls"

4. **Operations**
   - Operating systems, dashboards, feedback, reconciliation process

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**“Curate”**
From the Latin root “CURARE” → one responsible for the care of souls
How to Mitigate Risk

Initial analyses

Program development & implementation

Gain Sharing

Program Operations

Abstract results/capabilities to support commercial bundle expansion
Conclusion

- Majority of saving opportunities will be in post acute care, requiring key coordination with post acute providers.
- Analyzing historical data in a meaningful fashion to identify all areas for cost savings and quality improvement measures.
- Implementing quality measures for early identification of readmission patient populations.
- Developing strategic gain share options with all providers (physician groups and post acute providers)
- Accurately capturing high outlier group
- Utilizing data analytics for predictable outcomes
Thank You

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