NOTICEABLY DIFFERENT

Payment Reform & ACOs: Help Me Understand – A Two Part Series

Health Care Association of New Jersey – October 25, 2011

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LarsonAllen LLP
CPAs, Consultants & Advisors

1

Overview for Today (A Lot to Discuss)

- Healthcare Reform: What Does the Future Hold?
- Impacts to Aging Services Providers
- Where Do We Start?
- Questions & Discussion

2

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Part 1
Payment Reform & ACOs

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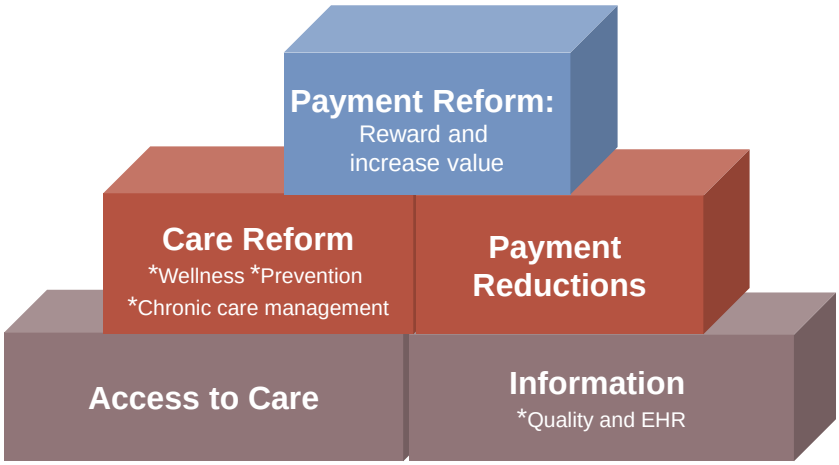
Forces Driving Reform …

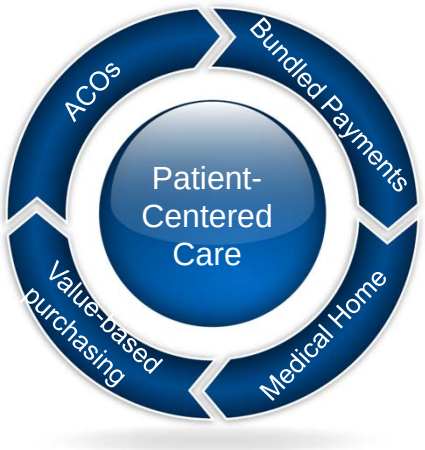
- Growing uninsured population
- Exponential growth in expenditures
- Looming Medicare insolvency
- Cost to quality comparisons

Themes of Health Reform



Health Reform Models

Payment Reform Models



Overview: The Future Under Health Care Reform

Health care reform is designed to significantly alter:

How we Pay for Care:

- *Payment reductions*
- *Bundled payments*
- *Shared Savings*
- *Value-based payment*

How Care is Organized:

- *Accountable care organizations*
- *Medical homes*
- *Episodes of care*
- *Health information exchange*

How Care is Delivered:

- *Center for Medicare and Medicaid Innovation*
- *Comparative effectiveness*
- *Multidisciplinary care teams*
- *Electronic Health Records*
- *Care Transitions*
- *Improved coordination of care for dual eligibles*

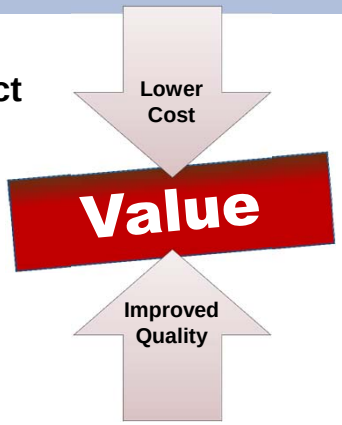
The Foundation: Value-Based Payment

Value Based Payment: *"a reform initiative whereby health care providers will receive payment for service based on their performance or the potential outcomes of the service"*

Tying payment to performance is perhaps the most significant aspect of health care reform.

The de facto definition of "value" in health care reform is the intersection of lower cost and improved quality.

Providers who can lower costs and deliver quality will be measured as "value-based providers"



Key Aspects of Value Based Payment (VBP)

VBP Objectives:

1. Encourage use of evidence-based medicine
2. Reduce fragmentation, duplication and inappropriate use of services
3. Encourage effective management of chronic disease
4. Accelerate the adoption of health information exchange
5. Empower and engage consumers

VBP Assumptions:

1. Performance based payments will drive change
2. Different practice arrangements will be accommodated
3. Multidisciplinary team members will be recognized
4. Accountability will be across multiple levels and sites of services
5. Plan will be budget neutral
6. Focus will be to change FFS and there will be a short term and long term strategy

Source: *Development of a Plan to Transition to a Medicare Value-Based Purchasing Program for Physicians and Other Professionals, Issue Paper,* Public Listening Session, December 9, 2008; CMS

Summary Payment Reform Timeline

2011

- *Plan for transitioning SNF & Home Health to value-based payment system submitted to Congress.*
- *Community-based Care Transitions program begins.*
- *Center for Medicare and Medicaid Innovation created to test reforms rewarding quality vs. volume.*
- *Physician Compare web site launched.*
- *10% bonus payment for primary care practitioners.*

2012

- *Medicare shared savings program begins - ACOs.*
- *Hospital Readmission Reduction Program penalties imposed.*
- *Independence at Home" demonstration project.*
- *Medicaid bundled payment demo starts in up to 8 states.*
- *Medicare value-based purchasing begins for hospitals.*
- *Productivity adjustments with market basket updates for certain providers.*

2013

- *National bundled . payment pilot for Medicare begins.*
- *Medicaid payments for PCPs increased to 100% of Medicare fee schedule.*
- *Hospice payment reform/payment reductions implemented*

Summary Payment Reform Timeline *(cont'd)*

2014

- *First Independent Payment Advisory Board report required to Congress.*
- *Medicare hospital DSH payments reductions begin.*
- *Rebasing of Home Health payments begins with four year phase-in.*

2015

- *Reductions for hospital acquired conditions .*
- *Home Health productivity adjustments incorporated into annual updates*
- *Physician value-based system implemented for Medicare.*

2016

- *Hospice value-based purchasing pilot program established (Medicare).*
- *National Medicare Bundled Payment Pilot program expansion permitted.*

Value-Based Purchasing Programs

- **For hospitals** (FY2013) – Final rules published
  - Ties % of hospital payment to performance on quality measures for common, high-cost conditions but not include a readmissions measure.
  - Includes critical access or low-volume hospitals
- **For SNFs and home health:** The HHS Secretary must submit a plan to Congress by October 1, 2011 for transitioning skilled nursing facilities and home health agencies to a value-based payment system.
- **For hospice:** In 2014, hospice providers will be required to report on quality measures identified by the HHS Secretary or face a 2 % market basket reduction. A pilot program to test VBP for hospice providers will be established no later than January 1, 2016.
- **For physicians:** Beginning by 2015, CMS will phase in over two years, a budget-neutral payment system that adjusts physician Medicare payments based on the quality and cost of care they deliver.

Value-based Payment – SNF Demonstration

- Started in SNFs for Medicare Part A stays in 2009
- Select facilities in: Wisconsin, New York and Arizona.
- The key performance metrics include:
  - Hours of care (30%)
  - State survey results (20%)
  - Re-hospitalizations and/or hospitalization rates (30%)
  - Nursing Home Compare measures – MDS outcomes (20%)

Performance incentives measured during first year and future payouts will be based upon:

- Improvement in performance
- Ranking in the top quartile
- Number of Medicare admissions and days
- Performance of other demonstrations sites in the state

Health Reform: Reducing Hospital Readmissions – Oct. 1, 2012

- CMS will rank hospitals based on 30-day readmission rate for **heart attack, heart failure and pneumonia**
  - Not limited to preventable, avoidable readmissions
  - Applies even if readmitted to another hospital
- In 2015, the program will expand to include: COPD, CABG, PTCA, and other vascular conditions for total of 7 conditions.
  - Secretary authorized to expand policy to additional conditions beyond these seven.
- Requires Secretary to publish patient hospital readmission rates for certain conditions.
- Does not apply to critical access hospitals

Payment Penalty for Acquired Conditions

- **Medicare:** Beginning in FY2015, hospitals in the top quartile of rates of hospital acquired conditions would be subject to a payment penalty under Medicare.
  - HHS Secretary is to report to Congress by Jan. 1, 2012 whether this policy should apply to other Medicare providers.
- **Medicaid:** No Medicaid payment for health care acquired conditions beginning July 1, 2011. Applies to hospitals and other facilities.
  - Final rules published June 4, 2011 and took effect July 1, 2011.
  - Each state will have its own list of "provider preventable conditions" in addition to current list of Medicare never event list that will not be eligible for Medicaid payment.

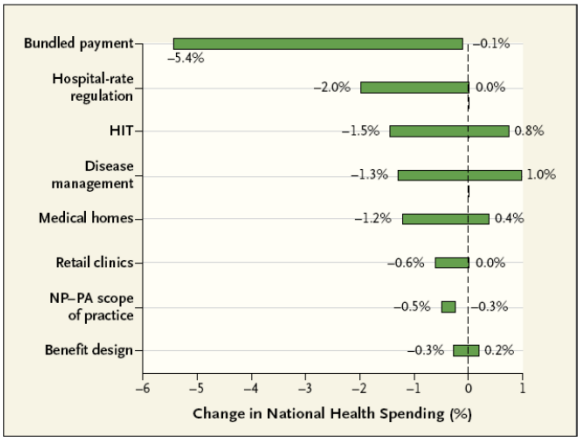
Bundled / Episodic Payment Will Overtake FFS

- **National Pilot Program on Payment Bundling**
  - CMS to establish a national, voluntary Medicare pilot by 2013
  - For hospitals, doctors and post-acute providers.
  - Aims to improve patient care and achieve savings through bundled payments.
  - Pilot can be expanded by 2016 if it appears to improve quality and reduce costs.
- **Medicaid episodes (Begins 2012)**
  - Pays bundled payment to acute care hospital to coordinate with physicians and post-acute services.
  - Demonstrations in up to 8 states
- **Bundled Payments for Care Improvement Initiative**
  - Announced by Center for Medicare and Medicaid Innovation in August 2011.
  - Offers four bundled payment models for potential participation, including two for post-acute
  - CMMI has indicated this is only the beginning of bundled payment initiatives they will be rolling out

Definition:

A single, fixed per person payment paid to provider(s) for the provision of all services and expenses for an episode of care, management of a chronic condition or an individual.

Why Bundled Payment Method is Key



Estimated Cumulative Percentage Changes in National Health Care Expenditures, 2010 through 2019, Given Implementation of Possible Approaches to Spending Reform.

* Source: Perspectives: *Controlling US Health Care Spending – Separating Promising from Unpromising Approaches,* Hussey, Peter, Ph.D., et. al., NEJM, 11/09; accessed via the web 12/09.

*"… under optimistic scenarios and with broad use of the Prometheus model of bundled payment for six chronic conditions and four acute conditions…health care spending could be reduced by 5.4% …"**

*"… many of the options being considered are likely to improve the value of our health care system, only some have the potential to reduce spending."**

CMS Acute Care Episode (ACE) Bundled Payment Pilot

- "Bundle" includes all services related to an inpatient stay.
- Involved five pilot hospitals for 28 Cardiovascular and 9 Orthopedic DRGs
- Three year demonstration project (2009-2011)
- Competitive bidding with CMS; hospitals could employ gain-sharing with physicians
- Only Part A FFS beneficiaries could participate – <u>but CMS shared savings with beneficiaries!</u>
- Planned expansion encompassed via the recent Bundled Payments for Care Initiative

Bundles and LTC?

Bundles may heavily utilize SNF & HHA, given lower costs – as compared to other post-acute settings

Average Cost for Post-Acute Care

Setting	Stroke	Heart Failure
IRF	$18,900	$14,700
LTCH	$22,100	$20,300
SNF	**$8,600**	**$6,500**
HHA	$2,500	$1,600

Source: MedPAC analysis of 5% Medicare claims files 2004 to 2006.

Thinking About Bundled Payment?

Acute Care Hospital	Physician	Post-Acute Care
• Patient Volume • Current outcome measure system • Operating EHR platform • Evidence-based practices • Established or evolving clinical pathways • Strong physician affiliation (either employed or partnered) • Staff resources to devote to bundled payment project • Sufficient reserves to embrace risk • Willingness to embrace care redesign	• Patient Volume • Current outcome measure system • Operating EHR platform • Evidence-based practices • Established or evolving clinical pathways • Staff resources to devote to bundled payment project • Disease registry participation • Acute hospital or post-acute affiliation or collaboration • Sufficient reserves to embrace risk • Willingness to embrace care redesign	• Patient Volume • Multi-site presence (unless already part of acute hospital/physician system) • Current outcome measure system • Operating EHR platform • Evidence-based practices • Established or evolving clinical pathways • Staff resources to devote to bundled payment project • Sufficiency of experience with distinct patient types (i.e., TJR, CHF, COPD, CVA, etc.) • Strong physician affiliation or collaboration • Sufficient reserves to embrace risk • Willingness to embrace care redesign

Community-Based Care Transitions

Establishes five-year community-care transitions program to assist Medicare beneficiaries at high-risk of a hospital re-admission with their transitions from inpatient to outpatient care

- Program to begin April 12, 2011 (per solicitation notice)
- $500M available to be paid to:
  - Community-based organizations that provide care transition services OR
  - Hospitals with high readmission rates that partner with such entities.
- "High-risk Medicare beneficiaries" = one or more chronic conditions and not enrolled in a Medicare Advantage program
- HHS may expand the program if the program proves to lower spending without reducing quality.

Independence At Home Demonstration: 2012

- Establishes a shared savings program for physicians and nurse practitioners to test the use of home-based primary care teams for certain Medicare beneficiaries
- Eligible Medicare beneficiaries:
  - 2 or more chronic conditions
  - Medical condition in past 12 months with non-elective hospitalization OR
  - Received acute or sub-acute rehab within past 12 months
  - Needs assistance with 2+ ADLs
- Practitioners are paid for care coordination and must provide home-based care

Goals

- Reduce health care costs
- Reduce preventable hospitalizations, readmissions and ER visits
- Improve health outcomes
- Improve efficiency of care (i.e., reduced duplication of labs)
- Achieve beneficiary and family satisfaction

CMS Fact Sheet:
http://www.cms.gov/DemoProjectsEvalRpts/downloads/IAH_FactSheet.pdf

Implications of New Payment Models/Reform

Implication #1:
New relationships with the C-suite will be necessary

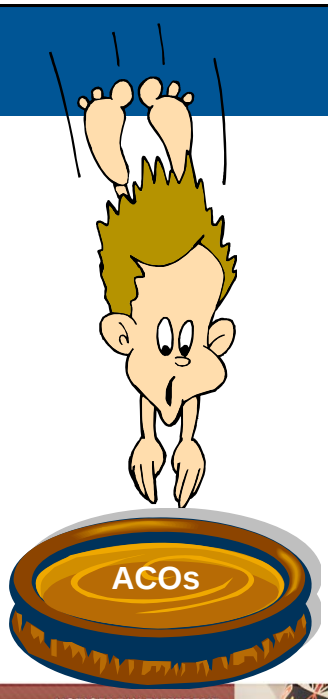
Implication #2:
FFS is going away
- Value not volume
- Quality
- Cost effective
- Care transitions

Implication #3:
New purchasers of service
- ACOs
- Consumers (i.e., CLASS Act)
- Other providers

Implication #4:
Providers will need more robust **quality measurement** system that includes predictive modeling, process and outcome measures

Implication #5:
Survival will depend on health information
- Tracking: quality, claims
- Care transitions
- Data mining & exchange
- Disease management

Accountable Care Organizations: A Deep Dive



"The good relationships and alliances you create, define your mutual ability to be effective."

-Reid Hoffman, co-founder of LinkedIn, as quoted in FastCompany.com

ACOs: General Definition

A group of health care providers working together to manage and coordinate care for a defined population, that share in the risk and reward relative to the total cost of care and patient outcomes.

ACO "Triple Aim" Goals

- **Better Care**
  - Improve/maintain quality and patient outcomes
  - Eliminate avoidable re/admissions
  - Eliminate potentially preventable conditions (e.g., never events)
- **Better Health**
  - Primary Care Driven
  - Focus on Prevention & Wellness
- **Reduce Cost**
  - Reduce/eliminate duplication
  - Improved coordination

Medicare Shared Savings Program: ACOs

- HHS Secretary to establish a Medicare Shared Savings program no later than January 1, 2012
  - Program requires the participating providers to form an Accountable Care Organization.
- Proposed rules published April 2011, comments were due by June 6, 2011
- Final rules are in final stages and with OMB

Goals

- Provider accountability for all patient care
- Coordination of Medicare Part A & B items and services
- Encourage investment in infrastructure
- Redesign care processes for high quality and efficient care delivery
- Achieved savings to be shared with eligible ACOs.

Modeled after the Physician Group Practice Demonstrations, which started in 2005.

Medicare ACO Requirements

Requirements:

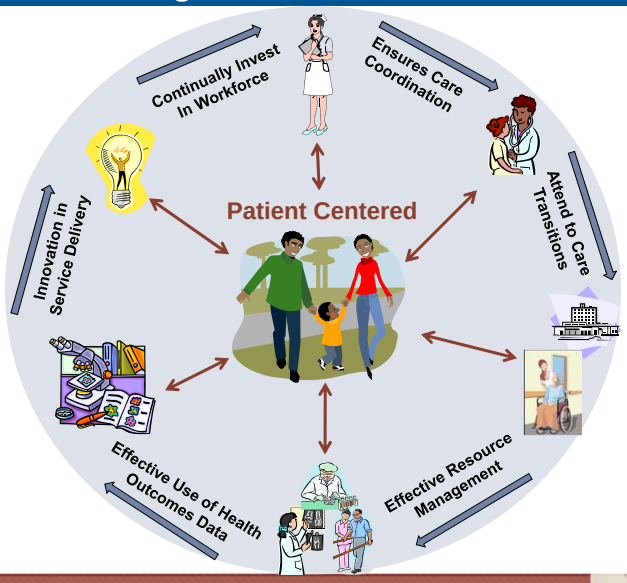
- Accountable for quality, cost and care
- Legal structure to receive/distribute incentives
- Sufficiency of PCPs to accept a minimum of 5,000
- Promote evidence-based medicine & patient engagement
- Patient-centered care processes
- Leadership and management structure
- Report on quality measures and other performance data
- Three-year agreement

Payment Structure
= Medicare FFS + Shared Savings

- Per beneficiary cost benchmark established annually by CMS
  - Risk adjusted
- Must exceed minimum savings rate AND meet quality performance goals to be eligible for Shared Savings

Proposed Medicare ACO Rules

The ACO Paradigm



Medicare Accountable Care Organizations

The following providers can <u>form</u> a Medicare ACO:

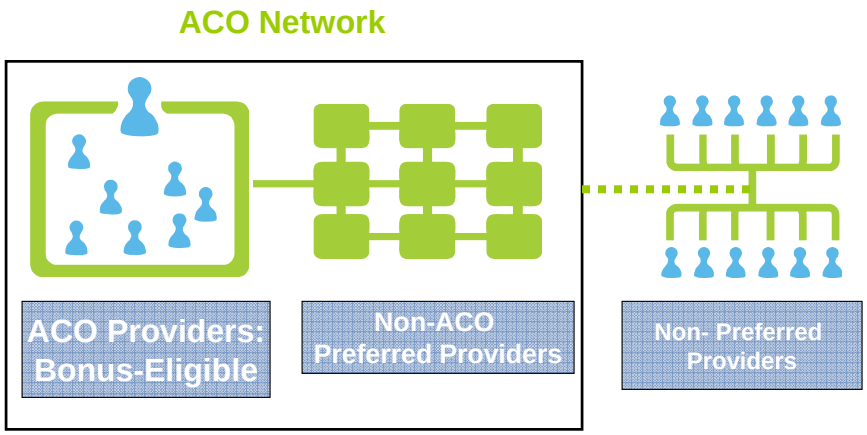
- ACO professionals in group practice;
- Networks of individual practices;
- Partnerships and joint ventures between hospitals and ACO Professionals;
- Hospitals employing ACO professionals OR
- CAHs billing under Method II

•Cannot include providers participating in other shared savings programs or demos or the Independence at Home pilot.

<u>ACO Participants:</u>

- Hospitals
- Physicians, NPs, PAs
- Clinical Social Workers
- Specialists
- Skilled Nursing Facilities
- Home Health Care
- Integrated Health Systems
- Critical Access Hospitals
- FQHCs & RHCs
- Comprehensive outpatient rehabilitation facilities
- Hospice providers

ACO Network

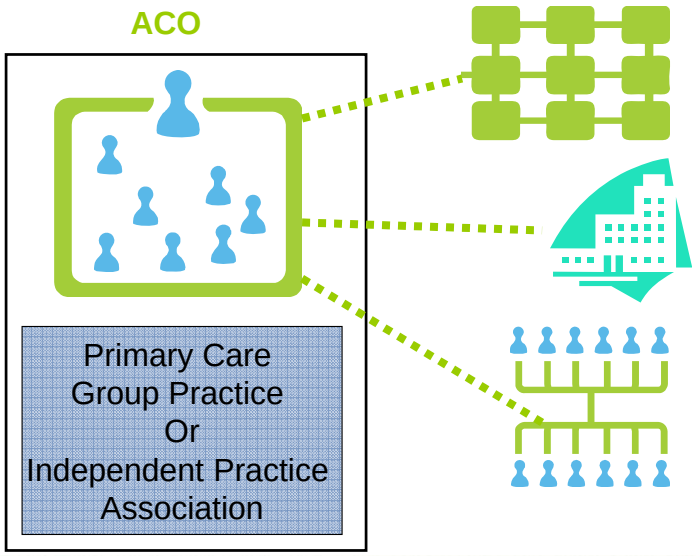


- Primary Care Practitioners
- Hospitals

- "Value" Providers

- Low Quality, High Cost Providers

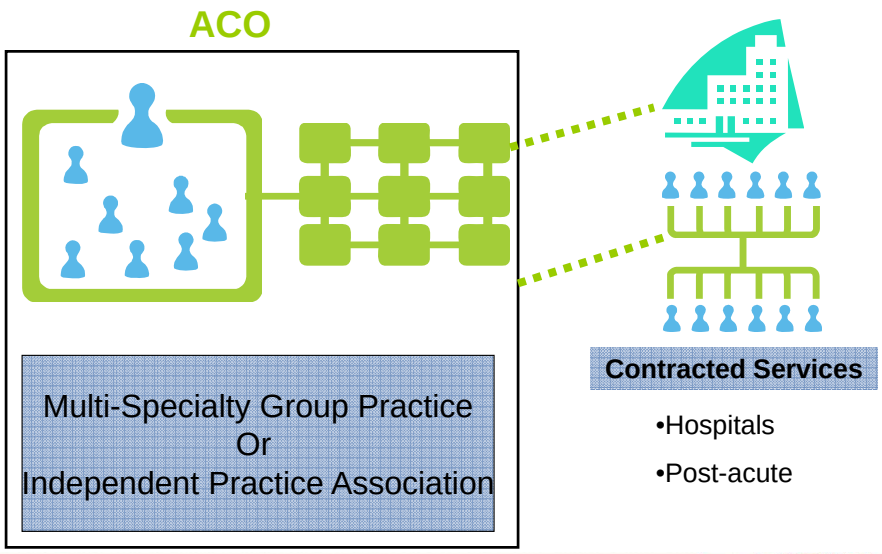
ACO Configurations Will Vary: PCP Model



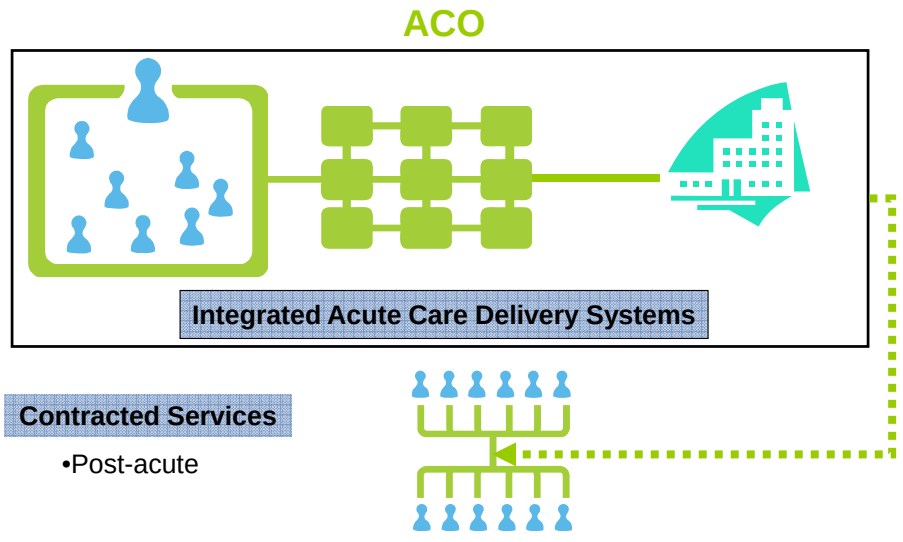
Contracted Services

- Hospitals
- Specialists
- Post-acute

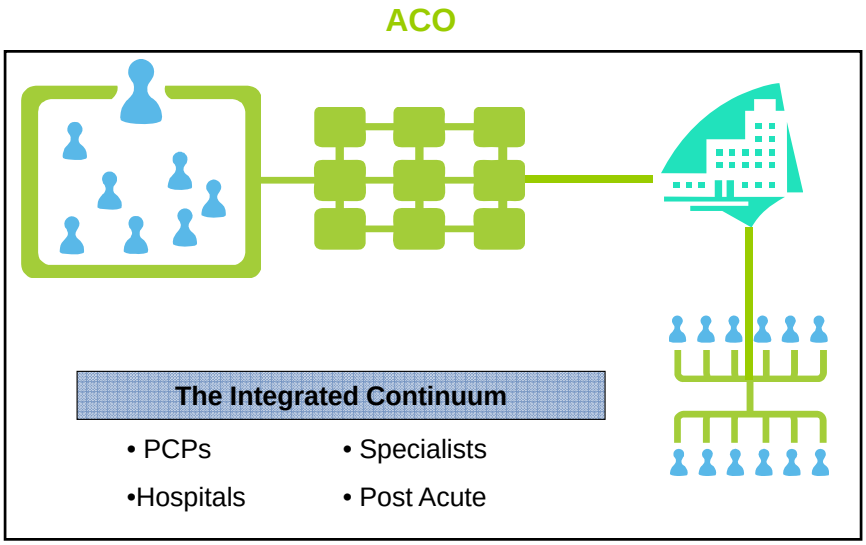
ACO Configurations Will Vary: Multi-Specialty



ACO Configurations Will Vary: Integrated Acute



ACO Configurations Will Vary: Continuum

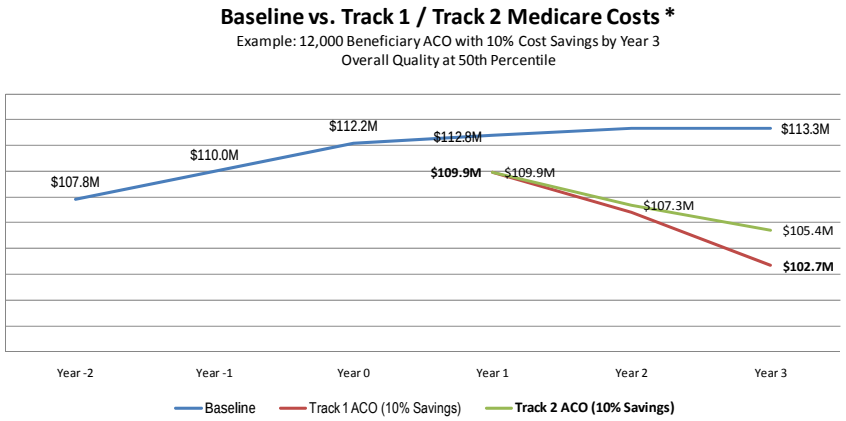


Proposed Medicare ACO Rules - Payment

- **Two Payment Tracks**
  - Track One: Yr 1 -2 = one-sided model; Yr3 = Two-sided model
  - Track Two: All three years = two-sided model
- **Payment Structure**
  - Same FFS payment continues but reconciled to benchmark for participating providers
  - Shared Savings only if exceed minimum savings rate AND meet quality metrics
  - Required to re-pay CMS for expenditures in excess of benchmark (only for two-sided model)
- **Shared Savings**
  - Up to 50% for Track One, plus potential for 2.5% more
  - Up to 60% for Track Two, plus potential for 5% more
  - Caps on savings apply under both Tracks

•**One-Sided Model** = Shared savings only
•**Two-Sided Model** = Shared savings and losses

Bending the Cost Curve
Baseline vs. Track1 / Track 2 Medicare Costs *



Cost Savings Achieved vs. Baseline: Yr 1 = 2.5% Year 2 = 6.6% Year 3 = 10%

Key Aspects of Proposed Medicare ACO Rules

- **Contract Terms**
  - Providers can be terminated from ACO for failure to meet established outcomes.
  - CMS can terminate ACO contract for failure to meet quality metrics or for avoiding at-risk beneficiaries
- **ACO Exclusivity**
  - Primary care providers = yes
  - All other providers/suppliers = no

Proposed Medicare ACO Rules

Emphasis on Quality

- **Emphasizes the Triple Aim**
  - Better care for individuals
  - Better Health for Populations
  - Lower Growth in Expenditures
- **First Year Quality Metrics Fall Into Five Domains**
  - Patient Experience of Care
  - Care Coordination
  - Patient Safety
  - Preventive Health
  - At-Risk Population/Frail Elderly Health

Proposed Medicare ACO Rules

Emphasis on Quality – Key Payment Factor

- ACOs required to report quality measures in all 3 years of contract
  - Year 1: quality performance standard is "full and accurate measures reporting" or quality = reporting outcomes
  - Years 2 & 3: propose quality performance standard based on a measures scale with a minimum attainment level
- Not eligible for shared savings if ACO fails to meet quality performance measures, regardless of how much per capita costs are reduced
- Failure to meet 1 or more domain attainment levels results in warning with re-evaluation in subsequent year.
- Failure to report on 1 or more measures within any domain, results in written request to submit data by specified date, and include written explanation for delay

Proposed Medicare ACO Rules Eligibility Requirements

Formal Legal Structure

- **Legal Entity Requirements**
  - Recognized & authorized to conduct business under applicable state law
  - Capable of receiving and distributing shared savings
  - Capable of repaying shared losses
  - Capable of establishing, reporting, and ensuring ACO participant compliance with program requirements
  - Performing any other ACO functions as outlined in statute

Proposed Medicare ACO Rules Eligibility Requirements

Formal Legal Structure

- **Governance Requirements**
  - Must be separate and unique to ACO
    - ◊ Exception: If ACO is "comprised of a self-contained financially and clinically integrated entity that has a pre-existing board"
  - Must be provider driven
  - ACO participants or designates – minimum of 75% representation/control
  - Medicare beneficiaries
  - Possesses broad responsibility for administrative, fiduciary, and clinical operations

ACOs: The Beneficiaries

- **Beneficiary Choice maintained**
  - Choice of Providers in/out of ACO
  - Can opt out
- **Assignment of beneficiaries**
  - Retroactive based on plurality of PC services
  - All patients benefit from changes.

Proposed Medicare ACO Rules Eligibility Requirements

Defined Processes to Promote

Evidence-Based Medicine

- **ACOs must**:
  - Establish and implement evidence-based guidelines
  - Base guidelines on best available evidence
  - Regularly assess and update guidelines to promote continuous improvement

Patient Engagement

- **Includes, not limited to:**
  - Shared decision making methods with patients on merits of medical care
  - Methods for fostering "health literacy" in patients & families

Medicare ACOs must describe how they intends to establish, implement and periodically update their evidence-based guidelines and patient engagement process.

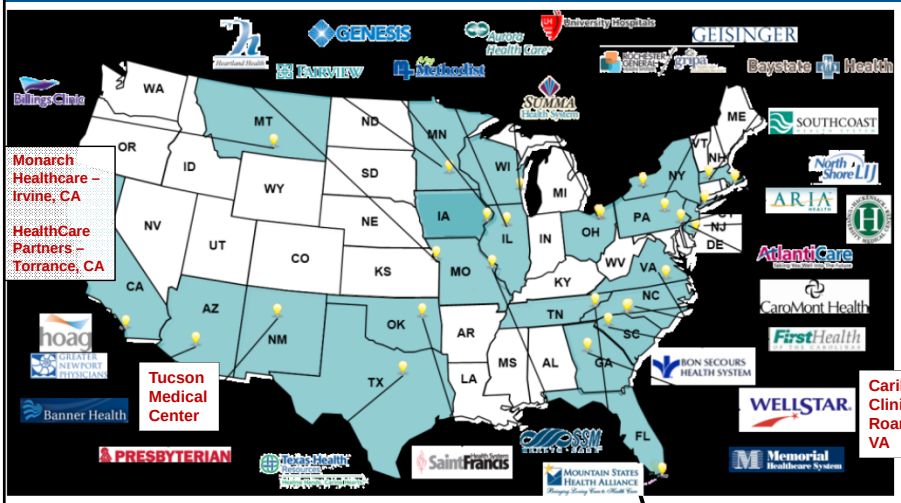
Pioneer ACO Model

- Separate ACO model being tested by Center for Medicare and Medicaid Innovation.
  - Designed for health care organizations and providers with experience in ACO-like delivery and payment arrangements.
  - Requires Pioneer ACOs to enter into other outcomes-based contracts with other purchasers so a majority of ACO revenues are derived from these arrangements
  - Prospective or retrospective assignment of min. of 15,000 Medicare beneficiaries
  - Model transitions ACOs to greater financial accountability faster.
  - Limited to 30 ACOs initially.
  - FQHCs are eligible applicants for this model but it is noted other CMMI initiatives for indigent communities and dual eligibles are forthcoming.

Pioneer ACO Model

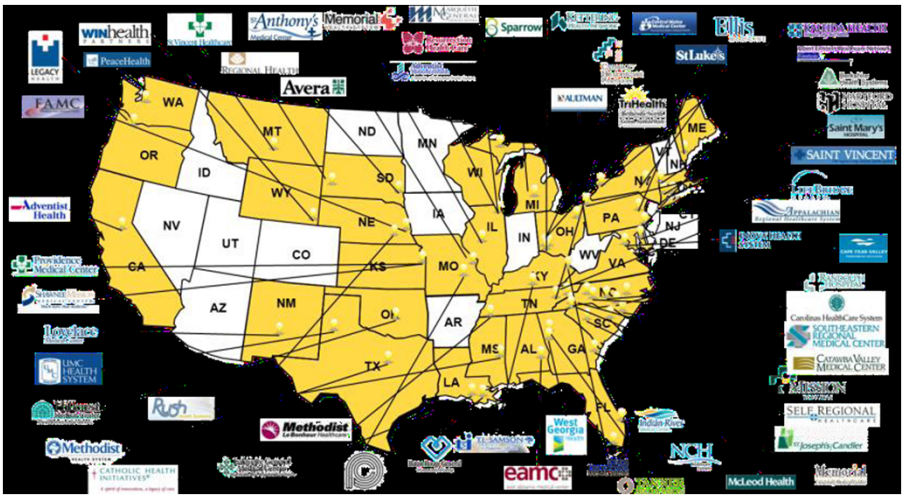
- Payment structure Differs from MSSP
  - Year 1 & 2: Higher levels of savings and risk
  - Yr 3: If min. annual savings met/exceeded in Yr 1 & 2, move to population-based payment
  - Alternate payment proposals from applicants will be reviewed and one selected.
  - No shared savings payment add-on for FQHC collaboration/inclusion

ACO Locations: Premier & Brookings/Dartmouth



Source: Premier Consulting , as accessed on 6/5/2011: http://www.premierinc.com/quality-safety/tools-services/ACO/aco-implementation-participants.pdf & Brookings Dartmouth, as accessed on 6/5/2011: http://tdi.dartmouth.edu/centers/population-health/policy-core/accountable-care-organizations/implementation-sites/

Premier members looking at becoming ACOs



Source: Premier, Inc., as accessed at: http://www.premierinc.com/quality-safety/tools-services/ACO/aco-readiness-participants.pdf

ACO Opportunities

- Potential additional revenue
- Rewarded for high quality and cost reductions
- Flexibility (e.g., eliminate 3-day hospital requirement)
- Secure increased referrals
- Specialize
- Explore new care delivery models
- Improve care transitions
- Increased physician involvement in resident care

Part 2
Impacts to Aging Services Providers

Leading Age Missouri – September 22, 2011

Chad Kunze, Principal (St. Louis, MO)
Andy Edeburn, Health Care Consultant (Minneapolis, MN)

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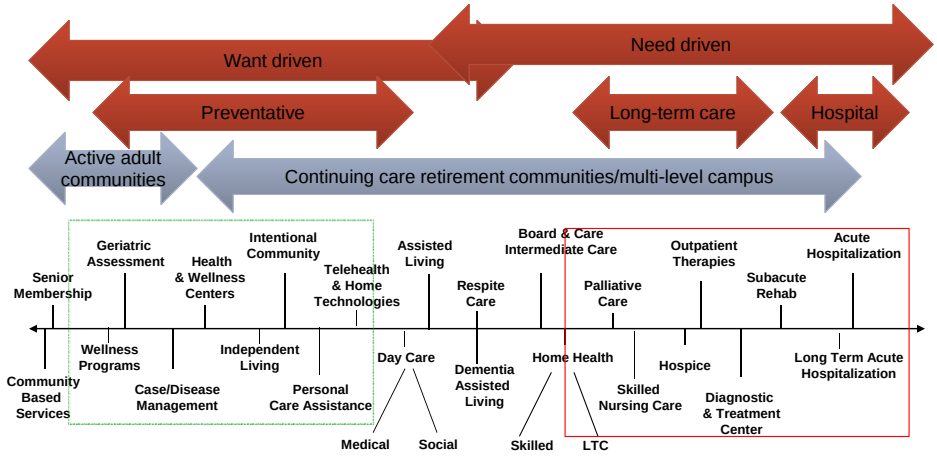
Key Trends

Drivers include local culture, customs, and care delivery patterns.

Successful strategic planning will require comprehensive understanding.

The Field of Aging Services is Evolving



Source: Adapted from previous Greystone and LarsonAllen LLP presentations

What Can We Expect?

1. Providers will be asked to **accept greater financial risk** for outcomes
2. **Operational efficiency** will be critical
3. Collaboration among **all providers** will be required for survival
4. Significant **investments in technology** will be necessary
5. **Increased quality** expectations, reporting and monitoring
6. Elevated **regulatory risk**
7. Increased focus on **community-based services and care** will result

Post-Acute Provider of Choice

Low/no hospital readmissions

Meaningful Use of Electronic Health Record

Past success partnering with other providers

High Quality

- Top of Class in Nursing Home or Home Health Compare
- High patient satisfaction
- Robust continuous quality improvement
- Innovative care delivery approaches
- Good community reputation

Demonstrated patient-centered approach to care

Cost of Care is lowest in comparison to peers with comparable quality.

Key Trends Impacting Aging Services

#1

Payment reform will focus on increasing value and lowering total costs.

Potential Implications to Aging Services

Robust measurement systems

Automated data collecting processes

Significant cost of care reductions

Changing gain-sharing payer expectations

Better payer contracting data

Implications of Reform: How Do We Track and Communicate Performance?

❑ **Tracking Systems-Are We There?**

Financial Management

Cost tracking by
- ✓ Specialty Unit
- ✓ Patient
- ✓ Payor
- ✓ Condition

Clinical Management

Electronic Health Record Quality Measures
- ✓ Readmissions
- ✓ Patient Outcomes
- ✓ Chronic Disease
- ✓ Acquired Conditions
- ✓ Medication Errors

Many Long-Term Care Facilities have purchased EHR-based systems in the last 4-6 years.

What % of the providers are using at least 50% of the EHR capability?

How we track performance: Today vs. Reform

TODAY:
- MDS Quality Indicators
- Nursing Home Compare
- Home Health Compare
- CASPER reports
- Resident Satisfaction Surveys
- Staffing ratios
- Employee turnover
- Nursing home survey
- Occupancy rates
- Waiting list
- FFS

Under Health Reform & Beyond
- Reduced hospital readmissions
- Better resident/patient outcomes
- Management of Chronic Disease
- Manage/reduce/know costs
- Eliminate health care acquired conditions
- Reduce/eliminate medication errors
- Improve care transitions
- Patient-centered care
- AND, all of the items TODAY

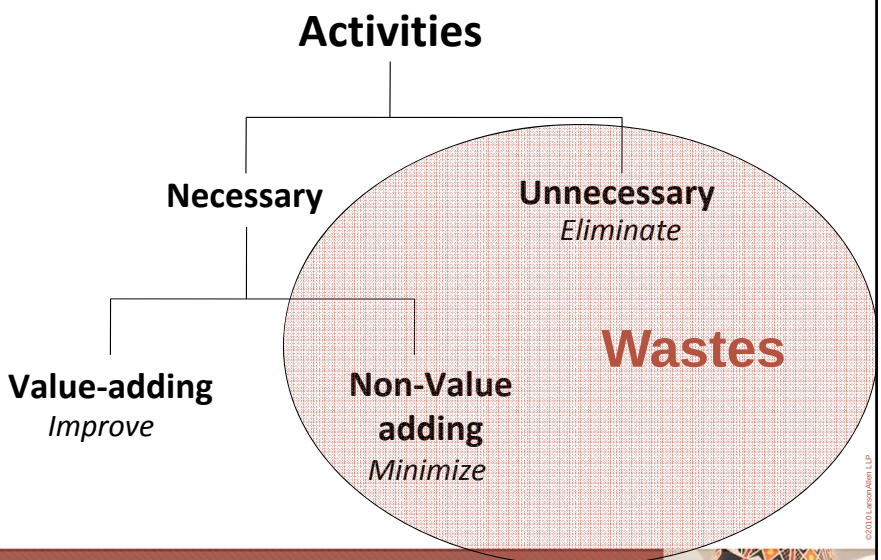
Efficient Use of Technology

- Multiple areas are tracked, reviewed, monitored, calculated and analyzed already as show on the previous slide
- Efficient use of technology is difficult today due to multiple interfacing products:
  - General Ledger, Payroll & Benefits
  - EMR and Health Records
  - Payroll and Benefits
  - Fixed Assets, Entrance Fees
  - List goes on!
- Solutions and new options will be coming but will involve new infrastructure and methods of input and output to obtain “tomorrows” required reporting

What is Operational Excellence
What is Operational Excellence?

The continual pursuit of delivering value for customers in the least-waste way.

Value-adding vs. Waste



Key Trends Impacting Aging Services

#2

Referral Sources are instituting changes in preparation for different payment models.

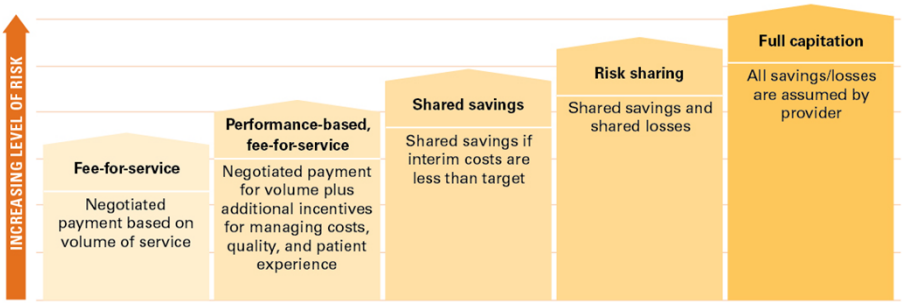
Potential Implications to Aging Services

- Hospital and physician relationships
- New provider roles
- Integrated care delivery models

- Best practice protocols
- Community and post-acute setting care delivery

An Evolving Array of Payment Options

Spectrum of Payment Models for Health Plans and Providers



Data-Driven Partnerships

"All My Friends Are Getting a Car for their Birthday!"

Name Five.

"We Provide Great Quality Care!"

PROVE IT.

From here on out, data (i.e., "evidence") are the distinguishing feature from one provider to the next – especially for a hospital or an ACO.

Data Driven Hospital Relationships

Hospital relationships must become data driven!

- For aging services providers, start seeing the world from the hospital's perspective:
  - Episodic Payment vs. Per Diem Payment
  - Intense Foci on Hospital LOS
  - Ever increasing concern about readmissions
  - Shifting toward value-based payment and reward for outcomes

Key Trends Impacting Aging Services

#3

Hospitals will experience significant financial strains over the next 5 to 7 years.

Potential Implications to Aging Services

More SNF and home care discharges

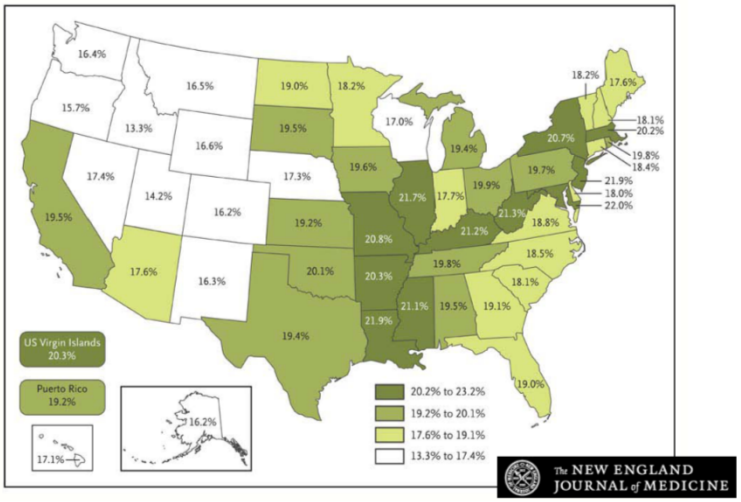
Frail and clinically complex residents

Greater hospital integration

Faster response times

Preferred provider networks

Hospital Readmission Rates Vary Across the Country!

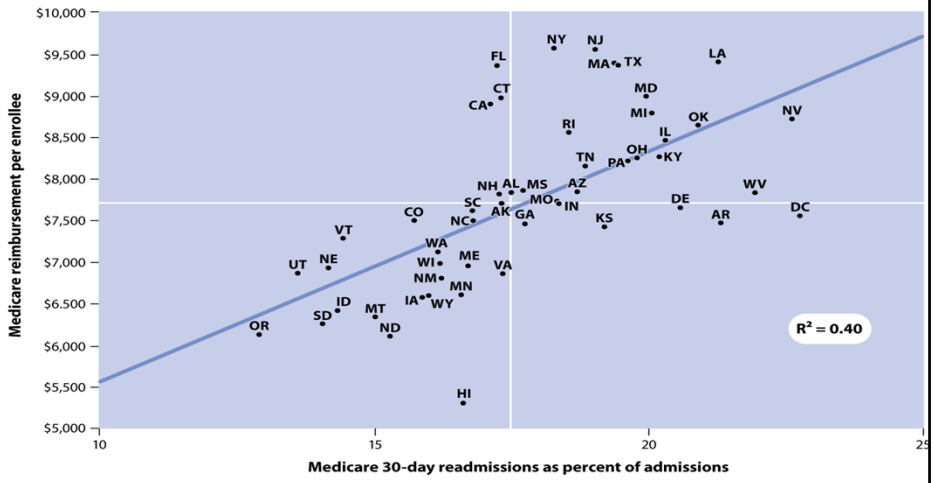


Jencks S, Williams MV, Coleman EA. et al. N Engl J Med 2009;360:1418-1428

The NEW ENGLAND JOURNAL of MEDICINE

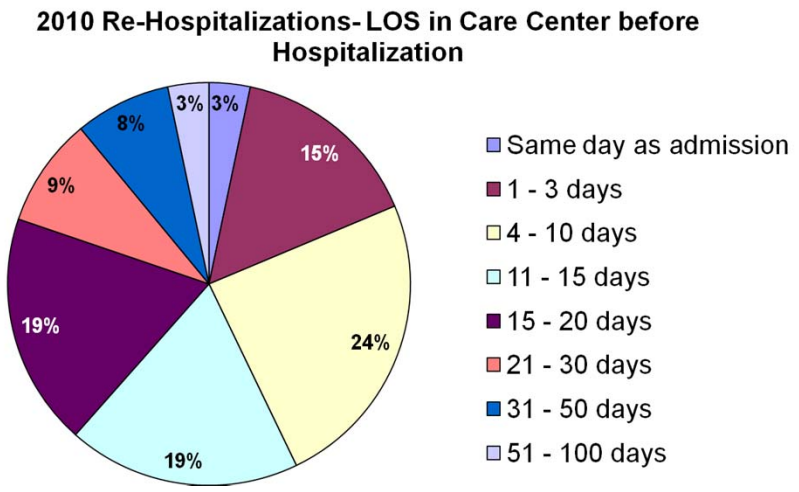
Medicare Per Beneficiary Costs & Readmission

Medicare Cost Per Beneficiary and 30-Day Readmissions by State

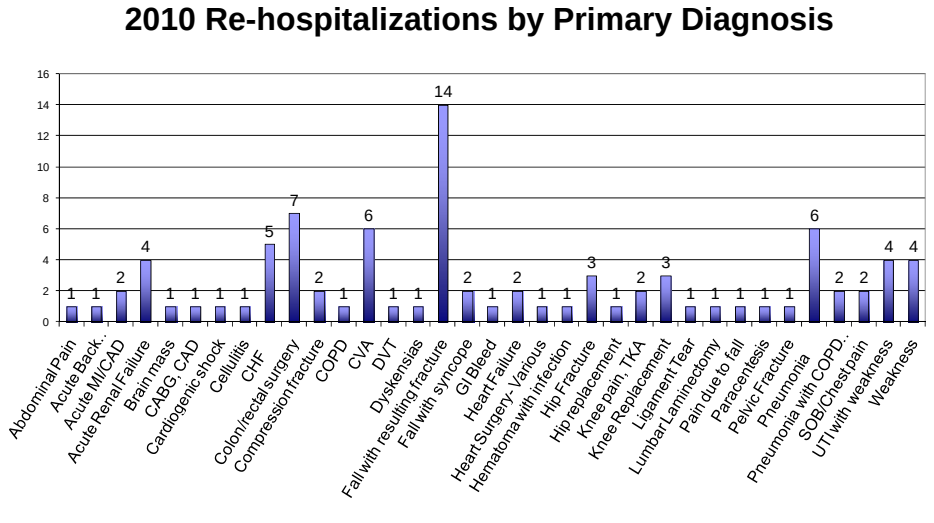


DATA: Medicare readmissions—2006–07 Medicare 5% SAF Data; Medicare reimbursement—2006 Dartmouth Atlas of Health Care
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009

Provider Perspective:
Length of Stay at SNF before Re -Hospitalization



Provider Perspective:
Acute Care Readmission by Diagnosis



Geisinger ProvenCare Results – Episodes of Care

Proven Care by the Numbers (18 months)	Before Proven Care	With Proven Care	% Improvement/ Reduction
Average total length of stay	6.2	5.7	-
30-day readmission rate	6.9%	3.8%	44%
Patients w/ any complication	38%	30%	21%
Patients w/less than 1 complication	7.6%	5.5%	28%
Incidence of atrial fibrillation	23%	19%	17%
Neurological complication	1.5%	0.6%	60%
Any pulmonary complication	7%	4%	43%
Blood products used	23%	18%	22%
Re-operation for bleeding	3.8%	1.7%	55%
Deep sternal wound infection	0.8%	0.6%	25%

Source: http://www.geisinger.org/provencare/numbers.html

Preferred Provider Network Evolution is Coming!

- The good news is that hospitals are really rediscovering post-acute care:

> *"Policymakers and health care providers increasingly recognize that coordination between acute care hospitals and post-acute providers is essential to improving the overall quality of care and reducing health spending."*
>
> *- Rich Umbdenstock, President & CEO, AHA*

The bad news is that hospitals have rediscovered post-acute care.

Selecting "Preferred" Partners

- Hospitals are interested in moving from venue-based discharge to care management via an integrated continuum.
  - Enhanced clinical integration
  - Increased physician integration into post-acute specialty practices
  - Emphasis on outcomes, quality and cost savings

Selecting "Preferred Partners"

- Acute hospitals are evolving specific criteria for selecting potential post-acute partners:
  - Quantifiable outcomes in key areas – readmissions, unnecessary admissions, patient improvement, patient satisfaction
  - Clinical capacity to manage medically complex patients – pathways, protocols, standing orders
  - Physician/APRN coverage
  - Downstream continuum management capacity – Home Health, AL, CareTransitions, Coaching

Key Trends Impacting Aging Services

#4

Future customer buying practices will likely not reflect historical patterns.

Potential Implications to Aging Services

More focus on value

Increased vacancies

New marketing messages

Short stay residents

Patients staying in their own homes

Seniors and Family Expectations and Research

Expectations:

- What is "Value" today is different from yesterday
- Economics
- Services
- Choice
- Competition

Research:

- Available tools
- Internet
- Interviews and Tours
- Word of Mouth
- Financial Statements and Tax Returns
- More transparency in the future

Declines in Net Income and Net Worth: Potential Impact

Impact of Declines in Wealth:

1. **Wealth of 65+ will be lower than current cohort**
   - May choose to work in retirement
   - May choose to live with children rather than other alternatives
   - May delay moves to senior communities
2. **Reportedly, increasing numbers of older adults are moving in with adult children to preserve assets & support children**
   - Increased use of emergency room, physician offices, home & community services and other venues as frail elders need services
3. **Adult children, who have also experienced declines in wealth, are assisting parents make aging services choices with a new lens**
4. **Financially stressed adult children may increasingly look to parents for assistance impacting the elder's financial strength**

Declines in Net Income and Net Worth: Confidence in Savings

Confidence in Having Enough Money to Live Comfortably Throughout Retirement, 2006-2010

	2006	2007	2008	2009	2010
Very confident	24%	27%	18%	13%	16%
Somewhat confident	44	43	43	41	38
Not too confident	17	19	21	22	24
Not at all confident	14	10	18	22	22

Source: Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc., 1993-2010 Retirement Confidence Surveys.

Additionally, 31% of those who said they have not saved for retirement feel *very or somewhat* confident that they will have a comfortable retirement.

Source: 2009 Retirement Confidence Survey Fact Sheet *Saving for Retirement in America,* April, 2009, Employee Benefit Research Corporation

Key Trends Impacting Aging Services

#5

Health Care Reform legislation will create opportunities for aging services providers.

Potential Implications to Aging Services

- Health information exchange
- Payment reform
- Quality and performance measurement
- SNF and Home Health payment reductions
- Shift to lower cost levels of care
- Growth in home and community based services

Measurement & Metrics Will Matter!

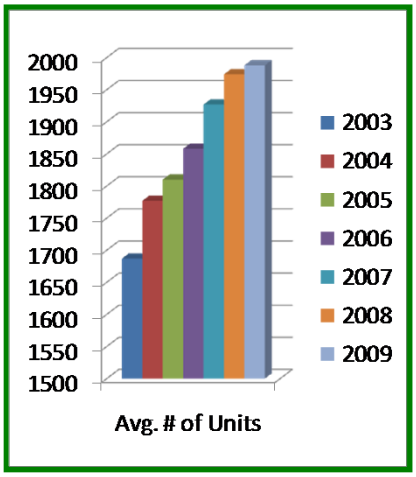
What We Know For Certain:

- Statistical correlation exists between SNF quality and staffing.
- Physician care can have a significant impact on quality of nursing home care and outcomes.
- Quality of care breaks down during transitions – from one setting to the next.
- Health information systems is underutilized in SNF, particularly in QA/QI and monitoring
- Improving quality (i.e., better outcomes) will require valid metrics, good data and proactive systemic approaches.

Source: A. Kramer, MD. "Evolving Role of Quality Assessment and Outcome Assessment in Post-Acute Care", NIC, 2011

The "bigger" the "better"

- The "big" get "bigger"
  - AZ 100 shows nearly 18% increase in average units operated by 100 largest systems over past 7 years
- While single site operators continue to grow – the majority of growth within the field is driven by the largest organizations
- The number of affiliations has increased over the past several years (with a significantly increased rate in 2009 and 2010)
  - Closures and dispositions have also increased



AAHSA/Ziegler 100 Largest Senior Living Systems

More "Hand Raisers"

With challenges, there will be more "hand raisers"

- Capital Needs
- Restructuring Needs
- Cultural Needs
- Transition of Leadership

Opportunities to grow and advance your mission

- Will growth come internally or through acquisitions or joint ventures?
- How will we meet the required demands and expectations?
- Due diligence will include the same or similar monitoring and evaluation we do internally

So, What Do We Need to Do?

Key strategies for aging services providers:

1.	***Bend the cost curve*** – lower costs and increase effectiveness
2.	***Understand and capitalize on strengths*** – Create an understanding of existing patient care delivery patterns; Identify and implement best practices and strategies by diagnoses
3.	***Meaningfully use technology–*** Develop electronic health exchange, monitoring tools and communication vehicles
4.	***Focus on patient, not process*** – Determine practices for patient-centered care and patient engagement approaches
5.	***Connect Quality to Value*** – Define a financially savvy path transitioning to value based/gain-sharing payments
6.	***Build new relationships –*** Develop ***relationships*** at the organizational level, not just referral level

Our Overall Perspective: The Critical Issues

Recessionary economy

Health care reform

Access to capital

Technology

Relationships

Accountability and value

Access to Capital Will Continue to be Difficult

High interest rates for non-rated credits

Consider alternate sources of capital

Fitch Ratings: “negative outlook for the senior living sector” for 2011

Borrowing capacity defined by operating results *and* balance sheet strength

Rating matters!

Business Relationship and Process Changes

Manage referral relationships

Add value in the “care delivery” stream

Implement sophisticated business processes

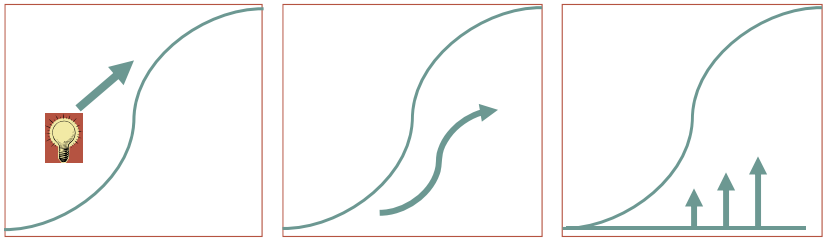
Adapt management and governance activities

Increasing Consumer and Payer Expectations

Demand for accountability and value

Targeted under health reform	Person-centered post-acute care	Home and community based services
A long range financing vehicle	Living arrangements	Expectation of "free!"

The Three Strategic Postures



Shape the future

Play a leadership role in establishing how the industry operates, for example:

- setting standards
- creating demand

Adapt to the future

Win through speed, agility, and flexibility in recognizing and capturing opportunities in existing markets

Reserve the right to play

Invest sufficiently to stay in the game but avoid premature commitments

Source: Harvard Business Review: Strategy Under Uncertainty, Nov-Dec 1997.

Readiness Assessment: Aging Services Providers

- Gain a more in depth understanding of your market: create processes to gather hospital length of stay, re-admission rates and discharge patterns in order to understand market opportunity
- Know your quality and value…compared to your competitors….measure it , communicate it and implement processes to improve it
- Cuts to reimbursement will require providers to re-examine care delivery to reduce costs….this will mean changes to historical care delivery models

Readiness Assessment: Aging Services Providers

- Identify key quality metrics that demonstrate value from a payer perspective (ACOs, Medicare, Medicaid, etc.), then track and report on them
- Build relationships with CEOs of hospitals, health systems, physician practices and other providers
- New payment models are coming from all payer sources not just Medicare; and will require new business models
- Integrate technology into care delivery to improve care and increase value

Discussion | Questions & Answers

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