Genesis HealthCare Presentation for the Health Care Association of New Jersey

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Genesis

CMS Goals for Adoption of Alternative Payment Models (APMs)

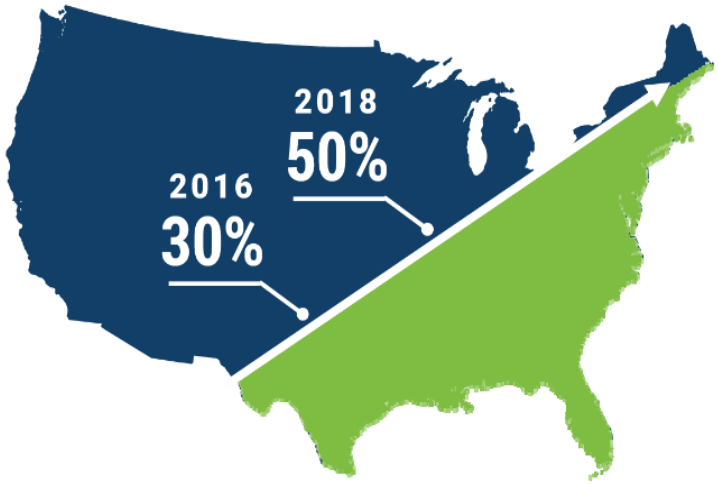
U.S. Adoption of APMs

2016
30%

In 2016, at least **30%** of U.S. health care payments are linked to quality and value through APMs

2018
50%

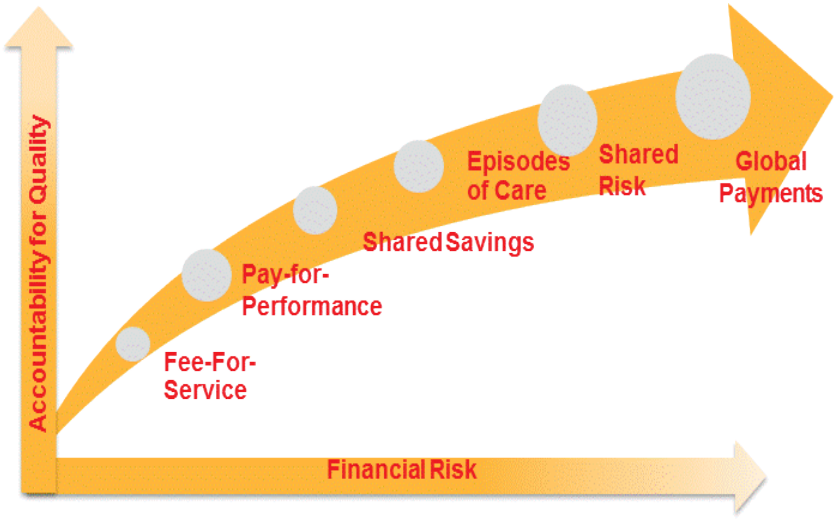
In 2018, at least **50%** of U.S. health care payments are so linked



CMS announced on March 3rd that it had already reached the 2016 30% goal for quality-based payments

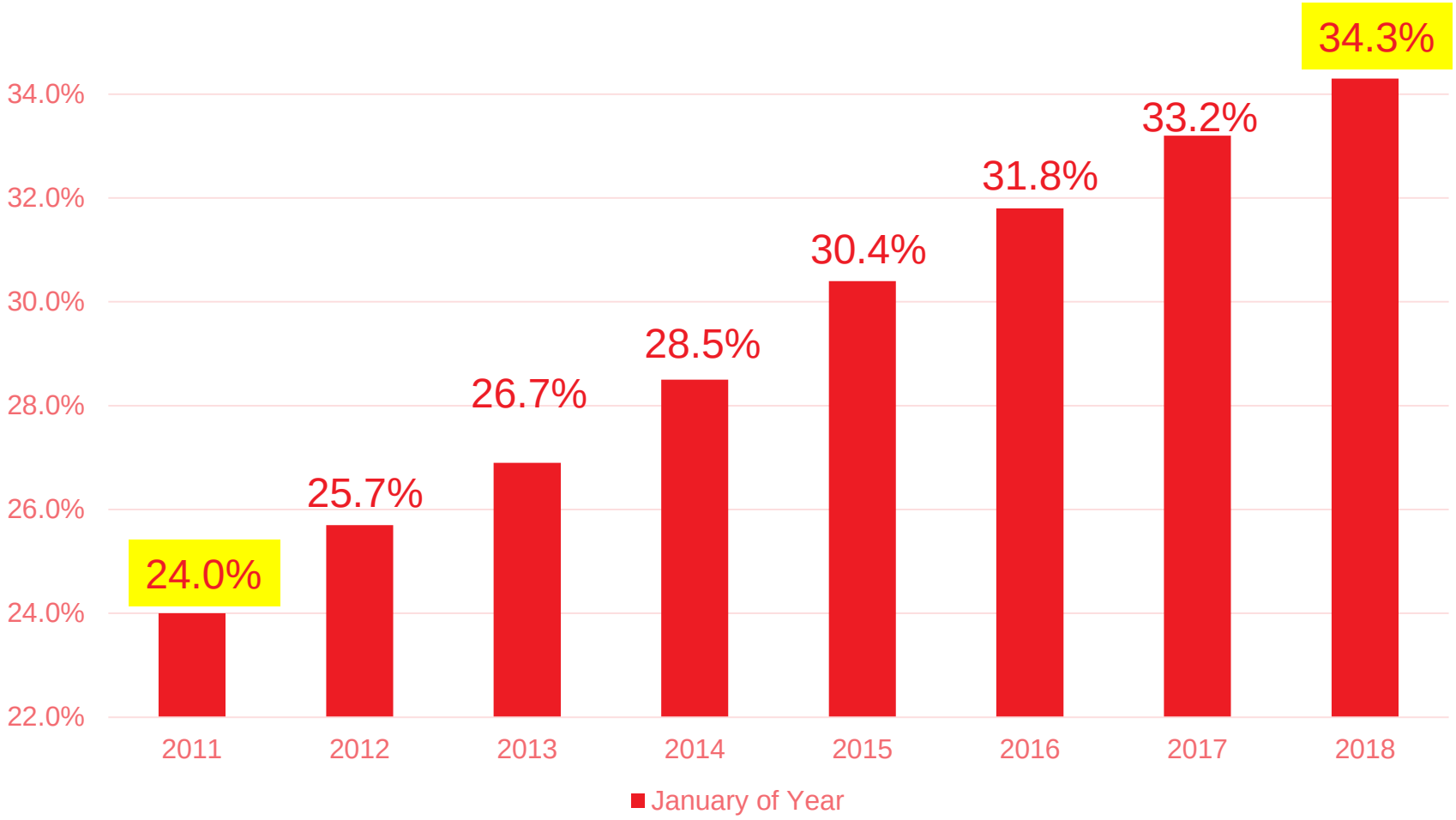
Shifting Payment Practices

Low Risk/Low Accountability to High Risk/High Accountability for Quality



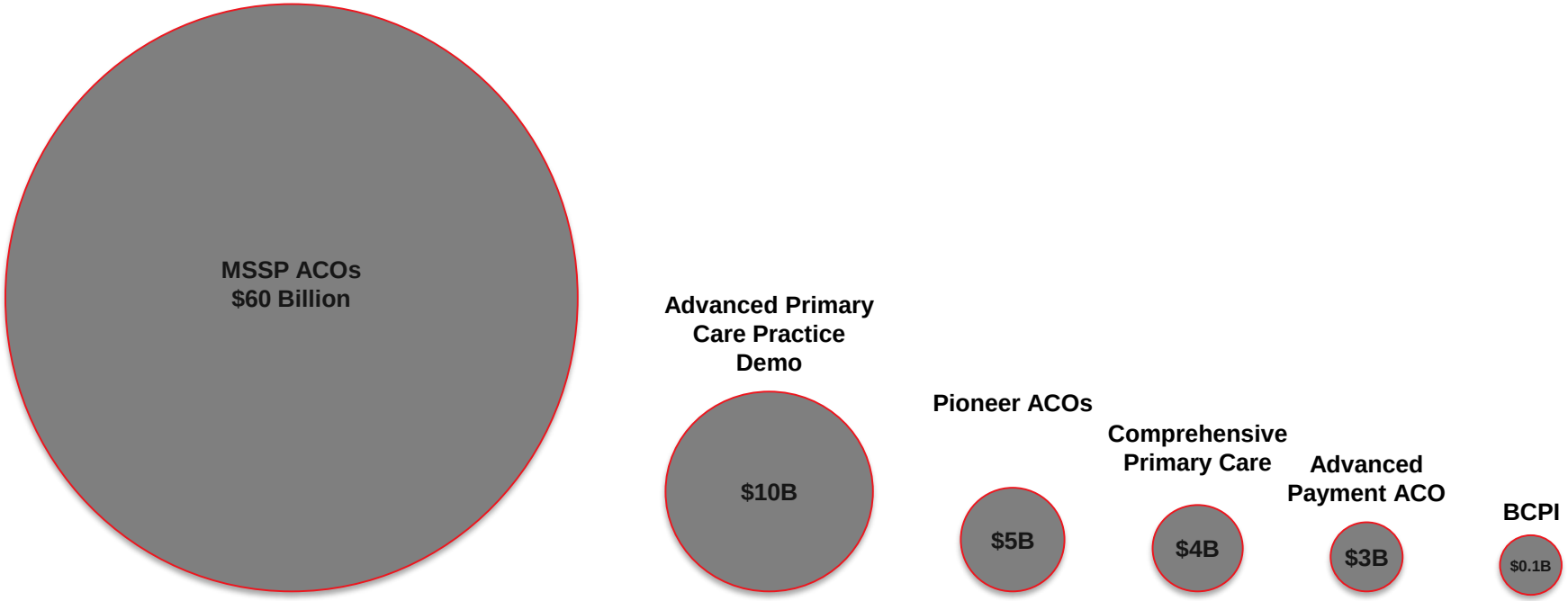
Better Care, Smarter Spending, Healthier People

Annual Medicare Advantage % Penetration of Medicare Eligibles January 2011 to January 2018



Overview of New Medicare Risk Models
MSSP is the largest Initiative to Reduce the Rising Cost of Health Care

Estimated Total Medicare FFS Spend Managed[(1)], 2015



# of Beneficiaries	7.3mm	900k	600k	340k	300k	130k

(1) Estimates based on total Medicare FFS expenditures of $445bn and number of Medicare beneficiaries enrolled in each model.
Source: Lewin Group BPCI Analysis, CMMI.

The Impact of a Value-Based World

- The world has become exponentially more transparent;
- Our distribution channel, i.e., hospitals, physicians, conveners, payers have our utilization and cost data;
- How did they get all this data on us?:
  - BPCI program
  - MSSP program
  - Demand management
- Narrowed networks:
  - Hospitals
  - Physicians
  - Conveners
  - Payers

Why did Genesis Choose to Participate in the MSSP?

- Genesis already has a physician practice with the appropriate infrastructure
- The attributed population is long-term care residents of Genesis
- Genesis has in place very sufficient care management infrastructure
- Genesis coordinates all services provided to its residents
- Genesis MSSP should interact favorably with community ACOs

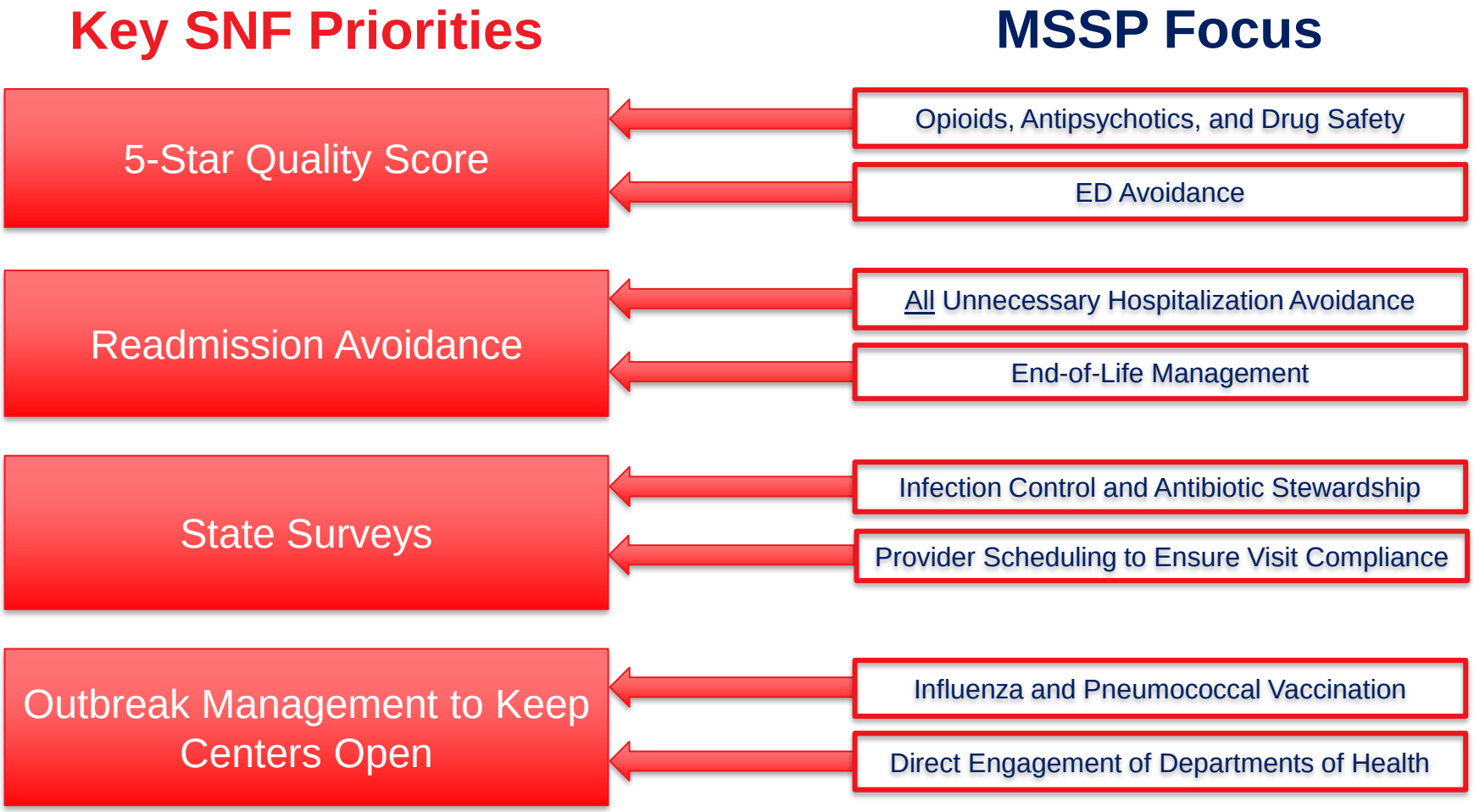
What Does a SNF Need to do to Prove Value?

- KNOW YOUR REAL DATA:
  - Hospital re-admission rates
  - ER transfer rates
  - Part A length of stay
- Focus on and reduction of these points are an imperative
- Understand how your distribution channel is measure on quality:
  - BPCI
  - BPCI Advanced
  - Medicare Shared Savings Program/Next Gen
- Understand how to talk to your partners…know their terms and what's important to them:
  - HEDIS
  - Stars
  - HCC Coding

Quality Measures Comparison

MSSP ACO			Medicare Advantage Stars	
Domain	**ACO #**	**ACO Measure**	**MA Star Measure?**	**MA Method of Submission**
Patient/ Caregiver Experience	ACO-1	CAHPS: Getting timely care, appointments, and information	Y	CAHPS Survey
	ACO - 4	CAHPS: Access to Specialists	Y	CAHPS Survey
Care Coordination / Patient Safety	ACO-12 (Care-1)	Medication Reconciliation Post-Discharge	Y	HEDIS
	ACO-13 (Care-2)	Falls: screening for future fall risk	Y	HEDIS/HOS
Preventive Health	ACO-20 (PREV-5)	Breast cancer screening	Y	HEDIS
	ACO-19 (PREV-6)	Colorectal cancer screening	Y	HEDIS
	ACO-14 (PREV-7)	Preventive care and screening: influenza immunization	Y	CAHPS Survey
	ACO-16 (PREV-9)	Preventive care and screening: body mass index screening and follow-up	Y	HEDIS
At-Risk Population	ACO-27 (DM-2)	Diabetes: hemoglobin A1c poor control	Y	HEDIS
	ACO-41 (DM-7)	Diabetes: Eye Exam	Y	HEDIS
	ACO-28 (HTN-2)	Controlling high blood pressure	Y	HEDIS

Alignment of MSSP with SNFs



Contracting with ACOs

- Next Gen ACOs will be the primary entity types looking for contracts (currently there are 58 nationwide)
- Next Gen ACOs are able to demand a reduction, typically 10-15 percent, on YOUR rates from Medicare (approved by Medicare)
- Make sure you have a way to make that money up through incentives:
  - Reduction in length of stay
  - Reduction in hospital re-admissions
  - Improvement in agreed upon quality measures
- Be aggressive and attempt to contract with them BEFORE they come to you. MSSP ACOs are primarily looking to narrowing networks to those providers that have proven to be efficient and with good quality outcomes
- Don’t forget, failure to comply with an ACO’s contracting demands could leave you out of their network
- BE CREATIVE IN WORKING WITH ACOs!!

Financial Assurance Program Goals

- Create a clinical program that will encourage ACOs to collaborate with a limited panel of post-acute providers to achieve the “triple aim” of greater quality, efficiency and patient experience
- Align clinical and financial incentive between ACOs and SNF to encourage enhance clinical collaboration that will generate demonstrated benefits to the ACO members
- Collaborative clinical opportunities with SNFs include:
  - Improvement to transitions of care at time of SNF admission
  - Effective pre-admission assessment of patients with high risk for readmissions
  - Timely and effective care planning including focus on high risk patients
  - Focus on Advance Care Directives
  - Reduce re-hospitalizations during SNF stay and after discharge home
  - Closer coordination with narrowed panel of home health providers
  - Reconnection with the primary care physician post discharge
  - Comprehensive medicine reconciliation
  - Integration of post discharge services including home care, etc. where appropriate
  - Electronic data sharing

Financial Assurance Program Description

- SNFs need to understand that opportunities exist to further collaborate with ACOs and create significant savings that can guaranteed
- Financial Assurance related to utilization reductions will be in length of stay reductions for SNF admissions including:
  - Existing SNF admissions
  - Potential additional admissions re-directed to SNF
- Financial assurance will relate only to admissions to your SNF
- If SNF is unable to meet the financial assurance goals (SNF los, re-admissions and agreed upon quality metrics), SNF will pay the shortfall between actual and projected results to ACO
- While there are quality outcome opportunities for ACO to collaborate with SNFs by having a larger number of admissions to your SNF, there is no requirement for the ACO to guarantee a certain number or volume of admissions
- Potential for re-admission incentive to further align interest to improve Hospital re-admissions to include both while in SNF and post discharge

Financial Assurance Program Description
Readmission Incentive/Penalty Program

- Program Description
  - Use recent utilization patterns to establish readmission statistical baseline
  - Calculate changes in annual readmission percentage with reductions or increases resulting in incentive or penalty payments for the change in expenses
  - Align incentives to encourage collaboration of reduction of readmissions as well as focused effort on improvement in certain clinical parameters
- Key Assumption Decisions, Assumptions and Examples
  - Current 90 day readmission % from admission to SNF is X%
  - Estimated average cost per acute hospital admission of $15,000
  - Corridor of 1% (X% to Y%) where no incentive/penalty are generated
  - 50% split of savings below X% readmission (ACO to pay SNF)
  - 50% penalty for readmissions above Y% (SNF to pay ACO)
  - Focused quality parameters to be agreed upon
    - Failure to achieve clinical targets can reduce SNF incentive participation opportunities