HMA 40 YEARS

NIXON PEABODY

Beyond Bundles: Preparing Hospitals for Success in TEAM and the Next Generation of Value-Based Models

Today's Panelists

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VBC Capabilities Overview: What We Do

*HMA's VBC-related service lines support clients at **all stages of their transformation journeys** and draw from **subject matter and functional experts** across strategy, policy, finance, actuarial services, quality, and operations.*

Understanding Value

Example services include:

- **Market & Model Intelligence**
  - Market monitoring and insights
  - Policy analysis and interpretation (federal and state)
  - Tailored education, trainings, curriculum development
  - Research and publications
- **Multi-Stakeholder Engagement**
  - Facilitated convenings (e.g., advisory groups, learning collaboratives)
  - Training and TA
- **Situational & Market Analyses for Strategic Growth**
  - Value proposition assessments
  - Market segmentation
  - Geographic market rankings
  - Due diligence

Engaging in Value

- **Readiness Assessments & Support**
  - Multi-domain gap assessments and recommendations tailored to model, population, provider type
  - Implementation support & TA
- **Organizational VBP Strategy**
  - Go-to-market strategies
  - Operating structure advisement
  - Partner evaluation
- **Model/Contract Evaluation & Entry**
  - Comprehensive assessment of model/contract options (e.g., regulatory, actuarial modeling, operations, etc.)
  - Application support
  - Contract negotiation support
- **APM Design**
  - Model framework development
  - Actuarial analysis
  - Stakeholder feedback & engagement

Optimizing Performance

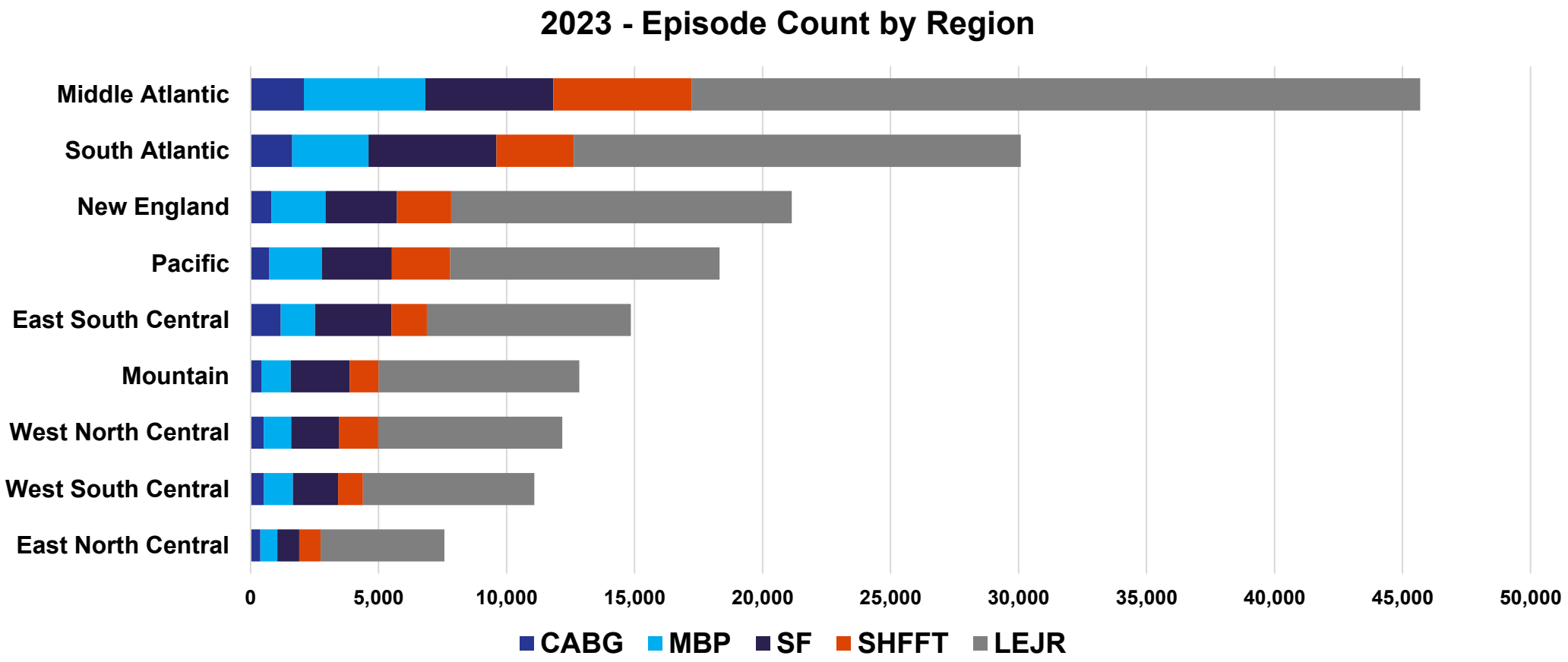
- **Performance Monitoring**
  - Financial projections
  - Emerging experience reporting
  - Opportunity analysis
  - Benchmarking
- **Operational Assessments & Enhancements**
  - Operational roadmaps for needed population health capabilities (e.g., IT infrastructure needs, care model design, clinical workflows, physician engagement, etc.)
  - Recommended investment priorities and sequencing
  - Practice transformation support

Data Insights

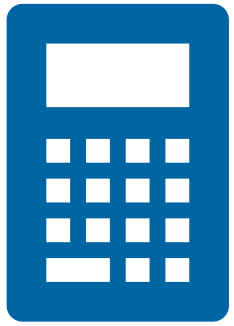
What Procedures are Covered?

2023 DATA

LEJR is ~60% of the procedures and ~40% of the Medicare FFS spend



Possible Financial Impact Nationwide



Average episode loss
is expected to be
~ $600

Almost 60% of hospitals
are expected to be in
a loss position

MANAGING RISK

Data Driven Approach

Looking at three levels of data

01 How is your hospital performing?

- Historical gain / loss position
- Historical performance vs. benchmarks
  - Anchor and post acute cost by service category: IP, OP, SNF, HH, Prof, DME, Hospice
  - Post acute SNF facility performance
  - Anchor surgeon

02 How are your competitors performing?

- What is happening in your market?
- It's important to understand how local market dynamics impact care and risk profile in market.

03 What are the trends & key cost drivers in the Benchmark Region?

- How are other hospitals in your Region performing now, and how will future improvement impact your target price and reimbursement?
- Where does your health system stack up as compared to other regional systems?
- Hospitals/health systems who are ahead of the curve will reap the rewards of their efforts in subsequent years as demonstrated on the next slide.

Going Beyond the Gain / Loss

Baseline Data
Understand Current Position in Program

Baseline Gain / Loss

- Historical episodic counts
- Actual historical cost per episode
- Estimated gain / loss compared to benchmark for the 5 surgical categories

Analytic Insights*
Leveraging data to find opportunities

- Baseline Gain / Loss
- Site of Service
- Bench-marking
- SNF / HH Provider Profile
- Primary Surgeon Profile

*Leveraging the CMS 100% Medicare data set (VRDC)

Benchmarking Post Episode 30 Day Spend

Example: HOW DO YOU COMPARE TO THE CENSUS REGION?

Post Episode 30 Day Spend - DRG 481 (Hip and Femur): 200 Episodes							
Top 25%	Top 25%	Middle 50%		Target Hospital	Bottom 25%	Difference in 2nd Quartile & Target Hospital/Episode	$ at Risk
Re-Admissions	$860	$930	$1,310	$1,240	$1,000	($310)	($62,000)
Outpatient	$310	$410	$410	$960	$570	($550)	($110,000)
Physician Services	$1,290	$1,140	$1,020	$780	$850	$360	$72,000
SNF	**$6,030**	**$8,450**	**$10,550**	**$11,350**	**$16,230**	($2,900)	($580,000)
HH	$730	$710	$590	$540	$450	$170	$34,000
DME	$150	$70	$100	$90	$50	($20)	($4,000)
Hospice	$160	$290	$140	$70	$160	$220	$44,000
Total	**$9,530**	**$12,000**	**$14,120**	**$15,030**	**$19,310**	($3,030)	($606,000)

- $606K savings opportunity of which $580K is SNF for this one DRG
- **This example illustrates that a negative cost variance on just one DRG (total of 29 in TEAM) could result in significant financial risk**

Managing the Post-Acute Phase of Care

Goals of a Post-Acute Strategy for the TEAM Model

01

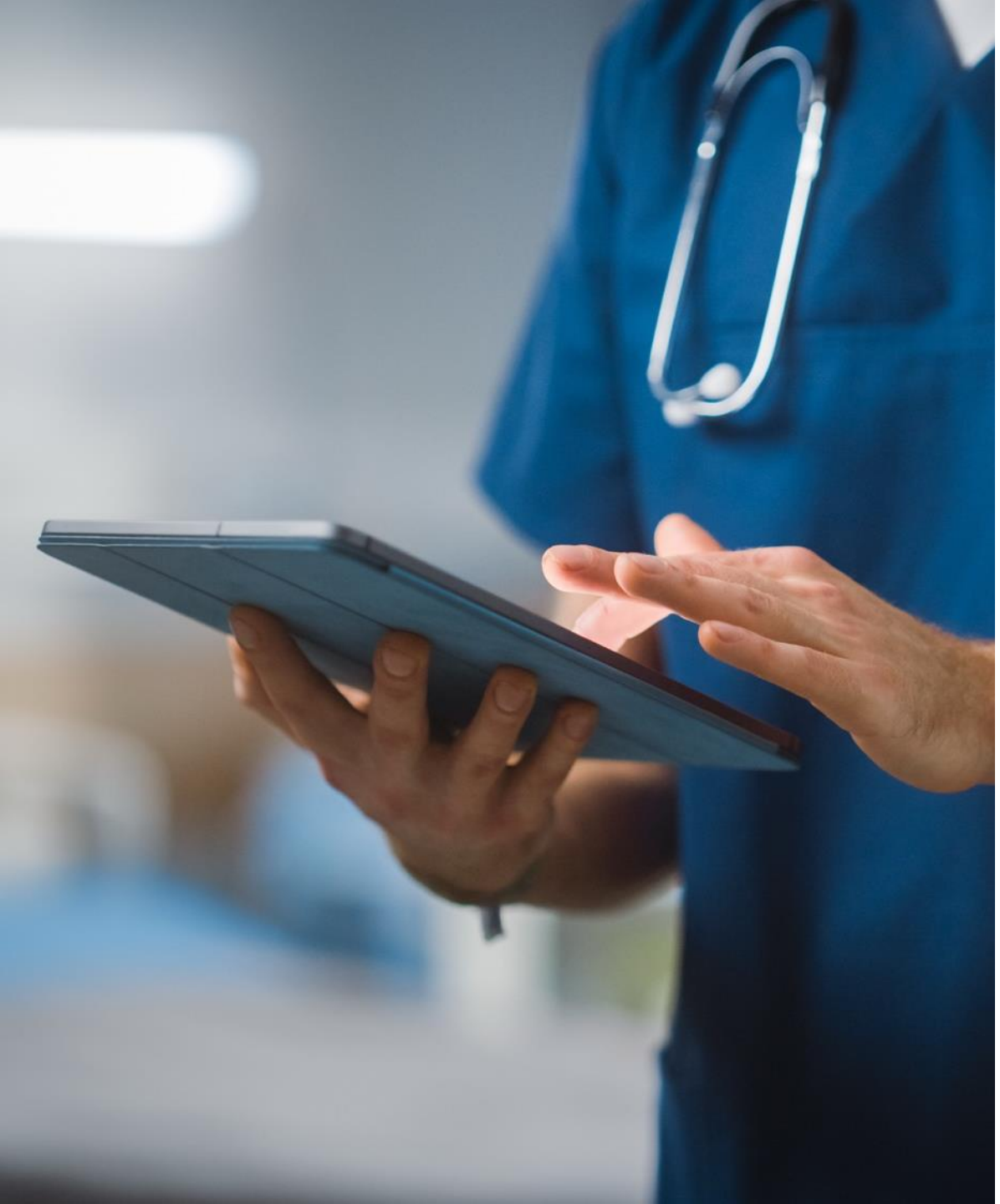
Right Location of Care – the lowest effective level of post-acute care

02

Right duration of post-acute care

03

Highest quality of post-acute care



Location of care is highly predictive of cost in the post-acute phase

- **Outpatient rehabilitation**
  - Hospital-based or in community clinics
- **Community-based post-acute care**
  - Delivered by home health agencies
- **Institutional post-acute care**
  - Skilled nursing facilities
  - Acute rehabilitation facilities
  - Long term acute care hospitals (LTACs)

Duration of the post-acute phase of care

Timely transfer to the post-acute setting

Monitoring and management of the SNF length of stay

Consider sequential decreasing levels of care

Key Actions for Success in TEAM

- Educate the hospital care team about the TEAM model
- Planning for post-acute care begins pre-admission
- Enhanced discharge planning
- Tighten management of transitions of care

Developing or enhancing the preferred network of collaborating SNFs

- **Key considerations:**
  - **Quality Metrics**
  - **Readmission rates**
  - **Patient experience data**
  - **Bed availability**
  - **Efficiency**

Managing care in the post-acute setting

- **Some hospitals may re-consider owning post-acute facilities**
- **Reserving or pre-purchasing bed-capacity**
- **Collaborate with or employ SNF-specialized providers to manage care in the SNF**
- **Develop post-acute centers of excellence** for specific procedures with standardized care and communication protocols, shared data and quality metrics

Financial Arrangement Considerations

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TEAM payment model

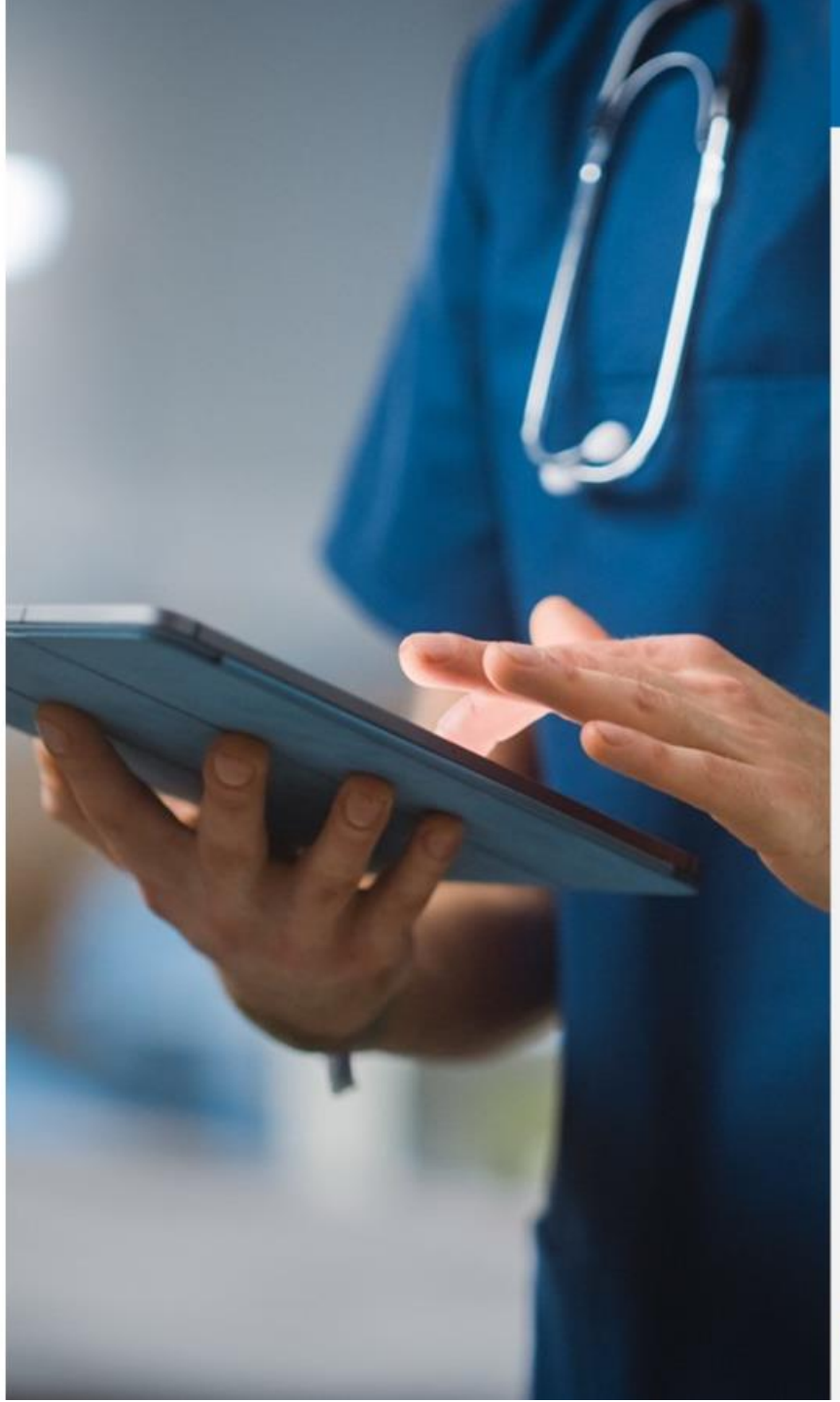
Hospitals and ALL providers rendering care during the 30-day episode will continue to receive traditional FFS payments during the care episode.

- At the end of the performance year, CMS will compare the total episode costs to a pre-set target price based on three years of historical data, adjusted for regional and hospital-specific factors.
  - If the actual costs are less than the pre-set target and quality standards are met, hospitals may receive a reconciliation payment, which serves as a performance bonus.
  - If the actual costs are more than the pre-set target, hospitals may be required to repay CMS

Gainsharing

Hospitals can share the savings and losses with ACOs and other providers (collaborators) through:

- Sharing Arrangement (upside and downside)
- Distribution Arrangement (upside only)
- Downstream Distribution Arrangement



Team collaborators

Must be a Medicare Enrolled Provider

- ACOs
- Skilled Nursing Facilities
- Long-Term Care Hospitals
- Inpatient Rehabilitation Facilities
- Comprehensive Outpatient Rehabilitation Facilities
- Home Health Agencies
- Hospital, including Critical Access Hospital
- Physician
- Therapist
- Group Practices
  - Physician Group Practice (PGP)
  - Non-Physician Group Practice (NPGP)
  - Therapy Group Practice (TGP)
- Enters into a "Sharing Arrangement" with the Hospital
- A list of collaborators, agents and downstream individuals that are physicians, practitioners or therapists in financial arrangements must be provided to CMS, quarterly, including their National Provider Identifier and Tax Identification Number.

Quality and other considerations

Quality

- Hospital readmission rates
- Patient safety and adverse events
  - Complication and infection rates
  - Falls with injury
  - Postoperative respiratory failure
  - 30-Day Risk-Standardized Death Rate
  - Patient Reported Outcome-based Performance
  - Patient experience (CHAHPS)

Experience

- Minimum # of services

Need policies addressing

- Quality
- Selection Criteria
  - Nothing based on volume or value of referrals

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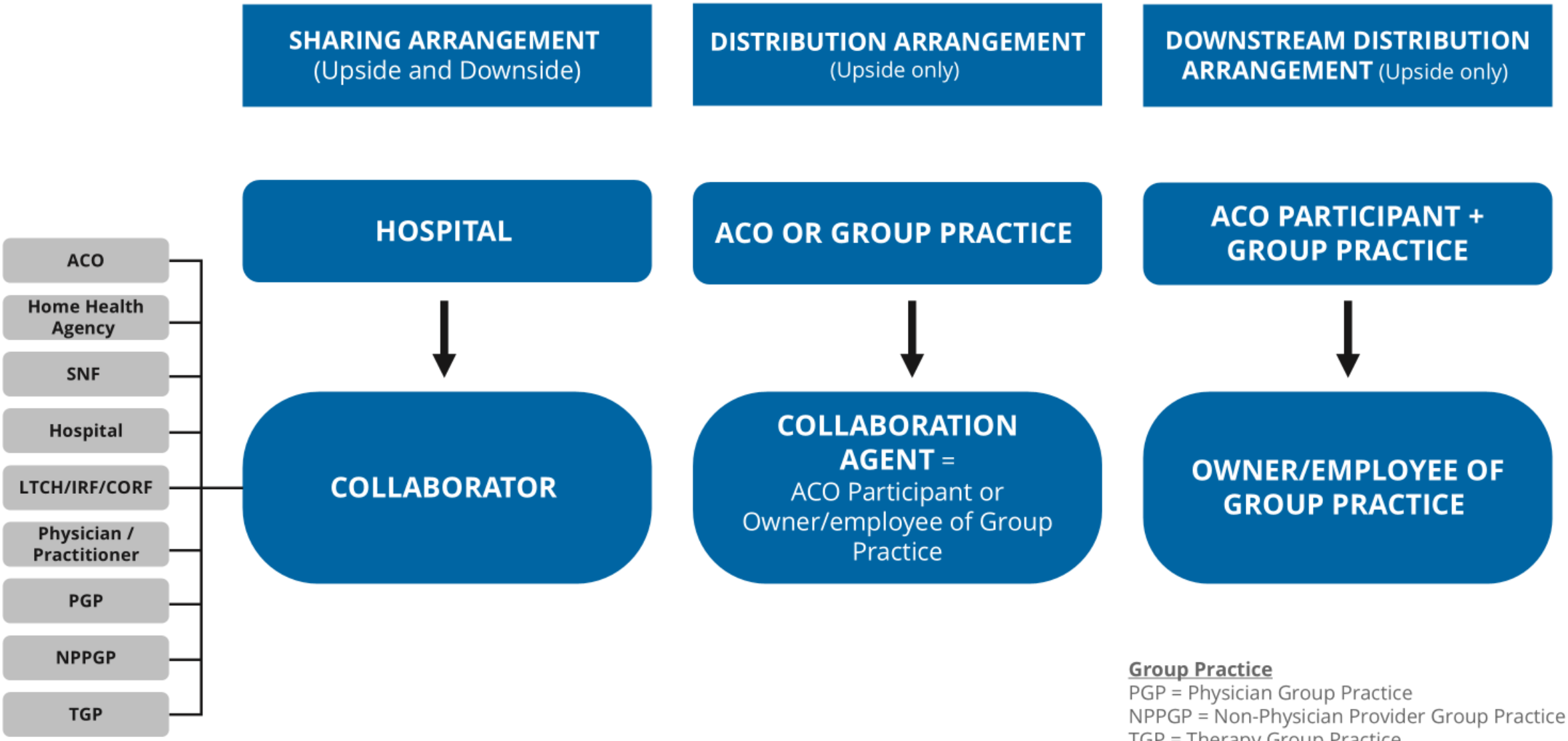
TEAM contractual arrangements

- **Sharing Arrangements** — a written contract between the Hospital and a TEAM Collaborator to make a gainsharing payment and/or receive an alignment payment.
- **Distribution Arrangements** — a written contract between an ACO or Group Practice and an ACO Participant or owner or employee of a group practice to distribute any gainsharing payments it receives.
- **Downstream Distribution Arrangements** — a written contract between an ACO Participant that is a Group Practice and an owner or employee of a group practice to share in distribution (gainshare) payments.
- **Data Sharing Arrangement and/or Business Associate Agreements** — written agreement(s) to ensure proper management and protection of data and pass down obligations on Hospital that flow from CMS and Hospital's Date Sharing Agreement.

Financial arrangements permitted



Group Practice
PGP = Physician Group Practice
NPPGP = Non-Physician Provider Group Practice
TGP = Therapy Group Practice

TEAM contractual arrangements

The TEAM model is intentionally designed to align with Medicare Accountable Care Organizations (ACOs) and promote primary care referrals.

- The purpose of Distribution and Downstream Distribution Agreements is to get incentive payments down to the individual level to incent efficiencies and coordination.

Sharing arrangements

42 CFR 512.565(b)

- Must be in writing and **executed prior to episode of care**.
- Must comply with Medicare enrollment and Medicare rules.
- Must include oversight of arrangement by Hospital.
  - Include review of Sharing Arrangements as part of Hospital's Compliance Plan
- Must include economic terms including:
  - Criteria for sharing gains and losses;
  - Frequency of payment (taking into consideration when CMS pays Hospital); and
  - Method and accounting for payment (caps on upside and downside).

Restrictions on Payments

Gainshare and alignment payments

Payments

- Paid out no more than once per year
- Must be derived from reconciliation payment from CMS or internal cost savings (based on GAAP or Yellow Book accounting standards)
  - No loans or advances.
- Gainshare payment must be clearly identified as “gainsharing payment”
- Alignment payments limited to no more than:
  - For ACOs – 50% of the Hospitals repayment obligation
  - Non-ACOs – 25% of the Hospitals repayment obligation
- Based upon meeting quality of care criteria based on Collaborator’s performance that is tied to billable services related to the episode in the performance year.
  - TEAM activities: Providing care coordination to TEAM Beneficiaries;
  - Engaging in care redesign strategies and performing a role in implementing such strategies; or
  - Coordination with providers and in implementing strategies designed to address and manage the comorbidities of TEAM beneficiaries.

Other contract terms for consideration

- Recoupment rights
- Gating items such as:
  - Quality measures;
  - Level of experience (Low volume threshold - 31+ episodes); and
- Post Termination rights such as:
  - Continuity of care;
  - Payment terms;
  - Audit rights; and
  - Retention of records.

- If financial arrangements will be used for other lines of business (Medicare Advantage or commercial payors), account for other terms and conditions to meet other safe harbor requirements (e.g., managed care safe harbors).

Fraud and Abuse Laws

Civil Monetary Penalty (CMP) Law (42 U.S.C. § 1320a-7a(b)):

Prohibits hospitals from knowingly making payments, directly or indirectly, to physicians as an inducement to reduce or limit medically necessary services to Medicare or Medicaid beneficiaries under the physician's direct care.

Stark Law (Physician Self-Referral Law) (42 U.S.C. § 1395nn):

Prohibits physicians from referring Medicare patients for "designated health services" (DHS) to an entity with which the physician (or an immediate family member) has a financial relationship, unless an exception applies.

- "Financial relationship" includes both ownership/ investment interests and compensation arrangements (direct or indirect).

Anti-Kickback Statute (AKS) (42 U.S.C. § 1320a-7b(b)):

Prohibits knowingly and willfully offering, paying, soliciting, or receiving any remuneration to induce or reward referrals for items or services reimbursable by a federal healthcare program.

- "Remuneration" is broadly defined and includes anything of value (cash, bonuses, gifts, etc.).
- **CMS-sponsored model patient incentive safe harbor**

Contact Us.

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