STATUS OF POST-ACUTE CARE:

REGULATORY UPDATE, FUTURE CHALLENGES, & MARKET TRENDS

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REGULATORY UPDATE

- IMPACT Act
- The Bipartisan Budget Act of 2013
- Budgetary cuts to post-acute care (PAC) providers

FUTURE CHALLENGES

- Dealing with demographic change & increasing demand on PAC providers
- Remaining financially viable with the downward pressure of reimbursement cuts
- Timely adoption of new payment models currently in development
- Integrating new assessment tools & understanding the data they produce
- Adapting to regulatory change & the lag of policy behind intentions

MARKET TRENDS AND SOLUTIONS

- Integration of PAC providers into a full continuum of care
- Clinical Co-Management as an increasingly popular tool to align interest and drive acute/post-acute integration
- Increasing vertical integration, growth of affiliation networks, & widespread Health IT adoption

Overview

Regulatory Update

IMPROVING MEDICARE POST-ACUTE CARE TRANSFORMATION ACT OF 2014 (IMPACT ACT)

Beginning in 2018, the IMPACT Act requires the submission of standardized data from:

- Long-Term Care Hospitals (LTCHs)
- Skilled Nursing Facilities (SNFs)
- Home Health Agencies (HHAs)
- Inpatient Rehabilitation Facilities (IRFs)

Designed to address the lack of uniform assessment information across PAC providers in regards to cost, patient outcomes, and quality of care received.

IMPROVING MEDICARE POST-ACUTE CARE TRANSFORMATION ACT OF 2014 (IMPACT ACT)

Benefits of Standardized Data

Facilitates the exchange and accessibility of data regarding patients' longitudinal health information.

Lays the foundation for cross-setting cost-effectiveness and quality comparisons.

Creates verifiable information sources from which evidence-based and outcome-centered policy decisions can be made.

Combine to produce more accurate information from which hospital administrators and policy makers can make informed decisions and from which physicians can improve the health outcomes of their patients.

Regulatory Update

BIPARTISAN BUDGET ACT OF 2013

LTACH Moratorium (Sunsets in September of 2017):

Reinstituted the moratorium to limit or prevent:

- Establishment of a satellite by an existing LTACH
- Increasing an existing LTACH's number of certified beds
- Development of any new LTACH facilities

All initially provided by the Medicare, Medicaid and SCHIP Extension Act of 2007 and extended by PPACA.

LTACH Payment Change:

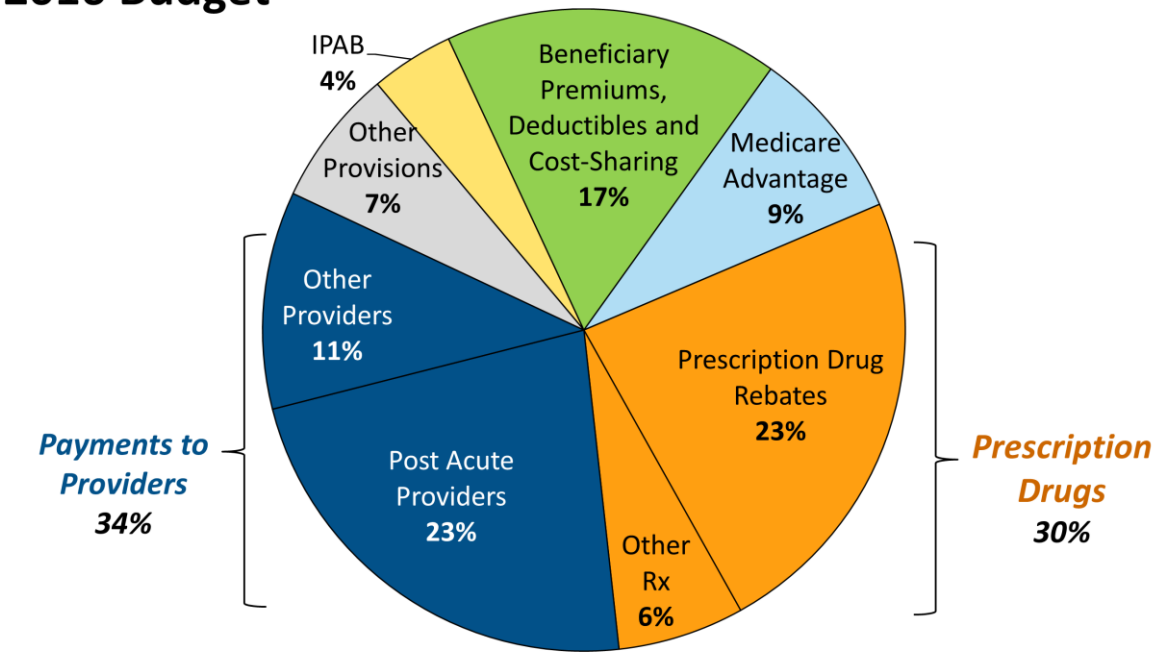
- Only qualified charges from LTACHs will be reimbursed at the LTACH Prospective Payment System (PPS) rate including patients with a length of stay of at least three days in a short-term acute care ICU and patients on ventilators for 96+ hours.
- Payment for disqualified patients will be made at a reduced, site-neutral rate.

PAYMENT REDUCTIONS

- President Obama's FY2016 budget contains provisions that would cut Medicare spending by $498 billion over the next ten years.
- 34% of these reductions would come in the form of provider payment reductions; 23% directly coming from PAC providers.
- This includes $113.56 billion in payment reductions to PAC providers through a restructuring of payments to IRFs and SNFs beginning in 2020.

Figure 1

Distribution of Medicare Savings in President Obama's FY2016 Budget



Total Medicare Savings, 2016-2025 = $498 billion

Note: Excludes provisions that would increase Medicare spending and excludes interactions between provisions. IPAB is the Independent Payment Advisory Board. Numbers may not sum due to rounding.
Source: Kaiser Family Foundation Analysis of the Budget of the United States Government, Fiscal Year 2016.

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Regulatory Update

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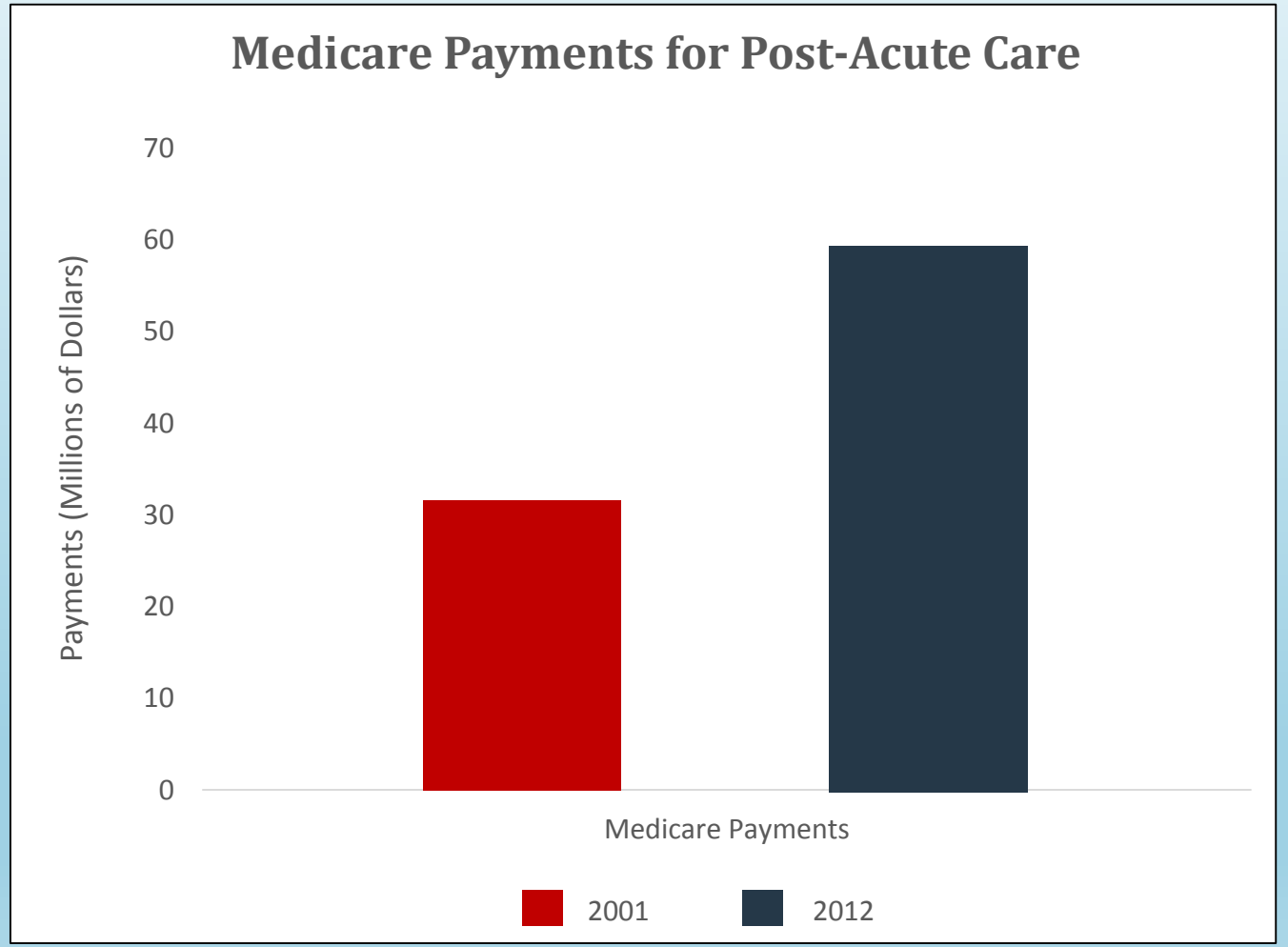
Future Challenges

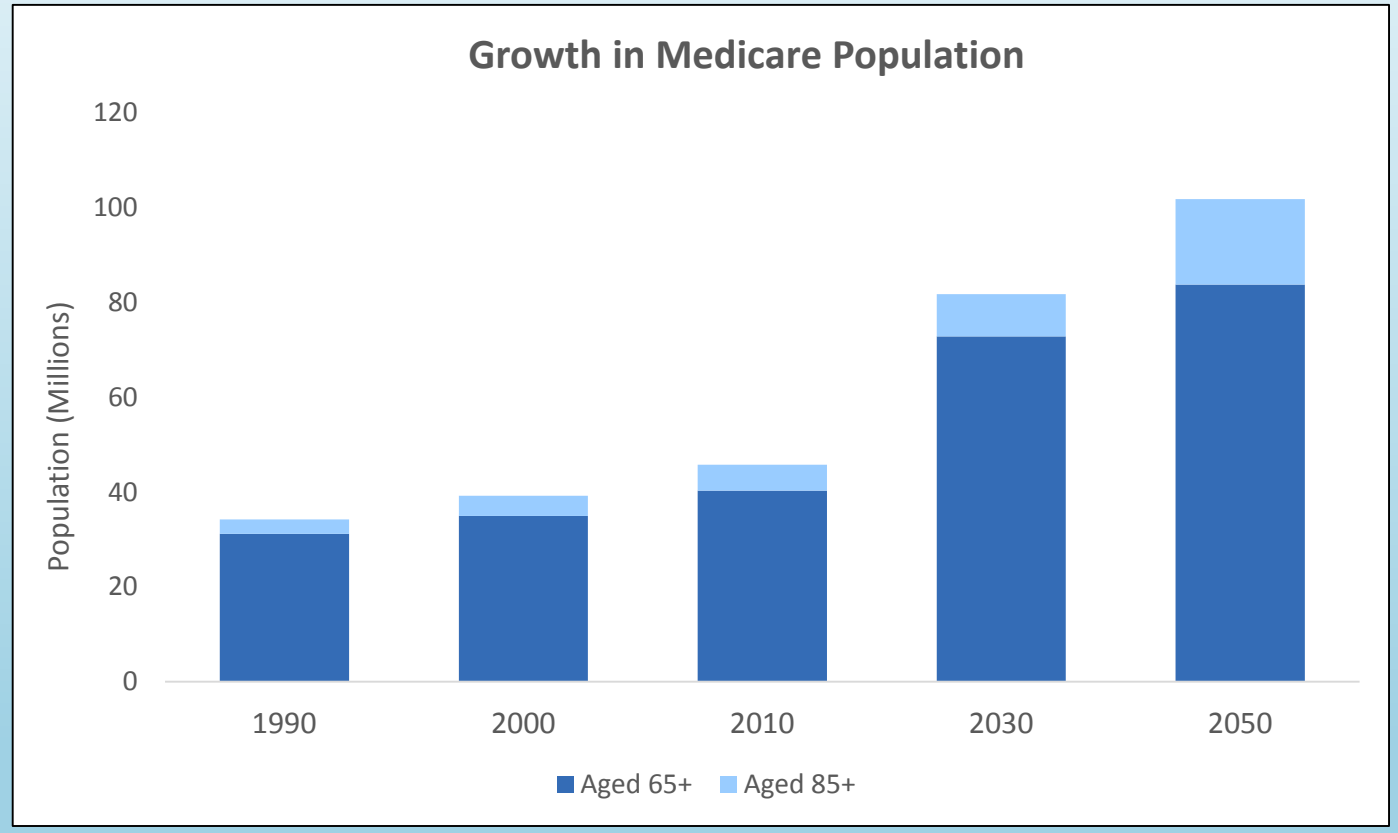
HISTORICAL GROWTH OF POST-ACUTE CARE

- Since 2001, Medicare payments for PAC have more than doubled.
- In 2013 alone, Medicare paid for nearly 10 million PAC encounters across nearly 30,000 PAC providers.
- 42% of all Medicare discharges from short-term acute care hospitals are to a PAC venue of service.



Future Challenges

CHANGING DEMOGRAPHICS WILL INCREASE DEMAND FOR PAC



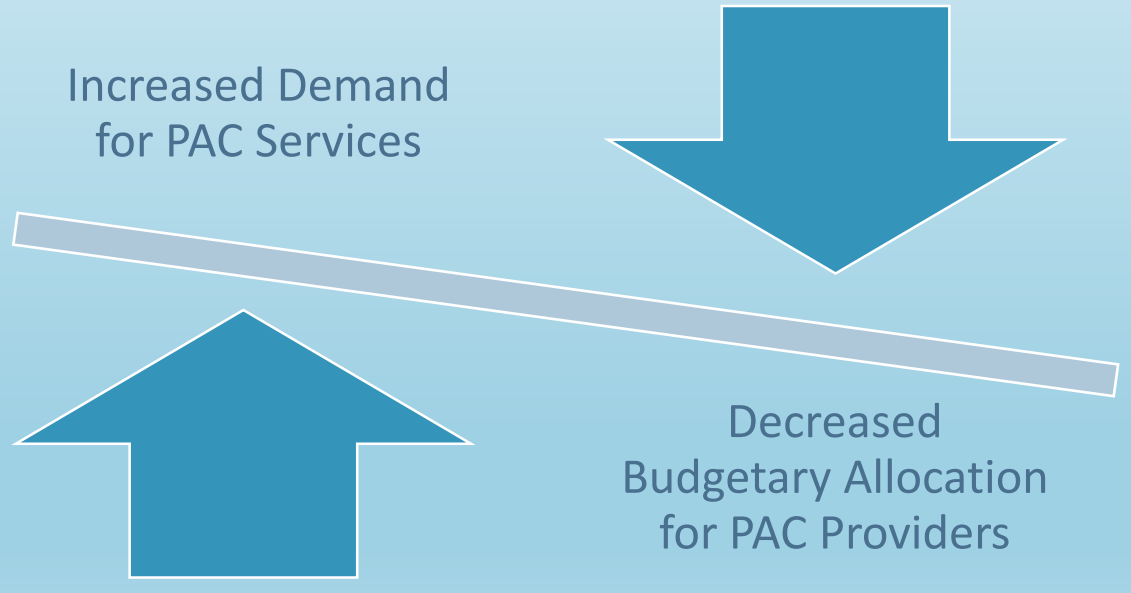
Demand for Post Acute Care Services Increase

Future Challenges

PUSH/PULL OF INCREASING DEMAND & DECREASING REIMBURSEMENT

Increasing demand and ever-decreasing reimbursement rates combine to create the biggest challenge currently facing PAC providers:

How to effectively treat larger volumes of patients at reduced rates?



DOWNWARD PRESSURE ON PAC REVENUES

- High Medicare margins for HHAs & SNFs since 2001.
- Growth in for-profit providers signal to CMS to lower program payments.

- Variation in costs among similar patients for similar conditions across venues of care.
- Need to normalize costs across PAC providers.

- Foundation is being laid for a PAC PPS through IMPACT Act and MedPAC studies.
- LTACH payment reform expected to reduce payments by $250 million in FY2016 alone.

Future Challenges

More Adjustments to Come

BUNDLING – POLITICAL & ECONOMIC GAMECHANGER

Future Challenges

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PAYMENT DELIVERY REFORM

Beyond direct reimbursement reductions, the ongoing development of the next generation of payment delivery presents both a challenge and an opportunity for PAC providers to get ahead of the curve and further integrate into the greater continuum of care.

Among these new payment delivery platforms, bundling episodes of care across providers and across venues of care holds the most promise for controlling cost and improving quality of care.

There are several current efforts to implement and to further study bundling including:

- The Bundling and Coordinating Post-Acute Care Act (BACPAC Act)
- Comprehensive Care Joint Replacement (CCJR) Program
- Medicare Bundled Payment for Care Improvement Initiative (BPCI)

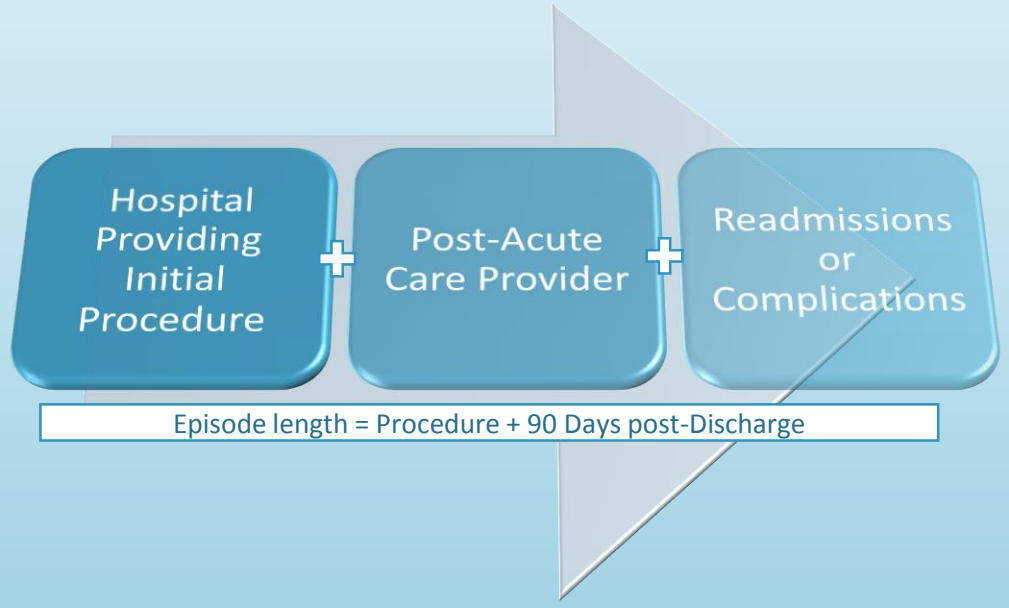
Future Challenges

BUNDLING & COORDINATING POST-ACUTE CARE ACT (BACPAC ACT) OF 2015

- Bill would bundle payments for all PAC services for a given patient for up to 90 days post hospital discharge.
- Bundle would be reduced by the amount paid for any hospital readmission during that 90 day window.
- Ultimately failed to pass due to potentially duplicative provisions with the IMPACT Act, potential interference with other bundling experiments (which will subsequently be discussed), and reliance on the CARE tool to assess patients (which will be discussed later in the presentation)

Future Challenges

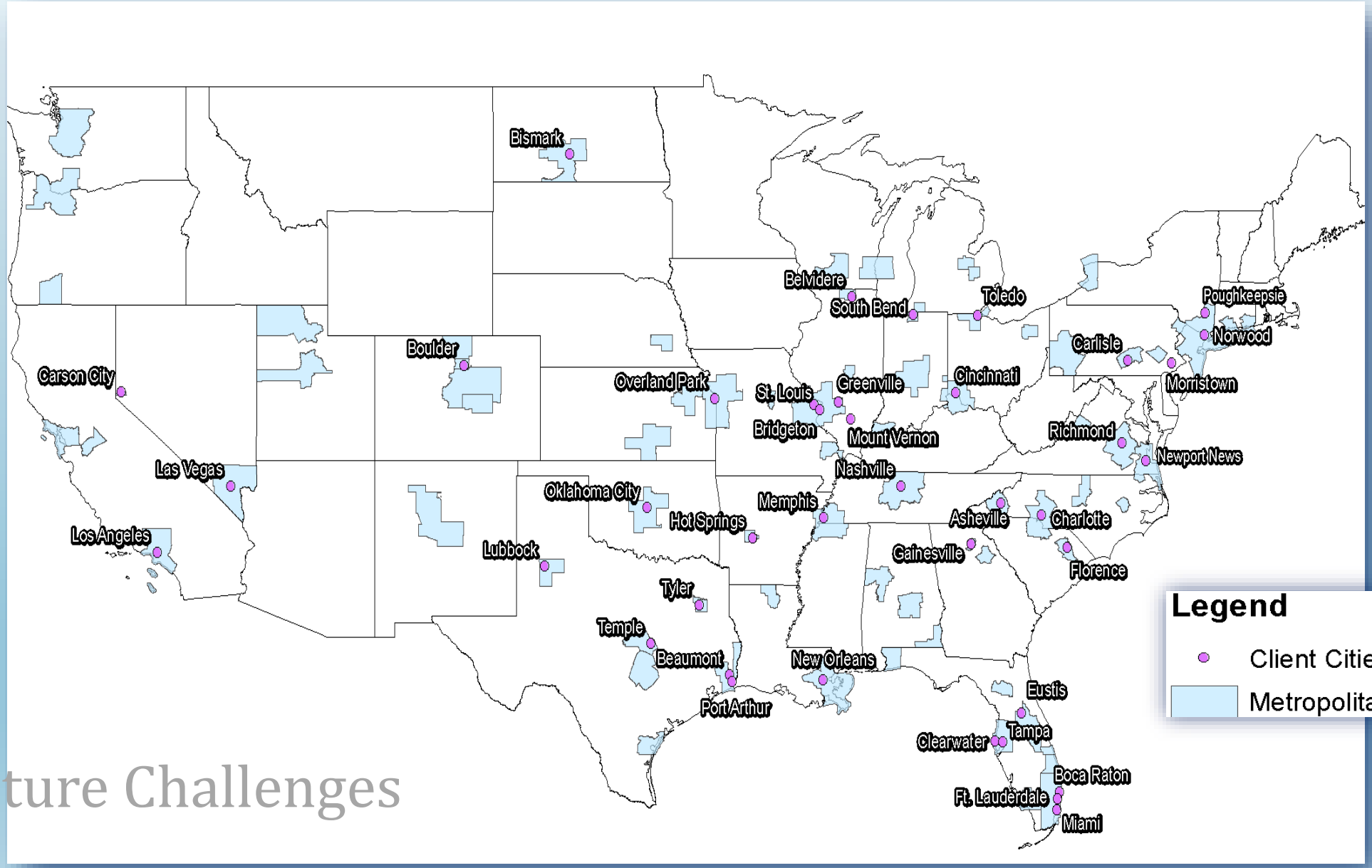
COMPREHENSIVE CARE FOR JOINT REPLACEMENT PROGRAM



- Announced in July 2015 by CMS, the CCJR represents one of the largest bundling experiments to date, involving nearly 800 hospitals spread out across 75 metropolitan areas nationwide.
- Under the CCJR, hospitals will receive a bundled payment for a hip or knee replacement and will be responsible to furnish care for the patient for up to 90 days post discharge.
- Hospitals will be at financial risk beginning in Year 2 if they do not meet target prices as established by CMS.
- Program is projected to bring in savings of $153 million over the next five years, according to CMS predictions.

Future Challenges

COMPREHENSIVE CARE FOR JOINT REPLACEMENT PROGRAM



Future Challenges

BUNDLED PAYMENTS FOR CARE IMPROVEMENT (BCPI) INITIATIVE

Begun in 2013, this three year pilot program recruited thousands of potential participants to test the effects of linking payments across providers on cost and quality of care.

Model 2: Retrospective Acute Care Hospital Stay Plus Post-Acute Care

- Bundled episode initiated by hospitalization and includes all services furnished during designated episode lengths of 30, 60, or 90 days.
- Model includes 48 different clinical condition episodes.
- Total spending is then reconciled against a target price with the initiating provider receiving cost-savings directly, or repaying any excess.

Model 3: Retrospective Post-Acute Care Only

- Bundled episode initiated by admission to PAC provider within 30 days of a qualified hospitalization and includes all services furnished by PAC providers for the designated episode length.
- As with Model 2, includes 48 different clinical condition episodes.
- Also as with Model 2, providers are initially paid on a FFS basis, with retrospective reconciliation against the targeted bundle price.

Future Challenges

DATA COLLECTION & EVALUATION STANDARDIZATION CHALLENGES

As a forerunner to the IMPACT Act, CMS has been in development of the Continuity Assessment Record and Evaluation (CARE) Tool to:

- Collect standardized information at discharge from short-term acute care hospitals and at admission to PAC venues of care;
- Facilitate the transition of care between acute and post-acute venues of care by building an accurate and reliable dataset;
- Evaluate patient outcomes from one point of care to another.

Development began in 2005 and results have been mixed to date, but critical for PAC providers to adopt and to understand as the IMPACT Act requires standardized assessment data.

Future Challenges

HOSPITAL READMISSIONS REDUCTION PROGRAM (HRRP)

- Includes up to a 3% penalty on all Medicare reimbursement for hospitals that have excessive preventable readmissions.
- Readmissions criteria is based on five diagnoses:
  i. Heart Failure
  ii. Myocardial Infarction
  iii. Pneumonia
  iv. Hip & Knee Replacement
  v. Chronic Obstructive Pulmonary Disease
- While only hospitals are penalized under the HRRP, integration and coordination between hospitals and PAC providers is critical in effectively reducing preventable readmissions.

Future Challenges

LAG OF LAWS & POLICIES BEHIND TECHNOLOGICAL ADVANCEMENT & INNOVATION

As technology continues to change healthcare, PAC providers will continue to have to balance the adoption of new practices and platforms with the lagging and reactionary regulatory environment.

A current example of this involves the development of telemedicine.

- Wide variation in telehealth policies creates a confusing environment for providers thinking of adopting telemedicine services.
- Reimbursement is not standardized between states and there remains disparity between public and private payer reimbursement rates.

Problem remains the same ten years later.

Future Challenges

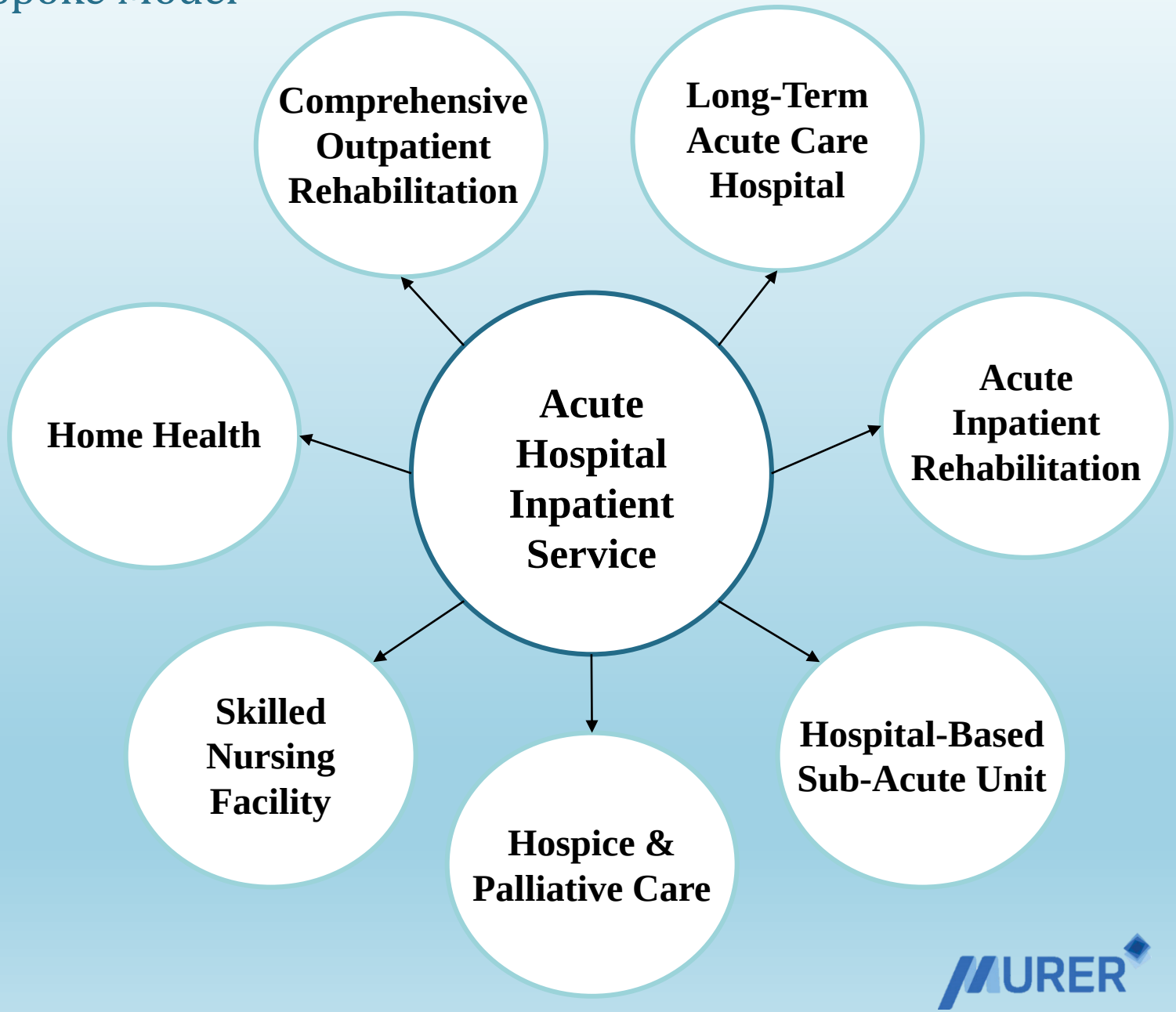
Market Trends

Trend One: Post-Acute Care Provider Integration into Continuum of Care

Market Trends

PAC Provider Integration: Hub & Spoke Model

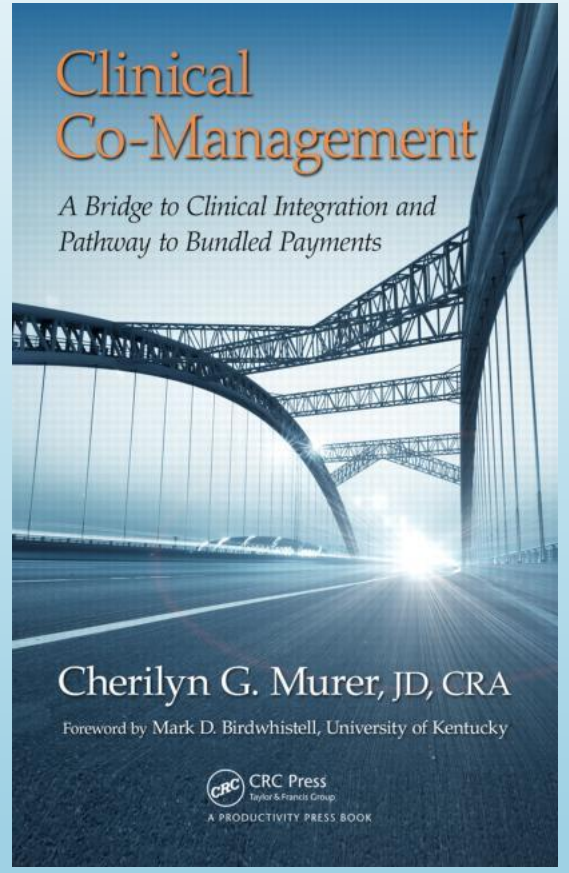
- Short-term acute care hospital as the center of the model, with care flowing outward as dictated by the patient's needs
- Requires moving beyond a silo-mindset to one of working as an integrated piece of a greater health system in order to ensure the proper care is being provided in the proper venue at the proper time
- Model has been reaffirmed time and time again through healthcare reforms and through Medicare rate setting



Trend Two: Clinical Co-Management as a tool to drive integration & to pave the way for bundling

Market Trends

Clinical Co-Management, Data Validation, & The Path to Bundling



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What Are a Hospital's Costs? Utah System Is Trying to Learn

By GINA KOLATA SEPT. 7, 2015

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HE NAMED ME MALALA

SALT LAKE CITY — Only in the world of medicine would Dr. Vivian Lee's question have seemed radical. She wanted to know: What do the goods and services provided by the hospital system where she is chief executive actually cost?

Most businesses know the cost of everything that goes into producing what they sell — essential information for setting prices. Medicine is different. Hospitals know what they are paid by insurers, but it bears little relationship to their costs.

No one on Dr. Lee's staff at the University of Utah Health Care could say what a minute in an M.R.I. machine or an hour in the operating room actually costs. They chuckled when she asked.

Dr. Vivian Lee set in motion a process that the University of Utah Health Care is using to save money and to improve care. Sallie Dean Shatz for The New York Times

Market Trends

- Recent New York Times article on September 8, 2015 highlights the difficulties in determining the actual cost of hospital goods and services.
- Clinical Co-Management serves as the tool to answer these questions and create verifiable trust built upon accurate and agreed upon data.
- These building blocks are critical if we are to achieve any kind of bundling success as a healthcare system.

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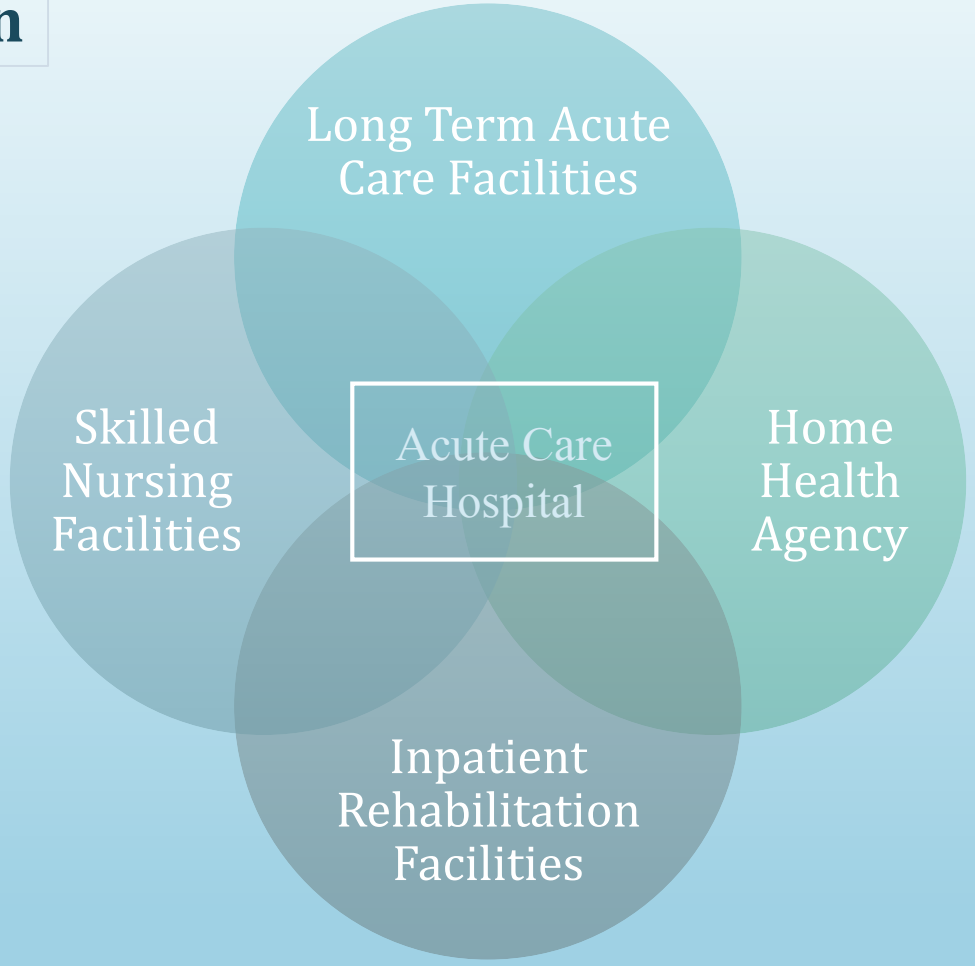
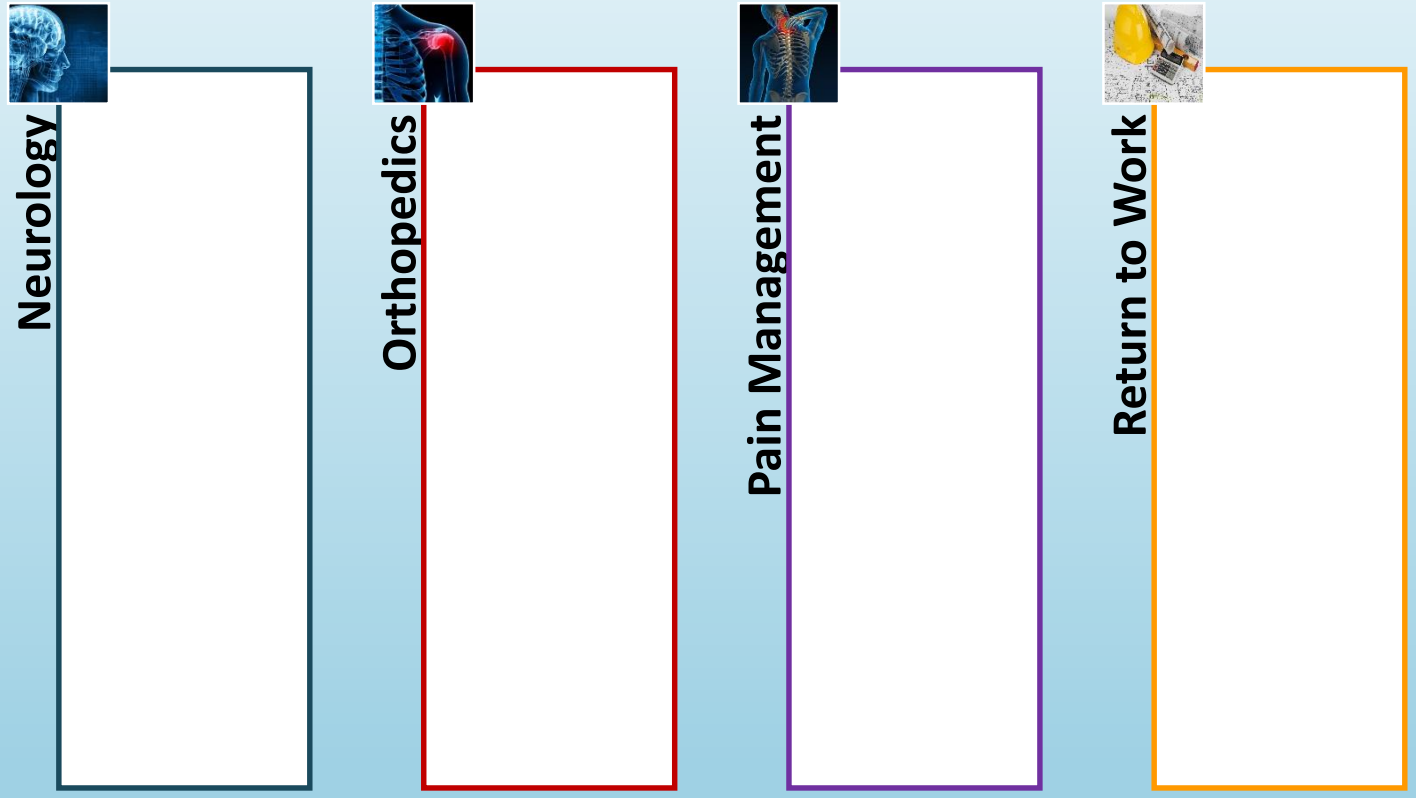
Trend Three: Increasing Vertical Integration

- Hospitals, health systems, and other providers expanding services into PAC through the purchasing, merging, and/or affiliation with PAC providers.
- Through the expanded and more integrated services, economies of scale are better realized.
- Patient care is better coordinated with immediate access to extensive patient information via uniform data collection methods and information sharing.
- Also reduces miscommunication to garner improved outcomes and efficiencies, and reduces redundant information gathering.



Market Trends

CASE EXAMPLE ONE: Regional One Health System & the Four Pillars of Post-Acute Care



Market Trends

CASE EXAMPLE TWO: University of Kentucky Regional Affiliation Network

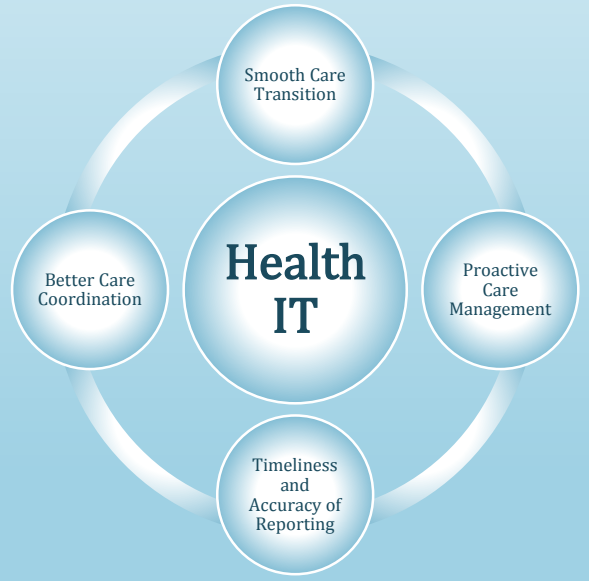
Market Trends

Trend Four: Broader Adoption of Health Information Technology

EHR adoption & meaningful usage

Development of Health Information Exchanges (HIE)

Leveraging of big data sets being produced



Market Trends

Wrap-Up/Takeaways

INTEGRATION

- Post Acute Care needs to be increasingly part of an integrated health system.
- No mechanical distinction between acute & post-acute care; informational and operational synergies exist when both work in unison.

CLINICAL CO-MANAGEMENT

- New regulations serve as opportunities for collaboration and innovation.
- Insufficient Case Management hinders success; role should be one of a conductor, not one of simple discharge planning.

THE HUMAN FACTOR

- Personal, political, & financial uncertainties will always exist within healthcare.
- Policy goals in an ideal world vs. the political realities of the current system.

Take-Aways

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