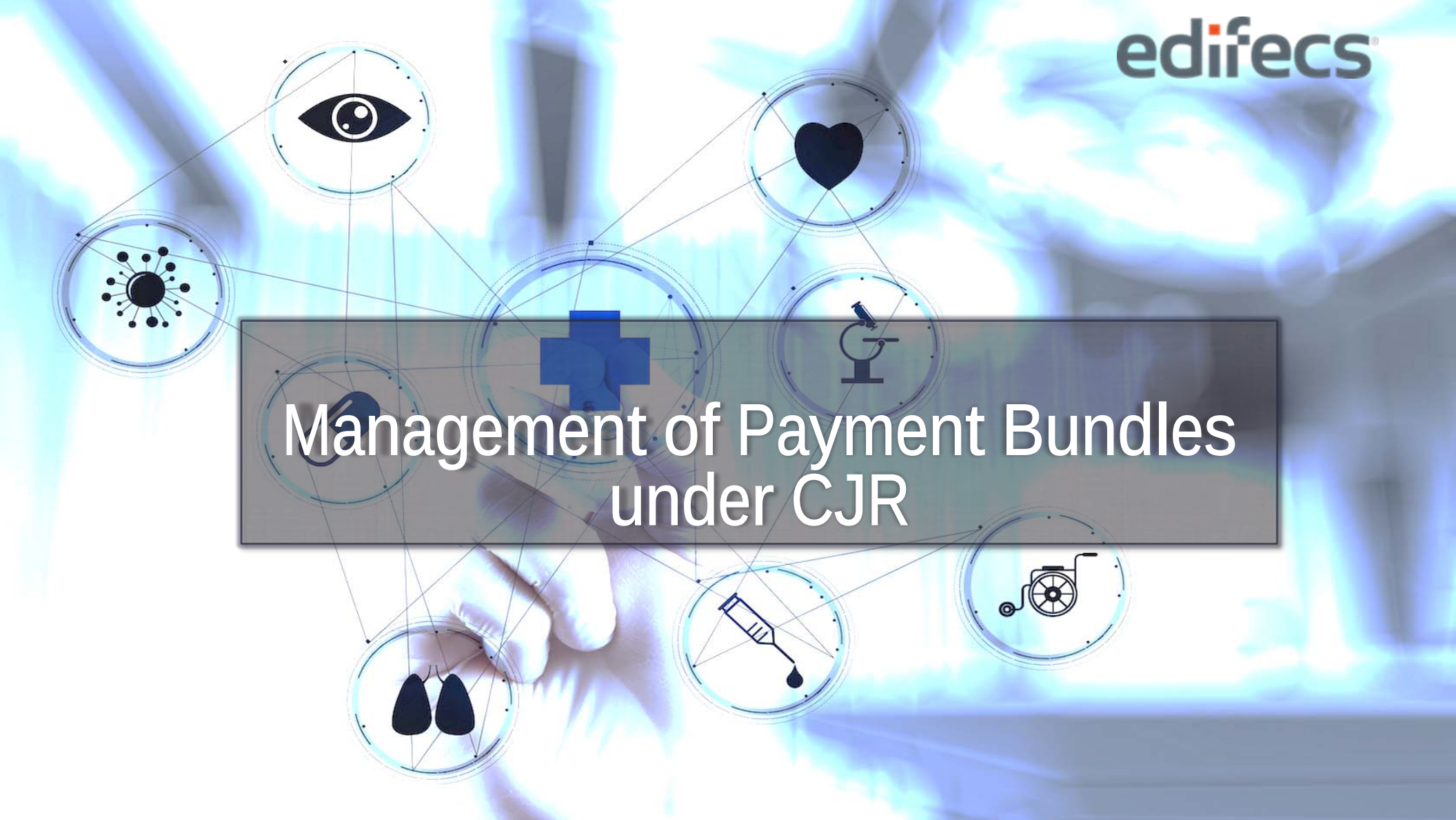
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Management of Payment Bundles under CJR

Software Innovator in Healthcare IT

Edifecs is the first SaaS based **Partnership Platform** for the healthcare industry

Serving more than **215 Million** lives through our customers

70+ Provider Customers

8/9 Top Health Plans

25/37 Blue Plans

24/52 State Medicaid Programs

Multiple Federal Agencies including CMS

Leaders in Trading and Compliance

Worldwide 745+ Employees

1996

Smart Trading
EDI / HL7 Validation
Any Format / Any Source

Mandate Compliance
HIPAA, CAQH, ICD-10, ONC, CMS

Business Solutions
Population Insights for ACOs, VBRs, PCMHs
HIX, PSR, RRM, and more

Partnership Platform **Present**
Cloud – SasS / PaaS, Future Exchanges

Why CJR?

Unwarranted Variation Between and Among Geographies

Pacific
469 – $48,874
470 – $23,425

East South Central
469 – $50,328
470 – $26,345

Middle Atlantic
469 – $52,028
470 – $27,406

Mountain
469 – $47,925
470 – $23,734

East North Central
469 – $50,954
470 – $25,480

New England
469 – $47,928
470 – $24,858

West South Central
469 – $55,448
470 – $27,464

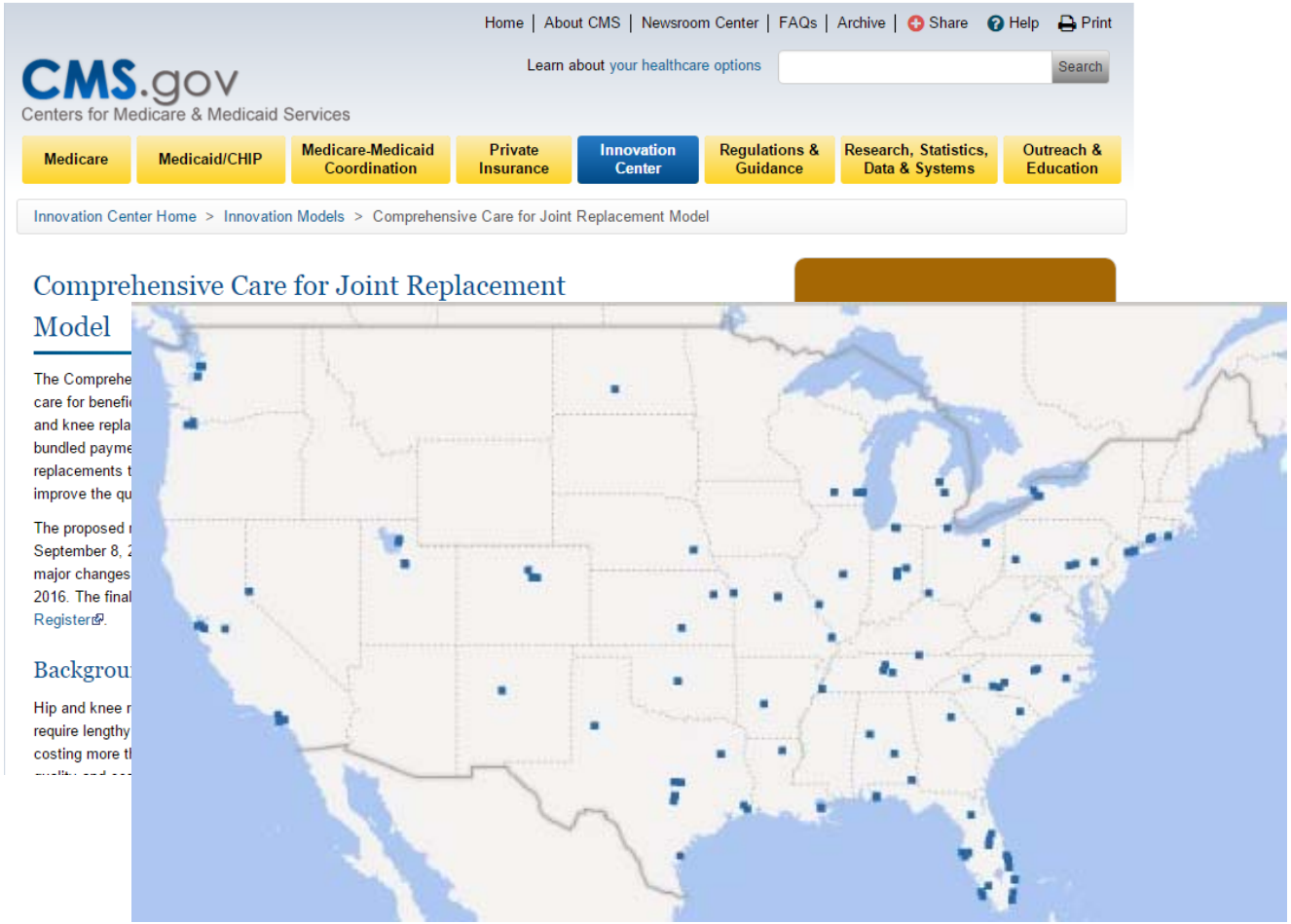
West North Central
469 – $46,189
470 – $23,800

South Atlantic
469 – $51,239
470 – $25,989

Average Regional Historical Episode Payments*
469 - average payment per MS-DRG 469 episode
470 - average payment per MS-DRG 470 episode

* Source: https://innovation.cms.gov/Files/worksheet/cmmi-avgreghistepisodes.xlsx

Comprehensive Care for Joint Replacement



CJR Highlights

Critical implications for hospitals

1. No choice about participation
2. Focus on post-acute care
3. Risk is borne by hospitals
4. New opportunities for improving care
5. Mandate to lower total episode costs
6. Episode impact will not be limited to CJR

Strategic Decisions to be Made

It doesn't matter how you get there if you don't know where you are going

How Hard Will You Try?

Do you see enough risk/reward to

- Devote executive sponsorship?
- Add new resources?
- Change care pathways?
- Manage proactively?

Sharing the Risk

Rethinking partnerships

- Who best drives utilization decisions?
- Do you need partners in post-acute?
- What is in it for them?

Better Care Appropriateness

Changing the calculus on treatment path

- Rethink medical criteria
- How will you manage?
  - ✓ If you never say no to something, you are not managing it

Better Site of Care

If you have multiple facilities doing joints

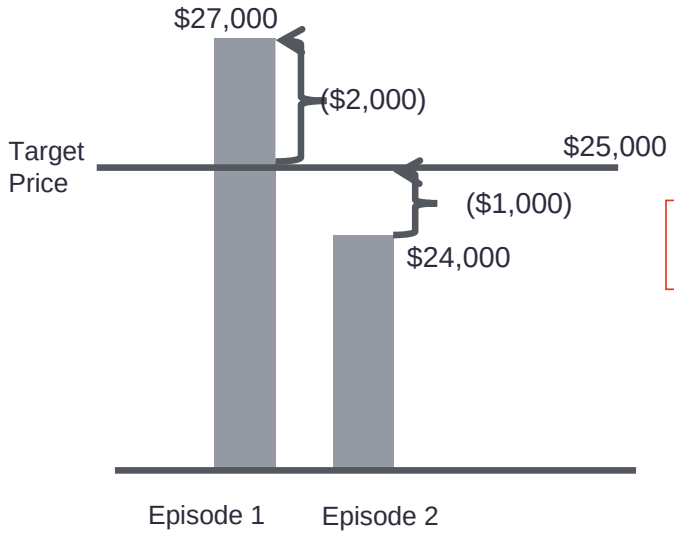
- Low acuity from outpatient to inpatient
- Steer Medicare patients in years 1 and 2 to worst performing facility assuming you will fix the problems

CJR Target Price Model

Model Year	Basis for Target Price
Years 1 and 2	2/3 of the hospital's own historical episode payments and 1/3 of the regional historical episode payments
Year 3	1/3 of the hospital's own historical episode payments and 2/3 regional
Years 4 and 5	Full regional historical episode payments

Reconciliation Model

CMS calculates raw net payment reconciliation amount (NPRA); episodes are evaluated individually; stop-loss/gain is applied in aggregate



Net (Raw NPRA) = $1K Bonus Payment

Thinking Through the Budget Calculation Implications

A budget tells us what we can't afford, but it does not keep us from buying it

The facilities with the worst historical performance will have the highest budgets in years 1 and 2

Consider:

•Budget calculation are done by Medicare ID

•The calculation for years 1 and 2 weigh the hospital's historic performance higher (including what happened post-discharge)

How can this work for you?

•If you are sure you can fix it, move as much traditional Medicare volume as possible to the facility that will have the highest budget

•Shift commercial and Medicare Advantage to the better facilities

•Re-evaluate each year as your improved performance impacts the following year's budget – it is a rolling calculation

•Rethink how care can be legally focused in the most advantageous place

Managing Two Cost Structures

CJR requires that hospitals manage two different cost structures

Managing the Hospital's Own Costs

- With or without CJR, all hospitals need to manage this
- Focus is on LOS, implantable costs, formulary, readmission
- Hard for most hospitals to do more without physician's cooperation

Managing CMS's Costs

- Within the gainloss and gainshare, the hospital earns or loses 100% of CMS's spend during the post-acute period
  - *Other providers are spending your money*
- A single patient who is discharged home instead of to a SNIF, means thousands of dollars in gained or lost revenue

Focus on Post Acute Care

- 300% variation in total cost by geography[1]
- Cost of post acute care growing 15% a year and is now greater than cost of actual surgery [2]
- 300% variation in nursing home utilization [3]

2013 Medicare Claims and Variation in Discharge Disposition for Major Joint Replacements (DRGs 469, 470)

MSA	# Medicare Claims	Discharged to SNF (# for every 10 Patients)	Discharged to IRF (# for every 10 Patients)	Readmissions (# for every 10 Patients)
New-York-Newark-New Jersey, NY-NJ-PA	22,171	5	2	1
Los Angeles- Long Beach-Anaheim, CA	10,226	4	1	1
Seattle-Tacoma-Bellevue, WA	4,836	4	1	1
Kansas City, MO-KS	4,103	3	1	1
Oklahoma City, OK	3,685	2	1	1
Virginia Beach-Norfolk-Newport News, VA-NC	3,306	6	1	1
Las Vegas-Henderson-Paradise, NV	1,844	1	4	1
National (U.S.)	**494,951**	3	1	1

Source: Definitive Healthcare, 2013 Medicare SAF (1/1/2013 – 12/31/2013)
Note: # for every 10 patients rounded to the nearest whole number

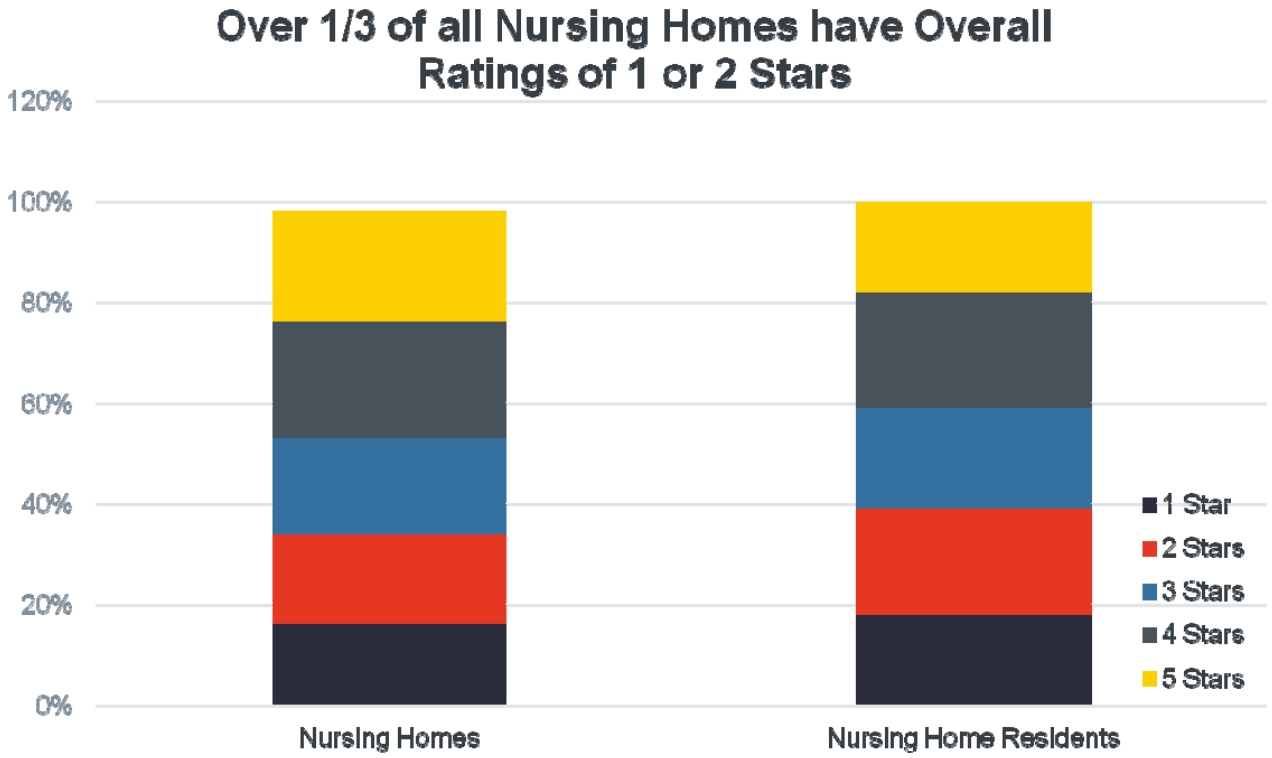
[1] BCBS Association, A Study of Cost Variations for Knee and Hip Replacement Surgeries in the U.S., January 21, 2015

[2] Chandra, Large Increases In Spending On Postacute Care In Medicare Point To The Potential For Cost Savings In These Settings Health Aff May 2013 vol. 32 no. 5864-872

[3] Rau, IOM Finds Differences In Regional Health Spending Are Linked To Post-Hospital Care And Provider Prices, Kaiser Health News, July 24, 2013

Quality Variation in Nursing Homes

Why is this important?
•Lower quality nursing homes will have worse outcomes – which you pay for
•Waiver of three day rule in year 2 requires that the SNIF have a 3 star or better rating



Source: CMS Nursing Home Compare Data, February, 2015. Based on overall composite star rating score for nursing homes certified by either Medicare or Medicaid, excluding those with unavailable star ratings.

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Data Analysis : CJR Program - Overlake Hospital

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5 | Update CMS Data | Close

Overview | Post Acute Care Analysis | What-If Analysis | Episodes

Select Reference Data Source | Year All | Episode Type All | Download Report

Reference Data Summary

$ 74,589,000 TOTAL COST

$ 47,721.69 AVERAGE COST

1,563 EPISODES

ACUTE vs. POST ACUTE COST

POST ACUTE COST

What-If Setup

$ 50,000.00 TARGET COST / EPISODE

1563 TARGET EPISODE VOLUME

Projected Cost Analysis

$ 70,331,156 TOTAL COST

$ 44,997.54 AVERAGE COST

1,563 EPISODES

ACUTE vs. POST ACUTE COST

POST ACUTE COST

Projected Savings / Loss

+ $ 7,818,845 TOTAL SAVING

+ $ 5,002.46 PER EPISODE

			Change in Spend			
ACUTE COST	42.92 %	$ 32,010,560	0 %	45.51 %	$ 32,010,560	ACUTE COST
POST ACUTE CARE (PAC)	57.08 %	$ 42,578,440		54.49 %	$ 38,320,596	POST ACUTE CARE (PAC)
AMBULATORY	4.05 %	$ 3,023,960	- 10 %	3.87 %	$ 2,721,564	AMBULATORY
HHA	4.76 %	$ 3,551,800	- 10 %	4.55 %	$ 3,196,620	HHA
SNF	12.94 %	$ 9,653,120	- 10 %	12.35 %	$ 8,687,808	SNF
PHYSICIANS	10.46 %	$ 7,802,400	- 10 %	9.98 %	$ 7,022,160	READMIT
LTAC	4.08 %	$ 3,042,360	- 10 %	3.89 %	$ 2,738,124	LTAC
IRF	2.28 %	$ 1,700,480	- 10 %	2.18 %	$ 1,530,432	IRF
OTHERS	18.51 %	$ 13,804,320	- 10 %	17.66 %	$ 12,423,888	OTHERS

Other Topics for Cost Management

- Pre-Admission (surgeon's office)
  - Better screening and management of conditions prior to admission to reduce LOS and complications
  - Better patient engagement (and education) pre-admission, to set expectations on pain and other topics and to start discharge planning with a presumption on home discharge when possible
- During Acute Care (hospital and physicians)
  - Better management of all costs related to implantable vendor choice
  - Better coordination between anesthesia and surgeon (reduction of unwarranted variation, better pain management)
  - Better engagement of physician in managing post acute (what they can do before or at time of discharge, what they can do post discharge)

Partnership Framework

Why Does CJR Lead to Partnership?

It is better to have half of something than all of nothing

The reality of bearing risk
•Under CJR, the hospital bears the risk
•If CJR meets the goals of CMS, some providers will win and some will lose

Why partner?
•How much of the CJR spend occurs with your organization?
•How much of the cost of a lower joint replacement can you control?

How to partner
•Strategy 1: Partner with the key doctor (to impact management)
•Strategy 2: Partner with the post-acute providers (to impact utilization and outcomes)

Physician Partnership

Which Physician?
- Orthopedic surgeon
- Hospitalist
- Anesthesia

What do you want them to do?
- Manage the hospital's cost structure
  - Implant and related consumables
  - Medical appropriateness and site of care choices
  - Better pre-care and expectation setting
- Manage the payer's cost structure
  - Work to avoid SNF discharge
  - Engage with patient on post acute care
- Improve quality
  - Care pathways, formulary, better care pre-admission

What is in it for them?
- Gainsharing
- Variable salary compensation
- Direction of hospital investment

Post-Acute Care Partnership

Which provider?

- SNFs
- Home health

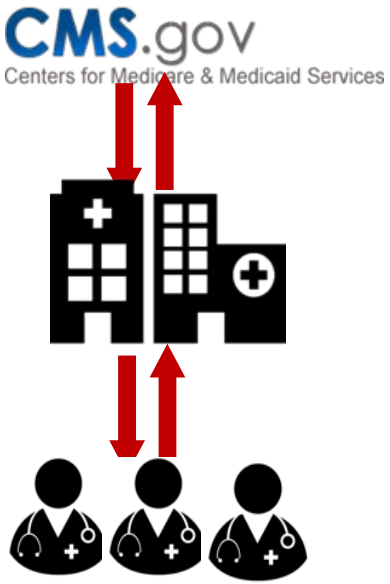
What do you want them to do?

- Manage their own utilization
- Help maintain patient engagement after discharge
- Improve quality
  - ✓ Care pathways, early intervention for complications
- Share data

What is in it for them?

- Soft steerage
- Gainsharing

Two Forms of Gainsharing under CJR



CMS to Hospital

Roles
- CMS is Payer
- Hospital manages CMS's cost structure

Technology
- Track and manage hospital performance during care
- Prepare to audit CMS results

Mandatory

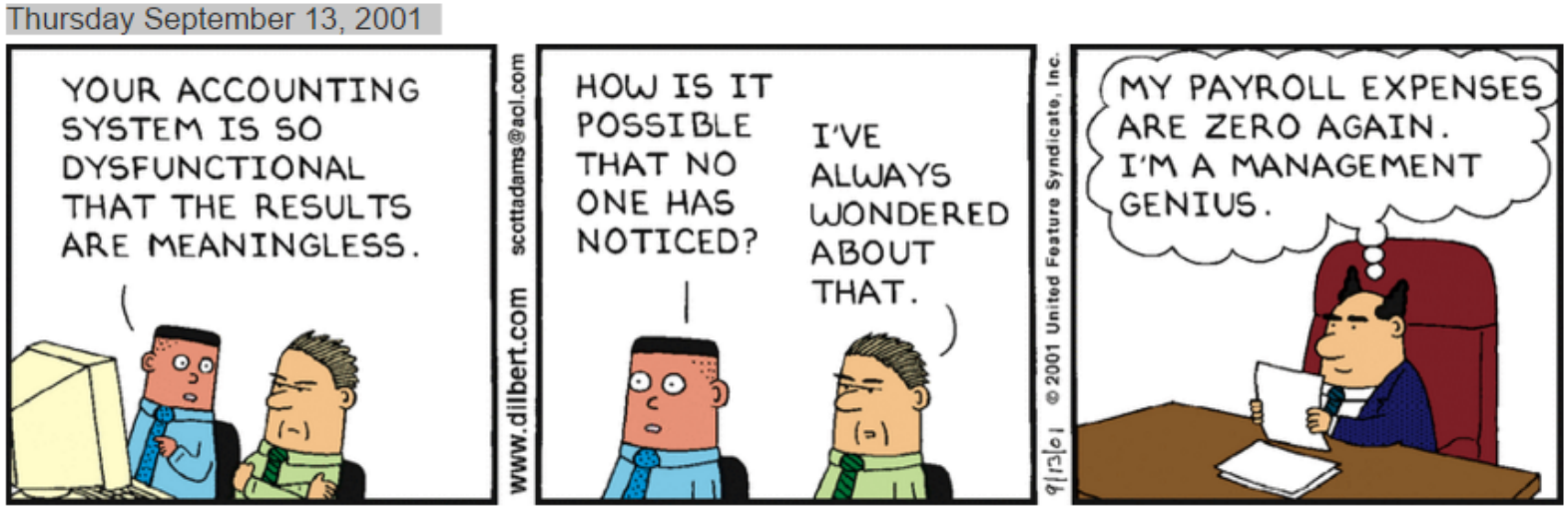
Hospital to (Surgeon, SNF)

Roles
- Hospital is Payer
- (Surgeon) manages Hospital's cost structure

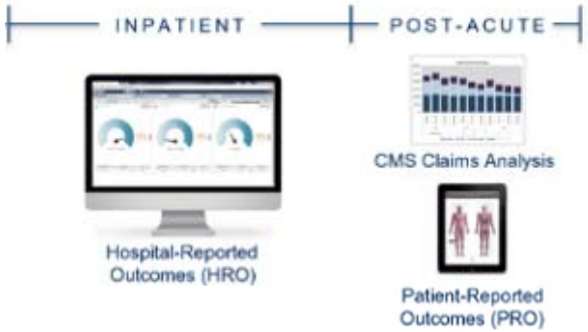
Technology
- Model program pre-contract
- Administer program during care
- Visibility to (surgeon)
- Reconciliation

Optional

Managing Episodes for Success

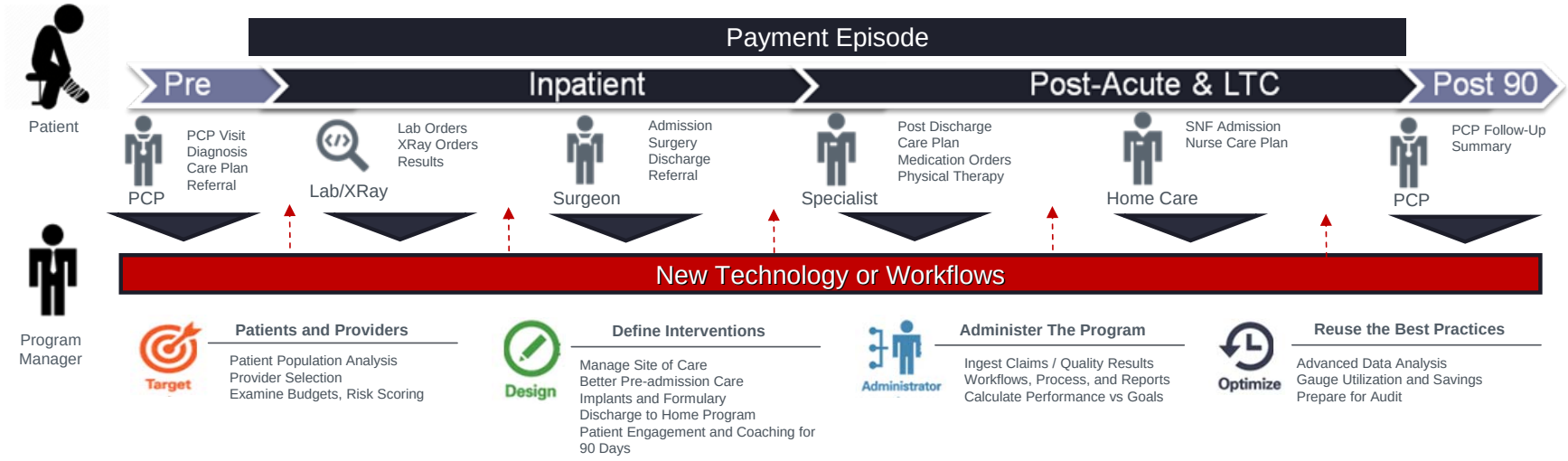


What You Need to Manage CJR

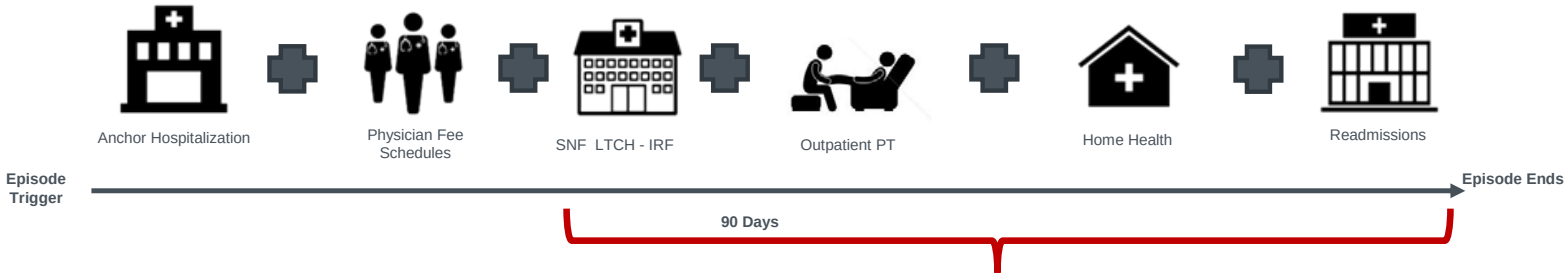


1. A plan
2. A way to engage the patient during the 90 days
3. Useful data about utilization
4. Tools that can help to manage both overall performance and patient-by-patient management
5. Tools to help with audit of CMS results

CJR Management



CJR Episode Bundle, MS-DRG 469, 470



Greatest variability in payer cost structure

Data Sources for CJR Management

Source	Pros	Cons
CMS Data	Exhaustive Source of truth	Too late to help with management
Hospital EMR/Billing	Immediate access Relatively easy to get	Primarily focused on pre-discharge costs
Patient	Might be complete	Hard to collect Might not be complete
Post-Acute Partners	Immediate access Relatively easy to get	Will not be complete

Data Analysis : CJR Program - Overlake Hospital

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5 | Update CMS Data | Close

Overview | Post Acute Care Analysis | What-If Analysis | Episodes

Year 2014

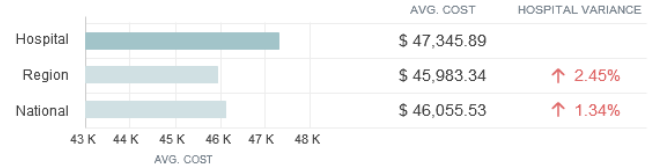
ACUTE COST POST ACUTE CARE

Summary by Episode Type

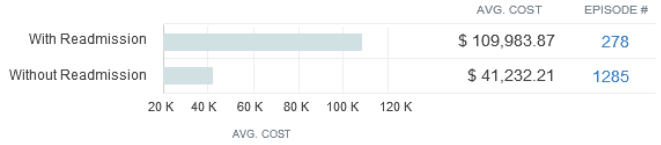
	EPISODES #	COST	ACUTE COST	POST ACUTE COST	AVG.COST / EPISODE	COMPLICATION COST	READMISSIONS RATE	ALOS
469 - HIP	584	$ 31,875,024	$ 15,323,532	$ 16,551,492	$ 42,873.98	$ 134,234.56	12.87 %	2.45
469 - OTHERS	234	$ 11,567,362	$ 5,092,894	$ 6,474,468	$ 37,783.54	$ 245,783.02	08.26 %	10.26
470 - HIP	403	$ 16,523,734	$ 7,936,154	$ 8,587,580	$ 54,073.54	$ 345,037.64	32.03 %	4.23
470 - OTHERS	342	$ 15,167,310	$ 4,845,632	$ 10,321,678	$ 52,875.23	$ 287,783.83	12.98 %	1.56
OVERALL	1563	$ 75,133,430	$ 33,198,212	$ 41,935,218	$ 47,345.89	$ 922,837	16.54 %	4.63

Details by Episode Type All

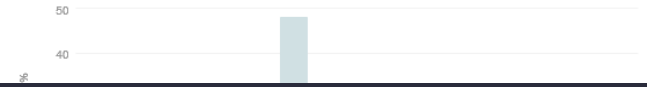
Per Episode Cost Regional Comparision



Per Episode Cost Comparision By Readmission



% Volume by Discharge Destination



Post Acute Care Cost by Provider Type for Discharge Destination All

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EpisodePaymentSolution

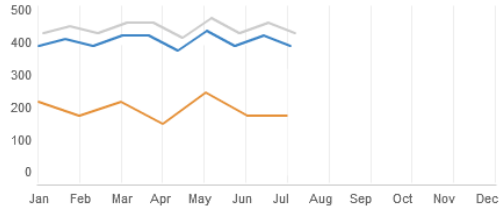
Episodic Payment Solution for CCJR

OVERVIEW | PROVIDER DASHBOARD | REPORTS

Period 2014 YTD | 1 Jan 2015 - 12 Aug 2015 | Episode Type All

Episode Trend

406 ACTIVE
205 RECON
44,642 COMPLETED



Unassigned Episodes
CLOSING Next Week
55
20 -ve savings
35 +ve savings

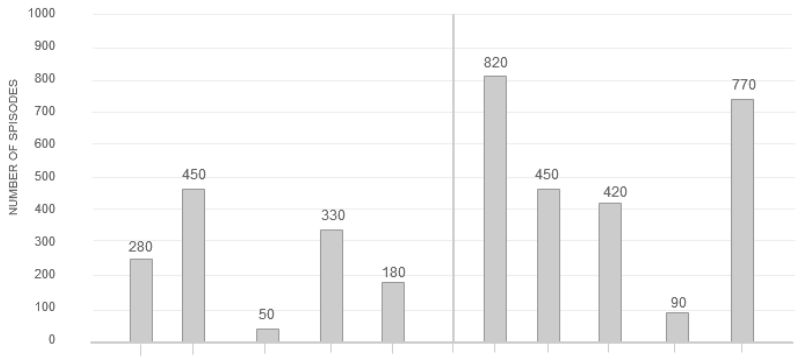
Episodes Cancelled
51

Episodes Voided
250

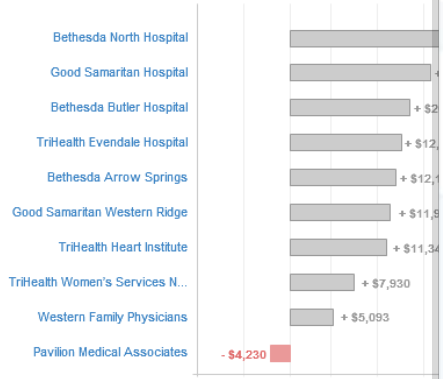
Episodic Budget Overview

406 ACTIVE	$ 650,000 BUDGET	$ 458,678 ACTUAL	$ 191,322 REMAINING
206 RECON	$ 145,000 BUDGET	$ 122,165 ACTUAL	$ 22,267 PENDING SA
44,642 COMPLETED	$ 125,000,000 BUDGET	$ 123,424,256 ACTUAL	$ 45,894 COMPLICATION

Episode Distribution by Saving Range



Top 10 Providers by Savings



TASK LIST

Episodes Cancelled (4)

TriHealth Women's Serv...	$11,872.34	09/30/2014
Bethesda North Hospital	$34,165.96	12/10/2014
Bethesda Butler Hospital	$56,435.00	12/02/2014
Good Samaritan Hospital	$34,034.85	12/10/2014

Episodes Voided (2)

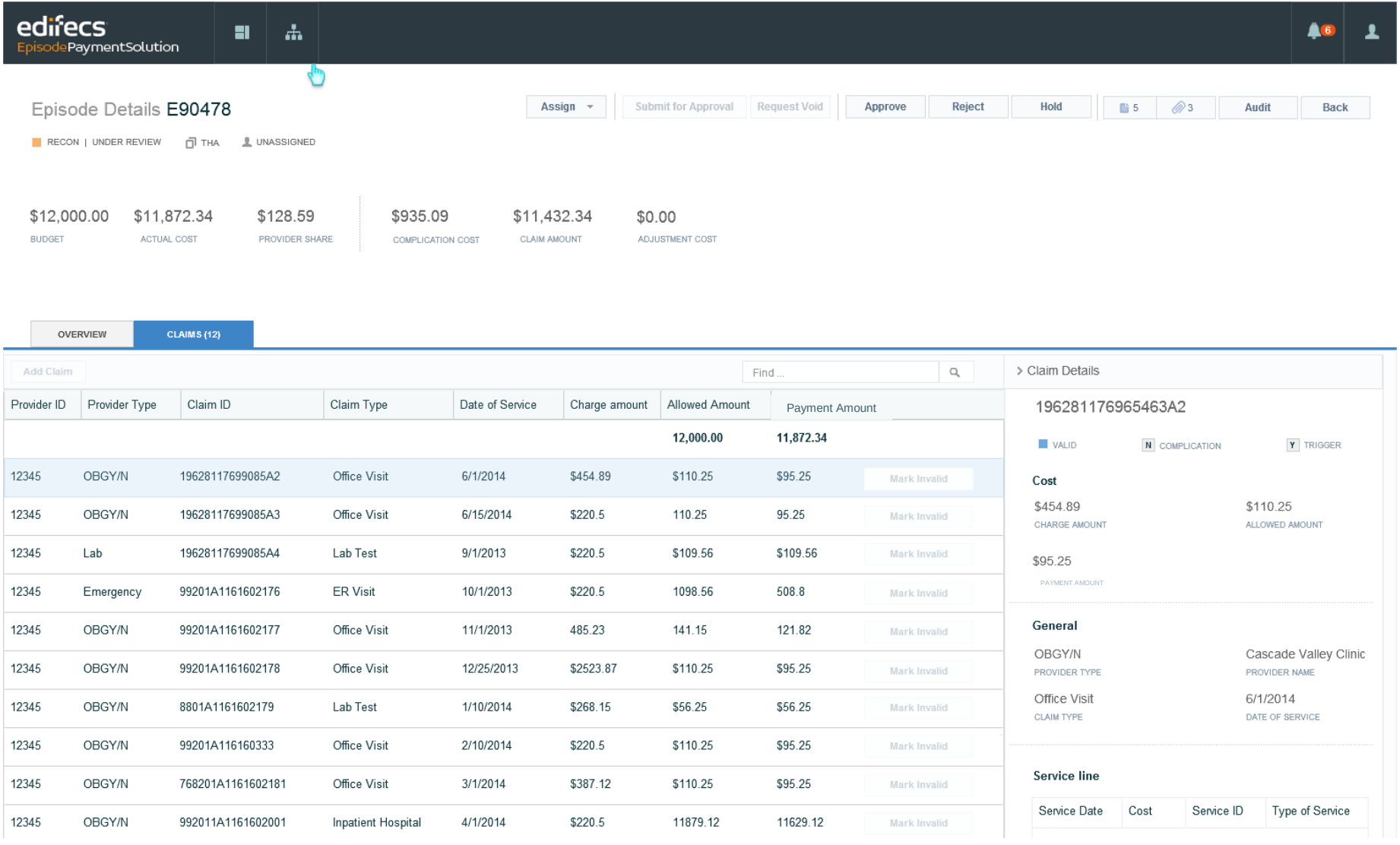
Western Family Physicians	$195,846.00	12/02/2014
Pavilion Medical Associates	$34,165.96	12/10/2014

Episodes Missing Expected Services (10)

TriHealth Heart Institute	$195,846.00	12/02/2014
TriHealth Evendale Hospital	$34,165.96	12/10/2014
Good Samaritan Western R...	$56,435.00	12/02/2014
TriHealth Evendale Hospital	$34,034.85	12/10/2014
Pavilion Medical Associates	$423,165.96	12/10/2014
TriHealth Women's Services N...	$34,165.96	12/10/2014
TriHealth Women's Services N...	$56,435.00	12/02/2014
Bethesda Arrow Springs	$34,034.85	12/10/2014

Unassigned Episodes Review Closing This Week (4)

Bethesda Arrow Springs	$423,165.96	12/10/2014
TriHealth Women's Services N...	$34,165.96	12/10/2014
TriHealth Women's Services N...	$56,435.00	12/02/2014
Pavilion Medical Associates	$34,034.85	12/10/2014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EpisodePaymentSolution
6
Episode Details E90478
Assign
Submit for Approval
Request Void
Approve
Reject
Hold
5
3
Audit
Back
RECON | UNDER REVIEW
THA
UNASSIGNED
$12,000.00
BUDGET
$11,872.34
ACTUAL COST
$128.59
PROVIDER SHARE
$935.09
COMPLICATION COST
$11,432.34
CLAIM AMOUNT
$0.00
ADJUSTMENT COST
OVERVIEW
CLAIMS (12)
Add Claim
Find ...
Provider ID
Provider Type
Claim ID
Claim Type
Date of Service
Charge amount
Allowed Amount
Payment Amount
12,000.00
11,872.34
12345 OBGY/N 19628117699085A2 Office Visit 6/1/2014 $454.89 $110.25 $95.25 Mark Invalid
12345 OBGY/N 19628117699085A3 Office Visit 6/15/2014 $220.5 110.25 95.25 Mark Invalid
12345 Lab 19628117699085A4 Lab Test 9/1/2013 $220.5 $109.56 $109.56 Mark Invalid
12345 Emergency 99201A1161602176 ER Visit 10/1/2013 $220.5 1098.56 508.8 Mark Invalid
12345 OBGY/N 99201A1161602177 Office Visit 11/1/2013 485.23 141.15 121.82 Mark Invalid
12345 OBGY/N 99201A1161602178 Office Visit 12/25/2013 $2523.87 $110.25 $95.25 Mark Invalid
12345 OBGY/N 8801A1161602179 Lab Test 1/10/2014 $268.15 $56.25 $56.25 Mark Invalid
12345 OBGY/N 99201A116160333 Office Visit 2/10/2014 $220.5 $110.25 $95.25 Mark Invalid
12345 OBGY/N 768201A1161602181 Office Visit 3/1/2014 $387.12 $110.25 $95.25 Mark Invalid
12345 OBGY/N 992011A1161602001 Inpatient Hospital 4/1/2014 $220.5 11879.12 11629.12 Mark Invalid
Claim Details
196281176965463A2
VALID
N COMPLICATION
Y TRIGGER
Cost
$454.89
CHARGE AMOUNT
$110.25
ALLOWED AMOUNT
$95.25
PAYMENT AMOUNT
General
OBGY/N
PROVIDER TYPE
Cascade Valley Clinic
PROVIDER NAME
Office Visit
CLAIM TYPE
6/1/2014
DATE OF SERVICE
Service line
Service Date
Cost
Service ID
Type of Service
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Important Strategies

Procrastination is the art of keeping up with yesterday

1. Request historical data from CMS
2. Align orthopedic surgeon leadership (or hospitalist or anesthesiologist)
3. Root cause analysis of unwarranted variation, acute phase and post-acute phase
4. Examine hospital cost structure reduction opportunities
5. Plan for improving engagement with patients before and during the episode
6. Create a network of preferred post-acute providers
7. Explore opportunities for hospital gainsharing with key providers
8. Plan for measuring and managing utilization during the episode
9. Implement protocols to increase the number of patients discharged to home
10. Develop new decision support capabilities to identify new revenue return to the hospital based on different intervention options


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Questions & Answers