“ The Next Evolution of Healthcare Delivery: Leadership Strategies”

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Celebrating 20 years as your trusted post-acute partner

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Market Alert
Healthcare is Experiencing Dramatic Changes

- The goal of this session:
  - What changes in the market require a deep dive look
    - Policy and payment models
    - FFS vs. Value-Based Care and emerging models
  - Provide information on how to create opportunities through examination of the dynamic nature of healthcare delivery
  - And explore your facility's readiness
- CMS is committed to the expansion of value-based care and ACOs as they have proven to be effective at driving collaboration across the network and have shown to improve patient outcomes, engagement, and value.
  - What are key considerations to your strategy development?
  - How can your facility respond effectively and deliberately?

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Important Strategic Probing Questions

- What is impacting your referrals sourcing
- What is causing providers to un-silo
- Rethinking your market positioning and market share
- How can you differentiate yourself from your competitors
  - Aligning healthcare and care delivery transformation to your strategic initiatives

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New Market Realities

- Innovative care models from non-traditional players which are altering the healthcare landscape
- Growth in the Medicare Advantage plans
- Shifts to value-based payment models. Away from traditional FFS
- New Care Models with heighted focus on:
  - Specific patient populations
  - Causing adoption of integrated provider collaboration
- Growth of alternative care sites:
  - Shift from inpatient to outpatient
  - Growth in home-based care

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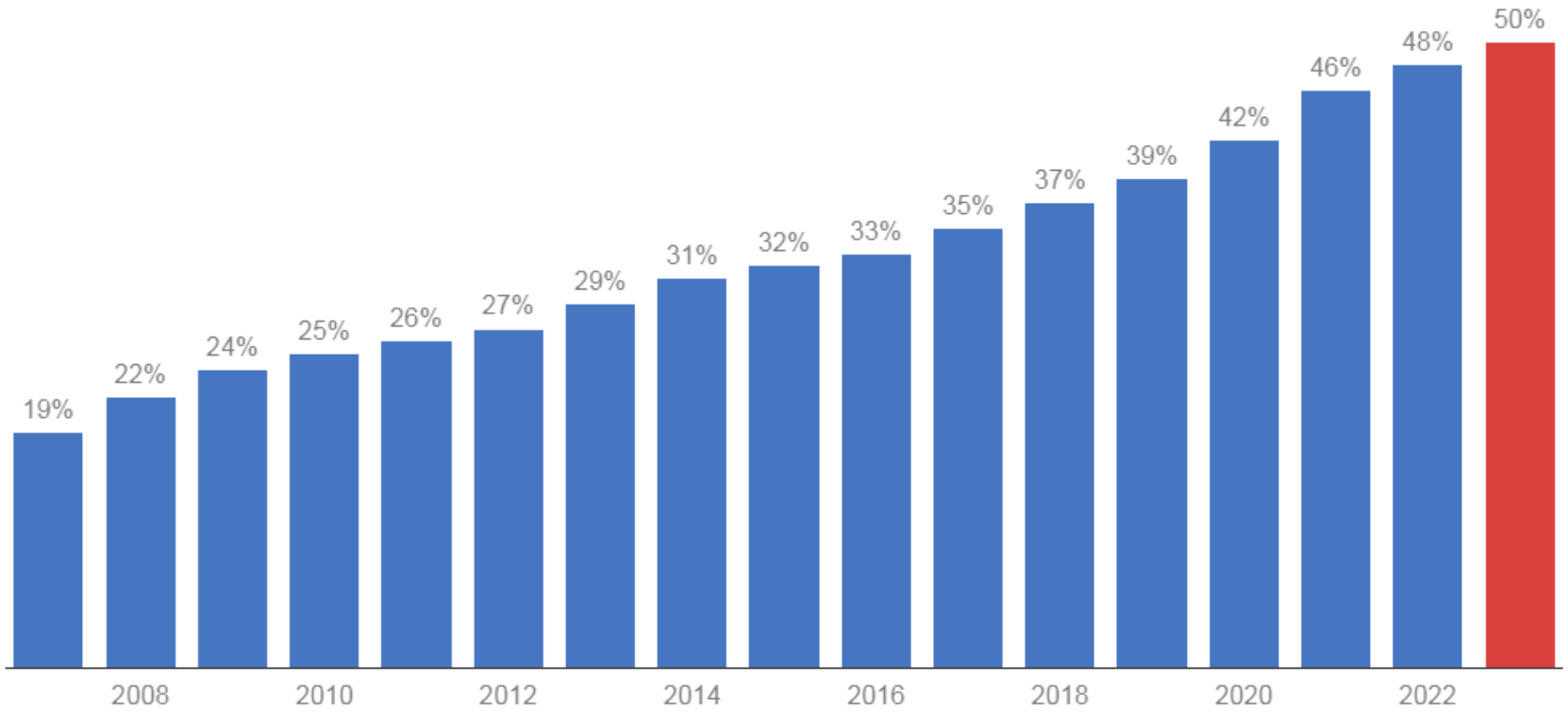
- According to CMS data, Medicare Advantage now provides Medicare coverage to over half the eligible beneficiaries
- CMS Goal: Enroll all traditional Medicare into accountable care by 2030

Figure 1

Half of All Eligible Medicare Beneficiaries Are Now Enrolled in Private Medicare Advantage Plans

Medicare Advantage Enrollment as a Share of the Medicare Part A and B Population, 2007-2023



NOTE: Includes Medicare Advantage plans: HMOs (including POS), PPOs (local and regional), PFFS, and MSAs. Excludes cost plans, PACE plans, HCPPs, and MMPs. About 59.82 million people are enrolled in Medicare Parts A and B in January 2023.

SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2007-2023; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2007-2017; CCW data from 20 percent of beneficiaries, 2018-2020; and Medicare Enrollment Dashboard 2021-2023. • PNG

KFF

Quintuple Aim:
A New Imperative to Advance Health Equity

- **“Triple Aim”-** Introduced in 2008
  - Framework to achieve three goals identified by CMS;
    1. Enhance the patient experience
    2. Improving the health of a population
    3. Spend less money on healthcare
- **“Quintuple Aim”-** for healthcare improvement
  1. Improving the well-being of the healthcare workforce
  2. Achieving healthcare equity

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Six Trends Impacting Hospital Delivery

1. Patient acuity rising
2. Inpatient volumes declining
   - Hospital inpatient volumes will slowly recover
   - Inpatient growth will be fueled by chronic disease
3. Outpatient volumes will grow
   - Shifts in sites of care will continue
4. Emergency department will soften
5. Home based services will increase
6. Medicare FFS is shrinking

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Understanding the Shifting Definition of Accountable Care

Accountable Care Relationship:

- **Accountable Care Organization:** A doctor, group of health care providers, hospital, health plan responsible for the quality, care coordination and outcomes for a defined group of pts, reducing care fragmentation and lower costs.
- **Accountable Care:** Care that is centered around the patient and aligns care team to support shared decision-making to realize best achieved outcomes through equitable, comprehensive, high quality, longitudinal care.
- **Value-Based Care:** Care designed to focus on quality, provider performance and the patient experience

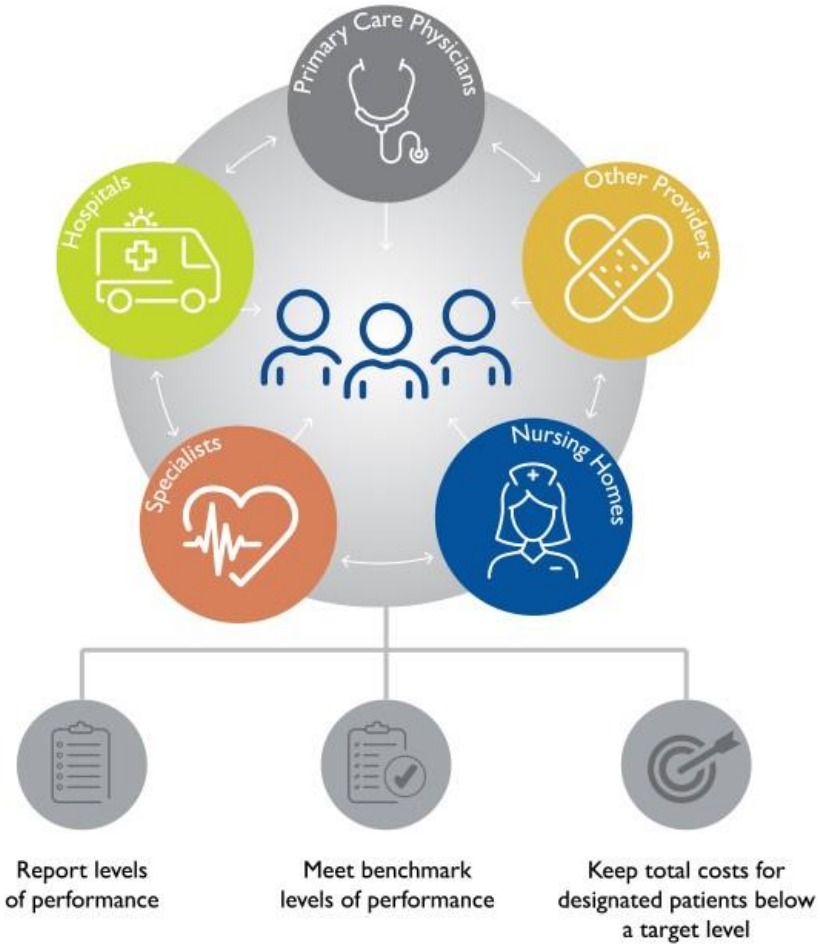
Accountable Care Organizations

GOAL: Align incentives of all stakeholders to optimize patient health

- Improve chronic disease management
- Lower costs
- Improve population health
- Reduce hospital admissions and ED visits

Bring together hospitals, healthcare providers and clinicians

Overall Care: Creating an integrated services model across the life of the patient's disease process. Care management, care transitions and care in the patient's home



- **Unsiloing Healthcare Pays Off**
- **ACOs:** Described as umbrella organizations with facilities across the patient's continuum of care
  - Pre-Acute- PCP, Specialists etc.
  - Acute- Hospitals
  - Post-Acute- Rehabilitation, LTC, SNFs and Home Health
- **FINDINGS:**
  - In order for an ACO to be successful, it needs representation across all parts of the patient's continuum of care
  - 2 Key Metrics-
    1. Partnership Scope
    2. Partnership Scale
- **RESULTS:**
  - According to a study from the Dept. of Health and Human Services, ACOs outperformed FFS providers on 81% of individual quality measures
  - Research has shown that more than 60% of ACOs have providers from only one care-continuum stage

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Payer: Six trends

1. Advancing footprint into care at home
2. New market positions for care at home insurers developing models to fill the gap with new care models
3. Focus on cost and revenue
4. Developing integrated care continuum delivery systems
5. Positioning Medicare Advantage Plans to expand care models
6. Creating non-traditional care delivery models

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Payviders: Industry Disruptors

- There are three different kinds of payvider models. They include:
  1. **Joint Venture:** A model where payers and providers together design a healthcare plan with shared goals.
  2. **Provider Plans:** This is when providers create their own insurance plans, so they control premiums and do not need to share the savings they create with insurance companies.
  3. **Insurance Companies Become Providers:** This is where payers (insurance companies) transition to providing healthcare and offering insurance. This is typically done through the acquisition of provider networks and healthcare companies as we will cover in the next section.

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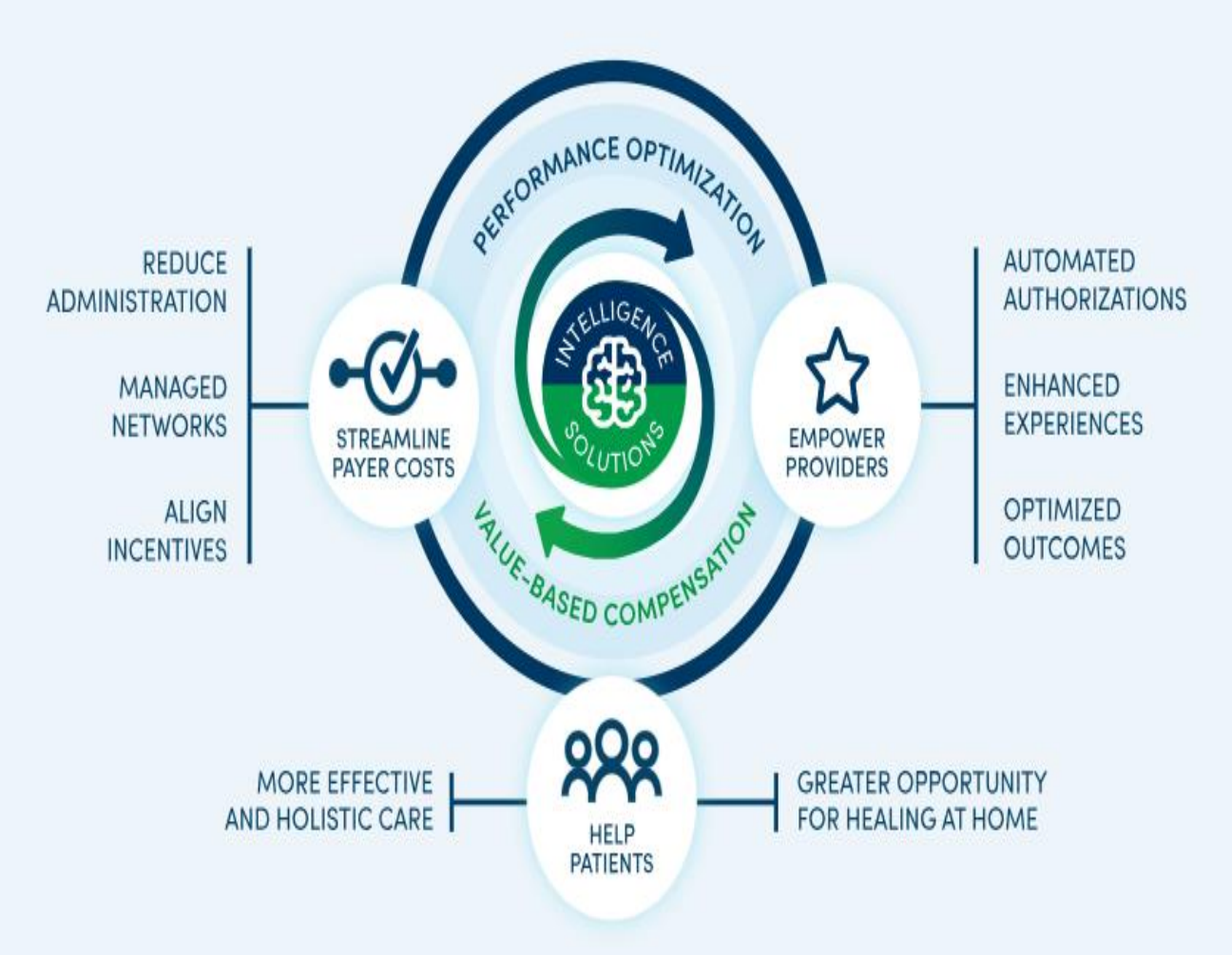
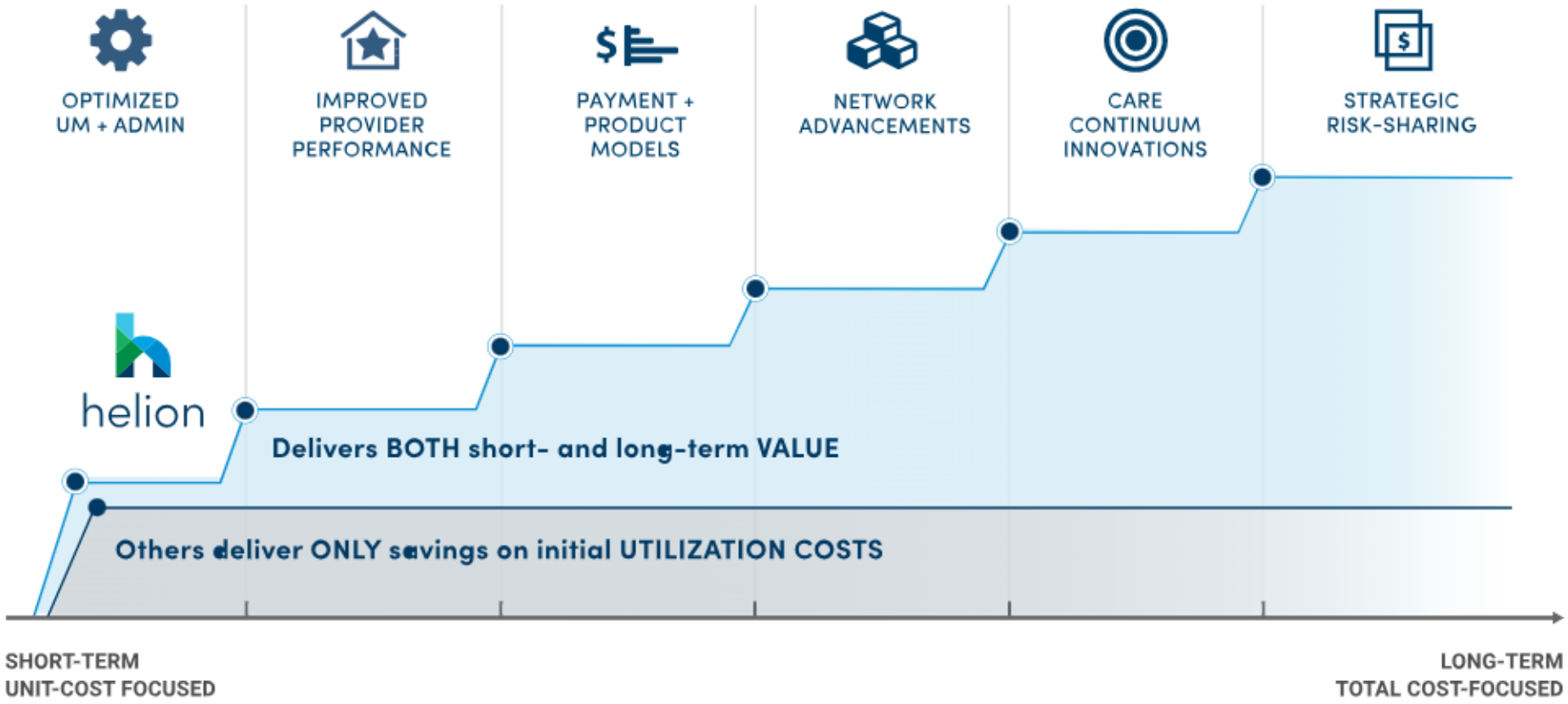
Helion's Solutions Transforming Post-Acute Care



- Built on core idea, that through collaboration with post-acute providers the following can be obtained:
  - Delivery of better care for patients
  - Reduced administrative burden
  - Creating downstream value for the payers
  - Better management of post-acute episodes of care
- Providers are empowered with:
  - The right insights
  - Tools
  - Guidance
  - And opportunities to earn incentives for providing better care across the continuum

Helion's Network Optimization System: A Path to Value-Based Care



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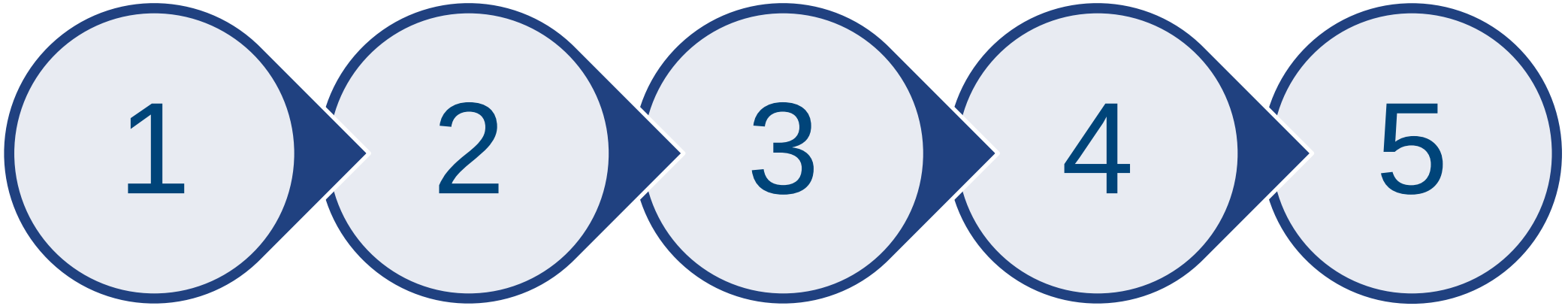
Payers Creating Non-traditional Care Delivery Models

- Primary goals:
  - Lowering the overall spend per beneficiary
  - Create an integrated delivery model to align all aspects of the member's journey
  - Owning assets of care delivery as a health solution company

Embracing Change: Out with the Old, FFS, and in with the New, Emerging Healthcare Delivery Models



Market Positioning

Opportunities for new market share and positioning

Payers

Accelerating of value-based care, going at risk creating aligned partnerships

VBP

Prepare your market position for value-based care

Integrated Ecosystem of Care

Uniting providers through quality, performance, while creating senior-focused ecosystem

Technology

Evaluating technology investments

Medicare Shared Savings Program ACOs Boasted Over $1.8B in Savings 2022

- 63% of ACOs under the MSSP were awarded payments based on their top-tier performance
- Shared-Savings Program ACOs has grown into one of the largest value-based payment programs in the US
- January 2023, the MSSP had over a half a million clinicians, caring for roughly 11M Medicare beneficiaries
- CMS has established a goal of 100% of individuals with traditional Medicare will be part of an ACO by 2030

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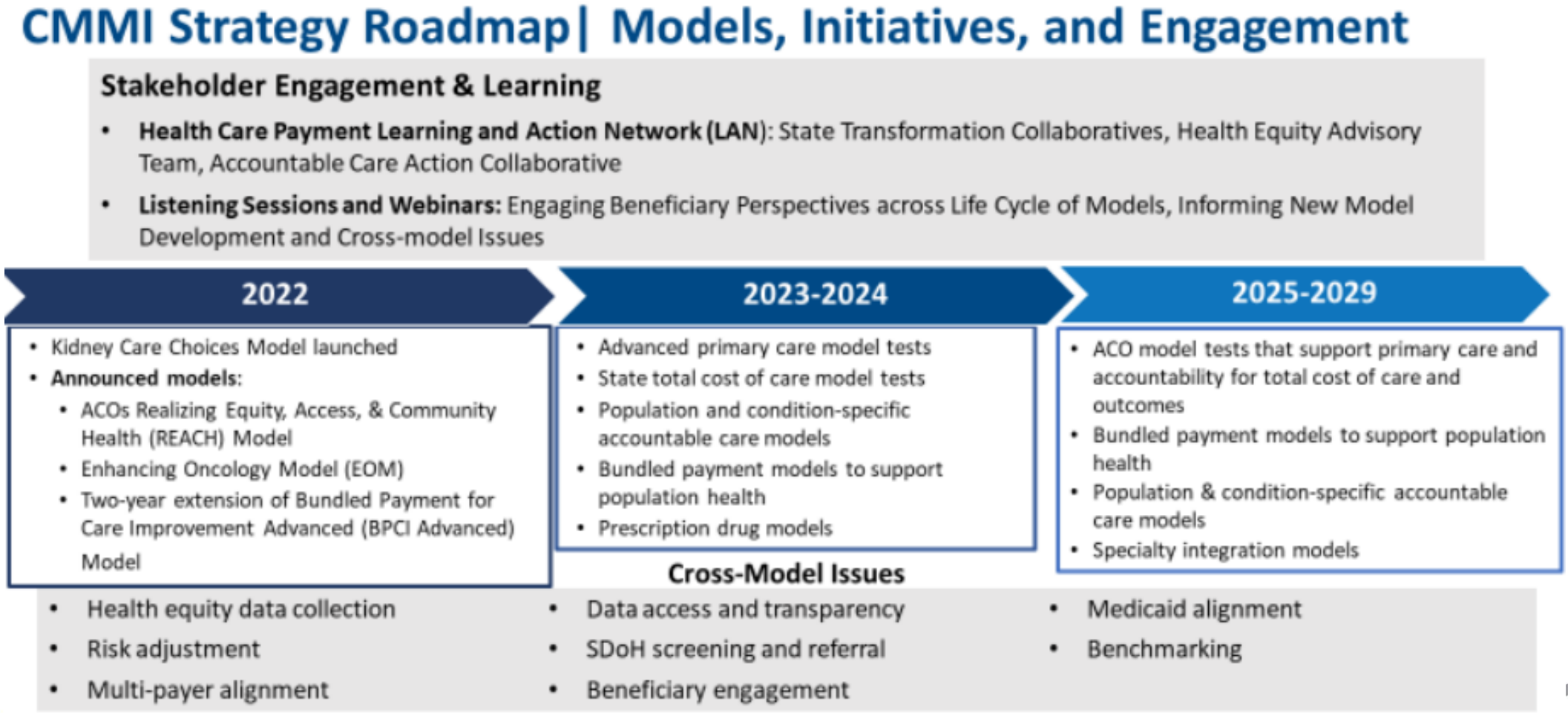
CMS Innovation Center's Strategic Roadmap



The Evolving Landscape of Value-Based Care and ACOs: Exploring the Shifts

Moving forward:

- Financial: movement to both upside and downside risks
- More incentives for ACOs, leading to an increase in applicants
- New models to move away from FFS

Goals:

- Development of strategic partnerships across providers
- Reducing avoidable hospitalizations and ED visits
- Health equity and social determinants
- Controlling costs and improving SNF quality
- Managing complex chronic conditions
- Engaging beneficiaries to improve their own health

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Reducing Clinician Burden through Universal Quality Measures

- Released 2023, across all programs, such as Medicare and Medicaid
- Function as the base additional provider alignment and population-specific measures
- Preliminary foundation for wellness and prevention, chronic conditions, behavioral health and person-centered care

- Re-focused CMS Vision requires:
  - Understanding of the changes in the care delivery model
  - Understand the organizations that are participating:
    - Characteristics
    - Capabilities
    - New participants attracted to these models
    - The push for un-siloing the care delivery system and fostering enhanced provider alignment

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