Executive Briefing: Navigating Financial Risk, Workforce Strain & System Shifts

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Agenda

- Navigating the Evolving Healthcare Delivery Landscape
- Identifying Risks and Opportunities in Episode-Based Alternative Payment Models
  - Focus on CMS MIPS, APP Plus, and the TEAM (Transforming Episode Accountability Model) initiatives
- Strategic Approaches to Enhance Operational Stability, Safeguard Margins, and Support Strained Teams
- Real-World Case Studies and Practical Examples

Healthcare Reform Overview

Over 21 million Americans are enrolled in ACA marketplace plans as of early 2024 — an all-time high (CMS).

U.S. health spending reached **$4.7 trillion in 2023**, about **17.6% of GDP**

Rural hospitals continue to close — over **140 rural hospitals** closed between 2010 and 2023, exacerbating care gaps

Medicare began negotiations in 2023 for **10 high-cost drugs**, with price changes expected by **2026** under the Inflation Reduction Act.

Over **13 million Medicare beneficiaries** were aligned with Accountable Care Organizations (ACOs) in 2024.

CMS aims for **100% of Medicare beneficiaries** to be in a value-based care model by 2030.

Prescription drug spending was approximately **$405 billion** in 2023, projected to rise by **5% annually**

Black and Hispanic populations are still **2–3 times more likely** to be uninsured compared to white populations

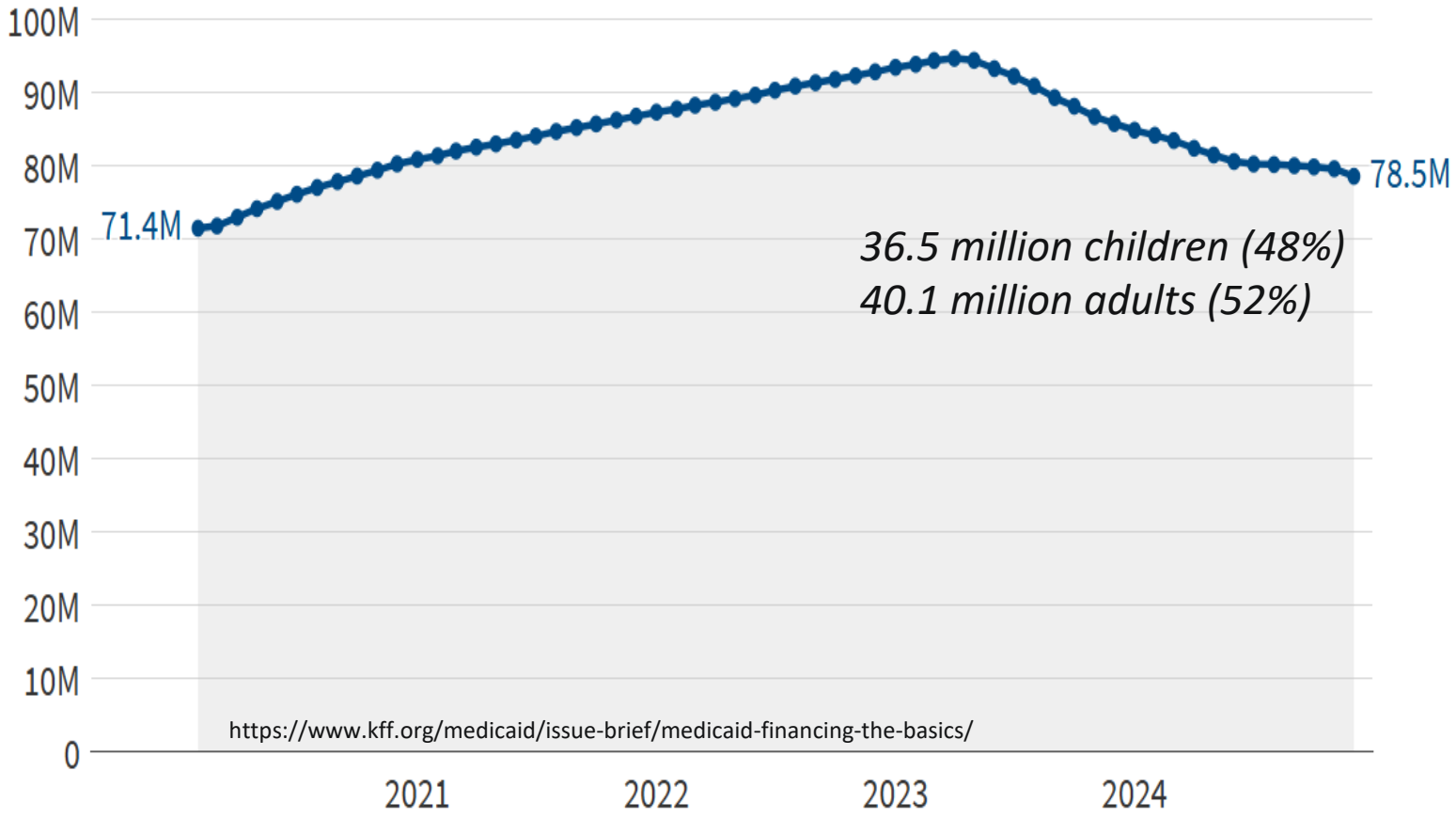
Medicaid Proposed Changes

Significant Medicaid cuts are currently under consideration in Congress as part of a broader Republican-led budget and tax proposal.

The House Energy and Commerce Committee has introduced legislation aiming to ***reduce federal spending by $880 billion over the next decade***, with a substantial portion of these cuts targeting Medicaid

National Enrollment in Medicaid & CHIP

February 2020 to December 2024



By the Numbers

Medicaid and CHIP Accounted for 8% of Net Federal Outlays in FFY 2024

Medicaid represents almost $1 out of every $5 spent on healthcare.

Medicaid is jointly financed by the federal government and the states

70% paid for by federal government

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Medicaid Proposed Changes (2025)

Work Requirements

The proposal mandates that able-bodied adults meet work, education, or service hour requirements to qualify for Medicaid

Eligibility Verification

Beneficiaries would undergo biannual eligibility checks, and stricter citizenship verification would be enforced

Cost-Sharing Measures

The plan introduces co-payments for certain Medicaid recipients, potentially increasing out-of-pocket expenses for low-income individuals

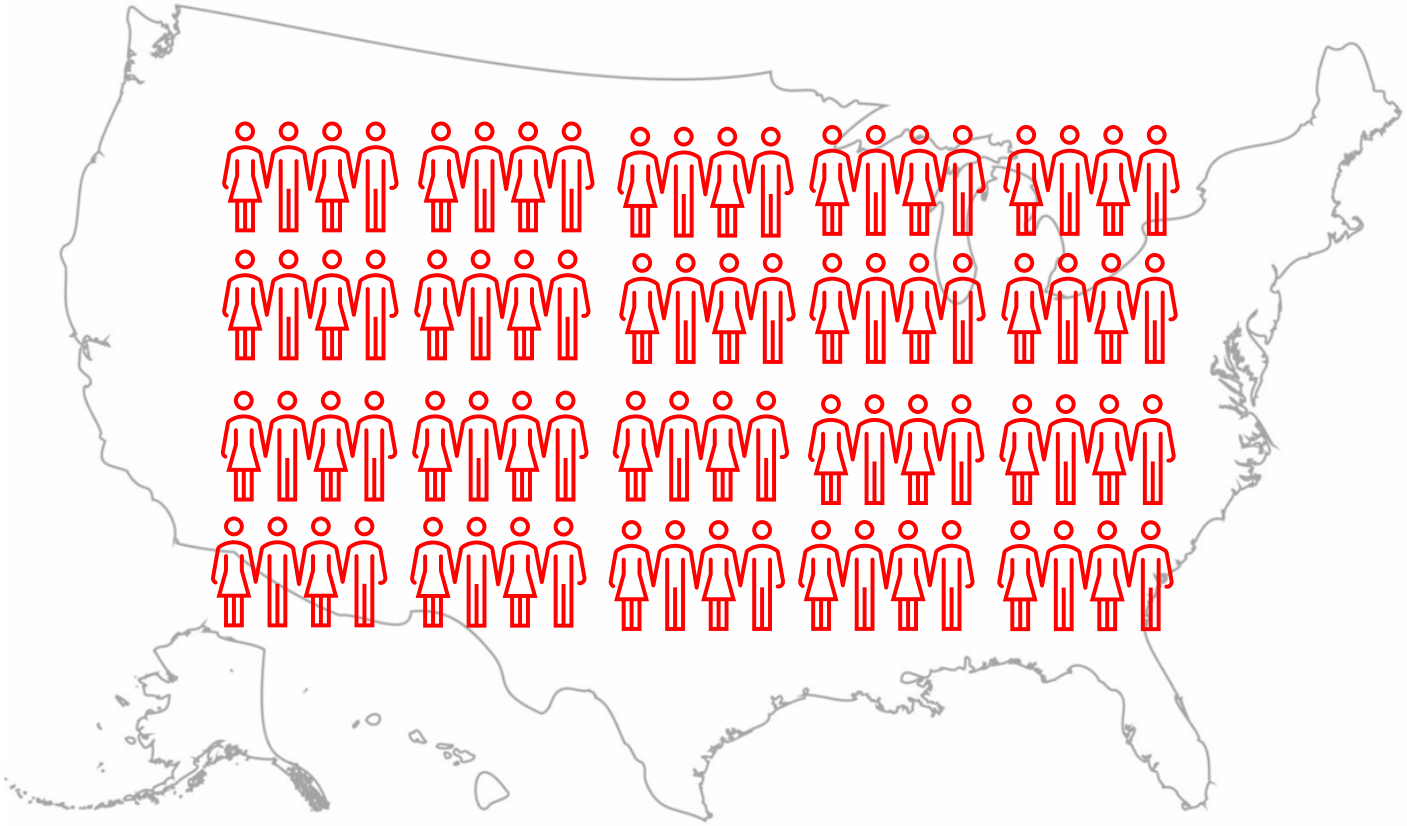
Provider Tax Freezes

States would face freezes on provider taxes, which could limit their ability to fund Medicaid programs effectively.

Medicaid Overhaul

Potential Impacts

The Congressional Budget Office (CBO) ***estimates up to*** ***10 million Americans*** *could loss Medicaid coverage*



Medicare Reforms

The **CMS Medicare 2025 changes** affect hospitals in several keyways, particularly through Medicare Advantage (MA) reforms, changes in payment policy, and service delivery expectations.

These adjustments could ***raise hospital payments by approximately 5 to 7 billion nationwide***

Medicare Reforms

Operating and Capital Payment Increase:

A finalized 2.9% increase in operating payment rates for general acute care. This adjustment is projected to raise hospital payments by approximately $2.9 billion nationwide.

Uncompensated Care Payments:

Disproportionate Share Hospitals (DSH) are expected to see an increase of about $560 million in Medicare uncompensated care payments

New Technology Add-On Payments:

CMS anticipates an additional $94 million in payments for inpatient cases involving new medical technologies

Outpatient Prospective Payment System (OPPS):

Hospital outpatient departments are set to receive a 2.9% increase in Medicare reimbursement, equating to an estimated $2.2 billion additional funding for the industry.

Physician Fee Schedule:

Conversely, physicians will face a 2.9% decrease in average Medicare payment rates in 2025, potentially impacting hospital-affiliated physician groups and services

Medicare Reforms

Quality Reporting and EHR Requirements:

Hospitals must continue to meet the Hospital Inpatient Quality Reporting (IQR) Program and meaningful electronic health record (EHR) use criteria to qualify for the full payment updates.

Bundled Payment Models:

CMS is progressing toward its goal of having all Medicare fee-for-service beneficiaries under value-based payment arrangements by 2030. As part of this initiative, a new mandatory bundled payment model will be implemented in 25% of core-based statistical areas (CBSAs), potentially affecting hospital reimbursement structures.

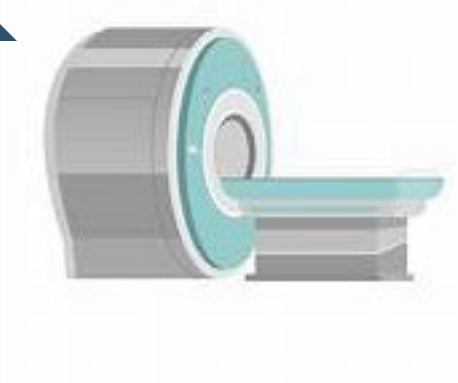
Potential Financial Impact

Category	Financial Impact (Approximate)
Inpatient Payment Increase	+$2.9 billion
Uncompensated Care Payments	+$560 million
New Technology Add-On Payments	+$94 million
Outpatient Payment Increase	+$2.2 billion
Physician Payment Decrease	-2.9%

How Tariffs Impact Healthcare Costs and Access

Import tariffs raise equipment costs

Medical Equipment



Hospitals pay more for essential tools

Increased raw material costs for drug production

Pharmaceuticals

Higher prescription prices for patients

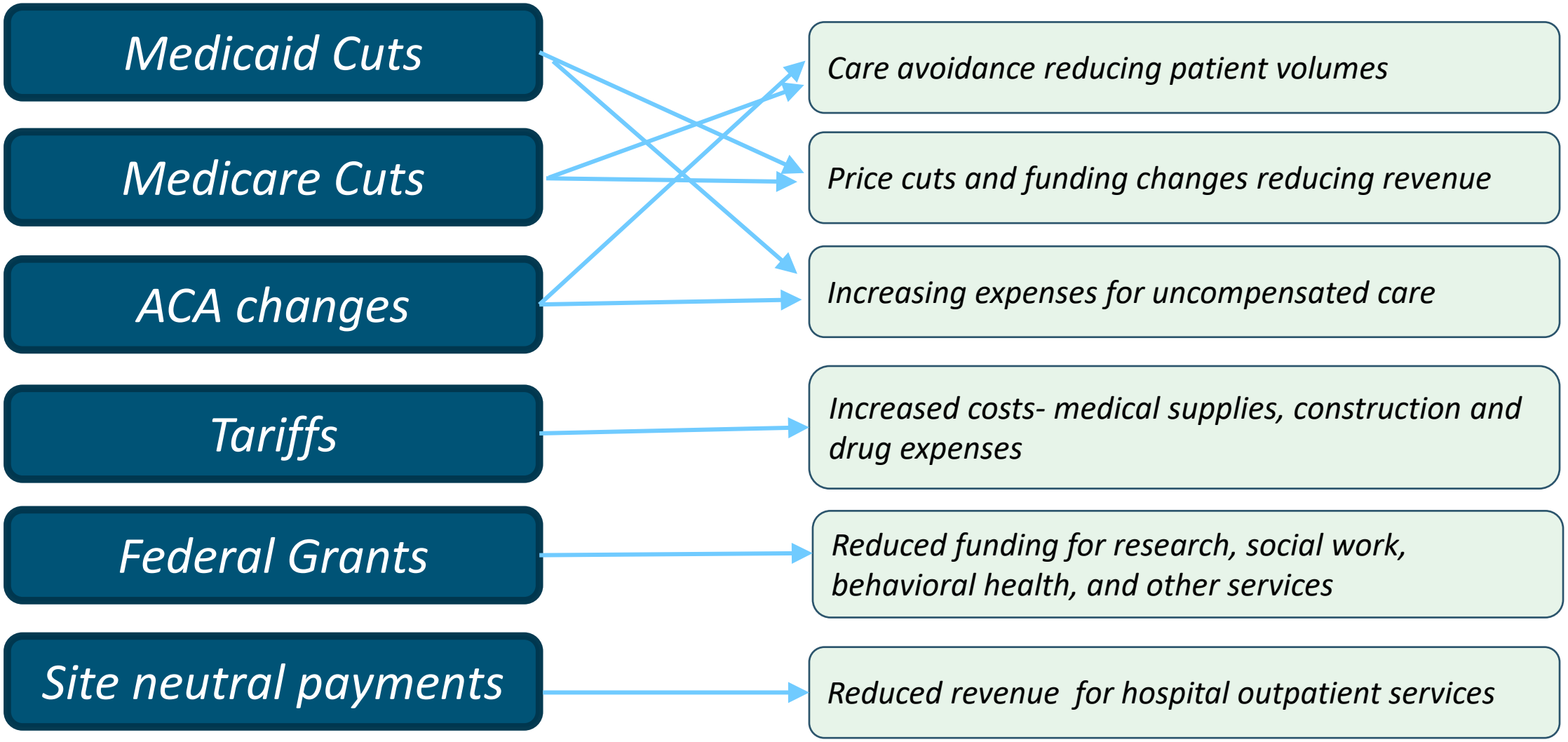
Tariffs disrupt global supply chain

Supply Chains

Delays in critical supplies & shortages

Tariffs indirectly increase healthcare costs, reduce efficiency, and can limit access to life-saving technologies

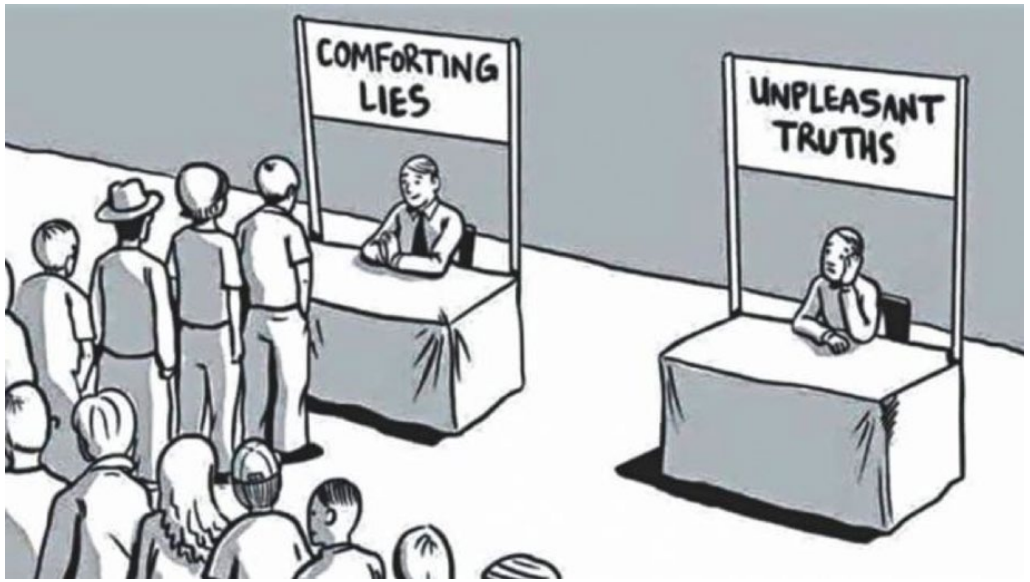
Potential Outcomes



Times Are Changing

THE TIMES THEY ARE A CHANGING…

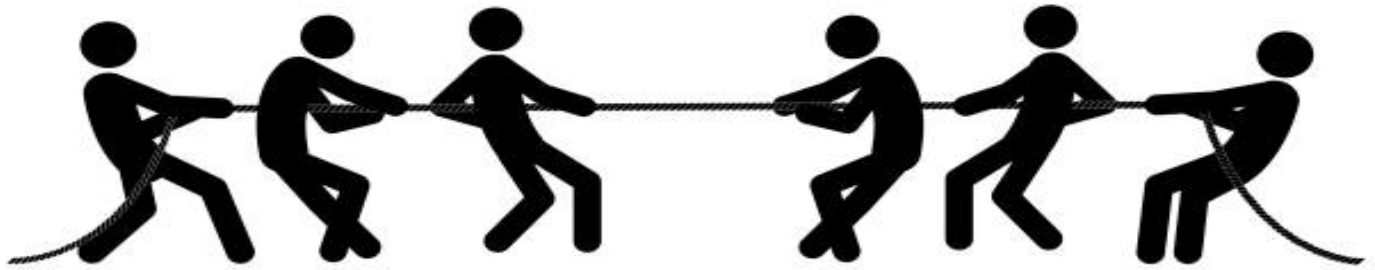
UNPLEASANT TRUTHS



- AGING POPULATION
- HEALTHCARE PROVIDER & STAFFING SHORTAGES
- “BURNOUT”
- BUDGET DEFICITS:
  FEDERAL > STATE > LOCAL > "HEALTHCARE"
- FFS Reimbursement Rates DECREASING
- MIPS EMPHASIS ON COST & QUALITY INCREASING
- PAYMENT ADJUSTMENTS INCREASING
- RISK MODEL CONTRACTING EVOLVING
- QUALITY OF CARE DECREASING

Fee For Service (FFS) vs. Value Based Care (VBC)

Volume Incentives vs. Cost & Quality Incentives (Risk Contracts – Population Management)



FFS vs VBC

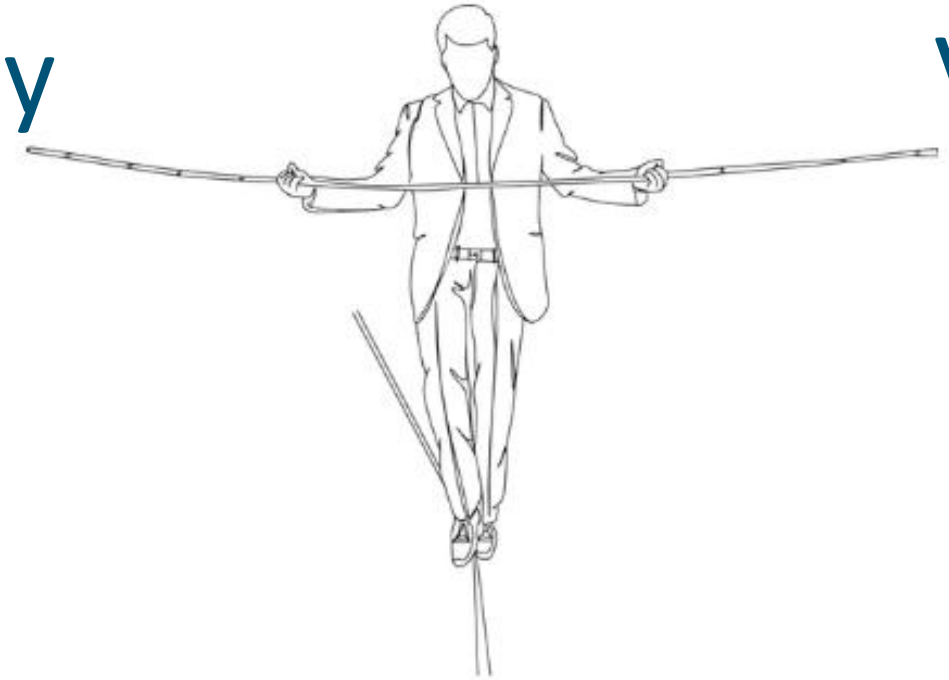
"Traditional" FFS reimbursement incentivizes Volume of Care

VBC requires controlling total costs of care while documenting improved quality of care and enhanced services

FIND YOUR BALANCE

FFS only

VBC only



FFS + VBC

Audience Poll 1

Is your group's financial incentives linked to FFS, VBC, or both?

A. Fee For Service ONLY

B. Value-Based Care ONLY

C. FFS & VBC

D. Unsure

PAYMENT ADJUSTMENTS MIPS 2025/2027

Projected 2025 MIPS Participation and 2027 Payment Adjustments (ROI Opportunity)

CMS estimates there will be **686,645 MIPS eligible clinicians** in the 2025 performance period, the median final score will be 86.42, and 78 percent of MIPS eligible clinicians will receive a positive payment adjustment.

- The increase in estimated final scores is largely due to CMS' proposal to modify the cost measure scoring methodology.
- For example, the median cost score increases from 59.16 under current policies to 73.85 based on proposed policies.
- However, even under the proposed policies, **solo practitioners and small practices remain more likely to be penalized.**
- CMS estimates **46 percent of solo practitioners and 21 percent of small practices will receive a penalty** compared to 15 percent overall. See the table below – next page.

CMS Projections

2027 Payment Year ; 2025 Performance

CMS projects the **median positive payment adjustment** in the 2027 payment year based on 2025 performance will be **1.31 percent**

CMS median penalty will be -1.48 percent. CMS expects median penalty will be **-6.42 percent for solo practitioners** and **-5.88 percent for small practices** because more solo practitioners and small groups are expected to receive the **maximum -9 percent MIPS penalty**.

	Estimated median final score	Estimated percent receiving a penalty
All MIPS eligible clinicians	86.42	15%
All solo practitioners	75.00	46%
All small practices	86.02	21%
All rural practitioners	85.41	16%
Rural solo practitioners	75.00	46%
Rural small practices	87.34	20%
All safety net practitioners	88.59	14%
Safety net solo practitioners	65.78	52%
Safety net small practices	84.50	27%

Quality (30%) + Improvement Activities (15%) + Cost (30%) + Promoting Interoperability (25%)

- Merit-based Incentive Payment System (Traditional MIPS)
- MIPS Value Pathways (MVP)
- Advanced Alternative Payment Models (Advanced APMs)
- Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO)

Audience Poll 2

What is your org's MIPS Participation Model?

A. Merit-based Incentive Payment System (Traditional MIPS)

B. MIPS Value Pathways (MVP)

C. Advanced Alternative Payment Models (Advanced APMs)

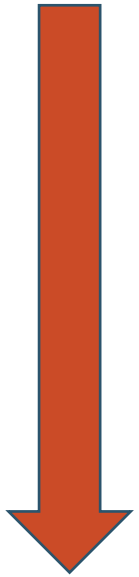
D. Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO)

2022-2025 Overall Star Rating Distribution

MA-PD Contracts (Source CMS)

Overall Rating	2022			2023			2024			2025		
	# of Contracts	%	Weighted by Enrollment	# of Contracts	%	Weighted by Enrollment	# of Contracts	%	Weighted by Enrollment	# of Contracts	%	Weighted by Enrollment
5 stars	74	15.71	26.59	57	11.24	21.87	38	6.97	7.64	7	1.34	1.79
4.5 stars	96	20.38	33.21	67	13.21	25.92	81	14.86	31.76	86	16.51	28.87
4 stars	152	32.27	29.87	136	26.82	24.26	123	22.57	36.94	116	22.26	31.47
3.5 stars	122	25.90	8.49	116	22.88	18.71	141	25.87	15.89	165	31.67	27.71
3 stars	25	5.31	1.80	90	17.75	6.73	126	23.12	6.77	123	23.61	9.16
2.5 stars	2	0.42	0.03	37	7.30	2.39	32	5.87	0.96	23	4.41	1.00
2 stars	0	0	0	4	0.79	0.12	4	0.73	0.03	1	0.19	0.01
Total Rated Contracts	471	100		507	100		545	100		521	100	
Average Star Rating*	**4.37**			**4.14**			**4.07**			**3.92**		

Average STAR Rating decreased from 4.37 to 3.02



Preventive Care Access is a Priority

Need for increased efforts to promote and facilitate access to preventive services

*Only **5.3%** of adults aged 35 and older received all recommended high-priority preventive services in 2020.*

*Baseline data showed a fall from **8.5%** in 2015.*

***Objective AHS-08, Healthy People 2030,** Office of Disease Prevention and Health Promotion (ODPHP)*

Preventive Care Best Practices Are Not Fully in Place

Diagnosis

59% of adults received a colorectal cancer screening (2021)

80% of females received a breast cancer screening (2023)

74% of received cervical cancer screening (2021)

41% of adults, who had not been diagnosed with prediabetes or diabetes, had undiagnosed prediabetes (2017-20)

9% of primary care office visits included screening for depression (2016)

Testing/Monitoring

52% of Medicare beneficiaries with diabetes mellitus had urinary albumin testing (2021)

66% of adults diagnosed with diabetes had an eye exam within the past 12 months (2023)

39 % of Medicare beneficiaries with chronic kidney disease received medical evaluation with serum creatinine, lipids, and urine albumin tests in (2021)

12% of Medicare beneficiaries who incurred acute kidney injury had a follow-up evaluation of their kidney function within 3 months post discharge (2021)

Appropriate Management

16% of adults with hypertension had it under control (2017-20)

42% of adults received treatment for elevated cholesterol (2017-20)

44% of adults with chronic kidney disease had elevated blood pressure (2017-20)

TREATMENT TO GOAL NOT MET

> Controlling BP

> HGBA1C at GOAL

> GDMT for CHF

A study by the **Commonwealth Fund** found that preventable diseases and conditions cost the U.S. healthcare system nearly **$1.1 trillion annually**

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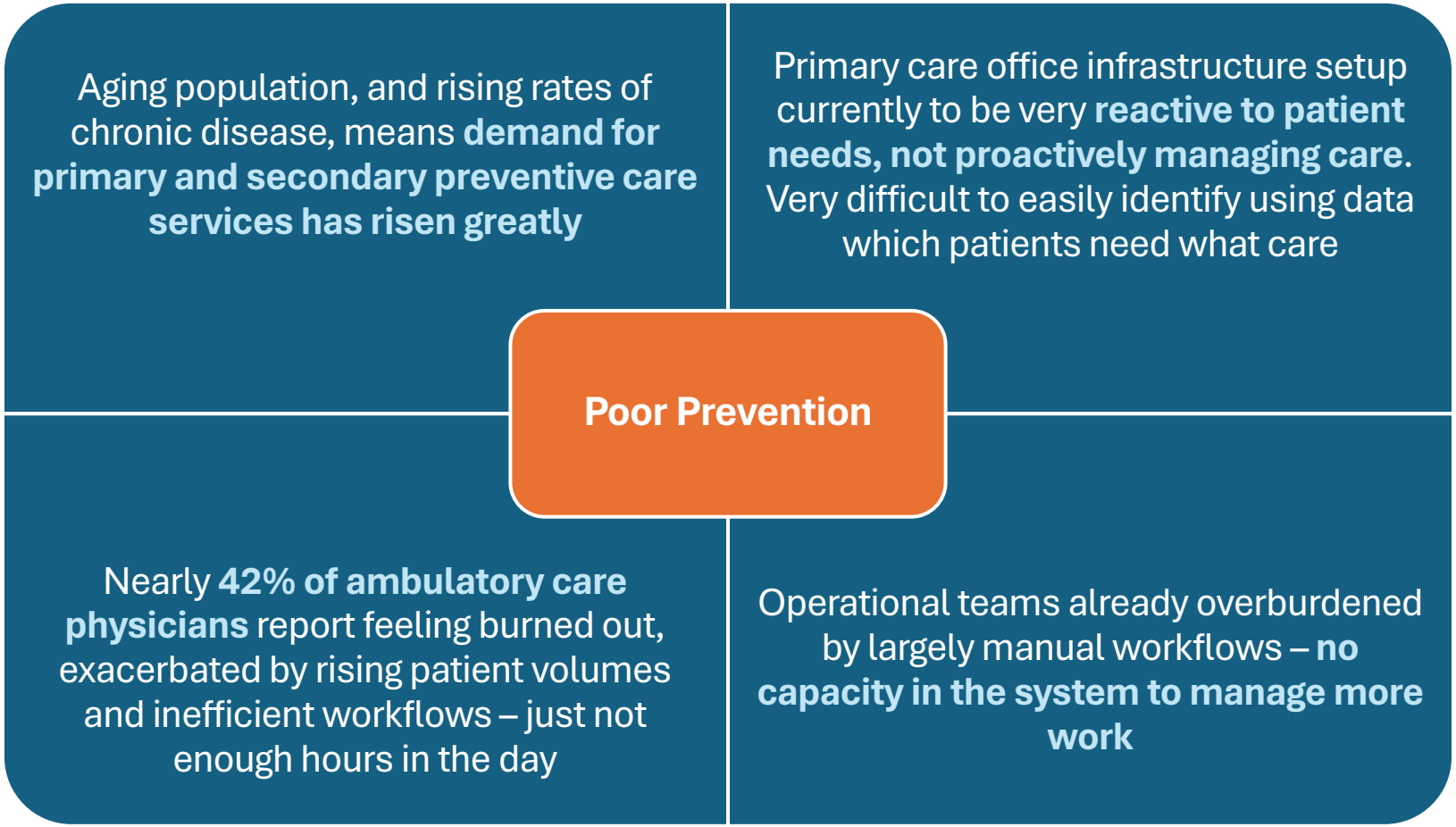
Data from Healthy People 2030 & USPSTF

Factors Contributing to Low Preventive Care Services



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Access/Availability: AAFP Report by Specialty

Specialty	Average wait time	% change since 2017
Cardiology	26.6 days	+26%
Dermatology	34.5 days	+7%
Family medicine	20.6 days	-30%
Obstetrics/gynecology	31.4 days	+19%
Orthopedic surgery	16.9 days	+48%

Source: AMN/Merritt Hawkins' 2022 Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates.

Source: https://www.aafp.org/pubs/fpm/blogs/inpractice/entry/wait-times.html

Audience Poll 3

What presents a greater challenge for your group: Access or Growth?

A. ACCESS: The ability to get timely appointments

B. GROWTH: The need to recruit new patients

C. BOTH: Access and Growth

D. NEITHER

Value-Based Care and/or Population Health Management Solution Requirements

DATA AGGREGATION & STORAGE

- Structured & Unstructured Data
- HIE/EHR Data Aggregation/Integration

HEALTH ANALYTICS

- Performance Analytics
- Reporting Tools
- Revenue Cycle Management
- Population Health Reports

PRACTICE MANAGEMENT/FINANCIAL SYSTEMS

- Billing and Coding
- Analytics
- Staffing and Workflow Management

PATIENT ENGAGEMENT

- Pre-visit, Point of Care, & Post-Visit (continuum of care)
- Preventive Care Services
- Chronic Disease Management, Care Management, and Transitions of Care

DO THE RIGHT THING!

(Not Always Easy)

Evidence-Based Best Practices

+

Quality

+

Efficiency (Automation)

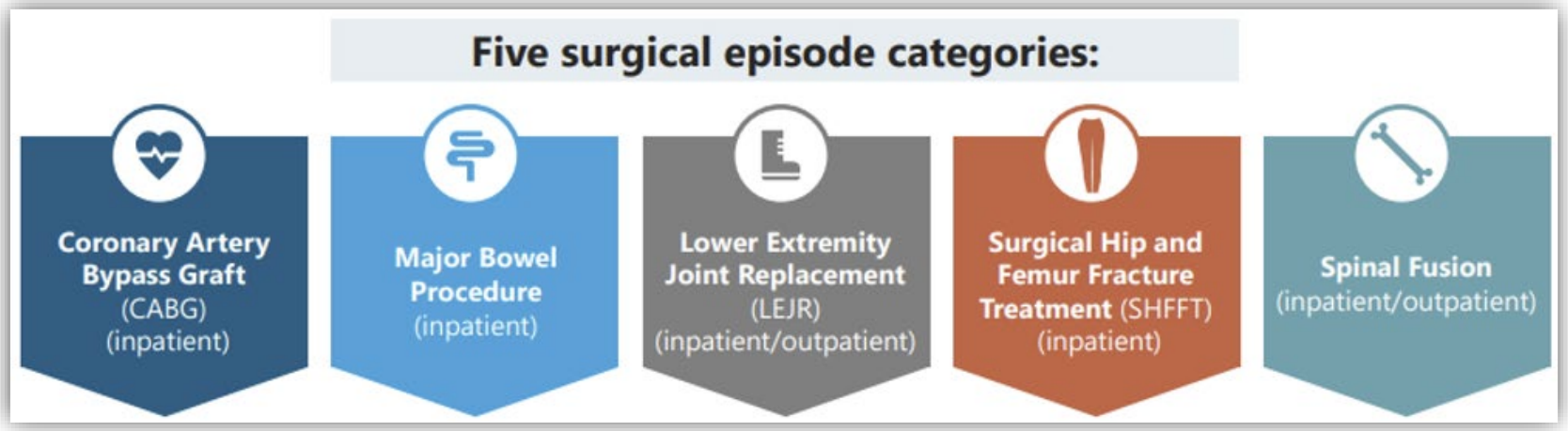
Orgs need the necessary tools…

- Infrastructure (Network)
- Leadership
- Evidence-based Best Practices
- Quality Improvement
- Workflow Efficiencies

FFS or VBC TECH ENABLED

Use Case Example

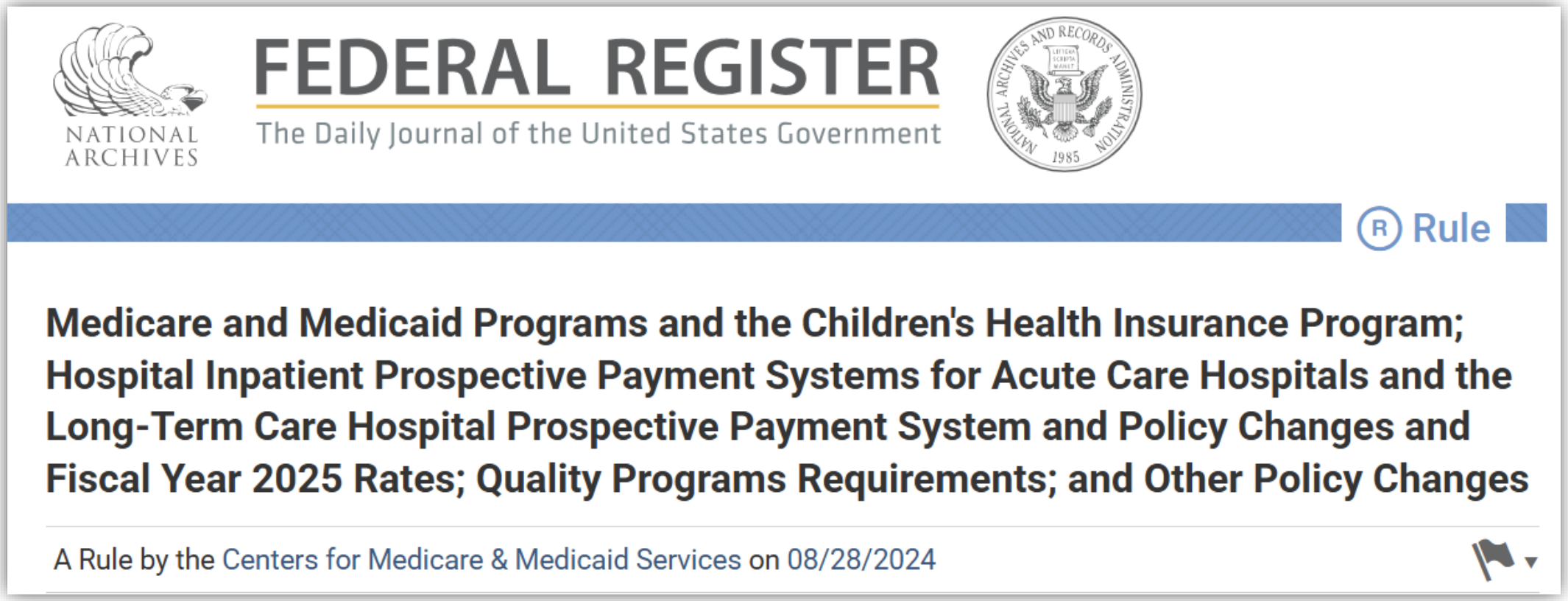
CMS TEAMs



PREVENTIVE CARE QUALITY IMPROVEMENT:

- LUNG CANCER SCREENING

CMS TEAMs (Transforming Episode Accountability Model)
Episode-Based Alternative Payment Models



Source: https://www.federalregister.gov/documents/2024/08/28/2024-17021/medicare-and-medicaid-programs-and-the-childrens-health-insurance-program-hospital-inpatient

CMS TEAMs (Transforming Episode Accountability Model)
Episode-Based Alternative Payment Models

- **Voluntary:** started January 1, 2025 through December 31, 2025
- **MANDATORY (select):** January 1, 2026 through December 31, 2030

- **Mandatory bundled payment initiative for ~750+ Hospitals**
  Core Based Statistical Areas (CBSAs)

- **Hospitals financially responsible for surgical encounter PLUS all costs of care delivered during the 30-day post-discharge period**
  - NEW RISK for Hospitals
  - Opportunity to improve financial performance IF they IMPROVE care coordination, cost containment, and quality outcomes

Audience Poll 4

Is your Group a CMS TEAM site? (Transforming Episode Accountability Model)

A. YES: Voluntary in 2025

B. YES: Voluntary in 2025 and Mandatory in 2026

C. Not currently, BUT MANDATORY starting January 1, 2026

D. NO

What is an EPISODE and What Costs Are Included

Surgical Encounter PLUS all related Medicare-covered services within 30 days after discharge:

All Medicare Part A and B items and services are included in the episode unless specifically excluded

Included Items and Services

- Physicians' services
- Inpatient hospital services (including hospital readmissions)
- Inpatient Psychiatric Facilities (IPF) services
- Long-Term Care Hospital (LTCH) services
- Inpatient Rehabilitation Facility (IRF) services
- Skilled Nursing Facility (SNF) services
- Home Health Agency (HHA) services
- Hospital outpatient services
- Outpatient therapy services
- Clinical laboratory services
- Durable Medical Equipment (DME)
- Part B drugs and biologicals, except for those specifically excluded
- Hospice services

Source: https://www.cms.gov/priorities/innovation/files/team-ovw-webinar-slides.pdf

EXCLUDED FROM EPISODES

The following items, services, and payments are **excluded from the episode:**

Select items and services considered unrelated to the anchor hospitalization/procedure, including, but not limited to, the following:

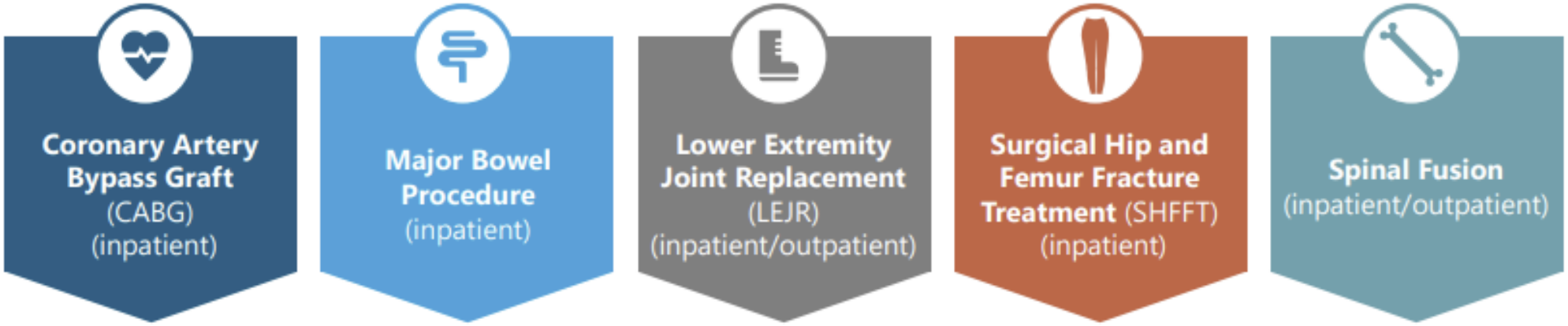
Inpatient hospital admissions for MS-DRGs that group to the following categories: ▪ Oncology, trauma medical, organ transplant, ventricular shunt
Inpatient hospital admissions that fall into the following Major Diagnostic Categories (MDCs): ▪ MDC 02 (Diseases and Disorders of the Eye), MDC 14 (Pregnancy, Childbirth, and Puerperium), MDC 25 (Newborns), MDC 25 (Human Immunodeficiency Virus)
Traditional pass-through payments for medical devices
New technology add-on payments
Hemophilia clotting factor products
Part B payments for low-volume drugs, high-cost drugs and biologicals, and blood clotting factors for Hemophilia

Please refer to the FY 2025 IPPS/LTCH PPS Final Rule, § 512.525, for detailed definitions of the excluded items.

Source: https://www.cms.gov/priorities/innovation/files/team-ovw-webinar-slides.pdf

TEAMS: WHAT SURGICAL EPISODES ARE INCLUDED?

Five surgical episode categories:

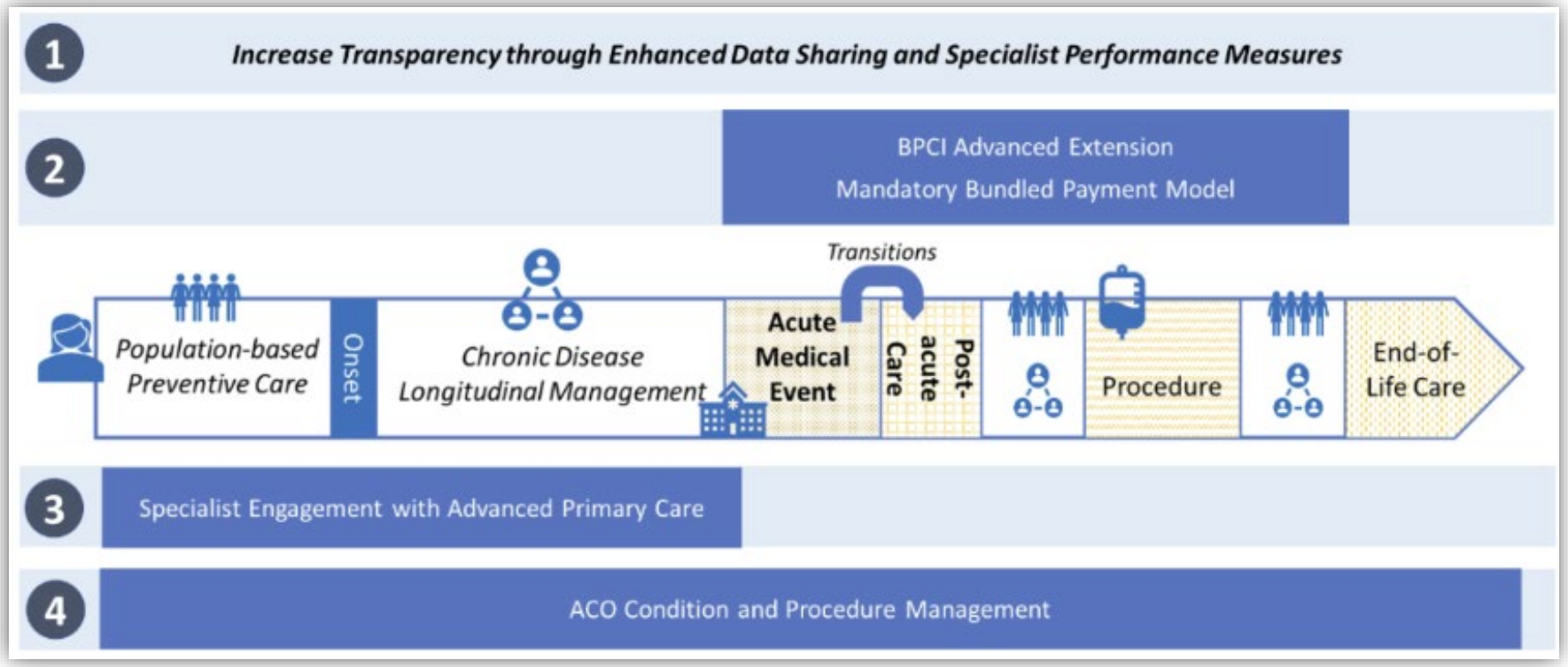


All participants are accountable for all episode categories unless an exclusion applies.

Episode Category	MS-DRG and/or HCPCS codes
CABG (inpatient)	MS-DRG: 231, 232, 233, 234, 235, 236
Major Bowel Procedure (inpatient)	MS-DRG: 329, 330, 331
LEJR (inpatient/outpatient)	MS-DRG: 469, 470, 521, 522 HCPCS: 27447, 27130, 27702
SHFFT (inpatient)	MS-DRG: 480, 481, 482
Spinal Fusion (inpatient/outpatient)	MS-DRG: 402, 426, 427, 428, 429, 430, 447, 448, 450, 451, 471, 472, 473 HCPCS: 22551, 22554, 22612, 22630, 22633

Source: https://www.cms.gov/priorities/innovation/files/team-ovw-webinar-slides.pdf

Aligned Elements of the Specialty Strategy and Beneficiary Care Experience



Participants will be required to refer patients to Primary Care Services to support patient continuity of care and positive long-term health outcomes.

Source: https://www.cms.gov/blog/cms-innovation-centers-strategy-support-person-centered-value-based-specialty-care

INCREASED DEMAND FOR PRIMARY CARE

TEAM encourages **coordination between specialists and primary care providers** to create smooth care transitions and promote beneficiary recovery.

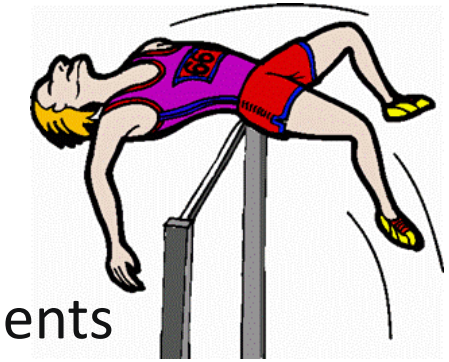
As part of discharge planning, TEAM participants are **required to refer TEAM beneficiaries to a primary care provider** on or prior to discharge from the anchor stay or anchor procedure.

TEAM participants must maintain **beneficiary freedom of choice** when making primary care referrals.

Source: https://www.cms.gov/priorities/innovation/files/team-ovw-webinar-slides.pdf

Episode Target Prices & Reconciliation Bonuses/Penalties

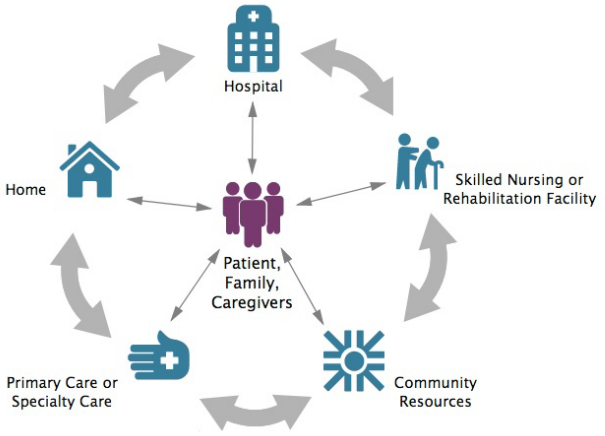
- Calculated using historical regional spending patterns **THEN DISCOUNTED 1.5-3%**
- ***NOTE: Hospitals must outperform regional historical averages to receive their bonus and avoid penalties***
- High-quality scores (good outcomes and patient satisfaction) can increase your reconciliation bonus or reduce penalties
- Low-quality scores can reduce your potential bonus or increase your repayment obligation
- Historical CMS programs (like CJR and BPCI Advanced) apply quality adjustments of around ±3% to the overall reconciliation payments



How Can You Control Episode Costs?

- **REDUCE Hospital Complications and Readmission Rates:**
  - Evidence-based Surgical Best Practices (ERAS®-like) Protocols: preoperative nutrition, comorbidity monitoring and management, infection prevention (SSIs), early mobility, DVT prophylaxis, adequate pain management

- **PROACTIVE Post-Acute Care (PAC):**
  - Facilitate safe discharge to home with Home Health vs. SNF/IRF Care (1/4th to 1/3rd the cost)
  - Coordinated discharge planning, automated transition of care processes, post-operative home assessments and monitoring with intensive patient education, and caregiver involvement



How Can You Control Episode Costs?

- **MINIMIZE Unnecessary or Redundant Services (PAT):**
  - Coordinate preoperatively and make available at time of surgery any necessary labs, diagnostics, imaging, or specialty consults
  - Prevent post-discharge emergency room visits through seamless transitions of care, automated post-discharge self-assessment and monitoring, intensive patient and caretaker education with primary care priority access
- **ESTABLISH Preferred Provider Network for Post-Acute Care (PAC):**
  - Primary Care Provider Network with tech-enabled automated PAC patient monitoring and assessments
  - SNF/IRF Networks known for best practices: short stays, low readmission rates, and high patient satisfaction

How Can You Control Episode Costs?

- **MAXIMIZE DATA & ANALYTICS**
  - Facilitate clean and comprehensive data acquisition of clinical and financial elements
  - Use analytics to proactively identify areas for improvement in clinical, quality, and financial metrics
  - Continuously gather, monitor, and analyze **Episode Costs**
  - Use Patient Reported Outcomes Data with patient-specific demographics and clinical data (comorbidities, functional status, etc.) to create AI predictive modeling to identify “good” and “bad” candidates for elective surgical procedures

Value-Based Care and/or Population Health Management Solution Requirements

DATA AGGREGATION & STORAGE

- Structured & Unstructured Data
- HIE/EHR Data Aggregation/Integration

HEALTH ANALYTICS

- Performance Analytics
- Reporting Tools
- Revenue Cycle Management
- Population Health Reports

PRACTICE MANAGEMENT/FINANCIAL SYSTEMS

- Billing and Coding
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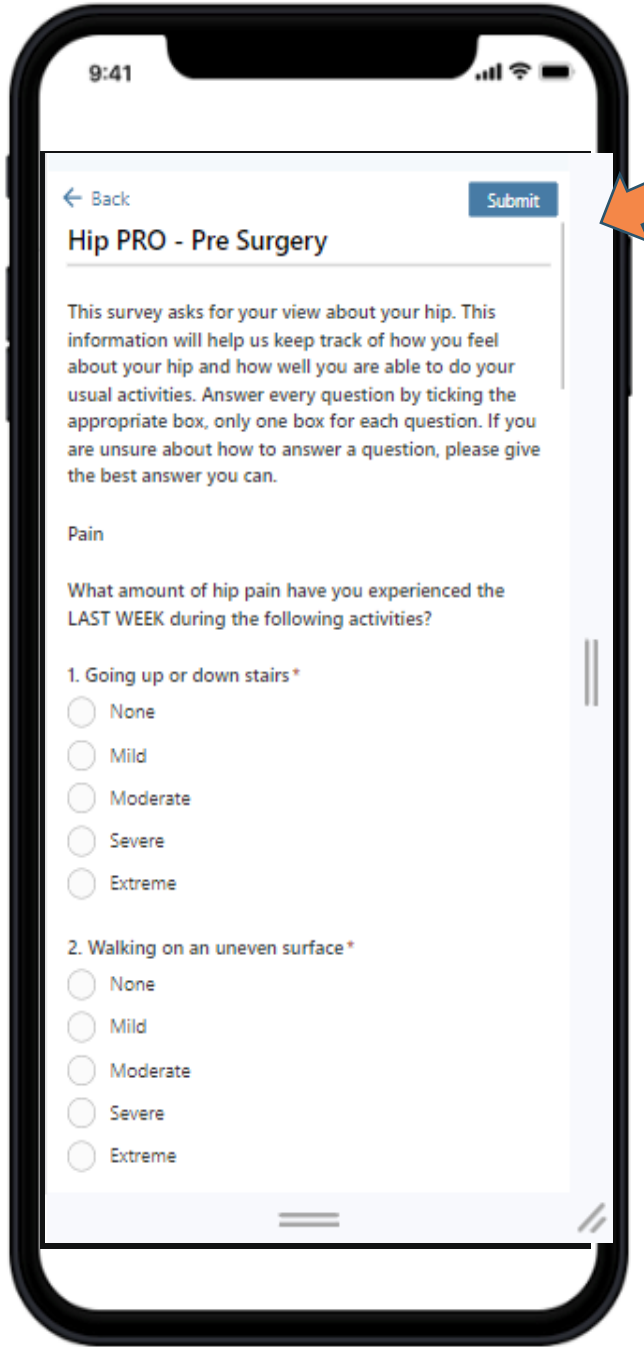
- Staffing and Workflow Management

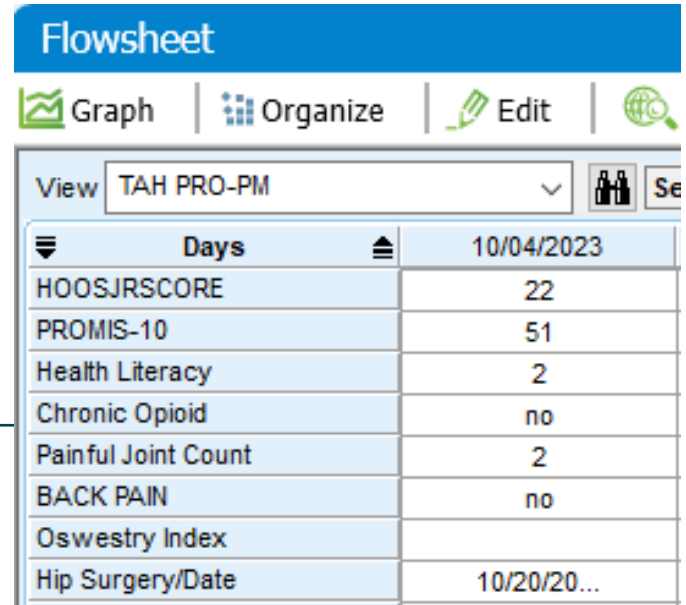
PATIENT ENGAGEMENT

- Pre-visit, Point of Care, & Post-Visit (continuum of care)
- Preventive Care Services
- Chronic Disease Management, Care Management, and Transitions of Care

Total Knee Arthroplasty Patient-Reported Outcome-Based Performance Measure (THA/TKA PRO-PM)

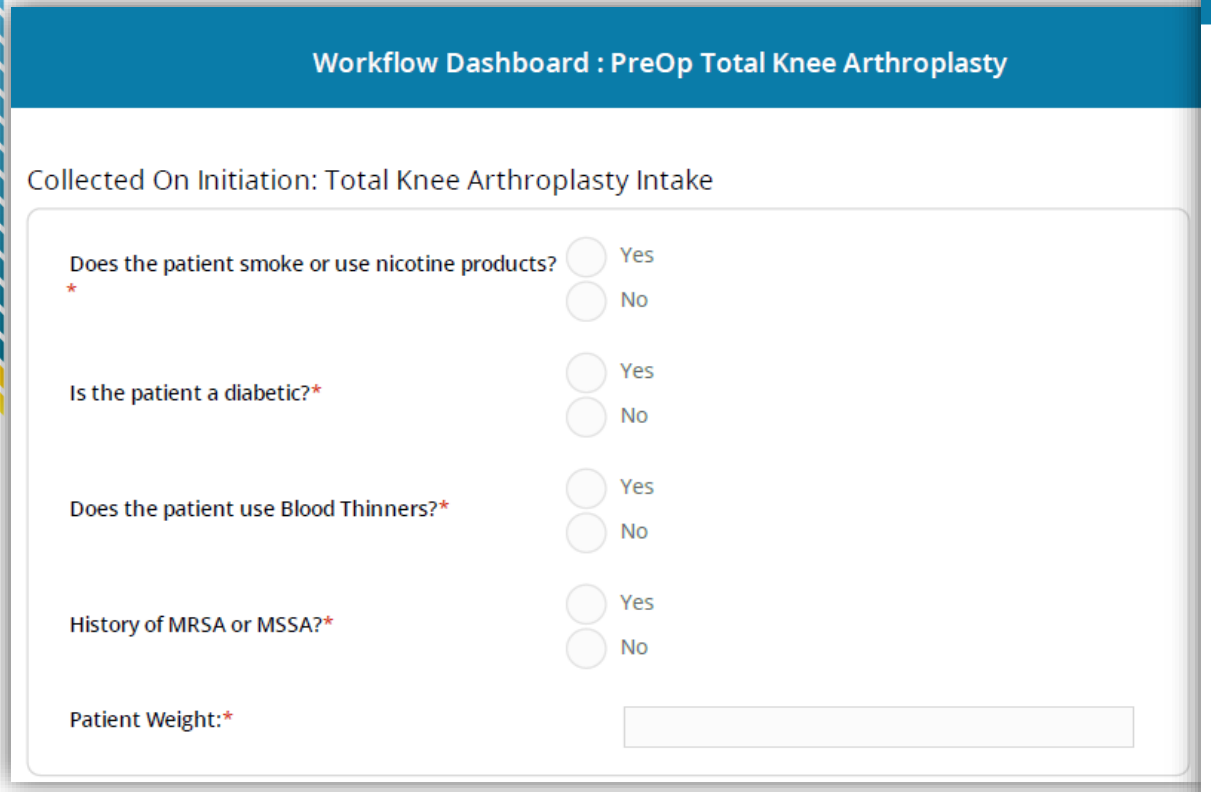


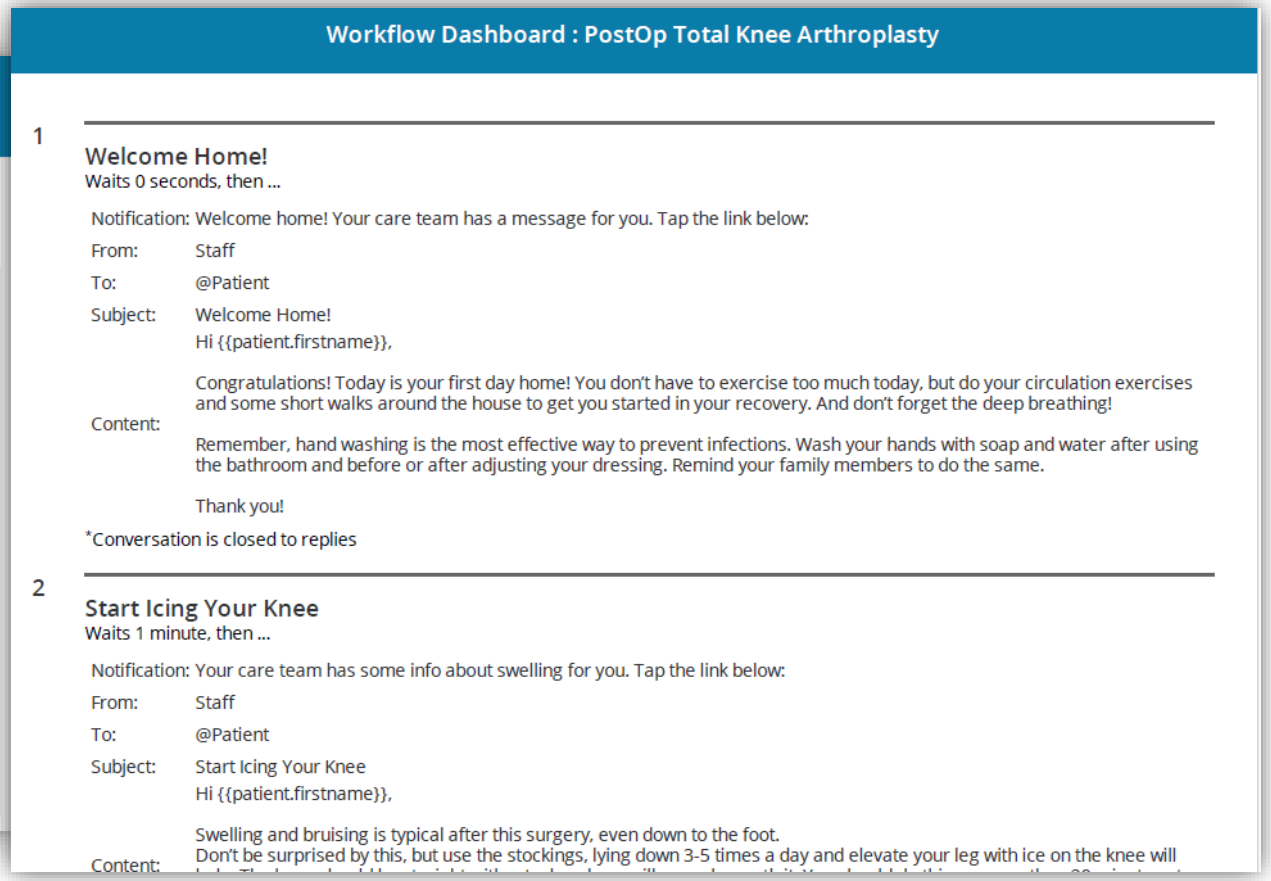
- Patient completes HOOS JR and additional required components in form and then “Submits”
- HOOS JR & PROMIS-10 automatically scored
- Results automatically sent as structured data to EHR



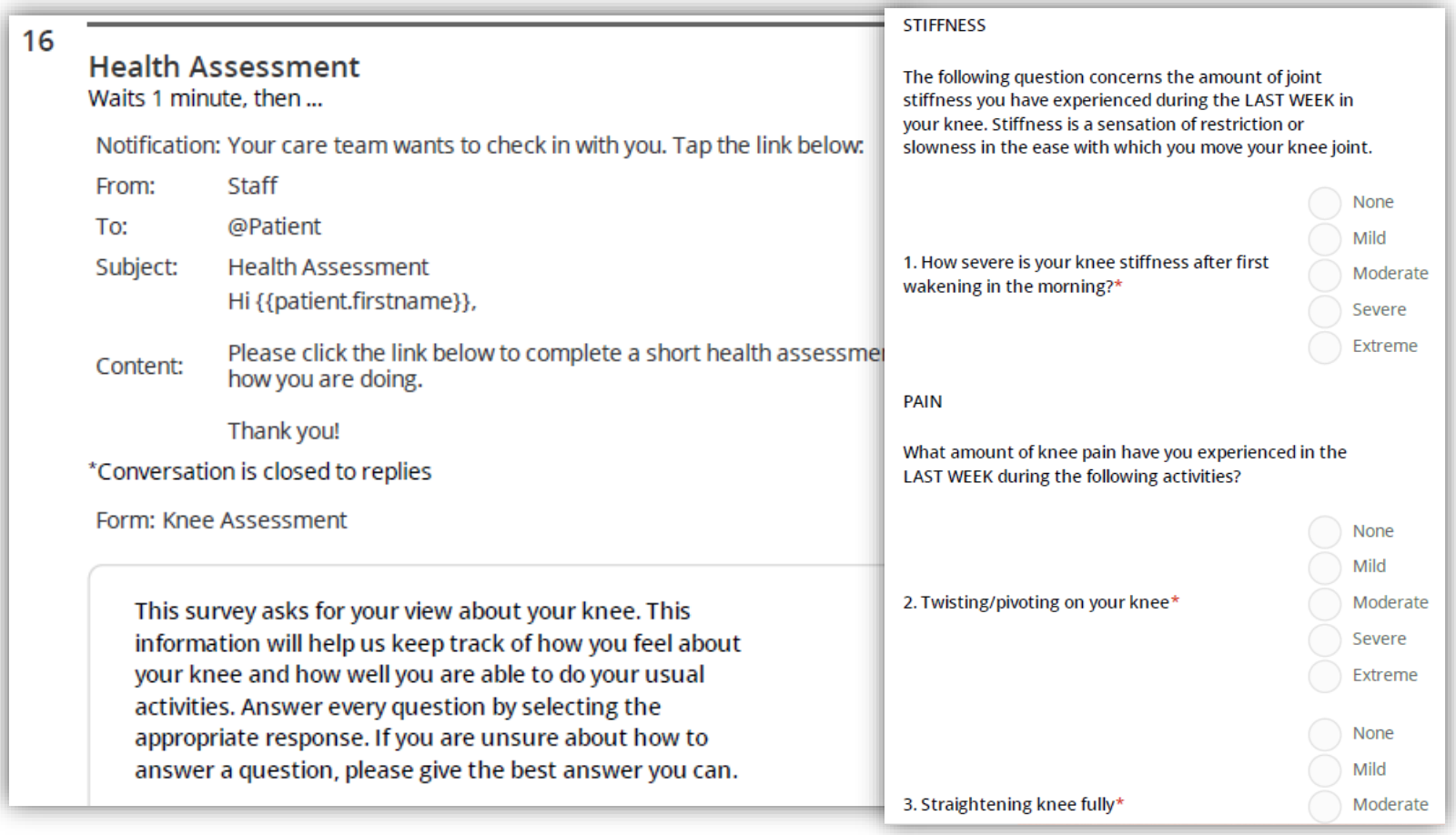
HealthCatalyst

Pre & Post-Operative Surgical Best Practices REDUCE Complications and Readmission Rates:



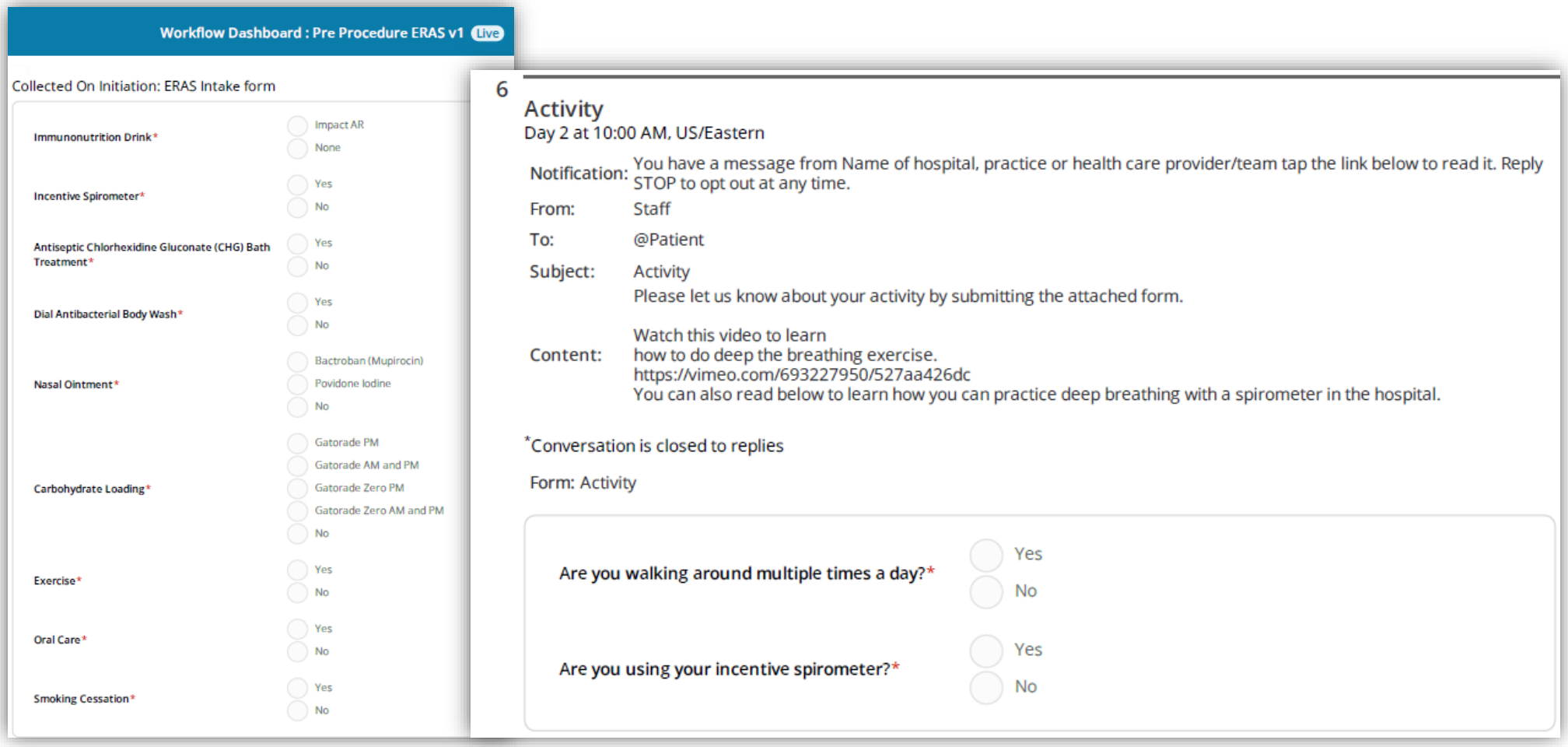


Pre & Postoperative Surgical Best Practices



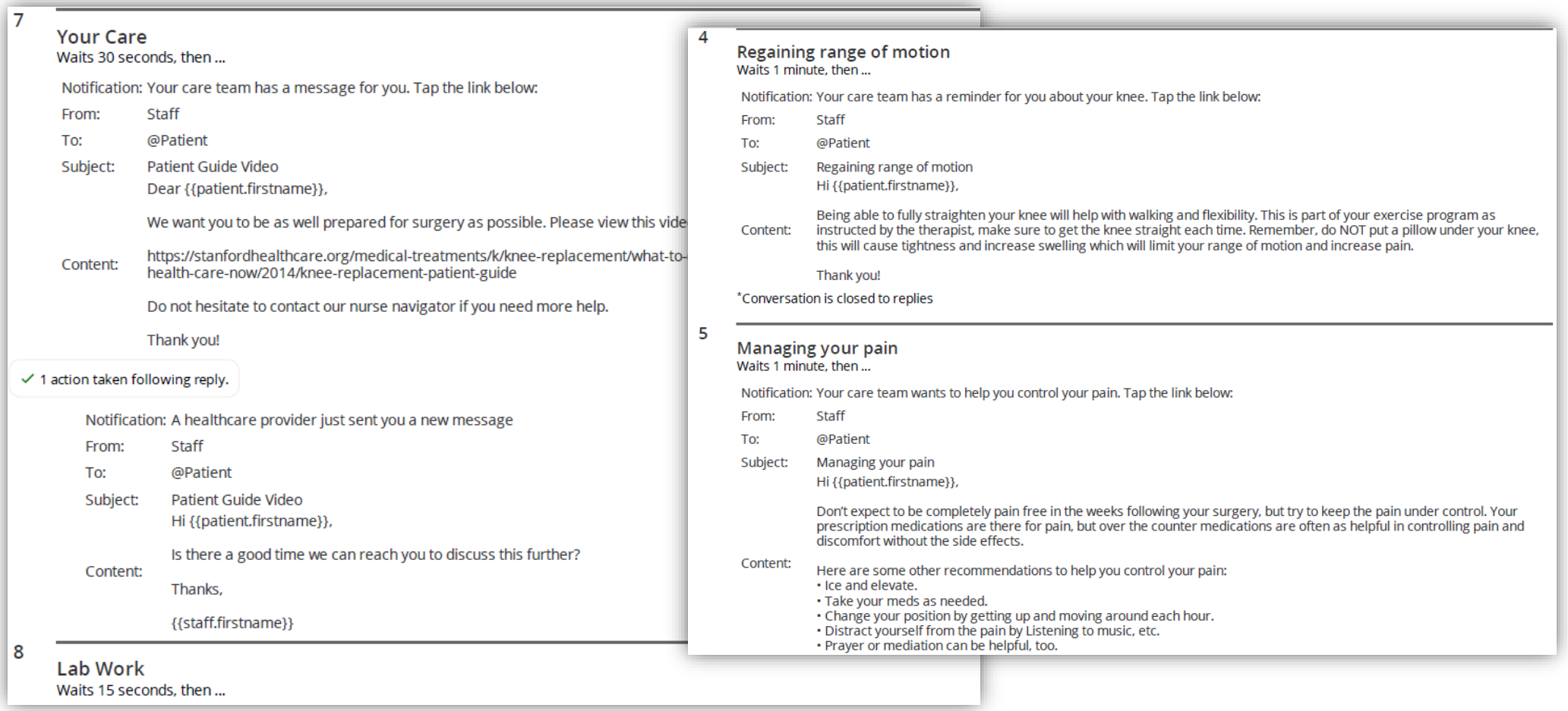
REDUCE Readmission Rates!

Pre & Postoperative Surgical Best Practices



REDUCE Readmission Rates!

Pre & Postoperative Surgical Best Practices



7

Your Care
Waits 30 seconds, then ...

Notification: Your care team has a message for you. Tap the link below:
From: Staff
To: @Patient
Subject: Patient Guide Video
Content: Dear {{patient.firstname}},

We want you to be as well prepared for surgery as possible. Please view this vide

https://stanfordhealthcare.org/medical-treatments/k/knee-replacement/what-to-health-care-now/2014/knee-replacement-patient-guide

Do not hesitate to contact our nurse navigator if you need more help.

Thank you!

✓ 1 action taken following reply.

Notification: A healthcare provider just sent you a new message
From: Staff
To: @Patient
Subject: Patient Guide Video
Content: Hi {{patient.firstname}},

Is there a good time we can reach you to discuss this further?

Thanks,

{{staff.firstname}}

8

Lab Work
Waits 15 seconds, then ...

4

Regaining range of motion
Waits 1 minute, then ...

Notification: Your care team has a reminder for you about your knee. Tap the link below:
From: Staff
To: @Patient
Subject: Regaining range of motion
Content: Hi {{patient.firstname}},

Being able to fully straighten your knee will help with walking and flexibility. This is part of your exercise program as instructed by the therapist, make sure to get the knee straight each time. Remember, do NOT put a pillow under your knee, this will cause tightness and increase swelling which will limit your range of motion and increase pain.

Thank you!

*Conversation is closed to replies

5

Managing your pain
Waits 1 minute, then ...

Notification: Your care team wants to help you control your pain. Tap the link below:
From: Staff
To: @Patient
Subject: Managing your pain
Content: Hi {{patient.firstname}},

Don't expect to be completely pain free in the weeks following your surgery, but try to keep the pain under control. Your prescription medications are there for pain, but over the counter medications are often as helpful in controlling pain and discomfort without the side effects.

Here are some other recommendations to help you control your pain:
- Ice and elevate.
- Take your meds as needed.
- Change your position by getting up and moving around each hour.
- Distract yourself from the pain by Listening to music, etc.
- Prayer or mediation can be helpful, too.

REDUCE Readmission Rates!

IU Health POWERR® Program
Published Results

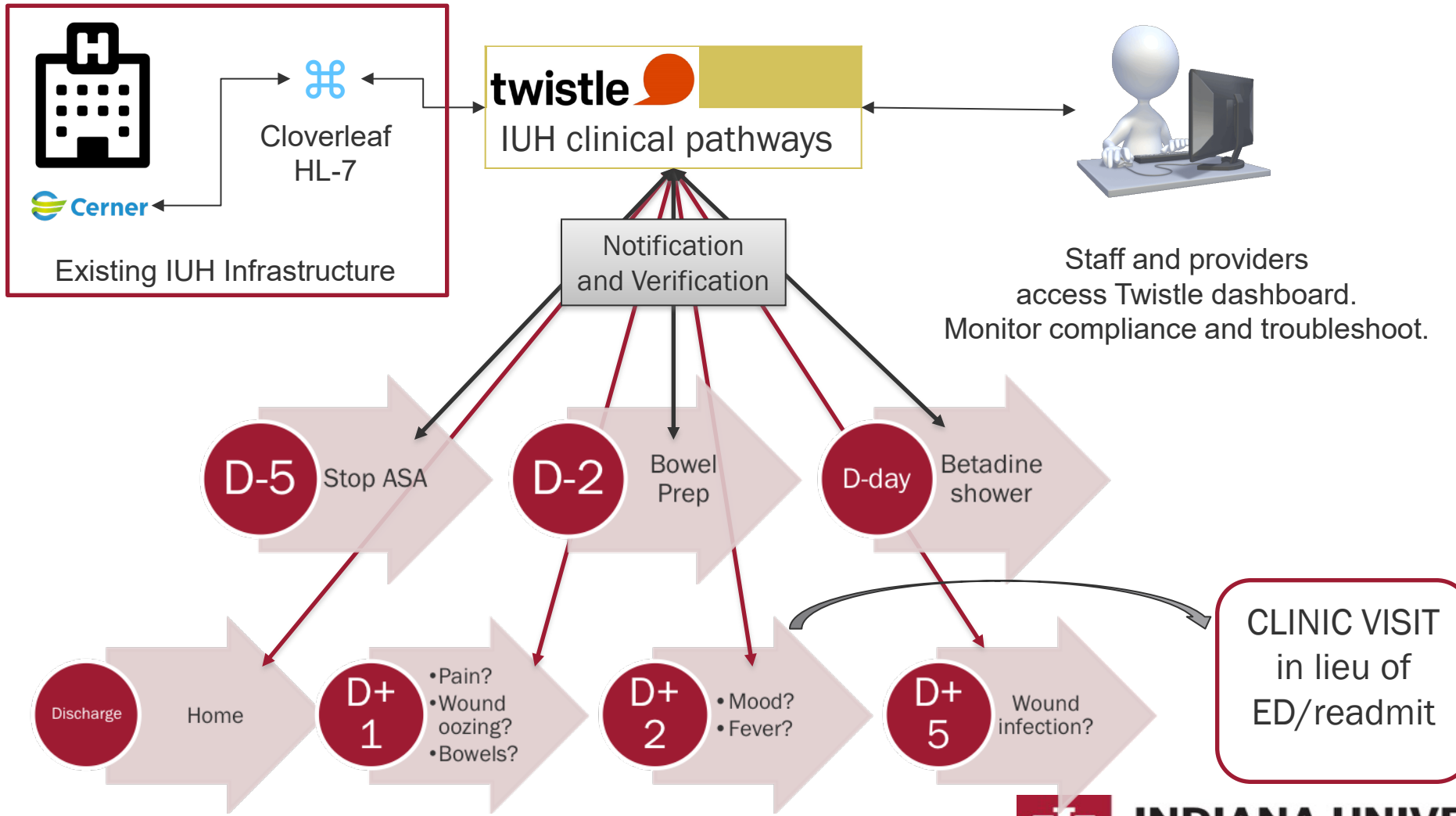
Impact of a Novel Preoperative Patient-Centered Surgical Wellness Program

Kristen E. Kelley, MPH, RN, CIC, Alyssa D. Fajardo, MD, FACS, FASCRS,†*
Nancy M. Strange, RDN, CNSC, CD,‡ Carol A. Harmon, MSN, RN,§ Kim Pawlecki, MSN, RN,§
Marnie Sieber, MSN, RN, Nikki Walke, MBA, RN,§ William F. Fadel, PhD,¶ William A. Wooden, MD, FACS,||*
Josh Sadowski, BS, Thomas J. Birdas, MD, FACS,|| Larry H. Stevens, MD, FACS,||*
*Grace S. Rozycki, MD, FACS,|| and C. Max Schmidt, MD, PhD, MBA, FACS**††*

Outcome Measure	Pre-intervention (n= 9202)	Intervention (n=6538)	p-value
Surgical site infection (SSI)	52	22	0.044
Catheter-associated urinary tract infection(CAUTI)	27	6	0.007
Clostridium difficile infection (CDI)	78	34	0.016
Patient safety indicators (PSI)	55	0	<0.001
Ventilator associated event (VAE)	14	6	0.367
Central line associated blood stream infection(CLASBI)	7	3	0.538
Methicillin-resistant Staph aureus (MRSA)	3	2	1.000

Outcomes:
- SSI, CAUTI, CDI and PSI were significantly reduced
- Total compliance to bundle elements lowered risk of HAI by 50% (p=0.003)
- Cost of POWERR kits were recovered in addition to $1,000,000 in cost savings

AI Secure-cloud-based patient communication tool that facilitates two-way active patient communication based on clinical pathways

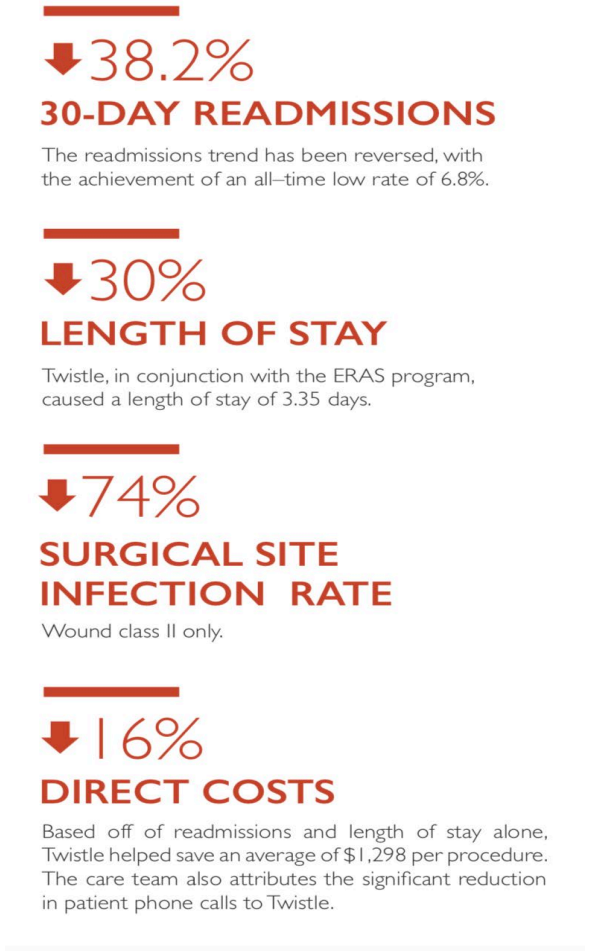


Indiana University Health

INDIANA UNIVERSITY
SCHOOL OF MEDICINE

Enhanced Compliance and Communication

- Patient communication is key to management
- A major consumer of FTE time and energy
- Miscommunication often leads to unnecessary visits, increased cost of care, dissatisfaction, and adverse events



twistle by HealthCatalyst®

Advocate Lutheran General Hospital's Surgical Services

Indiana University Health

INDIANA UNIVERSITY SCHOOL OF MEDICINE

Federal Anti-Kickback Statute Safe Harbor: Beneficiary Incentives

CMS has determined that the **Federal Anti-Kickback Statute Safe Harbor** for CMS-sponsored model patient incentives is available to protect TEAM beneficiary incentives.

TEAM participants may offer **in-kind patient engagement incentives** (e.g., technology) to TEAM beneficiaries.

- Subject to certain conditions, including relevance to the beneficiary's care
- Technology-based incentives subject to additional monetary value conditions

Several **clinical goals of TEAM** may be advanced by beneficiary incentives:

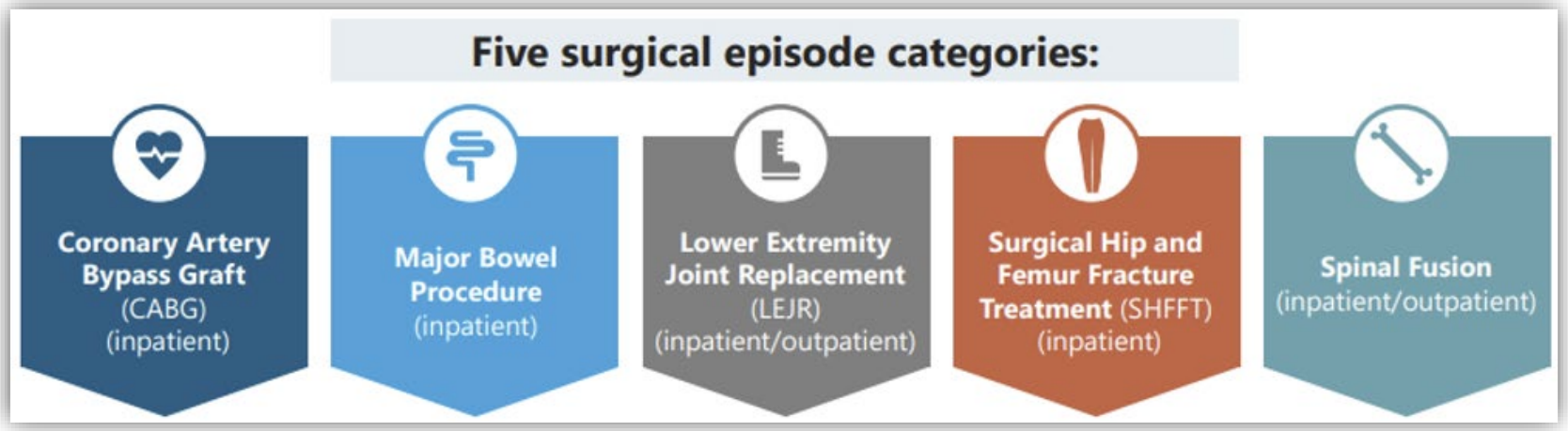
- Adherence to drug regimens
- Adherence to care plans
- Reduction of readmissions and complications
- Management of chronic conditions

Source: https://www.cms.gov/priorities/innovation/files/team-ovw-webinar-slides.pdf

FFS or VBC TECH ENABLED

Use Case Example

CMS TEAMs



PREVENTIVE CARE QUALITY IMPROVEMENT:

- LUNG CANCER SCREENING

Audience Poll 5

What is your group's **lung cancer screening rates**?

A. **>50%**

B. **>25-49%**

C. **<25%**

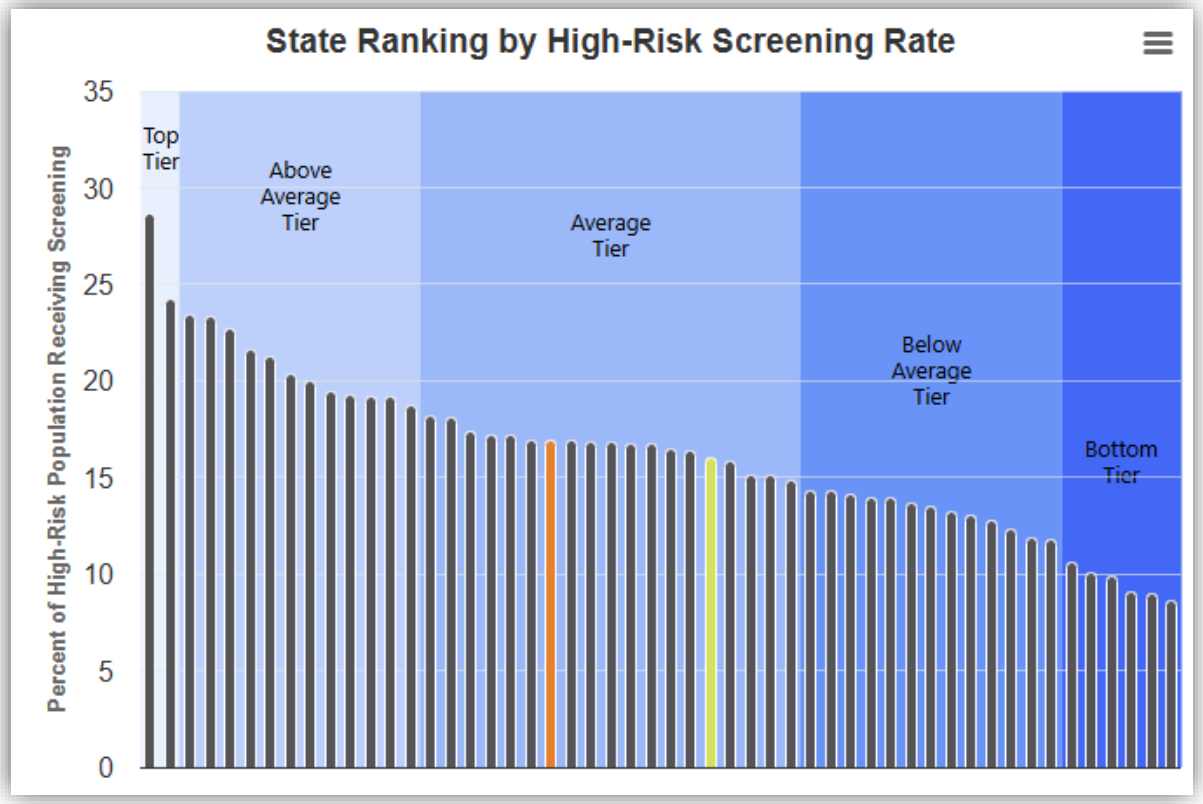
D. **Unknown**

Lung Cancer Screening Opportunity (FFS &/or VBC)

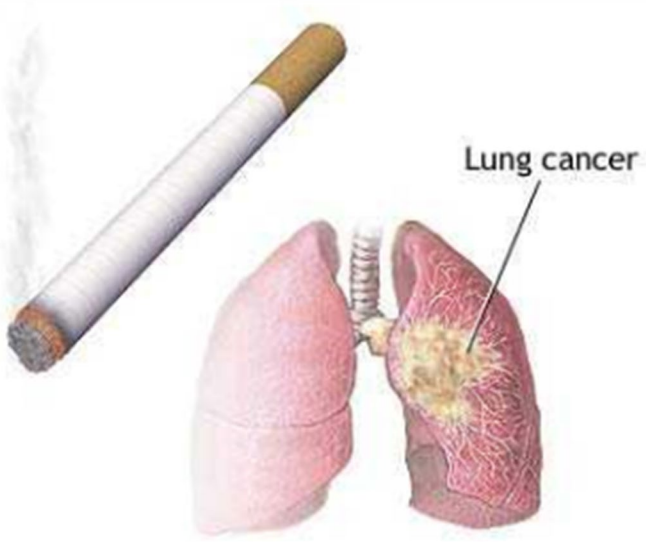
Lung Cancer Screening (LCS) rates ~6.5% as of 2020; compared to 63% for colon and 64% for breast cancer screening in 2019.

- In CA < 1% LCS rate

Increased to 16% in 2024



Why are LCS rates so low?



1. Provider & Patient Awareness of screening recommendations, outcomes, and options

2. Data Availability/Accuracy:
   Smoking status, year started, year quit, pack years history

3. Access Issues:
   - Medicare requires a shared decision-making (SDM) visit PRIOR to the first LDCT scan: CPT G0296: Evaluation and Management charges for an LDCT SDM visit
   - Scheduling SDM Visit & LDCT

Financial Impact of LCS: National Statistics

- G0296: SDM ~ $29.07
- CPT code 71271, which refers to a "computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)," is reimbursed by Medicare and is considered a covered benefit for eligible patients, with the reimbursement rate depending on the specific Medicare Administrative Contractor (MAC) in your region; however, it generally falls within the range of $100 to $110 per scan, with no patient copay or deductible due to its status as a preventive service
- 12-14% of initial screens are false positive (same as for mammography); drops to 6% for annual LCS; see the National Lung Screening Trial (NLST)
- 6% incidental findings another site; drops to 2% for annual LCS
- 2-3% new lung cancer findings; drops to 1-2% in subsequent years; NOTE: >50% of lung cancer found with LCS is early stage vs. < 25% without screening
- mean incremental cost-effectiveness ratio of $72,564 per quality-adjusted life-year (QALY) gained

Financial Impact of LCS: Healthcare System (FFS)

Using System DATA & ANALYTICS:

- # of LDCTs for Lung Cancer Screening in 2024 = 1,075 (~7% of eligible patients)
- average reimbursement $288; average Medicare Reimbursement $115
- Only ~10% billed for a G0296 SDM Visit; average reimbursement was $70, national average $30
- Assuming 6.5% screening rate (national average), 100% screening rate = 16,538
- If all "at risk" patients received SDM for LCS and only 60% opt in for LDCT LCS, then 9,923 patients would be screened (~10-fold increase)
- If 60% of pts opted in for LDCT for a G0296 SDM visit, annual revenue = $ 297,692.31 (9,923 X $30) ~30-fold increase from $10,970
- If 60% of pts LDCT Scan 71271, annual revenue would be $1,091,538.36 (9923 X $110) ~ 10-fold increase from $118,250
- TOTAL INCREASED ANNUAL REVENUE from implementing the Health Catalyst Automated LCS Clinical Pathway Workflow with increased G0296 & 71271 = $1,389,230.67 ~ 10-fold increase from $129,220

FFS REVENUE IMPACT

EARLIER DIAGNOSIS = LOWER TREATMENT COSTS

Non-small cell lung cancer (NSCLC), total per-patient per-month health care costs after diagnosis significantly higher among those diagnosed at a Stage IV and lower among those diagnosed at Stage I ($7,239 Stage I, $9,484 Stage II, $11,193 Stage IIIa, $17,415 Stage IIIb, and $21,441 Stage IV)

STAGE OF NSCLC	TOTAL PER-PT PER-MONTH COSTS
I	$7,239
II	$9,484
IIIa	11,193
IIIb	$17,415
IV	$21,441

Financial Impact of LCS: Healthcare System (VBC)

- Assuming 2-3/100 (initial scans) and 1-2/100 (f/u scans) identify a new lung cancer diagnosis, then this site would identify 100-300 new lung cancer diagnosis/year
- AND Assuming 50% of LDCT scans identify lung cancer at an earlier stage (I of II), then this site would identify 50-150 new diagnosis of lung cancer at an earlier stage
- AND Assuming mean incremental cost-effectiveness ratio of $72,564 per quality-adjusted life-year (QALY) gained per earlier Stage Lung Cancer Diagnosis
- non-small cell lung cancer (NSCLC), total per-patient per-month health care costs after diagnosis significantly higher among those diagnosed at a Stage IV and lower among those diagnosed at Stage I ($7,239 Stage I, $9,484 Stage II, $11,193 Stage IIIa, $17,415 Stage IIIb, and $21,441 Stage IV)
- **This sites potential cost savings ~ 25-33%/year = $2,400,000-$5,600,000** in total per patient health care costs for lung cancer post diagnosis.

VBC COST SAVINGS

EARLIER DIAGNOSIS = LONGER SURVIVAL

ACS 5-year survival rate for all stages of NSCLC is approximately 28%;

5-Year survival based on EARLIER (LOCALIZED) Stage 65-80%

Source: https://www.lung.org/research/state-of-lung-cancer/states

Lung Cancer Screening:
2025 MIPS Improvement Activity

Implementation of Protocols and Provision of Resources to Increase Lung Cancer Screening Uptake (IA_PM_24)

Improvement Activities 15%

- 104 Improvement Activities for 2025
  - 2 new:
    - **Implementation of Protocols and Provision of Resources to Increase Lung Cancer Screening Uptake (IA_PM_24)**
    - **Save a Million Hearts: Standardization of Approach to Screening and Treatment for Cardiovascular Disease Risk (IA_PM_25)**

DO THE RIGHT THING!

(Not Always Easy)

Evidence-Based Best Practices

+

Quality

+

Efficiency (Automation)

Orgs need the necessary tools…

- Infrastructure (Network)
- Leadership
- Evidence-based Best Practices
- Quality Improvement
- Workflow Efficiencies

Value-Based Care and/or Population Health Management Solution Requirements

DATA AGGREGATION & STORAGE

- Structured & Unstructured Data
- HIE/EHR Data Aggregation/Integration

HEALTH ANALYTICS

- Performance Analytics
- Reporting Tools
- Revenue Cycle Management
- Population Health Reports

PRACTICE MANAGEMENT/FINANCIAL SYSTEMS

- Billing and Coding
- Analytics
- Staffing and Workflow Management

PATIENT ENGAGEMENT

- Pre-visit, Point of Care, & Post-Visit (continuum of care)
- Preventive Care Services
- Chronic Disease Management, Care Management, and Transitions of Care

Questions?

Our Health Catalyst Experts

Dr. John Janas | Medical Director

Jacqueline Matthews, RN, MS| SVP, Solutions Consulting

Alora Martin | Webinar Program Manager

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