VANTAGE HEALTHCARE

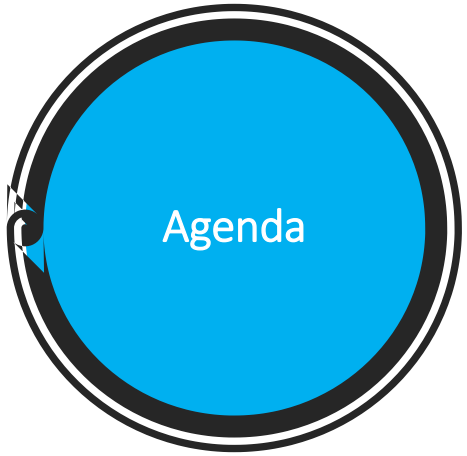
ACHCA 2025 National Conference
Wednesday, April 9th

Value-based Payment Models & Long-term Care Resident Populations

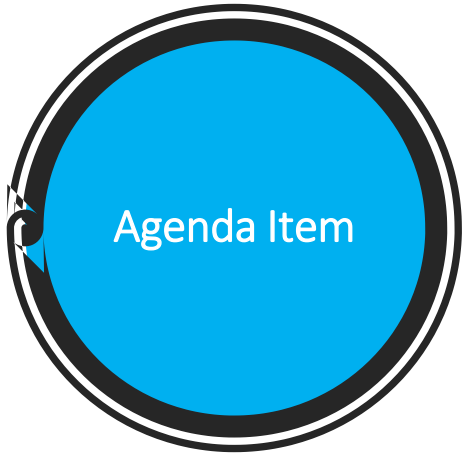
Introductions

Chris Wasel
President, Marketing & Strategic Partnerships
Vantage Healthcare

Amy O'Brien
Vice President of Business Development
Sound Physicians Long-Term Care Management ACO

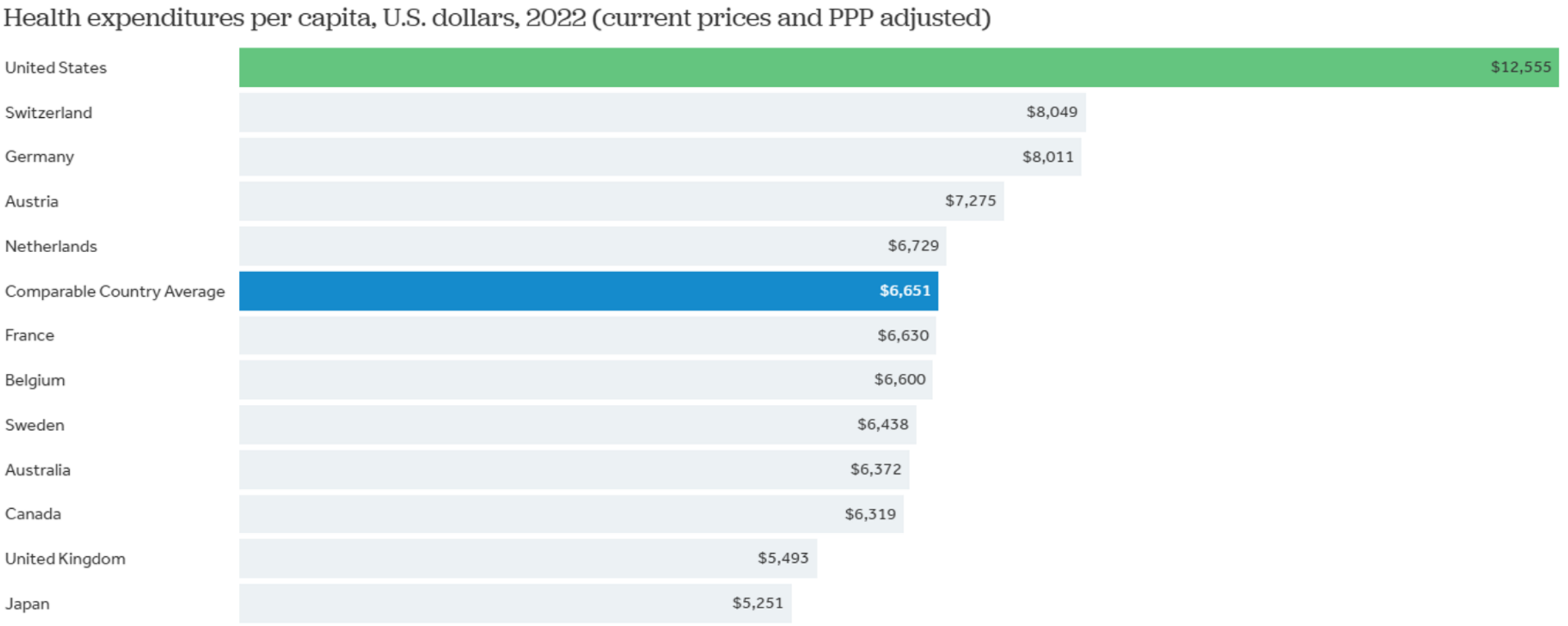


- Introductions
- Population and Medicare program trends
- The Affordable Care Act and CMS' goals
- Common SNF experience with value-based payment models
- Value-based payment models and SNF and ALF long-term care residents
- MSSP ACO model and long-term care - Sound ACO case
- ACO REACH model
- I-SNP model
- Considerations moving forward
- Questions



Population and Medicare program trends

U.S. Health Care Expenditures Compared to Other Developed Nations



Rapidly Growing Elderly Population in U.S.

Population by Age Group: Projections 2020 to 2060

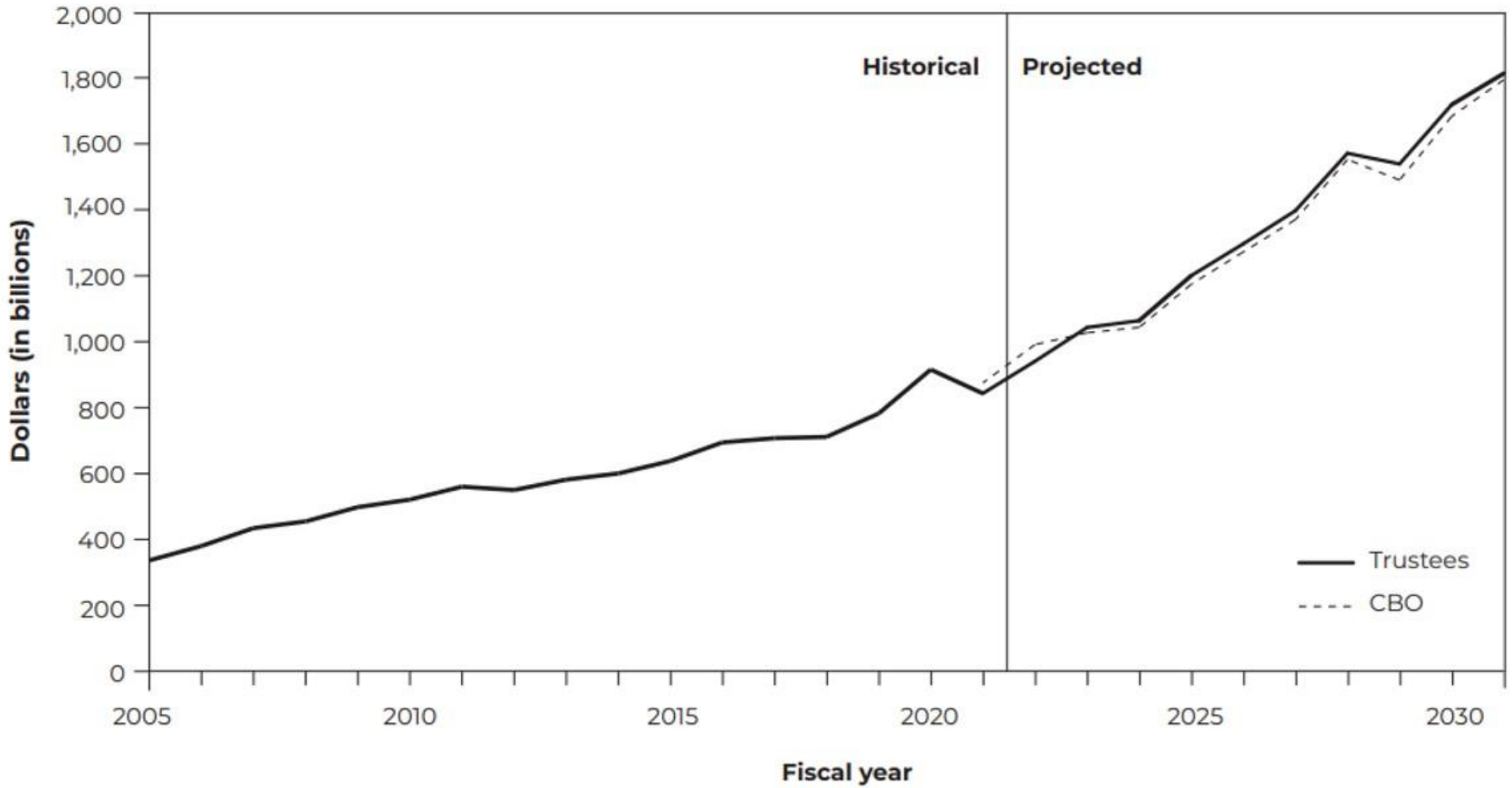
The population is projected to reach 404 million by 2060.
(In millions)

Characteristic	Population						Change from 2016 to 2060	
	2016	2020	2030	2040	2050	2060	Number	Percent
Total population	**323.1**	**332.6**	**355.1**	**373.5**	**388.9**	**404.5**	**81.4**	**25.2**
Under 18 years	73.6	74.0	75.7	77.1	78.2	80.1	6.5	8.8
18 to 44 years	116.0	119.2	125.0	126.4	129.6	132.7	16.7	14.4
45 to 64 years	84.3	83.4	81.3	89.1	95.4	97.0	12.7	15.1
65 years and over	49.2	56.1	73.1	80.8	85.7	94.7	45.4	92.3
85 years and over	6.4	6.7	9.1	14.4	18.6	19.0	12.6	198.1
100 years and over	0.1	0.1	0.1	0.2	0.4	0.6	0.5	618.3

Note: The official population estimates for the United States are shown for 2016; the projections use the Vintage 2016 population estimate for July 1, 2016, as the base population for projecting from 2017 to 2060.

Source: U.S. Census Bureau, 2017 National Population Projections.

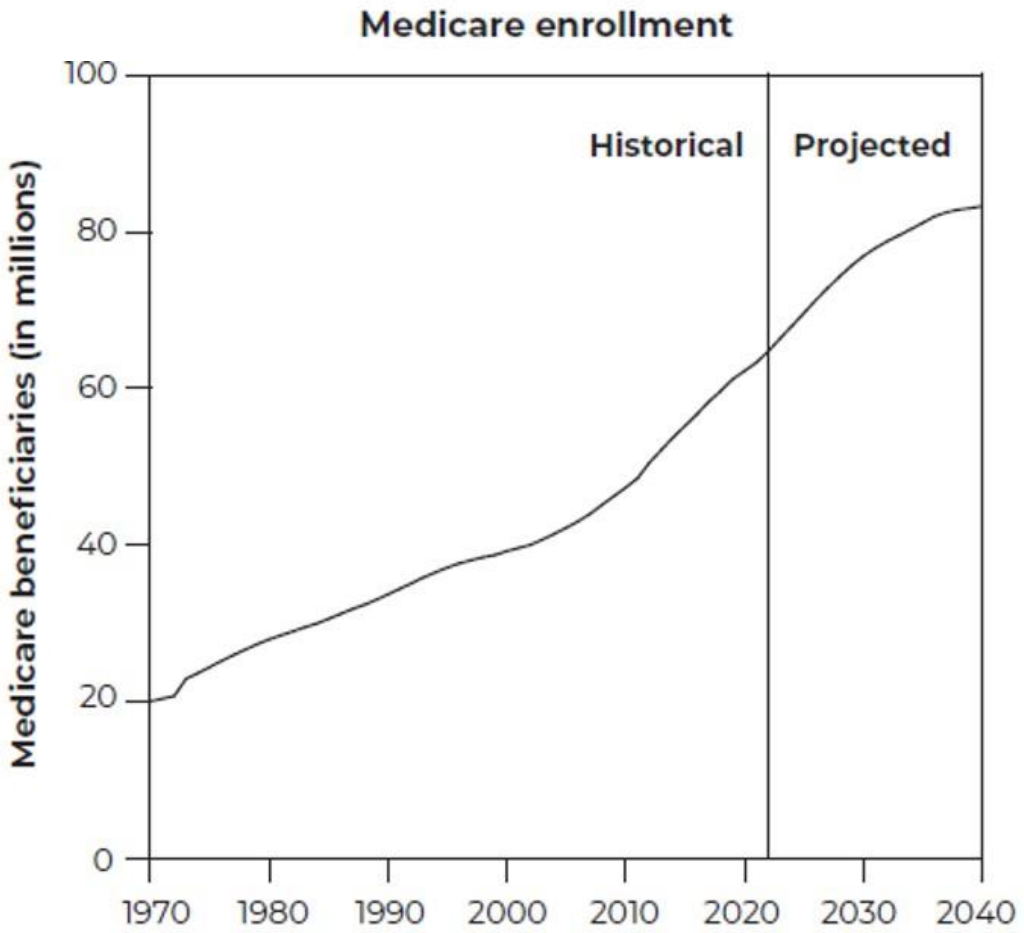
Medicare Spending Expected to Double in Next 10 Years

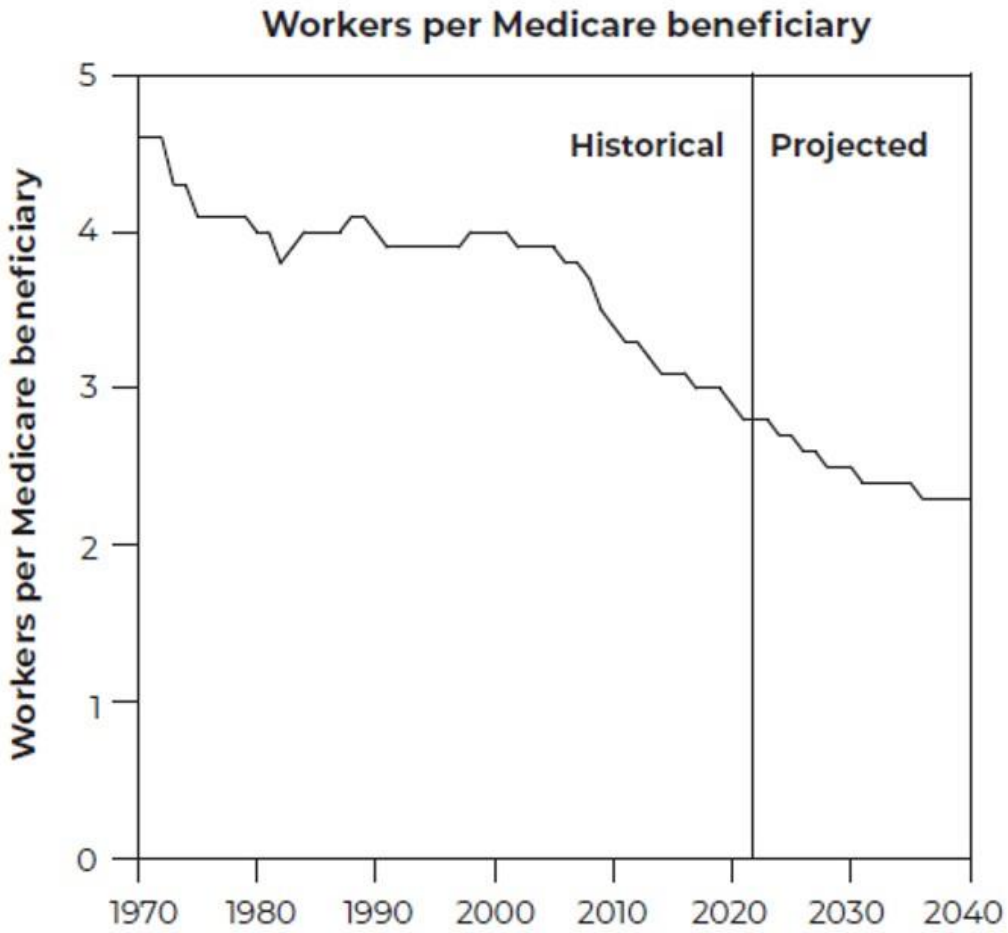


Note: CBO (Congressional Budget Office). First projected year in graph is 2022. The sharp increase in spending in 2020 includes $103.9 billion in Medicare Accelerated and Advance Payments paid to providers that year; these payments were expected to be repaid to the Medicare program in 2021 and 2022.

Source: 2022 annual report of the Boards of Trustees of the Medicare trust funds, Table V.H4; CBO's May 2022 baseline projections for the Medicare program.

Ratio of Workers Helping to Finance Medicare





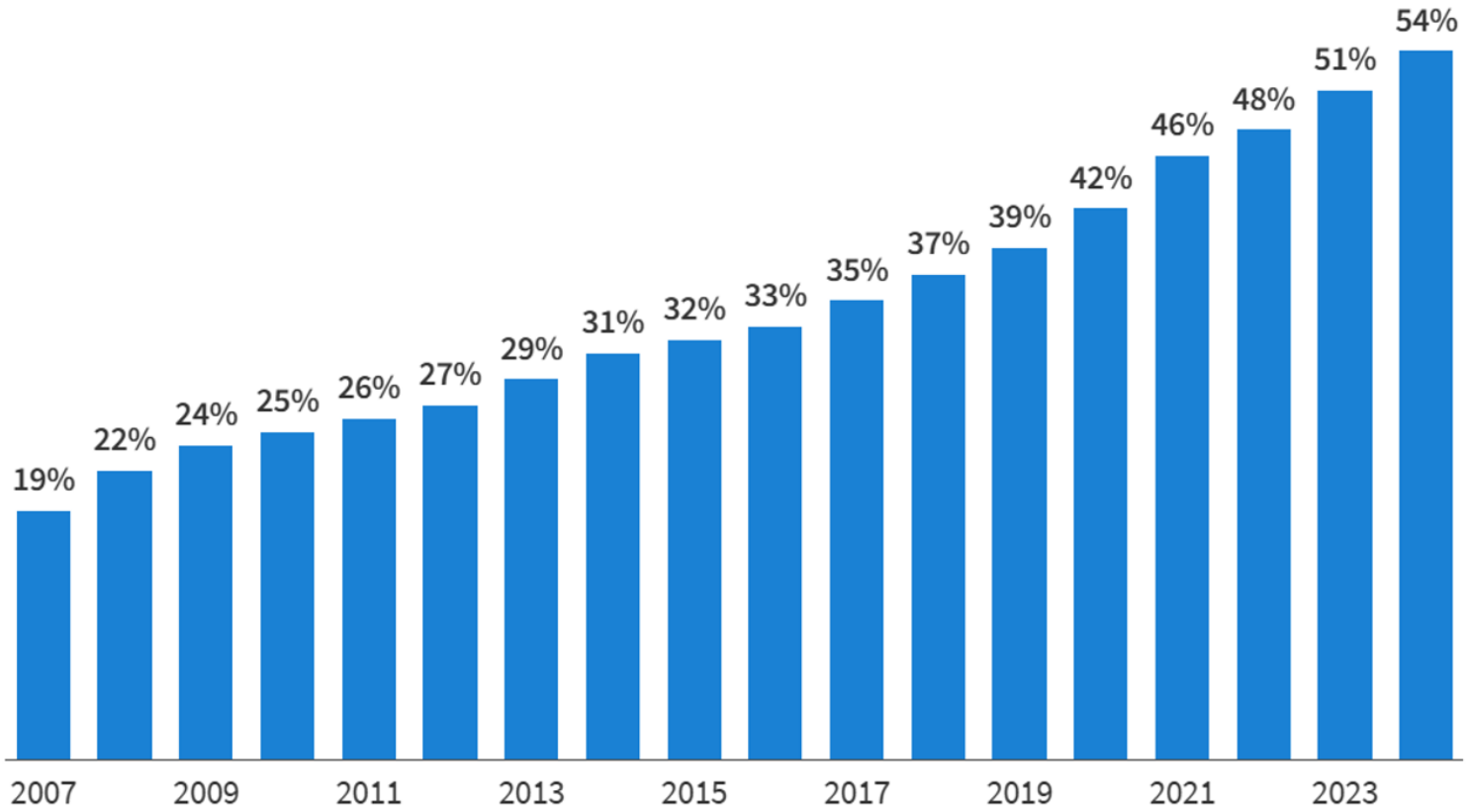
Note: "Beneficiaries" referenced in these graphs are beneficiaries enrolled in Medicare Part A (including beneficiaries in Medicare Advantage). First projected year is 2022. Part A services are financed by Medicare's Hospital Insurance Trust Fund and beneficiary cost sharing.

Source: 2022 annual report of the Boards of Trustees of the Medicare trust funds.

Promoting Medicare Advantage to Control Expenditures

Total Medicare Advantage Enrollment, 2007-2024

Medicare Advantage Penetration

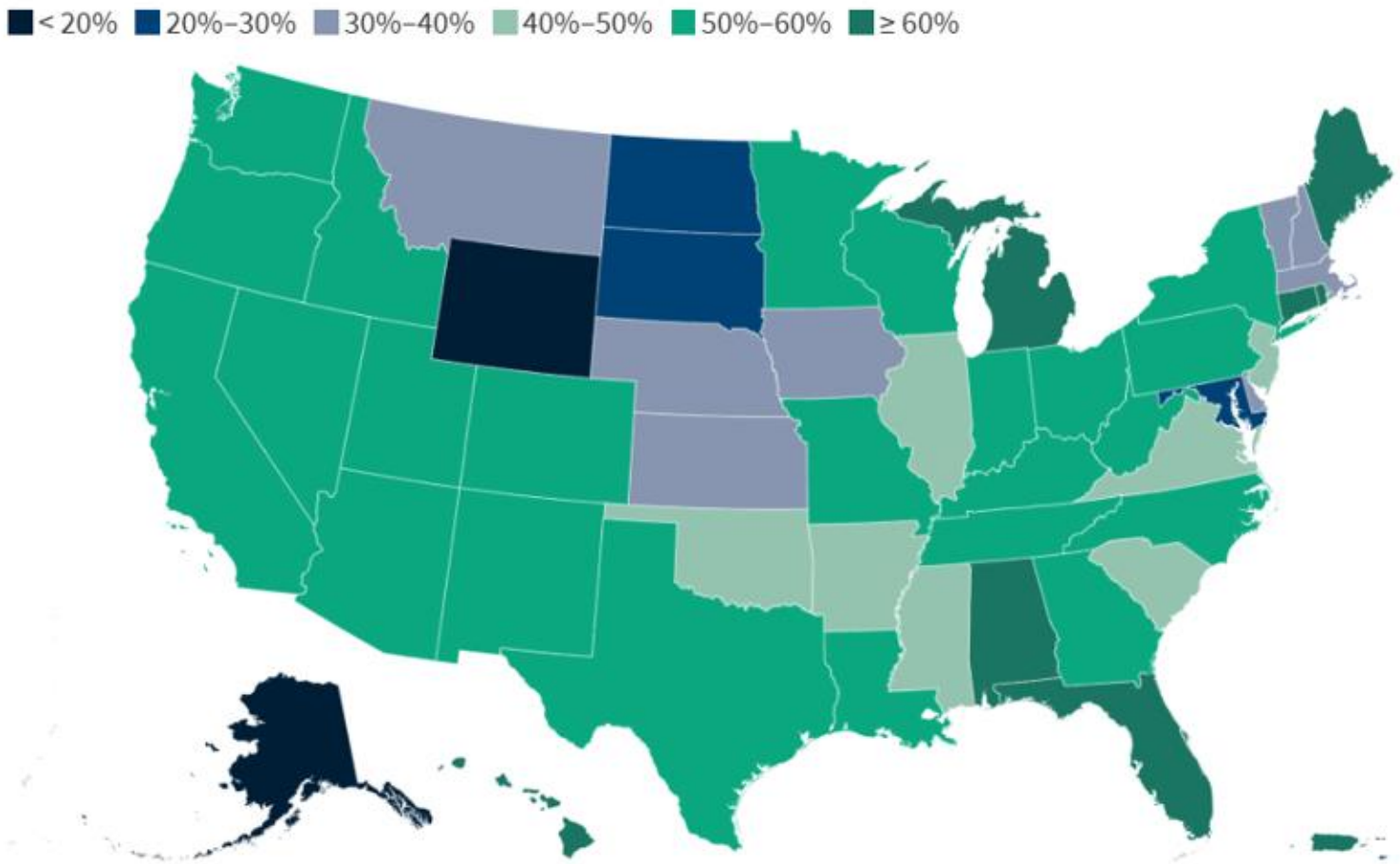


Note: Enrollment data are from March of each year. Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. About 61.2 million people are enrolled in Medicare Parts A and B in 2024.

Source: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2024; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2016; CCW data from 20 percent of beneficiaries, 2017-2020; CCW data from 100 percent of beneficiaries, 2021-2022, and Medicare Enrollment Dashboard 2023-2024. • Get the data • Download PNG

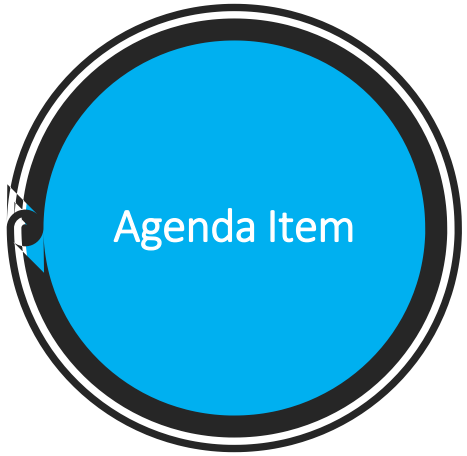
Promoting Medicare Advantage to Control Expenditures

Share of Beneficiaries Enrolled in Medicare Advantage in 2024, by State



Note: Includes only Medicare beneficiaries with Part A and B coverage.

Source: KFF analysis of CMS Medicare Advantage Enrollment Files and March Medicare Enrollment Dashboard, 2014 and 2024. • Get the data • Download PNG



The Affordable Care Act and CMS’ goals

Traditional Medicare Transitioning from FFS to Value-Based Payment

Affordable Care Act (ACA) of 2010 created

Accountable Care Organizations (ACOs) and the permanent Medicare Shared Savings Program (MSSP)

Provider-led organizations with a strong base of primary care that is accountable for the quality and per capita costs.

Broader **Center for Medicare and Medicaid Innovation (CMMI)** demonstration models (also referred to as CMS Innovation Center).

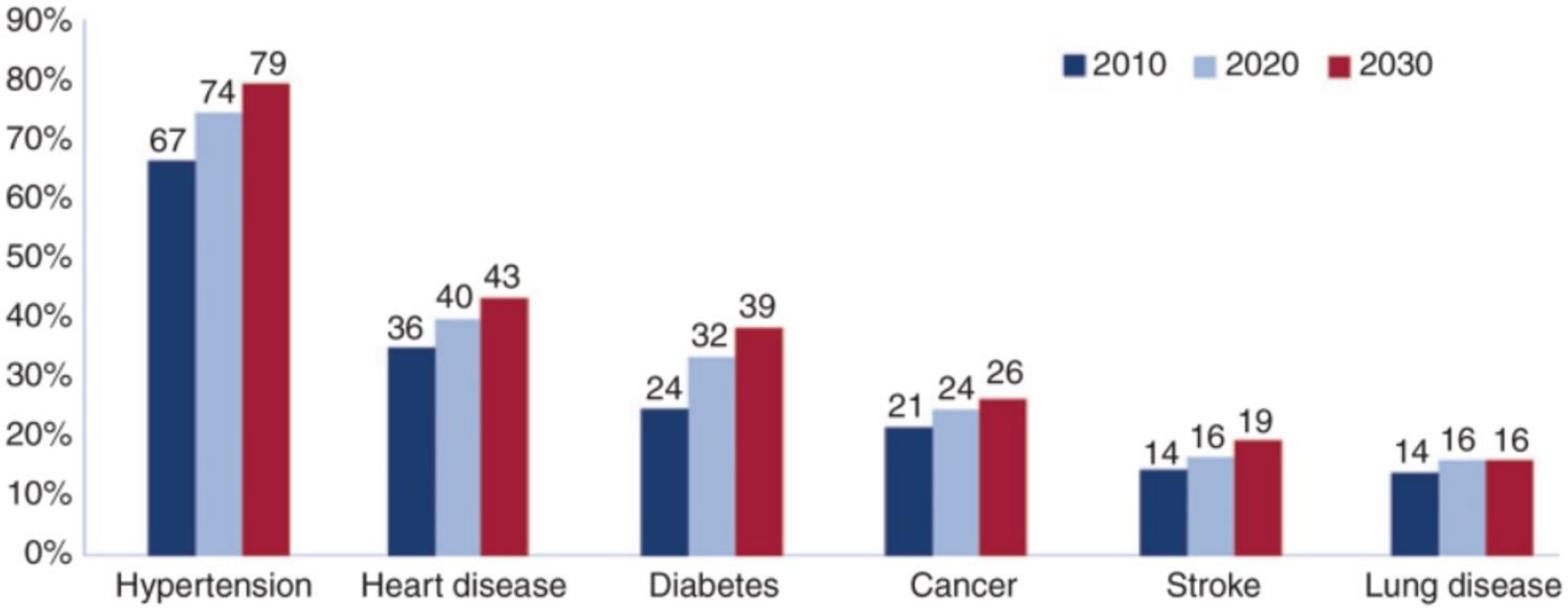
Established to “test innovative payment and service delivery models to reduce program expenditures … while preserving or enhancing the quality of care furnished to individuals”. Tested 50+ models.

Kury FSP, Baik SH, McDonald CJ. Analysis of Healthcare Cost and Utilization in the First Two Years of the Medicare Shared Savings Program Using Big Data from the CMS Enclave. AMIA Annu Symp Proc. 2016;2016:724-733.

H.R.3590 - Patient protection and affordable care act, Sec. 3201, US Congress, March 23, 2010.

Medicare Beneficiaries with Chronic Conditions

Chronic Conditions among US Population Aged 65 and Older, 2010–2030



Gaudette É, Tysinger B, Cassil A, Goldman DP. Health and Health Care of Medicare Beneficiaries in 2030. Forum Health Econ Policy. 2015 Dec;18(2):75-96.

CMS Innovation Center's Strategic Objectives

Five strategic objectives will guide the CMS Innovation Center's implementation of its vision.

Aim:
Increase the number of beneficiaries in a care relationship with accountability for quality and total cost of care.

Measuring Progress:
All Medicare fee-for-service beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.

Purva Rawal, Jacob Quinton, Dora Hughes, and Liz Fowler, The CMS Innovation Center's Strategy to Support High-quality Primary Care, CMS.GOV, June 9, 2023.

Agenda Item

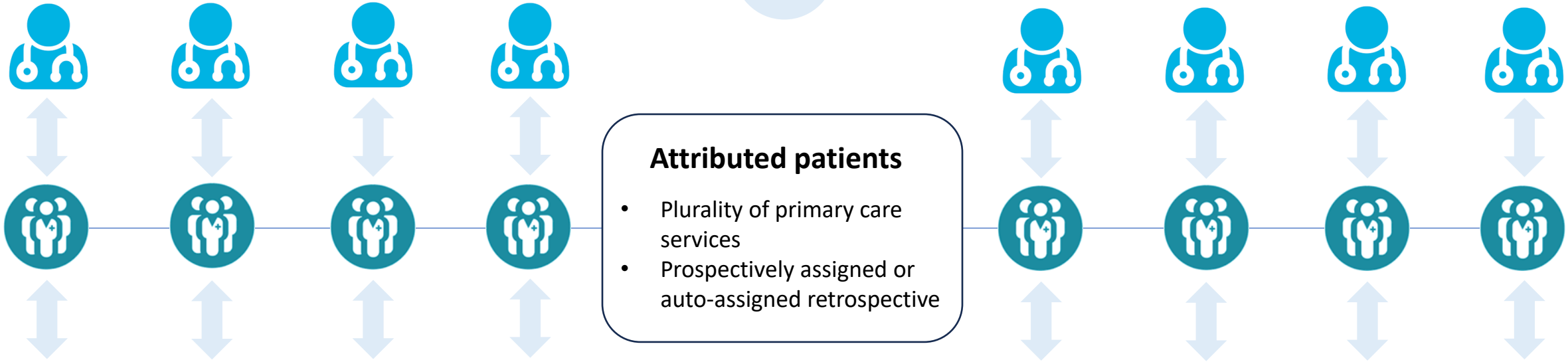
Common SNF experience with MSSP payment model

Hospital Participation ACO Example

Participating physicians – hospital employed PCPs

ACO

Participating physicians – independent PCPs



Attributed patients

- Plurality of primary care services
- Prospectively assigned or auto-assigned retrospective

Aggregate 5,000+ Patient Population

Aggregate Performance

Total Spend Benchmark vs. Actual

Quality Measures Threshold vs. Actual

- If actual aggregate spend < benchmark & actual quality measures better than threshold = Shared savings
- If actual aggregate spend > benchmark = Loss

Medicare Shared Savings Program as of January 2025

PROGRAM CHARACTERISTICS (as of Jan 1) / PERFORMANCE YEAR RESULTS

Performance Year	ACOs	Assigned Beneficiaries	Total Earned Shared Savings	Quality Score
2025	476	11.2 million	TBD	TBD
2024	480	10.8 million	TBD	TBD
2023	456	10.9 million	$3.1 billion	82%*
2022	483	11.0 million	$2.5 billion	81%*
2021	477	10.7 million	$2.0 billion	91%
2020	517	11.2 million	$2.3 billion	97%
2019	487	10.4 million	$1.5 billion	92%
2018	561	10.5 million	$983 million	93%
2017	480	9.0 million	$799 million	92%
2016	433	7.7 million	$700 million	95%
2015	404	7.3 million	$645 million	91%
2014	338	4.9 million	$341 million	83%
2012 / 2013	220	3.2 million	$315 million	95%

*The elimination of MIPS bonus points resulted in lower MIPS Quality performance category scores for ACOs

ACO Tracks	ACOs	Percent
One Sided (29% of ACOs)		
BASIC Track Levels A&B	137	29%
Two Sided (71% of ACOs)		
BASIC Track Levels C&D	5	1%
BASIC Track Level E	81	17%
ENHANCED Track	253	53%

HIGH / LOW REVENUE ACOs

	ACOs	Percent
High Revenue	183	38%
Low Revenue	293	62%

ACOs BENEFICIARY ASSIGNMENT METHODOLOGY

	ACOs	Percent
Prospective	145	30%
Preliminary Prospective with Retrospective Reconciliation	331	70%

Enrollment Type	Percent
Aged Non-Dual	87%
Disabled	7%
Aged Dual	6%
End Stage Renal Disease (ESRD)	<1%

ADVANCE INVESTMENT PAYMENTS (AIP)

Participating ACOs	28
Beneficiaries assigned to ACOs receiving AIP	282,724
Percent of AIP beneficiaries eligible for Medicaid or Low-Income Subsidy (LIS)	28%
Percent of AIP beneficiaries with Area Deprivation Index (ADI) scores ≥ 85	9%
Percent of AIP beneficiaries living in a Health Provider Shortage Area (HPSA) or Medically Underserved Area (MUA)	50%

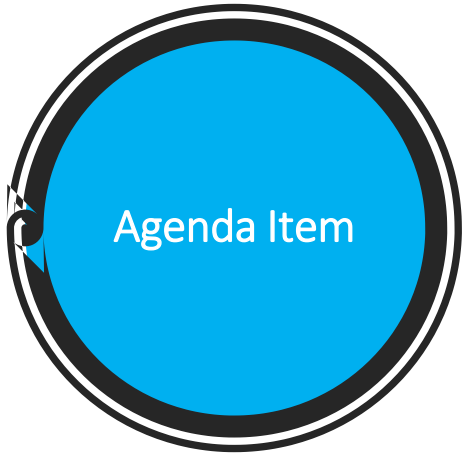
ACO PARTICIPANT LIST COMPOSITION

Participant TINs	15,135
Physicians and non-Physicians	643,768
Hospitals	1,502
Federally Qualified Health Centers (FQHCs)	7,036
Rural Health Clinics (RHCs)	2,872
Critical Access Hospitals	547

Skilled Nursing Facility (SNF) AFFILIATES & SNF 3-DAY RULE WAIVER

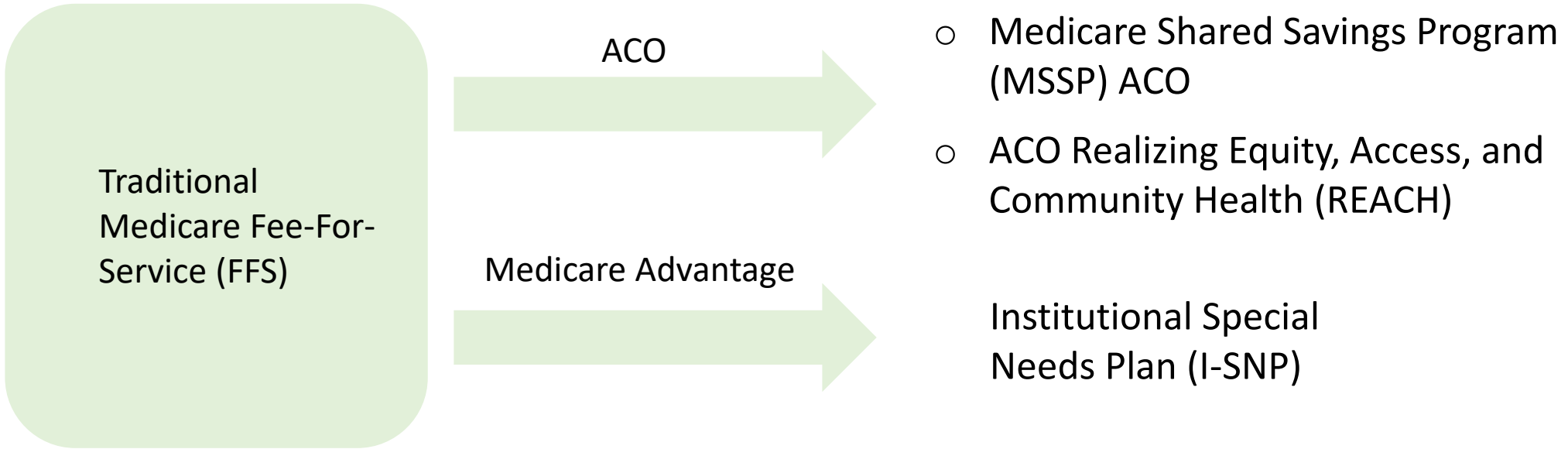
ACOs approved for a SNF 3-Day Rule Waiver	162
Total number of SNF affiliates	2,732

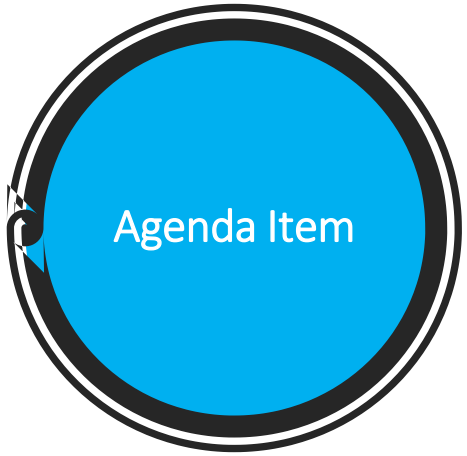
The Centers for Medicare & Medicaid Services, CMS.GOV, 2025.



Value-based payment models and SNF and ALF long-term care residents

Value-Based Payment Models - SNF and ALF Long-Term Care Populations





MSSP ACO model and long-term care
LTC ACO case

Our Vision

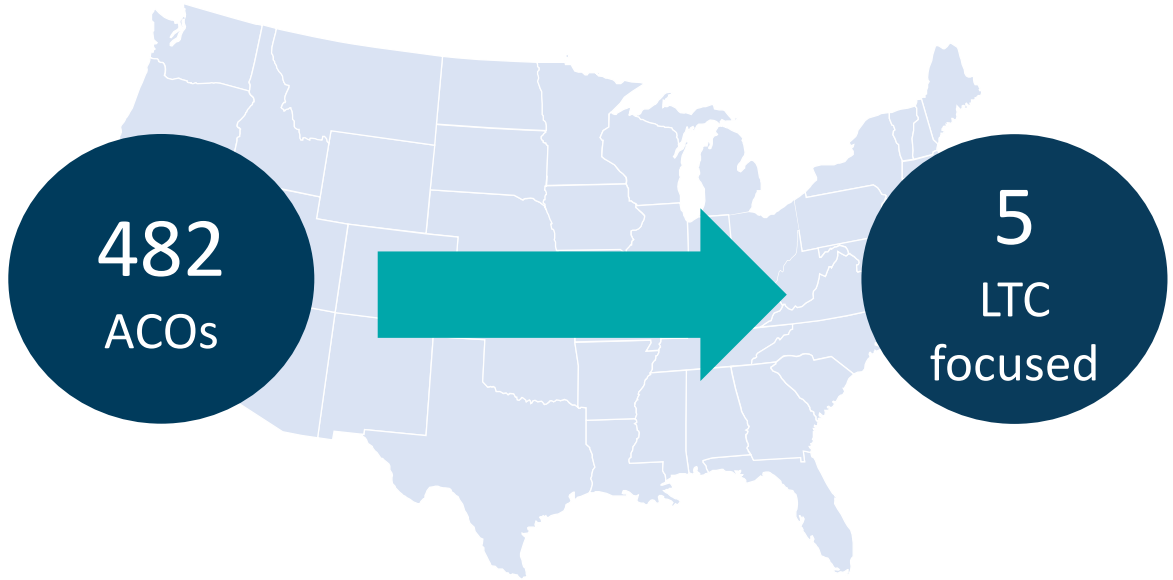
Vision: To dramatically improve the quality and lower cost of healthcare delivered to residents of long-term and assisted-living facilities, rewarding participating providers for achieving those outcomes that meet and exceed programmatic objectives.

What is an Accountable Care Organization (ACO)

ACOs (accountable care organizations) are groups of doctors, hospitals, and other health care professionals that work together to give patients high-quality, coordinated service and health care, improve health outcomes, and manage costs.

How ACOs Work

- Physicians/healthcare professionals join ACOs
- CMS assigns clinical & financial accountability to the ACO for its physicians' patients
- ACO providers do what they can to improve quality outcomes and manage costs
- CMS shares economic savings from improved outcomes with the ACO



In 2022, ***ACOs earned $2.5B+**** in shared savings from clinical quality improvements.

* https://data.cms.gov/medicare-shared-savings-program/performance-year-financial-and-quality-results

Why Sound Long-Term Care Management (SLTCM)?

Sound Physicians saw an opportunity to address a significant need

1.3M
long-term care residents in the US

< 10%
Approx. 100K in a care relationship

$35K
Annual cost ($2,900 PBPM)

3.5x
Higher cost than community-based Medicare FFS beneficiaries[1]

58%
Hospitalization rate

72%
ED visit rate with significant variations[1]

[1] RT Braun, et. al., JAMA Health Forum 2021;1(11):e213817

Our care model

Telemedicine

Annual Wellness Visits

Point of Care Tools

Quality Improvement Nurses

Proactive clinical care and treat-in-place support

Reduced ED transfers and hospitalization

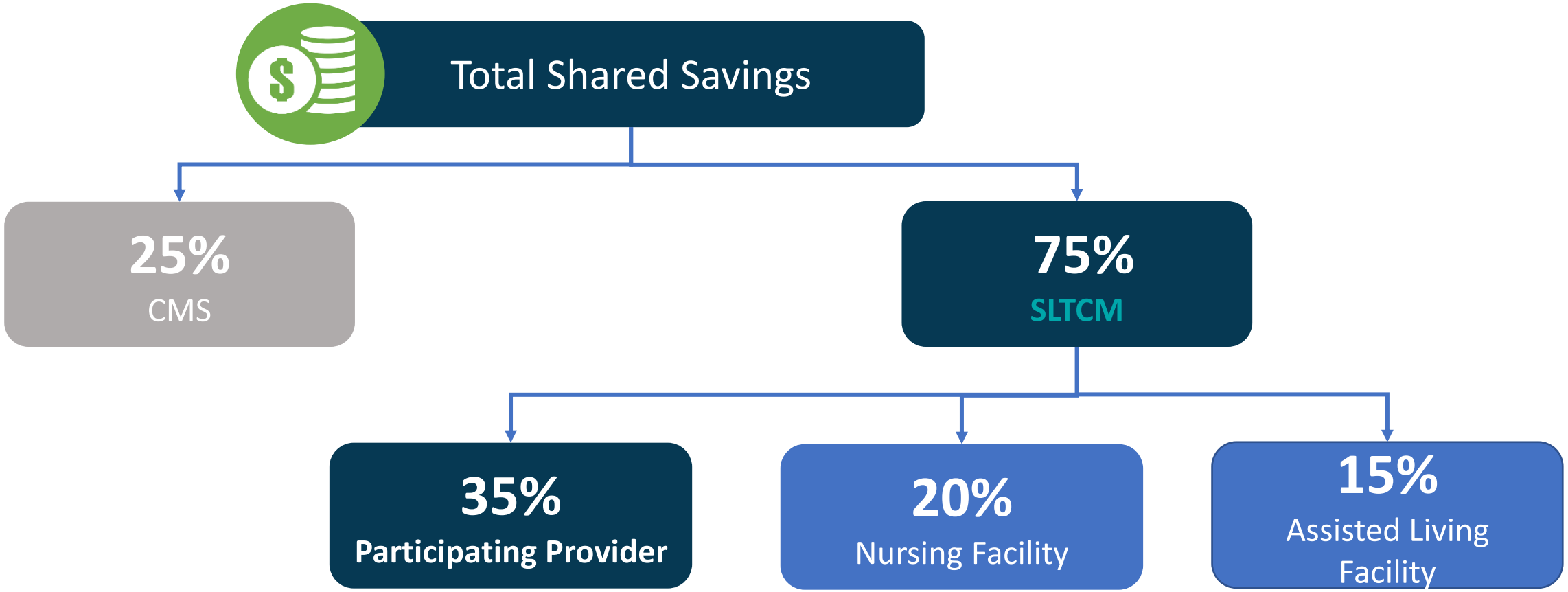
Better patient care outcomes and reduced costs

SLTCM is NOT an ISNP

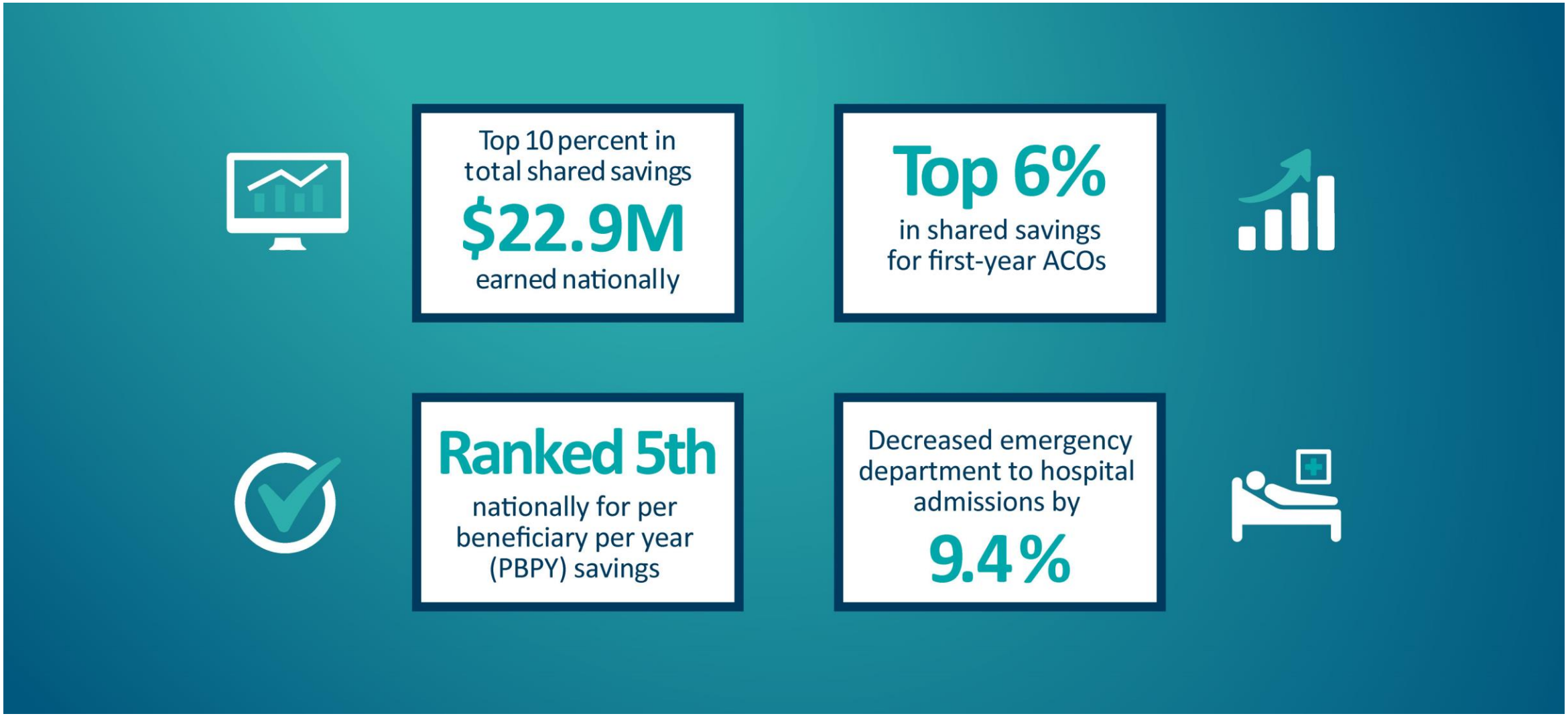
What is the difference between an ACO and ISNP?

ISNP	MSSP ACO
SNF value-based arrangement	Physician value-based arrangement
Medicare Advantage (MA) eligible individuals	Traditional (FFS) Medicare eligible individuals
Fixed-rate of reimbursement	No impact to FFS billing
SNF at risk	No downside risk
Programs typically rely on NPs	Models may use NPs or Physicians
Open enrollment	No open enrollment LTC patients are eligible through provider joining ACO

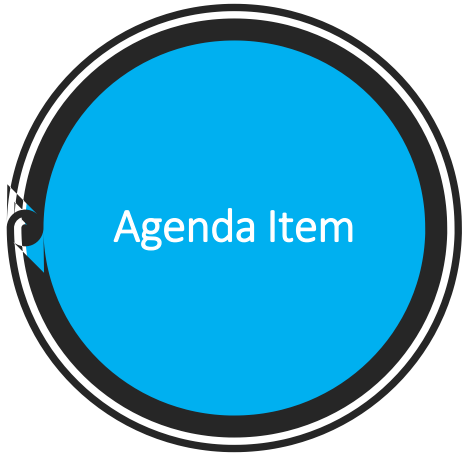
How Savings are Shared with Participants (Enhanced Track)



Success in 2023



SLTCM has the #1 benchmark in the country at **$43K per patient/per year** compared to the national average of **$12K**



ACO REACH (Realizing Equity, Access, and Community Health) model

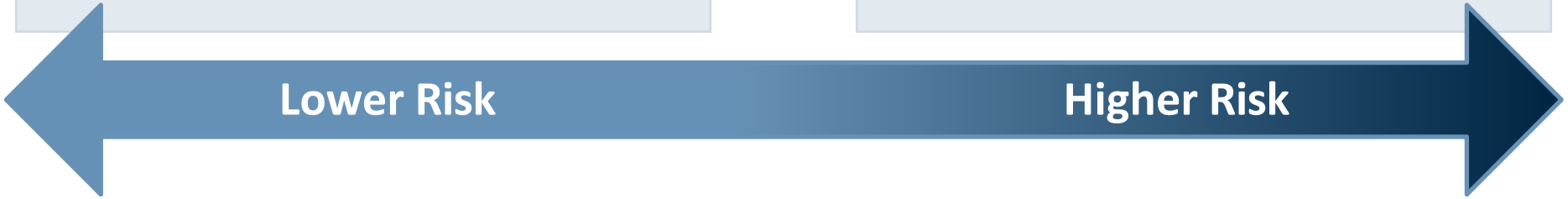
ACO REACH Model Formerly Direct Contracting Model

- Direct contracting model launched in 2019 attracted significant private equity funding...calls by many politicians that it was a backdoor effort to “privatize” traditional Medicare.
- ACO REACH redesigns the Direct Contracting model to advance Administration priorities, including commitment to advancing health equity.
- Direct contracting required providers to make up 25% of governing or voting rights, but ACO REACH requires providers to comprise 75%
- The first Performance Year of the redesigned model began on January 1, 2023 and will run for four Performance Years: Performance Year 2023 (PY2023) through PY2026.

The Centers for Medicare & Medicaid Services / CMMI, “ACO Realizing Equity, Access, and Community Health (REACH) Model Overview”, March 22, 2022.

ACO REACH Model Risk Options

Professional	Global
• ACO structure with Participant Providers and Preferred Providers defined at the TIN/NPI level • 50% shared savings/shared losses with CMS • **Primary Care Capitation (PCC)** equal to 7% of the PY Benchmark for enhanced primary care services	• ACO structure with Participant Providers and Preferred Providers defined at the TIN/NPI level • 100% risk • Choice between **Total Care Capitation (TCC)** equal to 100% of total cost of care provided by Participant Providers (and participating Preferred Providers), and **PCC**



The Centers for Medicare & Medicaid Services / CMMI, “ACO Realizing Equity, Access, and Community Health (REACH) Model Overview”, March 22, 2022.

ACO REACH Model Provider Relationships

REACH Accountable Care Organization (ACO)

- REACH ACOs must have arrangements with Medicare-enrolled providers or suppliers who agree to participate in the Model and contribute to the ACO's goals pursuant to a written agreement with the ACO.
- REACH ACOs may form relationships with two types of providers or suppliers:

Participant Providers (Required)

- Used to align beneficiaries to the ACO
- Required to accept payment from the ACO through their negotiated payment arrangement with the ACO, continue to submit claims to Medicare, and accept claims reduction
- Included in quality calculations
- Eligible to receive shared savings
- May participate in benefit enhancements or beneficiary engagement incentives

Preferred Providers (Optional)

- Not used to align beneficiaries to the ACO
- Can elect to accept payment from the ACO through a negotiated payment arrangement with the ACO, continue to submit claims to Medicare, and accept claims reduction
- Eligible to receive shared savings
- May participate in benefit enhancements and beneficiary engagement incentives

The Centers for Medicare & Medicaid Services / CMMI, "ACO Realizing Equity, Access, and Community Health (REACH) Model Overview", March 22, 2022.

ACO REACH Model Payment Mechanisms

The ACO REACH Model offers ACOs several mechanisms to receive stable monthly payments.

Capitation Payment Mechanisms	Advanced Payment
REACH ACOs receive a capitation payment covering total cost of care or cost of primary care services.	REACH ACOs that select Primary Care Capitation may receive an advanced payment of their FFS non-primary care claims.
MANDATORY	**VOLUNTARY**
Payment amount is **NOT RECONCILED** against actual claims expenditures.	Payment amount is **RECONCILED** against actual claims expenditures

The Centers for Medicare & Medicaid Services / CMMI, “ACO Realizing Equity, Access, and Community Health (REACH) Model Overview”, March 22, 2022.

ACO REACH Model Participants & Model Design Options

A REACH Accountable Care Organization (ACO) is generally comprised of health care providers and suppliers, operating under a common legal structure, which enter into an arrangement with CMS and accept financial accountability for the overall quality and cost of medical care furnished to Medicare FFS beneficiaries aligned to the entity.

Standard ACOs	ACOs that have experience serving beneficiaries in traditional Medicare program.
New Entrant ACOs	ACOs that have not traditionally provided services to a traditional Medicare FFS population and / or have not participated in FFS Medicare value-based arrangements. Beneficiaries may be aligned primarily based on voluntary alignment.
High Needs Population ACOs	ACOs that serve Medicare FFS beneficiaries with complex needs employing care delivery strategies similar to those used by Program of All-Inclusive Care for the Elderly (PACE) organizations.

The Centers for Medicare & Medicaid Services / CMMI, “ACO Realizing Equity, Access, and Community Health (REACH) Model Overview”, March 22, 2022.

ACO REACH High Needs Model Beneficiary Eligibility

For High Needs Population ACOs, beneficiaries must also meet at least one of the following criteria:

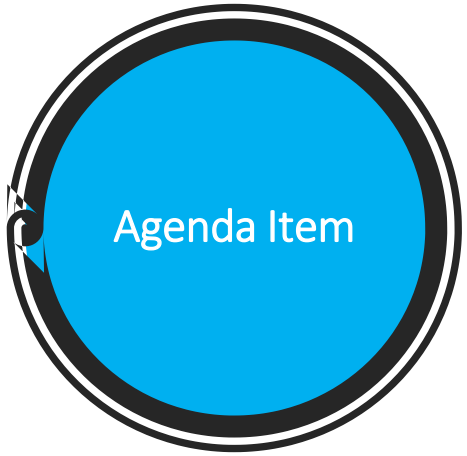
- Have one or more developmental or inherited conditions or congenital neurological anomalies that impair the Beneficiary's mobility or the Beneficiary's neurological condition
- Have at least one significant chronic or other serious illness (defined as having a risk score of 3.0)
- Have a risk score between 2.0 and 3.0 and two or more unplanned hospital admissions in the previous 12 months
- Signs of frailty based on hospital bed or transfer equipment use
- Qualified for and received skilled nursing and/or rehabilitation services in a SNF for a minimum of 45 days in the previous 12 months as determined by CMS
- Qualified for and received home health services for a minimum of 90 days in the previous 12 months as determined by CMS

The Centers for Medicare & Medicaid Services / CMMI, "ACO Realizing Equity, Access, and Community Health (REACH) Model Overview", March 22, 2022.
The Centers for Medicare & Medicaid Services, "ACO Realizing Equity, Access, and Community Health (REACH) Model PY 2025 Quality Measurement Methodology Report - PY 2025 Quality Measurement Methodology Report", October 2024.

ACO REACH Benefit Enhancements for 2025

Benefit Enhancement Type	Risk Option	Participant Type
Telehealth Expansion Waiver	Professional and Global	All
Post Discharge Home Visit	Professional and Global	Individual Practitioners only[1]
SNF 3-Day Stay Waiver	Professional and Global	Facilities with eligible CCN ranges[3]
Care Management Home Visit	Professional and Global	Individual Practitioners only[1]
Concurrent Care for Hospice Beneficiaries	Global only	All
Home Health Homebound Waiver	Professional and Global	Home Health Agencies only[4]
Diabetic Shoes Waiver	Professional and Global	Nurse Practitioners and Physician Assistants only[5]
Cardiac and Pulmonary Rehabilitation Waiver	Professional and Global	Nurse Practitioners and Physician Assistants only[5]
Home Infusion Therapy Waiver	Professional and Global	Nurse Practitioners and Physician Assistants only[5]
Medical Nutrition Therapy Waiver	Professional and Global	Nurse Practitioners and Physician Assistants only[5]
Hospice Care Certification Waiver	Professional and Global	Nurse Practitioners and Physician Assistants only[5]

The Centers for Medicare & Medicaid Services / CMMI, "Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model PY2025 Participant and Preferred Provider Management Guide, May 2024.



Institutional Special Needs Plan (I-SNP) model

Institutional Special Needs Plan (ISNP) Background

- EverCare demonstration project (United Healthcare)
- SNPs were introduced in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003
- SNPs were permanently reauthorized with the passage of The Bipartisan Budget Act of 2018
- Optum, UnitedHealth, most active in this space
- SNFs and ALFs have started Medicare Advantage Organizations (MAOs) and created institutional special needs plans (I-SNPs)

Brian E. McGarry, PT, PhD; and David C. Grabowski, PhD, "Managed Care for Long-Stay Nursing Home Residents: An Evaluation of Institutional Special Needs Plans", The American Journal of Managed Care, Volume 25 Issue 9, September 2019.

MedPac, "Report to the Congress: Medicare Payment Policy", Chapter 14 Medicare Advantage special needs plans, March 2013.

Institutional Special Needs Plan (ISNP) Overview

- Medicare Advantage special needs plan (SNP) restricts membership to beneficiaries with specific diseases or characteristics
- Institutional special needs plan (I-SNP) offers coverage to individuals who reside for 90 days or longer in a skilled nursing facility (SNF) or LTC nursing facility (NF)
- Members requiring an institutional level of care and residing in the community, in an ALF, may be offered coverage under institutional-equivalent special needs plan (IE-SNP)
- For IE-SNP must arrange for an institutional level of care (LOC) assessment using a state assessment tool and administered by an independent, impartial party

Kelly Backes and Matt Kranovich, Making the leap Nursing home and assisted living facility considerations when starting a Medicare Advantage organization, Milliman, September 9, 2022.

Institutional Special Needs Plan (ISNP) Benefits

- Larger pool of revenue, revenue covers all services, not just revenue for services provided directly by the SNF
- Prospective versus retrospective payment
- Payment methodologies that smooth revenue streams and reduce variability
- 3-day hospital stay waiver to allow to treat in place and access Medicare A level payment
- Census stability and increased resident days
- Ability to improve diagnosis coding improving payments over time
- Tailored benefits designed to improve medical outcomes
- Greater ability to manage and coordinate care contracting with external network of specialists
- Residents access supplemental benefits not offered by traditional Medicare
- Model of care greater level of care by dedicated clinical team
- Full view of utilization patterns and costs via claims data

Kelly Backes and Matt Kranovich, Making the leap Nursing home and assisted living facility considerations when starting a Medicare Advantage organization, Milliman, September 9, 2022.

I-SNP Models Based on Partnerships

- Nursing home organization becomes an insurance company as well
- Partnerships of different degrees with an insurance provider, which will take care of administrative aspects, sharing in the financial risk but also the profits with the nursing home
- Alignment with a large insurance provider, which will own the plan and realize most or all of the financial gains and losses but can offer benefits to nursing home partner

Siddiqi, Zahida, Skilled Nursing News, “Inside the I-SNP Journey: Nursing Home Operators Unlock Promise of Medicare Advantage with 3 Different Models”, October 2, 2023.

Medicare Advantage Organization (MAO) Overview

- Legal entity licensed to sell insurance
- Contracted with CMS to offer Medicare Advantage products to Medicare beneficiaries
- Medicare revenue for members rather than just the portion associated with the services they are directly providing
- Provide traditional Medicare Part A and Part B benefits
- May opt to provide additional benefits and reduced cost sharing

Kelly Backes and Matt Kranovich, Making the leap Nursing home and assisted living facility considerations when starting a Medicare Advantage organization, Milliman, September 9, 2022.

SNFs and ALFs Well-Positioned for I-SNP or IE-SNP

- MAO gets to choose own partners – provider network
- Knowledge of resident enrollees' needs and trusted relationship
- Active medical professional (e.g., nurse practitioner, medical director) engagement, resulting in improved care
- Existing infrastructure and services in place
- Abundant services provided including care management, home health, hospice, nursing, and access to primary care
- Management, improved quality outcomes, and greater accuracy in diagnosis coding
- Streamlined path to marketing to the facility's residents
- Commitment to high-quality care and member satisfaction
- Insight into benefits design having the greatest impact on resident needs

Kelly Backes and Matt Kranovich, Making the leap Nursing home and assisted living facility considerations when starting a Medicare Advantage organization, Milliman, September 9, 2022.

Leading Age Center for Managed Care Solutions and Innovations, "Medicare Advantage/Special Needs Plans: Considerations for a Provider-Led Frontier", August 2018.

Institutional Special Needs Plan (ISNP) Challenges and Risks

- Capital requirements
- Submit health maintenance organization (HMO) and/or preferred provider organization (PPO) license applications to the states intend to operate and then must submit contract application to CMS
- Need insurance expertise (e.g., claims payment, coordination of benefits, etc.)
- Build provider network that meets CMS adequacy requirements
- Managing risks for total cost of care
- Scale may be needed to spread investment and ongoing cost
- Managing clinical services
- Reacting to regulatory changes, Medicare Advantage is highly regulated
- Resource requirements
- New I-SNP or IE-SNP may grow more slowly than expected so fixed administrative costs are spread across a smaller enrollment base
- Keeping up with changes to risk score coding requirements

Health Management Associates, “A Vehicle for Success: Exploring Medicare Advantage as an Alternative Revenue Source for Nursing Homes and Other Post Acute Providers”, July 17, 2020.

Kelly Backes and Matt Kranovich, Making the leap Nursing home and assisted living facility considerations when starting a Medicare Advantage organization, Milliman, September 9, 2022.

Differences in Utilization Across I-SNP and FFS Medicare Beneficiaries

Utilization Measure	Unadjusted Differences		Adjusted for Demographics	
	I-SNP	FFS	I-SNP	FFS
Inpatient stays per 1000 residents	288	524	310	500
30-day readmissions per 1000 inpatient stays	167	334	175	318
ED visits per 1000 residents	218	452	217	441
SNF stays per 1000 residents	481	253	514	242

ED indicates emergency department; FFS, fee-for-service; I-SNP, Institutional Special Needs Plan; SNF, skilled nursing facility.

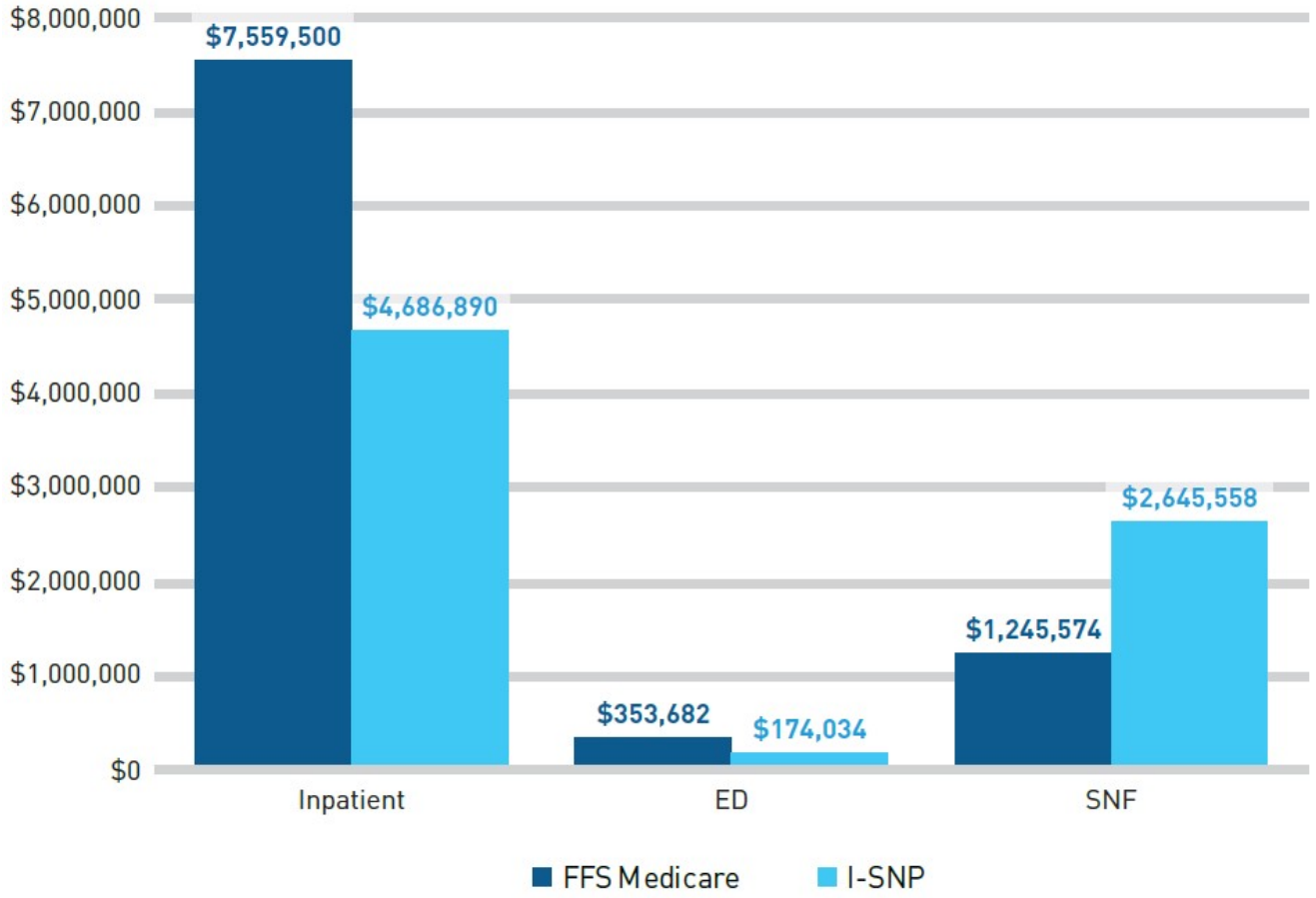
[a]All differences are statistically significant at the 5% level or better (adjusted and unadjusted). Demographic adjusters include age, gender, and state of residence.

Source: Authors' calculations based on UnitedHealthcare data of I-SNP enrollees and the Medicare 5% sample of FFS beneficiaries.

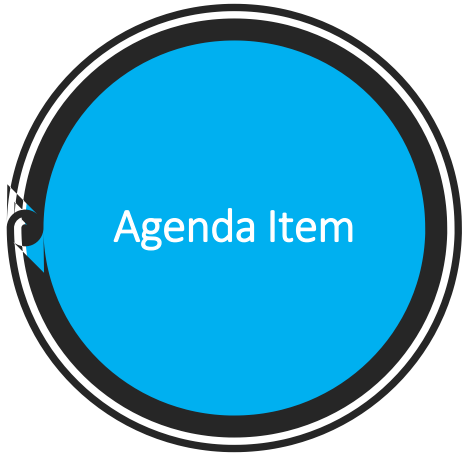
Brian E. McGarry, PT, PhD; and David C. Grabowski, PhD, Am J Manag Care, "Managed Care for Long-Stay Nursing Home Residents: An Evaluation of Institutional Special Needs Plans" 2019;25(9):400-405.

Differences in Utilization Across I-SNP and FFS Medicare Beneficiaries

Actual Medicare Expenditures per 1000 Long-term Nursing Home Residents in FFS Medicare Versus Projected Expenditures Based on Utilization of I-SNP Beneficiaries



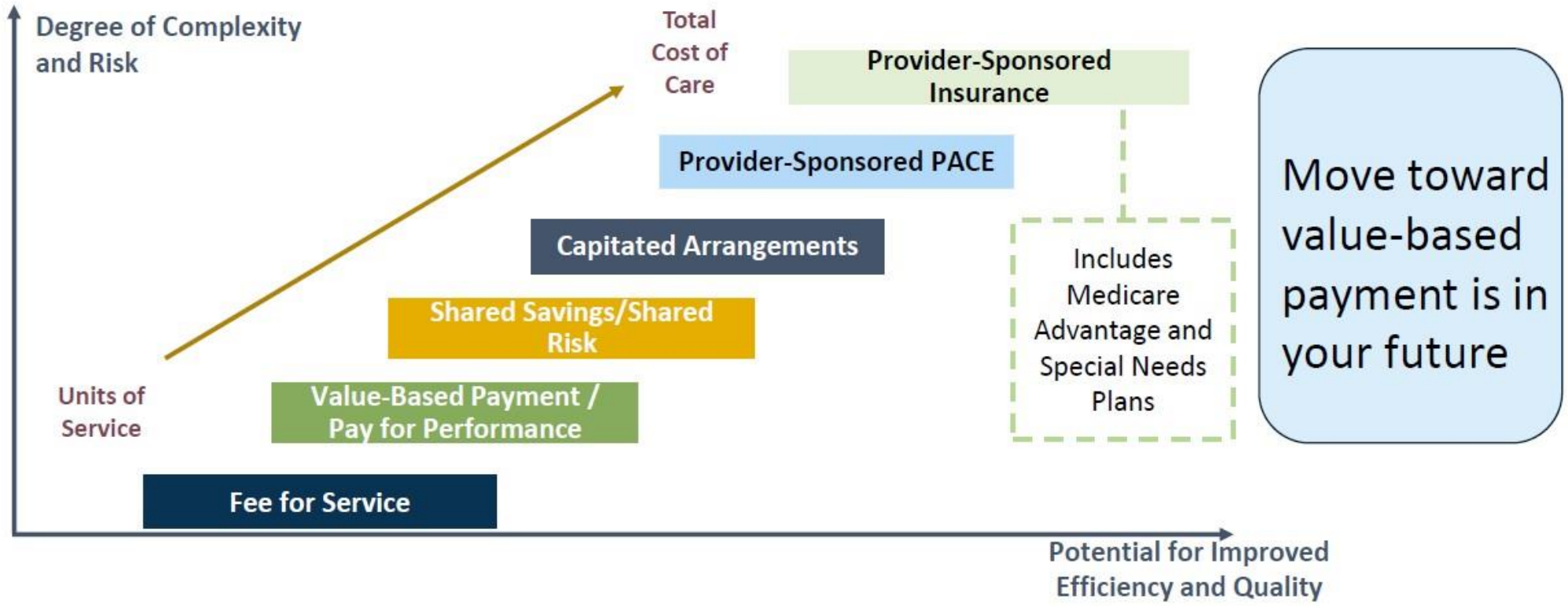
Brian E. McGarry, PT, PhD; and David C. Grabowski, PhD, Am J Manag Care, "Managed Care for Long-Stay Nursing Home Residents: An Evaluation of Institutional Special Needs Plans" 2019;25(9):400-405.



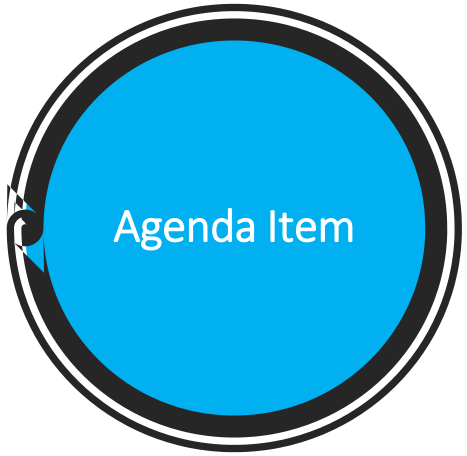
Considerations moving forward

Financial Risks Glidepath

Readiness for the spectrums of risks implies different strategies and internal capabilities



Health Management Associates, "A Vehicle for Success: Exploring Medicare Advantage as an Alternative Revenue Source for Nursing Homes and Other Post Acute Providers", July 17, 2020.



Questions

Contacts

Chris Wasel
President, Marketing & Strategic Partnerships
Vantage Healthcare
cwasel@vantagehcs.com
(781) 424-9195

Amy O'Brien
Vice President of Business Development
Sound Physicians Long-Term Care Management ACO
amyobrien@soundphysicians.com
(262) 825-6028