Establishing the Value of Mechanical Circulatory Support Today and Tomorrow

Robin Roberts Bostic
VP Health Policy/Economics and Government Affairs
Disclaimer

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“Obama Care” - The Affordable Care Act
- Three Goals

1. Expand health care coverage
2. Reform the delivery system, including insurance reform
3. Lower the overall costs of providing care; “bend the cost curve”
2010 Visual of Uninsured by State
2014 Visual of Uninsured by State
Expanding Coverage

Will Coverage Expansion Offset Decline in Per Capita Utilization?

Projected Coverage Expansion

Net Reduction in Uninsured Individuals²

2013-2023

ACA Hospital Payment Cuts

$260B

$56B

$316B

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Uninsured Admissions Down

Figure 1. Percent Change in the Volume of Uninsured Admissions, Q1 2013 to Q1 2014

- Overall
- Medicaid Expansion States
- Medicaid Non-Expansion States

<table>
<thead>
<tr>
<th>Hospital Type</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Systems</td>
<td>-13%</td>
</tr>
<tr>
<td>HCA</td>
<td>-29%</td>
</tr>
<tr>
<td>LifePoint</td>
<td>-26%</td>
</tr>
<tr>
<td>Tenet</td>
<td>-33%</td>
</tr>
<tr>
<td>CHA Survey</td>
<td>-30%</td>
</tr>
<tr>
<td>Colorado Hospitals</td>
<td>-30%</td>
</tr>
<tr>
<td>Arkansas Hospitals</td>
<td>-30%</td>
</tr>
</tbody>
</table>
Hospital Bad Debt Down

Figure 8. Percent Change in Bad Debt

- Community Health Systems: 10% (Q1 2013 to Q1 2014), -5% (Q2 2013 to Q2 2014)
- Tenet: 4% (Q1 2013 to Q1 2014), -19% (Q2 2013 to Q2 2014)
Hospital Earnings are Up

Hospitals benefit having more insured customers who can pay their bills. Especially in the states that expanded Medicaid to more people, as was allowed under the law.

Source: Bloomberg
Insurer Earnings are Up

Source: Bloomberg
Changes in the healthcare landscape will create a systematic focus on Heart Failure

There are a number of changes expected in the macro healthcare delivery landscape...

• Increased number of covered lives, offset by increasing pressure on hospital margins given potential payor mix shift (e.g., Medicaid expansion)
  – Declining reimbursement and DSH payments
  – Payments models sifting from rewarding “volume” to rewarding “value” with centers of excellence
  – Increasingly costs sensitive consumer
  – Need to operate at “Medicare breakeven”

• Consolidation into larger systems and networks
  – Up to 70% of hospital payments could be tied to one of 150 largest systems
  – Increasing alignment and employment of physicians within systems and networks

... As well as changes specific to heart failure management

• Hospital Readmissions Reduction Program
  – Tracks Heart Failure, Acute Myocardial Infarction, Hip/Knee, COPD and Pneumonia 30-day readmissions
  – Charge capped at 3% of all DRG payments per hospital in FY2015,

• Hospital Value-Based Purchasing
  – Incentive payments for providing high quality care or improving care after including AMI and HF Mortality
  – Funds for program collected by base operating DRG percent reduction of 1.0% for FY ’13; Ramps up by FY’17 to 2%

1. http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html

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Re-admission isn’t just a VAD problem- HF Re-admission

- 83.8% of patients surviving more than three months were re-hospitalized for heart failure within 2 years following the index hospitalization

<table>
<thead>
<tr>
<th>Died Within 3 Months of Index</th>
<th>Heart Failure Re-hospitalization (Row %)</th>
<th>Total N (Col %)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>690 (16.2%)</td>
<td>3,575 (83.8%)</td>
</tr>
<tr>
<td>Yes</td>
<td>2,197 (80.9%)</td>
<td>520 (19.1%)</td>
</tr>
<tr>
<td><strong>Total (ALL)</strong></td>
<td><strong>2,887 (41.4%)</strong></td>
<td><strong>4,095 (58.7%)</strong></td>
</tr>
</tbody>
</table>

2010-2013 US Medicare 5% Standard Analytical Files (SAF)
Reducing VAD 30 Day Readmissions
work group results

Most common themes as reported in the literature and confirmed by VAD center survey.

1. Improved or optimized patient education
   a. Self-care
   b. Identification and response to symptom
2. Multidisciplinary discharge planning and follow-up
3. Pharmacist medication reconciliation
4. Early (1 week) home follow-up
5. Telephone follow-up in the first 30 days
6. Involvement of case managers in discharge planning

Presented ISHLT Annual 2014 Meeting Poster; Reducing 30 Day Hospital Readmissions for Patients with Left Ventricular Support Devices; Paper in review

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Value-based payments will have a significant impact to providers’ revenue streams

Hospitals and health systems are facing 7% of their total MS-DRG based payments at risk within the next 2 years in addition to any commercial pay for performance revenues in play

<table>
<thead>
<tr>
<th></th>
<th>FY2013</th>
<th>FY2014</th>
<th>FY2015</th>
<th>FY2016</th>
<th>FY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value Based Purchasing</td>
<td>1.0%</td>
<td>1.25%</td>
<td>1.5%</td>
<td>1.75%</td>
<td>2.0%</td>
</tr>
<tr>
<td>(At Risk)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Value Based Purchasing</td>
<td>0.8%</td>
<td>1.0%</td>
<td>1.2%</td>
<td>1.4%</td>
<td>1.6%</td>
</tr>
<tr>
<td>(Bonus)¹</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Readmission Payment</td>
<td>1.0%</td>
<td>2.0%</td>
<td>3.0%</td>
<td>3.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>(At Risk)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Acquired</td>
<td>N/A</td>
<td>N/A</td>
<td>1.0%</td>
<td>1.0%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range of Impact²</td>
<td>2.8%</td>
<td>4.25%</td>
<td>6.7%</td>
<td>7.15%</td>
<td>7.60%</td>
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</tbody>
</table>

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Value-based payments will have a significant impact to providers’ revenue streams

**FOR EXAMPLE:** A 1,250 bed Midwest academic hospital, with $280M in Annual Medicare Inpatient Payments has an estimated **$79.8M** risk/opportunity in the 5 years between 2013 and 2017 from PPACA quality related reimbursement

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<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Value Based Purchasing (At Risk)</td>
<td>2.8M</td>
<td>3.5M</td>
<td>4.2M</td>
<td>4.9M</td>
<td>5.6M</td>
<td>21M</td>
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<tr>
<td>Value Based Purchasing (Bonus)</td>
<td>2.2M</td>
<td>2.8M</td>
<td>3.4M</td>
<td>3.9M</td>
<td>4.5M</td>
<td>16.8M</td>
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<tr>
<td>Readmission Payment (At Risk)</td>
<td>2.8M</td>
<td>5.6M</td>
<td>8.4M</td>
<td>8.4M</td>
<td>8.4M</td>
<td>33.6M</td>
</tr>
<tr>
<td>Hospital Acquired Conditions</td>
<td>N/A</td>
<td>N/A</td>
<td>2.8M</td>
<td>2.8M</td>
<td>2.8M</td>
<td>8.4M</td>
</tr>
<tr>
<td>Range of Impact</td>
<td>7.8M</td>
<td>11.9M</td>
<td>18.7M</td>
<td>20M</td>
<td>21M</td>
<td><strong>79.8M</strong></td>
</tr>
</tbody>
</table>
Hospital Value-Based Purchasing Program

Hospital Value-Based Purchasing

The Fiscal Year 2015 Hospital Value-Based Purchasing (Hospital VBP) Program adjusts hospitals’ payments based on their performance on four domains that reflect hospital quality: the Clinical Process of Care Domain, the Patient Experience of Care domain, the Outcome domain, and the Efficiency domain. The Total Performance Score (TPS) is comprised of the Clinical Process of Care domain score (weighted as 20% of the TPS), the Patient Experience of Care domain (weighted as 30% of the TPS), the Outcome domain score (weighted as 30% of the TPS), and the Efficiency domain score (weighted as 20% of the TPS).

The following data points are included in each data set:

A measure/dimension score
## VBP Outcome Measures

<table>
<thead>
<tr>
<th>Measure ID**</th>
<th>Measure Description</th>
<th>FY 2013</th>
<th>FY 2014</th>
<th>FY 2015</th>
<th>FY 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>MORT-30-AMI</td>
<td>Acute Myocardial Infarction (AMI) 30-Day Mortality Rate</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>MORT-30-HF</td>
<td>Heart Failure (HF) 30-Day Mortality Rate</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>MORT-30 PN</td>
<td>Pneumonia (PN) 30-Day Mortality Rate</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>AHRQ Composite (PSI-90)</td>
<td>Complication/Patient safety for selected indicators (Composite)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>CAUTI</td>
<td>Catheter-Associated Urinary Tract Infection</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>CLABSI</td>
<td>Central Line-Associated Blood Stream Infection</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>SSI</td>
<td>SSI - Colon Surgery SSI - Abdominal Hysterectomy</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

** Measure names:**
- MORT = Outcome Mortality Measure
- AHRQ = Agency for Healthcare Research and Quality
- PSI = Patient Safety Indicators
- SSI = Surgical Site Infection
Economic Impact of VADs
The Advisory Board reported a $3,000-$5,000 profit per VAD patient.
95% VAD Programs are Financially Viable

- Only 1/5th of hospitals making less than $100,000 in their first year
- Half were projected to make between $100,000 and $300,000

<table>
<thead>
<tr>
<th>Profitability at Year 1 with 5 VAD Implants</th>
<th>HMII N=127</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;$100,000</td>
<td>24</td>
</tr>
<tr>
<td>&gt;$100,000</td>
<td>37</td>
</tr>
<tr>
<td>&gt;$200,000</td>
<td>39</td>
</tr>
<tr>
<td>&gt;$300,000</td>
<td>18</td>
</tr>
<tr>
<td>&gt;$400,000</td>
<td>6</td>
</tr>
<tr>
<td>&gt;$500,000</td>
<td>3</td>
</tr>
</tbody>
</table>

Sources: Results 2011 Financial Analysis Model for all HM II Centers all payers 37 hospitals audited 800 bills reviewed Confirmed by Administrator network Economic Summit

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Cost Impact – Cost Comparison

VADs Compared to the Total Medicare Spend for Heart Failure

Medicare Expenditures (in $millions)

Heart Failure Cost
3% Medicare Total Budget

Sources
Cost from Russo 2008 data x 60% of estimated ESHF Patients in US (Medicare Proxy)
CMS MEDPAR 2011 MS-DRG 1 volume x average payment for Medicare DT patients

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Cost Impact – Cost Comparison
Costs of Treating Advanced Stage Illness – 1 Year or Less, per Person


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Medicare’s Cost of Medical Management End-Stage Heart Failure Patients

0-6mo
$78,880
50.5%

Last 2 years of life mean cost
$156,169 per Medically Managed patient

Note: this does not include current treatments like ICDs or biV Pacing

Temporal Changes in Hospital Costs for Left Ventricular Assist Device Implantation

Mark S. Slaughter, M.D., Robin Bostic, B.S., Kuo Tong, M.S., Mark Russo, M.D., and Joseph G. Rogers, M.D.

Conclusions: There has been a 50% reduction in the hospitalization cost associated with LVAD implantation since 2001. Improvements in operative technique and postoperative management appear to play critical roles in the observed cost reduction. doi: 10.1111/j.1540-8191.2011.01292.x (J Card Surg 2011;26:1-7)
Cost-Effectiveness Analysis of Continuous Flow Left Ventricular Assist Devices as Destination Therapy
Joseph G. Rogers, Robin R. Bostic, Kuo B. Tong, Rob Adamson, Mark Russo and Mark S. Slaughter

Conclusions—The cost-effectiveness associated with continuous flow LVADs for destination therapy has improved significantly relative to the pulsatile flow devices. This change is explained by significant improvements in survival, functional status and reduction in implantation costs.
ICER Trend for DT Therapy Compared to Medical Management


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Global Considerations

The use of VADs for destination therapy (DT) has been approved in various countries:

- United States 2003
- Germany 2007
- France 2007
- United Kingdom 2015
- Quebec 2014
- South Korea 2014

It should be noted that the same cost-effectiveness threshold (using an incremental cost-effectiveness ratio, for example) does not necessarily have to be applied to all health interventions and decision contexts.

“We found that VADs considered as a BTT yields ICERs of £122,730, £68,088 and £55,173, respectively, when compared with MM. We found that at a lifetime time horizon, using VADs as an ATT rather than as a BTT was complex. VADs as an ATT has a reduced cost and reduced QALYs. When considered over a lifetime horizon ATT as compared with BTT is £20,637 cheaper for each QALY lost.” Sutcliffe, P, et al

“It should be noted that the same cost-effectiveness threshold (using an incremental cost-effectiveness ratio, for example) does not necessarily have to be applied to all health interventions and decision contexts.”
ROADMAP and MOMENTUM 3 Cost Analysis

- Bill audits to ensure compliance with Category B IDE claims processing
- Collect claim forms and CMS Med Par data to conduct cost analysis
- Analyze cost results for publication alongside clinical data
  - Update and publish OMM cost
  - Publish cost of implant
  - Publish cost effectiveness

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Understand the Evolving Healthcare Delivery System

**Legacy**
- Impressive physical assets
- Buildings
- Equipment
- Traditional research, education & providers
- Surgeon selection

**Future**
- Emphasis on positive health outcomes
- Focus on Quality
- Partnership with patients
- Equity of care
- Technology committee evaluation

\[
\text{Value} = \frac{\text{Quality}}{\text{Cost}}
\]

**The New Value Equation**
\[
\frac{\text{Product Benefit}}{\text{Price}} + \frac{\text{Brand Equity}}{\text{Price}} + \frac{\text{Marketing Benefit}}{\text{Price}} = \text{Value}
\]
The Advisory Board Highlights Thoratec as going beyond product through Continuum Services

Patient Experience Beyond Your Product

Impact Ongoing Assistance and Management After Episode of Care

Services Offered by Thoratec Through Continuum

- Home delivery of LVAD accessories and driveline stabilization supplies
- LVAD equipment maintenance, including some performed in patient home
- 24/7 patient support
- Patient tracking and feedback for provider

>97%
Percentage of satisfied patients across first 11 months of 2014

Case in Brief: Thoratec

- Thoratec provides home delivery of its medical equipment via its subsidiary Continuum Services, Inc.
- Offers driveline stabilization supplies and reimbursement support necessary for ongoing LVAD patient care at no cost to VAD programs
Continuum | Full-service outsourced solution

Full-service, outsourced option, designed to provide **reliable, cost effective** VAD accessories, supplies and billing support for VAD Patients, their VAD Implanting Centers and their Insurers.

- Latest accessories-HM III
- High quality VAD driveline stabilization supplies- Weekly change- Percutaneous drive line management system.
- Delivery direct to VAD Patients
- Equipment tracking and reporting
- No cost to the hospital-direct billing to payer
- Cost-effective pricing
- Competitive payer contracts
- Expert, field-based 24/7 support
# Center 5 year Financial Analysis Model Summary

## Patient Throughput Estimates

<table>
<thead>
<tr>
<th></th>
<th>Lafayette General Medical Center</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals to Heart Failure/LVAD Program</td>
<td>% of Referrals Receiving LVADs for BTT or DT</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Total Patients with HeartMate II LVADs</td>
<td># Patients Off Support</td>
<td>Year 1 to 2</td>
<td>Year 2 to 3</td>
<td>Year 3 to 4</td>
<td>Year 4 to 5</td>
<td>Year 5</td>
<td></td>
</tr>
<tr>
<td>Patients with Ongoing Support</td>
<td>Number of Patients Receiving CentriMag Blood Pumps</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>11</td>
<td>13</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Revenues

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Total (Year 1-5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals - Screening &amp; Evaluation</td>
<td>$96,765</td>
<td>$116,110</td>
<td>$139,242</td>
<td>$157,210</td>
<td>$206,652</td>
<td>$720,060</td>
</tr>
<tr>
<td>Referrals - Other Hospital Services</td>
<td>$300,858</td>
<td>$366,789</td>
<td>$432,947</td>
<td>$519,536</td>
<td>$623,443</td>
<td>$2,237,373</td>
</tr>
<tr>
<td>Long-Term Management - Follow-up Clinical Visits</td>
<td>$21,548</td>
<td>$25,616</td>
<td>$29,688</td>
<td>$36,427</td>
<td>$42,097</td>
<td>$157,978</td>
</tr>
<tr>
<td>Long-Term Management - Follow-up Diagnostic Tests &amp; Services</td>
<td>$22,928</td>
<td>$28,766</td>
<td>$31,283</td>
<td>$40,162</td>
<td>$44,664</td>
<td>$165,192</td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>$1,868,858</td>
<td>$2,287,257</td>
<td>$2,384,796</td>
<td>$2,630,195</td>
<td>$2,781,557</td>
<td>$11,492,240</td>
</tr>
<tr>
<td>Hospital Outpatient*</td>
<td>$113,927</td>
<td>$162,036</td>
<td>$176,575</td>
<td>$245,686</td>
<td>$699,104</td>
<td>$1,070,076</td>
</tr>
<tr>
<td><strong>Total VAD Revenues</strong></td>
<td>$2,120,730</td>
<td>$2,900,487</td>
<td>$2,530,261</td>
<td>$3,572,126</td>
<td>$3,938,361</td>
<td><strong>$15,470,973</strong></td>
</tr>
</tbody>
</table>

## Operating Expenses

<table>
<thead>
<tr>
<th>Expense Description</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Total (Year 1-5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Staff Costs</td>
<td>$115,987</td>
<td>$79,967</td>
<td>$71,967</td>
<td>$22,000</td>
<td>$14,000</td>
<td>$303,900</td>
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<tr>
<td>Capital and Training Expense</td>
<td>$46,062</td>
<td>$50,059</td>
<td>$69,671</td>
<td>$83,005</td>
<td>$100,026</td>
<td>$360,043</td>
</tr>
<tr>
<td>Referrals - Other Hospital Services</td>
<td>$239,625</td>
<td>$342,760</td>
<td>$411,299</td>
<td>$492,599</td>
<td>$592,271</td>
<td>$2,125,594</td>
</tr>
<tr>
<td>Long-Term Management - Follow-up Clinical Visits</td>
<td>$10,674</td>
<td>$12,609</td>
<td>$14,944</td>
<td>$18,213</td>
<td>$21,346</td>
<td>$70,993</td>
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<tr>
<td>Long-Term Management - Follow-up Diagnostic Tests &amp; Services</td>
<td>$11,162</td>
<td>$13,304</td>
<td>$15,628</td>
<td>$20,091</td>
<td>$22,325</td>
<td>$82,596</td>
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<td>Hospital Inpatient</td>
<td>$1,455,312</td>
<td>$1,862,926</td>
<td>$2,110,340</td>
<td>$2,605,168</td>
<td>$2,852,582</td>
<td>$10,888,328</td>
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<tr>
<td>Hospital Outpatient*</td>
<td>$74,013</td>
<td>$103,610</td>
<td>$116,420</td>
<td>$162,022</td>
<td>$453,078</td>
<td></td>
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<tr>
<td><strong>Total VAD Operating Expenses</strong></td>
<td>$1,936,122</td>
<td>$2,443,917</td>
<td>$2,797,465</td>
<td>$3,382,057</td>
<td>$3,765,678</td>
<td><strong>$14,299,238</strong></td>
</tr>
</tbody>
</table>

## Net Income

<table>
<thead>
<tr>
<th>Net Income</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Total (Year 1-5)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$159,688</td>
<td>$456,681</td>
<td>$432,796</td>
<td>$210,068</td>
<td>$172,683</td>
<td><strong>$1,471,738</strong></td>
</tr>
</tbody>
</table>
New VAD Center Blue Print
Foundations 4.0

A Program to assist in establishing VAD Program Value
Reimbursement Support & Assistance

Thoratec leads the industry in not only shaping the clinical side of mechanical support, but also has paved the way for the establishment of governmental policies, payment structure, and certification. Each VAD program needs to provide ongoing education, implementation tools, and follow-up monitoring for their teams to ensure compliance with regulations and maintain a positive economic profile for VAD therapy.

To ensure your hospital has an economically strong program, accurate coding and billing processes need to be in place to secure adequate reimbursement. Thoratec leads the field in reimbursement by offering a comprehensive team that is positioned to adequately support all of these aspects of your program.

MEDICARE EXPANDS COVERAGE FOR CARDIAC REHAB

The Centers for Medicare and Medicaid Services (CMS) posted the National Coverage Determination (NCD) for Cardiac Rehabilitation (CR) on February 19, 2014. Medicare coverage is now expanded for cardiac rehabilitation services under 42 C.F.R. § 410.49(b)(1)(vii) to beneficiaries with stable, chronic heart failure defined as:

1. Patients with left ventricular ejection fraction of 35% or less and,
2. New York Heart Association (NYHA) class II to IV symptoms despite being on optimal heart failure therapy for at least six weeks.
3. Stable patients are defined as patients who have not had recent (≤6 weeks) or planned (≤6 months) major cardiovascular hospitalizations or procedures.

Reach the Team
Contact the Thoratec Reimbursement & Healthcare Initiatives Team via email.

2013 VAD Economic Summit Slide Presentations
Click here to view the agenda and download the presentations.

Looking for the Foundations Calculator? Click here.
Thoratec Resources

- Reimbursement help line vadreimbursement@thoratec.com
- Reimbursement Roundtable Teleconferences
- Reimbursement Concepts on Thoratec e-University www.thoratecu.com
- Reimbursement information on Thoratec website www.thoratec.com
- Annual Economic Summit
- Inpatient Bill Reviews
- Preparing for DT Certification Interactive Seminar and renewal
- Foundations Program
- “Heart Failure and VAD Therapy” Case Manager webinar

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