How Post-acute Providers Can Succeed in a Value-Based Payment World

LeadingAge New York Annual Conference

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Health Dimensions Group

Health Dimensions Group: What We Do

Strategic Consulting
- Strategic planning and positioning
- Health care continuum alignments
- Market growth strategies
- PACE development
- Bundling implementation
- Senior service line development
- Post-acute medicine development

Operational and Performance Improvement
- Clinical
- Financial and billing
- Regulatory compliance
- Reimbursement advisory
- Transaction advisory
- Business office support
- Operations re-engineering

Management Solutions
- Strategic planning and positioning
- Turnaround management
- Transitional leadership
- Full-service management
- Acquisitions & divestiture
- Interim management
Structure for Today’s Conversation

- Landscape for Value-Based Care
- Medicare Value-Based Initiatives
- New York’s Value-Based Roadmap
- Strategies for Success

What Value-Based Purchasing Feels Like Sometimes...

“Let’s just start cutting and see what happens…”
Learning About Value-based Payments
Can be Like Drinking from a Fire House

Understanding the New Landscape for Value-Based Purchasing
Payment Is Rapidly Shifting from Rewarding Volume to Value

No Quality Measurement  More Quality Measurement

FFS  Pay for Performance  Care Coordination  Episodes of Care  Shared Savings  Shared Risk  Global Payments

No Financial Risk  More Financial Risk


Value-based Payment (VBP) Rampant Goal Setting Underway!

“This is the first time in the history of our program that explicit goals for alternative payments and value-based payments have been set for Medicare.”

Sylvia Mathews Burwell
Secretary of Health and Human Services
January 26, 2015
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VBP Framework by HHS

<table>
<thead>
<tr>
<th>Category 1: FFS – No Link to Quality</th>
<th>Category 2: FFS – Link to Quality</th>
<th>Category 3: Alternative Payment Model Built on FFS Architecture</th>
<th>Category 4: Population-Based Payment Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments are based on volume of services and not linked to quality or efficiency</td>
<td>At least a portion of payments varies based on quality or efficiency of health care delivery</td>
<td>Some payment linked to effective management of population or episode or care; payments still triggered by service delivery, but opportunities for shared savings or two-sided risk</td>
<td>Payment not directly triggered by service delivery so volume not linked to payment; clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., greater than one year)</td>
</tr>
</tbody>
</table>

Medicare FFS
- Limited in Medicare FFS
- Majority of Medicare payments now are linked to quality
- Hospital value-based purchasing
- Hospital readmission reduction program
- Hospital-acquired conditions program
- ACOs
- Medical Homes
- Bundles
- Comprehensive Primary Care Initiative
- Comprehensive ESRD
- Financial Alignment Demo – FFS Model
- Pioneer ACO (Years 3–5)


HHS Goals for VBP: Payment Target Percentages by Year

- 30% of traditional Medicare fee-for-service (FFS) payments tied to alternative models by end of 2016; 50% of payments by 2018
- 85% of Medicare FFS payments tied to quality or value by 2016; 90% by 2018
- Launch Health Care Learning and Action Network that will work with range of partners to expand alternative payment models into their programs

Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

- All Medicare FFS (Categories 1–4)
- FFS linked to quality (Categories 2–4)
- Alternative payment models (Categories 3–4)

Federal Foundation for VBP: Standard Assessment Data & Quality Metrics

Improving Post-Acute Care Transformation Act (IMPACT) of 2014

Post-acute care (PAC) providers must report:
- Standardized assessment data
- Data on quality measures
- Data on resource use and other measures

Data must be standardized and interoperable to allow:
- Exchange of data using common standards and definitions
- Facilitation of care coordination
- Improvement of Medicare beneficiary outcomes

PAC assessment instruments must be modified to:
- Enable the submission of standardized data
- Compare data across all applicable providers

2022 Goal: Minimum 50% of Total Medicare Post-acute Provider Payments Bundled

Reduce Spend by -2.85%

<table>
<thead>
<tr>
<th>Year</th>
<th>Billions</th>
</tr>
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<tbody>
<tr>
<td>2013</td>
<td>$0</td>
</tr>
<tr>
<td>2015</td>
<td>$5</td>
</tr>
<tr>
<td>2017</td>
<td>$10</td>
</tr>
<tr>
<td>2018</td>
<td>$15</td>
</tr>
<tr>
<td>2020</td>
<td>$20</td>
</tr>
<tr>
<td>2022</td>
<td>$40</td>
</tr>
</tbody>
</table>

Pilot began Oct. 1
Add new participants Jan. 1
All PAC providers

Source: Budget of the United States Government, FY 2016; http://www.whitehouse.gov/omb/budget
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Private Health Care Transformation Task Force Sets Goal of 75% VBP by 2020

Providers

Patients

Payers

Employers

New York Medicaid Is Setting VBP Goals As Well

• Statewide goal: 80% to 90% of Medicaid payments from managed care organizations (MCOs) or performing provider systems (PPSs) be captured in at least Level 1 VBPs by Q2 2020

• State aims to have ≥ 70% of total costs captured in VBPs in Level 2 VBPs or higher, with periodic readjustment
  – Level 1 VBP means some linkage to quality with the opportunity for upside shared savings
  – Level 2 VBP means linkage to quality and both upside and downside risk

Source: http://www.capitalnewyork.com/article/albany/2015/05/8567234/broad-agreement-and-big-questions-on-value-based-payments
Fully Integrated Dual Advantage (FIDA) Has Strong Emphasis on VBP

- Under New York’s agreement with CMS for dual demonstration, plans are required by Year 2 of the demonstration (2016) to:
  - Develop plan for fully integrated payment system through which providers would no longer be paid on a traditional fee-for-service basis but would instead be paid on an alternative basis (e.g., pay for performance, bundled payment)
  - Dual eligible plans required to implement approved value-based approaches, which will remain in effect throughout duration of demonstration
- Whether the FIDA VBP requirement is revised to align with the overall NY VBP Roadmap remains to be seen

VBP Creates Opportunities and Challenges
How Post-acute Providers Can Succeed in a Value-based Payment World

Post-acute Care Plays a Key Role in Medicare Expenditures

Medicare Acute Hospital Discharges

40% Sent to Post-acute

Skilled Nursing 41%
Home Health 37%
Acute Rehab 10%
Outpatient 9%
LTACH 2%

With the bulk of post-hospital patients, SNF & HHA represent key settings for controlling total costs and managing outcomes

Health systems often have limited control of costs and outcomes sent to non-affiliated post-acute settings
Opportunity: About 25% of LTC Residents Are Hospitalized Annually

Annual Hospitalization Rate by Five-Star Rating in FY 2011

<table>
<thead>
<tr>
<th>Metric</th>
<th>Overall Metric</th>
<th>Survey Metric</th>
<th>Staffing Metric</th>
<th>Quality Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing homes</td>
<td>26.7%</td>
<td>26.1%</td>
<td>27.3%</td>
<td>25.1%</td>
</tr>
<tr>
<td>rated one, two, or three stars</td>
<td>22.8%</td>
<td>23.0%</td>
<td>22.3%</td>
<td>25.1%</td>
</tr>
<tr>
<td>Nursing homes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>rated four or five stars</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>


Nearly Half of Hospitalizations of Elderly May Be Preventable

- Medicare reimbursement policies for hospitals, NH, HHA & physicians
- Patient & family preferences
- ED time pressures & availability of community-based care options after ED discharge
- Availability of individual patient advance care plans & physician orders for palliative or hospice care
- Availability of trained MDs, NPs, PAs, RNs & PCAs in home & LTC institutional settings
- Availability of diagnostic & pharmacy services in home & LTC institutional settings
- Concerns about legal liability & regulatory sanctions for attempting to manage acute illnesses in non-hospital setting
- Concerns about legal liability & regulatory sanctions for attempting to manage acute illnesses in non-hospital setting

Challenge: Transition of LTC to Managed Care

- Transition of nursing home benefit to managed care, along with blended rate cell for MLTC, create downward pressure on nursing facilities
- Three years after transition to mandatory enrollment, managed care plans are required to pay either:
  - Benchmark rate or
  - Negotiated rate (only applies to alternative payment arrangements)
- The challenge is to identify within-Medicaid savings for medically complex, long-term residents of nursing facilities as the basis for negotiated rates that exceed benchmarks

Challenge: Too Many Downstream Providers

Example of downstream network for one Texas hospital for congestive heart failure and joint replacement:

- 59 downstream post-acute providers for CHF
- 218 downstream post-acute providers for Joint Replacement

<table>
<thead>
<tr>
<th>DRG</th>
<th>HHA</th>
<th>SNF</th>
<th>IRF</th>
<th>LTCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>291: Heart failure &amp; shock w MCC</td>
<td>39</td>
<td>14</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>470: Major joint replacement or reattachment of lower extremity w/o MCC</td>
<td>118</td>
<td>66</td>
<td>28</td>
<td>3</td>
</tr>
<tr>
<td>Total (All MS-DRGs)</td>
<td>577</td>
<td>218</td>
<td>55</td>
<td>27</td>
</tr>
</tbody>
</table>

Source: Dobson | DaVanzo analysis of 100% Medicare Claims data July 2009 to June 2012

In 2008, North Shore-LIJ started from a list of 266 SNFs and created a continuing care network (CCN) of 19 SNFs (Source: HFMA)
Challenge: Infrastructure for VBP Not There Yet

Needs include:

• Robust exchange of diagnostic and other clinical information across settings in real-time through interoperable EMRs
  – Is this admission an ACO or bundled patient?

• Readily accessible and uniform administrative data (claims, assessment data) and quality metrics
  – Federal IMPACT Act will help address this problem, but help needed at state level as well

• Clear understanding of how costs flow over an episode and by primary diagnosis
  – RUGs system hampers better understanding of costs

Opportunity/Challenge: Achieving Scale in VBP

Natural desire to cherry-pick most favorable scenarios can decrease volume of value-based care

Need to increase volume to diversify risk and achieve operational critical mass
VBP Landscape Summary

• VBP is both a challenge and an opportunity
  – High-performing providers will get in preferred networks based on quality and cost; others may get left out
  – Avoiding hospitalizations is a major area of opportunity

• Medicare has developed the know-how and data infrastructure and will accelerate VBP implementation; other payers are already following suit
  – Policies that are impediments to VBP will be changed

• Scale matters—certain markets will reach a tipping point quicker than others due to the interactive effect of payment initiatives and providers’ and plans’ ability to scale their care redesign

Medicare Value-Based Initiatives

FFS, Bundling, and ACOs
Value-Based Changes Are Already Underway for Medicare Fee-for-service

• Hospitals face reimbursement penalties based on 30-day readmissions rates for five diagnostic categories (with list likely to grow)
  – Diagnostic categories include acute myocardial infarction (AMI), heart failure (HF), and pneumonia (PN); COPD and elective total hips and knees
  – Formula calculates up to 3% payment hit based on three-year rolling average

• For 2015, hospitals are subject to a new adjustment based on Medicare spending per beneficiary
  – Directly incorporates efficiency of care across an episode that includes post-acute care
  – Further sensitizes hospitals to impact of downstream care

SNFs Will Eventually Have Readmission Penalties As Well

• SNF value-based purchasing, included in Protecting Access to Medicare Act of 2014 and the subject of a recently proposed SNF PPS rule, will eventually lead to reimbursement changes

• Two measures under consideration (both using 30 days):
  – All-cause, all-condition hospital readmission measure
  – All-condition, risk-adjusted potentially preventable hospital readmission rate

• Confidential reporting by October 1, 2016
• Incorporated into payments by October 1, 2018
  – Higher of improvement or attainment
  – Will include rankings and is funded by rate withholds
Medicare Bundled Payments for Care Improvement (BPCI) Initiative

• Established as a three-year, voluntary demonstration program by Centers for Medicare & Medicaid Innovation (CMMI)

• Four models to choose from:
  – Specifications vary by model, with upfront discounts of 2%–3% depending on model type and episode length
  – Most attention has been focused on Model 2 (hospital initiated) and Model 3 (post-acute initiated)
  – Opportunity for providers, including physician group practices (PGPs) to directly take risk as well

Bundles Occur for Diagnostic Categories Over an Episode

• Diagnostic categories are selected from one of 48 possible diagnostic groups
  – Major joint replacement of the lower extremity has been the most popular so far

• Episodes are 30, 60, or 90 days in length
  – Triggered by “episode initiating” anchor admission to hospital

• **Base Period** target price is compared to **Performance Period** expenditures on an apples-to-apples basis
  – Reconciliation occurs after the fact
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Model 2 Versus Model 3

**Model 2**
Bundle Holder/At-risk Entity = Hospital

- Episode-Initiating Hospital Admission
- PAC Services
- Physician Services
- Readmissions
- Other Services*

Initiated by Hospital with hospital admission

Model 3
Bundle Holder/At-risk Entity = PAC Provider

- Episode-Initiating PAC Service
- Other PAC Services
- Physician Services
- Readmissions
- Other Services*

Initiated by SNF/HHA admission after hospital discharge

**Note:** Bundle holders may put in place contracts with downstream providers in which they share both financial risk and reward for episodes

* Includes Part B drugs, hospital outpatient services, DME, and laboratory services, hospice and unrelated conditions excluded

Model 2 and Model 3 Bundling Are Virtual Programs

In Models 2 and 3 bundling, **no money changes hands upfront**

- All providers are paid through regular fee-for-service rules and coverage criteria

- Bundling is a retrospective calculation where actual fee-for-service expenditures for each quarterly performance period are compared to target prices with an upfront discount
Bundlers Must Select Diagnostic Families in Advance (48 Possible – listed in Appendix)

<table>
<thead>
<tr>
<th>Diagnostic Families (aka Clinical Episodes)</th>
<th>Percentage of At-Risk Model 2 Bundlers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major joint replacement of the lower extremity</td>
<td>86%</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>34%</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease, bronchitis, asthma</td>
<td>25%</td>
</tr>
<tr>
<td>Simple pneumonia and respiratory infections</td>
<td>21%</td>
</tr>
<tr>
<td>Hip and femur procedures except major joint</td>
<td>18%</td>
</tr>
<tr>
<td>Revision of the hip or knee</td>
<td>16%</td>
</tr>
<tr>
<td>Coronary artery bypass graft</td>
<td>15%</td>
</tr>
<tr>
<td>Acute myocardial infarction</td>
<td>15%</td>
</tr>
<tr>
<td>Lower extremity and humerus procedure except hip, foot, femur</td>
<td>13%</td>
</tr>
<tr>
<td>Double joint replacement of the lower extremity</td>
<td>12%</td>
</tr>
<tr>
<td>Removal of orthopedic devices</td>
<td>12%</td>
</tr>
<tr>
<td>Stroke</td>
<td>12%</td>
</tr>
<tr>
<td>Sepsis</td>
<td>12%</td>
</tr>
</tbody>
</table>

These percentages will likely change as more bundlers move to risk in 2015

Bundling FFS Patients After “Anchor” Hospitalization in Select Diagnosis

• Beneficiary must be eligible for Part A and be enrolled in Part B
• Beneficiary must not:
  – Qualify for Medicare solely through ESRD
  – Be enrolled in any managed care plan
• Beneficiary must have had an applicable anchor inpatient hospital admission

Beneficiaries must be informed about bundling and may opt out of care redesign activities, but will still be included in bundling reconciliations if otherwise eligible.
Services Included in Target Prices and Performance Period Claims

- Inpatient hospital services (Model 2 only)
- Post-acute care services
  - SNF
  - HHA
  - IRF
  - LTACH
- Inpatient hospital readmission services
- Physicians’ services
- DME
- Clinical laboratory services
- Outpatient services
- Part B drugs

Exclusions for:
- Unrelated conditions for each diagnostic condition
- Part D drugs
- Hospice claims

Target Price for Each Diagnosis Is Compared to Actual Expenditures

Reconciliations are quarterly and start 6 months after end of episode; adjusted up to 3 additional quarters as additional claims filed

<table>
<thead>
<tr>
<th>Target Price</th>
<th>$19,000 (base period costs) less CMS 3% discount</th>
<th>$18,400</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1, Patient 1</td>
<td>Actual fee-for-service spending during episode</td>
<td>$20,000</td>
</tr>
<tr>
<td></td>
<td>Amount to be paid back to CMS at reconciliation</td>
<td>($1,600)</td>
</tr>
<tr>
<td>Quarter 1, Patient 2</td>
<td>Actual fee-for-service spending during episode</td>
<td>$15,000</td>
</tr>
<tr>
<td></td>
<td>Amount of gain to bundler at reconciliation</td>
<td>$3,400</td>
</tr>
<tr>
<td>Quarter 1 Total Reconciliation</td>
<td>Net amount to be gained by/(paid back from) bundler</td>
<td>$1,800</td>
</tr>
</tbody>
</table>
Medicare’s Bundling Program Illustrates Many Key VBP Topics

- **Base or target price** – benchmark (with upfront discount) for performance period comparison purposes
- **Risk tracks** – tradeoff between risk and opportunity
- **Outliers** – process to mitigate effect of extreme cases
- **Exclusions** – method to factor out low volume, high cost events unrelated to care of the episode in question
- **Post-episode spending** – process to ensure that costs do not get shifted out of performance period
- **Precedence** – rules to establish which entity gets the case when multiple entities are possible
- **Target price erosion** – process by payers to recover system-wide savings over and above upfront discount

Providers Can Directly Take Risk or Deal with Intermediary Conveners

**naviHealth**

- Navigator and bundler of post-acute services
- Accepts financial risk through capitated contracts from health plans; bundled payment arrangements with hospitals/health systems and CMS
- Manages patients and risk via robust predictive analytics tools, proprietary patient assessment tools that match patient characteristics to resource needs, and field-based case managers who serve as resources to facility staff
- [http://navihealth.us/](http://navihealth.us/)

**remedy partners**

- Develops/manages bundled payments programs in partnership with hospitals, physician groups, health systems, skilled nursing facilities, and home health agencies
- Operates the nation's largest bundled payment program, with 22 live programs and more than 500 in development
- [http://remedypartners.com/](http://remedypartners.com/)
Potential Roles for Post-acute: Vendor or EIP to Model 2 & 3 Main Option *Today*

**Model 2**
- **Episode Integrated Provider (EIP)** to Model 2 Bundler (preferably with gainsharing)
- **Vendor** to Model 2 Bundler (accept referrals according to criteria)
- **Partner** to Model 2 Bundler (create and control bundling structure)

**Model 3**
- **Model 3 Awardee or Awardee Convener** (accept risk, control gains)
- **Model 3 Facilitator Convener** (gather together risk taking post-acute providers)
- **Vendor or Episode Integrated Provider** to **Model 3 Awardee**

Care Redesign Is Integral to Bundling

- Reinforces
- Informs

- Gain and Risk Sharing

- Quality and Performance Measurement

- Data Sharing
  Supports all Activities and Exchanges

Source: CMS, Contracting for Bundled Payment, 2011
Care Coordination Throughout Episode Is a Consistent Strategy

- Manage transitions
  - Between acute care and post-acute care
  - Coordination with primary care and specialty care
- Reinforce teaching and self-care
- Assure medication reconciliation at every transition
- Assure appropriate follow-up
- Some bundlers are contracting for care management services

Bundlers Need to Identify Who Is Most at Risk for Rehospitalization

- Stable
  - Goal: Support

- Rising Risk
  - Goal: Early Intervention

- High Risk
  - Goal: Stabilize
**Example of Simple Risk Stratification Form**

**Discharge Risk Assessment** (to be completed 2 days prior to discharge)

**CHECK ALL THAT APPLY:**
- Lives at home with limited or no community support
- Requires assistance with medication management
- Polypharmacy (greater than 7 medications)
- History of mental illness
- Issues with health literacy
- Requires assistance with ADLs/ADL’s
- Cognitive impairment
- End stage condition
- Diagnoses of CHF/COPD/diabetes/HIV/AIDS
- Incapacitated
- Acute/chronic wound or pressure ulcer
- History of falls
- Decreased adherence to treatment plan
- Repeat hospitalizations/ED visits
- Requires assistance in management of Oxygen and/or nebulizer

**TOTAL # CHECKED = **

**SCORE ≥ 5**
- The patient is HIGH RISK for rehospitalization.
- Refer to home care services immediately.

**SCORE of 2 - 4**
- The patient is at MODERATE RISK for rehospitalization.
- Refer to home care prior to discharge.

**SCORE < 2**
- The patient is LOW RISK for rehospitalization.
- Discharge to community.

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**Bundlers Must Realign Practice Patterns to Prepare Patient for Next Setting**

Utilize common care pathways and teaching tools across the continuum

**What is the right length of stay in each setting across the continuum?**
Telehealth: An Emerging Strategy in Care Redesign

OIG Waivers allow bundlers to provide beneficiary with incentivizing services and equipment during the episode if related to care redesign.

Early Results: Model 2 Bundling Is Changing PAC Relationships & Use

Model 2 hospitals and physician groups are forming new partnerships with post-acute care (PAC) providers by:

- Discussing quality with the PAC providers likely to receive their patients, even if the providers were not contractually involved in bundling
- Identifying higher quality providers for preferred list, although they must maintain patient choice
- Use of institutional post-acute care (SNF, LTACH, IRF) after the acute care stay fell from 66 to 47 percent of episodes, use of HHA after acute care stayed about the same
- Total spending for episodes with post-acute care fell in comparison to the base period by more than the comparison group (while episodes without post-acute care stayed about the same)

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**Medicare and Commercial ACOs Continue to Grow**

© HDG 2015 May 19, 2015

446 Medicare ACOs Serving 47 States

© HDG 2015 May 19, 2015

Source: CMS.gov, January 2015

© 2015 Health Dimensions Group
General Medicare ACO Requirements

Requirements:
- **Accountable** for quality, cost, and care
- **Legal structure** to receive and distribute incentives
- ** Sufficiency of PCPs** to accept a minimum of 5,000
- Promote **evidence based medicine & patient engagement**
- **Patient-centered** care processes
- **Leadership** and management structure
- **Report on quality** measures and other performance data
- **Three-year agreement**

Payment Structure:
- Medicare FFS + shared savings
- Per beneficiary cost benchmark established annually by CMS
- Must exceed minimum savings rate AND meet quality performance goals to be eligible for shared savings

Pioneer & MSSP Performance:
Quality Improvements Outpace Shared Savings

**Year 1 Results for 220 MSSPs Starting in 2012 or 2013**
- 53 held spending $652 million below targets and earned >$300 million in shared savings
- 1 MSSP in Track 2 overspent its target by $10 million and owed Medicare shared losses of $4 million
- Medicare Trust Fund saved $345 million
- Improvement on 30 of 33 quality measures, including patient rating of clinician communication & of doctor, health promotion & education, screening for tobacco use and screening for high blood pressure

**Year 2 Results for 23 Pioneer ACOs**
- 11 held spending $96 million below targets and earned $68 million in shared savings
- 3 Pioneer ACOs generated shared losses
- Medicare Trust Fund saved $41 million
- Improvement on 28 of 33 quality measures, including screening for future fall risk, screening for tobacco use, patient experience in health promotion and education and controlling blood pressure
CMS Has Proposed Changes Designed to Drive Growth in ACOs

- CMS proposed changes December 8, 2014, including provisions to encourage greater ACO participation by:
  - Allowing ACOs to continue longer with only upside risk
  - Reducing risk under two-sided model
  - Potentially allowing higher risk sharing rate and prospective assignment of beneficiaries
  - Requiring ACO applicants to describe how they will partner with LTC and post-acute providers to better coordinate care
- CMS also proposing “Next Generation ACOs” to experiment with new ways to share risk

Case Studies: ACOs and Post-acute Care

- **Franciscan Alliance ACO** (Indiana)
  - Narrowed network through thoughtful process from 30 to 10 PAC providers, initially using a survey and then on an ongoing basis by monitoring metrics important to the ACO
  - Achieved significant reductions in LOS for SNFs (42 to 28 days) as well as readmissions rates
  - Family and patient satisfaction with discharge management has also improved
  - ACO/PAC relationship is becoming increasingly collaborative by focusing on customer service, improved transitions, two-way communication using EMRs, implementing INTERACT and risk stratification protocols across PAC network and improving patient activation & health literacy
  - Acuity of referrals to SNFs is changing
    - e.g., 24/7 respiratory therapy and ventilator patients
Case Studies: ACOs and Post-acute Care

• Banner Health Network Pioneer ACO (Phoenix)
  - Initially offered basic rate withhold model to SNFs, which is now evolving into a more sophisticated use of case mix adjusted readmission and LOS metrics to allow providers to recover the withhold and achieve a bonus

• Monarch Pioneer ACO (CA)
  - Developed a post-acute network, which includes a targeted care management strategy based on risk stratification
  - Initial overall cost savings were largely achieved as a result of SNF utilization reductions
  - Looking at optimizing 3-day SNF waiver

Source: Norris Vivatrat, MD, Pioneer ACOs, A Review of the Grand Experiment, January 2014

New York’s VBP Roadmap

A Path toward Value Based Payment

New York State Roadmap

For Medicaid Payment Reform

© HDG 2015

May 19, 2015
DSRIP is Driving Medicaid VBP in NY

- On April 14, 2014, New York and CMS reached agreement on waiver that allows the State to reinvest $8 billion for comprehensive Medicaid delivery and payment reform
- **Delivery System Reform Incentive Payment** (DSRIP) program promotes community-level collaborations and aims to reduce avoidable hospital use by 25% over five years, while financially stabilizing the state’s safety net
- Safety net providers have come together in 25 Performing Provider Systems (PPSs), covering the whole state, to implement innovative projects focusing on system transformation, clinical improvement, and population health improvement
- All DSRIP funds are based on performance linked to achievement of project milestones

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**NYS Value-Based Roadmap Menu of Options**

- **Integrated Primary Care, including integrated care for:**
  - Diabetes
  - Asthma
  - Hypertension
  - Depression
  - Chronic Heart Failure
  - Coronary Artery Disease
  - COPD
  - Arrhythmia
  - GERD
  - Low Back Pain
  - Osteoarthritis
- **Care Bundles – Episodic:**
  - Maternity Care
  - Depression
- **Care Bundles – Specialty Chronic:**
  - Hemophilia
  - Chronic Kidney Disease
  - Bipolar Disorder
  - Substance Abuse
- **Total Care for Subpopulations:**
  - HIV/AIDS
  - Multimorbid disabled/frail elderly (MLTC/FIDA population)
  - Severe BH/SUD conditions (HARP population)
  - Care for the Developmentally Disabled (DISCO population)
### NYS VBP Roadmap: Moving from Shared Savings to Assuming Risk

<table>
<thead>
<tr>
<th>Options</th>
<th>Level 0 VBP</th>
<th>Level 1 VBP</th>
<th>Level 2 VBP</th>
<th>Level 3 VBP*</th>
</tr>
</thead>
<tbody>
<tr>
<td>All care for total population</td>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings when outcome scores are sufficient</td>
<td>FFS with risk sharing (upside available when outcome scores sufficient; downside is reduced when outcomes scores are high)</td>
<td>Global capitation (with outcome-based component)</td>
</tr>
<tr>
<td>Integrated primary care</td>
<td>FFS (+ PMPM subsidy) with bonus and/or withhold based on quality scores</td>
<td>FFS (+ PMPM subsidy) with upside-only shared savings based on total cost of care (savings available when outcome scores sufficient)</td>
<td>FFS (+ PMPM subsidy) with risk sharing based on total cost of care (upside available when outcome scores are high)</td>
<td>PMPM capitated payment for primary care services (with outcome-based component)</td>
</tr>
<tr>
<td>Episodic care</td>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings based on bundle of care (savings available when outcome scores sufficient)</td>
<td>FFS with risk sharing based on bundle of care (upside available when outcome scores sufficient; downside is reduced when outcomes scores are high)</td>
<td>Prospective bundled payment (with outcome-based component)</td>
</tr>
<tr>
<td>Total care for subpopulation</td>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings based on subpopulation capitation (savings available when outcome scores sufficient)</td>
<td>FFS with risk sharing based on subpopulation capitation (upside available when outcome scores sufficient; downside reduced when outcome scores high)</td>
<td>PMPM capitated payment for total care for subpopulation (with outcome-based component)</td>
</tr>
</tbody>
</table>

*NYS Value Based Roadmap, Third Draft March 2015, pg. 17

*only feasible after experience with Level; requires mature PPS

---

### NYS VBP Roadmap: Possible Contracting Combinations

<table>
<thead>
<tr>
<th>Integrated Primary Care</th>
<th>A beneficiary can only be attributed to one IPC provider at a time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episodic Bundle/ Specialty Chronic Care Bundle</td>
<td>A beneficiary will be expected to keep IPC services (e.g., non-related preventive activities, diabetes treatment) A beneficiary may receive two or potentially more episodes simultaneously; In some cases, a second episode (&quot;stroke&quot;) will be deemed to be a potential complication of a first episode (&quot;pregnancy &amp; delivery&quot;)</td>
</tr>
<tr>
<td>Subpopulation</td>
<td>This type of care is so comprehensive that a distinctive IPC role is difficult to care out TBD on the basis of the analyses: Some episodes (e.g., maternity care) may be so distinctive that they could be &quot;carved out&quot; A beneficiary can only be attributed to one sub-population at a time</td>
</tr>
</tbody>
</table>

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Overlapping Structures Will Make Navigating DSRIP/VBP Challenging

- Detailed rules for attributing covered lives among the menu of options will need to be created
  - Similar to precedence issue in bundling
- Multiplicity of contracting options within Performing Provider Systems further adds to the complexity

<table>
<thead>
<tr>
<th>Contracting at the PPS level</th>
<th>A PPS enters into a value-based arrangement (e.g. integrated primary care, total care for the total population, a bundle of care, care for a specific subpopulations) All providers within the PPS are held to the terms of that contract.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negotiating standard VBP terms with the PPS for direct MCO-Provider contracting</td>
<td>The PPS works with the MCO on how to contract with providers within the PPS on a value-based arrangement. Within that framework, MCOs can contract directly with combinations of providers to deliver that care.</td>
</tr>
<tr>
<td>No contracting at the PPS level</td>
<td>The PPS has no responsibilities for the contracting of a value-based arrangement. MCOs contract that care directly with combinations of providers within the PPS.</td>
</tr>
</tbody>
</table>

Comments on VBP Roadmap

- General support for concept, with the understanding that the Roadmap will be a living document
- Significant concerns about:
  - Ability to effectuate meaningful savings for medically complex persons requiring LTPAC
  - Readiness by LTPAC providers
  - Lack of data infrastructure
  - Impact of overlapping structures of FIDA IDT, DSRIP, MLTC
  - Integration with Medicare VBP policies
- Key recommendations include:
  - Redefine Level 1 VBP for persons requiring LTC, including considering P4P model
  - Develop VBP readiness checklist to guide providers and MCOs
  - Provide explicit funding for training and development of all-payor administrative databases
  - Align FIDA and VBP Roadmap expectations and timelines
  - Align with Medicare, including readmissions and IMPACT assessment strategy
  - Expand eligibility for VBP Innovator program
Other Medicaid Programs Have Begun to Adopt VBP Strategies

• Arkansas has a functioning example of Medicaid value-based payment system that is designed to work with multiple payers
• Uses concept of “principal accountable provider” to sort out who gets the bundle
• Providers are ranked by episodic cost after meeting quality threshold
• Applies to about a dozen chronic care conditions, with more to come

NY Nursing Home Quality Initiative: Example of Level 0 VBP Approach

• Quality (70 points)
  – 14 measures are calculated from MDS 3.0 data, NYS employee flu vaccination data, cost reports (contract/agency staff used) and the CMS five-star quality rating for staffing
  – Nursing homes rewarded for achieving high performance as well as improvement from previous years’ performance
• Compliance (20 points)
  – Consists of three areas: CMS five-star quality rating for health inspections, timely submission of cost reports, and employee flu immunization data
• Potentially avoidable hospitalization (10 points)
  – Applies to long-stay nursing home episodes

What will be required to change this to meet Level 1 VBP?
CHHA Medicaid Episodic Payment in VBP Context

• Reflects bundle of services and episodic design for chronic care population
  – Includes many payment features found in VBP
  – Quality metrics could be added to form upside shared savings arrangements, which could make it Level 1 VBP

• Case mix and episodic payment architecture could be applied to other home- and community-based services to form risk-adjusted sub-capitation arrangements
  – If OASIS data is not available, other patient assessment data would have to be obtained (e.g., UAS-NY)
  – Payment rates would have to be calibrated to different bundles

Five Things Post-acute and Long-term Care Providers Should Be Doing Right Now

To Prepare for Value-Based Payment
Five Things to Do Right Now

1. Understand Market Changes
2. Know Your Metrics
3. Conduct Outreach
4. Redesign Care
5. Understand Policy Interactions

Understand Market Changes:
Who Is At Risk in Your Market and What Do They Want?
Bundling Poised for Major Growth in 2015

Model 2
- 2,077 individual episode initiators (89 in NY)
- 695 convened under Remedy Partners (27 in NY)

Model 3
- 4,558 individual episode initiators (109 in NY)
- 2,825 convened under Remedy Partners (55 in NY)

Precedence rules and movement to risk will determine market impact.

The Next Six Months Will Clarify Who Is a Medicare Bundler

Applications were required April 2014
Awardees need to enter risk January, April, or July 2015
Last opportunity to add clinical episodes October 2015

Bundling is not far off in the distance… it is a right-now thing!
How Post-acute Providers Can Succeed in a Value-based Payment World

LeadingAge New York Annual Conference
May 19, 2015

26 Medicare ACOs in NY: Nine Started in 2014 or 2015

<table>
<thead>
<tr>
<th>ACO/HIE Name</th>
<th>Firm Type</th>
<th>City</th>
<th>Start Date</th>
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<td>Asian American Accountable Care Organization</td>
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<td>7/1/2012</td>
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<td>Balance ACO</td>
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<td>Bassett Accountable Care Partners LLC</td>
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<td>Beacon Health Partners LLP ACO</td>
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<td>Chautauqua County Health Network</td>
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<td>Jamestown</td>
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<td>Chinese Community Accountable Care Organization</td>
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<td>Healthcare Provider ACO, Inc.</td>
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<td>HHC Health And Hospitals Corporation ACO, Inc.</td>
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<td>Montefiore Pioneer (Briks) ACO</td>
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<td>Mount Sinai Hospital</td>
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<td>New York State Elite (NYSE) ACO, Inc.</td>
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<td>NewYork Quality Care</td>
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<tr>
<td>Primary PartnersCare Associates IPA Inc</td>
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<td>The Institute For Family Health</td>
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<td>Westmed Medical Group PC ACO</td>
<td>Medicare Shared Savings ACO</td>
<td>Purchase</td>
<td>7/1/2012</td>
</tr>
</tbody>
</table>

Source: Defhc.com, February 2015

Understand Your Options for Gainsharing

- CMS’ and OIG’s views for gainsharing in a bundling context are executed through explicit waivers
- Policy on gainsharing is rapidly evolving as alternate payment approaches flourish (see October 3, 2014 Federal Register)
- In general, gainsharing arrangements must:
  - Have a strong quality component, preferably using evidence-based guidelines
  - Not be created to directly or indirectly induce referrals
  - Not harm the beneficiary

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October 3, 2014 Federal Register

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Managed care for senior populations—both for Medicare and Medicaid, and especially for dual eligibles—continues to expand nationally.

- Despite expectations to the contrary, Medicare Advantage has grown by almost 30% nationally since 2010 and likely to keep growing.
- Pundits with Kaiser speculate that Medicare Advantage enrollment growth will be driven by “the influx of baby boomers who may have greater comfort with managed care plans than previous generations.”

### Medicare Advantage Penetration in NY by County

<table>
<thead>
<tr>
<th>County</th>
<th>Medicare Eligibles</th>
<th>Enrolled in MA</th>
<th>MA Penetration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monroe</td>
<td>142,029</td>
<td>89,741</td>
<td>63%</td>
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<tr>
<td>Erie</td>
<td>185,167</td>
<td>104,362</td>
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<td>Bronx</td>
<td>186,754</td>
<td>100,230</td>
<td>54%</td>
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<tr>
<td>Niagara</td>
<td>46,405</td>
<td>24,600</td>
<td>53%</td>
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<tr>
<td>Ontario</td>
<td>22,836</td>
<td>13,052</td>
<td>57%</td>
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<td>Wayne</td>
<td>20,145</td>
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<td>56%</td>
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<td>Livingston</td>
<td>12,170</td>
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<td>Genesee</td>
<td>12,072</td>
<td>6,640</td>
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<td>Orleans</td>
<td>8,170</td>
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<td>Wyoming</td>
<td>7,946</td>
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<td>Yates</td>
<td>5,423</td>
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<td>Cattaraugus</td>
<td>18,876</td>
<td>7,608</td>
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<td>Chautauqua</td>
<td>29,209</td>
<td>13,079</td>
<td>45%</td>
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<td>12,091</td>
<td>5,313</td>
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<td>29,563</td>
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<td>325,991</td>
<td>141,159</td>
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<td>Seneca</td>
<td>7,049</td>
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<td>Saratoga</td>
<td>41,605</td>
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<tr>
<td>Albany</td>
<td>55,186</td>
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<td>Kings</td>
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<tr>
<td>Madison</td>
<td>12,990</td>
<td>4,560</td>
<td>35%</td>
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<table>
<thead>
<tr>
<th>County</th>
<th>Medicare Eligibles</th>
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<th>MA Penetration</th>
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<tbody>
<tr>
<td>New York</td>
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<td>23,134</td>
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<td>Onondas</td>
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<td>Chemung</td>
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<td>Greene</td>
<td>11,080</td>
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<td>Schuyler</td>
<td>4,327</td>
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<td>Steuben</td>
<td>20,860</td>
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<td>Columbia</td>
<td>14,176</td>
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<td>Schoharie</td>
<td>6,107</td>
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<td>Lewis</td>
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<tr>
<td>Cuyahoga</td>
<td>15,160</td>
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<td>377</td>
<td>26%</td>
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<tr>
<td>Delaware</td>
<td>10,646</td>
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<tr>
<td>Jefferson</td>
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<td>4,604</td>
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<tr>
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<td>162,626</td>
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<td>St. Lawrence</td>
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<td>Sullivan</td>
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</table>
Medicare Advantage Plans May Become Next VBP Frontier for Post-acute Care

- Medicare Advantage remains a “black box” to many post-acute providers due to small scale by a specific plan for any given provider
- As scale grows, Medicare Advantage plans may increasingly copy initiatives like three-day prior stay waiver, bundling, and other alternative payment strategies
  - Medicare Advantage plans are accorded significant payment flexibility under federal law
- Alignment with physicians will become increasingly important

Consider approaching Medicare Advantage & FIDA plans with a simplified version of Medicare’s bundling program

25 Performing Provider Systems (PPS) Under DSRIP – Covers Whole State

| Adirondack Health Institute | Mount Sinai Hospitals Group (includes seven hospitals) |
| Adelphia Community Providers (AW Medical) | Nassau Queens PPS |
| Albany Medical Center Hospital | New York City Health and Hospitals |
| Bronx-Lebanon Hospital Center | Refuah Health Center |
| Catholic Medical Partners-Accountable Care IPA, Inc. | Richmond University Med Center & Staten Island University Hospital |
| Central New York PPS | Samaritan Medical Center |
| Erie County Medical Center Corporation | St. Barnabas Hospital (dba SBH Health System) |
| Finger Lakes PPS | Stony Brook University Hospital |
| iHANY (Ellis & St. Peters) | The New York and Presbyterian Hospital |
| Lutheran Medical Center | The New York Hospital Medical Center of Queens |
| Maimonides Medical Center | United Health Services Hospitals, Inc. |
| Mary Imogene Bassett Hospital | Westchester Medical Center |
| Montefiore Medical Center | |

Source: www.health.ny.gov, 03-03-2015
MLTC and FIDA Enrollment as of April 1, 2015

MLTC Enrollment

- 135,028
- 114,456 in NYC
- 21,572 in rest of state

FIDA

- 4,158 enrollees
- 41,906 opt outs

FIDA Enrollment Slow to Date, But Other States Indicate Growth Is Possible

- Early on in dual eligible programs there can be many opt-outs due to resistance to managed care; examples:
  - **California**—Three months into passive enrollment in 2014, only about 40,000 of estimated 450,000 dual eligibles had opted into the state’s *Cal MediConnect* program and nearly 40,000 had opted out
  - **Massachusetts**—started enrolling residents in its *One Care* demonstration in October 2013 and by May 1, 2014, just 13,000 had signed up and 21,000 had opted out

- Recent reports of dual eligible enrollment show larger estimates of penetration, particularly for states that have more mature programs (e.g., Ohio now close to 70%)

<table>
<thead>
<tr>
<th>State</th>
<th>Current Enrollment</th>
<th>Potential Enrollment</th>
<th>% Enrolled (Full Potential)</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>123,059</td>
<td>350,000</td>
<td>35.2%</td>
</tr>
<tr>
<td>Illinois</td>
<td>66,223</td>
<td>136,000</td>
<td>48.7%</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>17,583</td>
<td>90,000</td>
<td>19.5%</td>
</tr>
<tr>
<td>Michigan</td>
<td>105,000</td>
<td>178,000</td>
<td>58.7%</td>
</tr>
<tr>
<td>New York</td>
<td>406</td>
<td>178,000</td>
<td>0.2%</td>
</tr>
<tr>
<td>Ohio</td>
<td>66,892</td>
<td>114,000</td>
<td>58.7%</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>28,000</td>
<td>53,600</td>
<td>0.2%</td>
</tr>
<tr>
<td>South Carolina</td>
<td>83</td>
<td>168,000</td>
<td>0.0%</td>
</tr>
<tr>
<td>Texas</td>
<td>78,600</td>
<td>34.2%</td>
<td></td>
</tr>
<tr>
<td>Virginia</td>
<td>25,877</td>
<td>78,600</td>
<td>34.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>301,123</strong></td>
<td><strong>1,301,200</strong></td>
<td><strong>23.1%</strong></td>
</tr>
</tbody>
</table>

Source: Health Management Associates, February 2015
How Post-acute Providers Can Succeed in a Value-based Payment World

LeadingAge New York Annual Conference
May 19, 2015

Know Your Metrics
Over an Episode and by Primary Diagnosis

PAC Spending Varies by Condition

Post-acute often the most variable component and typically best aligned to address readmission challenges

Stroke
Hip and Femur Proc.
Cardiac Bypass
Heart Failure

Source: MedPAC September 2012; MedPAC Analysis of 2004-2006 5% Medicare claims files
Costs Vary by Initial Post-acute Setting

Average Medicare Episode Payment for MS-DRG 291 (CHF) by First-PAC-setting for 30-day Fixed-length Episodes (2007-2009)

<table>
<thead>
<tr>
<th>Setting</th>
<th>Average Medicare Episode Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHA</td>
<td>$13,470</td>
</tr>
<tr>
<td>SNF</td>
<td>$20,318</td>
</tr>
<tr>
<td>IRF</td>
<td>$33,295</td>
</tr>
<tr>
<td>LTCH</td>
<td>$45,293</td>
</tr>
<tr>
<td>STACH</td>
<td>$23,679</td>
</tr>
<tr>
<td>Community</td>
<td>$12,388</td>
</tr>
</tbody>
</table>

Overall Average = $14,928

Notes: Dobson | DaVanzo analysis of research-identifiable 5 percent SAF for all sites of service, 2007-2009, wage index adjusted by setting and geographic region, and standardized to 2009 dollars.

As Referral Patterns Change, Plan on Your Metrics Changing

National Averages of Medicare FFS
First Care After Hospitalization: Skilled Nursing Facility
7/1/2009–6/30/12

<table>
<thead>
<tr>
<th>MS-DRG No.</th>
<th>MS-DRG Name</th>
<th>Readmissions Rate Over 90 Days from SNF Admission</th>
<th>SNF Average LOS Over 90 Days from SNF Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Lower ADL Score</td>
<td>Higher ADL Score</td>
</tr>
<tr>
<td>469</td>
<td>Major joint replacement or reattachment of lower extremity with major complication or comorbidity</td>
<td>18%</td>
<td>24%</td>
</tr>
<tr>
<td>470</td>
<td>Major joint replacement or reattachment of lower extremity without major complication or comorbidity</td>
<td>10%</td>
<td>16%</td>
</tr>
</tbody>
</table>

Percent Difference -44% -36% -24% -24%

NOTE: Higher ADL score cutoff is ADL sum from RUGS IV >10
Source: Dobson DaVanzo analysis of Medicare limited data set
National Averages for SNF-Initiated 90-day Episodes by Major Group

Acute Hospital Readmission Rate

<table>
<thead>
<tr>
<th>Major Group</th>
<th>Total</th>
<th>Surgical</th>
<th>Respiratory</th>
<th>Medical</th>
<th>Low Cost Ortho</th>
<th>Infection</th>
<th>High Cost Ortho</th>
<th>Cardiac</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac</td>
<td>31.4%</td>
<td>25.5%</td>
<td>30.0%</td>
<td>28.3%</td>
<td>33.2%</td>
<td>31.4%</td>
<td>27.7%</td>
<td></td>
</tr>
<tr>
<td>Low Cost Ortho</td>
<td>33.2%</td>
<td>33.2%</td>
<td>33.2%</td>
<td>33.2%</td>
<td>33.2%</td>
<td>33.2%</td>
<td>33.2%</td>
<td></td>
</tr>
<tr>
<td>Infection</td>
<td>28.3%</td>
<td>28.3%</td>
<td>28.3%</td>
<td>28.3%</td>
<td>28.3%</td>
<td>28.3%</td>
<td>28.3%</td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>28.3%</td>
<td>28.3%</td>
<td>28.3%</td>
<td>28.3%</td>
<td>28.3%</td>
<td>28.3%</td>
<td>28.3%</td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td>33.2%</td>
<td>33.2%</td>
<td>33.2%</td>
<td>33.2%</td>
<td>33.2%</td>
<td>33.2%</td>
<td>33.2%</td>
<td></td>
</tr>
</tbody>
</table>

Episode Spending With/Without an Acute Care Hospital Readmission

<table>
<thead>
<tr>
<th>Major Group</th>
<th>Total</th>
<th>Surgical</th>
<th>Respiratory</th>
<th>Medical</th>
<th>Low Cost Ortho</th>
<th>Infection</th>
<th>High Cost Ortho</th>
<th>Cardiac</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac</td>
<td>$51,354</td>
<td>$51,354</td>
<td>$51,354</td>
<td>$51,354</td>
<td>$51,354</td>
<td>$51,354</td>
<td>$51,354</td>
<td>$51,354</td>
</tr>
<tr>
<td>Medical</td>
<td>$51,354</td>
<td>$51,354</td>
<td>$51,354</td>
<td>$51,354</td>
<td>$51,354</td>
<td>$51,354</td>
<td>$51,354</td>
<td>$51,354</td>
</tr>
</tbody>
</table>

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Source: Dobson | DaVanzo analysis of Medicare claims data (100% file - July 2009 through June 2012)

May 19, 2015

National Averages for HHA-Initiated 90-day Episodes by Major Group

Acute Hospital Readmission Rate

<table>
<thead>
<tr>
<th>Major Group</th>
<th>Total</th>
<th>Surgical</th>
<th>Respiratory</th>
<th>Medical</th>
<th>Low Cost Ortho</th>
<th>Infection</th>
<th>High Cost Ortho</th>
<th>Cardiac</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac</td>
<td>31.5%</td>
<td>29.0%</td>
<td>28.0%</td>
<td>28.0%</td>
<td>28.0%</td>
<td>31.5%</td>
<td>24.6%</td>
<td></td>
</tr>
<tr>
<td>Low Cost Ortho</td>
<td>28.0%</td>
<td>28.0%</td>
<td>28.0%</td>
<td>28.0%</td>
<td>28.0%</td>
<td>28.0%</td>
<td>28.0%</td>
<td></td>
</tr>
<tr>
<td>Infection</td>
<td>28.0%</td>
<td>28.0%</td>
<td>28.0%</td>
<td>28.0%</td>
<td>28.0%</td>
<td>28.0%</td>
<td>28.0%</td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>28.0%</td>
<td>28.0%</td>
<td>28.0%</td>
<td>28.0%</td>
<td>28.0%</td>
<td>28.0%</td>
<td>28.0%</td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td>28.0%</td>
<td>28.0%</td>
<td>28.0%</td>
<td>28.0%</td>
<td>28.0%</td>
<td>28.0%</td>
<td>28.0%</td>
<td></td>
</tr>
</tbody>
</table>

Episode Spending With/Without an Acute Care Hospital Readmission

<table>
<thead>
<tr>
<th>Major Group</th>
<th>Total</th>
<th>Surgical</th>
<th>Respiratory</th>
<th>Medical</th>
<th>Low Cost Ortho</th>
<th>Infection</th>
<th>High Cost Ortho</th>
<th>Cardiac</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
</tr>
<tr>
<td>Low Cost Ortho</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
</tr>
<tr>
<td>Infection</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
</tr>
<tr>
<td>Medical</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
</tr>
<tr>
<td>Respiratory</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
<td>$5,846</td>
</tr>
</tbody>
</table>

© HDG 2015

Source: Dobson | DaVanzo analysis of Medicare claims data (100% file - July 2009 through June 2012)

May 19, 2015
Managed care organizations, ACOs, and bundlers will pay attention in four key areas:

- **Length of Stay**
  Time frames typically less than that of fee-for-service (20%–30% less)

- **Unnecessary Hospitalization**
  Managing the patient aggressively in situ

- **Patient Outcomes (versus inputs)**
  Performance better than your peer group on their scale

- **Episodic Management Capabilities**
  Capacity to manage seamlessly across multiple settings
Redesign Care
Start With Reducing Avoidable Readmissions

Post-acute Care Provider Care Redesign Strategies

- Palliative Care
- Tele-health
- Care Coordination Role
- Health Coach Certification
- Care Pathways
- INTERACT 4.0
- PCP/NP On-site Access
- Risk-Stratification
- INTERACT Home Health
- Patient Education Teach-Back

Evidence-Based Care Practices
Opportunity: Bundlers and ACOs May Work Together

• CMS policy is to only pay once for savings, so it has decided to recoup duplicate savings from the bundler when those savings have been achieved for a beneficiary also enrolled in an ACO that has achieved its savings target.

• The duplicate recovery from bundlers is modest and generally should not dissuade bundlers from developing win-win relationships with ACOs.
  – Bundlers can be instrumental in helping ACOs achieve their shared savings targets.
Waivers Offer Opportunities for Changing Care and Increasing Value Proposition

• Modification of three-day qualifying stay for Medicare SNF
  – Allows SNF coverage for one- or two-day prior acute stay for Model 2 bundlers
  – Allows direct admission to qualifying SNF providers for Pioneer ACOs

• Post-discharge home visits
  – Allows billable visits monthly throughout episode which can be delegated by physicians to other clinicians

• Telehealth
  – Waives geographic restrictions on telehealth providing that all other Medicare coverage requirements apply

Summing It Up: Transition to VBP Requires Careful Navigation

• Requires real-time knowledge of who is in a bundle, ACO, Medicare Advantage, or FFS upon admission and…

• Broad-based application of care redesign and targeted interventions to those who are at higher risk of poor outcome all the way through the episode

• Knowledge of pertinent quality & utilization metrics in comparison to peers will be crucial

• Getting a seat at the table with risk-taking entities is critical
Success Will Be Defined by Delivering Quality Outcomes and Value

Wrap-up and Discussion
For More Information

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Appendix
### How Post-acute Providers Can Succeed in a Value-based Payment World

LeadingAge New York Annual Conference
May 19, 2015

---

#### 48 Possible DRG Families for Bundling

<table>
<thead>
<tr>
<th>Major Group Names</th>
<th>DRG Family Name</th>
<th>Number of MS-DRGs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low-Cost Ortho</strong></td>
<td>Back &amp; neck except spinal fusion</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Combined anterior posterior spinal fusion</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Major joint replacement of the lower extremity</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Major joint replacement of the upper extremity</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Other knee procedures</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Revision of the hip or knee</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Spinal fusion (non-cervical)</td>
<td>2</td>
</tr>
<tr>
<td><strong>High-Cost Ortho</strong></td>
<td>Cervical spinal fusion</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Complex non-cervical spinal fusion</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Double joint replacement of the lower extremity</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Hip &amp; femur procedures except major joint</td>
<td>3</td>
</tr>
<tr>
<td><strong>Respiratory</strong></td>
<td>Chronic obstructive pulmonary disease, bronchitis, asthma</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Other respiratory</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Simple pneumonia and respiratory infections</td>
<td>6</td>
</tr>
<tr>
<td><strong>Surgical</strong></td>
<td>AICD generator or lead</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Amputation</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Coronary artery bypass graft</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Cardiac defibrillator</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Cardiac valve</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Major bowel procedure</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Major cardiovascular procedure</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Other vascular surgery</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Pacemaker</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Pacemaker device replacement or revision</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Percutaneous coronary intervention</td>
<td>6</td>
</tr>
</tbody>
</table>

---

#### (continued)

<table>
<thead>
<tr>
<th>Major Group Names</th>
<th>DRG Family Name</th>
<th>Number of MS-DRGs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiac</strong></td>
<td>Acute myocardial infarction</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Cardiac arrhythmia</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Chest pain</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Congestive heart failure</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Stroke</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Syncope &amp; collapse</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Transient ischemia</td>
<td>1</td>
</tr>
<tr>
<td><strong>Infection</strong></td>
<td>Cellulitis</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Sepsis</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Urinary tract infection</td>
<td>2</td>
</tr>
<tr>
<td><strong>Medical</strong></td>
<td>Atherosclerosis</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Diabetes</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Esophagitis, gastroenteritis and other digestive disorders</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Fractures of the femur and hip or pelvis</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Gastrointestinal hemorrhage</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Gastrointestinal obstruction</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Medical non-infectious orthopedic</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Medical peripheral vascular disorders</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Nutritional and metabolic disorders</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Red blood cell disorders</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Renal failure</td>
<td>3</td>
</tr>
</tbody>
</table>
HOSPITALITY

STEWARDSHIP

INTEGRITY

RESPECT

HUMOR