Value-Based Payment Educational Webinar Series: #1
What Value-Based Payment Means to Post-Acute and Long Term Care
LeadingAge New York

Brian Ellsworth, MA, Director, Payment Transformation
Beth Carlson, EdD, RN, NHA, Director, Consulting Services
Health Dimensions Group

Your Presenters Today

Brian Ellsworth, MA
Director, Payment Transformation
Health Dimensions Group

Beth Carlson, EdD, RN, NHA
Director, Consulting Services
Health Dimensions Group
First in a Series of Four Webinars

Webinar 1
- What Value-Based Payment (VBP) Means to Post-Acute and Long Term Care

Webinar 2
- Bundled Payments as a Platform to Understanding VBP

Webinar 3
- New Models of Care Under VBP

Webinar 4
- Understanding Risk in a Value-Based World

Structure for Today’s Presentation

Introduction to Value-Based Purchasing

Value-Based Payment Models in Medicare

NY’s Value-Based Payment Roadmap

Readiness for Value-Based Transformation
Introduction to Value-Based Purchasing

What Is Value-Based Purchasing?

Value-based purchasing refers to a broad set of performance-based payment strategies that link financial incentives to providers’ performance on a set of defined measures.
The System Is Transitioning from Fee-for-Service to Value-Based Care

**Fee-for-Service (Bill Units and Get Paid)**
- Maximize revenue by driving volume
- Acute care-centric delivery system
- Uncoordinated care
- Limited home and community-based (HCB) care

**Value-Based Care (Payment Linked to Outcomes and Cost)**
- Value-based partnerships that minimize unnecessary care
- Persons as partners in their care
- Population health managers; care management across the continuum
- Chronic and palliative care in HCBS settings

Shift to Value-Based Payments Entails Measuring Quality and Imposing Risk

- **Fee-for-Service**
  - No financial risk
  - No quality measures
  - Payment tied to quality
- **Pay-for-Performance**
  - More financial risk
  - Shared savings
  - Episodes of Care
- **Shared Risk**
  - Global payments
Medicare Refers to Value-Based Payments as Alternative Payment Methods (APMs)

**Goal: 50% Alternative Payment by 2018**

- **2016**
  - Alternative Payment: 30%
  - Link to Quality: 50%
  - No Link to Quality: 20%

- **2018**
  - Alternative Payment: 85%
  - Link to Quality: 90%
  - No Link to Quality: 15%


CMS Established Health Care Payment Learning Action Network (HCP LAN)

*CMS is developing a framework for alternative payment models in an effort to accelerate implementation across the health system*

If you want to learn more about VBP, consider signing up for this network: https://publish.mitre.org/hcplan/
Broad-Based Private Task Force Sets VBP
Goal of 75% by 2020

Guiding Principles
- Shift 75% of our respective businesses to be under value-based care contracts by 2020
- Design programs that provide reasonable returns to deliver the triple aim of better health, better care and reduced total cost of care at or below GDP growth
- Equip market players with all tools necessary to compete in new market focused on person-centered primary care
- Encourage multi-payer participation and alignment to create common targets, metrics, and incentives
- Share cost savings with patients, payers, and providers to ensure adequate investment in new care models
- Foster transparency of quality and cost metrics in a manner that is accessible to, and easily understood by, consumers
- Support the needs of disadvantaged populations and help strengthen the safety net providers who serve them


Medicaid Programs Have Adopted Value-Based Purchasing Strategies

- **Arkansas** and **Tennessee** have functioning example of Medicaid value-based payment system designed to work with multiple payers
  - Providers ranked by episodic cost after meeting quality threshold
  - Applies to about a dozen chronic care conditions typical of an under-65 population, with more expected to be added

- **New York State** is expecting that 80%–90% of Medicaid payments be made under value-based framework within 5 years

Value-Based Payment Requires:
New Language and Payment Processes

Value-Based Payment Is Helped By:
Standardized Data and Quality Metrics

Improving Post-Acute Care Transformation Act (IMPACT) of 2014
Robust exchange of diagnostic and other clinical information across settings in real time through interoperable EMRs

- Is this admission an accountable care organization (ACO) or bundled patient?
- Health information exchanges (HIEs) are struggling to achieve scale and competing with closed systems
- LTPAC providers have been left out of much of the HITECH and other funding of health information technology

Value-Based Preparedness Scorecard

<table>
<thead>
<tr>
<th>Basic</th>
<th>Advanced</th>
</tr>
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<tbody>
<tr>
<td>✓ Preferred provider to hospital, bundler, or ACO</td>
<td>✓ Electronic medical record capable of 2-way exchange of clinical information</td>
</tr>
<tr>
<td>✓ Active implementation of protocol to prevent avoidable hospitalizations</td>
<td>✓ Routine risk stratification of admissions</td>
</tr>
<tr>
<td>✓ Measurement of outcomes in comparison to peers</td>
<td>✓ Standardized care pathways</td>
</tr>
<tr>
<td>✓ Able to view to clinical information from upstream providers</td>
<td>✓ Comprehensive discharge planning and follow-up process</td>
</tr>
</tbody>
</table>

| Very Advanced: Gainsharing arrangement; taking risk under bundling; value-based contracting with Medicare Advantage or SNP |
**Value-Based Payment Trends in Medicare**

FFS, ACOs, Bundling, Managed Care

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**Value-Based Changes Already Underway:**
*Medicare FFS Payments to Hospitals*

- Hospitals face reimbursement penalties (up to 3%) based on 30-day readmission rates for 5 diagnostic categories.
- For 2015, hospitals subject to new adjustment based on Medicare spending per beneficiary (MSPB).
- Government Accountability Office (GAO) found "modest" effects from hospital value-based purchasing program to date, but that may change over time.
- Hospital VBP adjustments are useful conversation starters between hospitals and post-acute care.
SNF Value-Based Purchasing: Based Solely on 30-Day Readmissions

- SNF value-based purchasing, included in Protecting Access to Medicare Act (PAMA) of 2014 and subject of recently finalized SNF PPS rule, will lead to rewards and penalties
  - Final rule adopts “30-day all-cause, all-condition hospital readmission measure” derived from claims data
- Confidential reporting first, then incorporated into payments by October 1, 2018
  - Will reflect improvement or attainment
  - Will include rankings and be funded by rate withholds
- INTERACT is becoming the de facto industry standard suite of tools for readmissions prevention

Home Health Value-Based Purchasing: Model Recently Finalized by CMS

- Under this new mandatory program, home health agencies in nine states* would experience up to +/- 3% Medicare payment adjustment (starting in 2018), eventually ramping up to +/- 8% adjustment (in 2022)
- Attainment and improvement on quality metrics determines whether rates will be increased or decreased
- Quality measures:
  - 6 process and 15 outcome measures
  - 3 new measures, including Advance Care Planning (for age 65+ patients who have an advance care plan or surrogate or documentation of about such)

*States are: Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington
Medicare Physician Payments: 
Undergoing VB Change As Well

MACRA of 2015 provides automatic 5% lump sum bonus to physicians (starting 2019) who receive significant portion of their revenue from alternative payment models (such as bundled payment or ACOs) and, for those who do not, potentially rewards or penalizes physicians by up to +/- 9% depending on their Merit-based Incentive Payment System (MIPS) score.

Intent is drive physicians to value-based behavior through multiple pathways

Accountable Care Organizations Are Growing

Current Growth

Future Growth

Source: Growth and Dispersion of Accountable Care Organizations in 2015, David Muhlestein, Health Affairs Blog, March 31, 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>Balance ACO</td>
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<td>Montefiore Pioneer (Bronx) ACO</td>
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<td>Mount Sinai Hospital</td>
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<td>Purchase</td>
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</table>

Source: Defhc.com, February 2015

How ACO Shared Savings Works

- Current average per-capita spending for Medicare patients in market area determined from claims for past 3 years
- Patient assigned based on where majority of physician care received
- Spending target determined by CMS
- If actual spending lower than target, savings are shared—IF quality targets also achieved

Adapted from Brookings Institute
CMS Adopted Changes Designed to Drive Growth in ACOs

- CMS finalized changes in May 2015, including provisions that:
  - Create Track 3, which includes higher rates of shared savings, prospective assignment of beneficiaries, and opportunity to use new care coordination tools
  - Streamline data sharing
  - Establish waiver of 3-day stay SNF rule for beneficiaries prospectively assigned to ACOs under Track 3
  - Refine policies for resetting ACO benchmarks
- CMS also implementing Next Generation ACOs to experiment with new ways to share risk

Medicare ACO Performance Results in the News Recently

- Medicare ACOs qualified for more than $422 million in shared savings in 2014 by meeting quality standards and savings threshold:
  - 11 of 20 Pioneer ACOs earned $82 million in shared savings, (Banner $29 million, Montefiore $13 million) while 3 owed $9 million in losses
  - 92 of 333 Medicare Shared Savings Program ACOs earned more than $341 million in shared savings
- Maturation key—ACOs with three years of experience in the program were twice as likely to earn savings than those with one

"Officials at both organizations [Montefiore and Banner ACOs] said performance was boosted by attention to post-acute care costs and quality. Banner Health’s ACO developed a preferred network of skilled-nursing facilities and recommends those facilities to patients."

Case Study ACOs and Post-acute: 
Franciscan Alliance Pioneer ACO (Indiana)

• Narrowed network of PAC providers through thoughtful process, initially by using a survey and then by monitoring metrics:
  – Achieved significant reductions in post-acute LOS and readmissions
  – Improved family and patient satisfaction with discharge care

• ACO/PAC relationship more collaborative by focusing on:
  – Customer service and transitions improvement
  – Two-way communication using EMRs
  – INTERACT and risk stratification protocols implementation
  – Patient activation and health literacy improvement

• Acuity of referrals to institutional post-acute increasing

Case Study on ACOs and Post-acute: 
Monarch Pioneer ACO (California)

• Developed post-acute network, which includes targeted care management strategy based on risk stratification

• Actual medical cost declined 2.8% in first year
  – Driven by lower SNF cost
  – Inpatient and physician expense both declined year over year

• Key drivers of success:
  – Post-acute network selection
  – Performance-based incentives
  – Targeted care management
Medicare Advantage Growing Nationally and in NYS

Medicare Advantage (MA) penetration grew by more than 30% in the last 5 years
Most growth is concentrated in 15 states...NYS is one of them, with 11 upstate counties over 50% MA penetration
Despite enrollment growth, MA remains a “black box” to many post-acute providers

Source: HDG analysis of CMS.gov files as February 2015

Medicare Advantage Plans May Become Next Frontier for Value-Based Payment

• As Medicare Advantage penetration grows, plans will increasingly copy FFS payment initiatives like bundling and other alternative payment strategies
  – Medicare Advantage plans are accorded significant payment flexibility under federal law
  – Special Needs Plans (SNPs) likely to be early adopters of value-based payment strategies
  – Fully Integrated Dual Eligible (FIDA) plans have value-based payment requirement in their contracts, but so far have had significant problems achieving scale (only 7,540 enrollees as of November 2015)

• Value-Based Insurance Design (VBID): CMS recently announced that MA plans in 7 states will be offered flexibility in benefit design (reduce cost sharing or offer extra benefits) so that beneficiaries with certain chronic conditions can be incentivized to pursue high-value treatments

Source: Medicare.gov, October 2011–2015
Examples of Institutional Special Needs Plans (I-SNPs) Value-Based Contracting

**I-SNP A**
- Waives 3-day prior hospital stay and treats resulting skilled stay as Part A stay
- Pays reduced rate for Part A stay according to 4 rate tiers
- Inserts nurse practitioners into facility
- Provides quality incentive payments and upside shared savings

**I-SNP B**
- Waives 3-day hospital stay, but authorizes limited Part A days
- Pays PPS rates and has *Intensive Service* per diem add-on
- Does not provide nurse practitioners, but pays administrative fee for additional chronic care management, credentialing, quality activities
- Shares higher percentage of savings; also requires facility to share in losses

Health Plans Are Now Implementing Large-Scale Shared Savings Programs

- Accountable cost and quality arrangement (ACQA)—ACO look-alike
- Mechanism to organize physicians and operate across payers (e.g., Medicare Advantage and commercial plans)

*This example operates in upstate NY*
Providers Looking at Clinical Integration Strategy for Value-Based Care

- **Pillar 1: Collaborative Leadership**
  - Governance body
  - Compliant legal structure
  - Payer strategy
  - Culture change

- **Pillar 2: Aligned Incentives**
  - Physician compensation
  - Program infrastructure
  - Physician support

- **Pillar 3: Clinical Programs**
  - Disease programs
  - Care protocols
  - Clinical metrics
  - Population health management

- **Pillar 4: Technology Infrastructure**
  - Health information exchange
  - Patient longitudinal record
  - Disease registry
  - Patient portal

**Clinically Integrated Care**

- **Post-Acute Care Providers Are Forming Networks and Integrating Care**

  - Cincinnati-based clinical integration model, LLC entity formed by 3 founding members, with 7 additional SNF participants
  - Centered on value-based shared savings reimbursement:
    - Medicare bundled payment convener
    - Negotiating performance-based reimbursement with Medicare Advantage and MyOhio duals plans
  - Any traditional reimbursement contracts will be messenger model

Number of Bundling Models Continues to Grow

- Medicare Comprehensive Care for Joint Replacement (CJR)
- Medicare Bundled Payments for Care Improvement (BPCI)
- Commercial
- Medicaid
- Medicare Managed Care

Bundling Comes in Many Shapes and Forms

- Can be triggered by presence of chronic condition or occurrence of acute event
  - Medicaid and Commercial payers tend to focus on bundling for chronic care conditions
  - Medicare has focused on episodes after an acute hospitalization (e.g., BPCI is triggered by 1 of 48 hospital events)
- Can be prospective or retrospective
  - Prospective means that the bundler must figure out how to pay other providers in the bundles
- Can have varying episode lengths (30, 60, 90, annual)
- Often factor out unrelated conditions and have ways to mitigate risk
**Medicare Bundled Payments for Care Improvement (BPCI) Initiative**

<table>
<thead>
<tr>
<th>Types of Services Included in Bundle</th>
<th>Model 1 Acute Hospital Stay Only</th>
<th>Model 2 Acute Hospital + Post-Acute</th>
<th>Model 3 Post-Acute Care Only</th>
<th>Model 4 Acute Hospital + Readmissions</th>
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</thead>
<tbody>
<tr>
<td>Inpatient hospital and physician services</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Related post-acute care services</td>
<td>✓</td>
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<td></td>
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<tr>
<td>Related readmissions</td>
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<td>✓</td>
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<tr>
<td>Other services defined in bundle (Medicare Part A &amp; Part B)</td>
<td>✓</td>
<td>✓</td>
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<td>Target to performance payment</td>
<td>Retrospective</td>
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<td>Retrospective</td>
<td>Prospective</td>
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<td>Number of NY participants</td>
<td>42</td>
<td>10</td>
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Established as 3-year, voluntary demonstration program by Center for Medicare & Medicaid Innovation (CMMI)

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**Second Application Period Grew BPCI Significantly**

- **2015**: 1,618 organizations
- **2013**: 214 organizations

- 723 SNFs
- 415 Hospitals
- 305 Physician Groups
- 103 HHAs
- 9 IRFs
- 1 LTCH

CMS has indicated that another round of bundling is possible after evaluation of current participants...

Source: CMS BPCI newsletter November 2015, Ed. 7

© HDG 2015  December 16, 2015
At-Risk Bundlers in NYS:
42 Model 2 (13 PGP)

<table>
<thead>
<tr>
<th>PGP Organization Name</th>
<th>#</th>
<th>City</th>
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<tbody>
<tr>
<td>Rockland Orthopedics &amp; Sports Medicine</td>
<td>1</td>
<td>Armonk</td>
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<td>Orthopedics New York, LLP</td>
<td>1</td>
<td>Albany</td>
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<tr>
<td>Exigence Hospitalist Medical Services of Hornell, PLLC</td>
<td>7</td>
<td>Amherst</td>
</tr>
<tr>
<td>UHS - United Health Services Medical Group</td>
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<td>Binghamton</td>
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<tr>
<td>Syracuse Orthopedic Specialists, PC</td>
<td>5</td>
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<tr>
<td>Exigence Hospitalist Medical Services of Lewiston, PLLC</td>
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<td>Advanced Orthopedics &amp; Sports Medicine, PLLC</td>
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<td>Northeast Orthopedic &amp; Sports Medicine, PLLC</td>
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<td>Premier Orthopaedics of Westchester and Rockland</td>
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<td>Orangefield Orthopedic Associates</td>
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<td>Clarkstown Orthopedics</td>
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# = Number of diagnostic categories at risk

At-Risk Bundlers in NYS:
10 Model 3 (1 PGP)

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<tr>
<th>PGP Organization Name</th>
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<tr>
<td>UHS - United Health Services Medical Group</td>
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<td>Binghamton</td>
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<table>
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<td>Village Center for Care</td>
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<td>New Hyde Park</td>
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<td>Belair Nursing &amp; Rehabilitation Center</td>
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<td>Melville</td>
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# = Number of diagnostic categories at risk
Bundlers Were Required to Select Diagnostic Families by October 1, 2015
(48 “Clinical Episodes” Possible)

<table>
<thead>
<tr>
<th>Diagnostic Families (aka Clinical Episodes)</th>
<th>Percentage of Model 2 (Hospital/PGP) Bundlers Selected Episode</th>
<th>Percentage of Model 3 (Post-Acute/PGP) Bundlers Selected Episode</th>
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<tbody>
<tr>
<td>Major joint replacement of the lower extremity</td>
<td>68%</td>
<td>58%</td>
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<tr>
<td>Congestive heart failure</td>
<td>35%</td>
<td>41%</td>
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<tr>
<td>Simple pneumonia and respiratory infections</td>
<td>34%</td>
<td>47%</td>
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<tr>
<td>Chronic obstructive pulmonary disease, bronchitis, asthma</td>
<td>32%</td>
<td>39%</td>
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<tr>
<td>Hip and femur procedures except major joint</td>
<td>27%</td>
<td>36%</td>
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Top 5 DRG Groups Are Bundled by Both Acute Model 2 and Post-Acute Model 3

Source: CMS analytic files, October 13, 2015; CMS BPCI newsletter November 2015, Ed. 7

Roles for Post-acute in Model 2 & 3 BPCI:
Vendor or EIP Until Another Round of BPCI Permitted

**Model 2**
- **Episode Integrated Provider** to Model 2 hospital or physician group practice (PGP), preferably with gainsharing
- **Preferred Vendor** to Model 2 hospital or PGP by accepting referrals and effectively managing care

**Model 3**
- **BPCI Awardee** (accept risk, control gains)
- **Episode Integrated Provider** to Model 3 awardee (e.g., SNF or HHA to Model 3 PGP)
- **Preferred Vendor** to Model 3 PGP or PAC (e.g., HHA to SNF)
Care Redesign Is Integral to Value-Based Transformation

- Data Sharing Supports all Activities and Exchanges
- Gain and Risk Sharing
- Quality and Performance Measurement
- Reinforces
- Informs

Care Redesign

Early Results: Medicare Bundling Will Change Post-acute Care Utilization

- First CMS evaluation of BPCI for small number of ortho bundlers showed that institutional PAC (SNF, LTACH, IRF) fell by 30%; use of HHA stayed about the same
- Cleveland Clinic Model 2 BPCI results for major joint replacement showed that discharges to SNFs dropped by 45% while discharges to home/home with HHA increased by 75%; Montefiore Model 2 BPCI results similar
- Recent letter to JAMA about NYU’s Model 2 BPCI program shows 49% and 34% reductions in discharges to institutional PAC for cardiac valve and joint replacement episodes, respectively

Caution: Early results are heavily influenced by ortho bundles and possible selection bias; nonetheless, the results and our experience with bundling indicates that bundling can drive market shifts
Waivers Offer Opportunities for Changing Care and Increasing Value Proposition

- Modification of 3-day qualifying stay for Medicare SNF:
  - Allows SNF coverage for 1-day or 2-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

Gainsharing in VBP Context: Expansion Will Take Time

- Gainsharing in a bundling and ACO context executed through waivers and will become more widespread after excess capacity is squeezed out first
- Policy on gainsharing is rapidly evolving as alternate payment approaches flourish
- In general, gainsharing arrangements must:
  - Have strong quality component, preferably using evidence-based guidelines
  - Not be created to directly or indirectly induce referrals
  - Not harm beneficiary
New CMS Bundling Program: Comprehensive Care for Joint Replacement (CJR)

Finalized for April 1, 2016, implementation

**Mandatory Program**
First mandatory demonstration, requiring participation from all hospitals in 67 metropolitan regions

**Hospitals Bear Financial Risk**
Hospitals must bear risk for hospital care and 90 days post-discharge for MS-DRGs 469 and 470 (major lower joint replacement)

**Shared Savings Directly Tied to Quality Measures**
To qualify for realized savings, hospitals must meet specified quality measure performance targets

Source: https://innovation.cms.gov/initiatives/cjr

Two CJR Regions in NYS

- **New York-Newark-Jersey City, NY-NJ-PA**
  - 70 Hospitals in NY portion of MSA

- **Buffalo-Cheektowaga-Niagara Falls, NY**
  - 8 Hospitals
Episodic View of Joint Replacement Demonstrates Opportunities/Threats

Medicare Spending for 90-Day Episodes by First Setting after Hospitalization

- Joint Replacement with Comorbidity (DRG 469)
- Joint Replacement without Comorbidity (DRG 470)

Source: Dobson | DaVanzo analysis of Medicare Limited Data Set, 2011–2013

CJR Will Likely Drive Care to Lower Cost Settings...
Especially for Elective Hip and Knee Replacements

SNF & IRF Care
Home Health
Outpatient Therapy
Multiple Medicare VBP Programs Can Operate at the Same Time

Overlap Between BPCI and CJR Is Example of Complicated Interactions
Bundlers and ACOs May Work Together

- CMS permits a beneficiary to be in BPCI/CJR and ACO at the same time
- Policy is to **only pay once for savings**, so CMS will recoup duplicate savings from the bundler when achieved for a beneficiary also enrolled in an ACO **that has achieved its savings target**
  - Duplicate savings recovery is the shared savings proportion (usually 50%) times the BPCI discount (2%–3%), so it is 1.0%–1.5% recovery from the bundler
- Since bundlers can be instrumental in helping ACOs achieve their shared savings targets, this recovery should not dissuade bundlers and ACOs from developing win-win relationships

Medicare Value-Based Payment Landscape Summary

- Both a **challenge** and an **opportunity**
  - High-performing providers will get in preferred networks based on quality and cost—others may get left out
  - Providers must navigate transition risk
  - Avoiding hospitalizations is a major area of opportunity
- Medicare has developed **know-how** and data infrastructure and will **accelerate** VBP implementation; other payers are already following suit
- **Scale matters**—certain markets will reach tipping point quicker than others due to interactive effect of payment initiatives and providers’ ability to scale their care redesign
**New York’s Value-Based Roadmap**

**Medicaid Payment Reform**

A Path toward Value Based Payment

New York State Roadmap For Medicaid Payment Reform

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**NYS’ Value-Based Payment (VBP) Goals: “Win-win, no haircut”**

- Approved by CMS in July 2015
- 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 in 5 years
  - Level 1 means some linkage to quality with the opportunity for upside shared savings
- 35% to 70% of total payments to be captured in Level 2+ VBPs
  - Level 2 means linkage to quality; with both upside and downside risk
- Goals to be evaluated each year, with annual reports to CMS
Key to Understanding VBP Roadmap: 
**DSRIP Is Driving the VBP Agenda**

- 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 5 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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NY VBP Goals Are Financed by Value Creation

- **Start Here**: Feds approve $8B DSRIP Plan
- **VBP Roadmap**
  - Providers achieve shared savings
  - NYS premium bump to MCOs/MLTC
  - Level 1 & 2 VBP goals
- **End Here**: NYS premium bump to MCOs/MLTC
NY’s Value-Based Payment (VBP) Roadmap Will Have Menu of Options

- **Integrated Primary Care, including for:**
  - Diabetes
  - Asthma
  - Hypertension
  - Depression
  - Chronic Heart Failure
  - Coronary Artery Disease
  - COPD
  - Arrhythmia
  - GERD
  - Low Back Pain
  - Osteoarthrosis
- **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)
### Roadmap Defines Four Levels of VBP

<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 outcome 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 sufficient; downside reduced when outcome scores are high)</td>
<td>PMPM capitated payment for primary care services (with outcome-based component)</td>
</tr>
<tr>
<td>Acute and chronic bundles</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 reduced when outcome scores are high)</td>
<td>Prospective bundled payment (with outcome-based component)</td>
</tr>
<tr>
<td>Total care for sub-population</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>

*only feasible after experience with Level; requires mature PPS

**NYS Value Based Roadmap, June 2015, pg. 15**

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### Value-Based Roadmap: NYS Will Create Benchmarks Based on Attributed Lives

- NYS will create benchmarks for VBP arrangements by measuring key metrics of attributed Medicaid patients in base period
- Benchmarks will be risk-adjusted as necessary and may be further adjusted by value modifiers to account for initial performance levels
- During the performance period, quality measures and costs will be compared to target metrics and, depending on the level of the arrangement, savings will be shared or payments due

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**Shared Savings Benchmark**

- **Target**
- **Actual**

**Opportunity for Shared Savings**

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VBP Example of Linkage of Quality and Savings: Level 1 Calculation

- **Greater than 50% of quality measures attained**
  - Up to 50% of shared savings with provider

- **Less than 50% of quality measures attained**
  - Between 0% and 50% of savings shared

- **Overall outcomes worsen**
  - No savings are shared with provider

Residual balances of shared savings inure back to Medicare or Medicaid in proportion to contribution

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VBP Roadmap Envisions Many Possible Contracting Combinations

<table>
<thead>
<tr>
<th>Integrated Primary Care</th>
<th>Episodic Bundle/ Specialty Chronic Care Bundle</th>
<th>Subpopulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A beneficiary can only be attributed to one IPC provider at a time</td>
<td>A beneficiary will be expected to keep IPC services (e.g., non-related preventive activities, diabetes treatment)</td>
<td>A beneficiary receives 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>This type of care is so comprehensive that a distinctive IPC role is difficult to care out</td>
<td>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;</td>
<td>A beneficiary can only be attributed to one subpopulation at a time</td>
</tr>
<tr>
<td>Integrated Primary Care</td>
<td>Episodic Bundle/Specialty Chronic Care Bundle</td>
<td>Subpopulation</td>
</tr>
</tbody>
</table>
### Comments on VBP Roadmap by LeadingAge New York

**General support for concept, with the understanding that the Roadmap will be a living document**

#### Significant Concerns
- 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
- Redefine L1 VBP for persons requiring LTC, including considering P4P model
- Develop VBP readiness checklist
- Provide explicit funding for training and development of all-payer administrative databases
- Align FIDA and VBP Roadmap expectations and timelines
- Align with Medicare initiatives and IMPACT Act
- Expand eligibility for VBP Innovator program

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### The Value-Based Challenge for NYS MLTC Population: Most Are Duals

Primary opportunity for value creation for many MLTC providers is impacting avoidable hospitalizations, which creates Medicare savings, but has cost implications for Medicaid

![Graph showing Medicaid-only MLTC Beneficiary Costs and Volume](Source: NYSDOH MLTC Clinical Advisory Group, November 2015)
Medicare-Medicaid Alignment Paper Submitted by NY to CMS

Two Main Proposals:

- NYS proposes to allow its providers and MCOs on voluntary basis to include Medicaid beneficiaries in CMS innovative payment models
  - Already included in Roadmap as off-menu options that would be automatically accepted as valid Level 1 or higher VBP arrangements

- In parallel, NYS requests CMS to allow NYS providers on voluntary basis to include Medicare FFS beneficiaries in the VBP arrangements outlined in NYS Payment Reform Roadmap
  - Proposal seeks to include both Medicare-only and duals in NY VBP arrangements, with NYS taking facilitative role in tracking Medicare shared savings

Source: NYSDOH Medicare Alignment Paper (v4) sent to CMS August 2015

VBP Is Potentially an Alternative to Market Pressures on SNFs

- Transition of nursing home benefit to managed care, along with blended rate cell for MLTC, create risk that use of nursing homes will be reduced by MLTC plans

- For 3 years after the transition to mandatory enrollment, MLTC plans are required to pay either:
  - Benchmark rate, or
  - Negotiated rate, which only applies to alternative payment arrangements (e.g., sub-capitation, managed FFS/ACO, and bundling)
VBP Roadmap: What’s Next?

• Recommendations from various workgroups will float up to overall workgroup
  – MLTC Clinical Advisory Group examining regulatory reform and VBP design for MLTC population
• Benchmarking data and model contracts to be developed
• 2–3 pilots per VBP arrangement (e.g., chronic bundles, integrated primary care, maternity bundles) in 2016
  – MLTC likely to go last, possibly 2017, due to need to get Medicare data
• VBP Innovator program to be initiated; aimed at large systems, IPAs willing to undertake significant L2/L3 risk

Readiness for Value-Based Transformation

Refining Your Value Proposition
What Problems Are We Trying to Solve Through Care Redesign?

- Poor communication among providers, patients, and families
- Failure to catch problems early and to address psychosocial issues
- Lack of coordinated, longitudinal care management
- Insufficient management of multiple medications
- Deviations from evidence-based care
Four Key Elements to Transforming Care

- Robust care redesign that targets avoidable hospitalizations in all settings and transitions
- Know outcomes and costs by diagnosis category
- Prepare the patient and family for the next level of care and get them there as quickly as safely possible
- Risk stratify using data analysis and customizing intensity of interventions

Opportunities and Risks in Various Value-Based Arrangements

<table>
<thead>
<tr>
<th>Value-Based Arrangement</th>
<th>Opportunities</th>
<th>Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Narrow Networks</td>
<td>Increased referrals</td>
<td>Being left out of network</td>
</tr>
<tr>
<td>Pay-for-Performance</td>
<td>Achieve bonus</td>
<td>Not attaining quality or utilization thresholds</td>
</tr>
<tr>
<td>Gainsharing</td>
<td>Share in gains through aligned incentives</td>
<td>Not attaining quality or utilization thresholds, Inadequate risk or inflation adjustment, Compliance risk</td>
</tr>
<tr>
<td>Bundles/Episodic Payments</td>
<td>Positive reconciliations</td>
<td>Small numbers risk</td>
</tr>
<tr>
<td></td>
<td>Learning how to take risk and think episodically</td>
<td>Ineffective care redesign</td>
</tr>
<tr>
<td></td>
<td>Access to market data</td>
<td>Target price erosion</td>
</tr>
<tr>
<td>Sub-capitation</td>
<td>Achieve surplus through care redesign</td>
<td>Ineffective care redesign, Regulatory or market barriers to innovation, Inadequate risk or inflation adjustment</td>
</tr>
</tbody>
</table>
Value-Based Transformation Checklist

✓ Become highly knowledgeable about value-based payment transformation occurring in your market
✓ Obtain data and develop analytic capacity to support articulation of your organization’s value proposition
✓ Undergo clinical and operational transformation by implementing standardized care pathways and protocols for reduction of avoidable hospitalizations
✓ Engage referring health systems and at-risk payers
✓ Define path to implement VBP arrangements for majority of your payers

The secret is paddling faster and harder than the current around you
Value-Based Payment Webinar Series

Webinar 1  December 16, 2015  What Value-Based Payment (VBP) Means to Post-Acute and Long Term Care

Webinar 2  January 2016  Bundled Payments as a Platform to Understanding VBP

Webinar 3  February 2016  New Models of Care Under VBP

Webinar 4  March 2016  Understanding Risk in a Value-Based World

Thank You!

Any Additional Questions?
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 and divestiture
- Interim management

For More Information

Brian Ellsworth, MA
Director, Payment Transformation
Health Dimensions Group
860.874.6169 cell
bellsworth@hdgi1.com

Beth Carlson, EdD, RN, NHA
Director, Consulting Services
Health Dimensions Group
763.201.1985
612.723.1779 cell
bethc@hdgi1.com

www.healthdimensionsgroup.com
@HDGConsulting
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