May 24, 2016

Value-Based Payments: Where Are We Now?

LeadingAge New York
2016 Annual Conference & Exposition

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

Our Presentation Today Builds Upon Value-Based Payment Webinar Series

<table>
<thead>
<tr>
<th>Webinar 1</th>
<th>December 16, 2015</th>
<th>What Value-Based Purchasing Means to Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Webinar 2</td>
<td>January 20, 2016</td>
<td>Bundling as a Platform for Understanding VBP</td>
</tr>
<tr>
<td>Webinar 3</td>
<td>March 1, 2016</td>
<td>New Models of Care Under Value-Based Purchasing</td>
</tr>
<tr>
<td>Webinar 4</td>
<td>March 23, 2016</td>
<td>Understanding Risk in a Value-Based World</td>
</tr>
<tr>
<td>Webinar 5</td>
<td>Date TBD</td>
<td>VBP Case Studies &amp; Readiness Guide Walkthrough</td>
</tr>
</tbody>
</table>
What’s New With Value-Based Payments?

- Medicare Continues Toward APM Goals
- NY’s Value-Based Payment Roadmap
- Readiness of Plans & Providers for VBP

Attributed to Mark Twain...

“If you don't like the weather in New England now, just wait a few minutes.”

Same could be said about value-based purchasing!
Value-based purchasing (VBP) refers to a broad set of performance-based payment strategies that link financial incentives to providers' performance on a set of defined measures.

Medicare Continues Towards Alternative Payment Method Goals

IMPACT Act for Post-Acute
Physician Proposed Rule
Accountable Care
Bundling
Medicare Continues to March Towards Its Goals for “Alternative Payment Models”

Alternative Payment Method Goals for Medicare Fee-for-Service Program

2016 Goal Already Met

Medicare Continues to March Towards Its Goals for “Alternative Payment Models”

Alternative Payment Method Goals for Medicare Fee-for-Service Program

2016 Goal Already Met

Alternative Payment & Service Models: Expansion Likely After Evaluation

- Centers for Medicare & Medicaid Services (CMS) Innovation Center is testing 25+ major payment & service delivery models and other initiatives under authority of the Affordable Care Act

- Each model will be comprehensively evaluated and could be expanded if certified by the CMS Actuary to be effective at:
  - Improving quality without increasing spending; or
  - Reducing spending while maintaining quality of care

Through Health Care Learning Action Network (LAN) and other initiatives, multi-payer adoption of value-based purchasing strategies is being actively encouraged
IMPACT Act Drives Changes for Post-Acute: Value-Based Payments and Much More

Bi-partisan statute enacted in 2014 requires:

- Development of uniform quality and resource measures
- Core set of assessment items across settings
- Detailed timelines and objectives

IMPACT Act is intended to facilitate:

- Interoperable, reusable core data set
- Creation of site-neutral payment policies
- Value-based payment approaches
- Improved care transitions and hospital discharge planning

Medicare Is Already Changing Publicly Reported Quality Metrics

- On March 3, CMS announced changes to quality measures for SNFs
  - Publicly reported as of April 1, 2016
  - Will affect 5-star rating as of July 1, 2016
- Last July, CMS implemented star ratings for certified home health agencies (CHHAs)

SNF Value-Based Payment in Proposed Rule:
Law Requires Implementation by 2018

• Proposed rule updates previously proposed all-cause readmissions with SNF 30-day Potentially Preventable Readmission Measure (PPRM)
  - Measure would be risk-adjusted and calculated using full year of data
    - Achievement threshold 20%*
    - Benchmark threshold 16%*
  - Rate adjustments will be funded by 2% withhold, with exact parameters for redistribution yet to be established

<table>
<thead>
<tr>
<th>Implementation</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Period</td>
<td>2015</td>
</tr>
<tr>
<td>Performance Period</td>
<td>2017</td>
</tr>
<tr>
<td>Affects Rates</td>
<td>2019</td>
</tr>
</tbody>
</table>

IMPROVEMENT versus ATTAINMENT are rewarded through a scoring methodology

*Approximate thresholds derived from proposed rule, subject to change

SNF Quality Reporting Program (QRP):
Three New Measures Proposed Starting in 2018*

Discharge to community
- Successful discharge to community with no unplanned readmission or death within 31 days of discharge from SNF

Medicare spending per beneficiary (MSPB)
- MSPB-PAC SNF measures episode of SNF care and associated services

Potentially preventable readmissions
- Risk adjusted potentially preventable unplanned readmissions within 30 days of SNF discharge

All measures are derived from claims data in 2017 for FY 2018 payment determinations

*Drug regimen review coming in 2020
Medicare Spending Per Beneficiary (MSPB):
Episodic View of Care & Associated Services


### MSPB-PAC SNF:
Calculation Is Similar to Model 3 Bundling

<table>
<thead>
<tr>
<th>Episode Characteristics</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Event</strong></td>
<td>Day of admission to SNF</td>
</tr>
</tbody>
</table>
| **Episode Window**      | Treatment period: begins at trigger, ends at discharge  
                          | Associated services: begins at trigger, ends 30 days after discharge |
| **Treatment Services**  | Attributed provider: all SNF services  
                          | Other providers: Part B & DME |
| **Associated Services** | Inpatient, outpatient, post-acute, Part B, DME, hospice |
| **Service Exclusions**  | Planned admissions  
                          | Routine management of pre-existing chronic disease  
                          | Genetic, congenital disease  
                          | Some routine screening  
                          | Select services billed first day of HHA |
| **Episode Exclusions**  | Claims outside U.S.  
                          | $0 claims  
                          | Not in FFS for whole episode or Medicare not primary |
| **Claim Exclusions**    | Claims with payment < 0 |
IMPACT Act Key to Large-Scale VBP: Standardized, Interoperable, Reusable Data

Source: CMS, Understanding the IMPACT Act, Special Open Door Forum, February 2, 2016

Physician Payment Rule Recently Finalized: Provides Foundation for Defining APMs

MACRA of 2015 (“Physician Fix”)

- Provides automatic 5% lump sum bonus to physicians (starting 2019) who receive significant portion of their revenue from alternative payment models (APMs), such as bundled payment or accountable care organizations (ACOs); OR

- 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

© 2016 Health Dimensions Group
Continued Growth in Medicare ACOs:  
However, Only 5% Are at Two-sided Risk

- CMS announced 100 new Medicare Shared Savings ACOs for 2016 (89 new in 2015)
  - Total of 434 Medicare Shared Savings Program (MSSP) ACOs
  - 21 Next Generation ACOs, with another round coming
- CMS also recently proposed further adjustments to ACO benchmarking methods, designed to move away from historical data to regional benchmarks
  - Would reward historically efficient regions

First LTPAC-Sponsored Medicare ACO:  
Genesis HealthCare Dives In

- Effective January 1, 2016, program targets long-term care (LTC) residents in 113 Genesis facilities in 4 states (PA, NJ, MD, WV)
- Genesis expects to have 16,000 of their LTC residents (and some post-acute patients) attributed to the ACO based on obtaining a plurality of primary care physician (PCP) visits while residents/patients are seen in the SNF
  - Genesis Physician Services (GPS) providers make approximately 500,000 visits to their LTPAC patients annually, driving attribution
  - Strategy will include after-hours visits, supplemented by telemedicine

“GPS providers have experience in caring for highly complex and costly patient populations. We plan to build upon our Company’s successful experience supporting other institutional managed care programs, such as UnitedHealthcare’s Evercare program, to achieve better outcomes at a lower cost for our long-term care patients in our own program,” continues Feuerman
What’s Next with ACOs?

- Continued maturation, formation of preferred networks, and greater assumption of risk
- Evolution of ACO/post-acute relationship resulting in higher acuity referrals, focus on patient satisfaction, two-way communication via EMRs, and implementation of standardized care pathways
- Better integration with palliative and hospice care through hardwiring palliative consults and promoting advance directives
- CMS will continue to tinker with benchmarking and attribution policies to make ACO model more user-friendly

Bundled Payments for Care Improvement: 
*Episode Triggered by Hospitalization*

- “Clinical episodes” are selected from one of 48 possible diagnostic families and are triggered by anchor hospitalization
- Episodes are 30, 60, or 90 days in length and commence at “episode initiating” provider
- Base period target price (less 2%–3% discount) is compared to performance period expenditures on apples-to-apples basis
Most Frequently Bundled DRGs Are the Same for Acute Model 2 & Post-Acute Model 3

Top 5 DRGs Selected for BPCI (of 48 Possible DRG Groups)

- Model 2
- Model 3

% of Awardees

<table>
<thead>
<tr>
<th>DRG Category</th>
<th>% of Awardees</th>
<th>Model 2 (%)</th>
<th>Model 3 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major joint replacement of the lower extremity</td>
<td>68</td>
<td>58</td>
<td></td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>35</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>Simple pneumonia and respiratory infections</td>
<td>34</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease, bronchitis, asthma</td>
<td>32</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>Hip and femur major joint</td>
<td>27</td>
<td>36</td>
<td></td>
</tr>
</tbody>
</table>

Source: CMS Analytic File, October 13, 2015; CMS BPCI newsletter November 2015, Ed. 7

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

Reduce Spend by -2.85%

Source: Budget of the United States Government, FY 2016; http://www.whitehouse.gov/omb/budget
Two Rounds of Voluntary Bundling: Significant Growth So Far

<table>
<thead>
<tr>
<th>2016</th>
<th>1,522 organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>214 organizations</td>
</tr>
</tbody>
</table>

Episode Initiators by Provider Type

- 681 SNFs
- 385 Hospitals
- 283 Physician groups
- 99 HHAs
- 9 IRFs
- 1 LTCH

Care Redesign Strategies

- Transitions management: acute, post-acute, and community
- Coordination with primary and specialty care
- Readmissions prevention
- Risk stratification
- Patient activation, teaching, and self-care
- Medication reconciliation
- Telehealth

Bundlers Assume Risk for Outcomes Over a Whole Episode
Waiver Opportunities Under Bundling

- 3-Day Hospital Stay
- Home Visits
- Telemedicine
- Gainsharing

SNF 3-Day Stay Waiver in BPCI:
Example of Opportunity & Hidden Risks

- Opportunity for SNFs to increase their value proposition to Model 2 bundlers by admitting persons with 1- or 2-day hospital length of stay & still receive Medicare coverage
- Eligibility for waiver of 3-day stay requirement for Model 2 BPCI is subject to rules:
  - Model 2 bundler must request waiver from CMS and be approved
  - Only applies to DRGs for which the Model 2 bundler is at risk (hospital's DRG assignment could change or be trumped)
  - 51% of SNFs in hospital's referral network for the at-risk diagnostic category must have 3 stars or higher in 7 of last 12 months
- Retroactive denial risk if all of the above rules are not met
Mandatory Bundling Program: Comprehensive Care for Joint Replacement (CJR)

Five-Year Program Went Live April 1, 2016

- **Mandatory Program**: Mandatory demonstration, requiring participation from all inpatient PPS hospitals in 67 metropolitan regions

- **Hospitals Bear Financial Risk**: Hospitals must bear risk for hospital care and 90 days post-discharge for all related costs to joint replacement (MS-DRGs 469 & 470)

- **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](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
Comparison of Key Features Between Model 2 Bundling & CJR

<table>
<thead>
<tr>
<th>Domain</th>
<th>Model 2 BPCI</th>
<th>CJR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation</td>
<td>Voluntary</td>
<td>Mandatory</td>
</tr>
<tr>
<td>Scope</td>
<td>Up to 48 MS-DRG families</td>
<td>Joint replacement only (MS-DRGs 469 &amp; 470)</td>
</tr>
<tr>
<td>Length of bundle</td>
<td>30, 60, or 90 days</td>
<td>90 days</td>
</tr>
<tr>
<td>Target price</td>
<td>Own historical data (2009–2012 trended)</td>
<td>Phase-in to trended regional prices</td>
</tr>
<tr>
<td>Reconciliation</td>
<td>Quarterly</td>
<td>Annual</td>
</tr>
<tr>
<td>Gainsharing</td>
<td>Allowed under waivers</td>
<td>Allowed under waivers</td>
</tr>
<tr>
<td>Hospice</td>
<td>Excluded</td>
<td>Included</td>
</tr>
<tr>
<td>Three-day SNF waiver</td>
<td>Majority of SNFs must be rated 3 stars or higher</td>
<td>SNFs must be rated 3 stars or higher (starts 2017)</td>
</tr>
</tbody>
</table>

CJR Has Direct Linkage of Payment to Quality

- Quality linkage is accomplished through creation of “composite” quality score, encompassing both joint replacement complications and patient satisfaction
- Gains are limited to only those hospitals that achieve minimum composite quality scores
- Additional incentive payments available for those hospitals with higher composite quality scores
Joint Replacement Bundler Strategies

- Increase discharges to home and/or outpatient therapy
- Develop tight relationship with preferred downstream providers
- Improve pre-operative care for elective cases
- Reduce costs of supplies (e.g., implants)
- For more complicated cases, or those lacking support at home, use SNFs with 7 day/week access to physicians; trained staff; and customer-friendly facilities

Source: Adapted from Ehrlich, Developing an Elective Joint Replacement Program, 2015

Early Evidence on Episodic Bundling: Savings Driven by Changing Use of Post-acute

- First CMS evaluation of BPCI for small number of orthopedic bundlers showed:
  - Institutional post-acute care fell by 30%
  - HHA use stayed about the same*
- Recent letter to JAMA about NYU’s Model 2 BPCI program shows 34% reduction in discharges to institutional post-acute care for joint replacement and 49% reduction for cardiac episodes

Studies repeatedly show that post-acute care is the most highly variable component of Medicare program and thus essential to address in bundling

Impressive Results from a Mature Joint Replacement Bundling Program

Cleveland Clinic’s Experience Under Model 2 BPCI for Major Joint Lower Extremity

<table>
<thead>
<tr>
<th>Year</th>
<th>Baseline Data</th>
<th>Euclid Hospital Results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013</td>
<td>2013</td>
</tr>
<tr>
<td>Quarter</td>
<td></td>
<td>Q1</td>
</tr>
<tr>
<td>Medicare A/B Patients* †</td>
<td>72*</td>
<td>65†</td>
</tr>
<tr>
<td>Caution Rate*</td>
<td>5.2</td>
<td>0</td>
</tr>
<tr>
<td>LOS*</td>
<td>3.40</td>
<td>2.90</td>
</tr>
<tr>
<td>Readmission*</td>
<td>5.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Discharge Disposition Home/HHC*</td>
<td>39%</td>
<td>71%</td>
</tr>
<tr>
<td>Discharge Disposition SNF*</td>
<td>56%</td>
<td>28%</td>
</tr>
<tr>
<td>HCAHPS Overall Rating*</td>
<td>73%</td>
<td>88%</td>
</tr>
</tbody>
</table>

Sources: * Cleveland Clinic; † 2014 Q3 CMS Reconciliation Report 2058-002

Preferred Post-Acute Provider Selection

- Hospital participating in bundled payment carefully selects small group of post-acute providers who will receive most of their referrals
- Preferred provider selection process often includes:
  - Five-star quality rating
  - Readmission rate
  - Medical director
  - Stability of management team
  - Depth and breadth of clinical capabilities
  - Patient satisfaction
Policy on Gainsharing Is Evolving

- Gainsharing in Medicare bundling currently executed through waivers of fraud, waste & abuse laws
- So far, most gainsharing activity in bundling is limited to hospitals and physicians
- Policy on gainsharing is rapidly evolving as alternate payment approaches flourish and may become more widespread

CJR Collaborators:
Next Step in Gainsharing Evolution

- Waives certain fraud, waste & abuse laws
- CJR collaborators must be Medicare providers (includes post-acute care) who are participating in care redesign
- Risk-bearing hospitals can share both upside and downside risk, as well as internally derived cost savings, up to certain limits with CJR collaborators
- Internal cost savings subject to gainsharing must be documented and be verifiable

These policies—though specific to CJR—provide further guidance on the “rules of the road” for gainsharing arrangements
What’s Next in Bundling?

- Continued formation of preferred networks, shifts in referral patterns, and expectation of shorter lengths of stay
- Further evolution of care redesign, risk stratification strategies, and quality metrics
- Increased alignment between ACOs and bundlers
- Evaluation of BPCI by CMS, followed by further growth opportunities
- Increased adoption of bundling and shared savings approaches by Medicare Advantage plans

New York’s Value-Based Roadmap

MLTC Population Poses Some Challenges
NY’s Medicaid VBP Roadmap: Initial Emphasis Is on Shared Savings

- New York State’s VBP Roadmap approved by CMS in July 2015: VBP goals will be embedded into Medicaid managed care contracts
- Statewide goal: 80% to 90% of Medicaid payments be captured in at least Level 1 VBPs in 5 years
  - L1 means some linkage to quality with the opportunity for upside shared savings
- 35% to 70% of total payments to be captured in Level 2+
  - L2 means linkage to quality; with both upside & downside shared risk
- Roadmap is in the process of first annual update

VBP Roadmap Vision of Integrated Delivery System

Source: MLTC Clinical Advisory Group Meeting 4, April 16, 2016
On Menu, Risk-adjusted Target Benchmarks Will Be Established by the State for Use by MCOs

Risk adjustment accounts for variation in acuity

Efficiency & quality adjustments account for differences in starting points

Stimulus adjustment designed to motivate increased risk


Linkage of Quality to Shared Savings:

*Level 1 VBP Example*

Greater than 50% of quality measures attained
- Up to 50% of shared savings (spending is less than target budget) 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 payor
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.

Medicaid-only MLTC Beneficiary Costs
Relative to Dual Eligible MLTC Beneficiary Cost
Total Spend in 2014: $11.3bn

$1.3bn, 13%
$10bn, 89%
= Medicaid-only ■ Dual Eligible

Medicaid-only MLTC Beneficiary Volume
Relative to Dual Eligible MLTC Beneficiary Volume
Total Members in 2014: 238,000

221k, 93%
47k, 7%
= Medicaid-only ■ Dual Eligible

Options Under Discussion for MLTC
Population As Part of Roadmap Update

Initial VBP
- A Home Care organization that can employ innovative care models to delay or prevent nursing home admissions and reduce avoidable hospitalizations.
- A nursing home organization willing to engage in P4P around reducing avoidable hospitalizations, step down/return to community programs, and possible other key quality measures.

Future VBP
- Arrangements with more flexible continuum of services to meet individual needs
- Opportunities for alignment with Medicare may be available

Outstanding Issues Include: P4P Option for Nursing Homes, Necessity for IPA Intermediaries, Integration with Medicare
Next Step for MLTC Population: 
*VBP Pilots*

Continually looking for organizations that are
- Motivated
- Forward thinking
- Focused on member care quality

Next Steps:
- **Summer '16**
  - Potential Pilot Participation Engagement
- **Fall '16**
  - Pilot Planning
- **TBD**
  - Medicare data enhancement capabilities
- **Q1 '17**
  - Pilot Launch

*Source: MLTC Clinical Advisory Group Meeting #4, April 18, 2016*

---

Readiness for 
*Value-Based Purchasing*

Where Are We Going Next?

"This really is an innovative approach, but I'm afraid we can't consider it. It's never been done before."

*Source:* [Image Source]
Value-Based Payment Thrives on Scale: *Which Can Be Challenging to Obtain*

Risk aversion can drive down scale of VBP and lead to unintended vulnerability

Increasing VBP volume diversifies risk and makes it easier to achieve critical mass

One Pathway to Scale: *Clinical Integration*
As Acuity Increases, Provider Performance Must Be Carefully Measured

**Hypothetical Example of a Provider’s Readmissions Rates Before & After Widespread Implementation of Bundling**

<table>
<thead>
<tr>
<th></th>
<th>Before Bundling</th>
<th>After Bundling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>% of Patients</td>
<td>% of Patients</td>
</tr>
<tr>
<td>Low Acuity</td>
<td>70% 14%</td>
<td>30% 11%</td>
</tr>
<tr>
<td>High Acuity</td>
<td>30% 30%</td>
<td>70% 23%</td>
</tr>
<tr>
<td>Provider Total</td>
<td>19%</td>
<td>19%</td>
</tr>
</tbody>
</table>

**Percent Change Readmits**

- Low Acuity: -25%
- High Acuity: -25%
- Provider Total: —

*25% Improvement in performance overshadowed by shift to higher acuity patients*

---

In Your Own VBP Arrangement or Someone Else’s—Performance Matters

**Data**

- E.g., length of stay costs; readmissions rates; costs (by key diagnosis)

**Quality**

- E.g., patient safety (wounds, falls, infections); patient satisfaction; star ratings

**Process**

- E.g., care transitions; care pathways; INTERACT
Value-Based Purchasing Readiness Guide

- As part of the webinar series, a value-based purchasing readiness guide will be made available to LeadingAge NY members
- Guide provides ability to document progress through 8-step process to help your organization with approach and follow-through with value-based payers in your marketplace
- Guide also contains supplement with high-level descriptions of value-based arrangements and guidance on how to identify those players in your marketplace

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  Beth Carlson, EdD, RN, NHA
Director, Payment Transformation  Director, Consulting Services
Health Dimensions Group  Health Dimensions Group
860.874.6169 cell  763.201.1985
bellsworth@hdgi1.com  612.723.1779 cell
bethc@hdgi1.com

www.healthdimensionsgroup.com  
@HDGConsulting
https://www.facebook.com/HealthDimensionsGroup
http://www.linkedin.com/company/health-dimensions-group
HOSPITALITY
STEWARDSHIP
INTEGRITY
RESPECT
HUMOR