Value-Based Purchasing and Bundled Payments

Indiana Association for Home and Hospice Care
2016 Annual Conference & Trade Show
Brian Ellsworth, MA, Director, Payment Transformation
Health Dimensions Group

Structure for Today’s Presentation

Landscape for Value-Based Purchasing
Value-Based Purchasing Strategies Underway
Where Are We Going Next?
What Is 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.
Value-Based Payment (VBP) Links Quality & Risk on a Continuum

- Medicare set a goal of 50% of fee-for-service to be in Alternative Payment Methods (APMs) by 2018
  - Met 2016 goal of 30% APMs in early March 2016
- Broad-based private Health Care Transformation Task Force self-imposed a goal to shift 75% of contracts to value-based methods by 2020
- Medicaid programs such as Tennessee, Ohio, Arkansas, and New York have set ambitious 5-year goals for value-based purchasing
Private Health Care Transformation Task Force Agenda for VBP

- Improve the ACO Model
  - Develop aligned public-private action steps and recommendations to improve the design and implementation of the ACO model

- Develop Common Bundled Payment Framework
  - Create detailed principles and tools to align and evaluate episode definitions/pricing for public/private payer bundled payment programs

- New Model Development - Improving Care for High-cost Patients
  - Create, test and recommend a delivery payment model that allows a wide range of provider organizations, including mental health with far less than 5% penetration, to engage in population health by starting with highest cost patients (top 5%)


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

- BPCI Voluntary Pilot Began
- Second Round of BPCI
- Mandatory Geographic Ortho Bundling
- All Post-Acute Care Providers

© 2016 Health Dimensions Group
**IMPACT Act of 2014: A Potential Game Changer**

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

---

**VBP Requires Standardized Data: IMPACT Act of 2014 Quality & Resource Use**

**Timeline Is Next 1–3 Years**

- SNF: October 1, 2016
- IPP: October 1, 2016
- LTOH: October 1, 2016
- HAH: January 1, 2017

Resource use and other measures will be specified for reporting:

- Total estimated Medicare spending per beneficiary
- Discharge to community
- Measures to reflect all-condition risk-adjusted potentially preventable hospital readmission rates

Source: CMS, Understanding the IMPACT Act, Special Open Door Forum, February 3, 2016
IMPACT Act of 2014 Ultimate Goal: Standardized, Interoperable, Reusable Data

Value-Based Payment Creates Opportunities and Risks
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

VBP Likely To Shift Referral Behavior: Mainly a Question of How Long It Will Take

Comparison of first PAC setting after hospitalization to theoretically most appropriate and cost effective

<table>
<thead>
<tr>
<th>Clinically Appropriate (Simulated) First Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP Therapy</td>
</tr>
<tr>
<td>OP Therapy</td>
</tr>
<tr>
<td>HHA</td>
</tr>
<tr>
<td>SNF</td>
</tr>
<tr>
<td>IRF</td>
</tr>
<tr>
<td>LTCH</td>
</tr>
</tbody>
</table>

Source: Dobson DaVanzo analysis of research-identifiable 5% SAF for all sites of service, 2008. wage index adjusted by setting and geographic region; Clinically Appropriate and Cost Effective Placement, Final Report, Dobson DaVanzo, 2012
Value-Based Purchasing Requires: New Language and Payment Processes

- Select VBP Arrangement
- 3 Years Weighted Baseline
- Target Baseline Performance Adjustments
- Stimulus Adjustment

Risk adjustment accounts for variation in acuity
Efficiency & quality adjustments account for differences in starting points
Stimulus adjustment designed to motivate increased risk


Now Is the Time to Embrace the Opportunities!

- Paralyzed by Confusion
- Embracing the Opportunities
- Happily Existing in Denial
- Resigned to Acceptance

Resiliency

Lower

Upper

Understanding

Greater

© 2016 Health Dimensions Group
Value-Based Purchasing Underway

Fee-for-Service Initiatives
Population Health
Bundling

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 became subject to new adjustment based on Medicare Spending Per Beneficiary (MSPB) as part of Hospital Value-Based Purchasing (VBP) program
Medicare Physician Payments: Rule Recently Finalized

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, 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

Medicare Physician Payments: Rule Recently Finalized

SNF & HHA Value-Based Purchasing: Both Will Affect Payments by 2018

SNF VBP

- Will lead to rewards and penalties initially based on “30-day all-cause, all-condition” hospital readmission measure
  - Confidential reporting first, then incorporated into payments
  - INTERACT is becoming de facto industry standard suite of tools for readmissions prevention

HHA VBP

- New mandatory program in 9 states* where HHAs get up to +/- 3% payment adjustment based on scores
  - Payment adjustment eventually ramps up to +/- 8%
  - Scoring based on 6 process and 15 outcome measures, including new advance care planning measure

Both programs will have process to reward IMPROVEMENT versus ATTAINMENT in measures

*States are: Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington
Indiana Association for Home and Hospice Care
2016 Annual Conference & Trade Show

101: Value Based Purchasing and Bundled Payments
May 10, 2016

464 Medicare ACOs Serving 48 States

Both MSSP and Next Generation ACOs (serving 9 states)
Both MSSP and Pioneer ACOs (serving 1 state)
MSSP, Pioneer, and Next Generation ACOs (serving 5 states)
MSSP ACOs (serving 48 states)
No Medicare ACOs (2 states)

Source: CMS.gov, January 2016

20

23 Medicare ACOs in Indiana:
16 Started Since 2014

<table>
<thead>
<tr>
<th>Medicare ACO</th>
<th>Service Area</th>
<th>Agreement Type</th>
<th>Start Date</th>
<th>ACO Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indiana Rural ACO</td>
<td>IN, KY</td>
<td>Initial</td>
<td>1/1/2016</td>
<td>Nevada City, CA</td>
</tr>
<tr>
<td>Indiana Rural ACO II</td>
<td>IN</td>
<td>Initial</td>
<td>1/1/2016</td>
<td>Nevada City, CA</td>
</tr>
<tr>
<td>Kentucky Physicians for Accountable Care, LLC</td>
<td>IN, KY</td>
<td>Initial</td>
<td>1/1/2016</td>
<td>Louisville, KY</td>
</tr>
<tr>
<td>National Rural ACO 22 LLC</td>
<td>IN, OR</td>
<td>Initial</td>
<td>1/1/2016</td>
<td>Nevada City, CA</td>
</tr>
<tr>
<td>Doctors ACO, LLC</td>
<td>GA, IN, OH</td>
<td>Initial</td>
<td>1/1/2015</td>
<td>Athens, GA</td>
</tr>
<tr>
<td>Franciscan Alliance ACO</td>
<td>IL, IN</td>
<td>Initial</td>
<td>1/1/2015</td>
<td>Indianapolis, IN</td>
</tr>
<tr>
<td>Franciscan Riverview Health ACO</td>
<td>IN</td>
<td>Initial</td>
<td>1/1/2015</td>
<td>Mishawaka, IN</td>
</tr>
<tr>
<td>MissionPoint Evansville, LLC</td>
<td>IL, IN, KY</td>
<td>Initial</td>
<td>1/1/2015</td>
<td>Nashville, TN</td>
</tr>
<tr>
<td>MissionPoint Indianapolis, LLC</td>
<td>IN</td>
<td>Initial</td>
<td>1/1/2015</td>
<td>Nashville, TN</td>
</tr>
<tr>
<td>Reid ACO</td>
<td>IN, OH</td>
<td>Initial</td>
<td>1/1/2015</td>
<td>Nevada City, CA</td>
</tr>
<tr>
<td>Suburban Health ACO</td>
<td>IN</td>
<td>Initial</td>
<td>1/1/2015</td>
<td>Nevada City, CA</td>
</tr>
<tr>
<td>Health Network of Western Kentucky, LLC</td>
<td>IN, KY</td>
<td>Initial</td>
<td>1/1/2015</td>
<td>Owensboro, KY</td>
</tr>
<tr>
<td>CHAACO, LLC</td>
<td>IN, MI</td>
<td>Initial</td>
<td>1/1/2014</td>
<td>South Bend, IN</td>
</tr>
<tr>
<td>Franciscan Select Health Network ACO, LLC</td>
<td>IN, MI</td>
<td>Initial</td>
<td>1/1/2014</td>
<td>South Bend, IN</td>
</tr>
<tr>
<td>Ingalls Care Network, LLC</td>
<td>IL, IN</td>
<td>Initial</td>
<td>1/1/2014</td>
<td>Harvey, IL</td>
</tr>
<tr>
<td>South Bend Clinic Accountable Care</td>
<td>IN, MI</td>
<td>Initial</td>
<td>1/1/2014</td>
<td>South Bend, IN</td>
</tr>
<tr>
<td>ACO Health Partners, LLC</td>
<td>CA, FL, IN, KY</td>
<td>Renewal</td>
<td>1/1/2013</td>
<td>Jacksonville, FL</td>
</tr>
<tr>
<td>Franciscan Union ACO</td>
<td>IL, IN</td>
<td>Renewal</td>
<td>1/1/2013</td>
<td>Indianapolis, IN</td>
</tr>
<tr>
<td>Indiana Care Organization LLC</td>
<td>IN</td>
<td>Renewal</td>
<td>1/1/2013</td>
<td>Indianapolis, IN</td>
</tr>
<tr>
<td>Indiana Lakes ACO</td>
<td>IN, MI</td>
<td>Renewal</td>
<td>1/1/2013</td>
<td>Goshen, IN</td>
</tr>
<tr>
<td>Franciscan AHN ACO, LLC</td>
<td>IN</td>
<td>Renewal</td>
<td>7/1/2012</td>
<td>Mishawaka, IN</td>
</tr>
<tr>
<td>Indiana University Health ACO, Inc.</td>
<td>IN</td>
<td>Renewal</td>
<td>7/1/2012</td>
<td>Indianapolis, IN</td>
</tr>
<tr>
<td>Quality Independent Physicians, LLC</td>
<td>IN, KY</td>
<td>Renewal</td>
<td>7/1/2012</td>
<td>Louisville, KY</td>
</tr>
</tbody>
</table>

**Medicare Shared Savings Program (MSSP):**

*Initials Compared to Annual Spending*

- **Current average per-capita spending for Medicare patients in market area determined from claims for past 3 years**
- **Patient attributed 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**

*Shared savings to be distributed among ACO doctors, hospitals, partners*

---

**CMS Adopted Changes Designed to Drive ACO Growth and Increased Risk**

- In May 2015, accountable care organization (ACO) rules were finalized that encourage more risk taking and use of new care coordination tools
- CMS announced 100 new MSSP ACOs for 2016 (*up from 89 new in 2015*)
  - Total of *434* MSSP ACOs in 2016
  - First post-acute sponsored ACO, Genesis Healthcare, goes online
  - 21 Next Generation ACOs started in 2016, with another round coming

---

Adapted from Brookings Institute
ACOs Take Time to Achieve Results

- About one-third of Medicare ACOs qualified for more than $422 million in shared savings in 2014 by meeting quality standards and savings threshold
- **Maturation** and **focus on post-acute** are keys to success
  - ACOs with 3 years of experience in the program were twice as likely to earn savings than those with 1 year
  - Pioneer ACOs that focused on post-acute have been among the most successful (Banner $29m, Montefiore $13m)

“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.”

(Modern Healthcare, August 25, 2015)

Possible Arrangements with ACOs for Post-acute Care (PAC)

- **Minimal commitment** – no formal arrangement: ACO engages in awareness activities, informing physicians of services billed, historic utilization trends, how a physician compares to his or her peers, readmission rates, and average length of stay in a facility
- **Conditional collaboration**: PAC becomes a preferred provider by adhering to the ACO’s standards and protocols; share data and work together to prevent readmissions, decrease costs, and improve outcomes
- **Partnership**: ACO partners with network of select post-acute providers; the patient EHR is accessible by partners
- **Financial and data integration**: ACO-PAC partnerships include quality measures and shared risk
- **System integration**: ACO formally partners with post-acute providers, sharing risk/reward; integration allows care management teams and transition coordinators to access all patient data
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

Medicare Advantage Growing Nationally and in Indiana

Medicare Advantage (MA) penetration grew by more than 30% in the last 5 years nationally; Indiana has 14 counties with >30% penetration. Most growth is concentrated in 15 states. 48 counties that have more than 25,000 Medicare-eligible persons and greater than 50% MA penetration. Despite enrollment growth, MA remains a “black box” to many post-acute providers due to small scale by a specific plan for any given provider and frequently non-competitive markets.
Top Indiana Counties for Medicare Advantage Penetration

<table>
<thead>
<tr>
<th>County</th>
<th>2011</th>
<th>2015</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Beneficiaries</td>
<td>MA</td>
<td>Percent</td>
</tr>
<tr>
<td>Whitley</td>
<td>5,467</td>
<td>2,476</td>
<td>45.29%</td>
</tr>
<tr>
<td>Huntington</td>
<td>6,832</td>
<td>2,569</td>
<td>37.46%</td>
</tr>
<tr>
<td>DeKalb</td>
<td>6,777</td>
<td>2,751</td>
<td>40.59%</td>
</tr>
<tr>
<td>Allen</td>
<td>51,068</td>
<td>18,550</td>
<td>36.32%</td>
</tr>
<tr>
<td>Noble</td>
<td>7,004</td>
<td>2,389</td>
<td>34.11%</td>
</tr>
<tr>
<td>Steuben</td>
<td>5,960</td>
<td>1,987</td>
<td>33.34%</td>
</tr>
<tr>
<td>Wells</td>
<td>4,888</td>
<td>1,509</td>
<td>30.87%</td>
</tr>
<tr>
<td>Kosciusko</td>
<td>12,212</td>
<td>3,908</td>
<td>32.00%</td>
</tr>
<tr>
<td>Wabash</td>
<td>7,121</td>
<td>2,391</td>
<td>33.58%</td>
</tr>
<tr>
<td>Fulton</td>
<td>3,989</td>
<td>1,278</td>
<td>32.04%</td>
</tr>
<tr>
<td>Marshall</td>
<td>7,721</td>
<td>1,965</td>
<td>25.45%</td>
</tr>
<tr>
<td>Adams</td>
<td>5,090</td>
<td>1,836</td>
<td>36.07%</td>
</tr>
<tr>
<td>LaGrange</td>
<td>4,643</td>
<td>1,202</td>
<td>25.89%</td>
</tr>
<tr>
<td>St. Joseph</td>
<td>41,249</td>
<td>8,486</td>
<td>20.57%</td>
</tr>
<tr>
<td>Hancock</td>
<td>10,562</td>
<td>1,789</td>
<td>16.91%</td>
</tr>
<tr>
<td>Elkhart</td>
<td>27,487</td>
<td>5,323</td>
<td>19.37%</td>
</tr>
<tr>
<td>Hendricks</td>
<td>17,254</td>
<td>3,270</td>
<td>18.95%</td>
</tr>
<tr>
<td>Franklin</td>
<td>4,621</td>
<td>1,134</td>
<td>24.54%</td>
</tr>
<tr>
<td>Marion</td>
<td>119,276</td>
<td>21,317</td>
<td>17.87%</td>
</tr>
<tr>
<td>Vanderburgh</td>
<td>31,774</td>
<td>7,582</td>
<td>23.89%</td>
</tr>
</tbody>
</table>

Source: CMS.gov, January 2015

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

- **Value-Based Insurance Design (VBID):** on September 1, 2015, CMS announced that MA plans in 7 states* (including Indiana) 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

- As MA penetration grows, plans will increasingly copy value-based payment initiatives
  - Medicare Advantage plans are accorded significant payment flexibility under federal law
  - Special Needs Plans (SNPs) are likely to be early adopters of VBP

Engaging Medicare Advantage plans with alternative payment approaches will become increasingly common

*Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee
Health Systems & Physicians Looking at Clinical Integration Strategy

- Primary purpose must be to integrate members’ clinical decision making and/or financial risk
- Must demonstrate benefit to payers and members
- Can negotiate reimbursement structures with managed care and other risk-bearing entities on behalf of its members that reward quality and efficiency

**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

Clinical Integration Examples: **Provider + Risk + Scale = Transformation**

**Indiana Examples:**
Inspire Health Partners – Columbus & Seymour
St. Vincent Health initiative with MissionPoint

Indiana University Health: Case Study of Provider-Sponsored Health Plan

Tailored Outpatient Care Mgmt Process

- 1. Identify Outpatient Populations
- 2. Patient Identification Process
- 4. Patient’s Health & Functional Status
- 6. Transition Program Process
- 7. Medicare Advantage Population

Bundling
Number of Models Continues to Grow
Medicaid Programs Are Bundling: TN & AK Are Bundling Chronic Conditions

Clinical episodes are selected from one of 48 possible diagnostic categories (MS-DRGs)

Episodes are 30, 60, or 90 days in length and commence with episode initiating anchor hospitalization

Base period target price (less 2%–3% discount) compared to performance period expenditures on apples-to-apples basis about six months after the episode is over

Bundled Payments for Care Improvement (BPCI): Episode Triggered by Hospitalization

Established as 3-year, voluntary demonstration program by Center for Medicare & Medicaid Innovation (CMMI)
In Retrospective BPCI Models (1, 2, 3), No Money Changes Hands Upfront

- All providers are paid through regular fee-for-service (FFS) rules and coverage criteria.
- Bundling is retrospective calculation where actual FFS expenditures for each quarterly performance period are compared to target prices with an upfront discount.

In Retrospective BPCI Models (1, 2, 3), No Money Changes Hands Upfront

In Retrospective BPCI Models (1, 2, 3), No Money Changes Hands Upfront

BPCI Target Price Is Compared to Expenditures in the Performance Period

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>Quarter 1, Patient 1</th>
<th>Quarter 1, Patient 2</th>
<th>Quarter 1 Total Reconciliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>$19,000 (base period spend) less 3% upfront discount to CMS</td>
<td>Actual fee-for-service spending during episode</td>
<td>Actual fee-for-service spending during episode</td>
<td>Net amount to be gained by/(paid back from) bundler</td>
</tr>
<tr>
<td>$18,400</td>
<td>$20,000</td>
<td>$15,000</td>
<td>$1,800</td>
</tr>
<tr>
<td></td>
<td>Amount to be paid back to CMS at reconciliation</td>
<td>Amount of gain to bundler at reconciliation</td>
<td></td>
</tr>
</tbody>
</table>
BPCI Is for FFS Patients Only: Triggered by Anchor Hospitalization

- 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

What’s Included and Excluded in Target Price Is Very Important

- Target prices contain exclusions for:
  – Unrelated conditions to bundle diagnosis (e.g., cancer diagnosis)
  – Part D drugs
  – Hospice claims
- Hospice services are not included in BPCI, but advance care planning, palliative care, and hospice services can be important elements of care redesign
Medicare’s Bundling Program Has Several Risk Mitigation Features

- **Risk Tracks**
  - Three risk tracks (A, B & C) that trade off between risk and opportunity

- **Outliers**
  - Process to mitigate effect of extreme cases (20% loss over upper threshold)

- **Exclusions**
  - Method to factor out low-volume, high-cost events unrelated to care of the episode in question

All 3 concepts are applied to base period and performance period

Two Rounds of Voluntary Bundling: Significant Growth So Far

- **2013**
  - 214 organizations

- **2016**
  - 1,522 organizations

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

Episode Initiators by Provider Type

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

Source: CMS BPCI Analytic File, April 5, 2016
Indiana Bundlers That Moved Forward to Risk as of October 1, 2015

<table>
<thead>
<tr>
<th>BPCI Model</th>
<th>Organization Name</th>
<th>No. Diagnostic Categories At Risk</th>
<th>City</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2 St. Joseph Regional Medical Center-Plymouth Campus, Inc.</td>
<td>10</td>
<td>Plymouth</td>
</tr>
<tr>
<td>2</td>
<td>Central Indiana Orthopedics PC</td>
<td>1</td>
<td>Muncie</td>
</tr>
<tr>
<td>2</td>
<td>Tri-State Orthopaedic Surgeons, Inc.</td>
<td>2</td>
<td>Evansville</td>
</tr>
<tr>
<td>1</td>
<td>Memorial Hospital of South Bend, Inc</td>
<td>1</td>
<td>South Bend</td>
</tr>
<tr>
<td>2</td>
<td>Elkhart General Hospital, Inc</td>
<td>2</td>
<td>Elkhart</td>
</tr>
<tr>
<td>2</td>
<td>St. Joseph Regional Medical Center-Mishawaka Campus</td>
<td>7</td>
<td>Mishawaka</td>
</tr>
<tr>
<td>2</td>
<td>St. Mary's Medical Center of Evansville, Inc</td>
<td>2</td>
<td>Evansville</td>
</tr>
<tr>
<td>3</td>
<td>Covington Manor Health and Rehabilitation Center</td>
<td>18</td>
<td>Fort Wayne</td>
</tr>
<tr>
<td>3</td>
<td>Clinton House Health and Rehab Center</td>
<td>21</td>
<td>Frankfort</td>
</tr>
<tr>
<td>3</td>
<td>Pyramid Point Post-Acute and Rehabilitation Center</td>
<td>7</td>
<td>Indianapolis</td>
</tr>
<tr>
<td>3</td>
<td>McCormick's Creek Rehabilitation &amp; Skilled Nursing</td>
<td>38</td>
<td>Spencer</td>
</tr>
<tr>
<td>3</td>
<td>Covenant Care Indiana, Inc. University Park Health &amp; Rehabilitation Center</td>
<td>11</td>
<td>Fort Wayne</td>
</tr>
<tr>
<td>3</td>
<td>Lakeland Skilled Nursing and Rehabilitation</td>
<td>3</td>
<td>Angola</td>
</tr>
<tr>
<td>3</td>
<td>Norwood Health and Rehabilitation Center</td>
<td>7</td>
<td>Huntington</td>
</tr>
<tr>
<td>3</td>
<td>Waldron Health and Rehab Center</td>
<td>3</td>
<td>Waldron</td>
</tr>
<tr>
<td>3</td>
<td>Chicagoland Christian Village, Inc.</td>
<td>4</td>
<td>Crown Point</td>
</tr>
<tr>
<td>3</td>
<td>Hoosier Christian Village Inc.</td>
<td>3</td>
<td>Indianapolis</td>
</tr>
<tr>
<td>3</td>
<td>Miller's Merry Manor (32 locations) (avg)</td>
<td>16</td>
<td>30 locations</td>
</tr>
<tr>
<td>3</td>
<td>Fort Wayne Healthcare Group, LLC</td>
<td>24</td>
<td>Fort Wayne</td>
</tr>
<tr>
<td>3</td>
<td>Sanctuary at Holy Cross Indiana</td>
<td>11</td>
<td>South Bend</td>
</tr>
<tr>
<td>3</td>
<td>Sanctuary at St. Paul's</td>
<td>7</td>
<td>South Bend</td>
</tr>
<tr>
<td>3</td>
<td>Diversicare of Providence, LLC</td>
<td>3</td>
<td>New Albany</td>
</tr>
<tr>
<td>3</td>
<td>St. Anthony Home</td>
<td>2</td>
<td>Crown Point</td>
</tr>
</tbody>
</table>

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)

- Major joint replacement of the lower extremity: 68% (Model 2), 58% (Model 3)
- Congestive heart failure: 41% (Model 2), 35% (Model 3)
- Simple pneumonia and respiratory infections: 34% (Model 2), 32% (Model 3)
- Chronic obstructive pulmonary disease, bronchitis, asthma: 47% (Model 2), 39% (Model 3)
- Hip and femur procedures except major joint: 36% (Model 3), 27% (Model 3)

Source: CMS Analytic File, October 13, 2015; CMS BPCI newsletter November 2015, Ed. 7
Bundlers Assume Risk for Outcomes Over a Whole Episode

Care Redesign Strategies
- Transitions management:
  - Between acute care and post-acute to community settings
  - Coordination with primary care
  - Coordination with specialty care
- Risk stratification
- Patient activation, teaching, and self-care
- Medication reconciliation at every transition
- Primary care engagement
- Utilization of telehealth

Waiver Opportunities
- 3-Day Hospital Stay
- Home Visits
- Telemedicine
- Gainsharing
Policy on Gainsharing Is Evolving

- Gainsharing currently executed through waivers or case-by-case review, which can be cumbersome; will become more widespread as ACOs & bundling grow
- Policy on gainsharing is rapidly evolving as alternate payment approaches flourish

Considerations for Post-Acute Providers in Gainsharing

- Key metrics of interest will include: hospitalizations; length of stay; functional outcomes; patient satisfaction & process of care
- Over time, performance expectations will increase, as will acuity of referrals to post-acute care, so there must be careful thought as to how key metrics are interpreted and risk-adjusted as VBP matures
The Importance of Risk Adjustment: 

**Acuity Increases Can Offset Performance Gains**

Performance expectations increase, as do acuity of referrals, so care must be taken in interpreting data as VBP matures.

### Hypothetical Example of Readmissions Rates 
**Before & After VBP Market Transformation**

<table>
<thead>
<tr>
<th>Before VBP Transformation</th>
<th>After VBP Transformation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patients</strong></td>
<td><strong>90-day Readmissions Rate</strong></td>
</tr>
<tr>
<td>Low Acuity</td>
<td>70% 14%</td>
</tr>
<tr>
<td>High Acuity</td>
<td>30% 30%</td>
</tr>
<tr>
<td>Provider Total</td>
<td><strong>19%</strong></td>
</tr>
</tbody>
</table>

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

---

**Early Results of Bundling: Savings Driven by Changing Use of Post-acute Care**

- 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 cases

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

Cleveland Clinic Model 2 BPCI Results for Major Joint Lower Extremity

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>Q1</td>
<td>Q4</td>
</tr>
<tr>
<td>Medicare A/B Patients* †</td>
<td>72*</td>
<td>65†</td>
</tr>
<tr>
<td>Cauti 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

Montefiore’s Model 2 BPCI Results for Major Joint Replacement Are Similar

**Goals:**
- Increase discharges to home
- Decrease hospital length of stay
- Improve pre-operative care
- Achieve functional outcome quicker

**How did they do it?**
- Through tight relationship with hospital-owned HHA, developed clinical protocols and education for staff, aides, patients, and families
- Developed relationship with SNF with 7 days/week access to physicians, trained staff, and customer-friendly facility

Source: Ehrlich, Developing an Elective Joint Replacement Program, 2015
New CMS Bundling Program: Comprehensive Care for Joint Replacement (CJR) Program

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

---

CJR Affects Three Regions in Indiana

- CMS finalized mandatory program in 67 randomly selected metropolitan statistical areas (MSAs), including:
  - Cincinnati (Dearborn, Franklin County, IN)
  - Indianapolis
  - South Bend
- Evansville was originally proposed, but was dropped in final rule
Comparison of Key Features Between Model 2 Bundled Payments & 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>

Unlike BPCI, CJR Has Direct Linkage of Payment to Quality

• Accomplished through creation of “composite” quality score, based on measure 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
CJR Collaborators:  
**Next Step in Gainsharing Evolution**

- CMS and the OIG created this concept to facilitate sharing of risk between hospitals and other providers through a process that waives the application of fraud, waste & abuse laws
- Comprehensive Care for Joint Replacement (CJR) collaborators must be Medicare providers participating in the care redesign and can share both up- and down-side risk, as well as internally derived cost savings, up to certain limits
  - Annual reconciliations will examine actual spending over 90-day episode compared to target price
  - Internal cost savings must be documented and verifiable

*This change is the next step in recognizing that value-based payment transformation requires more flexible application of fraud, waste & abuse laws that inhibit care redesign*

---

**Gainsharing Pools Can Also Contain Internal Cost Savings – CJR Example**

- Reduction in pharmacy expense (e.g., use of generics, formulary)
- Fewer marginal, but costly, diagnostic tests
- Shorter inpatient stays, when appropriate
- Reduction in administrative overhead
- Cost-effective use of critical care and telemetry units
- Efficient use of operating rooms and reduction in turnaround time
- Evidence-based selection and purchase of medical devices and hardware

Source: Applied Medical Software
### 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
Where Are We Going in Value-Based Purchasing?

Market Transformation

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 Payers First Option: 
*Squeeze Out Excess Capacity*

Example of downstream providers 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)

Across the country, preferred networks are on the rise, especially in markets with maturing ACOs and bundlers

Markets Will Undergo Value-Based Transformation At Different Rates

Multiple Initiatives Can Accelerate Transformation in Certain Markets

As Markets Transform Providers Must Pay Attention to Both FFS & VBP

Rapid Transformation
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

HDG’s Experience With Bundling

- HDG has assisted health care systems representing over 75 episode-initiating providers with participation in Medicare’s Bundled Payments for Care Improvement (BPCI) initiative, supporting 3 of the 10 largest private Model 3 conveners
- Along with our data partner, Dobson DaVanzo, HDG provides consulting and analysis for providers to self-convene (directly take risk) or to participate with other conveners, by:
  - Interpreting CMS policies
  - Analyzing Medicare claims data
  - Consulting on care redesign
  - Advising on optimal strategy

Dobson | DaVanzo
For More Information

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

www.healthdimensionsgroup.com
@HDGConsulting
https://www.facebook.com/HealthDimensionsGroup
http://www.linkedin.com/company/health-dimensions-group