The Emerging World of Value-Based Purchasing
Wisconsin Health Care Association/Center for Assisted Living
65th Annual Fall Convention
Brian Ellsworth, MA, Director, Payment Transformation
Health Dimensions Group
@HDGConsulting

October 20, 2016

Brian Ellsworth, MA
Director, Payment Transformation
- Over 30 years of experience in Medicare & Medicaid policy, payment, and care delivery transformation, with an emphasis on care integration for the chronically ill
- Background includes provider, payer, and governmental policymaking roles
  - Provider roles: American Hospital Association, CT Association for Home Care & Hospice (CEO), and LeadingAge NY
  - Payer roles: NY Medicaid and Optum (UnitedHealth Group)
- Consulting clients include over 75 providers taking risk under Medicare’s Bundled Payments for Care Improvement (BPCI) initiative; advise providers and plans on value-based payment strategic positioning and transformation
- Thought leader and frequent presenter; served on numerous policy and technical advisory groups

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!

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
- Sometimes referred to as alternative payment models (APMs) or VBP

Agenda for Today’s Presentation
- Value-Based Purchasing Landscape
- Alternative Payment Models
- How Markets Will Transform

Value-Based Purchasing Links Quality and Risk on a Continuum
Medicare Continues to March Towards Its Goals for Alternative Payment Models (APMs)

APM goals for Medicare Fee-for-Service Program

<table>
<thead>
<tr>
<th>2016 Goal Met in March</th>
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</thead>
<tbody>
<tr>
<td>2016</td>
</tr>
<tr>
<td>50%</td>
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Better Care, Smarter Spending, Healthier People

APM Goals for Medicare Fee-for-Service Program

2016 Goal Met in March

Physician Payment Rule (MACRA): Framework to Drive “Advanced APMs”

Provides automatic 5% lump sum bonus to physicians who receive significant portion of their revenue from Advanced Alternative Payment Methods

Rewards or penalizes physicians by up to +/- 9% depending on their Merit-based Incentive Payment System (MIPS)

What Are “Advanced” APMs?

✓ VBP participants must bear a certain amount of financial risk

Total Risk: • Minimum 4% of APM spending target

Marginal Risk: • Minimum 30% spending above APM target for which Advanced APM entity is responsible

Minimum Loss Rate: • Maximum 4% of amount by which spending can exceed APM benchmark before Advanced APM entity has responsibility for losses

✓ Base payments on quality measures

✓ Requires participants to use certified EHR technology

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
  – Acute myocardial infarction (AMI); heart failure (HF); pneumonia (PN); COPD; elective total hips and knees and CABG
• In 2015, hospitals became subject to new adjustment based on Medicare Spending Per Beneficiary (MSPB) as part of Hospital Value-Based Purchasing (VBP) program
• Determine local hospital penalties for these two issues and start a conversation about how you can help!

SNF Value-Based Payment: Law Requires Implementation by 2018

• Final 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

Wholesale expansion of Medicare APMs does not require an Act of Congress

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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

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

*Drug regimen review coming in 2020

IMPACT Act of 2014 Ultimate Goal:
Standardized, Interoperable, Reusable Data

Medicaid Programs Are Diving into VBP:
TN & AK Are Bundling Chronic Conditions

NY’s Value-Based Payment Roadmap:
Value-Based Payment + Managed Care

- 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%–70% of total payments to be captured in Level 2+
  - L2 means linkage to quality; with both upside & downside shared risk
- VBP Roadmap just completed its first annual update

Value-Based Payments:
Require New Contracting Relationships
Value-Based Payments:
Require a Whole New Language

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


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

Importance of Achieving Scale in VBP:
Do The Math!

Suppose there are 5 plans contracting with 10 providers for care representing, in total, 10% of each plan’s spend...

- Plan #1 = 20%
- Plan #2 = 20%
- Plan #3 = 20%
- Plan #4 = 20%
- Plan #5 = 20%

In this example, each provider represents only 0.2% of the plan’s spending

Math can be similar in urban versus rural environments

New Payment Models Demand New Capabilities

<table>
<thead>
<tr>
<th>Capability Required for Success</th>
<th>Today</th>
<th>1-3 Years</th>
<th>3-5 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay for Performance</td>
<td>Setting Specific Silos</td>
<td>Early Attempts at Care Coordination</td>
<td>Population Healthy Wellness</td>
</tr>
<tr>
<td>Care coordination and quality outcomes across select metrics</td>
<td>Ability to deliver highest quality at competitive cost</td>
<td>Episodic care management on a risk basis</td>
<td></td>
</tr>
</tbody>
</table>

Value-Based Payment Creates Opportunities and Risks

Now Is the Time to Embrace the Opportunities!

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

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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

Episodic Payment Models
Medicare Is Rapidly Expanding Mandatory and Voluntary Bundled Payments

Alternative Payment Methods
Fee-for-Service VBP
Episodic Payment
Accountable Care

How Medicare Episode Payment Works: Retrospective, Two-sided Risk

Reconciliation of target prices to spending occurs after episode is over

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

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
Bundled Payments for Care Improvement

- "Clinical episodes" are selected from one of 48 possible diagnostic families that 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 after the fact.

Most Frequently Selected Clinical Episode Groups For Model 2 & 3 Bundled Payments

<table>
<thead>
<tr>
<th>Clinical Episode Group</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip and femur procedures except major joint</td>
<td>36%</td>
<td>36%</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease, bronchitis, asthma</td>
<td>32%</td>
<td>27%</td>
</tr>
<tr>
<td>Simple pneumonia and respiratory infections</td>
<td>47%</td>
<td>34%</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>41%</td>
<td>35%</td>
</tr>
<tr>
<td>Major joint replacement of the lower extremity</td>
<td>68%</td>
<td>34%</td>
</tr>
</tbody>
</table>

Roles for Post-acute in Model 2 & 3 BPCI:

- Vendor or EIP Until Another Round 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).

Waiver Opportunities

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

Two Rounds of Voluntary Bundling: Despite Attrition, Significant Growth

- 2016: 1,386 organizations
- 2013: 214 organizations

<table>
<thead>
<tr>
<th>Year</th>
<th>Details</th>
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<tr>
<td>2016</td>
<td>1,386 organizations</td>
</tr>
<tr>
<td>2013</td>
<td>214 organizations</td>
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<table>
<thead>
<tr>
<th>Model 3 Bundlers in Wisconsin</th>
</tr>
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<tbody>
<tr>
<td>Organization Name</td>
</tr>
<tr>
<td>Meriter Hospital, Inc.</td>
</tr>
<tr>
<td>Golden LivingCenter - Heritage Square</td>
</tr>
<tr>
<td>Belmont Nursing and Rehab Center</td>
</tr>
<tr>
<td>Wakwasha Springs Health &amp; Rehab Center</td>
</tr>
<tr>
<td>Nazareth Health &amp; Rehab Center</td>
</tr>
<tr>
<td>Sunny Ridge Health &amp; Rehab Center</td>
</tr>
<tr>
<td>Milwaukee Health &amp; Rehab Center</td>
</tr>
<tr>
<td>Villa Pinna Living Center</td>
</tr>
<tr>
<td>Geneva Lake Manor</td>
</tr>
<tr>
<td>Holton Manor</td>
</tr>
<tr>
<td>Ingleside Manor</td>
</tr>
<tr>
<td>Montello Care Center</td>
</tr>
<tr>
<td>Northern Lights Services</td>
</tr>
<tr>
<td>River Falls Healthcare, LLC</td>
</tr>
<tr>
<td>Oak Park Nursing and Rehab Center LLC</td>
</tr>
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</table>
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
  - Hip and femur fractures to be added in July 2017

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

NEW Refinement & Expansion of CJR: Changes Would Apply to Existing 67 Regions

- On July 25, 2016, CMS issued proposed rule to refine and expand the CJR model; proposed refinements include:
  - Creation of a track whereby CJR will qualify as Advanced Alternative Payment Model (AAPM), and thus be of interest to physicians seeking AAPM bonus
  - Changes to composite quality scoring approach to align with AAPM approach
  - Expansion of CJR includes addition of surgical hip and femur fracture treatment procedures (SHFFT) to already mandatory joint replacement episodes (MS-DRGs 480-482)
- Expands program scope, creating more incentive for mandatory hospitals to develop an effective care redesign strategy

Milwaukee-Waukesha-West Allis MSA Hospitals in CJR

- Waukesha Memorial Hospital
- Columbia St. Mary’s Hospital Ozaukee
- Aurora Medical Center Milwaukee
- Oconomowoc Memorial Hospital
- St. Joseph’s Community Hospital of West Bend
- Wheaton Franciscan Healthcare-St. Francis
- Community Memorial Hospital
- Wheaton Franciscan-St. Joseph
- Aurora St. Luke’s Medical Center
- Aurora West Allis Medical Center
- Freidest Memorial Lutheran Hospital
- Orthopaedic Hospital of Wisconsin
- Columbia Center
- Wheaton Franciscan Healthcare-Franklin
- Milwaukee Orthopedic Specialty Hospital
- Aurora Medical Center
- Aurora Medical Center

Madison MSA Hospitals in CJR

- Monroe Clinic, The
- Divine Savior Healthcare
- St. Mary’s Hospital
- University of Wisconsin Hospitals & Clinics Authority

A Joint Replacement Tale of Two Cities

Milwaukee-Waukesha-West Allis, WI MSA

<table>
<thead>
<tr>
<th>First PAC Setting</th>
<th>Number of Episodes</th>
<th>Percent of Episodes</th>
<th>Readmissions Rate</th>
<th>Average Episode Payment</th>
<th>Percent Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>1,761</td>
<td>24%</td>
<td>5%</td>
<td>$19,731</td>
<td>1%</td>
</tr>
<tr>
<td>HRA</td>
<td>2,022</td>
<td>28%</td>
<td>6%</td>
<td>$19,627</td>
<td>2%</td>
</tr>
<tr>
<td>IRF</td>
<td>384</td>
<td>5%</td>
<td>8%</td>
<td>$33,138</td>
<td>35%</td>
</tr>
<tr>
<td>SNF</td>
<td>2,011</td>
<td>15%</td>
<td>12%</td>
<td>$29,506</td>
<td>17%</td>
</tr>
<tr>
<td>Total</td>
<td>7,309</td>
<td>100%</td>
<td>8%</td>
<td>$23,894</td>
<td>10%</td>
</tr>
</tbody>
</table>

Beaumont, Texas MSA

<table>
<thead>
<tr>
<th>First PAC Setting</th>
<th>Number of Episodes</th>
<th>Percent of Episodes</th>
<th>Readmissions Rate</th>
<th>Average Episode Payment</th>
<th>Percent Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>1,120</td>
<td>100%</td>
<td>16%</td>
<td>$25,703</td>
<td>16%</td>
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</table>
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

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>Q1</td>
<td>Q4</td>
</tr>
<tr>
<td>Medicare A/B Patients*</td>
<td>72%</td>
<td>63%</td>
</tr>
<tr>
<td>Cost 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>71%</td>
<td>75%</td>
</tr>
<tr>
<td>Discharge Disposition SNF*</td>
<td>28%</td>
<td>25%</td>
</tr>
<tr>
<td>HCAHPS Overall Rating*</td>
<td>73%</td>
<td>88%</td>
</tr>
</tbody>
</table>

NEW Mandatory Bundling Program: Episode Payment for Heart Attacks & Bypass Surgery

Proposed Program to Start July 1, 2017

<table>
<thead>
<tr>
<th>Domain</th>
<th>Voluntary BPCI</th>
<th>Mandatory CJR/EPMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation</td>
<td>Voluntary for awardees</td>
<td>Mandatory for hospitals</td>
</tr>
<tr>
<td>Scope</td>
<td>Up to 48 MS-DRG families</td>
<td>Specific DRGs</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>Risk</td>
<td>Immediate two-sided risk</td>
<td>Phase-in two-sided risk</td>
</tr>
<tr>
<td>Quality linkage</td>
<td>Indirect</td>
<td>Potential for gains linked directly to quality scores</td>
</tr>
<tr>
<td>Waivers</td>
<td>Certain waivers allowed</td>
<td>Certain waivers allowed with model-specific tweaks</td>
</tr>
</tbody>
</table>

Comparison of Key Features Between Voluntary BPCI & Mandatory CJR/EPMs

Example of Model-Specific Waivers: Three-day Qualifying Stay for SNF Coverage

<table>
<thead>
<tr>
<th>Model</th>
<th>Three-day Qualifying Stay Permitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 2 Voluntary BPCI</td>
<td>Yes if majority of SNFs are 3 stars or higher</td>
</tr>
<tr>
<td>CJR – Joint Replacement</td>
<td>Yes after 1/1/17 for 3-star SNFs only</td>
</tr>
<tr>
<td>CJR – Surgical Hip &amp; Femur</td>
<td>No due to longer expected hospital LOS</td>
</tr>
<tr>
<td>EPM – AMI</td>
<td>Yes after 4/1/18 for 3-star SNFs only</td>
</tr>
<tr>
<td>EPM – CABG</td>
<td>No due to longer expected hospital LOS</td>
</tr>
</tbody>
</table>

Proposed rule states that 3-day waiver will be applied to future EPMs on case-by-case basis having to do with typical hospital LOS and when the EPM is moving to downside risk

Proposed Rule Indicates Possibility to Voluntarily Take Direct Risk is Coming

"However, building on the BPCI initiative, the Innovation Center intends to implement a new voluntary bundled payment model for CY 2018 where the model(s) would be designed to meet the criteria to be an Advanced APM.”

Voluntary Bundling 2.0 likely to have greater linkage to quality and may use different episode triggering strategies
Why Engage in Voluntary Bundling?

- Learn by doing; force culture change
- Understand markets through data
- Improve quality through care redesign
- Earn positive margins

Medicare Episodic Payment Timeline

- Voluntary Bundled Payments for Care Improvement (BPCI)
  - Initial sign-up in 2012; subsequent sign-up in 2014
- Mandatory Comprehensive Joint Replacement Model (CJR)
  - Proposed July 2015; implemented in 67 markets April 1, 2016
  - Proposal to add Surgical Hip & Femur Fracture Treatment (SHFFT) for July 2017 implementation
- Mandatory Advancing Care Coordination Proposed Rule
  - Proposed July 2016 for implementation in 98 markets July 2017
  - Two new mandatory cardiac bundles: heart attack and bypass surgery, now called Episode Payment Models (EPM)
  - Cardiac rehab incentive payments
- Voluntary BPCI 2.0 intended for CY 2018

Continued Growth in Medicare ACOs:

- CMS announced 100 new Medicare Shared Savings Program (MSSP) ACOs for 2016
  - Total of 434 MSSP ACOs
  - 19 Next Generation ACOs (3 dropped out), 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
  - Physician-led ACOs appear to be more nimble

Case Study ACOs and Post-acute:

Franciscan Alliance (Indiana)

- Narrowed network of PAC providers through thoughtful process, initially by using 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

First LTPAC-Sponsored Medicare ACO:

Genesis HealthCare Dives In

- Effective January 1, 2016, program targets long-term care residents in 113 Genesis facilities in 4 states (PA, NJ, MD, WV)
- Genesis expects to have 16,000 LTC residents (and some post-acute patients) attributed to the ACO based on obtaining 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
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.

Wisconsin Medicare Advantage Penetration: Ten Counties at 50% or More

<table>
<thead>
<tr>
<th>County</th>
<th>%</th>
<th>County</th>
<th>%</th>
<th>County</th>
<th>%</th>
<th>County</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>Adams</td>
<td>24%</td>
<td>Randall</td>
<td>30%</td>
<td>Penelton</td>
<td>48%</td>
<td>Fond du Lac</td>
<td>48%</td>
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<td>Barron</td>
<td>33%</td>
<td>Bayfield</td>
<td>44%</td>
<td>Green</td>
<td>11%</td>
<td>Milwaukee</td>
<td>43%</td>
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<td>Brown</td>
<td>32%</td>
<td>Buffalo</td>
<td>32%</td>
<td>Eau Claire</td>
<td>30%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burnett</td>
<td>15%</td>
<td>Dunn</td>
<td>30%</td>
<td>Eau Claire</td>
<td>30%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brown</td>
<td>32%</td>
<td>Dunn</td>
<td>30%</td>
<td>Eau Claire</td>
<td>30%</td>
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<tr>
<td>Clinton</td>
<td>32%</td>
<td>Iron</td>
<td>59%</td>
<td>Marathon</td>
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<td>Chippewa</td>
<td>31%</td>
<td>Jackson</td>
<td>54%</td>
<td>Menominee</td>
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<td>Cheboyg</td>
<td>46%</td>
<td>Jefferson</td>
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<td>Menominee</td>
<td>43%</td>
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<td>Columbia</td>
<td>29%</td>
<td>Juneau</td>
<td>19%</td>
<td>Menominee</td>
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<td>Crawford</td>
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<td>Dane</td>
<td>24%</td>
<td>Marquette</td>
<td>32%</td>
<td>Marinette</td>
<td>29%</td>
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<td>Dodge</td>
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<td>Marinette</td>
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<td>Marinette</td>
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Medicare Advantage Is Growing Nationally

Medicare Advantage (MA) penetration grew by more than 30% in the last 5 years.

Most growth is concentrated in 15 states—48 counties that have more than 25,000 Medicare-eligible persons and greater than 50% MA penetration. Wisconsin is a high penetration state.

Despite enrollment growth, MA remains a "black box" to many providers due to small scale by a specific plan for any given provider and frequently non-competitive markets.

Medicare Advantage Plans May Become Next Frontier for VBP

- Value-Based Insurance Design (VBID): September 1, 2015, CMS announced that MA plans in 7 states* will be offered flexibility in benefit design (reduce cost sharing or offer extra benefits) so 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 accorded significant payment flexibility under federal law.
  - Special Needs Plans (SNPs) likely to be early adapters of VBP.

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

Example of Medicare Institutional Special Needs Plans (I-SNPs) Value-Based Contracting

I-SNP A
- Waives 3-day prior hospital stay and treats the resulting skilled stay as a 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.

14 States Pursuing Initiatives to Integrate Care for Medicare & Medicaid

- Capitated model only, MOU signed (10)
- MFFS model, MOU signed (2)
- MFFS model, No MOU signed (2)
- Not pursuing FAD.
How Markets Will Transform

Care Redesign
Narrow Networks
Gainsharing
Achieving Scale in VBP

Effective Care Redesign Is Essential

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

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>
<th>OP Therapy</th>
<th>NHI</th>
<th>SNF</th>
<th>IRF</th>
<th>LTCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP Therapy</td>
<td>29%</td>
<td>71%</td>
<td></td>
<td></td>
<td></td>
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<td>NHI</td>
<td>14%</td>
<td>86%</td>
<td></td>
<td></td>
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<tr>
<td>SNF</td>
<td>5%</td>
<td>15%</td>
<td>80%</td>
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<tr>
<td>IRF</td>
<td>3%</td>
<td>9%</td>
<td>18%</td>
<td>69%</td>
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<tr>
<td>LTCH</td>
<td>31%</td>
<td>11%</td>
<td>58%</td>
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</table>

Source: Diagnosis | Disease severity on research subject. % of all cases observed, 2006, average adjusted by setting and geographic region.

VBP Will Increase Acuity At All Levels: Which makes Risk Adjustment Important

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

<table>
<thead>
<tr>
<th>Before VBP</th>
<th>After VBP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Acuity</td>
<td>High Acuity</td>
</tr>
<tr>
<td>% of Patients</td>
<td>% of Patients</td>
</tr>
<tr>
<td>OP Therapy</td>
<td>29%</td>
</tr>
<tr>
<td>NHI</td>
<td>14%</td>
</tr>
<tr>
<td>SNF</td>
<td>5%</td>
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<tr>
<td>IRF</td>
<td>3%</td>
</tr>
<tr>
<td>LTCH</td>
<td>31%</td>
</tr>
</tbody>
</table>

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

Preferred Networks Will Continue to Form: Especially in Markets with Excess Capacity

- Hospitals participating in bundling, ACOs, and other VBP, along with managed care plans, will continue to seek to utilize preferred or narrow networks
- 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

Next Stop in VBP Transformation: Increased Gainsharing Possible

- Gainsharing is currently executed through case-by-case review or waivers of fraud, waste & abuse laws
- So far, most gainsharing activity is limited to hospitals and physicians
- Policy on gainsharing is rapidly evolving as alternate payment approaches flourish and may become more widespread as rules are clarified

- OIG proposed rule change
- Some changes made in Physician Fix (MACRA) legislation
- Likely gainsharing regulation rewrite by OIG
Gainsharing Rules Have Not Caught Up With VBP Transformation

- Policy on gainsharing is rapidly evolving as alternate payment approaches flourish
  - OIG proposed rule changes in 2014
  - Some changes were made in 2015
  - MACRA “physician fix” legislation
  - Likely to see regulation rewrite at some point
- 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 the beneficiary

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)

Process of Gainsharing for Medicare VBP: Uses Waivers of FW&A Rules

- Medicare Shared Savings Program (Medicare ACOs)
  - Various waivers of FW&A laws for ACO participants finalized in 2015
  - Waivers are self-executing, after ACO certifies that gainsharing is bona fide arrangement related to purposes of ACO
- Bundled Payments for Care Improvement (BPCI)
  - At-risk bundler includes description of gainsharing arrangement in implementation protocol approved by CMS
  - Bundler executes formal agreement with gainsharers and sends list of provider numbers to CMS for program integrity screening
- Comprehensive Care for Joint Replacement Model (CJR)
  - CJR collaborators must be Medicare providers participating in the care redesign; can share both upside and downside risk (as well as internally derived cost savings) up to certain limits

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

Clinical Integration Examples:

| Provider + Risk + Scale = Transformation |
|----------------------------------------|----------------------------------|
| Medicare Advantage Plan                | Multi-Hospital System & Physician Services |
| Accountable Care Organization          | Managed Care Contracting          |
| Post-Acute Provider                   | Managed Care Taker in Bundling or ACOs |
| Managed Care Contracting              | Vendor or Risk Taker in Bundling or ACOs |

One Possible Answer to Scale Challenge: Independent Provider Associations (IPAs)
Post-acute Providers Are Forming Networks and Pursuing Clinical Integration

- Cincinnati-based clinical integration model, LLC entity centered on value-based payments:
  - Medicare Model 3 bundled payment convener
  - Negotiating performance-based reimbursement with Medicare Advantage and MyCare Ohio duals plans
- Any traditional reimbursement contracts will be messenger model

Pillars of Value-Based Transformation: Whether It Is Your Risk or Someone Else’s

Data
- E.g., length of stay, costs, readmissions rates, understand costs (by diagnosis)

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

Process
- E.g., care transitions, care pathways, INTERACT

Define Your Value Proposition

To prepare for value-based care, define your value proposition in three key areas and then reach out to value-based payers:

- **Ability to Manage Readmissions & LOS**
  - Capabilities to manage the patient aggressively in situ, including telemonitoring and medical management strategies, all with lengths of stay within expected norms

- **Patient Outcomes (Versus Inputs) Relative to Peers**
  - Performance better than your peer group on key outcomes such as functional status relative to therapy provided

- **Episodic Management Capabilities**
  - Capacity to manage seamlessly across multiple settings, effectively communicate with the bundler

Value-Based Preparedness Scorecard

**Basic**
- Preferred provider to hospital, bundler, or ACO
- Active implementation of protocol to prevent avoidable hospitalizations
- Measurement of outcomes in comparison to peers
- Able to view to clinical information from upstream providers

**Advanced**
- Electronic medical record capable of 2-way exchange of clinical information
- Routine risk stratification of admissions
- Standardized care pathways
- Comprehensive discharge planning and follow-up process

Success Will Be Defined by Delivering Quality Outcomes and Value

Thank You!
Any Additional Questions?