Welcome & Introductions

Trissa Torres, MD, MSPH, FACPM
Senior Vice President
Institute for Healthcare Improvement

Molly Bogan, MA
Director
Institute for Healthcare Improvement
Welcome & Introductions

Richard Gitomer, MD
President & CQO
Emory Healthcare Network

George Kerwin, FACHE
President/CEO
Bellin Health

Objectives

- Identify common challenges and solutions to running a successful ACO
- Recognize opportunities to accelerate their efforts to achieve cost- and quality-related improvements at scale
- Engage in active peer sharing and learning
Icebreaker

- ACO start year
- Region
- Physician-driven v. Hospital-driven
- Employ or Contract physicians

Introduction to Accelerators
Healthcare is changing…
US Affordable Care Act (ACA)

President Obama signs the Affordable Care Act. (3/23/2010)

Prohibit Denying Coverage of Children Based on Pre-Existing Conditions (9/23/2010)

Provide Free Preventative Care (9/23/2010)

Bring Down Health Care Premiums (1/1/11)

Increase Access to Services at Home and in the Community (10/1/11)

Understanding and Fighting Health Disparities (3/1/12)

Open Enrollment in the Health Insurance Marketplace Begins (10/1/13)

Prohibiting Discrimination Due to Pre-Existing Conditions or Gender (1/1/14)

Encouraging Integrated Health Systems & Launch of ACO Pioneer Program (1/1/12)

Improving Preventative Health Coverage & Launch of SSP ACO model (1/1/13)

Establishing the Health Insurance Marketplace (2014)

HHS to tie 90% of all traditional Medicare payments to quality or value by 2018

IHI Triple Aim

- System designs that simultaneously improve three dimensions:
  - Improving the health of the populations;
  - Improving the patient experience of care (including quality and satisfaction); and
  - Reducing the per capita cost of health care.

Determinants of Health and their Contribution to Premature Death

Proportional Contribution to Premature Death

- Social circumstances: 15%
- Environmental exposure: 5%
- Health care: 10%
- Behavioral patterns: 40%
- Genetic predisposition: 30%

Adapted from: McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. Health Aff (Millwood) 2002;21(2):76-91.

Changing Healthcare Context

- Fee for Service
- Pay for Performance
- Shared Savings
- Shared Risk
- Global Payment
- Focus on Individuals
- Individuals and Populations
- Individuals, Populations and Communities
- Care
- Care and Cost
- The Triple Aim
- Do to
- Do for
- Do WITH
Population Management

DEFINITION

The design, delivery, coordination, and payment of services for a defined group of people to achieve specified cost, quality and health outcomes for that group of people.

Population Health

“Population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. These groups are often geographic populations such as nations or communities, but can also be other groups such as employees, ethnic groups, disabled persons, prisoners, or any other defined group.”

-David Kindig, MD, PhD
Managing Services for a Population

Our Framework: Five Accelerators

- Building robust improvement infrastructure
- Demonstrating effective leadership
- Integrating data systems to support performance improvement
- Engaging providers and community stakeholders in care redesign
- Leveraging payment models to achieve clinical and financial targets
World Café

Break
See you back here at 2:30PM!
Objectives

• Understand why we chose to pursue value-based payment models
• Understand how we engaged physicians
• Our approach to value-based contracting
• Emory’s population management strategy
Emory Healthcare Network

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<th>Private Practice</th>
<th>TEC</th>
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<th>% Total</th>
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<td>Specialists (non-hospital based)</td>
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<td>1407</td>
<td>161</td>
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<td>100%</td>
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<td>% Total</td>
<td>23%</td>
<td>69%</td>
<td>8%</td>
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5 Hospital Facilities
Increasing Accountability
Emory Value-Based Commercial Contracts

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<tr>
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<th>4th Major Payor</th>
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<td>2014</td>
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<td>2017 (Projected)</td>
</tr>
<tr>
<td>2015</td>
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<td>2017 (Projected)</td>
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*Full Risk Capitation

Objectives

- Understand why we chose to pursue value-based payment models
- Understand how we engaged physicians
- Our approach to value-based contracting
- Emory's population management strategy
THE CINDERELLA PARABLE - The pace of change to varies significantly by market and health system

Commercial Insurance (Employer) Timeline

- Market-specific
- Employers increasingly unable to afford increasing costs
- Communication challenge
  - Viewed as any other good or service – ↓ Cost & ↑ Value
  - Difficult to measure value – so low unit cost is assumed to be high value
  - Tension between short-term financial horizon & long-term investment for value-based provider
- Impact of private and public exchanges
  - Commoditization vs. Differentiation
  - Decisions: Plan → Network → Benefits
CMS’ Journey to World B

**Pioneer ACO Performance**

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<th>Year</th>
<th>Received Payment</th>
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<th>Losses No Payment</th>
<th>Losses Paid</th>
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<td>20</td>
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**Pioneer ACO Performance**

<table>
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<td>86</td>
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<tr>
<td>Failed Quality</td>
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<td>6</td>
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<tr>
<td>Savings No Payment</td>
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<td>89</td>
</tr>
<tr>
<td>Losses No Payment</td>
<td>101</td>
<td>152</td>
</tr>
<tr>
<td>Losses Paid</td>
<td>1</td>
<td>0</td>
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<tr>
<td>Total</td>
<td>220</td>
<td>333</td>
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Source: Medicare ACOs Provide Improved Care While Slowing Cost Growth in 2014, Centers for Medicare & Medicaid Services, August 25, 2015

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**CMS Timeline – Alternative Payment by 2019**

**2016 – 2017 Data Drive 2019 MIPS Score**

<table>
<thead>
<tr>
<th>Current System</th>
<th>Medicare and CHIP Reauthorization Act (MACRA or SGR Repeal)</th>
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</thead>
<tbody>
<tr>
<td>Present to 2015</td>
<td>‘19 to ’26 MIPS</td>
</tr>
</tbody>
</table>
| Sec. Burwell – Jan ’15 | Payment updates
| ‘16 | • APM – 30%
| • 85% value-based |
| ‘18 | • APM – 50%
| • 90% value-based |
| Current programs | • PQRS, Meaningful use, Value based purchasing |
| ‘19 to ’26 APM | • MIPS – Single Metric
| • Quality
| • Resource use
| • Improvement
| • Meaningful use
| • Max reduction
| • 4% to 9%
| ‘19 score based on 16 & 17 data |
| ‘19 score based on 16 & 17 data |
| ‘19 to ’26 APM | • Payment updates
| ‘15 – ’19: 0.5%
| ‘20 – ’26: 0% |
| • Bonus – 5%
| • APM
| • Minimum % of practice requirements (Medicare or total) |
| After ’26 | • Payment updates
| • MIPS: 0.25%
| • APM: 0.75%
| • MIPS maximum reduction – 9% |

APM = Alternative Payment Model
MIPS = Merit-Based Incentive Payment System
Objectives

• Understand why we chose to pursue value-based payment models
• **Understand how we engaged physicians**
• Understand our approach to value-based contracting
• Emory’s population management strategy

Recruitment & Provider Relations

What is your hook? What makes your network attractive to independent providers?

- Safety in numbers in times of uncertainty
- Competitive rates
- Access to expensive infrastructure
  - IT
  - Population management
- Preservation of referral stream
- CMS penalty avoidance
Governance – Why is it important?

- Organizational credibility
  - Facilitates transparency
  - Transparency facilitates trust

- Physician engagement
  - Structured to facilitate input from many constituencies
  - Trust and broad input facilitates engagement

- Difficult decision-making
  - Success will require disruption of the status quo
  - Inclusive governance improves decision-making and facilitates execution

Governance: Emory’s Approach

<table>
<thead>
<tr>
<th>Board of Managers</th>
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<tbody>
<tr>
<td><strong>Physician Class</strong></td>
</tr>
<tr>
<td>6 PCPs &amp; 6 Specialists</td>
</tr>
<tr>
<td>1 PCP &amp; 1 Spec from each LHN</td>
</tr>
<tr>
<td><strong>Ex Officio Class</strong></td>
</tr>
<tr>
<td>EHC CEO, FHG CMO/CFO, HCN Director, LHN President</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Value Management Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 PCP &amp; 1 Spec from each LHN</td>
</tr>
<tr>
<td>Hospital CMO's</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Participation Committee</th>
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<tbody>
<tr>
<td>1 PCP &amp; 1 Spec from each LHN</td>
</tr>
<tr>
<td>Hospital CMO's</td>
</tr>
</tbody>
</table>

- Emory LHN
- Emory Midtown LHN
- Emory Saint Joseph's LHN
- Emory Johns Creek LHN
- Southern Regional Medical Center LHN
- LaGrange LHN
Board of Managers – Official decision-making body

<table>
<thead>
<tr>
<th>Board of Managers</th>
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</thead>
<tbody>
<tr>
<td><strong>Physician Class</strong></td>
</tr>
<tr>
<td>6 PCP’s &amp; 6 Specialists (1 PCP &amp; 1 Spec from each LHN)</td>
</tr>
</tbody>
</table>

**Sample of Activities**
- Oversees & approves actions of the participation committee
- Oversees and approves actions of the value management team
- Key strategic decisions
  - Required EMR as condition of participation & limited EMR vendor choices
  - Required attendance at Quality Management Forum to qualify for shared savings

**Participation Committee**

**Value Management Team**
- Oversees all value-related programs
- Oversees individual and network performance
- Makes recommendations to the participation committee re: performance issues

**Participation Committee**
- Recommended participation criteria to the Board
- Reviews and approves all nominations & participants to the network
- Makes recommendations to the Board concerning membership termination
Objectives

• Understand why we chose to pursue value-based payment models
• Understand how we engaged physicians
• **Understand our approach to value-based contracting**
• Emory’s population management strategy
Why a commercial strategy first?
• Retrospective attribution
• Benefit design did not support value-based care
• Membership turnover
• Benefit from savings beyond one year

Contracting Goals
• “Fair share” of savings
• Incentive vs. risk-sharing
  • Incentive contracts – P4P, bundles, & shared savings
  • Risk-sharing contracts – Capitation
• Factors to be balanced
  • Infrastructure cost
  • Incentives
  • Investment for future performance – based on your strategy
Who manages the risk?

**Mitigating Medical Management Risk**
- High risk patient management
- Thoughtful use of resources
- Reliable care processes

**Mitigating Insurance Risk**
- Law of large numbers – Membership
- Financial reserves

Objectives

- Understand why we chose to pursue value-based payment models
- Understand how we engaged physicians
- Our approach to value-based contracting
- Emory’s population management strategy
Population Management

↑ Intended Care & ↓ Unintended Care

Avoidable Utilization
- Avoidable ED visits
- Avoidable hospitalizations
- Other avoidable services
- Avoidable harm

Care Plan Execution
- Gaps in care

Intended Care
- Inefficient care

Care Coordination Program
- Analytics
  - Data aggregation
- Care coordinator program
  - Patient risk stratification
  - Outreach to highest risk (3.5%)
- Patient-centered primary care
  - Team-based outreach
  - Outreach to “lower” high risk
Impact of Care Coordinator Outreach

Emergency Department Utilization

- c-chart: EHN Care Coordinator Tracked Pts # ED Visits: Carecoord Overall (most recent 12 months)
- Previous 12 months #ED AVG
- # ED Encounters
- UCL
- LCL

1,800 patient cohort: Approximate reduction of 15 ED visits/month and 7 hospitalizations/month for entire cohort

Population Management Analytics and Work Flow Redesign

- Avoidable harm
- Care Plan Execution
- Gaps in care
- Intended Care
- Inefficient care

Analytics & Work-Flow Redesign
- Disease registry
  - Disease registry candidates
  - Identify missing care elements
- Team-based work flow redesign
  - Visit-based standard work
  - Proactive outreach
Analytics & Decision-Support Platform

Data & Analytics Challenges
- Disparate data sources
- Non-analyzable data sources (paper, non-discrete electronic data)
- Data acquisition, normalization, & transformation
- Data presentation: Accessible, understandable, & timely

Emory Solutions
- Financial analytics platform (based on paid claims)
  - Financial measurement & limited clinical measurement
- Disease registry platform – Point of care and population-level analytics
- Care coordination platform – Stratification & work-flow support
Develop Population Management Capabilities

NCQA Level III Patient Centered Medical Home Recognition

- Training Program
- Cohorts of 8-10 practices per trainer

- WORKING AS A TEAM
  Coordinate care with all working at the top of their license

- USING DATA
  How to use cost & quality data to achieve practice & network success

- MANAGING CARE FOR POPULATIONS
  Prospectively managing patients with chronic conditions

- ENGAGING PATIENTS
  Skills to empower patient self-management

- COORDINATING CARE WITH THE MEDICAL NEIGHBORHOOD
  Facilitate high functioning relationships with specialists

- IMPROVING QUALITY
  Learn quality improvement techniques

- PRODUCING EVIDENCE FOR NCQA RECOGNITION
  Assist in creation of documentation for NCQA recognition

Population Management Episode-Specific Redesign

- Efficient Care
  - Avoidable harm
  - Reliable Care
  - Intended Care
  - Inefficient care

Episode-Specific Redesign

- Analytics
  - Identify unnecessary variation
- Multidisciplinary team redesign
  - Eliminate unnecessary variation
  - Develop new “care plan”
- Execution & sustainability
  - Decision support
  - Measurement and feedback
Table of contents:

Episode-Specific Redesign – Cardiology

Door to Balloon Time
Rate of meeting 90-minute FHR30 goal in EMS-transported STEMI patients

Bivalirudin Use

Radial Artery Access
Rate of radial accessing PCI (Cut 2013 through Nov 2014)

Bivalirudin Use

Episode-Specific Redesign – Colorectal Surgery

Colorectal Value Report for Surgery

SSI Trend at EUH in Colorectal Surgery
NSQIP SAR’s 2010-2014
System Transformation

Emory Healthcare Network Advantage

Risk Stratification

<table>
<thead>
<tr>
<th>Medicare Advantage Enrollees</th>
<th>Healthy Start Visit</th>
<th>Hospitalization</th>
<th>Prospective Risk Analytics</th>
<th>PCP Referral</th>
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<td>High Risk</td>
<td>High Risk</td>
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<tr>
<td>Mod Risk</td>
<td>Rising Risk</td>
<td>Moderate Risk</td>
<td>Rising Risk</td>
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<tr>
<td>Low Risk</td>
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Life Happens

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<th>Unstable</th>
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Risk Stabilization

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<tr>
<td>Low Risk</td>
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Outcomes

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<th>Readm 10% v. 18%</th>
<th>Avg HbA1c 7.08%</th>
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<tr>
<td>57% fewer amputation s</td>
<td>Fewer Bed Days Hosp – 63% SNF – 67%</td>
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Emory Healthcare Network Advantage

In collaboration with CareMore™
Emory Healthcare Network Advantage
In collaboration with CareMore™

Coordinated Care Centers
- Staff
- Extensivists
- Advanced Practice Providers
- Nurse Coordinators (RN)
  - Care Coordinators (MA)
- Administrative Staff
- 30 clinical programs (e.g. diabetes, CKD, wound, ...)

The PCP’s Sidekick

Improved Patient Outcomes

PCP | Extensivist

Care Center & Advanced Practice Providers

Care Coordination Team

Specialty Care, Acute Care, SNF

Clinical Programs
- Executed by Care Center APPs
- Evidence-based protocols
- 30 clinical programs
  - Diabetes, CKD, Wound...

Care Coordination Team
- Nurse coordinator (RN)
- Care coordinator (MA)

Support to Clinical Team
- Specialists, Skilled Nursing Facilities, Hospitals
- Referrals, prior auth., etc.
Questions & Comments
The Emory Healthcare Network

Rapid Fire Case Studies
George Kerwin, FACHE
President/CEO
Bellin Health
Session Objectives

- Describe how Bellin has organized itself to manage the health of populations.
- Share two critical areas of redesign necessary to successfully manage the health of populations.
- Stimulate sharing and learning with attendees.

Bellin is Organized to Assume Financial Risk for Our Population
Serving a Market of 636,682 People

Bellin Hospital, a 220-bed community hospital with proven excellence in heart and vascular care; orthopedics and sports medicine; family programs and services; cancer care; and minimally invasive procedures including robotic surgery

Bellin Health Oconto Hospital, a 10-bed critical-access hospital in Oconto

Bellin Medical Group and NorthReach Healthcare, a 121-member primary care group with 32 clinic sites and proven excellence in disease management and wellness care

Employer Clinics, 83 clinics located within employer facilities

FastCare Retail Clinics, 4 retail clinics located in grocery and discount retail stores

Physician Partners, Ltd incorporates all of Bellin Health System, their employed providers and approximately 116 independent providers

Bellin Psychiatric Center, a dominant provider of in- and outpatient behavioral health services, staffed by 10 psychiatrists, 4 psychologists and 24 licensed mental health & addiction therapists

Unity Hospice, providing hospice and palliative care services

Develop Capability

KEY TOOLS

- Electronic Medical Record (EMR), enterprise-wide using Epic software
- Patient Registry, CareManager software integrated into the EMR
- Health Risk Appraisal from Healics integrated into the EMR
- Access Platform
Develop Capability

Nine Steps to Achieving Population Health (handout)

1. Understand the population
2. Define GOALS for the population – 3 W’s
3. Create high level design – Match demand & capacity
4. Activate the team
5. Engage the individual
6. Measure outcomes
7. Provide feedback
8. 30 day improvement plans
9. Recalibrate GOALS
Move from Insuring Risk to Managing Health

A Shift in the Corridor

- Insure Health
- Manage Health

Low Risk - High Coordination - HIGH

TODAY

- Low Coordination
- -$
Organization-wide Alignment (handout)

Two Key Areas of Redesign
1. Redesign Patient Care

OLD MODEL OF PATIENT CARE

- Paper Work
- Medication Refill
- Chronic Disease Management
- Test Results
- Acute Visits
- Preventative Visits
- Patient Orders/Triage

Referral to Ancillary Services
CMA/LPN
RN
Referral to Specialist
Managing Messages, Test Results, Calling Patients

PROVIDER

NEW MODEL OF CARE

**Patient Needs**

- Paperwork
- Acute Visits
- Medication Refill
- Patient Orders/Triage
- Preventative Visits
- Chronic Disease Management
- Referrals

**CORE TEAM**

- Physician
- PA
- RN
- LPN/MA
- MT/PA
- BHC

**Extended Care Team**

- Diabetic Educators
- Case Manager
- CDMT
- Pharmacist
- Health Educator
- Behavioral Health
- RN Care Coordinator

11/23/2015
Transitioning to Assuming Financial Risk for Our Population
Payment Models along the Corridor

Low
Risk

High
Risk

Low
Coordination

High
Coordination

-$

TODAY

Insure
Health

Manage
Health

Risk Models
Shared Savings
Quality Metrics
Tiered to Create Steerage
Results Linked to Future Increases
Base Fee Schedule

Payment Models along the Corridor

Low
Risk

High
Risk

Low
Coordination

High
Coordination

-$

TODAY

Insure
Health

Manage
Health

Risk Models
Shared Savings
Quality Metrics
Tiered to Create Steerage
Results Linked to Future Increases
Base Fee Schedule

Bellin as an Employer
Health Results

Annual HRA Participant Results

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<tr>
<th>Year</th>
<th>Total Emp's</th>
<th>Total Spo's</th>
<th>Total Others</th>
<th>Total Par's</th>
<th>Total Avg Age</th>
<th>Percent of participants in health point ranges</th>
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<td>653</td>
<td>66</td>
<td>3122</td>
<td>42.8</td>
<td>74.1</td>
</tr>
<tr>
<td>2007</td>
<td>1983</td>
<td>852</td>
<td>66</td>
<td>2901</td>
<td>42.9</td>
<td>73.5</td>
</tr>
<tr>
<td>2006</td>
<td>1833</td>
<td>200</td>
<td>47</td>
<td>2080</td>
<td>42.1</td>
<td>72.1</td>
</tr>
<tr>
<td>2005</td>
<td>1745</td>
<td>181</td>
<td>47</td>
<td>1973</td>
<td>41.5</td>
<td>72.8</td>
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<tr>
<td>2004</td>
<td>1631</td>
<td>183</td>
<td>54</td>
<td>1868</td>
<td>42.1</td>
<td>72.7</td>
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<tr>
<td>2003</td>
<td>1321</td>
<td>71</td>
<td>49</td>
<td>1441</td>
<td>40.5</td>
<td>72.8</td>
</tr>
</tbody>
</table>

Cost Results

Bellin's Cost Difference Compared to Average (In Millions)

-2.2
-2.6
-2.0
-1.7
-1.1
-0.6
-1.2
-1.3
-2.1
-1.9
-2.5

$22.7+ Million Saved
Medicare & Medicaid

What's at Risk with the Various CMS Performance Programs?

Bellin's $26.6 Million at Risk for CMS Performance Programs between 2013-2017

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Incentives</td>
<td>$15,108,669</td>
<td>$12,947,769</td>
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<tr>
<td>Penalty Avoidance</td>
<td>0</td>
<td>($11,180,083)</td>
</tr>
<tr>
<td>Penalties</td>
<td>($11,145,360)</td>
<td>($150,769)</td>
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</tbody>
</table>
## Estimated $26.6M of CMS Performance Programs

### Reporting Programs

<table>
<thead>
<tr>
<th>Type</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Quality Reporting</td>
<td>-</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Outpatient Quality Reporting</td>
<td>-</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
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<tr>
<td>Inpatient Rehab Reporting</td>
<td>-</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
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<tr>
<td>Home Health Quality Reporting</td>
<td>-</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
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<tr>
<td>Inpatient Psychiatric Quality Reporting</td>
<td>-</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Ambulatory Surgery Centers Reporting</td>
<td>-</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
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</tbody>
</table>

### Wisconsin Medicaid Pay for Performance

<table>
<thead>
<tr>
<th>Type</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>1.5%</td>
<td>1.5%</td>
<td>1.5%</td>
<td>1.5%</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

### Medicare Value-Based Purchasing

<table>
<thead>
<tr>
<th>Type</th>
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<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>1%</td>
<td>1.25%</td>
<td>1.50%</td>
<td>1.75%</td>
<td>2%</td>
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</table>

### Readmission Reduction (5 Conditions)

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<tr>
<th>Type</th>
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<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>1%</td>
<td>2%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
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</table>

### Hospital Acquired Conditions

<table>
<thead>
<tr>
<th>Type</th>
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<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td></td>
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</table>

### Meaningful Use*

<table>
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<tr>
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<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incentive &amp; Penalty</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Physician Quality Reporting System (PQRS)*

<table>
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<th>Type</th>
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<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incentive &amp; Penalty</td>
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<td></td>
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### Pioneer Program

<table>
<thead>
<tr>
<th>Type</th>
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<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incentive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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---

*Penalties and incentives may vary depending on specific performance metrics and year.
### Commercial

### Commercial Customers

<table>
<thead>
<tr>
<th>Strategic Partner</th>
<th>Contract Type</th>
<th>Value Based $ (Penalty/Dow)</th>
<th>Value Based $ (Incentive /Upside)</th>
<th>Value Based $ (Expected)</th>
<th>Total Spend (P12 Mo)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ariens</td>
<td>Pay for Performance Employer RCI</td>
<td>$ -</td>
<td>$ 92,016</td>
<td>$ -</td>
<td>$ 1,073,405</td>
</tr>
<tr>
<td>Ashwaubenon School District</td>
<td>Shared Savings</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 1,301,209</td>
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<tr>
<td>Associated Bank</td>
<td>Sharp Savings</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 1,832,324</td>
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<tr>
<td>Associated Bank Eau Claire (GBIC)</td>
<td>Likelihood to Recommend</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
</tr>
<tr>
<td>Bellin</td>
<td>Full Risk</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 10,990,539</td>
</tr>
<tr>
<td>Belmark</td>
<td>Pay for Performance Employer RCI</td>
<td>$ -</td>
<td>$ 133,753</td>
<td>$ -</td>
<td>$ 890,263</td>
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<tr>
<td>Brown County</td>
<td>WIA Improvement</td>
<td>$ (43,656)</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 2,318,047</td>
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<tr>
<td>City of Green Bay</td>
<td>WIA Improvement</td>
<td>$ (19,706)</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 901,631</td>
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<tr>
<td>Green Bay Packers</td>
<td>Pay for Performance Employer RCI</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 742,864</td>
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<tr>
<td>Howard Saurocico</td>
<td>Shared Savings</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 1,977,335</td>
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<tr>
<td>JSI</td>
<td>Shared Savings</td>
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<td>$ -</td>
<td>$ -</td>
<td>$ 1,076,589</td>
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<tr>
<td>LaFrenz, Inc.</td>
<td>Pay for Performance Employer RCI</td>
<td>$ -</td>
<td>$ 70,954</td>
<td>$ -</td>
<td>$ 893,812</td>
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<tr>
<td>NEW Curative</td>
<td>Pay for Performance Employer RCI</td>
<td>$ -</td>
<td>$ 52,395</td>
<td>$ -</td>
<td>$ 74,250</td>
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<tr>
<td>WWCIC</td>
<td>Cost Plus Triple Aim</td>
<td>$ (462,353)</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 1,928,085</td>
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<tr>
<td>Oconto Schools /WEA</td>
<td>Pay for Performance Employer RCI</td>
<td>$ -</td>
<td>$ 214,760</td>
<td>$ -</td>
<td>$ 950,504</td>
</tr>
</tbody>
</table>
Moving Up The Corridor

A Shift in the Corridor
Questions?

Energizer
ACO Panel

Richard Gitomer, MD
President & CQO
Emory Healthcare Network

George Kerwin, FACHE
President/CEO
Bellin Health

Closing & Reflections
Thank You!

Please let us know if you have any questions or feedback following today’s session.

Trissa Torres
ttories@ihi.org

Molly Bogan
mbogan@IHI.org