PREMIER

Bundle Payment: Findings, Lessons Learned and the Torrance Memorial Experience

Steve Valentine and Peggy Crabtree of Premier, Inc. and John McNamara, MD of Torrance Memorial Medical Center

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Current Medicare Bundled Payments Programs

Retrospective bundle design

- Bundled Payment for Care Improvement Initiative (BPCI) Models 1-3
  - **Voluntary** program for multiple entity types
    - » Applicant period is closed
  - Entities first went live in October 2013

- Oncology Care Model (OCM)
  - **Voluntary** program for physician practices
    - » Applicant period is closed
  - Anticipated start date is July 2016

- Comprehensive Care for Joint Replacement Model (CJR)
  - **Mandatory** for hospitals within 67 selected geographic areas
  - Start date is April 1, 2016

Overview: BPCI Comprised Of Four Models Of Care

Retrospective Reconciliation:

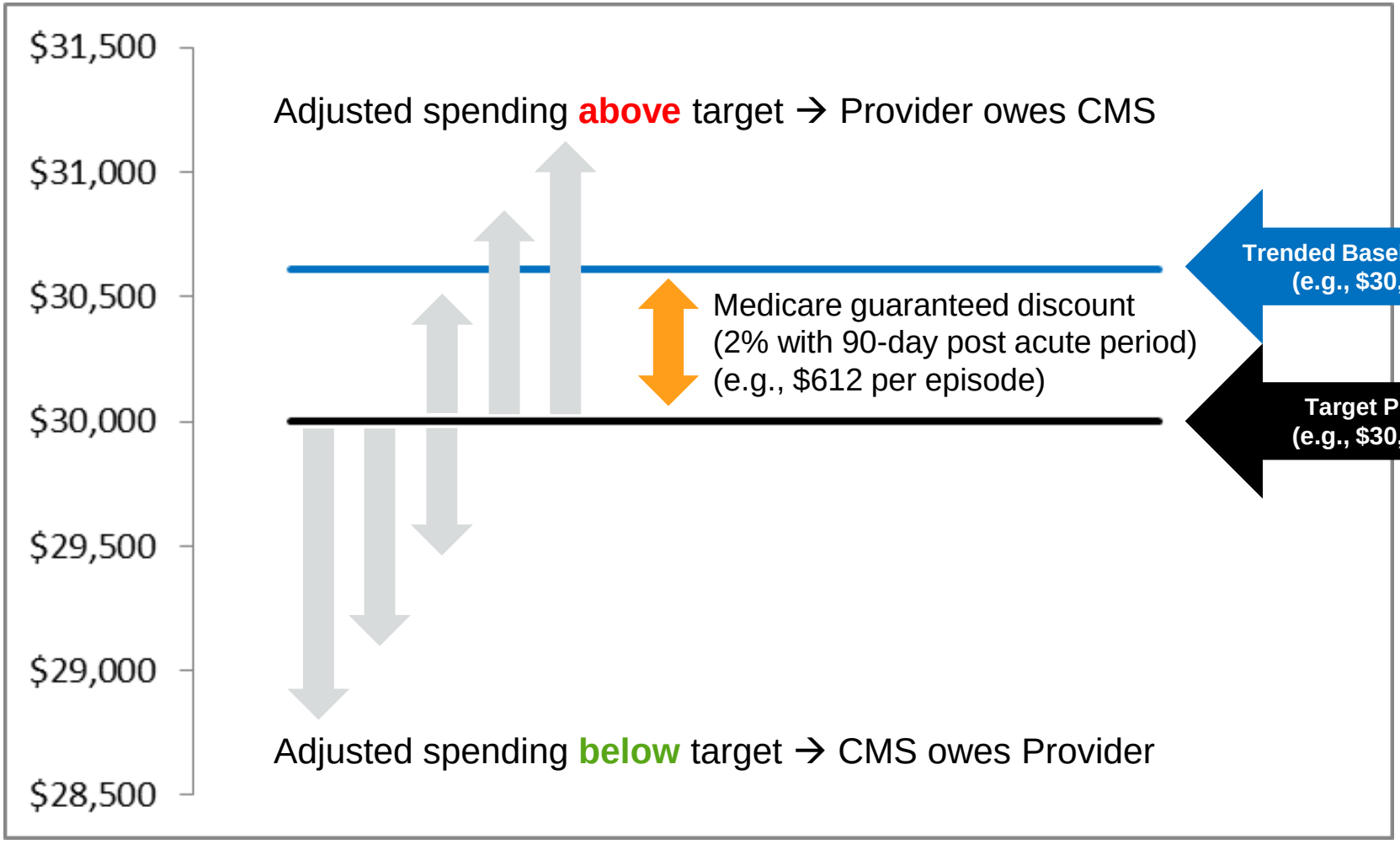
- **Model 1:** payment model for the **acute inpatient hospital** stay only.
- **Model 2:** bundled payment model for **hospitals, physicians, and post-acute** providers for an episode of care consisting of an inpatient hospital stay followed by post-acute care.
- **Model 3:** bundled payment model for **post-acute and physician** care where the bundle excludes the acute inpatient hospital stay.

Prospective payment:

- **Model 4:** administered bundled payment models for **hospitals and physicians** for the **acute inpatient hospital** stay only.

CMS BPCI Retrospective Risk Payment Example

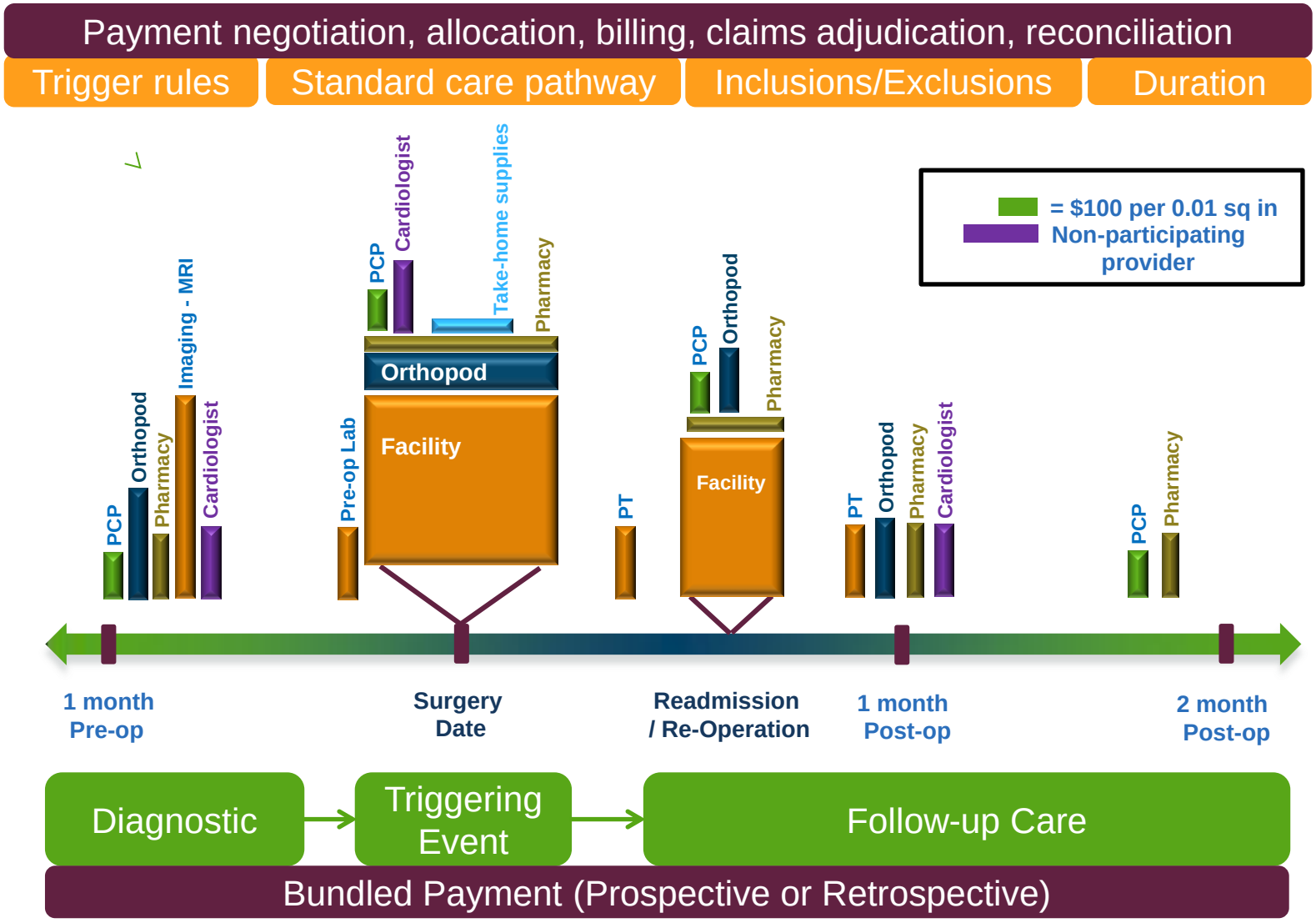
Medicare spend vs episode target



**Each MS-DRG within the episode family will have a different target price.*
**Total Savings and losses (aggregated at the Awardee level) are capped at 20% of the trended baseline price.*

View of an Episode

Hip or Knee replacement (55 year old male w history of heart disease)



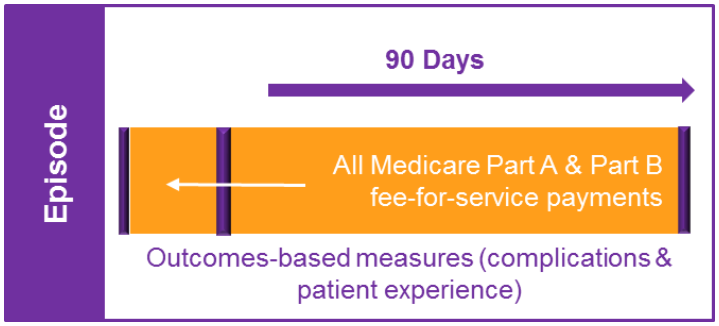
Adapted from McKesson Corporation

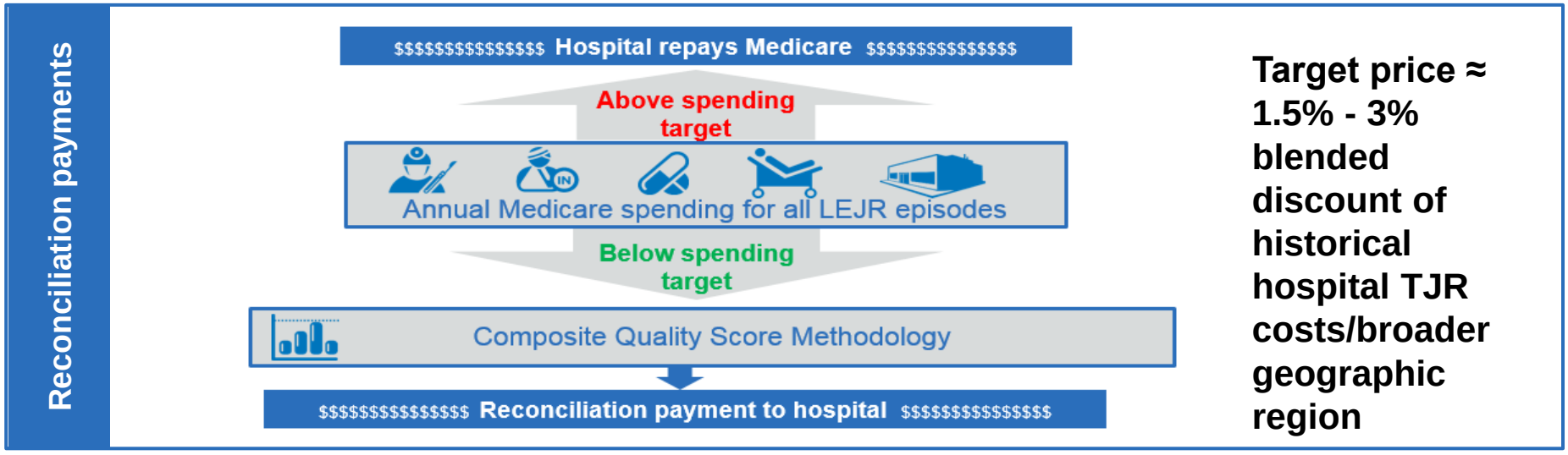
Top 10 BPCI Episodes Across The Nation

Rank	Episode	# of Active Organizations
1	Major joint replacement - lower extremity	770
2	Simple pneumonia and respiratory infections	395
3	COPD, bronchitis, asthma	383
4	Congestive heart failure	380
5	Sepsis	336
6	Urinary tract infection	300
7	Hip & femur procedures except major joint	295
8	Acute myocardial infarction	284
9	Medical non-infectious orthopedic	276
10	Other respiratory	265

Overview: CJR Model

- Mandatory 5-year program for 67 geographic areas
- Begins April 1, 2016
- Focused on hip and knee replacement (ankle too)
- Medicare Part A & B services
- Hospital held accountable for quality and cost of care from admission to 90 days post-discharge
- Two-sided financial risk - downside risk begins PY2
- Waivers provided

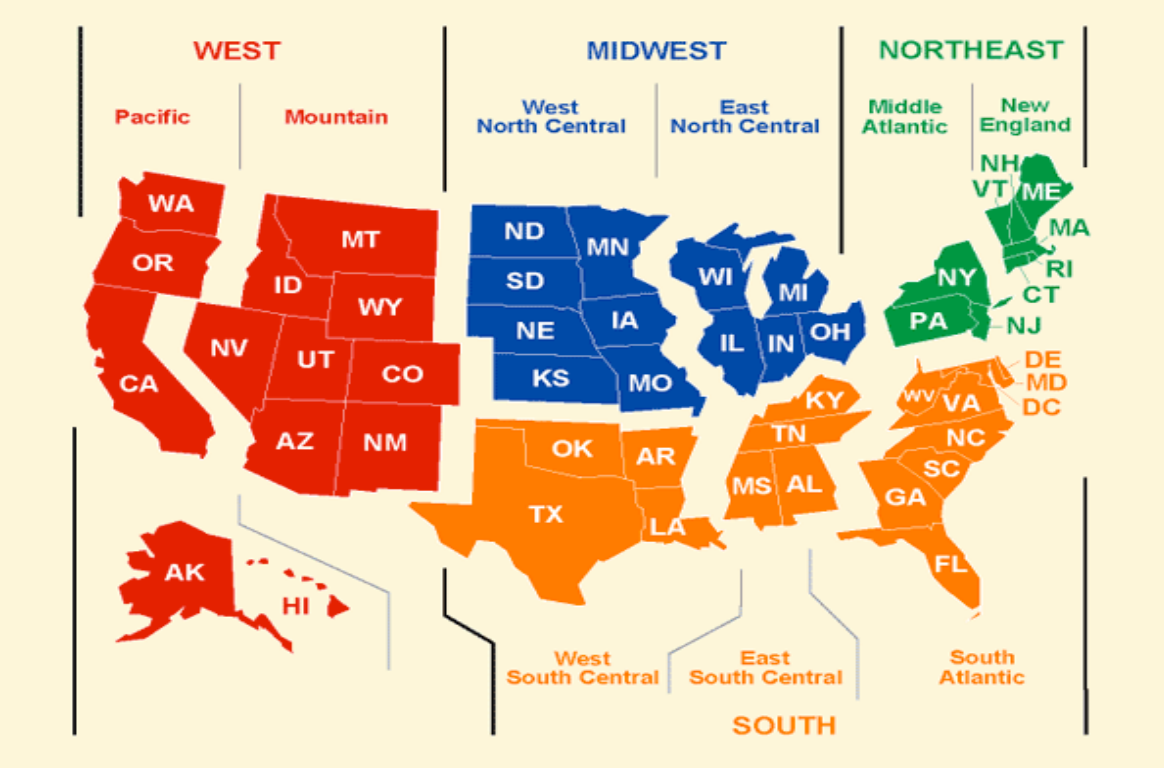




Target price ≈ 1.5% - 3% blended discount of historical hospital TJR costs/broader geographic region

CJR Using Blended Target Rates

Shifting to 100% regional by 2019



- Target rates begin as a combination of hospital-specific and regional (US census region) historical payments and transition to regional-only rates

	PY1	PY2	PY3	PY4	PY5
Hospital specific episode data	66.6%	66.6%	33.3%	0%	0%
Regional specific episode data	33.3%	33.3%	66.6%	100%	100%

CJR Overlap With Other Payment Models

- Bundled Payment for Care Improvement (BPCI)
  - Hospitals participating in BPCI Model 1 or Phase II of Models 2 and 4 remain in LEJR BPCI episode
  - Should Phase II participants terminate from BPCI – they are required to participate in CJR, if within a designated MSA
  - BPCI Model 2 and 3 episodes initiated by a physician group practice (PGP) or post-acute care facility will take precedence over CJR

- Accountable Care Organization (ACO)
  - Hospitals participating in CJR may also participate in an ACO
  - Financial reconciliation for beneficiaries in both programs performed similar to BPCI program

ACO Payment Model Overlap with CJR

Type of Model Overlapping with CJR	CJR Final Policy
MSSP and other ACO models when a CJR participant hospital also participates in the ACO and the beneficiary in the CJR episode is also aligned to that ACO	The CJR model will make an adjustment to the reconciliation amount if available to account for any of the applicable discount for an episode resulting in Medicare savings that is paid back through shared savings under the Shared Savings Program or any other ACO model. If a CJR hospital did not earn a reconciliation payment, no adjustment is made. CMS will not increase the amount of a hospital's repayment amount in order to account for the portion of the discount percentage paid out as savings.
MSSP and other ACO models when a beneficiary receives an LEJR procedure at a participant hospital and the beneficiary is aligned to an ACO in which the hospital is not participating	CMS will not make an adjustment to any CJR reconciliation amount to account for any of the applicable discounts for an episode resulting in Medicare savings that is paid out as shared savings. CMS recognizes that this policy would allow an unrelated ACO full credit for the Medicare savings achieved during the episode and leaves overlap unaccounted.

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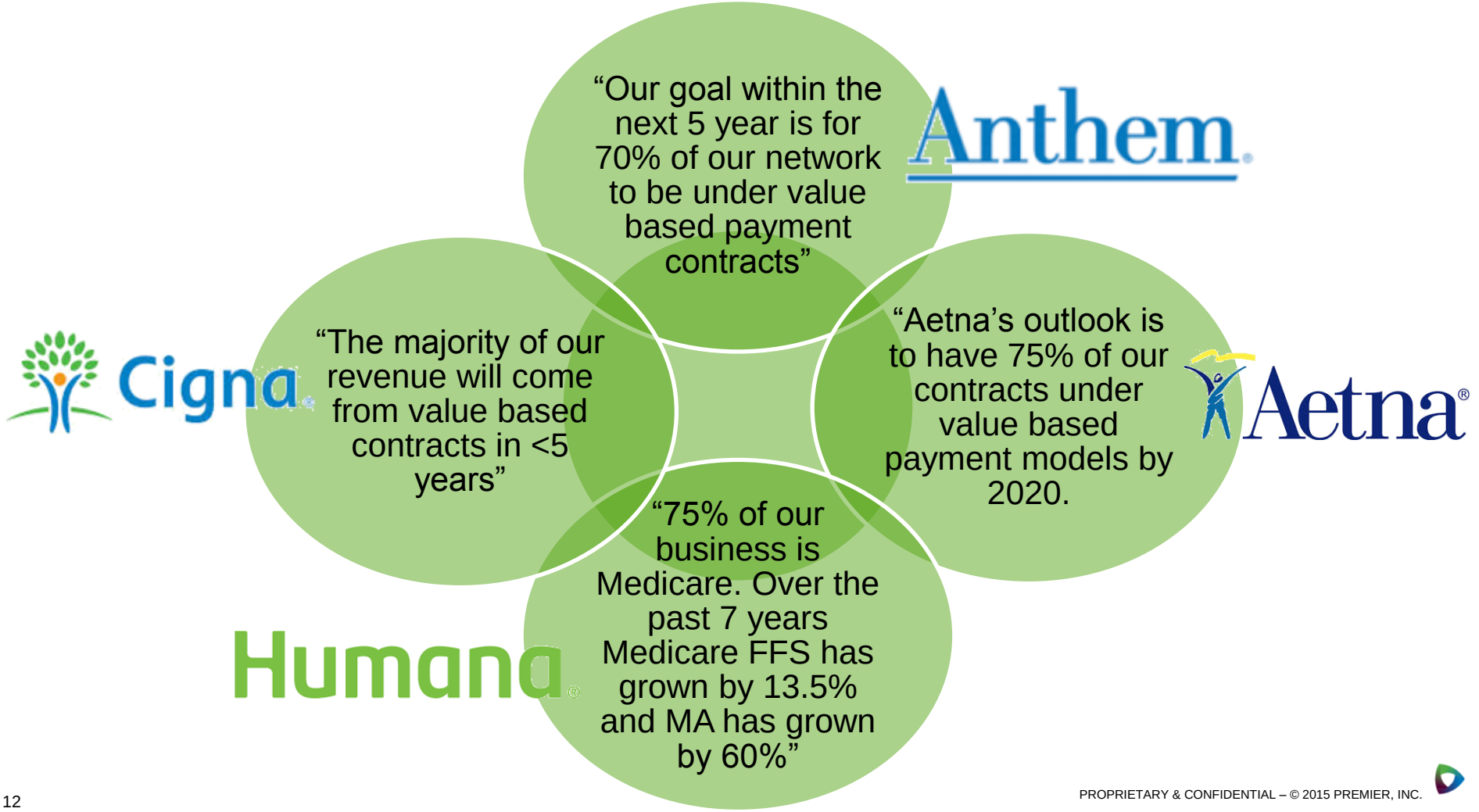
Volume to Value

	2016	2018
Track 1: Value-based payments	**85%** of all Medicare payments	**90%** of all Medicare payments
Track 2: Alternative payment models*	**30%** of all Medicare payments	**50%** of all Medicare payments

HHS Goals	Description
Incentives	▪ Promote value-based payment systems – Test new alternative payment models – Increase linkage of Medicaid, Medicare FFS, and other payments to value ▪ Bring proven payment models to scale
Care Delivery	▪ Encourage the integration and coordination of clinical care services ▪ Improve population health ▪ Promote patient engagement through shared decision making
Information	▪ Create transparency on cost and quality information ▪ Bring electronic health information to the point of care for meaningful use

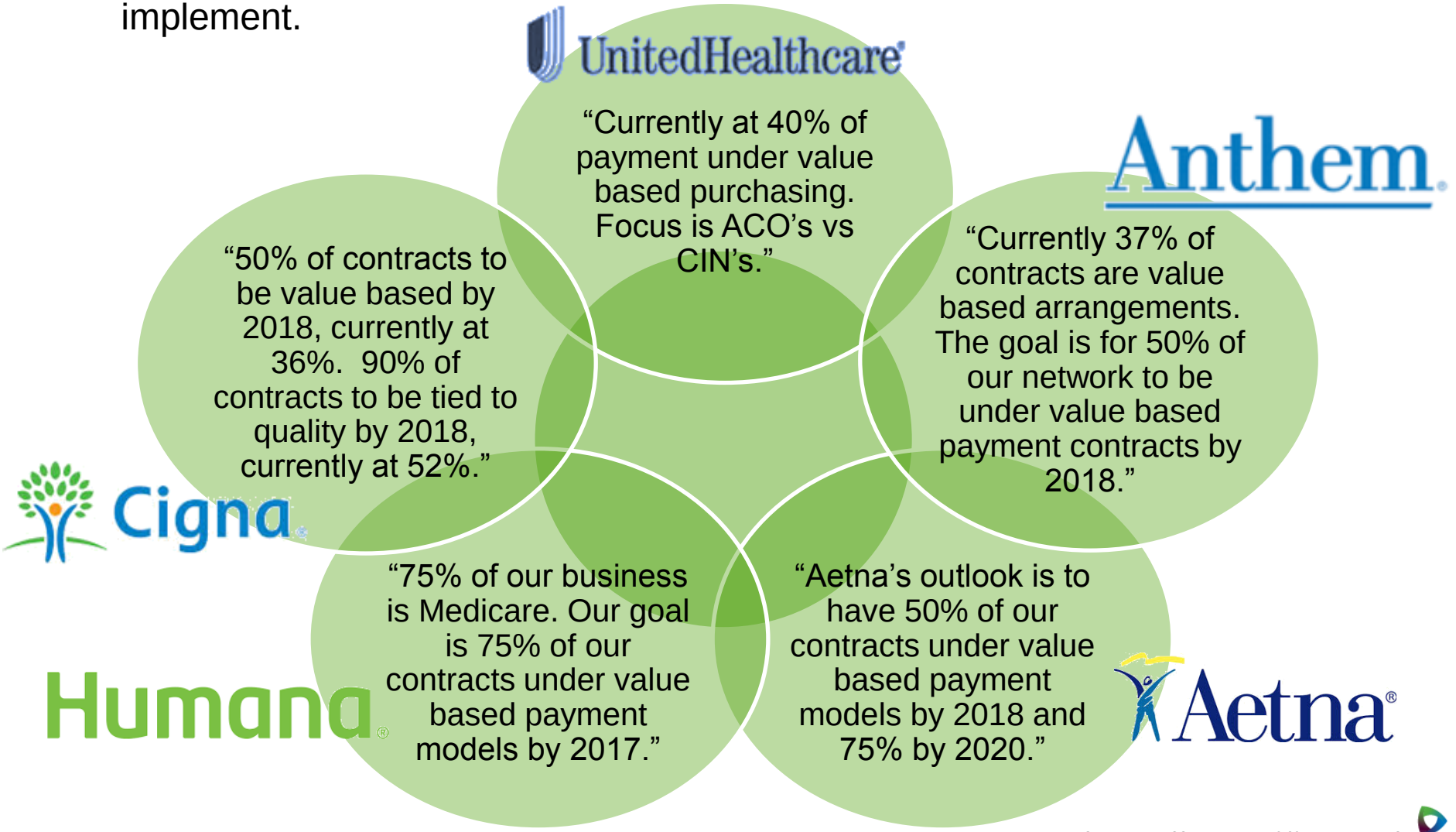
Key Themes From 2015 Commercial Payor Session

- **Commercial payors are aggressively transitioning to value based payment**: Each payor's strategic outlook is similar to the HHS' goal to shift aggressively to value based contracts over the next five years.



Key Themes From 2016 Commercial Payor Session

- **Commercial payors are aggressively transitioning to value based payment**: Since 2015 each has developed a VBP strategy and begun to implement.



Tools For Success: Medicare and Beyond

What Should We Be Doing Now?

Hospitals must be prepared in the following areas for program success:

Program oversight and financial risk elements

- Identify stakeholders/roles
- Identify CJR leader
- Identify other payment models (e.g. BPCI, ACO, MSSP)

Post-acute partnerships

- Identify PAC providers and referrals
- Evaluate quality performance, utilization patterns

Bundled payment analytics, reporting & reconciliation

- Review current state performance to identify improvement opportunity
- Identify ongoing analytic reporting capability

Cross continuum care pathways / care models

- Map current processes
- Identify opportunities for implementing leading practice
- Communication structure

Provider engagement

- Provide education on CJR
- Involve in PI efforts
- Consider gain sharing options

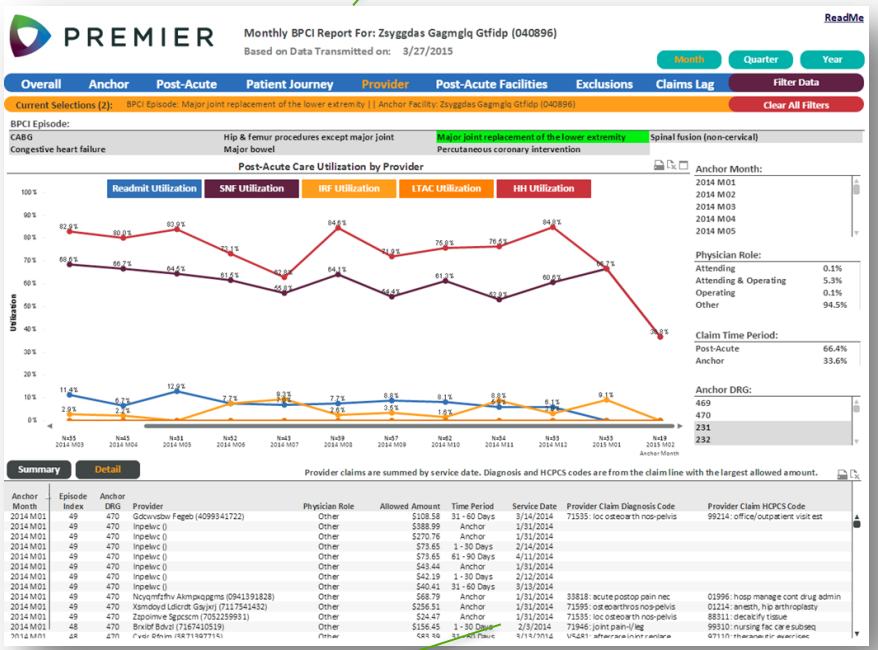
Quality performance measurement

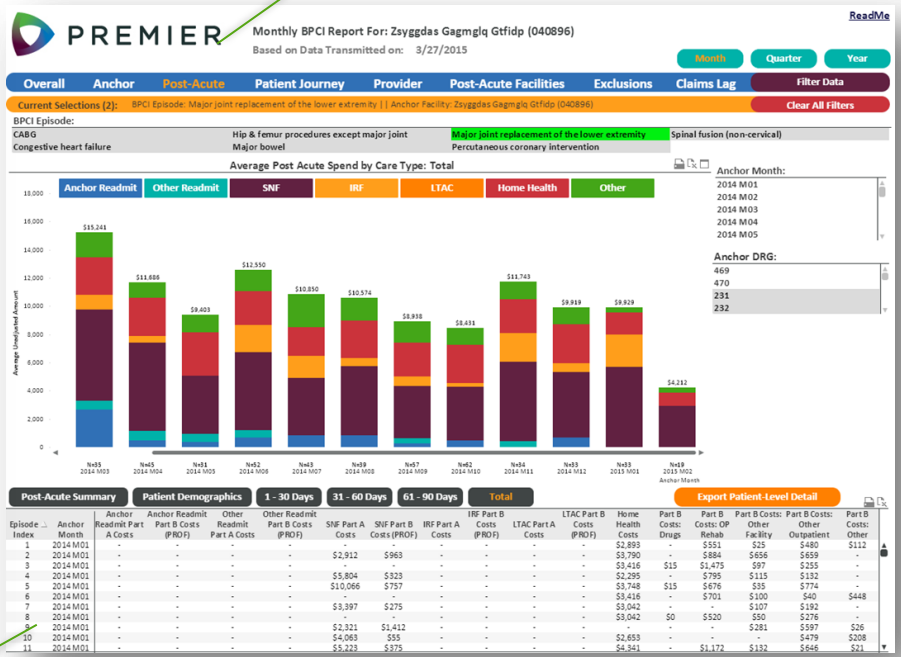
- Identify analyst resource
- Identify measures
- Create report structure

Analytics To Help You Manage Your Episodes

Episode cost and utilization trends

Performance reports





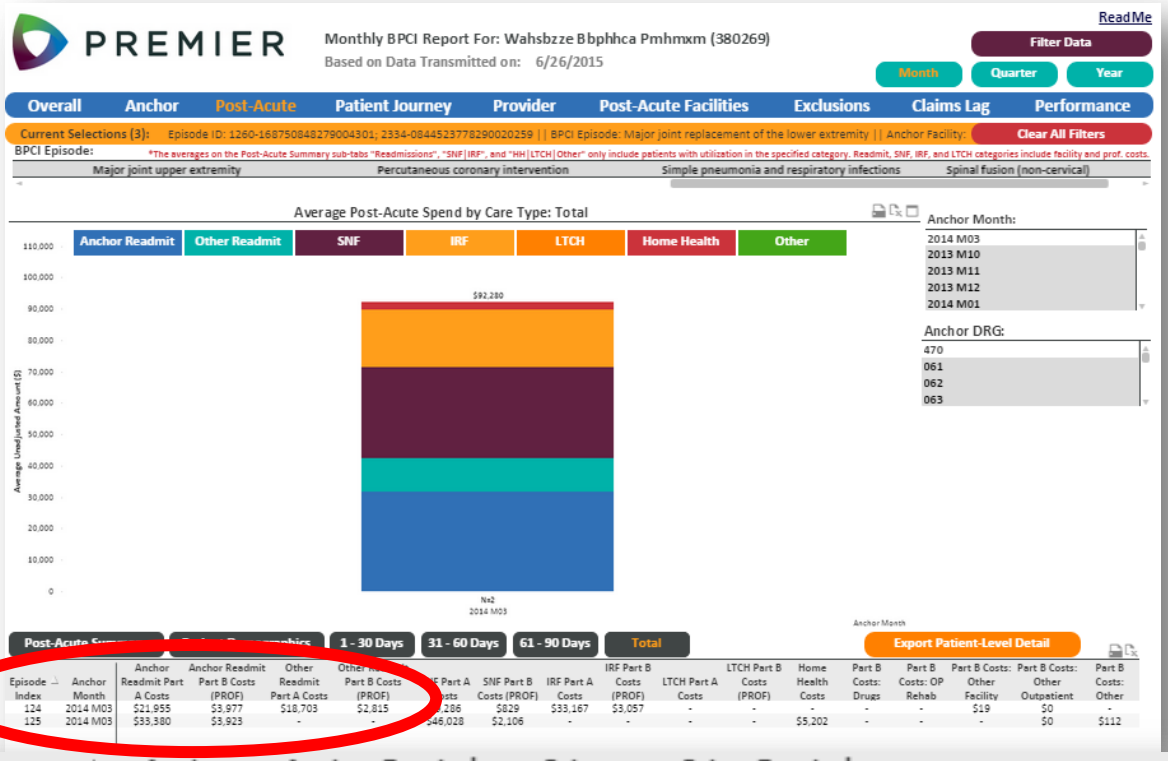
PAC Utilization

Provider-level reports

Patient-level reports

Analytics To Help You Isolate High Cost Cases

2 patients with episode cost over $100k



Episode Index	Anchor Month	Anchor Readmit Part A Costs	Anchor Readmit Part B Costs (PROF)	Other Readmit Part A Costs	Other Readmit Part B Costs (PROF)	SNF Part A Costs	SNF Part B Costs (PROF)	IRF Part A Costs	IRF Part B Costs (PROF)
124	2014 M03	$21,955	$3,977	$18,703	$2,815	$9,286	$829	$33,167	$3,057
125	2014 M03	$33,380	$3,923	-	-	$46,028	$2,106	-	-

Patients

$47,450 Readmit cost

$48,134 SNF cost

Optimizing Cross Continuum Care

Patient Preparation

- Standardized Processes
- Meets clinical indications for intervention
- Evaluation of risk with functional assessment
- Discharge discussions start before admission
- Decisions related to procedure/intervention

Inpatient Stay

- Admission processes
- Preparation, Operation, PACU processes
- Hospital stay processes
- Discharge processes

Follow-Up &Recovery

- Transition planning
- Discharge disposition (Patient discharged to?)
- Care coordination & medication reconciliation
- Rehabilitation and clinics
- Functional status evaluation
- Establish linkages With PAC

Post-Acute Care

- Transition planning
- Discharge to home
- Medication reconciliation
- Home Health requirements
- Care management
- Readmission reduction tactics
- Community Services
- PAC Network

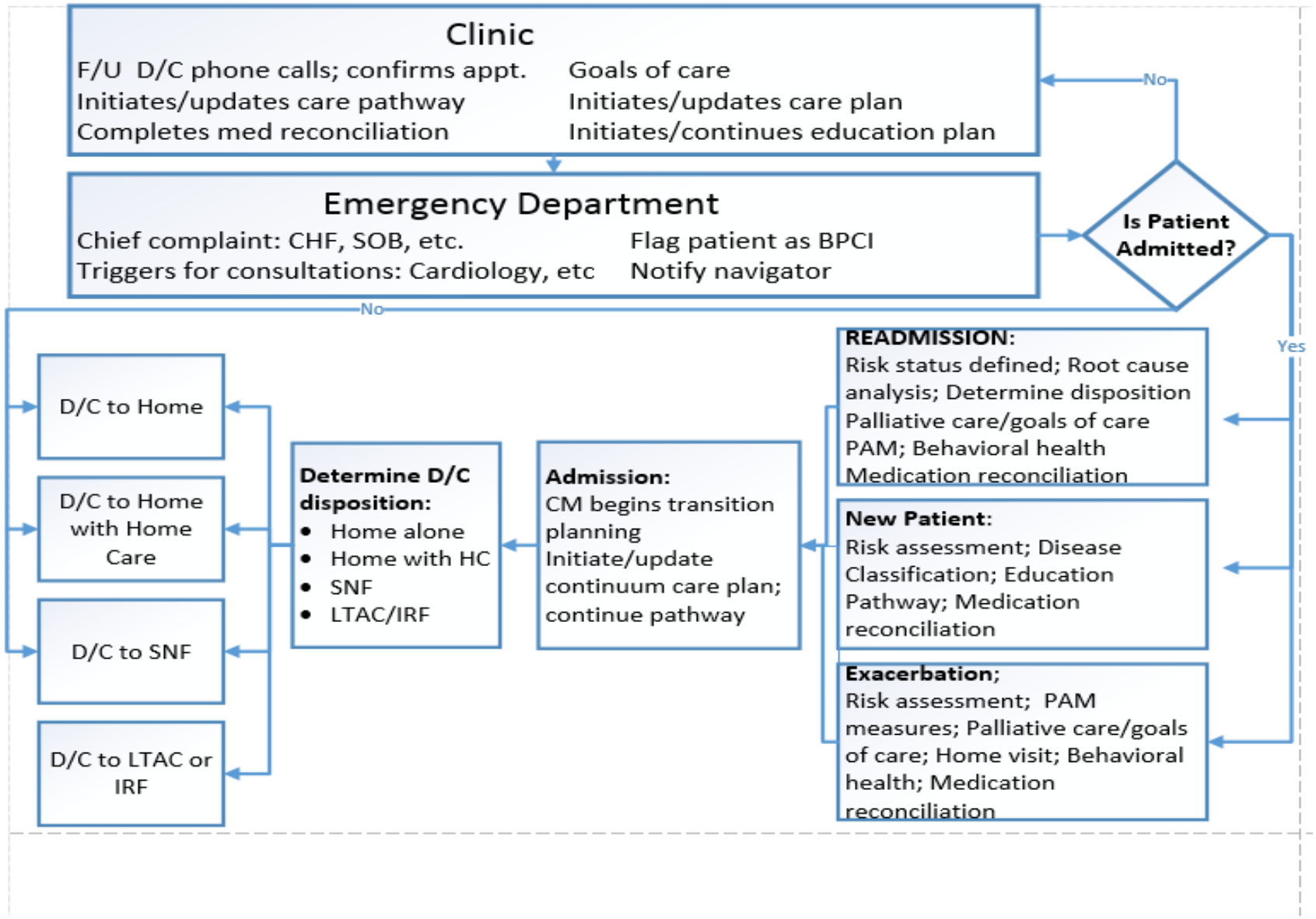
ENGAGE AND RETAIN **ASSESS AND PLAN** **COMMUNICATE AND EDUCATE**

Assessing Post Acute Care (PAC) Providers

- Identify market providers
- Analyze providers – using scorecards
  - Volume
  - ED utilization
  - Length of Stay
  - Readmission rates
  - Patient satisfaction
  - Quality measures
  - Star rating
  - Clinical Indicators
    - » Infection rates
    - » Long-term Residency %

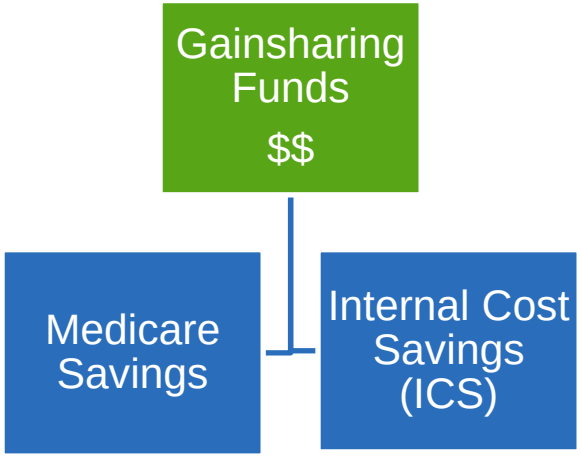
SNF Provider Scorecard		State	National
Date	5/1/2014	N/A	N/A
Facility Name	Nursing Center	N/A	N/A
Administrator	John Doe, NHA	N/A	N/A
Medical Director	Dr. Sample	N/A	N/A
Volume Metrics (provided by facility)	**FY2013**	State	National
Total number of licensed beds	170	N/A	N/A
Number of beds dedicated to post-acute/rehab	65	N/A	N/A
Number of beds dedicated to long-term-care	102	N/A	N/A
Number of referrals from HN (Annually)	312	N/A	N/A
Number of admissions (Annually)	492	N/A	N/A
Admission rate from HN (%) (Referral/Admissions)	63%	N/A	N/A
Case Mix Index	1.04	N/A	N/A
Case Mix by Payer	52% M/caid, 24.9% M/care, 13.7% MA, 9.4% PP	N/A	N/A
Average quarterly census (Post Acute/rehab) (%)	93%	N/A	N/A
Readmission Rate - 30 day (Provided by facility)	**FY2013**	State	National
Overall All Cause (%)	16%	N/A	N/A
Heart Failure (%)	19.5%	N/A	N/A
Pneumonia (%)	9.9%	N/A	N/A
COPD (%)	14%	N/A	N/A
Pt. to ED Without Admission (#)	35 per year	N/A	N/A
Patient Satisfaction (Provided by facility)	**FY2013**	State	National
Name of Tool or Vendor (insert)	MyInnerview	N/A	N/A
Overall Satisfaction (%)	91%	N/A	N/A
Would Recommend (%)	94%	N/A	N/A
Nursing Care (%)	96%	N/A	N/A
Overall Response Rate (%)	62%	N/A	N/A
CMS Quality Metrics (Requires supporting documentation & action plan for any indicator below 4 stars)		State	National
Overall rating (# of stars)	2	N/A	N/A
Quality measures (# of stars)	4	N/A	N/A
Staffing (# of stars)	3	N/A	N/A
Penalties (# of stars)	1	N/A	N/A
CMS Clinical Indicators (Facility rating vs. State average)	**FY2013**	State	National
Pressure Ulcer in Long Stay High Risk Residents (%)	5.9%	5.6%	6%
Nosocomial Infections (%)	6%	N/A	N/A
Total Residents Prescribed Antipsychotics Meds. (%)			
Long-term Residents (%)	15.2%	18.8%	20.3%

Understanding Access Points



Physician Alignment-Gainsharing with Physicians

- Determine which physicians to include
  - Surgeons
  - Medical Specialists
  - Anesthesiologists
  - Hospitalists
- Assess inclusion of ICS opportunities
  - Implant cost
  - Blood utilization
- Include physicians in care redesign strategies
  - Episodic care management
  - Post acute care
- Identify performance measures
- Develop ongoing analysis processes
- Create transparent reporting



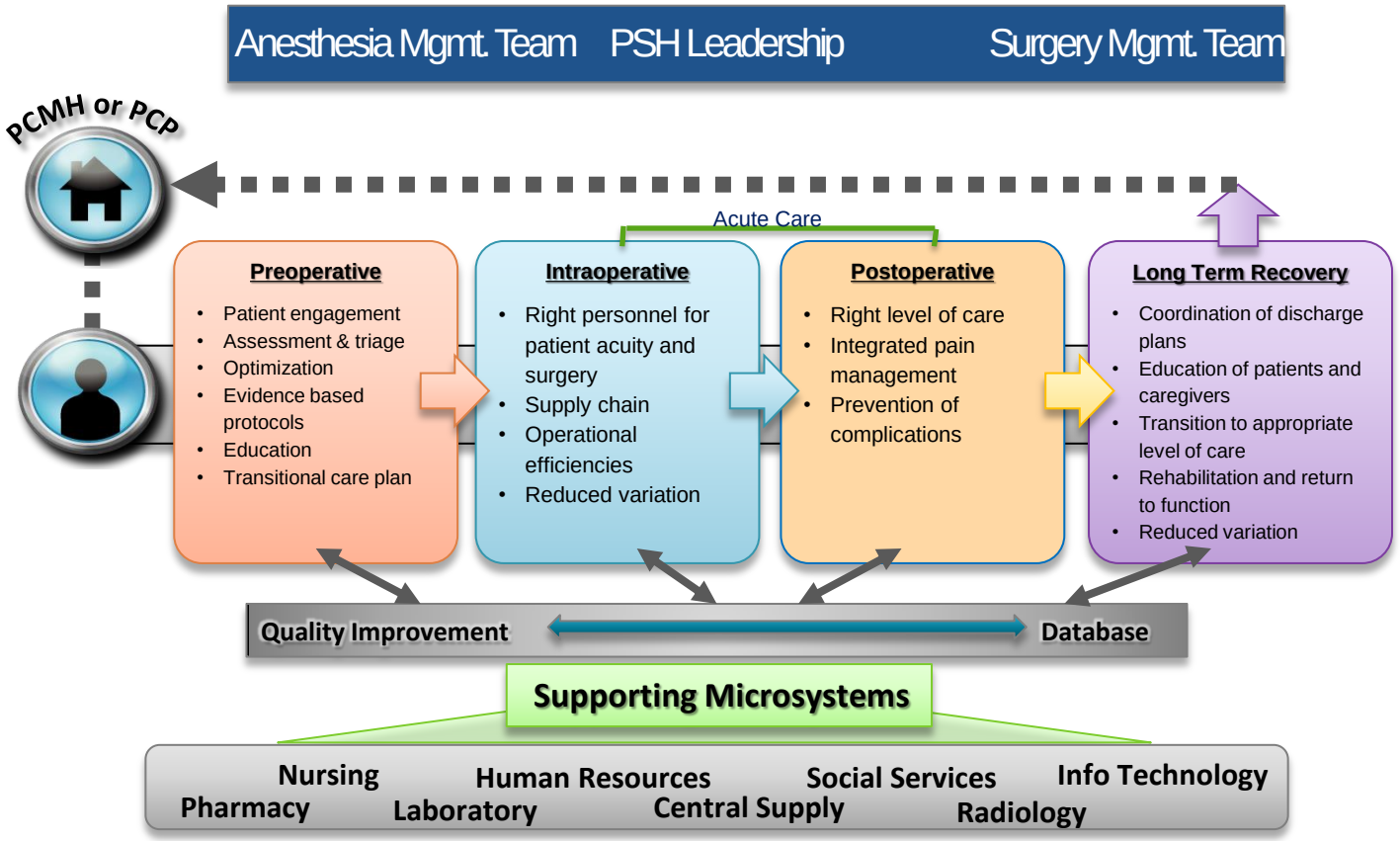
Examples of BPCI Member Innovations

- Development of home safety checklist for hip and knee rehabilitation
- Post-acute rehabilitation guideline for patients post hip and knee surgery (driven by milestones vs. day)
- Standardizing patient transition summaries and medication management discharge protocols
- Improved and focused patient education for post discharge condition management (e.g. stop light concept, providing bracelets with care provider contact information)
- Building up home health programs to include more intense care and physical therapy

Examples of BPCI Member Innovations

- Early discharge screening and planning along to include high risk identification and/or assigning a readmission risk score
- Embedding an Advanced Practitioner SNFist to improve quality of care
- Utilization of e-health as follow-up methodologies: telephonic, email, video conference
- Adding or enhancing clinics as first stop after discharge, before primary care
- Creating a perioperative surgical home model

Perioperative Surgical Home (PSH) Overview

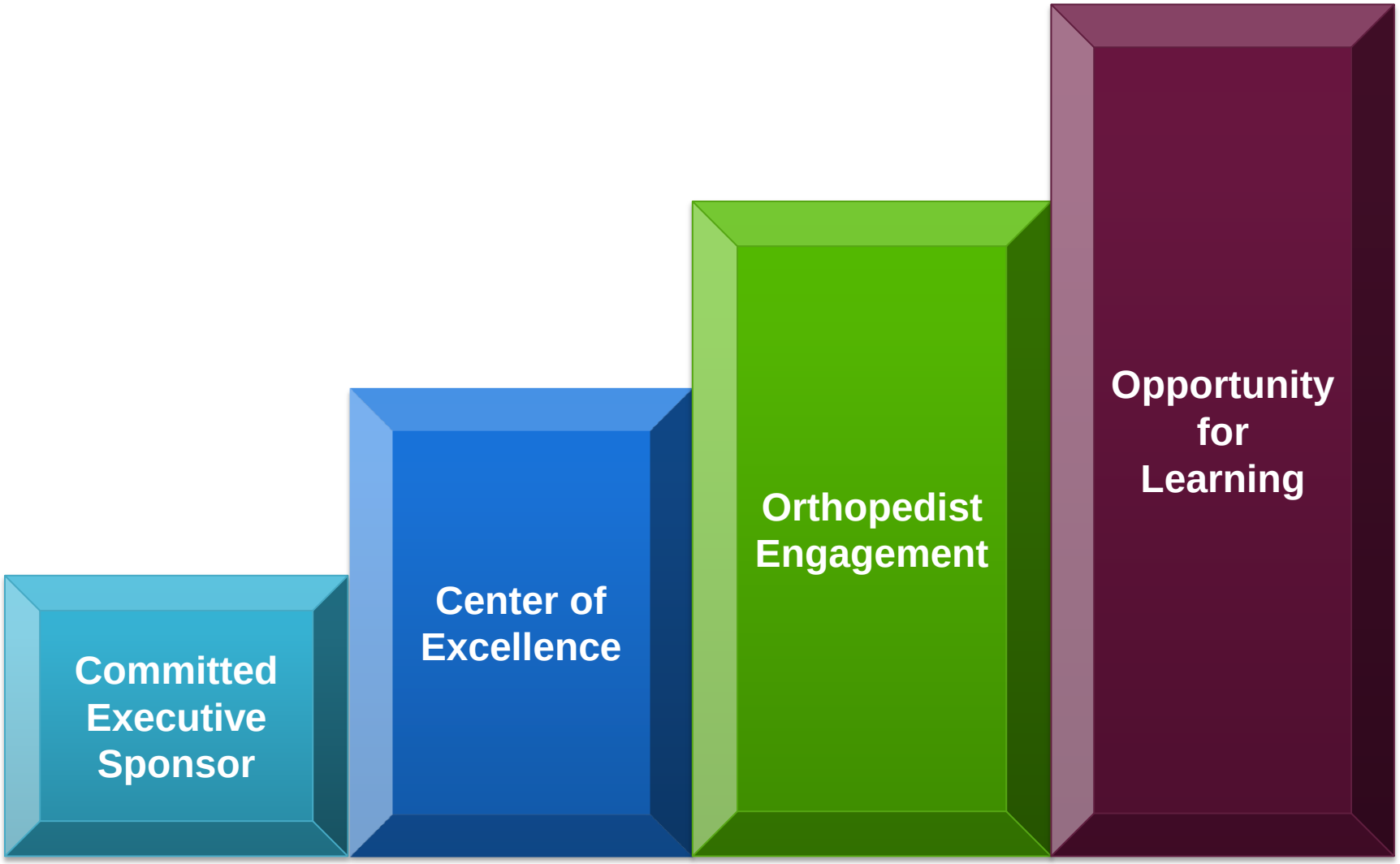


Bundled Payment: Required Capabilities Summary

Core Competencies	Required Capabilities	Capabilities Description
Episode Management	Governance & Legal Infrastructure	Ability to create transformative organizational culture, including formal committees and informal physician champions. Also develop legal and other infrastructure necessary for physician and payor partnerships.
	Episode Management	Ability to develop/understand a bundled definition, including service inclusions & exclusions, reimbursements and a discharge tail
	Cost Management	Ability to identify and implement cost reduction strategies in a safe and appropriate manner across the episode.
	Analytics, Technology and Other Services	Ability to understand current state and measure, monitor and evaluate future performance (internal trends, external benchmarks) across the episode.
Cross Continuum Clinical Care Delivery	Longitudinal Care Management	Ability to assess and re-design care across the episode and to execute continuous improvement processes.
	Post-Acute Network Planning	Ability to identify the optimal post-acute partners, appropriately manage utilization of services and jointly improve upon the patient transitions across the episode.
Provider Engagement	Provider Alignment	Ability to develop a culture of increased transparency & collaboration with physicians and other key providers. Also, ability to grow the network of participating providers and deploy gainsharing methodologies.

Torrance Memorial Medical Center-Case Study

Building On Our Strengths



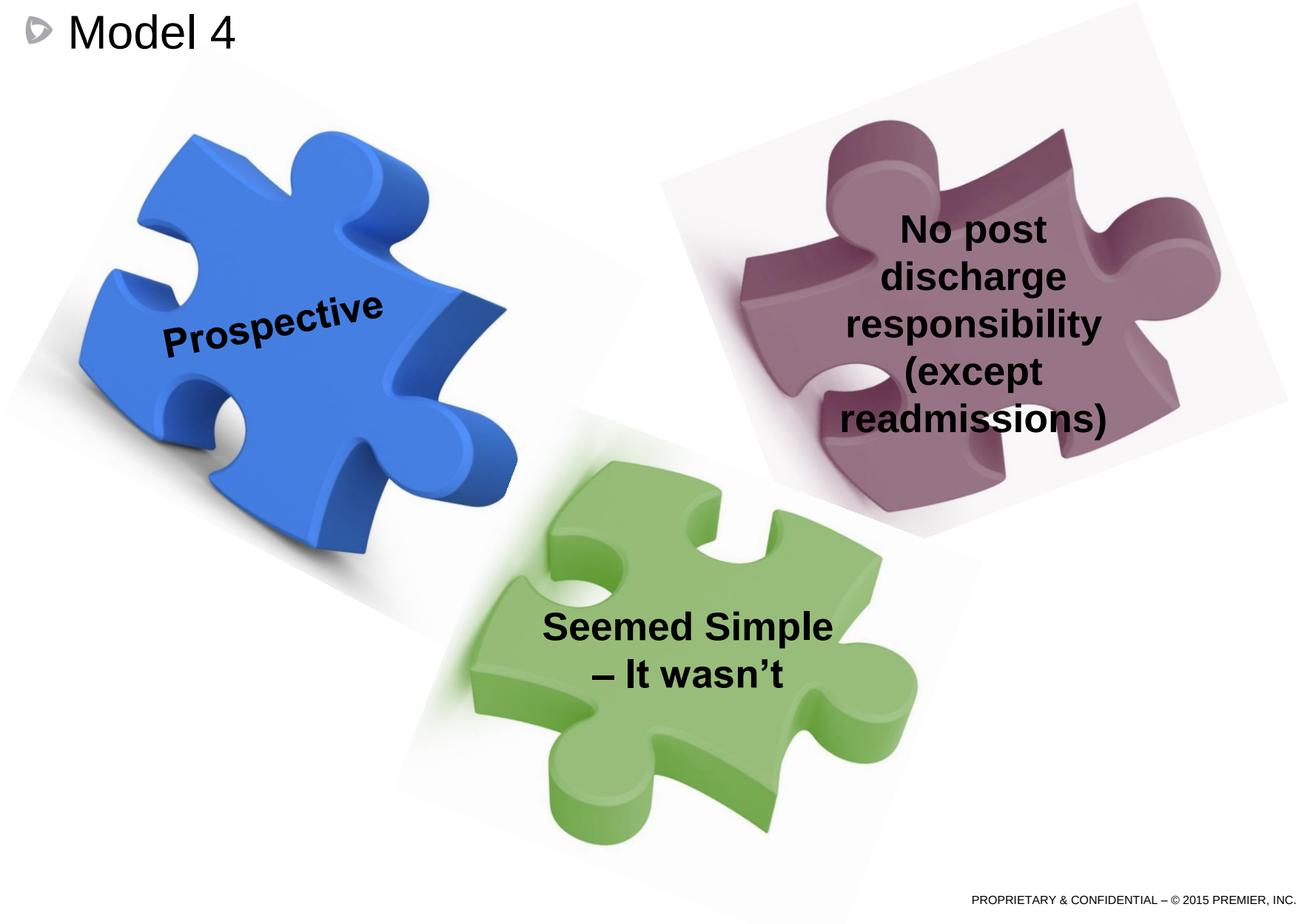
The Vendor Game

- Prosthetic Price Decrease
  - Pay to Play
    - » Started with 2 Vendors
    - » Quickly expanded to the rest

Thinking Vendor
VS
Hospital

Model 4 - Bundled Payment

- Model 4



Bundled Payment Model 4 - Prospective

BUNGLED PAYMENT

Model 4 Problems

Notice of Admission (NOA)

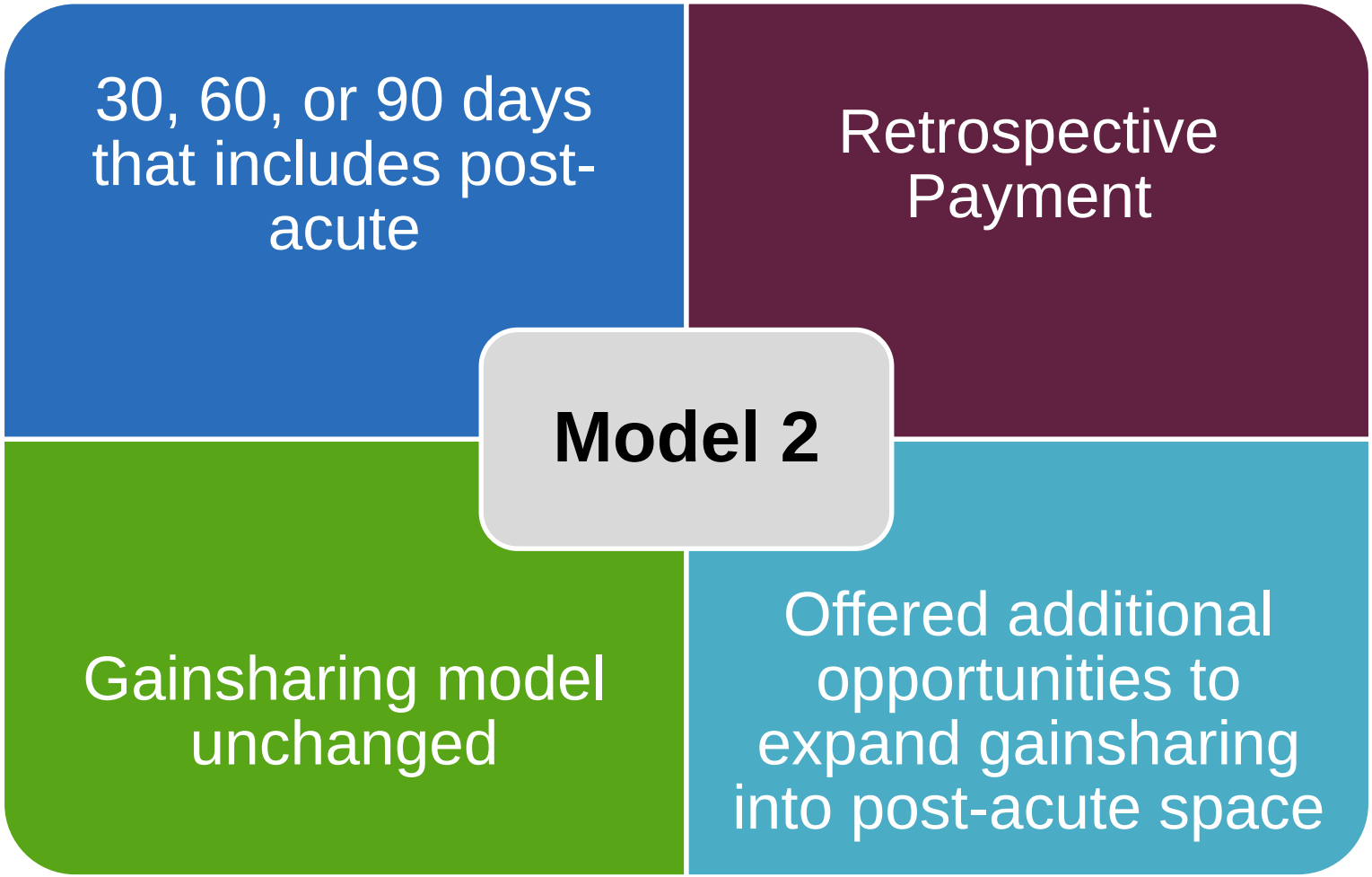
Agreements with Physicians

Co-payment issues

MACs not ready

Could not automate

Model 2 - Changing Course

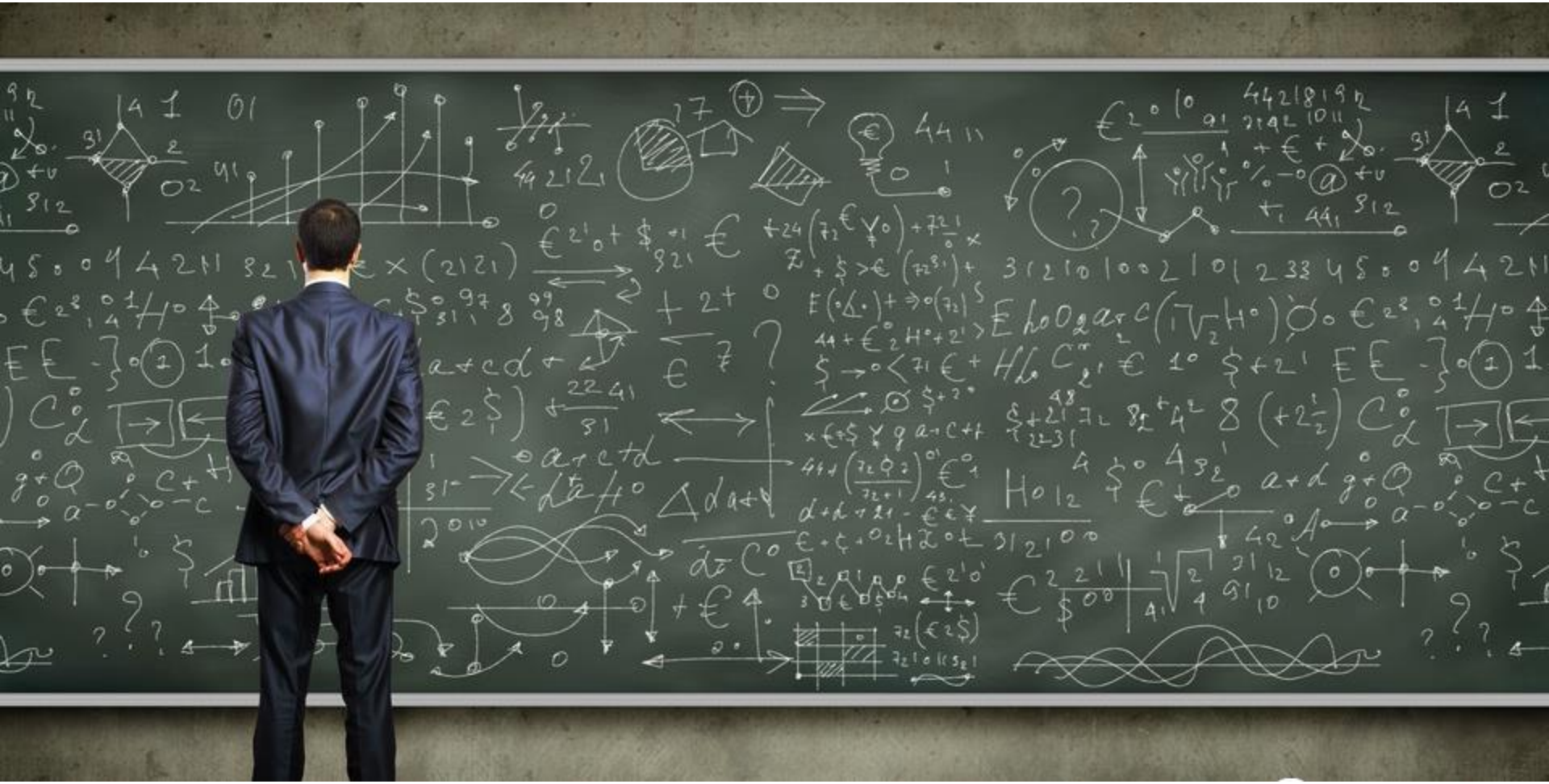


Model 2 - Benefits

- Retrospective model is easy
- Retrospective model is easy
- Retrospective model is easy

BPCI

- Analytics
  - We can track anything by individual patient.



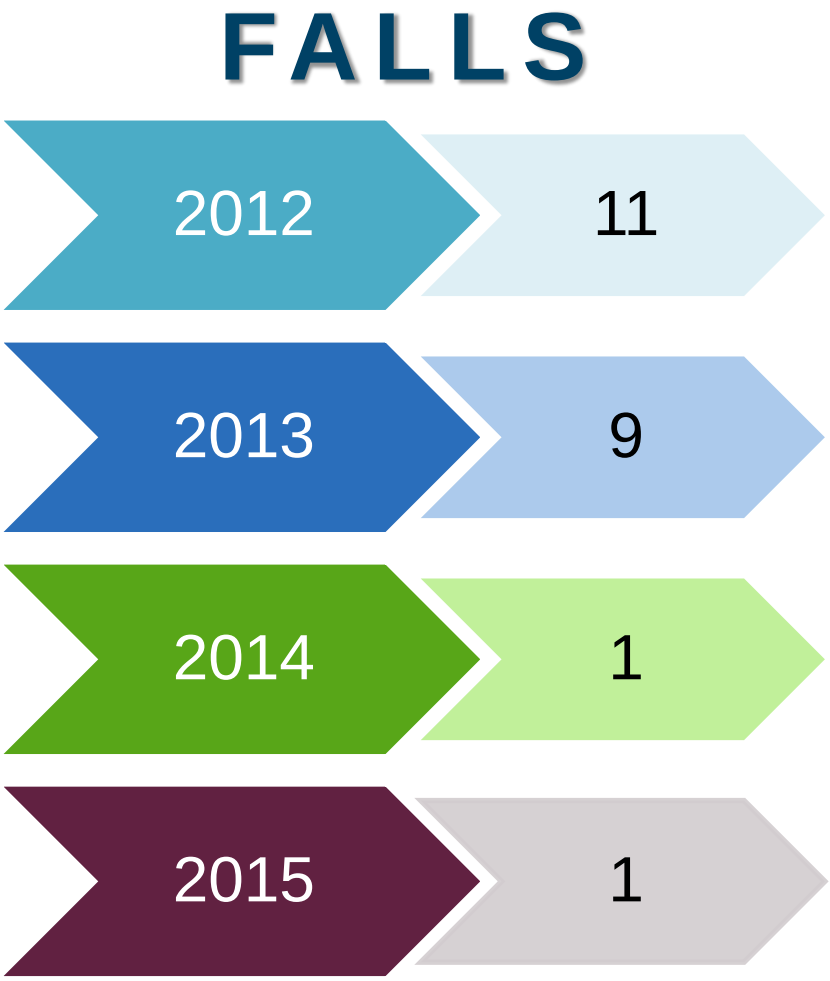
The Right Team is Essential

- Care Redesign and Center of Excellence
  - » Orthopedists
  - » Anesthesiologists
  - » Med Staff
  - » Nursing
  - » Physical therapy
  - » Pharmacy
  - » Infection Prevention

Opportunities in Care Redesign

- Post –Acute
  - We do most in our own Transitional Care Unit.
  - We still had opportunities for improvement and are seeing use rates decline in Transitional Care.
- Anesthesia
  - Must be able to perform an ultrasound guided nerve block.
  - Must use the bi-modal pain management protocol.

- Care Redesign and Center of Excellence



Care Redesign and Center of Excellence

	HIPS		KNEES	
	Cases	#PRC	Cases	#PRC
2011	248	113	359	62
2012	263	57	347	35
2013	296	8	394	5
2014	304	10	403	11
2015	315	6	480	4

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Steve_Valentine@Premierinc.com

Peggy_Crabtree@Premierinc.com