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
April 14 - 15, 2016
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

*Current Medicare Bundled Payments Programs*

*Retrospective bundle design*
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.
*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)

Payment negotiation, allocation, billing, claims adjudication, reconciliation

<table>
<thead>
<tr>
<th>Trigger rules</th>
<th>Standard care pathway</th>
<th>Inclusions/Exclusions</th>
<th>Duration</th>
</tr>
</thead>
</table>

Adapted from McKesson Corporation

Diagnostic → Triggering Event → Follow-up Care

Bundled Payment (Prospective or Retrospective)

= $100 per 0.01 sq in
Non-participating provider

Adapted from McKesson Corporation
## Top 10 BPCI Episodes Across The Nation

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

Reconciliation payments

$$\text{Hospital repays Medicare}$$

Above spending target

Annual Medicare spending for all LEJR episodes

Below spending target

Composite Quality Score Methodology

$$\text{Reconciliation payment to hospital}$$

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

<table>
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<tr>
<th></th>
<th>PY1</th>
<th>PY2</th>
<th>PY3</th>
<th>PY4</th>
<th>PY5</th>
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<tr>
<td>Hospital specific episode data</td>
<td>66.6%</td>
<td>66.6%</td>
<td>33.3%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Regional specific episode data</td>
<td>33.3%</td>
<td>33.3%</td>
<td>66.6%</td>
<td>100%</td>
<td>100%</td>
</tr>
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</table>
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

<table>
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<tr>
<th>Type of Model Overlapping with CJR</th>
<th>CJR Final Policy</th>
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<tbody>
<tr>
<td>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</td>
<td>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.</td>
</tr>
<tr>
<td>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</td>
<td>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.</td>
</tr>
</tbody>
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### Volume to Value

**Track 1:**
**Value-based payments**
- **2016:** 85% of all Medicare payments
- **2018:** 90% of all Medicare payments

**Track 2:**
**Alternative payment models***
- **2016:** 30% of all Medicare payments
- **2018:** 50% of all Medicare payments

### HHS Goals

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<tr>
<th>Incentives</th>
<th>Description</th>
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<tr>
<td></td>
<td>▪ Promote value-based payment systems</td>
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<tr>
<td></td>
<td>▪ Test new alternative payment models</td>
</tr>
<tr>
<td></td>
<td>▪ Increase linkage of Medicaid, Medicare FFS, and other payments to value</td>
</tr>
<tr>
<td></td>
<td>▪ Bring proven payment models to scale</td>
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</table>

<table>
<thead>
<tr>
<th>Care Delivery</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>▪ Encourage the integration and coordination of clinical care services</td>
</tr>
<tr>
<td></td>
<td>▪ Improve population health</td>
</tr>
<tr>
<td></td>
<td>▪ Promote patient engagement through shared decision making</td>
</tr>
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<table>
<thead>
<tr>
<th>Information</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>▪ Create transparency on cost and quality information</td>
</tr>
<tr>
<td></td>
<td>▪ Bring electronic health information to the point of care for meaningful use</td>
</tr>
</tbody>
</table>
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.

- "Our goal within the next 5 year is for 70% of our network to be under value based payment contracts"
- "The majority of our revenue will come from value based contracts in <5 years"
- "75% of our business is Medicare. Over the past 7 years Medicare FFS has grown by 13.5% and MA has grown by 60%"
- "Aetna’s outlook is to have 75% of our contracts under value based payment models by 2020."
Commercial payors are aggressively transitioning to value based payment: Since 2015 each has developed a VBP strategy and begun to implement.

- **Currently at 40% of payment under value based purchasing. Focus is ACO’s vs CIN’s.**
- **50% of contracts to be value based by 2018, currently at 36%. 90% of contracts to be tied to quality by 2018, currently at 52%.”
- **Currently 37% of contracts are value based arrangements. The goal is for 50% of our network to be under value based payment contracts by 2018.”
- **75% of our business is Medicare. Our goal is 75% of our contracts under value based payment models by 2017.”
- **Aetna’s outlook is to have 50% of our contracts under value based payment models by 2018 and 75% by 2020.”

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)

**Cross continuum care pathways / care models**
- Map current processes
- Identify opportunities for implementing leading practice
- Communication structure

**Post-acute partnerships**
- Identify PAC providers and referrals
- Evaluate quality performance, utilization patterns

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

**Bundled payment analytics, reporting & reconciliation**
- Review current state performance to identify improvement opportunity
- Identify ongoing analytic reporting capability

**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

Patients: $47,450
Readmit cost: $48,134
SNF cost: $48,134
Optimizing Cross Continuum Care

<table>
<thead>
<tr>
<th>Patient Preparation</th>
<th>Inpatient Stay</th>
<th>Follow-Up &amp; Recovery</th>
<th>Post-Acute Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Standardized Processes</td>
<td>• Admission processes</td>
<td>• Transition planning</td>
<td>• Transition planning</td>
</tr>
<tr>
<td>• Meets clinical indications for intervention</td>
<td>• Preparation, Operation, PACU processes</td>
<td>• Discharge disposition (Patient discharged to?)</td>
<td>• Discharge to home</td>
</tr>
<tr>
<td>• Evaluation of risk with functional assessment</td>
<td>• Hospital stay processes</td>
<td>• Care coordination &amp; medication reconciliation</td>
<td>• Medication reconciliation</td>
</tr>
<tr>
<td>• Discharge discussions start before admission</td>
<td>• Discharge processes</td>
<td>• Rehabilitation and clinics</td>
<td>• Home Health requirements</td>
</tr>
<tr>
<td>• Decisions related to procedure/intervention</td>
<td></td>
<td>• Functional status evaluation</td>
<td>• Care management</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Establish linkages With PAC</td>
<td>• Readmission reduction tactics</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Community Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• PAC Network</td>
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</tbody>
</table>

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 %
Understanding Access Points

Clinic
F/U & D/C phone calls; confirms appt.
Initiates/updates care pathway
Completes med reconciliation
Goals of care
Initiates/updates care plan
Initiates/continues education plan

Emergency Department
Chief complaint: CHF, SOB, etc.
Flag patient as BPCI
Triggers for consultations: Cardiology, etc
Notify navigator

Is Patient Admitted?

D/C to Home

D/C to Home with Home Care

D/C to SNF

D/C to LTAC or IRF

Determine D/C disposition:
- Home alone
- Home with HC
- SNF
- LTAC/IRF

Admission:
CM begins transition planning
Initiate/update continuum care plan; continue pathway

READMISSION:
Risk status defined; Root cause analysis; Determine disposition
Palliative care/goals of care
PAM; Behavioral health
Medication reconciliation

New Patient:
Risk assessment; Disease Classification; Education Pathway; Medication reconciliation

Exacerbation:
Risk assessment; PAM measures; Palliative care/goals of care; Home visit; Behavioral health; Medication reconciliation
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

Anesthesia Mgmt. Team  PSH Leadership  Surgery Mgmt. Team

**Preoperative**
- Patient engagement
- Assessment & triage
- Optimization
- Evidence based protocols
- Education
- Transitional care plan

**Intraoperative**
- Right personnel for patient acuity and surgery
- Supply chain
- Operational efficiencies
- Reduced variation

**Postoperative**
- Right level of care
- Integrated pain management
- Prevention of complications

**Long Term Recovery**
- Coordination of discharge plans
- Education of patients and caregivers
- Transition to appropriate level of care
- Rehabilitation and return to function
- Reduced variation

**Supporting Microsystems**
- Nursing
- Pharmacy
- Human Resources
- Laboratory
- Central Supply
- Social Services
- Radiology
- Info Technology

**Quality Improvement**

**Database**

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Acute Care

PCMH or PCP: Patient-Centered Medical Home or Primary Care Provider
# Bundled Payment: Required Capabilities Summary

<table>
<thead>
<tr>
<th>Core Competencies</th>
<th>Required Capabilities</th>
<th>Capabilities Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Episode Management</strong></td>
<td>Governance &amp; Legal Infrastructure</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Episode Management</td>
<td>Ability to develop/understand a bundled definition, including service inclusions &amp; exclusions, reimbursements and a discharge tail</td>
</tr>
<tr>
<td></td>
<td>Cost Management</td>
<td>Ability to identify and implement cost reduction strategies in a safe and appropriate manner across the episode.</td>
</tr>
<tr>
<td></td>
<td>Analytics, Technology and Other Services</td>
<td>Ability to understand current state and measure, monitor and evaluate future performance (internal trends, external benchmarks) across the episode.</td>
</tr>
<tr>
<td><strong>Cross Continuum Clinical Care Delivery</strong></td>
<td>Longitudinal Care Management</td>
<td>Ability to assess and re-design care across the episode and to execute continuous improvement processes.</td>
</tr>
<tr>
<td></td>
<td>Post-Acute Network Planning</td>
<td>Ability to identify the optimal post-acute partners, appropriately manage utilization of services and jointly improve upon the patient transitions across the episode.</td>
</tr>
<tr>
<td><strong>Provider Engagement</strong></td>
<td>Provider Alignment</td>
<td>Ability to develop a culture of increased transparency &amp; collaboration with physicians and other key providers. Also, ability to grow the network of participating providers and deploy gainsharing methodologies.</td>
</tr>
</tbody>
</table>
Torrance Memorial Medical Center-Case Study
Building On Our Strengths

Committed Executive Sponsor

Center of Excellence

Orthopedist Engagement

Opportunity for Learning
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

- Seemed Simple – It wasn’t

- No post discharge responsibility (except readmissions)

- Prospective
BUNDLED PAYMENT
Model 4 Problems

- Notice of Admission (NOA)
- Agreements with Physicians
- Co-payment issues
- MACs not ready
- Could not automate
Model 2 - Changing Course

30, 60, or 90 days that includes post-acute

Retrospective Payment

Gainsharing model unchanged

Offered additional opportunities to expand gainsharing into post-acute space
Model 2 - Benefits

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

**FALLS**

- 2012: 11
- 2013: 9
- 2014: 1
- 2015: 1
## Care Redesign and Center of Excellence

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<thead>
<tr>
<th></th>
<th>HIPS Cases</th>
<th>HIPS #PRC</th>
<th>KNEES Cases</th>
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Steve_Valentine@Premierinc.com
Peggy_Crabtree@Premierinc.com