Bundled Payments:
An Opportunity for Hospitals to Develop Post-Acute Services

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Chief Clinical Operations Officer
Traditional Medicare fee-for-service is transitioning to value-based reimbursement

"Change is inevitable. Growth is optional."

- John C. Maxwell
Succeeding in value-based care requires hospitals to develop a new set of services and capabilities.

**Fee-for-service**

*Internal focus on the acute inpatient encounter*

**Value-based care**

*Accountability for post-acute costs to effectively manage risk*

**Innovative Payment Models**

- ACO’s
- *Bundled payment programs*
- Patient-centered medical homes
- Direct contracting (new!)
The CMS Innovation Center has launched a new episode payment model: BPCI Advanced

The Bundled Payments for Care Improvement (BPCI) Advanced Program was set up to help you!

**CMS’ stated model purpose:**
“to better support healthcare providers who invest in *practice innovation, care redesign, and enhanced care coordination*”

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**Model timeline and key dates:**

- **Go Live for 1st Cohort**: October 1, 2018
- **Next Application**: Spring 2019
- **Go Live for 2nd Cohort**: January 1, 2020
- **Program End**: December 31, 2023

**Program website:**
https://innovation.cms.gov/initiatives/bpci-advanced
CMS is providing financial incentives for hospitals to reduce the cost of care for certain clinical episodes

Program overview:
Hospitals have the opportunity to be reimbursed for cost-savings achieved for Medicare FFS beneficiaries:

1. A clinical episode begins on admission (or procedure) and **extends for 90 days after discharge**
2. Hospitals and post-acute providers continue to receive Medicare FFS payments for services, but **Medicare sets a target price for each episode**
3. If the total claims for the 90-day episode are less than the target price, then **Medicare pays the difference to the hospital**

Illustrative example to demonstrate program economics

<table>
<thead>
<tr>
<th>Total Cost of Care</th>
<th>Target Price</th>
<th>Actual Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>$50,000</td>
<td>$40,000</td>
<td></td>
</tr>
</tbody>
</table>

**Financial Opportunity:**

\[
\text{Actual Cost} - \text{Target Price} = \text{Financial Opportunity}
\]

\[
= \$10,000/\text{case} \\
\times 100 \text{ cases/year} \\
= \$1\text{MM/year}
\]

Since hospitals receive DRG-based reimbursement from Medicare, the opportunity in this program comes from reducing expenses in the 90-day post-acute period (e.g., discharge destination, readmission, LOS at post-acute facility)

1: Target prices are calculated based on case mix, historical spending, peer and regional trends. Medicare also includes its own 3% cost savings built into the Target Price.

2: Payments are capped at 20% of the target price for each bundle, with reconciliation payments made every 6 months
The list of episodes is broad and diverse

**29 Inpatient Clinical Episodes**
- Disorders of the liver excluding malignancy, cirrhosis, alcoholic hepatitis *(New episode added to BPCI Advanced)*
- Acute myocardial infarction
- Back & neck except spinal fusion
- Cardiac arrhythmia
- Cardiac defibrillator
- Cardiac valve
- Cellulitis
- Cervical spinal fusion
- COPD, bronchitis, asthma
- Combined anterior posterior spinal fusion
- Congestive heart failure
- Coronary artery bypass graft
- Double joint replacement of the lower extremity
- Fractures of the femur and hip or pelvis

**3 Outpatient Clinical Episodes**
- Percutaneous Coronary Intervention (PCI)
- Cardiac Defibrillator
- Back & Neck Except Spinal Fusion

*Gastrointestinal hemorrhage*
*Gastrointestinal obstruction*
*Hip & femur procedures except major joint*
*Lower extremity/humerus procedure except hip, foot, femur*
*Major bowel procedure*
*Major joint replacement of the lower extremity*
*Major joint replacement of the upper extremity*
*Pacemaker*
*Percutaneous coronary intervention*
*Renal failure*
*Sepsis*
*Simple pneumonia and respiratory infections*
*Spinal fusion (non-cervical)*
*Stroke*
*Urinary tract infection*

HPMC has taken this opportunity to design and implement an effective post-acute care program.

HPMC assembled a team of partners to deliver high-quality care after discharge.

**Anchor Stay**

**Post-Acute Period**

(90 days)

- Patient tracking and notification
- On-campus clinic for post-discharge care coordination
- Patient navigators, home visits, and SNF support
- Comprehensive data and performance management platform
Early identification of target patients allows for risk-stratification to customized clinical pathways.

Identifying patients early during the anchor stay facilitates proactive bedside engagement, risk-stratification, and patient tracking after discharge.

Each clinical pathway has a standard schedule of operations, including an in-depth clinical assessment (within 24 hours of discharge), environmental assessments, and regular ongoing support throughout the 90-day post-discharge period.
Education materials engage patients, caretakers, and post-acute facility staff to be part of the team.
Badges identify patient membership in the program and alert health care providers to contact our team.

For Patients: Please present this card to your healthcare provider.

For EMS and Paramedics:
This patient is part of the CHA-HPMC Continuing Care Program, so please transport the patient directly to the CHA-HPMC Emergency Department:
1300 N. Vermont Ave.,
Los Angeles, CA 90027
(Corner of Vermont & Fountain)

For Health Care Providers:
In the event of emergencies, please contact Triage Hotline, available 24 hours:
888.404.2427.
Post-acute facilities and patients have access to a nurse advice line that is available 24/7

- Continuing Care nurses triage phone calls per the following algorithm:
  - **Care within 30 minutes**: call 911 to bring patient to ED
  - **Care within 4 hours**: nurse dispatched to post-acute facility or patient’s home
  - **All others**: patient scheduled for next available appointment (same day or next morning) with Continuing Care physician

- Collaborative workflows with HPMC’s outpatient pharmacy facilitates treatments to be delivered in the patient’s home, including:
  - IV fluids
  - IV antibiotics
  - Pain medications
  - Anti-emetics
If patients bounce-back to the ED, the Continuing Care Team is notified in real-time to respond.

When a patient registers in the ED:

- Continuing Care Team receives a text message notification and sends the patient’s navigator to see the patient in the ED
- Once diagnostic test results are completed, ED physician contacts Continuing Care Team to discuss patient disposition
- When clinically appropriate, the patient is discharged with close follow-up with the Continuing Care Team

If the patient is admitted to the hospital:

- Continuing Care Physician works closely with the Admitting Physician to manage the patient’s care, and assists with coordinating appropriate discharge planning needs
Early results indicate that the team is successfully achieving its program objectives

**All BPCI-A Target Patients:** *Sepsis, UTI, Pneumonia, Cellulitis, CHF, Acute MI, PCI*

### 30-day readmission rate

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>28%</td>
</tr>
<tr>
<td>Q4 2018</td>
<td>18%</td>
</tr>
</tbody>
</table>

### 90-day readmission rate

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>40%</td>
</tr>
<tr>
<td>Q4 2018</td>
<td>31%</td>
</tr>
</tbody>
</table>

**Sepsis Bundle Performance:**

<table>
<thead>
<tr>
<th>Cost Savings</th>
<th>Case Volume</th>
<th>Reconciliation Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>13% below target price:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 15% reduction in 90-day readmission rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 16% reduction in post-acute facility utilization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17% growth in sepsis cases:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Physician agreements and SNF working relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Clinical documentation improvement efforts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td>=</td>
<td>~$3MM/year</td>
</tr>
<tr>
<td>17% growth in sepsis cases:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SOURCE: CMS claims data for visits at HPMC between October 1 – December 31, 2018

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A data-driven approach informs priority areas for intervention to reduce the post-acute cost of care.

**Episode Cost**

*Anchor Stay + 90 days*

- **Target Price**: $78,120
- **HPMC Performance**: $67,876
  - Difference: -$10,244

**Episode Cost**

*Anchor Stay + 90 days*

- **HPMC Performance**: $67,876
- **Inpatient**: $17,553
- **SNF/Rehab**: $17,523
- **Readmissions**: $14,108
- **Medicare Part B**: $10,240
- **Other**: $8,452

**SOURCE**: CMS claims data for visits at HPMC between October 1 – December 31, 2018
Performance management of physicians helps to focus efforts on supporting the outliers

<table>
<thead>
<tr>
<th># Cases</th>
<th>Name</th>
<th>Sepsis Target Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>R.B.</td>
<td>$12,999</td>
</tr>
<tr>
<td>3</td>
<td>K.K.</td>
<td>$26,729</td>
</tr>
<tr>
<td>2</td>
<td>Y.L.</td>
<td>$33,475</td>
</tr>
<tr>
<td>5</td>
<td>F.K.</td>
<td>$47,278</td>
</tr>
<tr>
<td>1</td>
<td>M.F.</td>
<td>$49,510</td>
</tr>
<tr>
<td>3</td>
<td>A.A.</td>
<td>$51,619</td>
</tr>
<tr>
<td>3</td>
<td>L.C.</td>
<td>$68,366</td>
</tr>
<tr>
<td>9</td>
<td>T.Y.</td>
<td>$71,932</td>
</tr>
<tr>
<td>4</td>
<td>S.D.</td>
<td>$76,520</td>
</tr>
<tr>
<td>6</td>
<td>D.M.</td>
<td>$80,015</td>
</tr>
<tr>
<td>1</td>
<td>S.L.</td>
<td>$100,568</td>
</tr>
<tr>
<td>4</td>
<td>P.S.</td>
<td>$120,531</td>
</tr>
<tr>
<td>3</td>
<td>H.B.</td>
<td>$131,480</td>
</tr>
<tr>
<td>5</td>
<td>M.K.</td>
<td>$133,872</td>
</tr>
</tbody>
</table>

SOURCE: CMS claims data for visits at HPMC between October 1 – December 31, 2018
In addition to the program’s financial impact, there are positive effects for satisfaction and quality.

Patients and physicians are grateful for the support:

“I am so thankful for the triage line – they responded very quickly and sent a nurse to my home to take care of me.”

– BPCI-A Patient

“We are grateful to be recipients of this program. The program’s attention to me especially complements and supplements the care I receive from my primary doctor.”

– BPCI-A Patient

“I appreciate the extra support to help me monitor and take care of my patients. It is marvelous that the hospital has this team to support physicians – I could not do it all by myself!”

– BPCI-A Participating Physician

**CMS Hospital Readmissions Reduction Program**

**30-day readmission rate**

<table>
<thead>
<tr>
<th>Condition</th>
<th>2017</th>
<th>Q4 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congestive Heart Failure</td>
<td>40%</td>
<td>11%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>12%</td>
<td>9%</td>
</tr>
<tr>
<td>Acute MI</td>
<td>28%</td>
<td>18%</td>
</tr>
</tbody>
</table>
BPCI Advanced provides the financial incentives for a hospital to invest in post-acute services

**Near-term: Voluntary participation**
- Hospitals have the option to sign-up for alternative payment models (such as BPCI Advanced) with self-directed participation

**On the horizon: Mandatory bundles**
- Hospitals may be required to participate in bundled payment programs for certain diagnostic groups (similar to CJR)

**Future state: Fully shared risk**
- The list of DRG’s may continue to expand, until Medicare payments across all diagnoses are subject to value-based reimbursement

**Hospital transition costs can be funded through programs like BPCI-A**
- Establishing an effective post-acute service line requires investment in new infrastructure, systems, and technology
- CMS has given hospitals the financial incentive to fund this change – don’t miss out!
Questions

Alternatively, please email me:

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