

Bundled Payments for Care Improvement Initiative

A Physician-Focused Approach to Education and Awareness
 Presented by Elizabeth MacLeod Walls, Ph.D.,
 Catholic Health Initiatives of Nebraska

*Some slides for this presentation were provided by the Camden Group

Expected Learning Outcomes

Participants Will:

- › Learn and understand a clear definition of "bundled payment"
- › Understand the four different models of the CMS bundled payment initiative
- › Understand how data will be used in CHI's participation in Models 2 and 4 of the bundled payment initiative
- › Be able to identify physicians' role in bundled payment
- › Be able to identify and articulate the potential benefits and challenges related to bundled payment

Healthcare Reform "101"

- › Identified the current health care system as not financially sustainable
- › Medicare transforming to a value based purchaser emphasizing cost and quality
- › Reimbursement will be reduced across the board by all payers
- › National employers (ATT, IBM, GE) and national payers are taking the lead to transform payment models (Blues, United and Aetna)

*Some slides for Health Care Reform are authored by Dr. Clifford Deveny, CHI Colorado

Shifts in Consumer Expectation and Market Share

Transparency On:

- › Quality metrics
- › Charges/Costs/Margins
- › Patient satisfaction-HCAPS/CGCAPS
- › Conflict of interest
- › Audited financial reports

Market Share Changes Regarding:

- › Assumed reputation
- › Tiered benefits/copayments to designated providers
- › Exclusion of high cost and poor quality providers
- › Evolution to a retail market

"The New Normal": Navigating To Future Models of Care

<p>Maximize Clinical Operations "Highly effective delivery systems" (2010-2013)</p> <p>Maximize performance to manage to Medicare rates</p> <p>Capitalize on payment incentives</p> <p>Relentless pursuit of value</p> <ul style="list-style-type: none"> •Clinical excellence •Cost of care •Eliminate "waste" •Safety <p>Reduce variation in performance across CHI</p> <p>Balance the portfolio through selective MBO and system growth</p>	<p>Assume Performance Risk "Integrated health care delivery systems" (2012-2015)</p> <p>Develop interim levels of risk assumption for defined payers, complex procedures, and disease states</p> <p>Manage episodes and systems of care across defined settings</p> <p>Translate current financial models to greater risk assumption capability</p> <p>Build physician alignment models to support integrated care delivery</p>	<p>Manage Population Health "Clinical and financial risk" (2014-+)</p> <p>Move to integrated care capability and capitated models</p> <p>Establish insurance risk capability</p> <p>Manage and measure population health</p>
---	--	---

Moving to a New Paradigm of Care Delivery

Old World: Hospitals + Physicians to Deliver Care



New World:
 A system connecting hospitals, physicians, care providers, services—patient centered

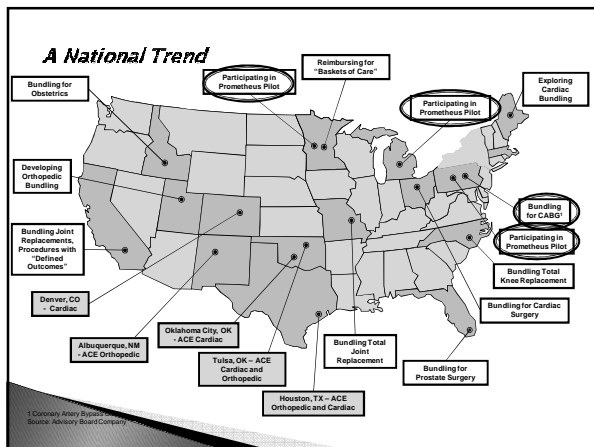


Focus Today: Bundled Payment

- ▶ Part of a payment model transition in the “New Normal”
- ▶ Other payment model transitions:
 - 30-day readmission focus
 - payment for high quality, lower cost care
 - wellness emphasis
 - proactive management of chronic care
- ▶ Not an “ACO”—but an important element of it

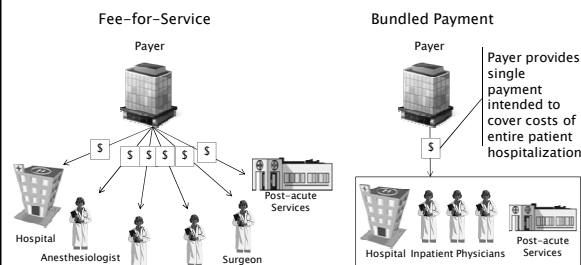
CMS Initiative: Bundled Payments

- ▶ Part of the Affordable Care Act, bundled payments provide a single payment for an episode of care, revising the pay-for-service model.
- ▶ It is grounded in the idea that continuity of care—overt collaboration among care providers before, during, and after an episode—can allow providers to identify areas of savings and to charge one price for the entire experience, a “bundled payment.”
- ▶ CMS has opened an opportunity for hospitals, physician groups, and insurers to participate in the Bundled Payments for Care Improvement Initiative, beginning in 2012.



Buils the Foundation for a Deeper Relationship

Inpatient Episode Payment Models



Centers for Medicare & Medicaid Innovation

- ▶ Bundled Payments for Care Improvement Initiative:
 - *Four Models*
 - Acute admission only; M.D.s bill directly to CMS
 - —Acute admission with post acute inclusive of M.D. fees but CMS pays M.D.s
 - Post Acute only with M.D.s’ fees but CMS pays M.D.s
 - — Prospectively paid global fee for part A and B; hospital pays M.D.s
 - All Models include gainsharing
 - Competitive process with applications due in the winter and spring, 2012



Current Viewpoints on Bundled Payment

Comments from Chief Medical Officers, Drs. Edwards, Hein, Hoover, and Ward:

- ▶ “There’s distrust around it, and fear of a shrinking overall basket.”
- ▶ “How will the formulas will work? Who gets what? How will payment be disseminated?”
- ▶ “It’s possible that bundled payment could create a conflict of interest in doing what’s best for the patient, while also spreading dollars around.”
- ▶ “There is a natural distrust between physicians and hospitals—and we will need to overcome this.”
- ▶ “My gut instinct is that there will be interest, but it needs to be sold as business development and improved quality.”
- ▶ “It’s time that we embraced this. Physicians need to understand that the landscape has changed. We should be proactive in changing with it.”

Why CHI Nebraska Is Exploring Bundled Payments

- ▶ CHI Nebraska's approach:
 - How can we be proactive on Reform trends while assuring quality, focusing on patients' needs, and collaborating with physicians and providers?*
- ▶ Develop management intelligence around bundling and ready organization for ACO development
- ▶ Grow clinical program and leverage existing brand and market position
- ▶ Gain market share because of unique physician and beneficiary incentives
- ▶ Be on the leading edge of reimbursement reform to develop a broader non-Medicare payer strategy

Why Physicians Would Be Interested in Exploring Bundled Payment

Opportunity to:

- ▶ "Make our own future" in a changing environment—i.e., be on the leading edge of reimbursement reform to develop a broader non-Medicare payer strategy
- ▶ Benefit from shared savings available through the Innovation Center's Bundled Payment Models
- ▶ Grow clinical programs and leverage existing brand and market position
- ▶ Gain market share because of unique physician and beneficiary incentives

Model 2

Episode of Care	<ul style="list-style-type: none"> •Inpatient stay •Post-acute care •Post-discharge, 30-90 days (applicant's choice) •DRGs are determined by the applicant •Quality assurance and improvement plans are determined by the applicant
Services/Other Expenses Included in the Target Price	<ul style="list-style-type: none"> •Physicians' services •Care by the post-acute care provider •Related readmissions •Other services as proposed by the applicant (e.g., clinical laboratory services) •Also includes: durable medical equipment, prosthetics, orthotics, and supplies •Also Includes: Part B drugs

Model 2 (cont.)

Target Price	<ul style="list-style-type: none"> •Determined based upon historical data (2009) on FFS payments for the episode •Minimum discount of 3% for 30-89 days post-discharge, 2% for 90 days or longer
Payment	<ul style="list-style-type: none"> •Made retrospectively •Follows the traditional FFS model •Aggregate Medicare payment per episode will be reconciled against the target price •Savings will be paid to participants and shared among providers (gainsharing) •If the Medicare payment exceeds the target price, the participant will reimburse CMS for the difference

Model 4

Episode of Care	<ul style="list-style-type: none"> •Inpatient stay •Post-discharge, 30-90 days (applicant's choice) •DRGs are determined by the applicant •Quality assurance and improvement plans are determined by the applicant
Services/Other Expenses Included in the Target Price	<ul style="list-style-type: none"> •Part A and B physicians' services •All other providers and services would be paid by the admitting hospital

Model 4 (cont.)

Target Price	<ul style="list-style-type: none"> •Determined based upon historical data (2009) on FFS payments for the episode •Minimum discount rate of 3%
Payment	<ul style="list-style-type: none"> •Made prospectively •Made to the acute care hospital •Hospital is responsible for distributing payment •Savings will be based upon efficiency and quality of care, including readmissions or unforeseen expenditures beyond the risk threshold 30 days after discharge

Benefit/Risk	Model 2 Inpatient Stay plus Post-Acute Care and Post-Discharge Services	Model 4 Inpatient Stay plus Post-Discharge Services
Benefits	<ul style="list-style-type: none"> Gain share with physicians up to an additional 50% of Part B fee schedule. Not all DRGs included. Hospital may propose scope of DRGs to be included. 	<ul style="list-style-type: none"> Gain share with physicians up to an additional 50% of Part B fee schedule. Not all DRGs included. Hospital may propose scope of DRGs to be included.
Risks	<ul style="list-style-type: none"> Minimum discount risk of 3% for 30-day episode and 2% for 90 day episode Retrospective comparison of target price and actual FFS payments Readmission risk 	<ul style="list-style-type: none"> Discount required, minimum 3%-higher discount expected DRGs in cardiac and ortho Readmission risk Most challenging to implement, particularly if hospital and physicians are not in shared fiscal intermediary.

CHI Nebraska's Uses of the CMS Data

- ▶ Data for our Health Referral Clusters (HRCs), which includes the geographic area from Omaha to Wichita, will be available February 28
- ▶ Identify DRGs to include with a potential emphasis on ortho, spine, and cardiology
- ▶ Analysis will be conducted longitudinally by DRG (from admission to 90 days post discharge) to determine potential financial risks/rewards and to understand what services are provided, by whom, where, and when

CHI Nebraska's Uses of the CMS Data (cont.)

- ▶ Analysis will determine which sites to use and which DRGs to focus on at these sites
- ▶ Analysis will also guide the establishment of a target price per episode of care, which will inform the decision on which partnerships to pursue and what gainsharing arrangements will be established

Value of Exploring Bundled Payment Models in Nebraska

- ▶ New partnerships and collaborations among hospitals, physicians, and care providers
- ▶ Gainsharing is an incentive to all participants to uphold quality, assure efficiency of care, and foster communication among disciplines and services
- ▶ This pilot effort will help to create new care mapping and delivery paradigms in Nebraska

Infrastructure: What it Takes

Interdisciplinary Teams

- Developed internal work teams:
 - ▶ Care Coordination
 - ▶ Quality and Patient Safety
 - ▶ Billing and Claims
 - ▶ Supply chain
 - ▶ Physician Oversight
 - ▶ System Oversight
 - ▶ Documentation and Coding
 - ▶ Transparency with the Beneficiary
- Identify processes to be redesigned and gaps in performance
- Set performance standards



Bundled Payment Example: Geisinger Health System

- ▶ General Parameters and Pricing
 - Elective Coronary Artery Bypass Graft (CABG) patients
 - Included in the bundle:
 - pre-op evaluation
 - hospital and professional fees
 - management of complications (including readmission) occurring within 90 days of the procedure
 - The fixed price was set at the cost of a typical hospitalization plus 50% of the average cost of post-acute care over 90 days
- ▶ Cost Reduction over 18 Months
 - Hospital costs by 5% (average length-of-stay by 0.5 days)
 - Post-acute care costs by 50%
 - Thirty day re-admission rates by 44%
 - Aggressive supply chain management (\$10m reduced in 5 years)




Source: Back to Basics, 1st ed., October 2010

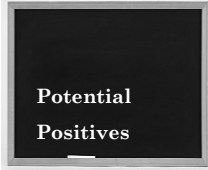
Bundled Payment Example: Geisinger Health System

- ▶ **Quality Outcomes**
 - Use of 40 best practice steps: 59% increased to 100% in 6 months
 - Reduced complications by 21%
 - Reduced sternal wound infection by 25%
 - "Warranty" for avoidable complications/90 days
- ▶ **Payment and Growth**
 - Geisinger pays practices % of eligible patients for expanded staff and services
 - Physicians also receive % of difference between expected and actual costs (split between physicians and practice)
 - Eligibility is based upon performance—10 quality measures
 - Now includes other DRGs (hip replacement, cataract)


Source: Back to Basics, October 2010



- ▶ **Compete on Cost and Quality:**
 - Eliminate waste and duplication
 - Reduction of costs
 - Enhanced operational efficiency
 - Enhance clinical quality
 - Improved patient experience
- ▶ **Protect current market share**
- ▶ **Build market share (commercial, Medicare)**
 - Preferred provider status within region
- ▶ **Stepping stone to clinical integration and Accountable Care**
 - Alignment in care management
 - Co-management of clinical services



- ▶ **Complexity of Payment**
 - Wholly new contract paradigm
 - Implementation can take years
 - Multiple departments must align
 - Must have clarity on "shared savings"
 - Claims systems are not currently designed to accommodate bundled payment
- ▶ **Lack of Clarity on Processes**
 - What constitutes a service that can be bundled?
 - How do you educate providers on quality measures?
 - Interdisciplinary communication must streamline
 - Health Information Management must be able to accommodate changes



Questions for Discussion

- ▶ What could be the benefit to physician practices participating in the bundled payment initiative?
- ▶ From a physician perspective, what would be the strategic benefit to CHI Nebraska to participating in the bundled payment initiative?
- ▶ What are the foreseeable challenges to interdisciplinary partnership and communication?
- ▶ Is well-defined, sustained quality of care possible in a bundled payment scenario?

Questions for Discussion (cont.)

- ▶ How could bundled payments affect small practices?
- ▶ How could it be implemented in rural or smaller communities?
- ▶ Ideally, how should private insurers be involved in bundled payment?
- ▶ What are the drawbacks or concerns from a physician perspective to participating in this initiative?

Next Steps

- ▶ CHI Nebraska is providing educational sessions on bundled payment in anticipation of applying to the CMS to be part of Models 2 and 4.
- ▶ CHI Nebraska is seeking physician partners in its application to participate in the bundled payment initiative.
- ▶ Interested physicians and care providers will be contacted to have further discussion on this initiative.