Navigating the Era of Fusion
Reimbursement – Bundled Payments
Introduction

Barbara Letts
Senior Manager

- Over 12 years of experience in healthcare, with extensive financial modeling, analysis, and strategy experience.
- For the past few years, heavily focused on bundled payments (Medicare and employer) as it relates to analytics and finance.
- Other areas of focus include feasibility studies for large capital projects or new/expanded service lines, assessment of physician groups for acquisitions, joint venture arrangements, and analysis of commercial contracts for potential new partnerships.
Bundled Payments Service Offerings

Assessment
- Gap analysis
- Financial assessment
- Organizational assessment
- Quality assessment
- Cost effectiveness and clinical variation
- Market assessment
- Physician culture assessment

Strategy & Analysis
- Market entry strategy
- Commercial, Medicare, Medicaid, Employer, Comprehensive Care for Joint Replacement (“CCJR”) Model
- Payer strategy
- Claims analysis
- Bundles selection and pricing constructs
- Pitch development

Implementation
- Program launch
- Structure and governance
- Dashboard development and execution
- Gainsharing methodology
- Bundled Payments for Care Improvement (“BPCI”) initiative ongoing support and tracking
- Quality monitoring process
- Hospital, physician, and organizational education
- Data analytics and episode evaluation
- Contracting

Ongoing Support
- Onsite project management
- Ongoing analytics support
- Dashboard monitoring
- Physician education
- Steering Committee support
- Contract management
- Program auditing and evaluation
Where We Have Bundled

States where The Camden Group has worked on Bundled Payment projects

© The Camden Group
Fee-for-Service vs. Bundled Payments

**Fee-for-Service**

- Payer
- Facility
- Anesthesiologist
- Surgeon
- Physical Therapy/Follow-Up

**Bundled Payments**

- Payer
- Facility
- Professional Services

Payer provides single payment for entire episode of care
The Best Leaders Optimize Data Analytics

- Enhances transparency
- Enables evidence-based decisions
- Facilitates efficiency
- Measures outcomes and progress
- Enables action
Payment Reform Roadmap
Bundles: Nothing New Conceptually

1991
Medicare Participating Heart Bypass Demonstration

1997
Medicare Participating Centers of Excellence Demonstration

1998
Medicare Cataract Alternative Payment Demonstration

2001
Medicare Participating Cardiovascular and Orthopedic Centers of Excellence Demonstration

2006
- Geisinger Health System
- PROMETHEUS® Payment Method

2010
- CMS* Medicare Health Quality Demonstration Project
- ACE** Demonstration “Value-based Care Centers”
- United Healthcare Oncology Bundled Payments
  - Oncology Care Model
  - CMS Joint Mandate

2012
- Integrated Healthcare Association California Commercial Bundled Payment Project
- Blue Cross New Jersey Orthopedics Bundled Payment
- CMS National Voluntary Pilot (BPCI)

2015

*CMS - Centers for Medicare & Medicaid Services, **ACE - Acute Care Episode
© The Camden Group
CMS Transitions to Value-Based Reimbursement

Historical Performance

<table>
<thead>
<tr>
<th>Year</th>
<th>Payments linked to alternative payment models</th>
<th>Fee-for-service (&quot;FFS&quot;) linked to quality</th>
<th>All Medicare FFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>0%</td>
<td>~70%</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>~20%</td>
<td>&gt;80%</td>
<td></td>
</tr>
</tbody>
</table>

Goals

<table>
<thead>
<tr>
<th>Year</th>
<th>Payments linked to alternative payment models</th>
<th>Fee-for-service (&quot;FFS&quot;) linked to quality</th>
<th>All Medicare FFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>30%</td>
<td>85%</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>50%</td>
<td>90%</td>
<td></td>
</tr>
</tbody>
</table>

Source: The Center for Medicare & Medicaid Innovation ("CMMI"), Bundled Payment Summit, June 2015
Bundles Offer Greatest Opportunity to Bend the Cost Curve

Estimated Cumulative Percentage Changes in National Healthcare Expenditures, 2010 through 2019

<table>
<thead>
<tr>
<th>Benefit Design</th>
<th>NP* – PA* Scope of Practice</th>
<th>Retail Clinics</th>
<th>Medical Homes</th>
<th>Disease Management</th>
<th>HIT*</th>
<th>Hospital-Rate Regulation</th>
<th>Bundled Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.2%</td>
<td>-0.3%</td>
<td>0.0%</td>
<td>0.4%</td>
<td>1.0%</td>
<td>0.8%</td>
<td>0.0%</td>
<td>-0.1%</td>
</tr>
<tr>
<td>-0.3%</td>
<td>-0.5%</td>
<td>-0.6%</td>
<td>-1.2%</td>
<td>-1.3%</td>
<td>-1.5%</td>
<td>-2.0%</td>
<td>-5.4%</td>
</tr>
</tbody>
</table>

NP* - Nurse Practitioner, PA* - Physician Assistant, HIT* - Health Information Technology
Bundles: What We Know for Sure

- Being first matters more than being perfect:
  - Failure tolerance

- A post-acute strategy and network are vital:
  - Challenges persist related to limited technology integration
  - Workforce competency and recruitment obstacles

- Not all bundles are created equally:
  - Medical episodes have a lower price point and higher complexity
  - Care transitions impose much greater risk
  - Need for patient activation

- Transparency and analytics are needed in real time to mitigate clinical variation

- Know your value proposition

- Predictive risk tools are necessary for success in risk based payment models and will become the norm
What CCJR can learn from BPCI Year 1 Results

Model 2 Findings

Within 90 days of discharge from the hospital, costly institutional post-acute care (“PAC”) was substituted by less costly home healthcare.

Model 2 participants experienced reductions in the anchor inpatient length-of-stay (“LOS”) and reductions in the 30-day readmission rates.

As a result, there were reductions in Medicare Part A payments to Skilled Nursing Facilities (“SNF”) and Inpatient Rehabilitation Facilities (“IRF”), accompanied by an increase in Part A payments to Home Health Agencies (“HHA”).

The most prevalent clinical episodes in Year 1 fall into orthopedic surgery, excluding the spine. Thus, Model 2 results were driven by patient episodes in this clinical episode group.

Source: CMMI, Bundled Payment Summit, June 2015
Bundled Payments impact of Medicare Readmission Rates

ALL-CAUSE, 30-DAY READMISSION RATES DECLINED 1% FROM 2010 TO 2014

*UCL - Upper control limit, **CL - Control limit, ***LCL - Lower control limit

Source: Healthy Policy and Data Analysis Group in the Office of the Enterprise Management of CMS. April 2014-August 2014 readmission rates are projected based on early data, with 95 percent confidence intervals as shown for the most recent five months.; CMMI, Bundled Payment Summit, June 2015
Comprehensive Care for Joint Replacement
Comprehensive Care for Joint Replacement Overview

- Lower extremity joint replacements ("LEJR") (MS-DRG 469 and 470)
- Commences January 1, 2016 (comments due September 8, 2015)
- Mandatory 5-year program
- No downside risk in Year 1

- Based on BPCI Model 2
- 90-day retrospective episode of care
- Payments tied to quality (complications and readmissions) and patient satisfaction (Hospital Consumer Assessment of Healthcare Providers and Systems ["HCAHPS"])

Source: CMS
Outlining the Financial Implications of CCJR

- Payments tied to quality and patient satisfaction
- Annual payment reconciliation
- Hospitals may assign up to 25 percent risk to collaborators, not to exceed 50 percent of total obligation to CMS (alignment payments)
- Hospitals may share 100 percent of savings achieved with collaborators (gainsharing payments)

**Diagram Explanation:**
- Hospital 1 (Cost $8,000) with CMS owes $2,000 (Potential gainshare payment to collaborators).
- Hospital 2 (Cost $15,000) with CMS owes $5,000.

© The Camden Group
CCJR: Anticipated 5-Year Timeline

- **Final Rule Anticipated**: NOV 1 2015
- **Program Begins**: JAN 2016
  - Baseline: 2012-2014
  - No Downside Risk

- **Anticipated Data Sets from CMS**: MAR 2016

- **Year 1**: JAN 2017
  - Baseline: 2012-2014
  - Downside Risk Begins

- **Year 2**: JAN 2018
  - Baseline: 2012-2014
  - Downside Risk Begins

- **Year 3**: JAN 2019
  - Baseline: 2014-2016

- **Year 4**: JAN 2020
  - Baseline: 2014-2016
  - Program Ends: DEC 2020

- **Year 5**: JAN 2020
  - Baseline: 2016-2018

**Likely number of participant hospitals**: 800

**Percent of national LEJR episodes in the program**: 25%

**Estimate of episode savings**: $153M

**Comment Period Ends**: SEP 8 2015
Hospitals Impacted by the CCJR Mandate

- Acute care hospitals are the primary risk holders

- Hospitals located in the 75 Metropolitan Statistical Areas (“MSA”) selected by CMS:
  - High density of Medicare recipients
  - Regions were excluded due to:
    - Insufficient volume of LEJR procedures
    - High BPCI penetration
    - Disproportionately low or high average costs

- BPCI Model 1, 2, and 4 acute care hospitals participating in joint replacement episodes as of July 1, 2015 are excluded

Source: CMS
Geographic Regions Identified for CCJR Span the Country

75 Mandated Metropolitan Statistical Areas

Source: CMS
## Identified MSAs for the CCJR Mandate

<table>
<thead>
<tr>
<th>State(s)</th>
<th>Metropolitan Statistical Area</th>
<th>State(s)</th>
<th>Metropolitan Statistical Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>OH</td>
<td>Akron</td>
<td>NC</td>
<td>Durham-Chapel Hill</td>
</tr>
<tr>
<td>NM</td>
<td>Albuquerque</td>
<td>IN-KY</td>
<td>Evansville</td>
</tr>
<tr>
<td>NC</td>
<td>Asheville</td>
<td>MI</td>
<td>Flint</td>
</tr>
<tr>
<td>GA</td>
<td>Athens-Clarke County</td>
<td>SC</td>
<td>Florence</td>
</tr>
<tr>
<td><strong>TX</strong></td>
<td><strong>Austin-Round Rock</strong></td>
<td>CO</td>
<td>Fort Collins</td>
</tr>
<tr>
<td><strong>TX</strong></td>
<td><strong>Beaumont-Port Arthur</strong></td>
<td>FL</td>
<td>Gainesville</td>
</tr>
<tr>
<td>ND</td>
<td>Bismarck</td>
<td>GA</td>
<td>Gainesville</td>
</tr>
<tr>
<td>CO</td>
<td>Boulder</td>
<td>NC</td>
<td>Greenville</td>
</tr>
<tr>
<td>NY</td>
<td>Buffalo-Cheektowaga-Niagara Falls</td>
<td>PA</td>
<td>Harrisburg-Carlisle</td>
</tr>
<tr>
<td>MO-IL</td>
<td>Cape Girardeau</td>
<td>AR</td>
<td>Hot Springs</td>
</tr>
<tr>
<td>NV</td>
<td>Carson City</td>
<td>IN</td>
<td>Indianapolis-Carmel-Anderson</td>
</tr>
<tr>
<td>NC-SC</td>
<td>Charlotte-Concord-Gastonia</td>
<td>MO-KS</td>
<td>Kansas City</td>
</tr>
<tr>
<td>OH-KY-IN</td>
<td>Cincinnati</td>
<td><strong>TX</strong></td>
<td><strong>Killeen-Temple</strong></td>
</tr>
<tr>
<td>CO</td>
<td>Colorado Springs</td>
<td>NV</td>
<td>Las Vegas-Henderson-Paradise</td>
</tr>
<tr>
<td>MO</td>
<td>Columbia</td>
<td>NE</td>
<td>Lincoln</td>
</tr>
<tr>
<td><strong>TX</strong></td>
<td><strong>Corpus Christi</strong></td>
<td>CA</td>
<td>Los Angeles-Long Beach-Anaheim</td>
</tr>
<tr>
<td>IL</td>
<td>Decatur</td>
<td><strong>TX</strong></td>
<td><strong>Lubbock</strong></td>
</tr>
<tr>
<td>CO</td>
<td>Denver-Aurora-Lakewood</td>
<td>WI</td>
<td>Madison</td>
</tr>
<tr>
<td>AL</td>
<td>Dothan</td>
<td>OR</td>
<td>Medford</td>
</tr>
</tbody>
</table>

Source: CMS
## Identified MSAs for the CCJR Mandate

<table>
<thead>
<tr>
<th>State(s)</th>
<th>Metropolitan Statistical Area</th>
<th>State(s)</th>
<th>Metropolitan Statistical Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>TN-MS-AR</td>
<td>Memphis</td>
<td>UT</td>
<td>Provo-Orem</td>
</tr>
<tr>
<td>FL</td>
<td>Miami-Fort Lauderdale-West Palm Beach</td>
<td>PA</td>
<td>Reading</td>
</tr>
<tr>
<td>WI</td>
<td>Milwaukee-Waukesha-West Allis</td>
<td>VA</td>
<td>Richmond</td>
</tr>
<tr>
<td>CA</td>
<td>Modesto</td>
<td>IL</td>
<td>Rockford</td>
</tr>
<tr>
<td>LA</td>
<td>Monroe</td>
<td>MI</td>
<td>Saginaw</td>
</tr>
<tr>
<td>AL</td>
<td>Montgomery</td>
<td>CA</td>
<td>San Francisco-Oakland-Hayward</td>
</tr>
<tr>
<td>FL</td>
<td>Naples-Immokalee-Marco Island</td>
<td>WA</td>
<td>Seattle-Tacoma-Bellevue</td>
</tr>
<tr>
<td>TN</td>
<td>Nashville-Davidson-Murfreesboro-Franklin</td>
<td>FL</td>
<td>Sebastian-Vero Beach</td>
</tr>
<tr>
<td>CT</td>
<td>New Haven-Milford</td>
<td>IN-MI</td>
<td>South Bend-Mishawaka</td>
</tr>
<tr>
<td>LA</td>
<td>New Orleans-Metairie</td>
<td>MO-IL</td>
<td>St. Louis</td>
</tr>
<tr>
<td>NY-NJ-PA</td>
<td>New York-Newark-Jersey City</td>
<td>VA</td>
<td>Staunton-Waynesboro</td>
</tr>
<tr>
<td>CT</td>
<td>Norwich-New London</td>
<td>FL</td>
<td>Tampa-St. Petersburg-Clearwater</td>
</tr>
<tr>
<td>UT</td>
<td>Ogden-Clearfield</td>
<td>OH</td>
<td>Toledo</td>
</tr>
<tr>
<td>OK</td>
<td>Oklahoma City</td>
<td>KS</td>
<td>Topeka</td>
</tr>
<tr>
<td>FL</td>
<td>Orlando-Kissimmee-Sanford</td>
<td>AL</td>
<td>Tuscaloosa</td>
</tr>
<tr>
<td>FL</td>
<td>Pensacola-Ferry Pass-Brent</td>
<td>TX</td>
<td>Tyler</td>
</tr>
<tr>
<td>PA</td>
<td>Pittsburgh</td>
<td>VA-NC</td>
<td>Virginia Beach-Norfolk-Newport News</td>
</tr>
<tr>
<td>FL</td>
<td>Port St. Lucie</td>
<td>KS</td>
<td>Wichita</td>
</tr>
<tr>
<td>OR-WA</td>
<td>Portland-Vancouver-Hillsboro</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: CMS
LEJJR Procedures: Understanding Regional Cost Variation

Average Regional Historical Episode Costs*
Calendar Years 2012 to 2014, MS-DRG 469 and 470

*Displayed figures reflect removal of special payment provisions under Inpatient Prospective Payment System (Value-Based Purchasing, Hospital Acquired Conditions, Readmissions, Disproportionate Share Hospital, Indirect Medical Education, etc.) but does not reflect removal of other prospective payment systems, http://innovation.cms.gov/initiatives/ccjr/

Source: CMS
Services Included

- Physicians’ services
- Inpatient hospital
- Inpatient hospital readmission
- Inpatient psychiatric facility
- Long-term care hospital
- Inpatient rehabilitation facility
- Skilled nursing facility
- Home health agency
- Hospital outpatient
- Independent outpatient therapy
- Clinical laboratory
- Durable medical equipment
- Part B drugs
- Hospice*

Services Excluded

- Acute care conditions not arising from existing episode-related chronic clinical conditions or complications from the LEJR surgery
- Chronic conditions that are generally not affected by the LEJR procedure or post-surgical care
- Hemophilia clotting factors
- New technology add-on payment

*Not included in BPCI
Source: CMS
Distribution of Hospital Claims – Fiscal Year 2014

Procedure Codes that Map to MS-DRGs 469 and 470

Note: Federal fiscal year ending September 30
Source: CMS
# Proposed Target Pricing Methodology for CCJR

<table>
<thead>
<tr>
<th>Year</th>
<th>Baseline</th>
<th>Blend of Hospital &amp; Regional</th>
<th>Downside Risk</th>
<th>Upside Opportunity</th>
<th>Methodology Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>CY* 2012-2014</td>
<td>2/3 hospital specific + 1/3 regional</td>
<td>None</td>
<td></td>
<td>Trended to performance period</td>
</tr>
<tr>
<td>2017</td>
<td>CY 2014-2016</td>
<td>1/3 hospital specific + 2/3 regional</td>
<td>Limited (10% stop-loss)**</td>
<td>20% gain cap</td>
<td>Pricing set at MS-DRG level</td>
</tr>
<tr>
<td>2018</td>
<td>CY 2016-2018</td>
<td>Entirely regional</td>
<td>Full (20% stop-loss)</td>
<td></td>
<td>Capped at a high payment ceiling (2 standard deviations from the mean)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Discount factor between 1.7 and 2 percent (based on successfully meeting voluntary reporting requirements)</td>
</tr>
</tbody>
</table>

*CY - Calendar Year, **If hospital owes CMS, the limited downside risk is based on a either 0.7 or 1.0 percent discount (based on voluntary reporting)

Source: CMS
3 Quality Measures are Required for Payment Eligibility

1. Complication Rates
   - Hospital-level risk-standardized complication rate ("RSCR") following elective primary total hip arthroplasty ("THA") and/or total knee arthroplasty ("TKA")
   - National Quality Forum ("NQF") #1550

2. Readmission Rates
   - Hospital-level 30-day, all-cause risk-standardized readmission rate ("RSRR") following elective primary THA and/or TKA
   - NQF #1551

3. Patient Satisfaction
   - HCAHPS survey
   - NQF #0166

Source: CMS
## Proposed Thresholds for Required Quality Measures

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>2016 - 2018</th>
<th>2019 - 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital-level RSCR following elective primary THA and/or TKA (NQF #1550)</td>
<td>30&lt;sup&gt;th&lt;/sup&gt; percentile</td>
<td>40&lt;sup&gt;th&lt;/sup&gt; percentile</td>
</tr>
<tr>
<td>Hospital-level 30-day, all-cause RSRR following elective primary THA and/or TKA (NQF #1551)</td>
<td>30&lt;sup&gt;th&lt;/sup&gt; percentile</td>
<td>40&lt;sup&gt;th&lt;/sup&gt; percentile</td>
</tr>
<tr>
<td>HCAHPS survey (NQF #1661)</td>
<td>30&lt;sup&gt;th&lt;/sup&gt; percentile</td>
<td>40&lt;sup&gt;th&lt;/sup&gt; percentile</td>
</tr>
</tbody>
</table>

Note: Thresholds based on the measure results from the Hospital Inpatient Quality Reporting Program.
Source: CMS
Voluntary Reporting Reduces CMS Discount

**Payment Eligibility**

- Successfully submits voluntary data (Patient Reported Outcomes [“PRO”])

**CMS Discount**

- 1.7 PERCENT
  Eligible to receive payment

- Only meets thresholds for 3 required quality measures

**CMS Discount**

- 2.0 PERCENT
  Eligible to receive payment

Note: Patient Reported Outcomes may include patient reported recovery of daily functions (e.g., mobility) or reduced symptoms (e.g., reduced pain)
Source: CMS
<table>
<thead>
<tr>
<th>Category</th>
<th>BPCI (Model 2)</th>
<th>CCJR Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible to Bear Risk</td>
<td>Physicians, hospitals, post-acute, conveners</td>
<td>Hospitals only</td>
</tr>
<tr>
<td>Action</td>
<td>Voluntary</td>
<td>Mandatory</td>
</tr>
<tr>
<td>Episode Length</td>
<td>30, 60, or 90 days</td>
<td>90 days</td>
</tr>
<tr>
<td>Baseline Period</td>
<td>July 1, 2009 to June 30, 2012</td>
<td>Years 1 and 2: CY 2012 to 2014; Years 3 and 4: CY 2014 to 2016; Year 5: CY 2016 to 2018</td>
</tr>
<tr>
<td>Target Price</td>
<td>Historical hospital performance</td>
<td>Years 1 and 2: Historical hospital 2/3 and regional 1/3 performance (weighted); Year 3: Historical hospital 1/3 and regional 2/3 performance (weighted); Years 4 and 5: Historical regional performance</td>
</tr>
<tr>
<td>Discount</td>
<td>30 or 60 days: 3% 90 days: 2%</td>
<td>Submits voluntary data: 1.7% Does not submit voluntary data: 2%</td>
</tr>
<tr>
<td>Stop-Loss or Gain</td>
<td>20% of target amount (2013 there was no downside risk)</td>
<td>20% of target amount (Year 1 no downside risk and Year 2 stop-loss 10%)</td>
</tr>
<tr>
<td>Reconciliation</td>
<td>Quarterly</td>
<td>Annually</td>
</tr>
<tr>
<td>Episode Initiators</td>
<td>Hospitals, physician groups, PAC facilities</td>
<td>Hospitals only</td>
</tr>
<tr>
<td>Quality Measures</td>
<td>Tracked, physicians accountable</td>
<td>Hospitals accountable</td>
</tr>
</tbody>
</table>

Source: CMS
### Proposed CCJR Program Waivers

<table>
<thead>
<tr>
<th>Rule</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SNF 3-Day Rule</strong></td>
<td>During years 2 through 5 of the model, CMS proposes to waive the SNF 3-day rule under certain circumstances. This is only valid if a patient is discharged to a SNF with at least a 3-star quality rating (ratings available on Nursing Home Compare website).</td>
</tr>
<tr>
<td><strong>Post-Discharge Home Visits, “Incident to” Rule</strong></td>
<td>CMS is not waiving the “homebound” rule, so beneficiaries are still required to be confined to their home to receive home health services. However, CMS proposes to waive the “incident to” rule for home visits allowing physicians to visit and charge for services in the home for up to 9 visits during the episode.</td>
</tr>
<tr>
<td><strong>Telehealth Services</strong></td>
<td>CMS proposes to waive the geographic site requirement and the originating site requirement for telehealth services to permit telehealth visits to originate in the beneficiary’s home or place of residence.</td>
</tr>
</tbody>
</table>
Preliminary Data Analysis and Gainsharing Considerations
Sharing Arrangements

- Participant hospital is responsible for episode spending and bears financial risk

- Hospital allowed to share in the reward and the risk with “collaborators” through sharing arrangements

- Potential collaborators:
  - SNFs
  - HHAs
  - LTCHs
  - IRFs
  - Physician group practices
  - Physicians
  - Non-physician practitioners
  - Outpatient therapy providers
  - Other

Requirements

- Only collaborators that provide direct care can receive gainsharing or contribute to CMS repayments

  Must enter into a written “Participant Agreement”

- Providers must specify a formula for calculating the percentage of CMS reconciliation payments used as gainsharing payments to collaborators

- Must notify patients of sharing arrangements

Source: CMS
Payments to a CCJR collaborator may be comprised of 2 sources of savings realized:

**Reconciliation Payments**

The amount a participating hospital may receive as a result of having an actual episode payment that is lower than the CMS target price

**Internal Cost Savings**

The cost savings realized by the hospital as a result of certain care redesign activities related to the CCJR episodes of care

**Risk-sharing restrictions**

- The hospital must retain 50 percent of repayment risk
- The maximum repayment amount a collaborator can pay is 25 percent

**Gainsharing restrictions**

- 100 percent of reconciliation payments can be shared with collaborators
- Capped at 50 percent of physician fee schedule payments (similar to BPCI)

Source: CMS
The Right Care Setting: Spend Across the Continuum

Daily Rates Across the Continuum for Medicare FFS

- Home Health: $190
- SNF: $432
- IRF: $1314
- LTAC Hospital: $1450
- Acute Hospital: $1819

Source: MedPAC 2013 Based on Fiscal Year 2011 Data
Hospitals are Strategically Evaluating Their PAC Partners

- Information Technology and Data Sharing
- Facility and Services
- Medical Directorship and Staffing
- Patient Satisfaction
- Quality and Outcomes
- Delivery Network and Care Continuum
Common Criteria for SNF Partner Selection

- 5-star rating
- Facility size, physical organization, and capacity
- Private vs. semi-private room distribution
- Average LOS for Medicare FFS and managed care
- Short-stay to long-term care transfer rate
- Program specialties and capacity
- Primary care coverage, medical director relationship
- Leadership tenure and turnover
- Staffing, especially RN coverage

- Therapy provision (5,6, or 7 days)
- INTERACT deployment and use
- Electronic health record deployment, use, and integration
- Functional Independence Measure subscriber status
- Admission volume and “churn”
- Complex care delivery by volume
- 30- to 90-day readmission rates
- Survey history
- Monetary penalties
- Community discharge rates
- Number of patients discharged to home health agency

Source: MedPAC September 2012; MedPAC Analysis of 2004-2006 5 percent Medicare claims files
Common Criteria for Home Health Agencies

- Years serving the community
- Approved Medicare provider
- Approved by an accrediting organization (CHAP*, TJC**)
- Licensed by the state
- Provide patients with a “Bill of Rights”
- Written plan of care provided for the patient’s treatment
- Documentation of the patient’s course of treatment (and educating family members)
- Supervisors assigned to oversee care
- Availability of caregivers 7 days a week

- Ensure patient confidentiality
- Nursing supervisor on call and available 24 hours a day
- Comprehensive employee hiring, training, and background check
- Procedures for resolving issues between the patient/family and home health staff
- Allowing questions or complaints regarding patient care to be addressed
- Alternatives if a staff member fails to make a scheduled visit
- Agency handling billing processes
- Agency providing a list of references

*CHAP - The Community Health Accreditation Program, **TJC - The Joint Commission
Source: Advancing Nonprofit Home Healthcare and Hospice. Home Health Care FAQ. June 2015
### Hospitals Are More Dependent on PAC Providers

**Cost-Saving Opportunities**

Variation and growth in PAC spending has earned PAC a spot on hospital and health systems’ priority list for cost-saving opportunities.

**New Care Delivery Models**

The success of new care delivery models, including hospital-driven bundles and accountable care organizations.

**Strategy-Driven Approaches**

Hospitals are pursuing more strategy-driven approaches by assessing the value of potential partners.

**Narrower Networks**

Hospitals are developing narrower networks of SNF and HHA providers to deliver high-quality care, leverage clinical expertise, and improve efficiency, patient outcomes, and the patient experience.

Overall Care Redesign Considerations

**Patient Activation, Engagement, and Risk Management**
- Enhanced pre-registration and patient/family education
- Pre-operative education class for patient and family
- Patient shadowing program
- Discharge management such as early identification of post-acute needs
- Standardized risk assessment tools for complex, co-morbid patients

**Enhancements in Care Delivery**
- Telehealth and/or telephonic communication for patient follow-up across post-acute episodes

**Redesign of Care Pathways**
- Lean/Process mapping to identify waste and inefficiencies
- Standardized care protocols across physicians and sites of care
- Early and regular physician rounding
- Reduction in ancillary testing
- Supply chain management/implant cost reductions
### Overall Care Redesign Considerations

#### Care Coordination
- Transitional care coordinator
- Patient navigator
- Longitudinal care plans that pre-determine care setting needs across the episode
- Engagement of nursing staff in program outcomes

#### System Changes to Support Care
- Early dashboard development using key clinical and cost metrics
- Physician scorecard
- Clinical effectiveness teams to address process and care delivery
- Electronic health record utilization and customization to identify CCJR patients and document care coordination across care settings
- Data sharing between acute and post-acute providers
Hip and Knee Care Redesign Considerations

**Pre-operative**
- Patient education
  - Setting care pathway expectations
  - Caregiver engagement
  - Joint camp attendance
  - Connection with Orthopedics Navigator
- Pre-operative assessment
  - Patient risk assessment tools
  - Comorbidity management prior to surgery
  - Functional assessment and discharge planning

**Anchor Admission**
- Discharge planning
- Hemoglobin management
- Implant costs
- Reduction of non-essential services without benefit (occupational therapy)
- Continuous risk assessment
- Care transitions
- Medication reconciliation
- Acute LOS vs. post-acute costs

**Post-Acute**
- Quality transition to preferred care
- Management of relationship between SNF and anchor hospital
- Patient tracking (e.g., Orthopedics Navigator)
- Essential Metrics
  - Ratio discharged to SNF
  - LOS in SNF
Preparing for the CMS CCJR Mandate

- Engage Physicians and Care Teams
- Standardize Clinical Care Protocols and Pathways
- Identify Cost Savings Opportunities
- Collect and Analyze Post-Acute Spend Data
- Determine Post-Acute Care Strategy
- Invest in Implementation Resources
Non-Medicare Bundled Payments
In The Headlines…

CRUNCH NETWORK
Risk And Reward: The Bundled Payment Opportunity For Tech Startups

Modern Healthcare
The leader in healthcare business news, research & data

Bundling risk: New demo program shows CMS' eagerness to ditch fee for service

May 22, 2012

BlueCross Announces Bundled Payment Agreements with Leading Orthopedic Groups in Tennessee
Medical practices across the state to provide treatment under new payment method for total knee and hip replacements

CHATTANOOGA, Tenn. — BlueCross BlueShield of Tennessee has reached agreements with four respected orthopedic practices for a new bundled payment that focuses on patient care, quality and outcomes for total knee and hip replacements.

Participating practices are Vanderbilt Medical Group and Tennessee Orthopaedic Alliance in Nashville, Campbell Clinic in Memphis and the Knoxville Orthopaedic Group.

This system is generally considered a new payment methodology, but make no mistake, this is a collaborative tool we can use to improve health outcomes and drive better results for patients.

GE will steer workers to Northwestern Memorial for hips and knees

By Bob Herman | November 24, 2014
An agreement between the prominent Chicago hospital and one of the largest employers in the country is yet another example that self-insured companies want to work more directly with high-quality health systems for certain procedures.
National Market

2015 Significant Growth in Both Medicaid and Employer Bundles

75% Medicare and Medicaid

15% Commercial

10% Self-Funded Employers

Source: The Camden Group
Commercial Payers in Orthopedic Bundled Payments

Horizon

Blue Cross Blue Shield of Tennessee

Anthem of Wisconsin

Cigna of Wisconsin

Aetna

ConnectiCare

blue of California

Horizon Blue Cross Blue Shield of New Jersey

Florida Blue
Current Bundled Payments and Looking Ahead…

- INPATIENT
- ORTHOPEDIC
- CARDIOVASCULAR
- MEDICARE
- PEDIATRIC AND MATERNITY
- OUTPATIENT
- GROWTH OF COMMERCIAL AND EMPLOYER CONTRACTS
- PROSPECTIVE PAYMENT
Questions?

Barbara Letts
Senior Manager
THE CAMDEN GROUP
100 N. Sepulveda Blvd., Suite 600
El Segundo, CA 90245
310.320.3990 ext. 3988
bletts@thecamdengroup.com