THE CAMDEN GROUP

October 22, 2015

Navigating the Era of Fusion Reimbursement – Bundled Payments

hfma south texas chapter
healthcare financial management association

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

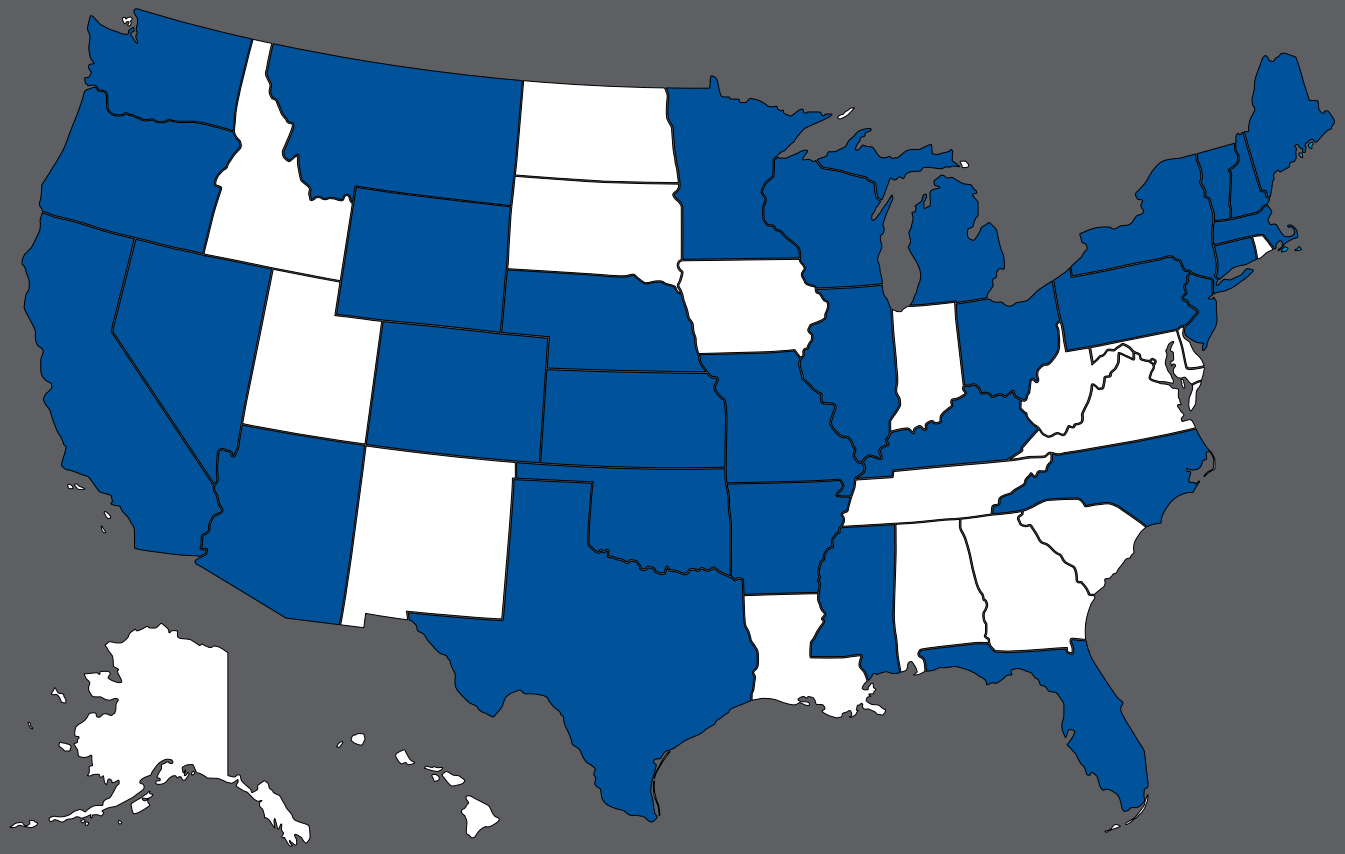
- Program launch
- Structure and governance
- Dashboard development and execution
- Gainsharing methodology
- Bundled Payments for Care Improvement ("BPCI") initiative ongoing support and tracking
- Quality monitoring process
- Hospital, physician, and organizational education
- Data analytics and episode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



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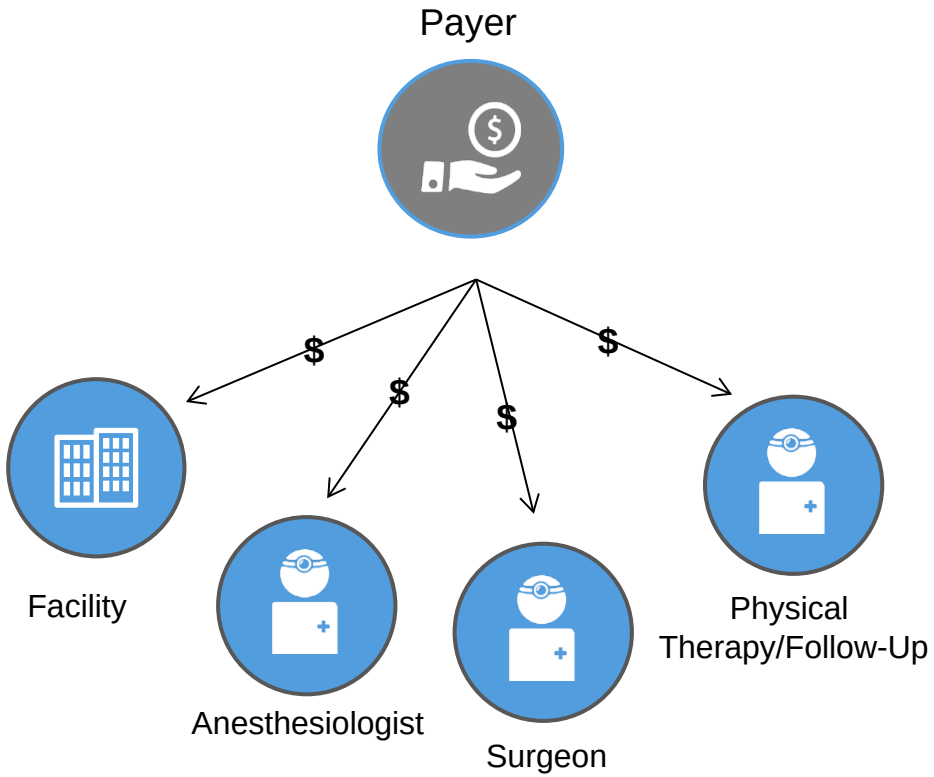
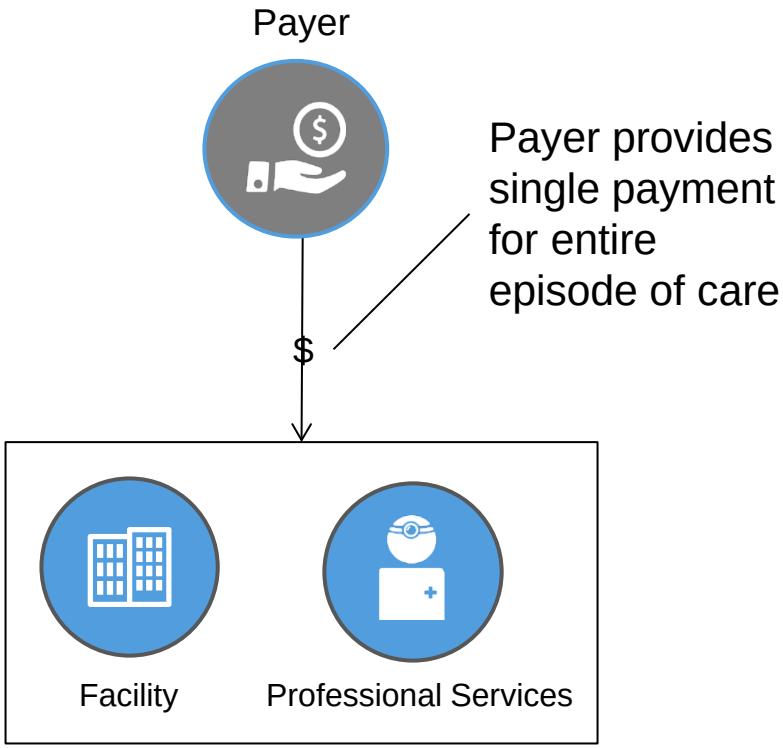
Fee-for-Service vs. Bundled Payments

Fee-for-Service



Bundled Payments



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

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

2015
- Oncology Care Model
- CMS Joint Mandate

*CMS - Centers for Medicare & Medicaid Services, **ACE - Acute Care Episode

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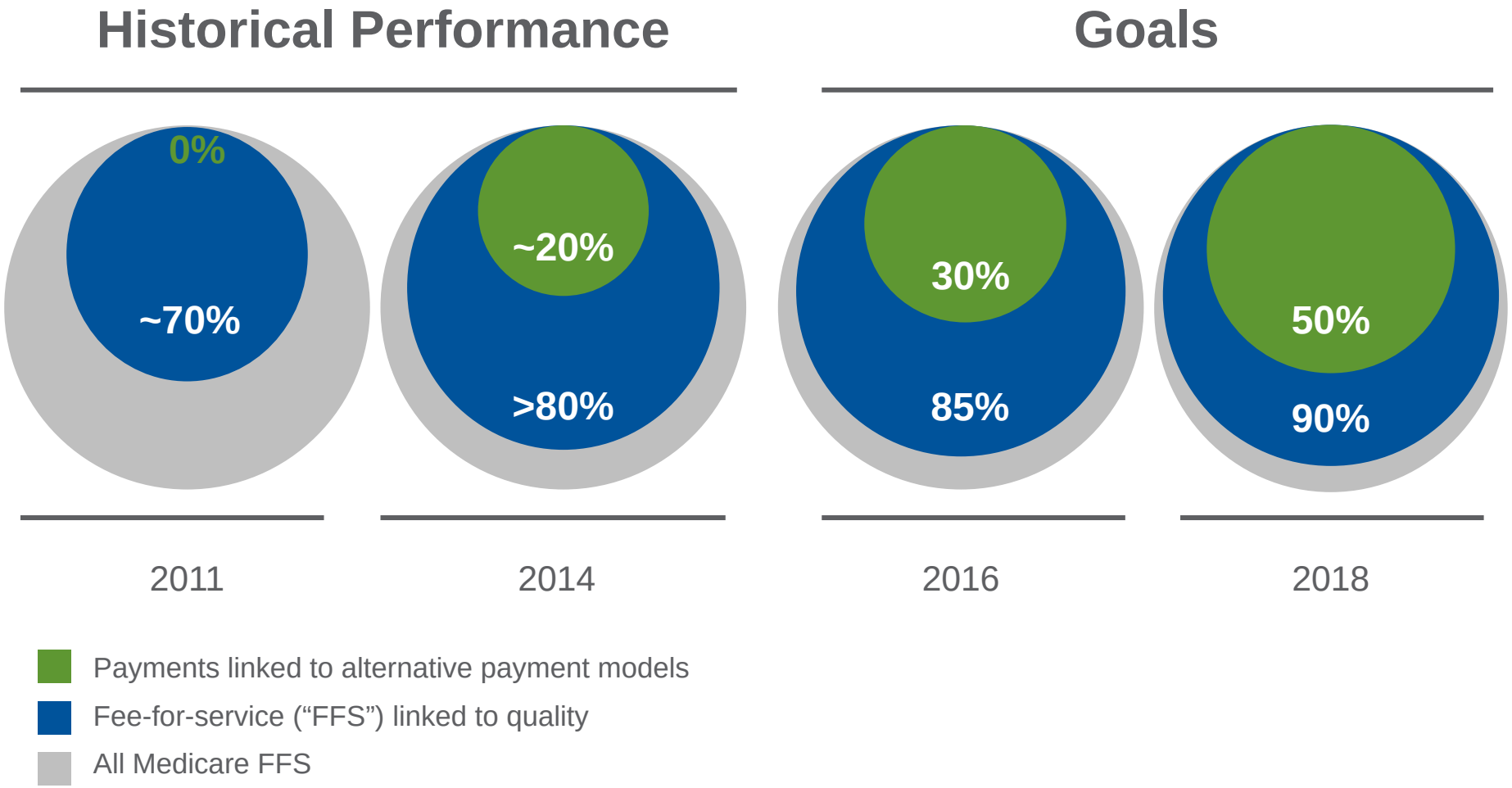
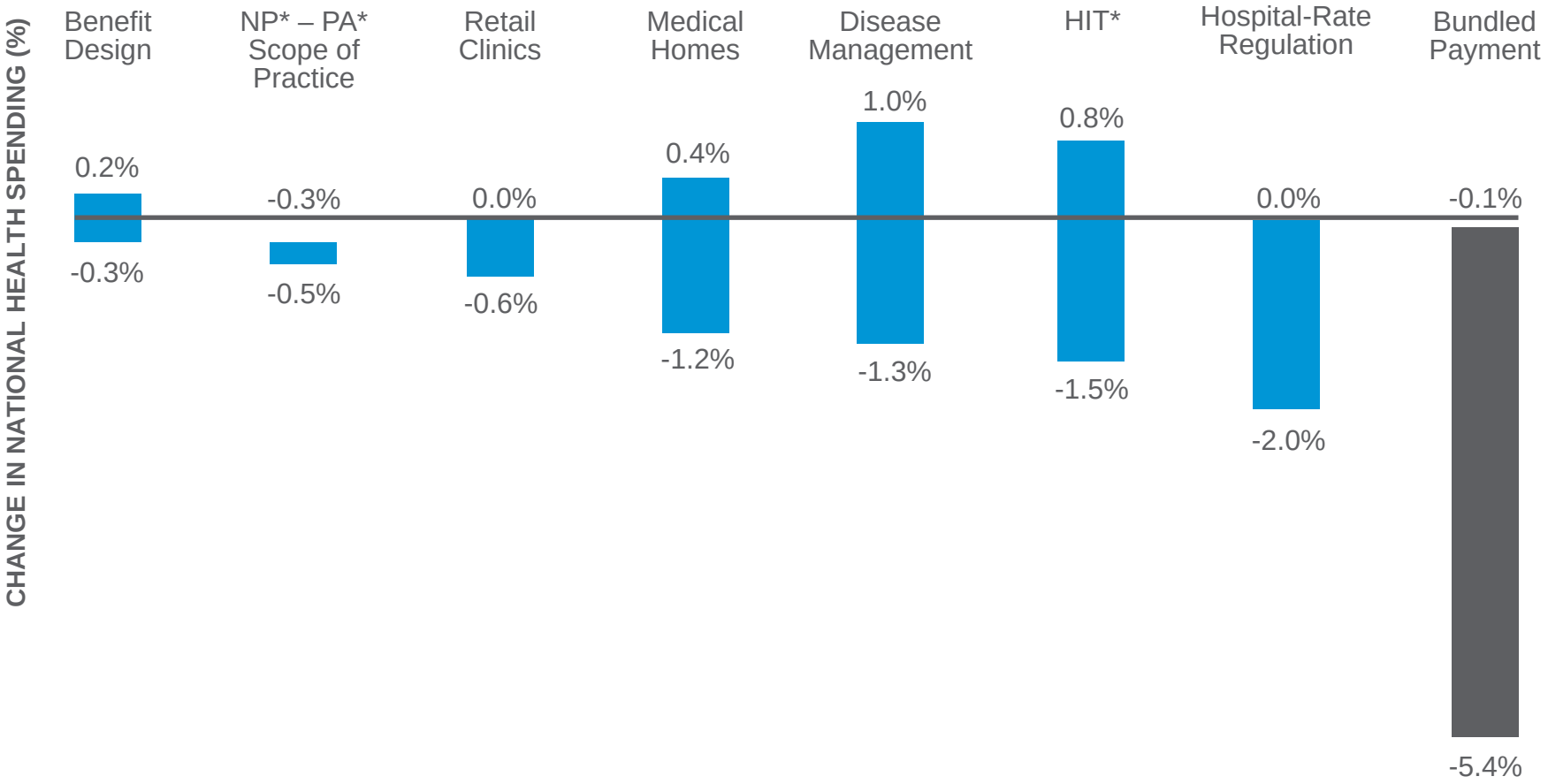
CMS Transitions to Value-Based Reimbursement



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



NP* - Nurse Practitioner, PA* - Physician Assistant, HIT* - Health Information Technology
Source: Hussey P., et al. New England Journal of Medicine 2009;361:2109-2111

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.

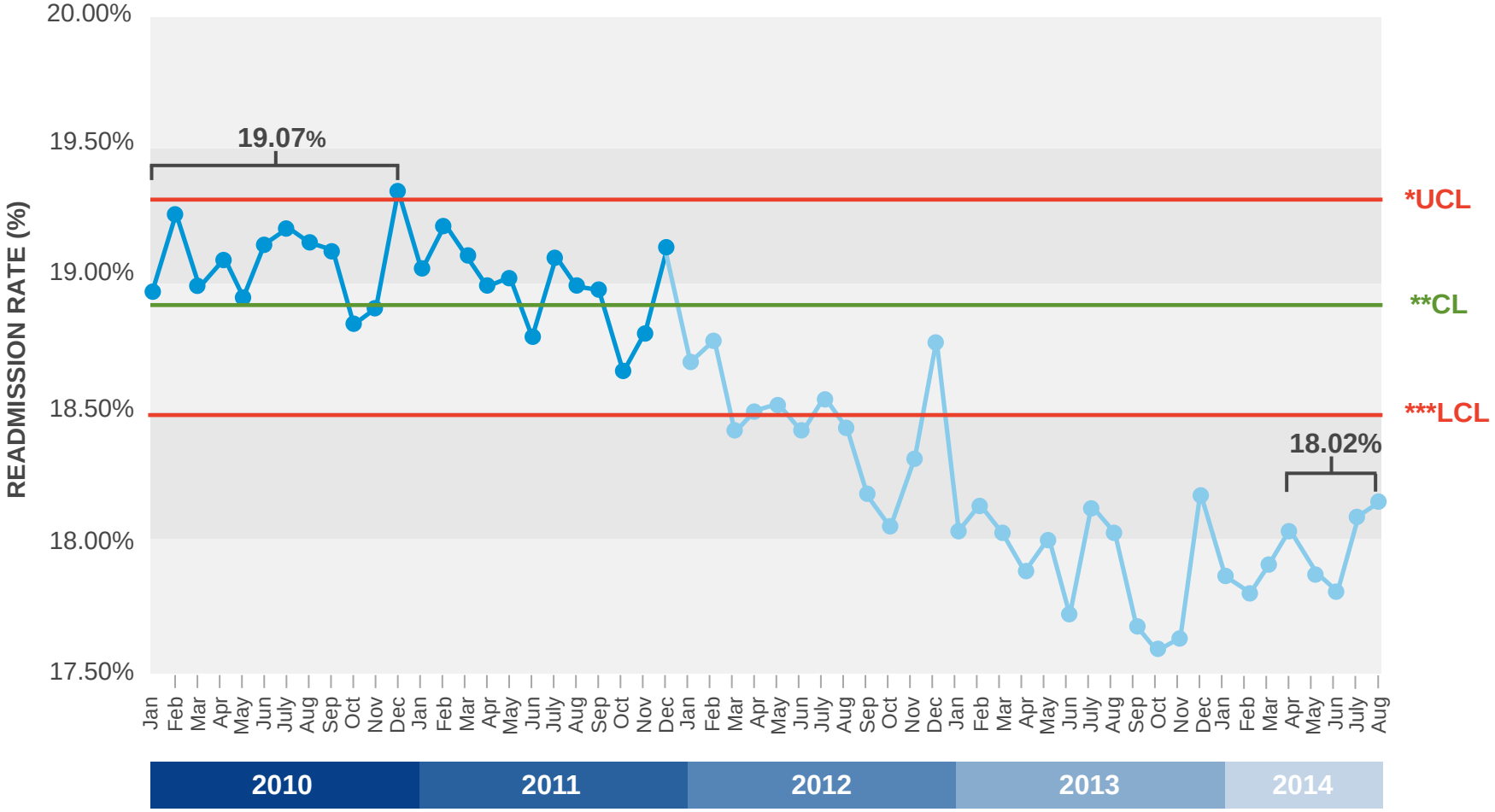
As a result, there were reductions in Medicare Part A payments to Skilled Nursing Facilities (“SNF”) and Inpatient Rehabilitation Facilities (“IRF”), accompanied by an increase in Part A payments to Home Health Agencies (“HHA”).

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

Inpatient Stay

(Facility and Professional Fees)

- **Skilled Nursing Facility**
- **Inpatient Rehab Facility**
- **Home Health**
- **Long-Term Acute Care ("LTAC")**
- **90 Days Post-Discharge (Including Readmissions)**

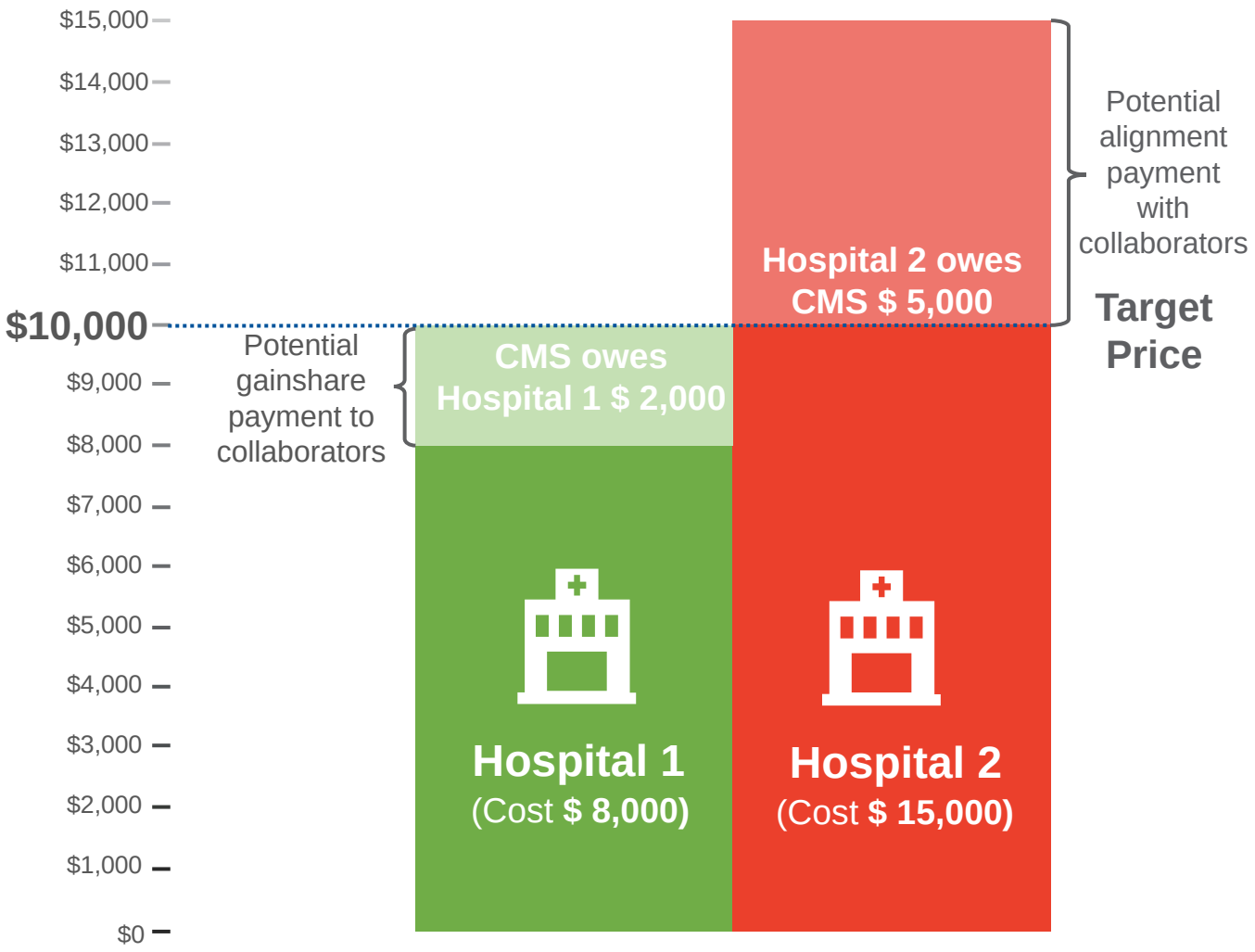
- Lower extremity joint replacements ("LEJR") (MS-DRG 469 and 470)
- Commences January 1, 2016 (comments due September 8, 2015)
- Mandatory 5-year program
- No downside risk in Year 1

- 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)



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CCJR: Anticipated 5-Year Timeline

800
Likely number of participant hospitals

25%
Percent of national LEJR episodes in the program

$153M
Estimate of episode savings

SEP 8 2015
Comment Period Ends

NOV 1 2015
Final Rule Anticipated

MAR 2016
Anticipated Data Sets from CMS

JAN 2016
Year 1
Program Begins
Baseline: 2012-2014
No Downside Risk

JAN 2017
Year 2
Baseline: 2012-2014
Downside Risk Begins

JAN 2018
Year 3
Baseline: 2014-2016

JAN 2019
Year 4
Baseline: 2014-2016

JAN 2020
Year 5
Baseline: 2016-2018

DEC 2020
Program Ends

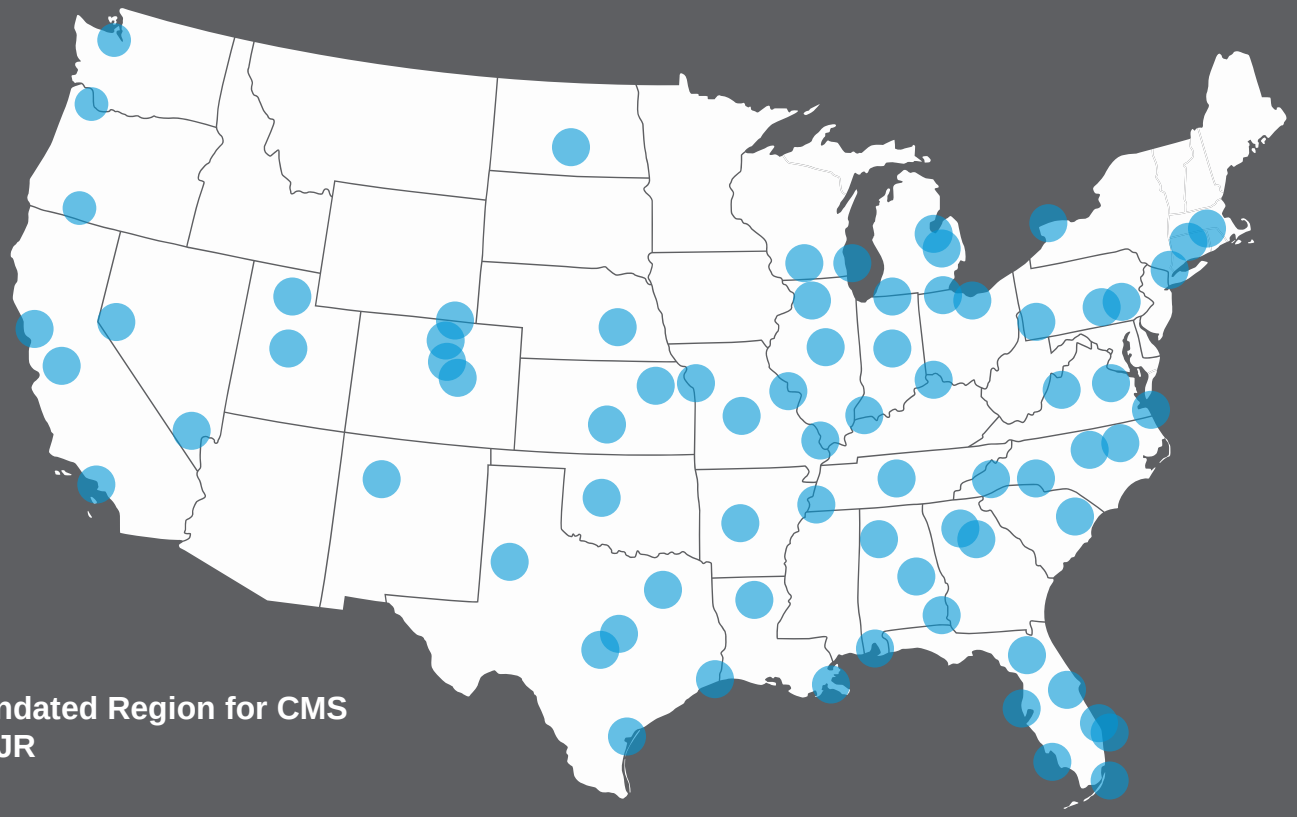
Hospitals Impacted by the CCJR Mandate

- 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



Mandated Region for CMS CCJR

Source: CMS

Identified MSAs for the CCJR Mandate

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

Source: CMS

Identified MSAs for the CCJR Mandate

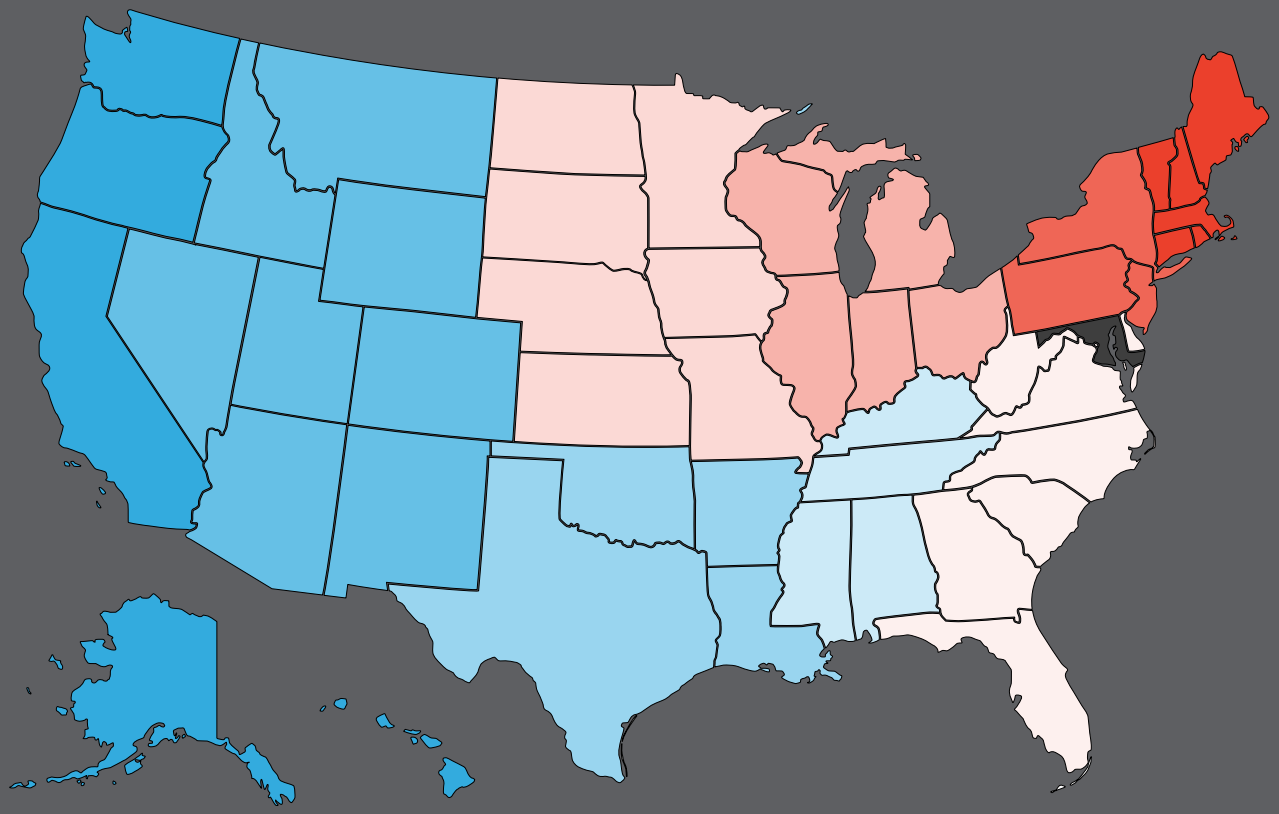
State(s)	Metropolitan Statistical Area	State(s)	Metropolitan Statistical Area
TN-MS-AR	Memphis	UT	Provo-Orem
FL	Miami-Fort Lauderdale-West Palm Beach	PA	Reading
WI	Milwaukee-Waukesha-West Allis	VA	Richmond
CA	Modesto	IL	Rockford
LA	Monroe	MI	Saginaw
AL	Montgomery	CA	San Francisco-Oakland-Hayward
FL	Naples-Immokalee-Marco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

Source: CMS

LEJR Procedures: Understanding Regional Cost Variation

Average Regional Historical Episode Costs*

Calendar Years 2012 to 2014, MS-DRG 469 and 470



1 NEW ENGLAND
469—$47,928
470—$24,858

2 MIDDLE ATLANTIC
469—$52,028
470—$27,406

3 EAST NORTH CENTRAL
469—$50,954
470—$25,480

4 WEST NORTH CENTRAL
469—$46,189
470—$23,800

5 SOUTH ATLANTIC
469—$51,239
470—$25,989

6 EAST SOUTH CENTRAL
469—$50,328
470—$26,345

7 WEST SOUTH CENTRAL
469—$55,448
470—$27,464

8 MOUNTAIN
469—$47,925
470—$23,734

9 PACIFIC
469—$48,874
470—$23,425

*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

CCJR: Defining the Bundle

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*

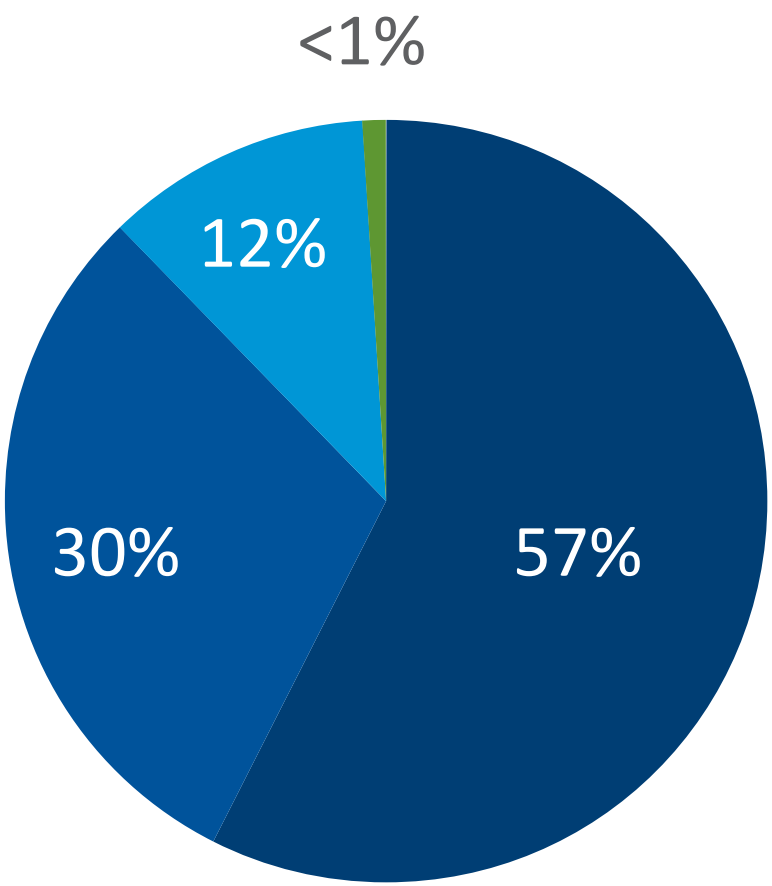
Services Excluded

- 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

Procedure Codes that Map to MS-DRGs 469 and 470

Distribution of Hospital Claims – Fiscal Year 2014



Code Descriptor (ICD-9-CM Procedure Code)
Total knee replacement (81.54)
Total hip replacement (81.51)
Partial hip replacement (81.52)
Total ankle replacement (81.56)
Resurfacing hip, total, acetabulum and femoral head (00.85)
Resurfacing hip, partial, femoral head (00.86)
Resurfacing hip, partial, acetabulum (00.87)
Lower leg or ankle reattachment (84.27)
Thigh reattachment (84.28)

Note: Federal fiscal year ending September 30
Source: CMS

Proposed Target Pricing Methodology for CCJR

	2016	2017	2018	2019	2020
Baseline	CY* 2012-2014		CY 2014-2016		CY 2016-2018
Blend of Hospital & Regional	2/3 hospital specific + 1/3 regional		1/3 hospital specific + 2/3 regional	Entirely regional	
Downside Risk	None	Limited (10% stop-loss)**	Full (20% stop-loss)		
Upside Opportunity	20% gain cap				

Methodology Considerations

- Trended to performance period
- Pricing set at MS-DRG level
- Capped at a high payment ceiling (2 standard deviations from the mean)
- Discount factor between 1.7 and 2 percent (based on successfully meeting voluntary reporting requirements)

*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

Quality Measure	2016 - 2018	2019 - 2020
Hospital-level RSCR following elective primary THA and/or TKA (NQF #1550)	30th percentile	40th percentile
Hospital-level 30-day, all-cause RSRR following elective primary THA and/or TKA (NQF #1551)	30th percentile	40th percentile
HCAHPS survey (NQF #1661)	30th percentile	40th percentile

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

Voluntary Reporting Reduces CMS Discount

Payment Eligibility	CMS Discount
Successfully submits voluntary data (Patient Reported Outcomes [“PRO”])	**1.7 PERCENT** Eligible to receive payment
Only meets thresholds for 3 required quality measures	**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

Comparing the CCJR Mandate with the BPCI Model 2

Category	BPCI (Model 2)	CCJR Model
Eligible to Bear Risk	Physicians, hospitals, post-acute, conveners	Hospitals only
Action	Voluntary	Mandatory
Episode Length	30, 60, or 90 days	90 days
Baseline Period	July 1, 2009 to June 30, 2012	**Years 1 and 2:** CY 2012 to 2014; **Years 3 and 4:** CY 2014 to 2016; **Year 5:** CY 2016 to 2018
Target Price	Historical hospital performance	**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
Discount	**30 or 60 days**: 3% **90 days**: 2%	**Submits voluntary data:** 1.7% **Does not submit voluntary data:** 2%
Stop-Loss or Gain	20% of target amount (2013 there was no downside risk)	20% of target amount (Year 1 no downside risk and Year 2 stop-loss 10%)
Reconciliation	Quarterly	Annually
Episode Initiators	Hospitals, physician groups, PAC facilities	Hospitals only
Quality Measures	Tracked, physicians accountable	Hospitals accountable

Source: CMS

Proposed CCJR Program Waivers

SNF 3-Day Rule	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).
Post-Discharge Home Visits, "Incident to" Rule	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.
Telehealth Services	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.

Source: CMS

Preliminary Data Analysis and Gainsharing Considerations

CCJR: Sharing both the Risk and the Reward

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

Potential Gainsharing Funds

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

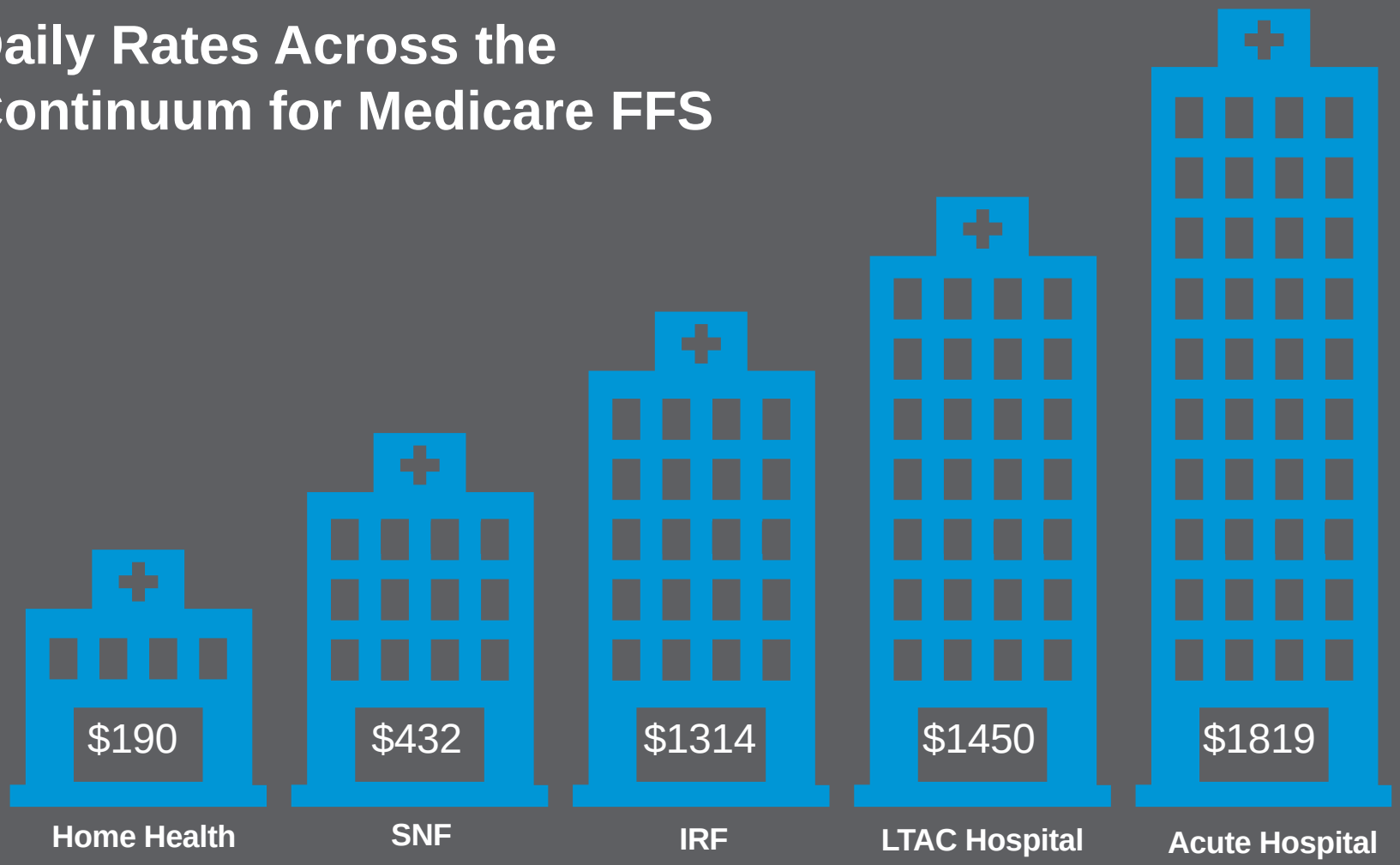
Gainsharing restrictions

- 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



Source: MedPAC 2013 Based on Fiscal Year 2011 Data

Hospitals are Strategically Evaluating Their PAC Partners

- Information Technology and Data Sharing
- Patient Satisfaction
- Facility and Services
- Quality and Outcomes
- Medical Directorship and Staffing
- 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

Source: http://www.mcknights.com/guest-columns/positioning-for-narrowing-pac-networks/article/362742

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

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Preparing for the CMS CCJR Mandate

- Engage Physicians and Care Teams
- Collect and Analyze Post-Acute Spend Data
- Standardize Clinical Care Protocols and Pathways
- Determine Post-Acute Care Strategy
- Identify Cost Savings Opportunities
- Invest in Implementation Resources

Non-Medicare Bundled Payments

In The Headlines…

CRUNCH NETWORK

Risk And Reward: The Bundled Payment Opportunity For Tech Startups

Posted Oct 18, 2015 by Rich Gliklich

FierceHealthcare

NEWS TOPICS ANALYSI

Topics: Care Delivery | Operations & Business Management

Cleveland Clinic, Wal-Mart partner in direct-employer services

October 12, 2012 | By Karen Cheung-Larivee

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Six major health centers are making a pact with the world's largest retailer to offer Wal-Mart employees free heart and spine surgeries, Reuters reported. As the first national program for covering heart, spine and transplant surgery, Wal-Mart employees qualify for complex surgeries at no cost to patients under arrangements with Cleveland Clinic in Cleveland; Geisinger Medical Cen Danville, Pa.; Mayo Clinic sites in Minnesota, Arizona and Florida; Mercy Springfield in Springfield, Mo.; Scott & White Memorial Hospital in Temple and Virginia Mason Medical Center in Seattle.

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

By Melanie Evans | July 18, 2015

The deteriorating hips and knees of the nation's seniors were an obvious

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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 Orthopaed

"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 anc

Small business self-insurance push threatens reform

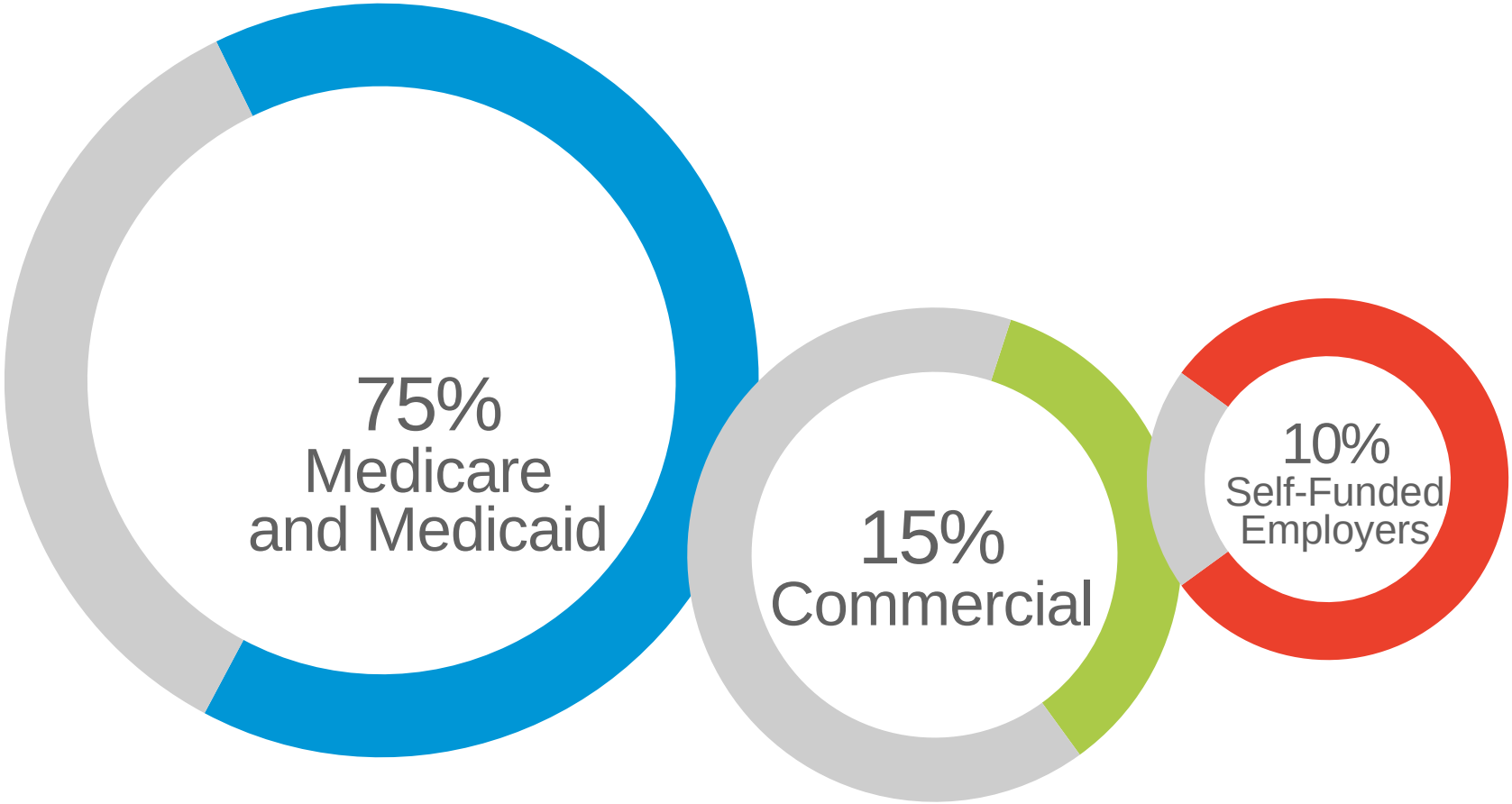
GE will steer workers to Northwestern Memorial for hips and knees

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



Source: The Camden Group

Commercial Payers in Orthopedic Bundled Payments

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Questions?

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