Bundled Payment: An Opportunity for Post-Acute Providers to Move Up the Health Care Delivery Value Chain

Leading Age Indiana

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Review the Health Care Reform Strategy Tool

Eight Steps to Becoming an Accountable Care Ready Provider

Step 1 • Create your health care reform strategy team
Step 2 • Understand your local marketplace; identify your strategic partners
Step 3 • Determine if you are accountable care ready
Step 4 • Prepare summary SWOT Analysis
Step 5 • Conduct additional research if needed
Step 6 • Formulate your desired value proposition for strategic partners
Step 7 • Develop and prioritize your strategies and tactics
Step 8 • Seek strategic partners/preferred hospital relationships
“These transformational models are no longer isolated pilots. They [ACOs and Bundled Payment Initiatives] are becoming the face of American medicine.”

Kathleen Sebelius, HHS Secretary to the American Medical Association, February 12, 2013

Today’s Agenda

- Forces of Change
- Bundled Payment Defined
- Key Steps to Create a Bundling Model
- Opportunities and the Challenge Ahead
- Q&A
Longitudinal Care Management Not Core Skill for Most Acute Health Systems... or Health Plans

Why Payment Reform: P4P, ACOs, Managed Care, Bundled Payment
Movement to Population-Based Health: Next Stop, Bundled Payment

- **2013**
  - Majority Fee-for-Service
  - Early P4P, Shared Savings, Bundled Payment
  - Limited Capitation

- **2016–2020**
  - Majority Fee-for-Value
  - Significant Capitation
  - Minority Fee-For-Service

- **2020**
  - Population-Based Health

Bundling Thought to Be the Greatest Opportunity to Bend the Cost Curve

Estimated Cumulative Percentage Changes in National Health Care Expenditures, 2010 through 2019

- **Bundled payment**
  - -5.4% to -0.1%

- **Hospital-rate regulation**
  - -2.0% to 0.0%

- **Disease management**
  - -1.5% to 0.8%

- **Medical homes**
  - -1.3% to 1.0%

- **Retail clinics**
  - -1.2% to 0.4%

- **NP–PA scope of practice**
  - -0.6% to 0.0%

- **Benefit design**
  - -0.3% to 0.2%


HIT denotes health information technology; NP denotes nurse practitioner, and PA denotes physician assistant.
Policies Increasingly Squeeze Medicare SNF and HHA Payments

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Proposal/Law</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facilities</td>
<td></td>
</tr>
<tr>
<td>No MB increase in 2014; rebase payments by -4%/year</td>
<td>MedPAC</td>
</tr>
<tr>
<td>Equalize payments (joints, pulmonary, other) for SNFs &amp; IRFs</td>
<td>President Budget, 2014</td>
</tr>
<tr>
<td>In 2017, reduce payments by 3% to SNFs with excessive hospital readmissions</td>
<td>President Budget, 2014</td>
</tr>
<tr>
<td>Home Health Agencies</td>
<td></td>
</tr>
<tr>
<td>Rebase HHA payment in 2014, 4 years, max reduction = 3.5%/year -2 years, no MB increase, remove therapy visits as payment driver</td>
<td>ACA</td>
</tr>
<tr>
<td>$100 co-pay/non-post-acute HH episode for new beneficiaries, 2017</td>
<td>President Budget, 2014, MedPAC</td>
</tr>
<tr>
<td>Reduce MB increase by 1.1%, 2014–2023, for HHA No MB increase for HHA</td>
<td>President Budget, 2014, MedPAC</td>
</tr>
</tbody>
</table>

With Lower Payments, Providers Must Accept Risk to Survive

FFS Payment Reductions Readmission Penalties

Value-Based Purchasing Pay-for-Outcomes

Acute/Post-Acute Bundling & ACOs

Capitation (Population Health) Managed Care

RISK
And It’s Coming: Rapid Expansion of Bundling

– In the next 5 years, bundled payments will represent 35% of U.S. health systems’ revenue

24% of health plans are currently implementing bundled payment contracts

Health Systems
Average Percentage of Hospital Revenues by 2018

Fee-for-Service: 38%
Bundled Payments: 35%
Capitated or other payments w/insurance risk: 27%

Health Plans
Bundled Payment Implementation Plans

Currently Implemented: 24%
Planning to Implement: 34%
No Plans: 42%

What phase of bundled payment plan implementation is your health plan currently in?
Early
Mid
Late
Unsure


And It’s Coming: Minimum 50% of Total PAC Provider Payments Bundled (2020 Goal)

Reduce Spend by -2.85%

BPCI pilot begins October 1
BPCI begins for all PAC providers

© HDG 2013
Bundled Payment Defined

For Immediate Release
Thursday, January 31, 2013

Contact
press@cms.hhs.gov

BUNDED PAYMENTS FOR CARE IMPROVEMENT INITIATIVE OVERVIEW
On January 31, 2013, the Centers for Medicare & Medicaid Services (CMS) announced the health care organizations selected to participate in the Bundled Payments for Care Improvement initiative, an innovative new payment model. Under the Bundled Payments for Care Improvement initiative, organizations will enter into payment arrangements that include financial and performance accountability for episodes of care.

What is Bundled Payment for Hospital and PAC Services?

Combined Inpatient Hospital-PAC Bundle or PAC-Only Bundle

Current Policy

Hospital

Physician Services During Hospital Stay

PAC Provider: SNF, HH, IRF, LTCH

Physician Services During Post-Acute Care

Readmissions

PAC-Only Bundle

Post-Acute Care Only Bundle

Readmissions (may be included in bundle)

Combined Hospital-PAC Bundle

Hospital + Post-Acute Care Bundle

Readmissions (may be included in bundle)
### Challenge: A Current Post-Acute Continuum Does Not Exist & Must Be Built from Existing Silos

<table>
<thead>
<tr>
<th>LTACHs</th>
<th>IRFs</th>
<th>SNFs</th>
<th>HHAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>424</td>
<td>1,165</td>
<td>14,935</td>
<td>12,199</td>
</tr>
<tr>
<td>76% PTY, 19% NP, 19% Gov</td>
<td>85% PTY, 63% NP, 14% Gov, 80% HB, 20% FS</td>
<td>70% PTY, 5% HB, 95% FS, 23% Revenue Medicare</td>
<td>89% of FS are PTY</td>
</tr>
<tr>
<td>2011 $38,664</td>
<td>2011 $17,398</td>
<td>2011 $12,200</td>
<td>2010 $2,815</td>
</tr>
<tr>
<td>2011 30-day hospital readmissions = 10%</td>
<td>2010 30-day hospital readmissions = 10%</td>
<td>2011 30-day hospital readmissions = 19.2%</td>
<td>2009 30-day hospital readmissions = 28%</td>
</tr>
</tbody>
</table>

PTY = proprietary; NP = not-for-profit; HB = hospital-based; Gov = government; FS = freestanding

Source: MedPAC Report to Congress, March 2013

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### Partnerships Key to Success Under Bundled Payment

**30-Day Episode Medicare Payment by Service Type, All Post-Acute Users, 2006**

- 14.0% All Other
- 15.9% Acute Readmissions
- 10.1% PAC: IRF/LTACH
- 25.8% PAC: SNF/HHA
- 34.3% Acute Care Hospitals

Medicare Episode Payment = $30,028; N = 109,236

Source: RTI 2009

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And Controlling SNF/HH Use Key to Managing the Post-Acute Bundle

And Controlling SNF/HH Use Key to Managing the Post-Acute Bundle

SNF 41%
HHA 37%
IRF 10%
OP 9%
LTACH 2%
HHA 30%
OP 9%
SNF 13%
HHA 8%
SNF 23%
HHA 46%
HHA 25%

Readmission Rates After PAC Setting

<table>
<thead>
<tr>
<th>Setting</th>
<th>SNF</th>
<th>HHA</th>
<th>IRF</th>
<th>OP</th>
<th>LTACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-Acute</td>
<td>22.0%</td>
<td>18.1%</td>
<td>9.4%</td>
<td>n/a</td>
<td>10.0%</td>
</tr>
</tbody>
</table>


Significance of PAC Costs Vary by Clinical Condition

<table>
<thead>
<tr>
<th>Condition</th>
<th>Hospital</th>
<th>Physician</th>
<th>Post-Acute Care</th>
<th>Readmissions</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>0%</td>
<td>20%</td>
<td>40%</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>Hip and Femur Proc.</td>
<td>20%</td>
<td>40%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Cardiac Bypass</td>
<td>20%</td>
<td>40%</td>
<td>40%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>0%</td>
<td>20%</td>
<td>40%</td>
<td>60%</td>
<td>80%</td>
</tr>
</tbody>
</table>

Source: MedPAC September 2012; MedPAC Analysis of 2004-2006 5% Medicare claims files
For This High-Risk Population, Know Your Costs by Condition including Co-Morbidities

Poor Discharge Outcomes

- Age 70+
- Lives alone
- Cognitive impairment
- 6+ medications
- 2+ chronic conditions
- Multiple ADL impairments
- Multiple hospital readmissions within 6 months
- Suspected non-adherence to diet or medication


Bundled Payments for Care Improvement (BPCI) Initiative Defined

© HDG 2013
### Four Models of Bundled Payment

<table>
<thead>
<tr>
<th>Types of Services Included in Bundle</th>
<th>Model 1 Acute Hospital Stay Only</th>
<th>Model 2 Acute Hospital + Post-Acute</th>
<th>Model 3 Post-Acute Care Only</th>
<th>Model 4 Acute Hospital Stay + Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital and physician services</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Related post-acute care services</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-acute care services</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Related readmissions</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Other services defined in the bundle (Part A &amp; Part B)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Awardees</td>
<td>32</td>
<td>193</td>
<td>166</td>
<td>76</td>
</tr>
</tbody>
</table>

### Bundled Payment Components

- Defined population
- Defined period of time
- Quality of care
- Fixed price

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Providers Must Be Prepared to Offer Upfront Savings of 3%

Target price and discount proposed based on historical costs trended forward to present; CMS required mandatory 3% savings upfront

Profile of the 166 Model 3 Awardees Across 27 States

- National versus local providers
  - Several large for-profit chains received multiple awards in different markets (e.g., Amedisys Home Health and Heartland/ManorCare)
  - More than one-third were local or regional providers, many were nonprofit organizations
  - Includes providers who predominantly offer one post-acute setting in multiple geographic markets as well as those providers who offer multiple post-acute settings within a defined market

- Clinical conditions
  - More than 50% of awardees will bear risk for all 48 clinical conditions and almost 90% took on three or more conditions
  - Most popular clinical episodes included orthopedic conditions (especially joint replacements) and cardiac conditions (such as congestive heart failure)

- Partnerships
  - Most Model 3 organizations engaged additional health care providers to build their bundled payment network
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Medicare Bundled Payment Awards: Models 2 and 3 in January 2013

Success will be defined by delivering quality outcomes and value

Here’s how you get there...
Key Steps to Create Bundling Model

1. Create episodes of care
2. Examine cost distribution across services
3. Identify sources of variation
4. Map pathways of care
5. Understand performance of partners
6. Assess levels and types of risk
7. Develop bundle price

Source: Moving Towards Bundled Payment, Issue Brief, American Hospital Association, January 2013

Step 1: Create Episodes of Care

- Needs defined beginning and ending
- Overlapping clinical issues still being fully addressed in BPCI and other models discussed
- CMS created 48 defined clinical episodes for BPCI with associated DRGs and exclusions
- Clinical episodes included most all major medical and surgical cases
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Spending Considerably Higher for Top 10 Conditions that Include Post-Acute Care

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percent Using PAC</th>
<th>Mean Episode Spending</th>
<th>PAC as % of Total Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With PAC</td>
<td>Without Any PAC</td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td>64%</td>
<td>$30,770</td>
<td>$8,534</td>
</tr>
<tr>
<td>Simple Pneumonia &amp; Pleurisy</td>
<td>36%</td>
<td>$20,522</td>
<td>$7,555</td>
</tr>
<tr>
<td>Coronary Bypass (w/cardiac cath)</td>
<td>58%</td>
<td>$45,213</td>
<td>$37,134</td>
</tr>
<tr>
<td>Heart Failure and Shock</td>
<td>43%</td>
<td>$21,219</td>
<td>$8,828</td>
</tr>
<tr>
<td>Major Bowel Procedures</td>
<td>37%</td>
<td>$32,110</td>
<td>$18,661</td>
</tr>
<tr>
<td>Major Joint Replacement</td>
<td>82%</td>
<td>$24,691</td>
<td>$14,162</td>
</tr>
<tr>
<td>Hip and Femur Procedures</td>
<td>94%</td>
<td>$36,633</td>
<td>$12,860</td>
</tr>
<tr>
<td>Fractures of Hip &amp; Pelvis</td>
<td>90%</td>
<td>$24,025</td>
<td>$5,671</td>
</tr>
<tr>
<td>Kidney &amp; UTI</td>
<td>49%</td>
<td>$21,464</td>
<td>$6,381</td>
</tr>
<tr>
<td>Septicemia (w/o vent)</td>
<td>48%</td>
<td>$27,585</td>
<td>$11,331</td>
</tr>
</tbody>
</table>

Source: Analysis of 5 percent 2007 and 2008 claims data prepared for MedPAC by 3M Health Information Systems

Step 2: Examine Cost Distribution Across Services (Vary by Episode Type)

Percent of Spending by Episode Type
30-day Fixed-length Episodes

- Other: 6.3%
- Readmission: 16.9%
- PAC: 17.2%
- Physician: 15.8%
- Index: 50.9%

Source: Dobson / DaVanzo (2012), Medicare Payment Bundling: Insights from Claims Data and Policy Implications

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Step 3: Identify Sources of Variation

Geographic Variation in Spending on Post-Acute Care
MS-DRG 291 Heart Failure and Shock with Major Complications

<table>
<thead>
<tr>
<th>Geographic Area</th>
<th>PAC Spending Only Ratio to U.S. Average</th>
<th>Total Spending Ratio to U.S. Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ridgewood, NJ</td>
<td>2.02</td>
<td>1.49</td>
</tr>
<tr>
<td>Hudson, FL</td>
<td>1.37</td>
<td>1.15</td>
</tr>
<tr>
<td>Lancaster, PA</td>
<td>1.21</td>
<td>1.00</td>
</tr>
<tr>
<td>Raleigh, NC</td>
<td>0.60</td>
<td>0.85</td>
</tr>
<tr>
<td>Owensboro, KY</td>
<td>0.59</td>
<td>0.71</td>
</tr>
</tbody>
</table>

Source: CMS Office of Information Products and Data Analytics, Medicare Claims Analysis 2010

Step 4: Map Pathways of Care

Understand Most Frequent Pathways by Clinical Condition

Highlight sources of costs and areas of opportunity
Develop network to provide care to particular population over time
Indicate structure to create and maintain provider network integrity

Care pathway is complex and includes the patient themselves and their compliance
Understanding Frequent Pathways of Care: First Setting of PAC Drives Episode Costs

Major Joint Procedure (MS-DRG 470), 2007–2009

- LTACH: $43,772
- IRF: $27,617
- Readmission: $24,957
- SNF: $21,742
- Home Health: $14,901
- Community: $14,372
- OP Therapy: $12,695

Source: Dobson DaVanzo (2012), Medicare Payment Bundling: Insights from Claims Data and Policy Implications

Step 5: Understand Your Performance and Your Partners’ Performance

- Key sources of costs
- Quality outcomes
- Underlying practice patterns

Remember—it is not just post-acute care but any providers’ costs that contribute to total episode costs
Allina Pioneer ACO: Provide Directly or Choose Partners Deliberately to Integrate Care Across the Continuum

- Personal care coordinator added to primary care team (physician’s office/health home) to act as “air traffic controller” or “care navigator”
- Expanding home health services with goal that all referrals handled by an Allina caregiver by end of 2014 (currently at 60%)
- Joint venture with SNF provider to create transitional care units of the future (Goal: 5 facilities; first two opening in 2013)

Step 6: Assess Levels and Types of Risk

Three Major Types of Risk Emerging

**Insurance Risk:**
Capitated payment structures for a set amount of services or lives

**Transition Risk:**
“Feet in both worlds”

**Performance Risk:**
Creating value through best-in-class quality

Source: HFMA The Future of Value: Managing Populations, Contracts, and Risk, April 2013
Step 7: Develop Bundle Price

1. Expect to offer minimum of 3% savings from current costs
2. Ensure each patient receives care in least-expensive setting appropriate to treat the condition
3. Actively manage utilization within settings of care, e.g., SNF ALOS; home health episodes per case, ancillary use
4. Integrate changes in clinical practice as further opportunity to reduce the bundle price (e.g., new technologies or new drugs)

Set bundle price based on historical costs trended forward to present day with opportunities for savings factored in

Case Study: Sharing PAC Risk Within a Model 2 Bundle

Hospital System
- 2 NP hospitals (700+ beds) in metro area
- Strong ortho focus with high volumes
- Active, independent ortho physician group
- Owned SNF, HHA within hospital system

Post-Acute Provider
- Integrated NP PAC provider in metro area
- Almost 200 IRF beds, 2 locations
- App. 250 SNF beds (2 community & 1 hospital-based SNU)
- One HHA serving 6 counties
- 26 OP rehab locations across state; 13 in greater metro area
- Unaffiliated with ACH
**Case Study: The Design**

<table>
<thead>
<tr>
<th>Hospital System</th>
<th>Post-Acute Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assume management and financial risk for all associated hospital and physician components and non-PAC readmissions</td>
<td>• Assume management and financial risk for all PAC components &amp; PAC readmissions</td>
</tr>
<tr>
<td></td>
<td>• Implement clinical quality standards, outcome measures, case management, provider training and education, &amp; benchmarking; collects any required data</td>
</tr>
<tr>
<td></td>
<td>• Establish preferred provider network (PPN) comprising PAC provider owned, hospital owned, and selected community providers (home care and SNF)</td>
</tr>
<tr>
<td></td>
<td>• PPN provides geographic coverage based on current patients</td>
</tr>
</tbody>
</table>

**Case Study: Financial Model**

• PAC provider guarantees hospital savings over and above 2% guaranteed to CMS

• Gain share based on actual savings achieved with distribution to PAC provider and hospital
  – PAC provider assumes risk for administrative costs for operating program within gain share
  – Hospital component of the episode and associated savings excluded from gain sharing and go 100% to hospital

• Transparency on program data related to quality outcomes, utilization, and referral patterns from all providers

• HIE connection between PAC provider and hospital
Future Bundling Opportunities

- National pilot program on payment bundling mandated by Affordable Care Act in 2013
  - Will involve a hospital and post-acute bundle
- Possible round two of Bundled Payments for Care Improvement (BPCI) initiative
- Commercial payors “bullish” on bundling
Is Your Continuum Positioned for Bundling?

- Determining future care continuum needs (owned, affiliated, and non-affiliated)? What are the partnership opportunities?
- Assuring effective care management across the continuum?
- Effectively managing cost, quality, and patient outcomes with owned, affiliated and non-affiliated providers?
- Effecting clinical integration, care transitions, and evidence-based care delivery?

Time Value of Taking Action

When is the right time to take risk-based reimbursement?

Impact of Per Diem and LOS Decreases on Revenue / Case

<table>
<thead>
<tr>
<th>Year</th>
<th>Per Diem</th>
<th>REV/CASE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>400</td>
<td>$13,000</td>
</tr>
<tr>
<td>Year 2</td>
<td>360</td>
<td>$12,000</td>
</tr>
<tr>
<td>Year 3</td>
<td>360</td>
<td>$11,000</td>
</tr>
<tr>
<td>Year 4</td>
<td>340</td>
<td>$10,000</td>
</tr>
<tr>
<td>Year 5</td>
<td>340</td>
<td>$9,000</td>
</tr>
<tr>
<td>Year 6</td>
<td>340</td>
<td>$8,000</td>
</tr>
</tbody>
</table>

Providers' Optimal Jumping On Point
Payers' Preferred Jumping Off Point

Revenue/Avg Case
Average Length of Stay
“If you think you can run your company the next ten years the way you ran it the last ten years, you are out of your mind…”

CEO
Coca-Cola

Next Step – Data Analysis

• Robust data on costs and utilization is key to assessing the bundled payment opportunity
  - Are hospitals/health systems in your market moving into bundled or other risk-based payment arrangements (ACOs, etc.)?
  - Do you have the data (internal and external) necessary to evaluate current care delivery patterns and identify possible areas for improvement?
Questions & Answers

Health Care Reform Learning Collaborative Strategy Café

Close out the Health Care Reform Learning Collaborative series with face-to-face dialogue with Health Dimensions Group and peers to learn about current trials and triumphs.

Take new ideas from others that you can take back to your organization.

A box lunch will be provided.
Upcoming Clinical Track Learning Circle Call

Reducing LTC Hospitalizations and Utilizing NPs in SNF
Kathleen Unroe, MD and Kathy Frank, PhD of IU OPTIMISTIC Program
Thursday, September 26
11 a.m. EDT

Through the Health Care Reform Learning Collaborative...

Gain Needed Knowledge & Tools
• Learn what hospitals and payors are seeking from partners
• Become clinically ready

Ask the HDG Experts
• Email your questions to HDG experts and receive timely guidance

Learn from Each Other
• HCR Listserv for answers from your peers and experts
• Learning circle calls to discuss clinical strategies
• In-person sharing of ideas/strategy cafe

Opportunities to Gain and Apply Expertise