Reports from the Front Lines

Uncovering Bundled Payments

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Road Map

1. Update on Bundled Payments
   - Henry Ford: Deciding to Participate in BPCI II
   - Emerson Hospital: Deciding Not to Participate in BPCI II
   - Anthem: Outpatient Bundling
Shifting Risk and Accountability to Providers

Bundled Payments Emphasize Reducing Cost of Care Within Episodes

Source: The Advisory Board Company analysis.
Creating a Platform for Shared Risk

The Bundle Price Smaller than Sum of Its Parts

Paying the Price up Front...

Revenue

...for a New Alignment Tool

Savings Available for Gainsharing

- **Fee-For-Service**
- **Bundle**

- Physicians
- Post-Acute Care
- Ancillaries
- Hospital

<table>
<thead>
<tr>
<th>Price Discount</th>
<th>Hospital Savings</th>
<th>Physician Savings</th>
<th>Net Gain</th>
</tr>
</thead>
</table>

New Incentives

- Single initial payment encourages all players to support common goal
- Any savings can be disbursed to stakeholders to reward individual as well as overall performance

Source: Advisory Board interviews and analysis.

Total bundle typically several percentage points smaller than sum of constituent parts
Devices and Post-Acute Care Main Sources of Savings

Distribution of Cost Savings

Inpatient-Only Cardiac, Ortho Bundles at Hillcrest Medical Center

- Device Standardization: 55%
- Reduced LOS, Complications: 25%
- Ancillaries, Other Supplies: 20%

Estimated Distribution of Potential Cost Savings from Improving Post-Acute Care

- Working closely with high-value providers to coordinate care, develop pathways, etc.: 75%
- Prioritizing referrals to high-value post-acute providers: 25%

Source: Hillcrest Medical Center, Tulsa, OK; Advisory Board interviews and analysis.

1) Length of stay.
Bundling Lowers Unit Cost, and May Increase Quality

Improving Quality Can Lower Costs Under Effective Bundles

Proportion of CABG\(^1\) Patients Returning to OR During Stay

Hillcrest Medical Center

<table>
<thead>
<tr>
<th></th>
<th>Pre-Bundled Payment</th>
<th>Under Bundled Payment</th>
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<tbody>
<tr>
<td>7%</td>
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<td>1%</td>
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Implant Savings

Vanguard Baptist Health System

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<thead>
<tr>
<th></th>
<th>Orthopedics</th>
<th>Cardiology</th>
<th>Total</th>
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<tbody>
<tr>
<td>$1.4M</td>
<td>$800K</td>
<td>$2.2M</td>
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Morbidity and Mortality Rates

Geisinger Health System

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<thead>
<tr>
<th></th>
<th>Complication Rate</th>
<th>Mortality Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to ProvenCare</td>
<td>3.5%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Under ProvenCare</td>
<td>0.9%</td>
<td>0.0%</td>
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</table>

Total Cost Reductions

Hillcrest Medical Center

<table>
<thead>
<tr>
<th></th>
<th>Orthopedics</th>
<th>Cardiology</th>
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</thead>
<tbody>
<tr>
<td>(10%)</td>
<td>(2%)</td>
<td>(3%)</td>
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</table>

All Payers        Medicare


1) Coronary artery bypass graft.
Examples of Bundled Payments in the Private Sector

Private Sector Fostering Innovative Bundling Programs Nationwide

1) Bundled payment program developed by Health Care Incentives Improvement Institute.
2) Coronary Artery Bypass Graft.

Bundling for obstetrics

Developing orthopedic bundling

Bundling joint replacements, procedures with “defined outcomes”

Bundling total joint replacement

Bundling for joint replacements

Bundling for prostatic surgery

Bundling for cardiac surgery

Bundling total knee replacement

Exploring cardiac bundling

Participating in Prometheus Pilot

Participating in Prometheus Pilot

Participating in Prometheus Pilot

Participating in Prometheus Pilot

Source: Advisory Board research and interviews.
CMMI Program Builds on ACE Demonstration

Initiative Furthering Provider Adoption of Risk-Based Payments

Comparison of Medicare Bundling Programs

<table>
<thead>
<tr>
<th>Bundled Services</th>
<th>ACE (Acute Care Episode) Demonstration</th>
<th>CMMI Bundled Payments for Care Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Acute Care</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Inpatient Acute Care</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>30-Days Post-Acute Care</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>30-Day Readmissions</td>
<td></td>
<td>✓</td>
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</tbody>
</table>

Overview of Four Models in CMMI Bundled Payments for Care Improvement Initiative

<table>
<thead>
<tr>
<th>Model</th>
<th>Services Included in Bundle</th>
<th>Timing of Provider Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hospital inpatient services for all DRGs</td>
<td>Retrospective</td>
</tr>
<tr>
<td>2</td>
<td>Hospital and physician inpatient services and post-discharge services for select DRGs</td>
<td>Retrospective</td>
</tr>
<tr>
<td>3</td>
<td>Post-discharge services for select DRGs</td>
<td>Retrospective</td>
</tr>
<tr>
<td>4</td>
<td>Hospital and physician inpatient services for select DRGs</td>
<td>Prospective</td>
</tr>
</tbody>
</table>

1) Acute Care Episode Demonstration: Three-year CMS Medicare demonstration launched in 2009 with five hospitals and health systems in the Southwest; bundles included cardiac and orthopedic procedures.
## Overview of BPCI Models

<table>
<thead>
<tr>
<th>Model 1: Hospital Inpatient Services for All DRGs¹</th>
<th>Model 2: Hospital and Physician Inpatient and Post-Discharge Services</th>
<th>Model 3: Post-Discharge Services Only</th>
<th>Model 4: Hospital and Physician Inpatient Services (Analogous to ACE)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligible Participants</strong></td>
<td>Model 1 participants plus post-acute care providers</td>
<td>Model 1 participants plus post-acute care providers, long-term care hospitals, inpatient rehab facilities, home health agencies</td>
<td>Model 1 participants</td>
</tr>
<tr>
<td><strong>Clinical Conditions</strong></td>
<td>All Medicare DRGs</td>
<td>Select inpatient DRGs, chosen by applicants</td>
<td></td>
</tr>
<tr>
<td><strong>Included Services</strong></td>
<td>Inpatient hospital services</td>
<td>Inpatient hospital and physician services; related post-acute care and readmissions</td>
<td>Inpatient hospital and physician services; related readmissions</td>
</tr>
<tr>
<td><strong>Expected Discount</strong></td>
<td>Minimum increases from 0% for first 6 months to 2% in Year 3</td>
<td>Minimum of 3% for 30-89 days post-discharge services; minimum 2% for 90+ days post-discharge</td>
<td>Minimum 3% discount (larger for DRGs in ACE Demonstration)</td>
</tr>
<tr>
<td><strong>Provider Payments</strong></td>
<td>IPPS payment less discount for Part A services; physicians reimbursed on traditional fee schedule</td>
<td>Traditional FFS payment, subject to reconciliation with target price</td>
<td>Prospectively established payment; hospitals distribute payment to clinicians</td>
</tr>
<tr>
<td><strong>Quality Measures</strong></td>
<td>All Hospital IQR measures, plus additional measures proposed by applicants</td>
<td>Proposed by applicants, with CMS ultimately establishing a standardized set of metrics aligned with measures in other CMS programs</td>
<td></td>
</tr>
</tbody>
</table>

¹ Model 1 (indefinitely) postponed.

Source: Center for Medicare and Medicaid Innovation; Advisory Board interviews and analysis.
CMMI Program Yielding Useful Insights as it Evolves

Timeline of Bundled Payments for Care Improvement Initiative

- **Aug 2011**: CMMI announces initiative
- **Fall 2012**: CMMI announces updates to initiative; suspends Model 1
- **Jan 2013**: No-risk Phase 1 trial period begins
- **Jun 2012**: Initial applications due
- **Dec 2012**: Deadline for applicants to submit supplemental application
- **Spring 2013**: Providers required to sign awardee agreement to continue to Phase 2
- **Jul 2013**: Phase 2 begins with providers financially at-risk but also eligible for savings

Key Observations from CMMI Bundled Payments Initiative

- **Participating in CMMI Initiative for Strategic Purposes**: Participants motivated by desire to develop improved capacity for care coordination, population health, and risk-based contracting, as well as desire to tighten physician alignment.

- **Evolving CMMI Program Creating Frustration, But Most Recent Changes Helping**: As CMMI program has evolved, providers have expressed some frustration, but “converged” bundles and no-risk Phase 1 have helped to allay concerns.

- **Economic Benefit of Expanding BPCI Bundles to Include Private Payers Uncertain**: The incentive to expand CMMI bundles to private payers depends on the magnitude of cost savings and demand destruction under the bundle.

- **Other Risk-Based Contracting Opportunities May Crowd-Out Bundling**: Some providers report forgoing CMMI’s bundling initiative in favor of other risk-based contracts.

Source: Advisory Board interviews and analysis.
Surprising Level of Interest in Non-Surgical Bundles

Orthopedic and Cardiac (Surgical and Non-Surgical) Bundles Generating Greatest Interest

Provider Response to CMMI Bundles

Which types of bundles do you plan to pursue?

- Surgical Only: 44%
- Non-Surgical Only: 12%
- Both: 44%
- n=75

Which types of surgical bundles do you plan to pursue?

- Ortho: 78%
- Cardiac: 65%
- Spine: 16%
- Gastro: 9%
- Urology: 9%
- n=55

What types of non-surgical bundles do you plan to pursue?

- Cardiac: 76%
- COPD: 49%
- Stroke: 35%
- Diabetes: 19%
- Oncology: 14%
- n=37

Source: Advisory Board Interviews and analysis.
Future Directions for Bundled Payments

- **Expanding Bundled Payments Among Current Participants:** Number of providers participating in CMMI initiative and private sector bundles likely to grow. In addition, there will be a focus on increasing the number of providers participating within a given health system as well as expanding the number of services for which the system signs bundled payment contracts.

- **Looking Beyond the Inpatient Setting to Outpatient Procedures:** Picking up on a broader trend of inpatient care migrating to the outpatient setting, there is interest in identifying effective opportunities for bundling payments for outpatient procedures.

- **Addressing Care Pathways With Greatest Variation:** Bundles might be useful for reducing variations in medical care without an inpatient triggering event (e.g., medical oncology, chronic disease care). Such bundles, however, remain largely untested, and the ability of providers and payers to operationalize these types of bundles is uncertain.
Hearing Directly From the Front Lines

Our Panelists Today

Dr. Charles Kelly
President and CEO of Henry Ford Physician Network, Detroit, Michigan

Christine Gallery
VP for Planning and Market Development, Emerson Hospital, Concord, Massachusetts

John Foley
VP of Provider Engagement and Contracting, Anthem Blue Cross Blue Shield, Waukesha, Wisconsin
Road Map

1. Update on Bundled Payments

2. **Henry Ford: Deciding to Participate in BPCII**

3. Emerson Hospital: Deciding Not to Participate in BPCII

4. Anthem: Outpatient Bundling
**Vision:** Make Henry Ford the system that physicians want to practice in—for its quality leadership in creating an integrated clinical framework with a focus on patients first and an imperative for excellence, collaboration, coordination and clinical value.
Learn what it takes to be successful while it’s still voluntary

• Industry quickly moving to bundled payment; starting now and learning to provide coordinated/integrated value based care while the program is voluntary positions early adopters when CMS requires it.
• Current way we deliver care will need to change to accomplish integrated care delivery

Good stepping stone to the Clinically Integrated Network (CIN)

• “The vast majority of physicians, hospitals and healthcare payers believe payment bundling is a stepping stone to accountable care organizations, a highly touted and promising model of post-reform care “ (Jay Sultan, TriZetto)

Increased volume from commercial payers

• Commercial rates are higher than Medicare
• Increases patient volumes through contracts
• Can expand service area of organization for selected procedures
Determining Criteria for Bundle Selection

**Quantitative Criteria**
- High volume of cases across system and within individual facilities; initially targeting DRGs with at least 100 cases across system hospitals
- Low to moderate variation in the cost of the bundle so have relative predictability
- Concentration of services and costs within Henry Ford facilities to ensure controllability

**Qualitative Criteria**
- Engaged and willing group of specialists and clinicians providing care for the identified DRGs
- Belief among physicians and clinicians that identified DRGs have opportunity for care standardization and improvement
- Areas with existing or planned performance improvement projects
An Overwhelming Data Set

Medicare Data in Brief

- Received 140 files representing all paid Medicare fee-for-service claims in 2009 for 5 counties in Southeastern Michigan
- Included over 45 million claims and data on 732,000 unique individuals and 200,000 providers
- Data included information for Medicare Part A claims, including hospitals, LTACs, SNFs and other facilities
- Data for Medicare Part B claims including physician services were provided but provider information was de-identified

Sample Patient Claim Experience

- Index Admission and inpatient stay at facility A (30 days)
- SNF admission at facility B
- Readmission to facility C (60 days)
- Home health visit from affiliated provider
- Follow-up office visit to specialist (90 days)
- Physical therapy visit at facility A
- Follow-up office visit to primary care physician
Plans for Improving Post-Acute Care

Henry Ford FFS Medicare patients admitted to over 180 skilled nursing facilities with half having greater than $100,000 in charges

Proposed Performance Improvement Strategy

1. Identify skilled nursing facilities, home health agencies, and inpatient rehab facilities with relatively high volumes and/or high rates of readmissions
2. Offer Henry Ford Health System performance improvement teams and resources to high volume or underperforming facilities
3. Encourage physician and case manager referrals to high quality providers
Lessons Learned to Date

• Keep analysis simple—sheer quantity of data available through Medicare and the variety of ways to slice and dice the information was overwhelming

• Emphasize qualitative criteria—the size of any DRG opportunity is irrelevant if the providers involved are not engaged with the work nor interested in care standardization

• Deploy a dedicated project manager—the size and complexity of Henry Ford Health System generates a large number of stakeholders and decision points; managing this complexity is a full-time job
Thoughts About Bundled Payments for Care Improvement Initiative

- The enormity and complexity of the data and limited time for analysis presented a challenge:
  - Utilized 2 consultants including the Advisory Board who partnered with Milliman
  - The changing specifications required significant rework and diluted the incentives available for redesigning care by changing the comparative price to a market adjusted rate instead of historical performance.

- Detailed and most complex application process ever completed by our Research Department, and one-year later there is still considerable confusion and lack of clarity around pricing and duration:
  - The recent listing of exclusion codes doesn’t exclude all clinically unrelated services, which is of paramount importance.

- Recent changes to the program have not curtailed our participation, but in retrospect it would have been easier to have just submitted a “statement of interest” and brief statement of capabilities and then have CMS send episode definitions and a target price with the option to either agree, abandon or negotiate; this would have saved considerable time, money and other resources.

- Success of payment reform must be linked to a viable ROI to those redesigning care through the opportunity to experience increased volume. Encouraging Medicare beneficiaries to choose providers participating in new payment models would increase the incentives for participation.
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Background on Emerson Hospital

Emerson Hospital in Brief

• 179-bed full-service regional medical center located in Concord, MA
• Employs 300 primary care doctors and specialists
• Provides services to 300,000 people in 25 towns
• Offers clinical collaborations with academic medical centers in Boston
• Evaluated application to CMMI Bundled Payments for Care Improvement Initiative
Interest in Bundling Driven by Strategic Aims

Motivations for Evaluating Bundled Payments

**Preparation for Increased Risk-Based Payments**
- Foresee payers introducing more risk-based payment models; want to begin developing experience with risk-based payments
- Need to increase efficiency/decrease costs in the near-term to position organization for risk-based payments

**Bundling Complements LEAN Initiatives**
- Began LEAN project to improve O.R. efficiency last year, focusing on start times, supply costs, etc.
- Opportunities to reduce costs under bundled payments mirror those identified in LEAN project

**Potential to Increase Market Share**
- Initially, hoped that CMMI’s bundled payment program would offer opportunity to increase market share, similar to what hospitals saw under ACE Demo

Frontline Report: Emerson Hospital
Engaged consulting firm to help with process
Submitted Letter-of-Intent to CMMI
Decided to focus on Model 4 (Prospective, Acute-Care Only)
Examined variability between surgeons to determine opportunity
Analyzed data received from CMMI
Modeled outcomes under four potential scenarios

Process for Deciding Whether to Apply for CMMI Program
After Resource-Heavy Process, Deciding to Not Apply

**Final Rationale for Deciding to Forego Applying**

<table>
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<tr>
<th>Opportunities for Savings Minimal</th>
<th>Insufficient Gainsharing</th>
<th>Limited to Medicare Cases</th>
<th>Participation not Justified</th>
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<td>• Analysis suggested greatest opportunity to reduce costs around devices</td>
<td>• The lack of significant savings meant that the funds available for gainsharing would likely be too modest an incentive to change physician behavior</td>
<td>• Contracting situation prevented extending bundled payment to private payers</td>
<td>• Ultimately, decided that participating wouldn’t generate enough return to make it worthwhile</td>
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<td>• But the surgeons are already pretty efficient and the potential savings were only incremental</td>
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• Limited to Medicare Cases
• Contracting situation prevented extending bundled payment to private payers
• Private payer participation might have increased incentives sufficiently

• Participation not Justified
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Additional Insights

**Analyzing Costs, Efficiency Beneficial Regardless:** Having access to the data from CMMI and performing a rigorous analysis to identify opportunities for improving efficiency and lowering costs has been beneficial even absent actual participation in the bundled payment initiative.

**Inpatient-Only Model More Attractive Given Lack of Post-Acute Ownership:** Without ownership of post-acute facilities, bundling for post-acute care was much less attractive, leading to emphasis on Model 4 (Prospective, Acute Care-Only).

**Ability to Grow Market Share Would Increase Adoption:** If hospitals could use their bundling arrangements to increase market share—like in the ACE Demo—incentives to participate would be much stronger.
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Bundling En Route to Greater Risk

Expected Path of Payment Transformation

- Fee-for-Value
  - Partially Integrated
    - Fee-for-Service
    - Enhanced FFS / P4P
    - PCMH
    - Bundled / Episodic
    - ACOs
  - Fully Integrated
    - Global Payments
Motivations for Bundling Outpatient Surgery

**Bundles Take Step Toward Risk**
- Bundled payment one step in the payment transformation continuum
- Bundle allows payer to take on actuarial risk associated with patient while providers take on clinical operating risk
- Piloting a provider's ability to coordinate care
- Improving the quality of care by transferring risk

**Procedures Shifting to Outpatient Setting**
- Variability in device cost and post-acute treatment pathways offer potential savings
- Improvement in quality and outcomes when clinical risk is transferred to providers

**Physicians Open to Bundling Initiatives**
- Physicians are interested in changing environment and want to benefit from savings and quality improvements
- Providers moving toward lean methods of management
- Builds a new trust between providers and payors
Frontline Report: Anthem

Developing Outpatient Bundle

Process for Designing Bundled Payment Arrangement

1. Hosted conversations with key orthopedic surgeons; showed potential for physicians to increase margins on each case...they manage the costs.

2. Negotiated length of bundled episode and created a list of unrelated services to exclude from the bundle with physician input.

3. Developed two bundles, one for patients residing near the ASC\(^1\) that includes physical therapy and another for patients living further away that doesn’t include physical therapy.

Services Included in Prospective Bundled Payment

- Procedure at the ASC\(^1\)
- Related physician and anesthesiology services
- Post-acute care including physical therapy
- 90 days Warranty on care – meaning any revision would not be reimbursed.
- Contract agreement on terms of bundle with patient

\(^{1}\) Ambulatory Surgery Center.
## Bundled Payments Not Without Challenges

### Challenges Faced by Providers and Payers

<table>
<thead>
<tr>
<th>Providers</th>
<th>Payors</th>
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<tbody>
<tr>
<td>- Managing risk and paying for revisions</td>
<td>- Systems are not ready for bundles payments</td>
</tr>
<tr>
<td>- Managing the payment to other providers</td>
<td>- Modeling appropriate payment levels due to variation in patients and practices</td>
</tr>
<tr>
<td>- Change in philosophy from fee-for-service model</td>
<td>- Managing “Warranty” related costs</td>
</tr>
</tbody>
</table>
Bundles Yielding Cost Savings

Device and Facility Costs Largest Sources of Cost Savings

Total Payment per Episode

- Unbundled Inpatient Procedure: $64-45K
- Bundled Outpatient Procedure: $25-30K

Over a 40% decrease in total episode payment

Savings Under Outpatient Bundled Payment by Source

- Device Costs: 44%
- Facility/Rehab Costs: 44%
- Surgeon/Anesthesiology Costs: 12%

Frontline Report: Anthem
Impact Extends Beyond Cost Savings

Outpatient Bundle Encourages Patient Adherence and Quality Outcomes

- Physicians and their care team are incentivized to follow-up with patients and ensure they are following recovery plans (Improved Patient Compliance)
- To date, only one infection has occurred with patients covered by the 90-day post acute care bundle. (a minor adjustment for both the physician and the patient)
- The bundle eliminates patient co-pays for discreet physical therapy visits, instead charging a one-time co-pay and saving patients an average of $1,000. (versus the historical copay per visit)
- Patients see the “one-stop shop” approach and 90-day warranty as an attractive feature. (and Employers are encouraging referrals to these specific sites of care)
Opportunities for Bundled Payments

**Current Services**
- Total Knee Replacement
- Total Hip Replacement

**Future Services**
- Colonoscopy
- Maternity
- Lower Back Procedures
- Select Cardiac Procedures