Bundled Payment Strategy
Part I: Meeting Public Payer Requirements for Episode Efficiency

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Bundled Payment Strategy

Part I: Meeting Public Payer Requirements for Episode Efficiency

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Contact: katzd@advisory.com
1. Market in Transition

2. Meeting CMS’s Episode Risk Requirements

3. Look Ahead: Trends in the Commercial Market (Part II)
Bundles Judged to Offer Great Savings Potential

2008 CBO\(^1\) Estimate of 10-Year Savings Associated with ACOs and Bundled Payments, 2010-2019

- **ACOs**: $5.3B
- **Bundled Payments**: $19B

**Analyses in Brief**

- 2008 and 2013 Congressional Budget Office analyses of 10-year savings based on savings generated to Medicare from ACOs versus bundled payments.
- Both estimates assume bundling across 48 clinical episodes, spanning inpatient admission through post-discharge period. Updated analysis expanded bundle window from 30 to 90 days, ramped up savings estimates.
- 2013 calculations estimate overall payouts on bundles to be 5% lower than Medicare’s projected average payments per episode under current law.


\(^1\) Congressional Budget Office.
How Did We Get Here?

CMS Has Been Building to Mandatory Bundles for Years

1. Acute Care Episode (ACE) Demonstration
   - 3-years, 5 participants
   - Cardiac, orthopedic MS-DRGs including 469 and 470

2. Bundled Payment for Care Improvement (BPCI)
   - 2013 – ongoing
   - 48 episodes, includes MS-DRGs 469, 470
   - First year preliminary results available

3. Comprehensive Care for Joint Replacement (CJR)
   - November 16, 2015 CMS finalizes mandatory lower extremity joint replacement bundles for hospitals in 67 markets

CMS’s CJR Goals

- Assess whether bundled payments reduce costs while maintaining, improving quality
- Test bundling in multiple settings with large, diverse group of providers
- Remove selection bias of voluntary programs

Source: CMS; Financial Leadership Council analysis; Health Care Advisory Board interviews and analysis.
## The Lessons Learned So Far

### Industry Conventional Wisdom on Bundles, Circa 2015

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<tbody>
<tr>
<td><strong>1</strong></td>
<td><strong>2</strong></td>
<td><strong>3</strong></td>
<td><strong>4</strong></td>
</tr>
<tr>
<td>No Downside for Physicians</td>
<td>Benefits Beyond the Episode</td>
<td>Bundles Don’t Reduce Utilization</td>
<td>Not a Significant Lever for Growth</td>
</tr>
<tr>
<td>Gains and losses seldom shared equally across stakeholders; hospitals typically own the risk</td>
<td>Improvements set into motion by incentives in a given bundle have registered in related services, across all payer populations</td>
<td>Bundles have historically not reduced per-capita utilization of episodes, only made unavoidable utilization more efficient</td>
<td>Significant steerage to providers on the basis of episode efficiency has been elusive</td>
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</table>
What Is a ‘Bundled Payment’ Today?

Getting Our Terms Straight

Bundled Payment, Circa 2015

Prospective Payment

• Paid via lump sum payment
• Employers most likely to use this payment method

Retrospective Payment

• FFS payment, followed by reconciliation
• Provider shares savings or repays overage relative to total charge target
• Commercial, public payers most likely to use this payment method

Bundle-Linked Gainsharing, Circa 2015

A Few Options for Accountable Party and Gainsharing Recipient

Any accountable party can, but does not have to, share incentives with other stakeholders

Source: Health Care Advisory Board interviews and analysis.
What Is an ‘Episode’?

Episodes Span Many Clinical Areas, Are Applicable to Any Payer Population

Pieces of the Care Continuum That May Be Included in an Episode

Accountable Entity

Pre-Visit

Anchor DRG

PAC\(^1\)

Example Episodes, Triggers, and Sources of Cost Variation

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<thead>
<tr>
<th></th>
<th>(\text{Hip/Knee Replacement})</th>
<th>(\text{AMI}^{2})</th>
<th>(\text{Maternity})</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Length</strong></td>
<td>90 days</td>
<td>90 days</td>
<td>40 weeks plus 6 days</td>
</tr>
<tr>
<td><strong>Trigger</strong></td>
<td>Inpatient admission</td>
<td>Inpatient admission</td>
<td>Inpatient admission; retrospective to 40 weeks</td>
</tr>
<tr>
<td><strong>Source of Cost Variation</strong></td>
<td>Medicare: Overuse of post-acute care</td>
<td>Avoidable acute hospital transfers; readmissions; Cost of index hospitalization</td>
<td>Overuse of C-section</td>
</tr>
</tbody>
</table>

\(1)\) Post-acute care.  
\(2)\) Acute myocardial infarction.

Purchasers Want It All

High-Priority Improvement Area for Episodes, by Purchaser

- **Utilization Control**
  Reduce avoidable per-capita and per-case usage of services

- **Unit-Level Cost**
  Reduce cost of service by raising quality, raising efficiency within the episode, dropping price

- **Quality**
  Improve clinical outcomes, deliver coordinated, patient-centered care

Source: Health Care Advisory Board interviews and analysis.
## Two Distinct Types of Episode Purchasers

Public and Commercial Objectives, and Improvement Levers, Differ

<table>
<thead>
<tr>
<th>Objective</th>
<th>Medicare</th>
<th>Commercial Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective</strong></td>
<td>Overutilization within the episode, especially of post-acute care</td>
<td>Price and quality/service differentiation</td>
</tr>
<tr>
<td><strong>Typical Improvement Lever</strong></td>
<td>Increasingly mandatory</td>
<td>Episodic shared savings</td>
</tr>
<tr>
<td>Medicare</td>
<td>Incentives and/or penalties introduced into Value-Based Purchasing Program (e.g., readmissions penalties); required episodic payment programs likely to become broader</td>
<td>Providers charge FFS; if accountable party can reduce those charges, may be able to qualify for a share of savings</td>
</tr>
<tr>
<td>Commercial Payer</td>
<td>Directed volume for value, e.g. by qualifying for episode-specific COE(^1) or top tier of a narrow network</td>
<td></td>
</tr>
</tbody>
</table>

1. Center of Excellence.

Source: Health Care Advisory Board interviews and analysis.
CMS Doubling Down on Episodes

SMARTCare¹

- A two-year cardiology program being launched at 11 specialty practices in Wisconsin and Florida via a $15.9M grant from CMMI²
- Seeks to reduce unnecessary imaging, testing, and interventional procedures performed on non-acute patients with chest pain by providing doctors and patients with decision-support tools to more accurately determine when stress tests or other procedures are necessary

Oncology Care Model

- Incorporates a two-part payment system with a $160 per-beneficiary-per-month (PBPM) payment for the duration of the episode and the potential for a performance-based payment for episodes of chemotherapy care

Multi-Payer State Level Initiatives

- Medicaid and private insurers in Arkansas, Ohio, and Tennessee have launched retrospective bundle for multiple episodes where either the hospital or physician group serves as accountable party

1) Smarter Management and Resources Use for Today’s Complex Care Delivery.
2) Center for Medicare and Medicaid Innovation.

Source: Health Care Advisory Board interviews and analysis.
More Light than Heat on Commercial Side

Name Brands in the Bundle Market

Providers
- Mayo Clinic
- Johns Hopkins Medicine
- Cleveland Clinic

Employers
- Lowe’s
- Walmart
- GE

Health Plans
- aetna
- UnitedHealthcare
- Horizon

Estimated Total Commercial Payment Through Bundles, 2014
Analysis Based on Data from 27 Commercial Plans

0.1%

Source: Catalyst for Payment Reform; Health Care Advisory Board interviews and analysis.
Episodic Shared Savings Are Ephemeral

The Narrower the Cost Savings Base, the Less Room to Run

Illustrative: Shared Savings Arrangement with Upside and Downside Risk

- Savings leads to possible bonus
- Overage leads to possible penalty

Y1 Target Price

Y2 Target Price

Y3 Target Price

Year 1  Year 2  Year 3

By Year 3, Hospital has maximized cost savings, but cannot meet reassessed target price baseline

Source: Health Care Advisory Board interviews and analysis.
How Can We Leverage Episodes for Growth?

Sustainable Sources of Upside for Providers with Efficient Episodes

Margin Protection
Reduce direct cost per case on inpatient procedures

Physician Share
• Increase proceduralist share
• Attract incremental referrals from PCPs with total cost risk

Plan and Employer Steerage
• Qualify for episode-level steerage as a Center of Excellence
• Qualify for specialty steerage through performance-based narrow or tiered networks

Source: Health Care Advisory Board interviews and analysis.
Introducing the Episode Efficiency Center

Launching in Late 2015

New Advisory.com Portal a One-Stop Shop for All Episode Efficiency Resources

“I need to understand CJR.”

1 Watch our video introducing bundled payments

2 Consult our study on Succeeding Under Bundled Payments

3 Access full web-conference on CJR

4 Read the CFO’s Guide to the CJR Proposed Rule

“How can I see my own data?”

1 Understand your costs using the Customized Episodic Cost Profiler

2 Assess your hospital’s performance using the Hospital Benchmark Generator

3 Learn about where your patients go for post-acute care using Care Transitions Mapping Tool

“How else can you help me?”

1 Learn best practices from the Post-Acute Collaborative or Population Health Advisor

2 Examine overall performance using Crimson performance technology

3 Get on the ground help with Consulting and Management practices

Source: Health Care Advisory Board interviews and analysis.
Translating Episode Excellence into Upside

**Succeed Under Medicare Bundles**
- Right-size intra-episode utilization despite conflicting or absent incentives

**Secure Incremental Commercial Volume Gain**
- Create a differentiated product
- Meet cost and quality demands
- Leverage utilization control competency to grow Medicare share
- Parlay learned competency and track record to secure commercial steerage

Source: Health Care Advisory Board interviews and analysis.
The Integrated Care Advantage

9 Imperatives for Securing Profitable Growth Through Efficient Episodes

Public-Payer Risk

1. Succeed under Medicare Bundles
   1. Forge strategic partnerships with proceduralists to build an episode-wide standard of care
   2. Use network curation, operational support—not ownership—to raise efficiency of post-acute sites
   3. Leverage episode efficiency to target physician share growth among proceduralists, risk-bearing PCPs

Commercial Steerage

2. Compete for Health Plan Steerage
   4. Minimize inpatient quality shortfalls to lower cost per case, support price drop option
   5. Focus episode-specific commercial steerage efforts on established COE programs
   6. Broaden efficiency initiative across top episodes to capture narrow and tiered network steerage

3. Capture Direct-to-Employer Contracts
   7. Steeply discount direct-to-employer procedural bundles to disrupt market share
   8. Differentiate episode on care standard, patient experience, and service
   9. Expand episode scope to deliver patient-centered right answer

Source: Health Care Advisory Board interviews and analysis.
1

Market in Transition

2

Meeting CMS’s Episode Risk Requirements

3

Look Ahead: Trends in the Commercial Market (Part II)
Succeed Under Medicare Bundles
Use CJR as Catalyst to Partner with Specialists, Drive Up the Efficiency of Post-Acute Care

1. Forge strategic partnerships with proceduralists to build an episode-wide standard of care
2. Use network curation, operational support—not ownership—to raise efficiency of post-acute sites
3. Leverage episode efficiency to target physician share growth among proceduralists, risk-bearing PCPs
Providers Nationwide Taking Notice

CJR Prompts New Initiatives, but Readiness Varies

Hospital Leader Projections on Impact of CCJR on Hospital Strategy and Priorities, 2015

- Lead to at least one major new effort: 45%
- Inspire one or two small projects: 23%
- Have limited impact: 27%
- Inspire a major rethinking: 5%

Leader Assessment of Their Hospital Organization's Current Sophistication in Managing Orthopedic Episode Efficiency, 2015

- Not very sophisticated: 29%
- Somewhat sophisticated: 35%
- Very sophisticated: 8%
- Strong in one or two areas: 27%

For More Information on CJR:
- Watch our web-conference on CJR (12/8/2015)
- Read our blog posts on the finalized CJR Rule

Source: Financial Leadership Council Poll; Health Care Advisory Board interviews and analysis.
CMS Spending Variance Is Tied to Utilization

Difference in Per Capita Medicare Spending Between Miami, FL and Salem, OR, Before and After Price Adjustment

Reduction in Total Geographical Medicare Spending Variance if Variance in Each Category Eliminated¹

1) Categories sum to more than 100% because of covariance terms.

ACOs Missing the Mark

Limitations of the Population Health Shared-Savings Model

1. Too Blunt an Instrument
   - The goal of population health is to lower PMPM spending per enrolled life
   - The payment mechanism does not indicate where to focus
   - Population health management takes time to pay off

2. Misses Unavoidable Utilization
   - Population health models focus on avoiding utilization of high acuity care settings as much as possible
   - Some utilization is not avoidable

3. Doesn’t Engage All Physicians
   - Specialists not greatly incentivized by ACOs—most payments go to PCPs
   - Available incentives often not significant enough to ‘move the dial’ for specialists

Source: Health Care Advisory Board interviews and analysis.
CMS Not Looking to Preclude Episodes

On Guard for Physicians Altering Case Mix to Game System

Volume Incentive Unchanged from FFS

Insufficient incentives to choose medical management over surgical intervention

Insufficient Safeguards Against Stinting

Existence of target price discourages surgery on patients who present as potential budget-busters

Worst Case Scenario

“Cherry Picking”

- Marginally-useful surgeries performed on low risk patients
- Cost-per-case in control but utilization soars

“Lemon Dropping”

- Care rationed for patients for whom surgery is medically indicated
- Utilization declines but patients are left untreated

Based on these preliminary measures …, there are no indications that providers have changed their mix of patients or coding of patient episodes under BPCI during the first quarter.”

The Lewin Group

Providers Handed More Accountability Per Episode

**Common Clinical Themes**

- Optimizing hospital efficiency during acute care delivery
- Pushing physicians to opt for medical rather than interventional management within an episode
- Enlisting providers to reduce low value post-acute utilization

**Supporting Cross-Continuum Value Accountability for Each Case**

- Align financial incentives for physicians, hospitals, and post-acute providers
- Provide cost and utilization data across the continuum to facilitate performance enhancement and review
- Reward high performance, penalize low performance
- Encourage innovation in care delivery

Source: Health Care Advisory Board interviews and analysis.
Why Not Just Reform PAC Payment?

Bundled Payment Solves Problems Where Direct Regulation Too Clumsy

PAC Regulation Problems

Site-specific regulation just “squeezes the balloon”
Historical reforms aimed at reducing utilization in one setting have just pushed patients toward the next setting

Case-by-case clinical judgement needed
No strong existing evidence-based clinical standard to dictate which patients should go to which post-acute facilities

Bundled Payment Solutions

Assigns a quarterback
Creates provider accountability for total usage over all settings

Recruits a clinical advisor
Engages clinicians in making informed decisions about patient care, with a focus on cross-site efficiency—and creating a care standard that others can use

Source: Grabowski DC, et al., “Medicare Postacute Care Payment Reforms Have Potential To Improve Efficiency Of Care, But May Need Changes To Cut Costs,” Health Affairs, 31, no. 9 (2012): 1941-1950; Health Care Advisory Board interviews and analysis.
Succeeding Under Medicare Bundles

Avoid Penalties, Seek Volume Growth in Medicare (and Beyond)

Three Lessons to Succeed Under Bundles

1. Forge strategic partnerships with proceduralists to build an episode-wide standard of care

2. Use network curation, operational support—not ownership—to raise efficiency of post-acute sites

3. Leverage episode efficiency to target physician share growth among proceduralists, risk-bearing PCPs

Source: Health Care Advisory Board interviews and analysis.
1. Forge strategic partnerships with proceduralists to build an episode-wide standard of care

Physicians the Key to Post-Acute Reform

Largely decide discharge disposition
Set patient expectations
Sign-off on lower acuity settings
Affect patient’s choice of post-acute provider (within setting type)
Help set standard of post-acute performance

“Discharge disposition” refers to the matching of patients to post-acute sites—e.g., SNF versus home health, or home with outpatient rehab

Source: Health Care Advisory Board interviews and analysis.
For Hospitals, Physician Help Critical to Everything

CJR Opens the Door to New Discussions with Specialists

Top Five Priorities for Hospitals and Health Systems, 2015
Advisory Board Poll of C-Suite Hospital Executives
n=150

1. Engaging physicians in cost and quality improvements
2. Redesigning service portfolios for population health
3. Establishing sustainable acute care cost structures
4. Patient engagement strategies
5. Controlling avoidable utilization

Source: Financial Leadership Council interviews and analysis; Health Care Advisory Board interviews and analysis.
An Opportunity to Address Specialist-Facing Trends

Pressures Focusing Specialists on Outcomes, by Degree of Market Risk

- **Total Cost Risk**
  - PCPs direct referrals to high-performing specialists
  - Care management reduces specialty care demand—specialists vie for remaining volume

- **Episodic Risk**
  - Only high-performing specialists included in bundled contracts with cost-sensitive employers, payers

- **De Facto Risk (FFS¹)**
  - Many specialists face stagnating or declining reimbursement—can’t depend on price-based growth
  - SGR² repeal means Medicare reimbursement will be at-risk based on performance
  - Narrow networks select specialists with high baseline quality, lower costs
  - Cost-sensitive patients seek out lower-cost specialists

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Source: Physician Executive Council interviews and analysis; Health Care Advisory Board interviews and analysis.

¹ Fee-for-service.
² Sustainable growth rate.
Hospitals Not an Obvious Partner to Specialists

Most Specialists Unaware of Hospital Strategy

Specialists agree, “I am kept informed of my organization’s strategic plans and direction”

Economically-Affiliated n=12,981

Independent n=7,072

45%

38%

Nearly Half of Independent Specialists Don’t View the Hospital as a Partner

Specialists agree, “I view this organization as a strategic partner in navigating the changing health care landscape”

n=6,857

55%

Selected Specialty-Specific Responses

Orthopedists n=477 42%
Cardiac Surgeons n=338 48%
Radiologists n=380 52%
ED Physicians n=496 64%

Making the Specialist Business Case

**Specialist Business Case**

**Quality Case**
“This is better for patients”

**Strategic Case**
“This is how we will win business together in the future”

**Business Case**
“We can make sure you are rewarded from this work in the short term”

“If you come down here and tell us we need to drop our costs, and I look around and see an organization that is making a billion dollars per year and the CEO makes a million in salary, that doesn’t make a lot of sense to me. But if you say, ‘Let’s improve outcomes for patients, and improve efficiency along the way, to create an upside for all…’ Well, that makes a lot more sense to me as the surgeon.”

*CEO*
Large Independent Orthopedics Group

Source: Health Care Advisory Board interviews and analysis.
The Hospital-Specialist Partnership for Outcomes

Eight Imperatives to Advance and Reward High-Value Specialty Care

1. **Creating a True Partnership Dynamic**
   1. Communicate market changes and strategic response
   2. Set vision and codify mutual expectations
   3. Elevate physicians to equal status in strategic planning

2. **Aligning Specialist Incentives with Outcomes**
   4. Make outcomes the basis of all hospital-based physician contracts
   5. Nudge local referral market toward high performers
   6. Deploy supplemental contracts with proceduralists

3. **Bolstering Practice with Outcomes-Focused Support**
   7. Build a scalable clinical governance platform
   8. Hardwire clinical wraparound services

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**Study in Brief: Building the Hospital-Specialist Partnership for Outcomes**

- Focus on forging no-regrets, mutually beneficial hospital-specialist partnerships
- Study is part of the Physician Executive Council 2015-2016 National Meeting Series

Source: Physician Executive Council interviews and analysis.
Bundles Just One of Many Potential Levers

Spectrum of Alignment Mechanisms

Baseline Integration
- Incentive-based PSA
- Management Services Agreement

Greater Integration
- Bundled Payments
- Co-Management
- Shared Savings
- Employment
- Clinical Integration

Factors to Consider when Selecting Specialist Alignment Mechanisms

Leverage
- Are the specialists dependent on the hospital for their business?
- What is the relative competitiveness of health systems, physician groups, and payers in the market?

Market Readiness
- Are local employers, payers interested in risk-based contracting?
- Is the hospital willing to take on risk for physician outcomes?

Reward-to-Effort Ratio
- What existing physician contracts can the hospital leverage to advance tighter alignment on outcomes?
- Which specialists influence key health system metrics?
## Remember Your Audience

### Two Types of Cases to Make to Different Specialist Groups

<table>
<thead>
<tr>
<th>Smaller or Integrated Groups</th>
<th>Large Independent Groups</th>
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<tbody>
<tr>
<td><strong>The Quality and Strategy Case</strong></td>
<td><strong>Hospital as Partner</strong></td>
</tr>
<tr>
<td>• Market-level changes pushing for improvement on outcomes (quality and cost)</td>
<td>• What the hospital can bring to the table—e.g., operational and strategic supports</td>
</tr>
<tr>
<td>• Strategic benefits for physicians and hospital</td>
<td>• How leadership will be shared</td>
</tr>
<tr>
<td>• Ability to improve patient outcomes</td>
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Source: Health Care Advisory Board interviews and analysis.
Clinical Standard Needed for Episode Transformation

Evidence-Based Practice (EBP)
Care standards based on evidence from the scientific literature
• When possible, clinicians create and implement standards that reflect universally-accepted clinical evidence

Rationale for Supplementing EBP with “Practice-Based Evidence”
• Most care variation is not addressed by published clinical evidence
• Published evidence typically does not account for variation in resource use, costs of care
• Standardized care provides the ability to monitor and assess the efficacy of new care standards

Consensus-Based Standard
Care standards based on evidence from provider system’s own practice
• In absence of published evidence, clinicians agree on care standards
• Standards implemented and monitored to confirm efficacy and identify any needed changes

A Robust Care Standard Draws on Two Methodologies

Patient Eligibility
Patient Care Team
Inpatient Optimization
Efficient PAC Utilization

Elements to be included in a comprehensive joint care standard

Source: Health Care Advisory Board interviews and analysis.
2. Use network curation, operational support—not ownership—to raise efficiency of post-acute sites

## Three Keys to PAC Performance Improvement

<table>
<thead>
<tr>
<th>Key</th>
<th>Objective</th>
<th>Action</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Improve Discharge Disposition</td>
<td>Partner with physicians and patients to send more cases to the lowest intensity clinically-appropriate setting</td>
</tr>
<tr>
<td>2</td>
<td>Curate PAC Network</td>
<td>Create a network of preferred PAC providers, and leverage control over referrals to improve performance</td>
</tr>
<tr>
<td>3</td>
<td>Reduce In-Setting Length of Stay and Readmissions</td>
<td>Use market leverage to set new baseline performance, educate PAC staff, fix shortfalls in information exchange, and care coordination</td>
</tr>
</tbody>
</table>

### Coming in 2016

The Strategic Planner’s Guide to Post-Acute Care
An Opportunity to Better Match Patients and Sites

Improving Discharge Disposition a Critical Piece of PAC Streamlining

Proportion of Medicare Patients Placed in an Avoidably High-Cost Setting
Statistical Simulation Results, by Setting¹

Keys to Shifting Discharge Patterns

- Engage doctors data to physicians on relative costs and patient outcomes for different settings
- Integrate physician into discharge planning team
- Educate patients and family, reduce roadblocks to home discharge

<table>
<thead>
<tr>
<th>Setting</th>
<th>Proportion (%)</th>
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</thead>
<tbody>
<tr>
<td>LTACH</td>
<td>11%</td>
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<tr>
<td>IRF</td>
<td>30%</td>
</tr>
<tr>
<td>SNF</td>
<td>31%</td>
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<tr>
<td>HHA</td>
<td>42%</td>
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</table>

¹ Study assessed top 100 most costly DRGs but excluded those with high concentration of spending in any one PAC setting.

Source: Dobson, DaVanzo, and Associates, Clinically Appropriate and Cost Effective Placement, Alliance for Home Health Quality and Innovation, 2012; Health Care Advisory Board interviews and analysis.
## Time to Pick Your Partners

Frequently Encountered Criteria for Choosing Preferred SNFs

### Operational Standards

- **Standardized admission**, patient acceptance and assessment processes
- **Electronic information exchange** for continuous performance monitoring
- **Low staff turnover rate, proper staffing ratios**
- **Established staff education processes and schedule**

### Clinical Standards

- **Individual care plans** (including projected LOS) created before discharge
- **Registered nurses on site 24/7**
- **Standardized rehab practices** established in collaboration with hospital’s rehab program
- **Guaranteed resident physician visit** within 24 hours of admission

Source: Health Care Advisory Board interviews and analysis.
Curation Reduces Number of PAC Providers

Network in Brief: Baystate Medical Center
- 716-bed hospital based in Springfield, MA
- After rigorous process, selected three SNFs in each county of service area

57 Candidate facilities
12 Partners

Network in Brief: North Shore-LIJ
- 16-hospital, not-for-profit health system based in Great Neck, NY
- In 2008, created a SNF affiliate network using strict performance criteria

266 Candidate facilities
19 Partners

Network in Brief: Michigan Pioneer ACO
- Part of Detroit Medical Center, a 2,000-bed system in Detroit, MI
- Pruned home-health network using data collection as well as in-person interviews

47 Candidate facilities
8 Partners

Source: Health Care Advisory Board interviews and analysis.
You Don’t Need to Own PAC to Improve It

Possibility of Increased Volume Creates Performance Incentive for PAC

We’ve had very frank discussions centered around the fact that the market has changed on them. SNFs either perform or they’re not going to see as many patients.”

CQO
Health System that Curated Its SNF Network

Hospital Ownership of PAC, 2013

- Home Health Services: 60%
- Hospice: 64%
- SNF: 37%
- Other LT care: 12%

8% decline since 2003

Source: Health Care Advisory Board interviews and analysis.
Steerage Not an Insurmountable Issue

Baystate Promotes Top Providers But Preserves Choice

Discharge coordinator distributes list of preferred SNFs to all patients

Clearly states that patient has freedom of choice over where to be discharged

A+
Emphasizes preferred providers’ high quality, close relationship, and continuity of care

Case in Brief: Baystate Medical Center

- 716-bed hospital based in Springfield, Massachusetts
- Participating in retrospective bundles via BPCI for CABG
- Achieved $1900 reduction in cost-per-episode for CABG, largely attributed to more efficient SNF usage

60%
BPCI CABG discharges going to a preferred SNF provider

Sources: Baystate Medical Center, Springfield, MA; Cardiovascular Roundtable interviews and analysis; Healthcare Advisory Board interviews and analysis.
Room to Improve on LOS and Readmissions

Seen in the Research

*Example SNF Average Length of Stay by Medicare Segment*

<table>
<thead>
<tr>
<th></th>
<th>Medicare FFS</th>
<th>Medicare Managed Care</th>
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<tbody>
<tr>
<td><strong>100%</strong></td>
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<td></td>
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<tr>
<td><strong>50%</strong></td>
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Keys to Reducing In-Setting Length of Stay

**Use Market Leverage**

Include LOS benchmark as a condition for inclusion in curated network; set expectations and monitor performance together with referring physicians.

**Provide Ongoing Quality Training**

Send hospital staff to deliver supplemental training to SNF frontline staff on best practices on reducing problems that can delay discharge (for example, suboptimal use of infection control protocols).

**Consider SNFist Program**

Embedded physicians provide the highest level of quality and performance control.

Sources: Health Care Advisory Board interviews and analysis.
CJR Already Making Proceduralists Who Split Business Think Twice

Right now over 80% of our patients are going to our SNF. Once there’s more of a standard in place at our competitor, it just won’t make sense to send 20% of patients to SNF over there, and 80% over here.”

CFO
Castle Health and Services

1) Pseudonym.
Many at Risk of Falling Short

Hospitals with Relatively Low Performance Eligible But Less Likely to Win

CMS-Estimated Percentage of CJR Composite Quality Measure Performance

Impact of Quality Performance on CJR Discount and Reconciliation Eligibility

1) Hospitals excluded due to no reported volumes of MS-DRG 469 or 470 and insufficient hip/knee readmissions/complications data to warrant evaluation.

Source: CMS: Final Rule for Comprehensive Care for Joint Replacement, released Nov. 16, 2015; Health Care Advisory Board data and analysis.
Opportunity to Compete for ACO Referrals?

Total Medicare and Commercial ACOs
Q1 2011-Q1 2015

- Q1 2011: 64
- Q1 2013: 447
- Q1 2015: 744

Referral Decision Guidance Provided to Risk-Bearing PCPs by ACO

- Comparative efficiency data at the specialist level
- General guidance on go/no-go policies for ACO at the hospital level

Source: Muhlestein D, “Growth And Dispersion Of Accountable Care Organizations In 2015,” Health Affairs Blog, March 31, 2015; Health Care Advisory Board interviews and analysis.
We’ve had difficult discussions with leaders of those hospitals. I get where they are coming from. But if the local high-cost hospital gets driven out of business, that’s really not my problem. As a population manager, my whole goal is to put all hospitals out of business. I’m going to start with the high-cost ones.”

*VP, Performance Management  
Physician-Led ACO*
Key Takeaways

Succeeding on Medicare Bundles

- **Hospitals—even those not affected by CCJR—should start streamlining PAC use in the “usual suspect” episodes now.** Expect expanded bundled payment programs—affecting more providers—for all episodes with substantial PAC components.

- **Momentum from Medicare bundling can be enough to spark a new discussion with proceduralists.** Leaders of hospital organizations should use this opportunity to put relationship with specialists on a new footing—preparing for the value-based market by working together toward cost, quality, and the possibility of future value-based steerage.

- **With specialists as allies, hospital organizations can effect tremendous performance improvement in post-acute utilization—without needing to contract directly with post-acute providers.** Pursue improvements by supporting physicians in creating care standards that better match patients with sites, curating the post-acute network, and extending operational supports to select post-acute providers.

- **Raising efficiency in commonly bundled Medicare episodes is more a matter of avoiding downside than it is about cultivating growth—however, some market share may shift at the physician level.** Depending on provider and market, hospitals may have opportunities to win (or lose) business from currently splitting proceduralists, and/or referrals from risk-bearing PCPs.
1. Market in Transition

2. Meeting CMS’s Episode Risk Requirements

3. Look Ahead: Trends in the Commercial Market (Part II)
The Integrated Care Advantage

9 Imperatives for Securing Profitable Growth Through Efficient Episodes

<table>
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<tr>
<th>Public-Payer Risk</th>
<th>Commercial Steerage</th>
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<tr>
<td>Succeed under Medicare Bundles</td>
<td>Compete for Health Plan Steerage</td>
</tr>
<tr>
<td>1. Forge strategic partnerships with proceduralists to build an episode-wide standard of care</td>
<td>4. Minimize inpatient quality shortfalls to lower cost per case, support price drop option</td>
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<td>2. Use network curation, operational support—not ownership—to raise efficiency of post-acute sites</td>
<td>5. Focus episode-specific commercial steerage efforts on established COE programs</td>
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<tr>
<td>3. Leverage episode efficiency to target physician share growth among proceduralists, risk-bearing PCPs</td>
<td>6. Broaden efficiency initiative across top episodes to capture narrow and tiered network steerage</td>
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Source: Health Care Advisory Board interviews and analysis.
Bundled Payment Strategy

Part I: Meeting Public Payer Requirements for Episode Efficiency

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What Did You Think of Today’s Session?

• Please take a minute to provide your thoughts on the presentation.

Thank You!