Bundled Payment Strategy

Part II: Leveraging Episode Excellence for Growth in Health Plan and Employer Contracts

David L. Katz, MD, JD
Principal and Executive Director
The Advisory Board Company
Contact: katzd@advisory.com
Managing Your Audio

**Use Telephone**

If you select the “use telephone” option, please dial in with the phone number and access code provided.

**Use Microphone and Speakers**

If you select the “mic & speakers” options, please be sure that your speakers/headphones are connected.

If you experience any issues:

Rachel Adler
AdlerR@advisory.com
Managing Your Screen

Questions Panel

To ask the presenter, please type your question into the question panel and press send.

Minimizing and Maximizing Your Screen

- Use the orange and white arrow to minimize and maximize the GoTo panel.
- Use the blue and white square to maximize the presentation area.
What Did You Think of Today’s Session?

• Once you or the presenter exits the webconference, you will be directed to an evaluation that will automatically load in your web browser.

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

Thank You!
1. Market in Transition

2. Episode Contracting with Health Plans

3. Winning Employer Steerage
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**

**Example Episodes, Triggers, and Sources of Cost Variation**

<table>
<thead>
<tr>
<th><strong>Length</strong></th>
<th><strong>Hip/Knee Replacement</strong></th>
<th><strong>AMI</strong></th>
<th><strong>Maternity</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>90 days</td>
<td></td>
<td>90 days</td>
<td>40 weeks plus 6 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Trigger</strong></th>
<th>Inpatient admission</th>
<th>Inpatient admission</th>
<th>Inpatient admission; retrospective to 40 weeks</th>
</tr>
</thead>
<tbody>
<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.

Two Distinct Types of Episode Purchasers

Public and Commercial Objectives, and Improvement Levers, Differ

**Medicare**

**Objective**
Overutilization within the episode, especially of post-acute care

**Typical Improvement Lever**
Increasingly mandatory incentives and/or penalties introduced into Value-Based Purchasing Program (e.g., readmissions penalties); required episodic payment programs likely to become broader

**Commercial Payer**

**Objective**
Price and quality/service differentiation

**Typical Improvement Lever**
Episodic shared savings
Providers charge FFS; if accountable party can reduce those charges, may be able to qualify for a share of savings

**Steerage**
Directed volume for value, e.g. by qualifying for episode-specific COE\(^1\) or top tier of a narrow network

- Employers will not offer shared savings, but may offer steerage
- Health plan unlikely to offer both shared savings and steerage

---

\(^1\) Center of Excellence.

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.
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.
Translating Episode Excellence into Upside

Succeed Under Medicare Bundles

- Right-size intra-episode utilization despite conflicting or absent incentives

Secure Incremental Commercial Volume Gain

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

Status quo

Time

Total Margin Improvement
9 Imperatives for Securing Profitable Growth Through Efficient Episodes

**Public-Payer Risk**

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

**Commercial Steerage**

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

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

Source: Health Care Advisory Board interviews and analysis.
In Commercial Segment, Price Drives Variation

Post-Acute Utilization Far Less Common Than in Medicare Population

Drivers Explaining Relative Proportion of Commercial Spending Variation

Multiple Commercial Populations

Percentage of Patients Discharged to Institutional PAC After Joint Replacement Surgery

2012

<table>
<thead>
<tr>
<th></th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Commercial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Price</td>
<td>50%</td>
<td>33%</td>
<td>18%</td>
</tr>
<tr>
<td>Markup</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quantity</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: HPC analysis of Massachusetts Health Data Consortium, inpatient discharge database, 2012; Harvard Medical School, Department of Health Care Policy, Geographic Variation in Health Care Spending, Utilization, and Quality Among the Privately Insured. Institute of Medicine of the National Academies, Washington, DC, 2012; Health Care Advisory Board interviews and analysis.
Dropping Rate Always an Option – But Is It Wise?

Commercial Procedural Margins Supporting Hospital Cross-Subsidy

Illustrative Price-Cost Ratios, by Payer and Service Type

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Medicaid Medical</th>
<th>Medicare Medical</th>
<th>Medicaid Surgical</th>
<th>Medicare Surgical</th>
<th>Commercial Medical</th>
<th>Commercial Surgical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Break-even</td>
<td>65%</td>
<td>85%</td>
<td>100%</td>
<td>110%</td>
<td>120%</td>
<td>180%</td>
</tr>
<tr>
<td>Source</td>
<td>Health Care Advisory Board interviews and analysis.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

©2015 The Advisory Board Company • advisory.com • 31490C
Compete for Health Plan Steerage

Two Ways to Offset Procedural Episode Discounts

Shore Up Margin

Minimize inpatient quality shortfalls to lower cost per case, support price drop option

Secure Steerage

Focus episode-specific commercial steerage efforts on established COE programs

Broaden efficiency initiative across top episodes to capture narrow and tiered network steerage

Source: Health Care Advisory Board interviews and analysis.
Lots of Running Room in Procedure Cost-Avoidance

Supplies Not the Only Issue; Quality Improvement a Major Lever

Crimson ‘Care Variation Short List’: Physician-Level Charge Variation by Cost Driver
n=2,620 (hip) and 2,372 (knee) physicians within 650 hospitals

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Supplies</th>
<th>ICU</th>
<th>Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip Replacements</td>
<td>$39,426</td>
<td>$27,501</td>
<td>$24,214</td>
</tr>
<tr>
<td>Knee Replacements</td>
<td>$42,088</td>
<td>$23,015</td>
<td>$22,090</td>
</tr>
</tbody>
</table>

Source: Health Care Advisory Board interviews and analysis.

4. Minimize inpatient quality shortfalls to lower cost per case, support price drop option
Making the Connection Between Quality and Cost

Providence Health and Services Quantifies Complications’ Impact

Impact of Complications on Hospital Cost, by Severity
Percentage Increase in Average Cost Per Case¹

<table>
<thead>
<tr>
<th>Complication</th>
<th>Percentage Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any CABG Complication</td>
<td>25%</td>
</tr>
<tr>
<td>Stroke, Prolonged Ventilation</td>
<td>90%</td>
</tr>
</tbody>
</table>

“This kind of merged cost/quality data is so hard to get, but so powerful. With it, you can look at cost savings opportunities that are not just ‘this generic drug instead of that one’, but instead, quantifying the degree to which good care is actually cheaper.”

Matthew Ducsik
Program Manager,
Cardiovascular Portfolio
Providence Health Services

¹ Contribution of complication to cost per case for CABG based on 350 cases.
Moving to Best Performance Across the Board

Historical Data Identifies Achievable Goals

- Median Cardiac LOS, in CICU, days
  - Benchmark (2009-2011): 7
  - Target: 6

- Median Time in CICU, hours
  - Benchmark (2009-2011): 49.6
  - Target: 43.6

14% reduction

Data Inspires Physicians, Makes Strategic Case for More Resources

- Physicians and entire care team engineer new standard, adopt specific care steps

Care Redesign Lowers Cost, Brings ‘Halo Effect’

- Reduction in inpatient direct cost per case for CABG after bundle implementation
  - 8%

- Entire cardiac service line benefits from new care standard

- Entire CICU benefits from new practices, not just cardiac patients

Source: Health Care Advisory Board interviews and analysis.

1) Goals formulated in advance of bundle implementation.
CFOs’ Estimated Breakdown of Total Hospital Cost Containment Opportunity, by Source of Savings

*HCAB Meta-Analysis of Hospital and System CFOs, 2015*

n=45

- Labor costs: 40%
- Supply costs: 25%
- Capital expenses: 10%
- Administrative overhead: 5%
- Clinical standardization: 20%

---

**Setting the Standard for Patient Care:**

*Overview of the Clinical Standardization Opportunity for Hospital Executives and Board*

- Web-based performance measurement tool facilitating rapid opportunity identification, peer cohort benchmarking, physician self-review, and clinical performance improvement
- Transforms siloed data into comprehensive dashboards and performance profiles at service line, specialty, and provider level

Even Providers with Demonstrated Results Turned Away by Plans

Case in Brief: McCabe Health System

- Three-hospital system with owned multi-specialty group
- Builds high-efficiency, high-quality episodes in total joint, CABG, AMI as part of BPCI participation
- Over the course of 18 months, holds discussions with four regional health plans to discuss the potential for commercial bundled payment contracts
- All conversations end with health plans declining to proceed

Health system approaches three regional health plans to propose bundles; a fourth approaches them

Discussions allow provider to share details on its track record of reducing episode costs, raising quality in BPCI

Plans all express support for program but decline to engage in bundled payment contracting

“Each plan had a different reason why. It was never a question of the goals or the program or whether it could get results. It always boiled down to how it just wasn’t feasible for them to administer.”

CEO,
McCabe Health System

Source: Health Care Advisory Board interviews and analysis.
Plans Face Stiff Headwinds for Episode Contracting

Diverse Problems All Contribute to Slow Commercial Bundle Adoption

Plan-Facing Complexities of Bundled Payment Programs

- Difficult to process bundled payments without disrupting claims process—especially challenging in legacy IT environments
- Time consuming to design bundle, negotiate terms with providers
- Complicated to create enrollee steerage—requires employer buy-in, enrollee-facing education, cost-waiving incentives
- Risk of relationship problems with other contracted providers

Low Return on Effort

- Commonly bundled episodes (cardiac surgery, joint replacement) not as prevalent in commercial populations
- Contracts offering broad base of savings—more case types, more overall cases—may be higher priorities than one-off bundle contracts with any given provider

Source: Health Care Advisory Board interviews and analysis.
Few Major Episode-Level COE Options Today

**OPTUM Health**

- Transplant COE developed in 1986; manages more than 14,300 transplant referrals annually plus other episodes
- Episodes also include cancer, chronic kidney disease, bariatric, women’s health services
- More than 9,675 payer groups representing 70 million individuals utilize Optum COE

**Blue Distinction**

- Designates hospitals as high performers based on expertise (and efficiency) in delivering specialty care; developed in 2006
- Episodes include bariatric surgery, cardiac care, complex and rare cancers, knee and hip replacement, spine surgery, transplants
- More than 1,900 hospitals across 46 states

---

### Average Charges per Transplant Episode

- **National Average**: $470K
- **OPTUM CEO**: $210K

- Lower cancer patient complication rate compared to national average

### Reduction in cost per case for angioplasties at Blue Distinction Centers

- **26%** lower bariatric surgery complication rate compared to national average
- **$2,500** reduction in cost per case

---

Plan COEs Have a Defined Performance Bar

Threshold Is Higher Than Medicare (in CCJR)

Example Quality Considerations for THA/TKA\(^1\) COE Participation

- Full accreditation
- THA/TKA volume and associated outcomes
- Program practices and standards following current trends and technological advances in THA/TKA
- Team experience and stability, and the ability of supporting personnel to manage the program

- National accreditation
- Comprehensive acute care facility
- Board certification
- Volumes of service
- Shared decision making
- Data management and patient tracking
- Complication rate for THA/TKA
- 30-day readmission rate for THA/TKA

Source: Controlling Cost and Quality Through Specialized Care Management, Optum, 2014, available at [www.optum.com](http://www.optum.com); Blue Distinction Centers, available at [www.bcbs.com](http://www.bcbs.com); Health Care Advisory Board interviews and analysis.

1) Total Hip Arthroscopy/Total Knee Arthroscopy.
Selective Contracting Maximizes Direct Gain; Look at Big Picture Too

**Brace for a Price Cut**

20%

Price drop on hip/knee rates heard in the research as minimum to qualify for contracting through Center of Excellence

**Plan Selection Criteria to Maximize Discount Offset**

- Relatively high pre-existing base rate relative to other contracts
- Low share of existing patient portfolio

**Two Key Questions for Assessing Strategic Value of COE Contract**

To what degree will this arrangement catalyze a physician-led initiative to reduce direct cost per case—by providing momentum and/or upside to proceduralists in the form of incremental cases?

If this contract helps reduce variable costs, how much of a “halo” benefit can we expect—i.e., being able to keep the difference between lower variable costs and the relatively higher rates remaining across rest of commercial portfolio?

Source: Health Care Advisory Board interviews and analysis.
Narrow, Tiered Networks the Next Steerage Option

Commonly Reported Health Plan Criteria for Narrow Network Contracts

Reported Examples of Health Plan Discount Requirements for Enrollee Steerage

<table>
<thead>
<tr>
<th>Smallest Likely Price Drop</th>
<th>Largest Likely Price Drop</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum 5-10% drop to participate in a narrow network</td>
<td>Minimum 10% to be designated as Tier One in a tiered network</td>
</tr>
<tr>
<td>20% to qualify for hip/knee replacement episode-level steerage through Center of Excellence</td>
<td></td>
</tr>
</tbody>
</table>

Considerations Beyond Cost

- Provider ability to inflect quality metrics included in Medicare Advantage Star Ratings (e.g., mammogram rate)
- Plan assessment of provider willingness to take on greater total risk in future

Source: Health Care Advisory Board interviews and analysis.
Capturing Maximum Momentum from Bundling

Out of the 48 possible episode bundles in risk-bearing phase of BPCI under way at St. Luke’s University Health Network

Case in Brief: St. Luke’s University Health Network

- Six-hospital system headquartered in Bethlehem, PA
- Largest BPCI participant in the country; four of six hospitals involved
- Working with Remedy Partners since 2013 to analyze data, create physician-driven care guidelines, curate SNF network
- Experienced financial gain every quarter; Medicare Spend Per Beneficiary now lower than national average post-BPCI

Medicare Spend Per Beneficiary, Pre- and Post-BPCI Program

You can’t be indecisive or shy about this. We needed to jump in with both feet to get the widespread change we wanted.”

Donna Sabol, Chief Quality Officer, St. Luke’s University Health Network

Source: Health Care Advisory Board interviews and analysis.
Key Takeaways

Competing on Episode Price and Quality

• **Contracts or no contracts, work with clinicians to reduce the cost of low episode quality now.** Reducing avoidable complications, dropping LOS can provide enough gains to support self-financed rewards for proceduralists (e.g. comanagement) if needed. It is the right answer for hospitals, physicians, and patients.

• **In the short term, it may not be feasible to engage local plans in negotiations for episodic bundles.** Major plan obstacles to bundling translate into limited opportunities for any given provider to create a contract with a plan for bundled payment. Look for opportunities to participate in plan programs that aggregate a higher volume of the relevant episodes across providers—such as a formal episode Center of Excellence program.

• **As long as it comes with steerage, even a steeply discounted bundle contract may be worthwhile if it provides the impetus for clinical transformation in that episode.** The common-sense case for improving quality and efficiency in any given episode is already strong; it may not take a lot of incremental cases to move the dial in the eyes of proceduralists.

• **Take advantage of transformation momentum in any given episode to inspire broad practice pattern change.** Physicians who recognize the quality and business case for raising episode-wide performance can apply the same principles to services far beyond the episode under contract.
Direct Contracting with Employers around Efficient Episodes

In Search of Employer Steerage

Percentage of Providers Interested in Direct Contracting with Employers\(^1\)
\(n=177\)

94%

Moderate or significant interest

Percentage of Providers Interested in Working with Employers via Bundles\(^2\)
\(n=97\)

99%

Moderate or significant interest\(^3\)

Percentage of Providers Currently Working with Employers via Bundles\(^4\)
\(n=97\)

9%

Providers Offering Bundled Services

---

1) Survey respondents asked, “Overall, what is your organization’s posture today with regard to serving (or selling to) employers directly?”

2) Survey respondents asked, “Assuming relevant employers were interested, would your organization be open to offering any of the following services directly to employers? Bundled Payments”

3) Moderate and significant interest includes respondents who answered: “maybe,” “probably,” “definitely,” or “already offering directly.”

4) Survey respondents asked, “Assuming relevant employers were interested, would your organization be open to offering any of the following services directly to employers? Bundled Payments”

Source: HCAB Direct to Employer PRELIM Summary, August 2015; Health Care Advisory Board interviews and analysis.
### Largest Barriers to Partnering with or Purchasing Services Directly from Providers

Percentage of Surveyed Employers Ranking Barrier in Top 3

n=106

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative complexity/resource constraints</td>
<td>66%</td>
</tr>
<tr>
<td>Providers lack sufficient geographic or service coverage</td>
<td>48%</td>
</tr>
<tr>
<td>Don't know how best to proceed</td>
<td>42%</td>
</tr>
<tr>
<td>Insufficient economic rationale</td>
<td>38%</td>
</tr>
<tr>
<td>Potential to jeopardize carrier relationships</td>
<td>26%</td>
</tr>
<tr>
<td>Broker pushback</td>
<td>20%</td>
</tr>
<tr>
<td>Employee pushback</td>
<td>18%</td>
</tr>
<tr>
<td>Providers lack track record and experience compared to others</td>
<td>16%</td>
</tr>
<tr>
<td>Lack of provider interest</td>
<td>11%</td>
</tr>
<tr>
<td>Providers don’t offer relevant services today</td>
<td>10%</td>
</tr>
<tr>
<td>Providers only looking to steer hospital volumes</td>
<td>4%</td>
</tr>
</tbody>
</table>

1) Employers were asked, “What are the three largest barriers to partnering with or purchasing services directly from providers?”

Source: CEB Survey of Employers on Future Health Benefits Changes; Health Care Advisory Board interviews and analysis.
### Drivers Motivating Employers to Change Health Benefits Over Next 3 Years

#### Percentage of Surveyed Employers Ranking Driver in Top 3

*n=106*

<table>
<thead>
<tr>
<th>Driver</th>
<th>Percentage of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need to control health care expense growth</td>
<td>75%</td>
</tr>
<tr>
<td>Remain competitive relative to industry peers</td>
<td>63%</td>
</tr>
<tr>
<td>Improve health of employee population</td>
<td>43%</td>
</tr>
<tr>
<td>Improve ability to attract and retain talent</td>
<td>39%</td>
</tr>
<tr>
<td>Avoid Cadillac Tax</td>
<td>32%</td>
</tr>
<tr>
<td>Improve employee experience with health benefits</td>
<td>30%</td>
</tr>
<tr>
<td>Reduce administrative burden to organization</td>
<td>15%</td>
</tr>
<tr>
<td>Address issues with absenteeism and productivity</td>
<td>2%</td>
</tr>
</tbody>
</table>

A small segment of employers chose this goal in top 3—but of those who did, 98% ranked it their overall No. 1 goal.

---

1) Employers were asked, “What are the top drivers behind changes you will make to your health benefits over the next 3 years?”

Source: Advisory Board-Corporate Executive Board Survey of Employers on Future Health Benefits Changes; Health Care Advisory Board interviews and analysis.
Employer Criteria Different from Plans’

Importance of Variables to Employers in Selecting a Provider Partner

Percentage of Surveyed Employers Ranking Driver in Top 3

n=106

Provider has implemented service before, with demonstrable results

Provider has proven ability to reduce cost trend

Provider is willing to put fees at risk to achieving quality and/or cost outcomes

Price is discounted

Evidence of superior clinical outcomes (e.g. lower mortality, complication rates)

Provider has implemented service before, with other employers

Price is guaranteed upfront

Evidence of adherence to evidence-based medicine protocols (e.g. avoiding unnecessary surgery)

Source: Advisory Board-Corporate Executive Board Survey of Employers on Future Health Benefits Changes; Health Care Advisory Board interviews and analysis.
Capture Direct-to-Employer Contracts

Three Lessons for Gaining Traction with a Differentiated Employer Segment

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.
Reference Pricing Incents Hospitals to Lower Costs

Average Knee Replacement Cost and Associated Variability, by Provider

<table>
<thead>
<tr>
<th>Provider</th>
<th>Average</th>
<th>St. Dev</th>
<th>Coef of Var</th>
<th>5%</th>
<th>25%</th>
<th>50%</th>
<th>75%</th>
<th>95%</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>$29,863</td>
<td>$8,439</td>
<td>0.28</td>
<td>$24,345</td>
<td>$25,552</td>
<td>$27,496</td>
<td>$30,660</td>
<td>$39,561</td>
</tr>
<tr>
<td>B</td>
<td>$27,557</td>
<td>$8,609</td>
<td>0.31</td>
<td>$19,845</td>
<td>$22,482</td>
<td>$25,228</td>
<td>$29,253</td>
<td>$47,567</td>
</tr>
<tr>
<td>C</td>
<td>$22,842</td>
<td>$4,902</td>
<td>0.21</td>
<td>$19,081</td>
<td>$20,540</td>
<td>$21,990</td>
<td>$23,118</td>
<td>$29,098</td>
</tr>
<tr>
<td>D</td>
<td>$26,158</td>
<td>$6,417</td>
<td>0.25</td>
<td>$20,217</td>
<td>$22,433</td>
<td>$24,400</td>
<td>$28,914</td>
<td>$38,976</td>
</tr>
<tr>
<td>E</td>
<td>$28,088</td>
<td>$7,502</td>
<td>0.27</td>
<td>$21,931</td>
<td>$23,907</td>
<td>$25,900</td>
<td>$28,517</td>
<td>$43,481</td>
</tr>
<tr>
<td>F</td>
<td>$22,839</td>
<td>$4,614</td>
<td>0.20</td>
<td>$20,043</td>
<td>$20,677</td>
<td>$21,182</td>
<td>$23,280</td>
<td>$25,590</td>
</tr>
<tr>
<td>Overall</td>
<td>$25,590</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The median price for the market is $25,590 and the orange highlights on each row/provider represent the percentile rank under which the provider’s procedure costs were lower than the market median.

Case in Brief: California Public Employees Retirement System (CalPERS)

- CalPERS provides coverage for 1.3 million state employees
- In January 2011, implemented reference pricing program for total hip and knee replacements for its PPO enrollees
- Reference pricing has resulted in both consumers shifting towards lower-priced providers, and in providers reducing their prices to mitigate potential loss of volumes

## Reference Pricing Proven to Drive Prices Down

### High-Profile CalPERS Case Illustrates Reference Price Efficacy

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Cost (2011-2013)</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint replacement</td>
<td>$2.8M</td>
<td>$1.3M</td>
</tr>
<tr>
<td>Cataract surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>$7.0M</td>
<td>$2.3M</td>
</tr>
<tr>
<td>Arthroscopy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Price Decline for High- and Low-Priced Hospitals

<table>
<thead>
<tr>
<th></th>
<th>High-priced</th>
<th>Low-priced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cataract</td>
<td>34.3%</td>
<td>5.6%</td>
</tr>
</tbody>
</table>

### California Hospitals Below CalPERS Reference Limit

<table>
<thead>
<tr>
<th>Year</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>46</td>
</tr>
<tr>
<td>2015</td>
<td>72</td>
</tr>
</tbody>
</table>

Reference Pricing with Bundle a More Sustainable Bet

Not Just a Price Cut—a Lever for Providers to Rethink Episode Efficiency

Reference Price Cost Risk

- Consumer at risk with reference price alone: $29K
- Provider at risk with bundle and reference price: $71K

Combining reference pricing with a bundled payment model can minimize member financial risk as well as manage provider financial risk.”


1) Illustrative figures.
To Be Accretive, Bundles Must Shift Market Share

Providers May Need Help To Make Out-of-Area Connections

Heard in the Research: Channels for Brokering Bundles Between Providers and Employers

Board Member Connections
Provider board members introducing bundle idea to board members of local employers

Regional Business Councils
Locally organized groups bring employers (including providers) together

Network Aggregators
Third party companies building national or regional networks for employer customers

Likelihood of Securing Cases from out of Market

Source: Health Care Advisory Board interviews and analysis.
Virtual Network Aggregation Its Own New Industry

Companies Working to Connect Employers with High-Value Episodes

- Health benefit navigation company that helps employees of large self-insured employers connect with high value physicians
  
- Health navigation and transparency company that connects employees with high value physicians and facilities using transparency database
  
- Crafts a national COE network of high performing hospitals and surgical teams for key procedures and negotiates preset case rates
  
- Builds regional and private COE networks of high performing hospitals with price cuts on a per case basis
  
- Third-party administrator that creates COE programs for self-funded employers

Source: Health Care Advisory Board interviews and analysis.
Additional requirements for private payers include full accreditation, high volumes, stable OR staff, etc.

**Virtual Network Aggregator Discounts Heard in Research**

- **25%** Hip and knee replacement
- **>30%** Spine surgery
- **50%** CABG
- **>40%** Across-the-board price cuts in ortho and cardio bundles

**Discount and Performance Rise Together**

- **Employer-Facing Network Aggregator**
  - 75th percentile reported metrics

- **Health Plan COE**
  - 50th percentile reported metrics

- **Medicare**
  - 30th percentile complications, HCAHPs, readmissions

**Virtual Network Aggregator**

- **>30%** Hip and knee replacement
- **50%** Spine surgery
- **>40%** CABG
- **>40%** Across-the-board price cuts in ortho and cardio bundles

**Discounts Heard in Research**

- **25%** Spine surgery
- **30%** CABG
- **40%** Across-the-board price cuts in ortho and cardio bundles

**Source:** Health Care Advisory Board interviews and analysis.
Building an Online Market for Episodes

Case in Brief: Carrum Health

- Start-up aiming to connect employers and providers via interactive online marketplace
- Providers who pass quality standard are allowed to offer bundles on marketplace; Carrum provides analytics to help providers set their prices based on their available capacity and current prices paid by employers (set price lower for greater steerage potential)
- Designed to expand the benefits of direct contracting to self-insured employers of all sizes (with at least 1,000 employees), Carrum provides fully packaged solution including contracting standardization across employers and support services to employees

Highlights price, rating, and location

Source: Carrum Health, Health Care Advisory Board interviews and analysis.
Filling Gaps for Providers and Employers

Value Proposition to Providers

- Aggregate demand from small-mid-large-sized employers
- Obviate the need for own employer-facing salesforce
- Standardize and manage diverse contracts across employers
- Manage internal employer systems and processes
- Drives employee adoption

Current and Planned Episode Offerings

- Location Sensitivity
  - Present
  - Planned

- Acute Procedures
  - Chronic Care
  - Primary Care

Source: Health Care Advisory Board interviews and analysis.
Taking Up the Regional Employer COE Mantle

Looking to Connect with Self-Insured Employers for Bundled Episodes

Case in Brief: Scripps Health

- Four-hospital system headquartered in San Diego, California
- Track record of contracting for bundles around transplant, interventional cardiology, cardiac surgery, and bariatric surgery
- Looking to connect with self-insured employers regionally for joint replacement, spine and CABG episodes
- Working with Carrum Health as anchor client in San Diego market

New bundled episode offerings:
- Hip and knee replacement, spinal fusion, CABG

Limited number of self-insured employers in general medical services catchment area

Many more self-insured employers located in regional range—a few hours’ drive or short flight

Source: Scripps Health; Health Care Advisory Board interviews and analysis.
In the Market for Something Different

Case Study: Pacific Business Group on Health

PBGH’s Selection Process for Employers Centers of Excellence Network (ECEN)

Investigate publically reported quality metrics
Phone call to assess physician buy-in, management readiness
Site visit to check operational integration of care cycle
Post-selection program development to improve care standard and coordination

Case in Brief: Pacific Business Group on Health

• Non-profit based in San Francisco, CA, leverages member influence, including both private and public employers, to drive change in health care payment and delivery
• Employers Centers of Excellence Network has negotiated direct-to-employer bundled travel surgery programs for Lowes, Walmart, JetBlue, McKesson, and other major employers
• Only four hospitals included in initial program: Virginia Mason Medical Center; Mercy Hospital, (Springfield, MO); Kaiser Permanente Irvine Medical Center; and Johns Hopkins Bayview Medical Center

Source: Pacific Business Group on Health; Health Care Advisory Board interviews and analysis.
Vast Majority of Providers Appear Unready

Centers Chosen Through PBGH ECEN Screening Process

- 1%

To date, over 100 providers screened; six selected

Common Roadblocks

- Cannot meet volume or outcomes prerequisites at both center and surgeon level
- Not collecting and reporting the right data
- Provider leadership doesn’t appear to fully understand what bundled payment entails
- Surgeons not already “at the table” on reducing the cost of low-value care
- Don’t have a formal care standard in place

Source: Health Care Advisory Board interviews and analysis.
Case in Brief: Johns Hopkins Bayview, Employers Centers of Excellence Network

- 527-bed hospital, part of the six-hospital Johns Hopkins Medicine system based in Baltimore, MD
- Chosen in 2013 to be a member of the Employers Centers of Excellence Network (ECEN) for total joint replacement for employees of Walmart, Lowe’s, and McKesson. Employers waive cost-sharing and pay travel expenses for participating patients
- Program administered by Health Design Plus for employer members of Pacific Business Group on Health
- 96% of patients said they would recommend the program to a friend, family, or coworkers.

Strong Existing Foundation of Cost and Quality

*Pre-Travel Program Elements of Hopkins Bayview Total Joint Care Standard*

- Consistent anesthesia and OR teams
- Defined patient eligibility criteria
- Limited number of implant vendors
- Anesthesia protocol
- Committed extended team in PT and pharmacy
- Pain management control

“This is the way medicine was already practiced at Hopkins. It’s part of the culture of the organization.”

Trisha Frick, Director, Bundled Rate Contracting
Johns Hopkins Bayview

Source: Health Care Advisory Board interviews and analysis.
Exceptional Service Required

Considerable Supports Required to Make Program Responsive Enough

Adding Supports Needed for Travel Program

Administrative
- Dedicated team to collect medical record and diagnostics from patient’s local providers
- Dedicated navigator FTE to support travel patients

Clinical
- New pre-travel assessment protocol to screen patients for appropriateness of surgery, travel

Timeline for Responding to Referrals

- Patient contacted within 48 hours of referral
- Surgery decision provided within two weeks of case review
- Clinical documentation assembled within four weeks

Hopkins Bayview Travel Program, by the Numbers

121
Referrals in the first three months

352
Referrals over 18 months

183
Surgeries completed over 18 months

23%
Of all joint replacement volumes at one Hopkins facility now contributed by travel program

96%
Patients who said they would recommend this program to family, friends, coworkers

Source: Health Care Advisory Board interviews and analysis.
Understanding the Surgery Eligibility Screen

Example Reasons ECEN Patients Not Cleared for Joint Surgery

1. **Surgery Not Clinically Indicated**
   - Disease not advanced enough
   - Medical management a better option

2. **Complication Risk Too High**
   - BMI exceeds 40
   - Active smoking
   - Needs dental care
   - HbA1c above 8
   - Recent MI (should not travel)

---

**Patient Receives Full Report**

If surgery is not indicated, team recommends avenues for monitoring or medical management.

If risk factors are the barrier, team directs patient to remedial steps as appropriate.

---

1) Composite case drawing on multiple sources.

Source: Health Care Advisory Board interviews and analysis.
## Avoided Interventions Net Employer Savings

**Illustrative Example Only**

### Employer Pro Forma\(^1\)

<table>
<thead>
<tr>
<th>Costs</th>
<th>Employers Cost per Case without Bundled Payment</th>
<th>Employer Cost per Case with Bundled Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cost for ‘Unbundled’ Episode</td>
<td>$30,000(^2)</td>
<td>---</td>
</tr>
<tr>
<td>Bundled Rate, Showing 10% Discount</td>
<td>---</td>
<td>$27,000</td>
</tr>
<tr>
<td>Broker’s Per-Case Fee</td>
<td>---</td>
<td>$500</td>
</tr>
<tr>
<td>Patient Cost-Sharing</td>
<td>---</td>
<td>$1,500</td>
</tr>
<tr>
<td>Patient Travel</td>
<td>---</td>
<td>$1,000</td>
</tr>
<tr>
<td>Total Cost to Employer</td>
<td><strong>$30,000</strong></td>
<td><strong>$30,000</strong></td>
</tr>
</tbody>
</table>

### Yearly Savings if Program Reduces Interventions by 20%

#### No bundling
- 100 joint replacement referrals to $3M
- 100 x $30K = $3M

#### With bundling
- 80 joint replacement referrals to $2.4M
- 80 x $30K = $2.4M

**$600K** Yearly savings to employer under bundling scenario

---

1) Composite case drawing on multiple sources
2) Dollar amounts are hypothetical.

Source: Health Care Advisory Board interviews and analysis.
The Patient-Centered Right Answer

Employers Looking for an Approach That Prioritizes Outcomes

Example: Gatekeeping versus Patient-Centered Use of Eligibility Criteria

Gatekeeping

Patient refused knee surgery

Doctor explains BMI complication risk, patient encouraged to lose weight

Provider checks in with patient to provide encouragement, monitor weight loss

Patient undergoes knee surgery

Patient reports improvement in overall quality of life

Patient-Centered Use of Eligibility Criteria

Holistic Care Pathway

Source: Health Care Advisory Board interviews and analysis.
Imagine Bringing All Your Assets to Bear

Orthopedics Episodes: Current Model Versus Potential Future Elements

<table>
<thead>
<tr>
<th>Current Model</th>
<th>Future of Designer Packages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard of Care</td>
<td>Enhanced Services</td>
</tr>
<tr>
<td>• Orthopedic surgery</td>
<td>• Sports psychology</td>
</tr>
<tr>
<td>• Physical therapy</td>
<td>• Exercise testing</td>
</tr>
<tr>
<td>• Post-acute care</td>
<td>• Biomechanical analyses</td>
</tr>
</tbody>
</table>

Source: Health Care Advisory Board interviews and analysis.
Key Takeaways

Competing on Episode Service and Experience

- **Employer priorities are diverse and nuanced.** While all employers will likely care about cost, quality, and service, the specific top priority motivating any future change to their health care benefit will depend on the employer. When talking to an employer, ask this question first.

- **Cast a wide regional net.** Today, the employer market for bundles is small and scattered. Explore ways to broadcast the offering to enough employers—with a standard-enough packaging to avoid over-complicating administration across contracts. Cultivate employers within the radius of a day trip by car or a short flight.

- **Minimizing discount on bundles will require substantially redesigning the service and experience components of today’s episodes.** Even providers with top quality performance and an existing care standard will have to go back to the drawing board.

- **Consider value from the patient perspective.** Reduction in low-value interventions can supply significant cost savings to employers, but cannot come at the expense of the right answer from the patient perspective. Understanding that the patient’s objective is to achieve maximum possible improvement (not just to buy a specific procedure), work with physicians to create a flexible and holistic experience that draws on all the provider organization’s many disparate assets to deliver a complete long-term best-case answer for each patient.
What Did You Think of Today’s Session?

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

Thank You!
Bundled Payment Strategy

Part II: Leveraging Episode Excellence for Growth in Health Plan and Employer Contracts

David L. Katz, MD, JD
Principal and Executive Director
The Advisory Board Company
Contact: katzd@advisory.com
The Advisory Board Company has made efforts to verify the accuracy of the information it provides to members. This report relies on data obtained from many sources, however, and The Advisory Board Company cannot guarantee the accuracy of the information provided or any analysis based thereon. In addition, The Advisory Board Company is not in the business of giving legal, medical, accounting, or other professional advice, and its reports should not be construed as professional advice. In particular, members should not rely on any legal commentary in this report as a basis for action, or assume that any tactics described herein would be permitted by applicable law or appropriate for a given member’s situation. Members are advised to consult with appropriate professionals concerning legal, medical, tax, or accounting issues, before implementing any of these tactics. Neither The Advisory Board Company nor its officers, directors, trustees, employees and agents shall be liable for any claims, liabilities, or expenses relating to (a) any errors or omissions in this report, whether caused by The Advisory Board Company or any of its employees or agents, or sources or other third parties, (b) any recommendation or graded ranking by The Advisory Board Company, or (c) failure of member and its employees and agents to abide by the terms set forth herein.

The Advisory Board is a registered trademark of The Advisory Board Company in the United States and other countries. Members are not permitted to use this trademark, or any other Advisory Board trademark, product name, service name, trade name, and logo, without the prior written consent of The Advisory Board Company. All other trademarks, product names, service names, trade names, and logos used within these pages are the property of their respective holders. Use of other company trademarks, product names, service names, trade names and logos or images of the same does not necessarily constitute (a) an endorsement by such company of The Advisory Board Company and its products and services, or (b) an endorsement of the company or its products or services by The Advisory Board Company. The Advisory Board Company is not affiliated with any such company.

IMPORTANT: Please read the following.
The Advisory Board Company has prepared this report for the exclusive use of its members. Each member acknowledges and agrees that this report and the information contained herein (collectively, the “Report”) are confidential and proprietary to The Advisory Board Company. By accepting delivery of this Report, each member agrees to abide by the terms as stated herein, including the following:

1. The Advisory Board Company owns all right, title and interest in and to this Report. Except as stated herein, no right, license, permission or interest of any kind in this Report is intended to be given, transferred to or acquired by a member. Each member is authorized to use this Report only to the extent expressly authorized herein.

2. Each member shall not sell, license, or republish this Report. Each member shall not disseminate or permit the use of, and shall take reasonable precautions to prevent such dissemination or use of, this Report by (a) any of its employees and agents (except as stated below), or (b) any third party.

3. Each member may make this Report available solely to those of its employees and agents who (a) are registered for the workshop or membership program of which this Report is a part, (b) require access to this Report in order to learn from the information described herein, and (c) agree not to disclose this Report to other employees or agents or any third party. Each member shall use, and shall ensure that its employees and agents use, this Report for its internal use only. Each member may make a limited number of copies, solely as adequate for use by its employees and agents in accordance with the terms herein.

4. Each member shall not remove from this Report any confidential markings, copyright notices, and other similar indicia herein.

5. Each member is responsible for any breach of its obligations as stated herein by any of its employees or agents.

6. If a member is unwilling to abide by any of the foregoing obligations, then such member shall promptly return this Report and all copies thereof to The Advisory Board Company.