Critical Intelligence for the Bundled Payments and Coming Risk Models

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July 2015
Learning Objectives

At the end of this session each participant will understand the following 5 key learning objectives:

• Understand the market drivers that are accelerating the need for new forms of Enterprise Intelligence

• Learn how new revenue models are accelerating intelligence needs

• Learn about the emerging analytics and intelligence capabilities required for risk capability

• Understand the top things that all healthcare organizations should consider tomorrow to advance enterprise intelligence through the risk capability continuum
**Risk Readiness**

**Clinical Maturity Level (CEM)**
A concept unique to DHG Healthcare, the CEM is a qualitative evaluation that measures numerous characteristics associated (among other things) with the state of an organization’s physician enterprise in combination with its overall clinical integration accomplishments and planning.

**Change Management Themes**
- "Do More Get More" vs. Right Care, Right Place, Right Time
- Fee For Service vs. Community Health Management
- Volume vs. Value

**Market Stage**
An evaluation of an individual market’s level of evolution with respect to resident payment models. This concept, which DHG Healthcare has developed and applies in our business planning practice, considers evolutionary facts such as depth of non-FFS transition, level of consolidation, employer base, and similar characteristics.
Agenda

• Big Data, Big Deal?

• Intelligence for What? A Framework of Coming Risk Models

• Enterprise Intelligence for BPCI

• “Intelligent” Things to Do Tomorrow
BIG DATA, BIG DEAL?
## Big Data – Big Deal?

<table>
<thead>
<tr>
<th>$600</th>
<th>40%</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>to buy a disk drive that can store all of the world’s music</em></td>
<td><em>projected growth in global data generated per year</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6.8 Billion</th>
<th>vs. 5%</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Cell phone subscriptions in 2013 including more subscriptions than people in the US (327M vs 318M)</em></td>
<td><em>growth in global IT spending</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>30 Billion</th>
<th>$300 billion</th>
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</thead>
<tbody>
<tr>
<td><em>pieces of content shared on Facebook every month</em></td>
<td><em>Annual value to US healthcare of “big data” – 2x total annual healthcare spend of Spain</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>60%</th>
<th>1.5 million</th>
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</thead>
<tbody>
<tr>
<td><em>potential increase in retailers margin possible with big data</em></td>
<td><em>MORE data savvy managers needed to take advantage of big data in the United States</em></td>
</tr>
</tbody>
</table>
Big Data – Not the Usual Suspects...

Google

Facebook

Twitter

sickweather

flu near you

do you have it in you?

Social Networks, Social Media, and Disease Surveillance

Traditional flu surveillance by the Centers for Disease Control and Prevention (CDC) relies on outpatient reporting and virological test results supplied by laboratories nationwide. That system confirms outbreaks within about 2 weeks after they begin.

Can social media give us a heads up?

We search for health information online.

We update or status to reflect our health.

We tweet our symptoms.

2 in 3 U.S. adults use social media.

Some organizations are putting all that data to good use.

Google uses people’s online searches to track flu trends.

"As you might expect, there are more flu-related searches during flu season, more allergy-related searches during allergy season, and more sunburn-related searches during the summer... But can search query trends provide the basis for an accurate, reliable model of real-world phenomena?"

http://www.google.org/flutrends/about/how.html

Twitter is playing an emerging role in the early detection of epidemics.

Scientists have found that tweet streams closely track reported cases of influenza-like illnesses, conditions.

In some instances Twitter content has predicted flu outbreaks 1-2 weeks ahead of the CDC’s surveillance average.

#thingsitspeoplesayontwitter

Head is pounding. Heart is racing. Hands are sweaty. Can’t sleep. I ain’t in love. #imssick

Still on the couch. I’ve been sleeping literally all day. 2015 is kicking my tail so far. #flu

Can’t breathe through my nose. sore throat, muscle ache, and chills. I want some soup. #BeingSick
An Industry Facing Substantial Challenges…

20%
Estimated increase in healthcare spend worldwide by 2015.
Worldwide per capita healthcare spending is outpacing per capita income.
(Source: Frost & Sullivan, Health Spending Projections Thru 2015: Changes on the Horizon)

75%
Amount of each healthcare dollar that is spent on managing chronic conditions.
(Source: Centers for Disease Control)

80%
Of chronic diseases (premature heart disease, stroke, diabetes, etc.) can be prevented.

20%-40%
World Health Organization estimate of all health spending wasted through inefficiency in the system.

Around the globe, countries are reforming
outcomes-based reimbursement • compliance and security (ICD-10 and 5010) • patient centricity & wellness • population health preparedness • efficiency & effectiveness improvement • care network integration • new partnership models (ACOs) • incoming participants
Estimated Long-Term Value of “Big Data” Levers

- Clinical Operations: $165 Billion
  - Outcomes and Cost Analytics
  - Clinical Decisions
  - Setting Management
  - Readmission Management
  - Transparency of Medical Data
  - Remote Monitoring
  - Advanced Profile Analytics

- Accounting and Pricing: $108 Billion
  - Predictive Modeling
  - Big Data Clinical Trials
  - Personalized Medicine (Genome)
  - Analyzed Disease Patterns

- Public Health: $47 Billion
  - Fraud Detection
  - Outcomes Based Pricing

- New Business Models: $200 Billion
  - Research and Development

$330 Billion Spending Reduction with Big Data Applications

How do you get real and determine the data needed to climb the hierarchy of risk?

### HIERARCHY OF RISK TACTICS

<table>
<thead>
<tr>
<th>Tactic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Health Management with Global Risk or Limited Risk Corridors, Global Budgeting, Single Payer</td>
</tr>
<tr>
<td>Bundled Payments, Shared Decision Making</td>
</tr>
<tr>
<td>Shared Savings Programs, Payment for Coordination, Medical Home</td>
</tr>
<tr>
<td>Value-Based Purchasing, Readmission Reduction, Physician/Hospital Gainsharing</td>
</tr>
</tbody>
</table>

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Legend:
- **Foundational, Entry-Level, Hierarchy of Risk**
- **Advanced**
INTELLIGENCE FOR WHAT? A FRAMEWORK FOR COMING RISK MODELS
Tipping Point In Sight?

1. Impact of Purchaser Pressure
2. What percentage of our net revenues will be tied to performance metrics?
3. When will our market tip?
CMS Accelerates the Tipping Point for Everyone

“...HHS goal of 30 percent traditional FFS Medicare payment through alternative payment models by the end of 2016... 50 percent by the end of 2018”

HHS Press Office 1-26-15

- 85% of payment tied to quality and value metrics (ex. HVBB, HRR)

![Graph showing the transition from traditional fee-for-service to alternative payment models from 2011 to 2018.](image)
### Another Way of Looking at This

<table>
<thead>
<tr>
<th>Category 1: Fee for Service—No Link to Quality</th>
<th>Category 2: Fee for Service—Link to Quality</th>
<th>Category 3: Alternative Payment Models Built on Fee-for-Service Architecture</th>
<th>Category 4: Population-Based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments are based on volume of services and not linked to quality or efficiency</td>
<td>At least a portion of payments vary based on the quality or efficiency of health care delivery</td>
<td>Some payment is linked to the effective management of a population or an episode of care Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk</td>
<td>Payment is not directly triggered by service delivery so volume is not linked to payment Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., &gt;1 year)</td>
</tr>
<tr>
<td>Limited in Medicare fee-for-service Majority of Medicare payments now are linked to quality</td>
<td>Hospital value-based purchasing Physician Value-Based Modifier Readmissions/Hospital Acquired Condition Reduction Program</td>
<td>Accountable care organizations Medical homes Bundled payments</td>
<td>Eligible Pioneer accountable care organizations in years 3-5 Some Medicare Advantage plan payments to clinicians and organizations Some Medicare-Medicaid (duals) plan payments to clinicians and organizations</td>
</tr>
</tbody>
</table>

85% by 2016 and 90% by 2018 of this category 30% by end of 2016 & 50% by end of 2018 of this category

Source: Rahul Rajkumar, MD, JD; Patrick H. Conway, MD, MSc; Marilyn Tavenner, RN, MHA CMS- Engaging Multiple Payers in Payment Reform. JAMA. 2014;311(19):1967-1968
The Business Intelligence Journey to Risk Capable

FFS Reimbursement Reductions

Penalty Avoidance and Pay for Performance

Bundled Payment (BPCI)

Capitation, Shared Savings (MSSP)

enterprise intelligence

revenue transformation

clinical enterprise maturity

risk capable
Fee For Service Payment Reductions

Medicare Fee-for-Service Payment Cuts

Reductions to Annual Payment Rate Increases


($4B) ($14B) ($21B) ($25B) ($32B) ($42B) ($53B) ($64B) ($75B) ($86B)

$415B in total fee-for-service cuts, 2013-2022

$260B
Hospital payment rate cuts, 2013-2022

$56B
Reduced Medicare and Medicaid DSH payments, 2013-2022

1) Includes hospital, skilled nursing facility, hospice, and home health services; excludes physician services.
2) Disproportionate Share Hospital.

Source: Centers for Medicare and Medicaid
The Business Intelligence Journey to Risk Capable

- FFS Reimbursement Reductions
- Penalty Avoidance and Pay for Performance
- Bundled Payment (BPCI)
- Capitation, Shared Savings (MSSP)

- Enterprise intelligence
- Revenue transformation
- Clinical enterprise maturity
### Penalties and Pay for Performance

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Value Based Purchasing</td>
<td>1.0%</td>
<td>1.25%</td>
<td>1.5%</td>
<td>1.75%</td>
<td>2.0%</td>
<td>2.0%</td>
<td>2.0%</td>
<td>2.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Readmission Reduction Program</td>
<td>1.0%</td>
<td>2.0%</td>
<td>3.0%</td>
<td>3.0%</td>
<td>3.0%</td>
<td>3.0%</td>
<td>3.0%</td>
<td>3.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Hospital Acquired Conditions</td>
<td>1.0%</td>
<td></td>
<td>1.0%</td>
<td>1.0%</td>
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<td>1.0%</td>
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<tr>
<td></td>
<td>2.0%</td>
<td>3.25%</td>
<td>5.5%</td>
<td>5.75%</td>
<td>6.0%</td>
<td>6.0%</td>
<td>6.0%</td>
<td>6.0%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Market Basket Reductions</td>
<td>0.1%</td>
<td>0.3%</td>
<td>0.2%</td>
<td></td>
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<tr>
<td>Multifactor Productivity Adj *</td>
<td>0.7%</td>
<td>0.5%</td>
<td>0.5%</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Documentation &amp; Coding Adj (DCA) **</td>
<td>1.0%</td>
<td>0.8%</td>
<td>0.8%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.8%</td>
<td>1.6%</td>
<td>1.5%</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Sequestration</td>
<td>2.0%</td>
<td>2.0%</td>
<td>2.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>?</td>
</tr>
<tr>
<td><strong>TOTAL IMPACT</strong></td>
<td>5.8%</td>
<td>6.9%</td>
<td>9.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

% = % of Medicare inpatient operating payments

* The Multifactor Productivity Adjustments is an estimate generated by the CMS Office of the Actuary

**DCA, also known as the behavioral offset.
# Mandatory Elements of Reform

## FFY 2015: 10/1/14 Impact
(1.5% VBP, 3% RRP, 1% HAC)
- All Measures

## FFY 2016: 10/1/15 Impact
(1.75% VBP, 1% HAC, 3% RRP)
- **Mortality**
  - CLABSI
  - CAUTI
  - SSI
  - AHRQ PSIs-90
  - Core Measures
  - HCAHPS
- **Efficiency (Per Beneficiary)**
- **Hospital Acquired Condition Readmissions**

## FFY 2017: 10/1/16 Impact
(2% VBP, 3% Readmissions, 1% HAC)
- **Mortality**
  - Safety: CAUTI, CLABSI, C. Diff, MRSA, SSI
  - Safety: AHRQ PSIs-90
  - Core Measures
  - HCAHPS
- **Efficiency (Per Beneficiary)**
- **Readmissions**
- **Hospital Acquired Condition**

## FFY 2018: 10/1/17 Impact
(2% VBP, 3% Readmissions, 1% HAC)
- **Mortality**
  - AHRQ
  - Readmissions

## FFY 2019: 10/1/18 Impact
(2% VBP, 3% Readmissions, 1% HAC)
- **Mortality**
  - Outcomes - TIA/TRA
  - Safety: AHRQ PSIs-90
  - Readmissions

### Performance Periods

<table>
<thead>
<tr>
<th>Year</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>Oct-Dec-Jan-Mar-May-Jul-Sep-Nov</td>
</tr>
<tr>
<td>2014</td>
<td>Jan-Mar-May-Jul-Sep-Nov</td>
</tr>
<tr>
<td>2015</td>
<td>Jan-Mar-May-Jul-Sep-Nov</td>
</tr>
</tbody>
</table>

### Legend
- **Mortality (VBP)**
- **Readmissions (RRP)**
- **HCAHPS (VBP)**
- **Hospital Acquired Conditions (HAC)**
- **Medicare Spend Per Beneficiary (VBP)**

### Notes
- ENDED 12/31/13
- May 2015
VBP Shifting of Domain Weights

FY 2013: 70% Clinical Care, 30% Patient Experience, 25% Safety - Outcomes, 25% Efficiency (MSPB), 5% Mortality
FY 2014: 45% Clinical Care, 30% Patient Experience, 30% Safety - Outcomes, 20% Efficiency (MSPB), 10% Mortality
FY 2015: 30% Clinical Care, 30% Patient Experience, 20% Safety - Outcomes, 25% Efficiency (MSPB), 10% Mortality
FY 2016: 40% Clinical Care, 25% Patient Experience, 25% Safety - Outcomes, 10% Efficiency (MSPB), 5% Mortality
FY 2017: 20% Clinical Care, 25% Patient Experience, 25% Safety - Outcomes, 25% Efficiency (MSPB), 5% Mortality
Medicare Spend Per Beneficiary

- Where are my opportunities to improve my MSPB score and maximize my VBP performance in this domain?
- What money is available to my organization in this domain?
- Who am I discharging to? By DRG? By post-acute care provider? By physician?
- Who is readmitting back to me?
- If I am considering alternative payment models, what information can I gather from this file to help with pre-planning?
The Business Intelligence Journey to Risk Capable

enterprise intelligence

risk capable

clinical enterprise maturity

revenue transformation

FFS Reimbursement Reductions
Penalty Avoidance and Pay for Performance
Bundled Payment (BPCI)
Capitation, Shared Savings (MSSP)
## Summary of Innovation Models

<table>
<thead>
<tr>
<th>Accountable Care</th>
<th>Episode Based Payment Initiatives</th>
<th>Primary Care Transformation</th>
<th>Medicaid &amp; CHIP Population</th>
<th>To Accelerate Testing of New Models</th>
<th>Speed Adoption of Best Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACOs</td>
<td>BPCI Models 1-4</td>
<td>Advanced Primary Care Initiatives</td>
<td>Reduce Avoidable Hospitalizations for NF residents</td>
<td>State Innovation Models: Round 1 &amp; 2</td>
<td>Beneficiary Engagement Model</td>
</tr>
<tr>
<td>Advanced Payment ACO</td>
<td>ACE Demonstration</td>
<td>Comprehensive Primary Care Initiative</td>
<td>Financial Alignment Incentive for Medicare &amp; Medicaid</td>
<td>Frontier Community Health Integration</td>
<td>Community Based Care Transitions</td>
</tr>
<tr>
<td>Comprehensive ESRD Care Initiative</td>
<td>Oncology Care Model</td>
<td>FQHC Advanced Primary Care Practice</td>
<td>Strong Start for Mothers &amp; Newborns</td>
<td>Maryland All Payer</td>
<td>Health Care Action and Learning Network</td>
</tr>
<tr>
<td>ACO Investment Model</td>
<td>Specialty Practitioner Payment Model</td>
<td>Graduate Nurse Education</td>
<td>Medicaid Innovation Accelerator Program</td>
<td>Health Care Innovation Round 1&amp;2</td>
<td>Innovation Advisors Program</td>
</tr>
<tr>
<td>Next Generation ACO Model</td>
<td>Comprehensive Care for Joint Replacement (CCJR)</td>
<td>Independence at Home</td>
<td>Medicaid Prevention of Chronic Diseases</td>
<td>Health Plan Innovation Initiatives</td>
<td>Million Hearts</td>
</tr>
<tr>
<td>Pioneer ACO</td>
<td>Multi Payer Advanced Primary Care Practice</td>
<td>Medicaid Emergency Psychiatric Demonstration</td>
<td>Medicare Care Choices Award</td>
<td>Medicare IVIG Demonstration</td>
<td>Partnership for Patients</td>
</tr>
<tr>
<td>Rural Community Hospital Demonstration</td>
<td>Transforming Clinical Practice</td>
<td>Medicaid Emergency Psychiatric Demonstration</td>
<td>Medicare Care Choices Award</td>
<td>Medicare IVIG Demonstration</td>
<td>Partnership for Patients</td>
</tr>
</tbody>
</table>
Experimenting with Bundled Payments

6,635 Entities
Oncology Care Model Key Facts

- Will start in 2016
- Length of the program is 5 years
- Episodes are 6 months of chemotherapy care
- Other payers and state agencies can participate
- Includes Part A, B and some D services
- Includes nearly all cancers
- One sided and two sided available (year 3)
- Quality Metrics are defined
- Financing includes a shared savings as well as a PBPM
Outpatient Bundling

- Referred to by CMS as: "Comprehensive Ambulatory Payment Classification (APC)"
- Finalized in the CY 2014 OPPS/ASC Final Rule
- Affect payments to 4,000 hospitals and 5,300 ASC’s
- Grouped 200+ APCs into 25
- Delayed implementation to January 1, 2015
Comprehensive Care for Joint Replacement Model

*Proposed July 2015 to be effective January 1, 2016*

- 5 year program
- Mandatory bundle for DRG 469 and 470 for 75 MSAs
- Hospital based vs. physician based or post acute
- Phase in the risk over the 5 year period up to 2%
- Any existing voluntary bundles remain in place
- Retrospective settlement on annual basis
<table>
<thead>
<tr>
<th>1</th>
<th>Bundled payment for lower extremity joint replacement (LEJR) procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>CCJR is <strong>mandatory</strong> in 75 selected geographies</td>
</tr>
<tr>
<td>3</td>
<td>Medicare chose LEJR intentionally</td>
</tr>
<tr>
<td>4</td>
<td>CCJR only applies to Medicare FFS beneficiaries</td>
</tr>
<tr>
<td>5</td>
<td>CCJR is a <strong>5-year program</strong> for CY 2016-2020</td>
</tr>
<tr>
<td>6</td>
<td>The bundle includes IP stay and 90-days post-discharge</td>
</tr>
<tr>
<td>7</td>
<td>Hospitals can share risk with physicians, PAC providers, etc.</td>
</tr>
<tr>
<td>8</td>
<td>Bundles are <strong>retrospective</strong> not prospective; revenue cycle is not impacted</td>
</tr>
<tr>
<td>9</td>
<td>Hospitals can earn <strong>bonuses or face repayment penalties in CCJR</strong></td>
</tr>
<tr>
<td>10</td>
<td>There is common misunderstanding about typical episodes</td>
</tr>
<tr>
<td>11</td>
<td>CCJR requires acceptable performance on three (3) pre-determined <strong>quality measures</strong></td>
</tr>
<tr>
<td>12</td>
<td>CCJR will <strong>indirectly affect post-acute care</strong> providers significantly</td>
</tr>
</tbody>
</table>
CCJR is mandatory in selected geographies

- Medicare used a two-part randomization process to select 75 MSAs for participation.
- IPPS hospitals in the selected MSAs are **required** to participate in CCJR.
- MSAs selected in 35 states.
- Only exceptions are:
  - BPCI Phase 2 LEJR hospitals
  - Non-IPPS hospitals
  - Maryland hospitals
Why did Medicare Choose LEJR?

Average Episode Payments and Total Population in Selected MSAs

$11,500 Variation in participating MSAs

2010 Census Population

Average Episode Payments

Medford, OR: $21,573

Miami-Fort Lauderdale-West Palm Beach, FL: $33,072
CCJR Quality Measures – Minimum Thresholds

- These quality measures are already collected, and would simply be applied to CCJR.
- Hospitals must meet the 30th or 40th percentile (depending on performance year) on all three measures to qualify for gain distribution from Medicare.
- Voluntary reporting on patient outcomes – separate from these three (3) measures – reduces the Medicare discount from 2.0% to 1.7%.

**Hospital-level 30-day, all-cause RSRR following elective primary THA and/or TKA**

**Hospital-level RSCR following elective primary THA and/or TKA**

**HCAHPS Survey measure**
Why Hospitals Should Pay Attention

1. Major financial consequences
2. Important orthopedic alignment opportunity
3. This is the warning shot... expect more!
4. Claims data is absurdly complex; almost exclusively outsourced
5. 75% of hospitals have no experience with episodic payments of this nature
6. Significant technical details that impact each market differently
ENTERPRISE INTELLIGENCE FOR THE RISK CAPABLE ORGANIZATION
The Business Intelligence Journey to Risk Capable

enterprise intelligence

revenue transformation

clinical enterprise maturity

FFS Reimbursement Reductions
Penalty Avoidance and Pay for Performance
Bundled Payment (BPCI)
Capitation, Shared Savings (MSSP)
Now, NOT Later

1. **FFS Reimbursement Reductions**
   - Every Provider
     - Need for Cost Variance Tools and Growth Strategies

2. **Penalty Avoidance and Pay for Performance**
   - Every Provider
     - Pay Minimization Tools, VBP Metrics

3. **Bundled Payment (BPCI)**
   - 6000+ BPCI Applicants
     - Tennessee Medicaid Bundling
     - Post Acute Planning

4. **Capitation, Shared Savings (MSSP)**
   - Alabama Hospitals
     - Reacting to Capitated Medicaid
     - Preparing to Accept PMPM Payment
Think and Act “Outside the Box”

Traditional Capabilities

- Connection and Integration
- Health Exchange Participation
- Revenue Cycle
- Cost Reduction/Mgmt.
- Clinical Processes/Paths
- MD Practice Mgmt.
- Quality Measurement/Reporting
- Electronic Health Records
- Departmental Analytics
- Patient Information and Mgmt.
- Financial Information and Mgmt.
- Internal IT/Platforms/Systems

+ Emerging “Enterprise Intelligence”

- Population Health Mgmt.
- Claims Data Mining
- Medicaid Alternative Payment
- Strategic Growth Assessment
- Gain Sharing/Funds Flow
- Physician Spend Performance
- Post Acute Provider Performance
- Cost Variation against Outcomes
- CMS Alternative Payment Mgmt.
- CMS Alternative Payment Modeling
- CMS Public/Private Datasets
- CMS Penalties/Performance
# Bundled Payments

<table>
<thead>
<tr>
<th>MODEL NAME</th>
<th>MODEL 1</th>
<th>MODEL 2</th>
<th>MODEL 3</th>
<th>MODEL 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Retrospective Acute Care Hospital Stay Only</td>
<td>Retrospective Acute Care Hospital Stay plus Post-Acute Care</td>
<td>Retrospective Post-Acute Care Only</td>
<td>Acute Care Hospital Stay Only</td>
</tr>
<tr>
<td>SCOPE OF EPISODES</td>
<td>Entire Hospital</td>
<td>Up to 48 Episodes</td>
<td>Up to 48 Episodes</td>
<td>Up to 48 Episodes</td>
</tr>
<tr>
<td>SERVICES INCLUDED IN EPISODES</td>
<td>All Part A services paid as part of the MSDRG Payment</td>
<td>All non-hospice Part A and B services during the initial inpatient stay, post-acute period and readmissions</td>
<td>All non-hospice Part A and B services during the post-acute period and readmissions</td>
<td>All non-hospice Part A and B services (including the hospital and physician) during initial inpatient stay and readmissions</td>
</tr>
<tr>
<td>PAYMENT</td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Prospective</td>
</tr>
<tr>
<td>BPCI DISCOUNT</td>
<td>0.5%, and increasing over time</td>
<td>2-3%</td>
<td>3%</td>
<td>3-3.25%</td>
</tr>
<tr>
<td>NUMBER OF ADMITTED BPCI HEALTHCARE ORGANIZATIONS AS OF 7/31/14</td>
<td>19</td>
<td>2,055</td>
<td>4,534</td>
<td>17</td>
</tr>
</tbody>
</table>

![Diagram of healthcare journey](image)
## Bundled Payment for Care Improvement (BPCI) Tools

### BUNDLED PAYMENT FOR CARE IMPROVEMENT (BPCI) TOOLS

<table>
<thead>
<tr>
<th>ANALYTICS TOOL</th>
<th>PURPOSE</th>
<th>BPCI STAGE</th>
<th>CMS DATA FILE</th>
<th>DATA PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Application Analytics</td>
<td>Identify BPCI Episode Potential - Volume, Cost Variation, Readmission</td>
<td>Explore</td>
<td>CMS Standard Analytical Files (SAF)</td>
<td>2010-2013</td>
</tr>
<tr>
<td>Precedence Profile</td>
<td>Identify Precedence Strategies, Competitive Activity, Potential Partners</td>
<td>Define</td>
<td>CMS Applicant File</td>
<td>as of March 2015</td>
</tr>
<tr>
<td>Episode &amp; Network Modeler</td>
<td>Select Episodes, MD and PAC Network Intelligence, Risk Track Selection, Go/No Go Decision Support</td>
<td>Optimize</td>
<td>CMS BPCI “Baseline Files” (19)</td>
<td>2009-2012</td>
</tr>
<tr>
<td>Episode Performance Estimator</td>
<td>Models Recent Monthly Data to Estimate Phase I Episode Performance vs. Target Price</td>
<td>Explore</td>
<td>CMS BPCI “Monthly Files”</td>
<td>Most recent 14 months</td>
</tr>
<tr>
<td>BPCI Monthly Manager</td>
<td>Monthly Mgmt of Episodes, Network Monitoring, Reconciliation Gaps, Episode Drilldown Capability</td>
<td>Define</td>
<td>CMS BPCI “Monthly Files”</td>
<td>Most recent 14 months</td>
</tr>
</tbody>
</table>

**LEGEND:**  
- [ ] Critical to Success  
- [ ] Optional
Target Price is Not Enough ....

CMS 2009-2012 Claims Data

CMS Monthly Claims Data

Baseline
Target Price

Trend Factors Applied

Current Performance vs. Target Price
How do you ‘WIN’ in BPCI?
Initial focus may be in two areas of spending that make the greatest difference: readmissions and post acute care settings.
Two Types of Gain Sharing

Net Payment Reconciliation Amount

- Medicare Spend Reduction

Internal Cost Savings

- Hospital Expense Reduction
Questions That Data Will Help Answer

1. Who else in our market is doing Bundled Payments?
2. Where are Beneficiaries/Patients going after leaving our facility?
3. How can we reduce utilization of services and prevent bad stuff from happening during the period of our responsibility?
4. How can we engage and integrate other providers to work with us on our bundled payment?
5. What does the financial model look like? Regardless of financial gain/loss, what value do we place on learning and development?
Who else in our market is doing Bundled Payments?

Encourages early adoption, broad implementation, and partnerships between various providers.
Precedence Will Matter

One Market as An Example

BPCI Experience
14 Hospitals/ 3 “Live”
1 Ortho Group (MD) “Live”
40 Pacs/2 “Live”

Any of these could take “precedence” over CCJR so an understanding of the local market is necessary to confirm CCJR opportunity/risk
What Do I Learn from Effective Analytics?

BPCI Monthly Manager
Name of Hospital Here
Time Period: January 2014- February 2015

Episode Name:
Major Joint Replacement Of The Lower Extremity

Represented DRGs: 469, 470

Navigation Buttons:
- Target Price Monitoring
- Operating Physician Summary
- PAC Physician - Discharge Trends
- Attending Physician Summary
- Discharge Trends - First PAC Setting
- Care Pathways
- Post Acute Care Summary
- Readmission Summary
- Readmission Detail
- Complete Episode Drilldown
- Incomplete Episode Drilldown

<table>
<thead>
<tr>
<th>DRG</th>
<th>DRG Description</th>
<th># of Episodes Completed</th>
<th># of Complete Episodes</th>
<th># of Incomplete Episodes</th>
<th>Unadjusted Spend</th>
<th>Unadjusted Spend Risk Track II</th>
<th>Estimated Target Price Risk Track II</th>
<th># of Complete Episodes with Estimated Profit</th>
<th># of Complete Episodes with Estimated Loss</th>
<th>Average Estimated Profit/loss</th>
<th>Total Estimated Profit/loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>469</td>
<td>Major joint replacement or reattachment of lower extremity w MCC</td>
<td>12</td>
<td>5</td>
<td>4</td>
<td>48,465</td>
<td>47,795</td>
<td>48,765</td>
<td>12</td>
<td>5</td>
<td>970</td>
<td>16,488</td>
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<tr>
<td>470</td>
<td>Major joint replacement or reattachment of lower extremity w/o MCC</td>
<td>123</td>
<td>55</td>
<td>62</td>
<td>28,328</td>
<td>27,444</td>
<td>27,369</td>
<td>122</td>
<td>62</td>
<td>(175)</td>
<td>32,128</td>
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</table>
### Readmission Detail

#### Percentage of Readmissions by Facility

#### Readmission Spend by Facility

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<tr>
<th>Episode Number</th>
<th>Anchor DRG</th>
<th>Type of Claim</th>
<th>Provider Name</th>
<th>Medicare ID Number</th>
<th>Begin Date</th>
<th>End Date</th>
<th>Readmitting DRG</th>
<th>Beneficiary HIC Number</th>
<th>Payment Amount</th>
<th>Anchor Begin</th>
<th>Day of Episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>3390-T40000000000001</td>
<td>470</td>
<td>Acute Care Hospital</td>
<td>Acute 1</td>
<td>943456</td>
<td>01-01-2023</td>
<td>01-31-2023</td>
<td>04-01-2023</td>
<td>17-01-2023</td>
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<td>12-31-2023</td>
<td>12-31-2023</td>
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<tr>
<td>3390-T40000000000001</td>
<td>470</td>
<td>Acute Care Hospital</td>
<td>Acute 2</td>
<td>943456</td>
<td>01-01-2023</td>
<td>01-31-2023</td>
<td>04-01-2023</td>
<td>17-01-2023</td>
<td>2500</td>
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<td>470</td>
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<td>470</td>
<td>Acute Care Hospital</td>
<td>Acute 2</td>
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<td>04-01-2023</td>
<td>17-01-2023</td>
<td>2500</td>
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</tr>
<tr>
<td>3390-T40000000000001</td>
<td>470</td>
<td>Acute Care Hospital</td>
<td>Acute 2</td>
<td>943456</td>
<td>01-01-2023</td>
<td>01-31-2023</td>
<td>04-01-2023</td>
<td>17-01-2023</td>
<td>2500</td>
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<tr>
<td>3390-T40000000000001</td>
<td>470</td>
<td>Acute Care Hospital</td>
<td>Acute 2</td>
<td>943456</td>
<td>01-01-2023</td>
<td>01-31-2023</td>
<td>04-01-2023</td>
<td>17-01-2023</td>
<td>2500</td>
<td>12-31-2023</td>
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<tr>
<td>3390-T40000000000001</td>
<td>470</td>
<td>Acute Care Hospital</td>
<td>Acute 2</td>
<td>943456</td>
<td>01-01-2023</td>
<td>01-31-2023</td>
<td>04-01-2023</td>
<td>17-01-2023</td>
<td>2500</td>
<td>12-31-2023</td>
<td>12-31-2023</td>
</tr>
<tr>
<td>3390-T40000000000001</td>
<td>470</td>
<td>Acute Care Hospital</td>
<td>Acute 2</td>
<td>943456</td>
<td>01-01-2023</td>
<td>01-31-2023</td>
<td>04-01-2023</td>
<td>17-01-2023</td>
<td>2500</td>
<td>12-31-2023</td>
<td>12-31-2023</td>
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<td>3390-T40000000000001</td>
<td>470</td>
<td>Acute Care Hospital</td>
<td>Acute 2</td>
<td>943456</td>
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<td>01-31-2023</td>
<td>04-01-2023</td>
<td>17-01-2023</td>
<td>2500</td>
<td>12-31-2023</td>
<td>12-31-2023</td>
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<td>470</td>
<td>Acute Care Hospital</td>
<td>Acute 2</td>
<td>943456</td>
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<td>01-31-2023</td>
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<td>17-01-2023</td>
<td>2500</td>
<td>12-31-2023</td>
<td>12-31-2023</td>
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</tbody>
</table>
Readmission Detail

Target Price Monitoring
Major Joint Replacement Of The Lower Extremity
DRGs: 469, 470

Navigation:
Operator Physician Summary

Target Price Monitoring
Average Adjusted Spend by Episode

- Estimated Target Price Risk Track B

<table>
<thead>
<tr>
<th>Month</th>
<th>DRG</th>
<th># of Episodes Completed</th>
<th># of Complete Episodes Awaiting Runout</th>
<th># of Incomplete Episodes</th>
<th>Unadjusted Spend</th>
<th>Adjusted Episode Spend Risk Track B</th>
<th>Estimated Target Price Risk Track B</th>
<th># of Complete Episodes with Estimated Profit</th>
<th># of Complete Episodes with Estimated Loss</th>
<th>Average Estimated Profit/Loss</th>
<th>Total Estimated Profit/Loss</th>
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</thead>
<tbody>
<tr>
<td>Total</td>
<td>470</td>
<td>129</td>
<td>55</td>
<td>62</td>
<td>$28,328</td>
<td>$27,444</td>
<td>$27,269</td>
<td>122</td>
<td>62</td>
<td>$ (175)</td>
<td>$ (32,128)</td>
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<tr>
<td>JAN2014</td>
<td>470</td>
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<td>-</td>
<td>-</td>
<td>$32,554</td>
<td>$30,520</td>
<td>$27,269</td>
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<td>9</td>
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<td>$(68,262)</td>
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<td>FEB2014</td>
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<td>-</td>
<td>$27,654</td>
<td>$27,101</td>
<td>$27,269</td>
<td>10</td>
<td>5</td>
<td>$ 168</td>
<td>$ 2,519</td>
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<tr>
<td>MAR2014</td>
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<td>16</td>
<td>-</td>
<td>-</td>
<td>$28,414</td>
<td>$27,613</td>
<td>$27,269</td>
<td>10</td>
<td>6</td>
<td>$ (344)</td>
<td>$(5,503)</td>
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</table>
Target Price Monitoring

Operating Physician Summary
Major Joint Replacement Of The Lower Extremity
DRGs: 469, 470

Operating Physician Summary

Average Adjusted Spend by Operating Physician

<table>
<thead>
<tr>
<th>Physician</th>
<th>Total Complete Episode Count</th>
<th>Unadjusted Spend</th>
<th>Adjusted Episode Spend Risk Track B</th>
<th>Average Estimated Profit/Loss</th>
<th>Total Estimated Profit/Loss</th>
<th>Unadjusted Spend</th>
<th>Adjusted Episode Spend Risk Track B</th>
<th>Readmit %</th>
<th>Incremental Cost of Readmit</th>
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</thead>
<tbody>
<tr>
<td>CP Phy 16</td>
<td>82</td>
<td>$26,856</td>
<td>$26,154</td>
<td>$1,015</td>
<td>$62,918</td>
<td>$25,147</td>
<td>$25,068</td>
<td>4.8%</td>
<td>140.4%</td>
</tr>
<tr>
<td>CP Phy 4</td>
<td>19</td>
<td>$25,024</td>
<td>$27,958</td>
<td>$729</td>
<td>$21,142</td>
<td>$28,119</td>
<td>$27,239</td>
<td>10.3%</td>
<td>27.6%</td>
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<tr>
<td>CP Phy 13</td>
<td>25</td>
<td>$23,507</td>
<td>$23,507</td>
<td>$3,762</td>
<td>$94,089</td>
<td>$23,507</td>
<td>$23,507</td>
<td>0.0%</td>
<td>0.0%</td>
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<tr>
<td>CP Phy 8</td>
<td>23</td>
<td>$30,830</td>
<td>$25,458</td>
<td>$1,169</td>
<td>$49,881</td>
<td>$28,833</td>
<td>$27,586</td>
<td>13.0%</td>
<td>51.7%</td>
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<tr>
<td>CP Phy 12</td>
<td>22</td>
<td>$31,307</td>
<td>$26,557</td>
<td>$1,288</td>
<td>$12,884</td>
<td>$27,108</td>
<td>$25,266</td>
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<td>77.4%</td>
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<tr>
<td>CP Phy 5</td>
<td>11</td>
<td>$32,460</td>
<td>$31,041</td>
<td>$3,772</td>
<td>$37,720</td>
<td>$27,616</td>
<td>$27,616</td>
<td>30.0%</td>
<td>58.5%</td>
</tr>
</tbody>
</table>
### Discharge Trends

Acute Readmission, SNF, IRF, LTCH (if within 3 days of index PAC stay), HHA (if within 14 days of index PAC stay), also "Home"

![Discharge Trends Chart]

### First PAC Setting - SNF Summary

<table>
<thead>
<tr>
<th>DRG</th>
<th>Provider Name</th>
<th>Complete Episode Count</th>
<th>ALOS</th>
<th>Readmit Rate</th>
<th>Unadjusted Spend - First PAC</th>
<th>Unadjusted Spend Variation From Average</th>
<th>Unadjusted Spend - Episode Total</th>
<th>Adjusted Episode Spend Risk Track B</th>
<th>Estimated Target Price Risk Track B</th>
<th>Average Estimated Profit/Loss</th>
<th>Total Estimated Profit/Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>470</td>
<td>Total</td>
<td>107</td>
<td>23.4</td>
<td>12.1%</td>
<td>$13,606</td>
<td>$24,279</td>
<td>$22,759</td>
<td>$27,269</td>
<td>$6,490</td>
<td>$(-587,280)</td>
<td></td>
</tr>
<tr>
<td>470</td>
<td>First Pac 22</td>
<td>32</td>
<td>25.6</td>
<td>3.1%</td>
<td>$14,492</td>
<td>$31,071</td>
<td>$32,728</td>
<td>$27,269</td>
<td>$5,449</td>
<td>$(-174,394)</td>
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<tr>
<td>470</td>
<td>First Pac 27</td>
<td>20</td>
<td>14.8</td>
<td>20.0%</td>
<td>$7,108</td>
<td>$29,576</td>
<td>$28,955</td>
<td>$27,269</td>
<td>$1,466</td>
<td>$(-53,926)</td>
<td></td>
</tr>
<tr>
<td>470</td>
<td>First Pac 24</td>
<td>13</td>
<td>25.2</td>
<td>23.1%</td>
<td>$14,559</td>
<td>$1,953</td>
<td>$41,011</td>
<td>$30,247</td>
<td>$27,269</td>
<td>$(-10,478)</td>
<td>$(-142,710)</td>
</tr>
</tbody>
</table>
Definition: PHM programs are a set of interventions designed to **maintain and improve people’s health** across the full continuum of care—from low-risk, healthy individuals to high-risk individuals with one or more chronic conditions.
Intelligent Things To Do Tomorrow
6 Things Every Provider Should Do Tomorrow

1. Inventory of current at risk contracts or models under discussion and analytics capabilities that have been deployed in these to date.

2. Focus on biggest and highest value opportunities first, these may very well be “outside the box”.

3. Assessment of current internal and external capabilities for enterprise intelligence. Narrow outsourcing to analytic resources, not care delivery or continuum management which will be a necessary core competency.

4. Process/Procedure for coordination of data/finance/clinical to be sure all are current with initiatives, assigning clear ownership and accountability.

5. Assess your options and accelerate a CMS alternative payment pilot to get in the game. This may involve joining in with a partner.

6. Accelerate care continuum thinking – it will matter.
Edward Stall, Principal

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