Key Success Factors for the CMMI Bundled Payments for Care Improvement Initiative

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We will focus on data driven decision making to succeed with the CMMI initiative

- **Bundle definition**
  - It is your contract with CMS
  - Financial and clinical consideration

- **Appropriate allocation of risk**
  - Probability event
  - Severity event
  - Control of waste

- **Understanding variation**
  - Patient factors
  - Potentially avoidable complications
  - The right care for every individual patient, in the right setting, at the right cost, but no more or less care
Bundle definition

Quantitative consideration must be made to . . .

• Providers and scope of services to be bundled based on historical data and clinical definitions
• Duration of episodes - ability to manage technical risk
• Identification of patient population
• Identification of avoidable events by service type, location, timing, provider
• Use of clinical protocols and quality of care standards
• Cost and reimbursement
• Safeguards for under utilization
• Evaluate the impact of volume – budget sensitivity to sample size can unduly put providers at risk
A well defined bundle will reduce risk
Analysis to determine optimal risk while delivering the right care

Comparison of Episode Payment by Percentiles: THKR1
All

<table>
<thead>
<tr>
<th>Percentiles</th>
<th>Mean Episode Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>10th</td>
<td>$30,000</td>
</tr>
<tr>
<td>20th</td>
<td>$25,000</td>
</tr>
<tr>
<td>30th</td>
<td>$20,000</td>
</tr>
<tr>
<td>40th</td>
<td>$15,000</td>
</tr>
<tr>
<td>50th</td>
<td>$10,000</td>
</tr>
<tr>
<td>60th</td>
<td>$5,000</td>
</tr>
<tr>
<td>70th</td>
<td>$0</td>
</tr>
<tr>
<td>80th</td>
<td>$20,000</td>
</tr>
<tr>
<td>90th</td>
<td>$30,000</td>
</tr>
<tr>
<td>100th</td>
<td>$30,000</td>
</tr>
</tbody>
</table>

- 30 D w/o exclusion
- 30 D w/ exclusion
Key to reduce cost is to control readmissions

Under a bundled payment not every readmission is created equal
Location, Location, Location

**Episode Payment by Type of Discharge: THKR1 All**

- Discharge to Home
- Discharge to HHA
- Discharge to SNF
- Discharge to IRF/LTCH
- Transfer to acute IP
- Other Discharges

<table>
<thead>
<tr>
<th>Discharge Type</th>
<th>Mean Episode Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$20,000</td>
</tr>
<tr>
<td>$40,000</td>
<td>$60,000</td>
</tr>
</tbody>
</table>

**Readmission Rate by Type of Discharge: THKR1 All**

- Discharge to Home
- Discharge to HHA
- Discharge to SNF
- Discharge to IRF/LTCH
- Transfer to acute IP
- Other Discharges

<table>
<thead>
<tr>
<th>Discharge Type</th>
<th>Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>5%</td>
</tr>
<tr>
<td>10%</td>
<td>15%</td>
</tr>
</tbody>
</table>

**ER by Type of Discharge: THKR1 All**

- Discharge to Home
- Discharge to HHA
- Discharge to SNF
- Discharge to IRF/LTCH
- Transfer to acute IP
- Other Discharges

<table>
<thead>
<tr>
<th>Discharge Type</th>
<th>% of Patients with ER visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>5%</td>
</tr>
<tr>
<td>10%</td>
<td>15%</td>
</tr>
</tbody>
</table>

**Complications by Type of Discharge: THKR1 All**

- Discharge to Home
- Discharge to HHA
- Discharge to SNF
- Discharge to IRF/LTCH
- Transfer to acute IP
- Other Discharges

<table>
<thead>
<tr>
<th>Discharge Type</th>
<th>% of Patients with Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>20%</td>
</tr>
<tr>
<td>40%</td>
<td>60%</td>
</tr>
</tbody>
</table>
80-20 Rule applies to reducing complications
Also helps to focus to where it matters

<table>
<thead>
<tr>
<th>Claim Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INDEX CONDITION RELATED COMPLICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute posthemorrhagic anemia</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TYPE 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exploratory Lap for peritonitis, perforation, leak, obstructive</td>
</tr>
<tr>
<td>Complication of implanted device, graft</td>
</tr>
<tr>
<td>Coma; stupor; and brain damage</td>
</tr>
<tr>
<td>Skin and subcutaneous tissue infections</td>
</tr>
<tr>
<td>Bacterial infection; unspecified site</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COMPLICATIONS DUE TO COMORBID CONDITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urinary Tract Infections</td>
</tr>
<tr>
<td>Respiratory Failure, respiratory Insufficiency</td>
</tr>
<tr>
<td>Acute Renal Failure</td>
</tr>
<tr>
<td>Pneumonia (except that caused by TB or STD)</td>
</tr>
<tr>
<td>Delirium</td>
</tr>
<tr>
<td>Syncope, Hypotension, Dizziness</td>
</tr>
<tr>
<td>Aspiration pneumonitis; food/vomitus</td>
</tr>
<tr>
<td>Postoperative shock, sepsis</td>
</tr>
<tr>
<td>Gastrointestinal hemorrhage</td>
</tr>
<tr>
<td>Diabetic Emergency, Hypo- Hyper-glycemia</td>
</tr>
<tr>
<td>Shock, cardiac arrest, ventricular fibrillation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TYPE 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combinations of surgical procedures or medical care</td>
</tr>
<tr>
<td>Adverse effects of drugs, overdose, poisoning</td>
</tr>
<tr>
<td>E Codes: Adverse effects of medical care</td>
</tr>
<tr>
<td>Deep Vein Thrombosis and Pulmonary Embolism following surgery or trauma</td>
</tr>
<tr>
<td>Fall and trauma</td>
</tr>
<tr>
<td>Septicemia</td>
</tr>
<tr>
<td>Decubitus Ulcer, Gangrene, Arterial Thrombosis</td>
</tr>
<tr>
<td>Catheter Associated Urinary Tract Infections (UTI)</td>
</tr>
<tr>
<td>Deep Vein Thrombosis (DVT) / Pulmonary Embolism (PE)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TYPE 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse effect of drugs</td>
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- **Type 1**
  - Acute post hemorrhagic anemia
  - Best controlled by treating provider
- **Type 2**
  - Urinary Track Infection
  - Best controlled by care-coordination
- **Type 3**
  - Adverse effect of drugs
  - Best controlled by process improvement
Post acute care claims breakdown by diagnosis code can provide helpful clues where to focus
Have a clear understanding of savings opportunity

Break-Even Analysis

![Image of graph showing HIPKNEE_470 Net Savings per Patient by Cost Reduction from Potential Saving Opportunities]

- **ACUTE + 30 DAYS**
- **ACUTE + 60 DAYS**
- **ACUTE + 90 DAYS**
Gain insights to inform gain sharing opportunity

Part B Specialty Analytics

Part B Professional Payment by Physician Specialty: THKRS 469

- Acute Care
- Post 1-30 days

Mean Episode Payment

- General Practice
- Physical...
- Nephrology
- Diagnostic...
- Pulmonary...
- Cardiology
- Family Practice
- Anesthesiology
- Internal Medicine
- Orthopedic...
Winners will master five areas of capability

- Rationalized cost and resource consumption:
  Minimal cost and utilization of materials, services, labor, and capital

- Fee-for-Value transition:
  Negotiation, collection, allocation across multiple reimbursement types

- Aligned care delivery:
  System-wide alignment of care based on standard protocols, measured and monitored through advanced analytics

- Reinvention through technology:
  Actionable insight from consolidated real-time data used in retroactive, bedside, and predictive analytical tools

- Consumer health engagement:
  Services and tools to expand provider-patient relationship and continuously manage patient care
Healthcare’s challenge: Mass customization
...an infinitely more complex challenge than any previous industry has faced

To improve quality, Healthcare must mass customize across an extraordinarily broad set of patients
A different level of execution and customization is required to succeed in tomorrow’s healthcare industry
Variance: Client example

Hospitals within the same IDN can see more than a 2x range in costs for the same DRG

Average variable cost per case ($/case)
Congestive Heart Failure (~5,000 cases in 2011)

Hospital #1: 3,908
Hospital #2: 3,897
Hospital #3: 5,598
Hospital #4: 5,105
Hospital #5: 4,183
Hospital #6: 2,520
Hospital #7: 2,991
Hospital #8: 3,277
Hospital #9: 4,844
Hospital #10: +122%

All constituents must know why this gap is true
$XX total cost reduction if all hospitals operated at costs of lowest member

$XX total cost reduction if all hospitals operated at costs of lowest member
Assess where you are and define a roadmap to get there

The Five Levels of Healthcare Population Health Capability

<table>
<thead>
<tr>
<th>PHC Level I</th>
<th>PHC Level II</th>
<th>PHC Level III</th>
<th>PHC Level IV</th>
<th>PHC Level V</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1.png" alt="Image" /></td>
<td><img src="image2.png" alt="Image" /></td>
<td><img src="image3.png" alt="Image" /></td>
<td><img src="image4.png" alt="Image" /></td>
<td><img src="image5.png" alt="Image" /></td>
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</table>

**A Health Ecosystem has achieved Level I Capability when:**
- Standard Fee-for-Service based delivery model without alignment across delivery channels
- Treatment protocols, supplies and costs across all care delivery channels not agreed upon with all physicians, clinicians, and materials managers
- Technology within each delivery channel based on stand alone cost/reimbursement within each entity
- Basic passive patient outreach efforts to influence population health behaviors

**A Health Ecosystem has achieved Level II Capability when:**
- Preliminary integration across delivery channels
- Utilization reduced through targeted PPI, service line cost, and procurement reductions
- Basic incentives for physicians/providers, risk-based contracting & value based purchasing
- Treatment protocols and supply usage standard across 99% of physician/provider
- System integration of clinical/Ops/financial data
- Targeted patient outreach efforts & risk pool stratification

**A Health Ecosystem has achieved Level III Capability when:**
- All key delivery channels integrated across the care continuum for cost & transitions of care
- Ability to track costs and quality delivery across delivery channels for an entire health delivery event
- Transitions of care fully monitored & managed across delivery channels
- Systems integration of Clinical/Ops/Financial data to enable basic Fee-for-Value tool deployment
- Ability to manage post-discharge compliance, readmission, and home monitoring capabilities

**A Health Ecosystem has achieved Level IV Capability when:**
- Cost/Utilization optimization across all delivery channels & shared Admin services
- Ability to offer/conduct basic capitation/ PMPM payment for services through direct employer contracting for membership
- Ability to manage overall referral/discharge/follow-up continuous care tracking and feedback
- Ability to track and manage all informatics across all delivery channels
- Ability and governance model for community/employer wide wellness

**A Health Ecosystem has achieved Level V Capability when:**
- Ability to manage a PMPM cost & reimbursement model across delivery channels
- Ability to manage a fully capable insurance offering for members across geographies
- Clinicians across all delivery channels fully aligned and incented to total cost & quality management
- Full integration of all clinical/Ops/Financial systems to drive a profitable insurance offering
- Fully engaged community/population in their own health & cost improvement

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"Fee for Service" -- "Fee for Value" -- "Per Member Per Month"
Each provider is currently at a different level of capability and preparation – all must advance, not all are ready.

A few, like IHC, Kaiser, & Geisinger might currently be a “6 or 7”

Most Providers in the Industry are “2” or “3” on a Scale of 10
Contact Information

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