Implementing Bundled Payments Plan-wide

June 11th 2013

Agenda

- Introductions
- Contracting For Bundles
  - Upside and Downside
  - Risk Sharing Between Providers
- Operations And Claims Payments
  - Defining Budgets
  - Reconciling Actual to Budget
  - Reporting
- Engaging The Consumer

Introductions

- Elaine Daniels, Senior Strategic Network Consultant, Blue Cross Blue Shield of North Carolina
- Lili Brillstein, Director, Episodes of Care, Horizon Healthcare Innovations, Horizon Blue Cross Blue Shield of New Jersey
- Jennifer Winchester, Senior Director, Provider Network Innovations and Partnerships, Blue Cross Blue Shield of South Carolina

Bundled Payment Implementation

Elaine Daniels
Sr. Strategic Network Consultant

BlueCross BlueShield of North Carolina

BCBSNC At a Glance

- North Carolina's Largest Health Insurer
  - 3.7 Million Customers
    - 900,000 On behalf of other Blues Plans
- Predominantly PPO
  - Virtually All Providers Participate in PPO Network
    - 98% of Medical Claims paid as In-Network

Episodic Bundled Payment Goal

Goal

Implement a program that will improve the quality and reduce the total cost of care associated with an episode of care

Improve Quality

- Reduce Potentially Avoidable Complications (PAC) Rates as defined by the PROMETHEUS algorithm for episode
- Achieve national benchmark performance levels for surgical care
- Achieve targeted performance levels on patient satisfaction metrics
- Achieve benchmark results based on provider-identified outcome measures

Decrease Medical Costs

- Reduce PAC rates while creating Patient Care Efficiencies through process improvement :
  - Establish episodic care team consisting of key hospital staff, surgeon (as necessary), and anesthesiologist that will develop care efficiencies through surgical team setup and process standardization based on evidence based clinical guidelines
  - Establishment of a negotiated episodic payment budget that promotes coordination of care and efficiency and leads to reduction in PAC events

Reconciliation is performed by reviewing and consolidating all claims from episodic care team providers on a member/patient specific basis. Claims consolidation is then compared to the episodic payment budget (or Evidence-informed Case Rate : ECR), at which time any over/underpayments are reconciled.

Historical Bundling Perspective

- Three bundled episodes to-date with different partners in NC
- Total knee/hip replacements selected as early models
  - Two highest cost drivers among orthopedic episodes
  - Operationally feasible to manage internally
- Do not use severity adjustments on bundles
- All contracts include upside/downside risk for providers

Contracting

BCBSNC Contracting Process

- Providers have historically approached BCBSNC to participate
- BCBSNC obtains buy-in from a senior level of each organization
- BCBSNC performs the initial analysis and shares the results with the providers
- BCBSNC shares the data to help the providers validate findings
- BCBSNC and provider work together to develop quality metrics

Contracting Process

Engagement

- Providers have historically approached BCBSNC to participate
- BCBSNC obtains buy-in from a senior level of each organization to identify the preferred path forward
- BCBSNC plans to improve its outreach to providers regarding participation in bundles

Contracting Process

Analysis

- Analyze claims for the procedure during a two year look back period using the procedure-specific PROMETHEUS payment methodology
  - Cost
  - Utilization
  - Leakage to facilities/providers outside of bundle
  - Regional trends
  - Operational feasibility

Contracting Process

Data Sharing

- Following analysis, BCBSNC shares the data with financials masked to help the providers validate findings, provide context
  - Gives providers opportunity to see utilization and performance relative to peers
  - Offers unique opportunity to see holistic data
  - Access to data throughout relationship is powerful incentive for participation

Contracting Process

Quality Metric Development

- BCBSNC and provider work together to develop quality metrics and reporting for episode.
  - Based on best practices and evidence-based practices identified by BCBSNC clinicians and provider group
  - Quality measures are negotiated and listed in contract
  - Quality progress reported on negotiated timeline
- Examples of quality measures used:
  - Reduction of members who experience potentially avoidable complications
  - HCAHPS measures
  - CMS Surgical Care Improvement Project (SCIP) metrics
  - Mutually agreed upon outcome measures

Contracting Process

Rate Development & Contracting

- The ECR determines services that are considered typical and services that are considered as potentially avoidable complications (PACs) for each episode
  - The episode may be defined as any related service starting thirty (30) days prior to the surgery and ending ninety (90) days after the discharge date
  - Services included in the episode:
    - All pre-op tests and office visits
    - All services occurring at the inpatient stay, including physical therapy and care related to complications
    - All related services performed on an outpatient basis. This includes physical therapy and care required due to complications
- Historically, all BCBSNC's bundles have included upside/downside risk for providers
- Negotiate the bundled payment budget, timing for payment based on ECR analysis and operational feasibility

Past Contracting Models:
Model 1- Total Knee Replacement

Hospital/Facility

Hospital Contract

BlueCross BlueShield of North Carolina

Orthopedic Contract

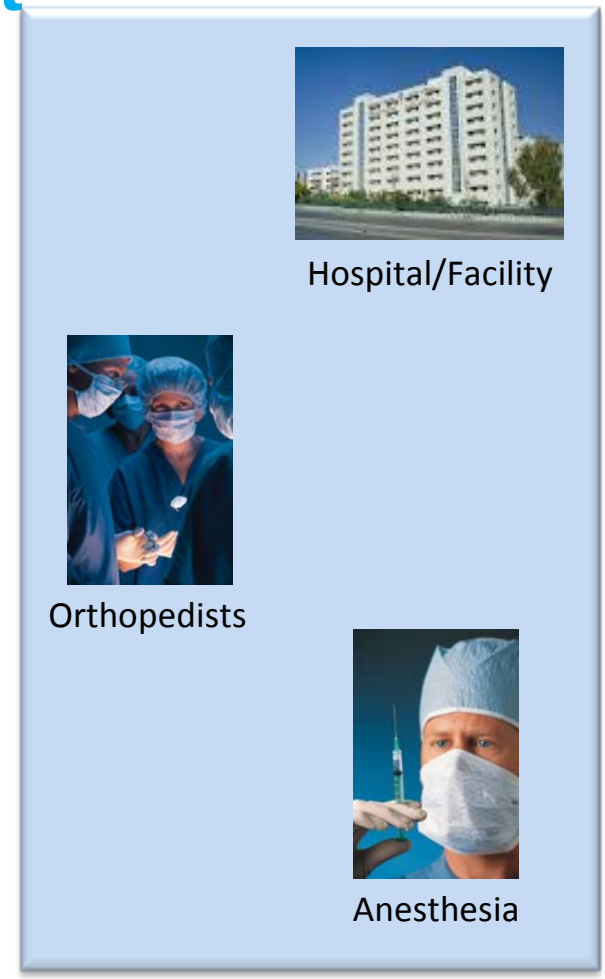
Orthopedists

Anesthesia Contract

Anesthesia

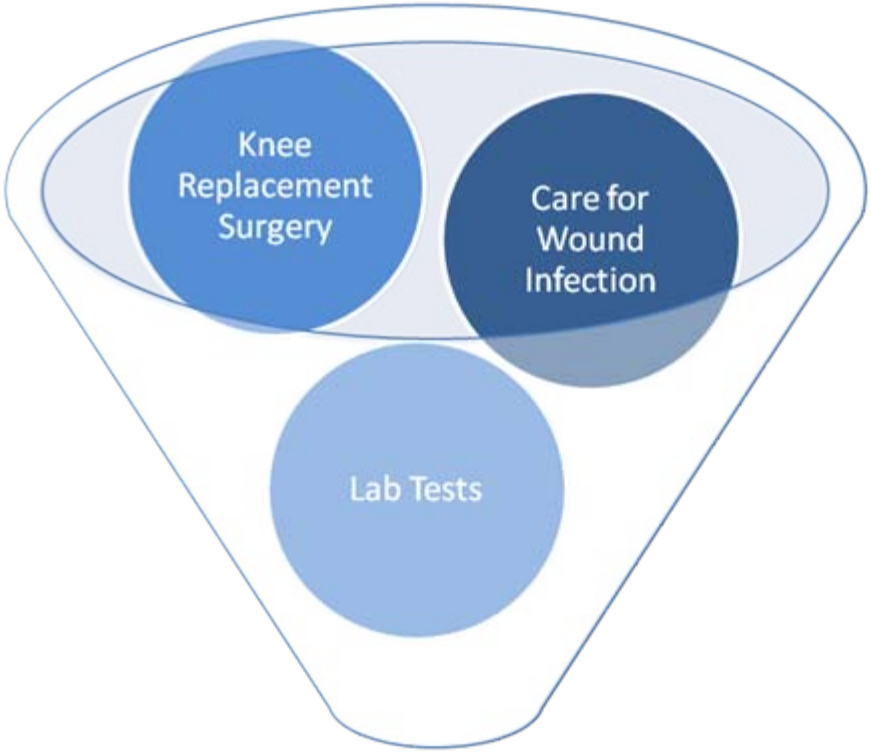
+ Each of the major providers involved in the episode receive their own contracts, which BCBSNC has to manage and adhere to. All contracts include upside/downside risk for providers.

Past Contracting Models:
Model 2- Total Knee Replacement



+ One contract is developed for the episode, with one provider partner taking the lead and managing the reimbursement to the appropriate parties. The contract includes upside/downside risk for providers.

PROMETHEUS Payment Methodology: Total Knee Replacement Surgery



Typical Risk Adjustment:

- Diabetes
- Hypertension

Typical:
Knee Replacement Surgery

Lab Tests

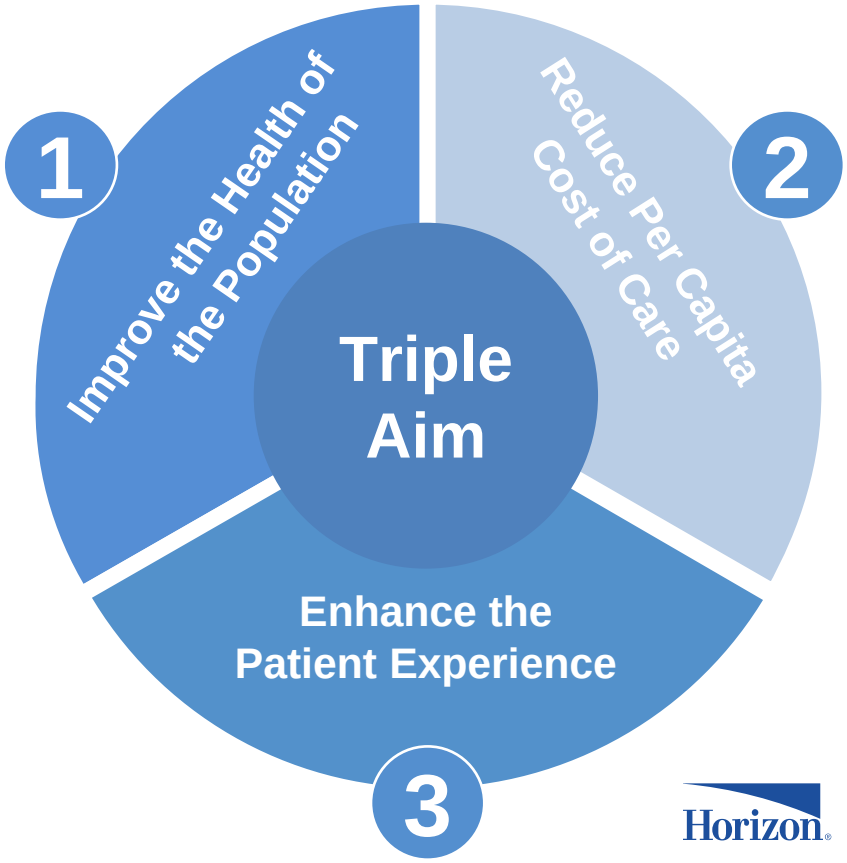
PAC:
- Care for Wound Infection

Exclude:
- CABG
- Breast Surgery

Types of PACs:
- Occurring during the surgery
- Due to member co-morbid conditions
- Due to patient safety failures

Horizon Blue Cross Blue Shield of NJ

Through **collaboration**, we are helping to create an **effective, efficient and affordable** health care delivery system.



Episodes of Care Development & Implementation

Lili Brillstein
Director, Episodes of Care
Horizon BCBSNJ

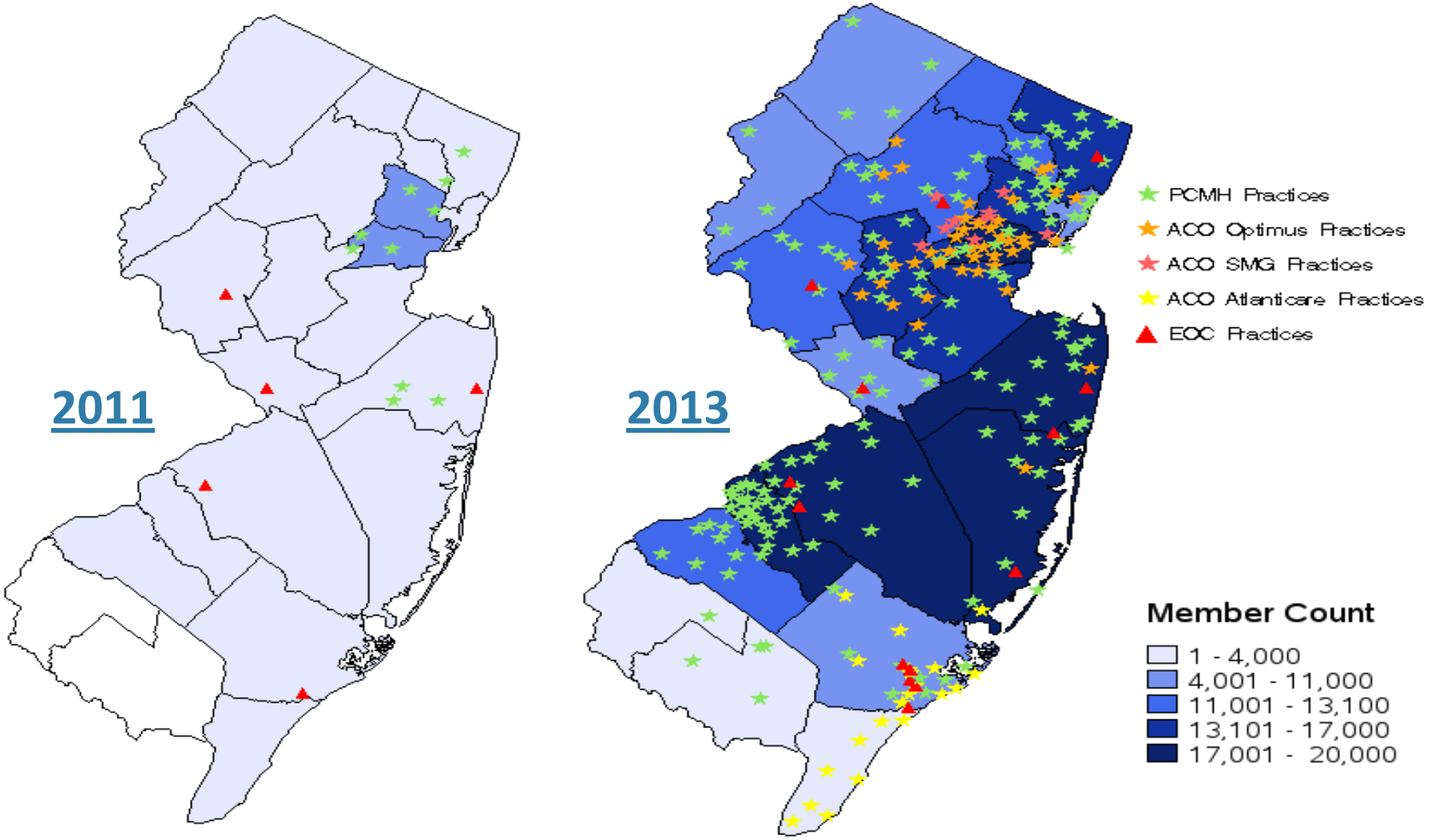
Horizon
Horizon Blue Cross Blue Shield of New Jersey

Transforming NJ's Delivery System

- Launched new care and payment programs
  - **Patient-Centered Medical Home Program (PCMH)** – working with over 700 physicians benefiting over 200,000 members
    - Participating in CMMI's Comprehensive Primary Care (CPC) initiative
  - **Accountable Care Organization (ACO)** – three ACOs in NJ
  - **Episodes of Care for Hip and Knee Joint Replacement** – included over 30 orthopedic surgeons

- Focused on program integration and expansion programs to all Horizon members
  - Linking PCMHs to ACOs to Episodes to Engaging Members
  - Initial success in:
    - Improving quality outcomes
    - Improving member experience
    - Reducing unnecessary utilization

Innovative Program Expansion



Source: Attributed members are based on Horizon BCBSNJ January 2013 enrollment and January 2012 Horizon BCBSNJ enrollment for the 2012 map. Practice locations are based on ZIP codes and there may be more than one practice per ZIP code. For Optimus and EOC, practice locations are based on TINs and ZIP codes. For SMG, locations are based on SMG website.

Horizon
Horizon Blue Cross Blue Shield of New Jersey

Episode of Care Program Overview

- Launched Total Hip and Total Knee Replacement program in January 2011

- Orthopedic Surgeons = Episode Quarterbacks - based on premise that surgeon can best manage the care of the member through the full spectrum of services delivered during the episode
  - ➢ One hospital-centric

- Retrospective Program
  - ➢ Episode of Care Philosophy
  - ➢ Shared Savings
    - No “bundles”
    - Bundling is virtual
  - ➢ Phased in reimbursement approach

Program Overview cont'd

- Program Structure

  - All providers paid FFS rates during the episode

  - Risk adjusted budgets/targets established, using Prometheus, at member level

  - Quality metrics reported
    - Qualify episode for consideration in outcomes based payment (process measures)
    - Outcomes measures tracked and reviewed for continued participation

  - Patient Experience surveyed/reported

  - Episode reviewed retrospectively to compare actual cost to budgeted/targeted cost

Because it matters how you're treated

Jennifer Winchester

South Carolina

Who we are

BlueCross BlueShield of South Carolina

- Leading health insurer and benefits administrator in the state
- Among the five largest private employers in South Carolina
- Provide health care coverage for more than one million South Carolinians

Provider Network Innovations and Partnerships

- Partner with providers and lines of businesses to test new payment and care models and support providers in the transition.

Current Initiatives

Total Knee Replacement

PALMETTO HEALTH

ROPER ST FRANCIS HEALTHCARE

PALMETTO HEALTH RICHLAND

ANMED HEALTH

BON SECOURS ST. FRANCIS HEALTH SYSTEM

Coronary Artery Bypass Graft (CABG)

PROVIDENCE HOSPITALS
A Ministry of the Sisters of Charity Health System

Outpatient (Back Pain, Diabetes)

PALMETTO HEALTH

How does it work?

Based on Internal Analysis, Provider Input and the PROMETHEUS Payment® Model (www.hci3.org)

Claims are analyzed to determine a patient's conditions and risk factors

Two Types of Claims: Typical Claims and claims associated with Potentially Avoidable Complications (PACs)

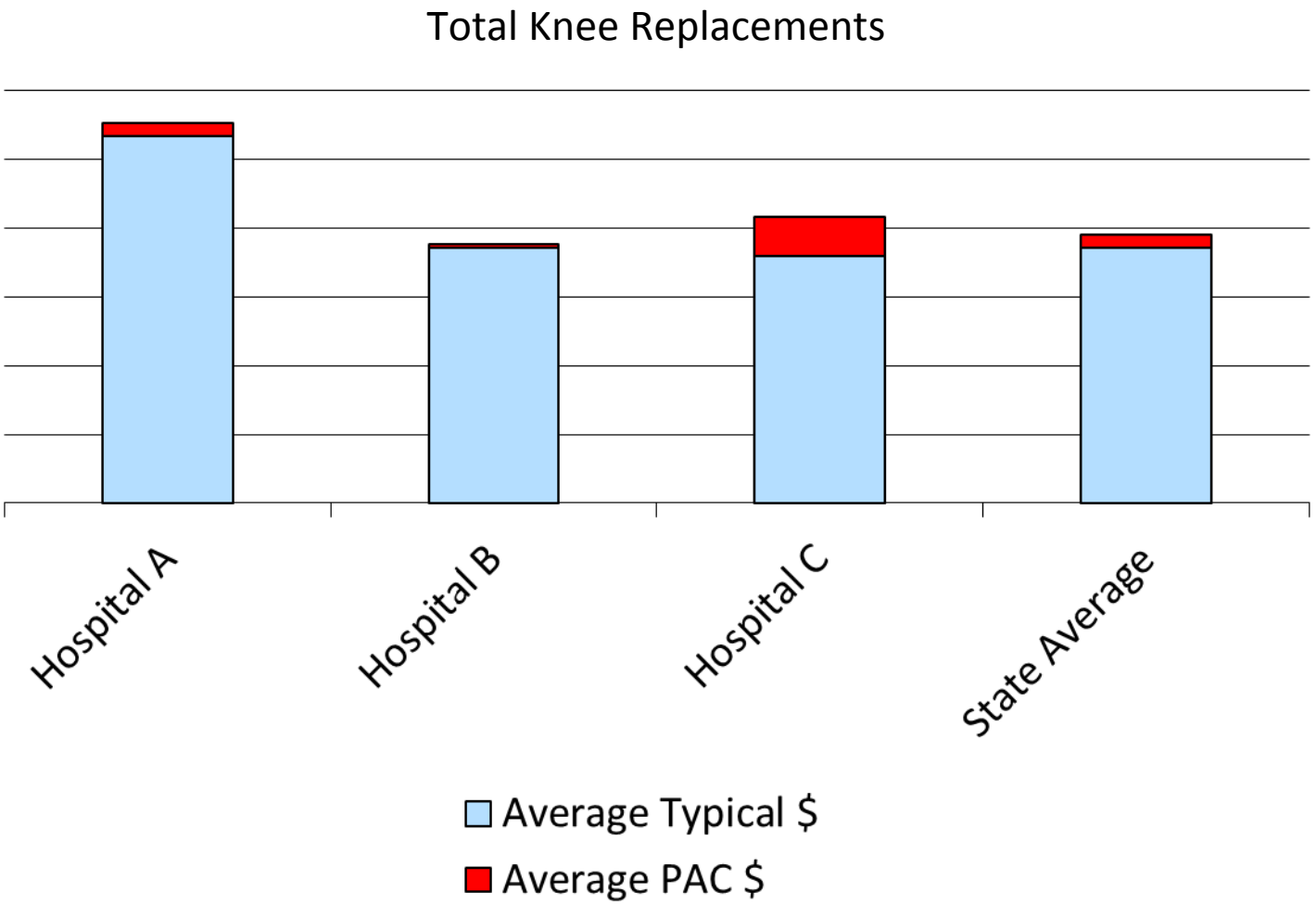
If PACs are reduced or eliminated, the leftover allowance is distributed among providers as shared savings

Implementation

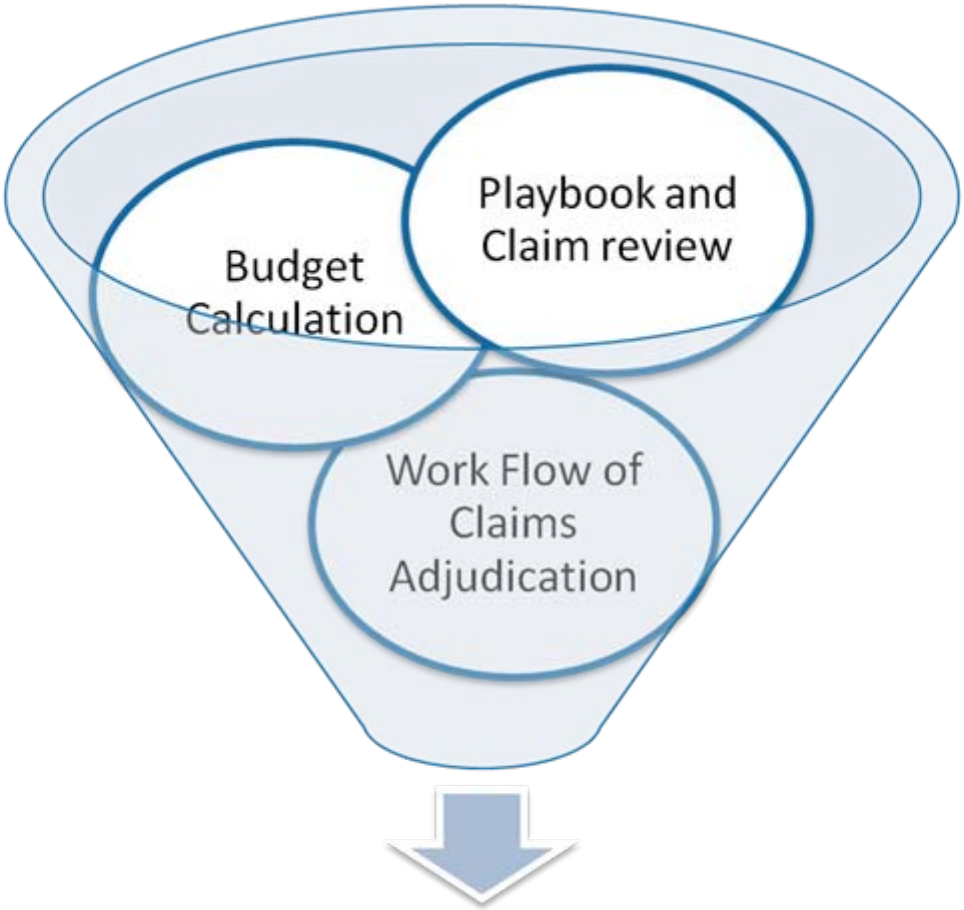
Contracting – Provider Selection

- Determine Best Provider Partner
  - Engaged Resources
    - CEO, Physician Champion, Project Manager, Quality Improvement
  - Volume Threshold
    - Statistically sound
  - Solid relationship between hospital and physicians
    - Removing barriers is critical for success
- Data Analysis of Provider Landscape
  - Compare volume, total dollars, state averages, etc.

Contracting – Provider Selection



Contracting – Education of a Bundle



"Dry Run" of Reconciliation

Contracting

- Budget Calculation/Shared Savings
  - Determine Typical Rate and PAC Rate
  - Calculate Risk-Adjusted Patient-Specific Budgets
  - Include Readmissions, SNF Admissions, etc.
  - Determine Percentage of Historical PACs or PAC Reduction Target
  - Establish Process for Distribution of Shared Savings

- Quality Measures
  - Benchmarks must be met before shared savings can be distributed

Operations

Reconciliation

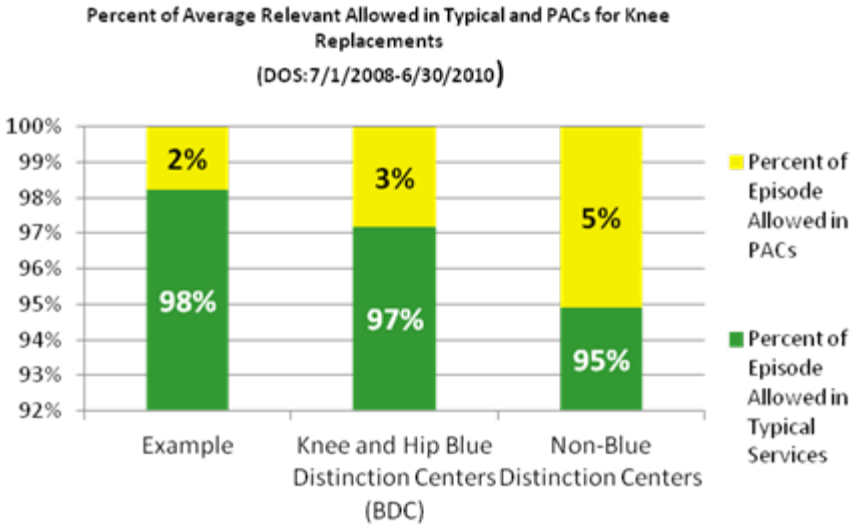
- Reconciliation will occur at the end of each episode to true-up to agreed upon rate
- Reconciliation process is the same for prospective (if leakage) and retrospective model
- Involves review of monthly claims detail and PAC analysis with provider (see next slide)
  - Claims detail offers providers opportunity to see current practice and modify behaviors
- Reconciliation occurs prior to claims adjustment claims to discuss and obtain buy-in from providers
- Must wait minimum of 60-days after completion of each episode to perform reconciliation to allow for claims run-out

Sample PAC Analysis

Notes:
1.A knee replacement episode consists of all claims relevant to the procedure, 30 days before the procedure and 180 days after the surgery.
2.PAC=Potentially Avoidable Complication
3.Exclusions: Patients enrolled in Medicare and ancillary products, patients not between the age of 18 and 64, claims where BCBSNC is not the primary carrier, bilateral procedures
4.Pharmacy costs not included in analysis. Pharmacy costs associated with episode are minimal.
5.A PAC inpatient value of 0 implies that the average cost of an inpatient stay involving a PAC did not result in any costs over what was observed for an inpatient stay that did not involve a PAC.
6.The average retrospective risk score is the average risk score for patients based on claims 12 months prior to surgery month and is based on Ingenix Episode Treatment Grouper (ETG) methodology. A small percentage of patients did not have risk scores. The risk of a patient (i.e. comorbidity) has not been found to be highly correlated with the probability of PAC occurrence.

Summary

Metric	Example
# of Patients	161
Percent Female	68%
Average Age	56
Average Retrospective Risk	3.34
Average Relevant Allowed	
Relevant Inpatient	
Relevant Outpatient/Professional	
Average Typical Allowed	
Typical Inpatient	
Typical Outpatient/Professional	
Average PAC Allowed (excluding PAC readmits)	
PAC Inpatient	
PAC Outpatient/Professional	
Average Readmit	
Typical Readmit	
PAC Readmit	
PAC Rate	**2%**
Percent of Members with a PAC	52%



Key Comparisons

	Example	Knee and Hip Blue Distinction Centers (BDC)	Non-Blue Distinction Centers
Percent Female	68%	65%	64%
Average Age	56	56	57
Average Retrospective Risk	3.34	3.48	3.32
PAC Rate	2%	3%	5%
Percent of Episode Allowed in Typical Services	98%	97%	95%
Percent of Episode Allowed in PACs	2%	3%	5%
Percent of Members with a PAC	52%	48%	48%
Percent of Members with PAC Readmit	2%	3%	4%
PAC Readmit Allowed per Patient with PAC Readmit	$6,793	$14,506	$12,739

Sample PAC Listing

PROMETHEUS Knee Replacement PAC Listing - Sample Hospital

Prepared by Jasper Harris, Clinical Informatics, 6/12/2011

Date of Surgery: 7/1/2008-6/30/2010

Inpatient PAC Listing

PAC	PAC Category	Number of Patients
ACUTE POST-HEMORRHAGIC ANEMIA	PAC RELATED TO PROCEDURE	42
ACUTE RENAL FAILURE	PAC DUE TO COMORBID CONDITIONS	1
COMPLICATIONS OF SURGICAL PROCEDURES OR MEDICAL CARE	PAC SUGGESTING PATIENT SAFETY FAILURES	4
DEEP VEIN THROMBOSIS AND PULMONARY EMBOLISM FOLLOWING CERTAIN ORTHOPEDIC PROCEDURES	PAC SUGGESTING PATIENT SAFETY FAILURES	1
PNEUMONIA, LUNG COMPLICATIONS	PAC DUE TO COMORBID CONDITIONS	4
REVISION PROCEDURES	PAC RELATED TO PROCEDURE	2
URINARY TRACT INFECTIONS	PAC DUE TO COMORBID CONDITIONS	7
# of Patients with Inpatient PAC	52	
Percent of Patients with Inpatient PAC	32%	

Outpatient/Professional PAC Listing

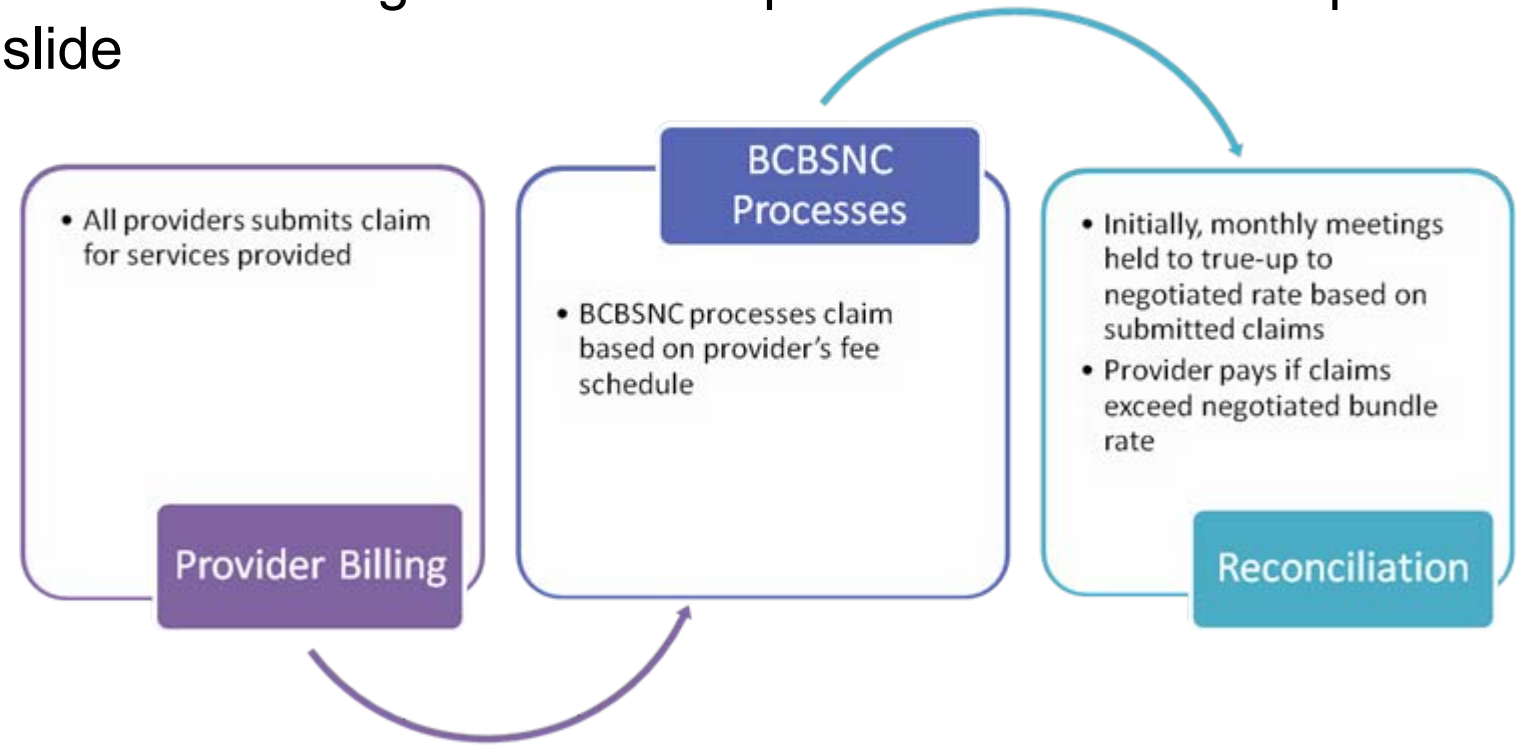
PAC	PAC Category	Number of Patients
ACUTE MYOCARDIAL INFARCTION, CORONARY THROMBOLYSIS	PAC DUE TO COMORBID CONDITIONS	1
ACUTE POST-HEMORRHAGIC ANEMIA	PAC RELATED TO PROCEDURE	2
ACUTE RENAL FAILURE	PAC DUE TO COMORBID CONDITIONS	1
ADVERSE EFFECTS OF DRUGS, OVERDOSE, POISONING	PAC SUGGESTING PATIENT SAFETY FAILURES	3
COMPLICATION OF IMPLANTED DEVICE, GRAFT	PAC RELATED TO PROCEDURE	11
COMPLICATIONS OF SURGICAL PROCEDURES OR MEDICAL CARE	PAC SUGGESTING PATIENT SAFETY FAILURES	3
DECUBITUS ULCER, GANGRENE, ARTERIAL THROMBOSIS	PAC SUGGESTING PATIENT SAFETY FAILURES	10
DEEP VEIN THROMBOSIS (DVT) / PULMONARY EMBOLISM (PE)	PAC SUGGESTING PATIENT SAFETY FAILURES	5
DIABETIC EMERGENCY, HYPO- HYPER-GLYCEMIA	PAC DUE TO COMORBID CONDITIONS	1
EMERGENCY ROOM	PAC RELATED TO PROCEDURE	10
GASTRITIS, ULCER, INTESTINAL OBSTR	PAC DUE TO COMORBID CONDITIONS	3
PNEUMONIA, LUNG COMPLICATIONS	PAC DUE TO COMORBID CONDITIONS	9
RESPIRATORY FAILURE, RESPIRATORY INSUFFICIENCY	PAC DUE TO COMORBID CONDITIONS	1
SKIN, WOUND, OTHER INFECTIONS	PAC RELATED TO PROCEDURE	7
STROKE, COMA	PAC DUE TO COMORBID CONDITIONS	2
SYNCOPE, COLLAPSE, TIA	PAC DUE TO COMORBID CONDITIONS	1
TRACHEOSTOMY, MECHANICAL VENTILATION, MINOR LUNG PROCEDURES	PAC DUE TO COMORBID CONDITIONS	1
URINARY TRACT INFECTIONS	PAC DUE TO COMORBID CONDITIONS	10
# of Patients with Outpatient/Professional PAC	57	
Percent of Patients with Outpatient/Professional PAC	35%	

Readmit PAC Listing

PAC	PAC Category	Number of Patients
ACUTE MYOCARDIAL INFARCTION, CORONARY THROMBOLYSIS	PAC DUE TO COMORBID CONDITIONS	1
DEEP VEIN THROMBOSIS AND PULMONARY EMBOLISM FOLLOWING CERTAIN ORTHOPEDIC PROCEDURES	PAC SUGGESTING PATIENT SAFETY FAILURES	2
EMERGENCY ROOM	PAC RELATED TO PROCEDURE	3
# of Patients with Readmit PAC	9	
Percent of Patients with Readmit PAC	9%	

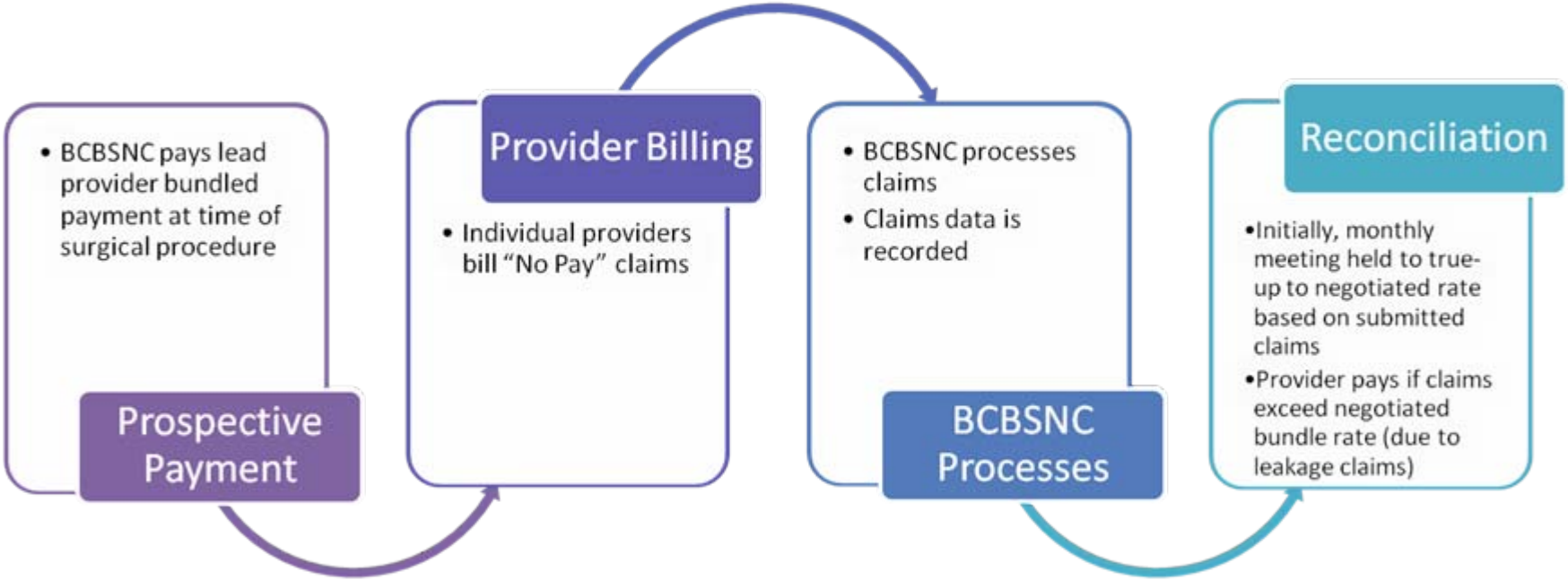
Claims Processing: Retrospective

- BCBSNC manages retrospective claims adjustment for one bundled episode
- Contract arrangement developed from **Model 1** on previous slide



Claims Processing: Prospective

- BCBSNC manages prospective claims adjustment for one bundled episode
- Contract arrangement developed from **Model 2** on previous slide



Transparency in Operations

- Providers:
  - Initial data analysis performed and presented during contracting
  - PAC analysis and monthly claims detail provided at reconciliation
  - Opportunity to negotiate attributable members and claims to bundle

- Consumers:
  - Providers outreach to potential bundled patients. Outreach methods vary by provider preference.
  - BCBSNC will include bundles in “Treatment Cost Estimator” tool for members.
    - Members will be able to identify bundles by participating provider and treatment type
    - Members can see whether total of cost care decreases as result of bundle

Episode – Phased in Approach

- **Phase I**
  - Established Clinical Advisory Panel (CAP)
  - Research/data gathering/information sharing
  - Developing metrics benchmarks
  - Developed Letters of Agreement for each phase

- **Phase II**
  - Each episode reviewed against budget
  - Outcomes based payment paid for every episode under budget
  - No provider risk for those over budget
  - CAP members paid for participation on panel
  - Participants paid for data exchange

Episode – Phased in Approach

- **Phase III**
  - "Net Zero"
    - Upside risk only
  - Episodes reviewed in aggregate
    - If all episodes, in aggregate, during the measurement period come in under budget, outcomes based payment is achieved
    - If all episodes, in aggregate, during the measurement period come in over budget, no outcomes based payment is achieved, and no money is owed by provider

Current State 2013

- 10 practice partners
  - All orthopedic surgeons
  - 1 hospital-centric model
  - Statewide
- Retrospective
- Standard LOA for EOC
  - 1st year is “Net Zero”
  - 2nd year, shared risk
  - No admin payments for data exchange
- Standard EOC Manual
- Using standard Prometheus-defined episodes
- EOC outcomes data shared with PCMH partners

Savings Model

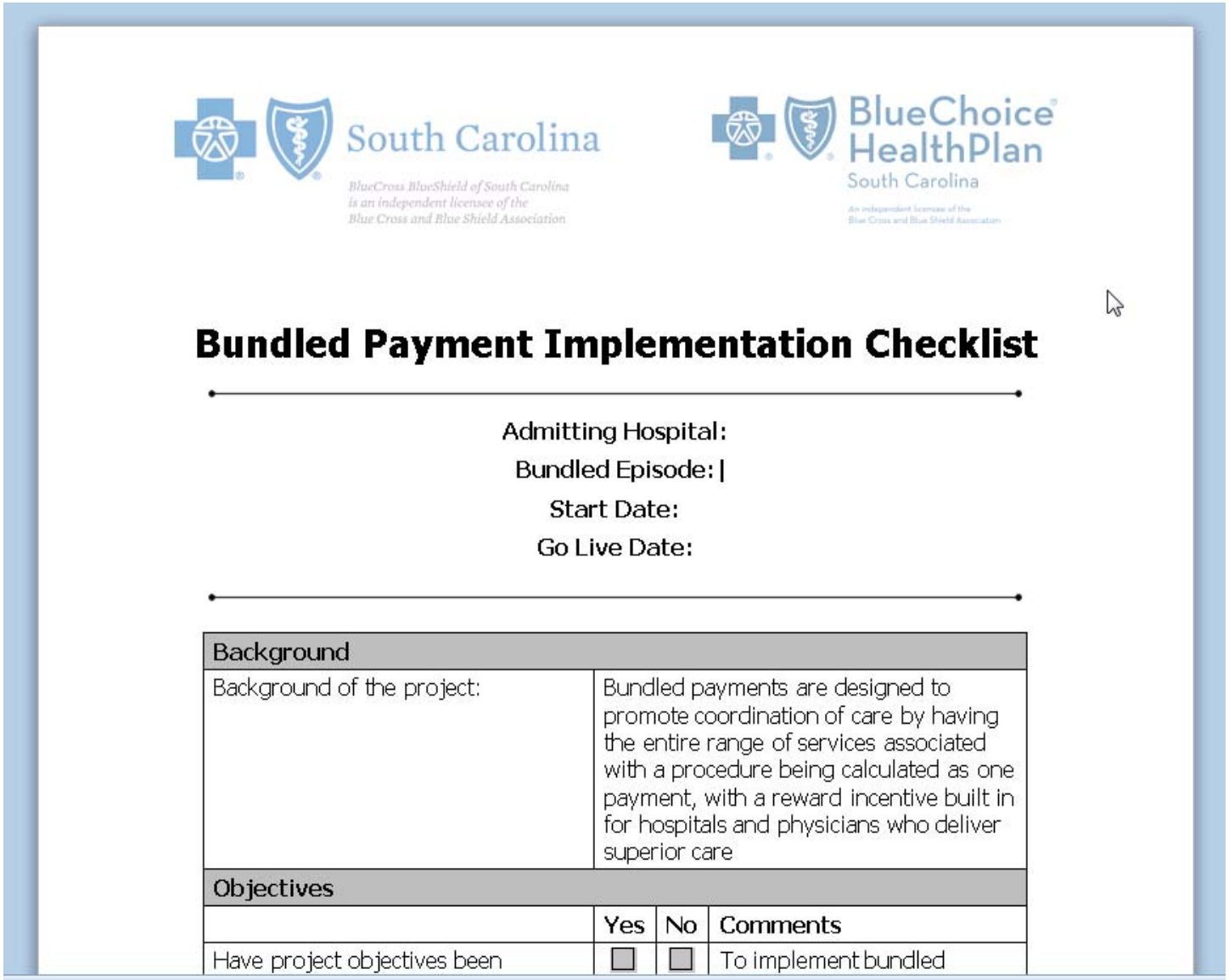
Year One

- The Model incorporates a ***"net-zero"*** concept, with analysis of results ***in the aggregate*** and consideration and handling of high or low outliers.
- If savings are achieved, they are shared; if no savings are realized, there is no share.

Year Two

- If savings are achieved, they are shared
- If episodes go over budget, in aggregate, reconciliation occurs; net deficits reduced from future payments

Operations – Checklist



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BlueChoice HealthPlan South Carolina

Bundled Payment Implementation Checklist

Admitting Hospital:

Bundled Episode: |

Start Date:

Go Live Date:

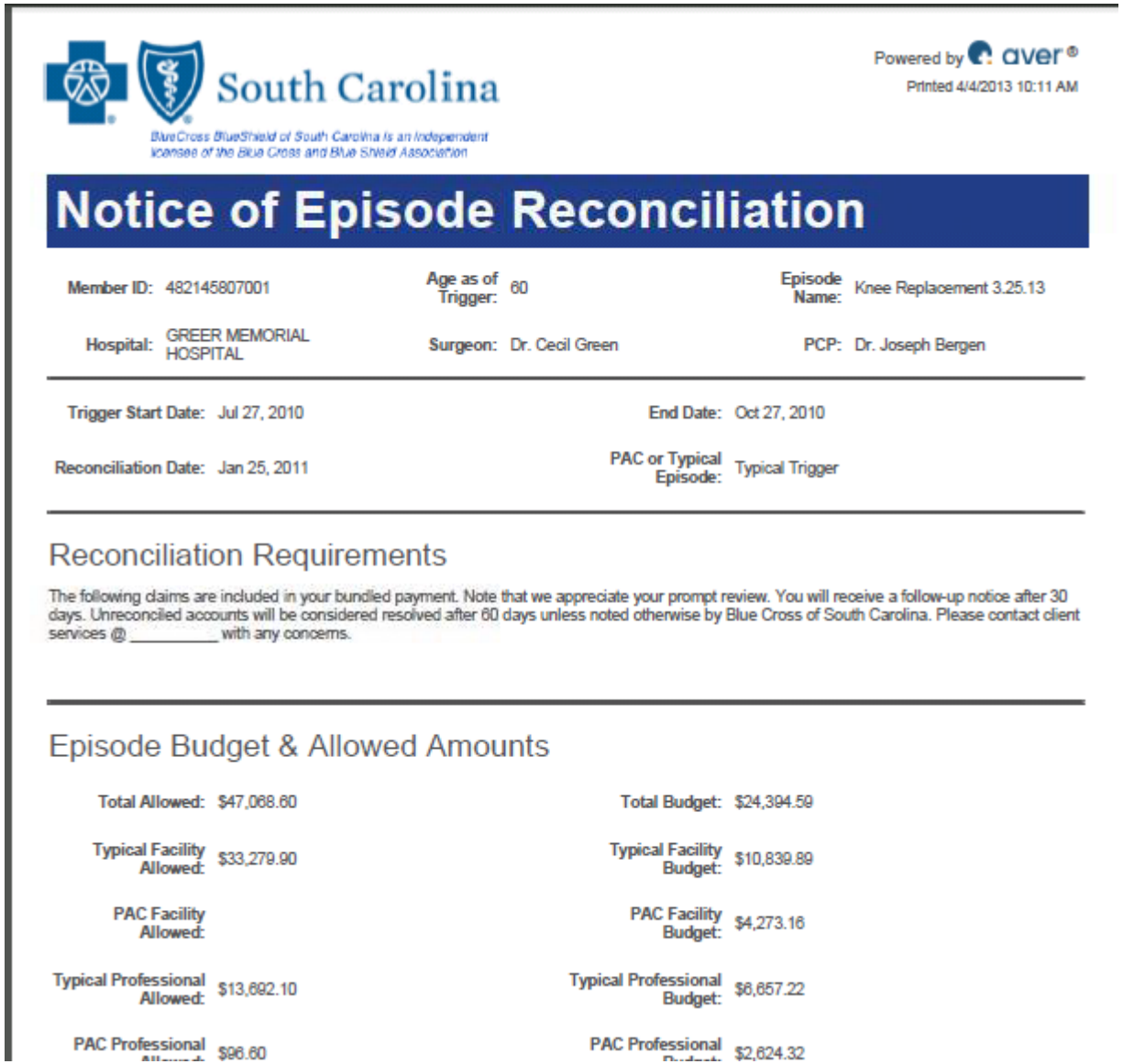
Background			
Background of the project:	Bundled payments are designed to promote coordination of care by having the entire range of services associated with a procedure being calculated as one payment, with a reward incentive built in for hospitals and physicians who deliver superior care		
Objectives			
	Yes	No	Comments
Have project objectives been	☐	☐	To implement bundled

Operations - Reconciliation

- Retro-Reconciliation
- Services are performed and claims are paid based on existing reimbursement methodology as services occur (fee-for-service, DRG, etc.)
  - Includes relevant claims with dates of service 30 days prior and 90 days post inpatient admission
  - Compare actual allowances for services related to the episode with budgeted allowance
    - If quarterly actual allowances are higher than budget = no settlement
    - If quarterly actual allowances are lower than budget = settlement via shared savings

Operations - Reporting

- List of patients in data set with provider names and performed procedures
- PAC types – volume and rates
- Volume, typical rates and PAC rates per provider
- Alerts



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Notice of Episode Reconciliation

Member ID:	482145807001	Age as of Trigger:	60	Episode Name:	Knee Replacement 3.25.13
Hospital:	GREER MEMORIAL HOSPITAL	Surgeon:	Dr. Cecil Green	PCP:	Dr. Joseph Bergen

Trigger Start Date:	Jul 27, 2010	End Date:	Oct 27, 2010
Reconciliation Date:	Jan 25, 2011	PAC or Typical Episode:	Typical Trigger

Reconciliation Requirements

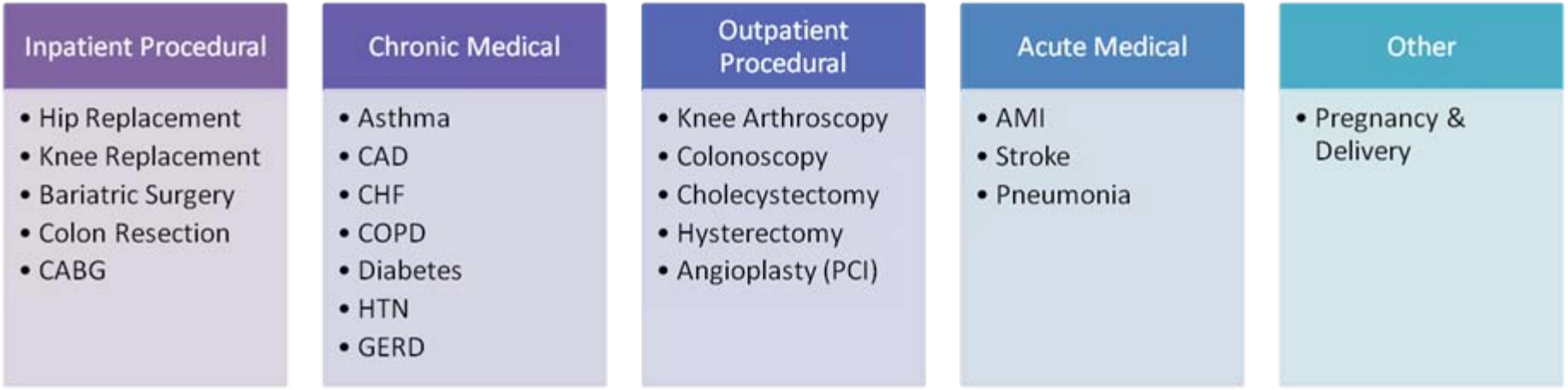
The following claims are included in your bundled payment. Note that we appreciate your prompt review. You will receive a follow-up notice after 30 days. Unreconciled accounts will be considered resolved after 60 days unless noted otherwise by Blue Cross of South Carolina. Please contact client services @ _____ with any concerns.

Episode Budget & Allowed Amounts

Total Allowed:	$47,068.60	Total Budget:	$24,394.59
Typical Facility Allowed:	$33,279.90	Typical Facility Budget:	$10,839.89
PAC Facility Allowed:		PAC Facility Budget:	$4,273.16
Typical Professional Allowed:	$13,692.10	Typical Professional Budget:	$6,657.22
PAC Professional	$96.60	PAC Professional	$2,624.32

Benefit Design and Lessons Learned

Bundles to Inform Benefit Design



- Current:
  - Using the PROMETHEUS to model Hips, Knees and CABG service consumption. Only knees implemented currently.
  - Contracted with vendor to automate claims bundling.
- Future:
  - Outpatient and Acute Medical modeling will be pursued after Inpatient Procedural and Chronic Medical are well-established
  - Once the bundling process becomes more automated with the TriZetto Bundler, BCBSNC will incorporate bundles more regularly
  - Plans to implement steerage toward bundles through benefits in the next year

Lessons Learned

- Sharing upside/downside risk with providers works
  - Especially when initiated early on
  - However, may discourage some providers from participating
- Engage internal and external partners early
  - Success of bundles involves many moving pieces. Make sure all partners understand process and communicate regularly.
- Choose provider partners wisely
  - Best experience with those providers who are flexible and willing to adjust as necessary
  - Select partners with sufficient volume
- Provider partners like to see the data
  - Make sure the data reported is easily consumable
  - If the data is simple enough to consume, providers will change the way they practice to prevent leakage and PACs

Key Takeaways

- **Clinical Advisory Panel (CAP):**
  - Provided regular input into program design
  - Variation of practices was evident
  - Developed and agreed upon clinical metrics
  - Encouraged idea sharing and development (e.g. same day knee replacements, complicated cases)

- **Web-Based Tool:**
  - Claims data alone is not sufficient
  - Tool allows us to capture entire picture of episode
  - Data by segments (pre-surgery, surgery, and post-op)
  - Since care is fragmented, tool can capture all encounters, increasing the likelihood of care coordination.

- **Grouper Technology:**
  - Strong, collaborative relationship with HCI3
  - Prometheus Workgroups

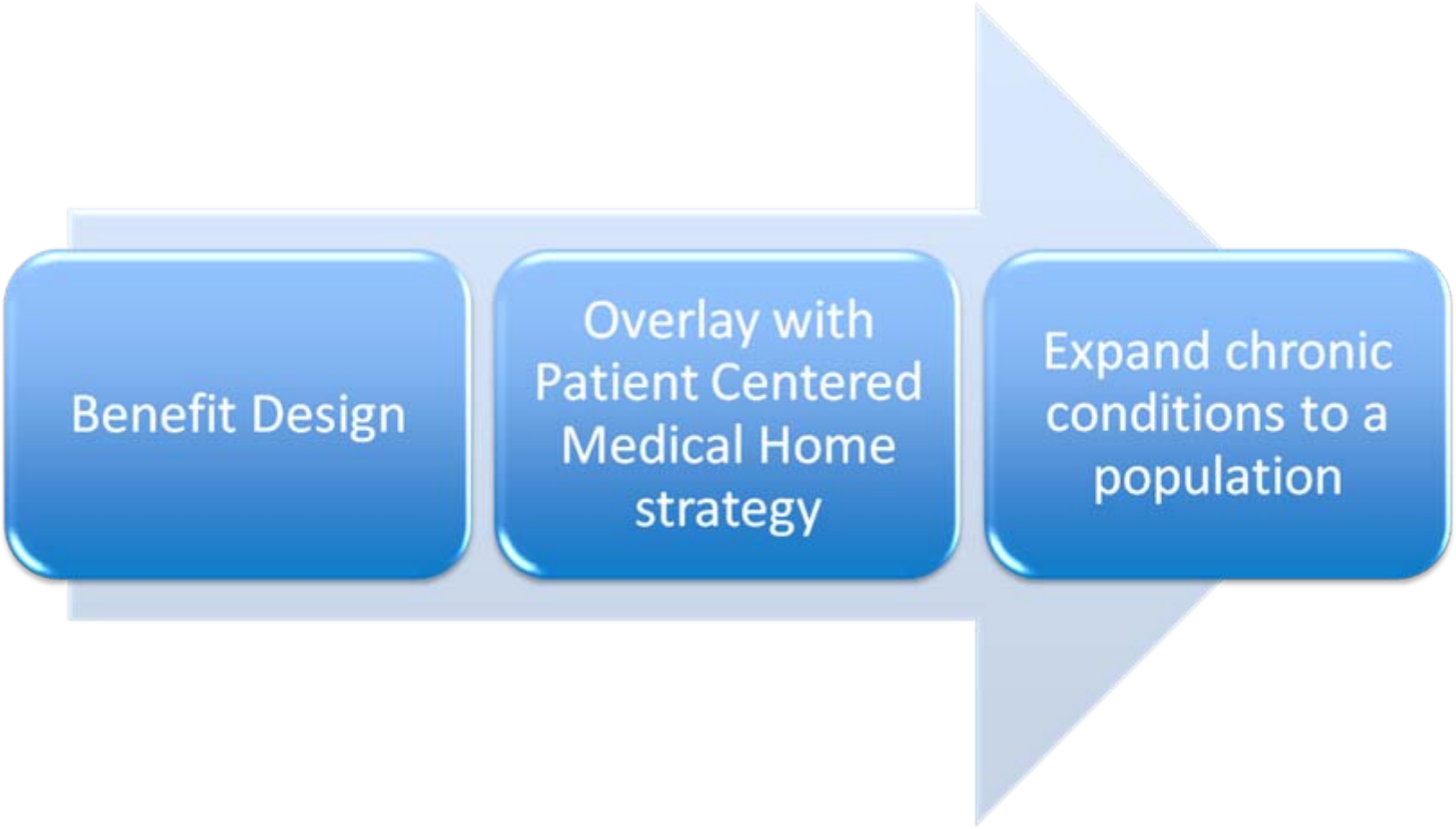
Future State Plans – 2013/2014

- Expanding Ortho
  - additional practices
  - additional ortho procedures (e.g., knee arthroscopy)
- Expanding to additional specialties (e.g., CABG, colonoscopy, Ob, one small custom-defined oncology episode)
- Will continue to be retrospective due to tech restrictions
- Practice-level budgets
  - Based on claims and case mix history
  - Periodic review to determine case mix status

Future State – 2014/2015

- TriZetto implementation
- Launch standard and custom-defined episodes
- Prospective bundling
  - ➢True bundled payments
- Value-based product deign to incentivize member engagement in innovative programs

What Comes Next?



Questions

FAIR, EVIDENCE-BASED SOLUTIONS.

Real and Lasting Change.

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