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Provider Bundled Payment Strategies

Bundled Payment Summit
Washington, DC
June 17, 2014

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Provider Bundled Payment Strategies
The National Bundled Payment Summit
Washington, DC
June 16-18, 2014

Karim A. Habibi, FHFMA, MPH, MS
Senior Vice President and Chief of Managed Care and Healthcare Reform

NYU Langone Medical Center

- Academic medical center comprised of four hospitals
- 1,069 licensed beds
- 39,000 patient admissions
- 670,000 outpatient visits
- Medicare beneficiaries represent 27% of NYULMC volume and 18% of revenue

- Established NYUPN, a Clinically-Integrated Network, in 2010
- 761 voluntary physicians (38%)
- 1262 Faculty Group Practice (FGP) physicians (62%)
- >1M FGP physician visits

Strategic Approach to Bundled Payment

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Why We Chose the October 1, 2013 Start Date?

- We were ready
- We were well prepared before the financial risk period that started on Oct. 1, 2013
- We didn't want to lose physician engagement

- We have been analyzing the risk, opportunity, and cost drivers since early 2010
- We began implementation in advance of the January 1, 2013 go-live and treated Phase 1 as the start of the risk-phase of the demonstration project
- Our physicians have been driving clinical changes for nearly a year
- The first possible gainsharing payout for physician incentives is summer of 2014

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Selecting Episodes

What we considered

Clinical opportunity

- Strong clinical leadership
- Manageable comorbidities
- Relatively predictable

Financial opportunity

- High volume
- Procedure-based

What we selected

Total Joint Replacement

•469-470 Major joint replacement of the lower extremity

- 800 Medicare cases annually
- 31 physicians; 55% employed / 45% voluntary

Spinal Surgery

•459-460 Spinal fusion (non-cervical)

- 235 Medicare cases annually
- 18 physicians; 56% employed / 44% voluntary

Cardiovascular surgery

•216-221 Cardiac valve

- 260 Medicare cases annually
- 8 physicians, 100% employed

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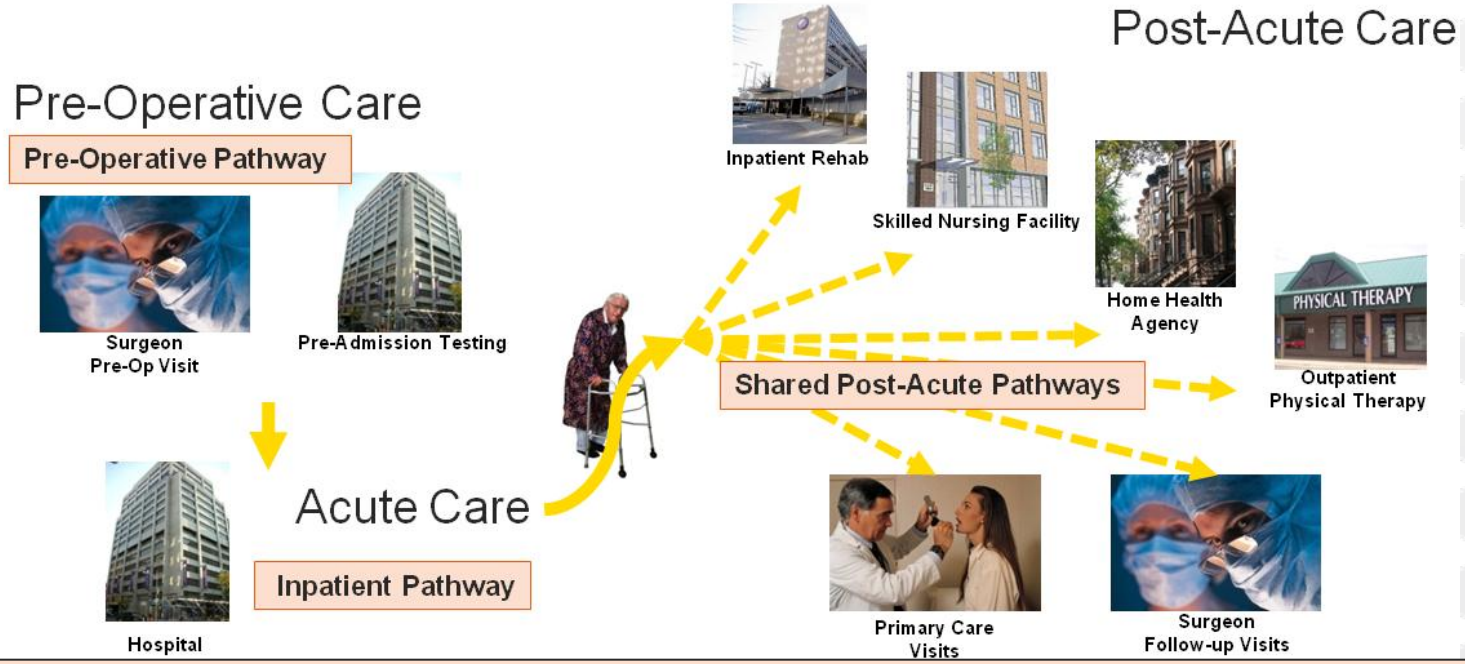
Clinical Management Throughout the Pathway

The Importance of Care Coordination

- Enforces best practices / standardization of pathways, workflows, and order sets
- Improves communication between providers and to the patient
- Ensures follow-up after care transitions
- Optimizes Patient Expectations and Outcomes



Goal : Develop a pathway with >80% use of all elements with exclusion determined by pathway criteria, not physician preference.

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Staffing- $3 million to Get Ready and $1.5M/yr to Manage

Care Coordination Staffing – *Dedicated to Bundled Payment*

•Clinical Care Coordinators (CCC) are the "General Manager" of the 90-day episode
- Help answer questions and facilitate communication with providers
- Receive regular updates on patient progress
- Help ensure follow-up visits with surgeon and PCPs

•5 RN FTE Clinical Care Coordinators manage 1,200 patients
- Preoperatively 1 CCC : 20-25 patients
- Inpatient 1 CCC : 4-6 patients
- 90-days post-discharge 1 CCC : 50-60 patients
- Annual staffing ratio 1 CCC : 240 patients

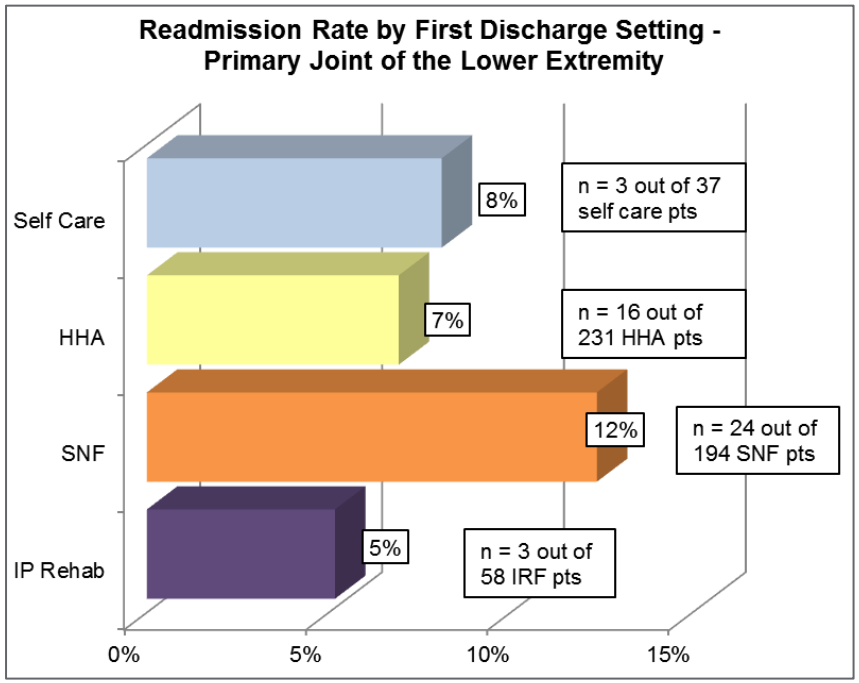
Program Staffing – *Support all Population Management Initiatives*

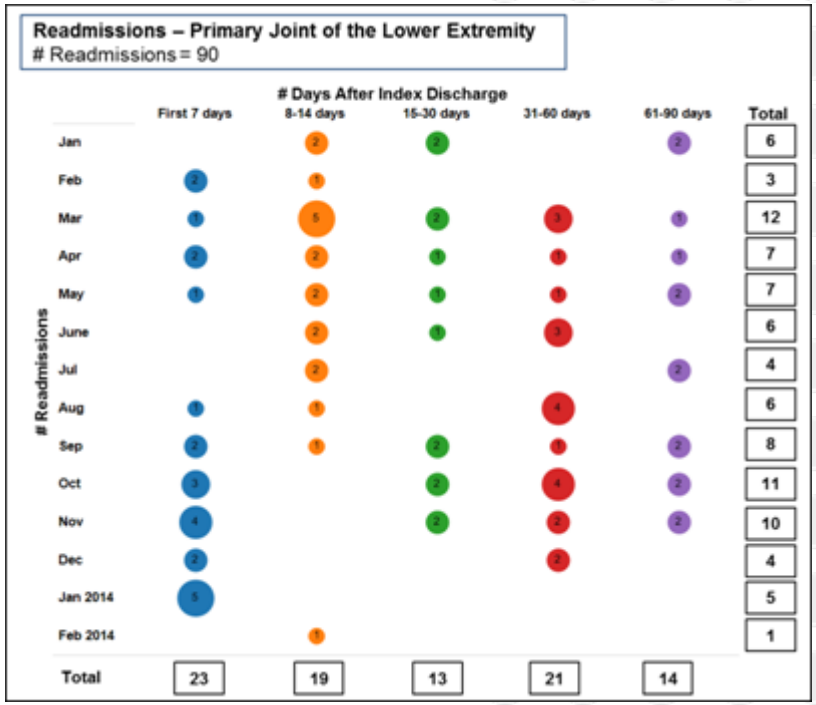
•The Network Integration and Payment Reform team consists of:
- MD Executive Sponsor
- RN Senior Director of Clinical Operations
- RN Director of Clinical Care Coordination
- RN Manager of Clinical Care Coordination
- Director of Program Implementation
- Manager of Payment Reform
- Data Analyst(s)
- Project Manager(s)
- Project Assistant(s)

Physician and Post-Acute Engagement

Physician Engagement

- ***Bundled Payment Weekly Dashboard***
  - ***Initiative-level reporting*** keeps the organization focused on achieving our targets





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Physician Engagement

- ***Physician-level reporting*** allows Chairs and Chiefs to monitor their departments' performance
- Promotes a continuous drive for improvement and results

NYULMC Physician Dashboard

			Discharge Disposition						90-Day Readmission Rate - *Closed Episodes Only*[1]		
	# Patients Discharged	ALOS	Rehab Facility	Skilled Nursing Facility	Total Facility-Based Care	Home Health Care Svc	Home/ Self Care	Total Home-Based Care	# Readmissions *(Closed Episodes Only)*	# Patients *(Closed Episodes Only)*	90-Day Readmission Rate *(Closed Episodes Only)*
Primary Joint of the Lower Extremity	**779**	**3.52**	**7%**	**37%**	**44%**	**53%**	**3%**	**56%**	**42**	**338**	**12%**
HJD	**733**	**3.41**	**6%**	**35%**	**41%**	**56%**	**3%**	**59%**	**35**	**317**	**11%**
DRG 469 - Primary Joint w MCC	**17**	**6.76**	**18%**	**35%**	**53%**	**47%**	**0%**	**47%**	**1**	**2**	**50%**
Physician 1	4	6.00	25%	50%	75%	25%	0%	25%	0	0	0%
Physician 2	4	8.75	25%	25%	50%	50%	0%	50%	0	0	0%
Physician 3	2	4.50	0%	50%	50%	50%	0%	50%	0	0	0%
Physician 4	2	9.00	0%	50%	50%	50%	0%	50%	0	1	0%
Physician 5	1	7.00	0%	100%	100%	0%	0%	0%	0	0	0%
Physician 6	1	3.00	0%	0%	0%	100%	0%	100%	0	0	0%
Physician 7	1	13.00	0%	0%	0%	100%	0%	100%	0	0	0%
Physician 8	1	3.00	100%	0%	100%	0%	0%	0%	0	0	0%
Physician 9	1	3.00	0%	0%	0%	100%	0%	100%	1	1	100%

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Physician Engagement: Reviewing Performance Data

Physician Chair or Chief reviews dashboard data and pinpoints areas of concern. BPCI clinical implementation team member is contacted to initiate meeting with selected physicians.

- Initial Meeting with physician and BPCI team member:
  - Review physician's own data as well as physician compared to baseline and peer trend
  - Discuss physician's specific patient population needs, including cultural preferences

- Next steps:
  - Identify appropriate post acute partner to team with physician and care team
  - Provide culturally specific information to the physician office
  - Meet again with physician and care team, including the Clinical Coordinator, Surgical Coordinator, and BPCI team member
  - Focus on communication and coordination between all members of care team
  - Continue to track physician performance

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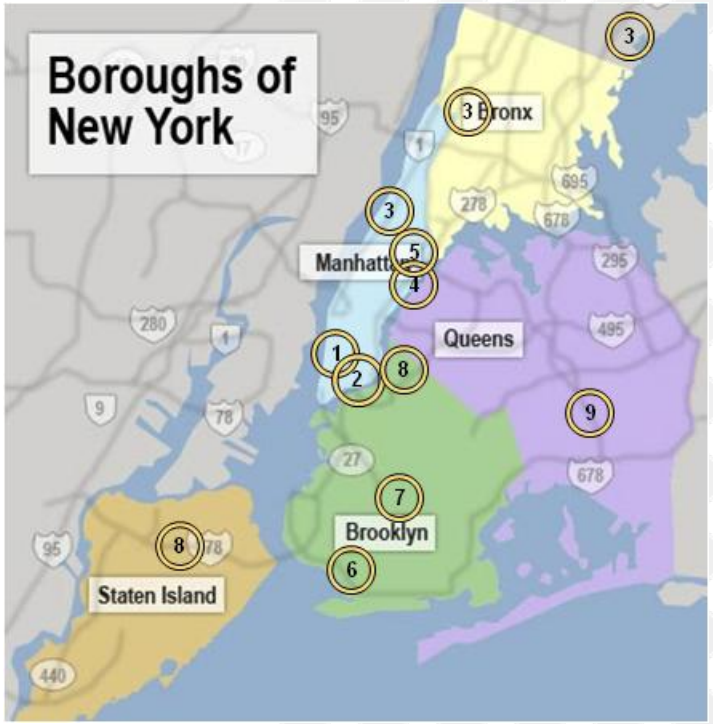
Post Acute Engagement – Improved Outcomes and Patient Experience
NYULMC Post-Acute Partners

Home Health Facilities

1. Visiting Nurse Service of New York Home Care CHHA
2. Village Center for Care CHHA
3. Revival Home Health Care
4. Jewish Home Lifecare Long Term Home Health Care

Skilled Nursing Facilities

1. Village Center for Care, Manhattan
2. Gouverneur Healthcare Services, SNF, Manhattan
3. Jewish Home Lifecare, Manhattan, Bronx, Westchester
4. Mary Manning Walsh, Manhattan
5. Terence Cardinal Cooke, Manhattan
6. Haym Salomon Home for the Aged, Brooklyn
7. Cobble Hill Health Center, Brooklyn
8. Clove Lakes Rehabilitation Center, Staten Island
9. Trump Pavilion for Nurse Rehab at Jamaica Hospital, Queens



NYULMC clinicians and staff selected facilities to partner with based on a set of rigorous quality and care coordination criteria, taking into account existing clinical relationships, patient geography, and physician discharging preferences.

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Post-Acute Partner Engagement

- Quarterly Post Acute Partners Collaboration Meeting
  - Share performance data based on BPCI claims received from CMS/Administrative update
  - One focus per meeting (e.g. readmissions)
  - High level Case Review by Clinical Care Coordinators

- Monthly WebEx
  - Pathway review
  - How to optimize care transitions

- Bi-weekly meeting with VNSNY Home Care
  - Discuss care redesign initiatives, including IT, clinical, and financial aspects
  - Case reviews

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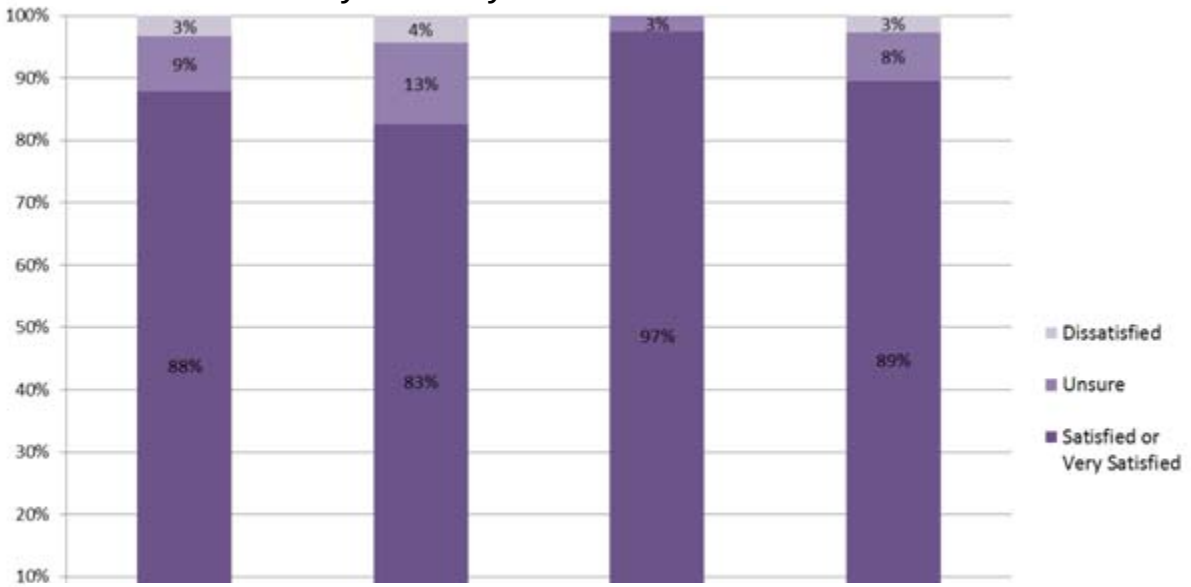
Patient Satisfaction Survey

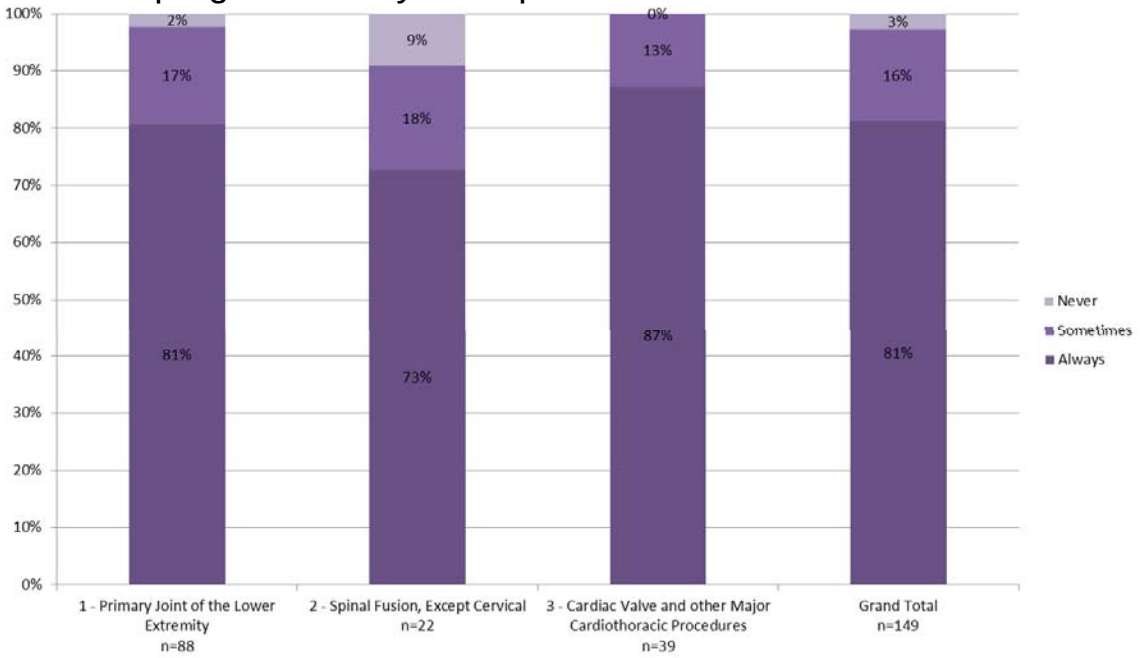

excellent
informative
help
staff
supportive
care
amazing
impressed
wonderful
extremely
grateful
compassion
service
satisfied

Patient Satisfaction Results

How satisfied were you with your CARE team / CCC?



Did the program meet your expectations?



- 89% of patients were satisfied or very satisfied with their CCC:
  - Primary Joint: 88%
  - Spine: 83%
  - Cardiac Valve: 97%

- 81% of patients said the program always met their expectations
  - Primary Joint: 81%
  - Spine: 73%
  - Cardiac Valve: 87%

Response rate: 58%

Future of Bundled Payment

Successes:

- The demonstration project has created dynamic and influential changes in the delivery of care
- The hospital, physicians, and post-acute partners are better coordinating care transitions and are communicating important clinical information about shared patients
- Our patients are experiencing improved care through enhanced coordination and communications between providers

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Future of Bundled Payment

Challenges:

- Based on the 2013 CMS baseline prices, the demonstration project is having a negative financial impact on NYULMC when you account to the cost incurred and the revenue lost due to care redesign.
  - $3 Mil in staffing cost to get ready and $1.5 Mil/year going forward
  - Loss of acute rehab revenue, $15,000 per case, 370-400 cases in 2013
  - Loss of IME, DME, DSH add-ons revenue associated with the acute rehab inpatient cases
  - Reduction in readmissions, estimated at 24 cases in 2013 at $12,500 per case plus $7,500 per case for IME, DME and DSH add-ons per case
- Recent data fluctuations are barriers to success. Baseline target prices and volumes keep changing, resulting in the inability to accurately predict financial performance and resulting in mixed messages to the physicians
- Without predictability of financial performance at both the initiative and physician-levels, it is difficult to maintain clinician engagement in existing bundles and will definitely hinder expansion to additional bundles

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Questions?

Contact Information:
Karim.Habibi@nyumc.org

Lancaster General Health

Provider Bundled Payment Strategies

Marion McGowan
EVP & Population Health Officer

Lancaster General Health

- Community health system 100+ years
- Lancaster County and South Central Pennsylvania
- 7,100 employees, 925 medical staff
- $1.1 billion revenues
- 250 physician group, 2 community Hospitals, 1 acute care rehab hospital, 7 ambulatory centers, regional home health service
- *PA College of Health Sciences*
- *The Community Care Collaborative (ACO)*
- *LGH Innovative Solutions, Inc.*

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CMMI Bundled Payment for Care Improvement

Payment of Bundle	Acute Care Hospital Stay Only	Acute Care Hospital Stay plus Post-acute Care	Post-acute Care Only	Chronic Care
"Retrospective" (Traditional FFS payment with reconciliation against a predetermined target price after the episode is complete)	Model #1	Model #2	Model #3	Model #7
"Prospective" (Single prospective payment for an episode in lieu of traditional FFS payment)	Model #4	Model #5	Model #6	Model #8

Current

Future

Bundling Surgical Episodes

- Global payment pilot with CMS
  - 3% discount
  - LGH distributes part B payments to physicians through a TPA
  - Gainshare savings with physicians
- Pilot duration: 3 years
  - 90 day "out" clause
- Started: January 1, 2014
- 345 Patients in the first 3 months

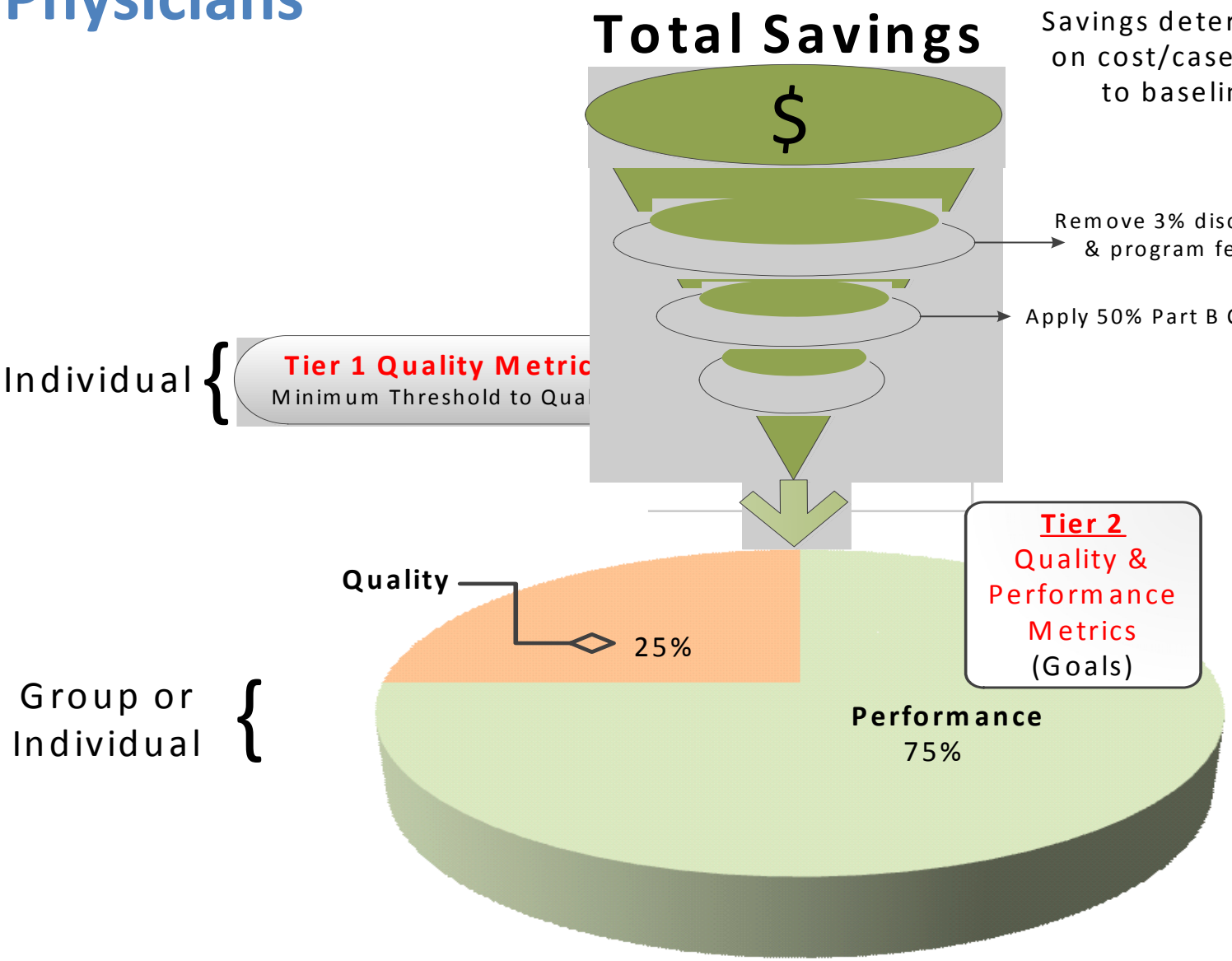
Clinical Episodes

- Joint Replacements
- Spine Procedures
- CABGs
- Pacemakers
- ICDs
- Cardiac Stents

Cost Drivers

- Length of Stay
- Utilization/Cost
  - Device/Implant
  - Testing
- Readmissions
- Physician claims (consultants)

Bundle Payment Episodes: Gainshare with Physicians



GAINSHARE & QUALITY

Early Impressions

1. Bundled payments may be **best suited to controlling cost variation** for selected acute care episodes
2. *Bundled payments **(Model 4 Type) emphasize cost variations per episode** but little on frequency and variation of episodes per condition*
3. It's unclear how successful **bundled payments can be outside of highly integrated health systems**

Early Impressions

1. **Administrative complexities** of these bundled payments has caused delays in wide-scale implementation
2. **Gainsharing methods may be time limited** given there is only a finite amount of cost savings to be achieved in a bundle
3. **Population-based payment models + bundled payment for acute episodes = Best Value?**

Future Expansion of Bundled Payments

- CMMI Model 2 – Stroke Patients
- Expansion of Model 4 to Commercial Lives
- Bundled Payments (Oncology and Ambulatory Procedures)

BROOKS SM
Rehabilitation



Michael Spigel, PT, MHA

Executive Vice President and Chief Operating Officer
Brooks Rehabilitation
Jacksonville, Florida

Brooks Rehabilitation
Post Acute System of Care


Rehabilitation Hospital


Skilled Nursing


Home Health


Outpatient Clinics


Assisted Living


Physician Practice


Clinical Research

Beyond Therapy: Community Outreach


Adaptive Sports and Recreation Program


Clubhouse and Vocational Tracks for job placements


Wellness Programs: Stroke, BI, Parkinson's, MS


Neuro-Recovery Center

System Clinical Programs

- **Neurology, BI**
- **Spinal Cord Injury**
- **Orthopedics**
- **Geriatrics**
- **Pediatrics**
- **Stroke & Cardiac**

BROOKS℠ Rehabilitation

Brooks Rehabilitation
CMS – Bundled Payment Participation

- Model 3: Hip Fractures, Total Knee and Hip Replacements – **start date, October, 2013**
- Model 2: In partnership with a local health system, accepting risk for the post-acute portion of episodes for total hip and knee replacements and spine surgery – **start date, January, 2014**
- **Expected number of cases annually, 1,050**

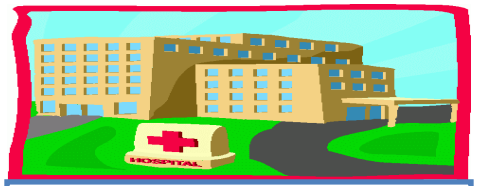
Jacksonville market:

- Population 1.3 M
- 5-health systems, 11 hospitals
- About 148,000 hospital discharges in 2013

Importance of Post Acute Care within a Total Episode of Care:

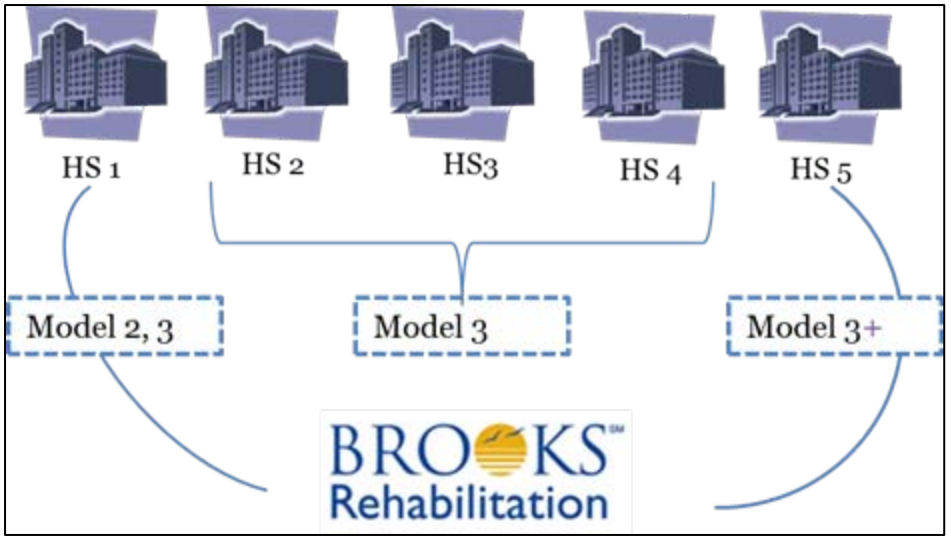
- 33-38% use rate for MC beneficiaries
- PAC accounts for wide variation in spending patterns
- Historically, high rates of readmissions
- Historically, little coordination between hospitals. physicians and PAC, and often, the relationships / referral decisions are driven by the wrong reasons

Various acute and post-acute relationships around the BPCI



HS – 1

- Model 2 for THR and TKR
- Brooks will assume risk for the post-acute component, including use of community-based SNF for several DRG



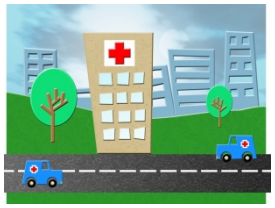
Management of multiple relationships, multiple clinical protocols, different hand-offs, varying degrees of focus on readmissions or relationships with PAC, etc.

HS -2

- Partnership with Hospital System(**EIP**) around our Model 3
- Distinctive care redesign program between Brooks and HS-2

Clinical Program Design

Our core thinking: All patients in each Episode family have certain universal characteristics, our care design needs to focus on identifying the characteristics that are unique to the patient



Longitudinal care planning

Care Navigators, other tools

BROOKS Rehabilitation

Early Results and Observations

- We've exceeded original expectations regarding:
  - Expected costs savings
  - Reduction in readmissions
  - Development of unique IS tools
  - Ability to manage our data
  - Staff knowledge, behaviors and buy-in
  - Interest in the program by our ACH patterns
  - How much we are learning about our patients and the "blind spots" we've historically faced and the "cracks" the patient's fall through
- The position of Brooks is that for many, but not all patients populations, Bundled Payment presents a better way to manage patients through the PAC portion of their episode
- We are looking towards analyzing the data with the possibility of adding additional Episode Families to our BPCI program

Lessons Learned

What we did well	What we wished we did better	What we are learning as we gain experience
Communication with staff	Better, more rapid feedback loop with clinical staff	Inconsistencies with the Medicare claim files
Blank slate	Addressing legacy behaviors	Outmigration of patients / market dynamics
Ability to live in the grey	Role confusion	What was the final DRG?
Commitment to developing IT application specific to PAC	Management of internal administrative costs	Trend factors and reconciliation
Investment in Care Navigators		Application of what we are learning to patients who are not part of the BPCI
Decision to manage data in-house		
Information sharing with acute care hospital partners		

Q&A