Provider Bundled Payment Strategies

Bundled Payment Summit
Washington, DC
June 17, 2014
Provider Bundled Payment Strategies
The National Bundled Payment Summit
Washington, DC
June 16-18, 2014
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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
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
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
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.
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
**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

<table>
<thead>
<tr>
<th>Discharge Disposition</th>
<th>90-Day Readmission Rate - Closed Episodes Only</th>
<th># Patients (Closed Episodes Only)</th>
<th>90-Day Readmission Rate (Closed Episodes Only)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># Patients Discharged</td>
<td>ALOS</td>
<td>Rehab Facility</td>
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<tr>
<td>Primary Joint of the Lower Extremity</td>
<td>779</td>
<td>3.52</td>
<td>7%</td>
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<tr>
<td>HJD</td>
<td>733</td>
<td>3.41</td>
<td>6%</td>
</tr>
<tr>
<td>DRG 469 - Primary Joint w MCC</td>
<td>17</td>
<td>6.76</td>
<td>18%</td>
</tr>
<tr>
<td>Physician 1</td>
<td>4</td>
<td>6.00</td>
<td>25%</td>
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<tr>
<td>Physician 2</td>
<td>4</td>
<td>8.75</td>
<td>25%</td>
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<tr>
<td>Physician 3</td>
<td>2</td>
<td>4.50</td>
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<tr>
<td>Physician 4</td>
<td>2</td>
<td>9.00</td>
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<tr>
<td>Physician 5</td>
<td>1</td>
<td>7.00</td>
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<tr>
<td>Physician 6</td>
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<td>3.00</td>
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<td>Physician 7</td>
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<td>Physician 8</td>
<td>1</td>
<td>3.00</td>
<td>100%</td>
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<tr>
<td>Physician 9</td>
<td>1</td>
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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
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.
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
Patient Satisfaction Survey
Patient Satisfaction Results

How satisfied were you with your CARE team / CCC?

- 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
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
Questions?

Contact Information:
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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.
# CMMI Bundled Payment for Care Improvement

<table>
<thead>
<tr>
<th>Payment of Bundle</th>
<th>Acute Care Hospital Stay Only</th>
<th>Acute Care Hospital Stay plus Post-acute Care</th>
<th>Post-acute Care Only</th>
<th>Chronic Care</th>
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<tbody>
<tr>
<td>“Retrospective”</td>
<td>Model #1</td>
<td>Model #2</td>
<td>Model #3</td>
<td>Model #7</td>
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<td>“Prospective”</td>
<td>Model #4</td>
<td>Model #5</td>
<td>Model #6</td>
<td>Model #8</td>
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<td>FFS payment)</td>
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- Current
- Future
Bundling Surgical Episodes

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

- Length of Stay
- Utilization/Cost
  - Device/Implant
  - Testing
- Readmissions
- Physician claims (consultants)
Bundle Payment Episodes: Gainshare with Physicians

Total Savings

$ Savings determined based on cost/case comparison to baseline period

Remove 3% discount & program fees

Apply 50% Part B Ceiling

Tier 1 Quality Metrics

Minimum Threshold to Qualify

Individual

Tier 2 Quality & Performance Metrics (Goals)

Group or Individual

Quality 25%

Performance 75%
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)
Michael Spigel, PT, MHA
Executive Vice President and Chief Operating Officer
Brooks Rehabilitation
Jacksonville, Florida
Brooks Rehabilitation
Post Acute System of Care

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
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
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.
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

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