PREMIER

National Bundled Payment Summit -2014

Outpatient Bundles Update

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The Current State

- Expenditures in ambulatory care provided by hospitals have grown, on average, 8.6 percent annually (1).
- Poor coordination of care, the lack of effective care transitions' plans and CMS payment policies in outpatient, increase the likelihood of adverse events occurring such as ED visits and hospitalizations.
- For patients admitted, due to the above, for chronic illnesses, post-acute care spending can average twice the cost of the initial hospital stay, and 90- day readmission rates can exceed 40 percent (2).

Why Medicare Outpatient Bundles?

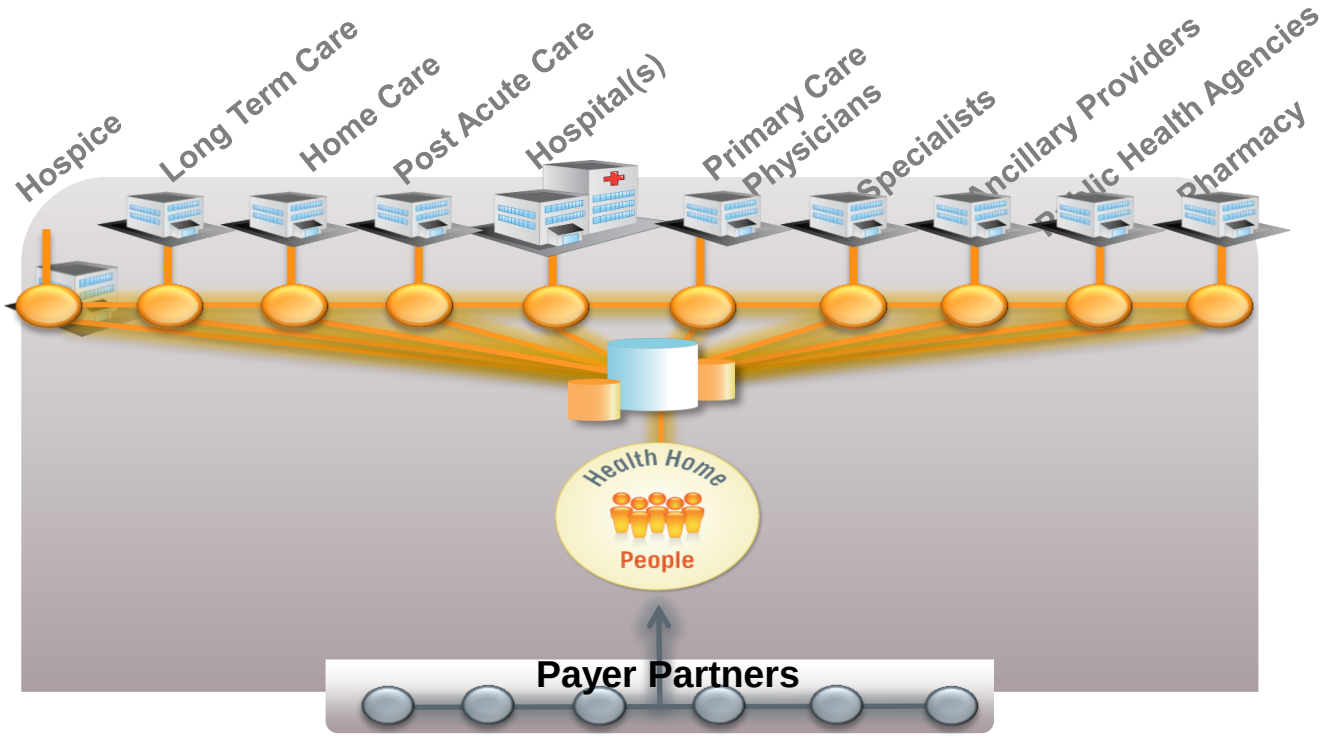
- An increasing number of patients are being treated in the ambulatory setting rather than the acute care setting.
- Medicare patients receiving care in an ambulatory setting (surgical or medical diagnosis) often do not receive coordinated care. Care Management activities have been focused on inpatient.
- They often return to the emergency department (ED) or eventually present as an admission in the acute care setting.

Why Medicare Outpatient Bundles-continued

- CMS is looking to change the way outpatient specialist practitioners are paid for both chronically ill beneficiaries and for patients with an ambulatory procedure . An RFI was issued in early Spring by CMMI.
- Outpatient has significant variation of costs, and their costs are growing
- Outpatient, observation, and inpatient definitions are blurring due to the Two Midnight Rule for the same diagnosis.

Case Study:
Outpatient Bundle Process and Design

Complete view of an episode



Define the Bundle

Bundle definition is comprised of three major components:

- Episode definition-defining what procedures and medical conditions to include
- Service inclusion-what services are included within a bundle and whether any services for an episode of care could be excluded.
- Episode duration-payers and providers must define the time period for when agreed upon services are considered part of the defined payment.

Outpatient Bundle Selection: Episode Selection

- Initially looked at 36 high volume outpatient surgeries and common chronic conditions.
- Selected 8 specific conditions and procedures based on the following:
  - Surgical procedures: incidence and procedure cost
  - Medical: prevalence and cost
- Through our examination of CMS claims data, we know that these eight conditions comprise 24 percent of beneficiaries and 57 percent of expenditures of total population cost for Medicare FFS beneficiaries.

Bundled Selection-continued

- Medical conditions:
  - atrial fibrillation, angina pectoris (chronic maintenance), chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF)
- Surgical procedures:
  - knee arthroscopy, cardiac pacemaker/device implant, percutaneous coronary intervention (PCI), iliac and femoral popliteal angioplasty
- Episode Duration Considerations: 30 or 90 days depending if surgical or medical

Outpatient bundled program design

- The trigger episode starts with an ***ambulatory event*** rather than an acute care hospitalization like BPCI.
- Retrospective reconciliation
- Bundle trigger discussed. Suggesting trigger be the first time the patient presents as an outpatient except in procedure (which is when it is scheduled)

Clinical Model

- Employ outpatient tools to identify gaps in care and segment patients on a real-time basis that are condition-specific and process of care-specific.
- Development of a robust outpatient care management approach is a must
- The program will enroll patients based on the triggering event. Once a patient experiences the triggering event from a participating provider, he or she becomes eligible for the program and is recruited via an outreach phone call.
- Because the bundled payment lasts 30 or 90 days depending on if medical or surgical condition after the triggering event, the principle physician will be responsible for monitoring the patient's progress

ROI considerations

- Savings in the Medicare Medical conditions were found in decreasing post acute spending, but was offset with increased primary care costs.
- Surgical procedures cost reductions in the Medicare patient related to supplies and location of services.
- The bulk of savings in Medicare outpatient bundles are in the medical conditions

Measurements of Success

- Suggest a parsimonious set of quality metrics designed to measure condition specific quality and outcomes that can be applied across the episode of care and conditions
- Consider measurements applicable to all conditions: including the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CGCAHPS) Survey,
- Consider: number of ED visits per episode, total per episode cost, follow-Up after hospitalization, all-cause mortality rate, patient experience, infections
- Seek to use measures that are in wide use and already collected as part of other programs, or measures that can be calculated through claims data.
- Consider how measures will be used in relation to payment from the start of the program.

Potential issues

- Grouper
- Triggers
- Education
- Defining the episode of care
- Transition back to the primary care provider
- Beneficiary recruitment, enrollment and retention
- Provider infrastructure
- Coding

Citations

- (1) MedPAC, Medicare Payment Policy. "Report to Congress." (2011)

- (2) Robert Mechanic, Christopher Tompkins, “Lessons Learned Preparing for Medicare Bundled Payments,” The New England Journal of Medicine, November 15, 2012. http://www.nejm.org/doi/full/10.1056/NEJMp1210823

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