Condition-based versus Procedure-based Bundles

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The original bundle construct – the inpatient prospective payment system (IPPS) – 1980's

- Diagnosis Related Groups (DRG) versus 'reasonable cost' based payments
- Primary (only) DRG has a relative weight based on expected consumption of resources
- Currently 745 MS-DRGs (510 until a few years ago) stratifies risk
- Payment: national standard amount (adjusted by local wage index) X DRG relative weight
- Medicare outlier threshold as stop loss (only second dollar i.e. not including 'gap')
- Relative weight reviewed periodically according to resource utilization/cost
- Physician services not included – RVUs ('averaged' for CPT codes given how these are derived i.e. 'typical patient', and sometimes 'bundled' under 'global' payments that include pre- and post-operative care

The 2nd original (carve-out) bundle construct – the transplant case rate (condition-based) – 1990s

- Phase 1: referral (i.e. may need a transplant) to listing (i.e. needs a transplant) includes transplant evaluation work-up, but not 'usual care' (…'related' but not 'unrelated' to condition)
- Phase 2: listing to transplant (waitlist); includes related to condition but not unrelated to condition
- Phase 3: transplant episode to discharge from acute care setting
- Phase 4: global period (30-90 days) after discharge; includes 'related' readmissions, meds, +/- rehab etc.
- Phase 5: 30-90 days to 1 year; includes outpatient follow-up and 'related' readmissions

Lessons Learned (I)

- Phase 1: referral (i.e. may need a transplant) to listing (i.e. needs a transplant) includes transplant evaluation work-up, but not 'usual care' (…'related' but not 'unrelated' to condition)
  - What about 'work-up' that consists of 'usual care' not being delivered?
  - Definition of 'related' versus 'unrelated'; who decides?
  - Does 'usual care' include condition-specific care? Dialysis – CMS demonstration project
  - Is there a time limit?
  - What if something happens that prevents Phase 3? Revert to default contractual agreement?
  - ➢ **Mostly dropped from bundle altogether or diluted down; 'minimal listing'**

Lessons Learned (II)

- Phase 2: listing to transplant (waitlist); includes related to condition but not unrelated to condition
  - Waiting time versus 'sickest first' (1998 DHHS Final Rule) – variable natural history of disease
  - Worsening organ shortage resulting in longer wait times
  - Transplant provider bundle contract through 'aggregator' versus provider contract with payer/employer for non-bundle services – disrupts default contractual agreement and continuity of care and
  - No ability to predict financial risk to provider
  - **Dropped from bundle altogether; still a problem with narrow networks pulling transplant bundles from non-network providers**

Lessons Learned (III)

- Phase 3: transplant episode to discharge from acute care setting
  - This works well in general
  - Internal splits (attribution) – some interesting solutions (Tiered payments to physicians)
  - Stop loss (1st and 2nd dollar) essential but need to avoid gaming the case rate); outliers straight forward but 'inlier clauses' may threaten efficiency (i.e. decreasing LOS)
  - Dissociation between hospital and physician reimbursement based on charge-to-cost innuendos
  - **Overall, proof-of-principle showing that can easily bundle services and payments around a procedural episode**

Lessons Learned (IV)

- Phase 4: global period (30-90 days) after discharge; includes 'related' readmissions, meds, +/- rehab etc.
  - This also works well in general
  - The original PAC bundle
  - The original Medical Home (transitions of care, reduce ED visits and re-admissions, especially for 'related' care)
  - Related care fairly well defined – but generated denials and conversations with Aggregator Medical Directors
  - Learned to optimize the 'bells and whistles' (meds, rehab, etc.)
  - Loss leader by itself, but helped create margins for the 'bundle'
  - ➢ **Another proof-of-principle showing that bundling procedural episode with PSC offers an opportunity to optimize care and cost-efficiencies**

Lessons Learned (V)

- Phase 5: 30-90 days to 1 year; includes outpatient follow-up and 'related' readmissions
  - Not worth the trouble since most if not all 'related' readmissions occur in first 30 days
  - Difficult to operationalize (Most of the care provided not related but the bundle always pops up and has to be undone)
  - Administrative costs of bundling this far out may be higher than any potential cost savings
  - Contrary to philosophy that transplantation is supposed to return patients to a 'normal' life, not one of being a professional patient; this is especially important in view of long life expectancy versus other chronic conditions

  ➢ **First to be dropped from bundle**

The 2nd original (carve-out) bundle construct – the transplant case rate (condition-based) – 1990s

- Phase 1: referral (i.e. may need a transplant) to listing (i.e. needs a transplant) includes transplant evaluation work-up, but not 'usual care' (…'related' but not 'unrelated' to condition): mostly gone
- Phase 2: listing to transplant (waitlist); includes related to condition but not unrelated to condition: gone
- Phase 3: transplant episode to discharge: going strong
- Phase 4: global period (30-90 days) after discharge; includes 'related' readmissions, meds, +/- rehab etc.: going strong
- Phase 5: 30-90 days to 1 year; includes outpatient follow-up and 'related' readmissions: gone

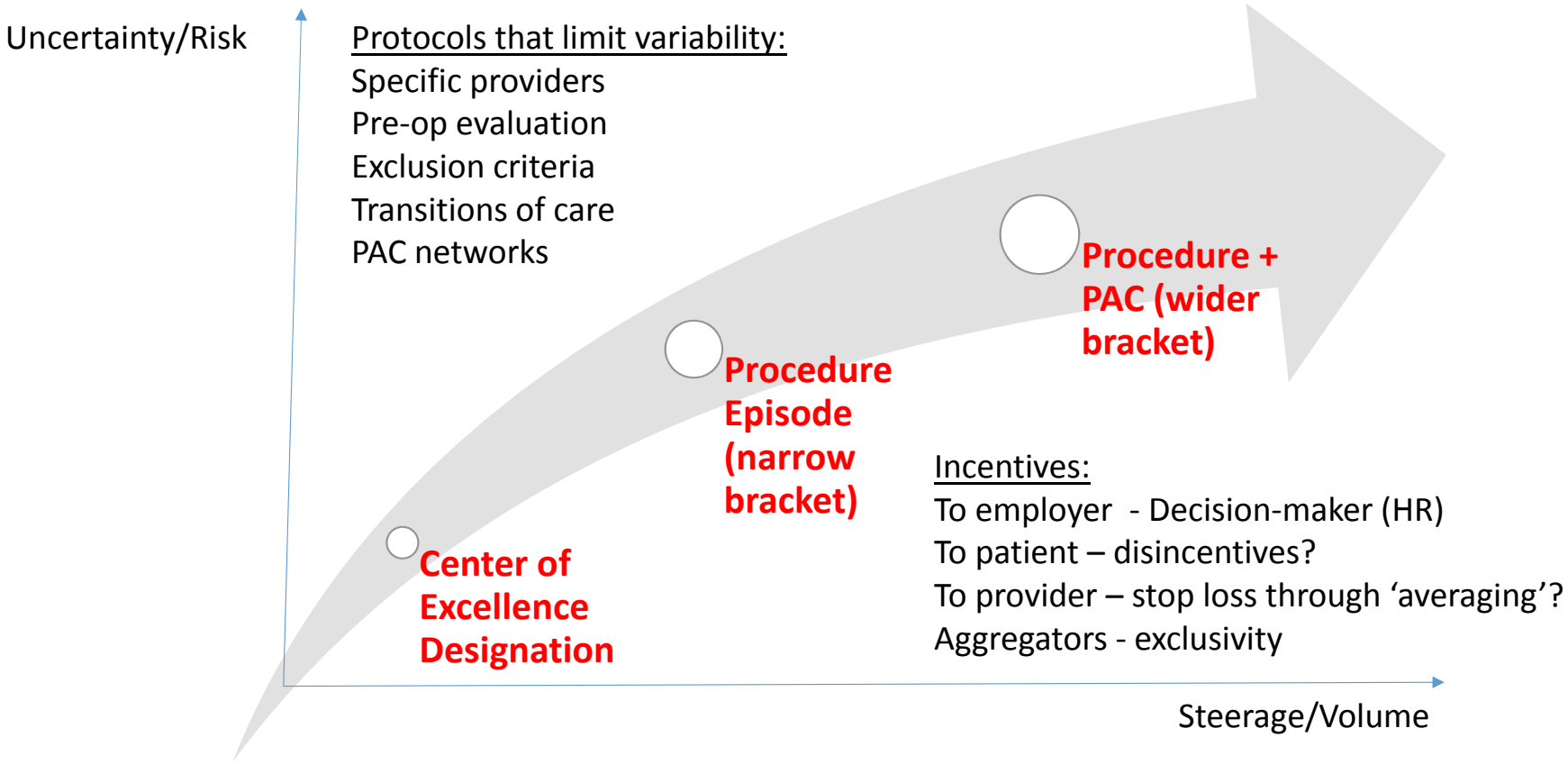
Summary of Lessons Learned from Transplant

- What works: (Phases 3 and 4)
  - Building a bundle is fairly straightforward, as long as the episode(s) is(are) well defined and the risk corridor is acceptable (performance versus actuarial risk)
  - Can manage episodes of care in the context of limited uncertainty as long as there is clinical and administrative provider integration, a culture of clinical and financial accountability, care re-design around the episode(s), aligned incentives and defined attribution
- What doesn't work as well: (Phases 1 and 2)
  - Youthful enthusiasm – too much too fast (from condition-based to procedure-based – a journey to a hybrid model)
  - Not being able to manage unlimited uncertainty
  - Taking on risk corridor(s) that one is not able to manage

Applying Lessons Learned from the Transplant Experience to 'New Marketplace' at Northwestern

- Direct to Employer Bundles for TJR and other procedure-based episodes
  - Define 'bundle busters' in lieu of stop loss
  - Operationalizing processes and scalability
  - High Performance Aggregators similar to transplant networks
  - Role of TPAs
  - Natural progression to include PAC
- Second wave of BPCI (TJR, CHF, Stroke, COPD)
  - An experiment in management of PAC
  - Can choose 'risk track' for each bundle
  - CHF perfect case study
  - Changing practices – i.e. stroke, valve surgery
  - Partnership with PAC provider networks

Direct to Employer Models – Challenges & Opportunities



Closing Thoughts

- Not discussed today, but important and relevant:
  - COE designation is the gateway to bundled agreements (i.e. process and outcomes measures and transparency are a given)
  - High cost variability x high volumes = bundling opportunity
  - Creating and maintaining demand and steerage requires a value proposition beyond financial efficiencies (simplicity and access to 'decision-makers')
- In the end, when there is a culture of clinical and financial accountability in the context of aligned incentives, everyone wins especially the patient
- Significant parallels between bundling and the 'paradox of thrift' (John Maynard Keynes – Keynesian economics)


How?
Where?
Which?
What?
Why?
Who?