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ideas. answers. action.

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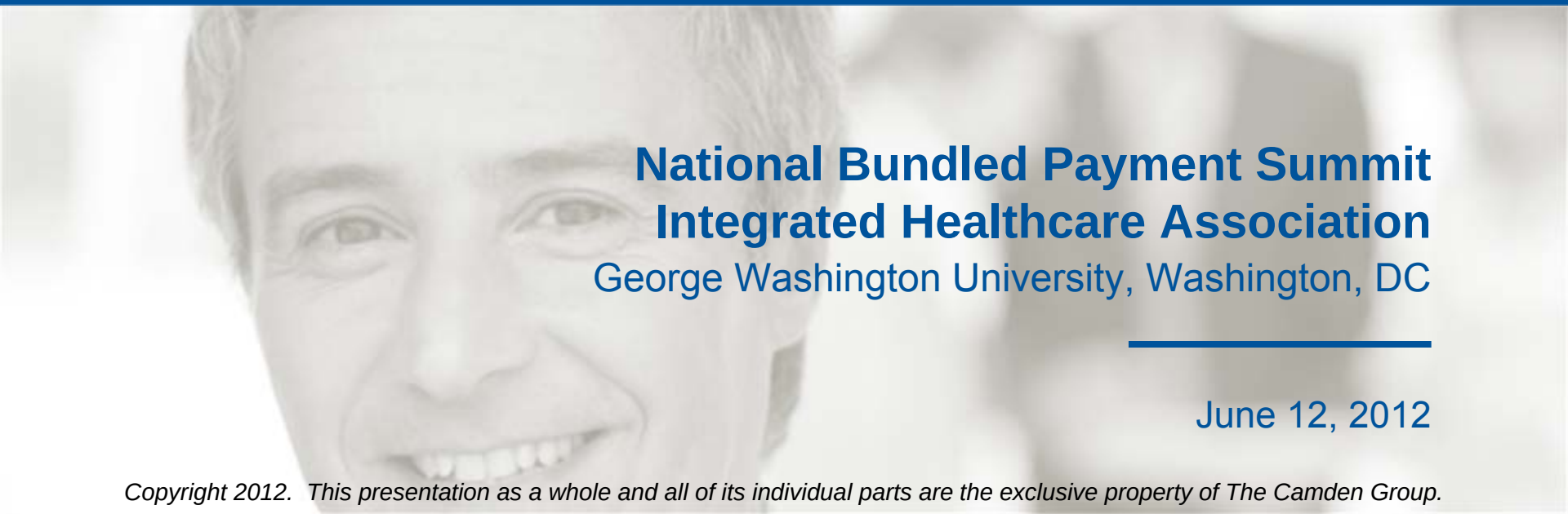
Medicare Bundling



National Bundled Payment Summit
Integrated Healthcare Association

George Washington University, Washington, DC

June 12, 2012

Agenda

Historical Perspective

Bundled Payment for Care Improvement Updates

Keys to a Successful Application

Organizational Readiness

Metrics

Features of Successful Gainshare Program

Lessons Learned from Model 1 Application Process

Future Models

Questions and Answers

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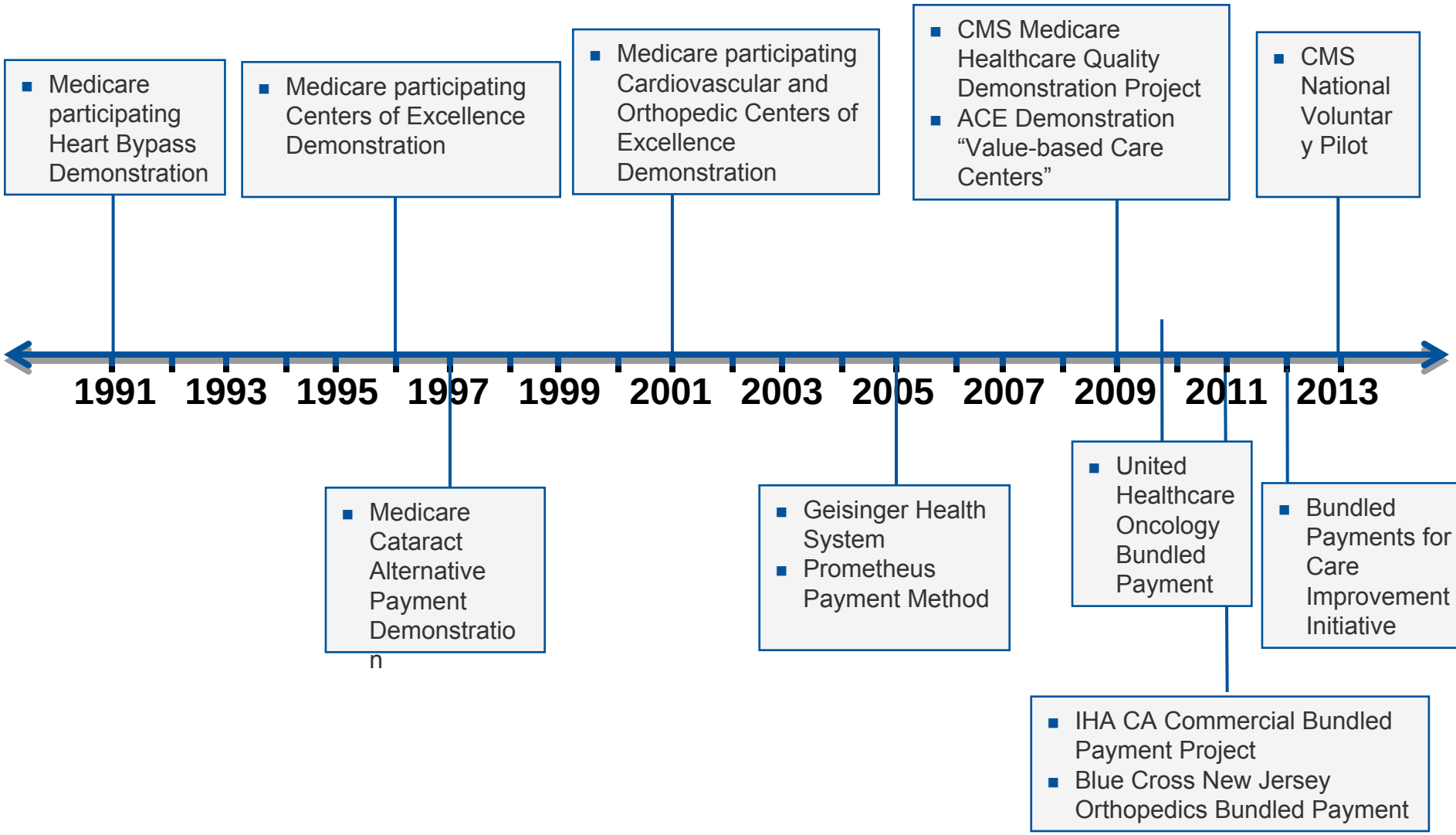
Bundled Payment: Nothing New Conceptually



Lessons Learned from Acute Care Episode Demonstration

- Acute Care Episode (“ACE”): validation study on bundles with elective procedures and inpatient elective procedures
- Gainsharing Works!
- Infrastructure Necessary for Success
- Analytics
- Physician Engagement
- Claims Adjudication
- Evidence-based Care Redesign
- Process Improvement Critical to Success
- Discount Range from one to six percent with ACE

Agenda

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Keys to a Successful Application

Organizational Readiness

Metrics

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Lessons Learned from Model 1 Application Process

Future Models

Questions and Answers

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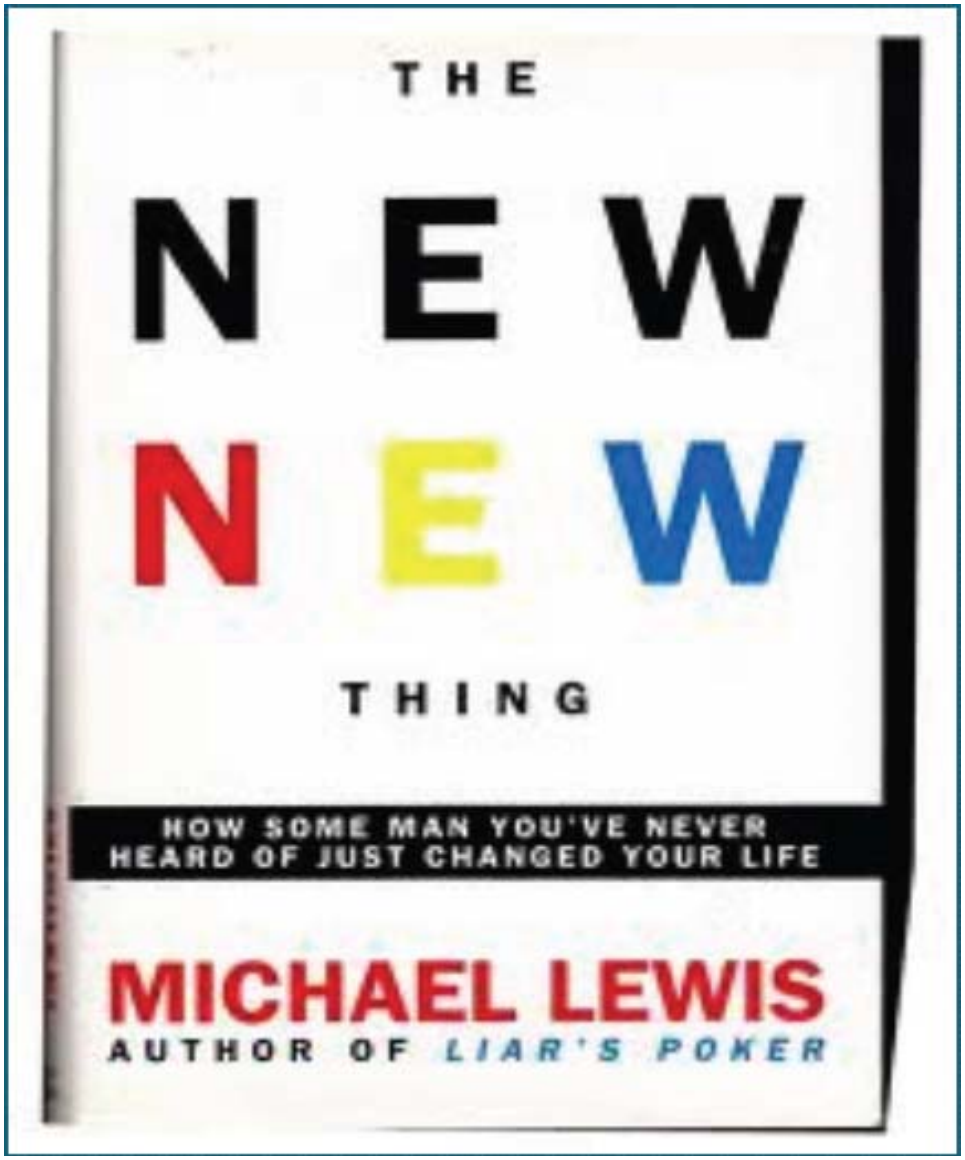
What Makes this Time Around Any Different?



CMS Innovation Center Perspective

Context: Triple Aim

- Better Health
- Better Care
- Lower Costs through Improvement

The Role of Bundled Payments in Achieving the Triple Aim

- **Improve** the **care** for beneficiaries who are admitted to the hospital, both during and following the hospitalization
- **Reduce** escalating **costs** including costs born by beneficiaries
- **Eliminate waste** by improving the coordination and continuity of care across providers and settings
- Provide a first **step toward accountable care** and an effective tool for established ACOs
- Create flexible payment arrangements that support the **redesign of care** and increase alignment across providers and settings

CMMI Release – April 4, 2012

New Deadline for Models 2-4: **June 28, 2012** and Online Portal Release Date

The **online portal for Models 2, 3, 4 was released May 4, 2012.** To ensure clarity and address the potentially large number of applications and the variety of partnerships CMMI will expect to see, CMMI has streamlined the application and incorporated all program clarifications that have been released to date.

CMMI has received a great deal of feedback from potential applicants requesting that they provide more time for the preparation of their applications. Based on those requests and the availability date of the online application portal, **CMMI is extending the Models 2-4 application deadline to Thursday, June 28, 2012 at 5:00 PM EDT.**

http://www.innovations.cms.gov/initiatives/bundled-payments/index.html

Agenda

Historical Perspective
Bundled Payment for Care Improvement Updates
Keys to a Successful Application
Organizational Readiness
Metrics
Features of Successful Gainshare Program
Lessons Learned from Model 1 Application Process
Future Models
Questions and Answers

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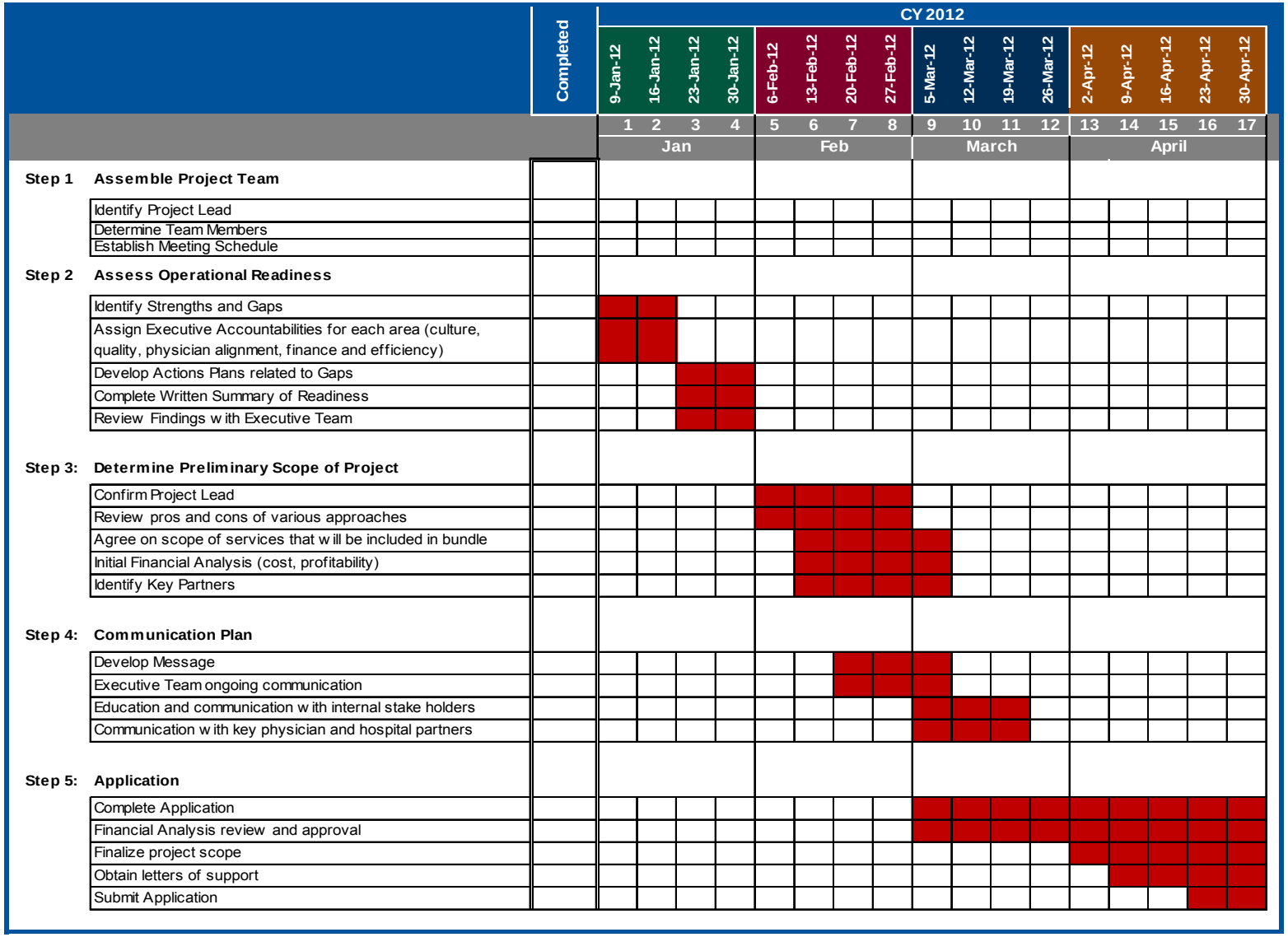
CMS BPCI Application Scoring

Selection Criteria and Weights

- Financial Model (40 points)
  - Overall savings to Medicare
  - Risk adjustment (if applicable)
  - Anticipated actions that will result in lower spending
- Quality and Patient Centeredness (25 points)
  - Proposed mechanisms to improve quality and patient experience of care
  - Proposed quality metrics
  - Quality assurance and continuous quality improvement
  - Beneficiary protections
- Demonstration Design (20 points)
  - Definition of episode
  - Level of provider engagement and participation
  - Care improvement
  - Design for gainsharing
- Organizational Capabilities, Prior Experience, and Readiness (15 points)
  - Financial arrangements
  - Commitment and credentials of executives and governance bodies
  - Success and readiness to participate
  - Partnerships

Sample Work Plan

Bundled Payment Awardee
January 2012 - April 2012 Bundled Payment Work Plan



Agenda

Historical Perspective
Bundled Payment for Care Improvement Updates
Keys to a Successful Application
Organizational Readiness
Metrics
Features of Successful Gainshare Program
Lessons Learned from Model 1 Application Process
Future Models
Questions and Answers

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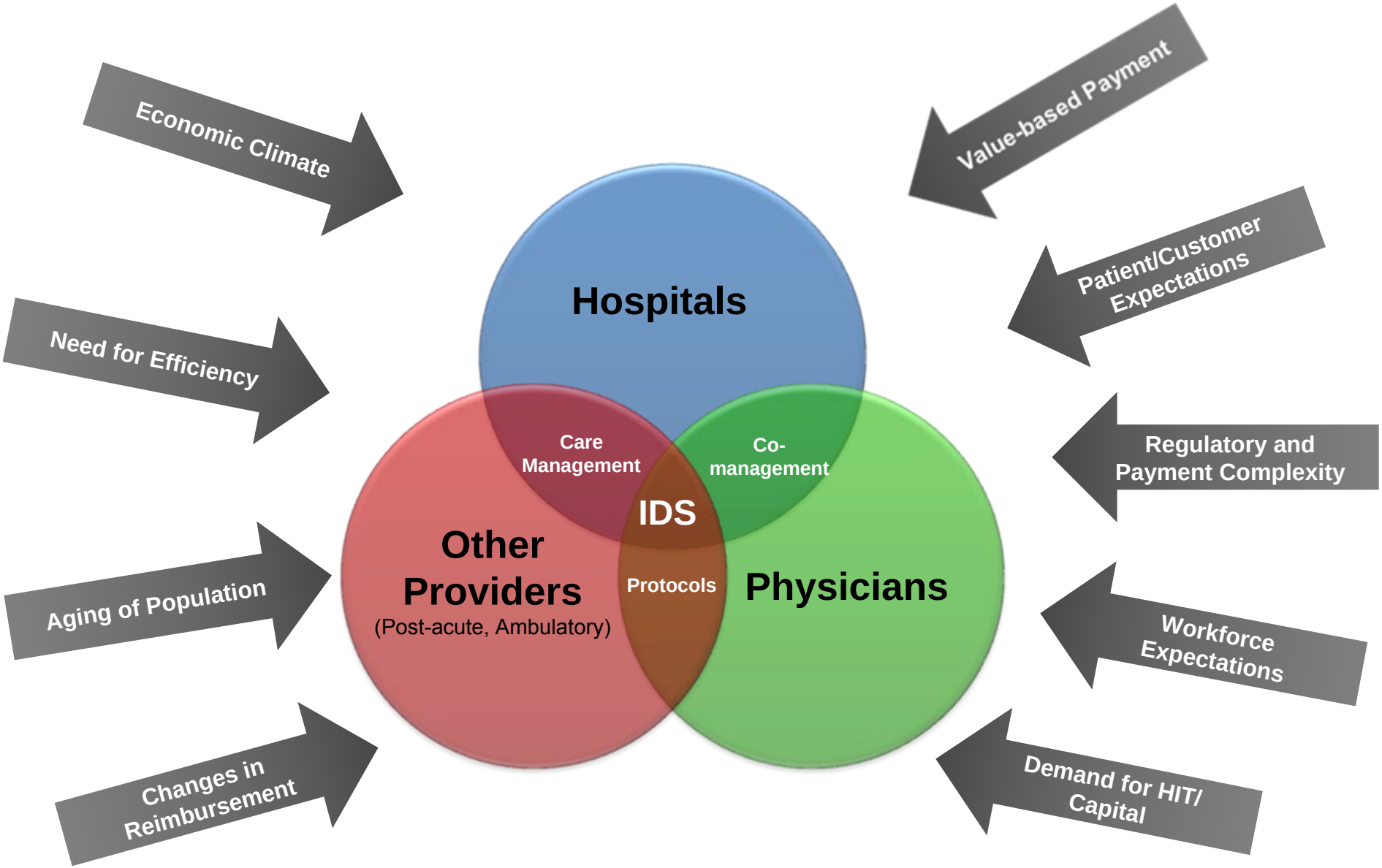
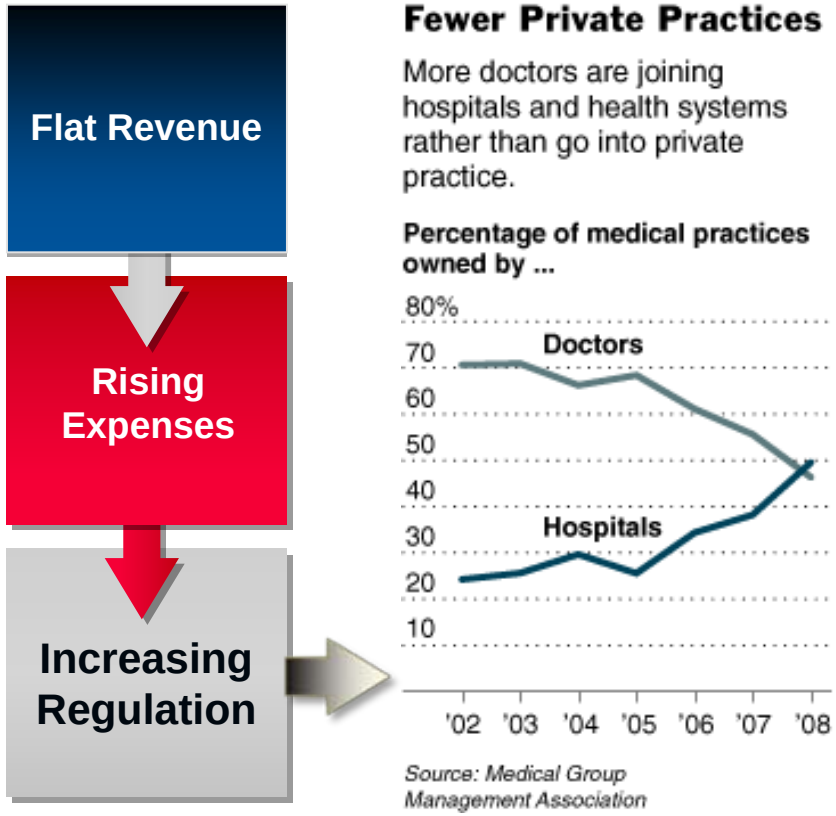
Drivers of Greater Integration



Hospital Employment of Physicians

We Have All Seen the Trends…

- Factors driving physicians to seek employment include:
  - Desire for economic stability/ security
  - Changes in government payments to doctors
  - Rising operating expenses
  - The growing emphasis on patient safety and quality
  - Lifestyle (e.g., predictable hours, less calls)
  - Inability to recruit new physicians



According to a 2010 survey of 193 hospitals by Modern Healthcare, 94 percent employ physicians.

Agenda

Historical Perspective
Bundled Payment for Care Improvement Updates
Keys to a Successful Application
Organizational Readiness
Metrics
Features of Successful Gainshare Program
Lessons Learned from Model 1 Application Process
Future Models
Questions and Answers

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Common Metrics Used in Bundled Payment

Example Metrics

- Cost
  - Implant cost compared to like size programs
  - Variable cost per case compared to best practice
  - Supply cost per case compared to best practice
  - Average cost per case compared to best practice
- Efficiency
  - Pre-procedure length-of-stay compared to best practice
  - Average inpatient length-of-stay compared to best practice
  - Case length compared to best practice
  - On time starts compared to best practice
  - OR/Cath lab turnaround time compared to best practice
- Quality
  - Alignment with other organizational initiatives
  - Alignment with clinical integration metrics
  - HCAPHS
  - Value-based purchasing
  - Society benchmarks (ACC, STS)

Performance Dashboards: Best With Hard-Hitting Data

Ref	CLINICAL OUTCOMES	FY 2010 Avg	FY Q1 Oct-Dec 10	FY Q2 Jan-Mar 11	FY Q3 Apr-Jun 11	FY Q4 Jul-Sep 11	FY 2011 Avg	Target Goal	Stretch Goal
1	Acute Care Admission Mortality - %	3.5	2.6	2.8			2.7	N/A	N/A
2	Overall Mortality Rate - %	3.5	1.7	1.9			1.8	N/A	N/A
3	Overall Mortality Expected (APR DRG Adjusted) - Rate	4.4	2.2	2.5			2.4	N/A	N/A
4	Mortality Ratio Observed/Expected (APR-DRG adjusted)	0.8	0.8	0.8			0.8	1.00	0.62
5	APR-DRG Mortality Ratio - #140 - COPD	0.0	0.0	TBD			0.0	0.96	0.77
6	APR-DRG Mortality Ratio - #720 - Septicemia & Disseminated Infections	1.10	1.0	TBD			1.0	0.98	0.79
7	APR-DRG Mortality Ratio - #139 - Other Pneumonia	1.00	1.10	TBD			1.1	0.82	0.66
8	APR-DRG Mortality Ratio - #194 - Heart Failure	0.74	0.0	TBD			0.0	0.82	0.66
9	Acute Care (all cases) Readmit < 31 days - %	13.8	9.1	10.0			9.6	15	13
10	HF % Readmits < 31 days - %	15.1	16.9	15.4			16.1	21.0	18.0
11	Heart Failure All-or-None Bundle - %	94.6	84.1	90.9			87.5	90	100
12	Heart Failure (HF1) - All Discharge Instructions	94.9	81.1	88.9			85.0	90	100
13	Heart Failure (HF2) - Evaluation of LVS Function	99	99	100			100	90	100
14	Heart Failure (HF3) - ACEI or ARB for LVSD	99.0	98	100			99	90	100
15	Heart Failure (HF4) - Adult Smoking Cessation Advice/Counseling	96	100	100			100	90	100

Patient and Physician Perception is Critical in Assessing Value

Ref	PATIENT SATISFACTION	FY 2010 Avg	FY Q1 Oct-Dec09	FY Q2 Jan-Mar10	FY Q3 Apr-Jun10	FY Q4 Jul-Sep10	FY 2011 Avg
1	Standard Overall Perception of Care	85	85.8	83.7			84.75
2	Time Physician Spent with You	80	81.7	76.4			79.05
3	Physician Concern Questions/Worries	84	84.8	80.1			82.45
4	Physician Kept You Informed	82	84.2	78			81.1
5	Friendliness/Courtesy of Physician	88	88.3	84.1			86.2
6	Skill of Physician	90	90.7	87.5			89.1
	Sample Size	n=552	n=204	n=278	n=	n=	

Peer Satisfaction Report

Indicator	Q2 FY 11	Target	Explanation of Variance	Action for Improvement
Communication with Specialist	**79.8**	80.0	1 SD below goal; new communication tool just started last quarter	Follow trend over three quarters
Coordination with Specialist	**74.2**	85.3	2 SD below goal; several new hospitalists joined the group	On-boarding program started this month
Communication with Primary Care Physician	**85.1**	85.0	At goal; PCP communication process implemented last FY	Continue to monitor to exceed 90

Agenda

Historical Perspective
Bundled Payment for Care Improvement Updates
Keys to a Successful Application
Organizational Readiness
Metrics
Features of Successful Gainshare Program
Lessons Learned from Model 1 Application Process
Future Models
Questions and Answers

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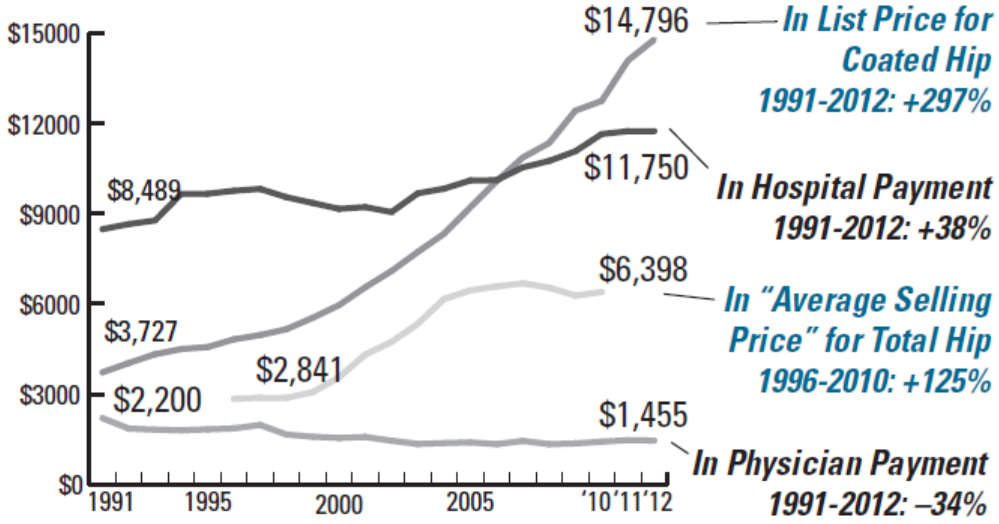
Hospitals Assessing Who Their Long-term Strategic Partners Are

Vendor Price Increases Outpacing Physician and Hospital Reimbursement

Trends in Implant Economics, 1991-2012



Sources:
Hospital Payment: DRG 209, 544, and 470 payment from Medicare for FY 1992-2012 as reported in ***Orthopedic Network News (ONN)****, October 1991-2011.*
Implant List Prices: Coated hip system price as reported in ***ONN****, January 1992-2012*
Implant Selling Price: Average hip implant price for 1996-2010 as reported in ***ONN****, July 1997-2011*
Physician Payment for total hip (CPT 27130) from Medicare as reported in ***ONN****, January 1992-2012*

2011 Net Profit Margin

Zimmer	22%
J & J (DePuy)	19%
Smith and Nephew	20%
Medtronic	21%
Edwards	15%
St. Jude	9%
Average Hospital Margin	**2.2%**

Source: SEC Filings 2011-2012, 10K reports

Gainsharing Arrangements

Gainsharing Arrangements – Request for Applications ("RFA")

Gainsharing arrangements will consist of the hospital and providers distributing gainsharing payments to physician(s) and/or other practitioners

- These payments will represent a share of the gains resulting from collaborative efforts to **improve quality and efficiency**

- Waiver of Statutory Requirements
  - Under Section 115A(d)(1)Title XI of the Social Security Act, as added by Section 3021 of the Patient Protection and Affordable Care Act, the **Security of Health and Human Services may waive such requirements** of Titles XI and XVII, as well as Sections 1902 (a)(13), and 1903 (m)(2)(A)(iii), as may be necessary for purposes of carrying out Section 115A with **respect to testing of models** described in section 1115A(b). The Secretary will consider exercising this waiver authority with respect to the fraud and abuse laws in Titles XI and XVIII **as may be necessary to develop and implement the BPCI initiative**. The Secretary may also consider waving additional provisions under Title XVIII for this purpose.

- Gainsharing Program Requirements
  - Ensure that care is not inappropriately reduced
  - Quality of care remains constant or is improved
  - No inappropriate changes in utilization or referral patterns
  - Guard against fraud, waste, and abuse

Gainsharing Program Requirements

Gainsharing Program Requirements - RFA

- Gainsharing Design
  - How gainsharing will support care redesign to achieve improved quality and patient experience, and anticipated cost savings
  - Methodology for the sharing of gains between or among the hospital or other care settings (e.g., post-acute facility) and physicians and other non-physician practitioners. This must include a discussion of with whom gains will be shared (e.g., physicians only), with what frequency gains will be shared, and under what criteria gains will be shared (e.g., quality standards)
  - Assurance of medically necessary care
  - Gainsharing arrangements must be transparent, auditable, and strictly voluntary
  - Not to have adverse consequences for physicians who choose not to participate
  - Design must include specific criteria that would deem a provider ineligible **based on quality** thresholds

Gainsharing Program Requirements

Gainsharing Program Requirements - RFA (cont'd)

- Quality
  - Must meet minimum quality requirements and then remain constant or improve for the duration of the arrangement
  - The applicant must propose the following, which will be reviewed and approved by CMS:
    - Minimum quality thresholds
    - A process for monitoring quality and quality improvement during the project period
    - A set of metrics for improving quality of care during the project period
  - The applicant must discuss how physicians and non-physician practitioners may become eligible or ineligible to participate in gainsharing
- Payment Methodology
  - Payments may not be based on the volume or value of referrals
  - Payments to physicians may not exceed 50 percent of the amount that is normally paid to physicians and non-physician practitioners for the cases included in the gainsharing initiative
  - The applicant must include a comprehensive plan regarding how they will distribute financial rewards in their application

Gainsharing Methodology

Sample Methodology

Sample Definitions

- Baseline: 2011 calendar year
- Measurement quarters: four calendar quarters in given year of project
- Patient populations
  - Medicare inpatients in fee-for-service program with Part A and Part B

Sample Quality Validation

- Baseline
  - Calculate quality indicators compared to benchmark targets for all physicians combined for all patients/payers within demonstration project DRGs
- Measurement quarter
  - Calculate quality indicators compared to benchmark targets for all participating physicians for the measurement quarter
- Compare baseline to measurement quarter practice to assure no significant changes from historical performance. There is an expectation that quality targets will be achieved and sustained relative to the baseline for physicians to qualify for payment.
- If significant changes occur, the appropriate committee will review individual physician data to determine if they were the result of change in practice due to the initiative. The committee may choose to conduct an audit of individual cases or implement individual action plans if there are specific physicians with quality outcomes that are significantly different from baseline.

Gainsharing Methodology

Sample Savings Calculation

- Baseline cost for savings initiatives
  - Calculate cost, utilization, and productivity baselines according to average practice for all physicians to determine “Average Baseline Costs” for each Clinical Category during the Program Period.
- Measure quarter cost for savings initiatives
  - Calculate cost, utilization, and productivity according to average practice for each individual participating physician to determine “Average Actual Costs” for each Clinical Category during the Program Period.
- Savings
  - Calculate savings for each initiative by comparing baseline to measurement practice period to determine “Average Savings” for each Clinical Category for Physician’s or Group’s patients.
- **Sample Geometric Mean Length-of-Stay Reduction**
  - All Physician Baseline Average = 2.1 days
  - Physician A Q1 Average = 1.5 days
  - Physician A Q1 Patient Volume = 40
  - Physician A Q1 Savings = (2.1 – 1.5 days) x 40 patients x $ XX dollars/day = savings

Gainsharing Methodology

Sample Eligibility and Ineligibility Criteria

Eligibility Criteria for Gainshare Participation

- In order to be eligible to participate in gainsharing, a physician must voluntarily consent to participation in the Gainshare Plan.
- Participating physicians must ensure that all medically necessary care is provided to beneficiaries throughout the three-year term of the project.
- Physicians must consent to tracking and analysis of individual performance and agree to be assessed via benchmark comparisons.
- Participating physicians must achieve and maintain minimum quality targets in order to be eligible for gainsharing.

Ineligibility

- The BPCI Physician-Hospital Steering Committee will be responsible for determining ongoing performance metrics as well as the analysis and achievement of performance relative to these measures. In addition, all CMS Innovation Center required metrics and BPCI measures, regardless of their impact on gainsharing, will be reported to the BPCI Physician-Hospital Steering Committee on a monthly basis. Deviations from acceptable performance will be acted upon in accordance with standard hospital procedures up to removal from the BPCI Gainshare Program.
- If significant changes occur, the appropriate committee will review individual physician data to determine if they were the result of change in practice due to the initiative. The committee may choose to conduct an audit of individual cases or implement individual action plans if there are specific physicians with quality outcomes that are significantly different from baseline.

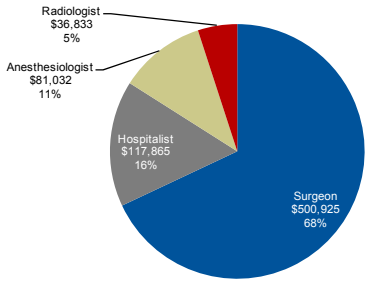
Gainsharing – Orthopedic Services

Hospital A
CMMI Bundled Payments for Care Improvement Initiative
Model 4 - Inpatient Stay Only
Projected Gainsharing Potential for Orthopedic Services
CY 2013-2015

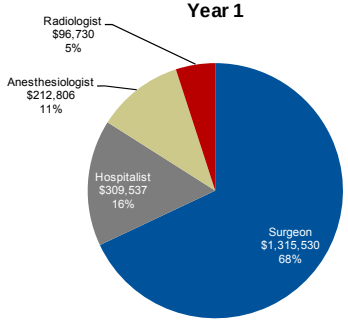
Orthopedic Services		Projection Period CY 2013	CY 2014	CY 2015	3-Year Total
Projected Medicare FFS		1,864	1,864	1,864	5,591
Calculated Gainsharing Bonus					
Gainsharing Bonus (Not to Exceed Maximum Allowable)		$736,654	$724,291	$712,473	$2,173,418
Average per Case		**$395**	**$389**	**$382**	**$389**
Distribution Sample Per Case					
Surgeon	68%	$269	$264	$260	$264
Hospitalist	16%	63	62	61	62
Anesthesiologist	11%	43	43	42	43
Radiologist	5%	20	19	19	19
Total per Case	100%	**$395**	**$389**	**$382**	**$389**
Maximum Gainsharing Bonus					
Maximum Gainsharing Bonus (50% of Part B)		$1,934,603	$1,934,603	$1,934,603	$5,803,810
Average per Case		**$1,038**	**$1,038**	**$1,038**	**$1,038**
Distribution Sample Per Case					
Surgeon	68%	$706	$706	$706	$706
Hospitalist	16%	166	166	166	166
Anesthesiologist	11%	114	114	114	114
Radiologist	5%	52	52	52	52
Total per Case	100%	**$1,038**	**$1,038**	**$1,038**	**$1,038**

Note 1: The agreement will include a performance period of 3 years with the possibility of extending an additional 2 years.
Note 2: Projections are based on CY 2010 volume and financial performance. No inflators/deflators were applied to service area volume, revenue, or expenses.

Potential Annual Distribution Gainsharing Bonus (NTE Allowable Amount) Year 1



Potential Annual Distribution Maximum Gainsharing Year 1



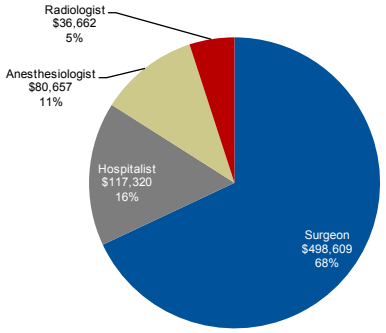
Gainsharing – Cardiac Services

Hospital A
CMMI Bundled Payments for Care Improvement Initiative
Sample Model 4 - Inpatient Stay Only
Projected Gainsharing Potential for Cardiac Services
CY 2013-2015

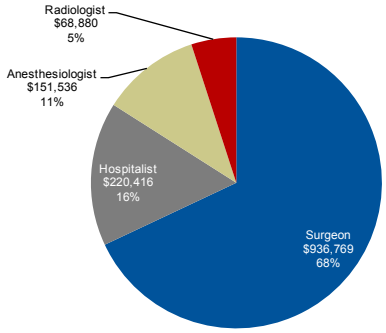
Cardiac Services		Projection Period CY 2013	CY 2014	CY 2015	3-Year Total
Projected Medicare FFS Cases		1,292	1,362	1,432	4,086
Calculated Gainsharing Bonus					
Gainsharing Bonus (Not to Exceed Maximum Allowable)		$733,249	$771,715	$810,060	$2,315,023
Average per Case		**$568**	**$567**	**$566**	**$567**
Distribution Sample Per Case					
Surgeon	68%	$386	$385	$385	$385
Hospitalist	16%	91	91	90	91
Anesthesiologist	11%	62	62	62	62
Radiologist	5%	28	28	28	28
Total per Case	100%	**$568**	**$567**	**$566**	**$567**
Maximum Gainsharing Bonus					
Maximum Gainsharing Bonus (50% of Part B)		$1,377,602	$1,452,465	$1,527,328	$4,357,394
Average per Case		**$1,066**	**$1,066**	**$1,066**	**$1,066**
Distribution Sample Per Case					
Surgeon	68%	$725	$725	$725	$725
Hospitalist	16%	171	171	171	171
Anesthesiologist	11%	117	117	117	117
Radiologist	5%	53	53	53	53
Total per Case	100%	**$1,066**	**$1,066**	**$1,066**	**$1,066**

Note 1: The agreement will include a performance period of 3 years with the possibility of extending an additional 2 years.
Note 2: Projections are based on CY 2010 volume and financial performance. No inflators/deflators were applied to service area volume, revenue, or expenses.

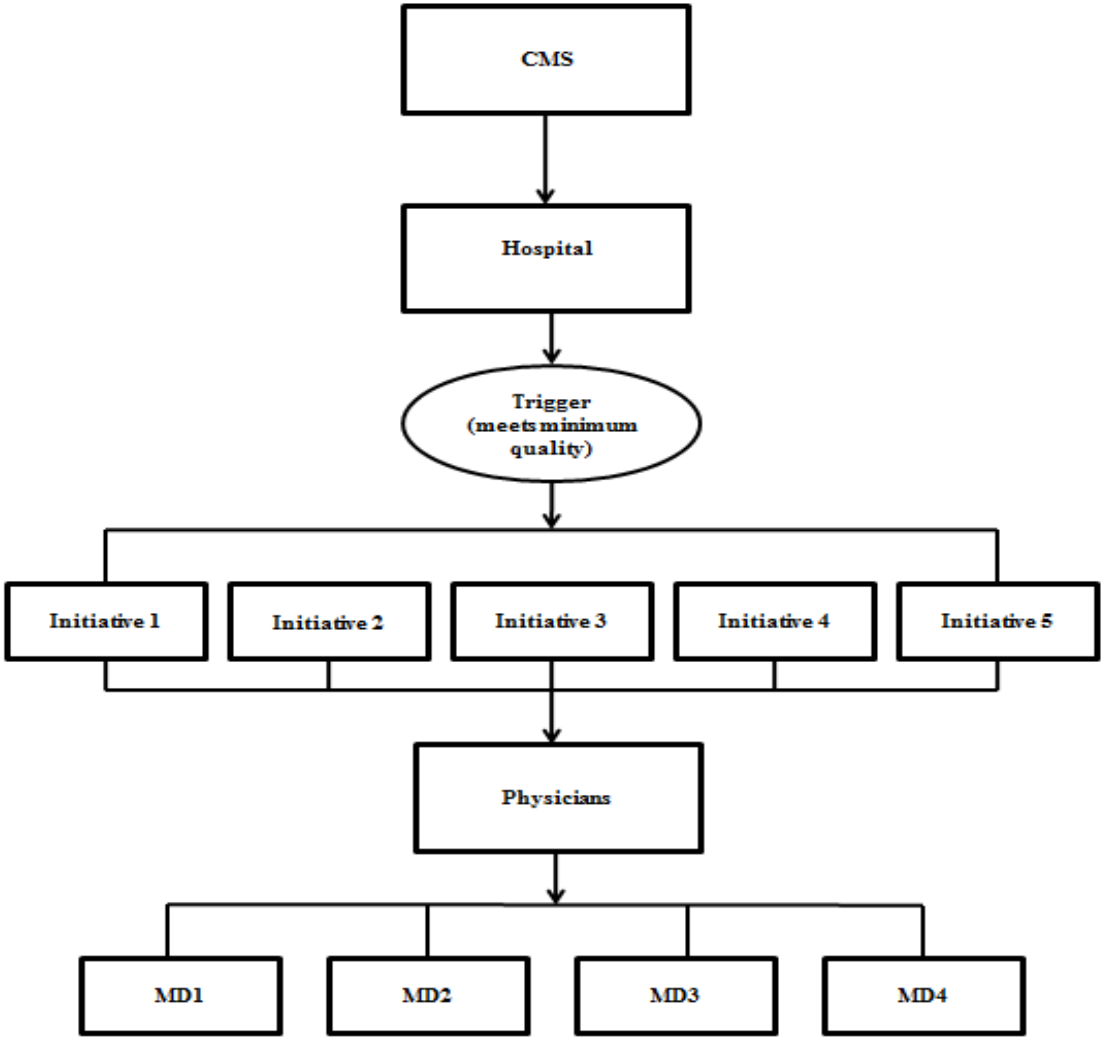
Potential Annual Distribution Gainsharing Bonus (NTE Allowable Amount) Year 1



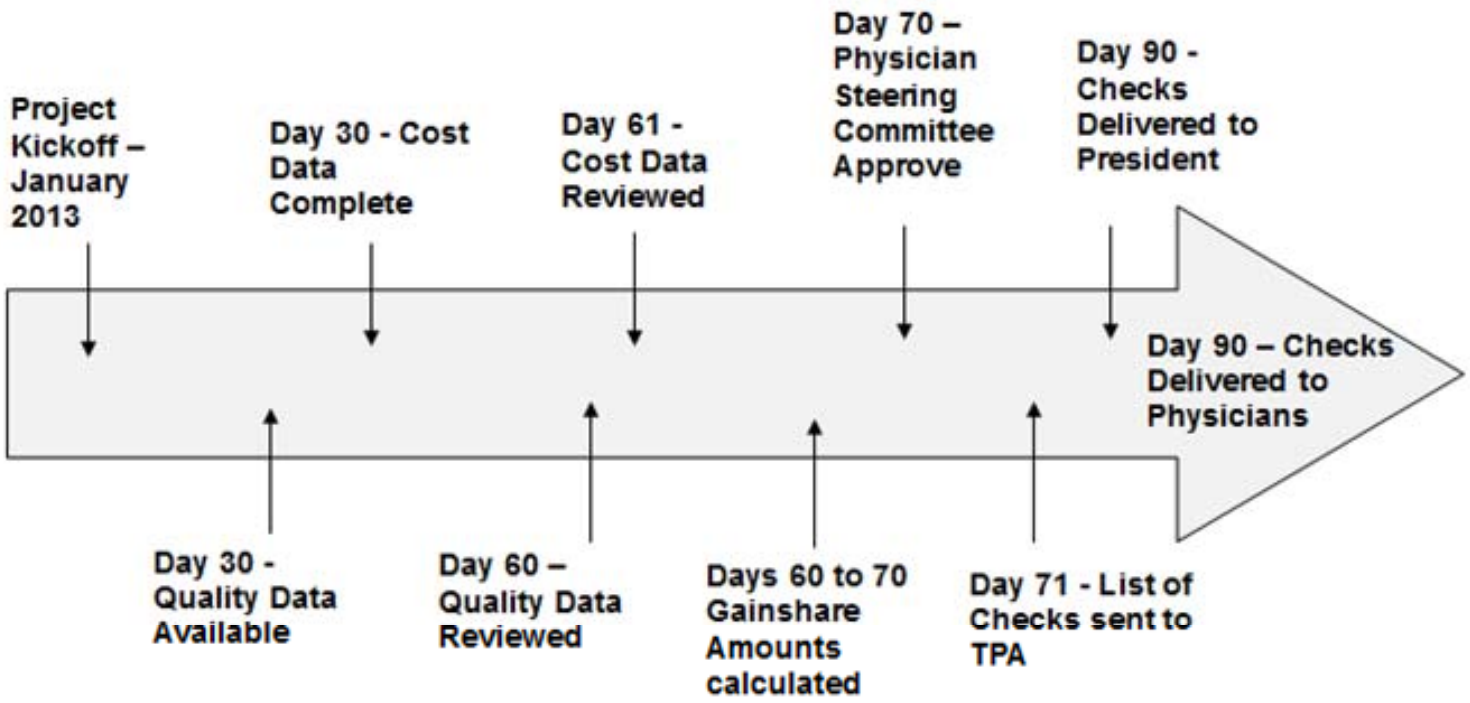
Potential Annual Distribution Maximum Gainsharing Year 1



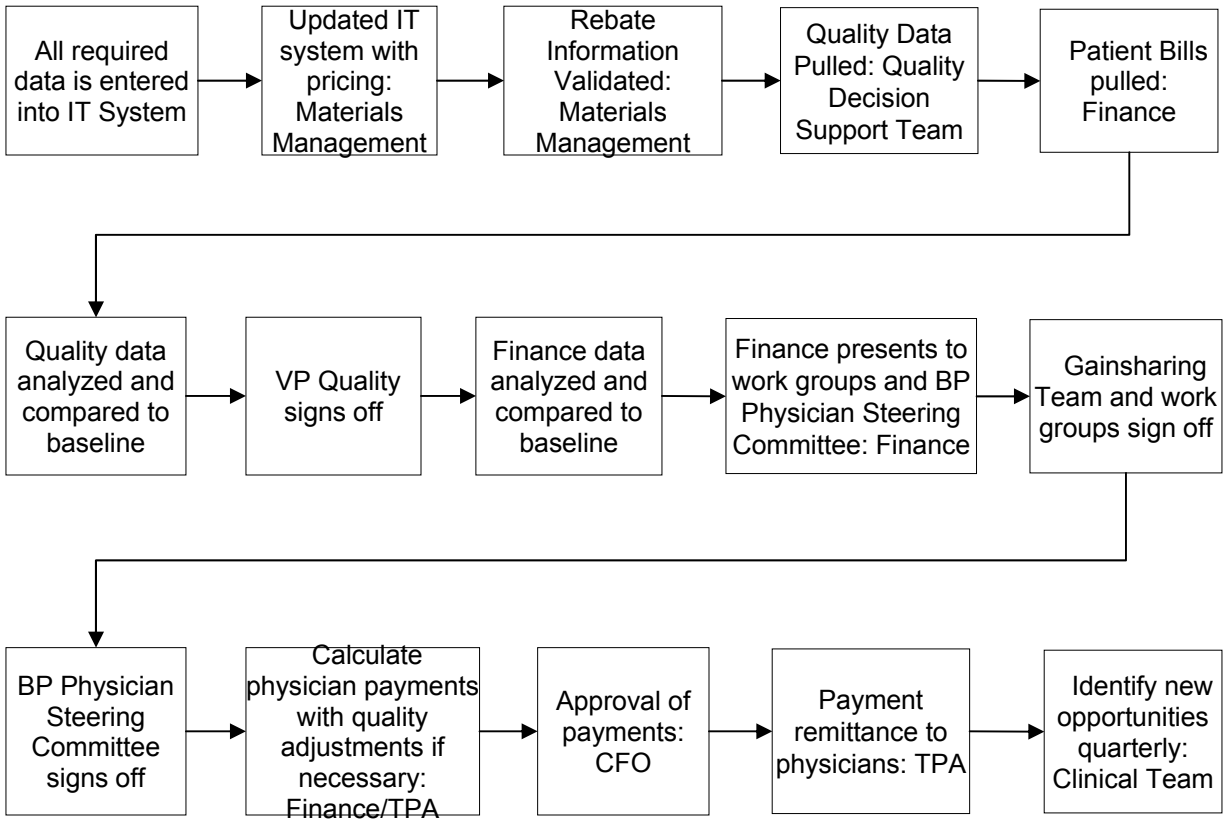
Model 4 Sample Gainshare Model, Prospective Payment



Sample Gainsharing Distribution Timeline



Sample Gainsharing Validation Process



Agenda

Historical Perspective
Bundled Payment for Care Improvement Updates
Keys to a Successful Application
Organizational Readiness
Metrics
Features of Successful Gainshare Program
Lessons Learned from Model 1 Application Process
Future Models
Questions and Answers

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Lessons Learned from Acute Care Episode Demonstration

- CMMI Budget Target for Model 1
- 74 applications received
- 70 applications reviewed
- Expert Panel Review
- Gainshare Structure
- Model 1 Approach to Care Redesign
- Beneficiary Choice
- Metrics
- Managing to Medicare margins
- Making it work

Agenda

Historical Perspective
Bundled Payment for Care Improvement Updates
Keys to a Successful Application
Organizational Readiness
Metrics
Features of Successful Gainshare Program
Lessons Learned from Model 1 Application Process
Future Models
Questions and Answers

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The Beginning of the End of Fee-for-Service

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

Agenda

Historical Perspective
Bundled Payment for Care Improvement Updates
Keys to a Successful Application
Organizational Readiness
Metrics
Features of Successful Gainshare Program
Lessons Learned from Model 1 Application Process
Future Models
Questions and Answers

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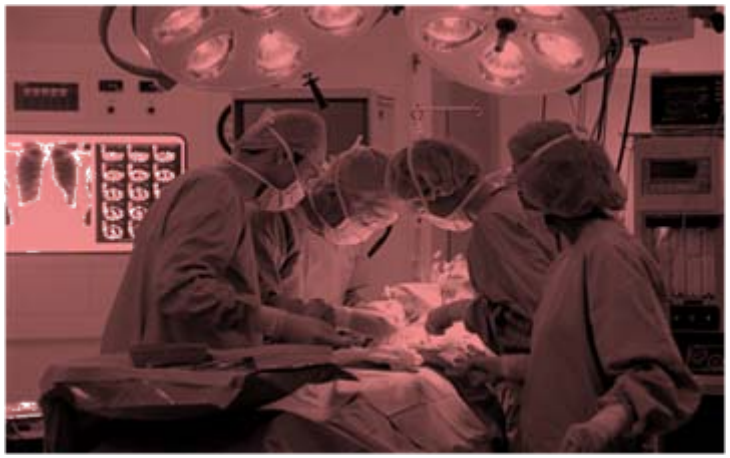
Questions and Discussion

Robert Minkin, MBA
Senior Vice President
The Camden Group
rminkin@TheCamdenGroup.com

Deirdre Baggot, Ph.D.(c), MBA, RN
Vice President
The Camden Group
DBaggot@TheCamdenGroup.com



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