Value-based care readiness webinar series:

Are You Ready for Bundled Payments?
Today’s agenda

01 General background on bundled payments

02 Patient oversight system needs

03 Care planning with acute partners

03 Discharge planning and relationships with ancillary provider

03 Changing the culture
Section 1: Background
Definitions

> Bundled payments - also known as "episode-based payments"
  - a single payment for all services over a period of time (e.g., 30, 90 days) related to a specific treatment or condition; include multiple providers and span across multiple settings

> Different from traditional Medicare payment per day based on RUG score or

> Rate per day by level paid by commercial payers for Medicare Advantage and under 65 members
Goal of bundled payments

> Predictable costs
  - Post acute providers are reimbursed part of a single sum of money for services related to an episode of care rather than for each day a patient is in-house
  - Must share total episode reimbursement with hospitals, professionals and home health providers

> Reduced spending
  - Creates incentives to eliminate unnecessary services and therefore costs
  - Encourages care coordination and lead to improved health outcomes
  - Moves away from volume-based rate per day that may affect behavior or clinical decisions
## Summary of BPCI and CJR Provisions

<table>
<thead>
<tr>
<th></th>
<th><strong>BPCI</strong></th>
<th><strong>CJR</strong></th>
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<tbody>
<tr>
<td><strong>Oct 1, 2013 – 3 Yrs (extended to 9/2018)</strong></td>
<td><strong>Apr 1, 2016 – 5 Yrs</strong></td>
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<tr>
<td>Participation</td>
<td>Voluntary</td>
<td>Mandatory</td>
</tr>
<tr>
<td>Geography</td>
<td>National</td>
<td>67 metro areas</td>
</tr>
<tr>
<td>Duration</td>
<td>3 years</td>
<td>5 years</td>
</tr>
<tr>
<td>Clinical episodes</td>
<td>48 episode types</td>
<td>Total hip &amp; knee replacement</td>
</tr>
<tr>
<td>Episode length</td>
<td>30/60/90 days</td>
<td>90 days</td>
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<tr>
<td>Responsible group</td>
<td>Physicians, hospitals, PAC</td>
<td>Hospitals</td>
</tr>
<tr>
<td>Target price</td>
<td>Provider-specific</td>
<td>Blend of provider and region</td>
</tr>
<tr>
<td>CMS discount</td>
<td>2 – 3%*</td>
<td>1.5 - 3%*</td>
</tr>
<tr>
<td>Reconciliation</td>
<td>Quarterly</td>
<td>Annually</td>
</tr>
<tr>
<td>Risk adjustment</td>
<td>MS-DRG only</td>
<td>MS-DRG and hip fracture status</td>
</tr>
<tr>
<td>Maximum gain</td>
<td>20%</td>
<td>0%/5%/10%/20% Yrs 1, 2,3, 4-5</td>
</tr>
<tr>
<td>Maximum loss</td>
<td>20%</td>
<td>0%/5%/10%/20% Yrs 1, 2,3, 4-5</td>
</tr>
<tr>
<td>Quality</td>
<td>Monitored</td>
<td>Required for NPRA payments</td>
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*BPCI discount is 2% for 90-day bundles & 3% for others. CJR discount varies with quality score. NPRA = Net payment reconciliation amount.

Source: American Hospital Association
Mechanics of bundle payments

> **Current Methodology**

- Medicare sets target cost for each episode applying the discount
- BPCI models 2 & 3, and CCJR - post acute paid current fee for service rates
- CCJR reconciliation of cost against target done for each calendar year - hospital may get more $ or have to pay Medicare- and pass it along!!
- BPCI reconciliation is quarterly with the final 6 months after the last quarter end.
- All current 658 SNF BPCI participants are in the risk phase from 10/2013 to 9/2018 – so hospitals may expect them to share in losses – they also should share in gains

> **Future Methodology**

- CMS and Commercial payers will pay hospitals a single amount per episode which will be dispersed among contracted continuum care partners
BPCI results

> Annual Report - August 2016- per Lewin
  - Statistically significant decline in allowed payment to post acute among patients receiving care for orthopedic, non-surgical and surgical cardiovascular cases from non-BPCI episodes
  - No significant difference in re-admission or quality metrics from non-BPCI episodes

> CMS BPCI Initiative Episode Analytic file
  - Updated each July
  - Lists by facility participants in each model and risk phase
  - Check if your peers or competitors are participating!
CJR Achievable Results

- Results achieved by a post-acute system from Jan 2014 to June 2016
  - Length of stay - two post acute facilities
    > Declined from average of 18 days to 5 in one site
    > Declined from average of 12 days to 7 in another
  - Re-admission to hospital
    > Declined from 5% to 0%, one site had 0% the entire period
  - Average payment per episode to post acute
    > Down from $12.2K to $2.8K one site
    > Down from $7.8K to $4.1 in the other
Key Takeaway

Key take away from both results is with the lower length of stay – must be more efficient and post acute provider of choice to increase number of admissions due to lower payment per case
How to achieve results

> Ease of admission – 7 days a week, simple process
> Focus on lowering length of stay, well coordinated therapy in a shorter time frame
> Focus on quality – indication is payers/hospitals will require a minimum 3 star rating to be considered as a bundle partner
> Focus on lowering re-admissions – hospital not paid so will not want partners with a % above peers
> Lower cost per day – allows for more room to achieve margins on lower LOS and is attractive to hospitals and payers
Section 2: Patient oversight system needs
Areas to assess for readiness

Organization and Management
- Commitment by senior leadership to move to bundled payments
- Market position – post acute of choice or one of the many
- Staff experienced in newer incentive based arrangements
- Clinical staff with experience or receptive to training in care pathways
- Staff to foster positive relationships with admission sources
- Multiple facilities in a system with several service lines or a single facility

Financial Position
- Balance sheet – cash flow to allow for investment in IT and training
- Number of revenue sources – dependence on one payer, admission source, or service line
Areas to assess for readiness

- Information Technology - Investment Required in EHR
  - Payment – MDS reporting no longer adequate –
  - Financial – Revenue by RUG category by day no longer adequate –

- Can your facility track financial data via dashboards - revenue, and costs by:
  - by payer AND if under a bundle
  - by service line (short term rehabilitation, long term, independent
  - by patient

- Can your facility capture and track clinical data:
  - Admitting diagnosis
  - Length of stay
  - Re-admission
  - Risk profile
Areas to assess for readiness

> Quality
  - Nursing home compare star rating
    > Staffing – direct control
    > Health inspection – state survey
    > Quality Measures – resident assessment
      – Patient satisfaction survey upon discharge

-- Discharge outcome reporting overall and by diagnosis
  > Re-admission
  > Mortality
Section 3: Care Planning with acute partners
Bundled Payments: focus on discrete episodes of care by establishing an overall budget for services provided to a patient receiving a course of treatment for a given clinical condition over a defined period of time.

Bundled payments provide incentives for providers to come in “under budget” for episodes of care.
> CMS has implemented the CCJR model in 67 geographic areas defined by metropolitan statistical areas (MSAs)

> Beneficiaries can retain their freedom of choice in selecting services and providers

> Physicians and hospitals, as well as post acute care providers are expected to maintain current standards of Medicare and quality care
> Hip and knee replacement surgeries are the most common inpatient surgeries for Medicare beneficiaries

> Even with the high numbers of these surgeries, the quality of care and cost of care vary greatly among providers

> In 2014 there were more than 400,000 hip and knee replacement procedures completed

> Cost of these procedures was greater than $7 billion for the acute care costs alone
Post Acute Care providers will be one of the targets for reducing CCJR spending with skilled nursing facility providers receiving more than 50% of the Post Acute Care dollars.

SNF providers must position themselves for success in the bundled payment environment which includes:
- Knowing the post acute market
- Communicating
- Identifying opportunities
- Positioning for success
- Becoming the provider of choice
Section 4: Discharge planning and relationships with ancillary providers
Providers must engage in active and collaborative partnerships with acute care providers
- Hospitals recognize that they need to partner with PAC providers to be successful with bundled payments
- PAC providers must also seek and engage in these partnerships if they have not been approached
- Providers can use quality data to determine opportunity for collaboration with hospitals
- PAC providers must be collaborative but recognize that they will be held accountable
PAC providers must manage risk through:
- Enhancing the competencies of the clinical staff
- Tracking clinical metrics AND evaluating root causes
- Implementing and utilizing clinical pathways – either PAC pathways or involving PAC in the hospital pathways
- Including acute care resources in the education of the clinical team members
- Evaluating staffing ratios and staff mix
- Evaluating and enrich resident satisfaction
- Enhancing relationships with hospitals, physicians and home health agencies
CMS will use the star rating and other quality metrics when evaluating the effectiveness of alternate payment methods
- CCJR program waives the 3 day qualifying stay rule for high performing SNFs beginning in year 2
- May only be used when the hospital is discharging to a SNF that is a 3+ overall star rating for 7 of the past 12 months
- SNFs who achieve this overall 3+ star rating will be posted on the CMS website each quarter
Discharge planning must begin on admission
- Where will resident be discharged to?
- What resources are available at that location?
- What support systems are available?
- How will the resident manage complications?
- Does the resident have the financial means for the plan?
- Communicate with resident and POA
Cannot wait to consider these questions

Must plan immediately to reduce the length of stay

Residents must know there is a plan and that it's solid
Section 5: Changing the Culture
Culture shift

> Must move from traditional thinking of maximizing functional capacity (longer LOS) to managing under a bundle to meet prescribed care pathways (lower LOS, intensity)
> Financial discipline required to keep costs down with lower LOS, but strive for increased admissions (increase efficiency)
> Foster relationships with admitting hospitals as well as patients
> Willingness to embrace or experiment with new care and reimbursement models
Leadership

- Requires commitment by senior staff to make bundled payments operational – bundles not just a passing phase
- Encourage open communication to address concerns
- Provide training to staff to feel comfortable with new data capture, and reporting requirements along with clinical initiatives
- Willingness to work with other care providers for the benefit of all in the continuum ultimately to provide a better outcome for the patient
Do you have the right staff for these roles?

> IT – do you have staff knowledgeable in guiding selection, implementation and maintenance of an EHR
> Clinical – is staff receptive to new care modalities, and recognize the importance of timely communication with care navigators
> Analytics – do you have staff capable of pulling and turning data into meaningful metrics to measure progress and report.
> Contracting – can’t lose track of current revenue streams while preparing for bundled payments - States starting to mandate managed Medicaid - MLTSS
> Increased migration of traditional Medicare to managed Medicare
Section 6: How to Prepare for Bundles and Challenges
Knowing the post acute care market
- CMS 5 Star Quality Rating Program comparison
- Comparative length of stay
- Capabilities of local post acute care providers
- Outcomes for orthopedic and basic cardiac programs
- Which of the local post acute care providers impacts your opportunity to increase a share in the bundled admissions?
Medicare CCJR program

> Positioning for Success
  - Decrease length of stay
    > Reducing the SNF average length of stay (ALOS)
    > Open beds more often for hospital discharges
  - Reduce hospital readmissions
    > Reduces the costs for both the hospital and SNF
    > Demonstrates ability to provide post acute care
  - Demonstrate value to the hospital
    > Timely SNF discharges to next level of care
    > Work within the care pathways of the acute provider
Identifying Opportunities

- Evaluate 5 Star Quality Rating
  > 3 stars or greater involved in the qualifying stay waiver
  > Where are your strengths and weaknesses?
- Collect data metrics for the involved diagnoses
  > Outcomes must be positive, repeatable and sustainable
  > Communicate outcomes to acute care providers
- Know the cost of care per episode
  > Understand utilization patterns
  > Know where there is opportunity
Medicare CCJR program

> Preparation for CCJR as an alternate payment method includes:
  - Consistent performance of every team member every day resulting in success and effectiveness
  - Focus on the relevant items of care
  - Emphasis on systems and processes that address:
    > Length of stay
    > Readmissions
    > Clinical competency
    > 5 star quality rating system
    > Relationships
Requires a culture shift to communicate, collaborate and coordinate

The larger and more pervasive focus for providers must be a refocus from

“we can’t do this” to

“how will we do this?” and

“let’s do this!”
Thank you
Required disclosure and Circular 230
Prominent Disclosure

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