AHA Webinar Series
Evolving Partnerships Between General Acute-Care Hospitals & Post-Acute Providers

Webinar #3: Bundling

Sept. 24, 2014
AHA Webinar Series:
Emerging Partnerships Between
General Acute-Care Hospitals and Post-Acute Providers

WEBINAR SERIES

• Highlights innovations in the field
• Hospital perspective
• PAC perspective
• Webinar #4 in Mid-October

WEBINAR 1: An Overview of Emerging Hospital and Post-Acute Care Partnerships
Monday, June 9, 3:00-4:30 ET
✓ Discuss policy and other factors spurring hospitals’ growing interest in post-acute care.
✓ Review common goals for partnerships across settings.
✓ Examine the data and criteria general acute-care hospitals are using to assess, compare, and select local post-acute care partners.

WEBINAR 2: Hospital and Post-Acute Care Perspectives on Partnering
Friday, August 1, 3:00-4:30 ET
✓ Review the current selection of partnership arrangements between general acute-care hospitals and post-acute care providers.
✓ Learn about a general acute care hospital case example that illustrates some current post-acute partnership approaches.
✓ A post-acute care organization will provide case examples of various partnership approaches with general acute care hospitals.

WEBINAR 3: Lessons on Post-Acute Care Bundling
Wednesday, September 24, 3:00-4:00 ET
✓ Examine current developments on post-acute bundling.
✓ Discuss key issues when considering whether to join a bundled payment effort.
✓ Present a case example on post-acute care bundling.

WEBINAR 4: All Healthcare is Local – Making the Post-Acute Care Value Case
October 2014 (date TBA)
✓ Learn how to reach out to acute hospitals to discuss new partnerships.
✓ Discuss common post-acute strengths and weaknesses.
✓ Review the most helpful data for making a value case to a referring hospital.

More information on this webinar series is available at www.aha.org/postacute
Webinar Overview:

- AHA Introduction
- Ellen Lukens, Avalere Health
- Michael Spigel, Brooks Rehabilitation
- Questions & Discussion
National Perspective on Bundling

Ellen Lukens, VP
September 2014
avalere.com
Today’s Agenda

- Affordable Care Act Principle Goals
- Bundling Overview
- Bundling Experience-to-Date
- Evaluating Participation
- Key Considerations for Future of Bundling
The ACA Had Three Principle Goals

Coverage & Insurance Market Reform
Make insurance more accessible and affordable for all individuals

Delivery & Payment System Reform
Pay for quality instead of volume of care

Financing Strategies for Health Reform
Find sustainable funding to pay for reform provisions

Bundling is one of many payment and delivery innovations

ACA Accelerated Medicare’s Shift Away from FFS Toward Greater Risk, Population-Based Care Models

Past

- FFS
- FFS VBP

Present and Future

- Bundled Payment
- Shared Savings (ACOs)
- Full Capitation

Risk-Based Spectrum

- Timing of FFS phasing out will be slow
- Facilitated by health plan contracting
- Stepping stone to more fully integrated systems
- Reinforced by growth in MA and increasing consolidation of providers
Today’s Agenda

- Affordable Care Act Principle Goals
- Bundling Overview
- Bundling Experience-to-Date
- Evaluating Participation
- Key Considerations for Future of Bundling
What is Bundling?

BUNDLING IS A SINGLE PAYMENT FOR AN ARRAY OF SERVICES

- Bundles are currently broadly to reimburse a single provider for services rendered.
  - For example, CMS makes a single payment to hospitals for the care provided based on the inpatient MS-DRG.
- Episode-based bundled payment programs (e.g., the CMS Bundled Payment for Care Improvement (BPCI)) hold providers accountable for total payments for a defined period of time, beyond the services provided in a single facility.

* Hospital outpatient services, Part B drugs, durable medical equipment (DME), clinical laboratory services and independent outpatient therapy services.
* LTCH = Long-Term Care Hospital, IRF = Inpatient Rehabilitation Facility; SNF = Skilled Nursing Facility; HHA = Home Health Agency; PGP = Physician Group Practice.
Why Bundle Post-Acute Care? Post-Acute Care is Sizeable but Not the Greatest Share of Provider Payments

IN 2012, SNF & HHA SPENDING REPRESENTED 16% OF MEDICARE FFS SPENDING

Medicare FFS Spending, 2012

- Inpatient Hospital: 47%
- Physician: 23%
- Post-Acute Care: 16%
- Hospital Outpatient: 12%
- Other: 2%

Source: MedPAC June 2013 Data Book, Chart 1-1
PAC includes SNF and HHA; LTACH & IRF included in Inpatient Hospital; Other includes Inpatient Psych and ASC
### Post-Acute Care Has Greater Payment Variation Than Other Services

**PROPORTION OF VARIANCE ATTRIBUTABLE TO EACH MEDICARE SERVICE CATEGORY**

<table>
<thead>
<tr>
<th>Variation in Total Medicare Spending</th>
<th>Adjusted Total Medicare Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Remaining Variance</td>
</tr>
<tr>
<td>Variation in Post-Acute Care Only</td>
<td>1,864</td>
</tr>
<tr>
<td>If No Variation in Acute Care Only</td>
<td>5,085</td>
</tr>
<tr>
<td>If No Variation in Either Post-Acute or Acute</td>
<td>780</td>
</tr>
<tr>
<td>If No Variation in Prescription Drugs</td>
<td>6,374</td>
</tr>
<tr>
<td>If No Variation in Diagnostic Tests</td>
<td>5,986</td>
</tr>
<tr>
<td>If No Variation in Procedures</td>
<td>6,020</td>
</tr>
<tr>
<td>If No Variation in Emergency Department Visits/Ambulance Use</td>
<td>6,972</td>
</tr>
<tr>
<td>If No Variation in Other</td>
<td>6,882</td>
</tr>
</tbody>
</table>

**NOTE:** Total Medicare spending and each component are input-price- and risk-adjusted. Each row shows the reduction in variance from eliminating only the variation in that service, with the exception of the acute and post-acute care rows. *The individual reductions sum to more than 100 percent because of covariance terms.

*Source: Variation in Health Care Spending, Institute of Medicine, October 2013*
Bundle Holders Succeed Only Through Reduced Utilization

BUNDLED PAYMENT HOLDERS MUST LOWER OVERALL SPENDING ACROSS AN EPISODE TO YIELD SAVINGS

Bundled Payment Target Amount

Spending per Episode
Today’s Agenda

- Affordable Care Act Principle Goals
- Bundling Overview
- **Bundling Experience-to-Date**
- Evaluating Participation
- Key Considerations for Future of Bundling
### CMS BPCI Program Includes Four Models

<table>
<thead>
<tr>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Episode</strong></td>
<td>All acute patients, all DRGs</td>
<td>Selected DRGs + post-acute period</td>
<td>PAC only for selected DRGs</td>
</tr>
<tr>
<td><strong>Services included in the bundle</strong></td>
<td>All Part-A DRG-based payments</td>
<td>All Part A and B services (hospital inpatient, hospital readmissions, physician, LTCH, IRF, SNF, HHA, hospital outpatient, independent outpatient therapy, labs, DME, part B drugs)</td>
<td>All Part A and B services (hospital readmissions, physician, LTCH, IRF, SNF, HHA, hospital outpatient, independent outpatient therapy, labs, DME, part B drugs)</td>
</tr>
<tr>
<td><strong>Payment</strong></td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Retrospective</td>
</tr>
<tr>
<td><strong>Episode Duration</strong></td>
<td>Inpatient stay only</td>
<td>Inpatient hospital plus 30/60/90 days</td>
<td>30, 60, or 90 days</td>
</tr>
<tr>
<td><strong>Discount Amount</strong></td>
<td>Up to 2 percent*</td>
<td>2-3 percent**</td>
<td>3 percent</td>
</tr>
<tr>
<td><strong>Participants</strong></td>
<td>15</td>
<td>2,068</td>
<td>4,537</td>
</tr>
</tbody>
</table>

* 0-0.5% in Year 1, 1% in year 2, and 2% in year 3
** 2 percent discount for a 90 day episode.
*** 3.25 percent applies to select cardiac and orthopedic conditions.
Source: CMS Innovation Partner Collaboration Site. Number of participants as of 12/18/2013.
Assignment Based on MS-DRG. BPCI includes 48 Clinical Episodes

FORTY-EIGHT CLINICAL EPISODES REPRESENT ABOUT 70 PERCENT OF SPENDING ON EPISODES OF CARE

<table>
<thead>
<tr>
<th>Acute myocardial infarction</th>
<th>AICD generator or lead</th>
<th>Amputation</th>
<th>Atherosclerosis</th>
<th>Back &amp; neck except spinal fusion</th>
<th>CABG</th>
<th>Cardiac arrhythmia</th>
<th>Cardiac defibrillator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac valve</td>
<td>Cellulitis</td>
<td>Cervical spinal fusion</td>
<td>Chest pain</td>
<td>Combined anterior posterior spinal fusion</td>
<td>Complex non-cervical spinal fusion</td>
<td>Congestive heart failure</td>
<td>COPD, bronchitis, asthma</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Double joint replacement of the lower extremity</td>
<td>Esophagitis, gastroenteritis and other digestive disorders</td>
<td>Fractures femur and hip/pelvis</td>
<td>Gastrointestinal hemorrhage</td>
<td>GI obstruction</td>
<td>Hip &amp; femur procedures except major joint</td>
<td>Lower extremity and humerus procedure except hip, foot, femur</td>
</tr>
<tr>
<td>Major bowel</td>
<td>Major cardiovascular procedure</td>
<td>Major joint replacement of the lower extremity</td>
<td>Major joint upper extremity</td>
<td>Medical non-infectious orthopedic</td>
<td>Medical peripheral vascular disorders</td>
<td>Nutritional and metabolic disorders</td>
<td>Other knee procedures</td>
</tr>
<tr>
<td>Other respiratory</td>
<td>Other vascular surgery</td>
<td>Pacemaker</td>
<td>Pacemaker device replacement or revision</td>
<td>Percutaneous coronary intervention</td>
<td>Red blood cell disorders</td>
<td>Removal of orthopedic devices</td>
<td>Renal failure</td>
</tr>
<tr>
<td>Revision of the hip or knee</td>
<td>Sepsis</td>
<td>Spinal fusion (non-cervical)</td>
<td>Stroke</td>
<td>Syncope &amp; collapse</td>
<td>Transient ischemia</td>
<td>Urinary tract infection</td>
<td></td>
</tr>
</tbody>
</table>

BPCI Model 2: Number of Episode Initiators by State (Phase 1 and Phase 2)
BPCI Model 3: Number of Episode Initiators by State (Phase 1 and Phase 2)
Number of BPCI Episode Initiators Grew by Over 4,000 with the Most Recent Application Period

<table>
<thead>
<tr>
<th>BPCI Model</th>
<th>Round 1</th>
<th>Round 2</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 1</td>
<td>21</td>
<td>15</td>
<td>-6</td>
</tr>
<tr>
<td>Model 2</td>
<td>688</td>
<td>2,068</td>
<td>+1,380</td>
</tr>
<tr>
<td>Model 3</td>
<td>1,895</td>
<td>4,537</td>
<td>+2,642</td>
</tr>
<tr>
<td>Model 4</td>
<td>23</td>
<td>17</td>
<td>-6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2,627</td>
<td>6,637</td>
<td>+4,010</td>
</tr>
</tbody>
</table>

Notes:
1. Round 1. Episode initiators prior to April 2014.
2. Round 2. Episode initiators post April 2014
Early Experience from Round 1 BPCI: Most Common Clinical Conditions

CHF, COPD AND PNEUMONIA ARE 3 SHARED CONDITIONS IN THE TOP 4 FOR MODELS 2 & 3

Top Four Conditions Selected by Model 2 Episode Initiators

- Major joint replacement of the lower extremity (75%)
- Congestive Heart Failure (35%)
- Chronic obstructive pulmonary disease, bronchitis, asthma (25%)
- Simple Pneumonia and Respiratory Infections (21%)

On average, Model 2 episode initiators selected only 5 conditions

Top Four Conditions Selected by Model 3 Episode Initiators

- Congestive Heart Failure (95%)
- Chronic obstructive pulmonary disease, bronchitis, asthma (78%)
- Simple Pneumonia and Respiratory Infections (76%)
- Urinary Tract Infection (72%)

On average, Model 3 episode initiators selected 19 conditions

Note: Most common episodes for Models 2 and 3 for Round 1 of the BPCI
BPCI Episode Initiators By Participant Type

IN MODEL 3, SNFs ACCOUNT FOR ALMOST THREE-QUARTERS OF ALL EPISODE INITIATORS

STACH: Short-Term Acute Care Hospital; PGP: Physician Group Practice
Note: Inclusion of LTCHs and IRFs in Model 2 might be CMS data error
TWO PARTICIPANT TYPES ARE RISK BEARING AND ONE IS NON-RISK BEARING

BPCI Participant Types

Risk Bearing
- Single Awardee
- Awardee Convener

Non-Risk Bearing
- Facility Convener

Most Providers Participate through Conveners in Models 2 and 3

### Top 15 Conveners by Number of Episode Initiators

<table>
<thead>
<tr>
<th>Round 1</th>
<th>Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remedy BPCI Partners, LLC (1,801)</td>
<td>Remedy BPCI Partners, LLC (3,519)</td>
</tr>
<tr>
<td>PA Holdings - SNF, L.P. (343)</td>
<td>PA Holdings - SNF, L.P. (408)</td>
</tr>
<tr>
<td>Amedisys Holdings (77)</td>
<td>Genesis Care Innovations Llc (353)</td>
</tr>
<tr>
<td>Signature Medical Group, Inc. (62)</td>
<td>Navihealth, Inc. (228)</td>
</tr>
<tr>
<td>Premier, Inc. (49)</td>
<td>Liberty Health Partners LLC (220)</td>
</tr>
<tr>
<td>Optum (46)</td>
<td>Community Health Systems Professional Services Corporation (183)</td>
</tr>
<tr>
<td>NaviHealth, Inc. (24)</td>
<td>HCA Management Services, L.P. (137)</td>
</tr>
<tr>
<td>The Evangelical Lutheran Good (24)</td>
<td>Premier, Inc. (113)</td>
</tr>
<tr>
<td>Catholic Health Initiatives (23)</td>
<td>Ensign Service, Inc. (106)</td>
</tr>
<tr>
<td>New Jersey Hospital Association (NJHA) (20)</td>
<td>Healthsouth Bundling Initatives, Llc (103)</td>
</tr>
<tr>
<td>The Cleveland Clinic Health System (9)</td>
<td>Medsolutions, Inc. (82)</td>
</tr>
<tr>
<td>CareLink Inc. (9)</td>
<td>Amedisys Holdings (76)</td>
</tr>
<tr>
<td>Estes Park Institute, at Hory, Springer &amp; Mattern (8)</td>
<td>Signature Medical Group, Inc. (73)</td>
</tr>
<tr>
<td>Banner Health (7)</td>
<td>Plum Healthcare Group, LLC (52)</td>
</tr>
<tr>
<td>Association of American Medical Colleges (7)</td>
<td>Optum (45)</td>
</tr>
<tr>
<td>Other (89)</td>
<td>Other (830)</td>
</tr>
</tbody>
</table>

**No Convener (29)**

**No Convener (109)**

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**Notes:**
1. Round 1. Episode initiators prior to April 2014.
2. Round 2. Episode initiators post April 2014

The Commercial Market is also Engaging in Bundled Payment Arrangements

COMMERCIAL PAYERS AND EMPLOYERS ARE ACTIVELY PURSUING BUNDLED ARRANGEMENTS WITH PROVIDERS

• More than 16 employers and 17 commercial payers have formed bundled payment contracts. Blue Cross Blue Shield has been an active commercial payer, while Walmart has been a pioneer in employer-based bundling (see following slide)¹.

• Commercial and employer-based bundles may differ from Medicare programs in structure and incentives².
  – Some commercial payers are offering premium payments to providers willing to assume bundled payment risk.
  – Employer-based agreements may offer financial incentives to patients.
  – Commercial bundling agreements require less time to implement, and may offer more flexibility for providers.

• Arkansas is implementing a state-wide bundled payment program, which is a collaboration between the states two largest private payers and the Medicaid program. The “Arkansas Health Care Payment Improvement Initiative” is live on 13 episodes for Medicaid. Private payers are participating in eight.

3 The Arkansas Center for Health Improvement, http://www.paymentinitiative.org/episodesOfCare/Pages/default.aspx
Since 2010, Cleveland Clinic has leveraged experience from higher patient volumes to offer better patient outcomes to self-insured employers for non-emergency surgical care. Despite the financial incentives, many patients still choose to receive care close to home. As a result, Cleveland Clinic is now developing affiliations with other systems, such as Long Island Jewish Health System and MedStar Health.

**Sources:**
2. Ostrom, Carol M. “Boeing to Send Some Insured Workers to Cleveland for Cardiac Care.” The Seattle Times. (2012)
3. Zeltner, Brie. “Walmart to Send Employees to Cleveland Clinic for Heart Care.” The Plain Dealer. (2012)
5. “Cleveland Clinic Partners with North Shore-LIJ for Heart Care”, Cheryl Clark, for HealthLeaders Media, August 20, 2014
States Are Also Testing Bundled Payment Arrangements

• Arkansas Medicaid and two commercial payers (Arkansas BCBS and QualChoice) joined in 2011 to implement the “Arkansas Health Care Payment Improvement Initiative” to reduce cost and improve quality through medical homes and episode-based payments\(^1\).
  – Arkansas model holds one provider accountable for performance risk
  – The state initially implemented bundles for 5 conditions: attention deficit hyperactivity disorder (ADHD), congestive heart failure (CHF), total hip and knee replacement, perinatal care, and upper respiratory infection.
  – As of May 2014, the Medicaid program has studied 24 possible episodes and implemented 13

• Tennessee received a grant from CMS to implement bundled payments in the TennCare Medicaid program\(^2\)
  – The program will implement bundled payment for defined episodes of care for TennCare enrollees and Tennessee state employees.
  – Condition episodes currently being discussed include total joint replacement, asthma, and perinatal care.

• More states likely to follow with multi-payer engagements through CMMI grants. Currently, 25 State Innovation Models have been awarded funding. California and Hawaii specifically include plans to implement bundled payment programs.\(^3\)

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\(^3\) CMS Center for Medicare and Medicaid Innovation: http://innovation.cms.gov/initiatives/state-innovations/
Today’s Agenda

- Affordable Care Act Principle Goals
- Bundling Overview
- Bundling Experience-to-Date

**Evaluating Participation**

- Key Considerations for Future of Bundling
Early Experience from BPCI

CMS HAS NOT YET RELEASED ANY PERFORMANCE DATA

Key Challenges for Participants

- Identifying Patients
- Low Volume to Share Risk
- Retrospective Reporting
- Real-Time Communication & Patient Tracking
- Care Redesign
- Reduction in Services
BPCI: What Happens Next? CMS Has Not Announced Plans for Another Round of Participants

PROVIDERS MUST GO LIVE WITH AT LEAST ONE EPISODE BY APRIL 1, 2015. CMS HAS NOT ANNOUNCED ANY IMMEDIATE PLANS FOR NEW ENTRANTS.

Awardees given option to begin the program on Oct 1, 2013 or wait until Jan 1, 2014

BPCI Round 2 RFA; Round 1 applications that did not enter Phase II re-opened

CMS to share baseline data and target pricing worksheets

Participants may move additional episodes to Phase II

Awardees announced, beginning of 6-month no-risk dry run

Initial end of Round 1, Phase I

Select participants entered Phase II with option to add more episodes later

CMS announces provisional acceptances of Round 2 and delay of baseline data and target pricing worksheets; Phase I extended through October 2015

Participants must move at least one episode to Phase II to remain in program

Participants may move additional episodes to Phase II.

Phase I ends.

Round 1 Applications Due

Round 1 Awardees selected

Select participants entered Phase II

Round 2 Applications Due

Round 2 Awardees selected

BPCI Round 1 RFA

Aug 2011

June 2012

Oct 2011

Oct 2012

Jan 2013

Jan 2014

Feb 2014

April 2014

July 2014

July 2015

Oct 2015

Evaluating Participation

PROVIDERS NOT CURRENTLY PARTICIPATING IN BUNDLING STILL NEED TO ENGAGE AND UNDERSTAND THEIR UTILIZATION, PERFORMANCE AND OPPORTUNITIES FOR IMPROVEMENT

<table>
<thead>
<tr>
<th>Participation</th>
<th>Organizations that are not bundle holders may still participate through gain sharing or preferred provider relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analysis</td>
<td>Understanding current performance and utilization is key to preparing for future value-based purchasing and ACO and bundled payment opportunities and partnerships</td>
</tr>
<tr>
<td>Care Redesign</td>
<td>Organizations can redesign care to improve outcomes to position themselves for bundling and preferred partnerships</td>
</tr>
<tr>
<td>Risk</td>
<td>The current models provide a framework for risk sharing that can serve as a foundation for evaluating different risk sharing arrangements</td>
</tr>
</tbody>
</table>
## Example Analytics: Categories of Spending by Episode Length

**READMISSIONS SPEND NEARLY DOUBLES WHEN EPISODE IS EXTENDED 30 TO 90 DAYS**

//Illustrative://

<table>
<thead>
<tr>
<th></th>
<th>30-Days</th>
<th>60-Days</th>
<th>90-Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHAs</td>
<td>1.20%</td>
<td>1.90%</td>
<td>2.20%</td>
</tr>
<tr>
<td>LTACHs</td>
<td>1.70%</td>
<td>2.10%</td>
<td>2.20%</td>
</tr>
<tr>
<td>IRFs</td>
<td>2.70%</td>
<td>2.80%</td>
<td>2.80%</td>
</tr>
<tr>
<td>SNFs</td>
<td>3.60%</td>
<td>4.30%</td>
<td>4.70%</td>
</tr>
<tr>
<td>Readmissions</td>
<td>3.60%</td>
<td>5.20%</td>
<td>6.20%</td>
</tr>
<tr>
<td>Physician / Supplier</td>
<td>10.00%</td>
<td>10.30%</td>
<td>10.50%</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>27.20%</td>
<td>23.40%</td>
<td>21.40%</td>
</tr>
</tbody>
</table>

Average Payment/Episode: $66,150, $70,000, $72,400
Example Analytics: Treatment-Specific Readmission Rates

All-Cause Readmission Rates (30-, 60-, and 90-days) for Heart Valve Therapy Procedures for All Hospitals, & Hospitals at 25th & 75th Percentile

//Illustrative//

All-cause readmission rates for hospitals at the 75th percentile were almost 3 times more than hospitals at the 25th percentile.

1. This analysis includes all readmissions within the episode timeframes for Heart Valve Therapy episodes.
## Example Analytics: PAC Patient “Flow” / Payment Comparisons

### COMPARISONS FOR 30-, 60-, AND 90-DAY AORTIC VALVE REPLACEMENT EPISODES

//Illustrative//

<table>
<thead>
<tr>
<th>Percent of Discharges to PAC Settings</th>
<th>30-Days</th>
<th>60-Days</th>
<th>90-Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>39.5%</td>
<td>$56,600</td>
<td>$58,000</td>
</tr>
<tr>
<td>SNF</td>
<td>24.6%</td>
<td>$72,200</td>
<td>$78,000</td>
</tr>
<tr>
<td>HHA</td>
<td>23.1%</td>
<td>$53,000</td>
<td>$55,000</td>
</tr>
<tr>
<td>IRF</td>
<td>10.2%</td>
<td>$83,000</td>
<td>$88,000</td>
</tr>
<tr>
<td>LTACH</td>
<td>2.7%</td>
<td>$155,000</td>
<td>$172,000</td>
</tr>
</tbody>
</table>

Different post-acute care settings yield different episodic averages

PAC=Post-Acute Care, SNF=Skilled Nursing Facilities, IRF=Inpatient Rehabilitation Facilities, LTCH=Long-Term Acute Care Hospitals, HHA=Home Health Agencies; PAC includes SNFs, IRFs, LTACHs, and HHAs
Today’s Agenda

• Affordable Care Act Principle Goals
• Bundling Overview
• Bundling Experience-to-Date
• Evaluating Participation
• Key Considerations for Future of Bundling
### Bundling: Future Considerations

<table>
<thead>
<tr>
<th>Section</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bundle Holder</strong></td>
<td>Who Should “Own” the Bundle? Hospitals or Post-Acute Care Providers?</td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>What is the Optimal Hospital/PAC Bundle Length?</td>
</tr>
<tr>
<td><strong>Volume</strong></td>
<td>What Volume is Sufficient to Spread Risk?</td>
</tr>
<tr>
<td><strong>Conditions</strong></td>
<td>What Conditions are Most Appropriate for Bundling? Can Medical Conditions Be Effectively Bundled?</td>
</tr>
<tr>
<td><strong>Long-Term Viability</strong></td>
<td>What is the Long-Term Viability of Bundling? Does Bundling Represent a One-Time Savings or Will it Reduce the Rate of Cost Growth?</td>
</tr>
</tbody>
</table>
American Hospital Association
Post-Acute Care Bundling
September 24, 2014

Michael Spigel, PT, MHA
Chief Operating Officer
Brooks Rehabilitation
Jacksonville, FL
Post-Acute Bundling - Agenda

- Background Brooks Rehabilitation
- History of our Bundled payment experience (who, what, when, where, why)
- Overview of Bundling demonstrations
- Year one performance and metrics monitored
- Lessons learned (the good, the bad and other stuff)
- Future of bundling for post-acute 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 and Pelvic 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 – 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 within a bundled environment

- 33-38%+ use rate for MC beneficiaries, who are among the most acute patients discharged from a hospital
- PAC accounts for wide variation in spending patterns
- Generally speaking, PAC operate as an “afterthought” to the hospital discharge; this is (beginning) to change
- Historically, high rates of readmissions
- Generally speaking, insufficient physician involvement in SNF as well as connections between MD and home health providers
- Historically, little coordination between hospitals. physicians and PAC, and often, the relationships / referral decisions are driven by the wrong reasons
There are two kinds of people in the world:
You and everyone else.
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

**HS -2**
- Partnership with Hospital System (EIP) around our Model 3

- Distinctive care redesign program between Brooks and HS-2

**Management of multiple relationships, multiple clinical protocols, different hand-offs, varying degrees of focus on readmissions or relationships with PAC, etc. — *How this influenced our program design***

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.
Care Navigator Team

The CARE NAVIGATOR TEAM is part of the Brooks CompleteCare Program, which is designed to assist you with your healthcare needs. The team is a resource available to help you and your family.

Contact a Care Navigator at 904-345-7350 or email at CompleteCare@BrooksRehab.org

Contact your Care Navigator when:

- You don’t understand something about your care plan
- You are worried about your health
- If something unexpected happens
- If you don’t have the support at home that you need

Our goal is to help you stay healthy! We can provide education on managing your health, identify critical changes in your condition, and connect you with resources in the community to help you stay on track.

BrooksRehab.org
Overview of the 4-Models within BPCI

<table>
<thead>
<tr>
<th>3 Days Pre-Acute1</th>
<th>Hospital Inpatient Stay</th>
<th>Inpatient MD Services</th>
<th>Post-Acute Facility Services</th>
<th>Post-Acute MD Services</th>
<th>Related Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 1</td>
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<td>Model 2</td>
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<td>Model 4</td>
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Background and History

- Brooks applied during the original cycle, way back in 2012.
- The original RFP from CMMI required a 100 page proposal and ultimately, a very detailed implementation plan.
- The rules were literally, written, through 2012 and 2013, kudos to CMMI!
- The original application was based on very little data, the 3-year historical dataset obtained in 2013 was the set that established pricing, risk corridors, baselines, etc.
## Rationale

- Be on the forefront of possible payment reform and healthcare policy changes that might affect post-acute providers
- Serve as a catalyst for our businesses to begin working together as a system
- Experiment with clinical redesign
- Have a stronger “voice” regarding future policy and payment reform changes
- Prove that post-acute care providers have the sophistication to work at a higher level, e.g., financial risk, complex systems, care redesign, etc.

## Expectations

- Bundled Payment would be an experiment, a form of “research”
- Breakeven financial performance
- Effective care redesign and program development would allow some patients seen in higher acuity settings to be seen in a lower acuity setting
- Development of the care navigator; we were not sure what it would mean
- The need for tools that would facilitate communication between settings – we never envisioned CareCompass
- Would we have the ability to self-manage Medicare claims data and Brooks clinical data?
Key Program Timeline and Monthly Cycles

- **Model 3 TKR/TKR/Fracture**
  - Live October 1, 2013

- **Model 3 TKR/TKR/Fracture**
  - Live January 1, 2014

- **First official Model 3 reconciliation**
  - July 2014

- **Projected start CHF, Spinal Fusions**
  - January or April 2015

- Weekly activity report
- Weekly steering committee
- Monthly quality meeting
- Monthly internal financial reconciliation
- CareCompass updates every 4-6 weeks

- Care redesign team
-Awaiting Medicare claims data
Year-one performance

What do you compare your performance to?

- Traditional setting specific indicators (SNF, IRF, HH, OP)
- Cost per episode
- Readmission rates
- Functional improvement
- Patient perception of their experience

Looking at the data
- In aggregate
- By referring hospital
- By episode initiator
- In network and out of network
- Shifts in site of service
- Qualitative data
Performance

- We have realized better than expected savings
- While we have made significant improvement in reducing readmissions (10-15+% compared to historical), we are learning how difficult it will be to make large meaningful improvements in hospital readmissions rates for patients with chronic medical conditions or those with complicated social situations – we have barely scratched the surface of the work we need to do
- Patient self reporting of their functional improvements is extremely strong; highly significant
- Patient experience matches our overall high performance of our individual businesses, and patients are interested in sharing their experience; a 30% survey return rate!
- Care navigators based in the field are critical to our performance
- We have gained tremendous experience managing Medicare claims data and internal clinical data
- Savings is very asymmetrical across our different referral partners
# 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>Learning to “mine” the Medicare claim files</td>
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<tr>
<td>Blank slate</td>
<td>Addressing legacy behaviors</td>
<td>Outmigration of patients</td>
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<tr>
<td>Ability to live in the grey</td>
<td>Role confusion</td>
<td>What was the discharge DRG?</td>
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<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>
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<td>Multi-faceted complexity</td>
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<tr>
<td>Decision to manage data in-house</td>
<td></td>
<td>Revelations about how many opportunities there are to improve patient care</td>
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<tr>
<td>Information sharing with acute care hospital partners</td>
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<tr>
<td>Discipline to follow the rules and methods we agreed upon regarding management of risk</td>
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</table>
Considerations around bundling as a PAC provider

- Fewer DRGs versus “all” DRGs
- Significant difference between procedural and medical diagnosis
- Develop or own a full network of PAC providers or operate the bundle within a couple of provider types, e.g., just SNF, etc.
- Appreciation of workforce dynamics in SNF and home care
- Careful consideration on how to link with referring hospitals and the need to think through the eyes of your referral partners
- Complexity of partnerships
- How will you track your patients through the episode?
- Organizational structure required to successfully execute and sustain
Future of Post-Acute Care Bundling

- It makes sense – it really creates an environment for better care
- All post-acute care is not created equal and all settings within a particular segment are not equal – but this is not always recognized
- PAC providers play a unique role in patients recovery and/or management of a chronic illness; we focus on function + health
- Traditional workforce dynamics in PAC are substantial impediments to successful execution and program sustainability
- Successful care redesign requires a significant challenge to belief systems
- Bundling is a “disruptive” act within the industry, there will be winners and losers, but we have to make sure we are using the right measures
- Lack of a common measurement tool across IRF-SNF-HH will create long term challenges to effective program design and internal evaluation
Future of Post-Acute Care Bundling

- Bundling around specific DRG is very difficult in PAC; redesigning episode definitions will be an important factor is program sustainability.
- Lack of IT and analytic tools for PAC will present significant impediments for PAC providers to be successful under bundled payment.
- Home care and home based services are a crucial component and often under-appreciated for its complexity but vital in sustaining the patient through an extended period of time.
- Do not underestimate the complicated social situations and how they can impact success under bundling or other risk-based arrangements.
- Long-term, constructive partnership between acute care and post-acute care are vital; it cannot become a “vendor” type relationship.
Questions & Discussion