What 2017 Holds for Medicare Value-Based Transformation: Finalization of the Advancing Care Coordination Rule and Much More

HDG Webinar Series

Brian Ellsworth, MA, Director, Payment Transformation
Beth Carlson, EdD, RN, NHA, Director, Consulting Services

Health Dimensions Group
Housekeeping

Your Participation

To open and close your control panel

Join audio:
• Choose **Mic & Speakers** to use VoIP
• Choose **Telephone** and dial using the information provided

All attendees have been placed on mute

Submit questions and comments via the Questions panel

**Note:** Today’s presentation is being recorded and will be provided within 24 hours
Introductions

Brian Ellsworth, MA
Director, Payment Transformation
Health Dimensions Group

Beth Carlson, EdD, RN, NHA
Director, Consulting Services
Health Dimensions Group
Today’s Webinar Agenda

• Introductions
• Context for Episode Payment Models
• Medicare Episode Payment Models
• Lessons Learned & Future Direction
• Questions and Discussion
Health Dimensions Group: What We Do

**Strategy**
- Strategic planning
- Preferred post-acute network development
- Strategic partnership & value proposition development
- PACE development
- Market demand & feasibility studies
- Business planning
- Education, speakers bureau, & retreats

**Operational Performance**
- Operational assessments
- Audits: Operational and Regulatory Compliance
- Revenue cycle management
- Market & census development
- Valuation & advisory services
- Interim management and staffing

**Value-based Payment & Care Transformation**
- Bundling advisement and implementation
- Value-based positioning
- Care continuum development and integration
- Value-based education & readiness
- Alternative payment model development

**Financial & Reimbursement Advisory**
- Cost report preparation and post-filing advisement
- Reimbursement optimization
- Financial benchmarking & modeling
- Billing & reimbursement education and training
- Accounting services

**Management**
- Full-service management
- Turnaround management
- Management oversight
- Start-up management
Register Within the Next Two Days and Save!
Enter Code: Bundling
Context for Episode Payment Models

Expanding Value-Based Payment Remains a Priority Despite Tumultuous Election
Medicare Continues to March Towards Its Goals for Alternative Payment Models (APMs)
Managed Care for Medicare Is Growing: Setting Value-Based Payment Goals As Well

• Medicare Advantage penetration has increased by more than **30% nationally in the last 6 years**
  – Medicare Advantage now covers close to one-third of enrollees
  – 5 states average greater than 40% Medicare Advantage penetration

• Medicare Advantage plans are also establishing goals for **value-based payment**, and CMS is working with plans on multi-payor initiatives to align fee-for-service and managed care value-based payment goals
Physician Payment Rule (MACRA): Important New Driver of Advanced APMs

Physicians will qualify for 5% lump sum bonus if they have a certain percentage of patients in Advanced APMs.

MACRA rewards or penalizes physicians by up to +/- 9% depending on their Merit-based Incentive Payment System (MIPS).

Those who participate in the most advanced APMs may be determined to be qualifying APM participants (“QP”); as a result, QPs:

1. Are not subject to MIPS
2. Receive 5% lump sum bonus payments for years 2019–2024
3. Receive a higher fee schedule update for 2026 and onward

Note: starting in 2021, other payors will be included in Advanced APM calculation.

Intent is drive physicians to value-based behavior through multiple pathways.
What Exactly Are Advanced APMs and Why Do They Matter?

Advanced APMs…

✓ Base payment on quality measures comparable to those in MIPS
✓ Require use of certified EHR technology
✓ Either (1) bear more than nominal financial risk for monetary losses OR (2) be a medical home model expanded under CMMI authority

…They Matter Because

• Imposing more than nominal risk drives behavior change
• Doctors will not qualify for Medicare Part B bonuses if Advanced APMs are not readily accessible
Repealing and replacing Affordable Care Act (ACA) is suddenly near top of the agenda, but exactly what does that mean?

- Reform of individual health insurance market and repeal of individual mandate (while preserving popular items)?
- Block grants to states for Medicaid?
- Medicare changes, including “premium support” and/or modifying the Innovation Center?

House and Senate Have Passed Budget Resolutions Allowing for Repeal and Replacement of the ACA with 51 Votes in Senate
Unwinding the Affordable Care Act...

• Will take time to enact and even longer to implement
• Exact scope is unclear
  – *Does it include the CMS Innovation Center?*
  – *Would it require unwinding of voluntary pilots and demonstrations?*
  – *What about mandatory demonstrations?*
• Meanwhile, federal budget deficits will persist
• Inter-relationships with other legislation
  – *Protecting Access to Medicare Act*
  – *MACRA and Advanced APMs*
  – *IMPACT Act*
Recent Congressional Proposal Indicates that Episodic Efficiency Remains a Priority

Medicare Post-Acute Care Value-Based Purchasing Act

- Would base its adjustments for all 4 post-acute provider types (LTCH, IRF, SNF, HHA) on the applicable Medicare Spending Per Beneficiary (MSPB) measure
- MSPB is a measure of episodic efficiency derived from claims and calculated pursuant to the IMPACT Act
- Improvement vs. attainment on MSPB score on both an individual provider and group level would be rewarded/penalized

This proposal’s almost exclusive reliance on an episodic measure of resource use shows that Congress wants to drive behavior in the direction of episodic efficiency
Medicare Episode Payment Models (EPMs)

Medicare Is Expanding Voluntary and Mandatory Bundled Payments
How Medicare Episode Payment Works: *Retrospective, Two-sided Risk*

- **Episode Initiation**
  - Episode Spending (less exclusions)

- **Target Price**
  - Reconciliation of target prices to spending occurs after episode is over

- **Gain**
  - Episode Spending (less exclusions)

- **Loss**
  - Episode Spending (less exclusions)
CMS Issues Final Rule December 20, 2016: Advancing Care Coordination through EPMs

• Implements 3 new mandatory episodic payment models (EPMs): coronary artery bypass graft (CABG); acute myocardial infarction (AMI); and surgical hip/femur fracture treatment (SHFFT)
  – Two new cardiac episodes will be tested in 98 randomly selected regions
  – Hip fracture episodes will be tested in the 67 current Comprehensive Joint Replacement (CJR) regions

• Establishes Cardiac Incentive Rehabilitation program
Other Notable Changes in the Final Rule

• Delays implementation of downside risk for AMI, CABG, and SHFFT Models until CY 2019 (but provides option of downside risk earlier if seeking qualification as Advanced APM)

• Makes modifications to CJR demonstration to allow providers to qualify for Advanced APM (AAPM) designation under new physician payment rules

• Establishes new “Track 1+” to Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs)

Ultimate fate of this rule uncertain, but these changes are designed to make the mandatory aspect less controversial & provide a necessary option for doctors to participate in AAPMs
Cardiac Rehabilitation Incentive Payments: Test of Providing Additional Targeted Payments

• Final rule establishes two-part cardiac rehabilitation incentive payment for 90-day period following AMI or CABG hospitalization

• Would be paid retrospectively based on total cardiac rehab use of beneficiaries attributable to participant hospitals:
  – Initial payment would be $25 per cardiac rehabilitation service for each of the first 11 services paid for by Medicare during the care period for a heart attack or bypass surgery
  – After 11 services are paid for by Medicare for a beneficiary, payment would increase to $175 per service paid for by Medicare during care period for heart attack or bypass surgery
  – Cardiac rehab services are subject to existing coverage rules

• Scheduled to be implemented in 90 regions, 45 of which overlap with mandatory cardiac EPM regions
## Comparison of Key Features Between Voluntary BPCI & Mandatory CJR/EPMs

<table>
<thead>
<tr>
<th>Domain</th>
<th>Voluntary BPCI</th>
<th>Mandatory CJR/EPMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation</td>
<td>Voluntary for awardees</td>
<td>Mandatory for hospitals</td>
</tr>
<tr>
<td>Scope</td>
<td>Up to 48 MS-DRG families</td>
<td>Joint Replacement, Hip Fracture, AMI, CABG</td>
</tr>
<tr>
<td>Length of bundle</td>
<td>30, 60, or 90 days</td>
<td>90 days</td>
</tr>
<tr>
<td>Target price</td>
<td>Own historical data (2009–2012 trended)</td>
<td>Phase-in to trended regional prices with stop loss</td>
</tr>
<tr>
<td>Reconciliation</td>
<td>Quarterly</td>
<td>Annual</td>
</tr>
<tr>
<td>Risk</td>
<td>Immediate two-sided risk</td>
<td>Phase-in two-sided risk</td>
</tr>
<tr>
<td>Quality linkage</td>
<td>Indirect</td>
<td>Potential for gains linked directly to quality scores</td>
</tr>
<tr>
<td>Waivers</td>
<td>Certain waivers allowed</td>
<td>Certain waivers allowed with model-specific tweaks</td>
</tr>
</tbody>
</table>
EPM Collaborators: Next Step in Gainsharing Evolution

• Waives certain fraud, waste & abuse laws

• EPM collaborators must be Medicare providers (includes post-acute care) who are participating in care redesign and providing a billable Medicare service

• Risk-bearing hospitals can share both upside and downside risk, as well as internally derived cost savings, up to certain limits with EPM collaborators

• Internal cost savings subject to gainsharing must be documented and be verifiable

CMS & the OIG are providing further guidance on gainsharing arrangements through these policies
Example of Model-Specific Waivers: Three-day Qualifying Stay for SNF Coverage

<table>
<thead>
<tr>
<th>Model</th>
<th>Three-day Qualifying Stay Permitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 2 Voluntary BPCI</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>If majority of SNFs are 3 stars or higher</td>
</tr>
<tr>
<td>CJR – Joint Replacement</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>After 1/1/17 for 3-star SNFs only</td>
</tr>
<tr>
<td>EPM – Surgical Hip &amp; Femur</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Due to longer expected hospital LOS</td>
</tr>
<tr>
<td>EPM – AMI</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>After 4/1/18 for 3-star SNFs only</td>
</tr>
<tr>
<td>EPM – CABG</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Due to longer expected hospital LOS</td>
</tr>
</tbody>
</table>

CMS has stated that 3-day waiver will be applied to future EPMs on case-by-case basis having to do with typical hospital LOS and when the EPM is moving to downside risk.
EPMs Link Gains to Quality Metrics: Standardized Outcome & Satisfaction Scores

• Heart Attacks
  – Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following AMI Hospitalization
  – Excess Days in Acute Care after Hospitalization for AMI
  – Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey
  – Voluntary Hybrid Hospital 30-Day, All-Cause, Risk-Standardized Mortality eMeasure data submission

• Bypass Surgery
  – Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following CABG Surgery
  – HCAHPS Survey

• Hip/femur Fractures (same measures as CJR)
  – Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)
  – HCAHPS Survey
  – Voluntary THA/TKA Patient-Reported Outcome (PRO) data submission
Final Rule on EPMs Sheds Light on Treatment of Overlapping APMs

• **Comprehensive Care for Joint Replacement (CJR)**
  - Due to clinical similarities, SHFFT model would be implemented in same regions as the CJR model, allowing providers to leverage strategies in place for CJR

• **Bundled Payments for Care Improvement**
  - BPCI episodes would take precedence in cases where a BPCI episode would otherwise occur concurrently with an EPM episode

• **Accountable Care Organizations**
  - ACOs would be eligible to become EPM collaborators and participate in the care redesign process and share upside and downside risk with EPM participants
  - Beneficiaries in Innovation Center prospectively aligned ACO models with two-sided risk, such as the Next Generation ACO model, would be excluded from the EPMs

Source: CMS webinar on Episode Payment Models, August 31, 2016
In 17 Regions, Hospitals Would Be Mandatory Bundlers Under All Four EPMs

<table>
<thead>
<tr>
<th>MSA</th>
<th>MSA Title</th>
<th>MSA</th>
<th>MSA Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>10420</td>
<td>Akron, OH</td>
<td>31540</td>
<td>Madison, WI</td>
</tr>
<tr>
<td>12420</td>
<td>Austin-Round Rock, TX</td>
<td>32820</td>
<td>Memphis, TN-MS-AR</td>
</tr>
<tr>
<td>16020</td>
<td>Cape Girardeau, MO-IL</td>
<td>33340</td>
<td>Milwaukee-Waukesha-West Allis, WI</td>
</tr>
<tr>
<td>17860</td>
<td>Columbia, MO</td>
<td>34980</td>
<td>Nashville-Davidson-Murfreesboro-Franklin, TN</td>
</tr>
<tr>
<td>19740</td>
<td>Denver-Aurora-Lakewood, CO</td>
<td>36420</td>
<td>Oklahoma City, OK</td>
</tr>
<tr>
<td>20500</td>
<td>Durham-Chapel Hill, NC</td>
<td>39740</td>
<td>Reading, PA</td>
</tr>
<tr>
<td>23580</td>
<td>Gainesville, GA</td>
<td>46220</td>
<td>Tuscaloosa, AL</td>
</tr>
<tr>
<td>26900</td>
<td>Indianapolis-Carmel-Anderson, IN</td>
<td>48620</td>
<td>Wichita, KS</td>
</tr>
<tr>
<td>28140</td>
<td>Kansas City, MO-KS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Mandatory Bundling Program: Comprehensive Care for Joint Replacement (CJR)

Five-Year Program Went Live April 1, 2016

- **Mandatory Program**: Mandatory demonstration, requiring participation from all inpatient PPS hospitals in 67 metropolitan regions.

- **Hospitals Bear Financial Risk**: Hospitals must bear risk for hospital care and 90 days post-discharge for all related costs to joint replacement (MS-DRGs 469 & 470).

- **Directly** To qualify for realized savings, hospitals must meet specified quality measure performance targets.

Source: https://innovation.cms.gov/initiatives/cjr
Joint Replacement Bundler Strategies

• Increase discharges to home and/or outpatient therapy
• Develop tight relationship with preferred downstream providers
• Improve pre-operative care for elective cases
• Reduce costs of supplies (e.g., implants)
• For more complicated cases, or those lacking support at home, use SNFs with 7 day/week access to physicians; trained staff; and customer-friendly facilities

Source: Adapted from Ehrlich, Developing an Elective Joint Replacement Program, 2015
### Mandatory Hip Fracture Bundling Expands Scope of CJR: Oklahoma City MSA Example

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>DRG Label</th>
<th>EPM Model</th>
<th>Fracture Status</th>
<th>No. of Episodes</th>
<th>Total Episode Payment</th>
<th>First PAC Payment</th>
<th>Readmit Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>469</td>
<td>Lower Joint w MCC</td>
<td>CJR</td>
<td>No Fracture</td>
<td>155</td>
<td>$38,808</td>
<td>$10,017</td>
<td>17%</td>
</tr>
<tr>
<td>469</td>
<td>Lower Joint w MCC</td>
<td>CJR</td>
<td>Fracture</td>
<td>151</td>
<td>$59,535</td>
<td>$19,396</td>
<td>23%</td>
</tr>
<tr>
<td>470</td>
<td>Lower Joint w/o MCC</td>
<td>CJR</td>
<td>No Fracture</td>
<td>7,874</td>
<td>$22,922</td>
<td>$4,550</td>
<td>11%</td>
</tr>
<tr>
<td>470</td>
<td>Lower Joint w/o MCC</td>
<td>CJR</td>
<td>Fracture</td>
<td>1,017</td>
<td>$43,337</td>
<td>$15,569</td>
<td>18%</td>
</tr>
<tr>
<td>480</td>
<td>Hip &amp; Femur Proc w MCC</td>
<td>SHFFT</td>
<td>Fracture</td>
<td>377</td>
<td>$53,411</td>
<td>$16,202</td>
<td>29%</td>
</tr>
<tr>
<td>481</td>
<td>Hip &amp; Femur Proc w CC</td>
<td>SHFFT</td>
<td>Fracture</td>
<td>1,493</td>
<td>$43,613</td>
<td>$15,898</td>
<td>22%</td>
</tr>
<tr>
<td>482</td>
<td>Hip &amp; Femur Proc w/o CC/MCC</td>
<td>SHFFT</td>
<td>Fracture</td>
<td>404</td>
<td>$37,169</td>
<td>$13,261</td>
<td>16%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td>11,471</td>
<td>$29,625</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Hip fractures expand the scope of CJR by 42% in this market, with increased use of institutional post-acute care**

**Source:** Analysis Medicare claims for 2012-2014
Lessons Learned & Future Direction

BPCI Evaluation
Next Round of Voluntary Bundling
Preparing for the Future
Bundled Payments for Care Improvement

Established as 3-year, voluntary demonstration program by Center for Medicare & Medicaid Innovation (CMMI)

- “Clinical episodes” are selected from 1 of 48 possible diagnostic families that are triggered by anchor hospitalization
- Episodes are 30, 60, or 90 days in length and commence at “episode initiating” provider
- Base period target price (less 2%–3% discount) is compared to performance period expenditures on apples-to-apples basis after the fact

Model 2 (hospital or physician group)
Model 3 (post-acute or physician group)

Anchor Hospitalization → Post-Acute Care → End of Episode (30, 60, 90 days)
Voluntary Bundled Payments: Despite Attrition, Significant Growth

Episode Initiators by Provider Type

- 642 SNFs
- 354 Hospitals
- 257 Physician groups
- 81 HHAs
- 9 IRFs

Source: CMS BPCI Website, November 28, 2016
What’s Been Learned So Far: CMS Evaluation of Second Year of BPCI

• Evaluation primarily focuses on 2013 to 2014 time period, before the large growth in BPCI occurred, so findings are limited in their generalizability due to systematic differences in BPCI participants, as well as small numbers problems.

• Analysis compared utilization of BPCI participants to a comparison cohort; in general, utilization of both groups (comparison & BPCI) was going down in time period reviewed.

• Analysis also reviewed participants’ qualitative experience under BPCI.

## CMS Evaluation of Second Year of BPCI: Summary of Model 2 and 3 Findings

### Model 2
- Most widely adopted model—approx. 75% of episodes, 50% of provider participants; majority of episode initiators (EI) were acute care hospitals, tended to be larger & urban and likelier to have teaching programs than non-participating hospitals; average participant in 5 clinical episodes.
- Average Medicare payments for the hospitalization and 90 days post-discharge estimated to have declined $864 more for orthopedic surgery episodes initiated at BPCI-participating hospitals than episodes initiated at comparison hospitals (due to reduced use of institutional PAC following hospitalization).
- For cardiovascular surgery episodes, institutional PAC use declined more for BPCI than comparison populations among those with any PAC.
- Among spinal surgery episodes, average Medicare payments increased more for the hospitalization and the 90-day post-discharge period for the BPCI than comparison population.

### Model 3
- SNFs were most dominant participants, followed by HHAs (only 1 each IRF, LTCH, and PGP participated); all Model 3 episode-initiating providers participated under a Convener and over two-thirds were under 1 of 3 Awardee Conveners.
- Average EI participated in 19 clinical episodes; most common was congestive heart failure, selected by 95% of EIs.
- SNF payments and SNF days for SNF-initiated BPCI episodes declined relative to comparison group across almost all clinical episode groups; however, did not result in statistically significant declines in total episode payments.
- Quality generally was maintained or improved, except in 3 isolated instances where BPCI participant quality outcomes declined relative to comparison group.
Model 2 Bundlers Look to Post-Acute Partnerships

Success of the acute care/PAC relationship depends on:

- Communication and shared goals
- Coordinated discharge planning
- PAC provider buy-in
- PAC partner’s willingness to collaborate and change behaviors

“When knowing the majority of our bundle episode cost and variations do occur within the PAC setting, any redesign success really demands key stakeholder involvement not only from those of us on the acute-care side but certainly from our PAC partners.”

“I think the [PAC providers] have a pretty good understanding that changes are coming down the road, and like us, you either jump on the train early and help to define it, or you can continue the status quo.”

Sources: Lewin Group, CMS BPCI Year 2 Evaluation & Monitoring Report, August 2016
Model 2 Bundlers Incentivize PAC Partners

• Higher patient volumes
  – Development of CMS-approved pamphlet listing specific PAC partners
  – Frustrations that hospitals can’t direct patients to PAC partners
  – If PAC partners not receiving significant volume, it is difficult to:
    • Incentivize monetarily through gainsharing
    • PAC less likely to invest in care redesign
    • Difficult to track patient and share outcome data
    • Difficult to motivate PAC to reduce length of stay

• PAC partners proactively engaging in care coordination partnerships

• Limited evidence of gainsharing with PAC (time frame of study pre-dates growth of BPCI)

“Our team does not have the bandwidth to reach out to all [SNFs in the area], and they would not listen to us anyway because if they have the chance of getting one patient, they are not going to pay any attention.”

Sources: Lewin Group, CMS BPCI Year 2 Evaluation & Monitoring Report, August 2016
Use of Three-Day Hospital Stay Waiver Remains Low Early in Program

Concerns exist regarding:

- Waiver increasing SNF utilization when HHA would have met needs
- Issues around waiver implementation
- Potential financial liability for providers and beneficiaries

Sources: Lewin Group, CMS BPCI Year 2 Evaluation & Monitoring Report, August 2016
Care Redesign in Bundling

"I think the pathway is the biggest thing that helped us standardize [the use of high-cost medication] and reduce costs."

"I think [BPCI] is the biggest opportunity that’s come along in American health care in at least 20 years for meaningful care redesign."

“I think that [the hospitals, nursing homes, and home care entities] are all talking the same language and communicating that same information across the care continuum… The navigators are reinforcing that and collaborating with the primary care physicians to hopefully decrease the readmission rate.”
## Changes in Utilization for Models 2 and 3 Between Baseline and Intervention (10/2013-9/2014)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Surgical</th>
<th>Orthopedic Surgery</th>
<th>Nonsurgical Respiratory</th>
<th>Nonsurgical Cardiovascular</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M2</td>
<td>M3</td>
<td>M2</td>
<td>M3</td>
</tr>
<tr>
<td>% Discharged to PAC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Of PAC Discharges, % Institutional</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Inpatient LOS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number HH Visits</td>
<td>2.0</td>
<td></td>
<td>-3.5</td>
<td>2.2</td>
</tr>
<tr>
<td>Number of Institutional Days</td>
<td></td>
<td></td>
<td></td>
<td>-3.5</td>
</tr>
<tr>
<td>Number of Readmission Days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of NSF Days</td>
<td>-2.5</td>
<td></td>
<td>-1.6</td>
<td>-3.4</td>
</tr>
</tbody>
</table>

90-day episodes
M2 starts with hospital admission
M3 starts with PAC admission

Blank indicates no significant changes
Orange indicates reduction
Green indicates increase

Sources: Lewin Group, CMS BPCI Year 2 Evaluation & Monitoring Report, August 2016
CMS Has Expressed Intent for Another Round of Voluntary Bundling

“However, building on the BPCI initiative, the Innovation Center intends to implement a new voluntary bundled payment model for CY 2018 where the model(s) would be designed to meet the criteria to be an Advanced APM.”

At-risk phase is preceded by a non-risk bearing learning phase
Next Round of Voluntary Bundling: Details Beginning to Emerge

- Models 1 and 4 of BPCI not likely to be continued
- Looking to build off existing BPCI risk-bearing structure
- Tweaks under consideration by CMS Innovation Center:
  - Allowing new participants
  - Longer performance periods (current max is 90 days)
  - Prospective target price
  - Ensuring that new model qualifies as Advanced Alternative Payment Method (e.g., includes an explicit link of payment to quality outcomes)

Stay Tuned...
Why Engage in Voluntary Bundling?

Learn by doing; force culture change

Understand markets through data

Improve quality through care redesign

Earn positive margins
Barriers to Success in Bundling

• Poorly focused or poorly executed care redesign
• Unwillingness to change
• Small-scale programs
• Unfavorable target prices
• Inadequate alignment among episode care providers
Mandatory EPM & Voluntary BPCI Timeline: 
*It's Not Too Soon to Prepare*

- **Mandatory Addition of Hip/Femur Fracture EPM to CJR Hospitals in 67 Markets**
  - CJR implemented April 1, 2016, two-sided risk started **January 1, 2017**
  - Surgical Hip & Femur Fracture Treatment (SHFFT) to be implemented **July 1, 2017**, unless repealed or modified

- **Mandatory Cardiac EPMs in 98 Markets**
  - Two new mandatory cardiac bundles: heart attack and bypass surgery, and cardiac rehab incentive payments
  - To be implemented in 98 markets **July 1, 2017**, unless repealed or modified

- **Voluntary Advanced BPCI intended for CY 2018**

For a list of mandatory EPM markets contact bettyi@hdgi1.com
Know Your Market and Episodic Performance

• At-risk bundlers receive detailed Medicare claims data on their episodes:
  – Claims data, combined with process metrics, often used to profile downstream providers and define performance expectations
  – Metrics vary significantly based on anchor hospitalization diagnosis

• Providers can ask bundlers for performance metrics or obtain market intelligence through third parties

• With Advanced APMs, quality outcomes are as important as utilization
In Your Own VBP Arrangement or Someone Else’s—Performance Matters

**Data**

- E.g., length of stay, costs, readmissions rates, costs (by key diagnosis)

**Quality**

- E.g., patient safety (wounds, falls, infections), patient satisfaction; star ratings

**Process**

- E.g., care transitions, care pathways, INTERACT
Even if you’re on the right track, you’ll get run over if you just sit there

Will Rogers
Thank You!

Any Additional Questions?
For More Information

Brian Ellsworth, MA
Director, Payment Transformation
Health Dimensions Group
860.874.6169
bellsworth@hdgi1.com

Beth Carlson, EdD, RN, NHA
Director, Consulting Services
Health Dimensions Group
763.201.1985
bethc@hdgi1.com
HOSPITALITY

STEWARDSHIP

INTEGRITY

RESPECT

HUMOR