Lessons Learned Implementing Bundled Payments

LeadingAge New York Financial Managers Conference

Brian Ellsworth, MA, Director, Payment Transformation
Health Dimensions Group

Lessons Learned from Post-Acute Bundling

Overview of Medicare Bundling

Lessons Learned in Post-Acute

Parker Jewish Institute Case Study
Overview of Medicare Bundling
Medicare Is Rapidly Expanding Mandatory and Voluntary Bundled Payments

Ultimate Goal for Post-Acute Care:
50% of Payments in Bundles by 2022

Source: Budget of the United States Government, FY 2016; http://www.whitehouse.gov/omb/budget
Bundled Payments for Care Improvement

“Clinical episodes” are selected from one 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.

Most Frequently Selected Clinical Episode Groups For Model 2 & 3 Bundled Payments

Top 5 Clinical Episode Groups Selected for BPCI (out of 48 Possible)

- Major joint replacement of the lower extremity: 58%
- Congestive heart failure: 41%
- Simple pneumonia and respiratory infections: 47%
- Chronic obstructive pulmonary disease, bronchitis, asthma: 39%
- Hip and femur procedures except major joint: 36%

Source: CMS Analytic File, October 13, 2015; CMS BPCI newsletter November 2015, Ed. 7
How Medicare Episode Payment Works: 
*Retrospective, Two-sided Risk*

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

- **Target Price**
  - Gain: Episode Spending (less exclusions) → Gain
  - Loss: Episode Spending (less exclusions) → Loss

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

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**BPCI Is for FFS Patients Only: 
*Triggered by Anchor Hospitalization***

- Beneficiary must be eligible for Part A and be enrolled in Part B
- Beneficiary must **not**:
  - Qualify for Medicare solely through ESRD
  - Be enrolled in any managed care plan
- Beneficiary must have had an applicable anchor inpatient hospital admission

**Beneficiaries must be informed about bundling and may opt out of care redesign activities, but will still be included in bundling reconciliations if otherwise eligible**
Medicare’s Bundling Program Has Several Risk Mitigation Features

Risk Tracks
• Three risk tracks (A, B & C) that trade off risk and opportunity

Outliers
• Process to mitigate effect of extreme cases

Exclusions
• Method to factor out low-volume, high-cost events unrelated to care of the episode in question

Generally these are applied to both target price and performance period expenditures

Waiver Opportunities Under BPCI

- 3-Day Hospital Stay
- Home Visits
- Telemedicine
- Gainsharing

Other mandatory episode payment models employ similar waivers with various tweaks
## Two Rounds of Voluntary Bundling: Despite Attrition, Significant Growth

<table>
<thead>
<tr>
<th>Year</th>
<th>Organizations</th>
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</thead>
<tbody>
<tr>
<td>2013</td>
<td>214</td>
</tr>
<tr>
<td>2016</td>
<td>1,386</td>
</tr>
</tbody>
</table>

### Episode Initiators by Provider Type

- **658 SNFs**
- **360 Hospitals**
- **262 Physician groups**
- **97 HHAs**
- **9 IRFs**

Source: CMS BPCI Website, August 4, 2016

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## 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)

- **Shared Savings Directly Tied to Quality Measures**
  - To qualify for realized savings, hospitals must meet specified quality measure performance targets

- **Hip and femur fractures to be added in July 2017**

Source: [https://innovation.cms.gov/initiatives/cjr](https://innovation.cms.gov/initiatives/cjr)
Two CJR Regions in NYS

- New York-Newark-Jersey City, NY-NJ-PA
  - 70 Hospitals in NY portion of MSA

- Buffalo-Cheektowaga-Niagara Falls, NY
  - 8 Hospitals

NEW Refinement & Expansion of CJR:
Changes Would Apply to Existing 67 Regions

- On July 25, 2016, CMS issued proposed rule to refine and expand the CJR model; proposed refinements include:
  - Creation of a track whereby CJR will qualify as Advanced Alternative Payment Model (AAPM), and thus be of interest to physicians seeking AAPM bonus
  - Changes to composite quality scoring approach to align with AAPM approach
- Expansion of CJR includes addition of surgical hip and femur fracture treatment procedures (SHFFT) to already mandatory joint replacement episodes (MS-DRGs 480-482)
  - Expands program scope, creating more incentive for mandatory hospitals to develop an effective care redesign strategy
NEW Mandatory Bundling Program: 
*Episode Payment for Heart Attacks & Bypass Surgery*

**Proposed Program to Start July 1, 2017**

- **Mandatory Program**
  - Mandatory demonstration, requiring participation from all inpatient PPS hospitals in 98 randomly selected MSAs (out of 291 eligible)

- **Hospitals Bear Financial Risk**
  - Hospitals must bear risk for hospital care and 90 days post-discharge for all related costs to heart attacks and bypass surgery

- **Shared Savings Directly Tied to Quality Measures**
  - To qualify for realized savings, hospitals must meet specified quality measure performance targets

Also includes incentive payments for cardiac rehab

Source: [https://innovation.cms.gov/initiatives/cjr](https://innovation.cms.gov/initiatives/cjr)

NEW Cardiac Rehabilitation Incentive Payments Proposed

- CMS proposes establishing two-part cardiac rehabilitation incentive payment; would be paid retrospectively based on total cardiac rehabilitation 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

- Number of cardiac rehabilitation program sessions would be limited according to coverage rules; can be extended upon approval
### 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>
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</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>Specific DRGs</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</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>

### Example of Model-Specific Waivers: Three-day Qualifying Stay for SNF Coverage

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

*Proposed rule states 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*
CJR & EPM Collaborators:  
*Next Step in Gainsharing Evolution*

- Waives certain fraud, waste & abuse laws
- CJR & 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 CJR & EPM collaborators
- Internal cost savings subject to gainsharing must be documented and be verifiable

These changes provide further guidance on gainsharing arrangements

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Lessons Learned

Necessity for Effective Care Redesign  
Market Shifts Likely  
Understanding Episodic Data Is Critical  
Opportunity to Directly Take Risk
Effective Care Redesign Is Essential

Care Redesign Strategies

- Revised hospital procedures
- Transitions management: acute, post-acute, and community
- Coordination with primary and specialty care
- Readmissions prevention
- Risk stratification
- Patient activation, teaching, and self-care
- Medication reconciliation
- Telehealth

Early Evidence on Episodic Bundling:
* Savings Driven by Changing Use of Post-acute

- First CMS evaluation of BPCI for small number of orthopedic bundlers showed:
  - Institutional post-acute care fell by 30%
  - HHA use stayed about the same*
- Letter to JAMA about NYU’s Model 2 BPCI program shows 34% reduction in discharges to institutional post-acute care for joint replacement & 49% reduction for cardiac episodes

Studies repeatedly show that post-acute care is the most highly variable component of Medicare program and thus essential to address in bundling

## Results from a Mature Joint Replacement Bundling Program

Cleveland Clinic’s Experience Under Model 2 BPCI for Major Joint Lower Extremity

<table>
<thead>
<tr>
<th></th>
<th>Baseline Data</th>
<th>Euclid Hospital Results</th>
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</thead>
<tbody>
<tr>
<td><strong>Year</strong></td>
<td>2013</td>
<td>2013</td>
</tr>
<tr>
<td><strong>Quarter</strong></td>
<td>Q1</td>
<td>Q4</td>
</tr>
<tr>
<td><strong>Medicare A/B Patients</strong>†</td>
<td>72*</td>
<td>65†</td>
</tr>
<tr>
<td><strong>Cauli Rate</strong>†</td>
<td>5.2</td>
<td>0</td>
</tr>
<tr>
<td><strong>LOS</strong></td>
<td>3.40</td>
<td>2.90</td>
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<tr>
<td><strong>Readmission</strong></td>
<td>5.0%</td>
<td>2.0%</td>
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<tr>
<td><strong>Discharge Disposition Home/HHC</strong></td>
<td>39%</td>
<td>71%</td>
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<tr>
<td><strong>Discharge Disposition SNF</strong></td>
<td>56%</td>
<td>28%</td>
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<tr>
<td><strong>HCAHPS Overall Rating</strong>†</td>
<td>73%</td>
<td>88%</td>
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</table>

Sources: * Cleveland Clinic; † 2014 Q3 CMS Reconciliation Report 2058-002

## A Joint Replacement Tale of Two Cities

### Buffalo, New York MSA

<table>
<thead>
<tr>
<th>First PAC Setting</th>
<th>Number of Episodes</th>
<th>Percent of Episodes</th>
<th>Readmissions Rate</th>
<th>Average Episode Payment</th>
<th>Percent Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>38</td>
<td>2%</td>
<td>—</td>
<td>$16,026</td>
<td>—</td>
</tr>
<tr>
<td>HHA</td>
<td>220</td>
<td>15%</td>
<td>7%</td>
<td>$19,274</td>
<td>—</td>
</tr>
<tr>
<td>IRF</td>
<td>44</td>
<td>3%</td>
<td>—</td>
<td>$39,604</td>
<td>68%</td>
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<tr>
<td>SNF</td>
<td>1,200</td>
<td>80%</td>
<td>8%</td>
<td>$26,463</td>
<td>13%</td>
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<tr>
<td><strong>Total</strong></td>
<td>1,502</td>
<td>100%</td>
<td>8%</td>
<td>$25,728</td>
<td>13%</td>
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### Beaumont, Texas MSA

<table>
<thead>
<tr>
<th>First PAC Setting</th>
<th>Number of Episodes</th>
<th>Percent of Episodes</th>
<th>Readmissions Rate</th>
<th>Average Episode Payment</th>
<th>Percent Fracture</th>
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</thead>
<tbody>
<tr>
<td>Community</td>
<td>65</td>
<td>5%</td>
<td>—</td>
<td>$17,138</td>
<td>—</td>
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<tr>
<td>HHA</td>
<td>589</td>
<td>48%</td>
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<td>$21,379</td>
<td>2%</td>
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<tr>
<td>IRF</td>
<td>454</td>
<td>37%</td>
<td>14%</td>
<td>$39,728</td>
<td>36%</td>
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<tr>
<td>SNF</td>
<td>112</td>
<td>5%</td>
<td>14%</td>
<td>$40,137</td>
<td>38%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,220</td>
<td>100%</td>
<td>10%</td>
<td>$29,703</td>
<td>18%</td>
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</tbody>
</table>

Sources: Dobson DaVanzo analysis of SAF, 2011 to 2014 claims data for AHHQI
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

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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
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
- Quality outcomes are as important as utilization

Proposed Rule Indicates Possibility to Voluntarily Take Direct Risk is Coming

“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.”

Voluntary Bundling 2.0 likely to have greater linkage to quality and may use different episode triggering strategies
Why Engage in Voluntary Bundling?

- Learn by doing; force culture change
- Understand markets through data
- Improve quality through care redesign
- Earn positive margins

Our View of Bundling So Far...

- Health Dimensions Group, along with our data partner Dobson DaVanzo, have assisted health care systems representing over 75 episode-initiating providers with participation in Medicare’s Bundled Payments for Care Improvement (BPCI) initiative, supporting 3 of the 10 largest Model 3 conveners
- Episode payment is the wave of the future, but it is not for the faint of heart
  - Timely data analysis, effective care redesign and scale are critical success factors
  - Clients are achieving positive outcomes on key utilization and quality metrics

Dobson|DaVanzo
Thank You!
Any Additional Questions?

For More Information

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Health Dimensions Group: What We Do

Strategic Consulting
- Strategic planning and positioning
- Health care continuum alignments
- Market growth strategies
- PACE development
- Bundling implementation
- Senior service line development
- Post-acute medicine development

Operational and Performance Improvement
- Clinical
- Financial and billing
- Regulatory compliance
- Reimbursement advisory
- Transaction advisory
- Business office support
- Operations re-engineering

Management Solutions
- Strategic planning and positioning
- Turnaround management
- Transitional leadership
- Full-service management
- Acquisitions & divestiture
- Interim management

Appendix
### At-Risk Bundlers in NYS:
#### 42 Model 2 (13 PGP s)

<table>
<thead>
<tr>
<th>Organization Name</th>
<th>#</th>
<th>City</th>
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</thead>
<tbody>
<tr>
<td>Albany Memorial Hospital</td>
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<td>Albany</td>
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<tr>
<td>St. Peter's Hospital</td>
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<td>Albany</td>
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<tr>
<td>Southside Hospital</td>
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<td>Bay Shore</td>
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<tr>
<td>United Health Services Hospitals</td>
<td>18</td>
<td>Binghamton</td>
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<tr>
<td>Montefiore Medical Center</td>
<td>2</td>
<td>Bronx</td>
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<tr>
<td>NYU Lutheran Medical Center</td>
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<td>Brooklyn</td>
</tr>
<tr>
<td>The Brooklyn Hospital Center</td>
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<td>Brooklyn</td>
</tr>
<tr>
<td>Buffalo General Medical Center</td>
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<td>Buffalo</td>
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<tr>
<td>Corning Hospital</td>
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<td>Flushing Hospital Medical Center</td>
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<td>Flushing</td>
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<td>Huntington Hospital</td>
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<tr>
<td>Jamaica Hospital Medical Center</td>
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<td>Long Island Jewish Hospital</td>
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<td>New Hydepark</td>
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<tr>
<td>Hospital for Special Surgery</td>
<td>1</td>
<td>New York</td>
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<tr>
<td>Lenox Hill Hospital</td>
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<td>New York</td>
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<tr>
<td>Mount Sinai Roosevelt Hospital</td>
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<tr>
<td>New York University Hospitals Center</td>
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<tr>
<td>The Mount Sinai Hospital</td>
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<tr>
<td>South Nassau Communities Hospital</td>
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<td>Oceanside</td>
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<tr>
<td>Canton-Potsdam Hospital</td>
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</tr>
<tr>
<td>Highland Hospital</td>
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<td>Rochester</td>
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<tr>
<td>Strong Memorial Hospital</td>
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</tr>
<tr>
<td>St. Joseph’s Hospital Health Center</td>
<td>2</td>
<td>Syracuse</td>
</tr>
<tr>
<td>Samaritan Hospital</td>
<td>4</td>
<td>Troy</td>
</tr>
<tr>
<td>Seton Health (St. Mary’s Hospital)</td>
<td>6</td>
<td>Troy</td>
</tr>
<tr>
<td>Saint Anthony Community Hospital</td>
<td>1</td>
<td>Warwick</td>
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<table>
<thead>
<tr>
<th>PGP Organization Name</th>
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<th>City</th>
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<tbody>
<tr>
<td>Rockland Orthopedics &amp; Sports Medicine</td>
<td>1</td>
<td>Airmont</td>
</tr>
<tr>
<td>Orthopedicsny, LLP</td>
<td>1</td>
<td>Albany</td>
</tr>
<tr>
<td>Exigence Hospitalist Medical Services of Hornell, PLLC</td>
<td>17</td>
<td>Binghampton</td>
</tr>
<tr>
<td>UHS - United Health Services Medical Group</td>
<td>17</td>
<td>Binghampton</td>
</tr>
<tr>
<td>Syracuse Orthopedic Specialists, PC</td>
<td>5</td>
<td>East Syracuse</td>
</tr>
<tr>
<td>Exigence Hospitalist Medical Services of Lewiston, PLLC</td>
<td>35</td>
<td>Lewiston</td>
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<tr>
<td>Advanced Orthopedics &amp; Sports Medicine, PLLC</td>
<td>1</td>
<td>Nanuet</td>
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<tr>
<td>Northeast Orthopedics &amp; Sports Medicine, PLLC</td>
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<td>Nanuet</td>
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<tr>
<td>Premier Orthopedics of Westchester &amp; Rockland</td>
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<td>New City</td>
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<td>Orangetown Orthopedic Associates</td>
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<td>Orangeburg</td>
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<td>St Joseph's Physician Health PC</td>
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<tr>
<td>St. Joseph’s Medical PC</td>
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<tr>
<td>Clarkstown Orthopedics</td>
<td>1</td>
<td>West Nyack</td>
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# = Number of diagnostic categories at risk

### At-Risk Bundlers in NYS:
#### 10 Model 3 (1 PGP)

<table>
<thead>
<tr>
<th>Organization Name</th>
<th>#</th>
<th>City</th>
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<tbody>
<tr>
<td>Visiting Nurse Service of New York Home Care</td>
<td>2</td>
<td>New York</td>
</tr>
<tr>
<td>Village Center for Care</td>
<td>13</td>
<td>New York</td>
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<tr>
<td>Parker Jewish Institute for Health Care and Rehabilitation (SNF)</td>
<td>6</td>
<td>New Hyde Park</td>
</tr>
<tr>
<td>Parker Jewish Institute for Health Care And Rehabilitation (CHHA)</td>
<td>6</td>
<td>Lake Success</td>
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<tr>
<td>UHS - Twin Tier Home Health Care - Vestal</td>
<td>1</td>
<td>Binghamton</td>
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<tr>
<td>UHS - United Health Services Medical Group</td>
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<td>Binghamton</td>
</tr>
<tr>
<td>Belair Nursing &amp; Rehabilitation Center</td>
<td>13</td>
<td>Bemore</td>
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<tr>
<td>Huntington Hills Center for Health &amp; Rehabilitation</td>
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<td>Melville</td>
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<td>The Pines at Poughkeepsie Center for Nursing &amp; Rehabilitation</td>
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<td>Poughkeepsie</td>
</tr>
<tr>
<td>Sands Point Center for Health &amp; Rehabilitation</td>
<td>1</td>
<td>Port Washington</td>
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<thead>
<tr>
<th>PGP Organization Name</th>
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<tbody>
<tr>
<td>UHS - United Health Services Medical Group</td>
<td>2</td>
<td>Binghamton</td>
</tr>
</tbody>
</table>

# = Number of diagnostic categories at risk
Roles for Post-Acute in Model 2 & 3 BPCI

Model 2
• **Episode Integrated Provider** to Model 2 hospital or physician group practice (PGP), preferably with gainsharing
• **Preferred Vendor** to Model 2 hospital or PGP by accepting referrals and effectively managing care

Model 3
• **BPCI Awardee** (accept risk, control gains)
• **Episode Integrated Provider** to Model 3 Awardee (e.g., SNF or HHA to M3 PGP)
• **Preferred Vendor** to Model 3 PGP or PAC (e.g., HHA to SNF)

CMS has announced a third round of voluntary bundling to commence in CY 2018

Interplay Between BPCI & CJR for Joint Replacement Episodes Is Complicated

• Hospitals in Model 1, 2, or 4 BPCI and at risk for joint replacement are **not** required to participate in CJR (unless they drop joint episodes from BPCI)

• Physician group practices (PGPs) and post-acute providers at risk in Model 3 BPCI for joint replacement episodes will **take precedence** over CJR
HOSPITALITY
STEWARDSHIP
INTEGRITY
RESPECT
HUMOR
Welcome

Case Study: Bundled Payments

Wednesday, August 31, 2016, 3:30 PM
Presented by:
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Objectives

- Background on organization
- Why we did this
- Journey into bundled payments
- Implementation
- Results
Our History

- Founded in 1907, the Institute was established by a group of benefactors as a shelter for homeless older people in 1914 and incorporated as the Harlem House of the Daughters of Israel.
- Due to the changing needs, the Home gradually expanded its services to include health care.
- Eventually, the high prevalence of medically complex residents led to the development of a modern facility with the resources to provide more sophisticated care.
- This led to the development of a geriatric facility with a revolutionary vision to create an institution that would provide total care for the geriatric patient. Its orientation would be unique: rehabilitation, restoration, and return to the community.

Parker Today

- A major health and rehabilitation center located in New Hyde Park, NY, comprising 527-bed skilled nursing facility, offering a comprehensive system of post-acute care, including short-term rehabilitation, nursing and medical services.
- We also offer a diversified network of outpatient services including:
  - Social Model Adult Day Health Center
  - Home Health Care Program
  - Hospice Program
  - Palliative Care Program
  - Research and Grants
  - Pharmacy
  - Physician Services
  - Queens-Long Island Renal Institute, Inc.
  - Lakeville Ambulette Transportation, LLC
  - AgeWell New York, LLC
  - Physician Home Visits Program
Our Service Area

We service multiple locations and people from rich and diverse backgrounds.

- Located in Queens on the border between New York City and Long Island—one of the largest and most diverse urban areas in the country.
- According to last U.S. Census, 48 percent of the population is foreign-born.
- Largest ethnic groups in Queens include Asian (Chinese, Korean), Hispanic, Jewish, Persian, African-American, West Indian, Italian, Greek, and Russian.
- Tremendous amount of immigration from South Asia, the Caribbean, and South America.
- Large number of people with limited proficiency in English who are less likely to access appropriate health & social services.
- 1 location in Queens, 3 locations in Nassau County, and 1 location in Manhattan.

Parker Mission

On The Wings of Compassion, Excellence and Innovation

“Provide, with compassion and dedication, superior quality health care and rehabilitation for adults. Through continual improvement of Parker’s programs and services, it will be a leader in health care delivery.”
Parker’s Bundling Program

- Episodes initiate in SNF and CHHA
- Orthopedic DRGs – Hip, Femur and Knee
- Go-live date: April 2015
- Episode length: 60 days
- Expected number of episodes: 120
- Initiator and Convener – No Intermediary

Why Did We Do This?

- Looking forward
- Learning
- Overall benefit to our patients
- Everyone should be doing this
### Episode Spending Breakdown

- **Inpatient Rehabilitation**: 74%
- **Home Health Care**: 5%
- **Outpatient Services**: 9%
- **Re-admissions**: 12%

### Implementation

**Patient Navigators**
- Proficient experience
- Familiar with organization
- Empowered

**Communication**
- Weekly meetings
- Shared decision making
- Targeted length of stay

**Care Pathways**
- Established protocols
- Customized
- Transitions of care

**Post-discharge**
- Follow up with patient
- No network
- No downstream risk sharing
Patient #2

Results Providers Should Expect Under Bundling

- Careful attention to LOS and readmissions
- Engagement of staff and patients in care redesign
- Collaboration with downstream providers
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