How to Succeed In A Bundled Payment Environment

The Future of Spine Conference
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Evolution Of Bundled Payments

- 2009 Brookings Institute Study – bundled payments most effective way to bend the cost curve
- BPCI
- CJR **
- BPCI Advanced
  - 32 Episodes of Care
    - 29 Inpatient
    - 3 Outpatient
  ** Mandatory bundled payment program shut down in 2017
Bundled Payment Success Stories

▪ Heart Bypass Demonstration Project – 1991
  • Decreased spending by 10% (CMS)

▪ Acute Care Episode Project – 2009
  • Cardiac and orthopaedic episodes
  • Costs decreased by 3% in five organizations (CMS)

▪ Bundled Payment Care Initiative (BPCI) – 2011
  • 14,000 bundles across 24 surgical and 24 medical conditions
  • Achieved savings an order of magnitude higher than ACOs
BPCI Advanced – Inpatient

- Disorders of the liver excluding malignancy, cirrhosis, alcoholic hepatitis
- Acute myocardial infarction
- Back & neck except spinal fusion
- Cardiac arrhythmia
- Cardiac defibrillator
- Cardiac valve
- Cellulitis
- Cervical spinal fusion
- COPD, bronchitis, asthma
- Combined anterior posterior spinal fusion
- Congestive heart failure
- Coronary artery bypass graft
- Double joint replacement of the lower extremity
- Fractures of the femur and hip or pelvis
- Gastrointestinal hemorrhage
- Gastrointestinal obstruction
- Hip & femur procedures except major joint
- Lower extremity / humerus procedure except hip, foot, femur
- Major bowel procedure
- Major joint replacement of the lower extremity
- Major joint replacement of the upper extremity
- Pacemaker
- Percutaneous coronary intervention
- Renal failure
- Sepsis
- Simple pneumonia and respiratory infections
- Spinal fusion (non-cervical)
- Stroke
- Urinary tract infection
BPCI Advanced – Outpatient

- Percutaneous Coronary Intervention (PCI)
- Cardiac Defibrillator
- Back & Neck except Spinal Fusion
How Bundled Payments Work

Projected Spend Determines Budget

- Cumulative FFS payments for appropriate care
- Reduction of FFS payments for potentially avoidable complication (PAC’s)
- Discount (3-5%) to drive coordination of care between providers and avoidance of duplication of services and other inefficiencies
- Quality / patient satisfaction goals must be met before any incentive payments are distributed
- Savings against budget shared between payer and providers
- If spending exceeds budget penalty payments also shared between providers and payers
## Bundled Payments Versus Capitation

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<thead>
<tr>
<th>Bundled Payments</th>
<th>Capitation</th>
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<tr>
<td>Providers are paid for the care of a patient’s medical condition across the entire care cycle.</td>
<td>The healthcare organization receives a fixed payment per year per covered life and must meet all the needs of a broad patient population.</td>
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<td>Primary care – bundles by patient population (adult, elderly, children)</td>
<td>Restricts patient choice</td>
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<td>Specialty care – bundles by clinical condition (total joint, spine surgery, transplant)</td>
<td>Not proven to change the cost trajectory – failed capitated managed care models of the 80’s and 90’s</td>
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<td>Sets up competition on value (quality / cost)</td>
<td>Efforts geared toward population health – overall spend, readmission rates, LOS</td>
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<td>Proven to bend the cost curve – BPCI, Transplant programs, Brookings Study</td>
<td>Providers at risk for things they can’t control</td>
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<td>Efforts geared toward each patient’s specific condition (what matters most) – complications, return to baseline health status</td>
<td>Hard to risk adjust a population</td>
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<td>Providers at risk for things they can control</td>
<td>Drives consolidation and monopolization (providers and payers)</td>
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<td>Risk adjustment easier for single conditions or patients</td>
<td>Drives competition and innovation</td>
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<td>Drives integrated, multi-disciplinary care</td>
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Drill Down On The Bundled Payment Model

- Appropriate care = evidence based, best practice, guidelines
- Discount = extra dollars that can be gleaned through coordination of care between providers and clear communication of roles and responsibilities
- Potentially avoidable complications = avoiding never events, allowing for PAC’s that happen despite best practice (emphasis on potentially avoidable)
- Quality performance triggers any payment of savings = distinct difference between this model and managed care / capitation models of the 80’s and 90’s
## Bundled Cost Breakdown For Spine Surgery

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<th>MS-DRG 473 Cervical Spinal Fusion w/o MCC</th>
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<tr>
<td>Facility Payment</td>
<td>$11,230.00 (72.8%)</td>
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<tr>
<td>Professional Fess</td>
<td>$3598.00 (23.3%)</td>
</tr>
<tr>
<td>Post-Acute Payments</td>
<td>$479.00 (3.1%)</td>
</tr>
<tr>
<td>Readmission Payments</td>
<td>$110.00 (0.7%)</td>
</tr>
<tr>
<td>Mean Total Payments</td>
<td>$15,417.00</td>
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1 Professional fees for MS-DRG 473 includes intraoperative surgeon payment, intraoperative anesthesiology payment, outpatient reimbursement (including clinic visits and outpatient imaging), neuromonitoring and dysphagia-related reimbursement.
Variations In Cost for Spine Surgery

Study 1: 30-day bundles for DRGs 491 and 456 (Cervical and Lumbar Spine Surgery)

- $11,180 (30-day bundle, DRG 491) to $107,642 (30-day bundle, DRG 456).”
- Total bundle costs for hospital stays remained relatively stable despite increased bundle length (increasing from $33,522 for 30-day to $35,165 for 90-day bundle).
- The largest portion of bundle costs—76%—payments to hospitals.

Study 2: 30-day episodes for spinal stenosis, spondylolisthesis, and lumbar/sacral disc herniation involving nearly 186,000 patients seen between 2005-2007

- $16,000 (lowest quintile) to just over $34,000 (highest quintile)—a variance of 113%.
- Following refinement of the dataset to adjust for patient risk factors and Medicare pricing differentials between markets, variation in cost between the highest and lowest quintiles was still 47%.
- Further refinement addressing procedure choice of the surgeon (eg, use of fusion) only reduced cost variation to 28%.

Association for Collaborative Spine Research (ACSR) presentation made during ISASS17, Bundled Payments in Spine Surgery: Lessons Learned, Alexander Vaccaro, MD, PhD, MBA
Bundled Payments – Five Essentials

1. Payment covers the overall care required to treat the condition
2. Payment is contingent on delivering good outcomes
3. Payment is adjusted for risk
4. Payment provides a fair profit for effective and efficient care
5. Providers are not responsible for unrelated care or catastrophic cases
Key Considerations for Bundles

1. Inclusion and exclusion criteria – which procedures will be included in the bundle and which will not
2. Patient selection criteria – which patients will be excluded from the bundle based on clinical criteria, e.g. co-morbid conditions
3. Location of surgery – will this include inpatient and outpatient surgical services?
4. Mapping of the care processes and procedures involved and ensuring that these include evidence-based, best practice components and exclude non-value-added care steps, i.e. those that add costs but don't improve quality or patient experience
5. Cost accounting of the care processes and procedures, ideally using a time-driven, activity-based, cost accounting (time-driven activity-based costing) methodology
6. Selection of quality and patient experience outcome measures and how these will be captured, aggregated and reported to payers, regulators and most importantly to front-line providers for use in continuous, data-driven, process improvement activities
7. Network formation – who will be in the narrow network surrounding the bundled services – surgeons, anesthesiologists, hospitals, post-acute care providers etc.?
8. Risk adjustment – how will the bundled agreement account for risk variation in different patient populations? What are the responsibilities of the providers to make sure that risks are reported and taken into account?
9. Marketing of spine surgery bundles – who will be the target market for these services – payers (government and commercial), employers (self-insured), ACOs or clinically integrated networks (via wrap around agreements)
Procedures – Inclusion and Exclusion

- Especially problematic for spine surgery – so many possible procedures
- If procedures identified by DRG – must know whether the DRG includes complications and comorbidities (CCs and MCCs)
- Know which procedures your current and future surgeons will be performing. Know the volumes for each type of procedure
- Anticipate which procedures might become mandatorily bundled by CMS – see BPCI Advance and look at the fine print
Patient Selection

- Probably one of the biggest obstacles to making bundles work in surgical specialties – high risk of cherry picking and adverse consequences for those that do not

- High risk area for surgeons who get the “tough” cases – re-do’s, tertiary referral centers, historical record of good outcomes for complex cases

- Goes against the grain of most surgeons / physicians who want to do the best for their patients

- Demands we do a better job of factoring in and managing socio-economic and behavioral aspects of patient care – weight loss, smoking cessation, compliance, etc.
Surgical Location

- Value (quality / cost) driving more and more surgeries to the ambulatory arena
  - Spine
  - Total joint
  - Cardiac procedures
  - Ophthalmology, ENT, Urology, GI

- Spine surgery dilemma
  - How to take advantage of cost advantages in the ambulatory space without sacrificing quality and patient safety
Care Process Mapping

- Many care processes not well understood, each local provider group must better understand and intentionally design their care delivery processes
- Use a modified Lean mapping technique
  - Squares equal major steps (what you do at least 10% of the time)
  - Diamonds equal decision steps (if this then that)
- Include processes (care process units or CPUs) across the continuum
  - Pre-acute (surgeon’s office visit, imaging, lab, pre-op consult)
  - Acute (pre-op eval, OR, post-op – nursing, imaging, rehab, discharge planning)
  - Post-acute (rehab (inpatient or outpatient), home health, surgical follow-up, nursing home, imaging)
- Include evidence-based (when available) and best-practice guidelines (not protocols or pathways) for each step
Cost Accounting of CPUs

- **TDABC**
  - For each step: staff, equipment, supplies, space and time (results in a cost / minute)
  - Cumulative (additive) costs for all steps used to determine costs for full CPU
  - CPUs can be connected to create integrated practice units (IPUs) and to determine costs for IPUs by adding up each CPU within the CPU

- **Costs for CPUs can be used to:**
  - Negotiate bundled budgets / prices
  - Determine if non-negotiable bundled budgets / prices will produce a profit
  - Identify costs that may be able to eliminate without sacrificing quality or patient safety

  » Note: Must account for true costs of producing / delivering services not the costs to the payer, i.e. paid claims
Selection of quality / experience measures

- May not have a say in which measures are used, e.g. CMS bundles

- When given a say in the matter:
  - Try to use outcome vs process measures
  - Consider patient reported outcome measures (can now track via mobile technology)
  - Consider experience measures as outcome measures (measuring experience too soon may factor in only superficial satisfiers)
  - Pick measures that providers feel are the most important and truly reflect quality of care delivery
  - Pick measures that can be measured in real-time or near-real time
  - Pick measures that you’re probably already collecting: complications, readmissions
Network Formation

Successful Bundled Operations Require a Network

- Surgeons
- Anesthesiologists
- Hospitalists
- PM&R
- Hospitals / ASCs
- Post-acute care providers and facilities

Consider Functioning as a Convener – Do Not Abdicate This to Hospitals or Health Systems

Networks Must be Clinically Integrated *

- Provider led and provider governed
- Focus on quality / cost measurement
- System of accountability

* spin off benefit is that clinically integrated providers can jointly contract even if they do not all share the same tax ID number
Risk Adjustment

- Remember: all bundled service agreements include an element of risk, i.e. under budget – shared savings, over budget – payback
- Bundled budget must be adjusted per risks – but how?
- Most common methodology – CMS HCC method.
  - 9000+ ICD-10 codes, map to 70+ HCCs (healthcare condition categories)
  - HCCs must be addressed by the provider and captured in the claims data
    - Addressing HCCs
      - Monitoring
      - Evaluating / Assessing
      - Treatment
    » Example: Diabetes Type II, stable on oral agents with Hgb A1C < 6
Marketing

- Potential target markets for bundled services
  - Government payers (CMS) – BPCI Advanced
  - Commercial payers – BCBS total joint bundles
  - Self-insured employers – procedures, chronic diseases, acute illnesses

- Step-wise approach
  - Select the bundled services
  - Form the network
  - Build the infrastructure (IT, CM)
  - Design the care process units and the integrated process units
  - Refine and improve the CPUs and IPUs to optimize value
  - Take the services to market
Conclusions

- Bundles are a popular and effective payment model and will likely be used more widely across the healthcare industry going forward.
- Spine surgeons are especially likely to see bundled payment models from all payers
- Successful operations under bundled payments will require providers to learn and master many new capabilities
- Those providers who can transform their operations to function well in a bundled payment model will have many first to market opportunities and the opportunity to capture the greatest market share of bundled payments
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With over 30 years in the healthcare arena, he has developed significant experience and knowledge in this industry. Before joining Coker, Dr. Knight served in several executive roles for Palmetto Health in Columbia, South Carolina. There, he oversaw Palmetto Health’s employed physician network, ambulatory services division (rehab, lab, home health, hospice care and imaging) and helped to develop and manage their clinical integration program. Earlier, he was Palmetto Health Richland’s vice president for medical affairs.

Dr. Knight graduated from Stanford University with a Bachelor of Arts degree in Human Biology and received his Doctor of Medicine degree, cum laude, from the University of Oregon Health Science Center's School of Medicine. He earned a Master of Business Administration from the University of Massachusetts at Amherst. Mac holds fellowships in the American College of Physicians, the Society of Hospital Medicine, and the American College of Healthcare Executives.

Dr. Knight oversees Coker’s Revenue and Quality Integrity (RQI) services, which offer expert services around coding, compliance and clinical documentation to healthcare organizations of all types. Dr. Knight serves as Coker Group’s chief medical officer and works on a variety of projects where his clinical background and knowledge of clinical operations can bring additional value to the client. He has a particular expertise in population health management, clinical care process design, cost accounting, clinical integration and clinical documentation/coding improvement.