OUTCOMES AND LESSONS LEARNED FROM CMS JOINT REPLACEMENT BUNDLED PAYMENT INITIATIVES

NOVEMBER 8, 2016

INTRODUCTIONS

Donna Cameron is a managing director in the Healthcare practice at Navigant. With 33 years invested in the healthcare field, Cameron has an eclectic repertoire of skills from which to draw when assisting her clients. She specializes in performance improvement, strategic planning, program development, organizational and process redesign, and physician-hospital integration. Cameron has extensive expertise in the post-acute and long term care continuum, both as a clinician, operational executive and consultant. She has led several engagements supporting clients’ transition to value based reimbursement models, including Bundled Payment for Care Improvement (BPCI), Comprehensive Care for Joint Replacement (CJR), and Accountable Care Organizations (ACOs). She has served as the project manager for large scale, multi-faceted client engagements focusing on horizontal integration and organizational transformation. Her clients include hospitals, post-acute providers, and physician practices.

Brian Fisher is a managing consultant with Navigant’s Healthcare Strategy Practice. He has expertise and experience in reimbursement contracting, risk-based contract development, shared savings models, bundled payments, and contracting financial impacts for various healthcare providers. His work has focused on analytic-driven, strategic support for both fee-for-service and value-based payment models. Some of Fisher’s work has included supporting organizational alignment and care coordination, analyzing performance and benchmarks, and projected / actual financial impacts. Fisher has worked intimately with clients in BPCI since 2013 and has led Navigant’s bundled payment analytic efforts for the past two years.
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**SECTION 1:**
HEALTHCARE REFORM AND VALUE-BASED REIMBURSEMENT MODELS

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As healthcare transitions from volume (curve 1) to value (curve 2), most markets requires multi-year “bridge strategies” to transition.

### Volume-Based Curve 1
- Fee-for-service reimbursement
- High quality not rewarded
- No shared financial risk
- Acute inpatient hospital focus
- Limited IT investment incentives
- Stand alones can thrive
- Regulatory actions impede collaboration

Source: AHA and Navigant analysis

### Value-Based Curve 2
- Payment rewards value
- Quality impacts reimbursement
- Partnerships with shared risk
- Increased patient severity
- IT essential for population health management
- Scale increases in importance
- Realigned incentives and encouraged coordination

### The Move to Value is Accelerating and Gaining Traction

CMS continues along its path to shift one-half of its Medicare payments to value-based models by 2018.

Subsequently, the Health Care Transformation Task Force, which includes 20 leading providers and insurers, committed to moving 75% of their businesses to value-based arrangements by 2020.

In January 2015, CMS set the Quality and Alternative Payment Model Goals for 2016 and 2018. In March of 2016, CMS announced they reached their initial goal well ahead of schedule. Note: This was before the 4/1/2016 implementation of CJR.
THE TRANSITION IS ACCELERATING DUE TO PRESSURES FROM MULTIPLE SOURCES

**Providers**
- #1 Increased provider consolidation by not only underperforming, thinly capitalized hospitals and physician groups, but strong providers are seeking new partnerships resulting in transactions that could not have been predicted two years ago

**Payers**
- #2 New payment models are emerging, value-based contracts offering incentives and shifting risk to providers results in less high-end imaging and ED avoidance are being embraced by primary care physicians, triggering acceptance by specialists and hospitals

**Employers**
- #3 Employers are using multiple levers to address health costs, e.g., price, wellness, increasing employee out-of-pocket, and transitioning from defined benefit to defined contribution

**Government**
- #4 Government fiscal pressures are forcing payment cuts that require provider cost reductions and performance improvement

SECTION 2: BUNDLED PAYMENT MODELS
There are multiple value-based reimbursement models; however, bundling and episode payment models (EPMs) have become a prevalent model to shift to value:

- **Bundled Payments for Care Improvement (BPCI):** CMS optional program with 48 different conditions to select from
- **Comprehensive Care for Joint Replacement (CJR):** Mandatory joint replacement bundle

### COMPARISON OF CMS BUNDLED PAYMENT MODELS

<table>
<thead>
<tr>
<th><strong>CJR</strong></th>
<th><strong>Bundled Payment Care Improvement (BPCI)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Medicare Fee-for-Service patients</td>
<td>- Medicare Fee-for-Service patients</td>
</tr>
<tr>
<td>- CMS mandatory program in defined 67 defined MSAs and over 800 hospitals</td>
<td>- CMS optional program</td>
</tr>
<tr>
<td>- CMS defined episode of 90 days</td>
<td>- Medicare BPCI defines four bundled payment models</td>
</tr>
<tr>
<td>- Awardees / episode initiators have to be hospitals</td>
<td>- Providers can select from 48 different conditions</td>
</tr>
<tr>
<td>- Defined quality metrics</td>
<td>- CMS option to select different episode lengths: 30, 60, or 90 days</td>
</tr>
<tr>
<td>- Payment for all services received during a defined episode / period of care</td>
<td>- Awardees / episode initiators can be hospitals, physician group practices, post-acute providers</td>
</tr>
<tr>
<td>- Fracture stratification mandated</td>
<td>- Payment for all services received during a defined episode / period of care</td>
</tr>
<tr>
<td>- CJR starts with hospital pricing includes a progressive track towards regional pricing</td>
<td>- Awardee selected quality metrics</td>
</tr>
<tr>
<td>- CMS documented informed choice language for post-acute provider networks</td>
<td>- Fracture stratification recently added as optional</td>
</tr>
<tr>
<td></td>
<td>- Target prices set by hospital historical prices</td>
</tr>
</tbody>
</table>
Key Components

- Three-year agreement with CMS
- Focuses on Medicare Fee-for-Service patients that are initiated by specific DRG level inpatient admissions (Medicare Advantage excluded)
- Hospital owns financial and performance risk
- Requires 2-3% discount on Medicare allowed across the full episode compared to historical claims for (30, 60, and 90-day episode)
- Providers bill the same and are paid the same as normal Medicare
- CMS reconciles payments with the organization against target at the conclusion of an episode
- Episode includes all care for inpatient admission, post-acute care, and all related services and readmissions for 90 days post-discharge
- Includes opportunity for facility and physicians to design a gainsharing model (up to 50% of professional fees) to share in internal cost savings and cost of care savings
- CMS provides claims data monthly which enables the organization to review facility and professional claims detail, including readmissions and post-acute care
- Success requires developing a detailed action plan to redesign care to maximize coordination, patient-centeredness, efficiency, and improved quality
- Of the 48 possible conditions, many organizations selected Model 2 with Joint Replacements as one of their bundling initiatives

BPCI MODELS

<table>
<thead>
<tr>
<th></th>
<th>Model 1: Inpatient Hospital Stay</th>
<th>Model 2: IP Stay + Post-Discharge</th>
<th>Model 3: Post-Discharge Only</th>
<th>Model 4: Inpatient Stay Only</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Included Services</strong></td>
<td>Inpatient hospital services</td>
<td>Inpatient hospital + related post-discharge services</td>
<td>Post-acute care following an inpatient stay</td>
<td>Inpatient hospital and physician services</td>
</tr>
<tr>
<td><strong>Clinical Conditions</strong></td>
<td><strong>ALL DRGs</strong></td>
<td>DRGs proposed by applicants</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Payment Stream</strong></td>
<td>Discount on DRG payment to hospital</td>
<td>Retrospective reconciliation to predetermined target price (discount)</td>
<td>Prospective payment to hospital, which distributes to physicians</td>
<td></td>
</tr>
<tr>
<td><strong>Expected Discount</strong></td>
<td>0% for first 6 months, increasing to 2% in year 3</td>
<td>Minimum of 3% for 30-89 days post-discharge; minimum 2% for &gt;90 days post-discharge</td>
<td>To be proposed by applicant</td>
<td>Minimum 3% discount</td>
</tr>
</tbody>
</table>
Background:

- Innovation Center program as part of Affordable Care Act, following the successful Acute Care Episode Demonstration from 2009-2012
- Two phases of implementation:
  - Phase 1: No risk – CMS sends claims files for analysis to inform redesign
  - Phase 2: Risk – Providers sign contract with CMS and assume performance risk
- Phase 2 participants – three-year agreement started 1/1/15
- Requires a 2-3% discount to Medicare depending on episode length selected (30, 60, or 90 days)
- Ability to share savings with physicians up to 50% of individual physician allowed amounts

As of April 1, 2016, there were 1,522 BPCI participants in Phase 2 (at-risk phase) comprised of 321 awardees and 1,201 episode initiators involved in care redesign – depending on the model, “Episode Initiators” can be: acute care hospitals, physician group practices, SNFs, HHAs, IRFs, LTACs

On April 18, 2016, CMS announced that it will offer the awardees in the BPCI initiative the opportunity to extend their participation in Models 2, 3, and 4 through September 30, 2018.

Source: innovation.cms.gov/initiatives/BPCI-Model-2

Key Components

- **Five-year agreement** covering 67 MSAs and over 800 hospitals that started on 4/01/2016
- Focuses on Medicare Fee-for-Service patients that are initiated by DRGs 469 and 470 inpatient admissions
- Requires 3% discount on Medicare allowed across the full episode compared to individual hospital and regional hospital historical claims for 90-day episode
- Episode includes IP admission and post-acute care and related readmissions for 90 days from IP discharge
- Includes opportunity for facility and physician collaborators to design a Gainsharing model (up to 50% of professional fees) to share internal cost savings and cost of care savings - Net Payment Reconciliation Amounts (NPRA)
- CMS to provide claims data upon request on a quarterly basis which enables participant hospitals to review facility and professional claims detail, including readmissions and post-acute care
- Success requires developing a detailed action plan to engage physicians, develop a post-acute preferred provider network, improve care transitions, reduce 90-day readmissions, and improve quality
Overview: Under CJR, Medicare will bundle Lower Extremity Joint Replacement (LEJR) procedures currently paid under the Inpatient Prospective Payment System (IPPS) [DRGs 469 and 470] for all traditional Medicare patients effective 04/01/2016.

Scope: Over 800 hospitals in 67 MSAs will be episode initiators and bear financial risk under the CJR Model. Hospitals will be responsible for coordinating and managing care throughout the 90-day episode (inpatient admission, post-acute and physician follow-up).

Quality: Centers for Medicare and Medicaid Services (CMS) adopted two quality measures and the voluntary reporting of Patient Reported Outcomes (PRO) data to come up with a composite quality score methodology.

Payment: Hospitals will continue to be reimbursed under the traditional Medicare Fee-for-Service (FFS) payment system; however, after completion of a performance year, Medicare will reconcile episode payments against an established CJR episode target price (multiple factors contribute to establishing a participant hospital’s target price).
WHY IS IT IMPORTANT TO USE THE DATA ANALYTICS?

- For both BPCI and CJR, CMS provides claims level data to analyze the baseline and ongoing performance.
- Organizations recognize that the CMS claims level data is not sent in a “user friendly” format and most select an analytics partner to support their ongoing bundling analytics.
- The data informs key opportunities to improve performance.
- The analytics provide the organization with the ability to prioritize strategies for initial impact and then subsequent strategies for continuous improvement.
- Data analytics become the vehicle to show how the organization is performing relative to their historical performance and creates the framework of performance relative to leading practice.
- Communicating the data analytics to key stakeholders (e.g., orthopedic surgeons, post-acute providers, case managers) initiates a dialogue regarding targeted tactics to improve performance.

CJR EXAMPLE

DRG 470

Allowed Per Episode Summary – DRG 470
CY 2012, 2013, 2014

Post-acute care allowed per episode cost increased each year

OTHER ALLOWED PER EPISODE INCLUDES READMISSIONS, HOSPICE COST; POST ACUTE CARE ALLOWED PER EPISODE INCLUDES SNF, HOME HEALTH, IRF, LTACH, DME, GP COST

AVERAGE TARGET PRICE IS CALCULATED AS TARGET PRICE * (NUMBER OF EPISODES) / NUMBER OF EPISODES AND IS SHOWN AS A RED DOTTED LINE ON THE CHART.
CJR EXAMPLE
DRG 469

Allowed Per Episode Summary – DRG 469
CY 2012, 2013, 2014

Total allowed per episode cost increased each year

- CY 2012: $20,428 Acute, $21,894 Post Acute, $3,303 Physician, $47,279 Total
- CY 2013: $22,139 Acute, $14,016 Post Acute, $3,653 Physician, $51,004 Total
- CY 2014: $24,981 Acute, $24,828 Post Acute, $4,372 Physician, $59,196 Total

Total Allowed Per Episode includes Readmissions, Hospice cost; Post Acute Care Allowed Per Episode includes SNF, Home Health, IRF, LTACH, DME, OP cost

Other Allowed Per Episode includes Readmissions, Hospice cost; Post Acute Care Allowed Per Episode includes SNF, Home Health, IRF, LTACH, DME, OP cost

Average Target Price is calculated as Target Price * (Number of Episodes) / Number of Episodes and is shown as a red dotted line on the chart

CJR EXAMPLE
PHYSICIAN VARIATION – DRG 470

Provider Allowed Per Episode – DRG 470

Physicians with high volume of episodes are generally observed to have lower allowed per episode cost

- MD 1: $100,000 Acute, $30,000 Post Acute, $10,000 Physician, $140,000 Total
- MD 2: $90,000 Acute, $20,000 Post Acute, $5,000 Physician, $115,000 Total
- MD 3: $80,000 Acute, $15,000 Post Acute, $3,000 Physician, $108,000 Total
- MD 4: $70,000 Acute, $10,000 Post Acute, $2,000 Physician, $82,000 Total
- MD 5: $60,000 Acute, $5,000 Post Acute, $1,000 Physician, $66,000 Total
- MD 6: $50,000 Acute, $2,000 Post Acute, $1,000 Physician, $53,000 Total
- MD 7: $40,000 Acute, $1,000 Post Acute, $1,000 Physician, $42,000 Total
- MD 8: $30,000 Acute, $500 Post Acute, $1,000 Physician, $36,000 Total
- MD 9: $20,000 Acute, $250 Post Acute, $1,000 Physician, $23,000 Total
- MD 10: $15,000 Acute, $125 Post Acute, $1,000 Physician, $17,000 Total
- MD 11: $10,000 Acute, $62.50 Post Acute, $1,000 Physician, $11,000 Total
- MD 12: $5,000 Acute, $31.25 Post Acute, $1,000 Physician, $6,000 Total
- MD 13: $1,000 Acute, $15.62 Post Acute, $1,000 Physician, $2,000 Total
- MD 14: $1,000 Acute, $500 Post Acute, $1,000 Physician, $2,000 Total
- MD 15: $1,000 Acute, $500 Post Acute, $1,000 Physician, $2,000 Total
- MD 16: $1,000 Acute, $500 Post Acute, $1,000 Physician, $2,000 Total
- MD 17: $1,000 Acute, $500 Post Acute, $1,000 Physician, $2,000 Total
- MD 18: $1,000 Acute, $500 Post Acute, $1,000 Physician, $2,000 Total
- MD 19: $1,000 Acute, $500 Post Acute, $1,000 Physician, $2,000 Total

Other Allowed Per Episode includes Readmissions, Hospice cost; Post-Acute Care Allowed Per Episode includes SNF, Home Health, IRF, LTACH, DME, OP cost
CJR EXAMPLE
PHYSICIAN VARIATION – DRG 469

Provider Allowed Per Episode – DRG 469

Physicians with few attributed episodes are generally observed to have high allowed per episode cost.

Other Allowed Per Episode includes Readmissions, Hospice cost; Post-Acute Care Allowed Per Episode includes SNF, Home Health, IRF, LTACH, DME, OP cost.

ANATOMY OF JOINT REPLACEMENT BUNDLE – DRG 470

Allowed Per Episode By Phase and Place of Service

Total Cost

Anchor Facility

$11,873

$3,510

$15,383

Post Acute Care

$604

$684

$179

$12,313

For Allowed Per Episode by Phase and Place of Service – Post-Acute Care cost includes Readmissions, SNF, Home Health, IRF, LTACH, DME, OP
Anchor Facility cost includes Anchor Facility and Professional

45%

40%

13%

5%

43%
POST-ACUTE CARE SPEND SUMMARY – DRG 470

Trend in PAC Spend by Type of Service Per Episode – DRG 470
CY 2012, 2013, 2014

PAC spend is primarily driven by SNF and Home Health.
Total Home Health spend is decreasing each year while SNF spend is increasing.

DATA ANALYTICS – LESSONS LEARNED

- Data analytics “tell the story” and mitigate emotional responses from key stakeholders about reducing practice variation.
- Data analytics need to be shared in a simple format; graphics are better received than worksheets and tables with lots of numbers.
- It is very important to share the data and educate the key stakeholders on how to interpret the data.
- The lag in the data for BPCI and CJR is difficult to capture the impact of current strategies; developing other vehicles to track performance with the available data is important to provide feedback and sustain momentum.
- Establishing leading practice targets for joint replacements align the multiple parties for performance targets.
- Providing ongoing access to data (e.g., web platform) can be helpful to use the data for ongoing feedback to improve performance.
- Communicate, communicate, communicate!
Navigant has several clients participating in the BPCI and CJR programs.

BPCI clients are participating in joint replacement as well as a variety of other conditions.

There are several factors that can impact a client’s success in value-based reimbursement related to bundled payments.

Critical success factors (CSFs) include:
- Physician engagement
- Coordinated education plans (for all appropriate stakeholders)
- Care redesign that standardizes care throughout the continuum
  - Standardize order sets and medical-surgical supplies (as able)
  - Risk stratification of patients
- Post-acute preferred provider network with agreed upon expectations and accountability platform
- Development of a comprehensive transition care management plan
- Readmission reduction plans that involve post-acute protocols and ED involvement

The following slides outline two bundling case studies.
CASE STUDY #1
BPCI RECONCILED QUARTERLY RESULTS CY 2015-Q3

This organization decided to participate in BPCI as a means to build capabilities for value-based payment. Initial efforts were focused on developing a post-acute network.

<table>
<thead>
<tr>
<th>Lower Joint Replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility</td>
</tr>
<tr>
<td>Facility A</td>
</tr>
<tr>
<td>Facility B</td>
</tr>
<tr>
<td>Facility C</td>
</tr>
<tr>
<td>Facility D</td>
</tr>
<tr>
<td>Facility E</td>
</tr>
<tr>
<td>Facility F</td>
</tr>
<tr>
<td>Facility G</td>
</tr>
<tr>
<td>Facility H</td>
</tr>
<tr>
<td>Facility I</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

CASE STUDY #1
DATA ANALYTICS: EPISODE SUMMARY

Episode Summary 2015 Q3 vs. Baseline Period

<table>
<thead>
<tr>
<th></th>
<th>2015 Q3</th>
<th>Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Episodes</td>
<td>181</td>
<td>2,119</td>
</tr>
<tr>
<td>Case Mix Index</td>
<td>2.16</td>
<td>2.20</td>
</tr>
<tr>
<td>Total Allowed</td>
<td>4,486,458</td>
<td>51,487,552</td>
</tr>
<tr>
<td>Total Allowed per Episode</td>
<td>24,798</td>
<td>24,289</td>
</tr>
<tr>
<td>Anchor Allowed</td>
<td>2,278,065</td>
<td>27,104,357</td>
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<tr>
<td>Anchor Allowed per Episode</td>
<td>12,586</td>
<td>12,791</td>
</tr>
<tr>
<td>Anchor ALOS</td>
<td>4.31</td>
<td>4.76</td>
</tr>
<tr>
<td>Readmits #</td>
<td>20</td>
<td>279</td>
</tr>
<tr>
<td>Average Readmits Per Episode</td>
<td>0.11</td>
<td>0.13</td>
</tr>
<tr>
<td>Total Readmit Allowed</td>
<td>144,986</td>
<td>2,007,437</td>
</tr>
<tr>
<td>Readmit Allowed per Episode</td>
<td>801</td>
<td>947</td>
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<tr>
<td>Total Post-Acute Allowed</td>
<td>1,746,665</td>
<td>19,719,445</td>
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<tr>
<td>Post-Acute Allowed per Episode</td>
<td>6,689</td>
<td>9,306</td>
</tr>
<tr>
<td>OP per Episode</td>
<td>622</td>
<td>542</td>
</tr>
<tr>
<td>ED per Episode</td>
<td>134</td>
<td>49</td>
</tr>
<tr>
<td>SNP per Episode</td>
<td>4,470</td>
<td>4,758</td>
</tr>
<tr>
<td>Home Health per Episode</td>
<td>2,771</td>
<td>2,781</td>
</tr>
<tr>
<td>IRF per Episode</td>
<td>9,563</td>
<td>963</td>
</tr>
<tr>
<td>LTC per Episode</td>
<td>279</td>
<td></td>
</tr>
<tr>
<td>DME per Episode</td>
<td>313</td>
<td>261</td>
</tr>
<tr>
<td>Total Professional Allowed</td>
<td>681,141</td>
<td>7,078,241</td>
</tr>
<tr>
<td>Anchor Prof per Episode</td>
<td>2,002</td>
<td>2,096</td>
</tr>
<tr>
<td>Post Prof per Episode</td>
<td>1,061</td>
<td>1,244</td>
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</tbody>
</table>
### PAC Utilization Metrics: 2015 Q3 vs. Baseline Period

<table>
<thead>
<tr>
<th></th>
<th>JREP 2015 Q3</th>
<th>JREP Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episodes with Home Health</td>
<td>158</td>
<td>1,819</td>
</tr>
<tr>
<td>Total Home Health Visits</td>
<td>2,369</td>
<td>29,617</td>
</tr>
<tr>
<td>% of Episodes with Home Health</td>
<td>87%</td>
<td>86%</td>
</tr>
<tr>
<td>Mean Visits</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td>Mean HH Payment Per Episode with HH</td>
<td>$3,175</td>
<td>$3,240</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>JREP 2015 Q3</th>
<th>JREP Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episodes with SNF</td>
<td>72</td>
<td>843</td>
</tr>
<tr>
<td>Total SNF Visits</td>
<td>79</td>
<td>958</td>
</tr>
<tr>
<td>% of Episodes with SNF</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Mean SNF Payment Per Stay</td>
<td>$10,242</td>
<td>$10,525</td>
</tr>
<tr>
<td>Mean Days Per SNF Stay</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>SNF Payment Per Day</td>
<td>$450</td>
<td>$461</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>JREP 2015 Q3</th>
<th>JREP Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episodes with IRF</td>
<td>9</td>
<td>164</td>
</tr>
<tr>
<td>Total IRF Stays</td>
<td>10</td>
<td>165</td>
</tr>
<tr>
<td>% of Episodes with IRF</td>
<td>5%</td>
<td>8%</td>
</tr>
<tr>
<td>Mean IRF Payment Per Stay</td>
<td>$18,007</td>
<td>$12,372</td>
</tr>
<tr>
<td>Mean Days Per IRF Stay</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>IRF Payment Day</td>
<td>$1,385</td>
<td>$1,036</td>
</tr>
</tbody>
</table>

### Take-Aways

- **Episodes with Home Health**: Slight decrease in visits per episode, with utilization remaining constant.
- **Total Home Health Visits**: No change since baseline period in utilization or ALOS.
- ** Episodes with SNF**: No change since baseline period in utilization or ALOS.
- **Episodes with IRF**: Decrease in IRF utilization but significant increase in spend per stay.

### CASE STUDY #1

**DATA ANALYTICS: POST-ACUTE UTILIZATION**

Post-acute is a significant area of opportunity, as it accounts for 40% of episode spend.

This system has recognized that simply developing a post-acute preferred provider network does not deliver results.

Post-professional spend is also being addressed as this increased by $500 an episode from baseline to current, highlighting the importance of managing patients across the continuum of care.

This client developed a post-acute network reducing the number of SNF and HH providers from 500 to 80 across multiple hospital markets.

Redesigning discharge planning processes will be critical to promote use of the aligned post-acute partners while honoring “patient informed choice.”

New data reporting has been developed in order to share results with the key stakeholders relative to leading practice.

The organization is now focusing their efforts to optimize the post-acute network performance and increasing engagement of the physicians to reduce variation in care.
To achieve the desired results from a post-acute network:
- Key physicians need to be engaged early in the adoption of the bundle to agree to criteria and performance metrics related to post-acute care
- Clear expectations need to be established with continuous feedback for performance improvement
- Documented performance metrics relative to leading practices are critical to set performance targets
- Aligned physicians managing patients in the post-acute network participants are imperative to “manage patients in place” and prevent readmissions
- There needs to be regularly scheduled communication both at the individual provider level and as a group
- Care management / discharge planning processes need to reinforce placement of patients in post-acute network providers
- Regular communication between the health system post-acute medical director and medical directors within post-acute providers enhances continuity of care
- Transition care management (i.e., resources and protocols) is imperative to support patient family engagement and accountability to agreed upon pathways and protocols
- Ongoing training by the health system increases clinical capabilities in the post-acute setting
- Execution of a robust readmission prevention program is imperative
- Effective process for exchange of patient health information will enable the ability to manage patient across the continuum of care
- Telehealth strategies improve access to care

CASE STUDY #1
LESSONS LEARNED

Key Results:
- Between 2009 and 2015 the average episode spending declined by 22.6% from $23,936 to $18,517
- Readmissions declined 1.4% and ED visits 0.9%
- Impact costs fell by $3,029 per case or 46%
- Post-acute care costs fell by $1,415 per case or 54% per case
- Overall patient risk scored remained steady as did quality performance
- Volumes rose from 192 cases per quarter to 246

Other Key Impacts:
- Internal cost savings improved their margins significantly
- Episode cost savings improved payer spend and created a great story to engage MA and commercial payers
- Volumes were up about 200 cases per year
- Keys to all were huge improvements in physician engagement – five competing independent groups came together to achieve a common approach

CASE STUDY #2 – BPCI JOINT REPLACEMENT FOR HEALTH SYSTEM

Key Results:
- Between 2009 and 2015 the average episode spending declined by 22.6% from $23,936 to $18,517
- Readmissions declined 1.4% and ED visits 0.9%
- Impact costs fell by $3,029 per case or 46%
- Post-acute care costs fell by $1,415 per case or 54% per case
- Overall patient risk scored remained steady as did quality performance
- Volumes rose from 192 cases per quarter to 246

Other Key Impacts:
- Internal cost savings improved their margins significantly
- Episode cost savings improved payer spend and created a great story to engage MA and commercial payers
- Volumes were up about 200 cases per year
- Keys to all were huge improvements in physician engagement – five competing independent groups came together to achieve a common approach
CASE STUDY #2
APPROPRIATE NETWORK ALIGNMENT CREATES A WIN FOR EVERYONE (PAYER, HOSPITAL, PAC, PATIENT)

<table>
<thead>
<tr>
<th>% of Episodes w/SNF</th>
<th>Phase 1 Average</th>
<th>Phase 2 Average</th>
<th>Δ</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td>26%</td>
<td></td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Days Per SNF Stay</td>
<td>17.7</td>
<td>13.8</td>
<td>-4.0</td>
<td>-22%</td>
</tr>
<tr>
<td>SNF Allowed Per Episode</td>
<td>$1,782</td>
<td>$1,881</td>
<td>$99</td>
<td>6%</td>
</tr>
<tr>
<td>SNF Allowed Per SNF Episode</td>
<td>$8,367</td>
<td>$6,681</td>
<td>-$1,686</td>
<td>-20%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% of Episodes w/IRF</th>
<th>Phase 1 Average</th>
<th>Phase 2 Average</th>
<th>Δ</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>21%</td>
<td>11%</td>
<td></td>
<td>-48%</td>
<td></td>
</tr>
<tr>
<td>IFR Allowed Per Episode</td>
<td>$2,735</td>
<td>$1,510</td>
<td>-$1,225</td>
<td>-45%</td>
</tr>
<tr>
<td>IFR Allowed Per IFR Episode</td>
<td>$13,122</td>
<td>$13,833</td>
<td>$711</td>
<td>5%</td>
</tr>
</tbody>
</table>

CASE STUDY #2
KEY STRATEGIES DEPLOYED BY HEALTH SYSTEM

- **Physician Engagement**
  - Created an orthopedic surgeon work group that had representation from five competing independent groups that regularly received physician-specific data and collectively established standards of care
  - Health system developed a gainshare model with the physicians

- **Post-Acute**
  - Developed a narrow post-acute network
  - Aligned physicians to manage patients in the post-acute partners (e.g., physiatrist rounded and did team conferences in SNF)
  - Set leading practice standards and actively managed performance
  - Created guidelines to shift patients to appropriate lower cost levels of post-acute care

- **Readmissions**
  - Identified reasons for readmissions and developed solutions to prevent continuation of key issues
  - Physicians request chart reviews for cases with readmits to understand what happened

- **Internal Cost**
  - Reduced internal costs by advancing and leveraging work done in the ACE project
KEY SUCCESS STRATEGIES

1. **Utilize data** to address prioritized areas of opportunity identified in data analytics.

2. **Engage physicians** internally through a series of meetings, data sharing and the establishment of a common goal, then engage your post-acute preferred providers.

3. **Develop a coordinated education plan** to ensure all appropriate stakeholders receive regularly scheduled program education, receive appropriate data and understand organizational goals.

4. **Establish your PAC preferred provider network** based on quality, level of care, volume and geographic needs. Then establish network expectations, metrics, agreements and ongoing accountability platform.

5. **Build a robust Transition Care Management (TCM) program** that allows you to risk stratify patients, standardize discharge planning process and packets, and assist with navigating moderate and high-risk patients.
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