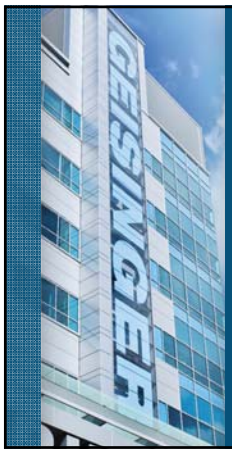

Preparing for Bundled Care: What Our Future Report Cards Will Look Like

Michael Suk, MD JD MPH FACS
Atlanta Trauma Symposium
Atlanta, GA
April 23, 2016

To understand the drivers of change

ECONOMICS AND VARIATION ARE DRIVING HEALTHCARE REFORM

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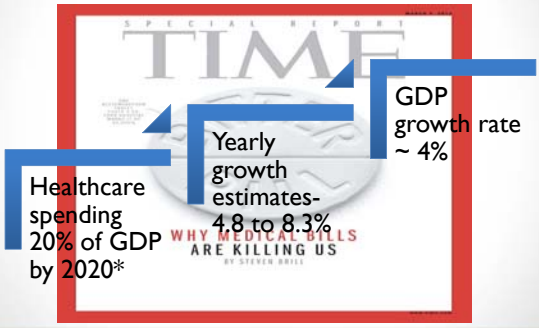
The State of Healthcare Today



GDP growth rate ~ 4%

Yearly growth estimates- 4.8 to 8.3%

Healthcare spending 20% of GDP by 2020*

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Inconsistency In Healthcare Delivery

N Engl J Med 2003; 348:2635-45

- Adults in the US received 54.9% of recommended care
- Acute care – 53.5%
- Care for chronic conditions – 56.1%
- Preventive care – 54.9%

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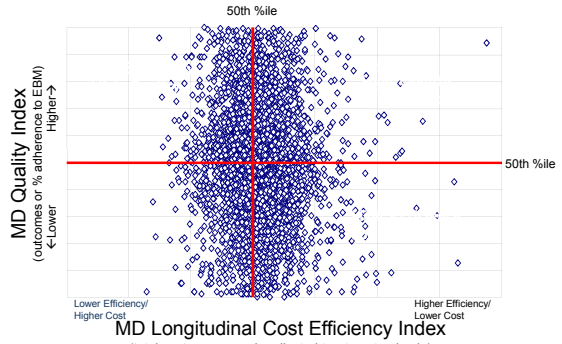
No Correlation Between How Much we Spend and Quality/Outcomes



Adapted from Regence Blue Shield; Arnie Milstein, MD - Mercer

Cost Inefficiency In Healthcare

Institute of Medicine $765B**

*Premier's Waste Dashboard, 1/22/12

**IOM (Institute of Medicine). 2012. *Best care at lower cost: The path to continuously learning health care in America.* Washington, DC: The National Academies Press.

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Accountable Care

Key Issues While We Operate in a Financially Challenging Environment

Where We Are Now	Where We Want To Be
Unjustified variation	Payment for value
Fragmentation of care-giving	Coordinated care
Adversarial payor-provider relationships	Continuous improvement/innovation
Perverse payment incentives	Patient activation
Patients as passive recipients of care	National health goals, accountability

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IHI Assumptions

Focus changes from paying for units of service to rewarding quality and outcomes.

Lower Cost

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To understand the market environment

NATIONAL LANDSCAPE IS SHIFTING FROM VOLUME TO VALUE

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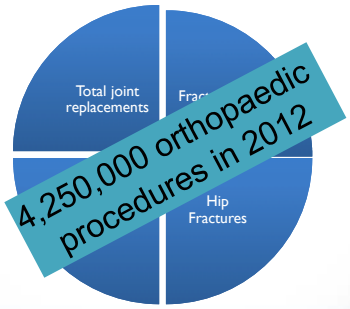
Why Governmental Attention



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How Did We Get Here?

Medicare Modernization Act of 2003

- first time linked Medicare payments to the reporting by hospitals of the quality of their services.

The Tax Relief and Health Care Act of 2006

- physician self-reporting by providing a 1.5 percent Medicare incentive.

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SGR Repeal Creates Two Tracks for Providers

Providers Must Choose Enhanced FFS[1] or Accountable Care Options

Merit-Based Incentive Payment System

- **2015:H2 – 2019:** 0.5% annual update
- **2018**: Last year of separate MU, PQRS, and VBM penalties
- **2019**: Combine PQRS, MU, & VBM programs: -4% to +12%[1] at risk
- **2020 – 2025:** Frozen payment rates
- **2020**: -5% to +15%[1] at risk
- **2021**: -7% to +21%[1] at risk
- **2022 and on**: -9% to +27%[1] at risk
- **2026 and on**: 0.25% annual update[1]

Advanced Alternative Payment Models[2]

- **2015:H2 – 2019:** 0.5% annual update
- **2019 - 2024**: 5% participation bonus
- **2019 - 2020**: 25% Medicare revenue requirement
- **2020 – 2025:** Frozen payment rates
- **2021 and on**: Ramped up Medicare or all-payer revenue requirements
- **2026 and on**: 0.75% annual update[1]

1. Pre-for-service
2. Positive adjustments for professionals who score above the benchmark may be scaled by a factor of up to 3 times the negative adjustment amount to ensure budget neutrality. In addition, top performers may earn additional adjustments of up to 10 percent.
3. APM participants who are close (at least 50 short of APM status requirement) will not qualify for bonus but can report PMPS measures and receive incentive or can decline to participate in MIPS.

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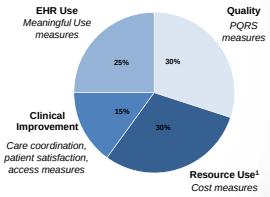
New Law Strengthens Move To P4P Incentives

Builds on Trend of Increasing Provider Accountability Even Within FFS

Merit-Based Incentive Payment System (MIPS) Summary

- Sunsets current Meaningful Use, Value-Based Modifier, and Physician Quality Reporting System (PQRS) penalties at the end of 2018, rolling requirements into a single program
- Adjusts Medicare payments based on performance on a single budget-neutral payment beginning in 2019
- Applies to physicians, NPs, clinical nurse specialists, physician assistants, and certified RN anesthetists
- Includes improvement incentives for quality and resource use categories

MIPS Performance Category Weights



1) Resource Use measures would be weighted less during first two years of MIPS program, reaching 30 percent in the third year of the program. Quality measures would be weighted more than 30 percent during the first two years to make up the difference.

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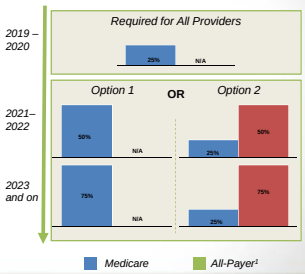
APM Bonus Rewards Participation in New Models

Option Signals Policymakers' High Expectations for Risk-Based Models

Advanced Alternative Payment Model (APM) Summary

- Requires significant share of provider revenue in APM with two-sided risk, and quality measurement; or in some cases participation in certified patient-centered medical homes (PCMHs)
- Provides financial incentives (5% annual bonus in 2019-2024) and exemption from MIPS requirements
- Includes partial qualifying mechanism that allows providers that fall short of APM requirements to report MIPS measures and receive corresponding incentives or to decline to participate in MIPS

Required Percentage of Revenue Under Risk-Based Payment Models



1. Risk-based contracts with Medicare Advantage plans count toward the all-payer requirement category.

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What exactly is a "bundle?"

DEFINITIONS

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Clinical "Bundles"

- Structured way of improving the processes of care and patient outcomes
- Evidence, execution and consistency
- A package of interventions that people know must be followed for every patient, every single time.

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Implementation

- All elements are *necessary and sufficient*,
  - It's a cohesive unit of steps that must *all* be completed to succeed.
- Based on the highest level or evidence
- Focuses on *how* to deliver the best care — not *what* the care should be.
- *All-or-nothing measurement.*
  - "Yes, I did this step and that one; no, I did not yet do this last one."
  - "Yes, I completed the ENTIRE bundle, or no, I did not complete the ENTIRE bundle."
  - There is no in between; no partial "credit" for doing some of the steps some of the time.
- Specific time and in a specific place, no matter what.

Bundle ≠ Checklist

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Application of clinical bundles…

ELEMENTS OF A HIP FRACTURE BUNDLE

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High Level Elements

Radiology	Timing of Surgery	Anesthesia
• AP/Lat v. AP/Lat/Pelvis v. AP/Lat/Pelvis/Traction View	• 24h v. 36h v. 48h	• Regional v. General

Intra-capsular Fractures	Extra-capsular Fractures	Co-Management
• ORIF v. Hemi v. THA	• SHS v. CMN	• Hospitalist v. Geriatrics v. Trauma

Evidence?

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High Level Flow

Pre-op	OR	Post-op	Post-discharge
•Patient Activation •Pre-surgery eval. •Disposition Planning •Blood Conservation	•Antibiotics •Confirmation of component position	•Antibiotics •Physical Therapy •VTE Prophylaxis •Dislocation Precautions •Disposition Planning •Blood Conservation •Occupational Therapy	•F/U clinic visits •Physical Therapy •VTE Prophylaxis

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Linking clinical bundles to payments

BUNDLED PAYMENTS IN HIP FRACTURE

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Shift from Fee for Service

Risk sharing: Payer → Providers

Bundled Payment System

- Patients in each DRG are clinically similar
- Similar use of resources

Same Reimbursement per DRG (90 day postop)

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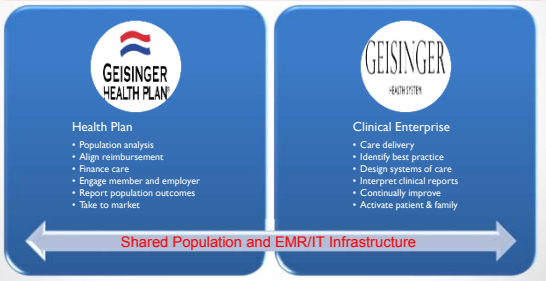
Leveraging the "Sweet Spot" to Drive Innovation

Aligned objectives between the health plan & clinical enterprise



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GHS Receives "All In" Global Fee

One fee for the ENTIRE 90-day period including all surgery-related care:

- ALL surgery-related pre-admission care
- ALL inpatient physician and hospital services, including orthopaedic surgeons, anesthesia, consultants, etc
- ALL surgery-related post-operative care
- ALL care for any related complications or readmissions

Aligns incentives across provider, patient and payor

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ProvenCare® Acute Orthopaedic Programs

- THA
- TKA
- Hip Fx
- Spine

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The "Warranty"

All inclusive fee

- Surgery-related pre-admission care
- All inpatient physician and hospital services
- Surgery-related post-operative care
- Any related complications or readmissions

Shared risk

- Across provider, patient and payor

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Hip Fx Improvements

Decreased LOS
- 3.6% reduction

Decreased 30 day readmission rate
- 58% reduction

Decreased DVT rate
- 49% reduction

Decreased PE rate
- 67% reduction

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Evolution of Bundled Payments on Orthopaedics

ACE
- 2009-2011 (3 hospital experiment)
- All three hospitals reduced the overall cost per episode between 10% and 15%.
- Savings from implant cost and LOS reduction

BPCI
- 2013-2016 (Voluntary participation over 48 episode groups)
- Retrospective reconciliation of all Medicare Part A and B (-3 to 90 days)
- Guaranteed 2% savings to CMS

CJR
- April 1, 2016 (Mandatory participation 75 geographically identified MSAs)
- Retrospective reconciliation of all Medicare Part A and B (-3 to 90 days)

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Hip Fracture Hemiarthroplasty in Total Joint Bundles?

- 2.5x post acute $$
- 1.5x total cost $$
- 2x readmission rate
- 5x SCU/ICU
- 1.5x LOS

Economically Not Viable

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Bundled Payment versus Population Health

- Bundled payment strategies are consistent with growth in clinical programs.
- More surgery is still better economically for hospitals in a world of bundles.
- Incentives can be aligned improve care coordination across the continuum of care and reduce waste and redundancy.

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How we will get measured…

QUALITY SCORECARDS

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Quality Measure Domains

Structural	Adoption of EMR (e.g., Meaningful Use)	• Easy to define • Difficult to manipulate	• Correlation with quality, outcomes?
Process	SCIP measures (e.g., Abx, DVT prophylaxis)	• Easy to define • Actionable • Allow feedback	• Clinical relevance • Correlation with quality, outcomes?
Patient Experience	HCAHPs, Press Ganey	• Patient-focused	• Influenced by patient expectations and engagement
Efficiency	Utilization of services, LOS, margins	• Easy to measure	• Correlation with quality?
Outcome	Complications (e.g., infection), readmissions, reoperations	• Best measure of quality	• Difficult to measure • Risk adjustment • Limited feedback • Lag time

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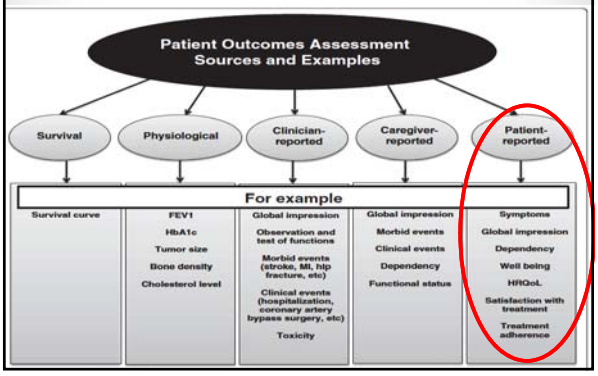
Which Outcomes are Important to Measure?



Conclusion

Value-based payment strategies such as bundled payments offer both risk and opportunity for orthopedic surgeons.

It is important to develop an understanding of the historical experience of bundled payments and the current payments models that are being tested.

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THANK YOU

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