Bundled Payment for Care Improvement (BPCI) Overview

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Retrospective Bundles

Surgeon  Hospital  SNF  Home Health

FFS Billing as Usual

PAC OPPORTUNITY & RISK FROM HOSPITAL EYES
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Hospitals are Increasingly Responsible for the Financial & Quality Outcomes for a Patient’s Entire Episode of Care

Why Bundled Payments Work

- Creates accountability for positive outcomes and efficiency
- Engages clinicians and drives a shift to coordinated, multidisciplinary care over the full Episode
- Promotes competition in an increasingly uncompetitive market
- Patients can choose the Provider that best fits their specific needs
- Providers with the greatest efficiency & best outcomes will grow, improving overall average outcomes and reducing average costs
- Providers with poor performance will need to either improve, or exit focus on areas where they can deliver clear value

Remedy Partners Overview

Remedy has created a comprehensive episode of care company with the largest footprint and broadest range of bundled payment capabilities enabling Payers and Providers to succeed with bundled payments.
Remedy Partners Overview

Spend & Episodes

- Remedy's role is to manage the bundled payment program for its Payer Partners including the development, organization, operationalization and ongoing management of the program.
- Remedy supports its Partners with the technology, analytics, expertise, and process implementation to operationalize the program, along with technology and care protocols to efficiently manage the complex program.

Remedy's Role in Program Success

Program Design & Administration
- Care coordination programs
- Contracts and populations
- Compliance

Software Tools
- Episode Connect

Network Management, Call Center
- Heart and vascular performance networks
- Post-acute physician network
- Care innovation center

Analytics
- Risk stratification and external support
- Predictive analytics
- Comprehensive reporting

BPO for Bundled Payments

Full Bundle Administration

- Diabetes
- Diabetes, gestational
- Other endocrine disorders
- Chronic kidney disease
- Heart and vascular performance networks
- Post-acute physician network
- Care innovation center
- Risk mitigation and actuarial support
- Predictive analytics
- Comprehensive reporting
- Heart and vascular performance networks
- Post-acute physician network
- Care innovation center

48 BPCI Bundles Representing 181 DRGs covering up to 50% of MLR

- Nutritional and metabolic disorders
- Other heart procedures
- Other respiratory
- Other musculoskeletal
- Flare-ups

- Percutaneous coronary intervention
- Red blood cell disorders
- Hemodialysis
- Breast, lacrimal

- Cholecystectomy
- Simple procedures and implants
- Ultrasound (non-Cervical)
- Syndrome and collapse
- Transplant tolerance
- Urinary tract infection
Remedy’s existing Partnerships are a platform for serving local Payers and self-funded employers.

**Episode Connect: Provider Platform**

The Operating System for Bundled Payments

- **User Portals**: Separate views for case managers, program administrators, patients and physicians.
- **Data Aggregation**: Integration with HL7 feeds from most major EMR systems.
- **Patient Attribution**: Predictive analytics for early DRG assignment and workflow tools to set up patients accruing into bundled payments.
- **Onboarding & Assessment**: Patient risk stratification and post-acute needs assessment.
- **Messaging & Alerts**: Dynamic care team creation and downstream/multi-channel messaging and alerts.
- **Workflow Tools**: Patient tracking and coordination software for call centers, case managers, administrators and physicians.
- **Report & Analytics**: Advanced patient and population level analytics, including process and performance reports to manage and track progress.
- **Decision Support**: Validated software tools to guide selection of best site for post-acute care and to calibrate post-acute care.

Remedy expects to deliver ~$100 million of savings to Medicare in 2016.
Model 3 Opportunities for SNFs
1. Only 6% of SNFs in the country have put their revenue at risk
2. Model 3 SNFs have a strong incentive to achieve high-quality, low-cost outcomes
3. Remedy’s partnership with 435 Model 3 SNFs represents over 60% of the entire BPCI Model 3 Program.
4. Helps with Model 2 Providers to see Model 3 Partner Commitment
5. Can retain savings compared to Adjusted Historical Rates
6. Advanced BPCI Forthcoming, narrow window to enroll

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**BPCI Initiative**

**Key Terms:**

- **Bundles:** There are approximately 181 DRGs collapsed into 48 Clinical Bundles
- **Episode of Care (Episode):** An episode begins upon hospitalization and includes most services covered by Medicare Part A & B provided to the patient over a period of 90 days – including the inpatient stay and the period after discharge, termed the post-acute period
- **Baseline Price:** Based on the Episode Initiator's (provider's) historic average costs between July 2009 and June 2012
- **Target Price:** Historical spending-price set by CMS against which current spending is compared to determine savings or penalties in the BPCI program
- **Funds Flow (Revenue Cycle):** CMS continues to pay FFS claims directly to doctors and hospitals; episodes are reconciled retrospectively against a Target Price

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**Episode Costs**

For a typical Model 2 90-day bundle, Medicare spends more on a patient's post-acute care than their initial hospitalization.

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**Patient Eligibility**

Patients are automatically enrolled in the BPCI program if they meet all of the necessary criteria.

**Necessary Criteria**
- Medicare is the primary payer
- Enrolled in Part A & B for the entire episode of care
- Condition falls into selected bundles
- Pt is only enrolled in one episode at a time

**Excluding Criteria**
- Medicare is not the primary payer for the entire episode
- Medicare coverage is changed or dropped
- Pt has ESRD
- Pt is covered under United Mine Workers
Key Levers of Success

- Strong Patient Navigators
- Appropriate Next Site of Care Decisions
- Optimal Lengths of Stay at Next Site of Care
- Strong Preferred Provider Networks
- Early Intervention
- Minimal Readmissions

What We Ask of Our Partners

- Manage Length of Stay (Meet/Exceed ELOS)
- Weekly Care Conferences Involving Pt Navigators
- Implement Tools to Prevent Readmissions

Questions?
Medicare Shared Savings Program (MSSP)
Accountable Care Organization (ACO) – Track 3
Elizabeth Barber, MSN, RN, CCM
Manager, Alliance Clinical Team (ACT)

- Established by section 3022 of the Affordable Care Act
- ACOs partner with CMS in Advance Payment Models Contracts (APMs)
- ACOs are groups of doctors and other healthcare providers who voluntarily work with CMS to provide high quality, cost effective care to Medicare Fee for Service Beneficiaries
- Saint Alphonsus was an Independent Track 1 (Pioneer Model) for 2 years (2015-16)
- Now a Track 3 Chapter participant (1 of 5) under Trinity Health Integrated Care (THIC, LLC)
- Track 3 offers shared savings AND is a risk model – if we don't perform, we write a check back to CMS
- Track 3 has several different benefits/structures from Track 1 – of note, the 3 day SNF waiver

CMS Shared Savings Program - MSSP ACO Track 3

- Traditional FFS Medicare is the primary payer (A&B)
- Patients may be dual eligible (Medicare/Medicaid)
- Patient cannot “opt out” of ACO
- Must be assigned by CMS to the ACO and on the current year master beneficiary list
- Patients retrospectively assigned from CMS using their methodology – largely claims based – can attribute to PCP or Specialist
- Most participating attributed providers are SAMG – one independent provider group
Proving “High Quality Care”

Some have higher implications for care management than others:

- Cost savings (must meet a minimum threshold to account for natural variance)
  - Reduce unnecessary utilization (ED/1000, IP/1000, readmit/1000)
  - Right level of care at right time (reduce SNF LOS, utilize 3 day SNF waiver)
  - Care Coordination/Care Management/Transitions
- Quality: meet report and/or performance thresholds for 34 quality measures
- Mandatory Reporting Requirements
- EHR utilization (at least 50%)
- Patient satisfaction (CAHPS) Survey for ACOs

3 Day SNF Waiver Patient Eligibility

- Assigned to the ACO in year admitted to eligible SNF
- Does not currently reside in SNF or other LTC setting
- Medically stable – does not require (further) inpatient evaluation/treatment
- Has a confirmed diagnosis
- Has identified skilled nursing or rehab need that cannot be met outpatient
- Evaluated and approved for admission by an ACO physician

3 Day SNF Waiver SNF Eligibility

- Must be enrolled in Medicare
- Existing written SNF Affiliation Agreement with ACO
- SNF must have and maintain an overall 3 star Quality Rating (this is verified monthly by the ACO and affiliate will be removed immediately if they fall below)
- Other quality/reporting components as determined by ACO, such as...
Preferred Post-Acute Providers (PAP)

- Quality data reported to ACO at regular intervals (SNF LOS, readmit rates, etc.)
- Collaborative Care Coordination – RN care managers attend meetings, works with PAP to follow and update Care Plan
- Engagement in collaborative post-acute initiatives (clinical care guidelines, patient education)
- 24/7 liaisons available for SNF waiver
- Still a work in progress…

Questions?