Participant Update from the Bundled Payment Pilot

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Participant Update from the Bundled Payment Pilot:
Upcoming PAC Policy and Perspectives from a Convener

Kelsey Mellard
January 2015
Post-Acute Opportunity >>> Value-Based Care

Extreme variance in practice patterns and overspending creates opportunity

$110 BILLION IN POST-ACUTE (PAC) SPENDING; <30% CURRENTLY AT RISK

>40% UTILIZING PAC AFTER DISCHARGE; SPEND GROWING >8% ANNUALLY

VALUE BASED PAYMENT MODELS INCREASING # OF PAC RISK HOLDERS

Primed for an innovative solution to improve outcomes and lower costs

Delivering a New PAC Model

Technology-enabled services model for managing post-acute care across multiple markets

SOLUTION

POWERED BY PROPRIETARY DATA & TECHNOLOGY

PARTNERS

INTEGRATED TECHNOLOGY PEOPLE AND PROCESS TO DELIVER RESULTS

FOOTPRINT

PAYERS AND PROVIDERS

>400,000 ANNUAL PATIENT ENGAGEMENTS IMPACTING ~$2.0 BILLION OF SPEND

EXPANDING OPERATIONS FROM 15 TO 23 STATES IN 2015

>1.8 MILLION MA MEMBERS SERVED

ONE OF THE LARGEST CMS BUNDLED PAYMENT (BPCI) CONVENERS

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PAC Policy and Market Alignment

Continued momentum and legislative initiatives to transform Medicare FFS reimbursement system, and incentivize more efficiently managed PAC

CMS FFS Shifts Focus to Managing Care

- 2009: CMS ACE Demonstration
- 2012: ACOs go live. Now over 350 Medicare ACOs
- 2012: Hospital Readmission Penalties instituted; up to 3% by 2015
- 2013: Bi-Partisan Bundling Legislation introduced in House
- 2013: CBO Re-Scores Bundled Payments; White House & MedPAC join conversation
- 2013: BPCI programs rollout
- 2014: Sen Wyden introduces Better Care, Lower Cost Act
- 2014: Rep McKinley introduces Bundling Legislation in House
- 2014: CMS releases 2 Bundling RFI’s
- 2015: BPCI participation expands
- 2016: Medicare FFS PAC Bundle

Other activity of historical relevance to the discussion includes the SNF Value Based Purchasing demonstration, Home Health Value Based Purchasing demonstration and the National Quality Strategy.

- 2014: CMS releases 2 Bundling RFI’s
- 2015: BPCI participation expands

The IMPACT Act: What does it do?

- Signed into law by President Obama on October 6, 2014
- Paves the way for "...standardizing post-acute care assessment data for quality, payment, and discharge planning, and for other purposes."
- All PAC providers including HH, SNF, IRF and LTCHs included
- Standardized collection on functional status, cognitive function, medical needs and conditions, impairments and other categories deemed necessary by Secretary
- Some data are already submitted by each PAC provider, but varies by type of provider, Act calls for replacing duplicative data collection
- Resource use data also collected to estimate per beneficiary spend
- Includes payment refinement provisions via report from MedPAC to Congress in 2016 based on PAC PRD data and report from CMS
Skilled Nursing Facilities

October 1, 2016

- Reporting “Quality Measures” for cognitive function and functional status
- Reporting “Quality Measures” for skin integrity
- Reporting “Quality Measures” for occurrence of major falls
- Reporting “Resource Use and Other Measures”

October 1, 2018

- Reporting “Quality Measures” for medication reconciliation
- Reporting “Quality Measures” for the ability of a PAC provider to relay health information, and “care preferences” of an individual
- Reporting “Alignment of Claims Data with Standardized Patient Assessment Data”

Inpatient Rehab Facilities

October 1, 2016

- Reporting “Quality Measures” for cognitive function and functional status
- Reporting “Quality Measures” for skin integrity
- Reporting “Quality Measures” for occurrence of major falls
- Reporting “Resource Use and Other Measures”

October 1, 2018

- Reporting “Quality Measures” for medication reconciliation
- Reporting “Quality Measures” for the ability of a PAC provider to relay health information, and “care preferences” of an individual
- Reporting “Alignment of Claims Data with Standardized Patient Assessment Data”
Long-Term Care Hospitals

October 1, 2016
- Reporting “Quality Measures” for skin integrity
- Reporting “Quality Measures” for occurrence of major falls
- Reporting “Resource Use and Other Measures”

October 1, 2018
- Reporting “Quality Measures” for cognitive function and functional status
- Reporting “Quality Measures” for medication reconciliation
- Reporting “Quality Measures” for the ability of a PAC provider to relay health information, and “care preferences” of an individual
- Reporting “Alignment of Claims Data with Standardized Patient Assessment Data”

Home Health

January 1, 2017
- Reporting “Quality Measures” for skin integrity
- Reporting “Quality Measures” for medication reconciliation
- Reporting “Resource Use and Other Measures”

January 1, 2019
- Reporting “Quality Measures” for cognitive function and functional status
- Reporting “Quality Measures” for occurrence of major falls
- Reporting “Quality Measures” for the ability of a PAC provider to relay health information, and “care preferences” of an individual
- Reporting “Alignment of Claims Data with Standardized Patient Assessment Data”
Bundled Payment for Care Improvement

*Initiative aimed at efficiently managing PAC utilization in the Medicare population*

- **BPCI has Four models:**
  1. Retrospective Acute Care Hospital Stay Only
  2. Retrospective Acute Care Hospital plus Post-Acute Care (Model 2)
  3. Retrospective Post-Acute Care Only
  4. Acute Care Hospital Stay Only

- **naviHealth went live Jan 1 with 5 health systems (11 hospitals) as an “Awardee Convener”**

- **Beneficiaries must have Part A and Part B. Medicare as Primary if a dual. Cannot be classified as an ESRD CMS Bene, Mine Worker Retiree, Railroad Union**

- **Structural highlights:**
  - Predetermined set of DRGs (179 DRGs/48 episode groups)
  - CMS guaranteed 2% savings (“at risk”)
  - Retrospective reconciliation
  - Waivers: Gainshare, Pt Incentive, Telehealth
  - naviHealth underwrites all post-acute risk

**Current**

<table>
<thead>
<tr>
<th></th>
<th>Acute</th>
<th>Post-acute</th>
<th>Part-B</th>
<th>Readmit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited coordination, promotes fragmentation, patient confusion</td>
<td></td>
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**naviHealth anticipates significant program expansion for January 1 and April 1, 2015 go-live period**

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**BPCI Model 2: Participation Growing**
Model 3: Still Gaining Initial Interest

Trumping rules will decrease participation

The Contractual Relationships

Center for Medicare and Medicaid Services (CMS)

Center for Medicare and Medicaid Innovation (CMMI)

NaviHealth Awardee Convener

Dignity Episode Initiator PAC Providers

Physician Gainshare Contract
### naviHealth Scope of Services

**naviHealth provides full suite of services to ensure successful BPCI program**

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Description</th>
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</table>
| Clinical & Actuarial Analytics        | ▪ Upfront analysis of potential opportunity  
▪ Ongoing reporting and analytics of program performance                                                                                   |
| DRG Selection & Underwriting          | ▪ Episode Group selection to optimize program performance  
▪ naviHealth takes full risk on post-acute spend                                                                                           |
| Program Implementation                | ▪ Detailed implementation workplans with devoted naviHealth implementation staff  
▪ Technical integration with EMR/care-management platform                                                                                   |
| Market Operations                     | ▪ In-market Care Coordinators to ensure patients receive right care in right setting  
▪ Proprietary LiveSafe decision support software to develop post-acute care plans                                                            |
| Network Development & Management      | ▪ Physician and PAC provider (SNF, HHA, IRF, LTAC) education and engagement  
▪ Preferred PAC network selection with quality reporting and gainshare opportunity                                                            |
| Administrative Support with CMS       | ▪ Contract negotiation and ongoing support as liaison with CMS  
▪ Ensure compliance with CMS committee setup, oversight, and reporting                                                                        |
| Policy Leadership                     | ▪ naviHealth has launched the Post-Acute Care Center for Research (PACCR)  
▪ Engagement with policy makers as CMS moves towards bundled payments                                                                        |

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### Framework that Delivers Predictable Results

**Framework that Delivers Predictable Results**

- **Proprietary Technology and Point-of-Care Analytics Engine**
- **Standardized Clinical Protocols Integrated Into Delivery System**
- **Improved Clinical Outcomes at Lower Costs**

Diagram:

```
+----------------+-----------------+-----------------+
| Proprietary    | Standardized    | Improved        |
| Technology     | Clinical        | Clinical        |
| and Point-of-Care Analytics Engine | Protocols       | Outcomes at     |
|                | Integrated      | Lower Costs     |
|                | Into Delivery   |                 |
|                | System          |                 |
```

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What is Required to Deliver Value

*naviHealth has developed the tools needed to innovate the post-acute landscape*

**Required Competencies**

- Big Data & Analytics
- Point of Care Technology
- Standardized Care Protocols
- Innovation

>$15 Billion In Claims

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Best in Class Post-Acute Technology

*LiveSafe™: the key differentiator versus other PAC solutions*

- Generates individualized patient centered care plan based on outcomes database containing >750,000 patient records
- Patient function is key variable
- Common language across all PAC settings, ability to integrate with existing platforms
- Risk adjusted reporting to plan on the network of PAC providers

**LiveSafe™ projects:**
- PAC setting
- Length of Stay
- Therapy Intensity
- Expected functional improvement
- Risk of readmission

Targeting improved post-acute outcomes and decreased unnecessary utilization through use of proven technology and in-market care management
Value-Based Results

Reduction in PAC Spend: -18%
Reduction in Readmissions from PAC: -15%
High Patient Satisfaction: 85%

Facing the Inevitable

Given recent provider interest, CMS needs to advance the payment structure to align payment, improve outcomes and reduce variation

Key Components of a Future Bundles Policy

- Convener lead
  - Bidding process utilizing current MSA for DME bids to identify 3 conveners per MSA
  - Hospital selects 1 of the 3 conveners
- Implementation for 10-50 MSAs: January 2016 and continue to expand through 2021 until Medicare rates deeming lifted
- Utilize subset of current 48 episodes with a 90 day episode
- Prospective Payment
- Establish Risk Corridors similar to Part D
- Preserve Patient Choice
- Leverage implementation of the IMPACT Act*
- Identify uniform quality metrics that extend across the continuum
- Leverage waivers for improved quality of care and alignment of finances

* Standardized collection on functional status, cognitive function, medical needs and conditions, impairments and other categories deemed necessary by Secretary across HCL, SNF, IRF, LTCH. For HCL, collection on reporting quality measures for skin integrity, medication reconciliation and resource use begins January 2017, with gradual increase in measures of reporting beginning in January 2018.
Bundled Payments for Care Improvement (BPCI) Model 2

DIWEN CHEN
EXECUTIVE DIRECTOR, PAYMENT INNOVATION & ACCOUNTABLE CARE
DIGNITY HEALTH

Dignity Health

- Founded in 1986 and headquartered in San Francisco, Dignity Health is the fifth largest hospital provider in the nation and the largest non-profit hospital system in California.
- More than 60,000 caregivers and staff across 17 states
- 38 Hospitals
  - 32 in California, 3 in Arizona, 3 in Nevada
- 9,000 Affiliated Physicians
- 4 Health Plans with 500,000 Members
- 55,000 Employees
- 366 Ambulatory Sites

Confidential and Proprietary
Dignity Health Today

Confidential and Proprietary

Where are we going?

Preferred Future State – Accountable Care
Leveraging strategies to build a system poised to address the demands of accountable care

Current
- Episodic Care
- Volume Driven/Fee-For-Service Payment Systems
- Acute Care Provider
- IT Systems in Silos
- Hospital-Physician Centric Interactions

Future
- Population Management
- Clinical Integration
- Bundled Payments/Pay-For-Performance
- Diversified and Integrated Delivery System
- Integrated Information Systems Across Multiple Care Delivery Locations

Physician Alignment

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Transition Between Payment Paradigms

Why Bundled Payments?

- Meeting the tenets of Triple Aim
- Proactive approach to health care reform, testing payment innovations, forging hospital-physician alignment
- Opportunity to reengineer and provide greater value in the delivery of high quality care at lower costs
- Active participation and collaboration of physician and administrative leaders
- Impetus to improve care along full continuum
CMMI Demonstration Pilots in Service Areas

- Medicare Fee For Service (Part A and B, Medicare as primary)
- No End Stage Renal Disease (ESRD)
- Discharge DRG falls within identified Clinical Episodes
- Episodes under consideration fall within:
  - Cardiac
  - Orthopedics
  - Chronic Diseases

BPCI Patient Population
CMMI Bundled Payment Models

The Four Models

- Model 1 – Retrospective Acute Care Hospital Stay Only
- Model 2 – Retrospective Acute Care Hospital Stay PLUS Post-Acute care
- Model 3 – Retrospective Post-Acute Care Only
- Model 4 – Prospective Acute Care Hospital Stay Only

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episode</td>
<td>All acute patients, all DRGs</td>
<td>Selected DRGs, hospital plus post-acute period</td>
<td>Selected DRGs, post-acute period only</td>
<td>Selected DRGs, hospital plus readmissions</td>
</tr>
<tr>
<td>Services Included in the Bundle</td>
<td>All Part A services paid as part of the MS-DRG payment</td>
<td>All non-hospice Part A and B services during the initial inpatient stay, post-acute period and readmissions</td>
<td>All non-hospice Part A and B services during the post-acute period and readmissions</td>
<td>All Part non-hospice A and B services (including the hospital and physician) during initial inpatient stay and readmissions</td>
</tr>
<tr>
<td>Payment</td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Prospective</td>
</tr>
</tbody>
</table>

Major Components of Model 2

- All providers (e.g., hospitals, physicians, post-acute facilities, etc.) bill CMS and receive reimbursement as they normally do today
- On a quarterly basis, CMS retrospectively benchmarks actual expenditures against a Target Price
- 2% discount is taken off of the Baseline Price (based on historical claims) to arrive at the Target Price
- Goal is to manage to a Target Price: (+) savings if expenses fall below and payments back to CMS if expenses exceed target price
Southern California – Inland Empire Pilot (Jan. 2014)

St Bernardine Medical Center
• 463 bed, admits 17,000 patients/yr
• Treats 70,500 patients in the ER
• Average Daily Census: 202*, BPCI: 24
• Monthly BPCI admission: 145
• Inland Empire Heart & Vascular Institute

Community Hospital of San Bernardino
• 343 bed, admits 14,000 patients/yr
• Treats 46,000 patients in the ER
• Average Daily Census: 85*, BPCI: 8
• Monthly BPCI admission: 32
• Behavioral Health Services

* Excludes Maternal/Child Health Services

What is the value proposition for stakeholders?

Value to Physicians
• Opportunity to Gainshare through:
  • Care Redesign
  • Quality Improvement
  • Patient Satisfaction

Value to Patients
• Better Health Outcomes
  • Value-Based Care
  • Patient Navigators
  • Care Coordination
  • Post-Discharge Follow Up

Value to Care Sites (Hospitals and Post-Acute)
• Focus on Shared Goals
  • Quality Improvement
  • Operational Efficiencies
Continuum of Care

Extending the Scope of the Organization to Meet Patients' Needs

- Medical Home
- Post-Acute Care Providers
- Hospital Network
- Home Health

Ongoing Care Management  Acute Care  Post-Acute Care

Appendix
BPCI Includes 179 MS-DRGs Grouped Into 48 Bundles

**Cardiology**
- Acute myocardial infarction
- AICD generator or lead
- Atherosclerosis
- Cardiac arrhythmia
- Cardiac defibrillator
- Chest pain
- CHP
- Pacemaker
- Pacemaker device replacement/revision
- Percutaneous coronary intervention
- Peripheral vascular disorders
- Transient ischemia
- Other vascular disorders

**Cardiothoracic Surgery**
- CABG
- Cardiac valve
- Major cardiovascular procedure

**Orthopedics**
- Amputation
- Double joint replacement of lower extremity
- Fractures of femur and hip/pelvis
- Hip and femur procedures ex. major joint
- Knee procedures
- Lower extremity & humerus procedures
- Major joint replacement - lower extremity
- Major joint replacement - upper extremity
- Medical non-infectious orthopedic problems
- Removal of devices (hip/femur and other)
- Revision of the hip or knee

**Orthopedics/Neurosurgery**
- Back and neck except spinal fusion
- Cervical spinal fusion
- Combined anterior/posterior spinal fusion
- Complex non-cervical spinal fusion
- Spinal fusion (non-cervical)

**Other**
- Cellulitis
- COPD, bronchitis, asthma
- Diabetes
- Esophageal, gastritis, other digestive
- Gastrointestinal hemorrhage
- Gastrointestinal obstruction
- Major bowel
- Nutritional and metabolic disorders
- Other respiratory
- Red blood cell disorders
- Renal failure
- Sepsis
- Simple pneumonia/respiratory infection
- Stroke
- Syncope and collapse
- UTI

Questions
Thank you

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