

# Episode-Based Bundled Payments: Opportunities for ACOs

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# Bundled Payment

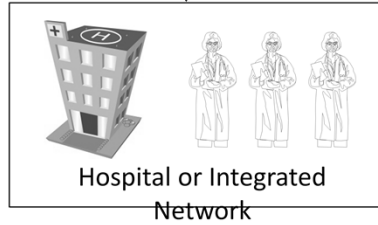
Payer



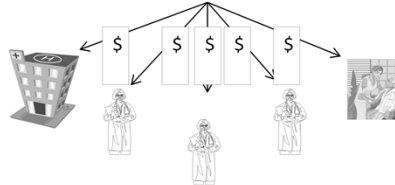
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Single payment  
to cover costs of  
episode of care  
(30, 60, 90 days)

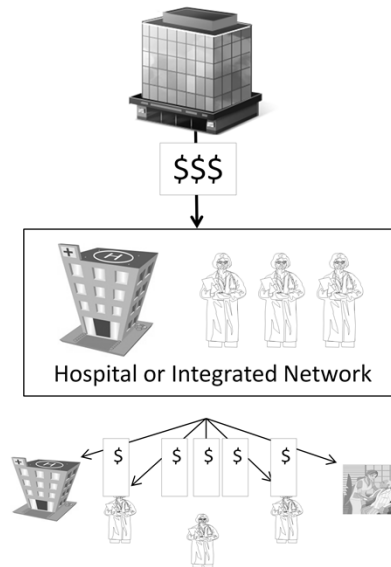
Shared  
Accountability



Group is  
responsible for  
all care within  
the episode



## Prospective



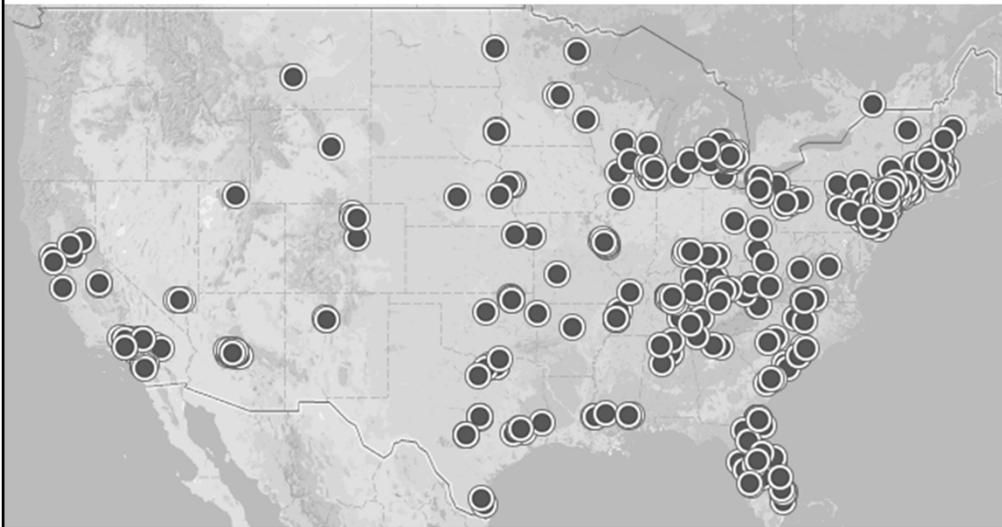
## Retrospective

- Target budget for each episode
- All providers paid FFS
- Periodic CMS settlements
  - Distribute surplus
  - Reclaim deficit
- Health system decides
  - Whom to contract with
  - Gainsharing arrangements

## Bundled Payment: Opportunities for ACOs

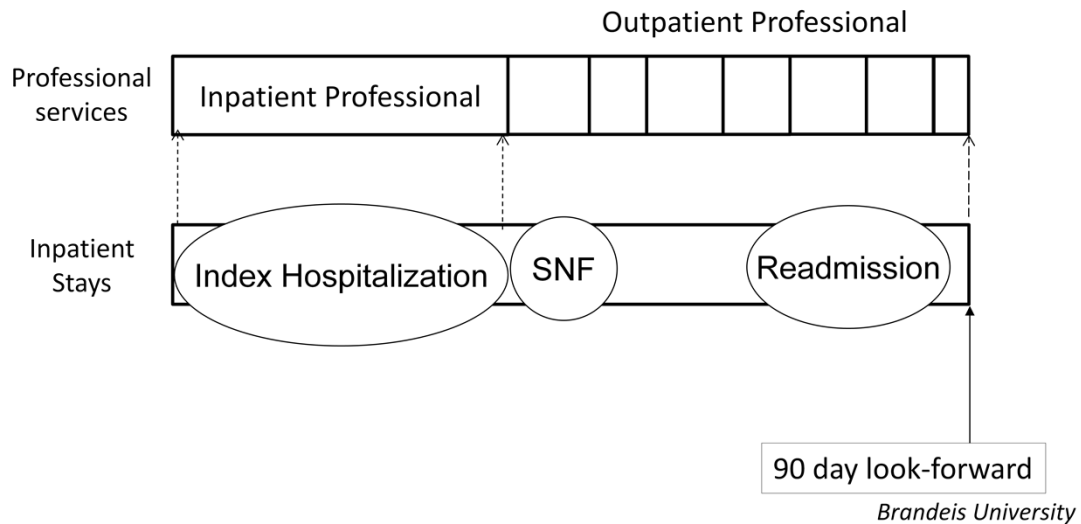
- Participate directly - accept risk for hospitalized patients not attributed to ACO
- Risk-share with partner hospitals
- Engage specialist physicians
- Analyze/reward network performance

## CMS Innovation Center Bundled Payment Pilot

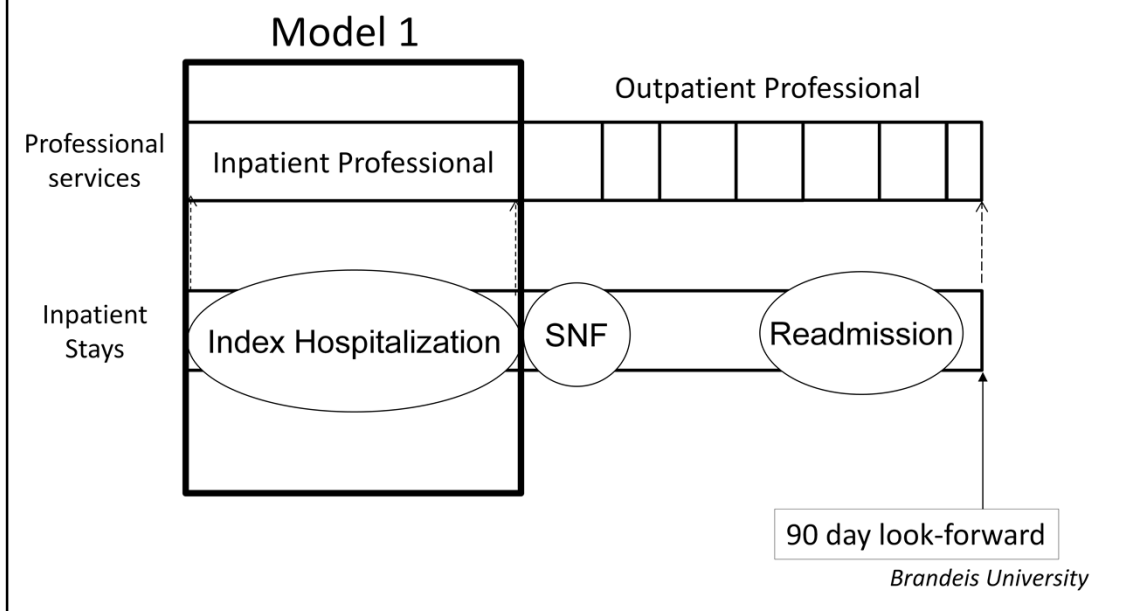


Note: Awardees include 32 Model 1; 193 Model 2; 166 Model 3; 76 Model 4.

# What's in an Episode?

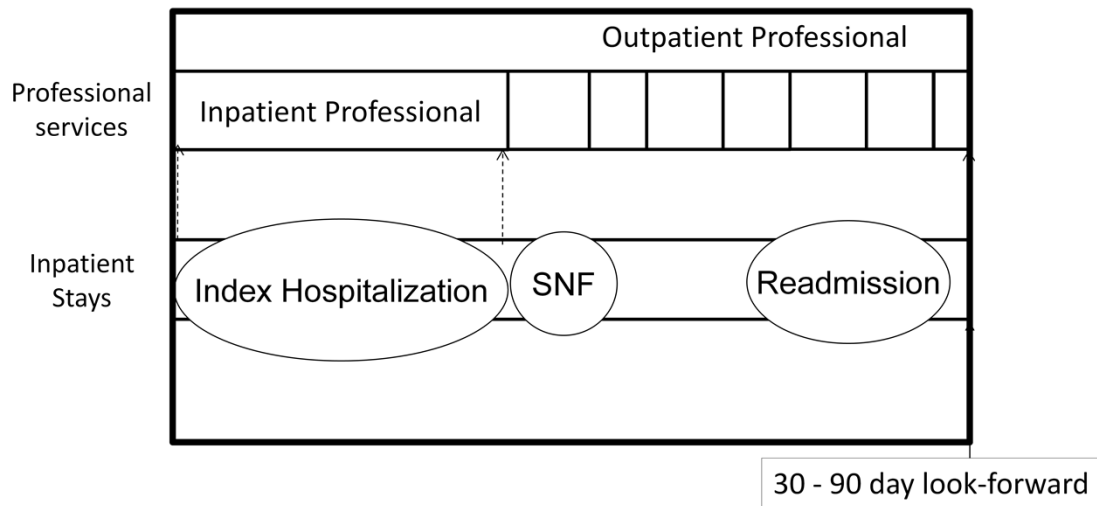


# CMMI Bundled Payment Pilot



# CMMI Bundled Payment Pilot

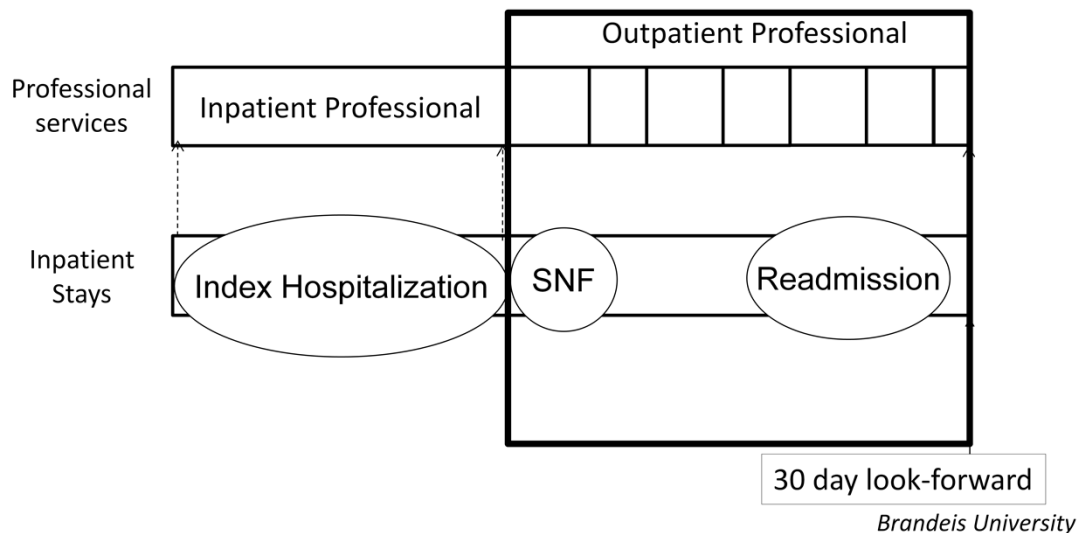
## Model 2





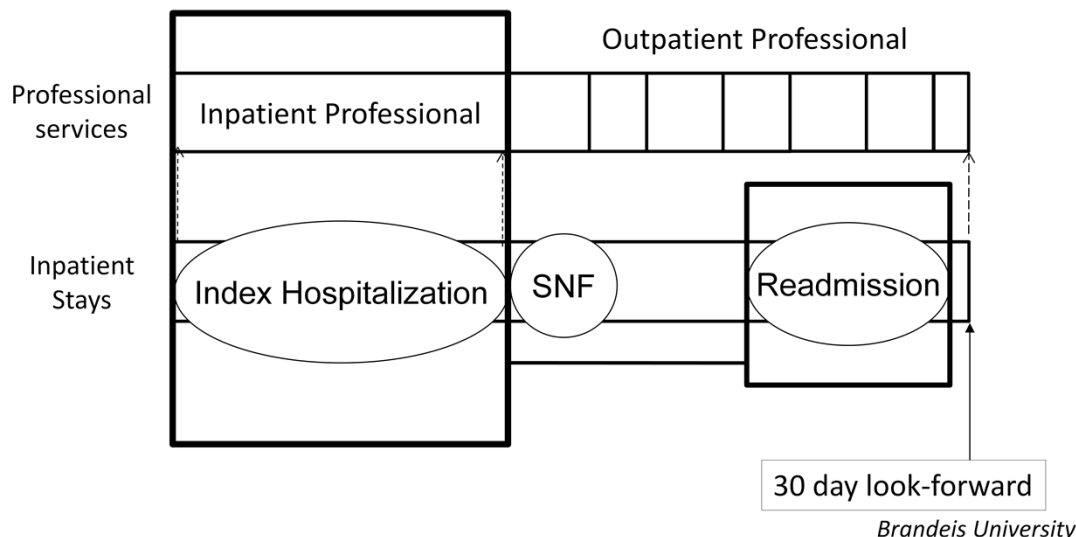
# CMMI Bundled Payment Pilot

## Model 3



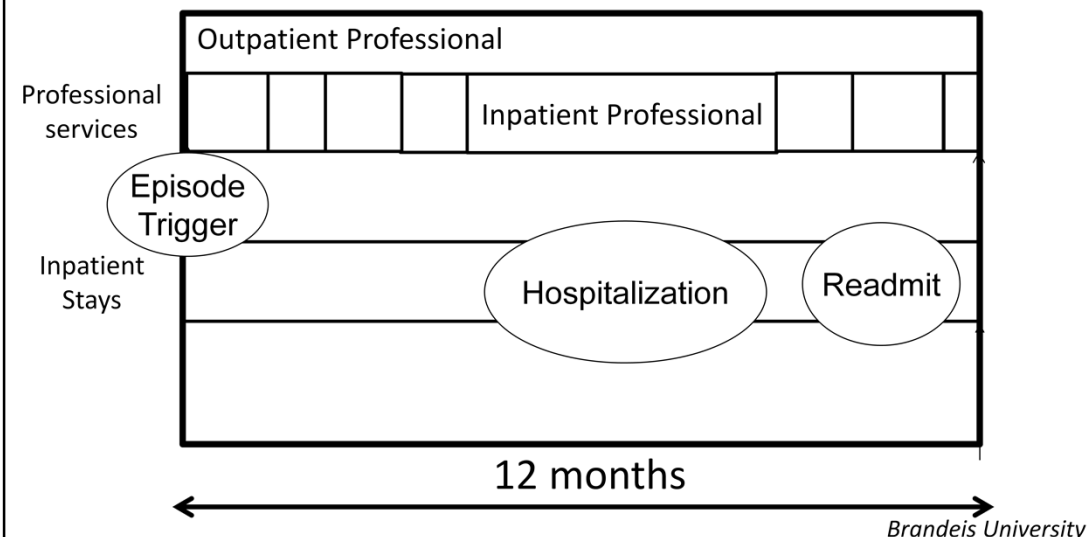
# CMMI Bundled Payment Pilot

## Model 4: Prospective Payment



# What's Next?

## Model 5: Chronic Care Episode



## CMMI Bundled Payment Initiative

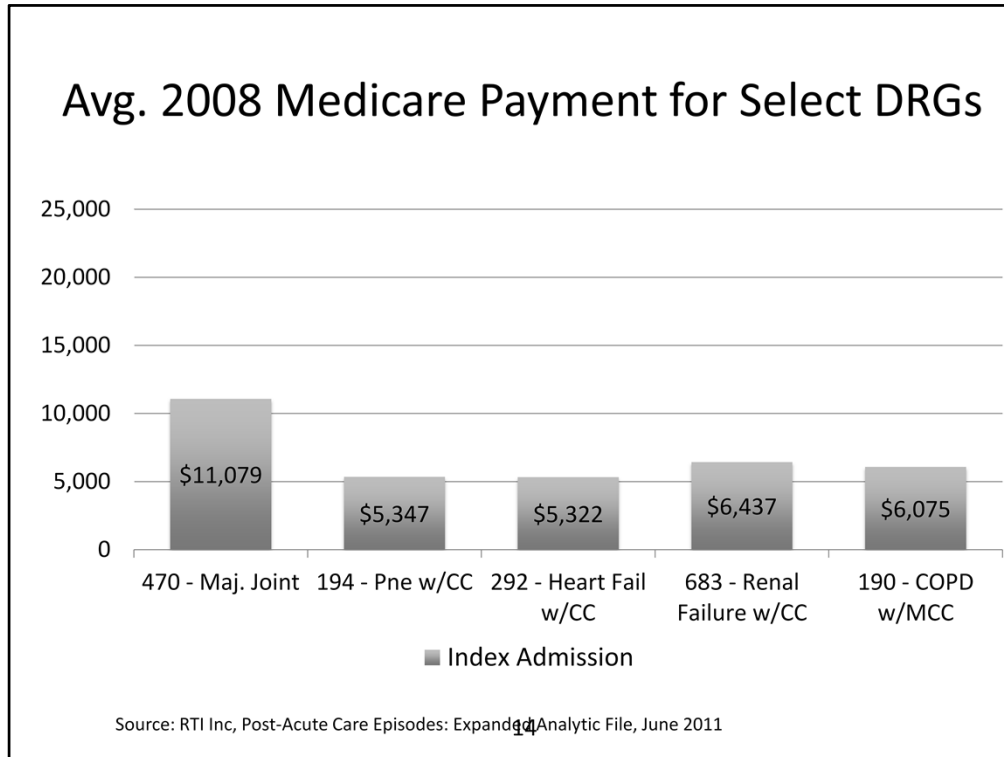
- November 2011 hospitals submitted LOI
  - Received 100% of claims for all Medicare patients
  - Brandeis analysis focused on 90-day episodes
- October/November 2012 Awardees notified
  - Choose up to 48 bundles
- BP “no-risk” period began January 1, 2013
- Regular BP program begins October 1, 2013

What Did We Learn?

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## Lesson #1

Medicare Spends a Tremendous  
Amount in the 30 – 90 Days After  
Patients Are Discharged from the  
Hospital



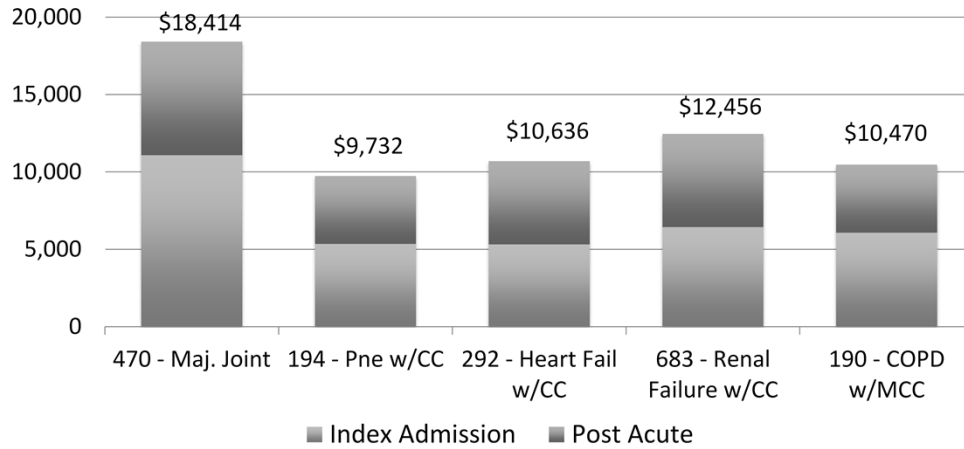
Lets start with some DRGs that are probably pretty common in your hospitals

And here's what Medicare pays ... and most of you are probably not making much of a margin on these – particularly the medical DRGs.

Guess what ... these rates aren't going to go up much. So how are you going to maintain your margins?

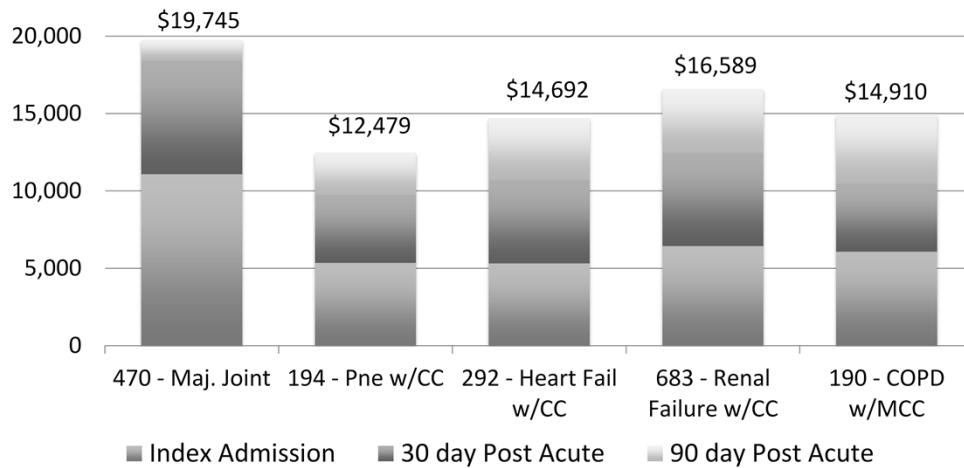
Bundled payment is one opportunity

## 2008 Medicare Acute and Post-Acute Payments for Inpatient-Initiated 30-Day Episodes



Source: RTI Inc, Post-Acute Care Episodes: Expanded Analysis File, June 2011. Thirty day fixed episodes include the full cost of all claims incurred within 30 days of discharge.

## 2008 Medicare Acute and Post-Acute Payments for Inpatient-Initiated 90-Day Episodes



Source: RTI Inc, Post-Acute Care Episodes: Expanded Analytic File, June 2011. 30-90 day amounts are estimated based on RTI, Analysis of Acute Care Episode Definitions Chart Book, November 2009.



## 2008 Post-Acute Care Spending For 30-Day Episode: DRG 292 – Heart Fail. With CC

Episode includes all claims incurred within 30 days of hospital discharge

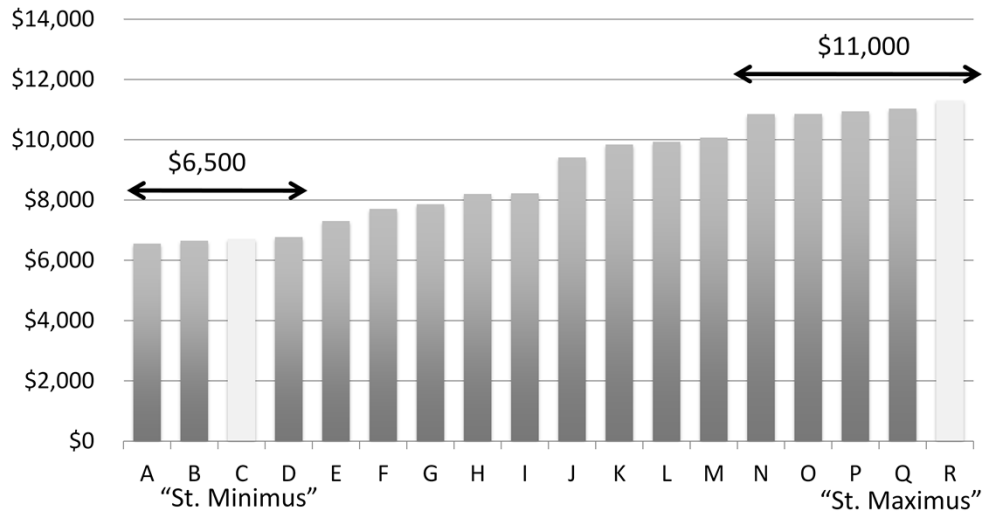
	<b>Percent With Claim</b>	<b>Mean Cost Per Service User</b>
Index Admission	100.0%	\$5,322
Rehab	2.0%	\$14,999
SNF	43.0%	\$10,674
LTAC	0.9%	\$22,971
Home Health	60.3%	\$2,545
Readmission	21.7%	\$10,765

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Source: RTI Inc, Post-Acute Care Episodes: Expanded Analytic File, June 2011.

## Lesson #2

There is Significant Variation in  
Post-Acute Care Spending Across  
Hospitals

## Average 2009 Post-Acute Care Spending per Episode for CHF Admission (90 day)



Source: Brandeis University analysis of Medicare Claims data. Figures adjusted for hospital wage index.

## A Tale of Two Hospitals: CHF Episode

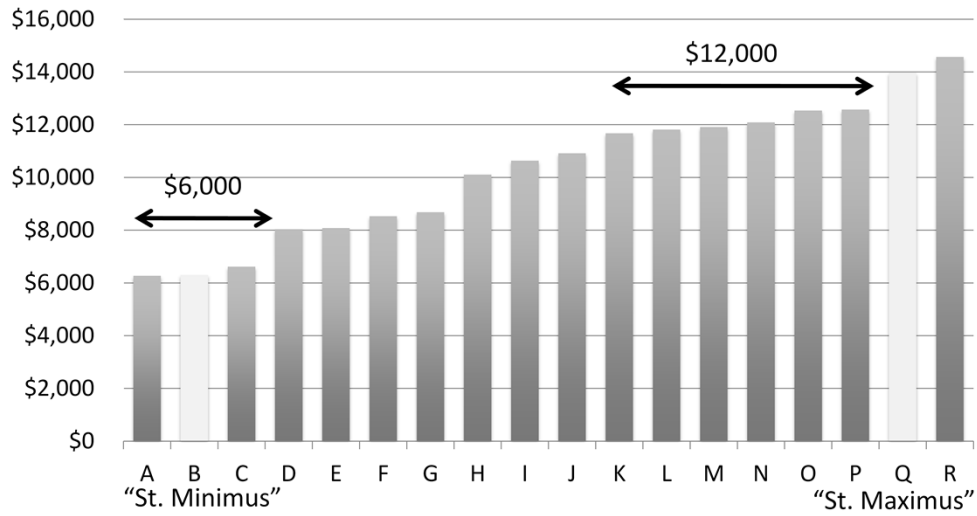
	St. Maximus	St. Minimus	Difference
Total	\$16,524	\$11,822	\$4,702
Index Stay (facility)	\$5,142	\$4,554	\$588
Index Stay (prof.)	\$1,272	\$1,284	(\$12)
Acute Readmission	\$5,947	\$2,333	\$3,614
Rehab Hospital	\$859		\$859
Skilled Nursing	\$1,153	\$1,886	(\$733)
Home Health	\$1,234	\$525	\$709
Other Professional	\$917	\$1,240	(\$323)

Source: Brandeis University analysis of Medicare Claims data. Unadjusted data.

## Opportunities for St. Maximus

- Put a program in place to monitor patients following discharge
  - Medication reconciliation
  - Home assessment
  - Primary care visit within 7 days
  - Emergency plan for likely events
- Develop programs/partnerships with SNF & HHA to improve coordination

## Average 2009 Post-Acute Care Spending per Episode for Total Joint Replacement (90 day)



Source: Brandeis University analysis of Medicare claims data. Figures adjusted for hospital wage index.

## A Tale of Two Hospitals: Joint Replacement Episode

	St. Maximus	St. Minumus	Difference
Total	\$26,231	\$18,509	\$7,722
Index Stay (facility)	\$10,459	\$10,805	(\$346)
Index Stay (prof.)	\$2,756	\$2,038	\$718
Acute Readmission	\$1,729	\$389	\$1,340
Rehab Hospital	\$283	\$0	\$283
Long-Term Hospital	\$503	\$0	\$503
Skilled Nursing	\$8,475	\$2,816	\$5,659
Home Health	\$1,054	\$1,978	(\$924)
Other Professional	\$972	\$483	\$489

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Source: Brandeis University analysis of Medicare Claims data. Unadjusted data.

## Opportunities for St. Maximus

- Expand home health and reduce SNF services where appropriate
- Review surgical quality – establish pathways and protocols to reduce defects
- Evaluate SNF costs and consider preferred relationships with efficient facilities.
- Put a program in place to monitor patients following discharge

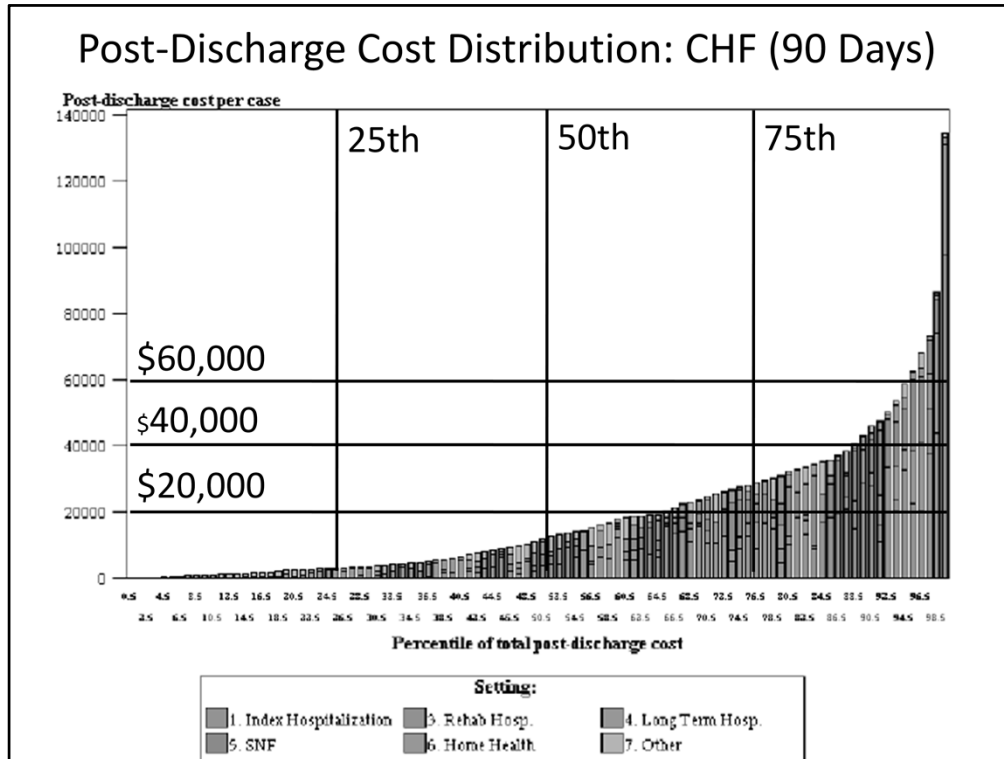


## Lesson #3

Hospitals face significant risk of random variation in year-to-year spending per episode (due to low volumes) – and require program features that mitigate risk

## 26





Another thing that you know – that is illustrated fairly starkly in this graph is that a few patients account for a disproportionate spending.

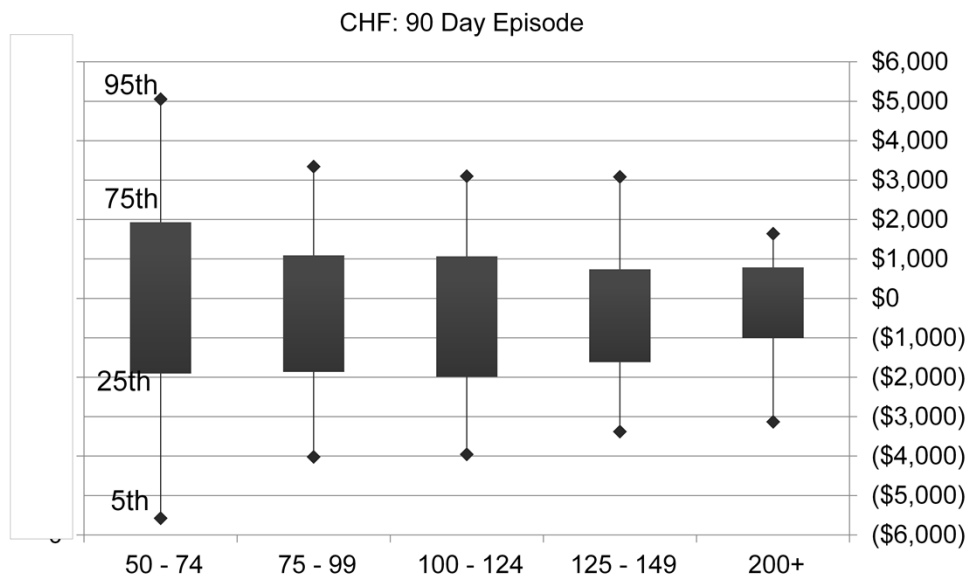
This chart shows the spending distribution for post-acute care services only in the 90 days after CHF patients are discharged

25% of patients have virtually no post-acute spending  
Half of the patients have spending less than \$10,000

Lets look at the most expensive 25% -- most of them are in the \$30 – 80K range.

## Random Variation in Avg. Episode Cost by Volume\*

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## Mitigating Risk in Bundled Payment

Strategies	BPCI Rules
Episode Selection	Choose from 48 Episodes
Exclusions	Limited. Must include all patients with DRG.
Risk Adjustment	MS-DRG only Regional Blend for low vol.
Stop-loss	99 <sup>th</sup> /1 <sup>st</sup> - 95 <sup>th</sup> /5 <sup>th</sup> - 75 <sup>th</sup> /5 <sup>th</sup>
Clinical reengineering and care coordination	

## Issues and Challenges: CMS BPCI

- Program issues
  - Transparency and complexity
  - Risk uncertainty
  - Reporting requirements (B-care)
- Operational issues
  - Getting infrastructure and IT in place
  - Identifying & tracking BPCI patients
  - Engaging providers
  - Aligning post-acute care

## Bundled Payment: Opportunities for ACOs

- Participate directly - accept risk for hospitalized patients not attributed to ACO
- Risk-share with partner hospitals
- Engage specialist physicians
- Analyze/reward network performance

# Questions

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