Evaluating BPCI Advanced

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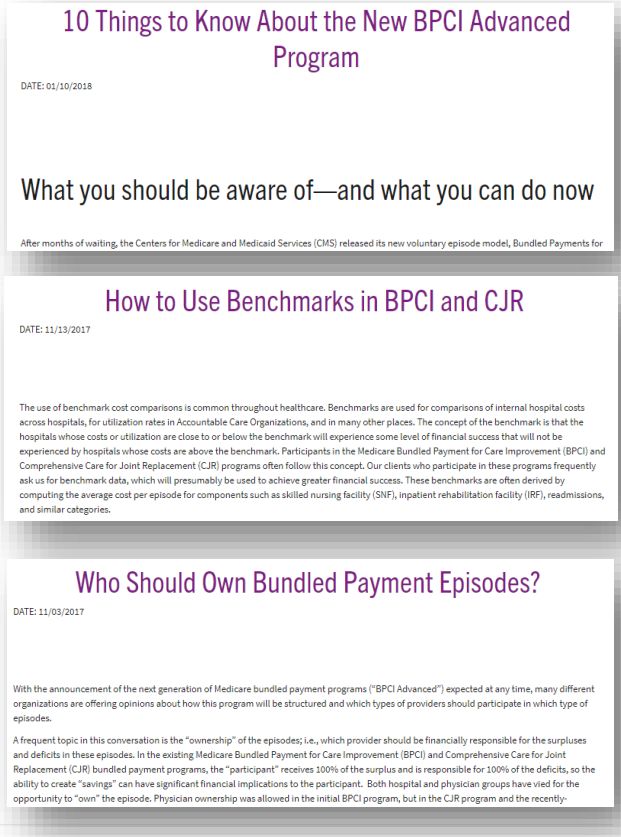
DataGen

Data partner for hundreds of Medicare BPCI, CJR, OCM participants of all sizes and types

Payment policy and quality analytics for associations, consulting firms, hospitals, physicians, and post-acute providers across the country

Policy-based analytics for 47 state hospital associations and 8 multi-state systems



10 Things to Know About the New BPCI Advanced Program

DATE: 01/10/2018

What you should be aware of—and what you can do now

After months of waiting, the Centers for Medicare and Medicaid Services (CMS) released its new voluntary episode model, Bundled Payments for

How to Use Benchmarks in BPCI and CJR

DATE: 11/13/2017

The use of benchmark cost comparisons is common throughout healthcare. Benchmarks are used for comparisons of internal hospital costs across hospitals, for utilization rates in Accountable Care Organizations, and in many other places. The concept of the benchmark is that the hospitals whose costs or utilization are close to or below the benchmark will experience some level of financial success that will not be experienced by hospitals whose costs are above the benchmark. Participants in the Medicare Bundled Payment for Care Improvement (BPCI) and Comprehensive Care for Joint Replacement (CJR) programs often follow this concept. Our clients who participate in these programs frequently ask us for benchmark data, which will presumably be used to achieve greater financial success. These benchmarks are often derived by computing the average cost per episode for components such as skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), readmissions, and similar categories.

Who Should Own Bundled Payment Episodes?

DATE: 11/03/2017

With the announcement of the next generation of Medicare bundled payment programs ("BPCI Advanced") expected at any time, many different organizations are offering opinions about how this program will be structured and which types of providers should participate in which type of episodes.

A frequent topic in this conversation is the "ownership" of the episodes; i.e., which provider should be financially responsible for the surpluses and deficits in these episodes. In the existing Medicare Bundled Payment for Care Improvement (BPCI) and Comprehensive Care for Joint Replacement (CJR) bundled payment programs, the "participant" receives 100% of the surplus and is responsible for 100% of the deficits, so the ability to create "savings" can have significant financial implications to the participant. Both hospital and physician groups have vied for the opportunity to "own" the episode. Physician ownership was allowed in the initial BPCI program, but in the CJR program and the recently-

Medicare BPCI Advanced
The Basics

Current Medicare FFS

Payment ***for*** each individual service ***to*** each individual provider

Bundled Payments

A single target price for the full spectrum of services over 90 days

BPCI Advanced

- Voluntary Model
- A single retrospective bundled payment and one risk track, with a 90-day Clinical Episode duration
- 29 Inpatient Clinical Episodes
- 3 Outpatient Clinical Episodes
- Qualifies as an Advanced APM

- Applications due 3/12/2018
- Performance year begins 10/1/2018

https://innovation.cms.gov/initiatives/bpci-advanced/

Convener vs. Episode Initiator

- Episode Initiator (EI): Hospital or Physician Group Practice (PGP) that triggers the clinical episode.
- Non-convener Participant: Hospital or PGP EI that bears risk for itself.
- Convener Participant: Takes risk for an EI or group of EIs A convener can be anyone including hospitals or a hospital system.

What Factors Influence Financial Performance?

- Targets
- Episode Cost (Medicare payments)
- Quality Performance

Episode Target

Provider baseline average episode cost - CMS discount (3%) = Target

*Case mix adjustment

*Adjustments for efficiency relative to peers

Episode Target

Episode 1 $10,000

Episode 2 $6,650

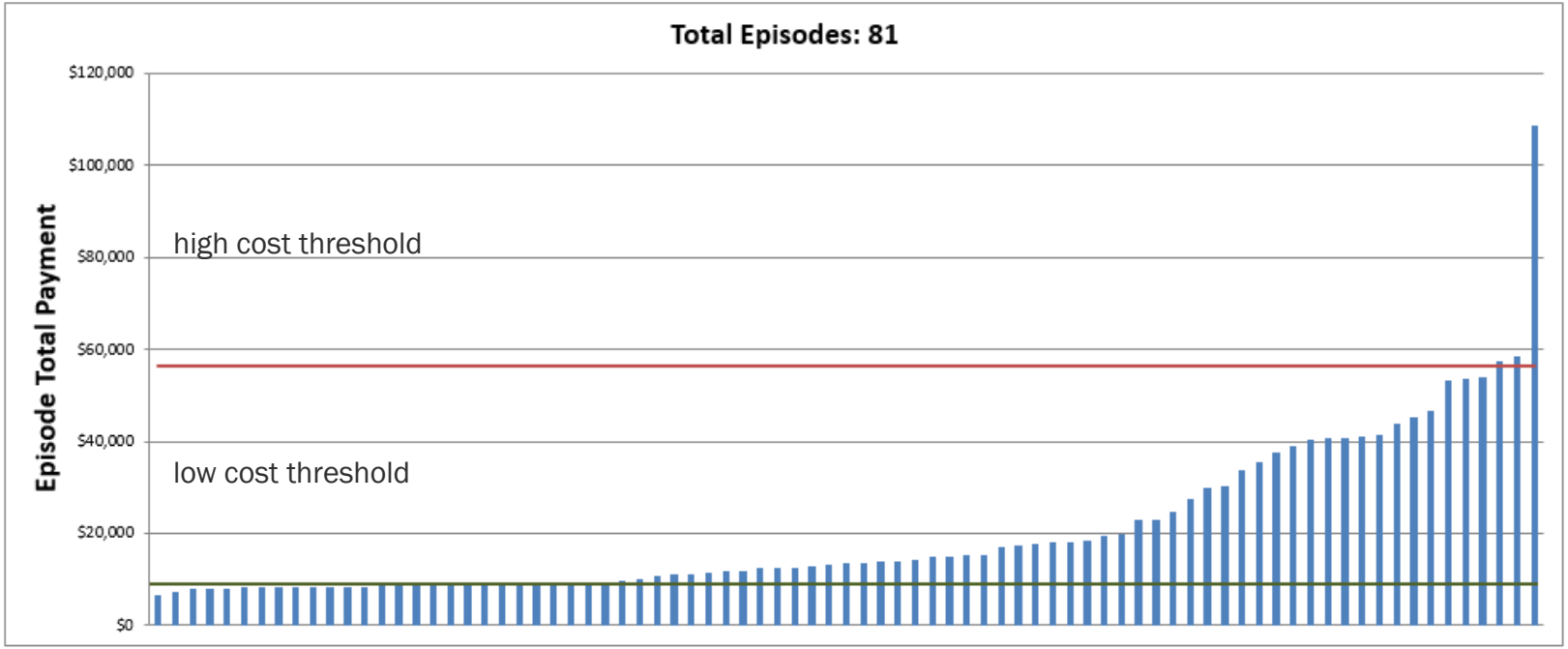
Episode 3 $10,500

Baseline average = $9,050

-3% CMS discount = ($271.50)

Target = $8,778.50

Winsorization



Prospective Targets
Retrospective Reconciliation

Providers will continue to be paid FFS payments

DRG	Performance Period Episode Count (a)	Performance Period Episode Target $ (b)	Total Performance Target $ (a*b)	Total Actual Performance $ (c)	Reconciliation Amount $ ([a*b]-c)
470	100	$24,000	$2,400,000	$2,200,000	$200,000
469	10	$40,000	$400,000	$550,000	-$150,000
Positive Reconciliation Amount	110	$24,455	$2,800,000	$2,750,000	$50,000

Quality performance impacts final Reconciliation Amount

20% stop loss/stop gain at Episode Initiator level

Bundle Payment Evaluation

Considerations for Choosing Episodes

- Volume
- Episode cost
- Episode risk and opportunities
- Organizational and clinical engagement

Episode Cost

Bundled Payments^{360}

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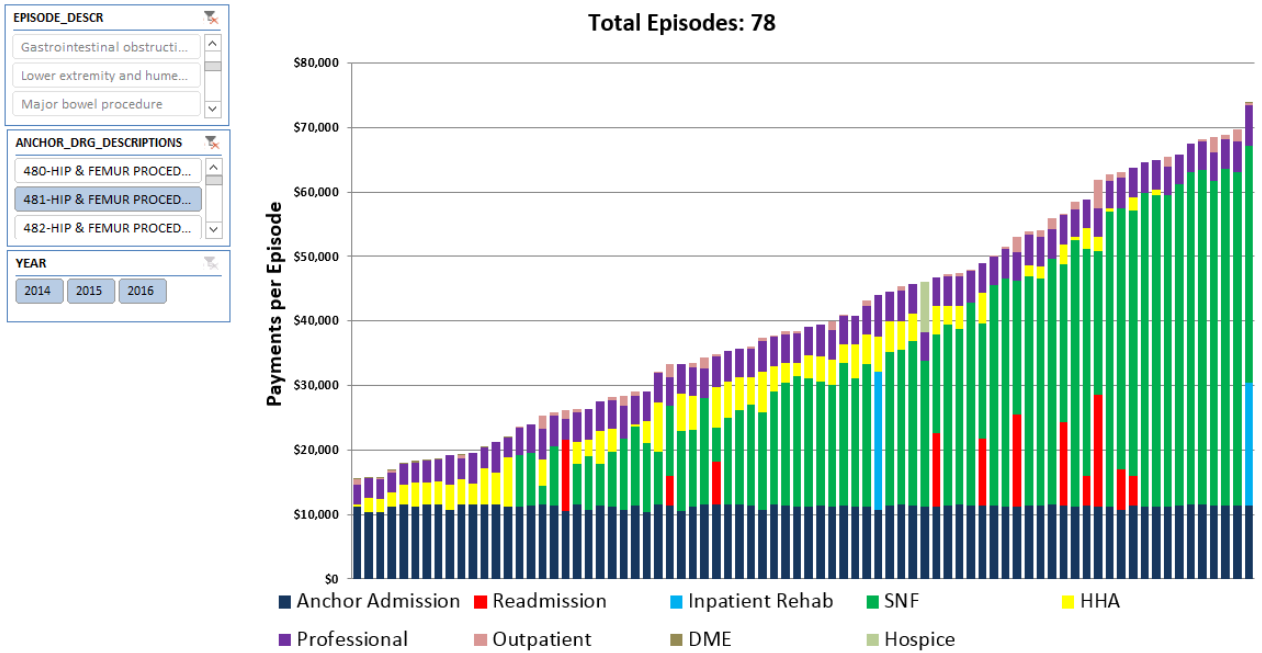
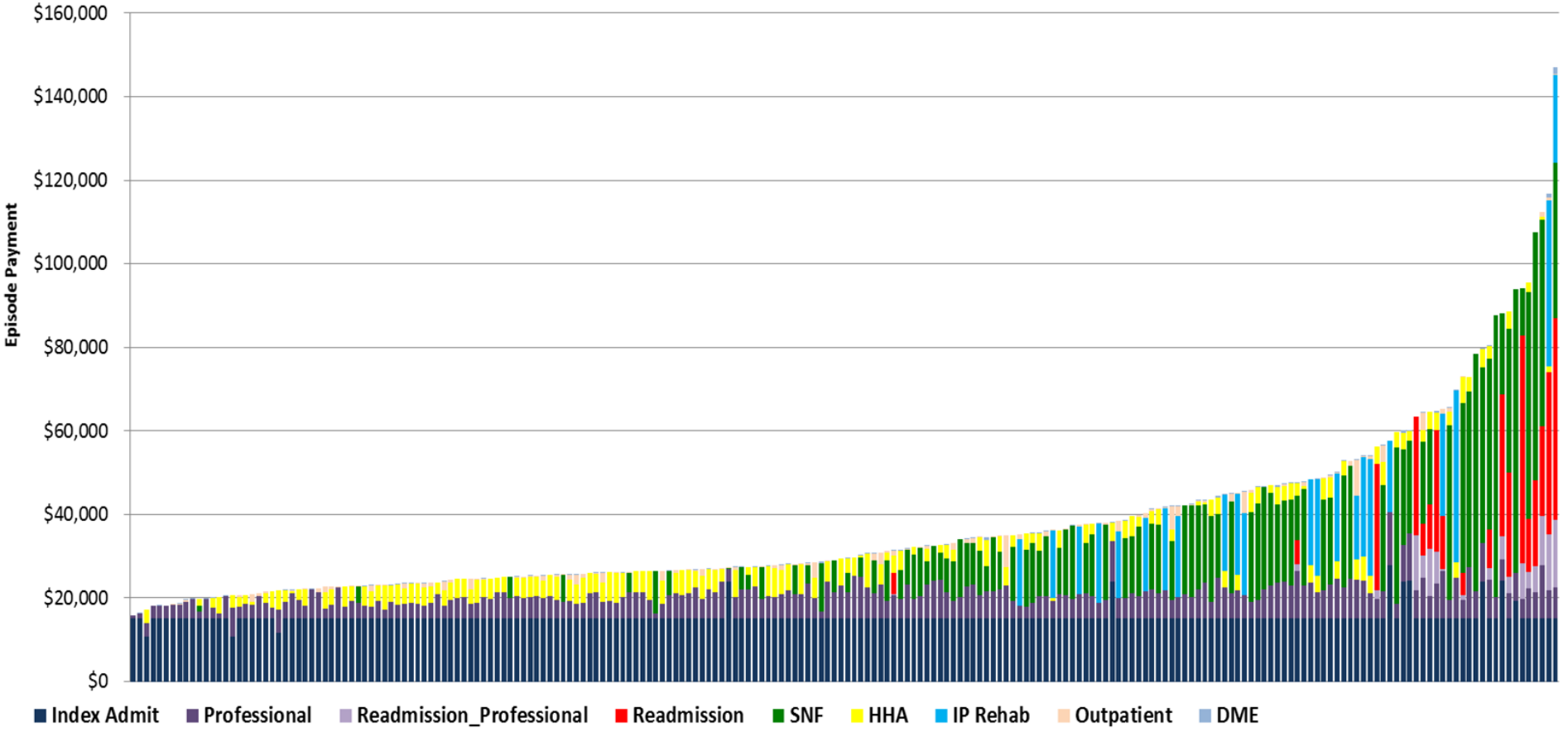


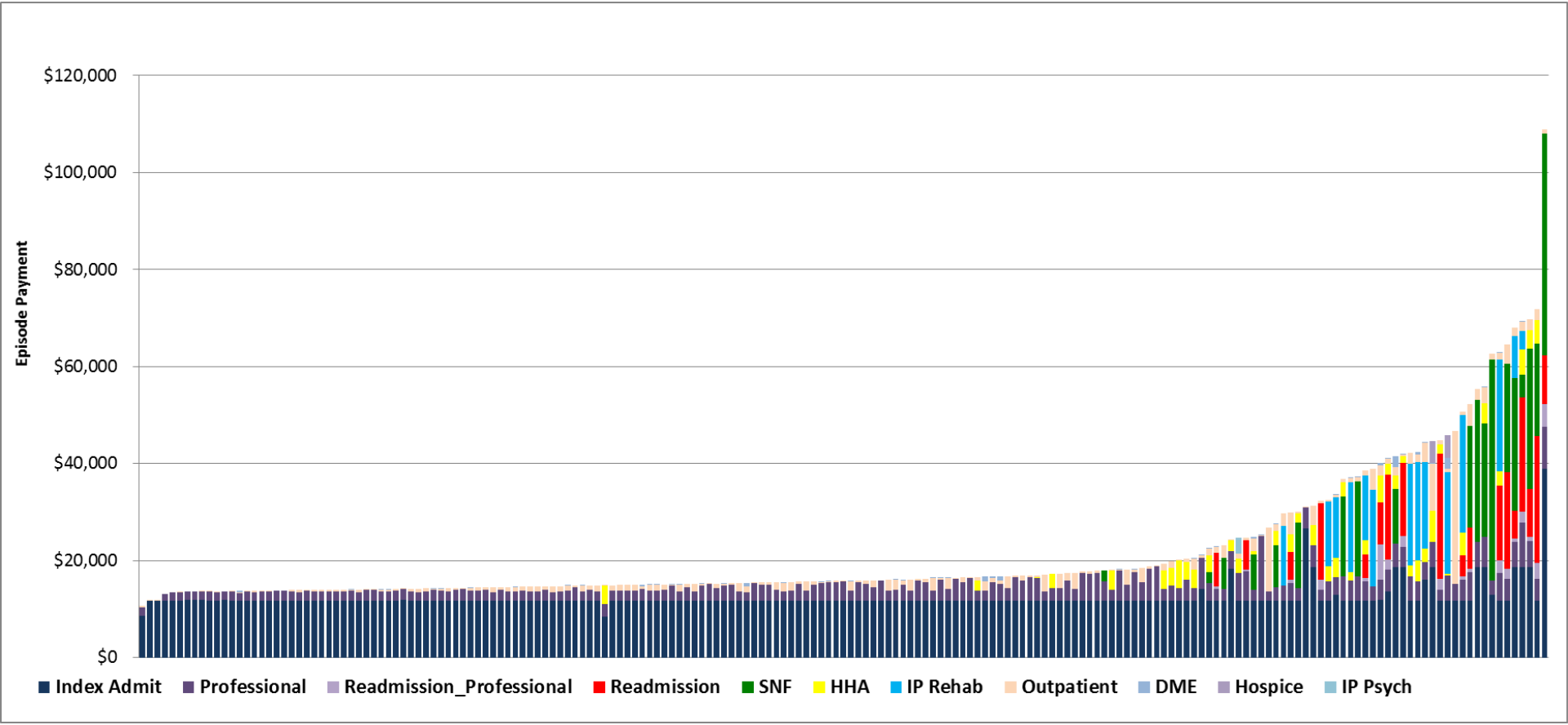
Costs = Medicare Payments.

Payments neutralized for provider specific adjustments to isolate utilization.

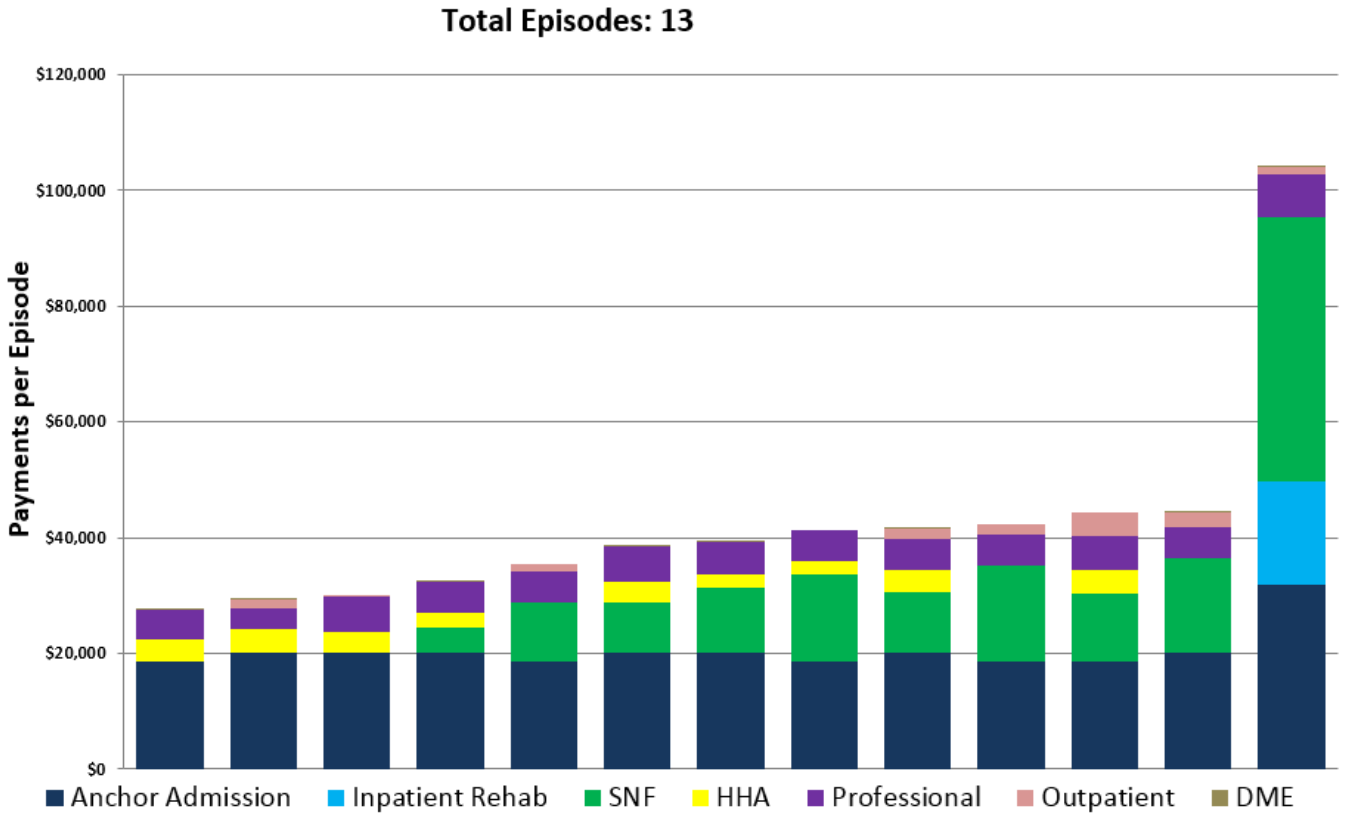
What are the cost drivers after discharge or outpatient procedure?

Can you do anything about it?



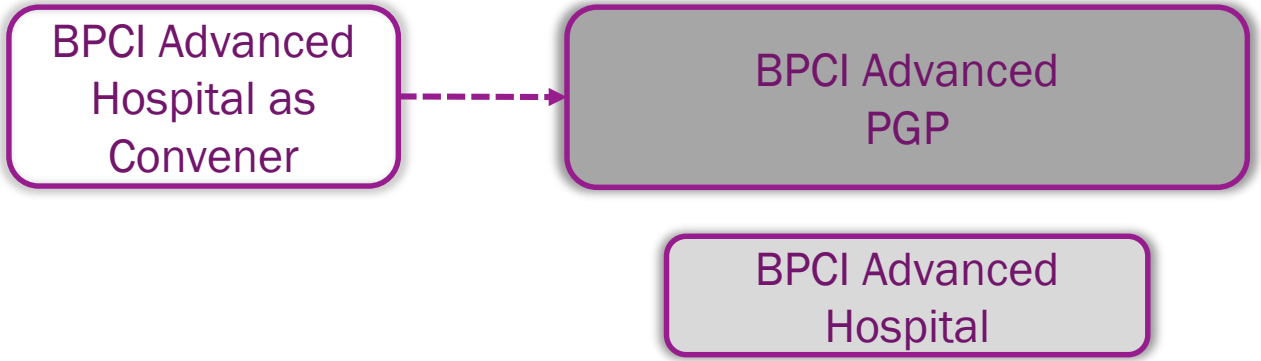


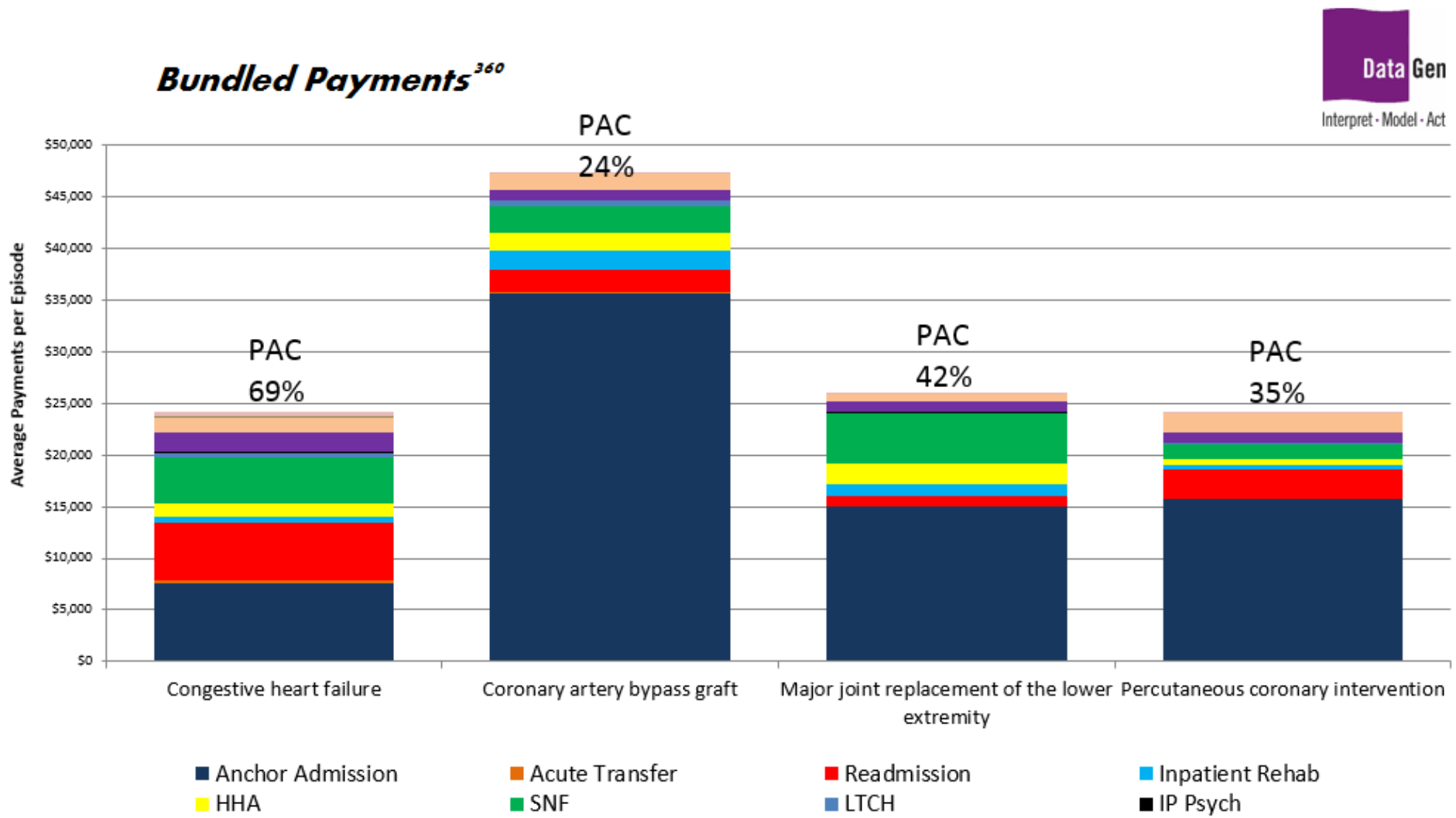
Volume



Precedence

CJR Program
DRGs 469/470




Bundled Payments360
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Average Payments per Episode
$50,000
$45,000
$40,000
$35,000
$30,000
$25,000
$20,000
$15,000
$10,000
$5,000
$0
PAC 69%
PAC 24%
PAC 42%
PAC 35%
Congestive heart failure
Coronary artery bypass graft
Major joint replacement of the lower extremity
Percutaneous coronary intervention
Anchor Admission
Acute Transfer
Readmission
Inpatient Rehab
HHA
SNF
LTCH
IP Psych

Post Acute Care Providers

Total Number of Episodes for DRG(s) Selected:	99					Star Rating Last Update:	2/14/2017
Provider Name	Total Episode Count	Total Provider Payment	Average Prorated Payments	ALOS/Visits Per Episode	Total Direct Readmissions	Direct Readmit Rate	Current Star Rating
HHA	**47**	**$121,183**	**$2,578**	**15**	**8**	**17.02%**	
4144116	41	$103,312	$2,520	13	6	14.63%	
5711047	1	$607	$607	4	0	0.00%	
9496620	1	$4,129	$4,129	46	0	0.00%	
7734406	1	$4,143	$4,143	22	0	0.00%	
3847757	1	$2,589	$2,589	5	1	100.00%	
3542532	1	$2,971	$2,971	8	1	100.00%	
2097385	1	$3,432	$3,432	56	0	0.00%	
Inpatient Rehab	**4**	**$81,736**	**$20,434**	**17**	**0**	**0.00%**	
7781952	3	$63,290	$21,097	17	0	0.00%	
2768481	1	$18,446	$18,446	14	0	0.00%	
SNF	**21**	**$401,561**	**$19,122**	**36**	**7**	**33.33%**	
8834230	7	$118,076	$16,868	36	2	28.57%	
6029417	6	$27,133	$4,522	9	2	33.33%	
6614324	1	$8,080	$8,080	14	0	0.00%	
8119212	1	$6,906	$6,906	14	0	0.00%	
7505479	1	$17,295	$17,295	32	1	100.00%	
4409009	1	$24,298	$24,298	42	0	0.00%	
4328338	1	$12,130	$12,130	22	1	100.00%	
1528258	1	$7,534	$7,534	13	0	0.00%	
5015569	1	$13,915	$13,915	24	0	0.00%	
7458486	1	$17,759	$17,759	32	0	0.00%	
5178900	1	$17,410	$17,410	33	0	0.00%	
7956030	1	$2,895	$2,895	6	0	0.00%	
5422539	1	$33,574	$33,574	58	0	0.00%	

Who are your post acute providers and what are their metrics?

Profile of Readmissions

Readmission Detail by Episode

Total Number of Episodes for DRG(s) Selected:	99

	Readmission Count			Readmission Payments		
Readmission DRG||Readmitting Hospital	0-30 Days	31-60 Days	61-90 Days	0-30 Days	31-60 Days	61-90 Days
SYNCOPE & COLLAPSE	**1**			**$4,289**		
Hospital M	1			$4,289		
SIMPLE PNEUMONIA & PLEURISY W CC	**2**			**$11,183**		
Hospital D	2			$11,183		
SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W/O MCC	**1**			**$6,069**		
Hospital A	1			$6,069		
SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W MCC	**1**			**$10,496**		
Hospital E	1			$10,496		
RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <=96 HOURS		**2**			**$26,562**	
Hospital D		2			$26,562	
RENAL FAILURE W MCC			**1**			**$8,774**
Hospital D			1			$8,774
RENAL FAILURE W CC	**2**			**$10,977**		
Hospital D	1			$5,491		
Hospital Z	1			$5,486		
PULMONARY EDEMA & RESPIRATORY FAILURE	**1**			**$7,010**		
Hospital D	1			$7,010		
POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W/O MCC	**1**			**$5,679**		
Hospital D	1			$5,679		
PERMANENT CARDIAC PACEMAKER IMPLANT W MCC			**1**			**$21,653**
Hospital F			1			$21,653
PERIPHERAL VASCULAR DISORDERS W CC	**1**			**$5,641**		
Hospital D	1			$5,641		

Why are patients being readmitted and where?

Is there a pattern and opportunity?

Clinical and Organizational Engagement

Challenges

- Motivating providers to understand and embrace change
- Identifying resources needed for sustainable success

Initial Steps

- Analyze current state
- Establish leadership and sponsorship
- Project and change management

Key Components

- Workflow redesign
- Health Information Technology (HIT)
- Practice culture

How DataGen Can Help

- Baseline data
  - Analyze episodes
  - Opportunity and risk identification
- Participation monitoring and analytic support

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