Improving Clinical Care Delivery Efficiency and Effectiveness For Value-Based Reimbursement Optimization

Nick Sears, MD, Chief Medical Officer, MedAssets
Mah-Jabeen Soobader, MPH, PhD, Vice President, Reimbursement Strategies & Analytics, MedAssets
Dave Munch, MD, Senior Vice President, Lean Healthcare Consulting, MedAssets

CONFIDENTIAL – PROPERTY OF MEDASSETS. MedAssets® is a registered trademark of MedAssets, Inc. Copyright MedAssets, 2013. All rights reserved.

Key Learning Objectives

- **How do get from where we are, to where we need to be?**
  - **Present key approaches to enhance total resource management and revenue alignment**
  - **Enhance process improvement to reduce waste, decrease variation and improve care**
  - **Provide acceleration strategies in management of episodes of care and bundled payment**
  - **Enhance physician engagement techniques in these endeavors**

MedAssets

CONFIDENTIAL Property of MedAssets

Paradigm Shift Impacts All Providers

CMS State Innovation Models
Funding at the State level to Design and Test new payments models that emphasize value, quality, and controlling cost.

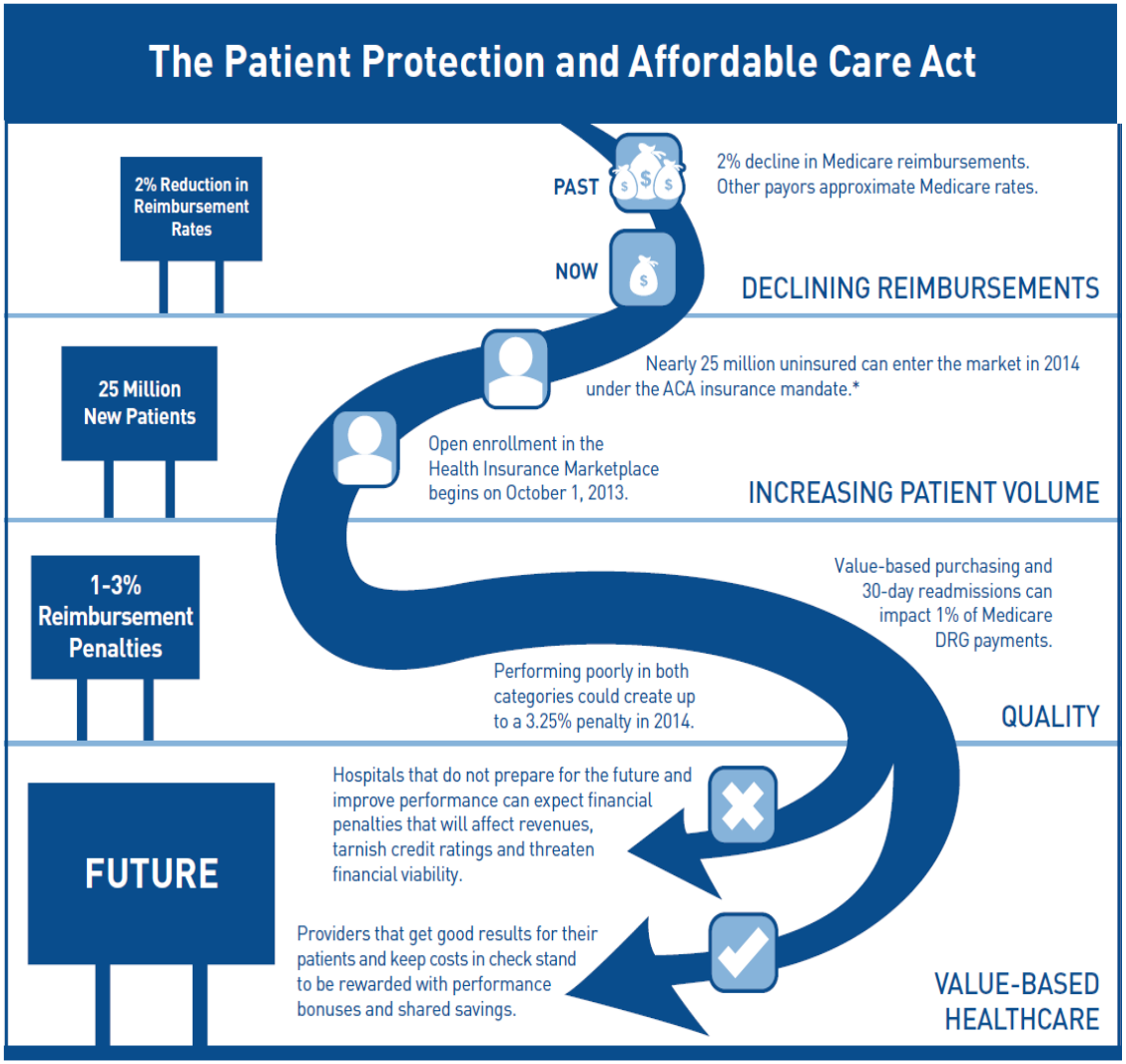
Up to $300 Million in Funding

Commercial Bundled Payment Contracts
Over 30 Contracts in 17 states, contracted for bundles focused on multiple areas including Oncology, Orthopedic Surgery, Cardiovascular, and Women's Health

CMS Health Innovation Awards: Round 2
Focused on New Payment and Delivery Models
Up to $1 Billion in Funding

CMMI Bundled Payment for Care Improvement Initiative
Over 400 Providers in 46 States

CMS Readmission Penalties
Up to 1% of Medicare Revenue is at risk due to 30 day readmissions, for Heart Failure, Pneumonia, and Heart Attack



Employer Bundled Payment Contracts
Multiple contracts across the county including Walmart, Lowes, Kroger, and health systems such as Geisinger, Scott and White, the Mayo Clinic, and others.

Patient Centered Medical Homes
PCMH are being implemented across the country as part of many organizations strive to improve their patient's health through better coordinated care.

Financial Alignment Initiative to Manage Dual Eligible Beneficiaries
6 States are participating in Capitated Agreements: MA, OH, IL, CA, VA, NY

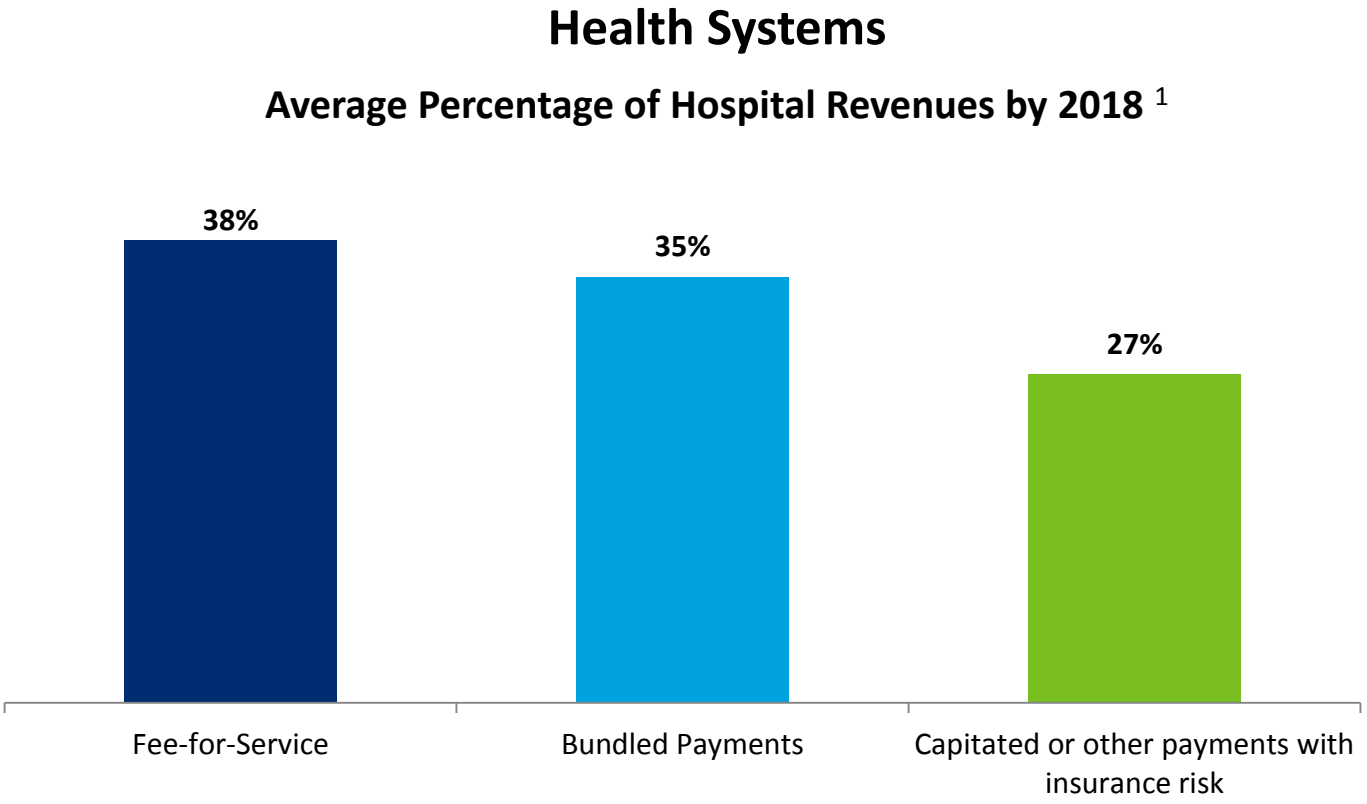
Comprehensive Primary Care Initiative (CPCI)
There are 497 primary care practices participating in the CPC initiative. This represents 2,347 providers serving an estimated 315,000 Medicare beneficiaries.

Medicare and Commercial ACOs
Currently there are a total of 492 Accountable Care Organizations, both Medicare approved, and with Commercial health Plans.

Sources and Notes: Centers for Medicare and Medicaid Innovation: http://innovation.cms.gov/
** Congressional Budget Office, staff of Joint Commission on Taxation, May 2013*

Rapid Market Expansion

In 5 years, bundled payments will represent 35% of revenue

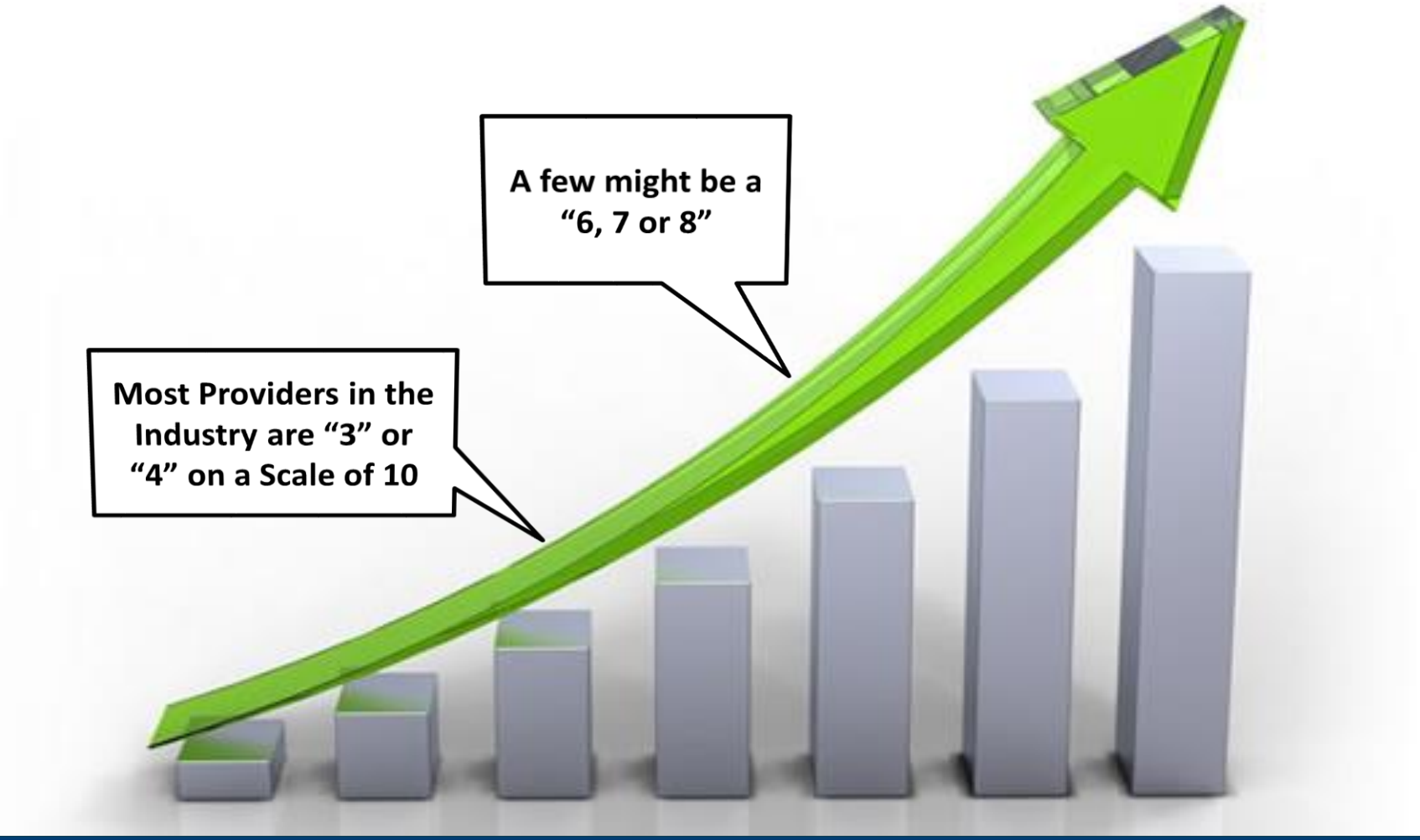


[1] Source: Health Enterprise Partners, " Seizing Opportunity in the Wake of Reform-Executive Perspective Survey, 2012.

.

The Opportunity: Move The Industry Forward

Scale of 1-10, Readiness Full Effects of Reform & Population Health Mgmt



Fundamental Challenge – Focusing on Value

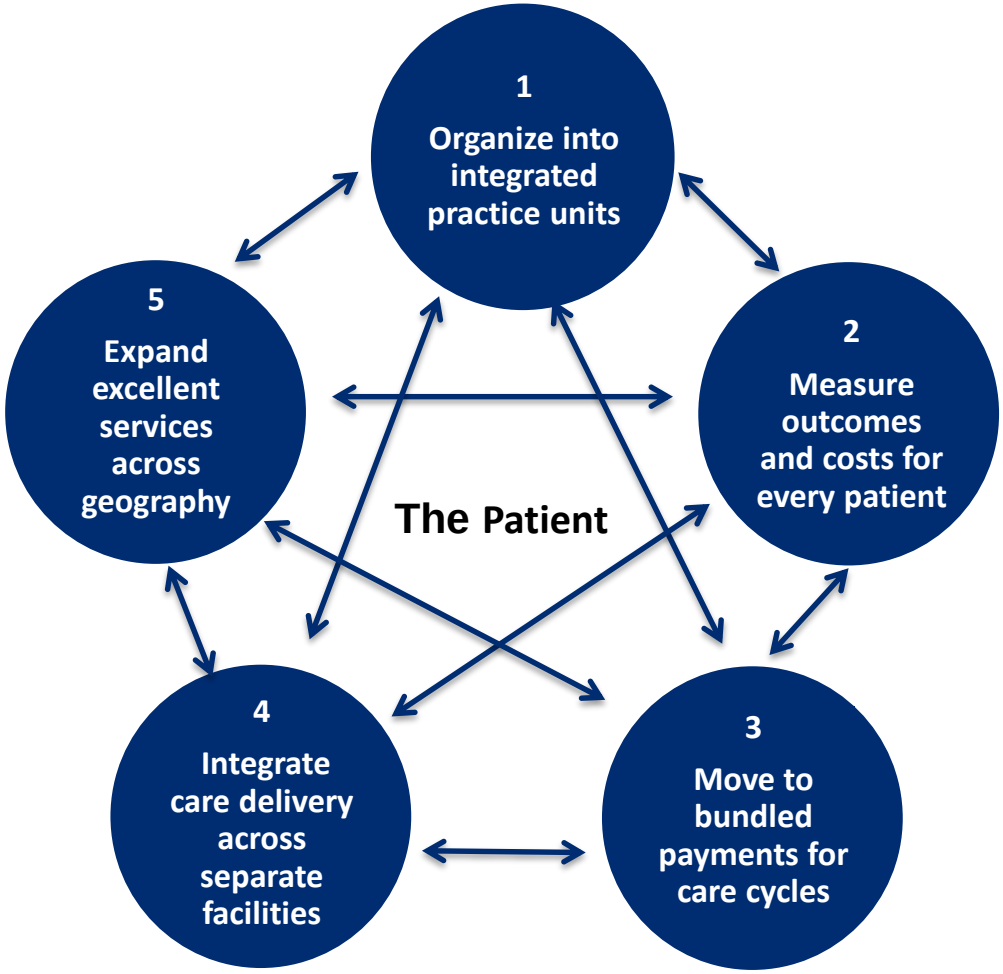
$$\text{Value}^* = \frac{\text{Health Outcomes Achieved}}{\text{Cost of Achieving Outcomes}}$$

"…providers that cling to today's broken system will become dinosaurs. ….Maintaining current cost structures and prices in the face of greater transparency will be untenable"

HBR – Oct 2013
Porter and Lee

**Source: Porter & Kaplan – HBR 2011*

Porter's Value Agenda Components



6 Build an enabling information technology platform

Bridging the Gap Toward Value

Source: Adopted from AHA RHEIT

Building Blocks for Cost and Quality Alignment

Drive down supply costs	Achieve optimal clinical resource utilization	Capture all reimbursement
▪ Leverage contracts to drive down costs of lab, pharma, and clinical supplies ▪ Engage physicians to down PPI costs	▪ Use of treatment protocols to drive down costs and LOS ▪ Enable provider / physician alignment through episode of care systems ▪ Drive change management and physician support	▪ Ensure accurate coding and documentation ▪ Drive claims processing speed and accuracy ▪ Connect full spectrum of providers relating to an episode of care for improved patient outcomes/preparation for bundled payment

Recommend focus on high volume DRGs initially

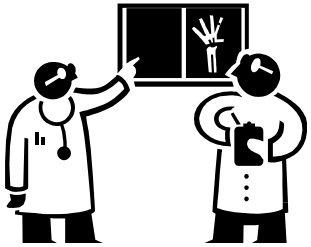
Combined solution has ability to drive 10%+ margin improvement

CONFIDENTIAL Property of MedAssets

Helping to Migrate to the “New World”

PROBLEM

But how does a doctor know which treatment to use?

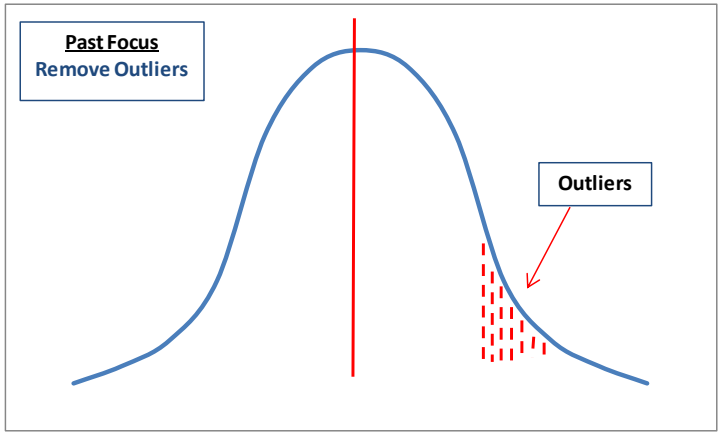


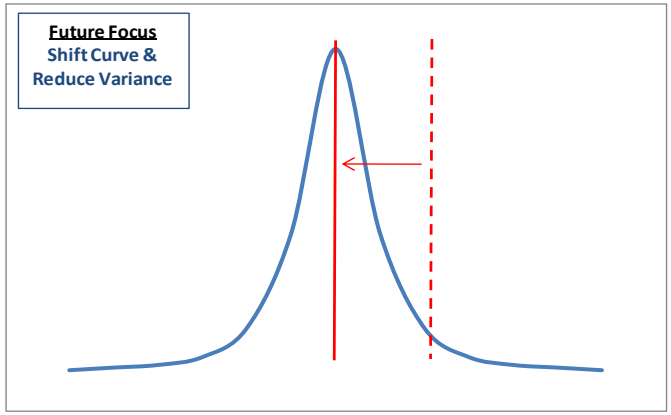
SOLUTION

Evidence based care guidelines based on **cost and quality data.**

NEW RESULT

More compliance, lower cost, better quality, better reimbursement.

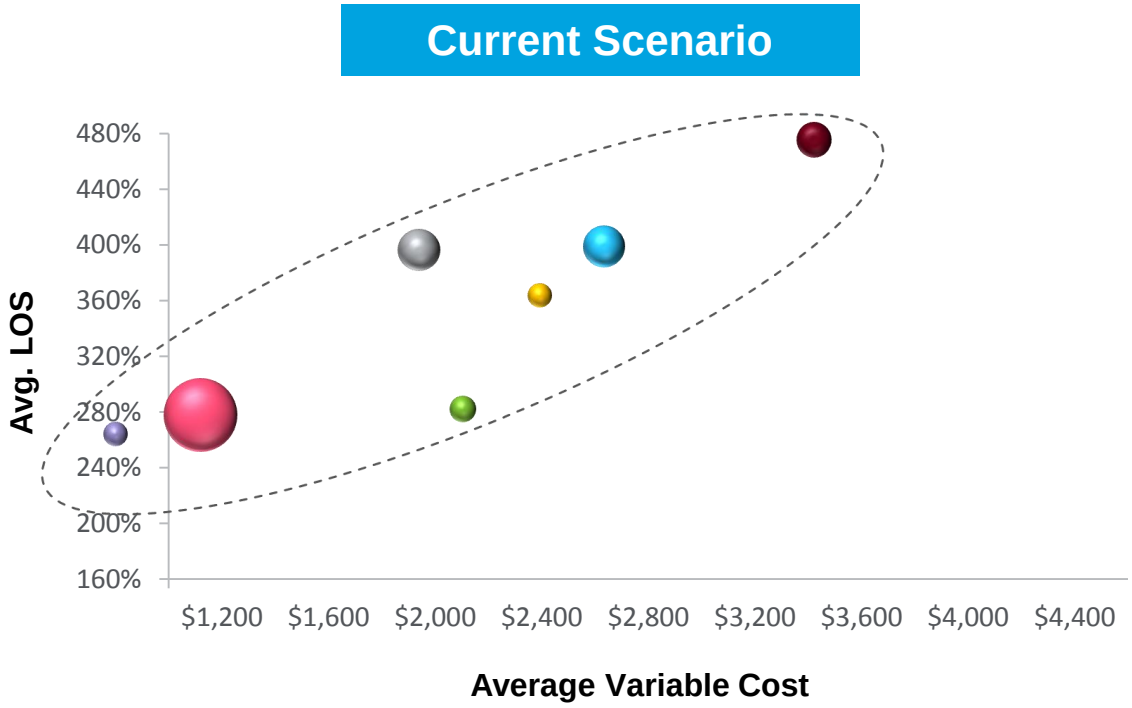




CONFIDENTIAL Property of MedAssets

Today – Significant Clinical Variation

Physician Variation
MSDRG 293 – Stage I Congestive Heart Failure



- **Example representative of common patient population within ~4,000 U.S. hospitals**
- **Variable cost of clinical procedure only**
- **Wide variation of clinical protocols and resources consumed**
- **Goal: Reduce cost through consistent processes, and improve quality of care**

Possible Future: Reduced Clinical Variation

Physician Variation
MSDRG 293 – Stage I Congestive Heart Failure

- **IDN/ACO-type model binds all providers and payors to the same economic model**
- **Significantly lower clinical variation when all providers and payors are "at risk"**
- **More predictable cost and quality outcomes**

MedAssets

CONFIDENTIAL Property of MedAssets

Readiness for Value-Based Payment Shift

- To deliver value – must consider core strategies as a whole unit
- Foundational elements
  - patient as “unit of measure”
  - identify “true cost” of care
  - identify “outcomes” associated with “true cost”
- Focus on clinical margin management
- Support ACO philosophy - aligned incentives for more effective coordinated care on high impact services
- Implement an effective and scalable bundled reimbursement system

Do you know your total cost of care?

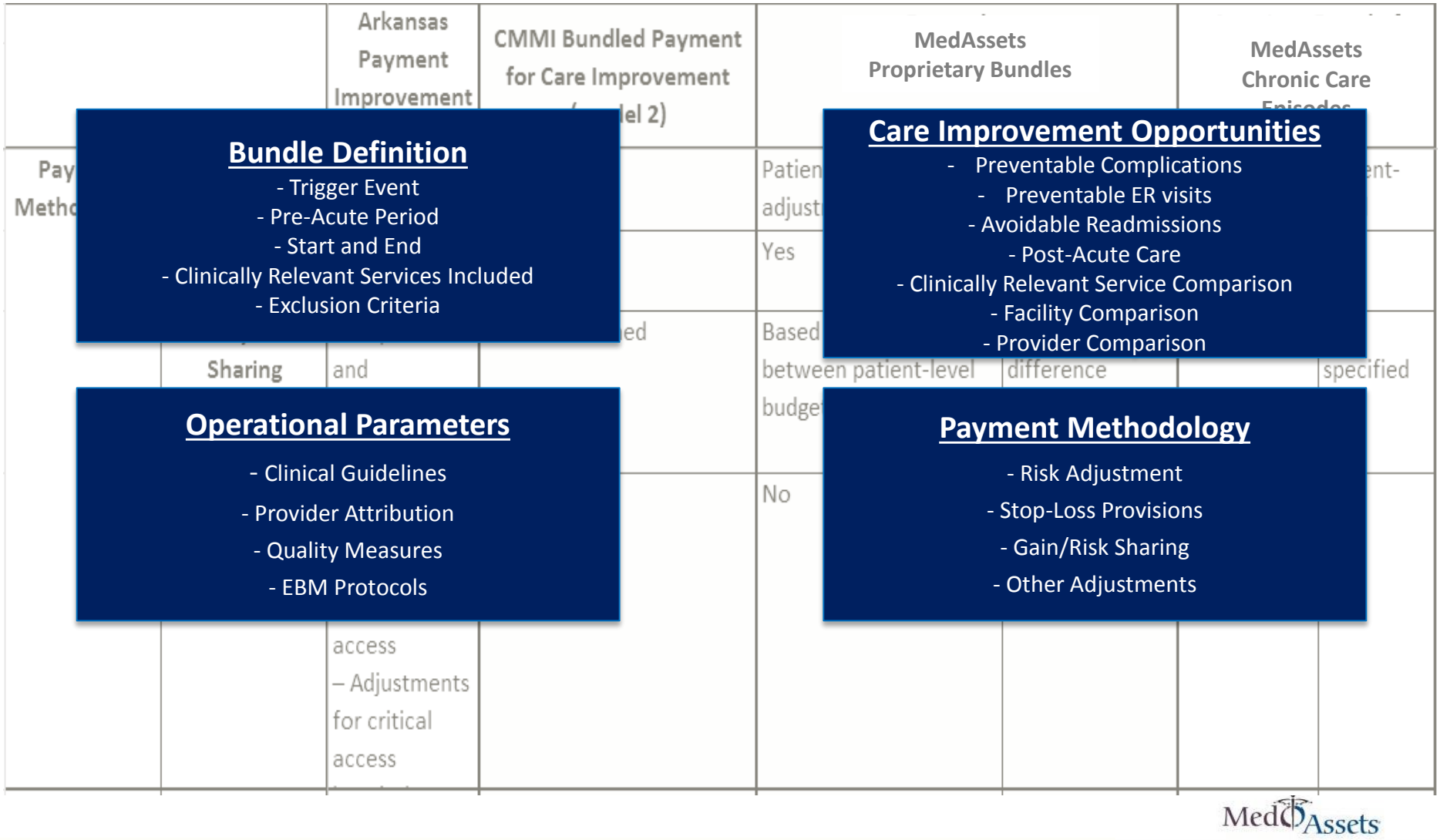
Episode of Care Reimbursement

Know Best Practices for Implementation of Episode Payments

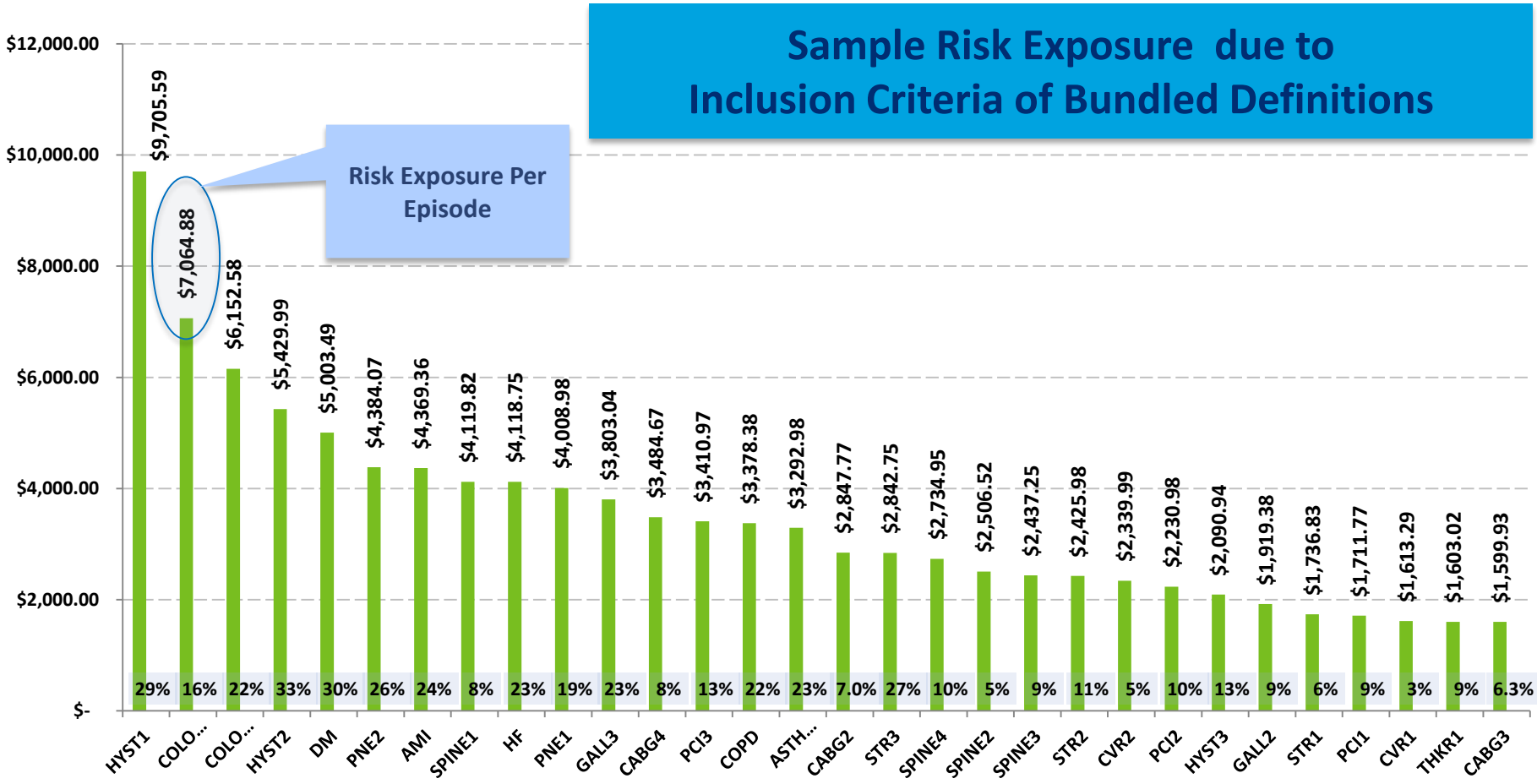
1) Choose the Right Episode Definition for your Organization
2) Determine the Right Episode Price
3) Identify Potential Savings Opportunities
4) Identify and Eliminate Variation in Services
5) Review Provider Performance, Identify High Performers
6) Manage Care Pathways, Improve Care Coordination
7) Assess Risk and Outliers, Understand the Impact

MedAssets

Choose the Right Episode Definition



Bundled Definitions and Pricing Drive Exposure Risk



Understand Your Readmission Exposure

Examples of the Exposure within the CMMI BPCI Episode Definitions

Pneumonia Mean Episode Payment:$17,278

Admission Date	Discharge Date	MS-DRG Description	Claim Payment	Percent of Mean Episode Payment
04/20/2009	05/22/2009	RENAL FAILURE W MCC	$41,589	241%
08/28/2009	09/21/2009	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	$36,566	212%
04/05/2009	04/21/2009	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W MCC	$34,894	202%
05/22/2009	07/02/2009	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	$33,125	192%
05/19/2009	06/23/2009	PSYCHOSES	$27,731	160%
02/13/2009	03/02/2009	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	$27,304	158%

Congestive Heart Failure Mean Episode Payment: $18,546

Admission Date	Discharge Date	MS-DRG Description	Claim Payment	% of Mean Episode Payment
02/13/2009	03/12/2009	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	$78,019	421%
04/14/2009	05/30/2009	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	$44,564	240%
02/27/2009	03/12/2009	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	$43,640	235%
06/19/2009	07/03/2009	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	$37,169	200%
04/24/2009	05/13/2009	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	$32,446	175%
03/22/2009	04/06/2009	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	$32,213	174%

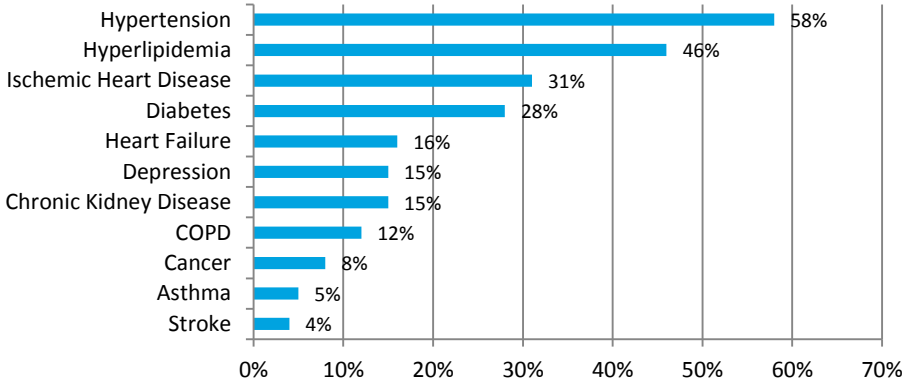
MedAssets

CONFIDENTIAL Property of MedAssets

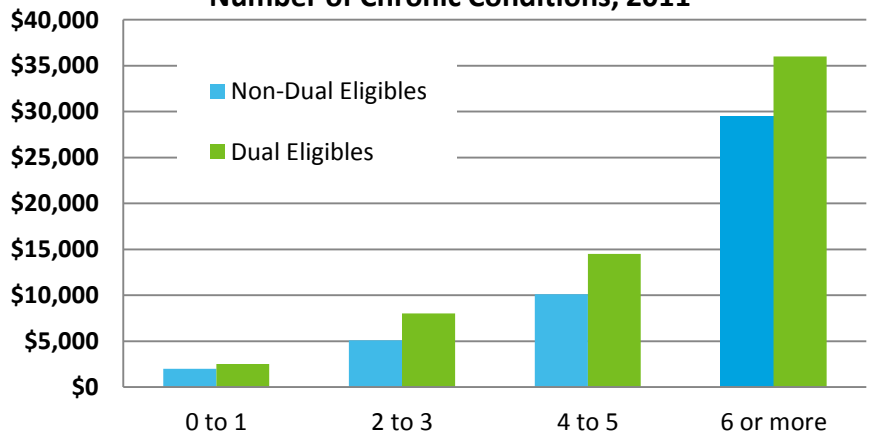
A Comprehensive Approach to Chronic Episode Management

Index Conditions	Rationale
Heart Failure	Major circulatory system conditions that require long term care. These conditions share common risk factors and similar management .
Ischemic Heart Disease	
Stroke/Transient Ischemic Attack	
Peripheral Artery Disease	
Hypertension	
Hyperlipidemia	Prevalent disorder and one of the important risk factors for circulatory diseases. E.g. Diabetes cited as a major cause for heart disease and stroke. Requires significant clinical coordination with other circulatory diseases.
Diabetes	

Prevalence of Chronic Conditions in Medicare Beneficiaries, 2011



National Per Capita Spending for Dual Eligibles by Number of Chronic Conditions, 2011



CONFIDENTIAL Property of MedAssets

Identify Care Improvement and Potential Savings Opportunities

Setting Clinical and Financial Benchmarks

Gold Standard Patient

Facility specific data- Compare within your own patient population.

- Identify the Patients with the best outcomes, aka: The Gold Standard Patients
- Compares patient population to the Gold Standard
- Calculate the difference in reimbursement as the savings opportunity

Gold Standard Physician

Facility specific data- Compare within your own provider population.

- Identify the Physicians with the Best Outcomes aka: The Gold Standard Physicians
- Compare physician population to the Gold Standard physicians
- Calculate the difference in reimbursement as the potential savings opportunity, based on physicians performing at the benchmark (Best) physicians

Core Metrics in the New Paradigm

Old KPIs

- Average Daily Census
- ALOS
- Patient Days
- Cost per patient day
- Occupancy Rate
- Support staff cost per physician
- Average revenue per bed
- Average case load per physician FTE

New KPIs

- Number of episodes
- LOS by episode
- Variance in budget to episode
- Average profit per episode
- Cost per episode
- Physician ranking per episode
- Preventable Complication Rates
- Preventable Readmissions
- Preventable ER Visits

DRGs

- Based on grouping for single inpatient stay
- Reward cost avoidance
- Reward shifting to post-acute setting
- Insensitive to health status impacts
- No incentive to coordinate care after discharge
- Not patient centric

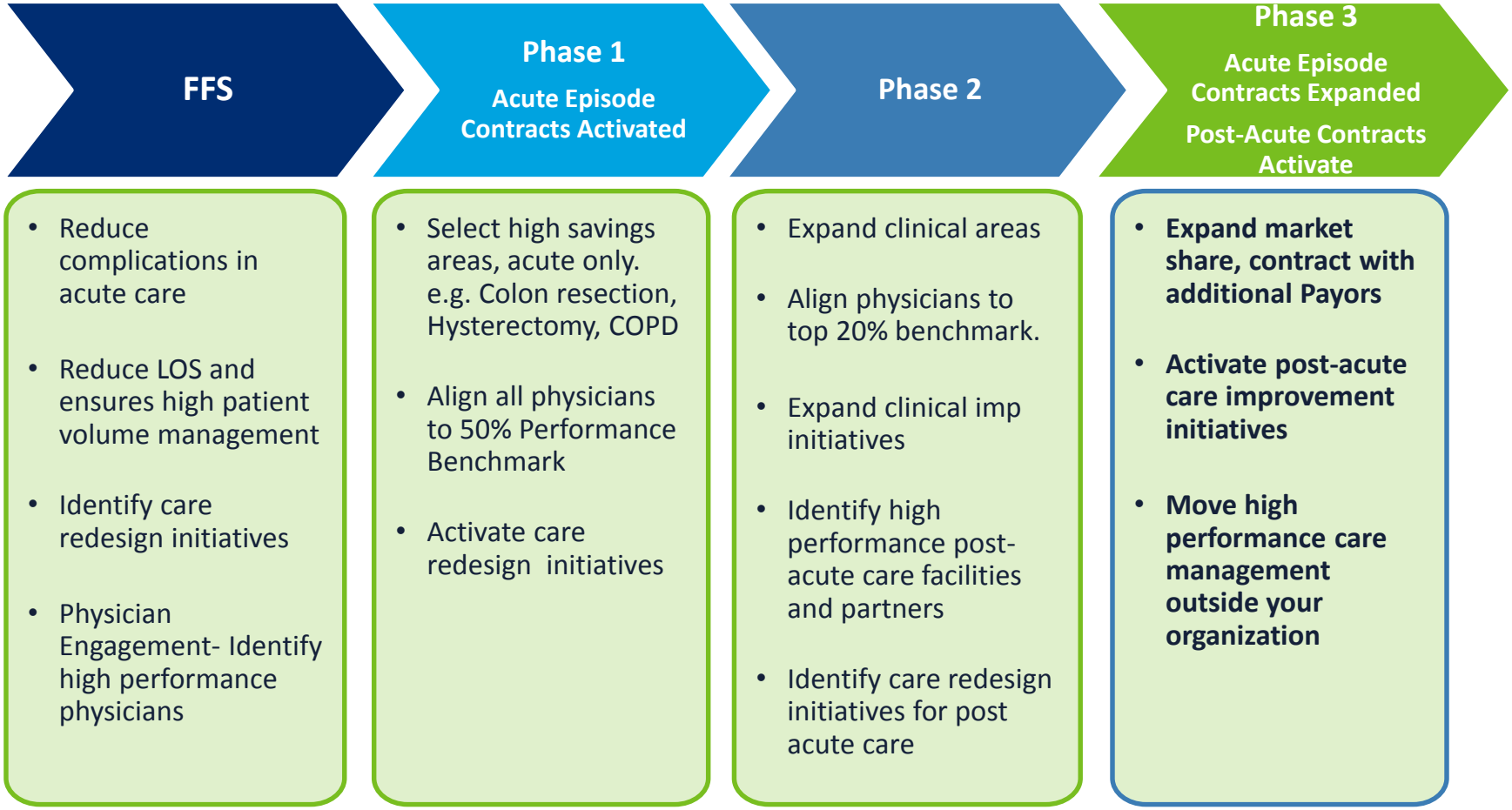
Episodes

- Based on the time span that includes the complete case/episode
- Reward outcome improvement by reducing preventable complications
- Consider care rendered in all settings to control total case cost
- Based on clinical guidelines
- Foster care coordination among providers
- Patient and outcome centered

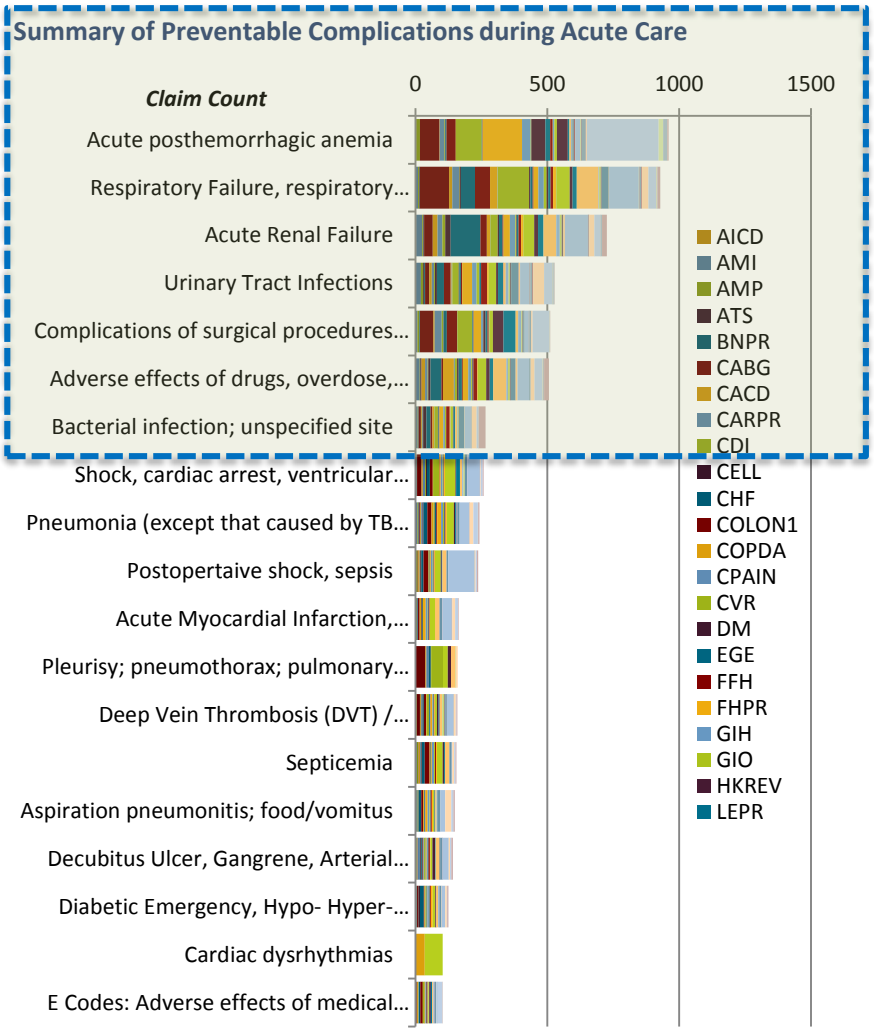
CONFIDENTIAL Property of MedAssets

Are you participating in CMMI's BPCI Program?

A Sample Transitional Strategy - From FFS to Risk Based Reimbursement

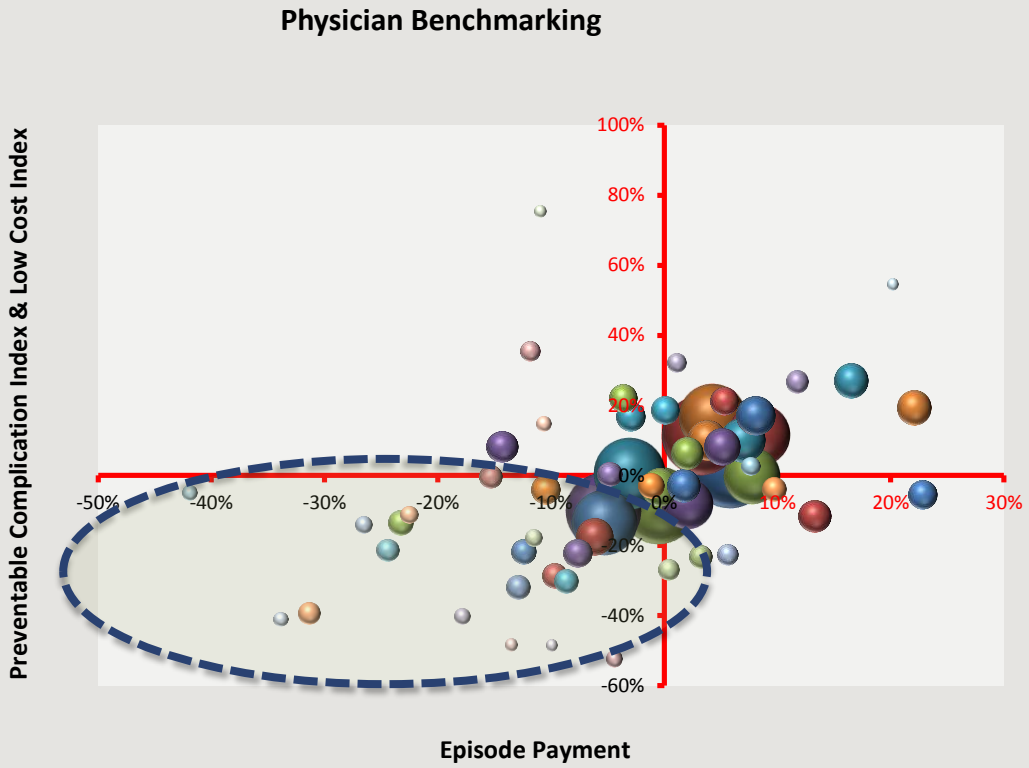


Understand Systemic Areas to Improve Patient Care, Across Multiple Episodes



- ✓ **Understand how claims would look under a value based model.**
- ✓ **Evaluate preventable complications, ER Utilization rates, avoidable readmissions, and mortality rates within each episode. Identify when these events occur, during the acute, and which section of the post acute phase. Understand the care setting in which these events occur, and which have better care outcomes.**
- ✓ **Evaluate patterns of preventable complications that occur within the acute phase across multiple episodes- signaling a systemic improvement opportunity.**
- ✓ **Quantify the achievable savings opportunity for each episode.**
- ✓ **Understand the variation of payments within each episode, identify outliers to standardize care delivery.**
- ✓ **Partner with your Providers to develop best care practices to reduce variation in care.**

Physician Engagement for Care Improvement



Identify which physicians are performing best based on key criteria such as low complication and readmission rates, mortality rates, and ER utilization.

These Providers are your key Change Agents.

It is important under a episodic reimbursement model to identify these high performing physicians to develop standardized best practices, and align poor performing providers to shadow and learn from these high achievers.

Under an episode of care, it is recommended that organization align care practices within their physicians, and provide standard care protocols to help eliminate variation in care outcomes and cost.

Understand Your Readmission Exposure

Acute Myocardial Infarction (AMI) Outlier Example

Post-Acute Care Revenue at Risk: $95,733

May 1st, 2011
Patient is discharged from their Acute Stay, for AMI Episode

Base DRG Payment for MS-DRG 281= $5,872

Episode Payment, to cover both the acute and post acute care = $22,178

May 16th, 2011
Patient is readmitted to another facility, Facility B, outside the index facility for a related diagnosis. The index facility has no control over the care provided to their patient.

The $8,177 that would be paid under a FFS model is now included in the bundled payment amount, not separately reimbursed.

OTHER CIRCULATORY SYSTEM DIAGNOSES W MCC

May 29th, 20011
The next day, the patient is readmitted back to the index facility for a related diagnosis.

The $4,855 that would be paid under a FFS model is now included in the bundled payment amount, not separately reimbursed.

CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O MCC

July 2nd, 2011
Patient is readmitted again, back to Facility B, not the index facility. Again, the index facility has no control over the care provided to their patient. Patient is discharged the next day.

The $2,641 that would be paid under a FFS model is now included in the bundled payment amount, not separately reimbursed.

ATHEROSCLEROSIS W/O MCC

July 3rd ,2011
Later that same day, the Patient is readmitted again, back to the index facility.

This time, this patient stays in the index facility for almost a month. The claim payment of $80,060 that would have been paid under a FFS model, is considered included under a bundled payment.

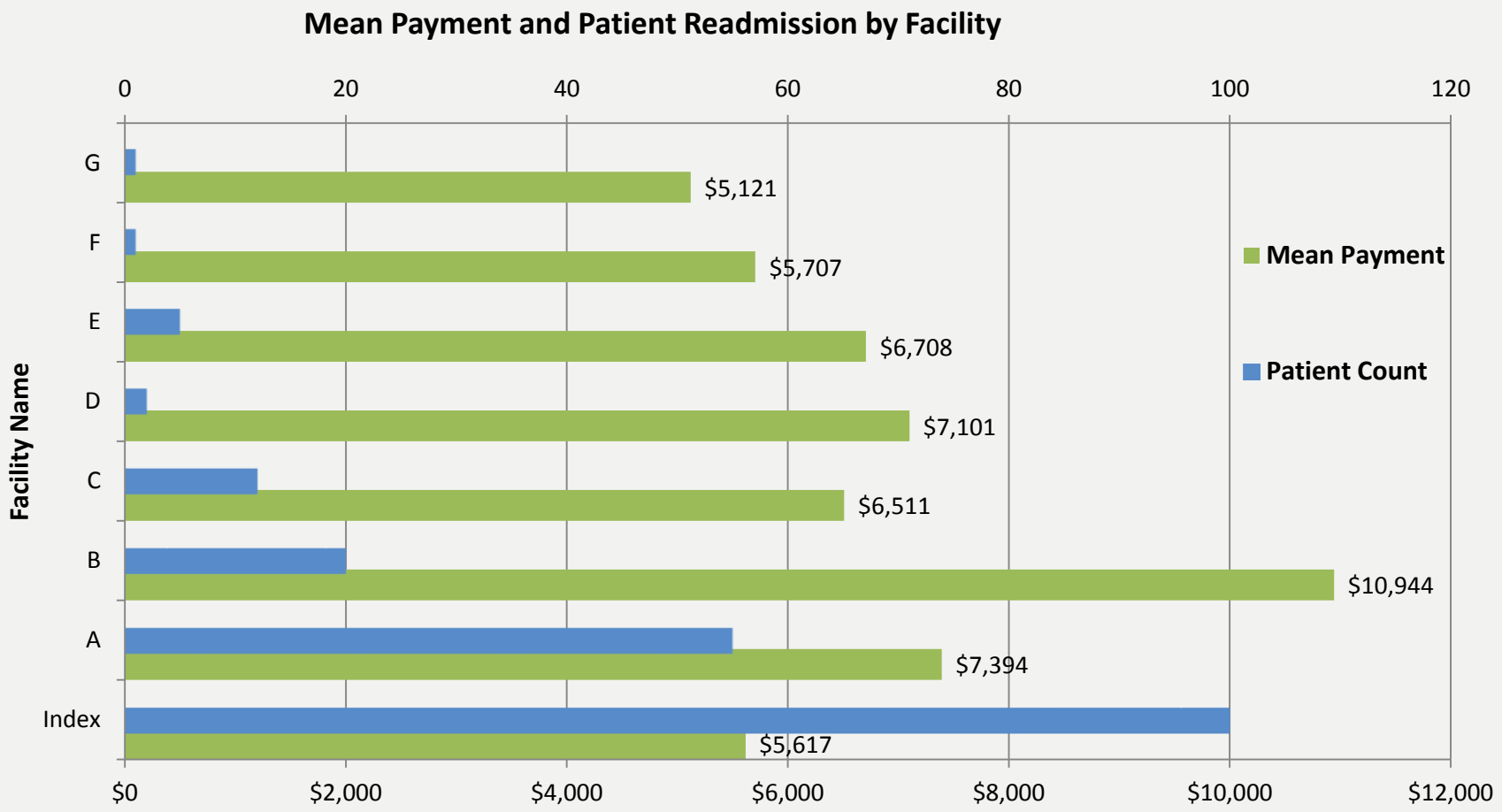
ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.

Acute Phase | **Post- Acute Phase** | **90 Day Post- Acute Phase**

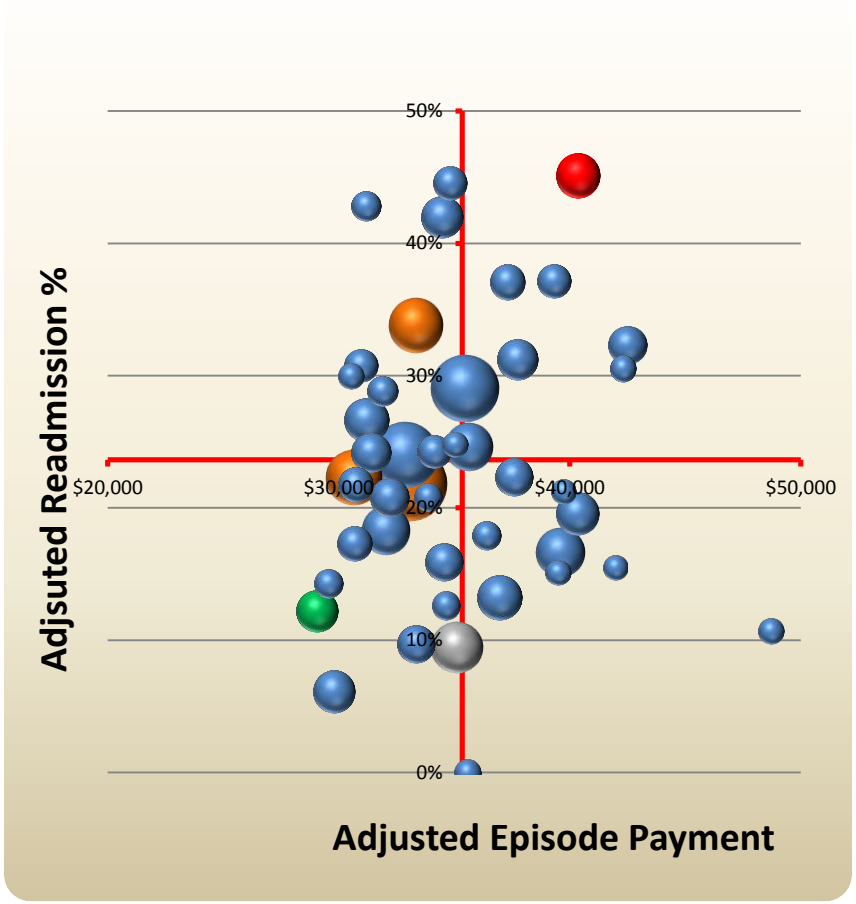
Note: Episode Payment amount includes the acute and post-acute care, for both the facility and the professional claims. The FFS amounts used in this example only include the facility claim payment amounts.

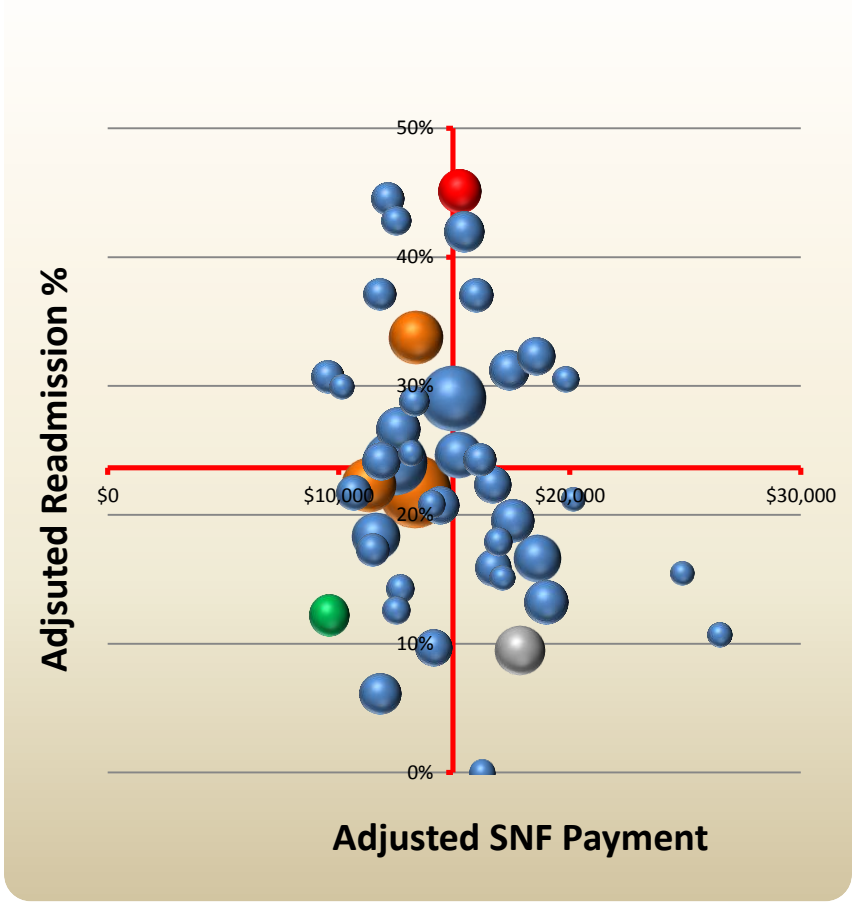
MedAssets

Patient trajectories: Highlight Readmission Exposure Risk by Facility



Identify variations in post-acute care: Creates the right partnerships for success





MedAssets

Are you delivering Value to patients?

Improving the Delivery of Patient Care

What Does Lean Do?

- **Lean is an approach:**
  - For evaluating and designing care that provides the Patient exactly what they want when they want it, defect free for the least cost.
- **How does it do that?**
  - By assessing current work flows in their ability to provide value to the patient, identifying the inefficiencies and eliminating them.

Lean is about making the right work easier to do

The Fundamental Concept of Lean

Patient and Customer Focused

Value-Added

- Giving Treatment
- Doing the Surgery
- Providing Education and Information
- Helping them with choices

Non-Value Added

- Searching for meds
- Waiting for OR to be cleaned
- Entering duplicate information
- Unnecessary use of materials or services

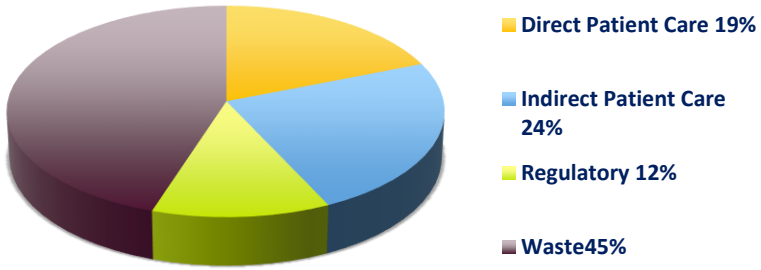
MedAssets

The 8 Faces of Waste

Everything the organization does needs to be treated as a process that serves the patient/customer.

Steps that don't directly provide better care to the patient/customer must be considered Non-Value added or WASTE!

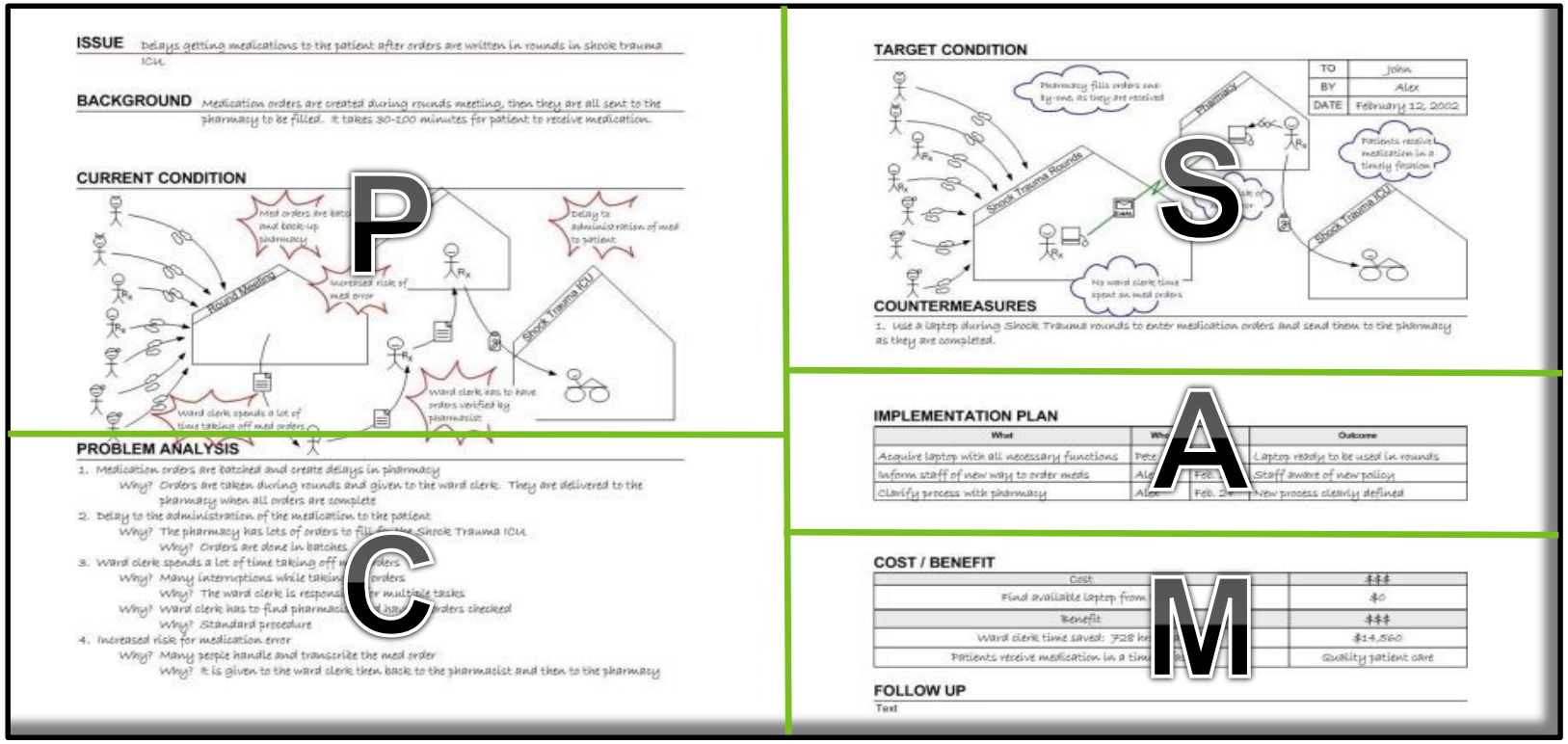
RN Time Distribution



- **D**efects
- **O**ver-Production
- **W**aiting
- **N**ot Clear (Confusion)
- **T**ransporting
- **I**nventory
- **M**otion
- **E**xcess Processing

CONFIDENTIAL Property of MedAssets

The Construct for Improving Care



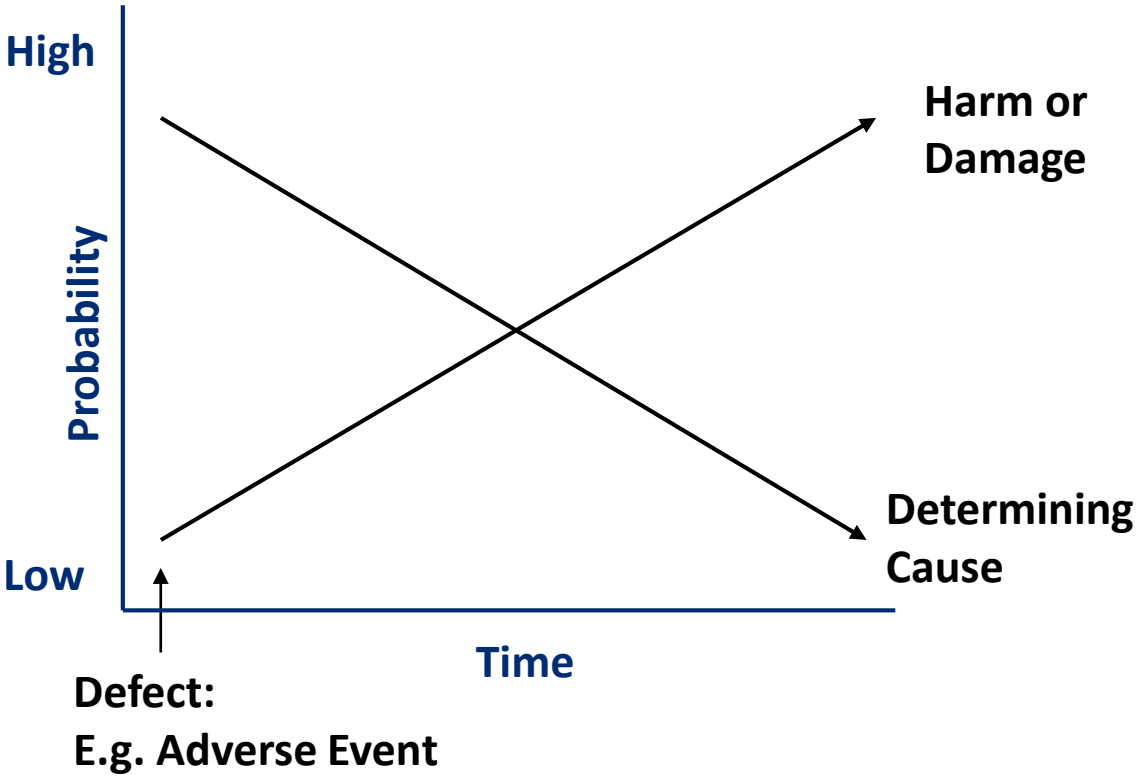
A3 Process Follows Scientific Method

Problem
Cause
Solution
Action
Measurement

Similar To Healthcare Familiar PDCA

Build in Reliability

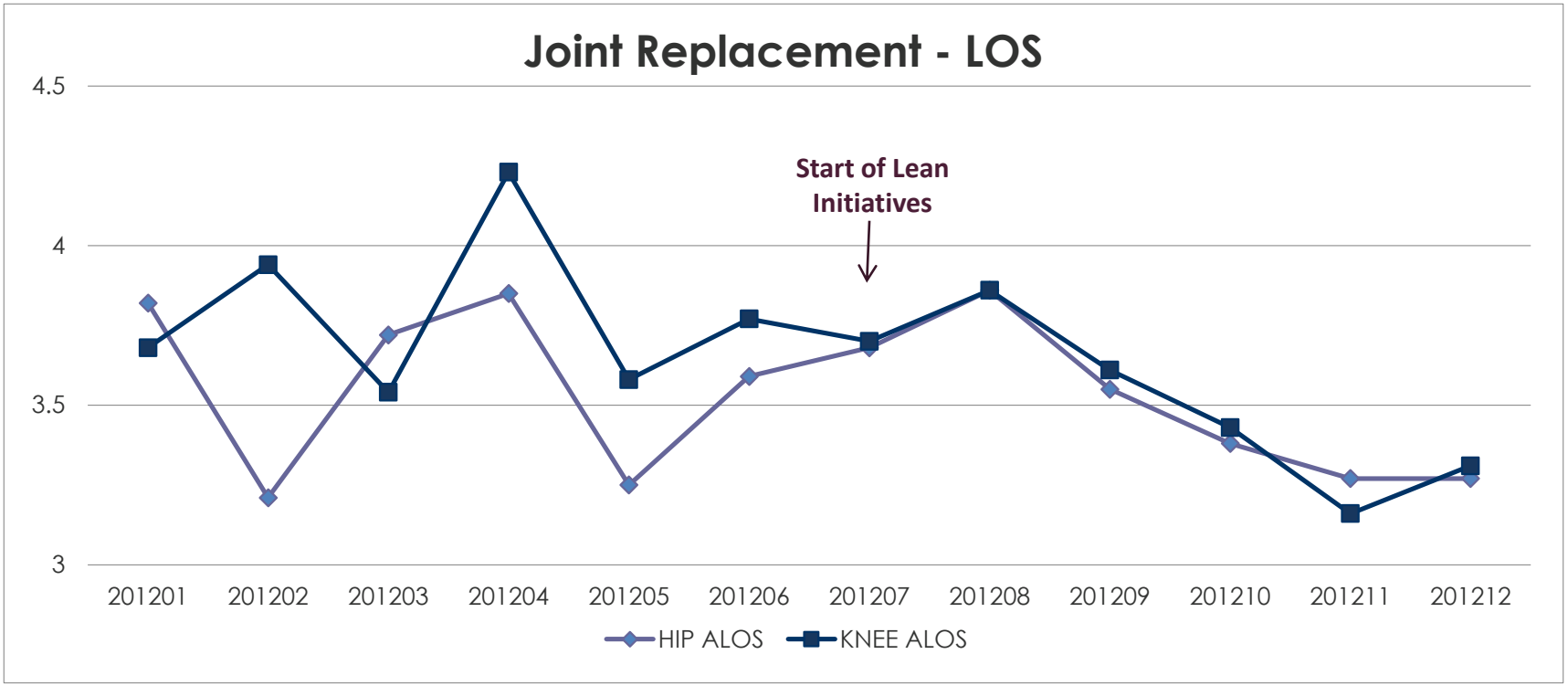
Lean is about knowing normal from abnormal right now and responding right now



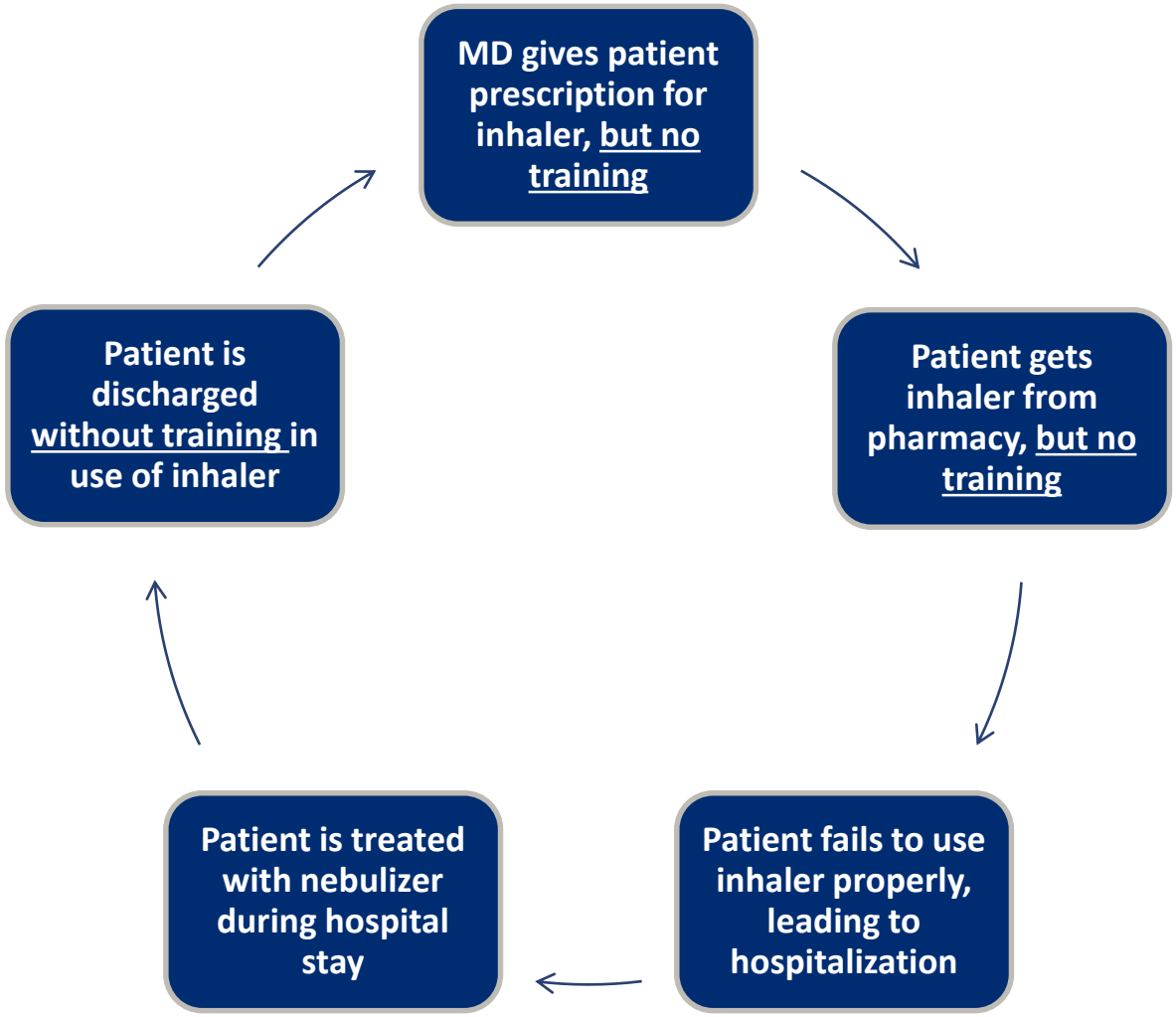
Adapted from slide by John Shook: U. Michigan

Efficiency and Predictability

Large Academic Medical Center in Philadelphia

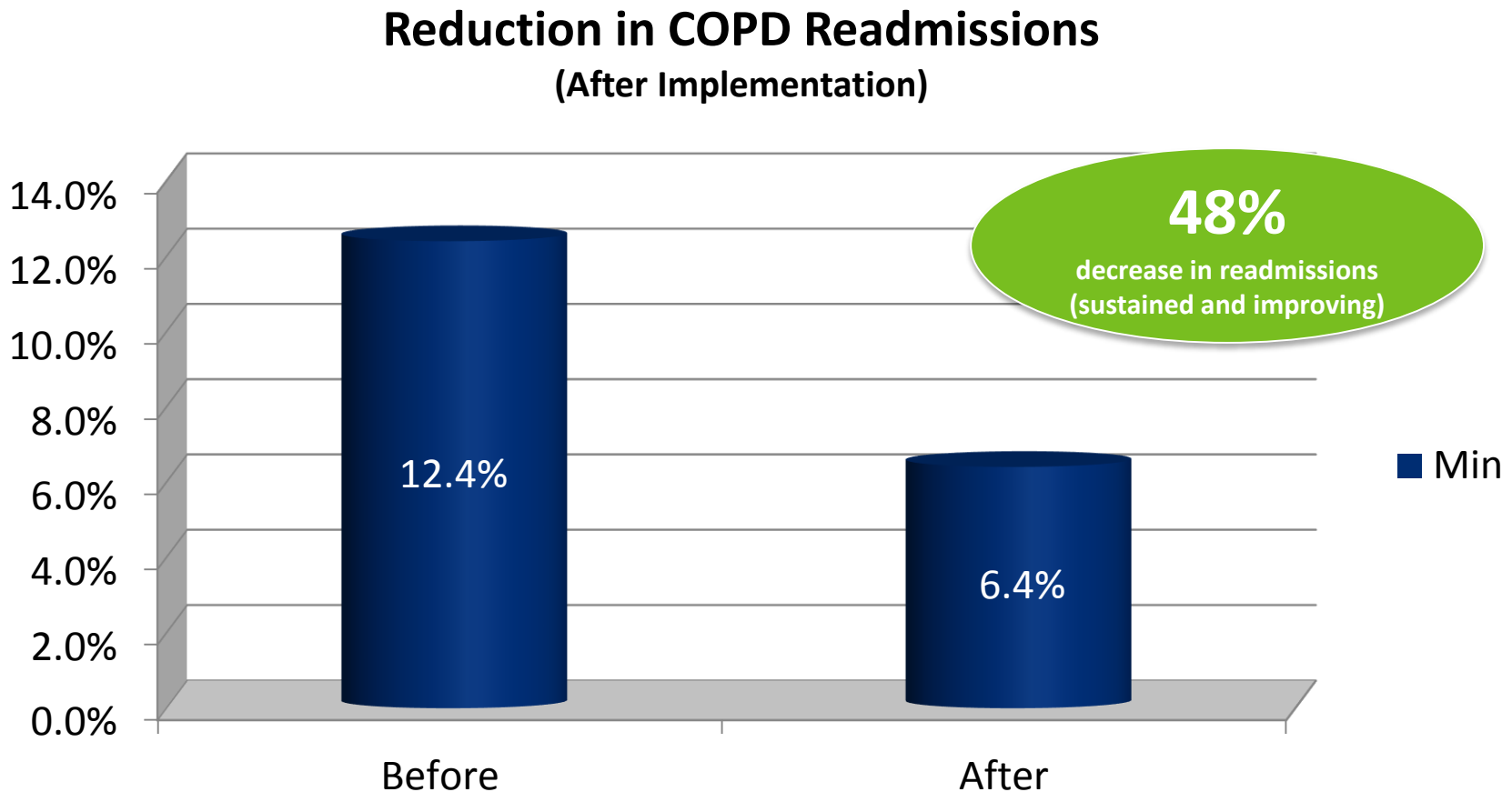


The Problem: Unnecessary COPD Hospitalizations

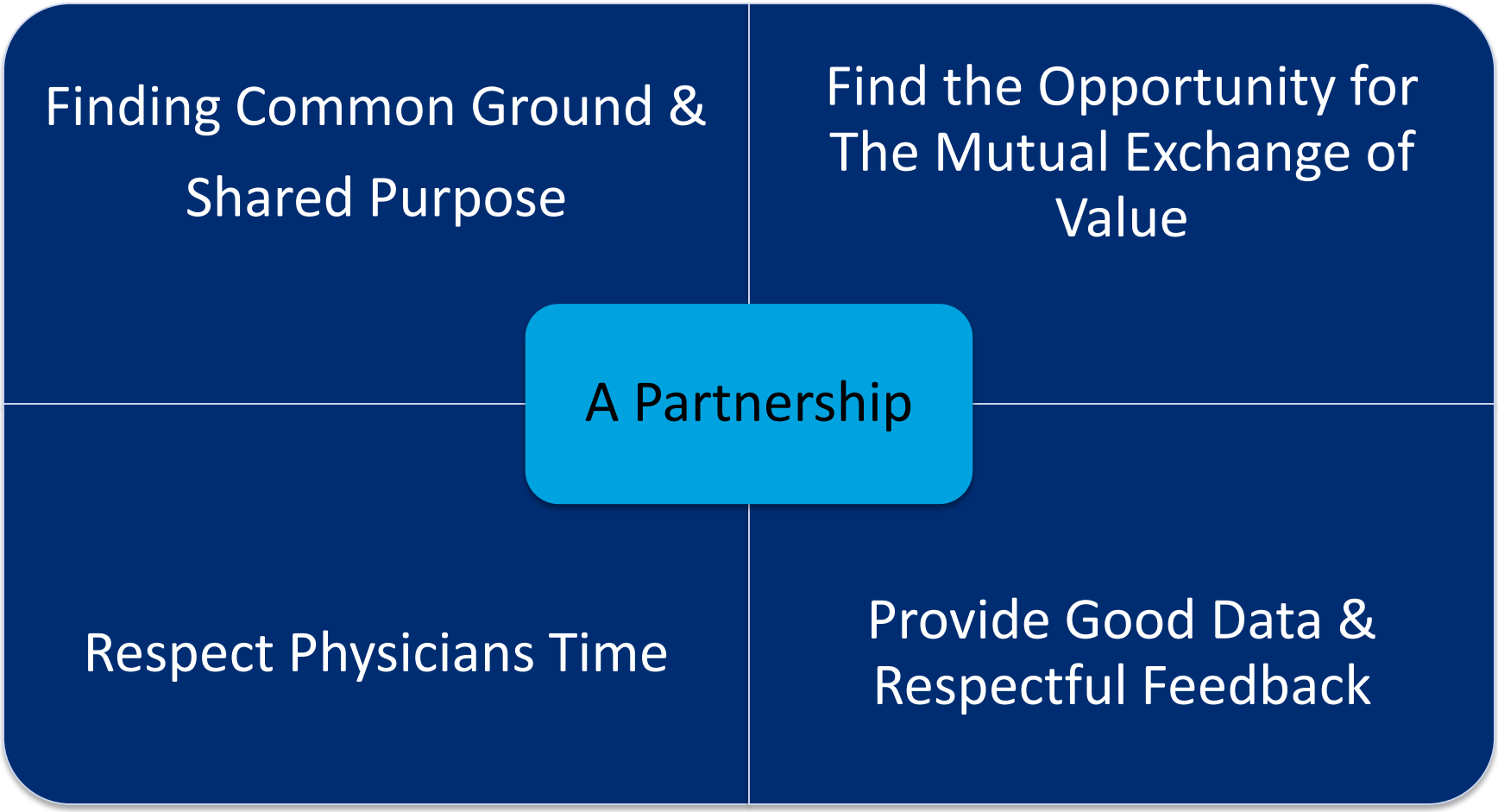


Improving Quality Metrics

PA Urban Medical Center (NFP)



Physician Engagement Framework



How to Contact MedAssets for Additional Information

Nick Sears, MD, Chief Medical Officer
nsears@medassets.com

Dave Munch, MD, Senior Vice President, Lean Healthcare Consulting
dmunch#hpp.bz

Mah-Jabeen Soobader, MPH, PhD, Vice President, Reimbursement Strategies & Analytics
msoobader@medassets.com

MedAssets®