



NAVIGANT

On Healthcare

HEALTHCARE

OUTCOMES AND LESSONS LEARNED FROM CMS JOINT REPLACEMENT BUNDLED PAYMENT INITIATIVES

Announcer: Welcome to Navigant On Healthcare, offering insights for healthcare leaders striving for success in an evolving industry.

Host: I'm your host, Bob Kim, and today we're speaking with Richard Bajner, managing director and leader of the value transformation segment of Navigant's healthcare practice. Rich works with leaders and providers in developing their integrated network, product and pricing strategies, including the design and implementation of accountable care organizations and bundled payments.

Hi, Rich. Thanks for joining us today on the Navigant On Healthcare podcast.

Richard Bajner: Great. Thanks, Bob. A pleasure to be with you and the team today.

Host: As I said in the intro, you work with payers and providers designing and implementing bundled payment initiatives. As we all know, the healthcare industry has been focused on the transition from volume to value. Can you tell us a little bit about the role of bundled payments in this transition?

Rich: Certainly. Bundled payments is not necessarily a new concept that maybe goes back 12, 24, 36 months, but it's really a test in new payment models that's been transitioning over five, six, seven years. If you look back to the start of pre-bundled payment for care improvement, or BPCI, that's known to many of the providers around the industry, there was a previous demonstration program called the Acute Care Episode (ACE) demonstration program that allowed five organizations, five health systems, around the country to pilot a payment methodology, retrospective in nature albeit, for physician services and hospital services within the inpatient setting that was deemed successful.

SPEAKER



RICHARD BAJNER

Managing Director

navigant.com

About Navigant

Navigant Consulting, Inc. (NYSE: NCI) is a specialized, global professional services firm that helps clients take control of their future. Navigant's professionals apply deep industry knowledge, substantive technical expertise, and an enterprising approach to help clients build, manage and/or protect their business interests. With a focus on markets and clients facing transformational change and significant regulatory or legal pressures, the Firm primarily serves clients in the healthcare, energy and financial services industries. Across a range of advisory, consulting, outsourcing, and technology/analytics services, Navigant's practitioners bring sharp insight that pinpoints opportunities and delivers powerful results. More information about Navigant can be found at navigant.com.

That was a prelude to bundled payment for care improvement where Medicare provided opportunities for health systems and physician groups to join voluntarily in bundled payment for care improvement across a number of different types of conditions. The ACE demonstration project was focused on acute care setting for physicians and hospitals in a limited number of DRGs, or conditions, really focused on cardiac and orthopedics. Bundled payment for care improvement extended that demonstration program in two ways, one, the number of conditions and episodes, but also two, that it extended the payment methodology or the bundled payment into the post-acute setting for 30, 60, or 90 days post-discharge. The transition from volume to value related to bundled payment has been ongoing for several years, and we're starting to see some early feedback and results from early adopters in the BPCI program.

Host: Great. That's a great overview, historical perspective for our listeners. Can you tell us a little bit about what's happening now then? That's how we got to where we are today, but where does bundled payments stand today within healthcare?

Rich: With the strong adoption of joint bundles specifically under BPCI, there's been a significant amount of work, a significant amount of energy by providers, and health system, and physician groups to develop and build capabilities to be able to manage care across an episode of care or across a bundled payment. Given the number of physician groups, the number of hospitals that are engaged in this type of work, it's our view or certainly the view of many of our clients that bundled payments is a key transition step to managing broader sets of risk whether it be in a Medicare population and a Medicaid population, a commercial population. Our provider systems, our healthcare clients, our healthcare system clients continue to move rapidly toward building capabilities at scale that will allow them to manage care not only in the acute care setting but for populations that extend beyond the acute care including home health services, skilled nursing services, inpatient rehab services, and so forth.

Host: When a hospital looks back and says, "Okay, we've spent a lot of time, and money, and effort on these initiatives," how do they measure their success?

Rich: I think there's some quantifiable ways to measure success, and there's other ways that are a little bit harder to quantify. Let me give you a couple of examples how our clients are starting to think of it. Some of the more early adopters of bundled payments that have been working on building capabilities, engaging their physicians, leveraging data to inform decision making are significantly further ahead in their learning curve. Those types of organizations are not only measuring things on a quantified basis, but on probably areas that are harder to quantify.

Let me give a couple of examples. One, certainly our clients generally start thinking about success from a financial perspective. Have they been able to drive down the cost of an episode of care? Behind that question, there's a couple key metrics that our clients are looking at. One, what percentage of their patients are being discharged to inpatient rehab facilities or skilled nursing facilities? Two, for patients that are discharged to skilled nursing facilities, what is the length of stay of those patients that are staying in the skilled nursing facilities, and what is the likelihood of readmission from those facilities? For our advanced clients, they've been able to impact both length of stay but also been able to manage down the readmission rate of patients going to skilled nursing facilities and returning back into the acute care environment. I think cost is a key driver.

Beyond cost, our more advanced clients are beginning to look at things like patient satisfaction, and they're putting together and leveraging technology to interview their patients to profile their patient segments to understand, are their patients getting better care as a result of how engaged physicians are in the care pathways in treating the patients differently? I think patient satisfaction is certainly a key driver for our more advanced clients.

Three, quality of care. Have clinicians been able to work together to reduce and prevent things like unnecessary complications, things like readmissions, managing to appropriate length of stays? There is different metrics of quality of care depending on the type of condition we're looking at. The majority of what we'll probably speak about in terms of some of the success stories later in our discussion will be around joint replacements. Some of our clients have done a terrific job being able to demonstrate that while they've been able to reduce cost of an episode, they've also been able to improve quality.

If you look at it beyond just the standard triple lane view of cost, quality, and access, I think some of our other clients are looking at it from a slightly different perspective. Maybe a fourth mechanism is have our clients been able to improve the level of engagement that their physicians have demonstrated as part of the partnership in bundled payments? Are physicians coming to their monthly meetings or coming into the quarterly meetings to discuss changes to operational mechanisms or clinical routines for these patients? I think physician engagement is a very important metric that needs to be reviewed and quantified.

Another one our clients are starting to look at is Gainshare. In reducing cost of care, these programs provide waivers that allow health systems to share savings with their physician partners. What percentage of the maximum allowable savings percent are health systems sharing with their physicians, 30%, 40%, 50%, 60% of the maximum allowable? What percentage of the Gainshare are physicians earning, and why or why not? Then maybe lastly, some of our more advanced clients are starting to look at volume trends. In proving the level of engagement with physicians and in proving the quality of care for patients, are they able to drive more impact within the market, resulting in market share shifts, resulting in growth in joint programs within their specific geography? I think more and more of our advanced clients are moving to those types of mechanisms.

Probably important to say is that some of these mechanisms and some of these metrics may be slightly different in a Medicaid or a commercial population, for example, in a commercial population, being able to quantify absenteeism or days away from being able to work. If a physician in the care team can get a joint replacement patient back to work quickly, that's a really important story to be able to tell an employer that maybe not be necessarily as important to track in the Medicare beneficiary segment.

Host: I'm sure that our listeners will be very curious to know what are some of the "a-ha" moments or some of the pitfalls of an unsuccessful potentially bundled payment implementation.

Rich: Let me talk about a couple of the areas where our clients struggled probably more so than they were anticipating. A couple of things come to mind. Certainly one is the data is complicated, and health system generally and historically don't have the capabilities and haven't looked at a full set of claims data that comes from multiple data feeds, and be able to integrate that into a single viewpoint to understand what's happening to patients. For example, health systems aren't used to being able to see payer data and aren't used to being able to or have the need for evaluating professional data and facility data together. I think the data challenges for many of our clients were pretty heavy up front.

Two is getting physician engagement and buy in. For many of our clients, they have a tendency to want to jump right into a discussion around, "Well, here's what the data shows. Here's where some of the opportunities are. Here's how we can address some of the opportunities," which seems like a very logical conversation to have with physicians. But if you don't have the right buy in to why we have to do things differently and what it means for the physician, "And oh, by the way, here's how we, the health system, are going to put together a program that will provide you data on a regular month to month basis. There's going to be a meeting scheduled on a quarterly basis," and just the overall logistics of managing the relationship with the physicians differently, if you don't start from that perspective and you run too quickly into the data, this can feel like a forced march with the physicians, and that the health system is doing something to the physicians versus really partnering with them. I think starting from that perspective and getting the right physician engagement, the right physician buy in, and then leveraging the data is really important for health systems to understand building that right infrastructure.

Once you move beyond engaging the physicians, then starting to understand the key levers, and the key opportunities to manage care across a continuum, and what organizations and what health systems can do in order to start to impact a couple of metrics. We talked about readmissions, but putting patients in the appropriate post-discharge location is really important and not a topic that most health systems have worked on with the depth required and the discipline required with their physicians. Then once the patients get discharged or are discharged from the health system, how do you maintain contact with those patients? How do you make sure they're getting the right care whether it's in the home health setting or a skilled nursing setting? How do you make sure that the appropriateness of care is maintained and that they're not receiving more services than are required or fewer than are required? How do you right size the care once the patient's outside of the acute care environment?

Those are probably some of the key challenges that our clients have had, but we have seen an increasing number of clients where they've been successful. For example, I know we've talked about in public forums around Baptist San Antonio and the success they've had, but their success has been very real and it didn't start out from a position where the physicians happily bought into doing and participating in joint replacement episodes of care. Once they got their physicians engaged, results followed pretty quickly.

They've been able to reduce the cost of care by more than 20%. They've been able to demonstrate improvements in quality. They've leveraged technology to engage patients to create a better patient experience, and right sizing expectations for patients. Pre-surgical, how do you prepare for the surgery? What should you be expecting? Having videos from their individual physicians so after the surgery there's a video of the physician explaining to the patient what they should be feeling, and what they should be aware of, and if they are experiencing anything that could trigger a need for calling the care team, so to make sure that the patient isn't being readmitted, that they're receiving the appropriate amount of care.

I think Baptist has been a really good example of things weren't rosy at the beginning. They really focused on engaging their physician community, getting the right buy in, leveraging data, and the results pretty quickly followed. They've been doing this for two or three years and have had significant amounts of financial success in sharing savings but also in improving quality in the patient experience.

Host: Speaking of Baptist, let me just give a quick plug for you on behalf of yourself and your co-authors. I know that recently, I think it was in February of this year that you co-authored an article in HFMA titled Bundled Payments: Value-Based Guidance where you shared some insights and observations of that experience of Baptist Health in San Antonio through some research that they conducted around bundled payments. Hopefully our listeners can go check that out on hfma.org. They could just simply search on value-based guidance and get your article.

Rich: Joint replacements are by largely an elective procedure, and about half of their spend happens outside of the acute care environment. If you contrast that with CABG, which is generally not an elective procedure and a much more significant portion of spend happens in the care environment, call it somewhere around 80%, there's less opportunity to create savings on managing care through the full episode, i.e., through post-discharge in a CABG versus a joint replacement. Really understanding the financials and what drives cost across an episode condition by condition, and the opportunity for improving or managing care across those and what it means from a financial perspective is really important if cost is going to be a primary driver of how success is measured.

Host: Great. Thanks so much, Rich, for sharing your expertise with us today. That's it for today's episode. I'm Bob Kim, and it's been a pleasure to host this podcast.

Announcer: That concludes today's episode. Be sure to check in with us for future installments of the Navigant On Healthcare podcast series on navigant.com/healthcarepodcast. Navigant On Healthcare is a podcast series produced by Navigant's healthcare practice. If you enjoyed this episode, please share with friends and colleagues on social media. Learn more at navigant.com.