Bundled Care Payment Initiatives

and BPCI Advanced

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April 28, 2018

OU Medicine

Speaker Disclosure

I have no relevant financial relationships or affiliations to disclose.

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OU Medicine

Speaker Disclosure

- Current appointment as a “Quality Payment Program Clinical Champion” for the Centers for Medicare & Medicaid Services
- Recently appointed member of the Technical Expert Panel (TEP) for the project entitled “Development of Inpatient Outcome Measures for the Merit-based Incentive Payment System”
- Rural Quality Advisory Panel for the Rural Quality Improvement Technical Assistance (RQITA) Program (funded by the Federal Office of Rural Health Policy)
- Co-Chair, National Quality Forum Technical Advisory Panel – Primary Care and Chronic Illness Safety Standing Committee

All are volunteer positions.

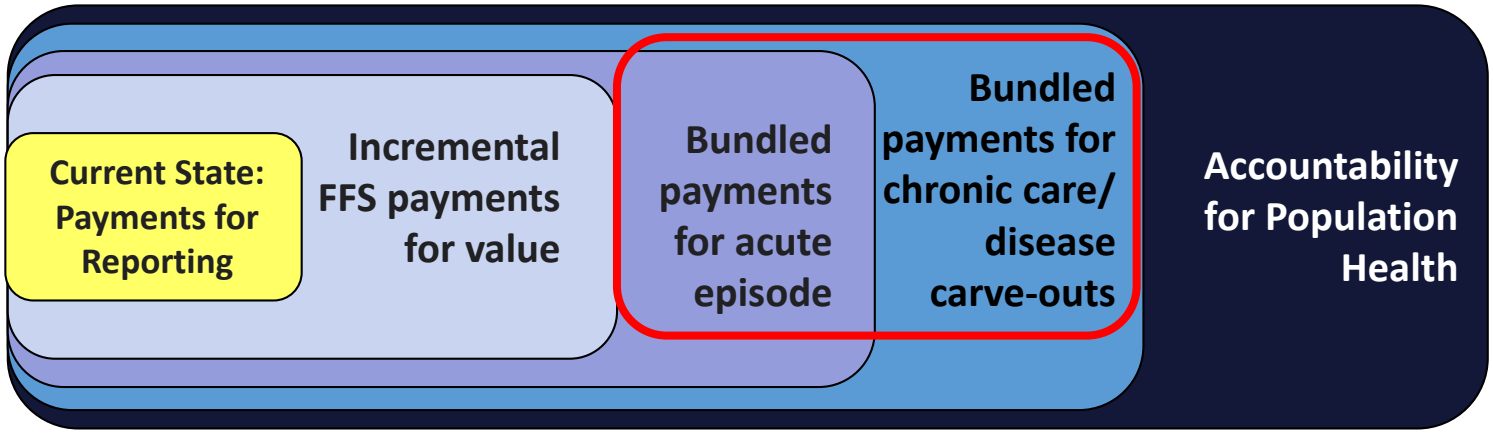
Objectives

- Describe the concepts of bundled payment.
- Discuss variation in cost and quality for episodes of care
- Describe the Bundled Payment for Care Improvement Advanced initiative of CMMI
- Review the evidence of impact of bundled payments

Moving from volume to value……

Increasing assumed risk by provider

Increasing coordination/integration required



From…. ..get paid more for doing more (i.e., FFS)

To…. ..profiting by keeping your population of patients healthy, delivering high-quality care, and doing so at less cost

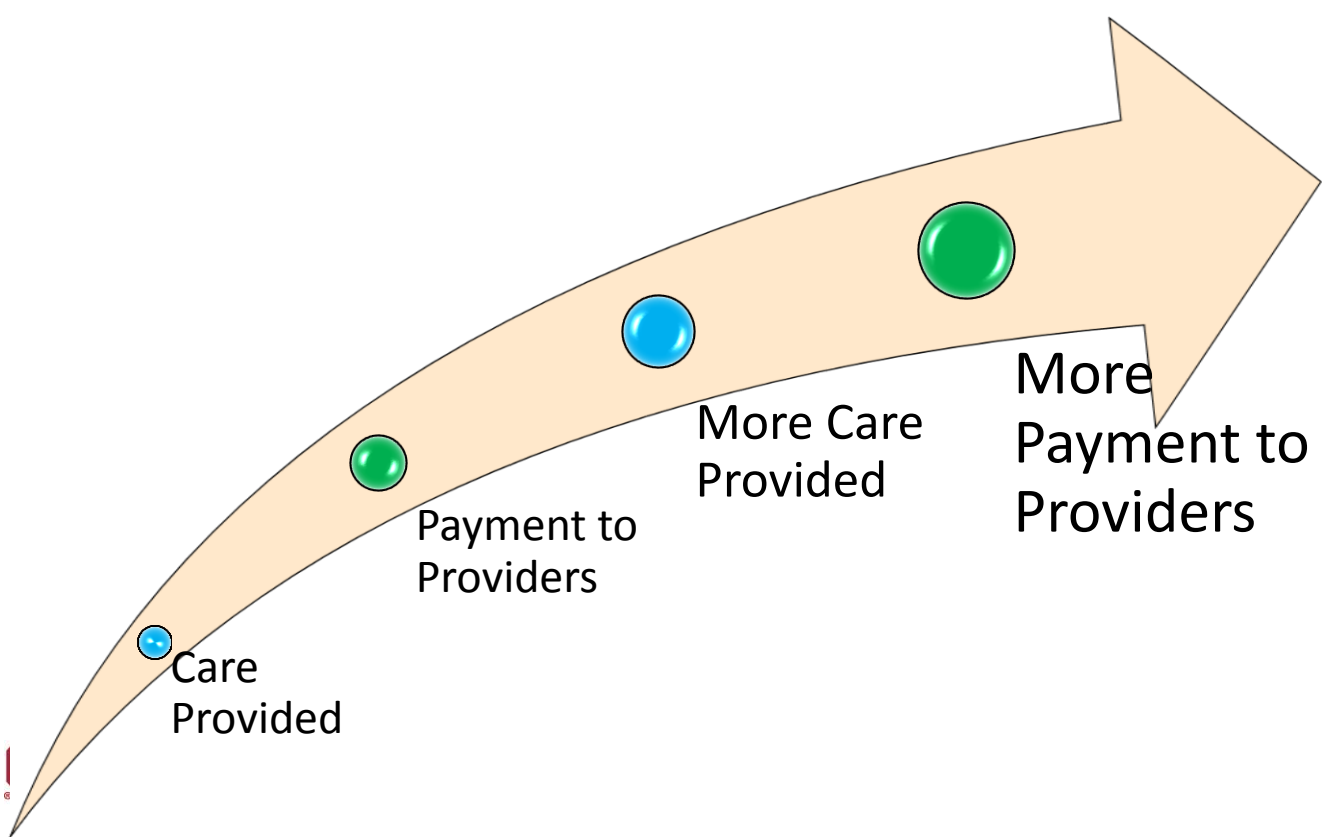
Fee-for-service Payment is Inflationary

FFS: Getting What You Pay For

"Fee-For-Service" pays for volume, so that is exactly what we get:

LOTS OF VOLUME

(visits, tests, procedures, duplication of services)



Very Expensive Health Care

FFS: not only rewarding volume, but rewarding volume of highly priced services

- **FFS payment provides a financial incentive to:**
  - Provide more of those services which are paid most handsomely – e.g., cardiology, orthopedics
  - Introduce new services that generate higher fees than longer-standing services

- **FFS payment provides a financial *dis*incentive to:**
  - Deliver services that generate comparatively lower remuneration – e.g., primary care, psychiatry
  - Provide services for which there is no FFS compensation – e.g., patient outreach, care coordination, treatment plan development, e-visits, web visits

FFS: No Financial Incentive for Quality

- Physicians get paid the same amount for one patient regardless of whether they provide excellent care or poor quality care

Providers may actually be paid more for poor quality due to the need for “rework.”

What is a Bundled Payment?

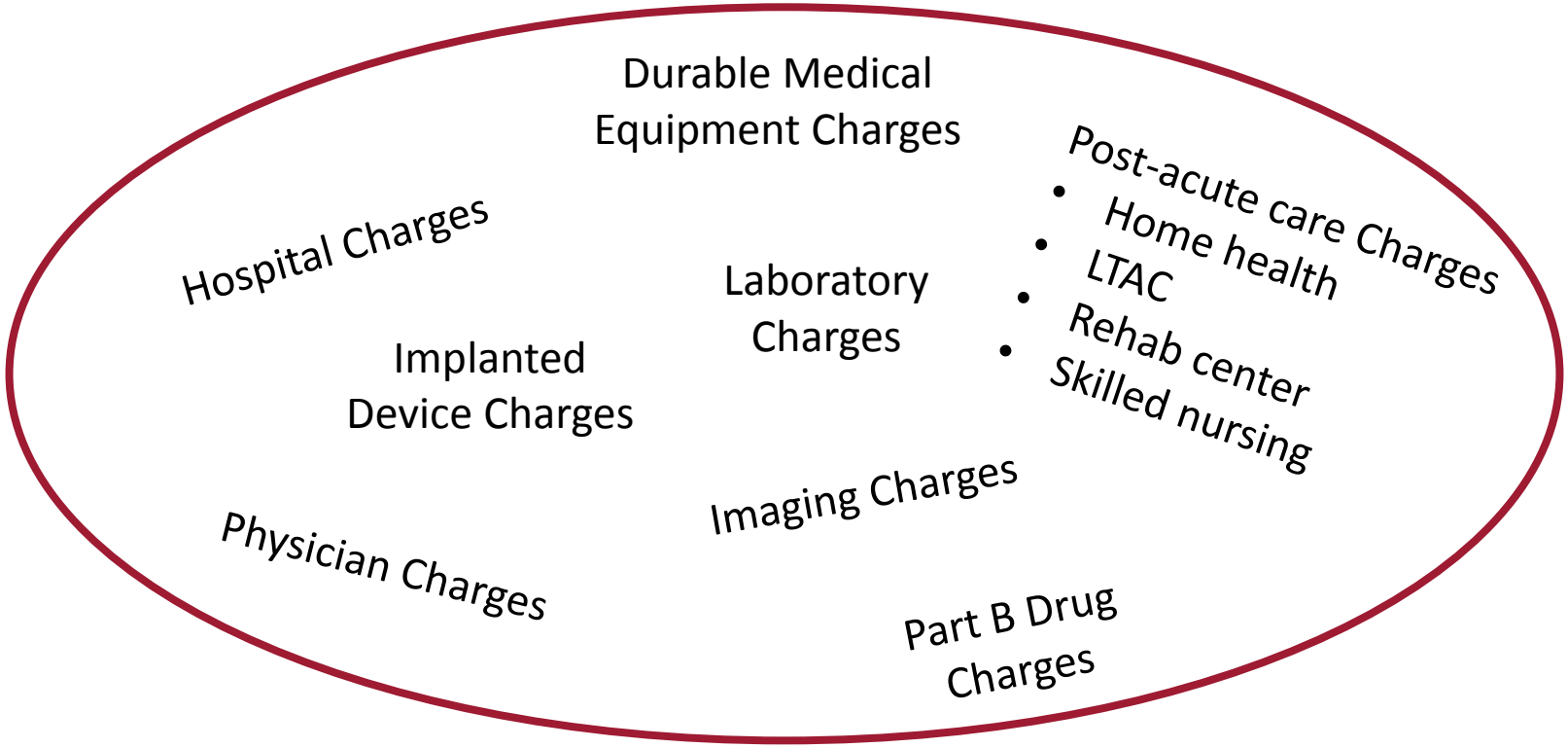
- Bundled payments offer reimbursement for all of the services needed by specific patient for a particular condition or treatment. Creates incentive for provider coordination of efforts.

  Primary goal: reduce costs by reducing cost variation, including through reduction in avoidable complications

- Generally includes payments for all of the providers and the care settings that may be required, but does not include services that are unrelated.
  - Example: hip replacement surgery bundle

    Include: the surgery, pre and post-operative appointments, rehabilitation and the treatment of any complications associated with the procedure.

Concept of Bundled Payments
A Clinical "Episode"



- **One fixed payment that is then distributed to all of the caregivers and facilities.**
- **Profit is driven by keeping costs low (efficiency) while providing high quality care!**

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Pros/Cons of Bundled Payments

- Pros:
  - provide a strong incentive to reduce costs – including both volume and price
  - provide an incentive to improve quality and reduce costly complications associated with the procedures
  - “strong”??? evidence of success at reducing costs in the Medicare population

- Cons:
  - impact limited to specific procedures/ treatment of specific conditions
  - does not provide an incentive to reduce the volume of procedures (only the costs associated with each procedure)
  - administratively challenging to administer

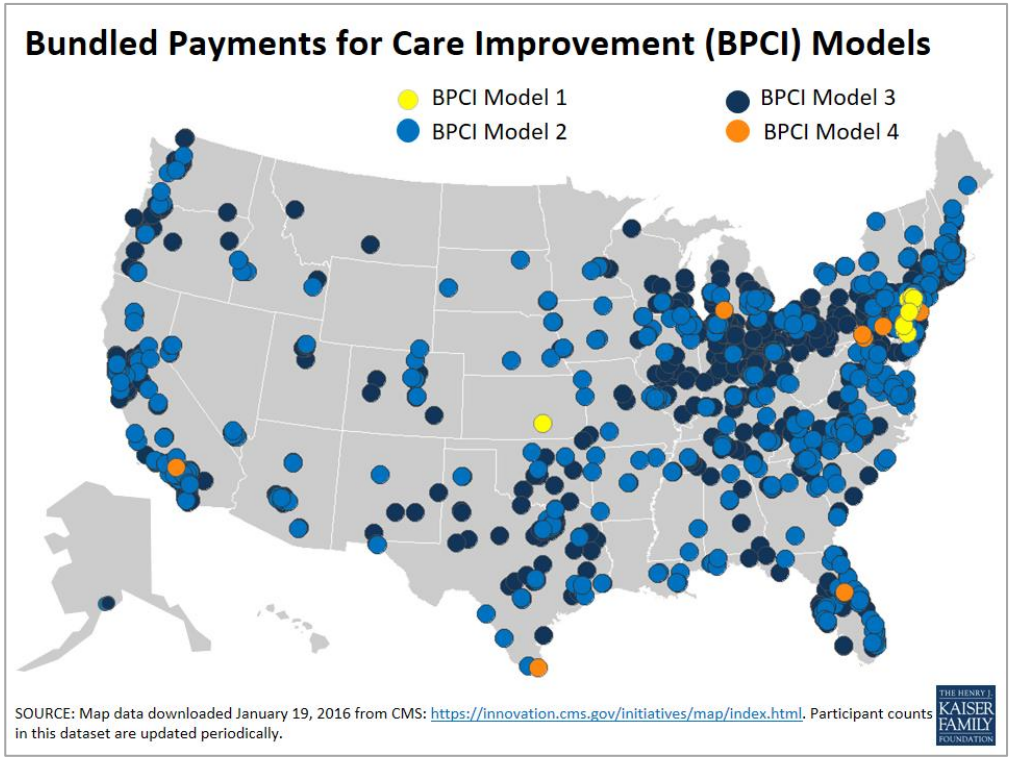
Opportunities with Bundled Payment

- Large opportunity to reduce costs from waste and variation
- Gainsharing incentives align hospitals, physicians and post-acute care providers in the redesign of care that achieves savings and improves quality
  - Improvements “spillover” to private payers
- Strategies learned in bundled payments lay the foundation for success in a value driven market
- Adoption of bundled payments is accelerating across both private and public payers
- Valuable synergies with ACOs, Medicare’s Shared Savings Program and other payment reform initiatives

Bundled Payment Models

Concept: Establish a total budget for all services provided to a patient for an episode of care (starting with a hospitalization), rather than individual provider/setting payments; providers can share in savings if episodes are below budget

- 6,000+ participants in four BPCI models serving 130,000 Medicare beneficiaries
- Model 1: lower cost growth during hospital stays, but not post-discharge; models 2-4: results based on small samples and limited timeframe (2013-2014)



Focus of services for each BPCI model

Model 1:	Inpatient hospital services
Model 2:	Inpatient hospital, physician, post-acute services
Model 3:	Post-acute services
Model 4:	Inpatient hospital, physician services

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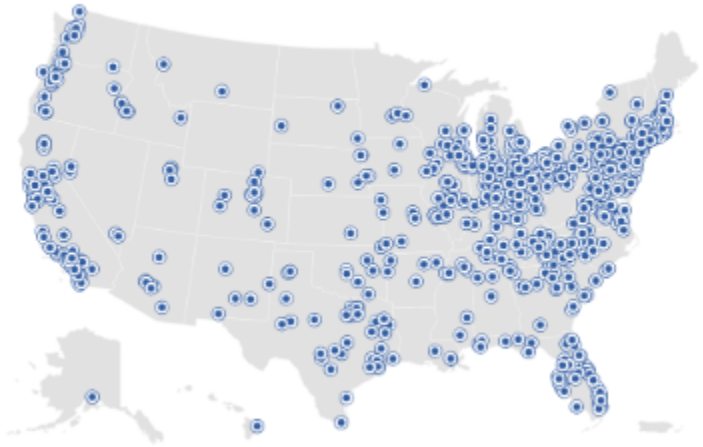
Innovation Center Home > Innovation Models > Bundled Payments

Bundled Payments for Care Improvement (BPCI) Initiative: General Information

Share

The Bundled Payments for Care Improvement (BPCI) initiative is comprised of four broadly defined models of care, which link payments for the multiple services beneficiaries receive during an episode of care. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality and more coordinated care at a lower cost to Medicare.

Select anywhere on the map below to view the interactive version



Source: Centers for Medicare & Medicaid Services

Where Health Care Innovation is Happening

See who's working with CMS to implement new payment and service delivery models.

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https://innovation.cms.gov/initiatives/bundled-payments/

CMMI has Identified Multiple Episodes

Acute myocardial infarction	Major bowel procedure
AICD generator or lead	Major cardiovascular procedure
Amputation	Major joint replacement of the lower extremity
Atherosclerosis	Major joint replacement of the upper extremity
Back & neck except spinal fusion	Medical non-infectious orthopedic
Coronary artery bypass graft	Medical peripheral vascular disorders
Cardiac arrhythmia	Nutritional and metabolic disorders
Cardiac defibrillator	Other knee procedures
Cardiac valve	Other respiratory
Cellulitis	Other vascular surgery
Cervical spinal fusion	Pacemaker
Chest pain	Pacemaker device replacement or revision
Combined anterior posterior spinal fusion	Percutaneous coronary intervention
Complex non-cervical spinal fusion	Red blood cell disorders
Congestive heart failure	Removal of orthopedic devices
Chronic obstructive pulmonary disease, bronchitis, asthma	Renal failure
Diabetes	Revision of the hip or knee
Double joint replacement of the lower extremity	Sepsis
Esophagitis, gastroenteritis and other digestive disorders	Simple pneumonia and respiratory infections
Fractures of the femur and hip or pelvis	Spinal fusion (non-cervical)
Gastrointestinal hemorrhage	Stroke
Gastrointestinal obstruction	Syncope & collapse
Hip & femur procedures except major joint	Transient ischemia
Lower extremity and humerus procedure except hip, foot, femur	Urinary tract infection

https://innovation.cms.gov/initiatives/bundled-payments/

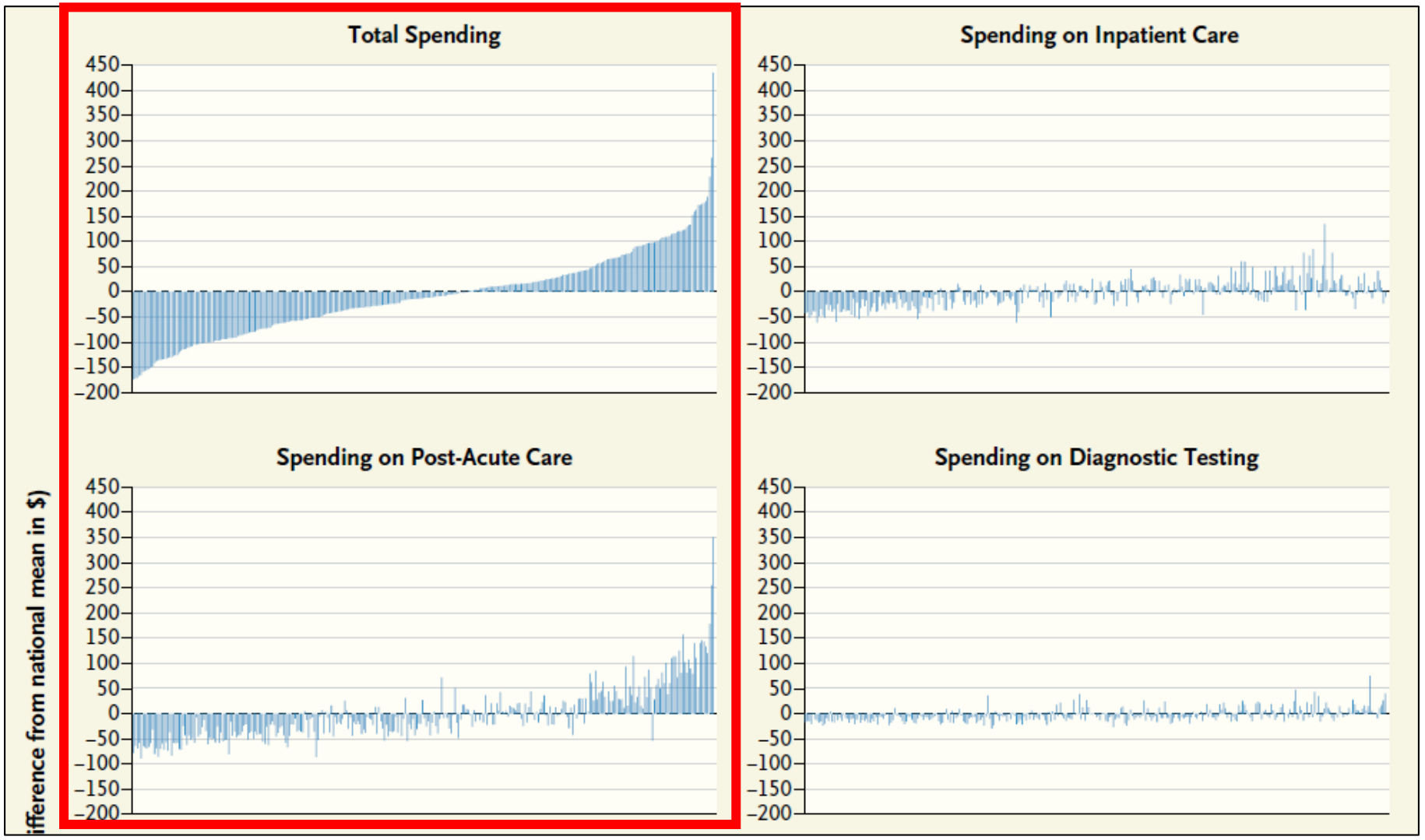
The NEW ENGLAND JOURNAL of MEDICINE

Perspective

APRIL 18, 2013

Geographic Variation in Medicare Services

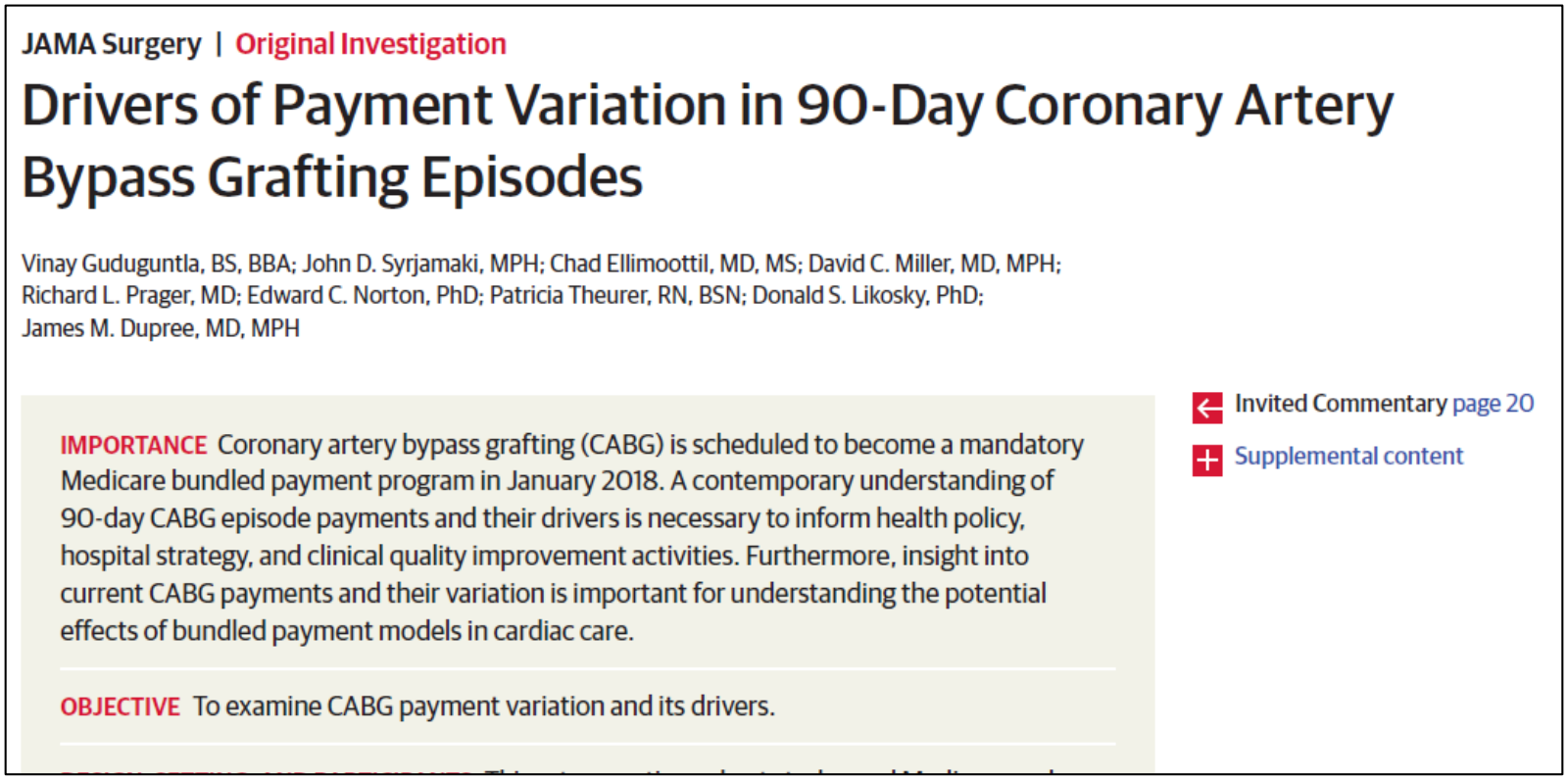
Joseph P. Newhouse, Ph.D., and Alan M. Garber, M.D., Ph.D.



"….a substantial part of the variation across HRRs stems from spending on post-acute care, meaning the use of home health services, skilled nursing facilities, rehabilitation facilities, long-term care hospitals, and hospices."

Medicine

N Engl J Med 2013; 368:1465-68.



JAMA Surgery | Original Investigation

Drivers of Payment Variation in 90-Day Coronary Artery Bypass Grafting Episodes

Vinay Guduguntla, BS, BBA; John D. Syrjamaki, MPH; Chad Ellimoottil, MD, MS; David C. Miller, MD, MPH; Richard L. Prager, MD; Edward C. Norton, PhD; Patricia Theurer, RN, BSN; Donald S. Likosky, PhD; James M. Dupree, MD, MPH

Invited Commentary page 20

Supplemental content

IMPORTANCE Coronary artery bypass grafting (CABG) is scheduled to become a mandatory Medicare bundled payment program in January 2018. A contemporary understanding of 90-day CABG episode payments and their drivers is necessary to inform health policy, hospital strategy, and clinical quality improvement activities. Furthermore, insight into current CABG payments and their variation is important for understanding the potential effects of bundled payment models in cardiac care.

OBJECTIVE To examine CABG payment variation and its drivers.

"At the hospital level, the highest payment quartile of hospitals had a mean total episode payment of $54,399 compared with $45,487 for the lowest payment quartile (16.4% difference, P < .001). The highest payment quartile hospitals compared with the lowest payment quartile hospitals had 14.6% higher index hospitalization payments ($34,992 vs $30,531, P < .001), 33.9% higher professional payments ($8060 vs $6021, P < .001), 29.6% higher post-acute care payments ($7663 vs $5912, P < .001), and 35.1% higher readmission payments ($3576 vs $2646, P = .06)."

Guduguntla V, et al. *JAMA Surg*. 2018; 153:14-19.

HSR Health Services Research

DOI: 10.1111/1475-6773.12681
RESEARCH ARTICLE

Medicare's Acute Care Episode Demonstration: Effects of Bundled Payments on Costs and Quality of Surgical Care

Lena M. Chen, Andrew M. Ryan, Terry Shih, Jyothi R. Thumma, and Justin B. Dimick

"Participation in Medicare's ACE Demonstration Program was not associated with a change in 30-day episode-based Medicare payments or 30-day mortality for cardiac or orthopedic surgery, but it was associated with lower total 30-day post- acute care payments."

Medicine

Chen LM, et al. *Health Serv Res*. 2017 Mar 28. doi: 10.1111/1475-6773.12681.

Research

JAMA | Original Investigation | INNOVATIONS IN HEALTH CARE DELIVERY

Association Between Hospital Participation in a Medicare Bundled Payment Initiative and Payments and Quality Outcomes for Lower Extremity Joint Replacement Episodes

Laura A. Dummit, MSPH; Daver Kahvecioglu, PhD; Grecia Marrufo, PhD; Rahul Rajkumar, MD, JD; Jaclyn Marshall, MS; Eleonora Tan, PhD; Matthew J. Press, MD, MSc; Shannon Flood, MS; L. Daniel Muldoon, MA; Qian Gu, PhD; Andrea Hassol, MSPH; David M. Bott, PhD; Amy Bassano, MA; Patrick H. Conway, MD, MSc

IMPORTANCE Bundled Payments for Care Improvement (BPCI) is a voluntary initiative of the Centers for Medicare & Medicaid Services to test the effect of holding an entity accountable for all services provided during an episode of care on episode payments and quality of care.

OBJECTIVE To evaluate whether BPCI was associated with a greater reduction in Medicare payments

Editorial page 1262 and Viewpoint page 1258

Supplemental content

CME Quiz at jamanetworkcme.com

In the first 21 months of the BPCI initiative, Medicare payments declined more for lower extremity joint replacement episodes provided in BPCI-participating hospitals than in comparison hospitals, without a significant change in quality outcomes.

Dummit LA, et al. *JAMA.* 2016; 316:1267-1278.

PAYING FOR VALUE

By Thomas C. Tsai, Karen E. Joynt, Robert C. Wild, E. John Orav, and Ashish K. Jha

Medicare's Bundled Payment Initiative: Most Hospitals Are Focused On A Few High-Volume Conditions

We identified participating hospitals and used national Medicare claims data to assess their characteristics and previous spending patterns. These hospitals are mostly large, nonprofit, teaching hospitals in the Northeast, and they have selectively enrolled in the bundled payment initiative covering patient conditions with high clinical volumes. We found no significant differences in episode-based spending between participating and nonparticipating hospitals. Postacute care explains the largest variation in overall episode-based spending, signaling an opportunity to align incentives across providers.

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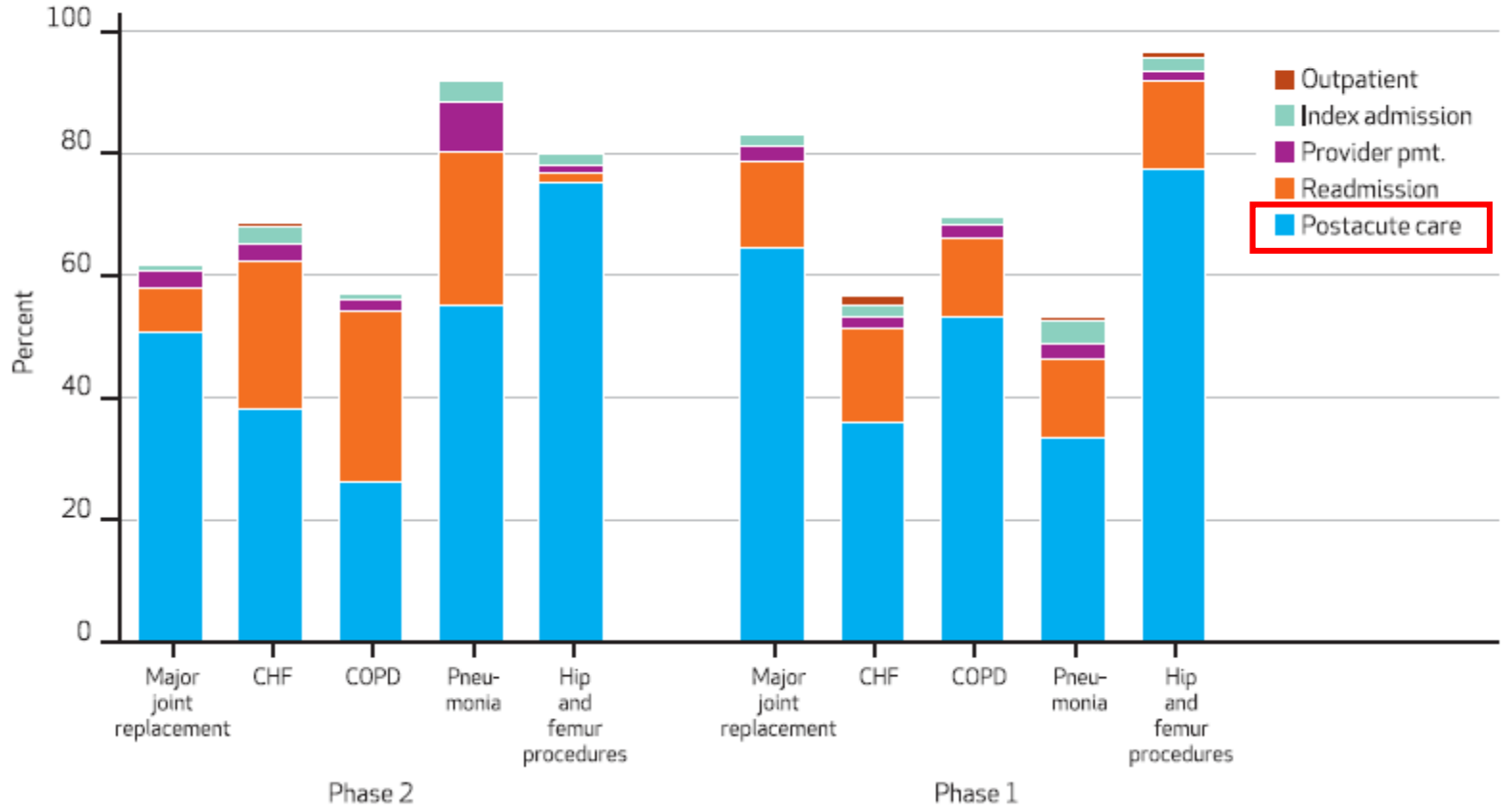
Tsai TC, et al. *Health Aff* (Millwood). 2015; 34:371-80.

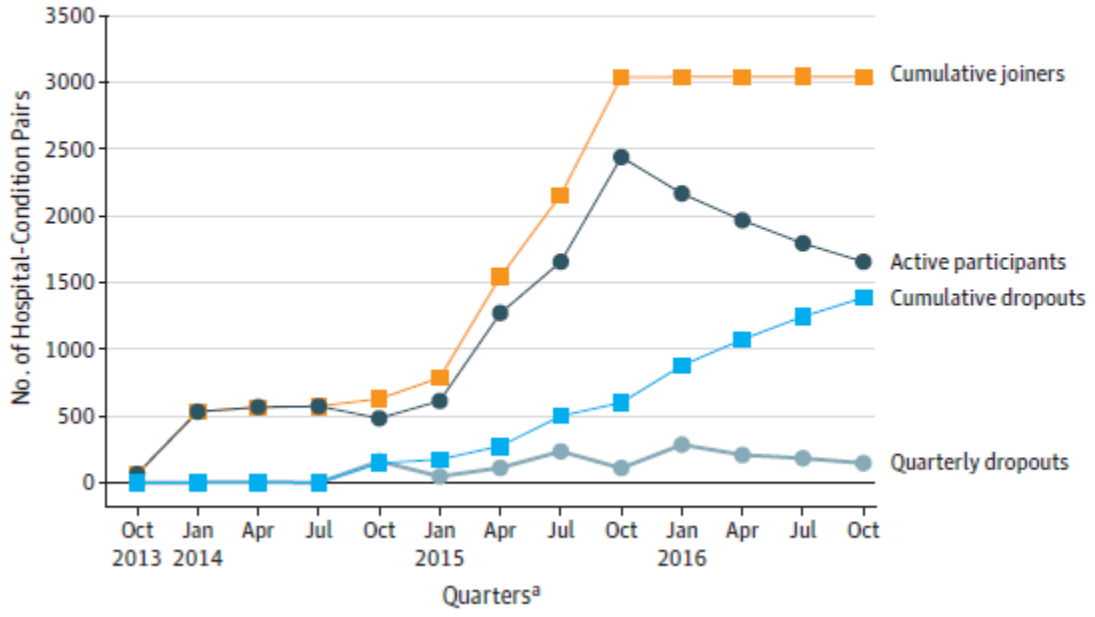
EXHIBIT 4

Percentage Of Variation In Total Thirty-Day Episode-Based Spending Explained By Components Of Care For Phase 1 And Phase 2 Hospitals, 2011



Tsai TC, et al. *Health Aff* (Millwood). 2015; 34:371-80.

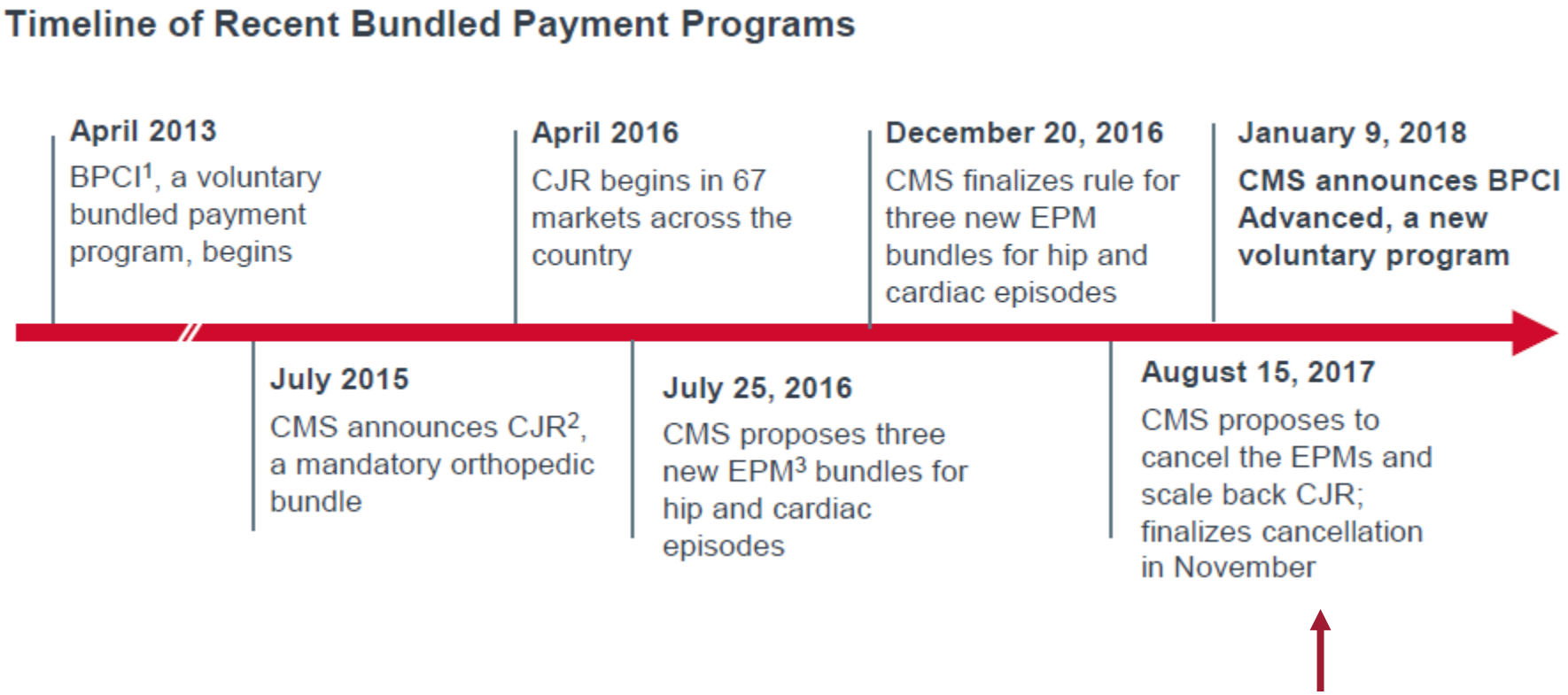
Figure. Dropouts of Hospital-Condition Pairs Over Time From the Bundled Payments for Care Improvement (BPCI) Initiative, 2013-2017



"Patterns of participation and dropout in the BPCI program suggest that for voluntary alternative payment models to have a broad effect on quality and costs of health care, barriers to participation and strategies for retention need to be addressed."

Maddox KE, et al. *JAMA* 2018; 319:191-3.

CMS History with Bundled Payments



Tom Price, MD
Secretary of DHHS

Modern Healthcare
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CMS makes it official: Two mandatory bundled-pay models canceled

By Virgil Dickson | November 30, 2017

The CMS has finalized its decision to toss two mandatory bundled-payment models and cut down the number of providers required to participate in a third.

Only 34 geographic areas will be required to participate in the Comprehensive Care for Joint Replacement Model, or CJR, according to a rulemaking released Thursday. Initially, 67 geographic areas were supposed to participate.

Up to 470 hospitals are expected to continue to operate under the model. That includes the CMS' estimate that 60 to 80 hospitals will voluntarily participate in CJR. Originally, 800 acute-care hospitals would have participated under the program.

RELATED CONTENT

CMS may have overcorrected in cancellation of cardiac models

Cancellation of bundled-payment models reflects White House's stance on value-based care

http://www.modernhealthcare.com/article/20171130/NEWS/171139986

Bundles are Back

HHS Nominee Alex Azar Signals Openness to Mandatory Payment Models

January 9, 2018 by Heather Landi | Reprints

During a Senate Finance Committee hearing on his nomination, Alex Azar, President Donald Trump's nominee for U.S. Department of Health and Human Services (HHS) Secretary, made comments indicating his openness to mandatory bundled payment models, which would represent, if Azar is confirmed, a potential shift in the Trump Administration's policy.

Azar is a former pharmaceutical industry executive at Eli Lilly and Company, where he oversaw the company's U.S. operations beginning in 2012 until he left the company in January of this year. S General Counsel s asked to stay at perating officer of

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INTELLIGENCE NEWS

HEALTH CARE

HHS Nominee Azar Says He Backs Mandatory Pilot Payment Programs

His stance contrasts with Trump administration's push for voluntary payment programs in shift to value-based care

In contrast with Trump administration, Azar backs mandatory bundled payments

Written by Emily Rappleye (Twitter | Google+) | January 10, 2018 | Print | Email

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BPCI Advanced

- Voluntary bundled payment model
- Single payment and risk track with a 90-day episode period
- 29 Inpatient Clinical Episodes
- 3 Outpatient Clinical Episodes
- Payment is tied to performance on quality measures
- Preliminary Target Prices provided prospectively 3

Qualifies as an Advanced APM

Advanced Alternative Payment Model (Advanced APM) Criteria

Participants will be financially at risk for up to 20% of the final Target Price

Quality Measures

Quality measures for:	
All Clinical Episodes	All-cause Hospital Readmission Measure **(National Quality Forum [NQF] #1789)**
	Care Plan **(NQF #0326)**
Specific Clinical Episodes	Perioperative Care: Selection of Prophylactic Antibiotic: First or Second Generation Cephalosporin **(NQF #0268)**
	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) **(NQF #1550)**
	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft Surgery **(NQF #2558)**
	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction **(NQF #2881)**
	AHRQ Patient Safety Indicators **(PSI 90)**

Inpatient Episodes

Spine, Bone, and Joint Episodes

- Back & neck except spinal fusion
- Spinal fusion (non-cervical)
- Cervical spinal fusion
- Combined anterior posterior spinal fusion
- Fractures of the femur and hip or pelvis
- Hip & femur procedures except major joint
- Lower extremity/humerus procedure except hip, foot, femur
- Major joint replacement of the lower extremity
- Major joint replacement of the upper extremity
- Double joint replacement of the lower extremity

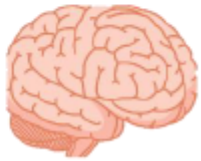
Kidney

- Renal failure

Infectious Diseases

- Cellulitis
- Sepsis
- Urinary tract infection

Neurology



- Stroke

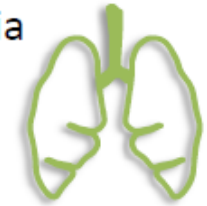
Inpatient Episodes

Cardiac Episodes

- Acute myocardial infarction
- Cardiac arrhythmia
- Cardiac defibrillator
- Cardiac valve
- Pacemaker
- Percutaneous coronary intervention
- Coronary artery bypass graft
- Congestive heart failure

Pulmonary Episodes

- Simple pneumonia and respiratory infections
- COPD, bronchitis, asthma



Gastrointestinal Episodes

- Major bowel procedure
- Gastrointestinal hemorrhage
- Gastrointestinal obstruction
- **Disorders of the liver excluding malignancy, cirrhosis, alcoholic hepatitis (New Episode for BPCI Advanced)**

Outpatient Episodes

- Percutaneous Coronary Intervention (PCI)
- Cardiac Defibrillator

- Back & Neck Except Spinal Fusion

IP Clinical Episode:
Anchor Stay
+ 90 days beginning the day of discharge

OP Clinical Episode:
Anchor Procedure
+ 90 days beginning on the day of completion of the outpatient procedure

What's included in an episode?

- IP or OP hospital services that comprise the Anchor Stay or Anchor Procedure (respectively)
- Physicians' services
- Other hospital OP services
- IP hospital readmission services
- Long-term care hospital (LTCH) services
- Hospice services
- Inpatient rehabilitation facility (IRF) services
- Skilled nursing facility (SNF) services
- Home health agency (HHA) services
- Clinical laboratory services
- Durable medical equipment (DME)
- Part B drugs

How is the target price set?

To determine the Episode Initiator specific **Benchmark Price for an ACH**, CMS will use risk adjustment models to account for the following contributors to variation in the standardized spending amounts for the applicable Clinical Episode:

1. Patient case-mix

2. Patterns of spending relative to the ACHs peer group over time

3. Historic Medicare FFS expenditures efficiency in resource use specific to the ACHs Baseline Period

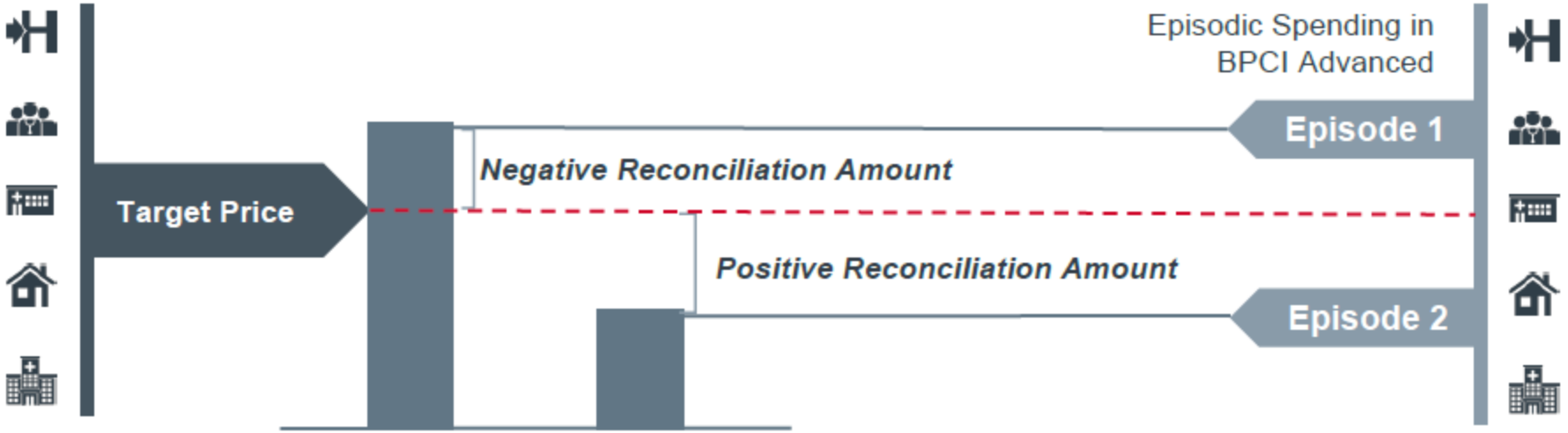
How is the target price set?

- CMS Discount = 3% for all Clinical Episodes
- Preliminary Target Prices will be provided prospectively
- Final Target Price will be set retrospectively at the time of Reconciliation by replacing the historic Patient Case Mix Adjustment with the realized value in the Performance Period

Retrospective reconciliation based on comparing actual Medicare FFS expenditures to the final Target Price

CMS Will Get Their Cut No Matter What

Reconciliation or Repayment Calculated Based on Actual Cost Compared to Target Price



Positive Reconciliation Amount

Amount by which all expenditures are less than the Target Price for an Episode

Negative Reconciliation Amount

Amount by which all expenditures exceed the Target Price for an Episode

No More Phased-In Financial Risk

Unlike earlier bundles, participants will take on total financial risk from the outset of the program

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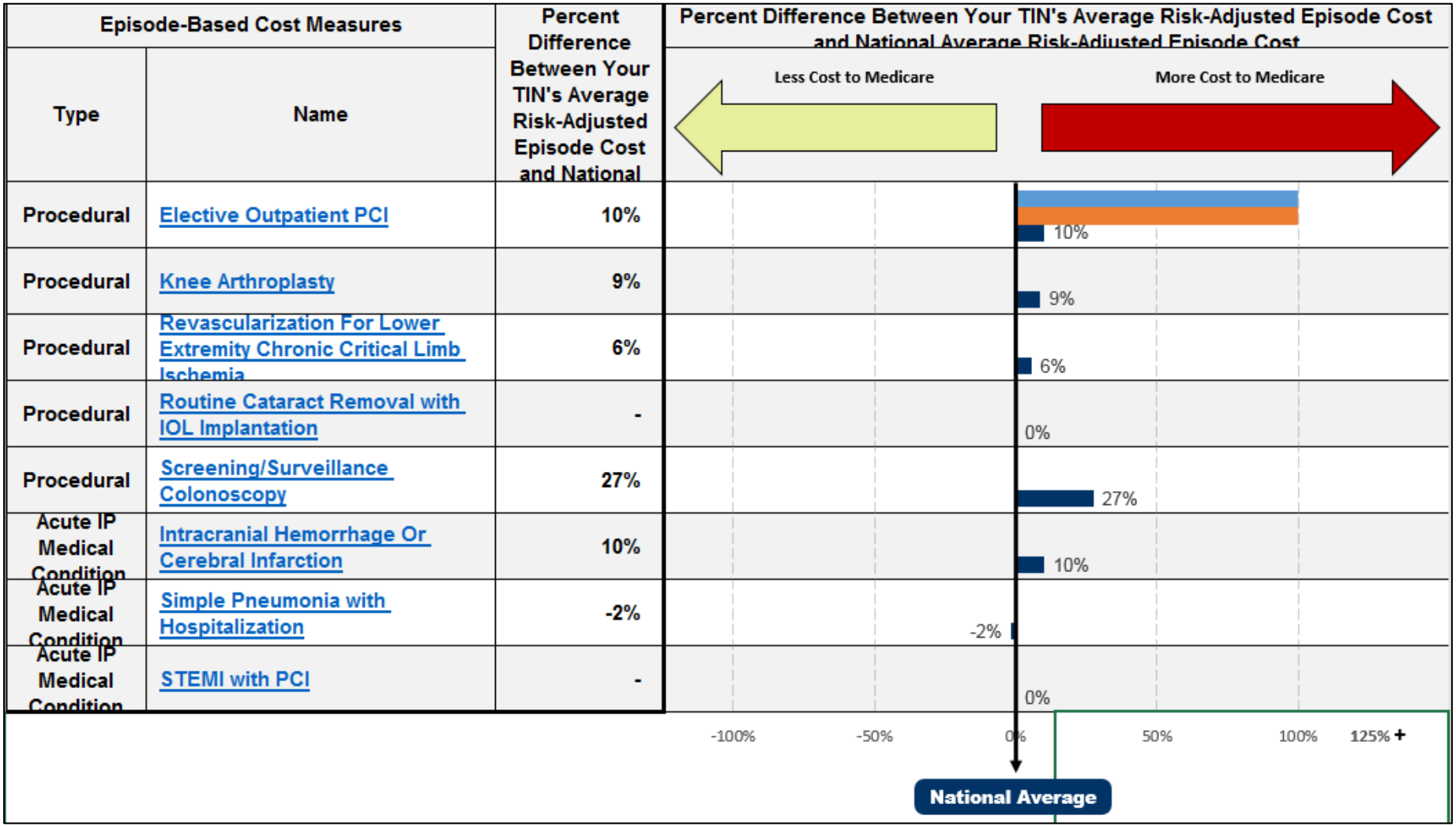
Episode Costs – OU Physicians

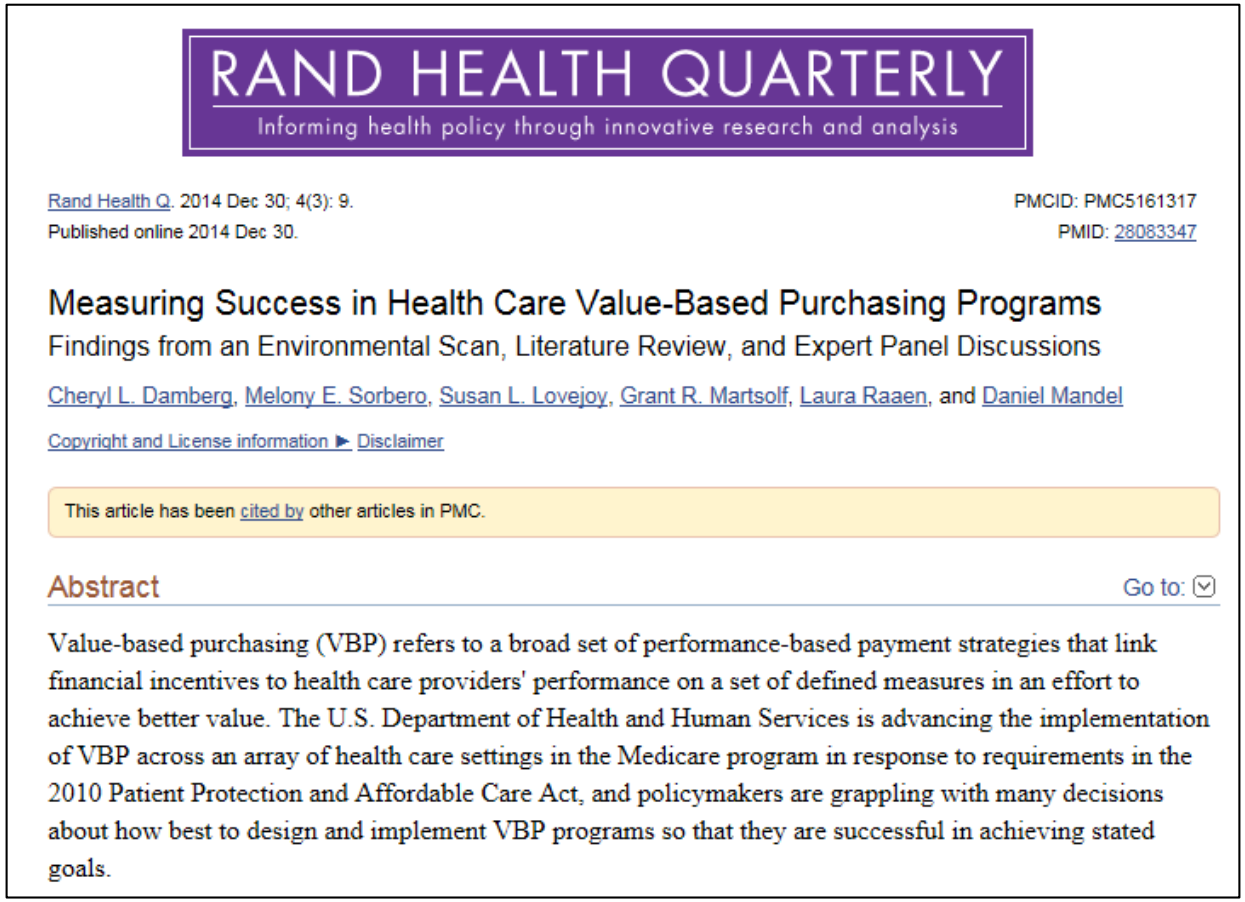
Measurement Period: 06/01/16 to 05/31/17

Episode-Based Cost Measures		Percent Difference Between Your TIN's Average Risk-Adjusted Episode Cost and National
Type	Name	
Procedural	Elective Outpatient PCI	10%
Procedural	Knee Arthroplasty	9%
Procedural	Revascularization For Lower Extremity Chronic Critical Limb Ischemia	6%
Procedural	Routine Cataract Removal with IOL Implantation	-
Procedural	Screening/Surveillance Colonoscopy	27%
Acute IP Medical Condition	Intracranial Hemorrhage Or Cerebral Infarction	10%
Acute IP Medical Condition	Simple Pneumonia with Hospitalization	-2%
Acute IP Medical Condition	STEMI with PCI	-



Medicine

Does bundled payment work?



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Rand Health Q. 2014 Dec 30; 4(3): 9.
Published online 2014 Dec 30.
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Measuring Success in Health Care Value-Based Purchasing Programs

Findings from an Environmental Scan, Literature Review, and Expert Panel Discussions

Cheryl L. Damberg, Melony E. Sorbero, Susan L. Lovejoy, Grant R. Martsolf, Laura Raaen, and Daniel Mandel

Abstract

Go to:

Value-based purchasing (VBP) refers to a broad set of performance-based payment strategies that link financial incentives to health care providers' performance on a set of defined measures in an effort to achieve better value. The U.S. Department of Health and Human Services is advancing the implementation of VBP across an array of health care settings in the Medicare program in response to requirements in the 2010 Patient Protection and Affordable Care Act, and policymakers are grappling with many decisions about how best to design and implement VBP programs so that they are successful in achieving stated goals.

Although the past decade has witnessed a fair amount of experimentation with performance-based payment models, primarily P4P programs, we still know very little about how best to design and implement VBP programs to achieve stated goals and what constitutes a successful program. The published evidence regarding improvements in performance from the P4P experiments of the past decade is mixed (i.e., positive and null effects); where observed, improvements were typically modest.

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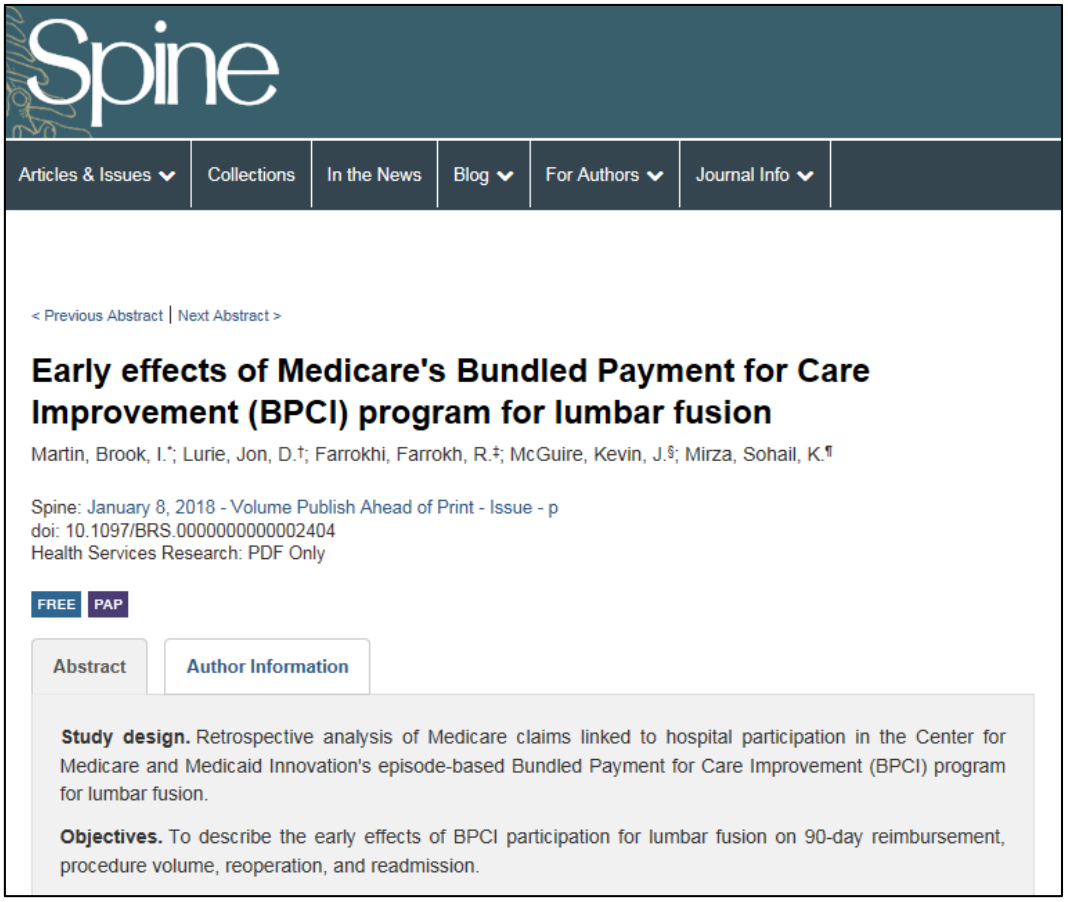
Rand Health Q. 2014 Dec 30;4(3):9.



Spine

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Early effects of Medicare's Bundled Payment for Care Improvement (BPCI) program for lumbar fusion

Martin, Brook, I.*; Lurie, Jon, D.†; Farrokhi, Farrokh, R.‡; McGuire, Kevin, J.§; Mirza, Sohail, K.¶

Spine: January 8, 2018 - Volume Publish Ahead of Print - Issue - p
doi: 10.1097/BRS.0000000000002404
Health Services Research: PDF Only

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Abstract | Author Information

Study design. Retrospective analysis of Medicare claims linked to hospital participation in the Center for Medicare and Medicaid Innovation's episode-based Bundled Payment for Care Improvement (BPCI) program for lumbar fusion.

Objectives. To describe the early effects of BPCI participation for lumbar fusion on 90-day reimbursement, procedure volume, reoperation, and readmission.

We included 89,605 beneficiaries undergoing lumbar fusion, including 36% seen by a preparatory hospital and 7% from a risk-bearing hospital……. Relative to non-participants, risk-bearing hospitals had a slightly increased fusion procedure volume from 2012 to 2013 (3.4% increase versus 1.6% decrease, p = 0.119), did not reduce 90-day episode of care costs (0.4% decrease versus 2.9% decrease, p = 0.044), increased 90-day readmission rate (+2.7% versus -10.7% percent, p = 0.043), and increased repeat surgery rates (+30.6% versus +7.1% percentage points. P = 0.043).

Medicine

Early effects of Medicare's Bundled Payment for Care Improvement (BPCI) program for lumbar fusion. *Spine* (Phila Pa 1976). 2017 Sep 6. doi: 10.1097/BRS.0000000000002404. [Epub ahead of print]

Letters

RESEARCH LETTER

Characteristics of Hospitals Earning Savings in the First Year of Mandatory Bundled Payment for Hip and Knee Surgery

Since April 2016, Medicare has bundled payments for hip and knee surgery at 799 hospitals through the Comprehensive Care for Joint Replacement (CJR) program, which combined payments for hospitalization and postdischarge care

A greater proportion of nonsavings hospitals were low volume (2% for savings hospitals vs 23% for nonsavings hospitals; P < .001) and safety-net hospitals (22% for savings hospitals vs 37% for nonsavings hospitals; P < .001).

Compared with nonsavings hospitals, savings hospitals were larger (mean No. of hospital beds, 301 for savings hospitals vs 230 for nonsavings hospitals; P < .001) (Table) and had higher volume (mean annual Medicare joint replacement volume, 216.9 for savings hospitals vs 133.3 for nonsavings hospitals; P < .001). Savings hospitals were more likely to be nonprofit (70% for savings hospitals vs 53% for nonsavings hospitals; P < .001), teaching (62% for savings hospitals vs 52% for nonsavings hospitals; P = .004), and integrated with a post–acute care facility (55.8% for savings hospitals vs 40% for nonsavings hospitals; P < .001) than nonsavings hospitals.

OU Medicine

Navathe AS, et al. Characteristics of Hospitals Earning Savings in the First Year of Mandatory Bundled Payment for Hip and Knee Surgery. *JAMA*. 2018; 319:930-932.

WOMEN'S HEALTH

Bundled Payment for Bundles of Joy

High Caesarean section rates. Too many babies in the NICU. There are indications that maternity and newborn care in this country is far from ideal. Some payers are betting that bundled payments for obstetricians will create incentives to make changes and reduce low-value care.

January 30, 2018

LOLA BUTCHER

High Caesarean section rates. Too many babies in the NICU. There are indications that maternity and newborn care in this country is far from ideal. Some payers are betting that bundled payments for obstetricians will create incentives to make changes and reduce low-value care.

"….because pregnancy, labor, and birth account for seven of the top 20 most expensive hospitalized conditions."

http://www.managedcaremag.com/linkout/2018/2/18

THE JOURNAL OF CLINICAL ETHICS

VOLUME 29, NUMBER 1 SPRING 2018

The Ethics of Bundled Payments in Total Joint Replacement: "Cherry Picking" and "Lemon Dropping"

"……This article considers the ethics of patient selection to improve outcomes; specifically, screening patients by body mass index to determine eligibility for total joint replacement. I argue that this type of screening is not ethically defensible, and that the bundled payment program as structured is likely to lead to unfair restrictions on who receives total joint replacements."

Humbyrd CJ. *J Clin Ethics*. 2018; 28:62-68.

Closing Thoughts

Closing Thoughts

- There is substantial, non-evidence-based variation in the costs and quality of care
- There is substantial waste in healthcare – particularly unnecessary testing and interventions that do not alter patient outcomes
- *In the next lecture – rates of growth in healthcare spending are not sustainable*

If you are going to participate in a bundle, you need to understand your costs!

Hospitals and clinicians entering bundled payment programs for CABG (and other episodes) should work to understand local sources of variation, with a focus on patients with multiple readmissions, inpatient evaluation and management services, and post-discharge care.

Guduguntla V, et al. *JAMA Surg*. 2018; 153:14-19.

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At the Margins

3 reasons hospitals can't afford to 'take their foot off the gas' on bundled payments

9:54 AM on January 22, 2018 by Laurie Sprung, PhD and Hunter Sinclair, MBA

1. ***While some aspects of payment reform have slowed, MACRA and increased scrutiny of health care costs are here to stay.***
2. ***Focusing on episodes of care can help align stakeholders around efforts to reduce unwarranted care variation and costs.***
3. ***Now is the time to build infrastructure and increase alignment between hospitals and physicians***

OU Medicine

https://www.advisory.com/research/financial-leadership-council/at-the-margins/2018/01/bundled-payments?WT.mc_id=Email|DailyBriefing+Headline|DBABBlog|DBA|DB|2018Jan22|OtherFinalDB20 18Jan22||||&elq_cid=2677568&x_id=003C0000027CYGBIA4

Value-based payment is here to stay!

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