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Early Learnings from the Bundled Payment Acute Care Episode Demonstration Project

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For Additional Information
Maulik S. Joshi, DrPH
Senior Vice President of Research, American Hospital Association
(312) 422-2622
mjoshi@aha.org

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EXECUTIVE SUMMARY

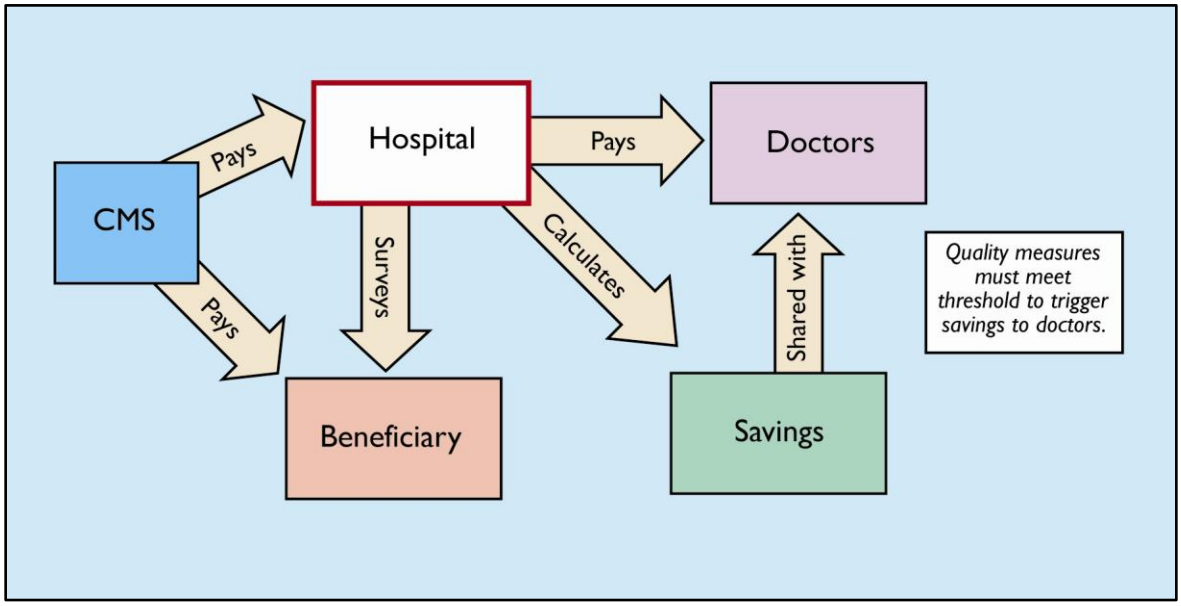
Early Learnings from the Bundled Payment Acute Care Episode Demonstration Project aims to explain the Acute Care Episode Demonstration or ACE Demo from the Centers for Medicare & Medicaid Services (CMS). Although it is a small demo (five test hospitals), the implications of the success of the program are far-reaching. From CMS' perspective, the goals of the project are to:

1. Improve coordination and quality of care
2. Align incentives between hospitals and physicians using bundled payment and other incentives
3. Designate *Value Based Care Centers*
4. Provide financial incentive for Medicare beneficiaries

Beneficiaries must be both Medicare Part A and Part B fee for service participants with conditions that fall under a variety of either cardiac or orthopedic MS-DRGs. The eligible MS-DRGs can be found in the appendix of this guide.

One of the five test sites, Hillcrest Medical Center, is the focus of this report. This Tulsa, Oklahoma hospital started the process of the ACE Demo first, so they are the farthest along in the three-year demonstration. Also of note is that Hillcrest Medical Center (and the adjoining Oklahoma Heart Institute) is a test site for both cardiac and orthopedic MS-DRGs.

The diagram below gives a quick overview of how the ACE Demo works at Hillcrest. The program is governed by a board of managers who direct the project. This board meets quarterly and consists of three committees (quality, financial, and gain sharing). The committees work with continual clinical oversight. While the hospital is required to lower costs, Hillcrest has done so without reducing reimbursement to its physicians. In fact, the doctors may participate in provider incentive payments if they share in implementing efficiency and quality improvements.



Throughout the early stages of the ACE Demo, Hillcrest has reported the following lessons learned. These lessons are expounded upon throughout the guide as Hillcrest's journey is examined.

1) Constructing a framework before beginning is helpful. This framework includes quality improvement initiatives, cost-accounting systems, and a robust data warehouse.
2) Getting more patient volume isn't as important as getting market share with supply vendors through renegotiation of contracts.
3) Bringing physicians on board early in the process to drive cost-cutting measures, quality metrics, and negotiations with suppliers is vital.
4) The monetary incentive, as designed by CMS, may not be a driver for patients when choosing a hospital.
5) Hiring a full-time case manager is necessary to track all patients in the program from admission to post-discharge.
6) Having prior health plan experience is a plus.

Questions still remain to be answered in the early stages of the ACE Demo, mostly due to the fact that the situations where they will be posed haven't actually occurred yet. However, the following are a list of questions that need to be answered as the process moves forward.

1) How can the ACE Demo be expanded into a post-hospital setting? What would a post-acute payment bundle that goes 30–60 days post discharge look like?
2) What will the provider incentives look like as the project enters future years of the demo, especially if it is harder to find savings as the "low-hanging fruit" is all picked.
3) How does the project work if there are multiple, competitive hospitals doing the same thing in the same market? Granted, the money doesn't seem to be an incentive to drive patient volume. But, how do vendors react if all hospitals in one market are working in this type of program?
4) How can this be expanded to non-surgical MS-DRGs? The benefit of the currently selected MS-DRGs is that there are very few outliers. Would this program work well for cancer patients, for example?
5) How do you create better beneficiary incentives? Are the incentives even worthwhile as the demo expands?
6) What quality measures do you use for other MS-DRGs? There are not easily measurable quality measures for everything.

INTRODUCTION

The Acute Care Episode Demonstration, or ACE Demo, is a demonstration project by the Centers for Medicare & Medicaid Services (CMS). The demonstration project works under the following three assumptions:

1. That the beneficiaries have to be both Part A *and* Part B Medicare fee for service
2. That the program utilizes a bundled payment system from admit to discharge, to include all related inpatient services.
3. That the program focuses on either orthopedic MS-DRGs or cardiac MS-DRGs (or both). The appendix lists the MS-DRGs for both areas of focus.

The five participant hospitals in the ACE Demo had to go through a selective RFP process. Two of these locations, Hillcrest Medical Center in Tulsa, Oklahoma, and Lovelace Health System in Albuquerque, New Mexico, are a part of Ardent Health Services. There is a twofold reason as to why Hillcrest Medical Center became the focus of this guide on the early learnings from the ACE Demo. For one, Hillcrest would be demonstrating on both the cardiovascular and orthopedic aspects of the project. The second reason is that Hillcrest was the first out of the gate and because of this they not only are the farthest along but they have also begun to serve as a mentor hospital for other organizations that are not as far along in the process.

Hillcrest Medical Center is a 691-bed facility that adjoins the newly opened (March 2009) Oklahoma Heart Institute. By virtue of participating in the ACE Demo, they've been designated a Value Based Care Center by CMS. This designation is one of four of CMS' goals for the ACE Demo. The goals are

1. Improve care coordination to improve quality of care.
2. Align incentives between hospitals and physicians through bundled payment and cost-saving incentives.
3. Designate selected facilities as Value Based Care Centers.
4. Provide financial incentives for Medicare beneficiaries.

The last goal is what makes the ACE Demo a somewhat unprecedented affair. Medicare beneficiaries who meet the Part A and Part B requirements and whose care falls under one of the eligible MS-DRGs will receive an incentive payment from Medicare. The incentive payment is 50% CMS' savings created by the program, which are not to exceed the typical annual Part B premium and carry a maximum rate of $1,157. Not all beneficiaries receive an incentive payment this high. The joint replacement MS-DRGs, have an average payment of $350.

What could possibly be the impact and the importance of such a small demonstration program on the current state of health affairs and health reform? How could the actions of a small group of hospitals in the middle of the county affect the wider health care community? The answer to this question is elegantly addressed by Atul Gawande in an example from a different field (agriculture) and a different time (early 20th Century). In the example provided by Gawande, demonstration farm projects engaged one farmer in a local community, this farmer, following all the suggestions of the USDA invariably ended up outperforming the other local farmers which then led to the spread of the new farming best practices across the local community. Farmers may not have trusted an outsider from the USDA to teach them new techniques to increase crop yields, lower prices, increase quality, and increase profit. But, if there was just one local farmer who could show these ideas in practice then the farmers would try them

themselves.[1] That is the power of the demonstration project. If Hillcrest Medical Center and the other participants of the ACE Demo can show the success of bundled payments and other cost-saving incentives then hospitals everywhere might take up the same practices.

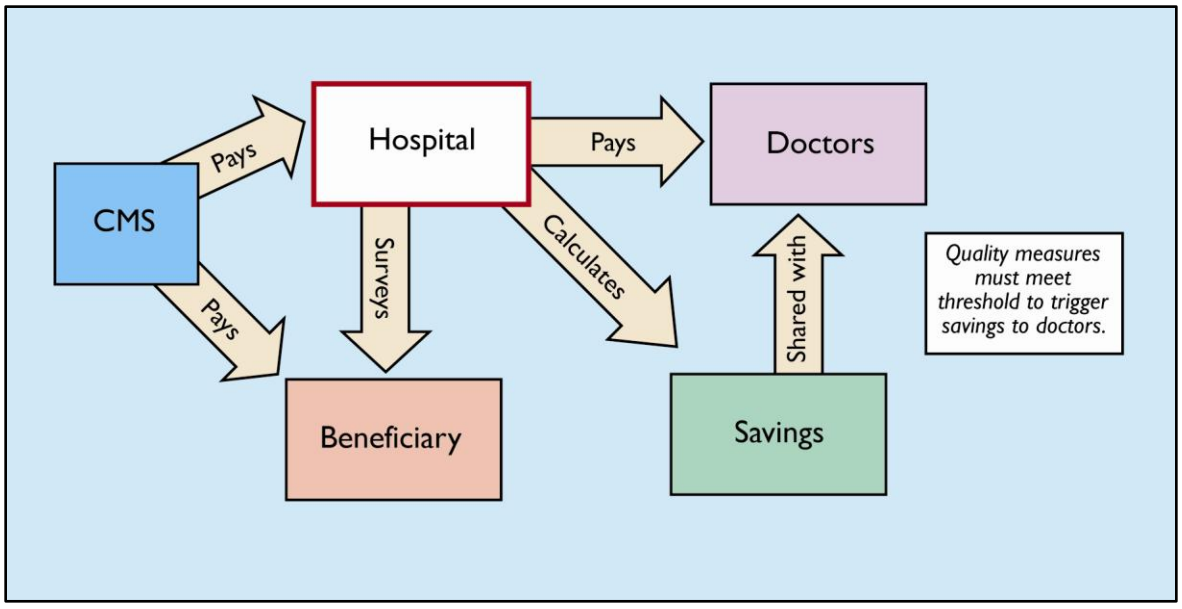
The purpose of this guide then is to share early learnings from the ACE Demo at Hillcrest Medical Center. If it accelerates the uptake of such practices, all the better. However, the main purpose of the guide is to share what is going on in the field and to allow others to form their own opinions as to whether the CMS "testing of new model opportunities" are something they are interested in engaging with and piloting.

PART 1: ACE in Action

Hillcrest is the farthest hospital along in the ACE Demo process. The process has been entirely engrained in the lifecycle of the two service lines (cardiology and orthopedics—hip and knee replacements). All patients that are eligible are included in the program. There is no choice.

The ACE Demo impacts all Hillcrest teams' work from clinical departments to billing and marketing. And it has done so with the addition of a limited amount of funds to the bottom line. In fact, Hillcrest has only hired one full-time employee (FTE) as a case manager. Other than that, direct costs have been mostly towards marketing the program. Hillcrest has cut costs and increased efficiency all while saving the money on supply chain issues and not cutting payment to their physicians.

The diagram gives a quick overview of how the ACE Demo works at Hillcrest. Following the diagram is a detailed description of ACE in action at Hillcrest.



[1] Gawande, A. "Testing, Testing," *The New Yorker.* December 14, 2009. Accessed online at: http://www.newyorker.com/reporting/2009/12/14/091214fa_fact_gawande, on June 16, 2010.

The program is governed by a board of managers that direct the project. This board meets quarterly and consists of three committees that carry out much of the work to support the project. The three committees are:

1) Finance committee: monitors the cost savings needed to be successful in the ACE demo
2) Quality committee: monitors the quality data that is used in order to trigger payment to the doctors. The quality metrics used are national.
3) Gain sharing committee: this committee includes a patient advocate for the community. It ensures gain sharing program requirements are met prior to distributing provider incentive payments to physicians.

The committees must go through the proper clinical channels when making any care-related decisions. However, these committees also enjoy a degree of autonomy that allows them to make decisions regarding aspects of the program like what can be addressed to save further funds, quality thresholds to trigger financial incentives, and then the actual savings distribution.

While part of the program requires that hospitals provide savings for CMS through competitive bidding. Hillcrest has not cut costs by lowering payment to their physicians. In fact, the physicians have the opportunity to receive additional compensation through the gain sharing program. As the diagram shows, provider incentive payments are not automatic. Instead, they are triggered by the physicians meeting a certain threshold of nationally benchmarked quality measures.

Physicians also benefit from this program by a possible increase in number of patients. It is hard to say with any certainty, however, whether the ACE Demo is driving any new business to Hillcrest. There has been a 28% increase in volume for the cardiologists. However, the recent opening of the highly advertised high-tech Oklahoma Heart Institute may cloud this data. There has also been a 31% increase in the orthopedic product line.

The main areas where Hillcrest Medical Center has beneficial lessons to share with the wider hospital community are in the following areas, which will be covered, along with lessons learned, throughout the following section.

Beneficiary outreach and marketing
Incentives
Case management
Materials management

Beneficiary Outreach and Marketing

In order to drive more potential patients to Hillcrest, the marketing team advertised using traditional forms of media. They stressed the fact to the public that there was an incentive payback for coming in for care at Hillcrest. These forms included newspaper, radio, and television as well as public relations outreach to local newspapers and community organizations. Advertisements included a facility contact number for patients to call with questions and additional information requests.

Direct outreach to beneficiaries went along less traditional advertisement lines as well. A proactive orthopedist agreed to hold symptom-based seminars. Seminars that focused on chronic knee or back pain drew large crowds of locals and the orthopedic staff followed up each individual with a phone call. Outreach was also needed for community physicians, physicians within the Hillcrest family, and Hillcrest staffers. Education and training sessions explained the ins and outs of who was eligible and the goals and benefits of the program.

Lessons Learned: Beneficiary Outreach and Marketing

- Advertisements can drive up volume on the orthopedic side.
- Symptom-based seminars also drive up volume—10%–25% of attendees came in for an appointment.
- Advertisement and outreach isn't as successful on the cardiac side.
- Since many of the cardiac MS-DRGs utilized by this demo were of an emergent nature, patients typically went to the facility where they had an established relationship with their physician or brand recognition of the facility.
- The best way to reach the patients with the cardiac MS-DRGs was through their cardiologists and physicians.

Incentives for Patients, Providers, and the Hospital

Financial provider incentives vary between the cardiac and the orthopedic settings at Hillcrest under the ACE Demo. The orthopedic physicians are an independent group so they are each eligible to receive a share of the savings out of the gain sharing plan. The cardiologists are employed by the Oklahoma Heart Institute and therefore do not receive direct payment. However, they benefit from the gain sharing through money being put aside for cardiac-related initiatives. Physicians also benefit from the higher volumes that may be the result of the ACE Demo and may also result in the increase attention paid to them by the marketing group and the interested media and public in general.

Incentives for the hospital include working closely with CMS and benefiting from being early adopters if bundled payment becomes an imminent reality. It has also forced the hospital to analyze their way of doing things. As a result of participating in the ACE Demo already high quality metrics improved and many lean processes have been enacted. Since no reduction in reimbursement was passed along to the physicians, Hillcrest continues to be forced to reexamine their processes and to find other ways to foster further cost reductions (see materials management section).

Quite plainly, the most obvious incentive for patients is the maximum patient incentive payment of $1,157.00. This incentive comes directly from Medicare and not from Hillcrest. However, Hillcrest reported that patients did not report that the incentive payment was a driver for them to attend the hospital. Despite the marketing outreach, patients may not have known about or understood the incentive payment or process. As the reimbursement comes in the form of a check directly from Medicare, patients may not have understood that the incentive was in any way tied to Hillcrest. Patients may have also been driven to Hillcrest because of the orthopedic outreach sessions or the simple fact that their cardiologist was employed by the Oklahoma Heart Institute.

Other incentives for patients are improved quality of care and outcomes because of the increased collaboration between staff and physicians on these issues. Patients also benefit from the enhanced care coordination that comes with a bundled payment program. Individual instances of care are no longer considered; instead the entire stay at the hospital for one of these MS-DRGs is one unit. The physicians, nurses, and other clinicians all work tightly together to create the same high quality outcomes of care consistently from patient to patient. The hospital is reimbursed the same per patient per DRG and does not receive case related outlier payments; outlier amounts were considered in the competitive bid.

Lessons Learned: Incentives

- By not lowering the reimbursement levels of physicians, there will be physician support
- The Lean processes and focus on outcomes has lead to a better patient experience
- Patients do not list the financial incentive as the reason for choosing the hospital
- Patients seem more interested in the fact that the hospital has been validated as a good place to have treatment by CMS (by an outsider)
- Conversely there may be a possible problem with the CMS term "value based" providing the perception to some that the services are slightly less than the highest quality

Case Management

A dedicated case manager is the only new FTE hired for ACE Demo at Hillcrest. The case manager may be the most important person in the entire process as he or she sets the process in motion by identifying qualified patients eligible for the program. Most of this reconnaissance work by the case manager is done with the cardiac patients. Based on their scheduled procedure, orthopedic patients are easier to identify on admission. Most of the eligible orthopedic MS-DRGs are primarily elective in nature.

Many of the eligible cardiac MS-DRGs come in through the emergency department or are direct admits and unplanned. Often times, it is easier to work through the cath lab to catch the cardiac patients because the emergency departments do not have the direct knowledge of what will happen to a cardiac patient upon being admitted. However, by the time the cath lab becomes a part of the patient's care, it is more certain as to the specific MS-DRG.

Once the case manager identifies the patient is eligible it is vital that the patient is flagged for the ACE Demo as early as possible. The role of the case manager in the ACE Demo is as follows:

1) Find all eligible patients and feed them into program
2) Follow traditional RN case management model by giving quality service to patient
3) Facilitate and coordinate staff to better serve the patient
4) Communicate to patient expectations of the program
5) Explain that the program will not impact future Medicare benefits
6) Communicate post-hospitalization

Lessons Learned: Case Management

- Case managers must be proactive in identifying eligible cases.
- It is imperative that eligible cases are found early in the process so they get into the demonstration as soon as possible.
- Patients will often believe that they should receive full financial benefit when in fact case managers need to explain $1,157 is maximum benefit. Many of the cardiac MS-DRGs have lower levels of patient incentive payment.
- Post-hospital communication is a key to continuing patient understanding of the project. It also may be helpful in reducing readmissions.

Materials Management

In the cardiac and orthopedic MS-DRGs there are many supplies used that can be considered physician preference items (PPIs). These PPIs are often implants and other supplies common in these sorts of procedures. The main source of savings for Hillcrest Medical Center in the ACE Demo has come from reconstructing the system for selecting these supplies.

Physician choice has not been taken away. However, the materials management team has approached the physicians of both disciplines with reports of how much their supplies cost. Since there is physician interest in lowering cost so they can increase the potential gain-sharing they may receive, the physicians have looked closely at the price of their supplies. They see that if they are willing to select one or two supplies instead of a multitude of PPIs they are able to get a better deal from vendors.

The materials management team has approached the vendors with the idea that they can obtain market share within Hillcrest Medical Center if they come up with the right price. This has led to reduced costs and to the physicians assisting with contract negotiations. Instead of the materials management team telling physicians to change supplies to cut costs, the physicians are telling the materials management people that they are willing to cycle between a variety of different vendors and brands in order to save money.

Lessons Learned: Materials Management

- Physicians will steer the ship towards lower cost when they see the cost of the supplies
- Physician brand loyalty is replaced by financial and clinical consideration
- ACE is a bargaining tool because vendors know they can move market share
- It is more useful to look at supplies through the lines of MS-DRG instead of product line

PART II: ADVICE TO THE FIELD

The following advice is culled from the lessons learned at Hillcrest Medical Center throughout the CMS ACE Demo. Some of the following advice is expounded upon in the lessons learned sections above while other advice is listed here solely.

Constructing a framework before beginning is helpful.

Certain systems need to be in place and running well before an endeavor along the lines of the ACE Demo is attempted. These systems include a robust data warehouse, a cost accounting system, and a quality accounting system. The investment in quality at Hillcrest came through tracking CMS core measures, hospital-acquired conditions, never events, and readmissions.

Getting more patient volume isn't as important as getting market share with the vendors.

Hillcrest learned that by far its greatest level of savings came not from a higher volume of patients drawn to the facility because of the incentives provided because of participation in the ACE Demo. Instead, the great savings came from creating opportunities for vendors to get market share for supplies related to the eligible MS-DRGs.

Bringing physicians on board early in the process is vital.

Physicians are concerned about hospitals controlling the revenue stream, even though at Hillcrest reimbursement to physicians was not reduced so there was no financial downside to their participation. Physicians should be given influence over supply selection and materials management issues as well as other cost saving measures. By doing this they have a hand in creating their own gain-sharing in the savings.

Understanding that money may not be a driving incentive for patients is important.

Although volume did go up for both the orthopedic departments and the cardiac departments at Hillcrest, there were a variety of mitigating elements that could have caused the increase. When surveyed, patients often did not list the patient incentive as the main reason for going to Hillcrest. Increased volume is not the key incentive therefore for hospitals. Instead, it is saving money, becoming more efficient, and increasing quality.

Hiring a full time case manager is necessary.

A case manager is needed first to shepherd all the eligible patients into the program, especially for the cardiac MS-DRGs since they are often unplanned admissions.

Having prior health plan experience is a plus.

From a financial perspective, during the ACE Demo Hillcrest effectively became an insurance plan for the eligible procedures.

PART III: QUESTIONS TO BE ANSWERED

The good work of Hillcrest Medical Center has been in the face of a great deal of risk and the strides they have made in the short months of their participation in the ACE Demo are remarkable. However, by their own account, they've gone after "low-hanging fruit" when reducing costs and increasing efficiencies and quality. What are the other areas that can be addressed in order to continue to increase efficiencies? Many other questions are also unanswered simply because the nature of the ACE Demo has not brought them to the forefront—yet.

7) How can the ACE Demo be expanded into a post-hospital setting? What would a post-acute payment bundle that goes 30–60 days post discharge look like?
8) What will the provider incentives look like as the project enters future years of the demo, especially if it is harder to find savings as the "low-hanging fruit" is all picked.
9) How does the project work if there are multiple, competitive hospitals doing the same thing in the same market? Granted, the money doesn't seem to be an incentive to drive patient volume. But, how do vendors react if all hospitals in one market are working in this type of program?
10) How can this be expanded to non-surgical MS-DRGs? The benefit of the currently selected MS-DRGs is that there are very few outliers. Would this program work well for cancer patients, for example?
11) How do you create better beneficiary incentives? Are the incentives even worthwhile as the demo expands?
12) What quality measures do you use for other MS-DRGs? There are not easily measurable quality measures for everything.

As the conversation continues around this demonstration project and others put forward by CMS, it is imperative that hospitals take the same risks as Hillcrest and the other participants have and stride forward. For those that aren't the demonstration sites, it is equally vital that they engage in conversation about the demonstrations and then be ready to implement the successful strategies in the same way farmers once embraced new methods of planting and raising their crops.

ACKNOWLEDGMENTS

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APPENDIX: ELIGIBLE MS-DRGs IN THE ACE DEMO

Orthopedic MS-DRGs

MS-DRG	Description
461	Bilateral or multiple major joint procedures of lower extremity w/MCC
462	Bilateral or multiple major joint procedures of lower extremity w/o MCC
466	Revision of hip or knee replacement w/MCC
467	Revision of hip or knee replacement w/CC
468	Revision of hip or knee replacement w/o CC/MCC
469	Major joint replacement (hip)
470	Major joint replacement (knee)
488	Knee procedures w/o primary diagnosis of infection w/ CC/MCC
489	Knee procedures w/o primary diagnosis of infection w/o CC/MCC

Cardiac MS-DRGs

MS-DRG	Description
216	Cardiac valve and other major cardiothoracic proc. w/cardiac cath w/MCC
217	Cardiac valve and other major cardiothoracic proc. w/cardiac cath w/CC
218	Cardiac valve and other major cardiothoracic proc. w/o cardiac cath w/o CC/MCC
219	Cardiac valve and other major cardiothoracic proc. w/o cardiac cath w/MCC
220	Cardiac valve and other major cardiothoracic proc. w/o cardiac cath w/CC
221	Cardiac valve and other major cardiothoracic proc. w/cardiac cath w/o CC/MCC
226	Cardiac defib implant w/o cardiac cath w/MCC
227	Cardiac defib implant w/o cardiac cath w/o MCC
231	Coronary bypass w/PTCA w/MCC
232	Coronary bypass w/PTCA w/o MCC
233	Coronary bypass w/cardiac cath w/MCC
234	Coronary bypass w/cardiac cath w/o MCC
235	Coronary bypass w/o cardiac cath w/MCC
236	Coronary bypass w/o cardiac cath w/o MCC
242	Permanent cardiac pace implant w/MCC
243	Permanent cardiac pace implant w/CC
244	Permanent cardiac pace implant w/o CC/MCC
246	Percutaneous cardiovascular procedure w/drug-eluting stent w/MCC or 4+ vessels/stents
247	Percutaneous cardiovascular procedure w/drug-eluting stent w/MCC
248	Percutaneous cardiovascular procedure w/ non drug-eluting stent w/MCC or 4+ vessels/stents
249	Percutaneous cardiovascular procedure w/ non drug-eluting stent w/MCC
250	Percutaneous cardiovascular procedure w/o coronary artery stent or AMI w/MCC
251	Percutaneous cardiovascular procedure w/o coronary artery stent or AMI w/o MCC
258	Cardiac pacemaker device replacement w/MCC
259	Cardiac pacemaker device replacement w/o MCC
260	Cardiac pacemaker revision ex. device replacement w/MCC
261	Cardiac pacemaker revision ex. device replacement w/CC
262	Cardiac pacemaker revision ex. device replacement w/o CC/MCC