Modeling Reimbursement in the Changing Payment Environment

David Hammer – Principal
Healthcare Performance Management Consultants, LLC

HFMA – Kentucky
Annual Summer Education Institute
Thursday 24 July 2014
1:15 PM – 2:30 PM
Content and Organization

- Introduction: Today’s World …and Tomorrow’s
- Transitioning to Fee for Value
- Medicare Break-Even – Response to Health Reform
- Bundles (Episodes) – The New Unit of Analytics
- Five Keys to Organizational Success
- The Way Forward – Where Do We Go From Here?
Where’s your focus?
Today’s World

…and Tomorrow’s
HFMA’S SPRING SEMINARS 2014

Today’s World
You know the trends…

The fiscal cliff cuts $1.9 billion from Obamacare. Here’s how.
Posted by Sarah Kliff on January 3, 2013 at 10:50 am

Spending on security of health data breaches to hit $70B by 2015
March 29, 2012 | By Dan Bowman

Hospital Systems Branch Out as Insurers

Hospitals Urge Medicaid Expansion
Today’s World
You know the trends...

US health care vs. socialized health care in 5 countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Covered by Government</th>
<th>Not Covered by Government</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td>70.4% $3,183</td>
<td>29.6% $1,339</td>
</tr>
<tr>
<td>France</td>
<td>76.8% $3,163</td>
<td>23.2% $955</td>
</tr>
<tr>
<td>Germany</td>
<td>76.5% $3,439</td>
<td>23.5% $1,056</td>
</tr>
<tr>
<td>Japan</td>
<td>82.1% $2,638</td>
<td>17.9% $575</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>82.8% $2,819</td>
<td>17.2% $586</td>
</tr>
<tr>
<td>United States</td>
<td>72.2% $2,398</td>
<td>27.8% $924</td>
</tr>
<tr>
<td>OECD Average</td>
<td>72.2% $2,398</td>
<td>27.8% $924</td>
</tr>
</tbody>
</table>

The US spends almost twice as much on health care than countries like Canada, Japan, and most in western Europe, where residents are more likely to be covered by government-sponsored health insurance. A routine visit to the doctor’s office costs four times as much in the US, as does an MRI scan. Here’s a breakdown of how the US health system compares on an international scale.

Source: OECD Health Data 2013
Today's World
If We Can Do THIS...
HFMA’S SPRING SEMINARS 2014

...Then Why Can’t We Come Up with Something Better Than THIS?!?
Today’s World
It’s not our fault, but it IS our problem!

Sure glad the hole isn’t at our end.
Today’s World
ACA Readiness – Not IF, WHEN!

Payment Mix Today

Incremental Payment-Mix Shift Under Payment / Delivery Reform

- Bundling (Episodic)
- FFS Shared Savings
- Traditional Capitation

Traditional FFS

- Global Payment +
  - Episodic Bundling
- FFS Shared Savings
- Traditional FFS

Global Payment +
- Episodic Bundling

“Next Generation” P4P: ~60% of all payment systems

“Next Generation” P4P: ~80% of all payment systems

P4P: Varying levels of use with
- Traditional Fee-For-Service

“Next Generation” P4P: ~60% of all payment systems

POV: Market Summary

≤2010

Government Programs Timeline

2011

Hospital value-based purchasing program

2012

2013

Bundled Payment Pilot

Shared Savings Program

Individual feedback physician reports

2014

Evaluation until 2016, w/extension

Voluntarily meet quality thresholds for ACOs

2014-Payments reduced for failure to submit quality measures

Physician Quality Reporting Initiative

ACA Readiness – Not IF, WHEN!
Today’s World
Where to Focus, and WHEN?

Comments from Stamford at Health Insights

“How can we scale for a 28% Medicare cut? Even if we merge it is not scalable”

“We do not think the majority of revenue will be value based – only certain products”

“I am a skeptic of population health management – when an insurance company wants to off load risk, then we do not want that risk”

“The government is not a good long-term business partner”

“The Pioneer ACOs are not working – the juice is not worth the squeeze”

“No incentive for patients to stop smoking, exercise, etc…”

“Stick to basics, manage costs, and grow volume”

“We will do an ACO for our employees – If we cannot do it there, we cannot do it anywhere (Frank Sinatra)”

“I sat with a bunch of Boston hospitals and they are still fee-for-service”

“Culture is the biggest challenge. Our physician group is not organic, but an amalgamation; the problem is that we are trying to change the tires on a moving car”
Today’s World
Relationships Being Shuffled as a Result of “Risk”
Transitioning to Fee for Value
Industry Response to Evolving Payment Systems
Transitioning to Fee for Value
We Have to Have Our Feet in Two Boats
Transitioning to Fee for Value
Need a Unified Reimbursement Solution

- Contractual Adjustments
- "What If" Modeling
- Payment Discrepancies
- Patient Estimates
- Episode / Bundle Management
- Development of Custom Bundles
- Payment Distribution
- Consolidated Collections
- Analytics

HOSPITAL  PROFESSIONAL  ACO  PAYER
Transitioning to Fee for Value
Affordable Care Act – Heralding Value-Based Payment

- Affordable Care Act created disruptive change
- Most-significant change since Medicare and the proliferation of employer-provided health insurance
- Similarly to those developments, ACA will dramatically change how providers will be paid
- Fee for Service (FFS) payment system evolving to value-based (FFV) reimbursement, dependent on patient-care quality and cost
- Specific ACA directives present a complex matrix of penalties, incentives, and reimbursement withholds
Transitioning to Fee for Value
Affordable Care Act – Heralding Value-Based Payment

- Organizations that don't fully understand these issues will find themselves at a significant competitive disadvantage
- Widespread development of core organizational competencies around value-based reimbursement has been virtually impossible
- This is due to a variety of well-documented factors:
  - No single repository for applicable regulations; few published books or reference guides
  - Final regulations can only be found by reviewing thousands of pages of complex CMS rules and policy statements in the Federal Register
  - New regulations often change portions of prior regulations without explanation; and the Administration continues to delay some of the Act’s provisions
  - Workloads continue to increase with little time to research the new regulations
  - Information is fragmented, located in multiple government sources, changes often, and is often contradictory
  - There are over 1,100 quality metrics that may determine reimbursement levels
Transitioning to Fee for Value
Physicians and Hospitals are “Stressing Out”

**Texas Medical Association**
2011 Survey of 29,540 MDs / 3,580 Replies
- Physicians are uncertain about how the Affordable Care Act will affect their practices and patients
- 74% are anxious; 62% confused
- “They're confronted by declining revenue that threatens to drive many of them from their practices and jeopardize their patients' access to care, increased scrutiny from insurers who want to rate them on their ‘cost efficiency,’ and a confusing federal overhaul of the health care system that may fundamentally change the way they practice medicine.”

**Healthcare Business News**
2013 McKesson Survey of 139 CFOs
- 40% “not at all” prepared to tackle population health via ACOs
- 53% “only somewhat” prepared to tackle population health via ACOs
- 14% “very prepared” to manage care under a value based care system
- 23% “not prepared at all” to manage care coordination
- Changing expectations:
  - Current: 77% of MD contracts contain productivity- or volume-based incentives
  - Future:
    - MD contracts based on efficiency will grow from 16% to 67%
    - MD contracts based on quality will grow from 65% to 85%
Transitioning to Fee for Value Hospitals, Physicians, SNFs, Rehabs, etc. MUST

- Master the Affordable Care Act’s value-based-reimbursement regulations
- Understand the current and future impact these regulations will have on Medicare reimbursement
- Assess potential for “copycat” initiatives from commercial payers
- Develop care-improvement strategies to raise quality and cut costs

What is needed

- Expert resources providing a “road-map” for navigating the new world
- Resources for the development of organizational competencies around value-based reimbursement
Paradigm Shift

- From reactive to proactive management
- From disease management to patient management
- From patient management to population management
- From siloed care to coordinated care
- From fee-for-service to fee-for-value
Transitioning to Fee for Value
Emerging Alternative Payment Models

Great Variety Among Potential Payment Methodologies / Contracts

- Accountable Care Organizations (ACOs)
- Bundled-payment arrangements
- Quality-performance incentives
- Narrow-network arrangements
- Gain-sharing with physicians
- Shared-risk contracts
- Full-risk contracts
- Capitation

Future Medicare Payments Will Likely Sort into Groupings

<table>
<thead>
<tr>
<th>Senate Bill (HR 3590)</th>
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<tbody>
<tr>
<td>Passed</td>
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<tr>
<td>~ $871 B</td>
<td></td>
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<tr>
<td>31 million</td>
<td></td>
</tr>
<tr>
<td>• Taxes on “Cadillac” plans</td>
<td></td>
</tr>
<tr>
<td>• Savings from delivery system</td>
<td></td>
</tr>
<tr>
<td>• Fees on industry participants</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>MedPAC with Rate-Setting Authority</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>• Includes a MedPAC-like body with rate-setting authority; excludes hospitals through 2019</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Value-Based Purchasing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reduces payment to facilities with lower than average quality, providing bonus payments to high-quality facilities; budget neutral</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Readmissions Policy</th>
<th></th>
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<tbody>
<tr>
<td>• Reduces reimbursement for all MS-DRGs based on higher than average readmission rates</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Innovative Payment System Pilots</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>• Establishes pilots for bundled payments and accountable care organizations</td>
<td></td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Imaging Services</th>
<th></th>
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<tbody>
<tr>
<td>• Increases advanced imaging practice expense utilization</td>
<td></td>
</tr>
</tbody>
</table>

**Elective / Procedural**
- Total Joint Replacement
- Bundled MC Part A and B

**Chronic / Medical**
- CHF, Pulmonary, etc.
- Episodic Payment to manage

**Emergency**
- Major Bowel, etc.
- Fee for Service
Transitioning to Fee for Value Financial-Assessment Models

An assessment aimed at gauging the true impact of value-based payment models should include separate analyses of:

- Direct contract results
- Impact of volume changes on net income
- Impact of operational and clinical improvements
- Net income at risk from competitor actions
- Other strategic benefits

Sample financial analysis could be based on estimated results for four different hypothetical contracts:

- Medicare ACO with 10,000 lives
- Commercial ACO with 20,000 lives
- Medicare bundled payments with 275 expected cases
- Commercial narrow network with 10,000 lives

SOURCE: Harris, John and Rashi Hemnani, “The Transition to Emerging Revenue Models,” hfm, Apr 2013
The four contracts would reduce net income by $740K on ~$200M of payer spend.

$200M of payer spend does not represent $200M of health system revenue, as payers are spending some of these funds on other types of providers.

In many cases, the direct result of the contract may be neutral or negative.

That does not mean the overall impact of the contract will be negative, particularly when competitor actions are considered.

**SOURCE:** Harris, John and Rashi Hemnani, “The Transition to Emerging Revenue Models,” hfm, Apt 2013
Transitioning to Fee for Value
Bundled Payment – Best Chance to Bend the Cost Curve

Estimated Cumulative Percentage Changes in National Healthcare Expenditures: 2010 through 2019

Bundled payment has the largest projected impact
Care-coordination methods tie in well with bundled-payment Initiatives, provide additional impact

Transitioning to Fee for Value Bundled Payment ROI – Prior Medicare Programs

Cardiac Bypass Center Project

In the first 27 months of the project, bundled payments saved more than $17 Million at four hospitals

Acute Care Episode (ACE) Program

As of May 2011, bundled payments in San Antonio’s Baptist Health System saved more than $2,000 per case, for a total of $4.3M saved since 2009

Additionally, physicians are receiving approximately $280 in bonus payments per episode

Transitioning to Fee for Value Bundled Payment ROI – Geisinger ProvenCare®

Geisinger ProvenCare® Coronary Artery Bypass Grafting (CABG)

- Hospital net revenue grew 7.8%
- Contribution margin of index hospitalizations grew by 16.9%
- 30-day readmission rate decreased by 44%
- Average LOS fell by 8.1% / 0.5 days (from 6.2 to 5.7 days)
- Overall Geisinger Health System volume increased
- Patient outcomes improved
- Employers have healthier employees and lower premiums

Source: Geisinger ProvenCare® - Premier® Conference Presentation and Executive Summary. Published December 2008.
Transitioning to Fee for Value
Market Share and Operational Improvement Models

### Market Share and Utilization Impact

<table>
<thead>
<tr>
<th></th>
<th>Medicare ACO</th>
<th>Commercial ACO</th>
<th>Medicare Bundled Payments</th>
<th>Commercial Narrow Network</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in Revenue from Utilization</td>
<td>$-2,700,000</td>
<td>$-2,369,000</td>
<td>$-198,000</td>
<td>$0</td>
<td>$-5,267,000</td>
</tr>
<tr>
<td>Change in Revenue from Market Share</td>
<td>$1,800,000</td>
<td>$1,280,000</td>
<td>$220,000</td>
<td>$960,000</td>
<td>$4,260,000</td>
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<tr>
<td>Impact of Volume Changes on Revenue</td>
<td>$-900,000</td>
<td>$-1,089,000</td>
<td>$22,000</td>
<td>$960,000</td>
<td>$-1,007,000</td>
</tr>
<tr>
<td>Variable Cost Savings</td>
<td>$360,000</td>
<td>$436,000</td>
<td>$-9,000</td>
<td>$-384,000</td>
<td>$403,000</td>
</tr>
<tr>
<td>Impact of Volume Changes on Net Income</td>
<td>$-540,000</td>
<td>$-653,000</td>
<td>$13,000</td>
<td>$576,000</td>
<td>$-604,000</td>
</tr>
</tbody>
</table>

### Impact of Operational Improvements

<table>
<thead>
<tr>
<th></th>
<th>Medicare ACO</th>
<th>Commercial ACO</th>
<th>Medicare Bundled Payments</th>
<th>Commercial Narrow Network</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational Cost Savings</td>
<td>$480,000</td>
<td>$200,000</td>
<td>$180,000</td>
<td>$0</td>
<td>$860,000</td>
</tr>
<tr>
<td>Impact on Medicare Value-Based Purchasing</td>
<td>$80,000</td>
<td>$20,000</td>
<td>$28,000</td>
<td>$0</td>
<td>$128,000</td>
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<tr>
<td>Impact on Medicare Readmissions Penalties</td>
<td>$40,000</td>
<td>$10,000</td>
<td>$6,000</td>
<td>$0</td>
<td>$56,000</td>
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<tr>
<td>Total Impact of Operational Improvements</td>
<td>$600,000</td>
<td>$230,000</td>
<td>$214,000</td>
<td>$0</td>
<td>$1,044,000</td>
</tr>
</tbody>
</table>
Transitioning to Fee for Value
Revenue Risk and Summary Assessment Models

<table>
<thead>
<tr>
<th>REVENUE AT RISK FROM COMPETITOR ACTIONS</th>
<th>Medicare ACO</th>
<th>Commercial ACO</th>
<th>Medicare Bundled Payments</th>
<th>Commercial Narrow Network</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>From Competitor Utilization Reduction Strategies</td>
<td>$540,000</td>
<td>$384,000</td>
<td>$72,000</td>
<td>$0</td>
<td>$996,000</td>
</tr>
<tr>
<td>From Competitor Market Share Strategies</td>
<td>$900,000</td>
<td>$640,000</td>
<td>$110,000</td>
<td>$688,000</td>
<td>$2,338,000</td>
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<tr>
<td>Total Revenue at Risk</td>
<td>$1,440,000</td>
<td>$1,024,000</td>
<td>$182,000</td>
<td>$688,000</td>
<td>$3,334,000</td>
</tr>
<tr>
<td>Variable Cost Savings</td>
<td>$576,000</td>
<td>$410,000</td>
<td>$73,000</td>
<td>$275,000</td>
<td>$1,334,000</td>
</tr>
<tr>
<td>Net Income at Risk from Competitor Actions</td>
<td>$864,000</td>
<td>$614,000</td>
<td>$109,000</td>
<td>$413,000</td>
<td>$2,000,000</td>
</tr>
</tbody>
</table>

**SOURCE**: Harris, John and Rashi Hemnani, “The Transition to Emerging Revenue Models,” hfm, Apt 2013
### Transitioning to Fee for Value Summary Financial-Impact Assessment

<table>
<thead>
<tr>
<th>Summary: Combined Impact</th>
<th>Medicare ACO</th>
<th>Commercial ACO</th>
<th>Medicare Bundled Payments</th>
<th>Commercial Narrow Network</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Contract Results for Health System</td>
<td>$150,000</td>
<td>$120,000</td>
<td>$160,000</td>
<td>$850,000</td>
<td>$740,000</td>
</tr>
<tr>
<td>Impact of Volume Changes on Net Income</td>
<td>$540,000</td>
<td>$653,000</td>
<td>$13,000</td>
<td>$576,000</td>
<td>$604,000</td>
</tr>
<tr>
<td>Total Impact of Operational Improvements</td>
<td>$600,000</td>
<td>$230,000</td>
<td>$214,000</td>
<td>$0</td>
<td>$1,044,000</td>
</tr>
<tr>
<td>Combined Net Impact on Health System Bottom Line</td>
<td>$210,000</td>
<td>$303,000</td>
<td>$67,000</td>
<td>$274,000</td>
<td>$300,000</td>
</tr>
<tr>
<td>Net Income at Risk from Competitor Actions</td>
<td>$864,000</td>
<td>$614,000</td>
<td>$109,000</td>
<td>$413,000</td>
<td>$2,000,000</td>
</tr>
<tr>
<td>Net Impact Compared with Risk from Competitor Actions</td>
<td>$1,074,000</td>
<td>$311,000</td>
<td>$176,000</td>
<td>$139,000</td>
<td>$1,700,000</td>
</tr>
</tbody>
</table>

- The result of these new models is a loss of $300,000. If a loss is expected, why do it?  
- The response should consider another question: “Compared with what other strategy?”  
- When status quos used for comparison, pursuing the new models doesn’t look preferable  
- But the future is likely to upset the status quo, and it is important to factor into the analysis the very real likelihood of competitor activity  
- This threatens market-share and utilization losses – yet offers the potential for a $2 million positive impact from countering this activity
Transitioning to Fee for Value
CMMI BPCI Initiative Includes Almost 500 Facilities

46 of 50 states participating
278 Providers, 175 IDNs, 463 Facilities, 48 Episodes, 178 DRGs
70% of inpatient Medicare spend impacted, due to inclusion criteria

On January 31, 2013, the Centers for Medicare & Medicaid Services (CMS) announced the health care organizations selected to participate in the Bundled Payments for Care Improvement initiative, an innovative new payment model. Under the Bundled Payments for Care Improvement initiative, organizations will enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality, more coordinated care at a lower cost to Medicare.

Numbers indicate total healthcare facilities participating in each state
Transitioning to Fee for Value
Rapid Market Expansion – Growth Trends

Bundled Payment Initiatives
(Number of Providers Participating in CMMI-BPCI, Commercial Payor and Employer Contracts)

<table>
<thead>
<tr>
<th>Payers - Bundled Payment Market</th>
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</thead>
<tbody>
<tr>
<td>1 Aetna</td>
</tr>
<tr>
<td>2 Anthem</td>
</tr>
<tr>
<td>3 Anthem BCBS of Missouri</td>
</tr>
<tr>
<td>4 Anthem BCBS of Wisconsin</td>
</tr>
<tr>
<td>5 BCBS of Arkansas</td>
</tr>
<tr>
<td>6 BCBS of Illinois</td>
</tr>
<tr>
<td>7 BCBS of Massachusetts</td>
</tr>
<tr>
<td>8 BCBS of Minnesota</td>
</tr>
<tr>
<td>9 BCBS of North Carolina</td>
</tr>
<tr>
<td>10 BCBS of Rhode Island</td>
</tr>
<tr>
<td>11 BCBS of South Carolina</td>
</tr>
<tr>
<td>12 BCBS of Tennessee</td>
</tr>
<tr>
<td>13 BCBS of Western New York</td>
</tr>
<tr>
<td>14 Blue Cross of Idaho</td>
</tr>
<tr>
<td>15 Blue Shield of California</td>
</tr>
<tr>
<td>16 CIGNA</td>
</tr>
<tr>
<td>17 Colorado Choice Health Plans</td>
</tr>
<tr>
<td>18 Community Health Choice</td>
</tr>
<tr>
<td>19 ConnectiCare</td>
</tr>
<tr>
<td>20 CoxHealth Plans</td>
</tr>
<tr>
<td>21 Florida Blue</td>
</tr>
<tr>
<td>22 Geisinger Health Plan</td>
</tr>
<tr>
<td>23 Health First</td>
</tr>
<tr>
<td>24 Health New England</td>
</tr>
<tr>
<td>25 HealthNow</td>
</tr>
<tr>
<td>26 Horizon BCBS of New Jersey</td>
</tr>
<tr>
<td>27 Humana</td>
</tr>
<tr>
<td>28 Independence Blue Cross</td>
</tr>
<tr>
<td>29 Medicare</td>
</tr>
<tr>
<td>30 Oxford Health Plan</td>
</tr>
<tr>
<td>31 Priority Health</td>
</tr>
<tr>
<td>32 Providence Health Plan</td>
</tr>
<tr>
<td>33 QualChoice</td>
</tr>
<tr>
<td>34 United Healthcare</td>
</tr>
</tbody>
</table>

Source: MedAssets Bundled Payment Market Database
In the next five years, bundled payments will be 35% of health systems’ revenue. 24% of health plans are currently implementing bundled payment contracts.

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**Health Systems**

Average Percentage of Hospital Revenues by 2018

- Fee-for-Service: 0%
- Bundled Payments: 5%
- Capitated or other: 10%

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**Health Plans**

Bundled Payment Implementation Plans

- No plans: 42%
- Planning to implement: 34%
- Currently implemented: 24%

Bundled Payment Implementation Progress

- Early: 43%
- Mid: 36%
- Late: 7%
- Unsure: 14%

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2 Source: Availity, The Health Plan Readiness to Operationalize New Payment Models, April 2013. The study was administered by independent research firm Porter Research in the fourth quarter of 2012. Porter Research completed interviews with qualified participants of 39 health plans that represented more than 50 percent of total covered lives in the United States. Target participants included Quality Management leadership, Medical Directors, and Chief Medical Officers.
Large employers, health payors, and integrated health systems have signed over 30 bundled-payment contracts

- Virginia Mason Medical Center: Walmart
- Black Hills Surgical Center: SD State Employee Health Plan
- Tria Orthopedic Center: BCBS of MN
- Mayo Clinic: Walmart
- Orthopedics Institute at Fox Valley: Anthem BCBS
- Cleveland Clinic: Walmart; and Lowes
- Kalieda Health: BCBS of Western NY
- St. Francis Hospital: ConnectiCare
- Geisinger: Walmart; and ProvenCare Initiative with GHP
- Johns Hopkins: Pepsi Co
- Mayo Clinic: Walmart
- Scott and White Memorial: Walmart
- Mayo Clinic: Walmart
- SSM Healthcare: BCBS of MO
- Mercy Hospital: Walmart
- Providence Hospitals: BCBS of SC
- Carolinas Health Care: Local Employers
- Caromont Health: BCBS of NC
- Duke University Hospital: BCBS of NC
- NC Specialty Hospital: BCBS of NC
- 21st Century Oncology: Humana
- Florida Orthopedic Institute: Florida Blue
- Mayo Clinic: Florida Blue; Walmart
- Mobile Surgery International: BCBS of Florida
HFMA’S SPRING SEMINARS 2014

Transitioning to Fee for Value
Rapid Market Expansion – ACOs Bundling Payments

442 ACOs – 53% owned by IDNs
Eight states represent 50% of ACOs
30% of IDN-owned ACOs are participating in CMMI-BPCI

(Number indicators total ACOs in each State. IDN-ACO lists IDNs that own ACOs in major states. IDN-ACOs participating in CMMI-BPCI is highlighted in red)

All counts are as of March 29th, 2013.

California
IDN-ACO:17
Adventist Health
Ascension Health
California Pacific Medical Center
Cedars Sinai Health System
Dignity Health
Hoag Memorial
John Muir Health System
Mercy Healthcare Sacramento
Providence Health and Services
Saint Joseph Health System
Scripps
Sharp HealthCare
Sutter Health
Torrance Memorial Health
Tri-City Healthcare District
UC Health
UCLA Health System

Texas
IDN-ACO:14
Ascension Health
Baptist Health System
Baylor Health Care
Memorial Hermann
Methodist Health System
Saint Luke’s Episcopal Health System
Texas Health Resources
UMC Health System
USMD Holdings Inc.

Florida
IDN-ACO:6
Baptist Health South Florida
BayCare Health System
Holy Cross Health Ministries
NCH Healthcare System
Orlando Health
Parrish Medical Center

North Carolina
IDN-ACO:9
Cape Fear Valley Health System
Carolinas HealthCare System
CaroMont Health
Cone Health
Mission Health System
Randolph Hospital
Southeastern Regional Medical
UNC Health Care System
WilMed Healthcare

Massachusetts
IDN-ACO:14
Baystate Health
Berkshire Health
Beth Israel HealthCare
Cambridge Health Alliance
Cape Cod Healthcare
Jordan Health
Lahey Health
Lowell General
Partners HealthCare
Sisters of Providence
Southcoast Health
Steward Health Care
Tufts Medical Center
Vanguard Health Systems

34
Transitioning to Fee for Value
Rapid Market Expansion – “Super ACOs” Forming

Forming or joining a Super ACO may offer systems several advantages over building their own ACOs or merging with other systems:

- **Economies of scale** can reduce each partner’s investment in accountable-venture health plans and other “go to market” vehicles.

- **Super ACOs** can expand the partners’ geographic coverage, to access a larger population base.

- **Super ACOs** can focus management attention and resources on closing gaps in care delivery that contribute directly to performance shortfalls.

- **Retaining separate health system ownership** avoids the complexity and costs associated with changes in health system ownership and governance.

### Super-ACO Readiness: Self-Assessment Questions for Health Systems

<table>
<thead>
<tr>
<th>Assessment Questions</th>
<th>Considerations (Partial List)</th>
</tr>
</thead>
</table>
| How “advanced” is our market, and how fast is it moving? | > Markets with significant risk contracting (e.g., Boston, Los Angeles) are ideal for Super-ACO development, because experienced partners are plentiful.  
> Moderately fast-moving markets are best for Super-ACO development. If the market is moving too fast, a Super ACO might not be able to keep up. |
| How concentrated are health systems in our market, and what is our relative strategic position? | > In markets with a relatively low provider concentration, a Super ACO could be a powerful consolidation tool.  
> For smaller systems, a Super ACO may provide an effective means to compete successfully against larger integrated systems. |
| How strong is our system’s financial position? | > Weak health systems may need to merge with other systems to protect their assets rather than join a Super ACO.  
> Financially sound health systems can use Super ACOs to strengthen their strategic position with less capital than it would take to build their own ACOs. |
| How “ready” is our system for accountable care and population health management? | > A Super ACO can help an organization that has little experience with risk contracting gain experience and build capabilities at relatively low cost.  
> An organization may have specific skills or programs that can be leveraged in a Super-ACO partnership. |
| Do we want to grow? | > Super ACOs can help a health system access patients in new geographic locations. |

**Source:** Anderson, David and Neal Hogan, “Emerging Super ACOs Fill Unique Needs,” *hfm*, Oct 2013
Potential initiatives are numerous, but some have more advantages than disadvantages

- New Super ACOs may benefit most from the use of tangible initiatives with short-term benefits
- Concrete, easy-to-understand initiatives that produce “quick wins” are the best way to generate excitement and build management support
- Market-facing initiatives are good they allow the ACOs to demonstrate unequivocal success. If successful, such initiatives may pay off well in one to two years
- Established Super ACOs can undertake more complex initiatives, such as joint infrastructure development projects.

Medicare Break-Even
Industry Response to Health Reform
Coherent program to achieve

- Best cost per case
- Optimal revenue
- Long term sustainability

For ALL payors

The Berwick Principle

“*The First Law of Improvement*”

Every system is perfectly designed to achieve exactly the results it gets.

Don Berwick, MD
Former CMS Director
April 27, 2012
Medicare Break-Even
Each provider is currently at a different level
All must advance, not all are ready

A few, like IHC, Kaiser, & Geisinger might currently be a “6 or 7”

Most Providers in the Industry are “2” or “3” on a Scale of 10
Medicare Break-Even
Future Success Will Depend on Alignment:
Clinical Integration, Costs, Payments, and Technology

Past Focus
Remove Outliers

Future Focus
Shift Curve & Reduce Variance

Outliers
### Medicare Break-Even Medicare Margin Analysis – by Facility

Analysis used actual volumes and payments, and vendor’s proprietary estimated cost per case.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Medicare Volume</th>
<th>Medicare Inpatient Revenue</th>
<th>Medicare Total Cost</th>
<th>Medicare Margin</th>
<th>% Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provena St Joseph Medical Center - Joliet, IL</td>
<td>13,019</td>
<td>$117,168,317</td>
<td>$130,928,210</td>
<td>-$13,759,893</td>
<td>-12%</td>
</tr>
<tr>
<td>Resurrection Medical Center - Chicago, IL</td>
<td>9,649</td>
<td>$112,595,281</td>
<td>$124,771,572</td>
<td>-$12,176,292</td>
<td>-11%</td>
</tr>
<tr>
<td>St Mary of Nazareth Hospital Center - Chicago, IL</td>
<td>7,799</td>
<td>$105,497,677</td>
<td>$122,401,702</td>
<td>-$16,904,025</td>
<td>-16%</td>
</tr>
<tr>
<td>St Joseph Hospital - Chicago, IL</td>
<td>5,495</td>
<td>$68,306,870</td>
<td>$77,370,591</td>
<td>-$9,063,721</td>
<td>-13%</td>
</tr>
<tr>
<td>Our Lady of the Resurrection Medical Center - Chicago, IL</td>
<td>4,804</td>
<td>$48,145,991</td>
<td>$53,302,017</td>
<td>-$5,156,026</td>
<td>-11%</td>
</tr>
<tr>
<td>Provena United Samaritans Medical Center - Danville, IL</td>
<td>4,772</td>
<td>$34,240,463</td>
<td>$38,589,626</td>
<td>-$4,349,162</td>
<td>-13%</td>
</tr>
<tr>
<td>Provena Covenant Medical Center - Urbana, IL</td>
<td>4,526</td>
<td>$44,207,443</td>
<td>$49,743,688</td>
<td>-$5,536,244</td>
<td>-13%</td>
</tr>
<tr>
<td>St Francis Hospital - Evanston, IL</td>
<td>4,520</td>
<td>$63,464,140</td>
<td>$70,856,386</td>
<td>-$7,392,246</td>
<td>-12%</td>
</tr>
<tr>
<td>Provena Mercy Medical Center - Aurora, IL</td>
<td>4,486</td>
<td>$40,950,211</td>
<td>$46,486,811</td>
<td>-$5,536,600</td>
<td>-14%</td>
</tr>
<tr>
<td>Provena St Mary's Hospital - Kankakee, IL</td>
<td>3,644</td>
<td>$31,602,006</td>
<td>$35,934,776</td>
<td>-$4,332,769</td>
<td>-14%</td>
</tr>
<tr>
<td>Holy Family Medical Center - Des Plaines, IL</td>
<td>634</td>
<td>$32,088,309</td>
<td>$35,833,059</td>
<td>-$3,744,750</td>
<td>-12%</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>63,348</strong></td>
<td><strong>$698,266,709</strong></td>
<td><strong>$786,218,436</strong></td>
<td><strong>-$87,951,727</strong></td>
<td><strong>-13%</strong></td>
</tr>
</tbody>
</table>

System’s Medicare and Medicaid Payer Mix is 63%

* Includes Medicare Advantage patients
## Medicare Break-Even Medicare Margin Analysis – by Service Line

<table>
<thead>
<tr>
<th>Service Line</th>
<th>Patient Volume</th>
<th>Inpatient Revenue</th>
<th>Total Cost</th>
<th>Service-Line Margin</th>
<th>Margin Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>10,573</td>
<td>$99,228,642</td>
<td>$109,654,007</td>
<td>-$10,425,365</td>
<td>-11%</td>
</tr>
<tr>
<td>Cardiac Surgery</td>
<td>560</td>
<td>$20,994,891</td>
<td>$22,197,877</td>
<td>-$1,202,986</td>
<td>-6%</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>1,445</td>
<td>$27,424,755</td>
<td>$30,608,828</td>
<td>-$3,184,073</td>
<td>-12%</td>
</tr>
<tr>
<td>Medical</td>
<td>27,175</td>
<td>$225,451,789</td>
<td>$254,916,708</td>
<td>-$29,464,920</td>
<td>-13%</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>5,171</td>
<td>$34,883,249</td>
<td>$46,616,597</td>
<td>-$11,733,348</td>
<td>-34%</td>
</tr>
<tr>
<td>Surgical</td>
<td>4,156</td>
<td>$87,712,004</td>
<td>$95,401,686</td>
<td>-$7,689,682</td>
<td>-9%</td>
</tr>
<tr>
<td>Women &amp; Children</td>
<td>415</td>
<td>$3,507,404</td>
<td>$4,216,548</td>
<td>-$709,144</td>
<td>-20%</td>
</tr>
<tr>
<td>Oncology</td>
<td>811</td>
<td>$9,303,203</td>
<td>$10,475,353</td>
<td>-$1,172,150</td>
<td>-13%</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>7,127</td>
<td>$94,310,050</td>
<td>$108,433,294</td>
<td>-$14,123,245</td>
<td>-15%</td>
</tr>
<tr>
<td>Neurosciences</td>
<td>4,405</td>
<td>$42,436,325</td>
<td>$46,959,063</td>
<td>-$4,522,737</td>
<td>-11%</td>
</tr>
<tr>
<td>Other</td>
<td>1,510</td>
<td>$53,014,396</td>
<td>$56,738,474</td>
<td>-$3,724,077</td>
<td>-7%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>63,348</td>
<td>$698,266,709</td>
<td>$786,218,436</td>
<td>-$87,951,727</td>
<td>-13%</td>
</tr>
</tbody>
</table>
### Medicare Break-Even
### Medicare Margin Analysis – Top 25 Target DRGs

<table>
<thead>
<tr>
<th>MSDRG</th>
<th>Description</th>
<th>Volume</th>
<th>Inpatient Revenue</th>
<th>Total Cost</th>
<th>Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>885</td>
<td>Psychoses</td>
<td>3,835</td>
<td>$27,529,374</td>
<td>$36,308,856</td>
<td>-$8,779,481</td>
</tr>
<tr>
<td>945, 946</td>
<td>Rehabilitation</td>
<td>2,460</td>
<td>$38,918,252</td>
<td>$43,381,297</td>
<td>-$4,463,045</td>
</tr>
<tr>
<td>871, 872</td>
<td>Septicemia w/o MV 96+ Hours</td>
<td>3,107</td>
<td>$39,485,698</td>
<td>$43,460,560</td>
<td>-$3,974,862</td>
</tr>
<tr>
<td>469, 470</td>
<td>Major Joint Replacement or Reattachment of Lower Ex</td>
<td>1,390</td>
<td>$20,176,131</td>
<td>$23,520,309</td>
<td>-$3,344,178</td>
</tr>
<tr>
<td>291, 292, 293</td>
<td>Heart Failure &amp; Shock</td>
<td>3,045</td>
<td>$24,325,052</td>
<td>$27,206,049</td>
<td>-$2,880,997</td>
</tr>
<tr>
<td>190, 191, 192</td>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>2,626</td>
<td>$17,682,821</td>
<td>$20,192,223</td>
<td>-$2,509,402</td>
</tr>
<tr>
<td>207</td>
<td>Respiratory System Diagnosis w Ventilator Support 96+ Hours</td>
<td>378</td>
<td>$21,947,021</td>
<td>$24,173,391</td>
<td>-$2,226,369</td>
</tr>
<tr>
<td>896, 897</td>
<td>Alcohol/Drug Abuse or Dependence w/o Rehabilitation</td>
<td>901</td>
<td>$4,698,768</td>
<td>$6,851,992</td>
<td>-$2,153,224</td>
</tr>
<tr>
<td>193, 194, 195</td>
<td>Simple Pneumonia &amp; Pleurisy</td>
<td>1,801</td>
<td>$13,358,163</td>
<td>$15,333,135</td>
<td>-$1,974,972</td>
</tr>
<tr>
<td>377, 378, 379</td>
<td>G.I. Hemorrhage</td>
<td>1,405</td>
<td>$11,362,649</td>
<td>$13,187,926</td>
<td>-$1,825,278</td>
</tr>
<tr>
<td>480, 481, 482</td>
<td>Hip &amp; Femur Procedures Except Major Joint</td>
<td>649</td>
<td>$9,000,552</td>
<td>$10,644,393</td>
<td>-$1,643,840</td>
</tr>
<tr>
<td>682, 683, 684</td>
<td>Renal Failure</td>
<td>1,810</td>
<td>$16,344,229</td>
<td>$17,915,816</td>
<td>-$1,571,586</td>
</tr>
<tr>
<td>391, 392</td>
<td>Esophagitis, Gastroent &amp; Misc Digest Disorders</td>
<td>1,543</td>
<td>$8,232,626</td>
<td>$9,777,927</td>
<td>-$1,545,301</td>
</tr>
<tr>
<td>602, 603</td>
<td>Cellulitis</td>
<td>1,231</td>
<td>$7,802,215</td>
<td>$9,325,779</td>
<td>-$1,523,564</td>
</tr>
<tr>
<td>689, 690</td>
<td>Kidney &amp; Urinary Tract Infections</td>
<td>1,913</td>
<td>$11,658,868</td>
<td>$13,061,482</td>
<td>-$1,402,614</td>
</tr>
<tr>
<td>252, 253, 254</td>
<td>Other Vascular Procedures</td>
<td>568</td>
<td>$10,704,869</td>
<td>$12,095,351</td>
<td>-$1,390,481</td>
</tr>
<tr>
<td>177, 178, 179</td>
<td>Respiratory Infections &amp; Inflammations</td>
<td>795</td>
<td>$9,912,811</td>
<td>$11,188,621</td>
<td>-$1,275,810</td>
</tr>
<tr>
<td>64 , 65 , 66</td>
<td>Intracranial Hemorrhage or Cerebral Infarction</td>
<td>1,231</td>
<td>$10,998,333</td>
<td>$12,158,266</td>
<td>-$1,159,933</td>
</tr>
<tr>
<td>329, 330, 331</td>
<td>Major Small &amp; Large Bowel Procedures</td>
<td>589</td>
<td>$14,599,652</td>
<td>$15,691,230</td>
<td>-$1,091,577</td>
</tr>
<tr>
<td>308, 309, 310</td>
<td>Cardiac Arrhythmia &amp; Conduction Disorders</td>
<td>1,646</td>
<td>$9,284,682</td>
<td>$10,249,834</td>
<td>-$965,152</td>
</tr>
<tr>
<td>208</td>
<td>Respiratory System Diagnosis w Ventilator Support &lt;96 Hours</td>
<td>368</td>
<td>$6,744,567</td>
<td>$7,701,036</td>
<td>-$956,469</td>
</tr>
<tr>
<td>640, 641</td>
<td>Nutritional &amp; Misc Metabolic Disorders</td>
<td>1,153</td>
<td>$6,372,284</td>
<td>$7,293,228</td>
<td>-$920,944</td>
</tr>
<tr>
<td>811, 812</td>
<td>Red Blood Cell Disorders</td>
<td>787</td>
<td>$4,837,423</td>
<td>$5,685,447</td>
<td>-$848,024</td>
</tr>
<tr>
<td>237, 238</td>
<td>Major Cardiovascular Procedures</td>
<td>269</td>
<td>$7,735,067</td>
<td>$8,562,160</td>
<td>-$827,093</td>
</tr>
<tr>
<td>246, 247</td>
<td>Perc Cardiovascular Px w Drug-Eluting Stent</td>
<td>692</td>
<td>$11,901,483</td>
<td>$12,718,792</td>
<td>-$817,309</td>
</tr>
</tbody>
</table>
# Medicare Break-Even Medicare Margin Analysis – by Two Top-5 Groups

## Top Chronic-Disease Populations

<table>
<thead>
<tr>
<th>Chronic</th>
<th>MC Volume</th>
<th>MC Reimbursement</th>
<th>MC Cost</th>
<th>MC Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Septicemia</td>
<td>3,107</td>
<td>$39,485,698</td>
<td>$43,460,560</td>
<td>$(3,974,862)</td>
</tr>
<tr>
<td>COPD</td>
<td>2,626</td>
<td>17,682,821</td>
<td>20,192,233</td>
<td>(2,509,412)</td>
</tr>
<tr>
<td>Simple Pneumonia</td>
<td>1,801</td>
<td>13,358,163</td>
<td>15,333,135</td>
<td>(1,974,972)</td>
</tr>
<tr>
<td>CHF</td>
<td>3,045</td>
<td>24,325,052</td>
<td>27,206,049</td>
<td>(2,880,997)</td>
</tr>
<tr>
<td>Stroke</td>
<td>1,231</td>
<td>10,998,333</td>
<td>12,158,266</td>
<td>(1,159,933)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11,810</strong></td>
<td><strong>$105,850,067</strong></td>
<td><strong>$118,350,243</strong></td>
<td><strong>$(12,500,176)</strong></td>
</tr>
</tbody>
</table>

## Top Bundled Populations

<table>
<thead>
<tr>
<th>Bundled Patient Type</th>
<th>MC Volume</th>
<th>MC Reimbursement</th>
<th>MC Cost</th>
<th>MC Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Joints</td>
<td>1,390</td>
<td>$20,176,131</td>
<td>$23,520,309</td>
<td>$(3,344,178)</td>
</tr>
<tr>
<td>Other Vascular</td>
<td>568</td>
<td>10,704,869</td>
<td>12,095,351</td>
<td>(1,390,482)</td>
</tr>
<tr>
<td>DES</td>
<td>692</td>
<td>11,901,483</td>
<td>12,718,792</td>
<td>$(817,309)</td>
</tr>
<tr>
<td>Hip and Femur</td>
<td>649</td>
<td>9,000,552</td>
<td>10,644,393</td>
<td>(1,643,841)</td>
</tr>
<tr>
<td>Major CV</td>
<td>269</td>
<td>7,735,067</td>
<td>8,562,160</td>
<td>(827,093)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,568</strong></td>
<td><strong>$59,518,102</strong></td>
<td><strong>$67,541,005</strong></td>
<td><strong>$(8,022,903)</strong></td>
</tr>
</tbody>
</table>

### Ten Patient Types
- $190M+ Cost
- $21M+ Losses
Medicare Break-Even
What if Medicare Became an All-Payer Proxy?

Today
Health System P&L

Net Operating Revenue $2.660B
Total Operating Expenses $2.645B
Operating Margin $0.015B

Medicare as Payment Proxy
(Revenues at 87% of today’s costs)

Net Operating Revenues $2.315B
Total Operating Expenses $2.645B
Operating Margin ($0.330B)

-$345M Swing in Operating Margin
Medicare Break-Even
What is Required to Close the Gap?

- Evidence Based Compliance
- Transition to Value-Based Purchasing
- Reinvention Through Technology Clinical Alignment
- Aligned Care
- Rationalized Cost and Resource Consumption
- Standardized Locations and Functions
- Patient Care Guidelines and Compliance
- Alignment of Incentives for Reform
- Standardized Materials and Logistics “Best Practices and Common Sense Applied”

$70M (2014)
$140M (2015)
$210M (2016)
$280M (2017)
$350M (2018)

Phase I

Level of Difficulty
Medicare Break-Even Phase I Implementation Approach

1. Attack costs at the patient level – Identify and group patient populations to:
   a. Realize savings in supplies, purchased services, and labor
   b. Reduce *clinically unnecessary* utilization thru evidence-based protocols

2. Address traditional fixed costs and redundant service areas

3. Achieve greater revenue predictability and integrity

4. Implement sustainable programs for cost and quality impact
Bundles (Episodes)
The New Unit of Analysis in Healthcare
Bundle Definitions

Background

Insights on the following slides are drawn from experience working with health systems and health plans

- Prometheus PAC¹ analysis
- Prometheus episode production in MedAssets Episode Manager system
- CMMI “Bundled Payment for Care Improvement Initiative” analytics
  - 35 MedAssets acute episodes *(developed to apply for CMMI initiative)*
  - 48 CMMI BPCI episodes *(run by MedAssets)*
- Physician compensation pilot, using MedAssets Chronic Care Episodes
- MedAssets Episode Builder definitions, including behavioral health, women’s health, and chronic systems

¹. Potentially avoidable complications (PACs) for patients with one or more chronic illness include events such as emergency department visits and hospitalizations. For patients hospitalized with an acute medical illness such as AMI, pneumonia, or stroke, these events may occur during the index stay or during the 30-day post-discharge period. PACs include measures that have already been tested and are widely used such as ambulatory-care sensitive admissions, hospital-acquired conditions, and inpatient-based patient safety failures.
Bundle Definitions
Key Success Imperatives

- The Right Bundle Definition
- The Right Price
- The Right Execution Plan
- The Right Monitoring System
Bundle Definitions
Who Has Bundling Expertise?

MedAssets Acute Care Episodes
- Asthma
- COPD (Pulmonary disease)
- CHF
- Diabetes
- Acute Myocardial Infarction
- Pneumonia
- Stroke
- Hysterectomy

Hip replacement
- Knee replacement
- CABG
- Colon resection
- Gall bladder
- Knee arthroscopy
- PCI (angioplasty)
- Renal Failure
- Spinal Fusion

American Board of Medical Specialties
- Breast Cancer
- Colon Cancer
- Low back pain
- Sinusitis

Integrated Healthcare Association
- Diagnostic Catheritization
- Angioplasty (PCI)
- Knee Menisectomy
- Hip Replacement
- Knee Replacement
- Knee Arthroplasty

Hartford Healthcare
- Women’s Health
- Behavioral Health

Geisinger ProvenCare
- CABG
- Thoracic
- PCI
- Bariatric
- Perinatal

Bundled Payment for Care Improvement
- 48 MS-DRG Episodes

Arkansas Healthcare Payment Improvement Initiative
- ADHD
- Long Term Care Services
- Tonsillectomy
- Developmental Disabilities
- Colonoscopy
- Cholecystectomy
- Ambulatory URI

HCI3 Prometheus/PACES
- Asthma
- COPD (Pulmonary disease)
- CHF
- Coronary Artery Disease
- Diabetes
- Hypertension
- Gastro-Esophageal Reflux Disease
- Acute Myocardial Infarction
- Pneumonia
- Stroke
- Hysterectomy
- Hip replacement
- Knee replacement
- Bariatric Surgery
- CABG
- Colon resection
- Colonoscopy
- Gall bladder
- Knee arthroplasty
- PCI (angioplasty)
- Pregnancy and delivery

1 Not currently available for non-Geisinger participants
Bundle Definitions
EVERY Encounter Must Be Properly Captured/Processed

**Professional Claims**

- **## Days Look-Back**

**Acute Inpatient Claims**

- **Index Hospitalization**

**Other Claims**

(Outpatient, SNF, HHA, Rehab, etc)

**Inpatient Professional**

**Readmission**

**Keys:**
- Black: Irrelevant Claims
- Yellow: Typical Claims
- Red: Claims with Potentially-Preventable Complications

**Notes:**

*Episode trigger and relevant services are defined based on diagnosis codes, procedure codes, DRG codes, or the combinations of above.*

**Typical services and complications are defined based on the clinical guidelines.**
Bundle Definitions
Must Be Refined and Customized

<table>
<thead>
<tr>
<th>Episode Type</th>
<th>Arkansas Payment Improvement Initiative</th>
<th>CMMI Bundled Payment for Care Improvement (model 2)</th>
<th>Prometheus</th>
<th>American Board of Medical Specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute CHF</td>
<td>Hospital discharge with DRG 291-293</td>
<td>Hospital discharge for CHF</td>
<td></td>
<td>Post Acute CHF</td>
</tr>
<tr>
<td>Acute CHF (Prospective)</td>
<td></td>
<td>Two ambulatory visits for CHF</td>
<td></td>
<td>Two ambulatory visits for CHF-related care with at least one visit &gt; 1 month prior to the measurement year</td>
</tr>
<tr>
<td>Chronically CHF (Prospective)</td>
<td></td>
<td>Hospital discharge for CHF (defined by ICD-9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post Acute CHF</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic CHF</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Start / End</th>
<th>Typical Services Included</th>
<th>Exclusion Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Period</td>
<td>Trigger Event</td>
<td></td>
</tr>
<tr>
<td>Trigger Event</td>
<td>Bundle Definition</td>
<td></td>
</tr>
<tr>
<td>Typical Services Included</td>
<td></td>
<td>Exclusion Criteria</td>
</tr>
</tbody>
</table>

- Typical Services Included:
  - ESRD, dialysis, LVAD, IABP, ...
  - Comorbidity: ESRD, dialysis, organ transplant...
  - Pregnancy
  - Comorbidity: ESRD, dialysis, organ transplant...

- Exclusion Criteria:
  - Age: <18
  - Enrollment gap during measurement year and prior period

- Prior Period:
  - be preceded by 30 day all

- Trigger Event:
  - Trigger admission
  - >= 30 days from last trigger
  - Date of discharge
  - Gaps in FFS enrollment during episode period
  - ESRD, dialysis, LVAD, IABP, ...
  - Comorbidity: ESRD, dialysis, organ transplant...
  - Pregnancy
  - Comorbidity: ESRD, dialysis, organ transplant...
Bundle Definitions Must Be Aligned with Care-Improvement Opportunities

<table>
<thead>
<tr>
<th>Episode Type</th>
<th>Arkansas Payment Improvement Initiative</th>
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<th>Prometheus</th>
<th>American Board of Medical Specialties</th>
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<tbody>
<tr>
<td></td>
<td>Readmission</td>
<td>Post-Acute Care</td>
<td>Typical Care Comparison</td>
<td>Facility Comparison</td>
</tr>
<tr>
<td>Drilldown Analysis</td>
<td>ER</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Post Acute Care</td>
<td>No</td>
<td>No</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>Typical Care Comparison</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td></td>
<td>Preventable Complications</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Physician Comparison</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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</table>

Care Improvement Opportunities

HFMA’s Spring Seminars 2014

Care Improvement Opportunities

Facility Comparison

Physician Comparison

Bundle Definitions Must Be Aligned with Care-Improvement Opportunities

Must Be Aligned with Care-Improvement Opportunities

Bundle Definitions

Facility Comparison

Physician Comparison

Bundle Definitions

Care Improvement Opportunities

Facility Comparison

Physician Comparison

Bundle Definitions

Care Improvement Opportunities

Facility Comparison

Physician Comparison
Bundle Definitions Must Take Your Implementation Strategy Into Account

HFMA’S SPRING SEMINARS 2014

Provider Attribution

Quality Measures

Clinical Guidelines

Core Services

Operational Parameters

---

<table>
<thead>
<tr>
<th>Episode Type</th>
<th>Chronic CHF (Prospective)</th>
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</thead>
<tbody>
<tr>
<td>Facility</td>
<td>Yes</td>
</tr>
<tr>
<td>Comparison</td>
<td></td>
</tr>
</tbody>
</table>

Quality Measures

- Following Measures are available through NDO:
  - % CHF patients given ACE-inhibitor/ARB therapy for LVSD
  - % CHF patients with LVSD receiving beta blocker prescription
  - % CHF patients with Atrial Fibrillation given Warfarin Therapy
  - CHF patients with current/recent smoking history given smoking cessation advice / counseling
  - Left Ventricular Function (LVF) Assessment
  - Patient Education
  - Discharge instructions for CHF patients

---

<table>
<thead>
<tr>
<th>Core Services</th>
<th>Arkansas Payment Improvement Initiative</th>
<th>CMMI Bundles for Care Improvement (model 2)</th>
<th>American Board of Medical Specialties</th>
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<tbody>
<tr>
<td></td>
<td>Not defined</td>
<td>Not defined</td>
<td>Not defined</td>
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</tbody>
</table>
Bundle Definitions
Definitions/Pricing Drive Financial-Risk Exposure

Spine
Exposure per case
Knee
## Bundle Definitions

### Definitions/Pricing Enable Provider Benchmarking

<table>
<thead>
<tr>
<th>Benchmark Group</th>
<th>Patient over Expected Payment, %</th>
<th>Total</th>
<th>Acute Care</th>
<th>Post-Acute</th>
<th>Average Length of Stay</th>
<th>Readmission Rate</th>
<th>ER Visit Rate</th>
<th>Complication Rate (All)</th>
<th>Mortality Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOP 20%</td>
<td>30.4% -2.7%</td>
<td>-1.8%</td>
<td>-0.9%</td>
<td>-3.6%</td>
<td>-13.6%</td>
<td>-19.5%</td>
<td>-14.7%</td>
<td>-100.0%</td>
<td></td>
</tr>
<tr>
<td>REST PHYS</td>
<td>38.9% 1.5%</td>
<td>1.0%</td>
<td>0.5%</td>
<td>1.9%</td>
<td>6.8%</td>
<td>9.6%</td>
<td>7.2%</td>
<td>26.9%</td>
<td></td>
</tr>
<tr>
<td>TOP 50%</td>
<td>30.8% -2.2%</td>
<td>-1.3%</td>
<td>-0.9%</td>
<td>-3.6%</td>
<td>-21.8%</td>
<td>-13.3%</td>
<td>-7.1%</td>
<td>-100.0%</td>
<td></td>
</tr>
<tr>
<td>REST PHYS</td>
<td>42.3% 2.7%</td>
<td>1.5%</td>
<td>1.1%</td>
<td>4.2%</td>
<td>23.4%</td>
<td>14.1%</td>
<td>7.5%</td>
<td>55.6%</td>
<td></td>
</tr>
</tbody>
</table>
## Bundle Definitions Definitions / Pricing Enable Tiered Networks

<table>
<thead>
<tr>
<th>Physician Name</th>
<th>Physician NPI</th>
<th>Episode Count</th>
<th>Patient over Expected Payment, %</th>
<th>Total</th>
<th>Acute Care</th>
<th>Post Acute</th>
<th>Average Length of Stay</th>
<th>Readmission Rate</th>
<th>ER Visit Rate</th>
<th>Complication Rate (All)</th>
<th>Complication Rate (Type I or III only)</th>
<th>Mortality Rate</th>
<th>Benchmark at 20%</th>
<th>Benchmark at 50%</th>
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<tbody>
<tr>
<td>Paul Bernard Murray</td>
<td>1376518035</td>
<td>526</td>
<td>30.4%</td>
<td>-2.7%</td>
<td>-1.8%</td>
<td>0.9%</td>
<td>-3.6%</td>
<td>-13.6%</td>
<td>19.5%</td>
<td>-14.7%</td>
<td>-15.1%</td>
<td>-100.0%</td>
<td>TOP 20%</td>
<td>TOP 50%</td>
</tr>
<tr>
<td>Durgesh G Nagarkatti</td>
<td>1285692798</td>
<td>290</td>
<td>31.4%</td>
<td>-1.3%</td>
<td>-0.3%</td>
<td>1.0%</td>
<td>-3.5%</td>
<td>-36.9%</td>
<td>-2.4%</td>
<td>6.4%</td>
<td>7.3%</td>
<td>-100.0%</td>
<td>TOP 20%</td>
<td>TOP 50%</td>
</tr>
<tr>
<td>Jeffrey K. Burns</td>
<td>1497971667</td>
<td>200</td>
<td>41.5%</td>
<td>1.5%</td>
<td>1.2%</td>
<td>0.3%</td>
<td>-3.6%</td>
<td>-32.4%</td>
<td>16.1%</td>
<td>-49.2%</td>
<td>-60.2%</td>
<td>-100.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mark Shekhman</td>
<td>1720245178</td>
<td>173</td>
<td>46.8%</td>
<td>3.9%</td>
<td>3.4%</td>
<td>0.5%</td>
<td>-4.5%</td>
<td>-43.7%</td>
<td>54.4%</td>
<td>1.1%</td>
<td>12.9%</td>
<td>154.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christopher J Lena</td>
<td>1407853773</td>
<td>42</td>
<td>35.7%</td>
<td>-4.4%</td>
<td>-2.4%</td>
<td>1.9%</td>
<td>-11.3%</td>
<td>-100.0%</td>
<td>-80.8%</td>
<td>-76.5%</td>
<td>100.0</td>
<td>-80.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peter R Barnett</td>
<td>1033116009</td>
<td>41</td>
<td>46.3%</td>
<td>-0.9%</td>
<td>0.4%</td>
<td>1.3%</td>
<td>-2.9%</td>
<td>61.1%</td>
<td>51.6%</td>
<td>7.1%</td>
<td>-13.1%</td>
<td>-100.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michael A Miranda</td>
<td>1205833308</td>
<td>15</td>
<td>33.3%</td>
<td>-7.0%</td>
<td>-4.3%</td>
<td>2.7%</td>
<td>4.2%</td>
<td>-100.0%</td>
<td>-100.0%</td>
<td>-100.0%</td>
<td>-100.0%</td>
<td>-100.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mahesh I Patel</td>
<td>1699960856</td>
<td>11</td>
<td>54.5%</td>
<td>10.5%</td>
<td>5.7%</td>
<td>4.8%</td>
<td>47.0%</td>
<td>69.4%</td>
<td>9.1%</td>
<td>18.3%</td>
<td>63.0%</td>
<td>655.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>James T Mazzara</td>
<td>1548224512</td>
<td>10</td>
<td>40.0%</td>
<td>11.1%</td>
<td>-0.6%</td>
<td>11.7%</td>
<td>-6.3%</td>
<td>312.7%</td>
<td>99.9%</td>
<td>79.2%</td>
<td>-100.0%</td>
<td>-100.0%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Bundle Definitions
Turning to Outside Expertise

CLIENT: Large health system with a contract-management system. Needed to define bundles, improve clinical protocols, and offer bundled-payment service lines to respond to market

GOAL: Reduce time to market by leveraging consulting and technology expertise to define bundled-payment offering

CONSULTING: Advisory Services helped Hartford’s clinical and financial teams define, create, implement, and automate five behavioral and five women’s-health bundles

SOFTWARE: Episode Manager provided the technology to automate the new reimbursement models

How Vendor Helped

Deliverables

- Create episode definitions
- Build models to validate episode definitions
- Test payment models and attribution logic for new bundles, and automate claims flow for payment
- Support clinical teams with analytics for delivery transformation
Five Keys to Organizational Success

Fee for Value Implementation Checklist
1. What is Your Organizational Readiness?

**Technology**
Organizational implementation of value-based reimbursement requires enhancement of many systems and technologies.

- EHR systems provide a key technological component in any value program. What additional EHR enhancements would need to be made?
- Will your current billing/accounting processes and vendors be able to support the demands?
- Select a solution that has scalable big data infrastructure, rapid episode design tools, and has truly automated the episode management process.
- Select a solution that has visibility into the episodes through dashboards, notifications, and episode coordination.
- Ensure your partner has the contract management support you will need as you expand your value based contracts.

**Human Capital**
- Do you have support of the provider community to engage in pricing and performance discussions? Will your contracts be able to be amended with new payment terms?
- Does this program have the support of leadership and fit with the mission and goals of the organization?
1. What is Your Organizational Readiness?

Payment by Service Type Highlights Patient Trajectories
1. What is Your Organizational Readiness?

Do you have the level of integration needed to manage the patient trajectory?

Do you have the right partners in the community?

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Readmission Count</th>
<th>Total Payment</th>
<th>Mean Payment</th>
<th>Mean LOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Center A</td>
<td>203</td>
<td>$1,289,394</td>
<td>$6,352</td>
<td>6.1</td>
</tr>
<tr>
<td>Medical Center B</td>
<td>11</td>
<td>$59,675</td>
<td>$5,425</td>
<td>5.3</td>
</tr>
<tr>
<td>Medical Center C</td>
<td>10</td>
<td>$92,858</td>
<td>$9,286</td>
<td>6.4</td>
</tr>
<tr>
<td>Medical Center D</td>
<td>5</td>
<td>$24,628</td>
<td>$4,926</td>
<td>4</td>
</tr>
<tr>
<td>Medical Center E</td>
<td>4</td>
<td>$17,068</td>
<td>$4,267</td>
<td>3.5</td>
</tr>
<tr>
<td>Medical Center F</td>
<td>2</td>
<td>$14,165</td>
<td>$7,083</td>
<td>4</td>
</tr>
<tr>
<td>Medical Center G</td>
<td>2</td>
<td>$110,319</td>
<td>$55,160</td>
<td>24</td>
</tr>
<tr>
<td>Medical Center H</td>
<td>2</td>
<td>$7,764</td>
<td>$3,882</td>
<td>5</td>
</tr>
<tr>
<td>Medical Center I</td>
<td>2</td>
<td>$7,025</td>
<td>$3,513</td>
<td>4</td>
</tr>
<tr>
<td>Medical Center J</td>
<td>1</td>
<td>$1,128</td>
<td>$1,128</td>
<td>2</td>
</tr>
<tr>
<td>Medical Center K</td>
<td>1</td>
<td>$8,780</td>
<td>$8,780</td>
<td>7</td>
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<td>Medical Center L</td>
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<td>Medical Center N</td>
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<td>$4,551</td>
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<td>Medical Center O</td>
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<td>$13,496</td>
<td>29</td>
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<td>Medical Center P</td>
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<td>$3,670</td>
<td>$3,670</td>
<td>5</td>
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<td>Medical Center Q</td>
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<td>Medical Center S</td>
<td>1</td>
<td>$7,989</td>
<td>$7,989</td>
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</tbody>
</table>
1. What is Your Organizational Readiness?

Do you know where your patients are going? Are you aligned with care providers?

<table>
<thead>
<tr>
<th>Skilled Nursing Facility Name</th>
<th>Admission Count</th>
<th>Total SNF Payment</th>
<th>Mean Episode Payment</th>
<th>Mean SNF Payment</th>
<th>Mean LOS</th>
<th>Readmission %</th>
<th>ER %</th>
<th>PAC %</th>
<th>Mortality %</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALL (Total)</td>
<td>90</td>
<td>$1,325,553</td>
<td>$30,785</td>
<td>$14,728</td>
<td>43.3</td>
<td>24%</td>
<td>38%</td>
<td>29%</td>
<td>3%</td>
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<tr>
<td>SNF 1</td>
<td>12</td>
<td>$261,707</td>
<td>$34,032</td>
<td>$21,809</td>
<td>55.6</td>
<td>33%</td>
<td>33%</td>
<td>33%</td>
<td>8%</td>
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<tr>
<td>SNF 2</td>
<td>7</td>
<td>$76,595</td>
<td>$31,943</td>
<td>$10,942</td>
<td>36.3</td>
<td>0%</td>
<td>14%</td>
<td>14%</td>
<td>0%</td>
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<tr>
<td>SNF 3</td>
<td>7</td>
<td>$141,471</td>
<td>$31,435</td>
<td>$20,210</td>
<td>47.7</td>
<td>14%</td>
<td>43%</td>
<td>14%</td>
<td>0%</td>
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<tr>
<td>SNF 4</td>
<td>6</td>
<td>$56,455</td>
<td>$25,695</td>
<td>$9,409</td>
<td>32.3</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>17%</td>
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<tr>
<td>SNF 5</td>
<td>5</td>
<td>$77,700</td>
<td>$35,486</td>
<td>$15,540</td>
<td>39.4</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>0%</td>
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<td>SNF 6</td>
<td>5</td>
<td>$35,516</td>
<td>$23,888</td>
<td>$7,103</td>
<td>18.2</td>
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<td>0%</td>
<td>0%</td>
<td>20%</td>
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<td>SNF 7</td>
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<td>$37,142</td>
<td>$21,315</td>
<td>$7,428</td>
<td>20.6</td>
<td>60%</td>
<td>80%</td>
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<td>SNF 8</td>
<td>4</td>
<td>$57,555</td>
<td>$28,894</td>
<td>$14,389</td>
<td>35.5</td>
<td>50%</td>
<td>75%</td>
<td>50%</td>
<td>0%</td>
</tr>
<tr>
<td>SNF 9</td>
<td>4</td>
<td>$69,493</td>
<td>$33,369</td>
<td>$17,373</td>
<td>55.8</td>
<td>50%</td>
<td>50%</td>
<td>75%</td>
<td>25%</td>
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<tr>
<td>SNF 10</td>
<td>3</td>
<td>$16,035</td>
<td>$30,214</td>
<td>$5,345</td>
<td>28.3</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>SNF 11</td>
<td>3</td>
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<td>$23,430</td>
<td>$13,217</td>
<td>37.7</td>
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<td>0%</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>SNF 12</td>
<td>3</td>
<td>$51,296</td>
<td>$23,567</td>
<td>$17,099</td>
<td>47.7</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>SNF 13</td>
<td>3</td>
<td>$56,267</td>
<td>$24,494</td>
<td>$18,756</td>
<td>54</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>SNF 14</td>
<td>2</td>
<td>$22,407</td>
<td>$26,148</td>
<td>$11,204</td>
<td>47.5</td>
<td>50%</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>SNF 15</td>
<td>2</td>
<td>$39,242</td>
<td>$29,643</td>
<td>$19,621</td>
<td>47</td>
<td>50%</td>
<td>100%</td>
<td>50%</td>
<td>0%</td>
</tr>
<tr>
<td>SNF 16</td>
<td>2</td>
<td>$17,208</td>
<td>$13,688</td>
<td>$8,604</td>
<td>35.5</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>SNF 17</td>
<td>2</td>
<td>$11,472</td>
<td>$22,699</td>
<td>$5,736</td>
<td>20</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>SNF 18</td>
<td>2</td>
<td>$32,780</td>
<td>$34,075</td>
<td>$16,390</td>
<td>40.5</td>
<td>50%</td>
<td>50%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>
1. What is Your Organizational Readiness?

Are your physicians ready?

Risk-adjusted Physician Performance Comparison

Source: MedAssets’ Provider Analysis.
2. What is Your Fiscal Readiness?

<table>
<thead>
<tr>
<th>Method</th>
<th>Examples</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete FFS</td>
<td>No Episode, FFS</td>
<td>No payment overlap, can be applied at individual patient/physician level</td>
</tr>
<tr>
<td>Individual Episode</td>
<td>CHF, AMI, Hypertension</td>
<td>High episode overlap. Difficult to separate out typical services or PAC among episodes that belong to the same system</td>
</tr>
<tr>
<td>Episode by Disease Category</td>
<td>Circulatory System Episode (CHF, AMI, Hypertension, Stroke, etc). Respiratory System Episode (asthma, COPD, etc)</td>
<td>Medium episode overlap. Easier to separate out typical services between different disease systems. Could still be changed to assign PAC to only one episode</td>
</tr>
<tr>
<td>Episode with Multiple Diseases</td>
<td>Chronic Episode vs. Mental Health Episode, etc.</td>
<td>Low episode overlap. Relatively easy to separate out typical services and PAC for chronic episode vs. others, but typical services and PAC definitions become very unspecific, due to the heterogeneity of the diseases included under chronic episode</td>
</tr>
<tr>
<td>Complete Capitation</td>
<td>No episode, PMPM</td>
<td>No payment overlap, can only be applied at large patient / provider population</td>
</tr>
</tbody>
</table>
2. What is Your Fiscal Readiness?

Value-Based reimbursement disrupts the established cash flow and collections processes on which organizations depend

- Change in care practices will require personnel, system resources, evaluation, refinement, etc.
- Do you have an adequate fiscal cushion to support these efforts?
- Are you prepared to manage the change in department cash flow and collections?

- Are you looking to offset a Medicare Bundled Payment program with Commercial Bundled Contracts?
- Are you currently exploring other revenue-enhancement opportunities within your business? (Boutique services, concierge medicine, etc.)

- Do you currently calculate the true cost of service and cost of preventable complications? This includes the costs related to delivery and episode (outpatient services, post acute, readmissions to other facilities).
- Payments to out-of-network providers are true costs in a bundled-payment environment.
2. What is Your Fiscal Readiness?

Bundle Definitions and Pricing Drive Your Exposure Risk

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Exposure per Case</th>
<th>Risk</th>
<th>Pricing</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI</td>
<td>$4,428</td>
<td>20%</td>
<td>$4,132</td>
</tr>
<tr>
<td>ASTHM A</td>
<td>$4,078</td>
<td>26%</td>
<td>$3,874</td>
</tr>
<tr>
<td>CABG2</td>
<td>$3,158</td>
<td>5%</td>
<td>$3,492</td>
</tr>
<tr>
<td>CABG3</td>
<td>$5,626</td>
<td>65%</td>
<td>$6,934</td>
</tr>
<tr>
<td>COLON1</td>
<td>$1,436</td>
<td>2%</td>
<td>$1,690</td>
</tr>
<tr>
<td>COPD</td>
<td>$3,815</td>
<td>2%</td>
<td>$1,220</td>
</tr>
<tr>
<td>CVR1</td>
<td>$4,471</td>
<td>7%</td>
<td>$1,150</td>
</tr>
<tr>
<td>CVR2</td>
<td>$3,042</td>
<td>7%</td>
<td>$3,665</td>
</tr>
<tr>
<td>DM</td>
<td></td>
<td></td>
<td>$4,066</td>
</tr>
<tr>
<td>HF</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCI1</td>
<td>$5,186</td>
<td>11%</td>
<td>$3,580</td>
</tr>
<tr>
<td>PCI2</td>
<td>$2,890</td>
<td>26%</td>
<td>$1,463</td>
</tr>
<tr>
<td>PCI3</td>
<td>$2,190</td>
<td>6%</td>
<td>$1,890</td>
</tr>
<tr>
<td>PNE1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PNE2</td>
<td>$1,890</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>PNE3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PNE4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STR2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>THKR1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AMI: Acute Myocardial Infarction
ASTHM A: Asthma
CABG2: Coronary artery bypass grafting
CABG3: Coronary artery bypass grafting
COLON1: Colorectal surgery
COPD: Chronic obstructive pulmonary disease
CVR1: Cardiac valve repair
CVR2: Cardiac valve replacement
DM: Diabetes mellitus
HF: Heart failure
PCI1: Percutaneous coronary intervention
PCI2: Percutaneous coronary intervention
PCI3: Percutaneous coronary intervention
PNE1: Pneumonectomy
PNE2: Pneumonectomy
PNE3: Pneumonectomy
PNE4: Pneumonectomy
STR2: Spinal fusion
THKR1: Total hip replacement

Spine and Knee procedures have a higher exposure per case and risk compared to other procedures.
Understand Your Risk Exposure

The episode definition you select determines much of the financial exposure for your organization.

The CMMI BPCI definition for COPD includes many clinically-unrelated MS-DRGs and diagnoses codes.

This poses significant financial risk for readmissions.

<table>
<thead>
<tr>
<th>Trigger MS-DRG</th>
<th>Readmission MS-DRG</th>
<th>MS-DRG Description</th>
<th>Mean Episode Payment</th>
<th>Readmission Claim Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>190</td>
<td>853</td>
<td>INFECTIOUS &amp; PARASITIC DISEASES W O.R. PROCEDURE W MCC</td>
<td>$17,427</td>
<td>$33,002</td>
</tr>
<tr>
<td>191</td>
<td>885</td>
<td>PSYCHOSES</td>
<td>$14,797</td>
<td>$4,328</td>
</tr>
<tr>
<td>191</td>
<td>853</td>
<td>INFECTIOUS &amp; PARASITIC DISEASES W O.R. PROCEDURE W MCC</td>
<td>$14,797</td>
<td>$26,272</td>
</tr>
<tr>
<td>202</td>
<td>372</td>
<td>MAJOR GASTROINTESTINAL DISORDERS &amp; PERITONEAL INFECTIONS W CC</td>
<td>$12,322</td>
<td>$6,578</td>
</tr>
</tbody>
</table>
## 2. What is Your Fiscal Readiness?

### Understand Your Risk Exposure

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>Description</th>
<th>Patient Count</th>
<th>Total Payment</th>
<th>Claim Count</th>
<th>Post-acute Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>192</td>
<td>CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC</td>
<td>2</td>
<td>$8,079</td>
<td>2</td>
<td>0 1 1</td>
</tr>
<tr>
<td>233</td>
<td>CORONARY BYPASS W CARDIAC CATH W MCC</td>
<td>1</td>
<td>$40,240</td>
<td>1</td>
<td>1 0 0</td>
</tr>
<tr>
<td>236</td>
<td>CORONARY BYPASS W/O CARDIAC CATH W/O MCC</td>
<td>1</td>
<td>$20,780</td>
<td>1</td>
<td>0 1 0</td>
</tr>
<tr>
<td>371</td>
<td>MAJOR GASTROINTESTINAL DISORDERS &amp; PERITONEAL INFECTIONS W MCC</td>
<td>1</td>
<td>$11,166</td>
<td>1</td>
<td>0 1 0</td>
</tr>
</tbody>
</table>

The above example is from an analysis of readmissions for CMMI’s BPCI Hip and Knee Episode, which includes MS-DRGs 469-470. Readmissions for these MS-DRGs are included in the BPCI Episode definition. Therefore, an organization will not be paid separately for these readmission claims. The total payment above represents the dollars at risk under this episode definition.
To prepare for risk-based contracts, providers should:

- Identify operational, competitive, and financial risks associated with the relevant patient populations.
- Improve organizational abilities related to patient care management, which is the key to managing operational risk.
- Address the competitive risks that happen when traditional lines of between providers and payers are crossed.
- Adopt strategies and tactics to manage financial risk, beyond buying malpractice and stop-loss insurance.

### SOURCE

<table>
<thead>
<tr>
<th>MANAGEMENT ISSUES BY TYPE OF RISK</th>
<th>Clinical and Administrative Operational Risk</th>
<th>Competitive Market Risk</th>
<th>Financial Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Day-to-Day Functions</strong></td>
<td>Care delivery, staffing, scheduling, coding, documentation, etc.</td>
<td>Facility and clinic placement, partnerships and affiliations, product and service portfolio</td>
<td>Pricing, budgeting, investing, reserving, and distribution of funds</td>
</tr>
<tr>
<td><strong>Potential Blind Spots</strong></td>
<td>Unexplained clinical practice variation</td>
<td>Unexpected patient behavior under various incentives such as high-deductible health plans</td>
<td>Ways that operational and competitive risks are factored into pricing, budgeting, and investment decisions</td>
</tr>
<tr>
<td></td>
<td>Cost/price of expensive new technology</td>
<td>Cherry picking “low-risk” and dumping “high-risk” patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disease prevalence and comorbidities in a given population</td>
<td>Product, network, and channel disruption based on competitors’ actions or organization’s inaction</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Out-of-network utilization</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Duplication of functions among physician hospital organization, independent practice association, and medical groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Success Metrics</strong></td>
<td>Process and structure metrics to eliminate systemic patient safety risks</td>
<td>Lives under management</td>
<td>Percentage of revenue at risk under performance contracts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Market proof points regarding quality, access, and affordability that distinguish your offerings from those of competitors</td>
<td>Percentage per-member-per-month that the system directly owns, controls, or outsources</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Commercial price points vs. market</td>
</tr>
<tr>
<td><strong>Who Manages It</strong></td>
<td>Chief clinical officer and COO</td>
<td>Sales and strategy</td>
<td>CFO</td>
</tr>
<tr>
<td><strong>Emerging Skills and Tools to Manage Risks</strong></td>
<td>Retooling primary care practices</td>
<td>Comprehensive action plan for product, network, and channel tactics for growth (e.g., a specific plan dedicated to direct-to-employer risk-based contracts)</td>
<td>Tools to stratify and quantify risks within patient populations</td>
</tr>
<tr>
<td></td>
<td>Clinical integration of delivery functions across the continuum</td>
<td>Development of an adequately sized and priced ambulatory and primary care footprint</td>
<td>Ability to influence patient benefit design/incentives directly with payers and purchasers</td>
</tr>
<tr>
<td></td>
<td>Adoption of regional and local governance models with clear decision-making rights</td>
<td></td>
<td>Underwriting and actuarial skills</td>
</tr>
<tr>
<td></td>
<td>Tools to communicate patient clinical data to patients and caregivers at point of care in an accurate and timely manner</td>
<td>“Single source of truth” date warehouse for analytics and reporting</td>
<td></td>
</tr>
</tbody>
</table>
3. What Project Scale is Best for You?

How many clinical departments, payers, providers, and patients do you want to start with? The phased, or gradual approach is often preferred to minimize workflow impact and financial risk.

Can you start with a limited population where you may have more control via financial incentives, etc.? Are there any current initiatives or programs in place that would transition well into a value based system?

Multiple episode definitions are available on the market today. Which definitions work best with your patient mix, quality programs, risk acceptance, etc.? Choose the right episode for your organization.

How much risk are you willing to take on, and for what length of time? This will help determine which other caregivers you look to partner with.

Which episodes should your organization start with? By starting with low risk episodes, there is lower gain, or savings opportunity. Episodes with more financial risk provide a greater opportunity for care improvement and delivery, as well as a high cost-saving opportunity – your best learning opportunity.
Not all episode definitions for the same disease condition will produce the same results:

- Patient identification (trigger mechanism, etc.)
- Length of episode: Pre episode period, episode start date, episode end date.
- Patient Exclusions
- Included and excluded services
- Principle Accountable Provider
- Core Services
- Quality Metrics
- Severity Calculation

The result can be a very different budget price, varying the fiscal impact to your organization for the “same” episode.
## 3. What Project Scale is Best for You?

<table>
<thead>
<tr>
<th>Episode Definition</th>
<th>Arkansas Payment Improvement Initiative</th>
<th>CMMI Bundled Payment for Care Improvement (model 2)</th>
<th>Prometheus</th>
<th>American Board of Medical Specialties</th>
<th>MedAssets Chronic Care Episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Episode Type</strong></td>
<td>Acute CHF</td>
<td>Acute CHF</td>
<td>Chronic CHF (Retrospective)</td>
<td>Chronic CHF (Prospective)</td>
<td>Post Acute CHF</td>
</tr>
<tr>
<td><strong>Trigger Event</strong></td>
<td>Hospital discharge with subset of ICD-9 codes related to MS-DRG 291-293</td>
<td>Hospital discharge with MS-DRG 291-293</td>
<td>E&amp;M visit for CHF (defined by ICD-9 diagnosis)</td>
<td>Two ambulatory visits for CHF-related care, one in measurement year and one in the prior year (defined by ICD-9 diagnosis)</td>
<td>Hospital discharge for CHF (defined by ICD-9 diagnosis)</td>
</tr>
<tr>
<td><strong>Prior Period</strong></td>
<td>Trigger must be preceded by 30 day all cause clean period</td>
<td>Not required</td>
<td>Not required</td>
<td>12 months prior to measurement to identify 1st trigger</td>
<td>12 months</td>
</tr>
<tr>
<td><strong>Episode Start</strong></td>
<td>Trigger admission date</td>
<td>Trigger admission date</td>
<td>Trigger service date</td>
<td>Start of measurement year</td>
<td>Trigger hospital discharge date</td>
</tr>
<tr>
<td><strong>Episode End</strong></td>
<td>30 days from trigger date of discharge</td>
<td>=&gt; 30 days from trigger date of discharge</td>
<td>12 months from trigger service date</td>
<td>End of measurement year</td>
<td>4 months from trigger discharge date</td>
</tr>
</tbody>
</table>

### Patient Exclusion
- Age: <18
- Pregnancy
- Comorbidity: ESRD, dialysis, LVAD, IABP, select organ transplants, cancer
- Incomplete episode: Inpatient death, LAMA

### Service Inclusion
- All cause readmissions (defined by MS-DRG)
- CHF-related readmissions (defined by MS-DRG)
- CHF-related inpatient and outpatient claims (defined by ICD-9, CPT or HCPCS )
- CHF-related prescription drugs
- All inpatient and outpatient claims / encounters with a CHF-related or cardiopulmonary-related diagnostic code appearing in any position.
- All claims / encounters with CHF-related services (CPT or HCPCS).
- All related prescription drugs

### Service Exclusion
- CHF-unrelated readmissions (defined by MS-DRG)
- CHF-unrelated inpatient and outpatient claims (defined by ICD-9, CPT or HCPCS )
- CHF-unrelated prescription drugs
- CHF-unrelated claims / encounters with prescription drugs
- Major procedures are not covered by the episode payment and will be paid separately as fee-for-service.
- Inpatient or outpatient facility and professional claims that are not related to the index condition as defined in the episode.
- Outpatient prescriptions that do not belong to the therapeutic categories as listed in the episode definition.
**What is the best approach for your organization? Make sure it fits your needs.**

### Aggressive = Greater Opportunity for Savings and Care Improvement in the Acute Care Phase

Example shown here is for a Hip / Knee Replacement Episode

### Conservative = Less Opportunity for Care Improvement, Smaller Margin of Cost Savings in the Acute Care Phase

Example shown here is for a COPD Episode

### Examples of Total Saving Opportunities

<table>
<thead>
<tr>
<th>Episode Phase</th>
<th>Total Episode Payment</th>
<th>PC Savings</th>
<th>Typical Savings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care</td>
<td>$15,594,272</td>
<td>$127,198</td>
<td>$669,394</td>
<td>$796,592</td>
</tr>
<tr>
<td>Post-acute Care</td>
<td>$47,148,067</td>
<td>$3,579,879</td>
<td>$1,722,819</td>
<td>$5,302,699</td>
</tr>
</tbody>
</table>

### Sources: MedAssets CMMI BPCI Analysis, data has been de-identified.
Ensure you have the right team in place, ready to provide the structure needed for success

- Inclusive project team: multiple levels, departments, and a dedicated project manager
- Developing, testing, refining the data-exchange components is the largest activity
- Ongoing data quality is key – repeatable QC processes must be in place
- Did I mention? Data quality is KEY!
- Start on legal issues early: PHI exchange, contracts, etc. [See the box to the right]
- Plan early for communication of metrics. Learning sessions are extremely valuable
- Establish communication plan and incorporate bundled payments into strategic organizational efforts

Think early the about legal issues around the transition to bundled payment

- Gainsharing and CMP law
- Coordination and Stark and Anti-Kickback law
- Medical-loss-ratio issues for plans
- Indemnification
- Dispute resolution and appeals
- Risk certification
- HIPAA
- Standards and the practice of medicine
- Participation and credentialing criteria
- Care attribution and payment allocation
- Payment for non-par providers
- Continuation of coverage issues
- Coordination of benefits
4. What is Your Implementation Strategy? Use a Data-Driven Strategy to Address the “CFO Dilemma”

Glide Path from FFS to Bundled Payment to Maximize Savings: Sample Plan

**FFS**
- Reduce complications in acute care settings. This reduces LOS and helps optimize patient-volume management
- Identify episodes for bundled payment reimbursement
- Identify high-performance physicians
- Identify care-redesign initiatives

**Bundled Payment: Phase 1**
- Select high savings opportunity bundles (acute care only) e.g. Colon resection, Hysterectomy, COPD
- Identify facilities for engagement
- Identify “top 50% benchmark” physicians
- Activate care-redesign initiatives

**Bundled Payment: Phase 2**
- Expand to additional bundles (acute care only)
- Activate physician-improvement initiatives to top 20%
- Expand clinical-improvement initiatives
- Identify high-performance post-acute care facilities and partners
- Identify care-redesign initiatives for post-acute care

**Bundled Payment: Phase 3**
- Expand market share payor contracts via demonstrated acute bundles: low-cost. High-quality care
- Evolve high-performance acute bundles to include post-acute care
- Activate post-acute care improvement initiatives

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HFMA’S SPRING SEMINARS 2014

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HFMA’S SPRING SEMINARS 2014

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- Activate post-acute care improvement initiatives
4. What is Your Implementation Strategy?

80-20 Rule applies to reducing complications
Focus to where it matters!

Respiratory Failure, respiratory insufficiency
Complications of surgical procedures or...
Acute posthemorrhagic anemia
Pleurisy; pneumothorax; pulmonary collapse
Shock, cardiac arrest, ventricular fibrillation
Septicemia
Postoperative functional GI disorders,...
Clostridium Difficile Associated Disease...
Gastrointestinal hemorrhage
Bacterial infection; unspecified site
Diabetic Emergency, Hypo- Hyper-glycemia
Deep Vein Thrombosis (DVT) / Pulmonary...
Coma; stupor; and brain damage
Decubitus Ulcer, Gangrene, Arterial...
Periop hemorrhage, hematoma, laceration
Mycoses
Deep Vein Thrombosis and Pulmonary...
Syncope, Hypotension, Dizziness
Pressure Ulcers, Stage 3 & 4

AMI
COPD
ASTHMA
CABG1
CABG2
CABG3
CABG4
CVR1
CVR2
COLON1
COLON2
GALL2
GALL3
GALL4
HYST1
HYST2
HYST3
DM
HF

Preventable Complication Counts During Index Stay
Your selected technology should promote pricing and performance transparency for various participants, including your physician partners. Data transparency is vital to allow you to gain support from both your internal organizational members and external partners.

Select a solution, or prepare a plan, that will allow you to deliver results with consultative information. Help providers understand the reports and metrics for changes to improve care management.

Evaluate performance of the episodes against the budgets to determine if modifications are required based upon changes in fee schedules, etc. Choose a partner or solution that will be flexible and expandable as you progress down the path of value based payment.
The Way Forward
Where Do We Go From Here?
The Way Forward
The River Moved!

© Vincent J. Musi
The Way Forward
My Water’s Gone!

BRAND CAMP

BRAND DROUGHT

HOW THE HECK AM I SUPPOSED TO GROW THIS BRAND WITH SO LITTLE WATER NEXT YEAR?!?

GOOD LUCK

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TOMFISHBURN.COM
The Way Forward
Key is Predictability of Cost and Quality

**Total Hip MS-DRG 470**
Variable Cost $8,917

- **Implants**
  Variable Cost $4,844

- **Ancillaries**
  Variable Cost $711
  - Lab & Blood
  - PT/OT
  - Diagnostics
  - EKG, etc.

- **Length of Stay**
  Variable Cost $1,381

- **Med/Surg Supplies**
  Variable Cost $590

- **OR/Anesthesia and Cath Lab**
  Variable Cost $1,129

- **Rx and IV**
  Variable Cost $262
The Way Forward
HFMA’s Value Project

How is Value defined?

How is Quality determined?

**Value** = \( \frac{\text{Quality}^*}{\text{Payment}} \)

* A composite of patient outcomes, safety, and experiences
† The cost to all purchasers of purchasing care

**Patient Quality Concerns**

- **Access**: Make my care available and affordable
- **Safety**: Don’t hurt me
- **Outcomes**: Make me better
- **Respect**: Respect me as a person, not a case
THE WAY FORWARD

HFMA’s Value Project

Blueprint for action for value-oriented providers

Business models for value

State of the industry and future trends

WHERE TO LOOK

- www.hfma.org/valueproject
- View and download reports, tools, & case studies
- Use web-based tools
- Conferences, including ANI: HFMA National Institute 2014
The Way Forward
HFMA’s Value Project – Four Key Capabilities

Value

- People and Culture
- Performance Improvement
- Contract and Risk Management
- Business Intelligence
- Collaboration, accountability, and communication
- Elimination of variation, unsafe practices, and waste
- Measurement, assessment, and mitigation of risk

HFMA Organizational Road Maps
The Way Forward
HFMA’s Value Project – Lead Through Collaboration

“Leadership has nothing to do with titles; it has everything to do with, “Do you inspire other people? Do they want to follow you? Do they want to be with you?”

- Tom Atchison, author of Followership: A Practical Guide to Aligning Leaders and Followers

HFMA’S SPRING SEMINARS 2014
The Way Forward
HFMA’s Value Project – Lead Through Collaboration

“The challenges that we face... will require leadership from everybody in this room.”

Steve Rose
2013-2014 Chair, HFMA
CFO, Conway Regional Health System

Speaking at ANI 2013
Where’s your focus?
Instructor’s Bio

David Hammer, Principal
Healthcare Performance Management Consultants, LLC

Mr. Hammer is a Principal at Healthcare Performance Management Consultants, LLC (HPMC), in Berkeley Lake, GA. In his leadership role at HPMC, he works with hospitals and health systems to optimize revenue cycle and managed care outcomes. Prior to joining HPMC, David was Senior Vice President of Revenue Cycle Advisory Solutions at MedAssets and is a former Partner at Accenture. David focuses on revenue cycle and healthcare reform issues for hospitals, health systems, and related entities. He serves many of the largest health systems, MD-led clinics, and academic medical centers in the US. He was formerly VP of enterprise revenue management at McKesson and previously Chief Revenue Officer for Charter Behavioral Health, a +100-facility health system. David has over 30 years of healthcare experience, including executive leadership and direction, revenue cycle transformation, information system planning / implementation, and consulting. He has worked for a variety of leading health systems, software vendors, and professional services firms.

Background and Affiliations

Mr. Hammer received an MBA in Management and an MHS in Health Care Administration from the University of Florida. He also received a BBA in Accounting with a minor in Information Systems from the University of North Florida. Mr. Hammer is certified by HFMA as a Fellow (FHFMA) and as a Certified Healthcare Finance Professional (CHFP). He has been repeatedly named an HFMA Distinguished Speaker, and is a 2007 recipient of HFMA’s Medal of Honor service award.

Recent Publications


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