



## **WEBINAR TRANSCRIPT**

### **The Value Proposition For Care Improvement Around Acute Hospitalization: Bundled Payments For Care Improvement Initiative**

**October 19, 2011  
11:30 am–1:00 pm (ET)**

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**Webinar: *The Value Proposition For Care Improvement Around Acute Hospitalization:  
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## INTRODUCTION

**Andy Shin:** Welcome everyone to the Webinar hosted by the Center for Medicare and Medicaid Innovation. For all of you who can hear me, that means you're probably dialed in. For those of you who can't hear me, you can't hear me because you're not dialed in.

If you have any colleagues who are perhaps not hear the audio it's because we can only hear audio via this phone line, so I encourage you, if you look at the chat box now, to see that phone number displayed for you.

With that out of the way, welcome to the Webinar hosted by the (Pro Game) Team for the Bundled Payments for Care Improvement Initiative. We are so happy you could all be with us today.

I'm Andy Shin with the Stakeholder Engagement Group here at the CMS Innovation Center and I'm going to be turning it over to Valinda Rutledge, Director of the Patient Care Models Group. But before then I will go over the agenda very briefly.

In the first 15 minutes of the presentation, we will give you a brief overview of the initiative as more in depth information on the (AIMS) opportunities for hospitals, decision groups, (unintelligible) providers, etc cetera, to use this initiative as a tool for care redesign and care improvement.

We will then have three experts speak to the, what we are terming the value proposition towards care redesign and care improvement. We are delighted to have with us today Patrick Falvey, Senior Vice President and Chief Integration Officers of Aurora Health Care.

Dr. Falvey works in partnership with clinical leadership to direct clinical improvement, decision support, medical management, credentialing and disease management. He will speak on some of Aurora Care's improvement initiatives.

Stu Guterman, who is the Vice President of Payment and System Reform and Executive Director of the Commission on a High Performance Health System with the Commonwealth Fund; the program on Payment and System Reform supports the analysis and development on payment policy options that include incentives to improve the (expectiveness) and efficiency of healthcare delivery while curving growth in health spending.

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In addition to other notable positions, Mr. Guterman was director of the Office of Research Development and Information at the Centers for Medicare and Medicaid Services from 2002 to 2005.

And finally, we're really pleased that Dr. Bruce Hall is joining us who is an active surgeon at the University of Washington St. Louis where he directs the American College of Surgeons National Surgical Quality Improvement Program for his hospital and the Barnes-Jewish Healthcare Corporation.

Dr. Hall has focused his research on the evaluation of quality in surgery with a particular interest in evaluation of individual providers and their contribution to the healthcare system as well as in this area of risk adjustment.

In the last 15 minutes of this presentation, both the program staff here at the CMS Innovation Center and the presenters will respond to your questions. Questions can be submitted through the chat box feature on the Webinar platform.

We will enable this feature at the end of the slide presentation. No audio questions will be taken.

Now, I would like to turn this over to Valinda Rutledge, who is Director of the Patient Care Models Group and, most recently, the CEO of CaroMont Health in North Carolina. Ms. Rutledge?

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## PRESENTATION 1: VALINDA RUTLEDGE

**Valinda Rutledge:** Thank you. Thank you, Andy. I'd like to thank all of you for joining us here. We have over 200 participants on this call and I would also like to thank each and every one of you for your commitment and your hard work to improve our nation's healthcare system.

As we are aware, we are all aware that we have several excellent aspects of our healthcare system in the United States. We have produced incredible innovation in pharmaceuticals, medical devices and ways to diagnose and treat disease.

We also just have a superb healthcare workforce and people come from all over the world to get trained in the United States for that. So we also know that the current system is uncoordinated and uneven. It has a fragmented delivery system with uneven quality around the United States.

The amount of chronic disease is growing in America, particularly childhood obesity and it's unsustainable, the cost arising at twice the inflation rate. And we currently have 46 million Americans that lack coverage and it is estimated that close to 50 million will probably lack coverage by 2012.

The opportunity we have, we have a wonderful opportunity right now to partner together both the Innovation Center and all of you out in the United States to transform our system and we want to be able to do that together.

All the Innovation System—Center projects are to support our goal of achieving the three-part (AIM) goal and the three-part (AIM) goal is that our health for population, that are care for individuals and lower cost through improvement.

And I would ask each and every one of you to go back to your organizations and look at your strategic plans, look at your goals for the next year and look at how you can achieve those three-part (AIM)s and that's what we do at a daily basis in the Innovation Center.

The goals of the Bundled Payments for Care Improvement are to, number one, align payment for how patients experience the care; number two, to support and encourage providers interested in redesigning the care; number three—and this is really important for us—is to provide as much flexibility as possible for all of you to redesign the care to meet the needs of your community.

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So in some communities it could be about stroke. In other communities it could be about congestive heart failure. So we want you to begin by looking at the needs of your community.

And then final, we want to have a program in which it removed barriers so you can partner with each other and other stakeholders.

There are four bundled payment models and Model 1 is that—Model 1 is in the acute care hospital stay. It includes all DRGs of a specific hospital. It is only a Part A DRG-based payment.

Model 2 included the DRG in the hospital as well as the post acute period and that one in Model 2, the applicants can decide which selected DRGs that they want to be a part of this pilot. It does include all Part A and Part B and it does include readmission.

It is retrospective in its payment in that it means that all the Part A and Part B participants will be reimbursed in their current feature service payment and then at a specific time and place in time we will do a retrospective reconciliation.

Part 3—Model 3 is post acute only and it does include Part A and Part B. It does include readmission. It is retrospective similar to Model 2 in that everybody will be paid as they are paid right now and then we will have a retrospective reconciliation.

Model 4 builds upon the (Ace) Demonstration Project. You can identify which selected DRGs you want. It does include Part A and Part B and it does include readmissions but it is prospective, which means you agree with the amount up front. We send that amount to the hospital and the hospital is responsible for paying everyone out of that amount.

We feel that the case for bundle payments serves as a foundation for success in a value-driven market. As we all know, we are moving from a buy-in based industry to a value-based. And we believe that participating in this pilot does serve as a strong foundation for success in the future.

We believe this because we have looked at the numbers and there's a large opportunity to reduce cost from waste and variation. Also gain sharing incentives can align hospitals and physicians and post acute providers in the redesign of care.

Also, the competencies that you will learn in being successful with the bundle payment will lay the foundation for success in a value-drive market.

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It will also allow you to be very successful when you are working with your private payers.

We're hearing from many private payers around the country that they are beginning, if they have not already, are implementing bundle payments. We also believe that there is valuable synergies with accountable care organization initiatives, the value-based purchasing, pay for performance and other payment reform programs that are both within the Innovation Center and within CMS overall.

Why payers are investing in bundle payments; well, as providers, you understand that there's a mounting pressure to make significant reductions in costs and at the same time to be increasingly accountable for quality.

The past tactics in terms of—and strategies that all of us have used in terms of trimming expense budgets have been exhausted. And typically these methods have not led to a provision of better care or, quite frankly, haven't been sustainable.

In terms of having meaningful cost reduction and maintaining high quality improvement care, that can only be done through redesigning the way care is provided.

So as a result, national leaders in cost and quality improvement have led the way in the use of bundle payments as a lever to improve overall performance.

Why our providers are interested in bundle payments; well, evidence shows that we have between 20% and 40% from eliminating waste, lack of coordination and over-treatment in the system.

This is because for the most part we're paid very separately. We have regulations that have prevented us from working together in terms of the redesign.

So evidence is showing that potentially there is a 20% to 40% potential savings when we look at redesigning care across the continuum. We also see a variation in the type of service costs and utilization and any of that variation does allow us to see opportunities for cost savings and some of our speakers will be speaking about that.

The beauty of the bundle payments is that it's a good step for organizations that are just beginning to move toward becoming accountable care organization as well as those that are established accountable care organizations.

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We are also hearing that integrated delivery systems are using bundle payments as a way to reshape their organizations as an opportunity to improve quality patient experience and reduce cost.

What can providers gain from the bundle payments? Well, the benefits of investing in bundle payments are significant. It includes a chance to improve patient care as well as sharing in the gains of improving efficiency.

It also is an opportunity for each and every one of you to partner with other providers such as hospitals, medical staff, both independent physicians and employed physicians as well as bringing the specialists in the transformation process.

It is also a way for hospital systems and physicians and post acute providers to come together around the table and say how can we redesign the care together?

So today we're going to go through all four of those models and we're sort of going to talk in terms of how a hospital or a physician or post acute provider could decide which model would be the best for them.

I would tell you that first you need to begin with your community needs. You need to look at where you're at in terms of quality and benchmark that across. You'll also understand from the community that you serve where the areas are that you need to improve the care.

So let's begin by highlighting the benefits for hospitals in Model 1. Imagine that your acute care facility that you have struggled to engage, your largely independent medical staff and looking at data and redesigning your care processes within the walls of the hospital.

You have a few physicians that are helping you but for the most part they're independent physicians and they just don't see any incentive for them to spend some time.

This will allow you—this will allow you to sit down with them and look at how to reduce complications, reduce infections or improve your discharge planning.

The gain sharing enabled by the bundle payment provides hospitals with a vehicle and a financial incentive to get physicians involved in reviewing the data and making changes when needed.

The level of gain sharing that you can do through the bundle payment can be up to 50% of what the physician or the provider would have normally been

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paid. This can provide a strong incentive for physicians to partner with the hospital in redesign of the care within the walls of the hospital.

Better alignment of the hospital medical staff including joint hospital physician improvement processes will better position the hospital for success in an environment that will increasingly tie payment with performance as we move to a value-based healthcare system.

Additionally, anyone that is an awardee in any of our (pockets) will participate with their colleagues around the country and a national learning collaborative. They will learn from each other. There will be site visits. We will have Webinars and any opportunities to disseminate best practices around all the applicants, we will be doing that.

In Models 2 and 4, the case for the hospital is the same as improved alignment for Model 1. But the inclusion of the post acute period provides the hospital with opportunities to coordinate with post acute providers to reduce your readmission rates.

So think about your acute care hospital and you realize that you have very high readmission rates for acute MI and congestive heart failure. And you recognize that you may have a possibility of some significant financial penalties under the new CMS rules.

You also recognize that your commercial payers and your self insured businesses are also developing similar payment incentives. So not only will you have CMS penalties but you will have the loss of your bonus payment from your commercial lines of business.

This hospital could decide to do Models 2 and 4 to begin to reduce a partner with their providers, both physicians and post acute providers, to reduce these readmission rates.

These hospitals can select DRGs that they want to work on. They can look at where the risk is at, where they're at in terms of benchmarking themselves and they can decide these are the DRGs we want to work on.

We need to engage our physicians in improving the care processes and readmission rates and we need to have our post acute providers at the table in terms of talking about how to move the patient from the hospital transition out into the community.

The gain sharing permitted under the CMS bundle payments will allow the hospital to align medical staff hospital financial incentive. The medical staff then are focused and have a financial incentive to work with the hospital,

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reducing readmission rates and we understand this is key because for us to reduce readmission rates we need to have the physicians at the table because they understand the drivers, they need to participate in revamping all the discharge planning and they need to work with the primary care practitioners in terms of assuring that the patients are seen timely following the discharge.

So not only will you have this benefit for Medicare but you will see a spillover into your hospital's commercial lines of business.

In Models 2 and 3, let's talk in term of the case for the post acute provider. So imagine that you're a (SNF) or a home healthcare agency and you determine that your costs when you benchmark are higher than regional and national benchmarks including a longer length of stay.

But you've also realized that under the current volume-based payment arrangement you haven't had very little incentive to redesign the care and current regulations have made it difficult for you to do that: the three day rule, the 25% rule.

So you have felt that there's opportunities to redesign but you really thought that some of the regulations was really making it difficult for you in terms of doing that.

The post acute providers can participate in Model 2 and 3. They can redesign the care and they have the potential to share in the gain from that reduction and length of stay and readmission rates.

Model 3 allow the post acute providers to take a leadership role in driving the redesign of the delivery post acute services, so when you are applying for Model 3 you can ask to have some of the regulations waived if you feel that that's important for the redesign.

Post acute providers will be rewarded for better coordination of care across the providers and getting the patients safely home as soon as possible. Also, as a post acute provider, you will benefit strategically by improved relationships with the acute care referral bases and you will becoming increasingly attractive for other acute care providers because your costs will be down and you will know how to redesign the care to improve that quality of care for the patient.

The case for the physicians; why would physicians want to purchase a (unintelligible) in this? Well, imagine that you're a large physician group and you determine that the best practices in stroke care from ER through

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discharge to a rehab facility are not being followed consistently and your community outcomes are not at a national benchmark.

And you want to be the best. You want to be able to provide the very, very best care and be a leader in the country in terms of those community outcomes.

The current payment arrangements provide very little incentive for this practice to sit down with the hospitals and the post acute providers in terms of redesigning the care.

With our bundle payment, it does allow you to sit down and participate financially in the gain sharing from the improvement across the spectrum of stroke-related services including the timely administration of emergency care, the appropriate use of imaging, the proactive management of a patient's functional status and avoidance of complications such as ulcer.

So in addition to the financial rewards, the participation, the physician participation in this initiative will allow—will provide you the opportunity for physicians to work with other physicians around the country in redesign and allows you to be able to say to your community that you are providing this care at a national standard, at a top national standard and you are working together with it.

The Bundle Payment initiative builds on the growing evidence of what has led to successful arrangements. For example, we know that targeting specific conditions and expanding the episode list can lower the financial risk of the participants in this. So the longer episode list that you have, studies have showed that you have a lower financial risk.

Models 2, 3 and 4, you can allow for a targeting and selection of key DRGs and it should be based upon your community needs; what do you want to provide to the community? And Models 2 and 3 allow for flexibility in determining the episode list with that.

In the Innovation Center, we continue to want to work in partner with you to meet you where you are in this transformation journey. The journey that we are on is we are moving from a volume-based industry to a value-based.

In able to do that, it provides what we need to do is learn those core competencies to be able to be successful in that. In able to develop those competencies, we understand that the Bundle initiative has some synergy with others.

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They have synergies with the Accountable Care Organization. We've heard several organizations that are Accountable Care organizations or are in the process of applying for pioneers that they're planning on using bundle payments as a way in term of looking at redesigning (tier) with their specialists.

We also feel their synergies with the Partner for Patients Initiative, that the Partnership for Patient goals are decreasing hospital core conditions by 40%, reducing readmissions by 20%. You can do that in both Models 1, 2, 3 and 4.

Others is synergies with other health reform initiatives. We understand that's value-based purchasing. There's going to be financial penalties with that, hospital readmission at reduction programs and meaningful use.

With all these you can use the Bundle payment pilot as a way in which you partner with your physician's post acute providers together to redesign the care to help us move forward in terms of achieving a value-based delivery system.

We believe overall that bundle payments provide an important strategic and financial opportunity for all providers and can serve as a foundation for your success in a value-driven market.

So I encourage all of you to begin a conversation with your physicians, with your post acute providers, with your community leaders in terms of what models are best for you and what models would be serve your community.

**Andy Shin:**

Thank you, Valinda, so much for that excellent presentation and for sharing your experience and expertise, which is clearly informed by your experience implementing Bundle Payments in your own hospital in a previous life.

And now it's my pleasure to turn it over to Patrick Falvey. Dr. Falvey will talk about the remarkable journey that Aurora Healthcare took to becoming a top performing hospital as part of the hospital quality improvement demonstration.

He will highlight the meaningful improvements in quality and reductions in cost achievable when hospitals and physicians work together. It's with my great pleasure that we turn it over to Dr. Falvey.

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## PRESENTATION 2: PATRICK FALVEY

**Patrick Falvey:** Thanks, Andy. I appreciate the opportunity to share the Aurora story around what we've been doing to prepare ourselves for a movement towards reimbursement models that really create incentives for our coordinated and higher value of care.

As you said specifically, I'm going to kind of address what we've done to improve performance, quality and efficiency and some of the efforts that we've (been) now positioned us well as we prepare for Bundle Payment models as well.

But first, for a context, I want to give a brief description of Aurora Healthcare. Aurora is an integrated, not-for-profit healthcare system serving communities throughout Eastern Wisconsin and Northern Illinois.

We have 15 medical centers, 155 clinics, 82 retail pharmacies and we employ over 1400 physicians and have over 30,000 caregivers. Annually, we have over 3.6 million ambulatory care visits and over 93,000 inpatient discharges.

Over 10 years ago, we began to include pay-for-performance strategies into our own payment models. As you mentioned, one of these early efforts was our participation in the hospital quality incentive demonstration project with CMS and (Premier).

This not only had the incentive payment behind us but also had the focus on transparency as well. When we first got into this, our observation was that the original participants were going in for one of two reasons.

First, they probably believed that the performance was already at a top tier level or, second, their CEO volunteered them. Unfortunately for us, we fell in that second category.

Our performance on the original measures was well below average prior to our participation but our CEO at the time believed that this was an opportunity to accelerate change and, as you mentioned, to really get the organization to focus on value.

We knew early on that we would need to leverage the integrated delivery system, move from doing quality improvement to the organization to what we call doing quality improvement with the organization.

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We also assumed that the rest of the participants would move rather quickly so we needed to move beyond an approach that we called relentless incrementalism to more of an approach that focused on transparency and drove movement towards our incentive payment models.

We wanted to have changed in our strategy that would focus around care redesign, leadership and physician engagement, incentives and a solid clinical and business intelligence support structure.

So the first thing that we did is we really took a look at the leadership role within quality improvement. What I mentioned earlier in terms of doing quality to the organization versus with the organization, as a lot of quality organizations or quality functions within healthcare systems, they spend a lot of time trying to drive out initiatives throughout the organization.

It really is a different process when you can have the leadership of the organization own the quality improvement in the value side and then it becomes more of a pull strategy.

So one of the things that our CEO did is he assigned quality improvement away from the quality departments within our organizations and assigned it directly to the medical center administrators and our medical group leadership teams. As I mentioned, this helped us move from more a push strategy to a pull strategy.

Examples of that, instead of going out and saying here's the best practice around diabetes or here's the best practice around heart failure AMI, instead we have the physicians and the leadership team saying I need the support and I need the resources to make sure that this is happening.

It also helped that the CEO also made proposed changes in the incentive plan. Prior to our participation in the hospital quality incentive demonstration, a significant part of the incentives process was around financial performance.

We now made quality improvement in patient experience and other key components of the overall incentive process for our medical center administrators and our medical group leaders.

We use a similar process to engage our physicians. Prior to this we had several physicians that were champions in helping us with a lot of our quality improvement efforts but it wasn't universally applied.

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We needed to leverage those individuals both in the performance to take our information and tools interventions to help limit the variation that we have across the organization, ultimately improve care.

Similar to our medical group leaders and our hospital administrative leaders, we also put a heavier weighting of quality and patient experience into the compensation of our physicians.

Our champions are now able to use academic detailing approaches to sit down individually with each of our physicians to share both of them, how they were performing, if they were performing well and identify options as they existed.

Both the incentive and the accountability that the organization was putting on our efforts around value really helped, again, moving into more of a pull strategy where the physicians were asking for this information and then planning ways that they could improve.

Where variations existed, we were able to offer specific support, both in resources, tools and any other intervention to help the physicians move to top tier performance.

These efforts help us in our overall care redesign strategy. We knew that we would be able to do more than just improve our current approach. We also needed to move towards more of a pursuit of perfection.

In the past what we did is we spent a lot of time on what we were calling relentless incrementalism. That was how do I take this process and moving it from 91% to 92% to 93% levels of improvement?

Instead, we now began to ask ourselves we need a pursuit of perfection type of a strategy that was if we weren't at perfection why was it that 5%, 4% or 3% of our patients weren't receiving the care they were expected?

It drove us to redesign care. First, we did this through standardization by setting up the appropriate guidelines and pathways. Then we addressed variation through our optimization strategies.

We looked specifically at all the processes of care where utilization was being done, the outcomes that we were receiving, the cost of the processes that we had in place and we weighted that out for all of our organization to see. We were very transparent internally.

We also capitalized on the integrated delivery system. We used integration approaches to address efforts that extended across the organization. As we

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looked at length of stay within our medical centers, we began to leverage our home health services agency to take a look both at the length of stay and at our readmission rates.

We were also able to leverage other parts of our organization such as care navigators and case managers to help our medical groups and disease management efforts as well, again, allowing us to take a look at our practitioners and having them operate at the highest levels of their license.

As part of our efforts to prepare for the evolution of new payment models, we continue to leverage these carry design models and we're doing that in our organization right now even though we don't have the payment models design around them.

We're actively pursuing eight pilots that are testing specific models of care delivery. These include everything around medical home models, accountable care and even Bundle Payment models.

As I mentioned earlier regarding the push and pull strategy, the resources that we had in place were always available to our organization both internally. But the emphasis with leadership and putting greater value and accountability, turning these more to pull efforts and the key ingredient of that was the change to our incentive model.

As I mentioned earlier, quality and the patient experience weren't even part of the incentive program. As we change that, that shifted significantly and we had more of the organization beginning to ask and request and outright demand support and resources to help and improve their processes and their structures.

Further incentive models continue to be tested in our current care redesign efforts as well. We're looking specifically at moving greater physician engagement and all the care (unintelligible) process through that approach.

With a need for agility and motivation of accountability incentives, we're beginning to also focus on having very timely and accurate information as part of the process. This is why we place a significant emphasis on what we're calling our clinical and business decision support infrastructures.

Specifically we're beefing up our data warehouse, making sure that we have the appropriate analytics tools and the data in place so that way we can share with our providers, our physicians specifically, how they're performing in a very timely approach so that they can see the key indicators both at the system level, the site level and the individual level so that way they can react and respond to their performance.

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As we've done this quality approach over the last 10 years, we've known a significant performance improvement in several areas. Key areas, we relatively moved quickly our performance in the (HQID) demonstration.

As I mentioned, we started out less than average and very quickly moved to a top performer, not just at one site but across all of our participating sites.

Beyond the demonstration initiative, we've also been able to use this approach, all of our quality performance measures and perform quite well in most publicly reported information around quality and safety.

In addition in this time period, our average length of stay decreased by over 20% and our readmission rates remained at top performer levels. This has also helped us manage our costs as well.

In fact, during the (HQID) process, an outside study was conducted and recognized that during that process Aurora Healthcare's net commercial charge has increased by just 11%. This was less than half the average of the metropolitan Milwaukee area.

So in summary, while Aurora is not currently operating under a specific Bundle Payment contract, we have prepared ourselves for the movement towards these models of reimbursement that are really focused on coordination and higher value.

We believe that the efforts that we've done in quality improvement around performance quality and efficiency are going to benefit us and our alignment around care redesign and internal incentives will benefit us as we explore the CMS Bundle Payment for care improvement models.

**Andy Shin:**

Thank you so much, Dr. Falvey. That was really, really interesting. With that, I'd like to turn it over to Stu Guterman. And it's really serendipitous that Mr. Guterman is joining us today immediately following the release of the commission on a high performance health systems national score card on health system performance.

Mr. Guterman is a highly accomplished health policy expert who understands the health system inside and out and he will talk about the value bundle payments within the context of broader health delivery reform. Stu?

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### PRESENTATION 3: STUART GUTERMAN

**Stu Guterman:** Thanks. Thanks for having me and it's a pleasure to participate in this event and to help where I can. The commission on the high performance health system as was mentioned released a report just yesterday or the third in our series of national score cards on health system performance and I think some of the findings that we presented reinforced the need for initiatives like the Bundle Payments for Care Improvement initiatives and to encourage and support the kinds of actions that people in the system, like Dr. Falvey, and Dr. Hall have undertaken.

So, you know, first, it's no secret that what we found in our score card was that there's one area in which the U.S. health system excels compared to any other country in the world and that is in spending money.

We spend 50% more than any other country on health care per person and as a proportion of our overall economic activity. And the effects of that spending are being felt not only in the federal budget deficit discussions which are dominating the policy arena in Washington but also are affecting state and local governments as well as businesses in the private sector and, of course, every household both workers and now, unfortunately a large number of people who have lost their jobs and, therefore, lost their health coverage as well.

And that spending is projected to continue to increase over time. The latest projections by the CMS actuaries are that over the next 10 years health spending will grow by a total of 79% and the GDP at the same time was projected to grow at the last estimate by only 60% over 10 years.

So even if we held health spending growth to the level that our economy is expected to grow by, there would still be substantial growth but just a big difference between what's projected and what we, as a society, can afford.

The problem, of course, is—and the major focus on the health score card is that the system's performance doesn't match that level of trended spending and we had an overall score that we gave health system performance that was along several dimensions: healthy lives, quality, access, efficiency and equity.

And our latest score card gives the U.S. health system an overall score of 64, which we wouldn't be happy if our kids brought home from school. We're not happy with it as a performance indicator of the healthcare system overall as well.

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And what's worse is that that score is lower than the scores from our two previous additions that came out in 2008 and 2006 respectively. So it kind of to us emphasizes the need for action for initiatives likes this and others and broader health reform because the system is not going to get there on its own. It needs help.

And some of the indicators that we focused on that are particularly relevant to this payment initiative is that quality of care varies tremendously across different areas and it's the, for instance, the 90th percentile in terms of quality of care in hospitals for heart attack, is at 100%.

So there are hospitals that are doing very well at this but the lower end of the distribution is considerably lower at 94%. For heart failure the range is 81% to 99%. So there are achievable benchmarks that the system as a whole should be able to form up to that it's not performing up to.

In terms of patient center and hospital care, the same thing. When you ask patients how well the hospital staff managed their pain, responded when they needed help and explained medications that they were taking, again, the variation is very wide from the highest performing hospitals to the lowest.

But the fact that the highest performing hospitals are there indicates the room for actual improvement that could take place. Similarly, when you look at the ability to prevent surgical complications, the overall system is getting better but there's still a wide variation between the best and the worst.

One of the big initiatives that has been promoted to try to help hospitals in the healthcare system as a whole to provide more coordinated care is the adoption of electronic health record systems.

And yes, in the United States, we still lag behind other countries in our adoption of health system, electronic health systems in hospitals. A survey that was done by the Harvard School of Public Health and the American Hospital Association found that 82% of hospitalized patients received care in hospitals with no electronic record system at all.

That lack of ability to coordinate and the lack of infrastructure to support coordination leads to high proportion of high incidence of medication and lab. Errors, a survey that we did in 2008 indicated that the U.S. had much higher rates of those kinds of complications than other countries did and that the U.S., although it ranked pretty well in terms of having medications reviewed when discharged in a hospital still was only a two-thirds rate in terms of patients who answered that they had review of their medications when they were discharged.

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Similarly, having heart failure patients giving complete written instructions when discharged, telling people what to do when they leave the hospital, again, there's a sense that when you leave the hospital you're kind of disconnected from the system.

And as a result, again, if you look at 30-day mortality rates, they vary very widely across hospitals even when you adjust for the mix of cases that are treated. And transitional care is also something that varies very widely and that can be very low in the worst performing hospitals and that's really critical for patients.

When they get discharged from hospital, they—you kind of get the image like in the last scene of *Gone With the Wind* when the—it's when the heroin asked Rhett Butler but, Rhett, where will I go. What will I do? And you feel like the patient asks the health system that. And the answer all too frequently is frankly, my dear, I don't give a damn.

So we need to do something to encourage coordination of care across the system and there's also a wide variation in costs as well as quality and as folks at Dartmouth have done with their Dartmouth atlas. There is—they pointed out very clearly that their relationship between cost and quality doesn't seem to be there. That in the area is where there's high spending there doesn't seem to be compartmentally high quality of care.

And a very interesting study that the folks at the Medicare Payment Advisory Commission did found that when they compared areas where there were very high-end costs for conditions like COPD that the factors that were driving the differences, the wide variations between the low cost areas and high cost areas tended to be (too).

The main things that explain that difference in spending tended to be the number of readmissions and the expenditures on post acute care and we have some questions to answer about how we use post acute care and how we follow up with patients to make sure that they don't end up back in the hospital within 30 days.

There's a wide variety, as Valinda showed, in that continuum of initiatives that CMS is developing. There's a wide variety of models of care, a wide variety of places where systems, existing systems are. In fact, even when you think about integrated delivery systems. There's a wide variety of models if you go down the list of those systems that are in place.

So the idea is to (egg) at the payment system to align with the coordinated care that our patients need to encourage shared responsibility, to put more emphasis on treating the patient as opposed to providing the service and

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Bundle Payment allows for more effective rewards also for good performance for coordinated, effective and efficient care.

So these four models are different ways of approaching that coordination but I think the results that come out of the national score card and that are becoming well known kind of emphasize the need for initiatives like this.

**Andy Shin:**

Stu, thank you so much for that. I think that context is really important because it's the same context in which we at the Innovation Center are working currently to design this and other initiatives that provide a pathway towards the three-part (AIM) of better care, better health at lower costs through continuous improvement and that really is the context in which we are doing all our work and so that's really helpful.

At this time I want to turn it over to Bruce Hall who is not only an accomplished surgeon but a national leader in the effort to improve quality while reducing costs. He will discuss unwarranted variation across hospitals and doctors highlighting the opportunity for care redesign to achieve the triple aim within the walls of the hospital. Dr. Hall?

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#### PRESENTATION 4: BRUCE HALL

**Bruce Hall:** Thank you very much, very kind of you. I'm honored to participate in this discussion today and particularly honored to followed Valinda, Patrick and Stuart and all of their very, very thoughtful comments.

I, myself, am not going to speak about bundling of payments so to speak. I'm going to speak instead about what I think are clear opportunities to improve care and reduce costs and these opportunities can be defined by variations between physicians or hospitals in performance that we already know about as well as documented savings that hospitals have told us about for certain projects and projections of that experience forward.

Again, I'm not going to give you specific evidence that bundled payments are an effective way to accomplish the (AIM)s of improving care, reducing cost. But I think there's much work to that affect and in the rest of today's discussion, which you've just heard, we have already heard a large amount of evidence that that is the case.

My own work focuses more on opportunities for improvement in reduction of costs and most of what I will talk to you about now comes from my work in the American College of Surgeons National Surgical Quality Improvement program.

The American College of Surgeons is a not-for-profit professional organization where the premier professional organization for the profession of surgery in the United States and North America perhaps.

And the National Surgical Quality Improvement program, or NSQIP, is our national program for data collection and risk adjusted performance reporting. I am one of the directors of that program on behalf of the American College of Surgeons and, again, the ACS is a not-for-profit organization.

The ACS has certain relationships with CMS but the NSQIP is not a CMS initiative or program. And as far as disclaimers go, apart from the fact that I am an advocate for the NSQIP and work on behalf of the ACS, I have no conflicts to divulge and I'm speaking to you today based on my own opinions.

So what I'll tell you about now is going to be quick and direct. I'm going to tell you that there's evidence that physician performance varies. There's evidence that hospital performance varies. There's evidence that hospitals

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can do something about their performance. And then there's some projections about what that adds up to in terms of dollars when they do.

So here we go. First of all, we published some work out of NSQIP back in the Journal of the American College of Surgeons in 2006. This work shows that there is substantial differences in the costs that are incurred by surgeons across all surgeons at an institution.

Even when you adjust for the patients that the surgeons treat and the cases that they perform, there is still substantial differences in the cost than any two surgeons might incur in taking care of a patient or a disease.

Even surgeons with very similar patients doing very similar procedures can have striking differences in the costs that they incur. And interestingly, it's not just in terms of the average cost that they incur. But there can be differences in terms of the volatility of costs between surgeons.

So in other words, one surgeon might on one case have a very low cost and on the next case, which is very similar, have a very high cost whereas another surgeon may have a reproducibly middle level cost case after case.

So we see all these types of differences between surgeons and in dollar terms roughly a quarter of all surgeons will be different from another referent surgeon by as much as 40% in terms of their costs. So we're really seeing differences in costs that are not trivial. They are really substantial.

Moving from the physician surgeon level to the hospital level, in the NSQIP we have 10 years plus now of experience with reporting performance out to hospitals every six months.

And in our typical semiannual reports, on any one measure whether it be mortality in a particular type of surgery or whether it be presence of complications like heart attacks, pneumonia, infections, whatever, we publish 50 plus models every six months.

Whatever model we look at, it's very, very typical that the difference between the 25th percentile performer and the 75th percentile performer, which we call the inner quartile range, right—and the beauty here of looking at the inner quartile range is that we're sort of chopping off the extreme tail.

So we're not talking about extremes. We're talking about the middle of the distribution of performance. The difference between the 25th percentile and the 75th percentile very typically is going to be a 66% or two-thirds difference in performance in terms of the frequency of complications or

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whatever it is that this model is talking about, the difference in performance between institutions very, very easily reaches 66%.

And, in fact, if you look at the 10th percentile of institutions versus the 90th, the difference between those points very easily reaches five fold, five fold difference in performance in terms of particular complications or whatever you're examining.

And to be perfectly honest, I can find occasional models where the differences are even more extreme. What's the point? The point is differences in performance are real. They exist. We've show it for a decade now.

Well, given that we see it, can hospitals do anything about it? Well, we also published some work in the (Analysts of Surgery) back in 2009 where we asked and answered this question to the best of our ability.

And what we showed was that over a three-year period, the period that we examined, about two-thirds of our hospitals could and did improve their performance with respect to mortality and even more, more than 80% of hospitals improved their performance with respect to morbidity.

And when we put that in terms of numbers of actual complications for real patients, if we talk about a fairly large hospital or certainly a middle-large to large hospital, a hospital that maybe does 5000 or more surgeries per year, it's not difficult to see a hospital like that saving 100 or more complications per year or a dozen or more deaths per year.

So 100 complications or a dozen deaths, what does that add up to? Well, that ups to dollars. And so we don't have to say what are we paying to improve care. We're improving care and saving money. That's critical.

How much money are we saving? Well, we have a long list now of very specific projects that hospitals have reported to us. They're just one-off projects that hospitals say, hey, look, we took the information you gave us and we did X, we did Y, we did Z.

So these can vary from one hospital who—which looked at urinary tract infections and reduced their incidents and saved \$380,000 in one year to a small group of hospitals that looked at infection rates and respiratory complications, reduced those incidences and saved about \$7.5 million in a year.

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The numbers vary anywhere from \$0.25 million for small improvement projects to \$7 million, \$8 million or \$9 million for larger improvement projects around more costly complications like pneumonias and infections.

And when we take that experience from hospitals and we do a little bit of theoretical projection across the entire hospital system, here's what we find. Let's say that a fairly large hospital could save about 250 complications a year.

Again, this is sort of in the middle of the range of what we're projecting. And let's use a very conservative cost of \$10,000 per complication. Again, we know that pneumonia can add \$50,000, \$51,000, \$52,000 to system cost. But let's use a very conservative number, \$10,000.

Well, it's not difficult to figure out 250 complications at \$10,000 is \$2.5 million. Again, for a fair sized hospital, a fairly easy savings to accomplish. Well, if we multiply that by 4000 hospitals across the country by 10 years of experience, we're up above \$100 billion being saved.

So my point to you, again, is not that I can prove to you that Bundling Payments works but what I can prove to you is that the opportunities are there. We've seen them. We've shown that they're there. We have experience with hospitals doing something about it, achieving improved care and reducing costs in the process.

So I will leave it at that and, again, I'm very appreciative to be included in this discussion.

**Andy Shin:**

Thank you, Dr. Hall. That was really, really helpful. At this time, I just want to take care of a little bit of housekeeping before we answer questions. If you look on your Webinar, hopefully the chat box feature function has been enabled and if you'd like to ask a question, please insert your questions there and we will try to aggregate as many similar questions as possible so we can get to everyone.

And if we don't get to you, I do want to just give off the email address that we (mend) almost 24/7. We will get to you as fast as possible and it's [bundledpayments@cms.hhs.gov](mailto:bundledpayments@cms.hhs.gov). And that link can also be found on our Web site, on the Bundled Payments for Care Improvement Web site, which is housed on the CMS Innovation Center Web site, which is [www.innovation.cms.gov](http://www.innovation.cms.gov).

## QUESTION & ANSWER SESSION

**Andy Shin:** And with that, we have some questions already and the first one we're going to ask our guest experts if they could field. And the first question is do the experts have any suggestions for how to approach physicians to partner in bundling programs? Perhaps, Dr. Falvey, did you want to take that one?

**Patrick Falvey:** Sure. In looking at that one, I think there was some of the early conversations that Valinda had (unintelligible) comments and with the thing that she wanted to look at was to understand the community needs. And I think if you're taking a look at what the community effort is, that's where I think you reach out to the community partner or to each of the partners that are addressing those and have that dialogue with them.

And if you've got a common community need that gives you a little bit more direction to reach out around that and, again, from my side, if you can support that with the appropriate data and the opportunity, that just helps focus the discussion.

**Andy Shin:** Great. I just want to—we're getting a lot of questions regarding the recording of this presentation as well as a slide deck and I just wanted to let everyone know that we will be posting a link to—or information regarding this recording. It will be available we hope in three business days or less and that will be on our Bundled Payments Web page as well as the slides.

You can find a slide deck that we have used that describes the Bundled Payments initiatives on the Web site as well and we will work to see if we can get the slides from this particular presentation posted as well but we'll have to work on that.

Going to the next question, so this is for the experts again. Based on their experience, do the experts have any estimated range of—and I'm just—any range of financial incentive payments in admitting attending primary care practitioner might receive from participation in a single bundled DRG?

**Patrick Falvey:** This is Patrick Falvey. From our point it's still too early. So, no, we don't have one at this point.

**Man:** It sounds to me like CMS may have run some of those numbers. Do you have any answers to that?

**Valinda Rutledge:** Well, they can get up to 50% but in terms of what—in terms of what is best practice and what optimizes in terms of the alignment, that is one of the things that we will achieve through this pilot is be able to determine what

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are the differences in the game sharing methodology that has been proposed by the participants and which ones are achieving the best practice. So we'll be able to know that through this pilot.

**Andy Shin:** Great. Thank you, Valinda. The next question is again for the experts around academic medical centers. And the question is: we would like to hear thoughts about the unique challenges for AMCs where many referrals come from regional systems.

When patients leave the facility, they go one or two counties over to rehab and follow up care where we have little or no relationship or influence. Does Dr. Falvey, Bruce or Stu want to take that?

**Bruce Hall:** We're more than happy to.

**Stu Guterman:** Well, let me jump in and so this is Stu Guterman. You know, unlike the other two speakers, I have no experience directly with the healthcare system. But the idea of bundled payment is to get folks to develop relationships where those relationships may not have been developed appropriately before.

And the general idea, even though it's attached to payment and it's payment that goes to providers, the idea is that payment ought to mirror what the healthcare system ought to look like, which is taking care of a patient across.

So the whole idea of trying to establish new relationship with providers who are going to be taking care of your patients after they leave your building I think is an important one to work on.

So that's something that both the discharging community hospital and the academic health center, you know, should be encouraged to work on and hopefully this alignment of financial incentives with that should encourage that kind of behavior.

**Valinda Rutelidge:** The other—I think along with that question, we get a lot of questions in terms of, you know, the applicants being concerned about having a financial risk and with the beneficiaries having choice.

And I think we've been very clear in all the (pollets) of the Innovation Center that we are going to protect beneficiary choice, which means that as we develop, whether it's pioneer or comprehensive primary care of bundle payments, we will be reinforcing that the beneficiaries have choice and so all the applicants have to look at innovative ways in which they are able to have a connection with the beneficiary that does not limit that beneficiary's choice.

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You can do that in several different ways. You can do that by having a lot in terms of education to make sure that you are explaining to the beneficiaries that you are part of this pilot; why, what's the value of the pilot, that they will be in a very coordinated manner and that the hospital physicians and the post acute providers will be working very—in a seamless continuum and so that they will feel that care coordination that they may not have felt in the traditional pay for service.

You can have educational materials that emphasize that. So I would tell anyone that says what kind of risk—I'm having a risk because I can't make the beneficiaries stay in the system and I'm like, yes, you do have a risk. And what we need to do as a system is figure out how to maintain the beneficiary choice but provide a care in which the beneficiary says I want to stay within this system. So that will be the challenge of all of this.

And I know that we're up to that challenge in terms of looking at how to engage beneficiaries to that they become full partners with us in terms of providing this care (unintelligible).

**Andy Shin:** Thank you, Valinda. We have a question now for Dr. Falvey in particular. And this is a question around the Aurora plan, which is if there are losses, does Aurora plan to impact physician reimbursement? In other words, how will losses be handled?

**Patrick Falvey:** That's one of the areas that we're looking in right now. As I mentioned, Aurora isn't currently in a bundled payment model. We're really in the pay for performance piece. So that's really, as we're looking at the community need piece on this and taking a look at the role of the physician and the incentive side behind it.

But as I said, we're in the application process and review ourselves right now, so we don't have a definitive answer on that now.

**Andy Shin:** Thank you. The next question we'll field here which is do all providers get paid their regular Medicare payments even when given a prospective payment? Is there any opportunity to negotiate rates where a proportion of the bundled payment for services with any of the providers?

So the first part of that question is whether or not providers get paid regular Medicare payments for the prospective payment in Model 4.

**(Carol Dize):** In Model 4, Model 4 is a prospective payment for both the hospital facility services that would be paid under Part A as well as the associated physician professional services for the physicians who are caring for the patient during that hospital stay.

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There is no—that payment will be made to the hospital. There is no requirement that the hospital pay the physicians at any specific rate in that regard. The physicians need to agree and we ask people to describe to us in their application what they intend to pay physicians as part of the program.

That's on Model 4. With respect to the other models, those don't directly affect physician payment Models 2 and 3. Everybody's paid under the usual fee for service and Model 1 is a scenario where there is basically a discount on the hospital DRG payment.

**Andy Shin:** Thank you. And for those on the phone, that was Dr. (Carol Dizel) who is the Deputy Director of the group if you didn't recognize the voice. And the next question is can sole community hospitals apply for this program?

**(Pamela Pogar):** This is (Pamela Pogar) with the Patient Care Models Group. Thank you for that question. We know that some confusing language has been perpetuated and we apologize for that. We would like to clarify at this time that sole community hospitals are eligible for this program. So if you are a sole community hospital, you are welcome to apply for the program because you are paid under the (IPPS) system, which is how the program is designed.

And if you have any questions about that or if you've been confused in the past and you want clarification, we would welcome you to use our email inbox for that purpose.

**Andy Shin:** Okay and here's another technical question which is a question regarding criteria for beneficiary inclusion in Model 3. Some post acute providers operate in large densely populated urban areas with millions of beneficiary and dozens of referring hospitals.

For the purposes of beneficiary identification, would CMS allow the applicant provider applying for Model 3 to limit the geography of the demo such that it would be restricted to beneficiaries living in some geographic area that was less than the applicant's full service area, for example, a subcounty or set of zip codes?

**(Carol Dizel):** This is (Carol Dizel) again. We have defined the episode under Model 3 as the initiation of post acute services at one of the four provider types within 30 days of hospital discharge for one of the eligible DRGs. So once the application and we have settled on those DRGs it's all patients who enter that post acute provider partnership with care who meet those episode criteria.

So that would not allow you to limit the patients based on the geography to one portion of your service area. It would be anybody initiating post acute

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services with you, if you were their awardee, that meets that episode definition.

And that episode definition is related to, again, the DRGs that are included here and then you must initiate those services within 30 days of your hospital discharge.

**Andy Shin:** Thank you, (Carol). So here's another question for the presenters on the phone. Have any of the organizations attempted to measure whether their total cost of caring for an enrollee member has declined since instituting any of the care redesigns?

And I understand that that is beyond just bundling for some of the presenters on the phone. But perhaps you can offer your general thoughts on that.

**Patrick Falvey:** This is Patrick Falvey. One of the things—well, we haven't done it specifically for Medicare beneficiaries. One of the things that we have been able to do is with our own health plan, Aurora Healthcare being itself an insured employer as well, we have over 40,000 members that we're helping manage their care.

And one of the things that we track on a regular basis is how well we're doing on both equality and the cost efficiency piece. And with our efforts, yes, we've been able to demonstrate a significant difference between our performance on our own employees compared to community averages of community targets.

And, in fact, over the last two years, we've been able to show a negative trend on some of our performance as well. So with that population, yes, getting the numbers on the others is a little bit difficult to do that same thing but not around Medicare beneficiaries at this point.

**Andy Shin:** Does anyone else have anything to add? Okay, the next question is about patient compliance or patient non-compliance. It says in your experience, how much of an impact does patient non-compliance have and is there a plan to address this component as it applies to readmissions?

So I guess we can describe the readmissions portion but if anyone on the phone first, the presenters, would like to discuss the impact of patient non-compliance or compliance.

**Patrick Falvey:** Well, again, Patrick. I know I keep responding but a lot of these are stuff that we're working on within our health system as well. It's a key component, you know, both the engagement of obviously the purchaser, the

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engagement of the provider and then a key component to the third part of that still is the patient's role in activating and engaging them.

And you know, some of the tools that were already mentioned from the, you know, patient education point, we're doing a variety of things around our electronic health record to make sure that we can communicate and stay engaged with the patient.

But that's going to be a key area to focus on to make a lot of these efforts work.

**Valinda Rutledge:** I would also anticipate that through this pilot we will be able to work with the applicants and determine what are best practices and be able to disseminate that. I think that, as you said, Patrick, I think it's something that we're beginning to learn as an industry that what works best in terms of patient engagement.

And I think that's something we'll learn through the pilot and we'll be working together with that and be able to disseminate that information with all of our awardees as we learn together.

**Andy Shin:** Thank you, Valinda. So the next question is more of a general philosophical question regarding whether or not any of the presenters on the phone have thought about payment arrangements, payment reforms that deal with downside risk for both physicians as well as the hospital, if you had any general thoughts about that or downside risk arrangements.

**Stu Guterman:** This is Stu Guterman. In the Pioneer (ACL) model and in the (ACL), the shared segments program, there is I think rightly the option for reaping more of the benefit if you succeed, if you're willing to take on more of the risk, if you don't succeed in holding cost down.

So, you know, I think that's a reasonable approach because there's been, you know, concern about one-sided risk models. So I think that's the tradeoff generally people face.

**Andy Shin:** Great. Thank you, Stu. So the other question was regarding the possibility of what sort of waivers regarding stark payment rules that we would, that CMS is considering for this initiative. And I guess our response would be— Valinda, do you want to take that?

**Valinda Rutledge:** Yes. So we have indicated in the application materials that are available that we understand that waivers may be necessary based on the program you're presenting to us. What we've asked that you do is request specifically the

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waivers that you need here. We're aware that some might be common across programs. Others might be unique to an individual program.

So we'd ask you to describe the waivers you need of our current regulations. We would ask you to explain the basis for the need for those waivers and then we'll assess that as part of our review of your application.

Once you come to the position where we're considering an awardee relationship with you, we would talk about those waivers specifically and we would make a determination about what waivers we would be offering to you and that would be incorporated in the agreement for your participation in the model.

So, again, we've specified—there are very clearly some areas where we anticipate many, many waivers but that holds really true across the board. So I would encourage you to be very specific in what you need and provide your rationale for that and then we'll evaluate that as part of our review of your application.

You know, in addition to what (Carol) said, I would also reinforce that it is important for us to understand that asking us to waive some of those regulations, those regulations were put in for the protection of the beneficiary.

So part of the conversation that we will have with each of you that are asking for waivers is how will you protect the beneficiary with the listing of that regulation? And so that will have to be part of our conversation but we have heard from many of you out into the industry that some of the regulations you think are preventing you from redesigning the care.

And so we certainly want to be able to discuss opportunities for you to get those waivers.

**Andy Shin:** Thank you, Valinda. Here's another question for you, if you don't mind. How are the post acute decisions and/or hospitals aligned within the Bundled Payment? Whom makes—or to whom or whom makes the alignment? So it's asking who does the alignment and how they...

**Valinda Rutledge:** Well, I think it depends on who's providing the leadership within the community. I think it could come from any of those three. It could come from a large physician group that sort of says, you know, how we take care of our patients that have stroke in this community is not best practice and we want to change that.

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So they can go to post acute providers. They could go to the hospital and sort of say let's have a meeting a talk about putting together an application for one of the bundles to allow us to look at a redesign. It could be the post acute provider that say I think there's a different way in which we're taking care of patients.

So once they're discharged from the hospital, so let's do a Model 3 and I want to put together a meeting of post acute providers in the community to look at a different way that we can provide the care.

So which one? It's all three. It's whoever provides the leadership within the community. It's whoever stands up and sort of says I think there is a new and better way that we can take care of our patients in this community and we have an ethical responsibility for that and let's work together in terms of redesigning that care.

I would tell you, Andy, what we're hearing is we're expecting an incredible amount of response for the Bundled initiative. As you know, Model 1 has closed already letters of intent and we got incredible numbers for Model 1 and we're expecting similar for Models 2, 3 and 4.

So I think it really is thrilling for all of us to recognize the degree of commitment that there is out into the community, out into the nation to sort of partner with each of us in the Innovation Center to redesign care for the entire nation.

I think this is an exciting time in our history and I would ask each and every one of you to be a part of this transformation with us.

**Andy Shin:**

Thank you, Valinda. And I think that we're going to take one last question which has been a—we've got this a lot and it's really at the heart of what this presentation was about. It's something that Dr. Falvey talked about doing in other means at Aurora and what Stu put into context of why we need certain payment and care delivery reforms.

It was something that Dr. Hall talked about in terms of quality and we really—the question that seems to have come up a lot is, Valinda, Ms. Rutledge, can you please explain to us what you believe are the key advantages of Bundling Payments?

**Valinda Rutledge:**

Yes, I would tell you that a key advantage is we all understand that cost needs to come down and will be coming down in the future. We all understand that the rates both from the government, from the state and from private will be decreasing over the next few years.

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We can look at it from a difference perspective. In the past, all we have done is looked at how can we reduce costs in a very traditional way? Some of that, as I said has not been sustainable. You take the cost out and 24 months later you are right back to where you were in the system.

And so we know that those have not been sustainable. And, in fact, at times, those actions have impact the quality of care. So we've got to look at it in a very different perspective. And what the Bundle Payment does is it allows you to work together with all the providers in your community and look at how you redesign care along the continuum.

You can start within the walls of the hospital with Model 1 and Model 4 but you can very quickly go to Model 2 and Model 3. And, in fact, we anticipate many organizations doing all four of them or at least 1, 2 and 3 together.

So we expect to see a lot of people sort of saying there's lots of opportunities here. We know that cost needs to come down and we want to do it in a way in which we protect quality of care and better serve our communities.

And so I think that is where we are at in terms of the implementation of the Bundle Payment initiative. It allows you to do that. We are going to work together as partners with all of you. We're going to give you the resources to be successful as you are awardees in this initiative.

We will learn together. We will work together for you to be successful, for us to learn as an innovation system and you will be a part of transforming healthcare in this country.

**Andy Shin:** Thank you, Valinda. That was very eloquently put. It really boils down to allowing or getting towards care redesign by getting the clinicians in different healthcare providers and all throughout the care continuum together on track for care redesign, wouldn't you say?

Valinda Rutledge: Yes.

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## CLOSING REMARKS

**Andy Shin:** Well, with that, we really want to thank the guest speakers for participating today as well as all the listeners. But before we close out I will go over some key dates and information, some of which is in front of you on your slide.

The letters on intent from Model 1 were due on October 6, 2011. We received a lot of great interest there. And if you did not submit a letter of intent for Model 1, unfortunately, we will not be accepting your application.

The applications for Model 1, however, are due on November 18th. If you have any questions regarding that, please send your questions to our email box, [bundledpayments@cms.hhs.gov](mailto:bundledpayments@cms.hhs.gov).

Further nonbinding letters of intent for Models 2 and 4 are due on November 4, 2011, along with a research request packet and data use agreement. If you are interested and requested CMS data for use in your application, we are providing that data.

The applications for Model 2 and 4 and due on March 15th and that will be 2012. Once again, if you have any other further questions, please see the Innovation Center Web site where we will post a link for this audio recording hopefully within three business days and then we will be able to answer any of your questions there either with the materials, the application materials, fact sheets, etc cetera, a slide presentation, not this one.

We'll work to get this one up; but once again, [bundledpayments@cms.hhs.gov](mailto:bundledpayments@cms.hhs.gov). We really want to thank you once again from—on behalf of Valinda Rutledge and the rest of the Bundled Payments team here at the Innovation Center, Dr. Falvey, Stewart Guterman, Bruce Hall.

Thank you so much and have a great afternoon.

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