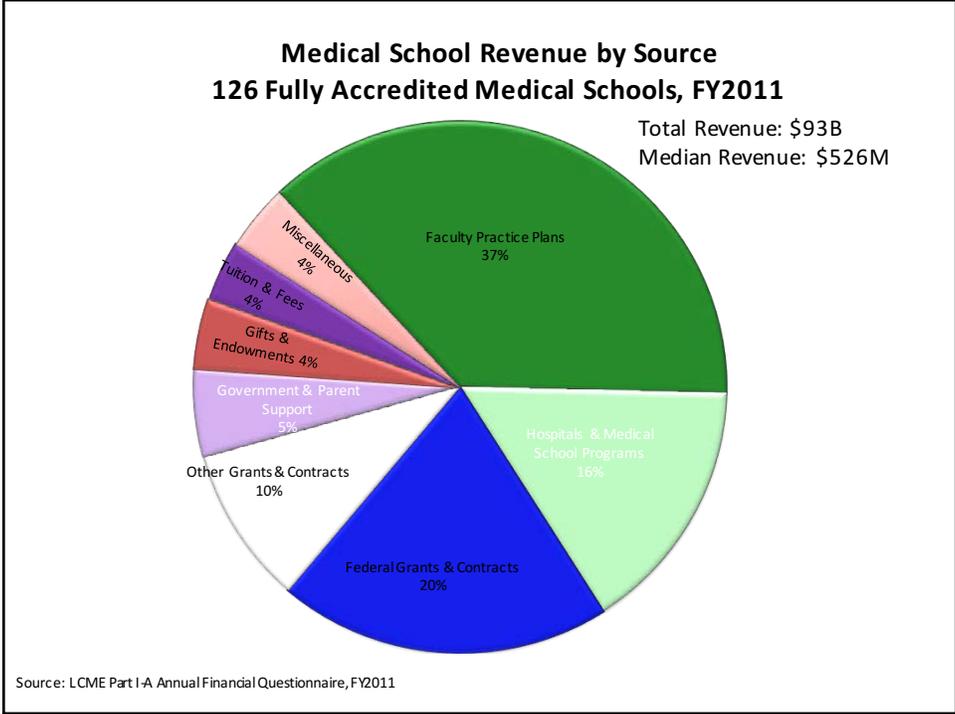
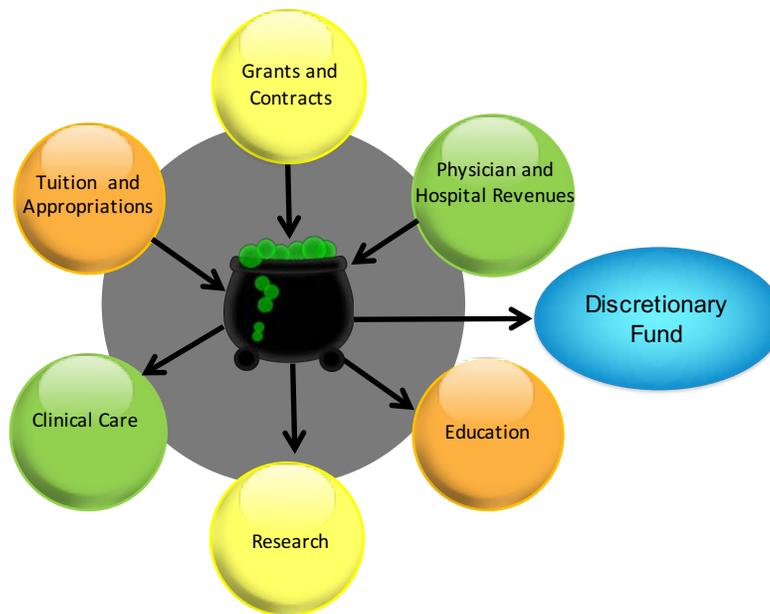


Receiving your fair share through Bundled Payments or Funds Flow

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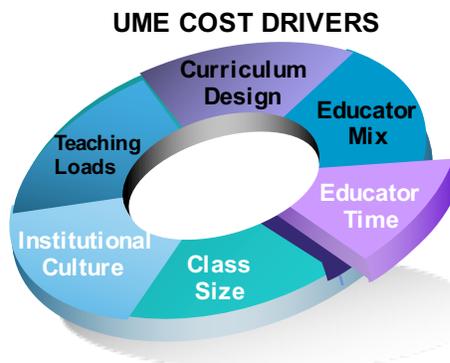


The Cauldron



We Lack Good Data on Cost

- Cost estimates vary widely by methodology—no basis for comparison
- Accurate assessment of faculty effort is key—and difficult to achieve
- Outcome measures are limited—for UME and GME



"The cost of medical education has been an issue of public concern for nearly 100 years."

*Robert Jones & David Korn
On the cost of educating a medical student.
Acad Med 72:200, 1997*

Why healthcare is local

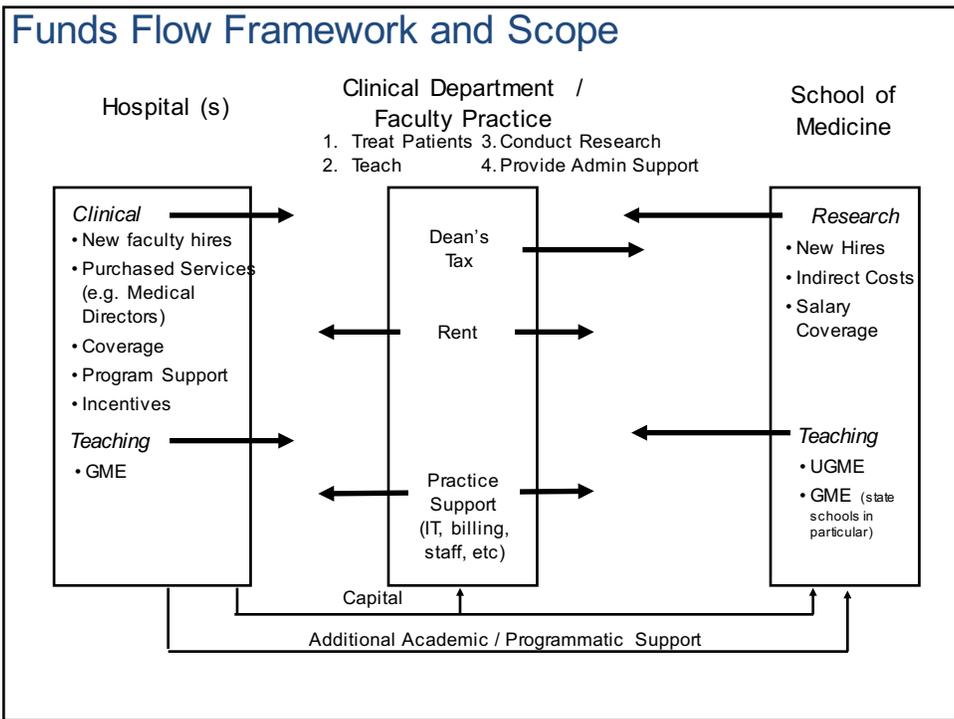
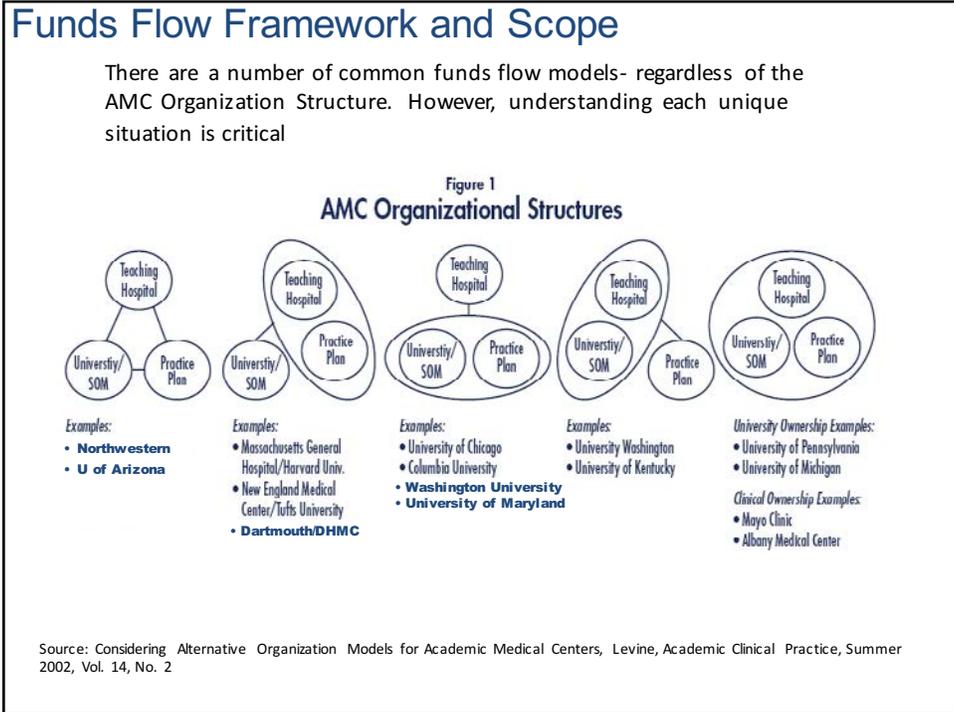
- Anesthesia units paid by private insurers at large multiple of Medicare rates
- Actual multiple varies greatly by geographic area and payer
- Payer mix has an exaggerated effect on total revenue compared to other specialties

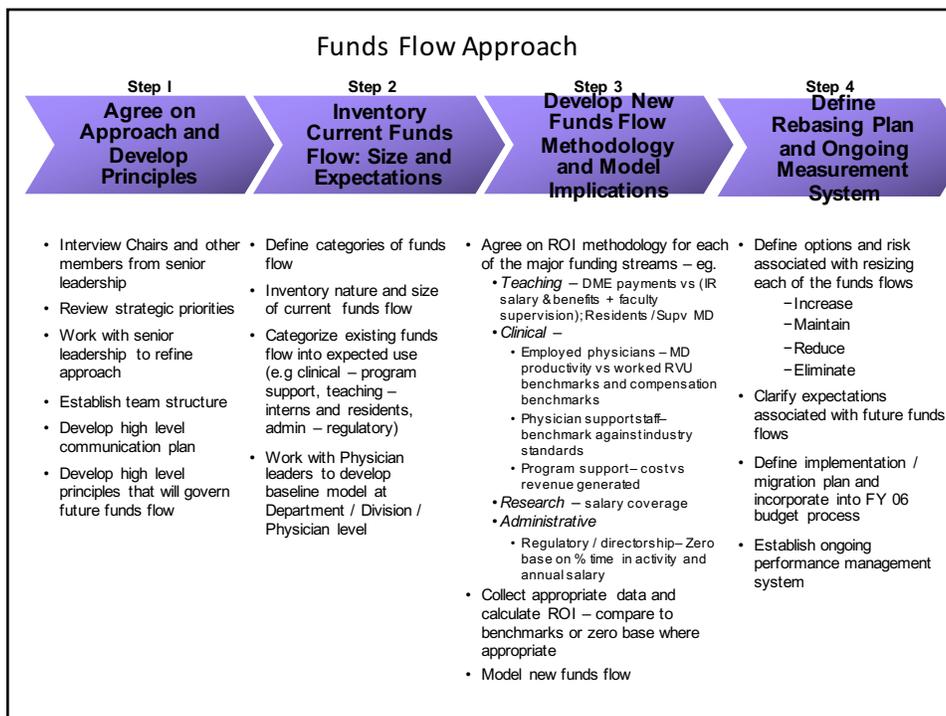


relationship between revenue and work has great variability between AMCs

Funds Flow Defined

Funds Flow is more than simply the exchange of money for services rendered. It is one of the major vehicles by which academic medical centers, schools of medicine and faculty practice plans *align their strategies, define expectations and support one another.*





Defining Various Funds Flow Methodologies: Teaching

- Faculty Supervision
 - **GME:** Support for faculty time spent supervising interns and residents, based on ratio of faculty to residents (1:6 in cognitive departments, 1:10 in procedural departments)
 - Based on average departmental faculty salaries (capped) and appropriate ratio of faculty to residents
 - **UGME:** Time spent by faculty in supporting medical student activities. Support based on teaching RVUs
- Administrative support to achieve ACGME standards/ requirements
 - 5-tiered system based on total # of residents/faculty and ACGME standards

Defining Various Funds Flow Methodologies: Research

- Academic development funds to support new faculty research
 - Support guarantee based on projected start-up and support costs for a 3-5 year period, using ROI approach
- Indirect cost sharing
 - Support for research administration and overhead expenses borne within the departments
 - Clinical departments will receive percentage of indirect cost revenues, based on home department of PI
- Salary coverage incentive payments
 - Provided to departments that meet research salary coverage targets, on a sliding scale
 - Coverage to help support scholarly time associated with research activities and salaries that are above the NIH cap
 - % of faculty salary up to NIH cap (% varies by faculty appointment)

Defining Various Funds Flow Methodologies: Clinical

- Purchased services:
 - Compensation for a clearly defined role which has a job description & specific performance measures, e.g., 25% of Chair salary, benefits, malpractice; 15% for Medical Director of ICUs
- New Hires:
 - Support for new physicians entering the marketplace and establishing their practice. Three-year guarantee provides incentive to outperform budgeted figures
- Programmatic Support:
 - Provide sufficient support so that the clinical mission is breakeven if department is clinically productive (65th percentile in UHC benchmarking) and is operationally productive (department infrastructure). Departments need to explain what is driving their losses (e.g. payor mix, malpractice, hospital mission, etc.)
- Incentives:
 - Provide to departments / services to support a specific outcome, e.g. new margin or improved patient satisfaction

Funds Flow – Broader Implications – Clinical Productivity

- Issue: Hospital leadership wants to ensure that monies being distributed on the clinical mission are for productive departments / faculty
- Solution: Clinical Chairs and Faculty Practice agree on a clinical productivity standard that will be measured at least annually
 - There are a number of different clinical productivity tools to consider though the UHC database is often used because:
 - Large dataset of *academic* practices
 - Frequent updates (quarterly vs annually)
 - Ability to choose percentile comparison
 - Clinical Chairs and faculty practice must also agree on a standard (e.g. 50th, 65th, 75th)
 - Tie funds flow to the department at large vs an individual faculty
 - Communicate CFTE expectations annually and share current performance at least quarterly

Lessons Learned

Lessons Learned

- Leadership – School, Faculty Practice Plan and Hospital – need to agree on objectives upfront and strategic importance
- Continue to remember that Funds Flow is as much about the external environment as it is about internal distribution of money
- Engage Clinical Chairs as soon as possible and communicate frequently
- Agree on Scope upfront – broader is generally better
- Be prepared to address a number of related issues including faculty productivity & comp, overhead, P&Ls by Mission, etc
- Data needs to be transparent – within the department, within the practice plan, between the entities
- Keep it simple
- Create incentives so that performance above expectations can be rewarded
- Aligning expectations may not be seen so favorably by all
- Make new agreements multi-year

Underlying Principles

- | | |
|--|--|
| Align with Penn Medicine Strategic Plan | <ul style="list-style-type: none"> • Promote partnership based on a shared commitment to vision, mission and values • Comply with all regulations |
| Fair and Transparent | <ul style="list-style-type: none"> • Foster open dialogue and full disclosure of all relevant information • Rely on data and fact-based information in making decisions <ul style="list-style-type: none"> – Realize data informs decision making but cannot replace it • Utilize consistent categories, practices and policies • Future funds flow will include clear articulation of the specific purpose of the funds, quantitative and / or qualitative performance expectations, as well as duration of support |
| Match Revenue with Expenses | <ul style="list-style-type: none"> • Be based upon a rational, value-based model, matching services and benefits to financial arrangements |
| Provide Appropriate Incentives | <ul style="list-style-type: none"> • Appropriate incentives (upside and downside) will be put in place to encourage <ul style="list-style-type: none"> – <i>Achieving</i> system growth objectives and goals; – <i>Exceeding</i> system growth objectives and goals • Expectations for individual faculty productivity must be tied to compensation and communicated at least annually • Funds flow should provide some opportunity for gain sharing related to future margin growth |
| Measure and Monitor Over Time | <ul style="list-style-type: none"> • Establish clear measures of performance for ongoing monitoring |

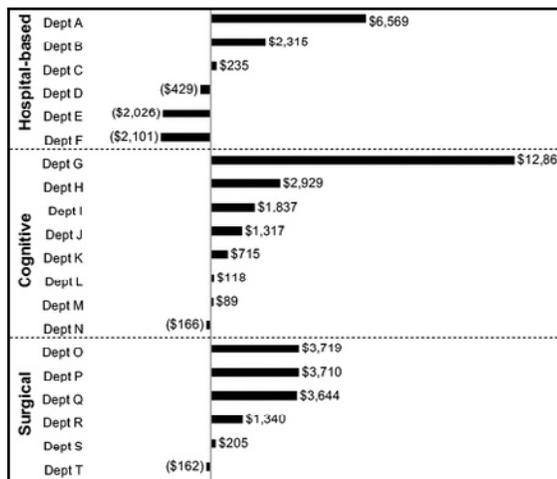
Clinical Model: Incentives

Incentives

- ▣ Incentives will be provided to departments / services to support a specific outcome – for example new margin or improved patient satisfaction
- ▣ Not all departments will receive an incentive payment. Incentives will generally be targeted to areas of strategic importance and / or ability to significantly contribute to the System's program growth targets
- ▣ Incentives should have some risk on both upside and downside – e.g. if Dept does not achieve a certain threshold than some portion of their programmatic support would be reduced. If however, the threshold is achieved and more, the department should get more than just the identified programmatic support

Aligning Academic and Clinical Missions Through an Integrated Funds-Flow Allocation Process.
Kennedy, David; Johnston, Elizabeth; Arnold, Ethan

Academic Medicine. 82(12):1172-1177, December 2007.
DOI: 10.1097/ACM.0b013e318159e1b8



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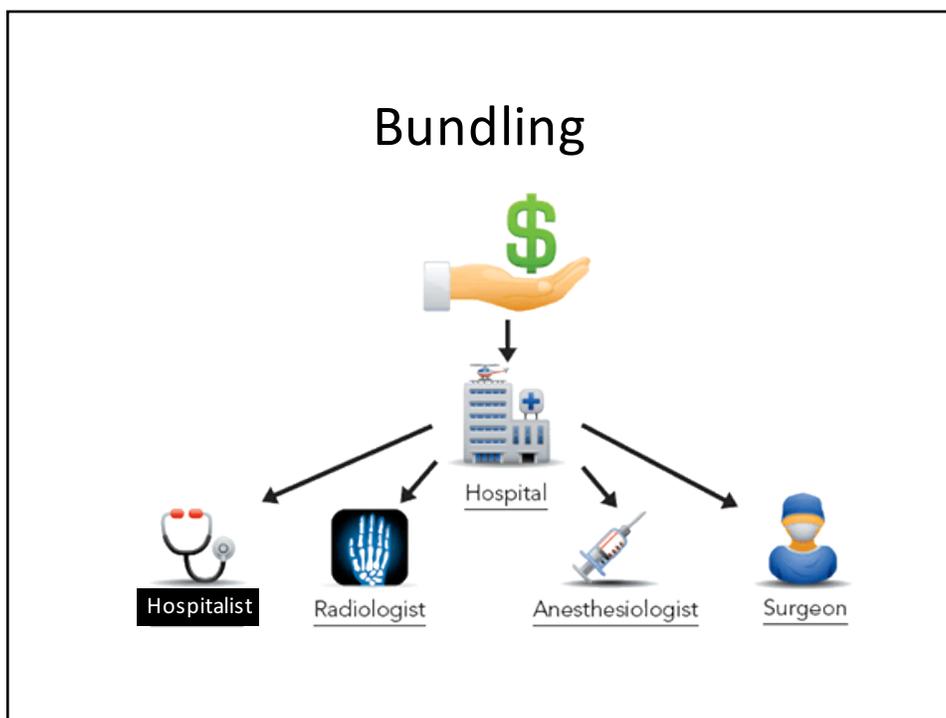
The NEW ENGLAND JOURNAL of MEDICINE

2018. Perhaps even more important, our target is to have 30% of Medicare payments tied to quality or value through alternative payment models by the end of 2016, and 50% of payments by the end of 2018. Alternative payment

Perspective

Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care

Sylvia M. Burwell



**DEPARTMENT OF HEALTH AND
HUMAN SERVICES**

**Centers for Medicare & Medicaid
Services**

42 CFR Part 510

[CMS-5516-P]

RIN 0938-AS64

**Medicare Program; Comprehensive
Care for Joint Replacement Payment
Model for Acute Care Hospitals
Furnishing Lower Extremity Joint
Replacement Services**

AGENCY: Centers for Medicare &
Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

Piece of Pie



■ THE OPEN MIND

The Perioperative Surgical Home as a Future Perioperative Practice Model

Zeev N. Kain, MD, MBA,* Shermeen Vakharia, MD, MBA,* Leslie Garson, MD,* Scott Engwall, MD, MBA,*
Ran Schwarzkopf, MD,† Ranjan Gupta, MD,† and Maxime Cannesson, MD, PhD*

we have made in patient safety.²⁰ Surgeons are typically not interested in the medical management of their patients and are currently not involved in their preoperative optimization. It is our opinion that while hospitalists are interested in getting involved in the management of the PSH, they lack the fundamental understanding of perioperative physiology that results from the surgical experience and thus are not ideally positioned to deliver optimal postoperative care.

Disrupt relationships



The American College of Surgeons (ACS) has a long-standing expectation that its members will safeguard their patients' care throughout the course of surgical treatment. The ACS *Statements on Principles* state, "The surgeon is responsible for the patient's safety throughout the preoperative, operative, and postoperative period, including the responsibility for eliminating wrong-site, wrong-procedure, and wrong-patient surgery."

The College and other stakeholders are now developing recommendations on how best to ensure that patients receive safe, high-quality surgical care. Some of you may be familiar with the perioperative surgical home (PSH), which the American Society of Anesthesiologists (ASA) has proposed. The ASA has brought forth the PSH as a model of delivering health care throughout the patient's entire surgical care experience—from decision making through recovery.

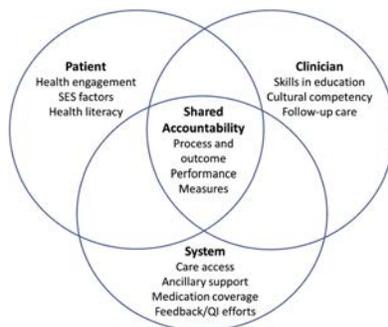
Under the PSH paradigm, the patient's care would be coordinated by a director of perioperative services. The ASA suggests that a physician is best suited to this role. Application of this concept must be compatible with the surgeon's sense of responsibility for overseeing all aspects of surgical patient care, although surgeons welcome collaborative efforts to ready patients for an operation with the anesthesiologist acting as partner. The leaders of the ACS and the ASA have been discussing perioperative care, and the ACS will continue to work with the ASA to ensure that all of the surgical patient's needs are properly met.



Bundled Payment Programs



What is shared accountability?



Surgery Quality Measures: Outcome

Quality Measure	HIQRP	HVBP	HRRP	HACRP
SSI: Procedure specific surgical site infection outcome measure (NQF #0753)	X	X		X
PSI 4: Death among surgical inpatients with serious, treatable complications (NQF #0351)	X			
PSI 90: Patient safety for selected indicators (composite) (NQF #0531)	X	X		X
CABG 30-Day Mortality: Hospital 30-day all-cause, risk-standardized mortality rate following coronary artery bypass graft surgery	X			
CABG 30-Day Readmission: Hospital 30-day all-cause, unplanned, risk-standardized readmission rate following coronary artery bypass graft surgery	X		X	
Elective THA/TKA 30-Day Readmission: Hospital 30-day all-cause, unplanned, risk-standardized readmission rate following elective primary total hip arthroplasty and/or total knee arthroplasty (NQF #1551)	X		X	
Elective THA/TKA Complications: Hospital-level risk-standardized complication rate following elective primary total hip arthroplasty and/or total knee arthroplasty (NQF #1550)	X	X		
All-Cause Unplanned Readmission: Hospital-Wide All-Cause Unplanned Readmission (NQF #1789)	X			

A couple of options



How do we divvy up the pie?

- Traditional FFS
- Fixed payment
- Lower fixed payment and share in any profit margin
 - Should the anesthesiologist be allowed to share in potential reward?
 - Does the anesthesiologist want to assume any risk?

