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**Bundled Payment Programs: Strategic & Tactical Planning**

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**Patient Protection and Affordable Care Act (PPACA) / Health Care Reform**

- Hospital Value-Based Purchasing
- CMS' Bundled Payment for Care Improvement
- Medicare Shared-Savings Program/Accountable Care Organizations
- Hospital Readmission Reduction Program

*Developing the competencies required to be successful in each of these initiatives contributes to achieving the goals of healthcare reform, and prepares providers to maximize performance-based reimbursement.*
**Agenda / Learning Objectives**

- Developing/implementing bundled rate programs
- Focus on the essential elements of bundled payment program development and operational requirements for “bundled” technical and professional (global) reimbursement administration
- Learn the requirements for developing a foundation for a bundled payment program, including financial alignment tactics with physicians and other healthcare providers
- Learn methods of gain-sharing and development of quality bonuses for high-performing providers and administration for bundled payment programs

**Medicare Advantage (MA) and Physician Incentive Plans (PIP)**

- MA organization: Requirements for “Physician Incentive Plan”
  - No specific direct/indirect payment to physician/physician group that may have the effect of reducing/limiting care to an enrollee
  - Individual/aggregate stop-loss protection for services not furnished by the physician/physician group
  - Enhanced reimbursement for the participating physicians
- Entity (i.e., Health System) may pool commercial and Medicare enrollees of several MA organizations with which a physician or physician group has contracts
- Physicians can receive up to 125% of the equivalent Medicare FFS rates with MA plans
Bundled Payment Programs

• Promoted by healthcare reform
  – To improve the delivery of care
  – To enhance efficiency
  – To manage/reduce costs
• Bundled payment programs
  – Acute Care Episode (ACE) Demonstration
  – CMS Bundled Payment for Care Improvement Initiative
  – National Pilot Program

CMS’ Bundled Payment for Care Four Models of Care

• Model 1 – Retrospective acute care hospital stay only
• Model 2 – Retrospective acute care hospital stay plus post-acute care
• Model 3 – Retrospective post-acute care only
• Model 4 – Prospective acute care hospital stay only
CMS’ Bundled Payment for Care
Four Models of Care, Cont.

• Models 1 – 3
  – A global budget target price is set for the entire EOC
  – Providers paid fee-for-service for all services within the EOC less a 2% discount by CMS
  – Upon completion of the EOC, payments are reconciled to target price
  – Savings achieved from target price are distributed
  – Spending over the target is at risk and returned to CMS
• Model 4
  – No reconciliation; a single prospective payment per EOC

Development of a “Value Proposition” for Bundled Payment Programs

• Business strategy – one fee for an episode-of-care (EOC)
• Defines the “value” of the bundled payment program
  – Quality of care
  – Cost management/reduction
  – Coordination of delivery of care/care management
• Differentiates provider’s program in the marketplace
• Provides enhanced customer satisfaction
Episodes of Care: Appropriate Services for Bundling

- Joint Replacement
- Obstetrics
- Bariatric Surgery
- Coronary Artery Bypass Graft (CABG)
- Valve Replacement
- Neurosurgery

The Future of Performance-Based Reimbursement

- No longer a trend
- Implemented by government payers; in process of adoption by private payers
- Rewards providers for quality of care improvements/health outcomes
- Requires providers to work collaboratively to coordinate care, manage costs and produce quality outcomes
- Payment for quality rather than volume
- Initial models were “no risk” – providers shared in upside savings only
- Newer models require providers to share or assume losses over target budget
**Direct Contracting: Definition and Characteristics**

- Direct contracting model: Large employer groups contract directly with a hospital(s) to provide medically necessary services to its employees
- Typical characteristics of direct contracting model
  - Providers are experienced specialists in service offered
  - Cost predictability for employers
  - Bundled professional and technical services
    - Single claim/bill from the hospital to employer/administrator
    - Physicians and other providers reimbursed by the hospital
  - Bundled payment/episode-of-care (EOC), may include pre-admission and post-discharge services
  - Qualified warranty for readmissions and revisions

**Direct Contracting: Bundled Payment Example**

- Baseline: Total of all hospital, physician and ancillary services at the payer’s negotiated rates
- Bundled payment under a direct contracting model may be 10% - 20% less than the baseline
- Bundled payments require provider integration and accountability to manage cost and deliver quality

Result: Maintain and increase marketshare for specified services under the direct contracting program
Example: Health System’s Bundled Payment Program

- Selection of orthopedics/joint replacement
  - Patient demand
  - Competitive advantage/protection of market share
  - “Bundling” and EOC
    - Single fee for an EOC, e.g., joint replacement includes pre-admission through 90 days post-discharge; readmission/revisions, as necessary
- Cost management
  - Medical devices/implants
  - Addresses complications
  - Supports readmission and revision reduction program

*Joint replacement procedures are somewhat more predictable to establish a bundled payment program.*

Bundled Payment Program, Cont.

- Joint replacement CMS MS-DRGs (v. 30) included:
  - DRG 466: Revision of hip or knee replacement with MCC
  - DRG 467: Revision of hip or knee replacement with CC
  - DRG 468: Revision of hip or knee replacement without MCC or CC
  - DRG 469: Major joint replacement or reattachment of lower extremity with MCC
  - DRG 470: Major joint replacement or reattachment of lower extremity without MCC
Bundled Payment Program, Cont.

• Providers to be included in the single payment
  – Hospital
  – Orthopedic surgeons
  – Physician assistants (PAs)/Surgical PAs
  – Anesthesiologists
  – Hospitalists
  – Physical therapists
  – Pathologists

Bundled Payment Program, Cont.

• Services to be included:
  – Professional and technical services
  – Pre-admission (3 days prior, limited to PAT)
  – Acute inpatient stay
  – Post-surgical follow-up
  – Physical therapy
  – Readmissions/revisions, as necessary, within 90 days post-discharge
Bundled Payment Program, Cont.

• Services *not included*:
  – Physician/professional consults for any physician specialty/allied health professional not specified above for the EOC duration
  – Services rendered by participating providers during the EOC that are not specific to the joint replacement (i.e., 3 days pre-admission, acute inpatient stay and 90 days post-discharge)
  – Revisions and/or readmissions not warranted by participating providers due to patient non-compliance and unrelated admissions, complications, co-morbidities
  – Patient convenience items; non-medically necessary services
  – Bi-lateral joint replacement procedures

The Bundled Payment Program: Defining Goals and Objectives

• Health System’s Objectives
  – To establish the joint replacement bundled payment program at the Health System Hospital
  – To expand the program to affiliated hospitals
  – To set the stage for cardiothoracic surgery (CTS) bundled payment programs (i.e., CABG, valve replacement)
  – To replicate the bundled payment programs for other services (e.g., obstetrics, bariatric surgery)
  – To align hospital and physician incentives and enhance the relationship with key physician groups
The Bundled Payment Program: Development of a Clinical and Financial Alignment Strategy

• Clinical alignment/collaboration
  – Coordination along the continuum of care
  – Use of best practices/evidence-based medicine
  – Focus on quality issues (i.e., HAIs, complications, revisions, readmissions) thereby improving outcomes
  – Management of resources/elimination of unnecessary use of resources
  – Enhancement of patients’ experiences of care
  – Refinement of patient compliance programs (i.e., post-discharge)


• Financial alignment
  – Identification of resources and costs
  – Planning for cost reduction and cost management
  – Hospital and surgeons collaboration in developing a more economical program for implant acquisition, using one to two vendors (i.e., basis for internal gain-sharing)
  – Arrangements with health plans (commercial, government payers) and direct contracting with large/local self-funded employers; opportunities to generate incremental revenue for the Hospital and physicians

Provider collaboration is essential to succeed in reimbursement methodologies based on performance.
Information Technology (IT)

• Identification of IT required to plan and operate the program
• Electronic health records (EHRs)
• Clinical and financial data collection and analysis; operations management
  – Historical data for analysis and planning (EOC definition, pricing)
    • Health System
    • Physician Practices
  – Budget design
  – Current data for tracking service delivery/coordination by providers
  – Tracking resource consumption

Information Technology (IT), Cont.

– Current data for Health System and payers to track the flow of funds
– Current data for distribution and reconciliation of funds between health plans and providers
• Health System (HS) and program participants jointly develop reporting for:
  – Communication platform among program participants
  – Meeting payer requirements
**Budget / Budget Structure**

- Identify the cost of services within the defined EOC (use historical data)
- Set a target price (e.g., total price, total cost plus)
- Need Agreement between HS and payers, and underlying agreement between HS and participating providers (i.e., provide single signatory authority, allocation of payments to providers)
- Specify and develop process to manage the flow of funds from payers to HS to participating providers
- Define measures that tie performance to payment

**Episode-of-Care Budget Line Items**

- Facility component
- Orthopedic surgery component
- Post-surgical radiology
- Anesthesia – surgery
- Anesthesia – consults
- Anesthesia – other (pain management)
- Consult reimbursement (if applicable)
- Pathology
- Post-discharge physical therapy
- Contingency
Contingency Budget

- Per-case contingency dollar amount
- Estimated total number of cases per year
- Total contingency budget: \# cases x per case contingency amount
- Contingency allocation: Funding for unexpected cost; remaining/unused funds
- Historical readmission data used to establish a baseline readmission and revision rates with a margin of error

Contingency Budget, Cont.

- Unused contingency budget dollars can be returned as a program revenue bonus and allocated based upon the percentage of total case reimbursement
- Allocations
  - Health System
  - Surgeons
  - Anesthesiologists
  - Pathologists
Potential Cost Savings: Implant Vendors

- Establish committee involving physicians
  - Align physicians toward goal of acquisition cost/efficiency
  - Try to maintain physician preference
- Reduce the number of vendors
- Negotiate with vendors based on a product price cap
- Utilize selected marketplace benchmarks to identify potential savings opportunities
- Implement gain-sharing and use this platform to expand to other surgical procedures

Business Considerations

- Approval of global budget for joint replacements (DRGs 466-470) – Health System and participating physicians
- Program administration – Health System
  - Negotiation with payers/local employers (direct contracting)
  - Program reimbursement and payment to providers (within 45 days of receipt of payment)
  - Percentage of program’s administrative cost may be allocated proportionally to participating providers as an offset to program reimbursement
Performance Measurement

• Preparation for performance measurement
  – Define performance to be measured/establish metrics
  – Staff education
  – Documentation requirements, including justified/unjustified variation from best practices
  – Test metrics for measuring performance

Hospital and Physician: Financial and Payment Models

• Development of internal hospital and physician financial and payment models and arrangements for allocating payments
• Determine negotiated payment for providers participating in the EOC
• Development of payment reconciliation procedures and structures to distribute payment to providers
Hospital and Physician: Financial and Payment Models, Cont.

- Coordinate programs for quality improvement/outcomes and efficiency
  - Development of quality bonuses for high-performing providers
  - Administration of payer-specified metrics (e.g., reductions in HAIs, HACs, LOS) for incremental reimbursement
- Mechanisms for shared-savings
  - Reconciliation of quality metrics to determine incremental reimbursement
  - Development of internal gain-sharing to allocate savings and/or incremental reimbursement from payers

Administrative Issues / Solutions

- Identification of participating patients during pre-authorization of services (e.g., new payer financial classes)
- Recording hospital and physician encounter data
- Reconciliation of retrospective adjustments
- Developing a “warranty” for inpatient services (i.e., defining preventable readmissions)
- Management of unrelated healthcare issues during the global episode
- Administration of billing and payment by both providers and health plans
Administrative Issues / Solutions, Cont.

• Determine a process for booking bundled payment revenue (technical and professional services)
• Creation of additional hospital expense categories to account for physician and other provider payments
• Develop in conjunction with the payers a method of allocation for the patient’s financial responsibility
• Identify the triggers to initiate and complete the bundled payment program from clinical and financial perspectives
• Commence and internal gain-sharing program inclusive of financial considerations in conjunction with appropriate cost-reduction and clinical outcomes
• Address the likelihood of duplicate payments to the physicians and other ancillary providers

Lessons Learned / Recommendations

Goal: The right services at the appropriate level of care, delivered cost efficiently, with targeted outcomes

• Physician engagement and financial alignment
• Timely communication and feedback
• Provider accountability
• Monitoring and control mechanisms
  – Documentation
  – Case management
  – Proactive responses to budget exceptions
  – Program administration
• Maintain and expand market share
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