M. Bundled Payment: Practicalities, Contracting, and Governance

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Overview

- Definitions, Distinctions, Conflations
- Medicare Bundling Experiences
- Commercial Bundled Payments
- Constructing Bundles
- Provider-Payor Contract Issues
- Provider-Provider Contracting and Governance Issues
Definitions

- "Bundled": Two different providers
  - Often paid in two different ways
    - e.g., DRG and FFS
  - Intent to align incentives by putting everyone in the same risk pool
- "Episode or Case Rates": More than a single admission
  - Care over a defined period of time
  - Pre-admission, admission, post discharge
  - Chronic care is usually for a year to coincide with premium year
  - Can be defined by the diagnosis to the end of the disease or condition
- Episodes need not be bundled, but almost all bundled payments entail episodes

Distinctions

- Payment
  - Post care reconciliation with providers paid in the ordinary course
  - Sometimes paid to one entity -- Medicare ACOs
  - Sometimes a bundled budget -- PROMETHEUS
  - Rarely prospective, but it can be
- Gainsharing
  - The incentive to work together to earn remainders in budget
  - Sometimes based on achieving a threshold of quality first
  - Sometimes based on saving over a baseline
- Technical risk (incidence risk) versus medical management risk
Conflations

- Capitation is not bundled payment
  - Primary care cap is not bundled with anything
  - There may be risk for utilization but it is not necessarily bundled
- Percent of premium and global cap can be bundled but aren’t necessarily
- Capitation is an insurance concept
  - Has nothing to do with quality; it is historical with incidence risk
  - The perverse incentive is underservice

Medicare Bundling Experience

  - 7 hospitals paid for hospital and physician services
  - Saved Medicare $42 million on 10,000 procedures – lower LOS, drug management, decreased post-discharge care
- 3 year cataract demonstration
  - Bundled facility costs, physician fees and supply costs
  - Saved $500,000 over 4500 procedures
Medicare ACE Demo –Began 2009

- Discounted payment from what would have been paid
- Cardiac procedures
  - CABG, heart valve, defibrillator and pacemaker implants, angioplasty,
- Hips and Knees
- Medicare shares 50% of the savings with *beneficiaries* up to the full Part B premium
- Physicians can get up to 25% additional payment

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Medicare Bundled Payment for Care Improvement Initiative

- Mandate in the ACA: §3023 adding §1866D to the Social Security Act
- What is to be bundled?
  - Physicians, hospital inpatient and outpatient services
  - Post-acute care including home health, skilled nursing, rehabilitation and long term care
  - Mix of chronic and acute, surgical and medical, high volume, subject to significant variation and opportunity to improve quality while reducing total expenditures
- Defined episodes to include 3 days prior to admission, length of stay, 30 days post discharge
- Evaluation by a third party
Looked like “design your own bundles”

☐ Pick the conditions you want
☐ Define them yourself
☐ Establish your own budgets
☐ Define your own bundles and who is included within them
☐ Choose among any of the four models initially proposed

BPCI Models

☐ Model 1: Retrospective payment for inpatient hospitalization only

- Physicians to be paid fee for service
- Physicians could share in upside (gainsharing)
- After applications were submitted CMMI pulled the model for further review
More BPCI Models

- Model 2: Retrospective payment for and admission and post-acute care – 30 or 90 days post discharge at the applicant’s option
  - Physicians and hospital care plus post discharge including laboratory, DME, drugs, rehab and whatever else the patient requires
  - Physicians can share in gainsharing
  - Downside risk too-- money has to be repaid to Medicare if the budget is exceeded
More BPCI

- Model 3: post-acute care only beginning 30 days post discharge
  - Bundle includes all services except the hospital admission
  - Upside and downside risk
- Model 4: Prospective payment
  - Based on a hospital stay
  - All services during the stay included
Methodological Problems

- Anchoring on MS-DRGs: Establishes the base period budget
  - DRGs are about hospital resources
  - They have nothing to do with quality
  - They include widely disparate medical conditions within the same DRG
- For chronic care much more is spent outside the hospital than on the DRG
- After applications were submitted CMMI decided to standardize the episodes
- Small numbers of patients
- No Stark or AKS waivers but they could be requested

Medicare ACOs

- Providers paid in the ordinary course
- ACO entity has to be able to accept Part A and Part B and allocate it
- Quality threshold to qualify for shared savings
- Savings measured against a benchmark
- Payment after three years
- No rules on allocation among providers
- Waivers for Stark and AKS
Commercial -- ProvenCare

- Geisinger owns the hospitals, the physicians and a health plan which pays for 30% of the hospital admissions
- No charge for services on readmissions within 90 days: a ‘warranty’
- Began with CABG
- Now includes elective angioplasty, perinatal care, bariatric surgery and lung cancer
- Technically it’s not bundled payment but bundled shared risk

Commercial – Bailit and Burns

- 19 non-federal bundled programs nationally as of May 2012
- 9 focused on inpatient procedures – mostly hips and knees
  - Booz & Co based on Oct 2012 found employer interest in chronic care bundles, e.g., diabetes
- Volume of bundles small 10-50 a year for each provider
- Not much savings reported
- Includes PROMETHEUS Payment but the data is outdated
Provider Payment Reform for Outcomes, Margins, Evidence, Transparency Hassle-reduction, Excellence, Understandability and Sustainability

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Experience

- **2004-2011: Design and Piloting**
  - $300,000 from CMWF to demonstrate that incidence risk and medical management risk could be separated
  - $6.7M from RWJF
  - Four pilots: IBC-Crozer (hips and knees), Priority Health, Rockford ECOH (lousy data), HealthPartners (already too far along to have it matter)

- **Since then:**
  - 6400 bundles have been triggered
  - Most are chronic care under Priority Health in MI
  - 300 are total knees under Horizon Health in NJ
Current Episodes V5.0

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Constructing Bundles

- **Triggers**
  - ICD-9; CPT, HCPCS
  - Reach back to capture diagnostics

- **How long?**
  - PROMETHEUS does admission plus 180 days
  - Chronic care is a year to coincide with premium year
  - Pregnancy until some defined post-natal date
What is the budget based on?

- BPCI: a base period DRG is the foundation
- Most use historical data which doesn’t factor in quality or value
- PROMETHEUS
  - CPGs or consensus says what science says the patient needs for the condition
  - The Episode Grouper for Medicare: PPACA 3003(a)(9)

Typical v. PAC

**Diabetes Relevant Services**
- Medical: $595 Million
- Pharmacy: $732 Million
- Total: $1.32 billion

**Potentially Avoidable Complications:**
- Medical: $488 Million
- Pharmacy: $325 Million
- Total: $813 million

**Typical claims and services:**
- Medical: $108 Million
- Pharmacy: $407 Million
- Total: $515 million

- All diabetes-related inpatient stays
- All professional services during stays
- All claims with “PAC” diagnosis codes
- All claims with “PAC” procedure codes
- Drugs used to treat PACs
- Claims that do not have a “PAC” code
HACs vs. PACs (Hip Replacement)

Risk Adjustment

- PACs come from the payor’s database
- PROMETHEUS has a software package that real time adjusts
  - Some ECRs (e.g., AMI) are complications of other ECRs (e.g., coronary artery disease)
  - Patient can have multiple ECRs open
- What breaks the bundle?
  - Car wreck
  - Don’t need stop loss: it’s condition specific
Payor-Provider Contract Issues

☐ Most are done as amendments to participation agreements
  ■ Are the rules clear??
☐ When does reconciliation occur? When does payment get made

☐ Data
  ■ What information do providers get to know how they are doing and how current is it?
  ■ What information do they get about other providers in the pool?
  ■ How is data challenged or corrected?

Dispute Resolution/Appeals

☐ What shouldn’t be appealable:
  ■ The budget
  ■ The rules for triggering, breaking or ending an episode
  ■ Rules for severity adjustment
☐ What should be subject to appeal?
  ■ Has an episode been triggered or broken?
  ■ Whether a provider qualified for upside payment or should pay on downside risk
  ■ The amount of payment if it varies with scores
  ■ Whether a provider met quality or efficiency tresholds
  ■ Whether the data supporting payment is accurate
Provider-Provider Issues: Governance

- A host of providers may be ‘in the pile’
  - MD groups, hospitals, PHOs, IPAs, ACOs, special purpose networks
- Different from 1995 PHOs
  - Subnetworks around conditions; not the whole medical staff unless it’s a real ACO
  - Hospitals may not be in the pile at all
- Similarities to PHOs
  - Most bundles are procedural and do involve hospitals
  - Governance decisions are similar: who owns, what’s the representation in the governance body, need for supermajorities for somethings
  - New issues: change to compensation metrics, change to allocation formula, terminating providers, adding providers, adding new classes of providers

Provider-Provider Issues: Contracts

- Downside risk and gainsharing
  - Attribution rules: go back to budget construction
  - Post-termination rules
  - Be careful about creating downside risk which the hospital then covers – stark and AKS
- What happens when two providers seek the same portion of the budget?
  - They have to settle it between themselves
  - There is a review body that decides on the basis of a formula - e.g., encounters; pro rata as established in the budget
  - No one gets it
- Termination:
  - Bases for voluntary termination – have to play for some period
  - Involuntary -- cherry picking, lemon dropping, creating leakage
Dispute Resolution Among Providers

☐ Mirrors payor agreements re what should and should not be subject to appeal

☐ What process?
  ■ Reconsideration, appeals council, record review, fair hearing, oral argument, attorneys, only by peers, AHLA ADR????

☐ What timeframes for everything?