Contracting for Performance: Fair Terms for Bundled Payment Arrangements

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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
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
BPCI Models

• Model 1: Retrospective payment for inpatient hospitalization only
  – Physicians to be paid fee for service
  – Physicians could share in upside (gainsharing)
• 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
- February 2014 call for more participants to get more robust information
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 automatic 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
• 19 non-federal bundled programs nationally as of May 2012, and again in 2013
• 9 focused on inpatient procedures – mostly hips and knees
  – Booz and Co surveyed employers in Oct 2012 and found interest in chronic care bundles – e.g., diabetes
• Volume of bundles small 10-50 a year for each provider
• Not much savings reported
• The first report included PROMETHEUS Payment implementations but the data was 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:
  – 7100+ bundles have been triggered
  – Most are chronic care under Priority Health in MI
  – 300 are total knees under Horizon Health in NJ
Current Episodes V.5.0

Cardiac
- CAD
- CABG
- CHF
- Valve
- AMI
- PCI
- Hypertension
- Stroke

Orthopedic
- Knee Replacement
- Knee Revision
- Knee Arthroscopy w/ Ligament Repair
- Knee Arthroscopy w/o Ligament Repair
- Hip Replacement
- Hip Revision

Pulmonary
- COPD
- Asthma
- Pneumonia

Women’s Health
- Hysterectomy
- Low Risk Pregnancy
- High Risk Pregnancy
- C-Section
- Normal Vaginal Delivery

GI (Gastrointestinal)
- GERD
- EGD (Upper GI endoscopy)
- Gall Bladder Surgery
- Colon Resection
- Colonoscopy

Endocrine
- Diabetes
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**
$1.32 billion

- Medical: $595 Million
- Pharmacy: $732 Million

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

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

- Claims that do not have a “PAC” code
- 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
HACs vs. PACs (Hip Replacement)

Percent of Total Stay Costs with either HACs or addIn PACs

- 15% Additional Burden of Stays with HACs
- 85% Additional Burden of Stays with addIn PACs

Additional Potentially Avoidable Complications (PACs): Prometheus Defined

Hospital Acquired Conditions (HACs): CMS Defined

Additional Burden of Stays with HACs

Additional Burden of Stays with addIn PACs

Hip Replacement ECR
Total Stay Costs by HACs (N=699 PAC Stays)

- Hemorrhage
- Complications of Medical Care
- Fluid and Electrolyte disturbances
- Fever of unknown origin
- Skin Infections, Phlebitis, Gangrene
- Adverse effects of drugs, overdose, poisoning
- Pneumonia, lung complications
- Urinary Tract Infections
- Gastritis, ulcer
- Complication of Implanted device, graft
- Catheter Associated Urinary Tract Infections (UTI)
- Deep Vein Thrombosis (DVT) / Pulmonary Embolism (PE)
- Ventilator Associated Pneumonia

Total PAC Stay Costs ($ in Millions)

- Hospital Acquired Conditions (HACs): CMS Defined
- Additional Potentially Avoidable Complications (PACs): Prometheus Defined
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
Allocation of Dollars: Will you get any?

- Payors mostly don’t care
- PROMETHEUS: 70% of your scores are what you do; 30% is what everyone else who touches the provider does
  - Quality threshold to get PAC Funds
  - Scores determine how much you get
- In Medicare ACO there are quality scores and efficiency has to be over a benchmark
- In PROMETHEUS providers can play for portions of the budget
  - Bundled budget not payment
  - Agnostic about size or configuration of providers
- For lawyers, the key is to understand the rules are clear in the documents and what dispute resolution mechanisms pertain
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?
Other issues

• Is medical management by plan necessary?
  – Provider selection helps
  – Prior authorization, UR and PBMs, IBMs RBMs, BHM may not be necessary

• Restrictions on roles of non-physicians are counter-productive

• Post-payment audits may not be necessary, particularly of E/M services
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 thresholds
  – 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?