

# HFMA Region 11 Symposium

## Optimizing Current Payments and Assimilating Proposed Methodologies

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# Our Speakers



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# Agenda

- I. Introduction
- II. Contracting Methodology: Situational Assessment
- III. Contracting Methodology: Contract Modeling
- IV. Contracting Methodology: Conclusions
- V. Health Reform Preparation
- VI. Value-Based Payment Models
- VII. ACOs
- VIII. Patient Centered Medical Home
- IX. Bundled Payments
- X. Contract Examples

# I. Introduction

# I. Introduction

## *Today's Objectives*

*This presentation has two main objectives: (1) provide a comprehensive review of the contracting process, and (2) explore changing reimbursement approaches under healthcare reform efforts.*

### **Contracting Methodology**

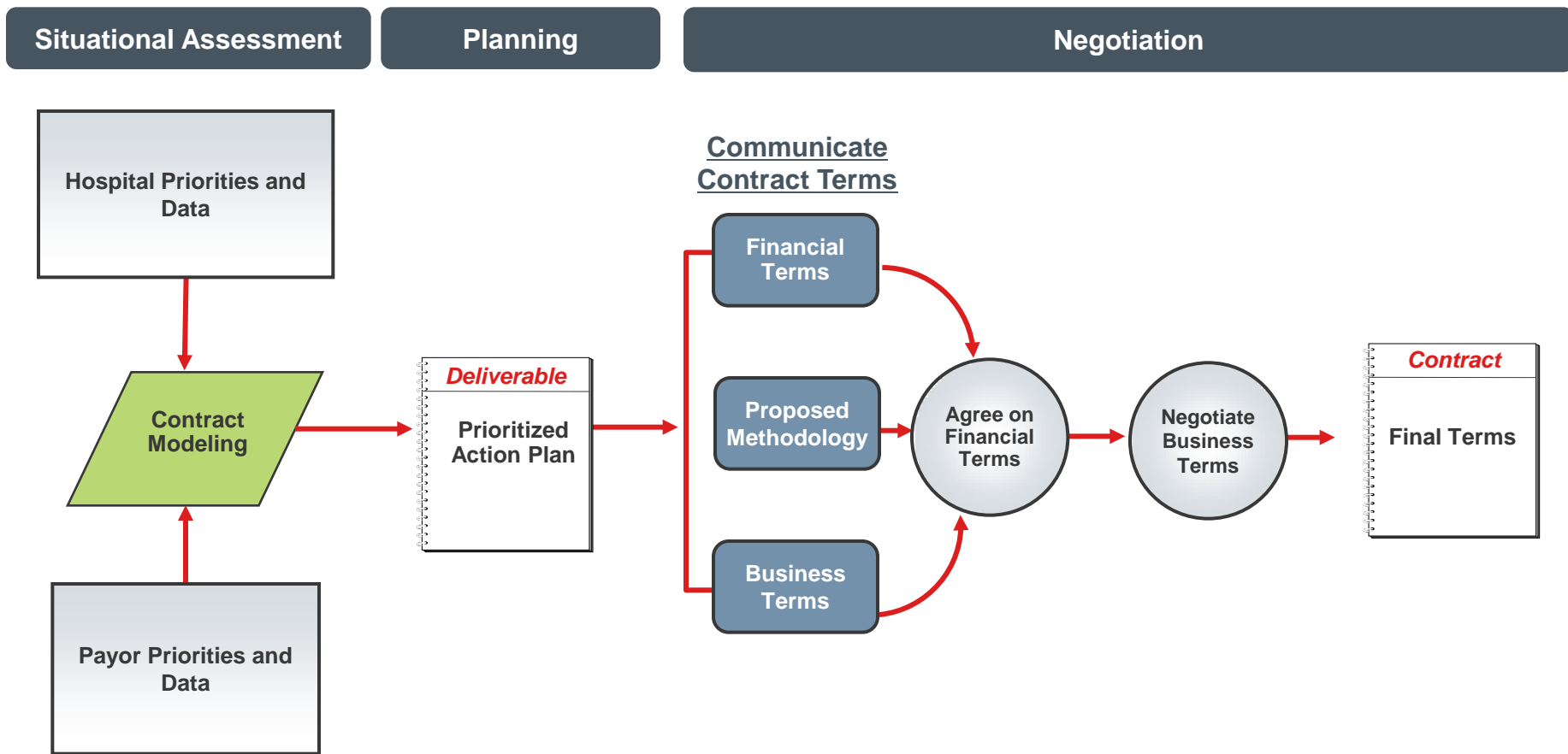
- Understand how to prepare for negotiations by gathering pre-negotiation intelligence and completing a situational assessment.
- Learn how to model the financial impact and assess the level of risk of a managed care agreement.

### **Changing Reimbursement Approaches**

- Understand the key tenets of healthcare reform impacting provider reimbursement.
- Consider contracting priorities from the perspectives of physicians, hospitals, and payors.
- Review new payment models, nationally and regionally, that are evolving out of various healthcare reform initiatives.

## **II. Contracting Methodology: Situational Assessment**

# II. Contracting Methodology: Situational Assessment *Negotiating Managed Care Contracts – The Process*



*The initial situational assessment creates the framework for a successful negotiation.*

## II. Contracting Methodology: Situational Assessment

### *Important Strategic Questions to Answer*

*In this preparatory stage, the negotiator seeks pre-negotiation intelligence that will inform the negotiating position.*

- How does the hospital or medical group fit into its market in terms of services offered, including volume, utilization of medical services, cost, quality, and reputation?
- How do the provider's patient origin demographics overlay with the health plan's network?
- How is the health plan positioned in the market compared to its competitors in terms of enrollment, as well as trends of premium and/or profitability increases?
- What strategic issues are important to the plan, such as its need to expand its network, offer competitive services, support important clients, or improve its local reputation?

## II. Contracting Methodology: Situational Assessment

### *Important Operational Questions to Answer*

- How do the health plan's payments to the hospital compare to other major commercial payors' payments, taking into account the payor mix and ensuring that the level of discount is consistent with the payor's proportion of the hospital's business?
- What are the plan's actual payments, as a percentage of charges (POC) and expected payments, compared to those of other major commercial payors?
- Does the health plan impose operational or administrative requirements or otherwise cause unreasonable increases in hospital expenses?
- What will be the operational and/or financial impact of a change in payment methodologies (such as from a POC to a prospective payment DRG-based system)?
- Are there any other performance issues that need to be addressed during the contracting process?

## II. Contracting Methodology: Situational Assessment

### *Develop the Negotiating Position*

***Tell the story that supports your negotiating position.***

- Why are you unique?
  - Services.
  - Quality.
  - Efficiency.
  - Reputation.
- What economic factors should be considered?
  - Unusual payor mix or high self-pay population.
  - Competition for qualified staff, which causes higher- than-normal wages.
  - Physician recruiting issues.



***Health plans respond well to data-driven positions.***

## II. Contracting Methodology: Situational Assessment *Other Pertinent Factors*

***What have you done to benefit the plan or its members?***

### **Capital Investment**

- Increased access (upgraded ER/trauma care).
- New services (neuroscience, NICU).
- Additional capacity or patient comfort (surgery center, OB, state-of-the-art breast care center).

### **Service Levels**

- Surveys.
- Additional specialties – members no longer need to travel to another potentially distant hospital.

### **Quality of Care**

- Hospitalists/intensivists/laborists.
- Affiliations.
- Specific disease management clinics (e.g., diabetes).
- Case management programs for large employers.

***Investments like these are a direct benefit to the plan's members.***

## II. Contracting Methodology: Situational Assessment *Health Plan Information – Tools*

- Plan financial performance.
  - National Association of Insurance Commissioners (NAIC).
    - » Quarterly and annual financial reports.
    - » *<https://eapps.naic.org/insData>*.
  - Annual and quarterly reports by publicly traded companies.
  - Annual rate filings (access is state-specific).
  - Local news.
- Membership distribution.
  - Patient origin reports (internal data).
  - Network adequacy reports (vary by state – show geographic distribution of membership).
  - Online provider directories – identify network participants in market area.
  - Major employers.

## II. Contracting Methodology: Situational Assessment *Health Plan Information – NAIC Sourced Information*

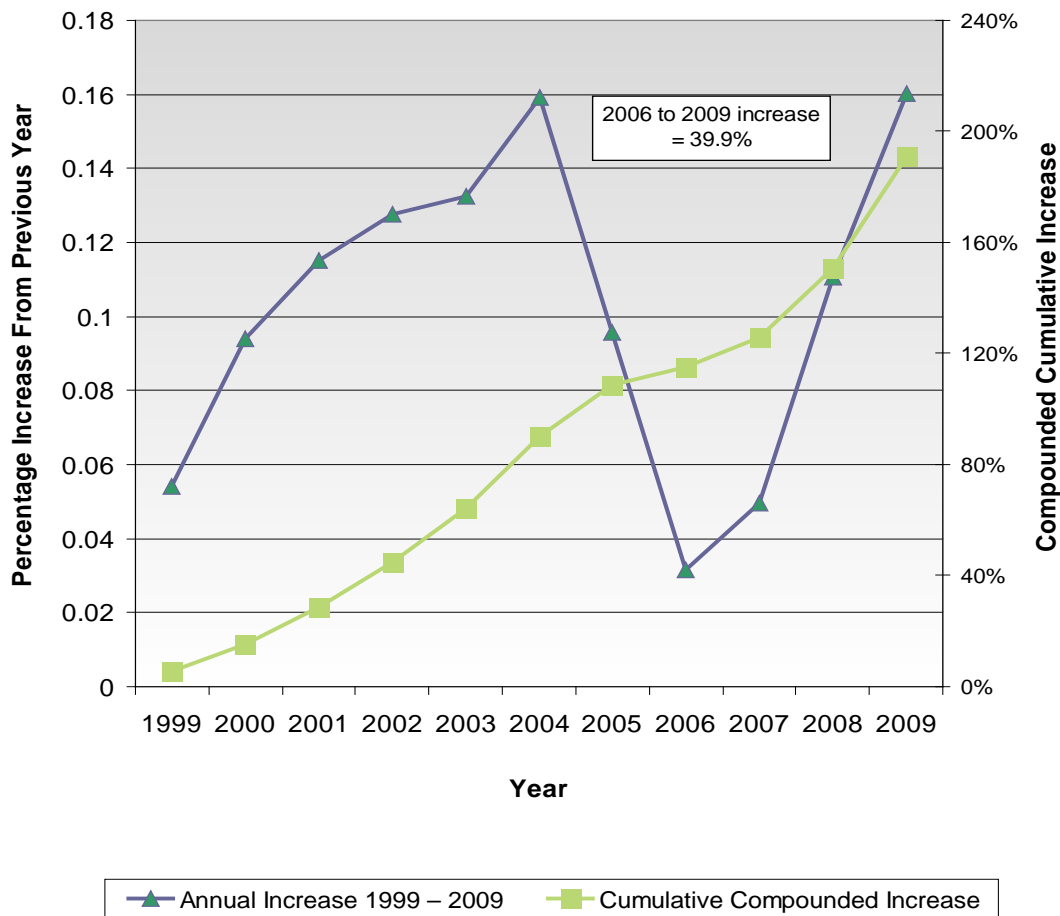
***Quarterly and annual financial reports provide key metrics relevant to understanding plan performance.***

- Statement of revenue and expenses (current and previous year), by line of business.
  - How is the plan performing financially and what is its most recent trend?
  - Member months.
  - Hospital and medical expense.
  - General and administrative costs.
  - Changes in reserves.
  - Underwriting gain or loss.
- Exhibit of premiums, enrollment, and utilization.
  - Member months by quarter (is plan growing or losing members?).
  - Utilization data – physician encounters and hospital admissions and bed days.
  - Total premium (calculate average premium).
  - Medical cost as a percentage of premium.

# II. Contracting Methodology: Situational Assessment

## Health Plan Information – State Rate Filing Data

**Example: Payor Annual Premium Increases<sup>1</sup>**



- It can be very interesting to compare annual contract increases to the plan’s filed premiums.
- This data is pulled from the publicly available annual rate filings submitted to the state’s Office of the Insurance Commissioner.
- Rate filing data is notoriously inconsistent (e.g., product names and benefit levels change from year to year). If possible, it is important to ensure use of the “base rate” or consistent co-pay/coinsurance benefit levels from year to year.

<sup>1</sup> Source: Annual rate filings – publicly available from Office of the Insurance Commissioner.

## II. Contracting Methodology: Situational Assessment *Risk Premium*

***The concept of a risk premium to compensate investors or insurers for accepting risk is well known and studied in the financial and insurance communities.***

- The financial definition of a risk premium is “... a form of compensation for investors who tolerate the extra risk compared to that of a risk-free asset in a given investment.” In essence, it is a form of hazard pay for investors.
- Consider that the hospital is the investor in this scenario.
- Factors that determine a risk premium:
  - *Uncertainty* – For example, impact of changing payment methodologies.
  - *Risk Aversion* – A charitable not-for-profit hospital has low tolerance for risk.
  - *Time* – Longer time horizons can add or reduce uncertainty depending upon the perspective of the entity in question.
  - *Business Risk* – Not easily predictable (e.g., changes in regulatory environment or business processes, such as to support a new payment methodology).

Source: J. David Cummins, Ph.D., et al., “The Risk Premium Project Phase I and II Report,” Casualty Actuarial Society Committee on Theory of Risk, June 30, 2000.

***We estimate that the risk premium from changing from inpatient per diem or outpatient POC to case rates is 3% to 6%.***

## II. Contracting Methodology: Situational Assessment *Inflation*

- Inflation data is obtained from the U.S. Bureau of Labor Statistics ([www.bls.gov](http://www.bls.gov)).<sup>1</sup>
- Understand how your annual increases have trended compared to inflation. Compare Medical CPI with the overall inflation.
- The impact of various inflation methodologies is subject to the index chosen as well as the timing of the measure (e.g., year-end vs. as of a certain month).

Year	All Items CPI	Change From Previous	Medical CPI	Change From Previous	Medical Inflation Compared to All Items Inflation
2005	198.9	N/A	322.9	N/A	N/A
2006	205.7	3.4%	337.1	4.4%	1.0%
2007	212.2	3.2%	354.3	5.1%	1.9%
2008	219.6	3.5%	368.7	4.1%	0.6%
2009	218.8	-0.4%	383.7	4.1%	4.4%
2010 (NOV YTD)	221.7	1.3%	399.5	4.1%	2.8%
<b>Total Change</b>	<b>22.8</b>	<b>11.4%</b>	<b>76.6</b>	<b>23.7%</b>	<b>12.3%</b>

<sup>1</sup> Consumer Price Index – All Urban Consumers Western Region which includes AK, AZ, CA, CO, HI, OR, WA. Basis year 1982 = 100; All items and Medical Care. Source: U.S. Bureau of Labor Statistics – [www.bls.gov](http://www.bls.gov). All Items Series: CUUR0400SA0, Medical Care Series: CUUR0400SAM.

## III. Contracting Methodology: Contract Modeling

# III. Contracting Methodology: Contract Modeling *Background*

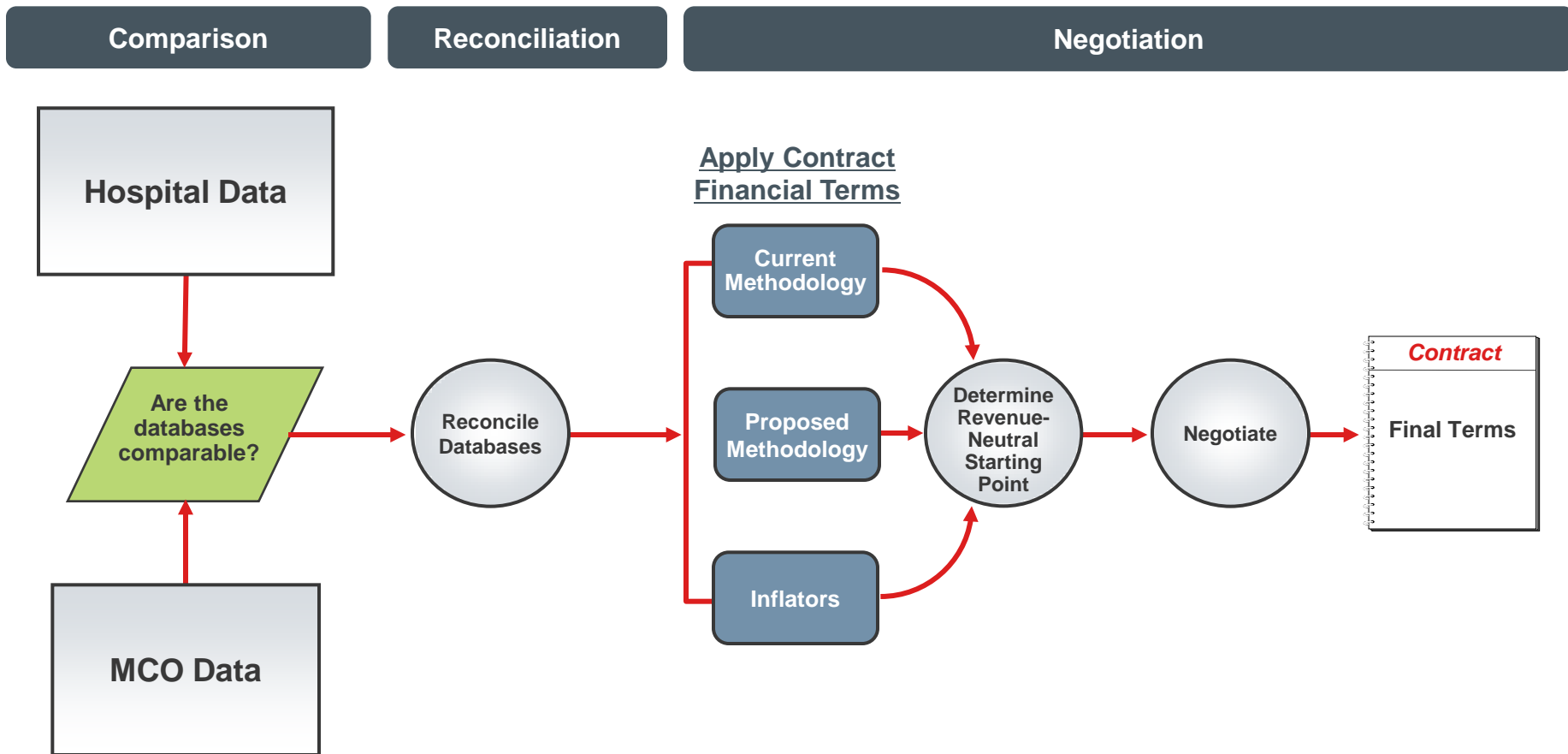
***A comprehensive contract model is critical in understanding the impact of changing payment methodologies.***

- Managed care organizations (MCOs)<sup>1</sup> seek predictable costs, which can be accomplished by moving to case rate payment methodologies.
- When MCOs seek to change compensation methodologies, such as from per diems or POC to case rate-based systems (e.g., APR-DRGs, APCs), it is critical that the hospital understand the financial impact of the change.
- Current economic conditions are placing exceptional stress on hospital finances, and there is little or no leeway for experiencing unanticipated payment reductions or incurring additional risk.
- Before a negotiation can begin, the hospital and MCO need to agree upon a common starting point, such as the DRG and APC base rates that yield revenue neutrality.

<sup>1</sup> Commercial health insurance carriers that manage the care and reimbursement of their members.

***Failure to understand the intricacies of hospital agreements can result in significantly misstating the expected performance.***

# III. Contracting Methodology: Contract Modeling Process



*While the parties may differ on the terms, there is generally collaboration to ensure that the data is accurate.*

# III. Contracting Methodology: Contract Modeling *Inpatient Services*

***In most of the country, commercial reimbursement either has moved or is moving to DRG-based models, but exact methodologies are variable. Notably, many California hospitals have so far been able to resist the transition.***

- POC.
- Per diems.
- DRGs/MS-DRGs/AP-DRGs/APR-DRGs.
- Outliers – stop-loss.
  - Method.
    - » First dollar.
    - » Second dollar.
  - Threshold.
    - » Total patient charges.
    - » Length of stay (LOS).
- Carve-outs – high-cost drugs, implants, other.
- Transfer cases.
- “Lesser of” methodology.

# III. Contracting Methodology: Contract Modeling

## California DRG Trend

***Commercial payors will likely continue to push for transition from per-diem/charge-based to DRG-based reimbursement in the coming years.***

- A recent study showed that through 2009 the prevalence of DRG-based reimbursement contracts in California appeared to be very limited.
- Most facilities are contracted under per-diem or charge-based reimbursement for commercial business, despite familiarity with DRG payments for Medicare patients.
- Despite health plan desire to transition, hospitals are reticent due to:
  - Perception that DRG approach could lower aggregate reimbursement.
  - Place more burden on hospitals to manage utilization and costs.
  - Lack of alignment with physicians, partly due to the inability to employ physicians, would limit a hospital's ability to manage utilization.
- In contrast to California, DRG-based reimbursement is more prevalent in most other states across the country.
- Payors are increasingly moving toward this type of payment structure and efficient well run hospitals can profit from a transition to DRG-based payments.

Findings from the Integrated Healthcare Association: DRG-Based Payment Assessment, July 2009, were used as background for this section.

### III. Contracting Methodology: Contract Modeling

## California DRG Trend – Hospital Benefits and Concerns

*It is imperative to model the impact of changing to a DRG-based structure so that negotiations are well informed, issues can be anticipated, and so that contract terms can be reached on good faith.*

#### Benefits

- Places responsibility for managing length of stay and resource utilization on hospital.
- Provides administrative savings due to single payment approach.
- Offers greater predictability of expenditures.
- Improves case mix management and expanded discharge data.
- Generates more meaningful outcomes data for physicians.

#### Concerns

- Represents additional financial risk.
- May result in additional cost to develop infrastructure to administer structure and assign DRGs.
- Requires broader coordination/communication with physicians.
- Low-volume hospitals have fewer cases over which to spread risk.
- Requires the determination of payments for outlier cases.

# III. Contracting Methodology: Contract Modeling *Inpatient Reimbursement Examples*

***Market position, strategic initiatives, and negotiation priorities influence the final agreed-upon methodology.***

Select Hospital	MCO 1	MCO 2	MCO 3	MCO 4
West	AP-DRG	Per Diem	AP-DRG	Per Diem
East	MS-DRG <sup>1</sup>	MS-DRG <sup>1</sup>	Per Diem	MS-DRG <sup>1</sup>
Midwest	Per Diem, Case Rates	Per Diem, Case Rates	DRG <sup>1</sup>	DRG <sup>1</sup>

<sup>1</sup> Methodology modified based on health plan interpretations, adjudication rules, and negotiated carve-outs:

- Mother/baby payment rules.
- Stop-loss.
- Per diem carve-outs.
- High-cost drugs and implants.

# III. Contracting Methodology: Contract Modeling *DRG-Based Systems*

***Use of DRG-based systems is common and depends on region and market.***

	<b>DRG (CMS Pre-10/2007)</b>	<b>AP-DRG (All Patient)</b>	<b>APR-DRG (All Patient Refined)</b>	<b>MS-DRG (Medicare Severity)</b>
Base DRGs	379	379	270	335
Total DRGs	538	602	863	745
CC Subclasses	2	3	4	3
CC Levels	<ul style="list-style-type: none"> <li>Without CC.</li> <li>With CC for certain base DRGs.</li> </ul>	<ul style="list-style-type: none"> <li>Without CC.</li> <li>With CC for certain base DRGs.</li> <li>Major CC across DRGs within MDC.</li> </ul>	<ul style="list-style-type: none"> <li>Minor CC.</li> <li>Moderate CC.</li> <li>Major CC.</li> <li>Severe CC.</li> <li>Severity levels collapsed within and across base DRGs.</li> </ul>	<ul style="list-style-type: none"> <li>Without CC.</li> <li>With CC.</li> <li>With major CC.</li> <li>Severity levels collapsed for some base DRGs.</li> </ul>
Comments	Relates patient type to costs.	More representative of non-Medicare populations.	Incorporates severity of illness and risk of mortality subclasses into AP-DRGs.	Uses APR-DRGs for newborns.

***There is a growing trend in California to utilize DRG-based reimbursement, which we will discuss further in a later section.***

# III. Contracting Methodology: Contract Modeling *Outpatient Services*

*MCOs are moving to CMS's APC-based methodologies at a slower pace due to the complexities of the change.*

- Health plans have moved away from traditional POC payments to case-based reimbursement.
- There is a major effort to push volume risk to hospitals, particularly for ED services and high-cost diagnostic services.
- Bundled services vary from payor to payor.
- The typical hospital has considerable variance in its outpatient payment methodologies.
  - APCs (CMS-based or a modified version).
  - Fee schedules.
  - ASC groupers.
  - Per visit and per case payments.

### III. Contracting Methodology: Contract Modeling

#### *Where Does a Negotiation Begin?*

- ***Identify a Starting Point*** – Before a negotiation can begin, the hospital and MCO need to agree upon a common starting point, such as the DRG and APC base rates that yield revenue neutrality.
- ***Agree on Data*** – The problem is that, for any given time period, data pulled from the hospital’s system may not match data pulled from the MCO’s system. The first step must be to agree on data.
- ***Determine Impact of the Proposal*** – The objective is to apply the current and proposed compensation terms to the actual mix of services and volumes to compare the results.
- ***Ensure Correct Application of Contract Terms*** – Subtle errors in interpreting the data may result in significant variation in modeled results. A key step is to ensure that the model correctly interprets the contract terms.

***“There are no facts, only interpretations.” – Friedrich Nietzsche***

### III. Contracting Methodology: Contract Modeling *Who Has the Best Data?*

***Hospital contracts are complicated, and the ability to model them with accurate data is the critical first step in understanding them.***

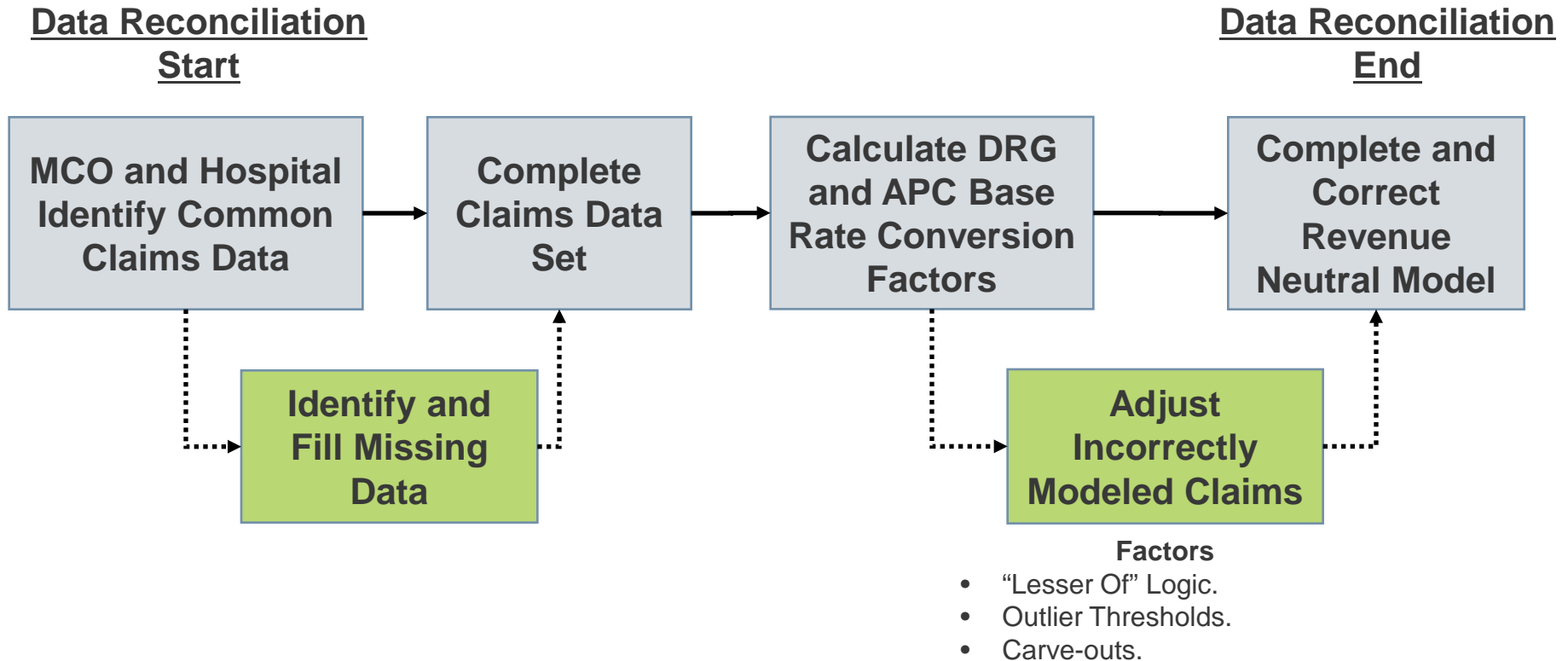
- Historically, MCOs have had accurate claims data. The problem is that changing payment mechanisms can have a profound effect on how to interpret claims when comparing payments under current and proposed scenarios.
- Hospital data may accurately reflect the services provided but not what was paid, and it does not account for the claims adjudication process.
- The MCO model may not accurately reflect the way the historic services would actually be paid under the new proposed scenario or otherwise might not account for important details that would impact the actual payment.
- The hospital may not have the capability to group claims into the applicable DRGs; in this case, it will be dependent upon the MCO's definition.
- While the parties to the negotiation would not intentionally misrepresent the data, they do not know what they do not know!
- Inadvertent errors can have profound effects on the results of the model.

***Differences in the data set can result in material differences in the modeled financial performance.***

# III. Contracting Methodology: Contract Modeling

## Key Steps in Reconciling the Data

*Before the contract model is acceptable, the data must be correct.*



*Data and modeled payment errors can over/understate the anticipated yield and charges.*

# III. Contracting Methodology: Contract Modeling

## *Key Modeling Factors*

***Many contract provisions have significant financial implications but are overlooked in the modeling of proposed agreements.***

- Lesser of (APC/DRG/per diem) rate or charges.
  - Payments in a DRG model will be overstated if cases that meet the lesser-of criteria are missed.
- Annual charge description master (CDM) increases and existing inflation factors.
  - Failure to account for annual CDM increases will overstate the difference between the current and proposed arrangements, thereby making the arrangement look better than it really is for the hospital.
- Case rate thresholds (outlier protection).
  - Understanding the “trim” or “attachment points” and methodologies, as well as the impact on reimbursement, is critical. Some proposals do not include thresholds, so the hospital must be vigilant to recognize the potential impact.
- Interim billing.
  - If the current arrangement is a POC or per diem arrangement, interim bills may cause the total charges for a case to be split, so the model of the proposed terms may indicate payment for multiple cases of the same DRG.

# III. Contracting Methodology: Contract Modeling

## *Key Modeling Factors (continued)*

- Service bundling rules.
  - It is important to ensure that the proposed model does not overstate payments by including charges for services that would not otherwise be reimbursed.
- Outpatient case rate precedence (surgery, observation, ED, etc.).
- Carve-outs.
  - How are high-priced implants addressed?
  - What is included in ER cases (e.g., imaging)?
- Short-stay or transfer rates.

### **Operational Factors**

- ***Refunds to the Health Plan*** – If the health plan shows the expected revenue in the proposed model, it overstates the yield. Both the charges and the payments should be excluded from the current and proposed model calculations.
- ***Registration Errors*** – If the hospital initially registers a patient as being enrolled in a different health plan, the claim is subsequently denied and submitted to the plan under negotiation. In this case, the hospital's data would be understated compared to the health plan's.

# III. Contracting Methodology: Contract Modeling

## Example Contract Projection Model

CDM Adjustment	1.00
Lesser Of (On/Off)	Off
ED Methodology*	1

\*1 = POC/Fee Sched. 2 = Case Rate

Inpatient Outlier	
Method*	1
Factor	2.00
Percentage	70%

\*1 = Factor 2 = Threshold

Lesser of is turned off.  
Factor threshold method selected.

Inpatient	Rate	Cases	Charges	Current Contract		Proposal		Change From Current	
				Total	Percentage of Charge	Total Expected	Percentage of Charge	Amount	Percentage Change
Case Rate	\$9,600	669	\$ 14,000,000	\$ 7,000,000	50.0%	\$ 5,000,000	35.7%	\$ (2,000,000)	-29%
Outlier	70%	226			-	1,700,000		1,700,000	-
Transfers	70%	10	300,000	100,000	33.3%	175,000	58.3%	75,000	75%
<b>Total Inpatient</b>		<b>905</b>	<b>\$ 14,300,000</b>	<b>\$ 7,100,000</b>	<b>49.7%</b>	<b>\$ 6,875,000</b>	<b>48.1%</b>	<b>\$ (225,000)</b>	<b>-3%</b>
<b>Outpatient</b>									
<b>Ambulatory Surgery</b>									
Grouper 1	\$1,950	352	\$ 900,000	\$ 525,000	58.3%	\$ 704,925	78.3%	\$ 179,925	34%
Grouper 2	\$2,500	192	900,000	475,000	52.8%	547,000	60.8%	72,000	15%
Grouper 3	\$3,450	99	800,000	350,000	43.8%	383,863	48.0%	33,863	10%
Grouper 4	\$3,450	84	700,000	250,000	35.7%	319,300	45.6%	69,300	28%
Grouper 5	\$5,000	70	800,000	325,000	40.6%	373,050	46.6%	48,050	15%
Grouper 6	\$4,850	-	-	-	-	-	-	-	-
Grouper 7	\$4,500	19	200,000	95,000	47.5%	110,100	55.1%	15,100	16%
Grouper 8	\$5,000	2	12,000	7,500	62.5%	10,000	83.3%	2,500	33%
Default	70%	50	500,000	290,000	58.0%	350,000	70.0%	60,000	21%
<b>Total Surgery</b>		<b>868</b>	<b>\$ 4,812,000</b>	<b>\$ 2,317,500</b>	<b>48.2%</b>	<b>\$ 2,798,238</b>	<b>58.2%</b>	<b>\$ 480,738</b>	<b>21%</b>
<b>ED</b>									
Level I	\$600	60	\$ 35,000	\$ 20,000	57.1%	\$ 24,541	70.1%	\$ 4,541	23%
Level II	\$1,250	507	770,000	500,000	64.9%	504,849	65.6%	4,849	1%
Level III	\$3,750	702	2,700,000	1,800,000	66.7%	1,729,833	64.1%	(70,167)	-4%
Level IV	\$4,350	302	1,500,000	1,000,000	66.7%	995,487	66.4%	(4,513)	0%
<b>Total ED</b>		<b>1,571</b>	<b>\$ 5,005,000</b>	<b>\$ 3,320,000</b>	<b>66.3%</b>	<b>\$ 3,254,710</b>	<b>65.0%</b>	<b>(65,290)</b>	<b>-2%</b>
<b>Cardiac Catheterization</b>	<b>\$11,300</b>	<b>20</b>	<b>\$ 375,000</b>	<b>\$ 210,000</b>	<b>56.0%</b>	<b>\$ 226,000</b>	<b>60.3%</b>	<b>\$ 16,000</b>	<b>8%</b>
<b>Non-Case Rate</b>									
Radiology	4.00		\$ 2,750,000			\$ 2,060,974	74.9%		
Lab	3.50		100,000			96,142	96.1%		
POC	70%		3,900,000			2,730,000	70.0%		
Not Reimbursed			75,000			-			
<b>Total Non-Case Rate</b>		<b>5,391</b>	<b>\$ 6,825,000</b>	<b>\$ 4,250,000</b>	<b>62.3%</b>	<b>\$ 4,887,116</b>	<b>71.6%</b>	<b>\$ 637,116</b>	<b>15%</b>
<b>Total Outpatient</b>		<b>7,850</b>	<b>\$ 17,017,000</b>	<b>\$ 10,097,500</b>	<b>59.3%</b>	<b>\$ 11,166,064</b>	<b>65.6%</b>	<b>\$ 1,068,564</b>	<b>11%</b>
<b>Total Contract</b>		<b>8,755</b>	<b>\$ 31,317,000</b>	<b>\$ 17,197,500</b>	<b>54.9%</b>	<b>\$ 18,041,064</b>	<b>57.6%</b>	<b>\$ 843,564</b>	<b>4.91%</b>

### III. Contracting Methodology: Contract Modeling

#### *Another Way to Use the Contract Model*

***Contract models can also be used to compare the performance of existing contracts.***

- When preparing for negotiations, it is helpful to understand the relative performance of each of the hospital's contracts and how different methodologies impact the same service mix.
- One common data set that is representative of the hospital's mix of services within a given line of business (for example, a year's worth of claims data for the hospital's largest commercial agreement) is applied against the terms of each agreement.
- Variations can be compared within diagnostic categories or the hospital's service lines.

***Using an accurate model can help highlight specific contractual terms that should be addressed in the negotiations.***

# III. Contracting Methodology: Contract Modeling

## *Another Way to Use the Contract Model (continued)*

***Using the same data set for each contract allows comparison of the impact of the various financial terms.***

	MCO 1	MCO 2	MCO 3
<b>Inpatient</b>			
Methodology	Per diems, OB and joint case rates, carve-outs.	AP-DRG.	AP-DRG.
Inpatient Carve-Outs	Implants at POC.	Implants at POC.	Implants at POC.
Maternity Cases	Newborns included in case rate.	Neonates are carved out.	Neonates are carved out.
Outlier Threshold	POC after threshold.	POC after multiple of AP-DRG.	POC after multiple of AP-DRG.
Lesser Of (Maximum Allowable)	Yes.	Yes.	Yes.
Transfers	Per diem for transfers to another short-term acute care facility.	Lesser of DRG case rate or per diem for transfers to short-term acute care facility.	Prorated for DRG based on number of days compared to ALOS.
<b>Outpatient</b>			
Outpatient Surgery	Case rates on proprietary groupers.	Case rates on proprietary groupers with catheterizations and PTCA carve-outs.	Medicare groupers.
Notes About Outpatient Surgical Rate	Implants at POC.	Implants at POC.	
Multiple Procedures	First – 100%, second – 50%, all subsequent – 25%.	First – 100%, second – 50%, third – 25%. No reimbursement for additional procedures.	First – 100%, second through sixth – 50%.
Other Lab, Radiology, Rehabilitation	Fee schedule.	CT and MRI priced per visit. Other radiology at POC.	Fee schedule.
ER	POC.	POC.	Case rates.

# III. Contracting Methodology: Contract Modeling

## Example Comparison Model

*In this example, a common database was used to compare the performance of several contracts.*

Category	Charges	MCO 1				MCO 2				MCO 3		
		Normal	Outlier	Expected	Percentage of Charges	Normal	Outlier	Expected	Percentage of Charges	Normal	Outlier	Expected
<b>Inpatient</b>												
Musculoskeletal System	\$ 17,000,000	\$ 9,650,000	\$ 550,000	\$ 10,200,000	60%	\$ 8,600,000	\$ 400,000	\$ 9,000,000	53%	\$ 9,600,000	\$ 1,400,000	\$ 11,000,000
Digestive System	7,500,000	3,700,000	500,000	4,200,000	56%	2,650,000	1,250,000	3,900,000	52%	2,500,000	1,000,000	3,500,000
Pregnancy and Childbirth	5,600,000	4,000,000	-	4,000,000	71%	2,550,000	450,000	3,000,000	54%	2,500,000	300,000	2,800,000
Circulatory System	5,000,000	1,850,000	150,000	2,000,000	40%	1,900,000	400,000	2,300,000	46%	2,200,000	400,000	2,600,000
Nervous System	4,000,000	1,400,000	600,000	2,000,000	50%	1,250,000	750,000	2,000,000	50%	1,300,000	700,000	2,000,000
Female Reproductive	4,000,000	1,400,000	-	1,400,000	35%	1,550,000	350,000	1,900,000	48%	1,500,000	300,000	1,800,000
Newborns and Other Neonates	4,000,000	1,550,000	700,000	2,250,000	56%	2,500,000	-	2,500,000	63%	2,500,000	-	2,500,000
Respiratory System	3,000,000	1,525,000	225,000	1,750,000	58%	1,075,000	625,000	1,700,000	57%	1,050,000	450,000	1,500,000
Endocrine, Nutritional, and Metabolic	2,000,000	850,000	150,000	1,000,000	50%	450,000	600,000	1,050,000	53%	670,000	430,000	1,100,000
Hepatobiliary and Pancreas	2,000,000	930,000	70,000	1,000,000	50%	650,000	350,000	1,000,000	50%	800,000	200,000	1,000,000
Infectious and Parasitic DDs	1,500,000	800,000	200,000	1,000,000	67%	400,000	400,000	800,000	53%	750,000	350,000	1,100,000
Skin, Subcutaneous Tissue, and Breast	1,500,000	500,000	-	500,000	33%	400,000	200,000	600,000	40%	375,000	225,000	600,000
Kidney and Urinary Tract	1,000,000	490,000	10,000	500,000	50%	300,000	250,000	550,000	55%	425,000	150,000	575,000
Other	3,000,000	1,070,000	680,000	1,750,000	58%	900,000	600,000	1,500,000	50%	(310,000)	460,000	150,000
<b>Total Inpatient</b>	<b>\$ 61,100,000</b>	<b>\$ 29,715,000</b>	<b>\$ 3,835,000</b>	<b>\$ 33,550,000</b>	<b>55%</b>	<b>\$ 25,175,000</b>	<b>\$ 6,625,000</b>	<b>\$ 31,800,000</b>	<b>52%</b>	<b>\$ 25,860,000</b>	<b>\$ 6,365,000</b>	<b>\$ 32,225,000</b>
<b>Outpatient</b>												
Surgical Procedures	\$ 11,000,000											
Surgical-Related	15,000,000											
<b>Total Surgery</b>	<b>\$ 26,000,000</b>			<b>\$ 10,750,000</b>	<b>41%</b>			<b>\$ 8,000,000</b>	<b>31%</b>			<b>\$ 13,000,000</b>
Other Schedules	26,000,000			15,000,000	58%			14,400,000	55%			14,000,000
POC	8,000,000			5,500,000	69%			5,800,000	73%			6,800,000
Not Reimbursed	4,000,000			2,250,000	56%			1,800,000	45%			2,500,000
<b>Total Outpatient</b>	<b>\$ 64,000,000</b>			<b>\$ 33,500,000</b>	<b>52%</b>			<b>\$ 30,000,000</b>	<b>47%</b>			<b>\$ 36,300,000</b>
<b>Total Contract</b>	<b>\$ 125,100,000</b>			<b>\$ 67,050,000</b>	<b>54%</b>			<b>\$ 61,800,000</b>	<b>49%</b>			<b>\$ 68,525,000</b>

## IV. Contracting Methodology: Conclusions

## IV. Contracting Methodology: Conclusions

***Effective negotiations require pre-negotiation intelligence and accurate modeling of financial terms.***

- Develop a data-driven business case to support your contracting position.
- Ensure that the model includes all of the significant financial terms and adjudication rules.
- Reconcile MCO and hospital data and agree on the starting point for negotiations.
- Create a model and validate that it accurately calculates predicted payments relative to the contractual terms.
- Use the model to determine the aggregate impact of changes to each of the key terms.
- Account for allowable inflation factors included in the current agreement.

***A change in methodologies introduces additional risk, making it especially important to understand the financial implications.***

## IV. Contracting Methodology: Conclusions

### *Important Contract Considerations*

- If necessary, seek an extension with an interim increase to offset the “opportunity cost” and create an incentive for both parties to complete the agreement.
- Define the methodology with specificity and/or agree to a specific period to negotiate the metrics to be measured and other specific details.
  - Metrics and milestones should be achievable and measurable and should support existing initiatives where possible.
  - Consider making implementation milestones a metric for at least the first year.
- Address the implementation period and the additional business and operations risk associated with the new program.
  - For example, seek an interim “floor” to the incentive payments. As the arrangement “matures,” the floor can decrease and the upside earning potential should rise at the same time.
- Understand that there may be implementation expense involved, and negotiate a cost-sharing or grant-like investment to fund the program.
- Use base rate increases to cover inflation.

## IV. Contracting Methodology: Conclusions

### *Important Contract Considerations (continued)*

- See opportunities to align incentives to support components of current payment methodologies that may be retained. For example, outlier payments for DRG case rates will provide incentives for the health plans to help the hospital discharge patients to a sub-acute setting.
- If applicable or necessary, identify opportunities to redistribute (on a budget-neutral basis) payments between care settings to be consistent with expenses.
- If there are particular areas that will not benefit from the incentives, ensure that they are not overlooked in the agreement. For example, target specific non-incentive-based increases for critical access hospitals if the incentives do not impact them.
- Consider using a neutral and independent third party to ensure consistent measurement and avoid disagreements over data.

## V. Health Reform Preparation

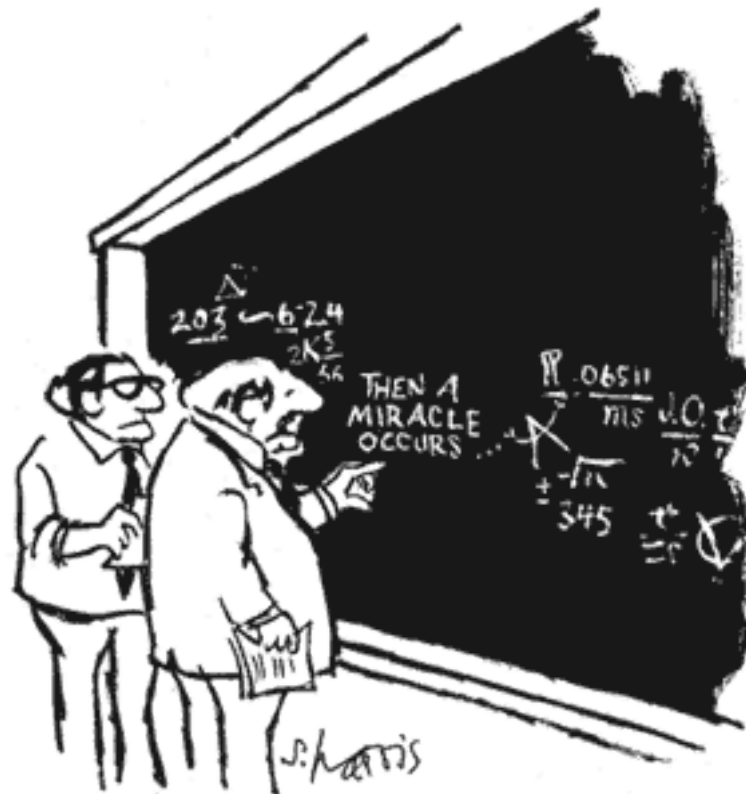
# V. Health Reform Preparation

## Step 1 – Healthcare Reform, Step 2 ...?

*Healthcare reform legislation initiated the process of change, but the path for successfully realizing the broader vision remains largely unclear.*

- Healthcare reform legislation set things moving.
- Recent political leadership changes could delay some of the key components.
- The next steps are less clear ...

***“Then a miracle occurs.”***



**“I THINK YOU SHOULD BE MORE EXPLICIT HERE IN STEP TWO.”**

# V. Health Reform Preparation

## *What Can Physicians and Hospitals Do to Prepare?*

*However health reform unfolds, an increased focus on integration, quality, and data transparency is coming.*

**2010**

- Focus on IT/EMR implementation.
- Invest in quality measurement.
- Build relationships across the care continuum.
  - Hospitals.
  - Physicians.
  - Community providers.
  - Post-acute care.
  - Payors.

**2015**

- Manage cost under changing incentives.
  - Ensure data transparency.
  - Establish bidirectional flow of clinical data (e.g., between physician and hospital).
  - Develop value proposition for care.
  - Implement new clinical and business models.
- Streamline care processes.
  - Ensure value proposition.
  - Move toward a single, comprehensive patient medical record.

# V. Health Reform Preparation

***The writing is on the wall – payment levels will vary based on quality and efficiency.***

## **Value-Based Purchasing (Hospitals) Fiscal Year 2013 (October 2012)**

- Must include measures.
  - Acute myocardial infarction (AMI).
  - Heart failure.
  - Pneumonia.
  - Surgeries.
  - Healthcare-associated infections.
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.
- By FY 2014, must include risk-adjusted efficiency measures, including measures of Medicare spending per beneficiary.

## **Physicians Quality Reporting System**

- By 2015, physicians will be penalized for not submitting quality data.
- By 2012, measures must be selected to report on meaningful use and quality of care.

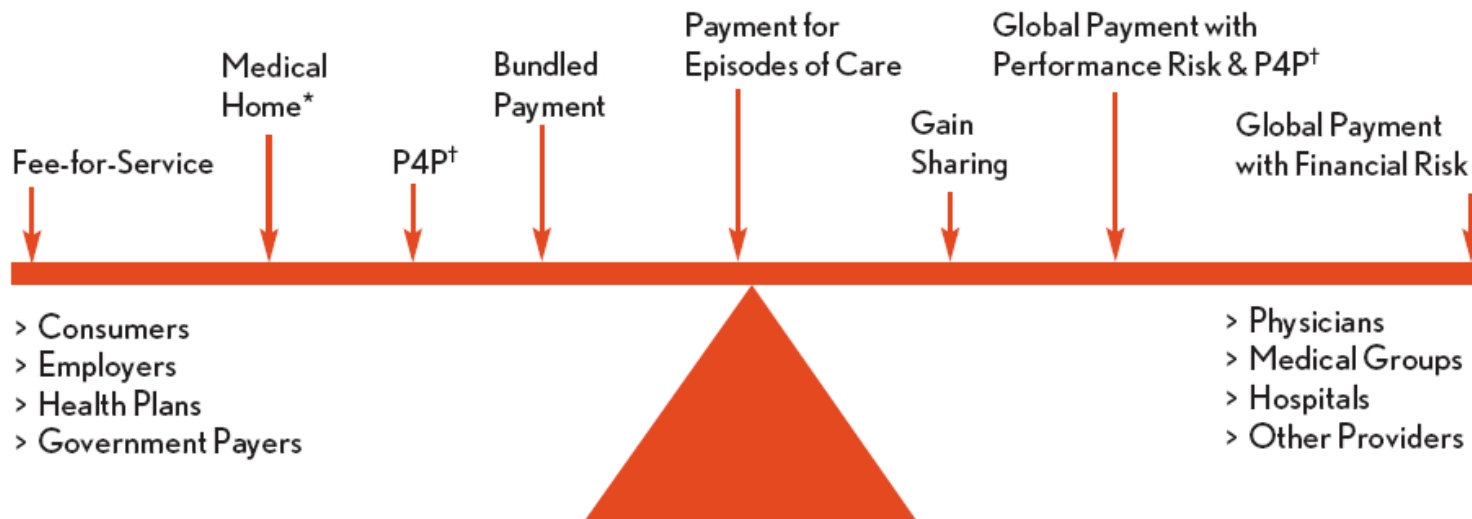
***While we wait for regulations, healthcare providers and payors are already emphasizing value-based arrangements.***

# V. Health Reform Preparation

## Shifting Payment System

***As reimbursement shifts from payments based on FFS (volume) to a more value-based system, risk will shift from payors to providers.***

### THE RISK CONTINUUM ASSOCIATED WITH EXISTING AND PROPOSED REIMBURSEMENT STRUCTURES



\* Medical homes that receive extra dollars for patient management.

† P4P = pay for performance.

Source: Keith D. Moore and Dean C. Coddington, Healthcare Financial Management Association, "Accountable Care: The Journey Begins," August 2010.

***The models we will discuss are moving us toward the tipping point. The shifting risk will place greater emphasis on integrated care models.***

# V. Health Reform Preparation

## Risk Sharing

***Providers must be mindful of the critical drivers of success/failure learned from previous risk models.***

### Physician

- Clinical integration across care continuums.
- Outcomes-driven approach.
- Strong care management.
  - Referrals.
  - Inpatient days or admissions.
  - Emergency department (ED) visits.
  - High-tech radiology events.
  - Prescription rates of generic pharmaceuticals.
- Strong data collection and analytical capabilities.

### Hospital

- Strong case management.
- Strong data collection and analytical capabilities.
- Physician/hospital integration.
- Efficient and effective ED care management.
- Reducing unnecessary readmissions.
- Implant/high-cost drug expense management.
- High-tech radiology management.

### Health Plan

- Linking payment to utilization and quality.
- Bundling individual services within a payment system (e.g., dialysis).
- Stop-loss/catastrophic case coverage.
- Premium pricing.
- Administrative expense management.
- Strong data collection and analytical capabilities.
- Data sharing across risk partners.

# V. Health Reform Preparation Payment Methodology Pilots

***Value-based payment methodologies are under careful study at the national and local levels by government and commercial payors.***

Model	Currently in Progress	Characteristics
ACOs	15 Initiatives	<ul style="list-style-type: none"> <li>• Include Medicare, Medicaid, and commercial populations.</li> <li>• In most examples, the details to support the relationships are in the formative stages of determining payment methodologies and quality and efficiency metrics.</li> <li>• Implementation ranges from demonstration projects/pilots to readiness assessments.</li> </ul>
PCMH	65 Initiatives	<ul style="list-style-type: none"> <li>• A wide variety of payment methodologies and metrics are in use.</li> <li>• Grants.</li> <li>• Enhanced FFS based on meeting criteria.</li> <li>• Disease management fees.</li> <li>• Shared savings.</li> <li>• Care management.</li> <li>• Quality and outcome measures.</li> <li>• Process measures.</li> </ul>
Bundled Payments	11 Initiatives	<ul style="list-style-type: none"> <li>• Includes well-known examples.</li> <li>• Prometheus.</li> <li>• Geisinger.</li> <li>• Others are just getting organized.</li> <li>• Surgeries and episodes of care.</li> <li>• Intended to make providers accountable for cost and quality while sharing related savings.</li> </ul>

Source: American Hospital Association database of major reform-oriented P4P programs.

## VI. Value-Based Payment Models

# VI. Value-Based Payment Models

## *Pay for Performance*

***In a 2009 survey conducted by ECG Management Consultants, Inc., of faculty practice plans, 59% of respondents were participating in a P4P program.***

- Payors and providers are collaborating to implement various pay-for-performance (P4P) arrangements intended to promote an adherence to evidence-based medicine (EBM) and eliminate the incentives to perform unnecessary services ahead of reform.
  - Develop and gain experience with measuring and improving quality and efficiency metrics.
  - Begin the long process of changing internal culture.
  - Perhaps maintain some control over their destiny by being proactive.
- Measures vary from program to program. Most use a combination that includes:
  - Clinical quality and effectiveness.
  - Utilization and cost management.
  - Patient satisfaction and safety.
  - Administrative involvement.
- A prepared hospital will have the capacity to negotiate performance-based incentives into a contract and sufficient clinical integration to demonstrate outcomes.

***89% of survey participants stated that P4P was tied to less than 5% of reimbursement.***

## VI. Value-Based Payment Models

### *Reimbursement Redesign – Option #1 (For Discussion)*

***All payment models seen in the industry recognize the need for a smaller panel size and more time and infrastructure investments toward care management.***

- Payment components:
  - Enhanced FFS at some percent of Medicare fee schedule.
  - PMPM Monthly Care Management Payment – for PCPs achieving NCQA certification for PCMH as follows:
    - » \$ value 1 PMPM for Level 1 certification.
    - » \$ value 2 PMPM for Level 2 certification.
    - » \$ value 3 PMPM for Level 3 certification.
    - » Enhanced FFS and care management payments are contingent upon meeting metrics associated with the operation of a PCMH practice, such as:
      - Health risk assessment completion rate percentages (e.g., 85%).
      - Appropriate acceptable scores for HEDIS measures (TBD).
      - Notification rate to plan of 95% for inpatient admissions.
  - Infrastructure development payments offered totaling a given \$ value.

## VI. Value-Based Payment Models

### *Reimbursement Redesign – Option #2 (For Discussion)*

*The pilot should be for multiple years to provide adequate time for care delivery change and program measurement.*

- Payment components are centered on methods to support effective chronic care management:
  - **FFS** – Reimburses providers under current FFS schedule.
  - **PMPM Monthly Care Management Payment** – Supports medical home and care coordination.
  - **Performance-Based Incentive Payment** – For achievement of clinical and quality outcomes.

## VII. ACOs

## VII. ACOs *Description*

***ACOs would be eligible for bonuses beginning in 2012. To qualify, an ACO would need to meet the following criteria:***

- Agree to become accountable for the overall care of its Medicare Fee-for-Service (FFS) beneficiaries.
- Agree to a minimum of 3 years of participation.
- Have a formal legal structure that would allow the organization to receive and distribute bonuses to participating providers.
- Include PCPs for at least 5,000 Medicare FFS beneficiaries.
- Provide CMS with information regarding PCPs and specialist physicians in the ACO, as appropriate.
- Have arrangements in place with a core group of specialty physicians.
- Have in place governance and management structure, including with regard to clinical and administrative systems.
- Define processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care.
- Demonstrate to the Secretary that it meets patient-centeredness criteria as defined by the Secretary (e.g., individualized care plans).

Source: Douglas A. Hastings, Health Care Delivery System Reform Provisions in the Baucus Bill: A Substantive Set of Provisions.

## VII. ACOs

### Medicare Rationale

*The motivation for establishing ACOs (i.e., Medicare Shared Savings Program) is to allow various types of physician organizations to share in the efficiency gains and cost savings that accrue from the increased care integration of Medicare patients.*

#### **Under the Proposed Option From the Senate Finance Committee<sup>1</sup>**

- Organizations eligible to qualify as ACOs would include: individual physician practices, physician group practices, networks of physician practices, hospital/physician JVs, and hospitals employing physicians.
- ACOs would be rewarded for improving the integration and cost efficiency of Medicare services by better coordinating Part A (hospital) and Part B (physician) services, providing better care management, and achieving improved outcomes, particularly for chronically ill patients.
- To earn incentive payments, ACOs would have to meet certain quality thresholds related to clinical processes and outcomes, patient satisfaction, utilization, and costs.
- If Medicare payments to the ACO are below a preset threshold, an ACO would be eligible to share in 50% of the savings generated.

<sup>1</sup> Source: Transforming the Healthcare Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs, Senate Finance Committee

## VII. ACOs Payment Approaches

***Two payment approaches were included as pilot programs in legislative proposals: a shared savings program (SSP) and population-based payment (PBP).***

### Payment Approach and Description

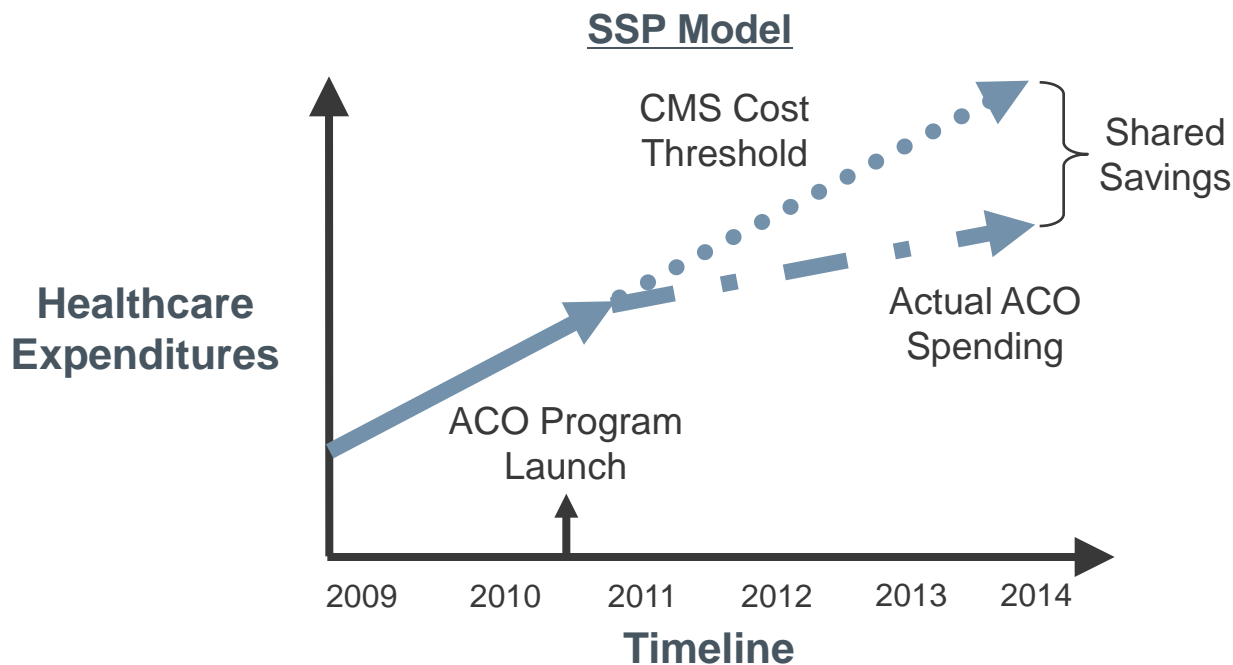
<b>SSP</b>	Providers are paid on an FFS basis and, if they deliver care below expected costs, are eligible to receive a portion of the savings they generate. A variation of the SSP concept would withhold a portion of FFS payments that would be paid out only if the ACO delivers care below expected cost levels.
<b>PBP</b>	Providers are paid based on a capitation system in which they receive a global payment for each designated beneficiary.

Source: K. Devers and R. Berenson, "Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?" Robert Wood Johnson Foundation, Princeton, October 2009.

***Between the two approaches, an SSP is more likely to be utilized at the outset, because it remains largely based on the existing FFS system.***

## VII. ACOs Payment Approaches (continued)

***Through more integrated care delivery, cost control measures, and meaningful quality thresholds that improve care, ACOs could reduce actual healthcare expenditures and financially benefit from those efforts.***



Source: K. Devers and R. Berenson, "Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?" Robert Wood Johnson Foundation, Princeton, October 2009.

***There is some skepticism that the shared savings payments will be large enough to incentivize providers to make meaningful changes.***

## VII. ACOs

### *Payment Approaches (continued)*

***While the SSP may be more feasible in the short term, it has distinct weaknesses when compared to the PBP approach.***

The PBP approach's strengths over SSP are focused on the following areas:

- ***Care Delivery*** – It would encourage new care delivery and management approaches that are not recognized and reimbursed under an FFS system.
- ***Payment Incentives*** – PBP would fundamentally alter the underlying incentives in patient care delivery, which could lead to a variety of improvements.
- ***Cost Reduction*** – ACOs would be incentivized to not only lower costs in a fixed time period, but also to improve their cost structure over the long term.
- ***Organizational Financing*** – ACOs would receive funding at the onset of the fixed time period for which capitated payments will be provided, as well as a regular stream of funds on which to base financing and capital expenditure decisions.

Source: K. Devers and R. Berenson, "Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?" Robert Wood Johnson Foundation, Princeton, October 2009.

***Despite these clear benefits, few provider organizations exist that are capable of succeeding in a purely capitated payment environment.***

# VII. ACOs

## Performance Measurement

***Performance measurement is equally important as the payment methodology, yet it remains relatively undefined.***

**1****Clinical Processes and Outcomes**

Performance measurement could be based on the frequency with which an ACO adheres to best practice clinical processes, achieves meaningful use of EMRs, and attains desired clinical outcomes.

**2****Utilization**

Utilization metrics could quantify how efficiently an ACO delivers health services and identify areas where more care is provided than is necessary.

**3****Patient Perspectives**

Patient perspectives on care could indicate an overall level of patient satisfaction and pinpoint opportunities for improvement.

**4****Weighted Quality Score**

The Medicare Payment Advisory Commission (MedPAC) has suggested that multiple quality measures could be aggregated into a single quality score.

***Developing meaningful and widely accepted performance measures will be a critical component of the ACO model.***

## VIII. Patient Centered Medical Home

# VIII. Patient Centered Medical Home Description

***The provision of PCMH may allow better access to healthcare, increase satisfaction with care, and improve health.***

- PCMH is defined as "an approach to providing comprehensive primary care...that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family."<sup>1</sup>
- Medicare interest in PCMH:<sup>2</sup>
  - PCMH programs encourage practitioners to coordinate their patients' care between visits and among providers.
  - Efforts to promote the use of primary care services can increase quality and efficiency.
  - Qualifying PCMH programs would receive compensation through two methods:
    - » Services provided and reimbursed based upon Medicare fee schedules.
    - » Monthly payment for PCMH infrastructure and care-coordination activities.
      - Monthly amount is yet to be determined but must be sufficient to encourage participation and pay practices adequately for the activities.
      - It is also unclear if payment should be made to a practice or to the beneficiary's individual practitioner.<sup>1</sup>

<sup>1</sup> American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association. Joint Principles of the Patient-Centered Medical Home. 2007 March. Accessed June 30, 2009.

<sup>2</sup> MedPac Report to Congress: Reforming the Delivery System June 2008.

# VIII. Patient Centered Medical Home *CMS, MedPAC, and Reform Activities*






***CMS has extensively reviewed the PCMH model as a major reform initiative, and MedPAC has touted the model as one that can increase quality and efficiency.***

- The reform bill specifies that primary care services by a primary care practitioner between January 1, 2011, and January 1, 2016, will receive a 10% bonus over regular payment amounts (PPACA § 5501).
  - “Primary care physician” includes family medicine physicians, internal medicine physicians, geriatric medicine physicians, pediatricians, nurse practitioners, clinical nurse specialists, and physician assistants for whom primary care services constituted at least 60% of allowed charges during some previous period (to be determined by the Secretary).
- CMS announced on November 16, 2010, a major PCMH demonstration for eight states:
  - “To evaluate the effectiveness of doctors and other health professionals across the care system working in a more integrated fashion and receiving more coordinated payment from Medicare, Medicaid, and private health plans.”
  - Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota.
  - The Multi-Payer Advanced Primary Care Practice Demonstration is expected to include 1,200 medical homes serving up to 1 million Medicare members.

# VIII. Patient Centered Medical Home

## Example of Transformation to a P4P Model – PCMH

***PCMH is a model of care in which each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care.<sup>1</sup>***

Current Model	PCMH
Care is episodic and based on illness and patient complaints.	 Care is coordinated and focused on a long-term healing relationship.
Providers operate in silos with limited communication.	 A physician-led care team takes responsibility for all patient care needs, arranging for referrals as appropriate. Communication among providers and the patient (and family) is continuous.
The patient is a passive participant with limited say in treatment.	 Patients actively participate in decision making, and patient feedback is sought to ensure that expectations are being met.
Practice patterns vary widely according to physician preference.	 EBM and clinical support tools guide consistent decision making.
Payment is procedure-based, and volume is rewarded.	 Payment recognizes the value of care management and communication with the patient outside of face-to-face visits. Measurable and continuous quality improvements are rewarded.

<sup>1</sup> Source: The National Committee for Quality Assurance (NCQA).

# VIII. Patient Centered Medical Home PCMH Pilot

## 21-Month Performance Summary

Metric	May 1, 2008 – March 31, 2010 System	May 1, 2008 – March 31, 2010 Control Group
ER Expense	↓ 17%	↑ 22%
Inpatient Expense	↓ 12%	↑ Not Reported Due to Outlier Case(s)
Participating Facility Utilization	90% ↑ 7%	83% ↓ 8%
Generic Dispense Rate	71% ↑ 10%	69% ↑ 10%
Pharmacy Expense	↑ 23%	↑ 16%
Diagnostic Imaging Expense	↑ 9%	↑ 17%
Primary Care Office Visit Expense	↑ 11%	↑ 11%
ER Visits/1,000	↓ 15%	↑ 9%
Bed Days/1,000	339.4	390.8
Average Length of Stay	3.6	4.1

NOTE: Percentage change compared to respective baseline.

Source: 2010 AMGA IQL: AMGA's National Summit on ACOs.

## VIII. Patient Centered Medical Home *Group Health Research Institute*

***Group Health recently reported that it realized a \$1.50 return on every dollar invested into its PCMH initiative.***

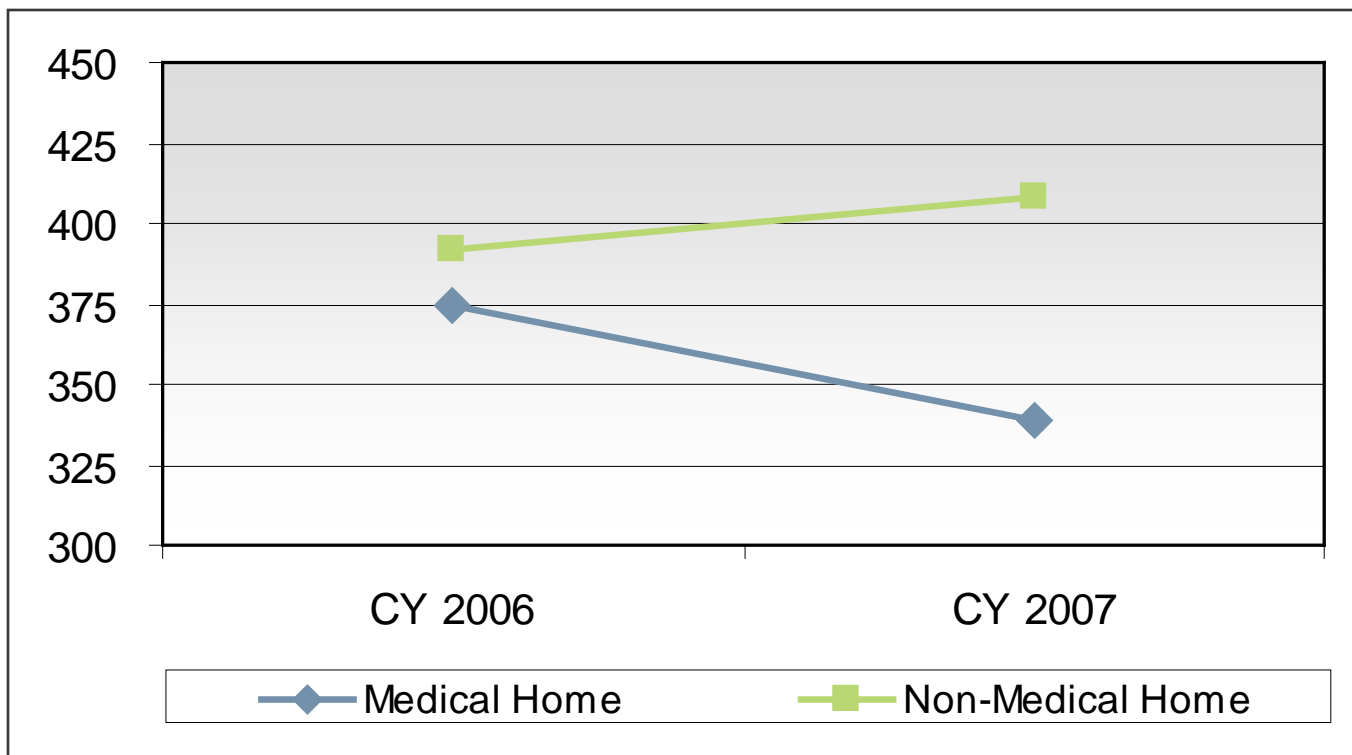
- The Group Health Research Institute studied costs and outcomes for 9,200 patients receiving treatment via a medical home.
- Patients went to the emergency room (ER) 29% less often.
- Patients were hospitalized 6% less often.
- The favorable outcomes have prompted Group Health to implement the program at its 26 medical centers across Washington State.

Source: Medical home program leads to “significant” cost savings, fewer hospitalizations, 2010.

# VIII. Patient Centered Medical Home *Geisinger – Hospital Admissions*

***Geisinger PCMH sites reduced the number of hospital admissions compared to non-PCMH sites.***

## Hospital Admissions Per 1,000 Medicare Patients

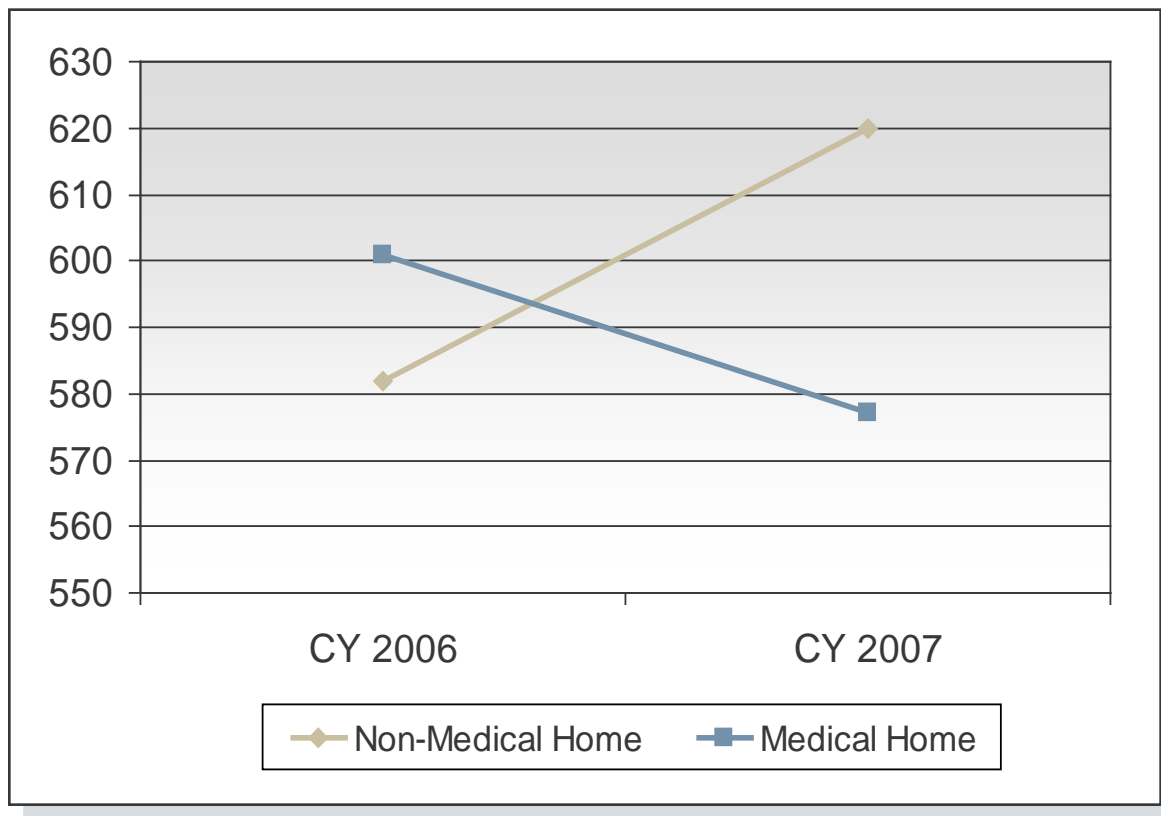


Source: Geisinger Health System, 2008.

# VIII. Patient Centered Medical Home *Geisinger – Total Medical Costs*

***Geisinger PCMH pilot sites reduced medical cost by 4% in first year.***

## Allowed PMPM

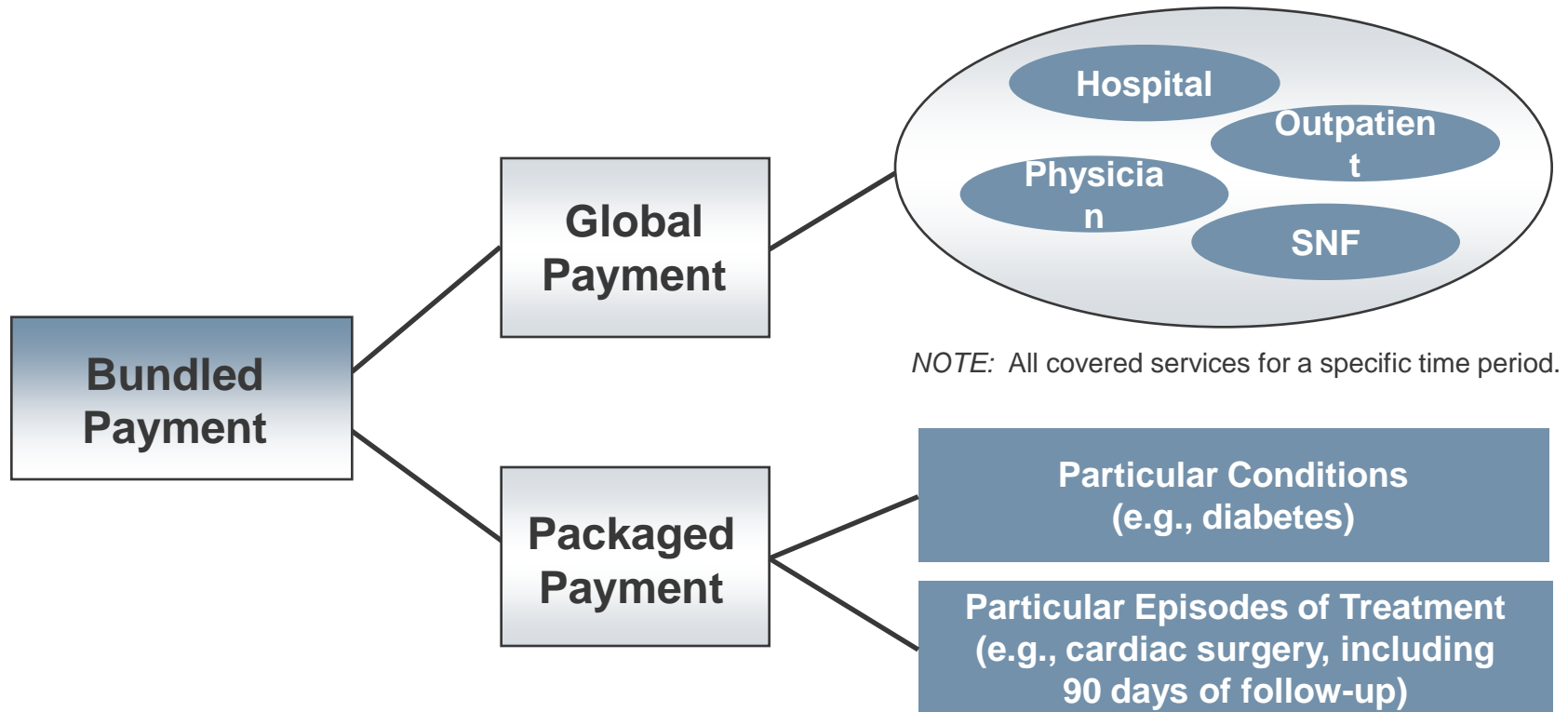


Source: G. Steele, "Geisinger Quality – Striving for Perfection," Presentation to The Commonwealth Fund Bipartisan Congressional Health Policy Conference, January 10, 2009.

## IX. Bundled Payments

# IX. Bundled Payments Overview

*The term “bundled” can be used broadly to include a wide range of payment models. ECG typically defines it as payment that encompasses more than discrete patient encounters, including global and packaged payments.*



# IX. Bundled Payments

## MedPAC

***“Bundling” all Medicare payments for an episode of care has the potential to improve incentives for providers to offer the right mix of services at the right time.***

According to MedPAC, bundling payments would:<sup>1</sup>

- Allow Medicare to pay a set fee per hospitalization episode instead of separate hospital (IPPS), physician (RBRVS), SNF (SNFPPS), and outpatient department (OPPS) payments.
- Have the potential to improve efficiency and quality, reduce Medicare costs, and better align the interests of hospitals and physicians, particularly in regard to requests for specialty consultations, discharge planning, and the utilization of ICUs and DME.
- Require changes in the way hospitals are reimbursed for readmissions and the revision of existing restrictions that inhibit hospitals from financially rewarding physicians.
- Have the potential to produce undesirable consequences, such as underutilization of services on the part of hospitals and the avoidance of certain “low margin” patients (those that require extensive hospital resource use) on the part of physicians.

<sup>1</sup> Source: MedPAC July 2008 Report to Congress. MedPAC is an independent agency established to advise the U.S. Congress on issues affecting the Medicare program.

# IX. Bundled Payments *CMS Pilots*

***Currently, CMS is preparing to pilot bundled payments for select conditions beginning in 2013. Any Medicare provider will be eligible to apply.***

- According to the Senate Finance Committee's proposal, the HHS Secretary would be required to select eight conditions for a "bundled" payment pilot program beginning in 2013.
- The "bundled" payment would be made to a Medicare provider to cover the costs of acute care inpatient and outpatient hospital services, physician services, post-acute care, and any rehospitalizations that occur during that time period.
- Any Medicare provider, including hospitals or physician groups, would be eligible to apply to participate in the pilot.
- Any entity assuming responsibility for bundled payment would be required to have an arrangement with an acute care hospital for initiation of bundled services.
- If the pilot is successful in reducing costs and increasing quality, the HHS Secretary would be required to submit an implementation plan in FY 2016 to become part of Medicare in FY 2018.

Source: Douglas A. Hastings, "Health Care Delivery System Reform Provisions in the Baucus Bill: A Substantive Set of Provisions," BNA's *Health Law Reporter*, 2009.

# IX. Bundled Payments

## *Example Initiatives*

### **Geisinger ProvenCare**

- “Warranty” covers any follow-up care needed for avoidable complications within 90 days at no additional charge.
- The model was initially for coronary artery bypass graft surgery. It is expanding to hip replacement, cataract surgery, angioplasty, and so forth.
- The provider defines the care process standards to be followed.

### **Prometheus Payment**

- Covers the *full* episode of care and *all* providers.
- Deals with both integrated and nonintegrated providers by offering a default scheme for allocating payment.
- Estimates the appropriate payment amount based on historical costs and any guidelines for EBM.
- Pilot sites in Rockford, Illinois; Minneapolis, Minnesota; and Philadelphia, Pennsylvania.

### **Minnesota Health Reform – Baskets of Care**

- The purpose is to uniformly define a scope and set of care components for a given condition, procedure, or episode of care.

# IX. Bundled Payments

## *Example Initiatives (continued)*

- The Minnesota health reform initiative is known as “baskets of care.”
  - Initial areas of focus:
    - » Asthma (children): management of asthma as a chronic disease.
    - » Diabetes: without comorbidities, does include hypertension and hyperlipidemia.
    - » Lower back pain: management of acute episode of lower back pain.
    - » Obstetric care: prenatal, uncomplicated vaginal delivery, cesarean section delivery.
    - » Preventive care: adults and children.
    - » Total knee replacement.
- Baskets of care relies on state-run programs and interested insurance or medical provider organizations.
- Effective date for programs is 2010.

# IX. Bundled Payments

## *Cost Breakdown for Hospitalization Example*

### Historical Inpatient Costs<sup>1</sup>

Service Category	Mean	Standard Deviation
Facility Fees	\$17,000	\$3,000
<b>Professional Fees</b>		
• Surgeons	\$ 2,000	\$ 200
• Anesthesiologists	570	210
• Pathologists	0	0
• Radiologists	10	40
• Other	<u>550</u>	<u>300</u>
Total Professional	<u>\$ 3,120</u>	\$ 360
<b>Total Hospitalization</b>	<b>\$20,120</b>	

<sup>1</sup> Example Hospital Based on 2009 utilization and cost data. Results are rounded to protect confidentiality.

# IX. Bundled Payments

## *Cost Breakdown for Post-Discharge Care Example*

### Historical Post-Discharge Costs<sup>1</sup>

Service Category	Rehab PT and DME	Other Services in Bundle	Services Not in Bundle	Total
<b>Readmission</b>				
• Facility	\$ 0	\$105	\$ 0	\$ 105
• Professional	<u>0</u>	<u>15</u>	<u>0</u>	<u>15</u>
<b>Readmission Total</b>	<b>\$ 0</b>	<b>\$120</b>	<b>\$ 0</b>	<b>\$ 120</b>
<b>Hospital Outpatient</b>				
• Facility	\$630	\$225	\$ 15	\$ 870
• Professional	0	0	5	5
<b>Hospital Outpatient Total</b>	<b>630</b>	<b>225</b>	<b>20</b>	<b>875</b>
Physician Office	145	50	100	295
Other Place of Service	<u>0</u>	<u>30</u>	<u>5</u>	<u>35</u>
<b>Grand Total</b>	<b>\$775</b>	<b>\$425</b>	<b>\$125</b>	<b>\$1,275</b>

<sup>1</sup> Example Hospital Based on 2009 utilization and cost data. Results are rounded to protect confidentiality.

# IX. Bundled Payments

## *Cost Breakdown for Episode of Care Example*

### Historical Episode of Care Costs<sup>1</sup>

Service Category	Mean	% of Total
<b>Hospitalization</b>		
• Facility	\$17,400	80.2%
• Surgeon	1,850	8.5%
• Other Professional	1,110	5.1%
Discharge to 90 Days	1,180	5.4%
91 Days to 180 Days	<u>160</u>	<u>0.7%</u>
<b>Total</b>	<b>\$21,700</b>	<b>100.0%</b>

<sup>1</sup> Example Hospital Based on 2009 utilization and cost data. Results are rounded to protect confidentiality.

# IX. Bundled Payments

## *CMS ACE Demonstration*

- Five sites took part in a 3-year Acute Care Episode (ACE) demonstration project on the use of bundled payments for certain cardiovascular and orthopedic procedures.
- The Patient Protection and Affordable Care Act (PPACA) created a 5-year Medicare pilot to test bundled payments for a wider array of services.
  - Scheduled to begin in January 2013 and covers acute-care and post-acute care services, including rehab and physician office visits.
  - Similar to the Anthem bundle.
- Cost reductions in the ACE demonstration were achieved primarily by standardizing devices and reducing surgical supply costs.
- Under the ACE pilot, Medicare saved 4.4% on the base rate to Hillcrest.
- CMS established guidelines for the program stating that incentive payments to physicians may not exceed 25% of the amount normally paid to physicians for such cases.
- Hillcrest physicians are paid standard fees and receive a bonus of up to 25% of their fee-for-service reimbursement if they:
  - Demonstrate savings.
  - Follow clinical protocol in 98% of their cases.
  - Maintain quality scores in areas such as low infection and readmission rates.
  - Work with the hospital to report to CMS on 22 quality metrics every quarter.

# IX. Bundled Payments

## *CMS ACE Demonstration – Hillcrest and Baptist*

- Hillcrest reduced its costs by approximately 5%:
  - Surgeons persuaded the medical staff to stop using antibiotic cement for implants rather than the standard version.
  - Physicians reduced the number of surgical drapes and disposable drill pins.
  - Physicians worked with the hospital to negotiate greater discounts on implants and other supplies.
- The hospital made a slight profit on 120 orthopedic patients.
- Orthopedic cases increased by 2% and cardiac cases increased by 27%.
- If Baptist physicians meet certain quality and financial criteria, they may receive up to a 25% bonus.
  - In the first month, only a few of the 150 eligible physicians received bonuses.
  - That figure has grown steadily to 90 physicians which is indicative of costs coming down and quality going up.

# IX. Bundled Payments

## *Follow the ACE Demonstration Model*

### **ACE Example**

- Average surgeon reimbursement per case = \$2,000.
- Establish a incentive bonus of up to 25% = \$500.
- Total case reimbursement = \$22,000.
- 5% cost reduction = shared savings of \$1,100.

# X. Contract Examples

# X. Regional Trends and Contract Examples

## *Current Examples of Similar Arrangements*

*Payors and providers are learning to collaborate under alternative P4P arrangements.*

### **Case Studies**

- Medicare Advantage Patient-Centered Medical Home
- Multiple Hospital and Region P4P
- Blue Cross Blue Shield of Massachusetts Alternative Quality Contract (AQC)

*P4P is not new, but it is becoming a very high-priority approach with payors and providers.*

# X. Regional Trends and Contract Examples

## *Case Study: Medicare Advantage Patient-Centered Medical Home*

***PCMH infrastructure catalyzed a P4P Medicare Advantage strategy.***

- 200-plus-physician multispecialty group.
- Developed a patient-centered medical home strategy with largest payors.
- Each agreement shared common methodologies.
  - Enhanced FFS.
  - Grants or investments for infrastructure.
  - Quality and/or efficiency measures.
  - PMPM medical management fee.
- Funding based on shared savings from anticipated reductions in utilization and increased premium due to appropriate risk adjustments from accurate hierarchical condition coding.
- While the details differed between plans, the incentives were consistent and in line with the group's infrastructure and philosophy.

***This program was physician-oriented, and the hospitals were not part of the arrangement.***

# X. Regional Trends and Contract Examples

## *Case Study: Multiple Hospital and Region P4P*

***This health-plan-mandated P4P program encourages a collaborative approach.***

### **Quality- and Efficiency-Based P4P**

- Hospital payments include a variety of mechanisms to reward performance, with a goal of improving cost and quality while providing a mechanism to support the transition.
- Incentives and compensation support:
  - A lengthy transition period to negotiate and implement mutually agreeable quality and efficiency metrics.
  - Phased reduction in incentive “floor” with increasing upside potential.
  - Investment dollars available to develop systems and infrastructure to support the arrangement.
  - Inpatient outlier protection aligns incentives between the hospital and health plan to reduce length of stay for DRG-based cases.
- Inflation protection.
- Health plan insisted on the use of a neutral third-party vendor to measure quality and efficiency metrics.

***The hospitals see this as an opportunity to change culture and prepare for future VBP.***

# X. Regional Trends and Contract Examples

## *Case Study: Blue Cross Blue Shield of Massachusetts AQC*

***Combines a per patient global budget with performance measures based on quality measures.***

Key parameters include:

- Financial structure – a global budget with opportunity to share meaningful savings.
- Performance measures – oriented around safe, timely, and effective patient-centered care, and supportive of developing innovative new measures.
- Long term (5 years) – encourages investments to make improvements.
- Opportunity for significant savings by reducing waste and realizing other savings.

This Model is *not* the same as the past “capitation” model.

- Based on historical costs – not premium – and is risk-adjusted.
- Incentivizes appropriate utilization with a focus on outcome – not purely cost-based.
- Risk-adjusted historic budget eliminates tendency for providers to avoid sick patients.
- Includes a range of risk sharing and stop-loss provisions.

***This model incorporates the lessons learned from past attempts at population management.***

# X. Regional Trends and Contract Examples

## 2010/2011 Contracting Priorities and Initiatives

Hospitals	Physicians	Health Plans
<b>Physician Alignment:</b> Will seek stronger ties to physicians.	<b>Hospital Alignment:</b> Will seek stronger ties to hospitals to mitigate reimbursement/expense pressures.	<b>Membership Stabilization:</b> Counteract membership decreases due to declines in the insured population.
<b>Volumes:</b> Will seek to stabilize volumes and grow strategic service lines.	<b>Small Groups:</b> Will look to maintain and/or increase rates and strengthen ties to larger groups.	<b>Competitive Discounts:</b> Respond to employer comparison shopping with aggressive contracting.
<b>Quality:</b> Will become more focused on quality reporting, outcomes, and data management.	<b>Large Groups:</b> Will become organized around quality and data management and embrace innovative payment mechanisms.	<b>Product Focus and Differentiation:</b> Will focus on targeted product growth strategies that may span commercial, MA, leased, workers' compensation, and secondary insurance.
<b>Service Lines:</b> Will differentiate service strengths in the marketplace.	<b>Technical Revenue:</b> Will continue to seek opportunities for accessing technical revenue.	<b>Consistent Payment Methodologies:</b> Will streamline methodologies within similar provider types.
<b>Cost Coverage:</b> Will be more active regarding contract performance. May be more apt to terminate bad contracts.		<b>Pricing Transparency and Consumer-Directed Care:</b> Will increasingly involve members in making choices to access lower-cost providers.
<b>Consistent Payment Methodologies:</b> Will attempt to streamline methodologies across commercial business.		<b>Payment Reform Pilots:</b> Will test innovative care management and bundling models through select pilots.
<b>Employed Physicians:</b> Will seek to improve financial performance through contracting and revenue cycle.		<b>Medical Management:</b> Will refine medical management policies and procedures.
<b>Payment Reform Pilots:</b> Will test innovative care management and bundling models through select pilots.		<b>P4P:</b> Will implement P4P and/or increase percentages tied to existing P4P components.

# Questions & Answers

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