
Bundled Payments and Payment Reform

Medicare's Acute Care Episode Demonstration

HFMA Region 11 Symposium
Las Vegas, Nevada

January 24 to 27, 2010



ECG

Subjects and Speakers

- Introduction and context.
 - » Mr. Scott F. Burns, ECG Management Consultants, Inc., San Diego, California.
- CMS Acute Care Episode (ACE) demonstration experience.
 - » Ms. Deirdre Baggot, Exempla Saint Joseph Hospital, Denver, Colorado.
- What you should do to prepare for payment reform.
 - » Mr. John N. Fink, ECG, San Diego, California.

What are some of the biggest problems with the U.S. healthcare system?

- Poor quality.
- Inability to measure quality.
- Medical errors.
- Lack of care management and accountability.
- Poor communication.
- High-cost care (intensive interventions) rewarded over higher-value (preventative) care.
- Symptoms of a bigger problem – fragmentation.

Our healthcare system is fragmented because of the incentives driving the delivery of care.

Fee-for-service is the root cause of many of our problems.

Fee-for-Service (FFS) Characteristic	Incentive for Healthcare Providers
The more services you provide, the more you are paid.	➔ Encourages high volume over high value and causes over-utilization.
The more intense the services are, the more you are paid.	➔ Encourages use of high-cost services.
Readmissions and sicker patients result in additional payments.	➔ Penalizes effective care and preventive care.
Compensation is provided for narrow units of services by a single provider.	➔ Promotes silos and transactions rather than relationships with patients.
Global fees are paid to individual providers (e.g., IPPS for hospitals, global surgical fee for surgeons).	➔ Improves a provider's efficiency but not the aggregate volume of services provided.

Payment reform can drive lower costs while improving outcomes.

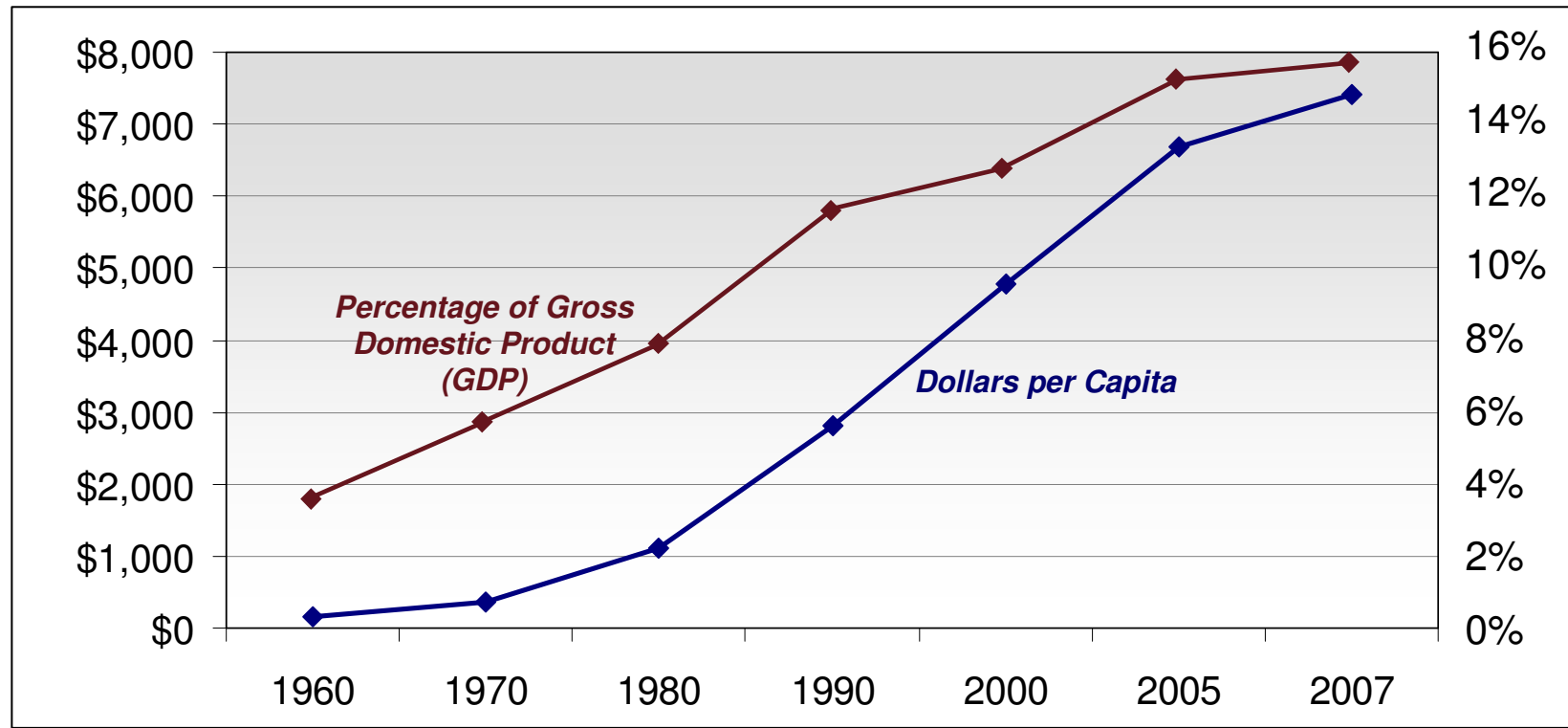
Payment Reform	Initiatives
Incremental Payment Reform	<ul style="list-style-type: none">■ Enhanced pay-for-performance (P4P) programs.■ Expanded scope.■ Increased funding.■ Improved performance measures.
Primary Care Payment Reform	<ul style="list-style-type: none">■ Medical homes.■ Risk-adjusted global fees.
Episode-Based Payment Systems	<ul style="list-style-type: none">■ PROMETHEUS Payment Inc.■ Medicare's ACE demonstration.

Trends

Rising Costs

Healthcare spending in the United States has risen sharply since 1960, drastically outpacing growth in GDP.

Healthcare Spending in the United States, 1960 to 2007

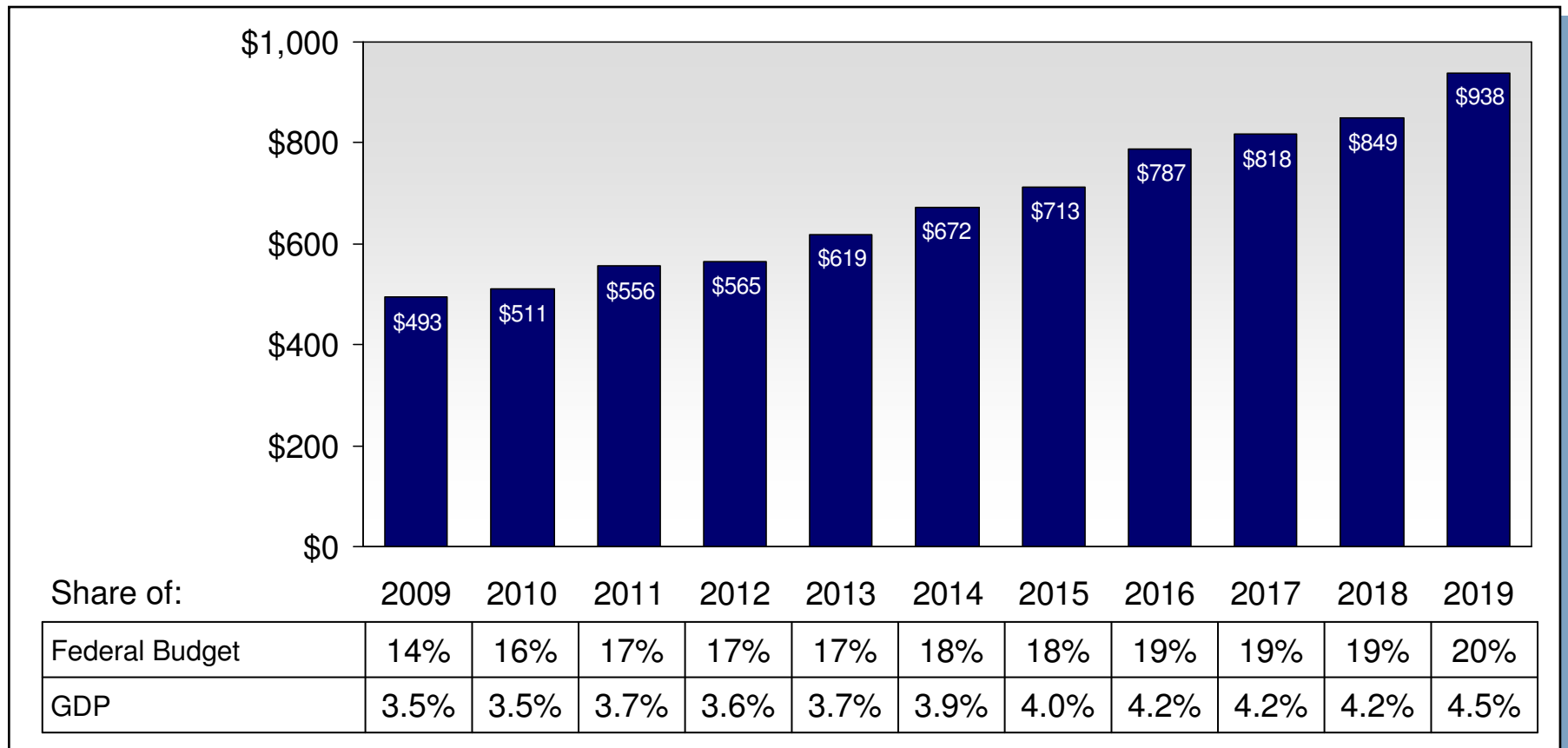


Source: CMS, Office of the Actuary, National Health Statistics Group.

Trends

Rising Costs (continued)

Projected Medicare Outlays, 2009 to 2019
(in billions)



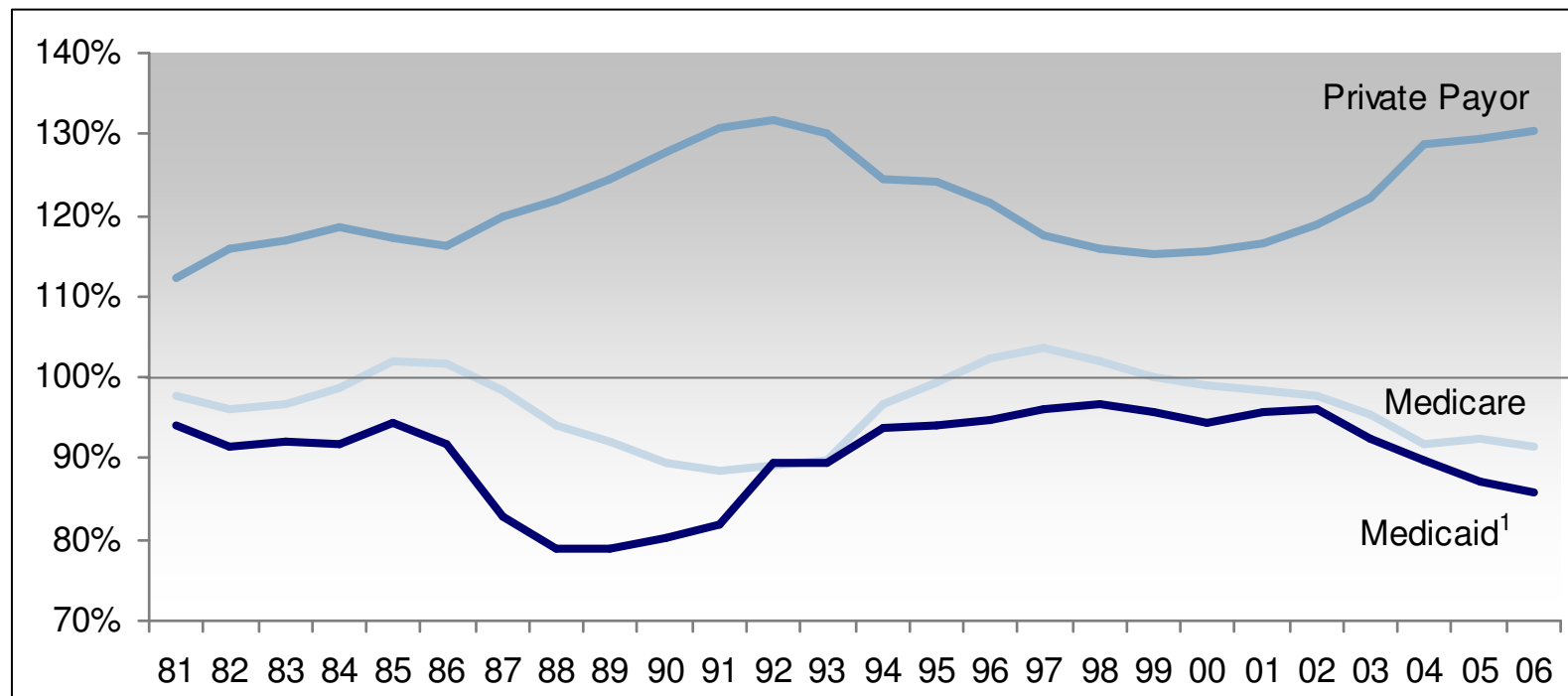
NOTE: Figures may not be exact due to rounding.

Source: The Henry J. Kaiser Family Foundation, based on data from the Congressional Budget Office (CBO): *The Budget and Economic Outlook: An Update*, January 2008, and *A Preliminary Analysis of the President's Budget and an Update of CBO's Budget and Economic Outlook*, March 2009.

Trends

Shifting Healthcare Costs to Private Payors

Providers rely on reimbursement from commercial payors to offset the below-cost reimbursement of government payors.



NOTE: Payment-to-cost ratios show the degree to which payments from each payor cover the costs of treating its patients. They cannot be used to compare payment levels across payors, however, because the service mix and intensity vary. Data is for community hospitals.

Source: Avalere Health LLC analysis of American Hospital Association (AHA) *Annual Survey* data, 2006, for community hospitals.

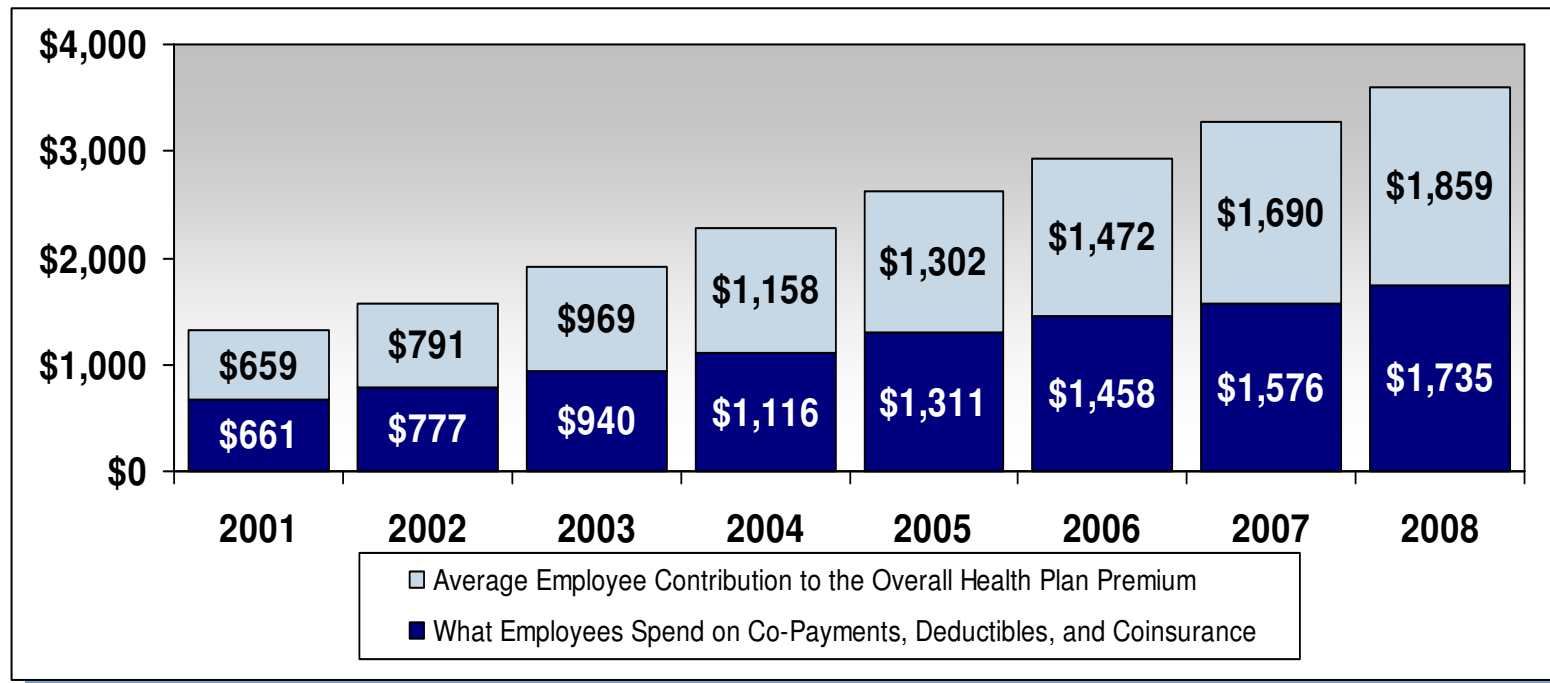
¹ Includes Medicaid disproportionate share payments.

Trends

Cost Burden of Private Health Insurance

A greater proportion of the cost of healthcare is being shifted to the consumer, resulting in an increased demand for price transparency, as well as rising levels of bad-debt expense.

Changes in Insurance Premiums and Out-of-Pocket Costs



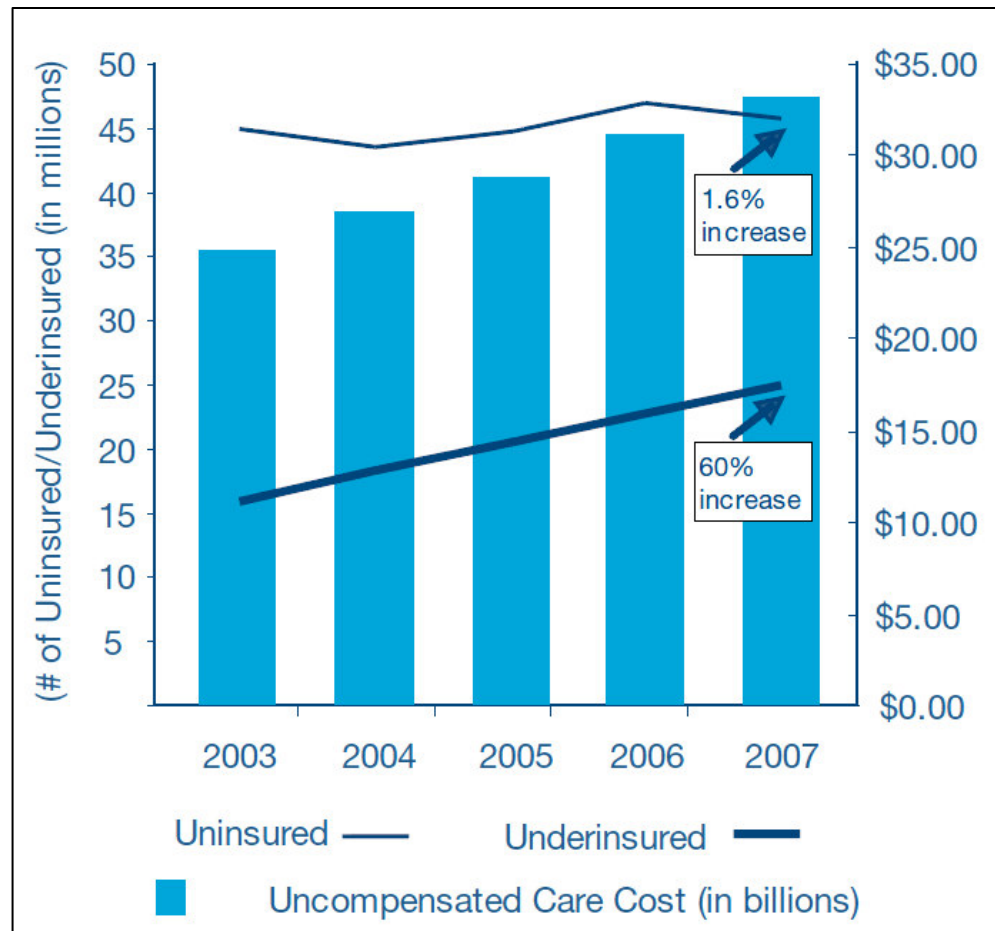
Source: *Modern Healthcare*, "By The Numbers," Hewitt Associates LLC.

Between 2001 and 2008, patient out-of-pocket healthcare costs grew at an average rate of 15% per year.

Trends

Comparison of Uninsured to Underinsured

Uncompensated Care Costs Driven by Growth in Underinsured



Sources: U.S. Census Bureau, The Commonwealth Fund, AHA, and PricewaterhouseCoopers' Health Research Institute.

Trends

Physician/Hospital Alignment

Physician's News
DIGEST
February 2009

“The boomerang effect: Hospital employment of physicians coming back around”

September 2008
Robert Wood Johnson Foundation

“The decline of the voluntary medical staff model”

Modern Healthcare

January 2005

“Hospitals revisit old strategy: Buying doc practices”

AMA
AMERICAN
MEDICAL
ASSOCIATION

“Economy sends physicians to hospitals for help”

December 2008

MANAGED
Care
MAGAZINE

“Many Changes in Store As Physicians Become Employees”
July 2008

Puget Sound
BUSINESS JOURNAL
Business Leaders Get It.

October 2005

“Docs quit independent practices to join hospitals”

HealthLeaders

January 2006

“The ‘hire’ road: Physician employment makes a comeback”



hfma healthcare financial management association

November 2006

“Physician employment: This time around, give finance a leading role”

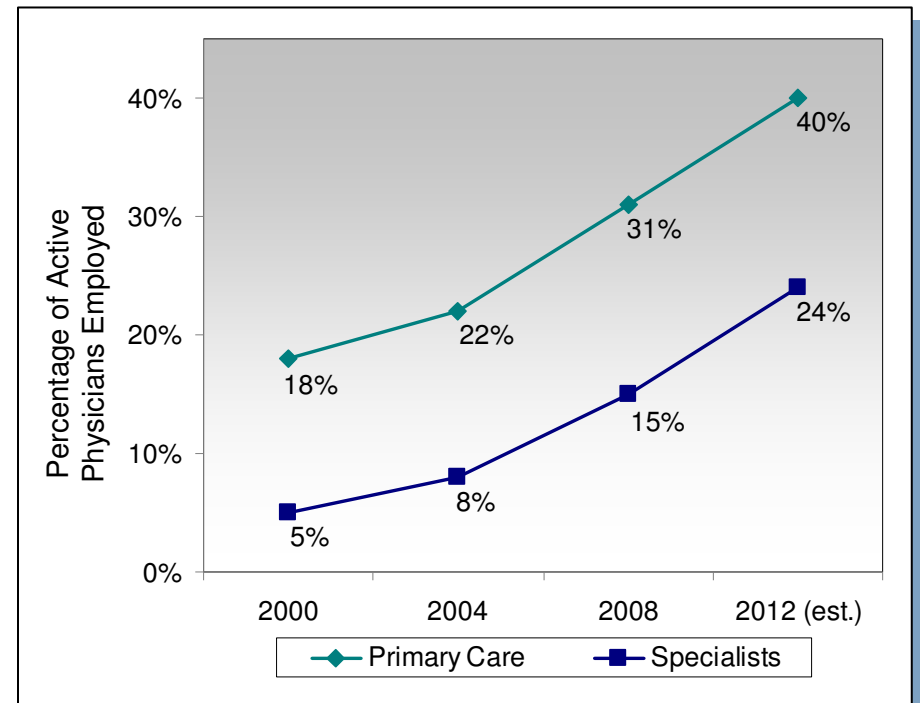
Trends

Physician Employment and Consolidation

The growth of medical groups and the employed model is significant, as physicians are seeking to join larger, more leveraged organizations.

- From 1965 to 1998, the number of physicians in groups grew from 28,000 to 207,000 (three times the growth of the physician population).
- From 1998 to 2008, the number of physicians in groups grew to 600,000.
- Younger physicians are more interested in joining medical groups because of the stability, access to capital, and competitive advantage.
- Medical groups, whether independent or hospital-affiliated, are investing in the systems required for performance accountability, which is beginning to be linked to reimbursement.

Physician Employment

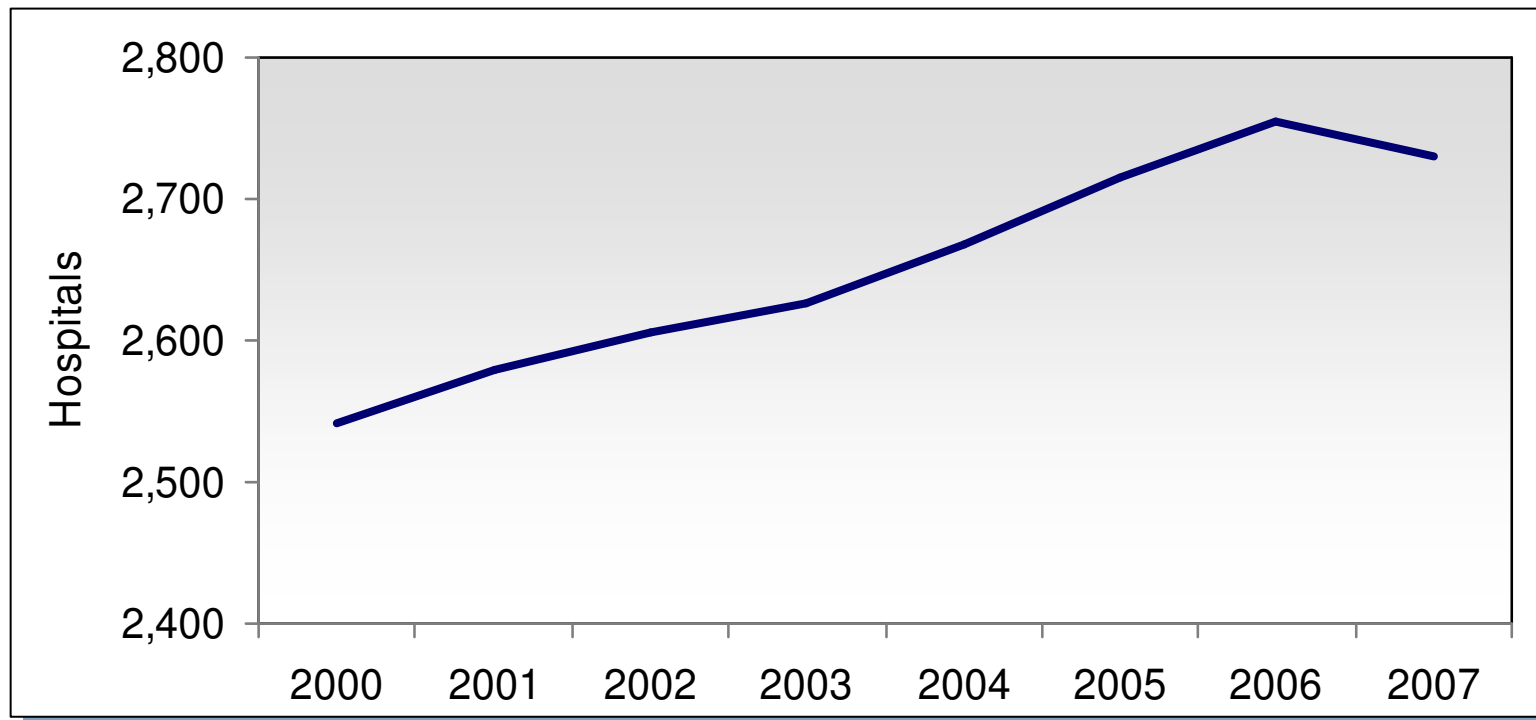


Trends

Hospital Consolidation

Physicians are not the only providers that are consolidating. Hospitals are increasingly joining multi-hospital systems in order to increase efficiency/cut costs, while boosting bargaining power with payors.

Number of Hospitals in Health Systems, 2000 to 2007



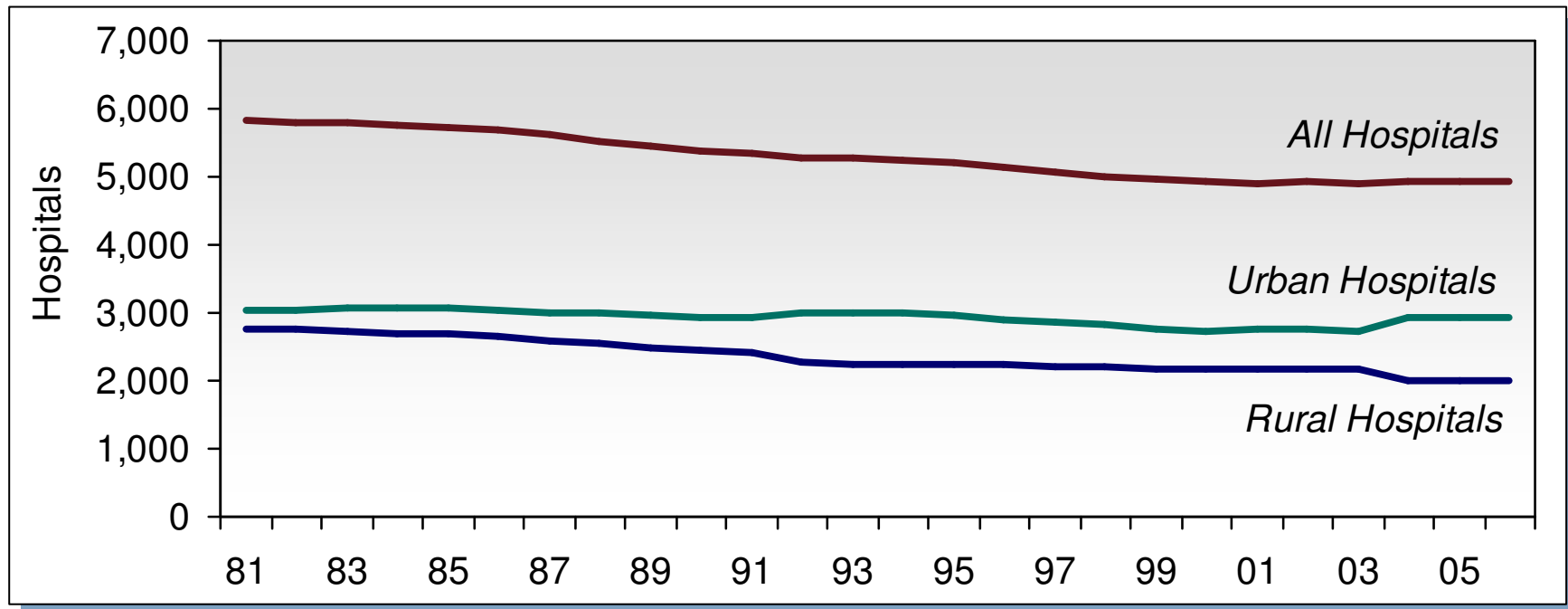
Source: Avalere Health analysis of AHA *Annual Survey* data, 2007, for community hospitals.

Trends

Hospital Consolidation (continued)

The increased number of hospitals in multi-hospital systems is even more dramatic given the decreasing number of hospitals overall.

Decline in the Number of Community Hospitals, 1981 to 2005



Source: Avalere Health analysis of AHA *Annual Survey* data, 2006, for community hospitals.

Trends

Implications

Pressures pertaining to reimbursement and access require that providers exploit revenue opportunities and be extremely cost-efficient.

- Nationwide, the percentage of hospitals with negative total margins has increased from 31% to 53%.
- The payor mix proportion of low-paying Medicaid reimbursement is increasing.
- Bad debt and charity care are increasing.
- Rising healthcare costs result in increased amounts of uninsured and underinsured patients.
- The shifting cost burden to the consumer has affected the demand for elective health services.
- Decreased utilization has been reported for (some but not all) inpatient and outpatient services.
- Hospitals' reductions in their workforces are in response to the recent economic downturn and the need for operational optimization.
- Programs that do not provide a bottom line will face more scrutiny (e.g., community need criteria) or elimination.
- Healthcare reform has never had more momentum.

Case for Healthcare Reform

The Perfect Storm

While the implications of reform remain uncertain, health plans are actively studying payment models that facilitate efficient and effective care outcomes.



Congress is asking:

- How do we promote access for all Americans?
- What can be done to enhance efficiency and promote value?
- How can the healthcare system be made more equitable?
- How can we make the transition to a higher-performing system?

Building Blocks of Reform Legislation



Systematic reforms to the U.S. healthcare system require efforts and investments in multiple, interdependent areas of focus.

Building Blocks of Reform Legislation *(continued)*

Coverage and Choice

- Health insurance exchange.
- Public health insurance option.
- Guaranteed coverage and insurance market reforms.
- Essential benefits.

Affordability

- Sliding-scale affordability credits.
- Out-of-pocket spending caps.
- Increased competition.
- Expands Medicaid.
- Improves Medicare.

Shared Responsibility

- Individual responsibility.
- Employer responsibility.
- Assistance for small employers.
- Government responsibility.

Controlling Costs

- Medicare modernization and improvement.
- Innovation and delivery reform.
- Preventing waste, fraud, and abuse.
- Administrative simplification.
- Improving accuracy and eliminating overpayments.

Prevention and Wellness

- Removal of barriers to preventive services.
- Promotion of primary care through healthy homes and care integration.
- Community health centers.
- Incentives for healthy lifestyles.
- Improved data collection efforts.

Workforce Investments

- Efforts focused on training primary care doctors.
- Increased funding for nursing development.
- Expanded pipeline of healthcare professionals.
- Greater support for workforce diversity.

House and Senate Healthcare Bills Compared

	House	Senate
Requirements of Individuals	Penalties of as much as 2.5% of income for those who do not get insurance, some with exceptions.	Penalties of as much as \$750 per adult and \$2,250 per family or as much as 2% of income for those who do not get insurance, some with exceptions.
Changes to Insurance Market	<ul style="list-style-type: none"> Prohibits insurers from denying coverage based on preexisting conditions. Creates regulated insurance exchanges where those who are uninsured by employers can shop for coverage. 	Generally, the same as the House bill.
Government Insurance Plans	Creates new government insurance plan to compete with private plans in a regulated insurance marketplace.	<ul style="list-style-type: none"> No government insurance plan. Government contracts with insurers to provide alternatives to commercially available plans.
Premium Assistance	<ul style="list-style-type: none"> Tax credits for individuals and families making up to 400% of the FPL \$(43,320 per individual) who do not get insurance from employers. People receiving subsidies would not be required to pay more than 12% of their income for the lowest-cost plans available in the new insurance exchange. 	<ul style="list-style-type: none"> Tax credits for individuals and families making up to 400% of the FPL who do not get insurance from employers. People receiving subsidies would not be required to pay more than 9.8% of their income for the lowest-cost plans available in the new insurance exchange.

House and Senate Healthcare Bills Compared *(continued)*

	House	Senate
Employer Requirements	<ul style="list-style-type: none"> Businesses with annual payrolls above \$500,000 must provide coverage to EEs or pay a penalty. Employers must pay 72.5% of insurance premiums for individuals and 65% for families. 	<ul style="list-style-type: none"> Businesses with more than 50 EEs would be fined if they did not provide health benefits and if their workers qualified for federal subsidies to buy insurance on their own.
Major Funding Sources	<ul style="list-style-type: none"> A 5.4% surtax on individual taxpayers with adjusted gross incomes over \$500,000 per year, and couples with incomes over \$1 million per year. Cuts in Medicare payments to hospitals and other providers. 	<ul style="list-style-type: none"> A 40% excise tax on every dollar of yearly insurance premiums above \$8,500 for an individual and \$23,000 for a family. Cuts in Medicare payments to hospitals and other providers. Yearly fees on pharmaceutical companies, health insurers, medical device companies, and clinical laboratories.
Gross Cost for Expanding Coverage and Impact on Deficit Over 10 Years	<ul style="list-style-type: none"> Cost: \$1.05 trillion. Effect on deficit: \$109-billion reduction. 	<ul style="list-style-type: none"> Cost: \$871 billion. Effect on deficit: \$132-billion reduction.

Source: CBO and Senate Democratic leadership, December 2009.

CMS Acute Care Episode (ACE) demonstration experience.

Ms. Deirdre Baggot, Exempla Saint Joseph Hospital,
Denver, Colorado.

Medicare's ACE demonstration is encouraging collaboration and quality using bundled payments.

- ACE demonstration: “To use a bundled payment to better align incentives for both hospitals and physicians, leading to better quality and greater efficiency in the care that is delivered.” – CMS
- “The ACE demonstration reflects CMS’s ongoing commitment to break down silos in health care by creating better teams and improved communication between caregivers and their patients.” – *Mr. Kerry Weems, CMS Acting Administrator*

Case Study Approach

Objectives

- A CMS snapshot – current state of the ACE demonstration and Obama imperative.
- Rationale for the administration believing bundling payments is the vehicle by which Obama will expand coverage to the nearly 50 million uninsured Americans.
- Examining the risks and understanding the frameworks that must be in place in order to achieve success under the new reimbursement model.
- Impact on revenue cycle – how billing works under ACE.

Research Question

The research question that CMS is attempting to answer is:

Do financial incentives impact quality of care and consequently provider of choice and provider referrals?

On Capital Hill

The draft healthcare reform bill from the House released on July 15 calls for:

- “Promoting the use of bundled payments.”
- “Convert(ing) the acute care episode demonstration ... to a pilot program.”
- “Expand(ing) such program ... to include post-acute services.”
- “Nothing ... shall be construed as Limiting the Number of Hospital and Physician Groups ... that may participate in the pilot program.”

Senate Bill November 18th: section 1866c

- “taking into account the evaluation...the Secretary may, through rulemaking, expand duration and scope of a demonstration project.



VIDEO

Obama National Address on Healthcare Reform *September 2009*

“Now, because Medicare is such a big part of the health care system, making the program more efficient can help usher in changes in the way we deliver health care that can reduce costs for everybody. We have long known that some places, like the Intermountain Healthcare in Utah or the Geisinger Health System in rural Pennsylvania, offer high-quality care at costs below average. The commission can help encourage the adoption of these common-sense best practices by doctors and medical professionals throughout the system.”



Background

- 1991** Medicare Participating Heart Bypass Demonstration
- 1996** Medicare Participating Centers of Excellence Demonstration
- 2001** Medicare Participating Cardiovascular and Orthopedic Centers of Excellence Demonstration
- 2009** ACE Demonstration Value-Based Care Centers

The Goals of ACE

The goals of the CMS demonstration are threefold:

- Improve quality through transparency.
- Drive physician collaboration as a mechanism to improve efficiency.
- Reduce or stabilize growing costs to Medicare for acute care services.

Application Process

- Organizational structure and capabilities.
- Quality and efficiency standards.
- Financial viability.
- Marketing plan.
- Volume.

Mechanisms Used in the Demonstration to Drive Quality and Efficiency

A Market Approach

- Bundling or global payments.
- Competitive bidding.
- Gain sharing.
- Shared savings.

Participating Hospitals

Exempla Saint Joseph Hospital – Denver, Colorado (Cardiac)

Projected start date: Q1 2010.

Baptist Health System – San Antonio, Texas (Cardiac and Orthopedics)

Commenced project on June 1, 2009.

Hillcrest Medical Center – Tulsa, Oklahoma (Cardiac and Orthopedics)

Commenced project on May 1, 2009.

Lovelace Health System – Albuquerque, New Mexico (Orthopedics)

Projected start date: Q1 2010.

The Oklahoma Heart Hospital – Oklahoma City, Oklahoma (Cardiac)

Commenced Q1 2010.

Geography



Participant Characteristics

Exempla Saint Joseph Hospital – Denver, Colorado

- Only not-for-profit and only teaching hospital in demonstration.
- At present, does not employ cardiac specialists.
- High percentage of Medicare managed care/Kaiser patients in population.

Baptist Health System – San Antonio, Texas

- Five hospitals operating under common provider number.
- Member of for-profit Vanguard Health Systems of Nashville, Tennessee.
- At present, does not employ cardiac or orthopedic specialists.
- Medicare market share leader in very close market – includes a MedCath Heart Hospital.

Hillcrest Medical Center – Tulsa, Oklahoma

- Single-location medical center.
- Employs both cardiac surgeons and cardiologists.
- Member of for-profit Ardent Health Services of Nashville, Tennessee.
- Third place in market share for both cardiac and orthopedic services.

Participant Characteristics *(continued)*

Lovelace Health System – Albuquerque, New Mexico

- Three hospital system operating under different provider numbers.
- Does not employ orthopedic surgeons.
- High degree of Medicare managed care patients in population.
- Trails Presbyterian hospital in orthopedic market share.

Oklahoma Heart Hospital – Oklahoma City, Oklahoma

- Joint venture for-profit, stand-alone heart hospital.
- 51% owned by not-for-profit Mercy Hospital; 49% owned by Oklahoma Cardiovascular Associates (multispecialty cardiovascular group).
- Market share leader in Oklahoma City.

Scope and Duration

- 28 cardiovascular and 9 Orthopedic DRGs included in the demonstration.
- Demonstration length: 3 years.
- Inclusion criteria: Medicare FFS beneficiaries.

Cardiac DRGs

- 216–221 Valves.
- 226–227 Defibrillators.
- 231–236 CABG.
- 242–244 Pacemaker.
- 246–251 Stents.
- 258–262 Pacer Revisions.

The Difference With ACE

- CMS will share 50% of its savings with Medicare beneficiaries (not to exceed their annual Part B premium – up to approximately \$1,150) through a “shared savings payment.”
- One fiscal intermediary handles both Parts A and B.

Inclusion Criteria for Beneficiaries

- FFS Medicare **only** (excludes Medicare Risk, Medicare Managed Care, KP, etc.).
- Inpatient procedures only.
- Patients must have Medicare Part A and B coverage.
- Patients with Medicaid as secondary insurance are included but **do not** qualify for a shared savings payment (tax implications).

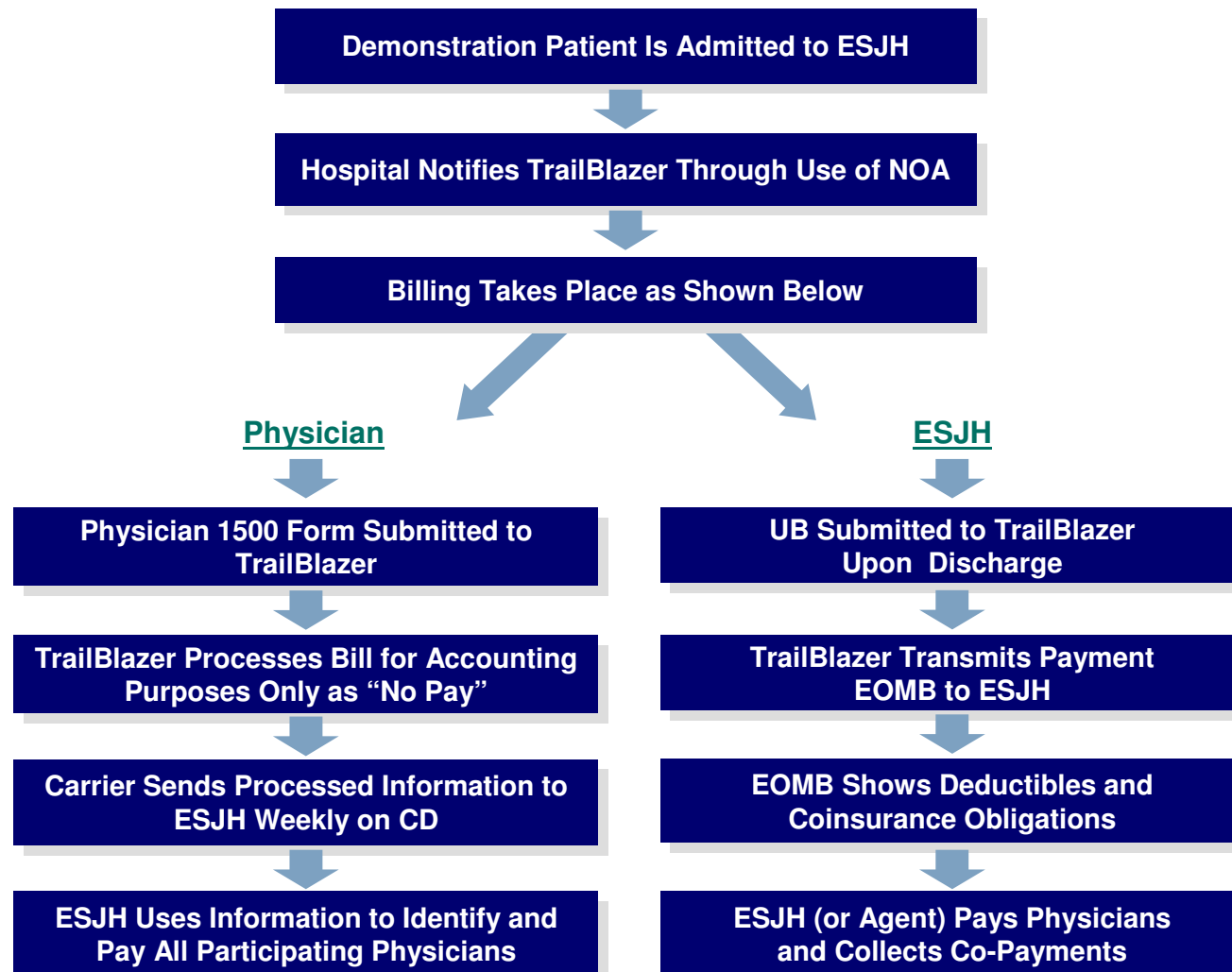
What is in it for Hospitals?

- Gain market share because of unique physician and beneficiary incentives.
- Protect current market share – spread payor risk.
- Attract new physicians to medical staff.
- Develop package for non-Medicare payors.
- Be on the leading edge of reimbursement reform.

FAQ

- What's in it for CMS?
 - » It desires to test “alternative payment methodologies” resulting in transparency, predictability, reduction in variance, better alignment between hospitals and physicians, and significant shifting of risk to providers.
- Why is CMS sharing cost savings with beneficiaries?
 - » It wants to see if economic incentives will move market share.
- Why does CMS care about moving market share?
 - » It may want to create a consolidation of services.

Billing Process



Billing and Claims

Impact on Physicians

- Bill as usual – 1500 to TrailBlazer.
 - » Need to include entity NPI Number.
 - » TrailBlazer training for physician offices.
- Claims processed as “no pay.”
- Physicians reimbursed by CPT code for services provided.
- Reimbursement will include 20% Part B co-payment.
 - » No cost of billing or collection.
 - » No delay in receipt of co-payment.
 - » No bad debt.
- Physicians to be reimbursed within similar time frame as today for “clean claims.”

**Medicare Acute Care Episode Demonstration
Shared Savings Payment**

TFS Group, Inc.
P.O. Box 1001, McLean, VA 22102
ph: 877-402-3693

CHECK



Name
Street Address
City, State ZIP

Dear _____:

Medicare is conducting a number of projects designed to improve the quality of health care for people with Medicare and reducing the costs of care. In one of our current projects, the Acute Care Episode Demonstration, some hospitals and their doctors are charging Medicare discounted fees for certain surgical procedures. Under this project, hospitals must provide detailed reports on the quality of care related to these surgical procedures. **To encourage people with Medicare to use these hospitals, Medicare is sharing up to half of its savings with patients who undergo one of these procedures.**

The attached check for \$_____ represents your share of what Medicare saved on your recent stay at _____(hospital)_____, which ended on ___(discharge date)_____. You are responsible for paying any Federal, state, and other taxes that may be owed on this amount. At the end of the calendar year, you will receive an IRS Form 1099 reflecting this amount as taxable income.

Please contact Medicare's contractor, TFS Group, Inc., at 1-877-402-3693 if you have any questions regarding this check. If you have any questions regarding this project or your hospital stay, please contact _____(hospital)_____ at _____(hospital's demo information number)_____.

Thank you for being a part of this important project.

Sincerely,

Cynthia Mason
Project Officer
Acute Care Episode Demonstration
Office of Research, Development, and Information

Keys to Success Under Bundling

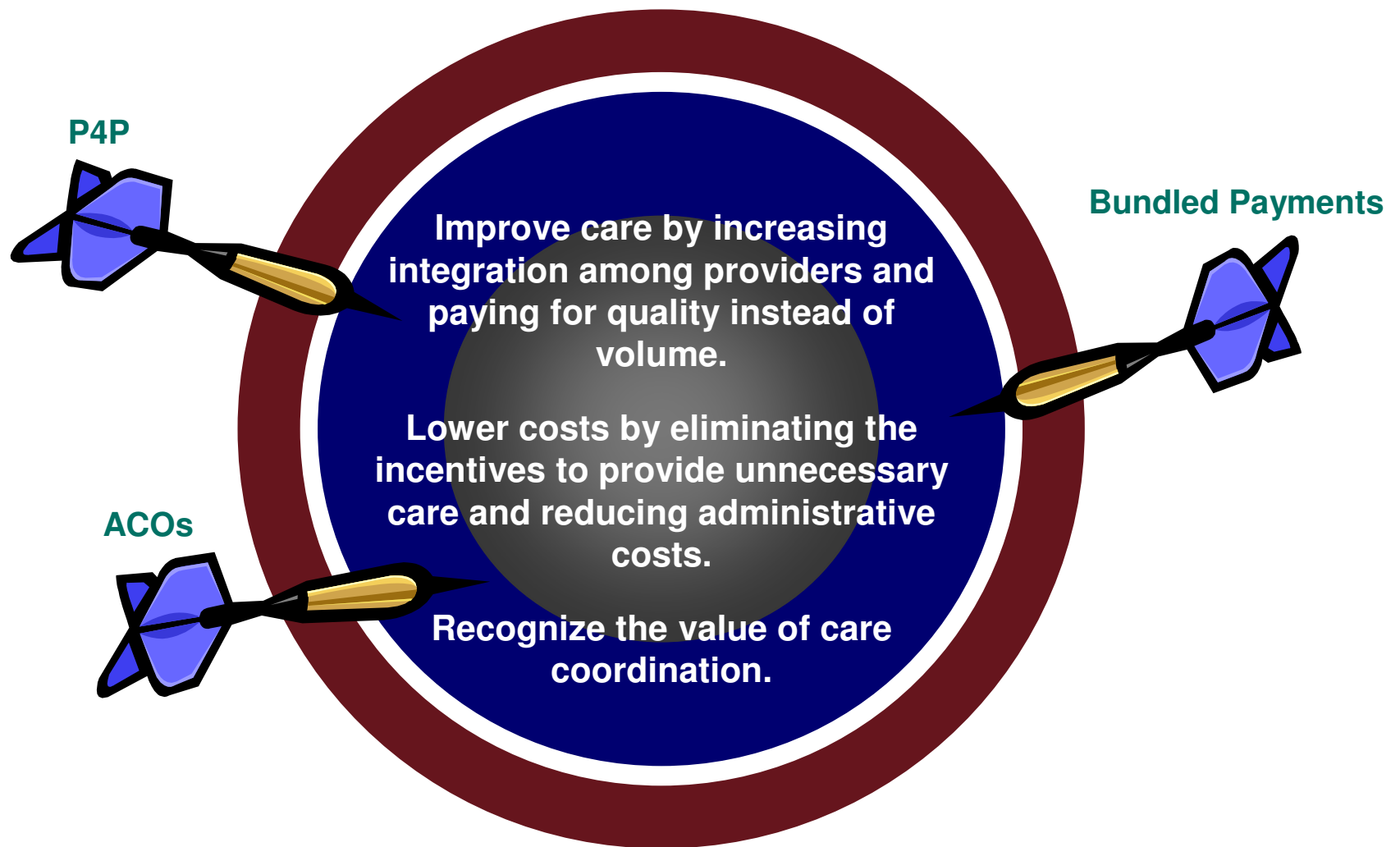
- Physician participation in value creation.
- Targeted marketing and education to distribution channels.
- Best practices in cost, efficiency, and effectiveness.
- Top decile in quality.

Lessons Learned

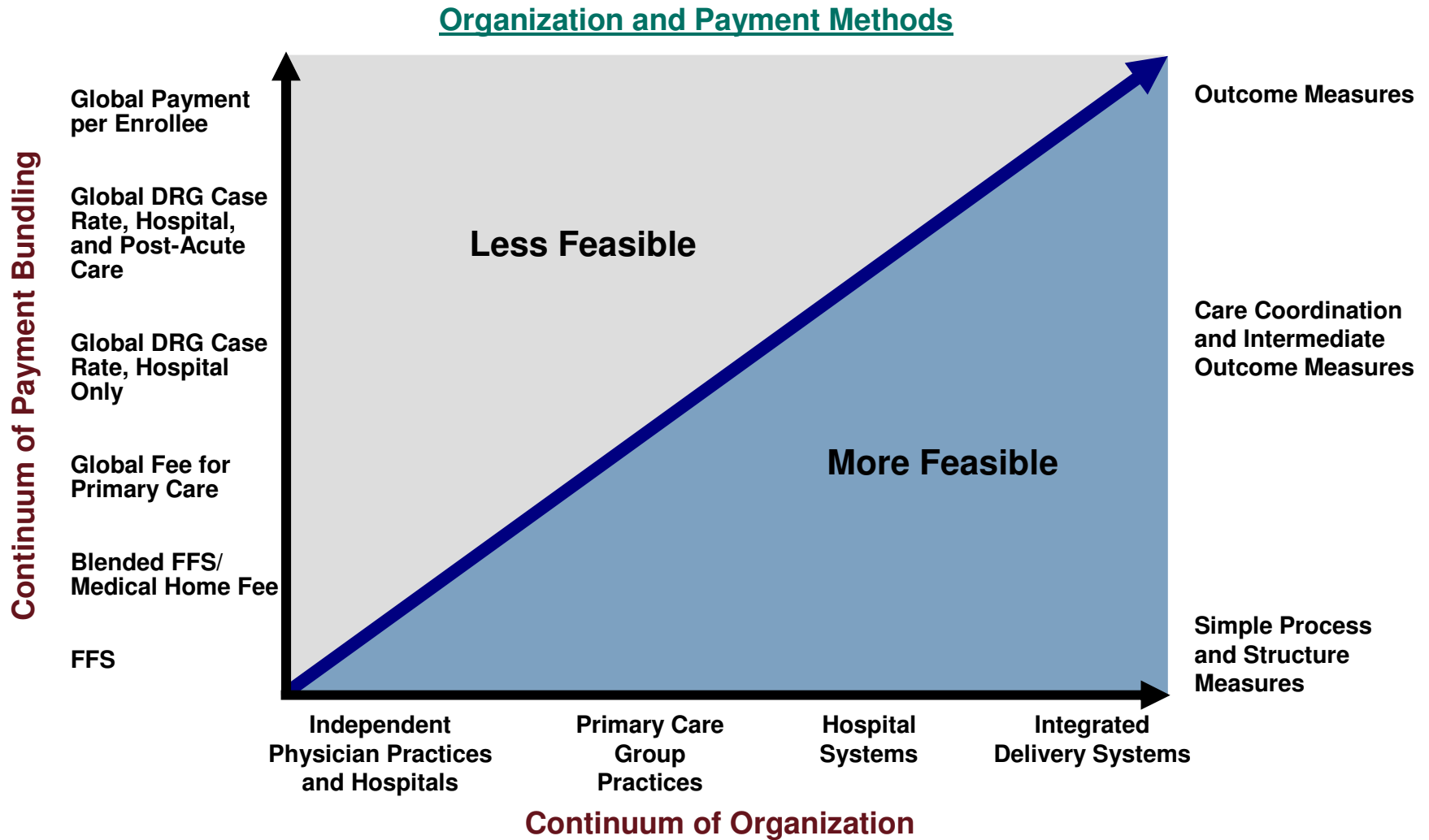
- Application process – be inclusive.
- Physician partners are critical.
- System approach vs. site.
- Cost accounting system.
- Quality Metrics.
- Communication strategies – advisory committee, internal work groups.
- External expertise.
- Infrastructure.
- Evaluating gain sharing.

Preparing for Payment Reform

Goals of Payment Models



Improving Integration and Coordination Reimbursement/Care Delivery Models



Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, February 2009.

Medical Leadership

Evolution of the CMO Role








<ul style="list-style-type: none"> ■ Patient Safety ■ Quality Improvement ■ Physician Liaison ■ Credentialing ■ GME 	<ul style="list-style-type: none"> ■ Clinical Oversight ■ Patient Satisfaction ■ Patient Safety ■ Quality Improvement ■ Physician Liaison ■ Credentialing ■ GME 	<ul style="list-style-type: none"> ■ Hospital-Based Physicians ■ Operational Strategy ■ Medical Informatics ■ Risk Management ■ Clinical Oversight ■ Patient Satisfaction ■ Patient Safety ■ Quality Improvement ■ Physician Liaison ■ Credentialing ■ GME 	<ul style="list-style-type: none"> ■ Physician Satisfaction ■ Physician Retention ■ Physician Recruiting ■ Hospital-Based Physicians ■ Operational Strategy ■ Medical Informatics ■ Risk Management ■ Clinical Oversight ■ Patient Satisfaction ■ Patient Safety ■ Quality Improvement ■ Physician Liaison ■ Credentialing ■ GME
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Medical Leadership

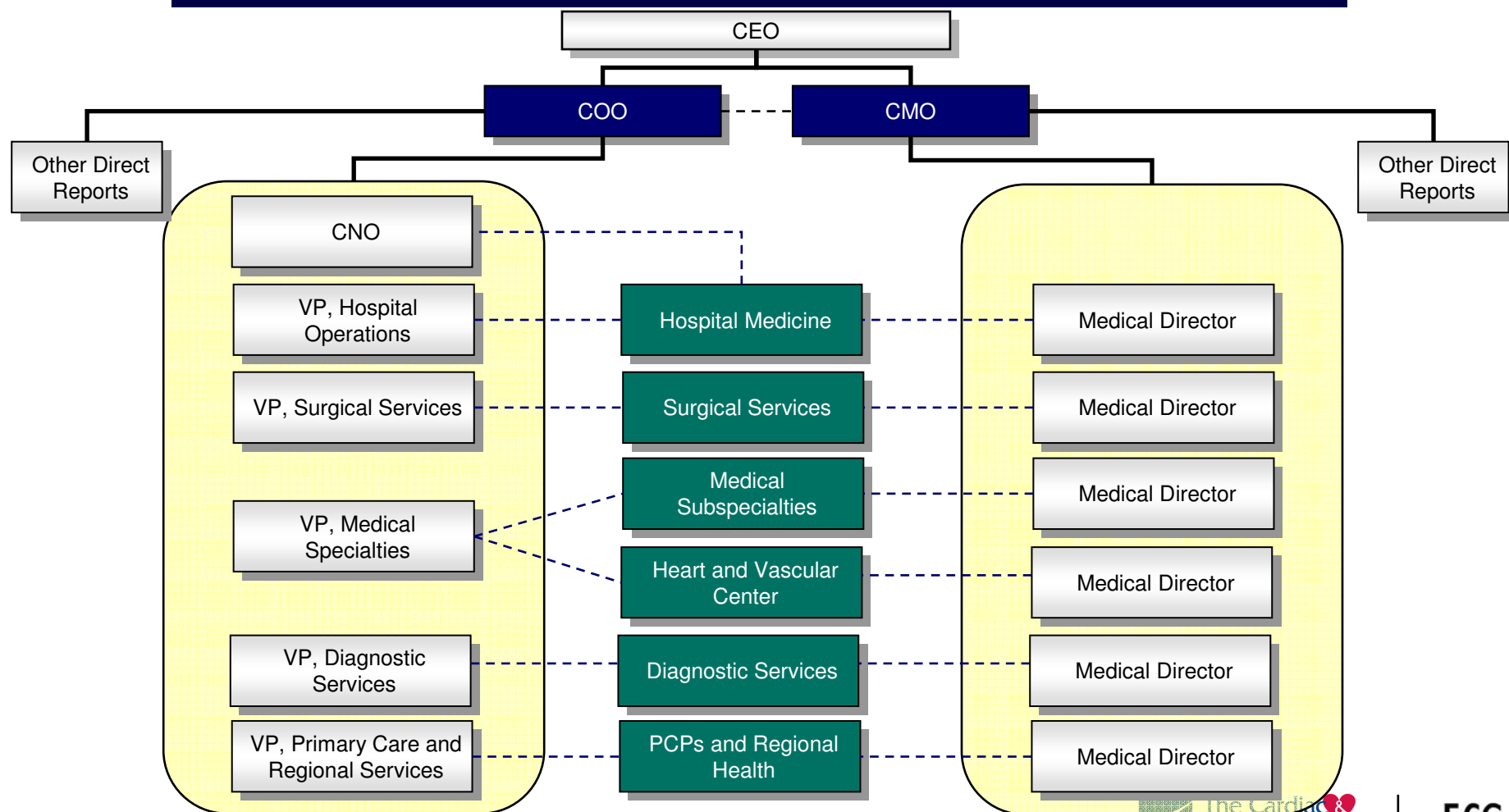
P4P Medical Directorships

Reasons to Move to Performance Based Medical Directorships

1. Quality		The market pressure to demonstrate to consumers that a clinical program is of high quality will only intensify. Medical directors are best suited and positioned to help answer the call.
2. Program Focus		A well-structured arrangement can rechannel the attention away from the individual interests of each party to focus on setting common goals and objectives to improve the program.
3. Partnership		Collaborative goal-setting and greater communication will strengthen the relationship and likely lead to more innovative approaches, with a positive impact on the program and the institution.
4. Performance		It has been well-established in the healthcare provider sector that an effective financial incentive (or disincentive) system can directly influence behavior and achieve the desired outcomes.
5. Bottom Line		If the quality and market reputation of a program improves from the patients' perspective, economic benefits will follow in the respective program and/or at a system level (e.g., downstream revenue).
6. Value		With continued escalation of payment rates and the elimination of the suggested safe harbor methodologies, hospitals should ensure the arrangements yield value at least equal to the rising costs.
7. Legal Exposure		A new wave of scrutiny from the Office of Inspector General (OIG) specifically targeting medical directorship agreements legally exposes hospitals and physicians for vague, under-monitored contracts. ⁴ This, mixed with less-restrictive definitions from Stark III, presents a fitting opportunity to establish well-structured agreements with clear deliverables that are actively referenced throughout the year to mitigate/eliminate pending legal risks.

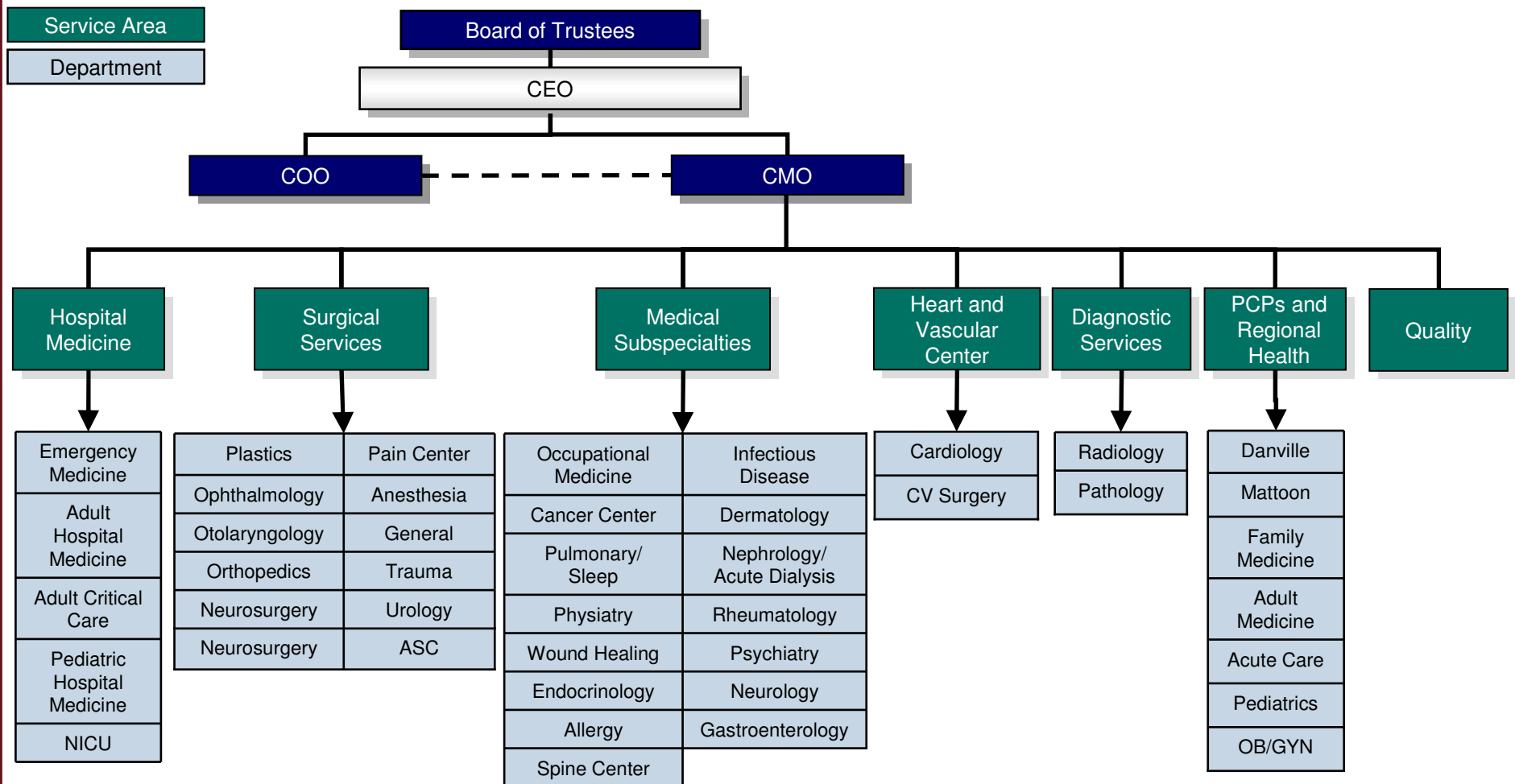
Medical Leadership Dyad Leadership Model

Successful healthcare organizations integrate physician leadership into the hospital management structure at every level.



Medical Leadership

Sample Physician Leadership Structure



Medical Leadership

Achieving Physician “Ownership” of the Hospital

The structures are designed to integrate physician and administrative leadership throughout patient care areas of the organization.

The goals of the structure are as follows:

- **Integration** – Physicians are fully integrated into the organizational structure and become leaders in program management and strategic/business decision making.
- **Accountability** – Physician leaders work directly with administrators to improve operations and performance and develop budgeting strategies.
- **Transparency** – Physician leaders have clear expectations with regard to reporting relationships, roles, and responsibilities.
- **Efficiency** – The physician/administrative pairing creates an environment for effective decision making.

Integration of physician and administrative leadership will foster a noneconomic ownership in the organization among physicians.

Questions & Answers

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