Bundled Payment Contracting Issues

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Agenda

• What is driving payor concern?
• What is at issue in negotiating a bundled price?
• Limitations of the methodology
• Place for bundling on spectrum of provider incentivization
• What paradigms might be employed in participant contracting around episode/bundled or other risk contracting programs?
CMS’ Concern with Post Acute Spending

- Studies argue that rate of increase in post acute care ("PAC") spending outstrip acute care, physician and drug
- E.g., Chandra et al. argue that Medicare PAC spending increased in 1994-2009
  - 250% heart attacks
  - 164% for CHG
  - 99% for hip fractures
**PAC Costs Under A Microscope**

- PAC as % of growth in Medicare Spend (365 day episode)
  - Heart Attack – 38.4% (from 4 to 11%)
  - CHF – 37.2% (from 8 to 16%)
  - Hip Fracture – 69% (from 24-36%)
### PAC Relative to Other Costs

**Per Episode Medicare Cost For Heart Attack, Congestive Heart Failure, And Hip Fracture At 365 Days, 1994 And 2009**

<table>
<thead>
<tr>
<th>Condition/type of care</th>
<th>1994 cost ($ thousands)</th>
<th>2009 cost ($ thousands)</th>
<th>Absolute cost growth ($ thousands)</th>
<th>Cumulative cost growth (%)</th>
<th>Percent of 365-day growth</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HEART ATTACK</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>28.2</td>
<td>31.9</td>
<td>3.7</td>
<td>13.3</td>
<td>35.5</td>
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<tr>
<td>Postacute</td>
<td>1.6</td>
<td>5.7</td>
<td>4.0</td>
<td>250.4</td>
<td>38.4</td>
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<tr>
<td>Outpatient</td>
<td>1.8</td>
<td>3.3</td>
<td>1.5</td>
<td>85.3</td>
<td>14.6</td>
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<td>Physician</td>
<td>7.8</td>
<td>9.0</td>
<td>1.2</td>
<td>16.0</td>
<td>11.8</td>
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<tr>
<td>Total</td>
<td>39.5</td>
<td>50.0</td>
<td>10.5</td>
<td>26.7</td>
<td>100.0</td>
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<tr>
<td><strong>CONGESTIVE HEART FAILURE</strong></td>
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<td></td>
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<tr>
<td>Acute</td>
<td>22.0</td>
<td>26.8</td>
<td>4.8</td>
<td>21.9</td>
<td>38.2</td>
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<tr>
<td>Postacute</td>
<td>2.8</td>
<td>7.5</td>
<td>4.7</td>
<td>164.2</td>
<td>37.2</td>
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<tr>
<td>Outpatient</td>
<td>2.4</td>
<td>3.5</td>
<td>1.1</td>
<td>43.3</td>
<td>8.4</td>
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<tr>
<td>Physician</td>
<td>6.4</td>
<td>8.4</td>
<td>2.0</td>
<td>31.4</td>
<td>16.0</td>
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<tr>
<td>Total</td>
<td>33.7</td>
<td>46.3</td>
<td>12.6</td>
<td>37.3</td>
<td>100.0</td>
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<tr>
<td><strong>HIP FRACTURE</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Acute</td>
<td>22.0</td>
<td>24.8</td>
<td>2.8</td>
<td>12.6</td>
<td>19.2</td>
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<tr>
<td>Postacute</td>
<td>10.0</td>
<td>19.9</td>
<td>9.9</td>
<td>99.9</td>
<td>69.0</td>
</tr>
<tr>
<td>Outpatient</td>
<td>1.9</td>
<td>2.4</td>
<td>0.5</td>
<td>21.3</td>
<td>2.9</td>
</tr>
<tr>
<td>Physician</td>
<td>7.0</td>
<td>8.2</td>
<td>1.3</td>
<td>18.1</td>
<td>8.8</td>
</tr>
<tr>
<td>Total</td>
<td>40.9</td>
<td>55.4</td>
<td>14.4</td>
<td>35.2</td>
<td>100.0</td>
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</table>
Health Affairs Article Thesis

• No clear consensus on amount and intensity of PAC appropriate
  – No good cost-effectiveness data

• MDs have incentive to over prescribe PAC
  – LOS in SNFs driven not by medical necessity
  – No evidence of reduction in mortality associated with increased stays
Why Bundling Would Happen?

• “Given that PAC is less suited for evaluation by clinical trials…and FFS reimbursement has few incentives to promote cost effectiveness....we expect cost savings could be achieved by bundled payments.”

• “It remains to be seen whether separate bundling schemes for acute and PAC would perform better than large bundles that included both.”
June Letter from Congressional Leaders

• “We find the substantial variation in Medicare spending, utilization, quality and profit margins within the post-acute sector troubling”

• Asks for feedback on:
  – PAC Market Basket Cuts, site neutral payment, IRF 75% Rule, SNF Readmission Penalty and Bundled Payment
  – Notes bundles idea supported by MedPAC, Bipartisan Policy Center and FY 14 President’s Budget

• Signatories: Chair and Ranking Members of the Senate Finance and House Ways and Means Committees

• Discussion draft—PAC Bundles in FY 2018—Secretary to specify the conditions covering 50% of PAC, periods, reducing spend 2.85%, appears to favor the “initial PAC provider”
Moving Parts in Bundle Payment Negotiation

• Define the episode
• Define the price
• Define the payment
• Any patient incentives
Episode Definition

- **Scope of services**
  - Service or clinical condition
    - Major diagnosis
    - Major medical event
    - Chronic condition over period (month?)

- **Initiation**
  - by acute hospital claim, other facility encounter?,
  - community entrant?

- **Duration**
  - Include testing pre-acute care episode?
  - Post acute
    - fixed (with prorating)
    - or variable length?
  - Readmissions?
  - Interval between episodes
  - Challenges for chronic episodes

- **Grouper**
  - MS-DRG (eg., for HHA would MDC from claims be considered?)
  - ETG, MEG?
  - Prometheus
  - New public domain groupers (Medicare, other)
Define the Price

• Projected price based on prior experience
  – What period?
  – Same provider group?
  – Same patient group?
  – Same co-morbidities?
    – data on “all fours” with services in candidate bundle?
• Any Case Mix adjustment?
• Will patient severity be deemed constant?
  – Or adjusted when coding improves?
• Does the price reflect optimal treatment path?
  – “evidence informed rate?” (Prometheus)
    – Or simply past practice?
• Adjustment during or at the conclusion of the contract term
Define Payment

• What patients are subject to it?
• Retrospective?
• Prospective?
• Sufficient volume in the DRG to be valid?
• Discounts to FFS before episode reconciled?
• Adjustments for comorbidities?
  – Huge variation across Dx in a DRG
• Were patient who died during period excluded?
• Adjusted or predicated on attaining quality benchmarks?
• Any inflation factor?
• Any “step down” in price over term of contract?
• Any reopener if care path or technology changes?
Consider The Determinants Of Success

- Episode parameters
- Risk adjustment accuracy
- Baseline data in target price
- Case mix experience during performance year
- Care management success
Good Candidate Episodes

- Where utilization and cost variation are subject to participants’ control
  - Predictable service patterns
  - Predictable involvement of specialists and services
  - Predictable disease or condition course
- Where clinical paths exist or could be easily developed
  - Consensus as to best practices
- Where initiation of episode is obvious
- Provider appetite most pronounced when 3rd party’s payments can be reduced-availability of avoidable costs
  - Cost effective diagnostic option
  - Supply vendors, post-acute actors
  - Wide variation in episode costs due to provider behavior not case mix
- Sufficient volume
Limitations to Episodes for Provider Incentivization

- Volume may not be there to make negotiation of the bundle/episode cost-effective to implement
  - Out of network usage imperils participant enthusiasm
- Disagreement as to the past costs
- Disagreement as to whether risk adjustment is adequate, whether it should be dynamic
- Limitation of coding and claims relative to grouping and episode application
- Organizational tasks to translate into changed behavior at the physician level
- Need for more case management and IT retooling for success
<table>
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<tr>
<th>Incentive</th>
<th>variants</th>
<th>Pricing Risk</th>
<th>Incidence risk assumption</th>
<th>Select Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical process measures</td>
<td>-Bonus only? -Penalty? -Prerequisite for shared savings?</td>
<td>Arguably no</td>
<td>no</td>
<td>-Is interim ffs payment discounted? -Have trend increases been held hostage? -How is pool funded?</td>
</tr>
<tr>
<td>Clinical outcome measure</td>
<td>Bonus only? -Penalty? -Prerequisite for shared savings?</td>
<td>Arguably no</td>
<td>no</td>
<td>-Is interim ffs payment discounted? -Have trend increases been held hostage? --Where does pool come from?</td>
</tr>
<tr>
<td>Patient Experience measure</td>
<td>Bonus only? -Penalty? -Prerequisite for shared savings?</td>
<td>Arguably no</td>
<td>no</td>
<td>-Is interim ffs payment discounted? Have trend increases been held hostage? --Where does pool come from?</td>
</tr>
<tr>
<td>Shared Savings</td>
<td>-process or quality prerequisites? --minimum savings? --upside or 2 way? --savings/loss share percentages?</td>
<td>Depends on degree of discount for interim payment</td>
<td>Upside only – no Downside --potentially but not if CMS is paying providers regardless</td>
<td>--trend assumptions for target --risk adjustment considerations --effect of out of network? --beneficiary incentives?</td>
</tr>
</tbody>
</table>
Some Differences Between Conventional HMO Risk Pools And ACO Surplus/Deficit Distributions

<table>
<thead>
<tr>
<th>Who was or is paying the incentive?</th>
<th>Who was or is receiving the incentive?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incentives in the 90s</td>
<td>HMO</td>
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<tr>
<td>Accountable care incentives</td>
<td>• Insurer</td>
</tr>
<tr>
<td></td>
<td>• Hospital sponsoring arrangement</td>
</tr>
<tr>
<td></td>
<td>* ACO sponsored by hospital</td>
</tr>
<tr>
<td></td>
<td>• Often employed physicians</td>
</tr>
<tr>
<td></td>
<td>• Physicians who are not at risk for deficits</td>
</tr>
</tbody>
</table>
What Has Changed In The Science Supporting Provider Incentivization?
Thinking About Who The Risk Taker Is

• Postulate: hospital systems will be the predominant “awardee” (bundled payment contract holder)
  – But there are some episodes where the PAC could be the most appropriate—e.g., Hip fracture when PAC spend is high

• Most frequently physicians and non-acute facilities will be “participants” with an awardee but not first line risk bearers.
  – While hospitals, physicians, and post-acute providers are encouraged to engage with each other as participating partners in the episode of care, applicants should recognize that awardees will be financially liable for Medicare payment in aggregate beyond the predetermined target price, including care for included beneficiaries that is furnished by providers who are not participating in testing the bundled payment model...CMI RFA
  – But note that the assumption of risk is tricky when disease burden of patient produces wide variation in the cost of the procedure
Contract Risk Allocation Thesis

• Hospital system often appropriate primary risk taker and thus contract holder
  – but nature of the episode should be considered
  – Ability to address inappropriate variability is the key issue
• Individual physicians not well suited to take down-side risk for CMMI bundles
  ➢ No ability to spread the risk
  ➢ Not financially well-positioned
• Physicians should assume quality and process performance risk and clinical outcome risk
  – not actuarial, case mix, contract price risk
  – unless organized to address variability
Clinical Process Measures

• **Ambulatory Care**
  – **Diabetes**
    - HbA1c Testing (2X)
    - eye Exams
    - Nephropathy Screening

• **Hospital**
  – **AMI**
    - ACE/ARB for LVSD
    - Aspirin at arrival
    - Aspirin at discharge
    - Beta Blocker at arrival
    - Beta Blocker at discharge
    - Smoking Cessation
Clinical Outcome Measures

- AMI-30 day readmission rate, 30-day mortality rate
- Heart failure – 30 day readmission rate, 30 day mortality rate
- Pneumonia—30 day readmission rate, mortality rate
- Reduction in hospital acquired complications relative to select targets
  - Identify medical specialty and DRG target
  - Identify target complications (Sepsis, PE/DVT, etc.)
Value Based Payments Every Bit as Important as Bundling and MSSP Savings Share

• 1% of every discharge funds the pool starting in 2013 increasing .25% a year until it reaches 2% in 2017
  – deductions for the pool start in October
• Currently hospitals being measured on process of care and experience of care
  – AMI, heart failure, pneumonia, health care acquired infections, and surgical care
    ➢ E.g., percent of heart attack patients given PCI within 90 minutes of arrival
  – By 2014, outcome (mortality) measures will be added
What Risk Systems Do You Want The Sub-Incentive System Or Systems To Support?

- Medicare Advantage Star Ratings
- Commercial payor quality scorecards
- Value based purchasing payments
- Aggregate physician level incentive metrics
The Case For Individual Provider Payments To Be Tied To Clinical Performance And Patient Experience Rather Than $
Questions?

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Addendum

• Medicare Bundles
• IHA Bundle
• SNF Payer Contract Basics (EBG Advisors’ Grey Partners)
CMMI’s Episode RFP--Overview

• An episode of care may be structured around any MS-DRG for an inpatient stay.

• The key element in the definition is what services will be included.
  – Model -1 focuses on hospitals and physicians for the hospital inpatient stay.
  – Model -2 expands on Model – 1 to also include after care providers such as home health or skilled nursing facilities.
  – Model - 3 differs from Model - 2 by focusing only on the care provided after acute hospitalization (exclusion of inpatient services).
  – Model 4 is similar to Model – 1 except payment is prospectively set.
<table>
<thead>
<tr>
<th>Feature</th>
<th>Model 1- Inpatient Stay Only</th>
<th>Model 2- Inpatient Stay Plus Post-Discharge Services</th>
<th>Model 3- Post-Discharge Services Only</th>
<th>Model 4- Inpatient Stay Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible Awardees</td>
<td>• Physician group practices</td>
<td>• Physician group practices</td>
<td>• Physician group practices</td>
<td>• Physician group practices</td>
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<tr>
<td></td>
<td>• Acute care hospitals paid under IPPS</td>
<td>• Acute care hospitals paid under IPPS</td>
<td>• Acute care hospitals paid under IPPS</td>
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<tr>
<td></td>
<td>• Health systems</td>
<td>• Health systems</td>
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<tr>
<td></td>
<td>• Physician-hospital organizations</td>
<td>• Physician-hospital organizations</td>
<td>• Physician-hospital organizations</td>
<td>• Physician-hospital organizations</td>
</tr>
<tr>
<td></td>
<td>• Conveners of participating health care providers</td>
<td>• Conveners of participating health care providers</td>
<td>• Conveners of participating health care providers</td>
<td>• Conveners of participating health care providers</td>
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<tr>
<td>Payment of Bundle and Target Price</td>
<td>Discounted IPPS payment; no separate target price</td>
<td>Retrospective comparison of target price and actual FFS payments</td>
<td>Retrospective comparison of target price and actual FFS payments</td>
<td>Prospectively set payment</td>
</tr>
<tr>
<td>Clinical Conditions Targeted</td>
<td>All MS-DRGs</td>
<td>Applicant to propose based on MS-DRG for inpatient hospital stay</td>
<td>Applicant to propose based on MS-DRG for inpatient hospital stay</td>
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<td>Model 4- Inpatient Stay Only</td>
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<td>---------------------------------------------</td>
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<td>-----------------------------------------------------</td>
<td>--------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Types of Services Included in Bundle</td>
<td>Inpatient hospital services</td>
<td>Inpatient hospital and physician services. Related post-acute care services. Related readmissions Other services</td>
<td>Post-acute care services Related readmissions Other services defined in bundle</td>
<td>Inpatient hospital services Related readmissions</td>
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<tr>
<td>Expected Discount Provided to Medicare</td>
<td>To be proposed by applicant; CMS requires minimum discounts increasing from 0% in first 6 mos. To 2% in Year 3.</td>
<td>To be proposed by applicant; CMS requires minimum discounts of 3% for 30-89 days post-discharge episode; 2% for 90 days or longer episode.</td>
<td>To be proposed by applicant</td>
<td>To be proposed by applicant; subject to 3%; larger discount for MS-DRGs in ACE Demonstration</td>
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<tr>
<td>Payment from CMS to Providers</td>
<td>Acute care hospital IPPS payment less predetermined discount Physician: Traditional fee schedule payment (not included in episode)</td>
<td>Traditional fee-for-service payment to all providers and suppliers subject to reconciliation with predetermined target price</td>
<td>Traditional fee-for-service payment to all providers and suppliers subject to reconciliation with predetermined target price</td>
<td>Prospectively established bundled payment to admitting hospital; hospitals distribute payments from bundled payment</td>
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<tr>
<td>Quality Measures</td>
<td>All hospital IQR measures and additional measures to be proposed by applicants</td>
<td>To be proposed by applicants, but CMS will ultimately establish a standardized set of measures that will be aligned to the greatest extent possible with measures in other CMS programs.</td>
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</table>
Integrated Healthcare Association Pilot

- Integrated Healthcare Association established a pilot project to explore bundled payments for the commercial population.
  - The pilot project is early in its development, but key takeaways include:
    - Demonstration component of project well behind timeline.
    - Key barriers include: (1) small sample size in orthopedic procedures within commercial population; (2) lack of capability of commercial payers to adjudicate bundled payments, and (3) decision by some plans to pursuit bundled payment outside pilot.
    - Participants have struggled to negotiate and execute contracts in timely manner.
    - Hospitals and physician organizations have had difficulty executing the organizational changes and agreements necessary to support a bundled price bid, given the small numbers of patients for knee and hip replacement at any given facility for any given commercial PPO population.
    - The implementation delays will limit the evaluation period.

See IHA summary
SNF Payer Contracts Basics

(underlying the bundled payment budgets)
SNF Payer Contracts Basics

• Specify hours per day and days per week for direct nursing care, physical rehabilitation

• Differentiate wound care, trach care, ventilator, etc. based on acuity

• Specify treatment of IV medications, TPN, chemotherapy administration, etc.

• If you provide (and bill for) additional and/or specialized services such as dialysis, ensure the contract includes them
SNF Payer Contracts Basics

Duals?

- If contract applies to dual-eligibles (D-SNP), make sure it pays:
  - Medicare (or Medicare Advantage) rates for Medicare-eligible admissions
  - Only drops to Medicaid reimbursement after exhaustion of Medicare benefits
SNF Payer Contracts Basics

Miscellaneous Provisions

• Use applicable law as the criteria whenever possible
  ➢ For medical record retention, insurance limits, copying costs, etc.
  ➢ This standardizes operations and simplifies contractual compliance

• Limit period for overpayment recovery and financial audit
  ➢ One or possibly two years, depending on regulatory limitations

• Amendment only with mutual written consent, except, perhaps, when regulatory changes require an amendment

• Material changes to payment policies or the provider manual require advance notice (typically at least thirty days)

• Limit certification/accreditation requirement to CMS and/or Medicaid (if applicable)
  ➢ E.g. not CARF, TJC, etc.

• Claims Submission
  – Try to get at least 180 days from discharge, and 180 from the receipt of payment from the primary payer in the case of coordination of benefits
SNF Payer Contracts Basics

Carve Outs

• HD beds (threshold based on patient weight)
• Expensive medications (threshold based on cost per day)
• TPN solution
• Specialized DME
• Isolation, etc.