GREATER HOUSTON HEALTHCARE ALLIANCE – FALL HAPPY HOUR CONFERENCE

Pat Harris

Harris County Medical Society

Bridges to Excellence

GREATER HOUSTON HEALTHCARE ALLIANCE – FALL HAPPY HOUR CONFERENCE

Value Based Reimbursement

Roundtable Leader: John Adams

Moderator: Mark Worthen

JOHN ADAMS- IPA’S, BUNDLED PRICING

Bundled Pricing

Where a fixed price is paid for a wide range of health care services over a specific period of time, known as an “episode of care.”

BUNDLED PAYMENTS BENEFITS

Bundled payments can help align financial and quality of care incentives.

Payors

- Predictable, stable costs
- Reduced claims costs

Providers

- Incentive to incorporate "best practices"
- Incentive to control costs

Patients

- Ability to comparative shop
- Single bill for comprehensive care

PIONEERING EFFORTS

Medicare Heart Bypass Demonstration Project	CMS Acute Care Episode (ACE) Demonstration
1991 – 1996	Three year project began in 2009
7 Participating Hospitals	Five participating sites
Single Payment for CABG	Single Payment to PHO for selected Cardiovascular and Orthopedic Procedures
Medicare savings $42.3M, or 10%	Savings shared with Hospitals, Physicians, and Patients

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PIONEERING EFFORTS

CMS Bundled Payments for Care Improvement Initiative
Introduced in August 2011, 3-5 year project
Two Payment Types and Four Models
Retrospective
Model 1: IP Hospital Services, Discounted Hospital Payment, FFS to Physicians, Gainsharing
Model 2: IP Hospital and Post-Acute Care, FFS with Reconciliation, Gainsharing
Model 3: Post-Discharge Services Only, FFS with Reconciliation, Gainsharing
Prospective
Model 4: Inpatient Hospital, Bundled Payment for All Providers, Gainsharing

Center of Excellence Programs
Wal-mart -Heart, Spine and Transplant Procedures -6 sites
Lowe's -Cardiac Procedures -Cleveland Clinic
PepsiCo -Cardiac and Complex Joint Replacement surgeries -Johns Hopkins
Shell Oil -Cardiac Procedures -Texas Heart Institute at St. Luke's Episcopal Hospital

Texas Heart Institute / Cardiovascular Care Providers Inc.
Developed Bundles in 1984
Cardiology and Cardiovascular Procedures
24 Managed Care and Employer Contracts

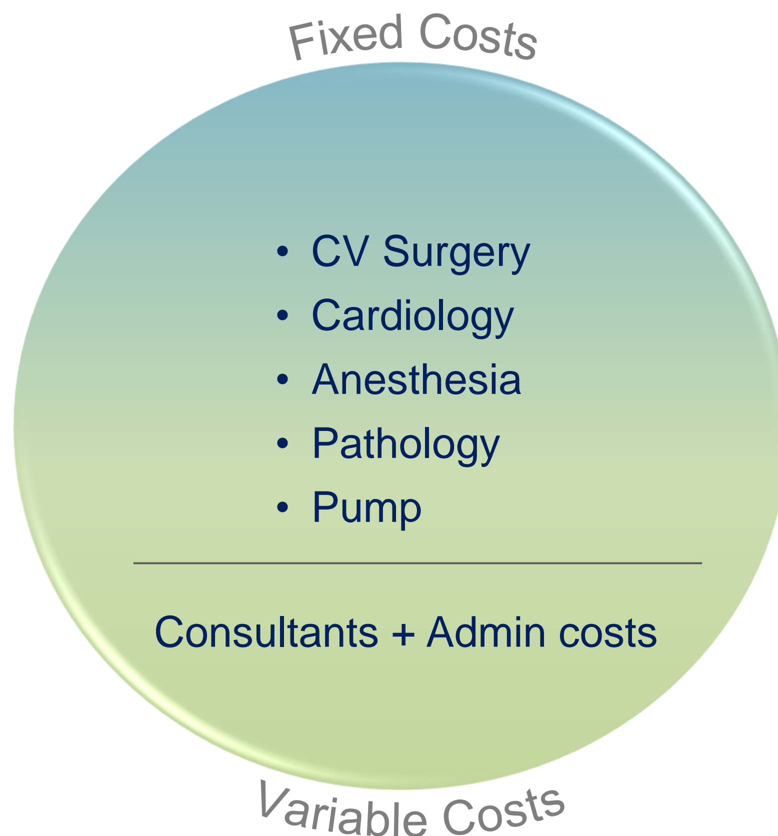
CVCP GOVERNANCE

- Physician-driven
- 13-physician Board
- Committees
  - Contract Committee
  - Credentialing Committee
  - Financial and Reimbursement Committee
  - Medical Management Committee

Expanded to additional physicians and facilities

- The Methodist Hospital (TMH) in 2002
  - Baylor College of Medicine
  - The Methodist Hospital Physician Organization (TMHPO) employed physicians
  - TMH private physicians
- St. Luke's Episcopal Hospital Woodlands in 2010
- TMH satellite hospitals

(Package Price – Fixed Costs = Gross Margin) – Variable Costs = Net Margin



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BUNDLED ADMINISTRATION - ORGANIZATION

CVCP

- Provider Contracts
- Payor Contracts

Global Healthcare Alliance, Inc. (Global)

- Licensed TPA
- Staffing
- Technology

HCFA Demonstration Project

- 1993-1998
- Medicare DRG106 – 5% decrease in costs
- Medicare DRG107 – 11% decrease in costs
- LOS decreased 15.8% (DRG 106) and 11.4% (DRG 107)

Shell Center of Excellence Results

- 30-40% cost savings for all CABG surgical admissions
- 10-20% cost savings for all percutaneous coronary intervention (PCI) procedures (i.e., cardiac catheterization)
- 0% mortality in patients studied, even though there was a high-risk subgroup of patients
- Favorable outcomes for patients admitted with significant complications due to existing co-morbidities and/or treatment rendered prior to admission to St. Luke's
- 0% of patients with re-do's for CABG within 12 months of initial surgery

Payor Savings at Satellite Hospital

- 3 years of historical data provided by major payor for FFS payments for CABGs
- Compared to CVCP package rate for CABGs
  - Payor paid 10.35% in excess of CVCP package rate
  - Non-complex, routine CABGs were 11.64% higher than package
  - Complex cases were up to 59.17% higher than package

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Financial Considerations

- Define the bundle episode
- Analyze the historical utilization
- Analyze the historical unit price reimbursement
- Identify costs of services
- Establish an actuarially sound bundle rate
- Develop a reimbursement model for providers

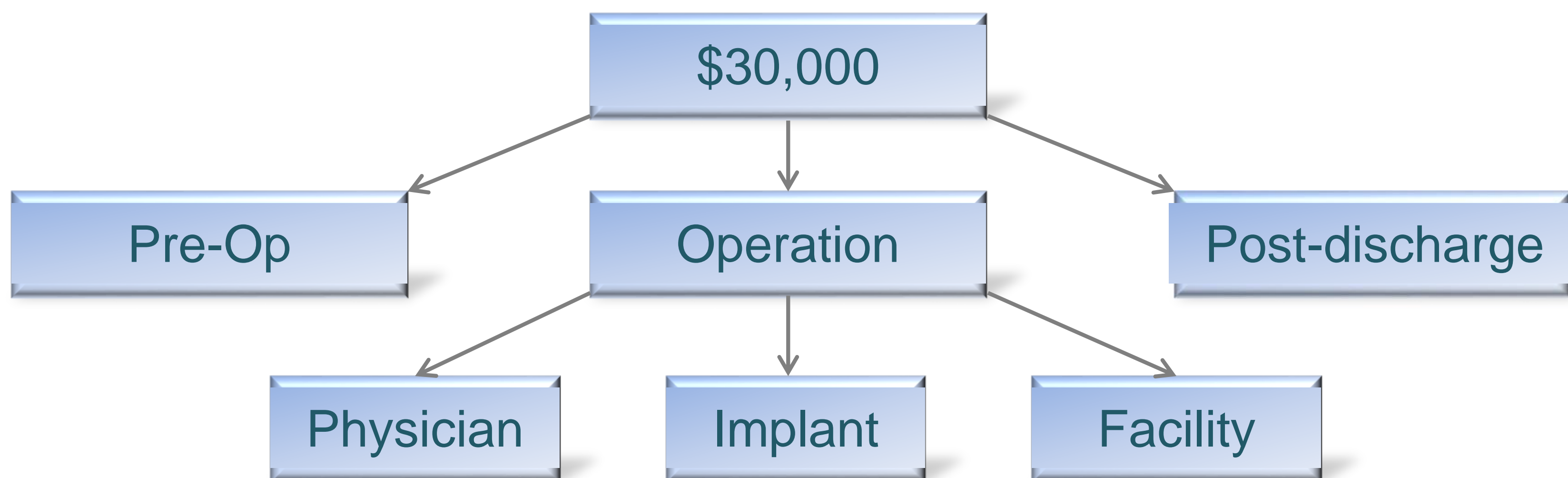
Operational and Organizational Considerations

- Leadership
- Legal entity
- Contracting entity
- Information system for bundling and paying claims and reporting

Quality Considerations

- Extent of clinical integration of network
- Ability to measure quality protocols

A SIMPLE BUNDLED MODEL FOR KNEE REPLACEMENT



Allocation: Based on Historical Costs or Resources

Dong, L., Fitch, K., Pyenson, B., & Rains-McNally, K. (December 2011).
Milliman Healthcare Reform Briefing Paper, “Evaluating Bundled Payment Contracting”

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SUMMARY OF ALLOWED DOLLARS BY TREATMENT PHASE
ALLOWED CHARGES REFLECT CY 2008 DATA

REGION	AVERAGE LENGTH OF STAY	ALLOCATION OF ALLOWED DOLLARS PRE-OP	OPERATIVE	POST-DISCHARGE	TOTAL
East North Central	3.2	$719	$25,399	$2,608	$28,725
East South Central	3.6	$352	$24,078	$2,201	$26,630
Middle Atlantic	3.5	$585	$25,920	$2,564	$29,069
Mountain	3.2	$458	$26,887	$1,997	$29,342
New England	4.0	$740	$29,370	$2,559	$32,669
Pacific	3.1	$445	$35,932	$2,313	$38,691
South Atlantic	3.4	$368	$26,359	$2,181	$28,909
West North Central	3.4	$578	$26,446	$2,129	$29,153
West South Central	3.5	$421	$27,980	$2,241	$30,643
Nationwide Average	**3.4**	**$481**	**$27,308**	**$2,292**	**$30,081**

Notes:
Pre: Related pre-operative services performed up to 30 days prior to the admit.
Operative: Services performed during the hospitalization.
Post-discharge: Related post-discharge care performed within 60 days of discharge.

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SUMMARY OF ALLOWED DOLLARS AND RESOURCES (RELATIVE VALUE UNITS) BY TREATMENT PHASE

	ALLOCATION OF ALLOWED DOLLARS				ALLOCATION OF RESOURCES (RVUS)			
REGION	PRE-OP	OPERATIVE	POST-DISCHARGE	TOTAL	PRE-OP	OPERATIVE	POST-DISCHARGE	TOTAL
East North Central	3%	88%	9%	100%	1%	94%	4%	100%
East South Central	1%	90%	8%	100%	1%	96%	3%	100%
Middle Atlantic	2%	89%	9%	100%	1%	93%	6%	100%
Mountain	2%	92%	7%	100%	1%	95%	4%	100%
New England	2%	90%	8%	100%	1%	94%	5%	100%
Pacific	1%	93%	6%	100%	2%	94%	5%	100%
South Atlantic	1%	91%	8%	100%	1%	94%	5%	100%
West North Central	2%	91%	7%	100%	1%	96%	3%	100%
West South Central	1%	91%	7%	100%	1%	95%	4%	100%
Nationwide Average	**2%**	**91%**	**8%**	**100%**	**1%**	**94%**	**4%**	**100%**

Notes:
Pre: Related pre-operative services performed up to 30 days prior to the admit.
Operative: Services performed during the hospitalization.
Post-discharge: Related post-discharge care performed within 60 days of discharge.
Relative Value units based on RBRVS Physician Fee Schedule and Milliman RBRVS for Hospitals™

Dong, L., Fitch, K., Pyenson, B., & Rains-McNally, K. (December 2011).
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ALLOCATION OF FACILITY/PROFESSIONAL CHARGES AND RESOURCES DURING INPATIENT STAY FOR KNEE REPLACEMENT

	ALLOCATION OF ALLOWED CHARGES			ALLOCATION OF RESOURCES (RVUS)		
REGION	PHYSICIAN	FACILITY	TOTAL	PHYSICIAN	FACILITY	TOTAL
East North Central	19%	81%	100%	15%	85%	100%
East South Central	17%	83%	100%	11%	89%	100%
Middle Atlantic	17%	83%	100%	13%	87%	100%
Mountain	17%	83%	100%	14%	86%	100%
New England	16%	84%	100%	9%	91%	100%
Pacific	12%	88%	100%	11%	89%	100%
South Atlantic	14%	86%	100%	14%	86%	100%
West North Central	17%	83%	100%	12%	88%	100%
West South Central	14%	86%	100%	15%	85%	100%
Nationwide Average	**15%**	**85%**	**100%**	**14%**	**86%**	**100%**

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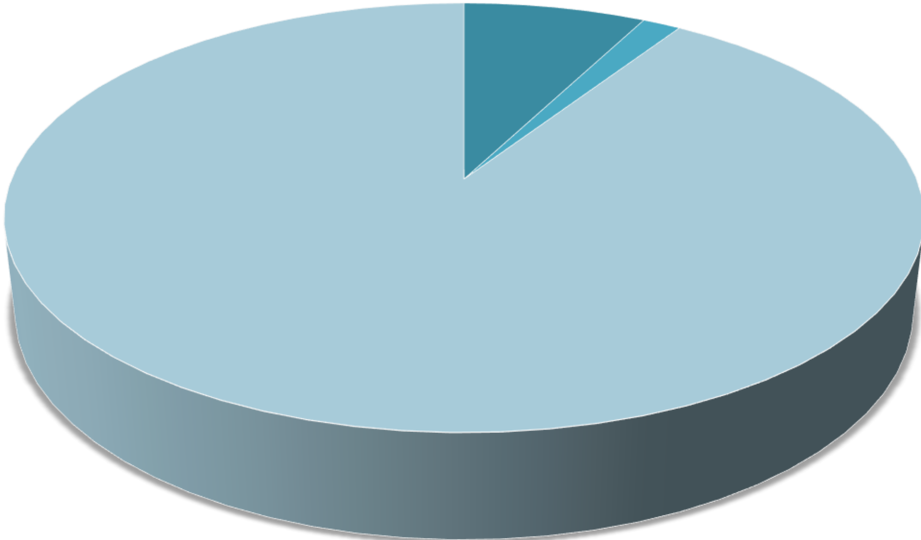
AVERAGE ALLOWED COSTS PER CASE – KNEE REPLACEMENT SURGERIES



- 60-day Post-discharge (7.6%) $2292
- Pre-operative (1.6%) $481
- Inpatient (90.8%) $27,308

Total average cost per case = $30,081
Total number of cases = 10,497

Dong, L., Fitch, K., Pyenson, B., & Rains-McNally, K. (December 2011).
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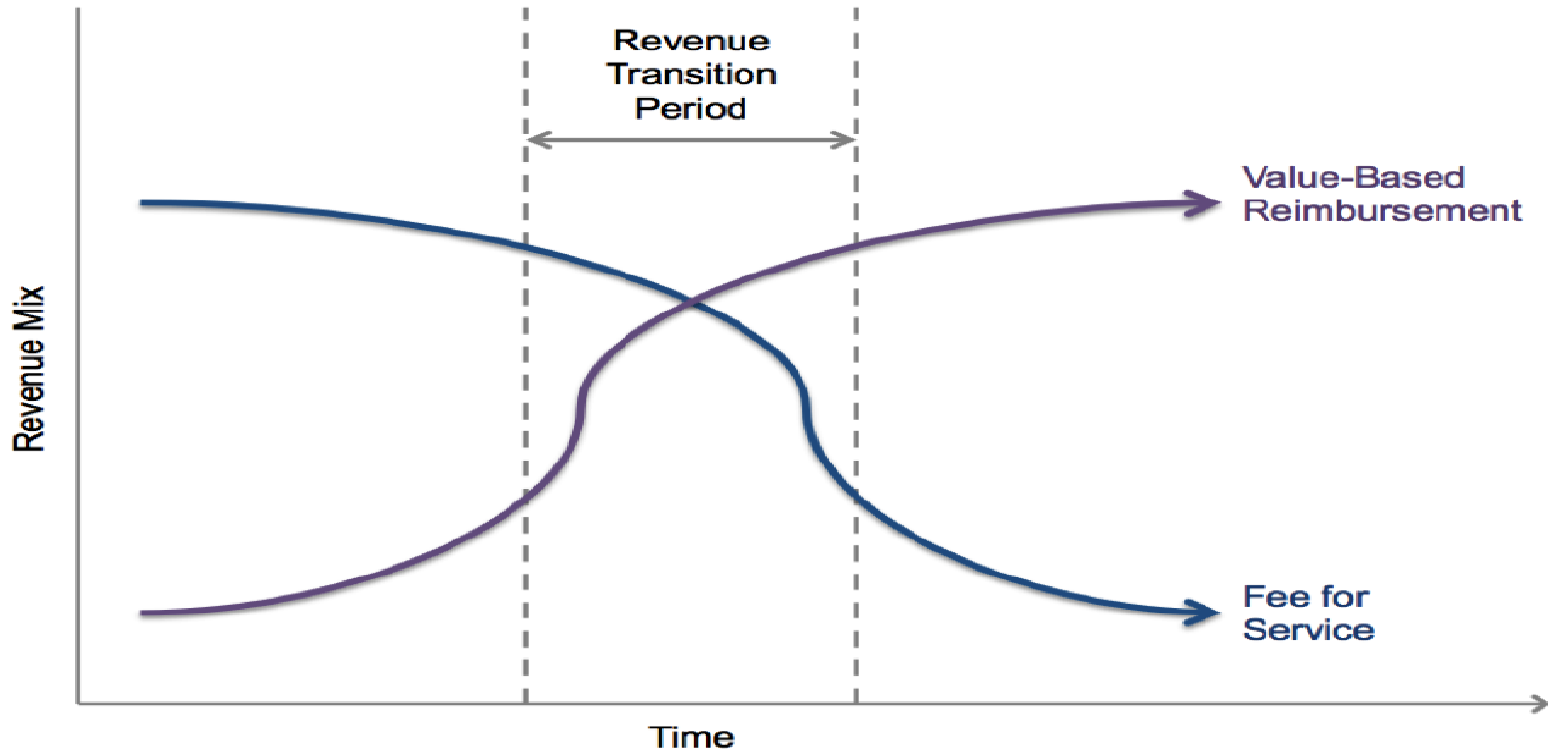
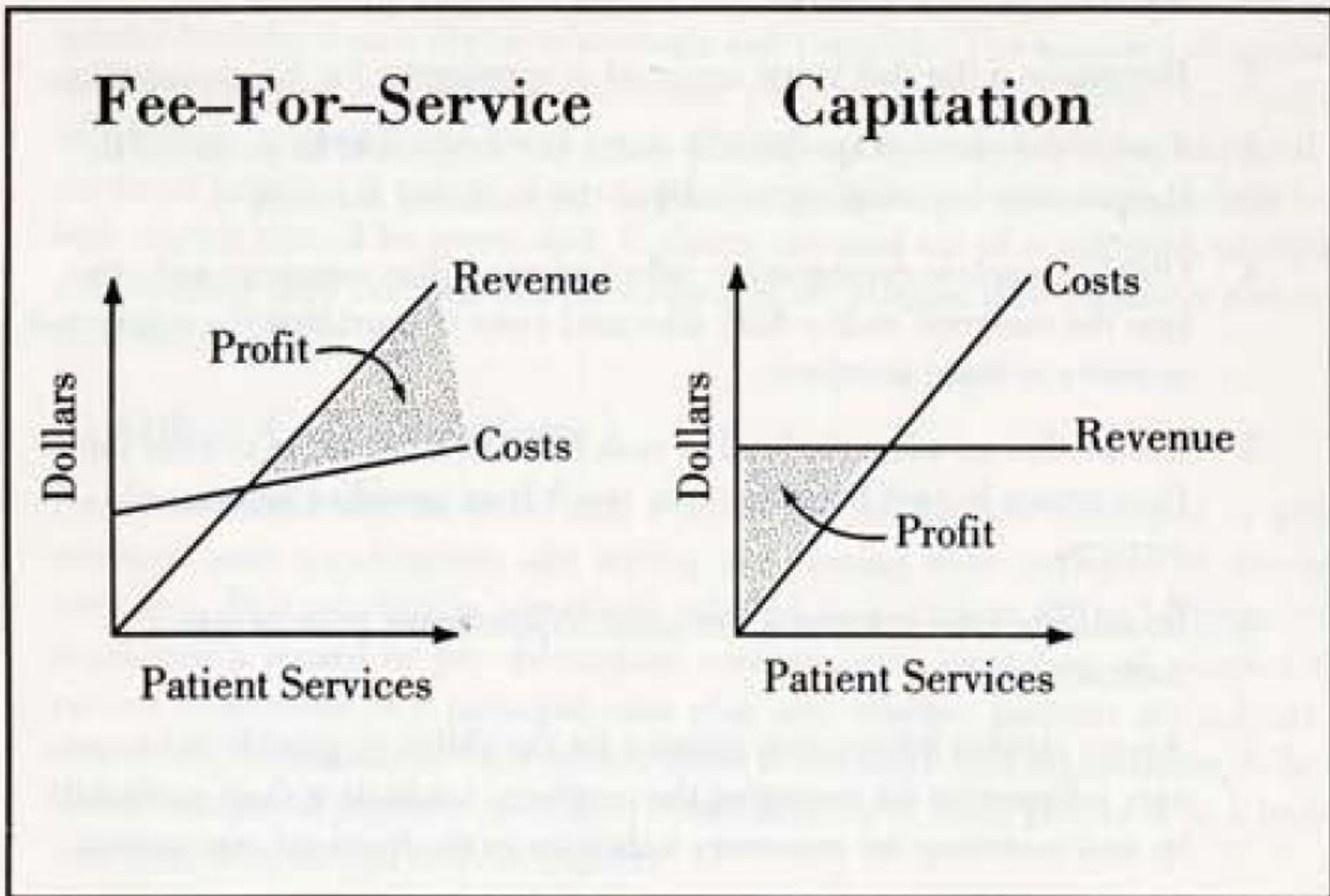
CATHERINE LIGHTFOOT- ACCRUING FOR RISK

Transitioning from Fee-for-service to Value-based Reimbursements



Notice how's there's no specific unit of time to mark the transition from fee-for-service to value-based reimbursement. Nobody knows yet how long this process will take.



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CATHERINE LIGHTFOOT – WHO HAS THE RISK?

Fee for Service – purchasers and insurers

Value Based Reimbursement (VBR) – risk sharing occurs among all three parties

Some VBR Models more than others

- Pay for Performance
- Accountable Care Organization (ACO)
- Shared Risk Model
- Capitation

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Action Steps:

- Calculate costs
- Have a sufficient population
- Focus on quality – change as necessary

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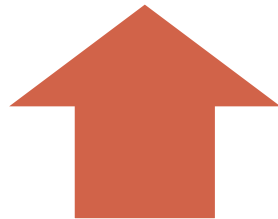
JEFF LEVY - LIMITING RISK FOR CAPITATION

JEFF LEVY - LIMITING RISK FOR CAPITATION

Capitation Risk - The provider has effectively become an insurance company – receiving a guaranteed payment in return for an agreement to provide services whose value is not known.



Goal of Capitation:

To Accept Risk

Goal of Provider Stop Loss:

To Mitigate Risk

The transfer of financial risk to the provider may be based on a patient population that is too small to permit the law of large numbers to provide actuarially predictable outcomes.

Stop Loss - It therefore becomes prudent to retain only the "predictable" layer of risk, passing the "unpredictable" layer onto a third party, thus creating the need for Stop Loss or Reinsurance.

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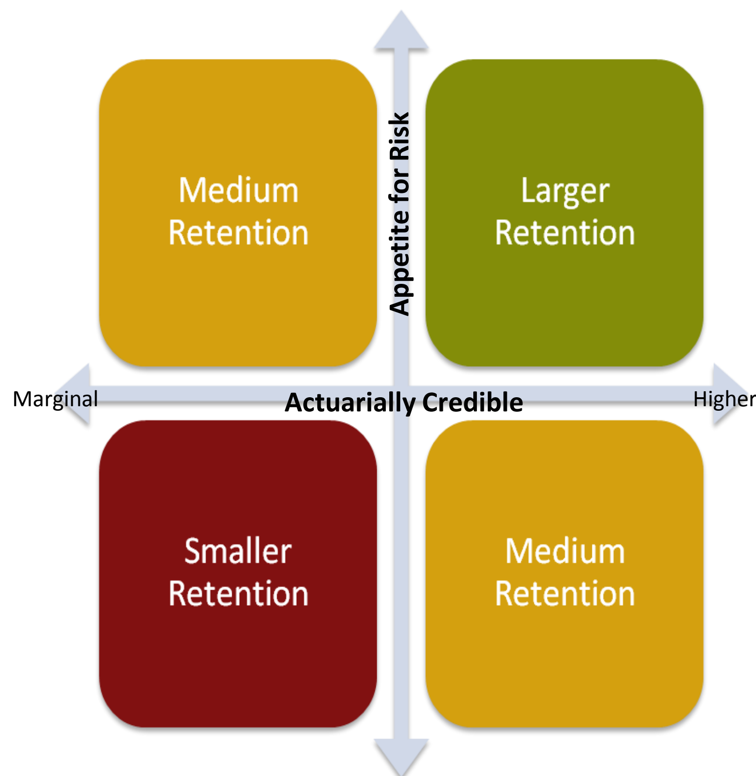
Stop Loss Terminology:

- HMO Reinsurance – Medical Excess purchased by a licensed insurance entity
- Provider Excess – Medical Excess purchased by Providers

Premium – Price depends on the size of the Retention & Actuarial Data.

- Health plan membership size affects actuarial data – larger populations are more statistically predictable and permit the insured to accept a larger retention



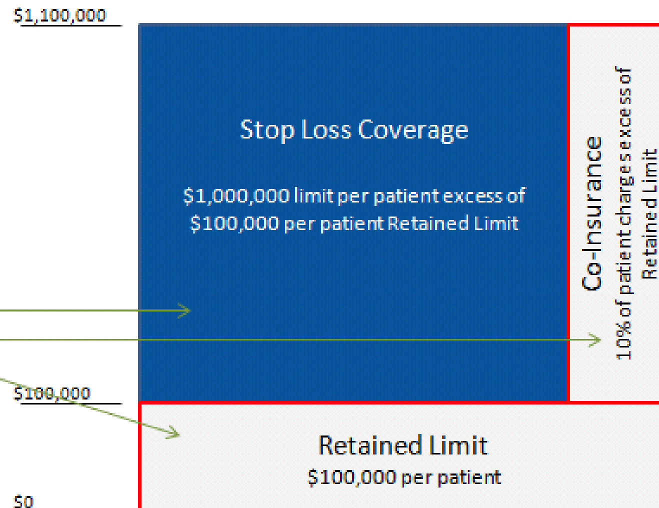
Retention - Size of the Retained Layer (deductible plus co-insurance) must reflect the Insured's appetite for risk, the experience of the population as compared to the general public and the professional services or medical products to be covered

Net Revenue Formula:

Capitated Revenue
Less – Out of Network "Leakage"
Less – Stop Loss Premium Paid & Co-Insurance Retained
<u>Plus – Losses Reinsured</u>
Net Revenue

Claim Example:

Individual patient charges	$ 225,000
Retained Limit	$ 100,000
Per patient limit	$1,000,000
Co-Insurance	10%
Paid by Insurer	$ 112,500
Co-Insurance portion	$ 12,500
Patient charges within Retained Limit	$ 100,000
Total patient charges	$ 225,000



JOHN GOING - IMPACT ON FINANCIAL POSITION

Tax-deductible contributions:

401k	**$17,500/$22,500**
w/Profit Sharing Plan	**$52,000/$57,000**
Defined Benefit Plan	**could be six-figure contribution**

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LORI RAMIREZ: THE IMPACT OF NARROW NETWORKS ON ANCILLARY PROVIDERS

- Over 600 active ACOs in the country.
- Triple Aim:
  - Improve the experience of care
  - Improve the health of populations
  - Reduce per capita costs
- Surgical care accounts for 1/2 of all hospital expenditures.
- Medicare's ACOs have put little emphasis on surgery. They are 60% of all ACOs.
- Only 10 % have reduced the number of unnecessary surgeries.
- MHHS and Aetna have an ACO in Houston.

ACOs that incorporate ASCs are not prevalent in Texas, although the pressure of ACO's and Obamacare have had a direct impact on ASCs.

1) Decline in reimbursement or no payment.
2) Deny access to patients (calling patients). Aetna is an example.
3) Have placed higher co-pays / deductibles.
4) Threaten to delist physicians.
5) Require more ownership disclosure and OON disclosure to the patients.
6) Higher transparency of quality outcomes.

ASC's counter to payor pressure:

1) Reduce cost – GPOs, working with surgeons on cost containment measures.
2) Consider alternative reimbursement options.
3) Look at alternative revenue sources to generate additional income.
4) Joining up with systems that have better access to payor leverage in creative ways.
5) Consolidation
6) Strong legal and PAC involvement.

QUESTIONS?

- John Adams
- Catherine Lightfoot
- Jeff Levy
- John Going
- Lori Ramirez
- Mark Worthen