Key Operational Challenges for Payers and Providers in a Payment Bundling Program

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Alternate Payment Methodologies (VBR)
A Continuum of Provider Risk

Provider Risk

Provider Sophistication

- Fee for Service
- Fee for Service Plus P4P or Shared Savings
- Episode of Care / Payment Bundling
- Partial Capitation
- Global Capitation
Agenda

Has Payment Bundling worked?

Implementation Status - Moving Beyond Talking

Payer Operational Challenges

Provider Operational Challenges
## Early Results Reported by Select CMS ACE Hospitals

### Win-Win-Win-Win

<table>
<thead>
<tr>
<th>Payer</th>
<th>CMS received 5% discount (average)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Technical risk shifted to providers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Decrease in cost (7% average) per case</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Increased market share (40% in one quarter)</td>
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<tr>
<td></td>
<td>Saved $4.3M net over 18 months ($2k/case)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician</th>
<th>130 of 150 physicians receiving 25% increase fee-for-service</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Greater increase available (up to 100%) if CMS cap removed</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Patient</th>
<th>Improved patient quality measurement</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Improved patient satisfaction</td>
</tr>
<tr>
<td></td>
<td>$300-$1100 per patient cash incentive from CMS</td>
</tr>
</tbody>
</table>
Other Results from Payment Bundling

- **HCFA Bypass Demonstration Project**
  “Only project to deliver significant savings”

- **HCFA Cataract Care**
  5% reduction in cost with no quality reduction

- **Commercial Project in Michigan: Arthroscopy with Warranty**
  Payer saved money, provider made more money, quality improved

- **Medicare Project in Texas: Various Cardiovascular Procedures**
  Reduced cost to half of then-current Medicare

- **Commercial Project in Pennsylvania: Cardiac Care + Warranty**
  Payer cost reduced, 44% reduction in readmissions

- **Commercial Transplants: Industry Wide**
  Alabama example:
  - Cost reduction of $53,000/case including 50% reduction in length of stay
  - Higher Quality
Agenda

- Has Payment Bundling worked?
- Implementation Status – Moving Beyond Talking
- Payer Operational Challenges
- Provider Operational Challenges
Who are the Players

This presentation is based on the speaker’s personal experiences at:

Two hospital systems who have implemented ACE

Five commercial payers who are currently implementing commercial bundling programs and their participating provider organizations, as well as two provider organizations developing payment bundling on their own

- Payers ranging from 120k members to 2.4M members
- Provider organizations a mix of surgical groups, hospitals, and IDNs

Few of these are in production yet, so this is not a complete view
### Episode Designs

**There has been a lot of variation**

<table>
<thead>
<tr>
<th>Two payers are using Prometheus</th>
<th>One is using both designs created by their state and IHA episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>One has created their own episodes, with their providers, based on a combination of IHA and Prometheus</td>
<td>One is planning to use straight IHA episodes</td>
</tr>
</tbody>
</table>

In some cases, episode designs are more complex - especially in regard to technical implementation - than originally considered.
Including Lines of Business

Generally, everyone wants to include as many as possible

However, exceptions do occur

All exclude dental, optical, secondary insurance, workman’s comp, etc.

No one has included FEP

Specific problem areas include

ITS

ASO business out of state

Programs run for the state
Prospective and Retrospective Payments

- Three payers are paying prospective
- One payer is paying retrospective
- One payer is paying prospective for some and retrospective for others
  - Retrospective: Fee-for-service is simply paid; after months have passed, episodic performance is evaluated and pay-for-performance bonus paid
  - Prospective: Episode of care payments paid when claims submitted (example: fee-for-service claims from providers paid as a multi-provider global case rate)

Considerable disagreement between Prospective and Retrospective

**Prospective Payment**

- **Transforms care.** Immediate nature creates a stronger incentive to change behavior.
- **Immediate ROI.** Contract sets fixed discounts that the payer gains when care is delivered.
- **Greater cost predictability.** The episode of care cost is fixed and can be budgeted by the payer.
- **Reduced payer and provider tension.** Contracting is transparent and explicit. No question about what’s in or out.
- **More immediate feedback to providers.** Providers know what and when they will get paid.
## Sources of National Standard Bundle Definitions

<table>
<thead>
<tr>
<th>CMS / ACE</th>
<th>IHA</th>
<th>Prometheus (2012)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Bypass or Valve - Major</td>
<td>Hip Replacement</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Heart Bypass or Valve - Minor</td>
<td>Knee Replacement</td>
<td>CHF</td>
</tr>
<tr>
<td>Insertion of Heart Defibrillator</td>
<td>Outpatient Heart Stent</td>
<td>COPD</td>
</tr>
<tr>
<td>Insert Stent in Heart</td>
<td>Non-emergent Diagnostic Cardiac Catheterization;</td>
<td>Asthma</td>
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<tr>
<td>Pacemaker</td>
<td>Angioplasty with Stent</td>
<td>CAD</td>
</tr>
<tr>
<td>Hip /Knee Replacement</td>
<td></td>
<td>HTN</td>
</tr>
<tr>
<td><strong>State of Arkansas (2012)</strong></td>
<td></td>
<td>GERD</td>
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<tr>
<td>Pregnancy</td>
<td>Knee Meniscectomy</td>
<td>AMI</td>
</tr>
<tr>
<td>Attention Deficit Disorder</td>
<td>Partial Knee Replacement</td>
<td>Stroke</td>
</tr>
<tr>
<td>Hyperactivity Disorder</td>
<td>Maternity (2012)</td>
<td>Pneumonia</td>
</tr>
<tr>
<td>Type 2 Diabetes</td>
<td>Spinal Fusion (2012)</td>
<td>Hip Repl / Knee Repl,</td>
</tr>
<tr>
<td>Back Pain</td>
<td></td>
<td>CABG</td>
</tr>
<tr>
<td>CHF (acute)</td>
<td></td>
<td>Bariatric Surgery</td>
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<tr>
<td>Upper Respiratory Infection</td>
<td></td>
<td>Colon Resection</td>
</tr>
<tr>
<td>Long Term Care and Prevention</td>
<td></td>
<td>Angioplasty (PCI)</td>
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<td></td>
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<td>Knee arthroscopy</td>
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<td>Hysterectomy</td>
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<td></td>
<td>Cholecystectomy</td>
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<tr>
<td></td>
<td></td>
<td>Colonoscopy</td>
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<tr>
<td></td>
<td></td>
<td>Pregnancy &amp; Delivery</td>
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</tbody>
</table>
Specific Challenges to be Addressed

**Payers**
- Processing claims
- Provider contracting
- Member responsibility and Payment Bundling

**Providers**
- Determining what risk you can manage
- Cost accounting limitations
- Distributing a bundled payment among providers
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Payer Operational Challenges

Provider Operational Challenges
General Themes

- It takes 3-12 months to create an episode payment program at a payer.
- New workstreams are a good idea, to focus on mitigation and impact to:
  - Claims processing
  - Benefits and product design
  - Reports and BI
  - Clinical edits
- It is necessary to create analytics for both the plan use and to share them with your providers prior to contracting and during the program.
- Even sophisticated payers struggle with the idea of administration of ‘unbundling’ payments and calculating / distributing performance dollars.
Payment Bundling Implementation is Far More than Installing NxPBA

Payment Bundling can impact a large number of payer business areas and processes

- Product development
- Actuary/Underwriting
- Benefit design
- ASO considerations
- Eligibility changes during an episode
- Seepage
- Provider contracting/contract management
- Accounting/finance
- Withhold/clinical edits/accumulators
- Provider relations/communications
- Legal/compliance
- UM/Quality
- Member communications
- Specialty plans
Payment Bundling Claims Processing

Work with existing provider / payer processes, including authorizations, existing provider payment claims stream, and benefits processing

Support different models of payment bundling payment
- Multi-provider global case rates
- FFS with a withhold on claims in the episode
- Reference pricing on multiple claims
- Budget-based differential payment
- PMPM payment for an episode
- Stop loss and outlier automation

Support numerous and different definitions of payment bundles
- Automatically determine which version of an episode definition to use
- Allow changes or customization to bundle design – or creation of new designs
- Use pre-configured bundles from national sources (IHA, CMS, Prometheus, others)

Tightly integrate into the payer’s core administration system
- Tight integration allows a cleaner application of bundle logic within the context of claims processing
- Otherwise, the actions of the bundle repricing cannot be coordinated with all the other claims activity

Want to know more? Ask for a copy of “NetworX Payment Bundling Administration Fact Sheet”
**NetworX Payment Bundling Administration (PBA) Features:**

- Automates the payment of episodic care
- Creates bundles from existing fee-for-service claims
- Processes claim adjudication through claim re-pricing
- Potentially integrates with any claims adjudication system
- Contains powerful rules engine for automating bundle definitions
- Handles pre-admission, post-discharge services and warranty care

**Business Logic**

- **Payment Bundling Content**
- **Core Administration System**
- **Provider Group**
- **PBA**
  - Non Bundled Claims
  - Bundled Claims
  - Repriced Claims
  - Single Bundled Payment

**Episodes are created and paid prospectively, at the time of care delivery**

**Related Services**
Contracting with Providers

- One payer has a contract in place and doing it manually, with other interested providers being put off until automation is in place.
- One is contracted now but not paying differentially until their automation solution is in place.
- One has launched a statewide effort to enroll all providers in one specialty.
- One is working collaboratively in a statewide effort that includes other payers in multiple specialty areas.
- One had strong interest from a single provider, who is now running for political office and may not follow through.

Experience here is varied

- Always, for any contract.
- Providers scared of risk, but more scared of losing control.
- Best contracts include multiple providers, which are harder.
- Barriers exist for providers.
- Yet, providers do sign contracts and interest is still building.
Payment Bundling and Member Responsibility – the Good

Best Practice:

Create benefit designs specifically for payment bundling

WHY?

- Simplified member responsibility greatly preferred by members
- Enables steerage to high value narrow network
- Enforces narrow network, making seepage easier to manage
- Translates contracted savings back to value choice for member
  - Payment bundling is a tool to reduce premiums in consumer enrollment environments
- Eases administration
Payment Bundling and Member Responsibility – the Ugly

But what do I do until then?

- Add flexible language to template group contracts, allowing benefit design flexibility
- Determine what your core system will do with repriced claims and create a program based on how your core works
- Evaluate
  - administrative cost (and error)
  - against a desire to stay revenue neutral
  - against the need to strictly comply with existing benefit designs
- Whatever approach you select
  - Educate your people
  - Educate the impacted providers
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Payer Operational Challenges

Provider Operational Challenges
CMS ACE Demonstration Project
Operational Lessons

Provider Experience

Collaboration between hospital and physicians essential – and challenging
- Leadership is critical
- You cannot communicate enough

Devote the correct resources
- During design and stand-up, multidisciplinary resources needed
- Full-time coordinator/case manager

Administrative Issues
- Cost accounting challenges
- Data collection
- Processing and distributing payments
- Claims Processing
  - One hospital processing approximately 10,000 part B claims per year for qualified procedures
  - Claim volume is cost prohibitive in typical health plan claims processing operation
  - Technology solution needs to be scalable in anticipation of additional bundled services or expanded product lines
Important Message on Accepting Risk

**First:** determine what risk you can manage

- **What are the unwarranted variations of care that exist?**
  - Implantaed pricing
  - LOS and complications for mildly diabetic patients receiving surgeries

- **What clinical interventions can you make to address them?**
  - Reduce vendors and use a “first pull” approach
  - Implement tight glycemic control peri-operatively

- **What other providers must align with you to achieve this?**
  - Ortho surgeon, cardiac surgeon, interventional radiologist
  - Anesthesiologist, endocrinologist

- **How will you measure and manage the risk and your changes?**
  - Track physician compliance with first pull and vendor policy; track implantable costs directly to patient
  - Intensive tracking of glucose levels; measure LOS, step-down utilization, and post-op infections on 100% of patients in the program

...only then should you contract with a payer
Payment Reform is Not Magic Pixie Dust

WARNING

Contracting for risk is easier than clinical transformation
If Payers Can Manage Risk, How Hard Can It Be?

Accepting risk is easier than managing risk
What Is Required to Determine Manageable Risk?

Data – longitudinal data for the patients who will be in the risk pool

- With a few IDN exceptions, no one provider has this
- Combining provider data is hard to do effectively
- Payers are a key partner, but barriers exist

Analytics

- What are the unwarranted variations that matter?
- What are the systematic areas of waste?

Collaboration among necessary providers

- Is it realistic to make changes?
- One man’s waste is another man’s wages” – Ian Morrison’s Eight Law of Accountable Care
How to Support Opportunity Identification

Identifying Possible Care Transformation

- Requires modeling capability of longitudinal episode of care
- Include care from all providers, post (and perhaps pre) discharge
  - EMR data is probably not enough
- Examine utilization, cost, process, and outcomes
- Looking for unwarranted variations in care or systematic wasteful utilization
  - There are two areas of utilization improvement
    - Your cost structure
    - Services provided by others
Cost Accounting

How to Measure Improvement?

Cost Accounting / Performance Measurement

Software and process must allow the measurement of what you expect to change, at a patient level

Must be able to measure actual variable costs, not imputed costs

Must be able to measure the performance / process change – at a patient level

If you cannot measure it, you cannot fix it
Measuring and Communicating Performance

My Patient List

<table>
<thead>
<tr>
<th>Disease Registry</th>
<th>Diagnosis Profile</th>
<th>Utilization Profile</th>
</tr>
</thead>
</table>

Physician Demographics (based on all patients for the current physician)

<table>
<thead>
<tr>
<th>Physician Name</th>
<th>KHZGS, CHKKHTL H</th>
<th># Patients</th>
<th>738</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician ID</td>
<td>0461178</td>
<td>Avg Risk Index</td>
<td>1.99</td>
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</table>

Guideline Compliance Information

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>DOB</th>
<th>Primary Disease</th>
<th>Risk Index</th>
<th>Motivation Index</th>
<th>Asthma</th>
<th>CAD</th>
<th>COPD</th>
<th>CVA</th>
<th>Depression</th>
<th>Diabetes</th>
<th>Drug Man.</th>
<th>HIV</th>
<th>Heart Fail.</th>
<th>Hem.</th>
<th>Hep.</th>
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<tbody>
<tr>
<td>VNIXHMZ, JTS...</td>
<td>02/0...</td>
<td>Gastrointestinal ...</td>
<td>48.45</td>
<td>1.99</td>
<td></td>
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<td></td>
<td></td>
<td>100 %</td>
<td></td>
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<tr>
<td>LVWTHMXK, IN...</td>
<td>04/1...</td>
<td>ENT neoplasm</td>
<td>29.67</td>
<td>1.40</td>
<td></td>
<td></td>
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<td></td>
<td>100 %</td>
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<td>RTDSNMI, OGEK...</td>
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<td>1.50</td>
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<td></td>
<td>100 %</td>
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<tr>
<td>WXLORXE, TIL...</td>
<td>10/2...</td>
<td>Metabolic Disorder ...</td>
<td>11.74</td>
<td>0.79</td>
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<td>100 %</td>
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<td>LNRXKXE, RSX...</td>
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<td>100 %</td>
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<tr>
<td>VTOQQT, ONUXO...</td>
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<td>Degenerative Or...</td>
<td>9.53</td>
<td>1.69</td>
<td>100 %</td>
<td>75 %</td>
<td></td>
<td>100 %</td>
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<td>100 %</td>
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<td></td>
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<td>KXTVG, QHVJXE...</td>
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<td>CHKKHTLH, LTO...</td>
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<td>Gastrointestinal ...</td>
<td>9.07</td>
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<td></td>
<td></td>
<td>53 %</td>
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<td>GTLHKSNM, MT...</td>
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<td>50 %</td>
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<td>100 %</td>
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Distribution Payment - One Example:

CMS ACE Demonstration Project

- CMS Pays Case Rate
- CMS Pays Incentive
- Hospital Pays Fee for Service
- Member Responsibility
- Calculate
- Shared with
- Savings
- Shared with Hospital
- Shared with Patient
- Shared with Physician
- Patient
- Savings

Distribution Payment - One Example:
Distributing Accountable Care Payments

Whether global case rates or shared savings, payers make payments that must be distributed among providers

Distribution is typically based on two things:

- **Utilization/volume**: source is payer data
- **Performance**: source is provider data
- Formula should be based upon the alignment needed to accomplish the clinical transformation

Making such payments has been a Payer function:

- Provider administrative systems poorly suited to automate this
- Payers may offer to be a fiscal intermediary
- Providers can contract with a third party
Solution to Distribute Payments

- Can distribute a single payment among the group of providers
- Payment consists of two parts:
  - "Internal FFS" – payment of claims within the group of providers
    - Much like a TPA service
  - Performance – distributes "savings" or bonuses based upon individual performance
    - A pay-for-performance program within the provider group
- TriZetto will distribute funds from Payer or Provider Organization’s account using system generated bills
- Includes related services, such as 1099s, reporting, EOBs, etc.

Not an offer for services
Final Planning Thoughts – Payer and Provider

What is the physician group?
- Who gets incentivized?

Legal structure and governance

Establish risk within group
- Basic model: hospitals indemnify the physicians and take on risk themselves
- Physician Gainsharing Profit Sharing
  - Overall program must be profitable
  - Physicians must meet higher quality standards
  - For qualifying physicians, 50% of savings shared
  - Savings apportioned among qualifying physicians based on volume

Legal and statutory considerations

Managing and administering seepage

When getting started, look for opportunities to simplify complex problems
Thank You

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