

Understanding and Managing Risk in Bundled Payment Arrangements

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Presenters

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- Bundled Payments for Care Improvement
- Oncology Care Model
- Other specialty physician models as yet unannounced / never implemented



What is a Bundled Payment?

A bundled payment arrangement assigns a **fixed per-patient price** to a collection of **temporally or clinically related services** that may have **variable utilization** across patients

Why Engage in Bundled Payment Models?

Payers or Employers

- Reduce the cost of care
- Increase cost predictability (shift risk to providers)
- Encourage patients to use lower cost – higher quality providers
- Standardize patient care / reduce variability
- Improve quality of patient care

Why Engage in Bundled Payment Models?

Providers

- Increase business from certain insurers, self pay patients, medical tourism
- Increase payments
- Align financial and quality of care incentives among providers
- Develop consensus on clinical best practices
- Open opportunities for physician integration (from a hospital or system perspective)
 - Reduce inpatient expenses → potential increased revenue to hospital
- Reduce administrative burden

Balancing the Possible Gains with Potential Challenges

- **Development and negotiation** of episode definitions
- **Implementation** of unique arrangements
- **Potential gain** compared to administration effort
- **Defensible target setting** given small sample sizes
- **Additional burden** to collect quality metrics and monitor arrangements
- **Distribution of claims data** for ongoing reporting and reconciliation

Episode
definition

Pricing

Insurance
parameters

Administrative
parameters

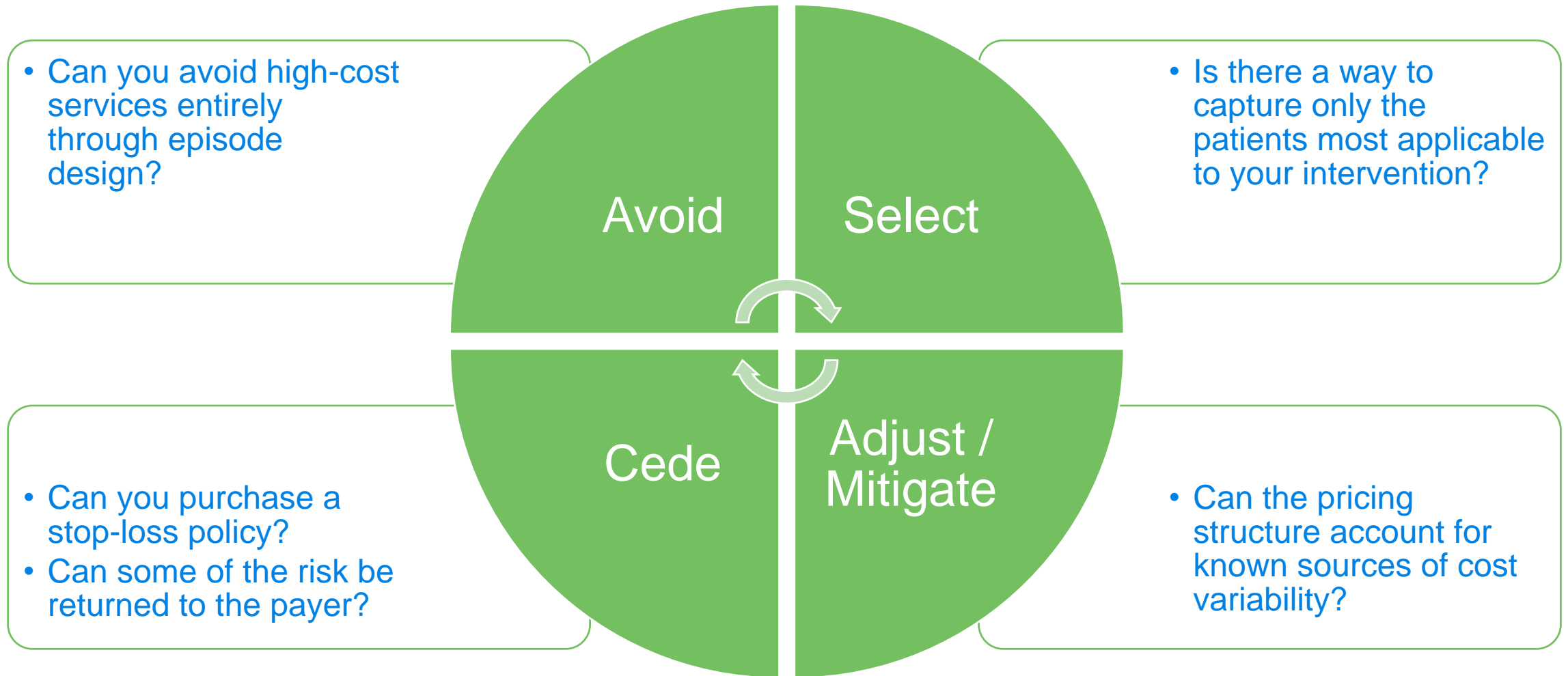
Quality
measurement

Understanding the Importance of Variability

| BPCI Advanced Clinical Episode Category | Average Semi-Annualized Number of Episodes (1) |
|---|--|
| Scenario 1 - No Reduction in PAC Spending | |
| Congestive heart failure | 34.6 |
| Gastrointestinal hemorrhage | 17.0 |
| Renal failure | 15.6 |
| Sepsis | 33.3 |
| Scenario 2 - 5% Reduction in PAC Spending | |
| Congestive heart failure | 34.6 |
| Gastrointestinal hemorrhage | 17.0 |
| Renal failure | 15.6 |
| Sepsis | 33.3 |
| Scenario 3 - 10% Reduction in PAC Spending | |
| Congestive heart failure | 34.6 |
| Gastrointestinal hemorrhage | 17.0 |
| Renal failure | 15.6 |
| Sepsis | 33.3 |

| Simulated Total 6-month Value of Gain / Loss (2) (3) | | | | | | | | | |
|--|--------------------|------------|-------------|----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Average | Standard Deviation | Minimum | Maximum | 5th Percentile | 10th Percentile | 25th Percentile | 50th Percentile | 75th Percentile | 90th Percentile |
| Scenario 1 - No Reduction in PAC Spending | | | | | | | | | |
| \$59,478 | \$178,123 | -\$751,912 | \$678,593 | -\$244,510 | -\$172,004 | -\$57,035 | \$65,699 | \$182,715 | \$224,844 |
| \$13,702 | \$134,105 | -\$608,813 | \$441,708 | -\$215,223 | -\$161,214 | -\$74,474 | \$19,112 | \$108,372 | \$235,377 |
| \$59,013 | \$117,914 | -\$558,696 | \$406,398 | -\$147,952 | -\$99,033 | -\$16,775 | \$67,601 | \$143,574 | \$1,058,042 |
| \$224,844 | \$235,377 | -\$768,380 | \$1,058,042 | -\$174,445 | -\$82,506 | \$68,423 | \$231,724 | \$388,086 | |
| Scenario 2 - 5% Reduction in PAC Spending | | | | | | | | | |
| \$97,654 | \$173,832 | -\$693,285 | \$701,221 | -\$198,833 | -\$128,186 | -\$16,150 | \$103,866 | \$217,848 | \$230,000 |
| \$30,810 | \$130,846 | -\$574,733 | \$449,162 | -\$192,708 | -\$139,767 | -\$55,134 | \$36,077 | \$123,081 | \$1,094,634 |
| \$73,197 | \$114,746 | -\$526,763 | \$413,031 | -\$128,125 | -\$80,492 | -\$650 | \$81,465 | \$155,480 | |
| \$279,906 | \$230,000 | -\$691,000 | \$1,094,634 | -\$110,084 | -\$20,514 | \$127,053 | \$286,813 | \$439,231 | |
| Scenario 3 - 10% Reduction in PAC Spending | | | | | | | | | |
| \$135,830 | \$169,551 | -\$634,659 | \$723,917 | -\$152,938 | -\$84,390 | \$24,803 | \$141,857 | \$253,033 | \$224,640 |
| \$47,918 | \$127,596 | -\$540,653 | \$456,617 | -\$170,246 | -\$118,503 | -\$35,985 | \$53,084 | \$137,890 | \$1,131,225 |
| \$87,380 | \$111,585 | -\$494,831 | \$419,664 | -\$108,275 | -\$62,028 | \$15,649 | \$95,375 | \$167,374 | |
| \$334,969 | \$224,640 | -\$613,620 | \$1,131,225 | -\$45,953 | \$41,218 | \$185,859 | \$341,672 | \$490,545 | |

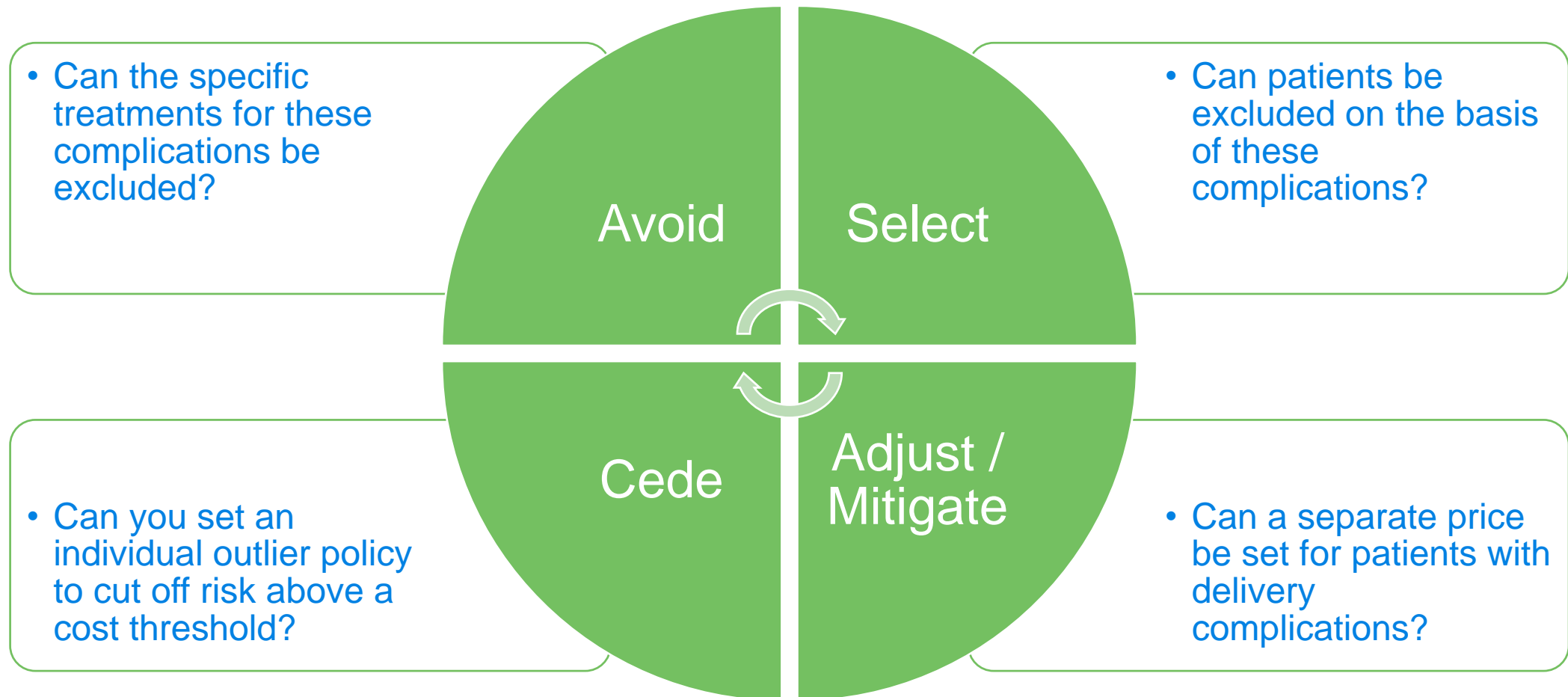
Risk Management Tools and Techniques



...not all of these may be possible within an arrangement. Prioritize!

Risk Management Tools and Techniques: Example

- You are building a maternity episode program, and you're worried about taking risk for high-cost complications of delivery that your physicians feel are out of their control.



Key Design Parameters for Risk Management

- Episode definition
 - Trigger event
 - Duration of episode
 - Patient eligibility criteria
 - Services included and excluded from the episode
- Bundle pricing
 - Establishing the benchmark price
 - Addressing outliers (truncation commonly used)
 - Updating benchmark to the performance year (if applicable) and setting the target price
 - Risk adjustment
- Insurance parameters
 - One-sided or two-sided risk
 - Cancelling the episode
 - Stop-loss/stop gain

Build In Fail-Safes: Monitor / Adapt

- This is a learning process
- Build in time to learn, as well as touch points to re-evaluate contract terms



Thank you

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