Key Thoughts on Managed Care Contracting and Opportunities with Bundled Payments

Becker’s ASC 23rd Annual Meeting
The Business and Operations of ASCs
October 27, 2016
Current Environment
Current Environment

Affordable Care Act

- ASC Hospital JVs
- Hospital Consolidation
- Physician Employment and Mega Groups
- Payor Consolidation
- Ambulatory Care Networks
The payor environment in the U.S. is changing and extremely complex!

Virtually no two payors pay providers equitably or use the same exact payment system in any given market.

Providers that do not understand the cost of their business relative to a payor’s methodology can easily go out of business.

Inadequate reimbursement and payor dominance motivates consolidation among providers.

Changing payment methodologies enables payors to reduce reimbursement without negotiating a new contract.
Access to reimbursement is becoming limited without a payor contract due to benefit designs targeted at changing consumer behavior.

The growing Medicare population increases the need for enhanced reimbursement rates from commercial payors.

Understanding cost is critical to negotiating reasonable and adequate reimbursement.

Payors are working with employers to reduce premiums by limiting access to high-dollar, out-of-network providers and encouraging price sensitivity among employees.

Payor consolidation is rampant and diminishes provider ability to negotiate rates.

Traditional fee-for-service reimbursement is diminishing.
Payor Implications and Ambulatory Surgery

**MEDICARE**
- Inpatient-to-HOPD code approval
- HOPD-to-ASC code approval
- Outpatient Prospective Payment System (OPPS) for HOPDs and ASCs
- Closure of gap on reimbursement methods and rates
- Device-intensive codes
- Bundling logic

**COMMERCIAL PAYORS**
- CMS approvals to HOPD validate medical director approvals for ASC lists
- Expansion of commercial payor ASC-approved lists is growing beyond CMS-approved list
- Inpatient-to-outpatient cost-saving opportunities with outcomes data validate medical director approvals
- Alignment of commercial payors with ASCs to move volume
Five Key Thoughts on Managed Care Contracting
Do your physician users have a contract with the payor?
Alignment with payors enhances access.
How much volume does each payor represent?
What is the overall average cost per case of providing surgery?
What is the average net revenue per case represented by the contract?
Does the value of the contract represent a loss?
How does the payor compare against other payors the ASC is doing business with in the market?
Do not sign a contract just to get access to patients!
A contract must represent revenue value that makes it economically feasible to provide services.
## Evaluate Payor Mix

<table>
<thead>
<tr>
<th>2</th>
<th>What Is Payor Mix Analysis?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ranking Among Payors</td>
</tr>
<tr>
<td></td>
<td>What percentage of business does the payor represent and how do they rank against other payors?</td>
</tr>
<tr>
<td></td>
<td>Volume</td>
</tr>
<tr>
<td>2</td>
<td>What Product lines are you contracted for?</td>
</tr>
<tr>
<td></td>
<td>HMO/PPO</td>
</tr>
<tr>
<td>3</td>
<td>Will a contract create access to new volume or increased volume?</td>
</tr>
</tbody>
</table>
3 — Assess ASC Value in the Market

» What value does the surgery center provide to the payor’s network?
» How many other ASCs are there in the market?
» What is your Case Mix?
» Do you provide services other ASCs do not offer?
» How many hospitals are there in the market?
» What makes your surgery center different?
  › Doctors
  › Special equipment
  › Multispecialty versus single specialty
Develop a Strategy and Demonstrate Value

**STEP 4**

1. Build a business case
   - Determine ASC volume that can shift from hospital.
   - Present concerns with facts relative to reimbursement.
   - Collect EOBs to demonstrate cost in hospital setting versus ASC proposed rates.
   - Quantify the value to the payor.

2. Existing business concerns
   - If you are subsidizing the payor, STOP!
   - Educate payor about the implications of payment methods and inadequate reimbursement.
   - Provide surgeons with talking points for communications to payor medical directors.
Do not do cases that you are losing money on until contracts are in place!

» First contracts are the most important!
» Actions speak louder than words!
» Do not subsidize the insurance company.
» Only so many losses will be made up on volume
» Provide hospital volume by surgeon that will move to the Center.
» Provide total projected savings to the payor and benefit of the contract.

Provide data carefully

» Use cost data when you are subsidizing the payor.
» Provide proof of inadequate reimbursement.
» Demonstrate savings to payor by maintaining and enhancing contract rates and methodology.
» Demonstrate impact of changes in payment methodologies.
5 — Assess Payment Methodologies

» What questions should you ask the payor about payment methodologies?
  › Current Medicare or Medicare groupers?
  › Payor defined methodology mappings?
  › What year APCs?
  › Area adjusted or national?
  › Date of publication?
  › Multiple-procedure logic or add-ons?
  › Implants?
  › Extended Recovery Care/Overnight Stay?
  › Flexibility with payment method?
  › Carve outs?
  › Annual escalators?
Why is this critical to your success?
› Empowers you to collect the data and structure a proposal for the services provided
› Reduces timeline for negotiation
› Asking payors for a method or logic they cannot administer is typically a waste of time

What about alternative payment systems?

✓ Bundled Payments?
Opportunities with Bundled Payments in ASCs
Acknowledgements
Political Landscape: Blowing in the Wind
Make Good Choices
Bundled Payment Experience

Our industry-leading team helps to develop and implement customized strategies that position organizations to reduce costs, improve care delivery, and foster a truly collaborative clinical culture across multiple sites and disciplines. Our team has a demonstrated track record of success with projects involving:

- Medicare
  - ACE
  - BPCI
  - CJR
  - ESRD
  - OCM
  - EPM

- Medicaid
  - NY Medicaid
  - Arkansas Medicaid

- Commercial Payors
  - Arkansas BlueCross BlueShield
  - Empire Blue Cross
  - United Healthcare
  - Aetna
  - Cigna
  - EmblemHealth

- Direct-to-Employer Arrangements
  - Walmart
  - Icahn Enterprises
  - SEIU
  - DaVita HealthCare Partners
National Bundled Payment Landscape
The History

2000s
- CMS Cardiovascular and Orthopedic Centers of Excellence
- Geisinger Health System
- PROMETHEUS Payment Method

1990s
- CMS Heart Bypass
- CMS Cataract Surgery Alternate Payment
- CMS Centers of Excellence

2010s
- ACE Demonstration
- UHC Oncology
- IHA California Commercial Bundles
- Horizon Blue Cross Blue Shield of New Jersey Orthopedic Bundles
- CMS BPCI Initiative
- CMS CJR Mandate
- CMS OCM
- CMS EPM Proposed Mandate
The Evolution

Now

Better Care.
Smarter Spending.
Healthier People.

As Goes Medicare, So Goes Healthcare...
Funding for digital healthcare companies—which blend tech and health-related services—has quadrupled since the Affordable Care Act passed in 2010.

**U.S. Digital Healthcare Funding**
($ in Billions)

Four Bundle Domains

- Medicare
- Medicaid
- Commercial
- Employer
National Bundled Payment Landscape

Source: Adapted from CMS.
Transplants and end-stage renal disease are already paid through a bundled payment.

Source: CMS proposed rule as of July 25, 2016.

NOTE: On July 25, 2016 CMS announced mandatory bundled payment models for AMI, CABG, and SHFFT that are scheduled to start July 2017.
**ASCs—The Lowest-Cost Alternative**

Medicare Pacemaker Reimbursement Variation by Facility Setting

- **Inpatient**: $16,736
- **Outpatient**: $9,493
- **Ambulatory Surgery Center**: $7,851

Ambulatory Surgery Centers Offer Savings of **53%** Over an Inpatient Setting for Pacemaker Insertion

Source: [http://www.ascaconnect.org/HigherLogic](http://www.ascaconnect.org/HigherLogic)
Bundled Payments and CJR

1. It’s happening.
   Commercial payors and employers are rapidly following CMS.

2. It’s mandatory.
   Previously bundled payments were voluntary.

3. Regional pricing.
   Understanding and managing the implications.
Regional Pricing

469 Fracture
469 Non-Fracture
470 Fracture
470 Non-Fracture

Source: CMS regional target prices provided by DataGen on April 20, 2016.
The Shift to Outpatient Bundles
Outpatient Bundle: Orthopedics

According to the Ambulatory Surgery Center Association, as of May 2016 there are 40 centers around the country performing outpatient joint replacements.

**Midwest Orthopaedics at Rush**

<table>
<thead>
<tr>
<th>Direct to Consumer Bundle Payments</th>
<th>Includes:</th>
<th>Does not include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACL repair: $10,800</td>
<td>» Surgeon fees</td>
<td></td>
</tr>
<tr>
<td>Hip arthroscopy: $13,250</td>
<td>» facility fees</td>
<td>» MRI or X-rays</td>
</tr>
<tr>
<td>Knee arthroscopy: $5,000</td>
<td>» anesthesia fees</td>
<td>» Postoperative rehabilitation</td>
</tr>
<tr>
<td>Rotator cuff repair: $11,300</td>
<td>» supplies and implants</td>
<td>» Home health services</td>
</tr>
<tr>
<td>Shoulder arthroscopy: $10,000</td>
<td>» and any uncomplicated follow-up care</td>
<td>» Physical therapy</td>
</tr>
</tbody>
</table>

Source: Modern Healthcare, June 2016, Midwest Orthopaedics at Rush
# Outpatient Orthopedics Bundle: Orthopedic Surgery Center of Orange County

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Direct-to-Consumer Bundled Payments</th>
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<td>ACL repair:</td>
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<td>$11,600</td>
</tr>
<tr>
<td>Rotator cuff repair:</td>
<td>$10,475</td>
</tr>
<tr>
<td>Open rotator cuff repair:</td>
<td>$7,925</td>
</tr>
<tr>
<td>Minimally invasive hip replacement and 23-hour stay:</td>
<td>$20,250</td>
</tr>
<tr>
<td>Partial knee replacement and overnight stay:</td>
<td>$20,250</td>
</tr>
</tbody>
</table>

Includes:
- Surgeon fees
- Facility fees
- Anesthesia fees
- Supplies and implants
- Radiology used during procedure
- **Overnight stay** (for certain procedures)

Outpatient Spine Reimbursement

There is a large variation in spine surgery costs, as 30-day bundles can range from $11,180 to $107,642. The majority of spine payments go toward the hospital stay.

» Of the 700,000 spine procedures performed in 2015, 300,000 were performed on an outpatient basis.
  › There has been a 40% growth in outpatient spine procedures over the last 10 years (5% of all spine procedures were done in the outpatient setting during 2005).

» CMS reimburses certain surgical spinal procedures in both the outpatient and ASC settings.
  › CMS added nine new procedure codes effective in 2015, which helped drive historic inpatient volume to the outpatient setting.

» There is an increasing interest in outpatient spine bundled payments from commercial payors.

# Outpatient Spine Bundle: Orthopedic Surgery Center of Orange County

## Direct-to-Consumer Bundled Payments

<table>
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<tr>
<th>Procedure</th>
<th>Price</th>
</tr>
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<tbody>
<tr>
<td>Discectomy, laminectomy, laminotomy:</td>
<td>$14,225</td>
</tr>
<tr>
<td>2-level discectomy, laminectomy, laminotomy:</td>
<td>$16,200</td>
</tr>
<tr>
<td>1-level lumbar fusion and <strong>overnight stay</strong>:</td>
<td>$30,000</td>
</tr>
<tr>
<td>2-level lumbar fusion and <strong>overnight stay</strong>:</td>
<td>$38,000</td>
</tr>
<tr>
<td>Facet joint injection, cervical/thoracic at one level:</td>
<td>$2,100</td>
</tr>
<tr>
<td>Transforaminal epidural lumbar/sacral:</td>
<td>$2,100</td>
</tr>
<tr>
<td>Radiofrequency ablation, cervical:</td>
<td>$2,475</td>
</tr>
</tbody>
</table>

## Includes:

- Surgeon fees
- Facility fees
- Anesthesia fees
- Supplies and implants
- Radiology used during procedure
- **Overnight stay** (for certain procedures)

ASC Colonoscopy Bundle: DIGESTIVE HealthCare Center

6 Member GI Group
- Own one ASC in NJ

Currently engaged in two bundled payment contracts for colonoscopy with two payors

**Prospective** bundle contract with small payor
- Bill for contracted, pre-established bundle price
- Practice distributes payment among providers involved in episode of care

**Retrospective** bundle contract with large payor
- Negotiated pre-established bundle price based on 2-year retrospective analysis of practice’s cost for services
- Practice continues to receive fee-for-service payments
- Every quarter, retrospectively calculate the total reimbursement paid for each patient participating in bundle and compare to pre-establish bundle price
- Practice receives and distributes savings among providers if:
  - Actual costs were below pre-established bundle price
  - Quality targets and patient satisfaction targets were met

Source: American Gastroenterological Association.
Designing Outpatient and ASC Bundles

1. Select elective procedures.

2. Ensure a clear and defined care pathway.

Failure Tolerance is Essential
What did you fail at this week.”

-Sarah Blakely’s dad
Failure Tolerance is Essential (continued)
Failure Tolerance is Essential (continued)
Discussion

QUESTIONS & ANSWERS
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