Bundled Payments and Effects on Prices

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Agenda

- Bundled Payments in Facilities
- Bundled Payments for Physician Payments
- Home Health and Hospice Payments
- Variations to Payments
  - Hospitals
  - Outpatient Facilities
  - Physicians

Acute Hospitals-DRG

- Groups of diagnoses combined with the presence/absence of certain procedures (e.g. AMI w/o complications or procedures).
- Global payment that covers the bed, nursing staff, cleaning, feeding, ICU and OR use. Typically bundles cost of devices too (e.g. hip replacement), though there are some pass throughs.
- Version 25 (MS-DRG) started Q4 2007. Many more DRGs- allows for more refined payments based on level of complexity/comorbidity.
- Global payment based on actual national experience (LOS, ICU time, actual hospital costs etc)
- Hospitals can apply for outlier payments (extra $) when LOS is at least 2 days > geometric mean LOS.
- Hospitals get paid less when a person is quickly transferred alive.

Surgical admissions

- CMS under pressure to increase flexibility and reduce overall costs by bundling total cost of major procedures that often require post acute care: Hip and knee replacments
- https://innovation.cms.gov/initiatives/cjr
- Still under review.
- Providers get a single global payment for 90 days of associated care (hospital payment, surgeon, follow up visits, post acute care)

Surgical admissions

- Post discharge visit (with surgeon) often bundled into DRG payment.
- Makes it less feasible for TDI to measure post-discharge f/u, a quality measure.

Critical Access Hospitals (CAH)

- Provide the same basic services as acute hospitals but get paid (higher than DRG based) per diem rates in exchange for agreeing to certain conditions (e.g. not to do certain types of procedures).
- Identified as having '13' in position 3 and 4 in provider #.
- Vast majority of local hospitals are (APD, almost all in VT except Fletcher Allen).
- Tend to have local patients admitted for medical conditions (e.g. pneumonia, CHF etc). Transfer out a lot of people for procedures.

Transfers in

- Full payment for transfer in- DRG based on status of person in hospital, not what happened before.

e.g. admission 1- DRG 535 (Medical): FX of hip/femur

Transfer to another hospital

DRG 480 (surgical)- hip/femur procedure.

Two admissions cost >> one!

Transfers out

- Full Payment as long as LOS is within 2 days of geometric mean for DRG.
- Else per diem payment (150% for day 1, 100% after).

SNFs

- Per-diem payment rate where payment per day is higher for the first several days, then drops a bit.
- Adjustments based on patient severity (RUGS system).
- We found RUGs did not have major effect on payments.

Outpatient Departments

- Prospective payment system covers facility payments- use of their ORs, prep and recovery rooms/services.
- Called the APC system- groups of similar procedures (e.g. eye procedures).
- In the outpatient file we also found FQHC/RHC (clinic) bills. Covered by a prospective payment system- one payment regardless what gets done.

Physician Payments

- Based on the Relative Value Unit (RVU) system.
- Each service has a total RVU that's a combination of labor and facility. For instance, when billing for an office visit the majority of the billing is for the actual MD's work, but part is associated with the cost of overhead (the building, clerical staff etc).
- Work and total RVUs are assigned each year to almost all billable HCPCS code (the universe of MD and ancillary provider codes). Tests are simply assigned a standard cost each year. Newly assigned procedures often have temporary codes
- A commission in DC decides how to allocate RVUs each year- must be budget neutral. So if one goes up, another needs to go down.

Physician Payments

- Modifiers submitted by the MD explain how what they did varied from a standard complete procedure. For instance, one can bill for just reading a Catscan if the scan was done elsewhere (all technical, no facility). There are modifiers for only doing part of the service, bilateral, several procedures at once (anesthesiologists). Modifiers act as multipliers for the base RVU.

Home Health and Hospice

- A per-diem rate but with several levels based on the skill of the providers. When an MD is involved the payment goes up.
- Based on visits/days

Variations to Payments: Hospitals

- Disproportionate share (DSH). Extra $ per admission based on how much free care is provided (to non-medicare patients). ACA partially financed through reductions in DSH since uninsured rate drops.
- Indirect graduate education (IME). Extra $ per admission based on the ratio of residents to beds. 0 if non-teaching.
- Local (CBSA) wage index, cost of buildings (and perhaps cost of insurance).
  - CMS publishes provider specific values because some places lobby to be considered part of an adjacent city.

Variations to Payments: Hospitals

- Outlier payments- patients stay longer than expected (2+ days greater than geo mean).
- 11 specialty cancer hospitals. Payments based on actual costs. Going up under ACA. Payment field is DRG price, extra payment provider at the end of the year (which should be evident in cost reports).
- MD hospitals. For some reason MD hospitals are paid based on costs. Should be evident in cost reports..

Variations to Payments: Outpatient Facilities

- Adjustments based on local wage index and local facility costs. CMS publishes provider specific values but we've found a lot of non-merges (likely due to special characters sometimes added to provider numbers).
- Only a fraction of the standard price is wage index adjusted (~60%). This varies by service type.

Variations to Payments: Physicians

- Tests and DME are pretty much universal costs across the country.
- CBSA based adjustments due to facility and insurance costs and wage index. Insurance costs may be state level.
- CBSAs are defined by groups of counties.
- Each state that has non-CBSA locales (non-urban) has a default value.