FMV Considerations for Bundled Payment Arrangements

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Today’s Roadmap

- Healthcare Transactions Refresh
- Bundled Payments – Where Are We Now
- FMV and Commercial Reasonableness Considerations
Generally, any transaction between potential patient referral sources must be:

- Commercially reasonable; and
- At terms that are consistent with fair market value

Separate and distinct (but interrelated) terms.

FMV and commercial reasonableness are vaguely defined terms from a regulatory standpoint.
Hospital-Physician Transactions

Commercial Reasonableness Defined

- The term “commercially reasonable” is defined as an arrangement that would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician of similar scope and specialty, even if there were no potential business referrals between the parties.

Key questions:

- Would the parties enter into this arrangement if there were no potential patient referrals?

- If it weren’t for possible referrals, would the arrangement even be suggested?
Hospital-Physician Transactions

FMV Defined

“...the value in arm's-length transactions, consistent with the general market value.

‘General market value’ means the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party. Usually, the FMV is the compensation that has been included in bona fide service agreements...where the compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.”

Key question: What is this service worth absent any consideration of downstream patient referrals?
Bundled payments set a spending target for all healthcare services provided during a defined episode of care.

Bundled payments are different from ACOs (broader in population, scope) and capitation (involves insurance risk).

Typically, more reliance on specialists than other alternative payment models.

Bundle pricing is usually a few percentage points lower than the sum of the expected payments if paid individually.

Payments are made in the form of prospective fixed payments or on a fee-for-service basis with retrospective reconciliation.

If actual costs are less than targeted costs, the participants may share in the savings.

Under retrospective models, if actual costs exceed targeted costs, the contracting entity must repay the excess.
Bundled Payments

Notable Programs

- 1983: Episode-based reimbursement broadly implemented for hospitals with the creation of the IPPS.
- 1984: Texas Heart Institute implements flat fees for both facility and physician services for CV surgery.
- 1993: Medicare Participating Heart Bypass Center Demonstration is in place at 7 hospitals.
- 2008: Medicare Acute Care Episode Demonstration (ACE) is announced for certain CV and ortho procedures at 5 facilities.
- 2013: CMS launches Bundled Payment for Care Improvement (BPCI) Initiative
- 2015: CMS announces Oncology Care Model
- 2015: CMS announces Comprehensive Care for Joint Replacement (CJR)

Obama administration set a goal to shift 30% of all Medicare FFS payments to alternative payment models by 2016, and 50% by 2018.
Bundled Payments

Advantages to Bundled Payments

- Enhanced alignment of objectives and incentives among payors, hospitals, physicians, and post-acute providers.
- Increased focus on care coordination and best practice clinical pathways.
- Can be implemented across a broad range of providers, both big and small (as compared to MSSP, which requires large PCP base).
- Experience shows bundled payments have the ability to reduce costs without negatively impacting outcomes.
- From a fiscal policy standpoint, bundling programs are designed to guarantee cost savings on the part of Medicare.
Risks/Challenges of Bundled Payments

- Cost savings may not be realized, resulting in financial penalties.
- Bundling is a difficult exercise and payor leverage can result in overly aggressive pricing.
- Incentives must be well-designed to achieve desired results.
- Quality metrics may overlook long-term outcomes.
- Potential for *underutilization* of services to achieve savings.
- Adherence to established practices may inhibit clinical experimentation and innovation.
- Success requires proficiency in cost accounting.
- Innovative payment models may require innovative approaches to managing compliance risk.
The Alignment of Objectives

**Patients:** Successful resolution of medical issue; simplicity

**Payors:** Focus on the purpose and necessity of clinical decision points

**Hospitals:** Increased control over a main cost driver: Physicians

**Physicians:** Shared financial opportunity + maintained autonomy

Bundled Payment
Bundled Payments

Current Medicare Bundled Payment Programs

- Bundled Payment for Care Improvement (BPCI)
  - Voluntary
  - Broad in scope (48 clinical episodes)
- Comprehensive Care for Joint Replacement (CJR)
  - Mandatory in specific MSAs
  - Narrow in scope (2 DRGs)
- Oncology Care Model (OCM)
  - Limited to chemotherapy administration
  - Commercial payors also participating
  - Monthly fee + performance-based payment
Medicare Programs

Bundled Payment for Care Improvement

Voluntary program

Over 1,400 current participants including acute care hospitals, physician groups, and SNFs

BPCI participants may share incentive payments with partners, including physicians and post-acute providers.

CMS and OIG jointly issued waivers of certain fraud and abuse laws (i.e., self referral, anti-kickback) for CJR participants to allow sharing of gainsharing savings and other distributions.

These waivers do not apply to commercial or state-level programs.

Physician gainsharing cannot exceed 50% of Medicare FFS payments received for the episode.
## Bundled Payment for Care Improvement

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Episode Definition</strong></td>
<td>All DRGs; Acute inpatient stay only; All Part A services</td>
<td>Select DRGs; Acute inpatient stay, post-acute; Parts A &amp; B</td>
<td>Select DRGs; Post-acute only; Parts A &amp; B</td>
<td>Acute inpatient stay only; Parts A &amp; B</td>
</tr>
<tr>
<td><strong>Payment Method</strong></td>
<td>Prospective to Hospital; FFS to Physicians</td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Prospective; All providers paid from bundle</td>
</tr>
<tr>
<td><strong>Reconciliation</strong></td>
<td>No</td>
<td>Yes; actual FFS reconciled against target price</td>
<td>Yes; actual FFS reconciled against target price</td>
<td>No</td>
</tr>
<tr>
<td><strong>Popularity</strong></td>
<td>Low (1 current participant; concluding 12/31/16)</td>
<td>High (601 current participants)</td>
<td>High (836 current participants)</td>
<td>Low (10 current participants)</td>
</tr>
</tbody>
</table>
BPCI Participants

Source: Centers for Medicare & Medicaid Services
Comprehensive Care for Joint Replacement (CJR)

- Retrospective bundled payment program for lower extremity joint replacements.
- Mandatory for ~800 hospitals in 67 MSAs found to have the highest FFS costs for hip and knee replacement.
- CMS and OIG jointly issued waivers of certain fraud and abuse laws (i.e., self referral, anti-kickback) for CJR participants to allow sharing of gainsharing savings and other distributions.
- These waivers do not apply to commercial or state-level programs.
- Physician gainsharing cannot exceed 50% of Medicare FFS payments received for the episode.
Methods of Base Payments to Physicians

**Retrospective Models:**

- Physicians typically continue to receive FFS payments from the payor with reconciliation at episode conclusion.
- Physicians may or may not share in risk of repayment obligation.

**Prospective Models:**

- Payor makes payments to hospital and other participants according to negotiated terms that ensure the total payment does not exceed the target amount; or
- Contracting entity (e.g., Hospital) makes payments to participants out of fixed bundled payment funds received from payor.

**Common physician payment methods under prospective models:**

- FFS payment for services rendered (lowest risk to physicians)
- FFS payment for services rendered, “warranty care” excluded (some risk to physicians)
- Payment as fixed case rate for all services (highest risk to physicians)
Methods of Distributing Incentive Payments

- Gainsharing/shared savings
- Payment as a pre-determined percentage of base rate or overall bundle price
- Payment for documented time devoted to defined program services
- Incorporation into existing Co-Management arrangements
Approaches to FMV

Income Approach

“A general way of determining a value indication of a business, business ownership interest, security, or intangible asset using one or more methods that convert anticipated economic benefits into a present single amount.”

How applied to service arrangements? Payment based on distributable earnings generated by the subject service (i.e., revenue less expenses).

Cost Approach

A general way of determining a value indication of an individual asset by quantifying the amount of money required to replace the future service capability of that asset.”

How applied to service arrangements? Payment based on the cost to replicate the subject service or outcome.

Market Approach

A general way of determining a value indication of a business, business ownership interest, security, or intangible asset by using one or more methods that compare the subject to similar businesses, business ownership interests, securities, or intangible assets that have been sold.”

How applied to service arrangements? Payment based on observable data regarding what comparable organizations are paying for similar services.
Valuation Approaches Applied to Bundled Payments

Income Approach

- Can be useful in establishing incentive payments.
- Identify and quantify revenue stream.
  - Bundled payment amount
  - Payor bonuses for quality and other performance objectives
- Identify and quantify all episode costs.
  - Episode costs are much more difficult to quantify than revenue. Requires good understanding of baseline episode costs and drivers of such costs.
  - Cost savings are driven by purchasing efficiencies (easy to quantify) and “quality” considerations (difficult to quantify).
  - Quality-related cost reductions can be impacted by throughput efficiency, LOS reductions, lower infection rates, documentation improvement.
- Net positive difference between revenue and costs can be shared among participating providers who contributed to the savings (i.e., shared savings).
Valuation Approaches Applied to Bundled Payments

Cost Approach

Can be useful in establishing incentive payments and/or recognizing program development contributions (i.e., what are the costs associated with improving quality?).

Payments can take into consideration the documented time physicians are required to devote to quality-improvement and cost-reduction tasks.

- Developing clinical pathways
- Establishing performance metrics
- Compliance with performance metrics and reporting
- Researching and negotiating medical device and pharmaceutical costs
- Preparing and reviewing quality reporting
- Participation in retrospective “lessons learned” sessions

Can be useful in establishing FMV for bundled payments in the context of existing co-management arrangements.
Valuation Approaches Applied to Bundled Payments

Market Approach

Can be useful in establishing base compensation and incentive compensation amounts.

Reasonable base compensation can be determined by examining prevailing reimbursement rates for comparable services provided in the absence of the bundling arrangement.

Market-level will vary based upon the payor source applicable to the population (i.e., commercial vs. Medicare).

Market-level may vary based upon geographical considerations and the participants’ negotiating leverage. Examination of the specific participants’ existing reimbursement levels is usually prudent within legal limits.

Can be helpful to examine total medical revenue benchmarks published in surveys.

Incentive compensation distribution (e.g., shared savings percentages) can be compared to other existing arrangements for reasonableness.

A Market Approach can be useful in evaluating the aggregate compensation received by the providers for services rendered (e.g., as compared to revenue/compensation per wRVU benchmarks).
Developing a Bundled Payment Program

Step 1: Engage the participants
Step 2: Define the target population
Step 3: Define the episode
Step 4: Develop the payment methodology
Step 5: Establish the performance measures
Step 6: Price the bundle
Developing a Bundled Payment Program

Step 1: Engage the participants

Will require a high-level definition of the patient population and episode to identify stakeholders.

Early engagement of physicians is crucial to developing a successful program.

FMV considerations:

Selection of participants should not consider the volume or value of referrals.

It may be reasonable to compensate physicians for their participation in program development activities.

Payments can be based on FMV hourly rates for comparable administrative or consulting services.

Ensure payment for development is reasonable in the context of potential future disbursements after “go-live” date.
Step 2: Define the target population

- Patients are not homogenous, nor is the severity of their medical problems.
- It is vital to clearly define which patients fall within the scope of the program.
- High risk patients with significant co-morbidities will likely be excluded.

FMV Considerations

- Payment rates should align with population’s payor source (i.e., Medicare vs. commercial).
- A key valuation concept is that risk and reward are positively correlated. A higher-risk patient population (and therefore a higher degree of difficulty in achieving performance metrics) may support higher value.
Step 3: Define the episode

- Participants must establish what events trigger the bundle and what events terminate the bundle (whether time-based or event-based).
- Duration and scope of services will directly impact pricing considerations and scope of FMV analysis.

FMV Considerations

- A clearly identified episode scope (i.e., at the individual DRG, CPT level) is crucial to accurately determining value.
- Degree of providers’ exposure to “warranty risk” may impact FMV compensation.
Step 4: Develop the payment methodology

- Assess whether a retrospective or prospective model is most appropriate based on experience level (retrospective is often used at outset).

- Establish the degree of downside risk to each party.

- Determine reasonable allocations to the incentive pool based on distribution of risk.

FMV Considerations:

- Payment methodology should not consider the volume or value of referrals.

- Ensure that reward is reasonable in proportion to each participant’s risk.

- More “skin in the game” may justify higher incentives.
Step 5: Establish the performance measures

- The use of existing metrics (e.g., Surgical Care Improvement Project measures, HCAHPS scores, reoperation rates, readmission rates) is useful to establish baselines.

- Develop methodology and infrastructure for calculating pathway savings for shared savings distributions.

- Agree on re-basing methodology.

FMV Considerations

- Reward should be proportional to risk of not achieving targets. A good understanding of baseline performance is helpful for determining FMV.

- Measures should be easily quantifiable to allow accurate calculation of performance relative to targets and episode cost savings.

- Re-basing is important, but may eventually lead to diminishing returns.
Step 6: Price the bundle

- Price bundle based on population definitions, clinical episode scope, warranty risk, margins necessary to support incentive programs.

- Consider including cost of administrative duties/costs, “amortized” program development costs in bundle pricing.

- Do not overlook or underestimate the cost of stop loss insurance, indirect overhead costs in pricing.
Key Questions to Ask:

- Is the compensation in any way contingent on the volume or value of referrals, or could it be construed as such?

- Did the selection of participants in any way consider the volume or value of their referrals, or could it be construed as such?

- Is the overall percentage distribution of the bundle among the hospital, physicians, and post acute participants reasonable for services rendered?

- Is the compensation distributed to participating physicians consistent with market-level reimbursement for a similar basket of services in the absence of a bundled arrangement?

- Have benchmark reimbursement rates been appropriately adjusted for costs that may not apply under a bundled payment arrangement (e.g., billing and collecting)?

- Is the hospital sacrificing existing facility margins to meet payors’ desired bundle pricing while keeping physicians whole? Is this ok?
FMV and CR in Bundled Payments

Key Questions to Ask:

- Are quality-based payments based upon the achievement of measurable objectives?
- Are baseline and actual costs per episode accurately calculated?
- Are savings being shared with the participants most likely to have directly assisted in achieving the cost savings?
- Is the opportunity for rewards well-aligned with the proportion of risk assumed?
- How often are quality and performance metrics re-based?
- Do quality-based payments overlap with any other existing arrangements (e.g., co-management, medical directorships)?

Participants must closely examine all existing contractual relationships to avoid double counting.
Questions?

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