G&H Advanced Sample Detailed Study Manual

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If you have additional questions about the detailed study manual or any aspect of the exam, please email me.

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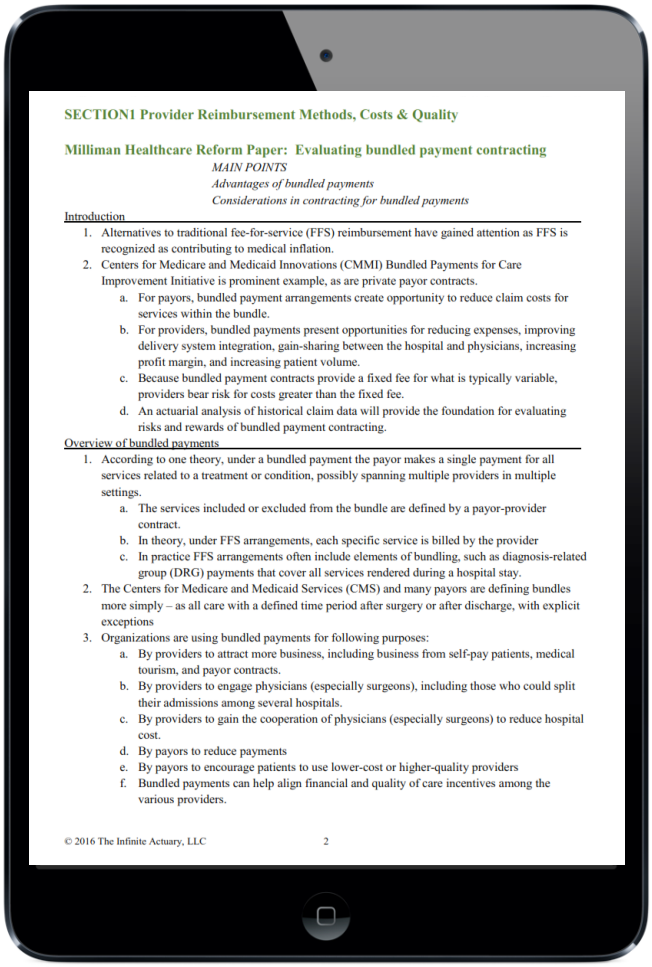

SECTION1 Provider Reimbursement Methods, Costs & Quality

Milliman Healthcare Reform Paper: Evaluating bundled payment contracting

MAIN POINTS
Advantages of bundled payments
Considerations in contracting for bundled payments

Introduction

1. Alternatives to traditional fee-for-service (FFS) reimbursement have gained attention as FFS is recognized as contributing to medical inflation.
2. Centers for Medicare and Medicaid Innovations (CMMI) Bundled Payments for Care Improvement Initiative is prominent example, as are private payor contracts.
   a. For payors, bundled payment arrangements create opportunity to reduce claim costs for services within the bundle.
   b. For providers, bundled payments present opportunities for reducing expenses, improving delivery system integration, gain-sharing between the hospital and physicians, increasing profit margin, and increasing patient volume.
   c. Because bundled payment contracts provide a fixed fee for what is typically variable, providers bear risk for costs greater than the fixed fee.
   d. An actuarial analysis of historical claim data will provide the foundation for evaluating risks and rewards of bundled payment contracting.

Overview of bundled payments

1. According to one theory, under a bundled payment the payor makes a single payment for all services related to a treatment or condition, possibly spanning multiple providers in multiple settings.
   a. The services included or excluded from the bundle are defined by a payor-provider contract.
   b. In theory, under FFS arrangements, each specific service is billed by the provider
   c. In practice FFS arrangements often include elements of bundling, such as diagnosis-related group (DRG) payments that cover all services rendered during a hospital stay.
2. The Centers for Medicare and Medicaid Services (CMS) and many payors are defining bundles more simply – as all care with a defined time period after surgery or after discharge, with explicit exceptions
3. Organizations are using bundled payments for following purposes:
   a. By providers to attract more business, including business from self-pay patients, medical tourism, and payor contracts.
   b. By providers to engage physicians (especially surgeons), including those who could split their admissions among several hospitals.
   c. By providers to gain the cooperation of physicians (especially surgeons) to reduce hospital cost.
   d. By payors to reduce payments
   e. By payors to encourage patients to use lower-cost or higher-quality providers
   f. Bundled payments can help align financial and quality of care incentives among the various providers.

MC Chapt. 9: Physician practice behavior and managed health care

MAIN POINTS
Helpful principles when changing physician behavior
Tools and programmatic approaches for changing physician behavior
Addressing noncompliance by individual physicians

General aspects of physician practice behavior

1. Education and training lead many physicians to believe they are superior to other humans
2. This makes medical management difficult when it inhibits physician cooperation
3. Environmental factors that pressured the traditional independent physician practice model
    a. Articles from the Institute of Medicine challenged the quality and effectiveness produced by the profession
    b. Tighter medical management
    c. Many have demonstrated that it is possible to lower cost, raise quality, and provide greater value if an enterprise has infrastructure and aligned goals and incentives
    d. The market for physician services is becoming national and sometimes global
        i. Internet empowers purchasers to shop for value beyond traditional geographic boundaries
    e. We can no longer afford as a nation to devote an ever increasing portion of our gross domestic product to health care

How physicians are responding to these factors

1. Many physicians initially choose to resist any medical management as an infringement
2. Authoritarian approaches to medical management are likely to fail because they reinforce physicians' fears of loss of respect, loss of position, and guilt for "not having done the right thing"

What we should do instead

1. Principle one: relationships matter
    a. The medical manager should approach the conversation as a respectful colleague, and not as a punishing authority
2. Principle two: let the data speak for itself
    a. View performance differences between practitioners as a startingpoint for investigation
    b. After investigating, if differences persist, present the data with peer comparison
    c. sets up peers to have the conversation with the physician with the unusual practice pattern
3. Principle three: peers are a powerful influencer of physician practice patterns
    a. the peer doctor has advantages
        i. the peer is doing exactly the same thin in a similar setting, so has immediate acceptance
        ii. can answer objections from her own experience
        iii. fits physicians' training and minds, that physicians should modify each other's behaviors, and not have it done by no physicians
4. Principle four: peer leaders must understand and communicate the big picture
    a. it is important that medical manager be able to speak to the organization's intent when dealing with other physicians in the network

Tools for changing physician behavior

1. communicate, communicate, communicate
    a. electronic or paper newsletters, updates, and network notifications have the worst penetration rates
    b. group meetings with physicians, office managers give a chance to meet and evaluate personally
    c. the more humility or empathy demonstrated, the more likely the physician is to view the medical manager as an ally
    d. social networking creates the opportunity to know the organization by increasing the number of brief contacts it offers physicians
        i. limitations: lack of privacy and security
2. data: information or knowledge?
    a. Availability of current data to change utilization patters is fundamental to medical management
    b. Knowing a doctor's costs are higher is information, but knowing why is knowledge that may affect a physician's referral choices going forward
    c. One's data presented to physicians must be check for accuracy
        i. If a suspected error is raised, it should be investigated promptly and transparently to preserve the integrity of the reporter
    d. Correct analysis for population differences where possible
3. Mission clarity: what are we trying to do?
    a. Widespread understanding of what the organization is trying to accomplish is valuable in changing behavior

Financial incentives

1. While physicians show differences in their use of discretionary care based on payment methodology, they show no differences in the use of life-saving care

Programmatic approaches to changing physician behavior

1. Formal continuing medical education (CME)
    a. Seminars, conferences, home-study that provides CME credits by the sponsoring body
    b. Relatively ineffective when it comes to changing behavior on its own
    c. May be a useful adjunct to other approaches to changing physician behavior
2. Data and feedback
    a. Data that stays with medical managers and is never shared is of limited value
    b. Providing regular and accurate data about performance is important for changing behavior
    c. Factors that improve the effectiveness of feedback
        i. Physicians must believe that their behavior needs to change
        ii. Feedback must be credible
        iii. Feedback must be consistent and usable
        iv. Feedback needs to be closely related to what a physician is doing at the time
        v. Feedback must be regular
        vi. Feedback linked to economic performance more likely to produce substantial change
3. Practice guidelines and clinical protocols

a. Codified approaches to medical care using evidence based medical care (rely on research published in peer reviewed medical journals)
b. When protocols are accompanied by direct presentations by opinion leaders, then changes are more sustained
c. The use of evidence based medical guidelines to achieve change is best done through combining several attributes:
    i. Efforts must be focused: choosing one or two guidelines at a time has a higher success rate
    ii. Focus on those conditions or practices that occur frequently and for which there is a lot of practice variation
    iii. Accompanied by regular feedback on a consistent basis
    iv. Financial rewards such as pay for performance

4. Small group programs can produce positive changes
    a. Investment required is potentially sizable

Addressing noncompliance by individual physicians

1. Geographic location, local practice attitudes, the training a physician has received, financial conditions, acceptability of data, personality, will affect the success medical managers will achieve
2. In some cases medical managers must undertake an approach focused on an individual physician
3. Medical groups, closed-panel HMOs, and health systems with a large panel of employed physicians are most likely to focus resources here
4. Positive feedback is powerful
5. Stepwise approach to changing behavior in individual physicians
    a. First step is collegial discussion: discussing cases colleague to colleague
    b. Next, persuasion: refers to plan managers persuading providers to act in ways the providers may no initially choose
    c. Next, firm direction of plan policies, procedures, and requirements
    d. Avoid global responses to individual problems (i.e. do not make a global change in policy because of the actions of one or two physicians)
    e. Final step is discipline and sanctions
6. Discipline and sanctions
    a. Discipline may involve verbal warnings or letters
        i. Document the behavior and describe the consequences of failure to cooperate
    b. Ticketing
        i. Requires the offending physician to make an appointment at a future date to discuss the issue (similar to a court date)
    c. Disciplinary letter
        i. Like a ticket, describes the offending behavior, required corrective action, and invites the provider to make an appointment to discuss
        ii. Consequence of failure to change is initiation of the formal sanctioning process
    d. Formal sanctioning
        i. Due process (a policy regarding rights and responsibilities of both parties) is a requirement

ii. Healthcare quality improvement act (HCQIA) formalized due process in the sanctioning procedure
    1. HCQIA promotes actions against physicians for quality problems
    2. Following the HCQIA is the final step before removing a physician for reasons of poor-quality care
iii. Situations where a physician's performance is a mismatch with managed care practice philosophy
    1. Quality may be adequate, but the physician overutilizes resources
    2. Organization may terminate the relationship solely on the basis of contractual terms

