Exploring Bundled Payment Models for Colonoscopy

Joel V. Brill, MD, AGAF
AGA Institute Practice & Economics Committee
Medical Director, FAIR Health

Charles A. Accurso, MD
President, Digestive HealthCare Center, Hillsborough, NJ
Bundled Payment Framework for Colonoscopy Performed for Colorectal Cancer Screening or Surveillance

Joel V. Brill, MD, AGAF
What is a Bundled Payment?

• Single payment for a condition or treatment
• Covers a pre-defined set of services across multiple providers and multiple settings
• Aims to improve the value of health care (quality/cost) by:
  – Controlling costs
  – Improving collaboration among providers
  – Improving patient outcomes and reducing the incidence of complications
Reducing Fragmented Care

• Currently, Medicare makes separate payments to providers for the services they furnish to beneficiaries for a single illness or procedure
  – Fragmented care
  – Minimal coordination across providers and health-care settings
  – Payment is based on how much a provider does
  – Not based on how well the provider does in treating the patient

• CMS Bundled Payments for Care Improvement Initiative
  – Links payment for multiple services patients receive during an episode of care
Cost Variation in Colonoscopy

The cost of a colonoscopy in the United States varies widely, from place to place, and even within a city. The map shows the highest amount paid for a colonoscopy in metropolitan areas, based on an analysis by Healthcare Blue Book.

Why Colonoscopy?

• Clear “beginning” and “end” of episode
  – Predictable range of expected services helps to limit variability in costs for both payors and providers

• Opportunities for cost inflection and quality improvement
  – Significant opportunity for quality care at a lower cost to payors/purchasers with the potential of financial upside for physicians
## Incenting Cost-Efficient Care

<table>
<thead>
<tr>
<th>Fee-for-Service</th>
<th>Bundled Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treat patient in most convenient location of care (e.g., HOPD)</td>
<td>Treat patient in cost-efficient, high-quality facilities (e.g., ASC)</td>
</tr>
<tr>
<td>Employ anesthesiologist for all colonoscopies performed</td>
<td>Employ anesthesiologist when clinically warranted</td>
</tr>
<tr>
<td>Compensated for repeat colonoscopies due to poor prep</td>
<td>Held accountable for providing consistently excellent prep for procedure</td>
</tr>
<tr>
<td>Encouraged to perform surveillance colonoscopies when not clinically warranted</td>
<td>Encouraged to perform surveillance colonoscopies consistent with multi-society recommendations</td>
</tr>
<tr>
<td>Incented to obtain pathology specimens</td>
<td>Obtain pathology specimens when clinically indicated</td>
</tr>
</tbody>
</table>
Project Scope

• AGA identified a team of physicians to develop the content (and carve outs) of a screening colonoscopy bundle

• Goal: provide gastroenterologists with a framework to identify costs and risks when contracting for a bundled payment
Defining the Bundle

• AGA developed a bundle for colonoscopy services performed for the following:
  – As a **screening** service for an asymptomatic patient who is being screening for CRC
  – As a **diagnostic** service for a patient who has undergone CRC screening (e.g. FIT, stool DNA, septin 9, Ffex sig, etc.) and found to have an abnormality that warrants referral for colonoscopy
  – As a **surveillance** service for a patient who has previously undergone CRC screening and is now returning for follow-up colonoscopy in accordance with the September 2012 U.S. Multi-Society Task Force (MSTF) recommendations
Population Exclusions

• Patients undergoing therapeutic colonoscopy
  – E.g. control of bleeding, place stent, dilate stricture, remove foreign body, ablate lesion, EMR, EUS, decompress volvulus
• Pediatric, age < 18 years
• Asymptomatic patients with history of certain pre-malignant conditions, such as:
  – Lynch syndrome (hereditary non-polyposis colon cancer)
  – Familial adenomatous polyposis
  – Peutz-Jeghers syndrome
  – IBD requiring four-quadrant biopsies every 10 cm
  – Other defined high-risk conditions
Pre-Procedure Interval

- Pre-procedure evaluation
- Preparation agents
- Prophylactic antibiotics
- Pre-procedure lab tests
Colonoscopy (day of service)

• Professional fee
• Facility fee
• Sedation fee
• Pathology fee
Post-Procedure Interval

• Post-procedure evaluation/management follow-up

• Repeat colonoscopy due to:
  – Poor prep/inadequate visualization of lumen\(^1\)
  – Incomplete procedure\(^1\)
  – Post-polypectomy bleeding (occurring within seven days of procedure)\(^2\)

• Use of alternative technology (CT colonography, barium enema, colon capsule) due to incomplete procedure\(^1\)

\(^1\)Performed by same or different endoscopist within one year of procedure

\(^2\)Performed by same or different endoscopist
Colonoscopy Bundle

Pre-op Eval (as required)
Prep
Lab Tests
Antibiotics

Anatomic Path
Anesthesia
Endoscopist

Facility
Post-procedure coverage:
- Inadequate prep
- Post-polypectomy bleed
- Incomplete exam

Post-op Eval (as required)

Pre-op Interval
Colonoscopy
Post-procedure Period
Additional Data

• Claims data from national payor (commercial, Medicare) analyzed to identify frequency and nature of post-colonoscopy visits

• ICD diagnosis codes are included or excluded from the bundle depending on relevancy to index procedure

• Examples:
  – *Inpatient exclusions:* UTI, benign neoplasm of ovary
  – *Inpatient inclusions:* Perforation of intestine, diverticulosis of colon with hemorrhage
  – *Outpatient exclusions:* Muscle weakness, anemia
  – *Outpatient inclusions:* Abdominal pain, intestinal obstruction, bleeding post-polypectomy
What This Does

• Aligns
  – Patient expectations about waiver of cost-share for preventive services when patient undergoes initial screening service and then referral for colonoscopy
  – Health-care professionals to perform high quality, cost-effective, patient-centered services
What This Can Do

• Support transparency initiatives around colonoscopy quality; measuring rates of:
  – Complete exam to cecum/small bowel — colon anastomosis
  – Prep adequacy
  – Adenoma detection rate (screening)
  – Complications warranting post-procedure follow-up

• The AGA Digestive Health Recognition Program CRC module will allow health-care professionals to:
  – Report on these measures and obtain Bridges to Excellence recognition
  – Benchmark your data, which may be a negotiation point for payor contracts
What This Can Do (cont.)

- Support 2012 MSTF recommendations for CRC surveillance intervals

<table>
<thead>
<tr>
<th>No polyps, or hyperplastic polyps in rectum/sigmoid</th>
<th>Repeat in 10 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neoplasia found</td>
<td></td>
</tr>
<tr>
<td>Serrated polyps/lesions</td>
<td>High risk adenomas</td>
</tr>
</tbody>
</table>
| Serrated polyposis  
Repeat in 1 year | > 10 Adenomas  
Repeat in less than 3 years | |
| ≥ 10 mm or With dysplasia or traditional serrated adenoma  
Repeat in 3 years | 3–10 Adenomas  
Repeat in 3 years | 1–2 Tubular adenomas  
< 10 mm  
Repeat in 5–10 years |
| < 10 mm in Proximal colon and without dysplasia  
Repeat in 5 years | Adenoma(s) with high grade dysplasia  
Repeat in 3 years |

These recommended intervals assume a complete exam to cecum, adequate bowel prep, and complete removal of polyps at the baseline exam.

Implementation Suggestions

• Tie payment to cost efficiency and quality outcomes

• Distributing payment
  – **Prospective contract:** Lump sum payment is delivered to practice, which distributes payment to practitioners involved in episode of care (GI, pathology, anesthesia)
  – **Retrospective contract:** Practice continues to receive fee-for-service payments; retrospectively calculates reimbursement paid for patients participating in bundle and distributes savings among practitioners if quality and cost targets are met
Implementation Suggestions

• May wish to negotiate a contract with upside risk only as a starting point

• Assess your patient population risk
  – Post-procedure visits to ER/urgent care centers
  – Hospital admissions
  – Repeat colonoscopies due to complications/poor prep
  – Surgical procedures
  – Medications
AGA SECTION

A Bundled Payment Framework for Colonoscopy Performed for Colorectal Cancer Screening or Surveillance

Joel V. Brill,¹ Rajeev Jain,² Peter S. Margolis,³ Lawrence R. Kosinski,⁴ Worthe S. Holt Jr.,⁵ Scott R. Ketover,⁶ Lawrence S. Kim,⁷ Laura E. Clote,⁸ and John I. Allen⁹

¹Predictive Health, LLC, Paradise Valley, Arizona; ²Texas Digestive Disease Consultants, Dallas, Texas; ³University Gastroenterology, Providence, Rhode Island; ⁴Illinois Gastroenterology Group, Elgin, Illinois; ⁵Humana, Inc, Louisville, Kentucky; ⁶Minnesota Gastroenterology, PA, Saint Paul, Minnesota; ⁷South Denver Gastroenterology, PC, Englewood, Colorado; ⁸American Gastroenterological Association, Bethesda, Maryland; and ⁹Yale University School of Medicine, New Haven, Connecticut
Negotiating a Bundled Payment Model for Colonoscopy

Charles A. Accurso, MD
Digestive HealthCare Center

- Six member GI group (large in NJ)
- Employ anesthesiologists
- Own pathology lab
- Own one ASC
- Vast majority of equipment in-house
  - CAT scan
  - Virtual colonoscopy
  - Ultrasound
  - Infusion therapy
Practice Environment

• Part of Optimus ACO

• All Digestive HealthCare Center physicians attend at Somerset Medical Center (merged with RWJ-University Hospital)

• Top referring PCP practice was bought by a competing hospital

• Approximately 20 competing GI/colorectal surgeons in market
In Next Three Years, We Expect...

• Decreased Medicare reimbursement
• Inability to negotiate higher fee-for-service rates with commercial payors
• Decreased referrals from PCPs due to employment/alignment with competitor hospitals
• Patients becoming price conscious for their GI care
Colonoscopy Bundle: Why?

- Experiencing downward pressure on fee-for-service
- Aligned with providers involved in episode of care (anesthesia, pathology)
- Potential increase in income if total cost of episode is less than negotiated cost
- Method to help us continue to be recognized as high-quality, cost-efficient practice
- Opportunity to lead in development of new payment models for GI
- Potential to experience “halo effect” — cost and quality improvement in managing other conditions (potential to develop other episodes of care)
Basics of Our Bundle

• Currently engaged in two bundled payment contracts for colonoscopy with two payors
• All types of colonoscopy procedures are included in bundle (screening, diagnostic, surveillance, therapeutic)
• All colonoscopies are performed in ASC setting
• Contracts include services performed on day of colonoscopy, pre-colonoscopy and post-colonoscopy
Contract #1

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

### 7 Days Pre
- Initial in-office consultation
- Prep

### Day of Service
- Professional endoscopy fee
- ASC facility fee
- All pathology fees
- All anesthesiology fees

### 21 Days Post
- Follow-up appointment in office
- Post-polypectomy bleeding
- Repeat colonoscopy if prep was inadequate
Contract #2

• **Retrospective** bundle contract with large payor
  – Negotiated pre-established bundle price based on two 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-established 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
      – Patient satisfaction survey
      – Adenoma detection rate
      – Cecum intubation rate
Contract #2 (cont.)

7 Days Pre
- Initial in-office consultation
- Prep

Colonoscopy (Triggering Event)
- Professional endoscopy fee
- ASC facility fee
- All pathology fees
- All anesthesiology fees

30 Days Post
- Follow-up appointment in office
- Post-polypectomy bleeding
- In process of negotiating potentially avoidable complications due to colonoscopy with the aim of coordinating care with referring physicians
Is There Risk?

• We are not assuming any downside financial risk in either contract
  – Only upside potential to receive savings

• Contracts do not involve taking a price cut
  – Pre-established bundle price based on average cost for services

• Financial incentives are aligned with those of the payor
Negotiations with the Payor

• Be ready to present objectively obtained patient satisfaction and quality data

• You may have to implement what the payor can achieve with their current systems
  – If payor cannot easily process claims that are part of a bundle, practice may be required to provide significant billing support

• Trust is necessary between payor and provider
Issues to Consider

• It is possible to negotiate a bundled payment contract that does not include a price cut and entails no downside risk
• Developing and implementing a bundle requires excellent physician leadership, billing systems and staff
• It’s time-consuming — may wish to compensate physicians who lead effort
• May be difficult to align providers/distribute payment if practice is not tightly affiliated with professionals involved in episode of care (e.g., pathology/anesthesiology)
• It is important to ensure that financial ramifications of bundle align with goals of affiliated hospitals/ACO
My Reflections

• Involvement has led to opportunity
• Financial incentives drive behavior, even in medicine
• Bundled payment models allow us to take care of patients while taking care of ourselves
• Jump in and develop these programs even if all of the details have not been worked out
• Become directors of care, not just providers
Reading List

- *Clinical Gastroenterology and Hepatology: Win-Win-Win Approaches to Healthcare Cost Control Through Physician-led Payment Reform*
- Harvard Business Review Blog Network: *A Role for Specialists in Resuscitating Accountable Care Organizations*
- Harvard Business Review: *The Strategy that Will Fix Health Care*
- Robert Wood Johnson Foundation: *Making Prometheus Payments Real*
- American Medical Association: *Evaluating and Negotiating Payment Options*
- Additional AGA Resources
Questions?