Bundled Payments: Strategy Overview

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HEALTHGROUP WEST

Contents

Overview

- The documented success of the CMS Bundled Payment program has driven adoption among commercial payers and employers.
- A 2016 survey* reported that 31% of payers and 20% of employers have adopted bundled payment models.
- Employer respondents in the same survey indicated an interest in pursuing bundles that offered a greater financial impact and a wider variety of scope, suggesting bundled payments will be a critical component of a successful employer outreach strategy in future.
- Bundled payment models have traditionally been procedurally-defined (e.g hip replacement) though conditionally-defined bundles (e.g. hip pain) are gaining traction.

**Strategy&, Annual Bundles Survey, 2015/2016 Results: Hospitals, Employers, and Consumers*

Overview

There are six primary components to defining a Bundled Payment:

- What is bundled?
- What patients are included in the bundle?
- What time frame does the bundle cover?
- How is the bundle managed?
- How is the bundle paid?
- Which providers/payers will participate in the bundle?

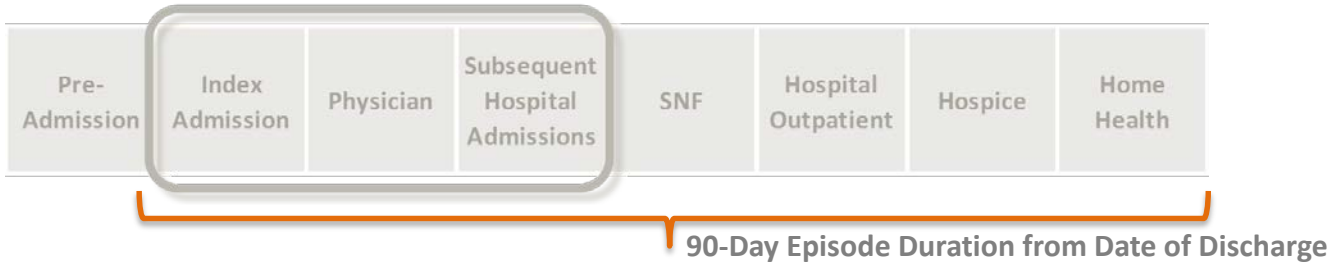
Bundling Program Basics: *Participants*

Participants in a Bundled Payment program may vary, depending on how the Bundle is ultimately defined. Typical participants include the following:

1. Party Representing the Insured (Employer, Insurance Carrier, etc.)
2. Hospital Providing Service
3. Physicians Involved in the Episode of Care
4. Optional: May include Rehab or SNF

Bundling Program Basics: *Defining Episodes of Care & Model*

- **Episodes of Care:** Episodes of Care are "what" is in the Bundle. The key to selecting episodes of care to be included in the bundled payment program is to carefully and clearly define bundles, which should be done only after a thorough review of costs and a complete understanding of which costs can be controlled by both parties, and which cases are higher risk.
  - Procedures with the highest degree of cost variability indicate cost savings opportunity.
  - All costs are further examined for cost distribution and variability for index admission, physician, subsequent hospital admissions, hospital outpatient, SNF, home health, etc.
  - **Episode Duration**: Episode Duration is the time frame the bundle will cover, typically 30, 60, or 90 days after date of discharge. Average episode cost targets may be based on selected duration to include post-acute care (PAC) and readmissions.
  - Episode may include days prior to admission.
- The **Bundle Model** may include hospital, physician, and readmissions only, or it may be broadened to include select SNF/rehab partners and hospital outpatient services.



Example: *Defining Cardiovascular Surgery Episodes of Care*

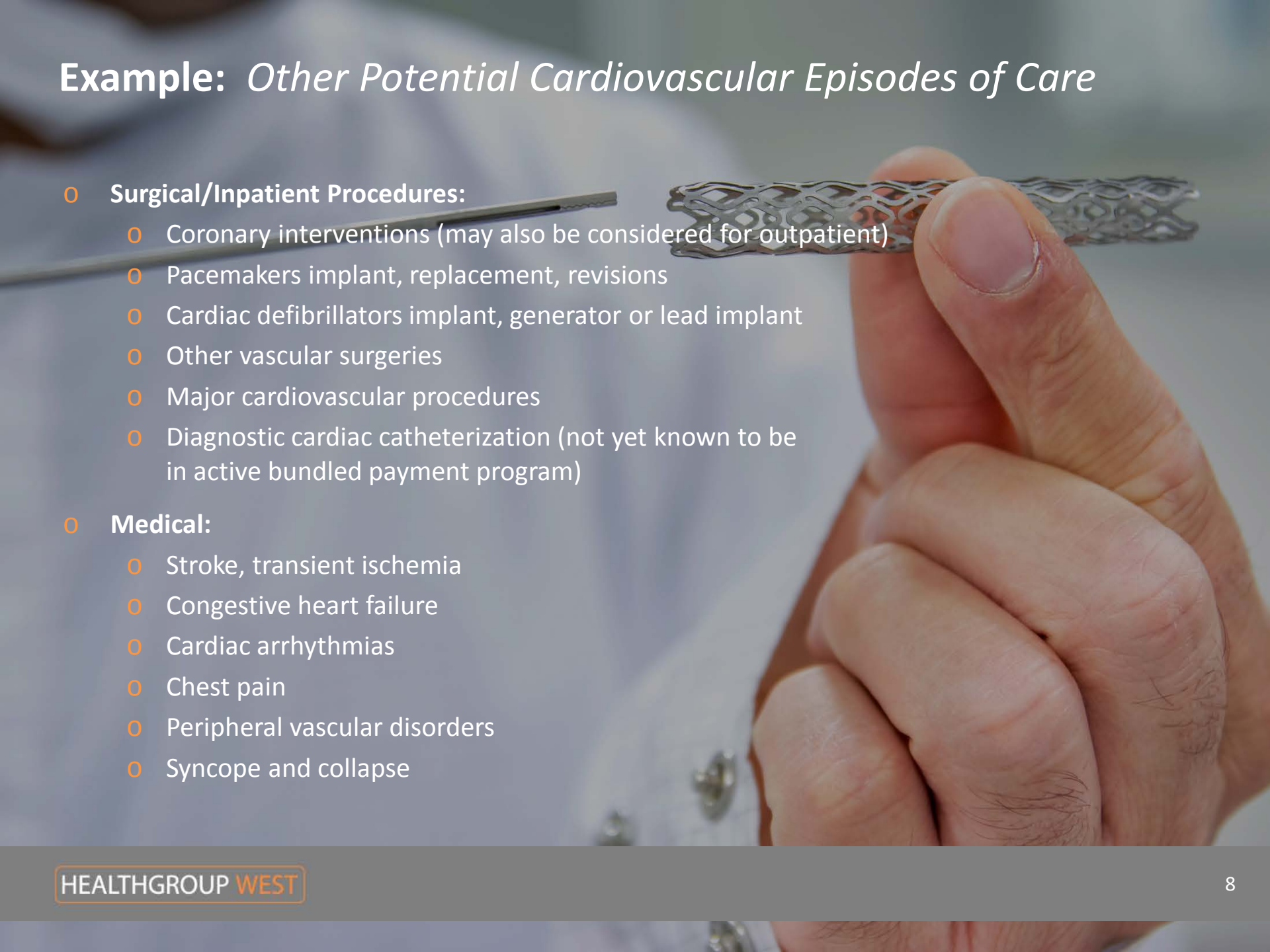
- Cardiovascular bundle models are often limited to cardiovascular surgeries with the ability to add episodes of care in future phases:

- **CABG Surgeries Included in Bundle Model (Example)**:
  - CABG w/PTCA (DRG 231-232)
  - CABG w/Cardiac Cath (DRG 233-234)
  - CABG w/o Cardiac Cath (DRG 235-236)

- **Cardiac Valve Surgeries Included in Bundle Model (Example)**:
  - Cardiac Valve w/Cardiac Cath (DRG 216-218)
  - Cardiac Valve w/o Cardiac Cath (DRG 219-221)

- Episodes may exclude higher risk medical severity DRGs and be limited to cases *without major complications and comorbidities* (5 out of the 12 DRGs listed above: DRG 232, 234, 236, 218, 221)

Example: *Other Potential Cardiovascular Episodes of Care*



- **Surgical/Inpatient Procedures:**
  - Coronary interventions (may also be considered for outpatient)
  - Pacemakers implant, replacement, revisions
  - Cardiac defibrillators implant, generator or lead implant
  - Other vascular surgeries
  - Major cardiovascular procedures
  - Diagnostic cardiac catheterization (not yet known to be in active bundled payment program)
- **Medical:**
  - Stroke, transient ischemia
  - Congestive heart failure
  - Cardiac arrhythmias
  - Chest pain
  - Peripheral vascular disorders
  - Syncope and collapse

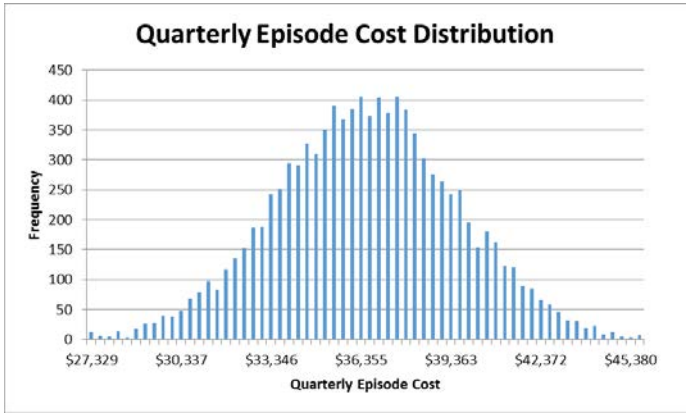
Bundling Program Basics: *Identify Cost Saving Opportunities*

1. Within the service line, review episodes of care to determine the range of variation in cost.
2. Consider including episodes with enough variation to provide cost saving opportunities, but not such high variation that it may pose excessive risk.
3. For the episodes of care under consideration, further review the distribution of cost between spending categories (admission, physician services, outpatient care, rehab, etc.)
4. An internal analysis at this level for every case and DRG of the proposed bundle will help to identify the highest costs and which costs have the most variability.

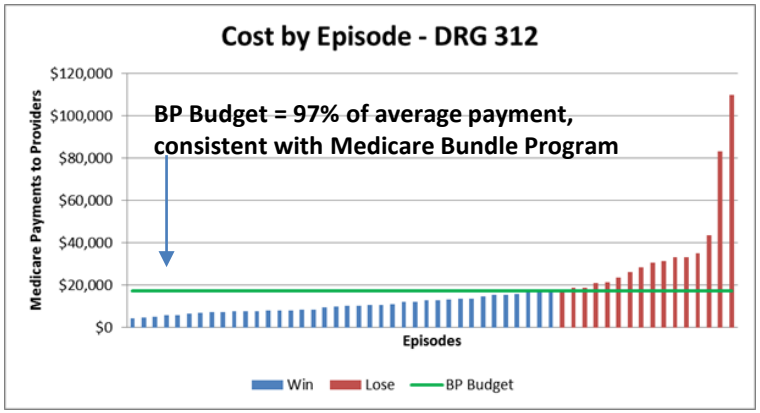
Photo Credit: Solaire Medical

Example: *Evaluating Variation in Episode Cost*

Evaluating the distribution of costs by episode will help to identify both the level of variation and the improvement opportunity. In the chart below, each vertical bar represents the frequency of a particular cost for the defined episode.



In the chart below, each patient is represented by a vertical bar. The green line represents the bundle price (97% of the average payment). Red lines are patients with costs above the bundle price (on which the providers will "lose" money, and blue lines represent patients on which the cost fell below the bundle price.



Source: Becker's Hospital Review

Bundling Program Basics: *Qualification*

- Episode of Care Qualification:
  - Inpatient admission or “triggering event”
  - Patient Qualification (below)
  - Episode bundle eligibility (defined by DRG, CPT, ICD procedure and diagnosis codes)

- Patient Qualification:
  - Inclusions
    - Defined patient population (insured by **Third Party** participating in contract)
    - Patients who received a procedure defined as a bundled episode
    - Provider is a participating **Physician** from the “episode team” of surgeons
    - Index admission at participating **Hospital**.
  - Exclusions:
    - Age (defined), BMI (defined), pregnancy
    - Transfer to other hospitals for further intervention
    - Interruption in coverage
    - Patient is readmitted during selected episode of care duration (i.e., 30, 60, 90 days) for diagnosis unrelated to original admission
    - Other, as deemed appropriate

Bundling Program Basics: *Example Index Procedure Trigger*

Example: CABG w/o Cardiac Cath

- **Trigger Event**: Index admission to **Hospital** with the following codes:
  - MS-DRG 236 – Coronary Bypass without cardiac catheterization without major complications or comorbidities

  AND CABG Procedure Codes:
  - ICD-9 36.10-36.17, 36.19 – Coronary Bypass

  AND EXCLUDES:
  - Other predetermined risk factors not already accounted for by medical severity DRG.
  - Non-related procedures within same 90-day duration (i.e., heart surgery index admission, readmitted for hip fracture).

Bundling Program Basics: *Contracts*

1. Any existing contract between the **Party Representing the Insured** and the **Hospital** must be amended to exclude episodes included in bundle.

2. Any existing contract between the **Party Representing the Insured** and the **Physicians** must be amended to exclude episodes included in bundle.

3. Bundled Payment Agreement: **Party Representing the Insured, Hospital** and **Physicians:**

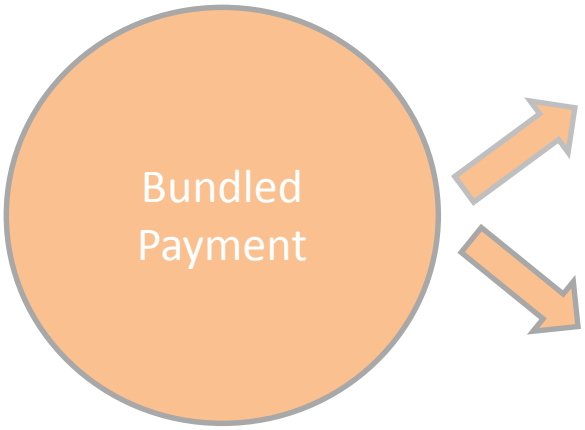
    - Defines and covers specific episode of care

    - **Party Representing the Insured** agrees to make one payment to **Hospital** for entire episode of care

    - Optional provision may include payment to rehab facility or SNF

4. Shared Savings Program Agreement: **Hospital** and **Physicians**

Payment Model: *Bundled Payment Calculation Models*



- Achieving cost benchmark targets will determine shared savings vs. reduced payment (retrospectively). There are a couple of different methods:
  - **Average cost benchmark:** If episode cost is at or below average cost benchmark, shared savings rate is paid to **Hospital**; if above, shared savings payment is forfeited.
  - **A high-low cost benchmark:** Agreed-upon rate is paid for being within a target range, reduced payment for coming in above the range, or an additional "shared savings" payment for coming in below the range.

Payment Model: *Bundled Payment Calculation Example*

- Payment structure is retrospective:
  - Payer pays provider fee-for-service rates
  - Payer then reconciles payments against quality/cost targets
  - If costs are better than target and quality requirements are met, payer pays shared savings to provider
  - If over budget, provider has to make payment back to payer

Payment Model: *Bundled Payment Distribution Models*

- There are three general methodologies for bundled payment distribution among participants for programs with gainsharing concepts, and complying with federal law:

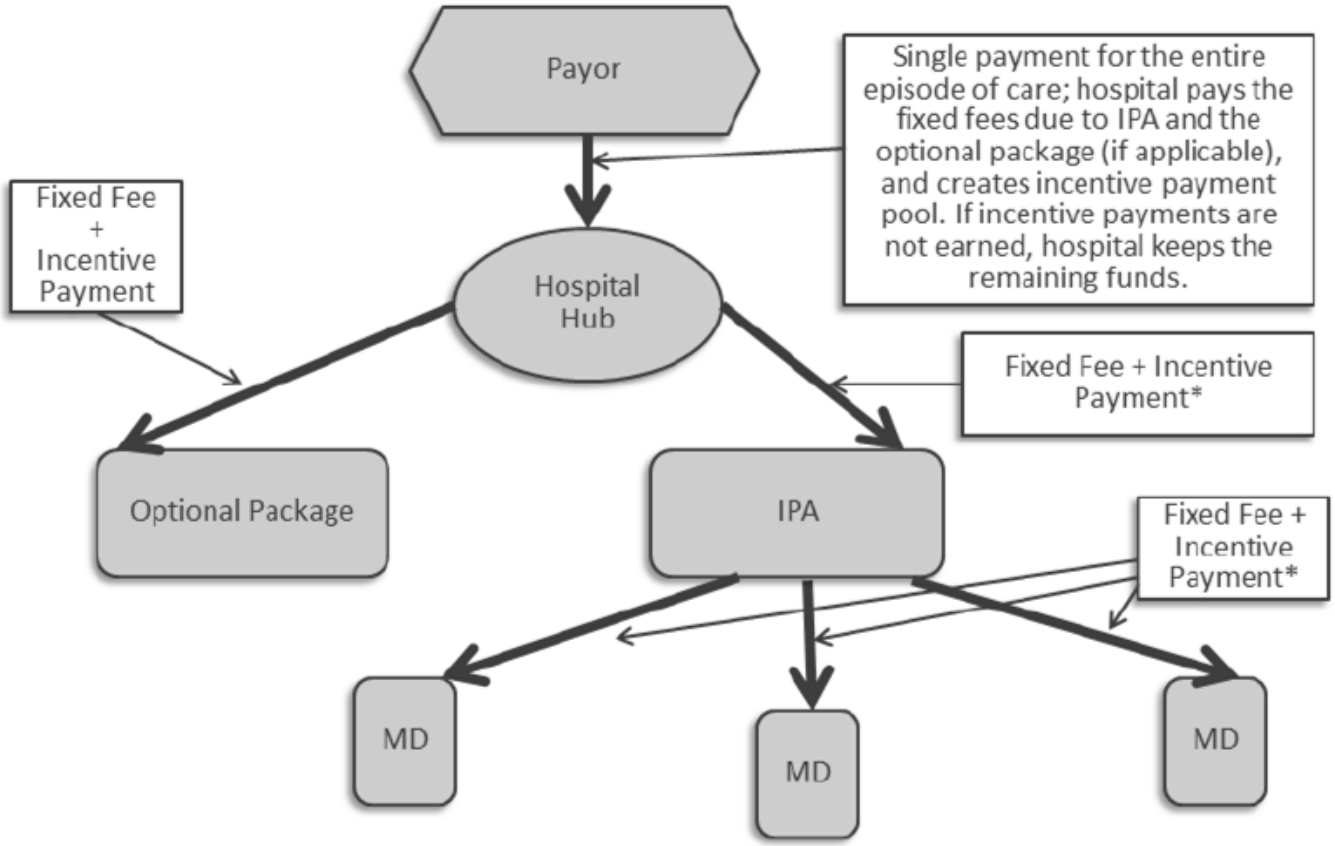
  A. Two-part payment of fixed amount + incentive bonus based on achieving cost and quality metrics; OR

  B. Payment based on average LOS or some other allocation of risk between physicians and hospital; OR

  C. Hybrid, combination of the two

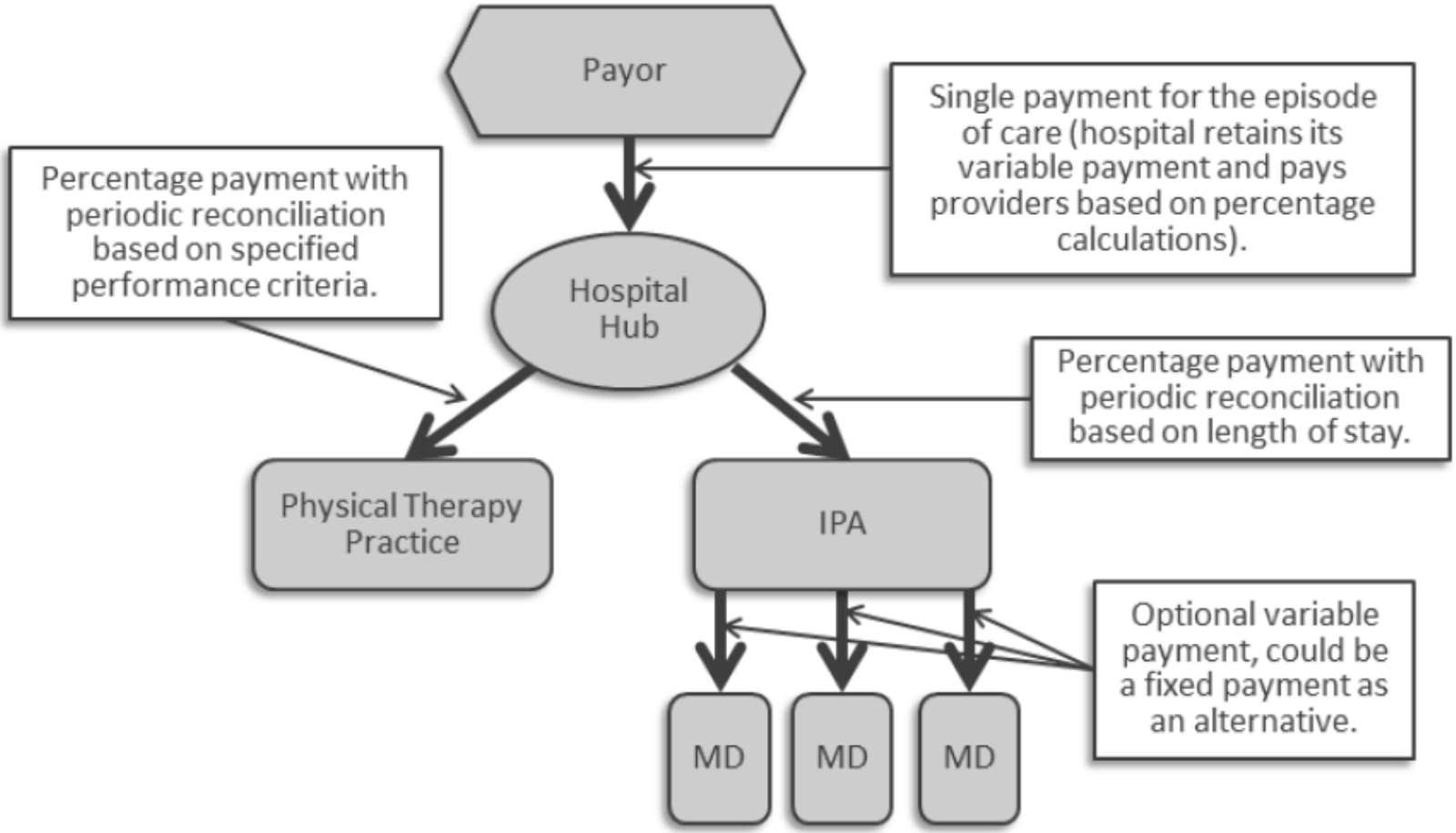
- In each case, a single payment for episode of care is made from the **Third Party Representing the Insured** to the **Hospital**. See the following sample model diagrams (with optional physical therapy package)

Sample Model A
Fixed Fee + Incentive Payment to Physician Group

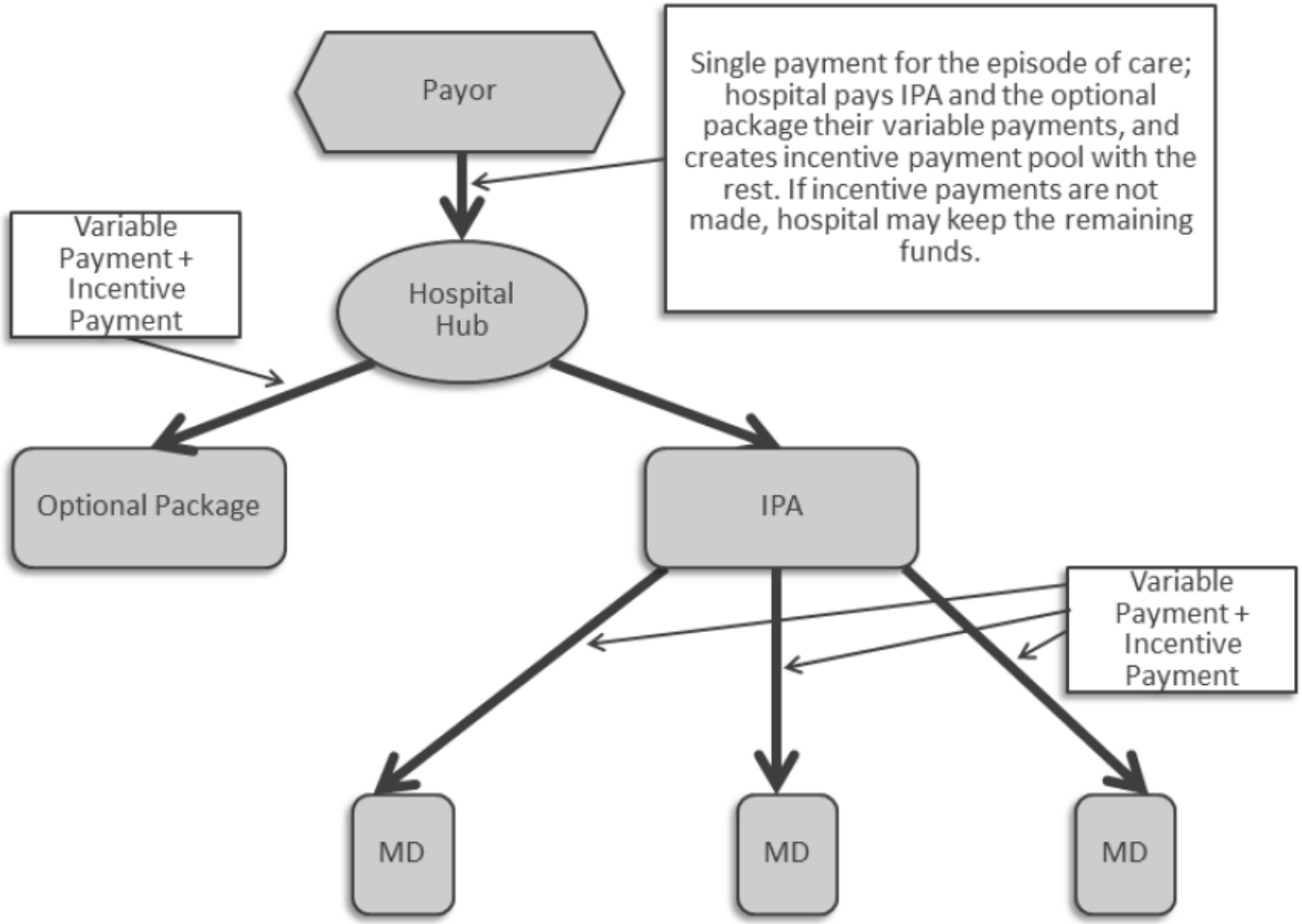


* Incentive payments can be made at the hub or IPA level or both.

Sample Model B
Percentage Payment based on LOS/Clinical Risk



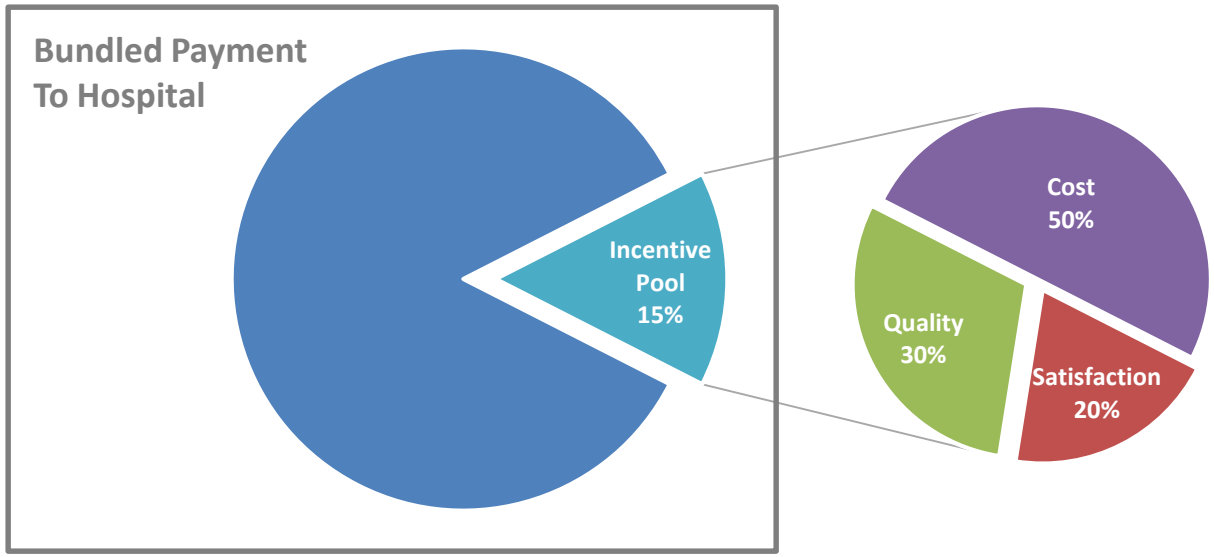
Sample Model C
Hybrid Payment Option



Payment Model: *Defining Benchmarks*

- **Costs, Quality and Satisfaction** are the driving factors in bundled programs, with benchmark targets established to determine shared savings eligibility.
- Costs for episode of care can be reduced by controlling device costs, lengths of stay, reducing readmission, and referring patients to top-quality post-acute care providers (i.e., physical therapists, SNF).
- Clinical quality outcomes and processes of care targets should be established and required to achieve shared savings.
- Patient satisfaction, as well as physician and hospital satisfaction, targets should be established, measured and monitored.

Payment Model: *Incentive Payment Example*



Incentive Pool Components:

1. **Cost Pool (50%)**
2. **Quality Pool (30%)**
   Outcomes (15%)
   Process Measures (15%)
3. **Satisfaction Pool (20%)**
   Patient (10%)
   Physician (5%)
   Hospital (5%)

- A portion of the bundled payment paid to the **Hospital** (15%) is set aside in an **Incentive Pool:**
  - Incentives are pooled for a three month period and disbursed quarterly.
  - **Incentive Criteria** determines all or partial payment of potential payout (see next slide).
  - Funds remaining in incentive pool at the end of 3-month period (i.e., physicians either collectively or individually did not meet incentive criteria) are retained by **Hospital**.

Payment Models: *Incentive Payment Example (cont.)*

- **Cost (50%)**
  - ALL Clinical Outcomes targets must be met to receive Cost Incentive
  - *Cost pool incentives are not rewarded if ANY of the clinical outcomes targets are not met.*

- **Quality Outcomes (30%):** Based on collective performance against national benchmarks
  - **Outcome Measures (15%)** i.e., mortality rates, complications, etc.
  - **Process Measures (15%)** i.e., followed defined clinical pathway related to condition
  - *All quality outcomes measures must be met in order for ANY of the quality outcomes pool funds to be distributed.*

- **Satisfaction (20%):** Based on Collective Performance
  - **Patient Satisfaction (10%):** i.e., happy with physician and staff, etc.
  - **Physician Satisfaction (5%):** i.e., hospital is a great place to practice, hospital and staff responsive to requests, etc.
  - **Hospital Satisfaction (5%):** Physicians work well with hospital staff, etc.

Targets: *Implementing Quality and Satisfaction Benchmarks*

- Quality metrics should be established for *all* episodes of care.
- Quality measures should be established for specific episodes of care as available:
  - Example: for total knee replacement metrics could include range of motion or duration out of work
- Form a **Quality Committee** to establish quality measures and targets, and to monitor and re-evaluate targets over time:
  - Include clinicians to develop standards of care for each episode of care.
  - Review quality targets quarterly.
  - Create action plans for variances as they are identified.
  - Define bundled payment participation consequences for provider performance: (e.g. if quality target performance is poor and does not improve, providers may be dropped from the program).
- Satisfaction targets should be established:
  - Patient satisfaction
  - Physician satisfaction
  - Hospital satisfaction

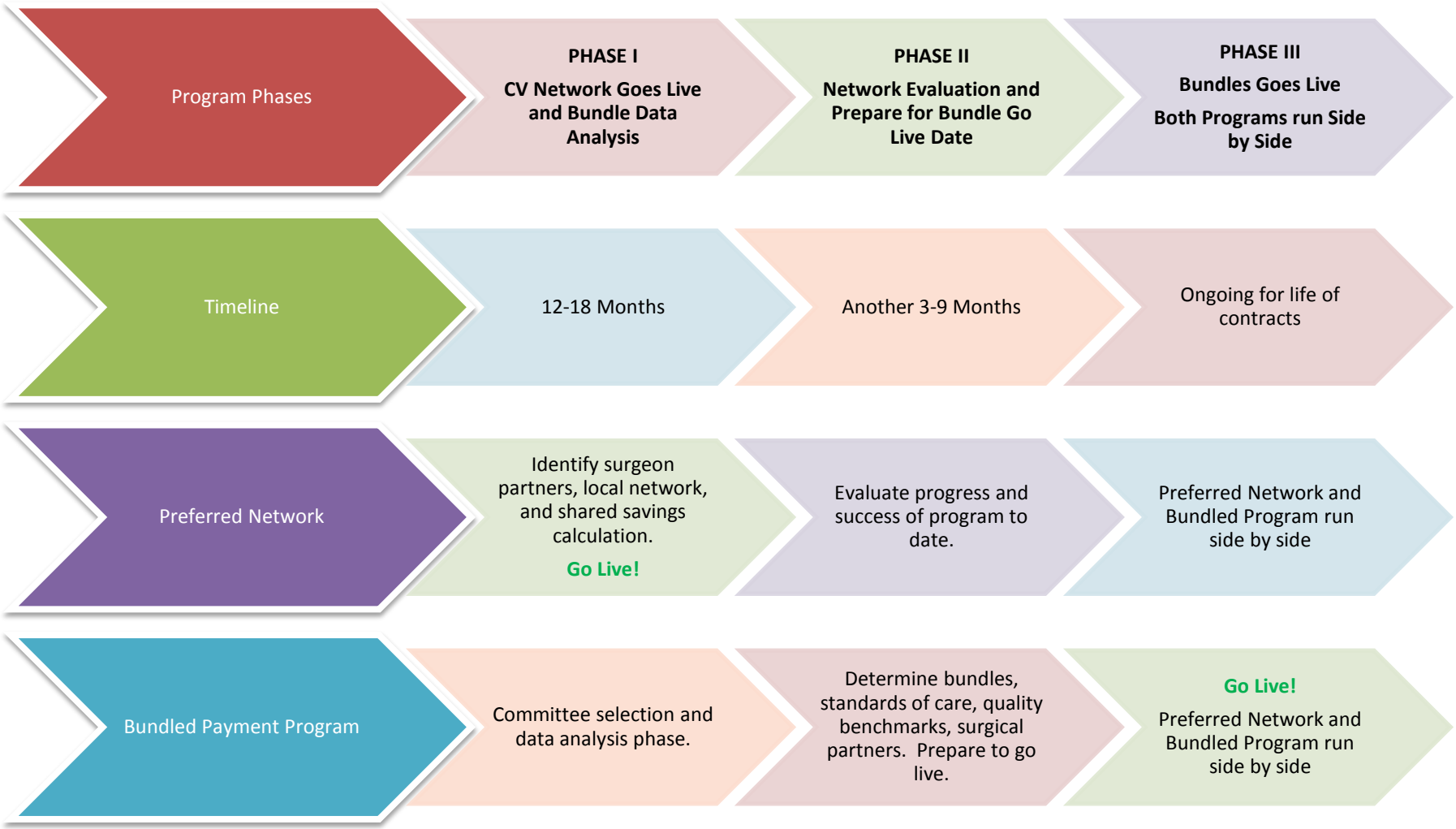
Targets: *Establishing Cost Benchmark*

- Establish an **Episode Cost Committee** with representatives of all parties to establish the cost baseline for each episode bundle.
  - Cost targets should be based on two years of historical cost data (as opposed to a moving average which goes down each year, making targets more difficult to achieve over time).
  - Costs for entire patient episode of care should be analyzed:
    - Including post acute care (e.g., SNF, imaging, physical therapy, rehab, and readmissions) for the selected episode duration (i.e., 90 days)
  - Outlier cases should be eliminated before determining average costs.
- Once cost targets are established, they should be monitored and re-evaluated.

Local Preferred Provider Network

- Determine which physicians will participate in the Bundled Program; these physicians will form the **Local Preferred Provider Network.**
- The **Local Preferred Provider Network** would be available to patients within the defined population for cases at the **Hospital**, and would be limited to episodes of care included in the bundled program.
- The local provider network should not have a narrowing affect on any currently defined provider networks. Customers can still receive care within their current network and pay established out-of-pocket expenses without penalty.

Program Timelines: *Example*



Implementation Phase I:

Phase I – Establish Local Preferred Provider Network; Prepare for Bundled Program

- Timeline: 18 Months
- Establish an Episode Cost Committee
  - Representatives from **Third Party Representing the Insured**, **Hospital**, and **Physicians**
  - Evaluate data, establish bundles, baseline costs, and cost-saving opportunities
  - Create action plans for achieving cost targets, as needed
  - Establish post-acute care partners based on quality of care and costs
- Establish a Quality Committee
  - Representatives from **Third Party Representing the Insured**, **Hospital**, and **Physicians**
  - Establish, monitor and re-evaluate standards of care processes, quality benchmarks, and patient satisfaction metrics
  - Create action plans for improved quality/satisfaction, or if group and/or physician scores decline

Implementation Phase I:

Phase I – Continued

- **Data collection**: historical and ongoing data collection from hospital, physicians, payers, and post-acute care, as available
- **Data analysis**: In-depth cost and pathway of care analysis to establish bundles, baseline costs, and cost-saving opportunities
- **Standards of Care**: A large part of the data analysis phase will be performed by a team of clinicians to develop agreed-upon standards of care for each episode of care.
- **Physician Eligibility**: Review physician historical costs, infection rates, outcomes, complications, and reasons for readmissions to determine eligibility.

Implementation Phase II:

Phase II – Evaluate Phase I Results / Prepare for Bundled Go-Live Date

- Evaluate Phase I Local Preferred Provider Program
  - ✓ Analyze program savings, customer utilization
  - ✓ Address quality targets achievements/problems
  - ✓ Identify surgical group partners for shared savings incentives
  - ✓ Decide if ready to expand to include additional episodes
- Evaluate readiness to begin bundled program:
  - ✓ Data analysis completed
  - ✓ Bundles defined
  - ✓ Cost, Quality and Satisfaction benchmarks established
  - ✓ Bundled Pricing Implementation Plan initiated
- Decide if best to extend Phase I for longer period without bundle

Implementation Phase III:

Phase III – Begin Bundled Program Along Side Local Preferred Provider Network

- Establish a Go-Live date
- Finalize Bundled Implementation Plan
  - Action plans to improve quality, reduce costs, increase patient satisfaction
  - Systems for measuring, monitoring, and reporting quality and satisfaction regularly
- Finalize contracts among all parties
- Finalize benchmarks and standards of care

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