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Bundled Payments with Commercial Payers

Building a Strong Foundation for a Successful Program

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Bundled Payments with Commercial Payers: Building a Strong Foundation for a Successful Program

Bundled Payment Background

In an effort to curb rising healthcare costs and improve quality of care, healthcare providers around the country are considering adopting value-based payment systems. Programs such as accountable care organizations, comprehensive primary care initiatives, and bundled payments are designed to promote quality and value of healthcare services across the continuum of care. Reimbursement models are moving away from traditional fee-for-service toward payments based on outcomes.

Bundling Basics

Bundle models will differ greatly in terms of eligible cases, scope of services, and payment structure, while commercial programs may allow for more flexibility in their design.[1] Regardless of the payer relationship, these are the fundamental elements of bundled pricing:

- **Risk Group.** The group of clinical providers, hospital(s), and other care providers that come together to bear financial risk for an episode of care.

- **Episodes of Care.** The spectrum of services associated with an index hospital admission: pre-admission services, main hospital admission, physician care, readmissions, and all related post-acute care for one to three months post-discharge.

- **Scope of Services.** Providers establish the scope of services within the episode of care to be included in the bundle. For example, scope of services may be limited to index hospital admission, physician care, and related hospital readmissions, or it may be expanded to include skilled nursing facilities, which account for about half of Medicare's post-acute care spending.[2] The CMS bundled program offers four pre-defined models with varying scopes of service, as discussed in the next section.

- **Duration of Care.** The duration of care is established for each episode of care as 30, 60, or 90 days post-discharge. Durations take into consideration the timeframe in which most post-acute care and complications typically occur.

- **Payment Structure.** Most bundles use the retrospective payment structure, in which payments are made to each provider as fee for service followed by a reconciliation of costs. The less popular prospective payment structure requires participating physicians to submit "no-pay" claims, while the hospital is paid one bundled payment for the entire episode of care and administers payment to providers.[3]

- **Aggregate Costs.** Aggregate fees for service for all providers within the defined scope of services are calculated and are reconciled against targets to determine if benchmarks have been met or exceeded.

- **Shared Savings.** If quality benchmarks are met and episode costs fall below the pre-determined cost benchmark, the difference is paid to the provider as "shared savings." If costs are above target, the difference is paid back to the payer. Cost benchmarks may be a single number with nominal measurement ("achieved" or "not achieved"), or they may be defined as a target range. Landing within a cost range earns a standard payment, above the cost range results in reduced payment, and coming in below the target cost range earns additional shared savings.

- **Shared Savings Bonus Model.** Based on program eligibility and participation, physicians who achieve quality benchmarks stand to gain a portion of the shared savings.

Shared Risk and Aligned Financial Incentives

The driving factor steering the bundled payment program is the integration between hospital and physician providers. Aligned incentives promote: shared accountability of costs, quality, and outcomes; shared financial risk of discounted payments for poor performance levels; and shared savings for achieving cost and quality benchmarks. Bundled payment programs that are supplemented with a shared savings bonus program for eligible physician providers create greater incentives for active physician participation, while raising awareness of episode costs across all providers.

The BPCI Initiative

The Center for Medicare and Medicaid Innovation (CMMI) bundled payment initiative, Bundled Payments for Care Improvement (BPCI), initially attracted over 450 provider participation applications. CMS developed a list of 48 eligible episodes of care represented by 179 inpatient MS-DRGs. There are four bundled payment models that differ in terms of eligible cases, scope of services, and payment method. Retrospective Models 2 and 3 were the most popular, and Model 1 was delayed due to too few applicants.[3]

Model	Design / Scope of Service	Payment
1	Acute care hospital stay only; Medicare Part A – All DRGs	Retrospective
2	Acute care hospital stay plus post-acute care episode Select DRGs; up to 30, 60, 90 days of care	Retrospective
3	Post-acute care only, including readmissions Select DRGs; up to 30, 60, 90 days of care	Retrospective
4	Acute care hospital stay only Select DRGs; up to 30 days post-discharge	Prospective

The BPCI program is considered the most successful voluntary payment program for CMMI, and they have added an additional enrollment period for new providers. As of this writing, more than 6,500 candidates have shown an interest in the Medicare BPCI initiative.

Private Payer Bundle Initiatives

There are already a handful of employer and commercial payer bundle programs in the market today. Major employers such as Boeing, Walmart, Kroger, Lowes, and PepsiCo are creating bundled arrangements for their private health plans, mostly for orthopedic and cardiovascular procedures.[1, 4, 5]

Blue Cross Blue Shield is the leader in commercial bundle programs in multiple states, with a few programs from Aetna, Cigna, and Humana also being introduced.[1, 4, 5] Historically, commercial bundled programs began with major joint procedures and grew to include other orthopedic procedures, back and spine, and heart surgery. Programs are now moving toward chronic diseases and other non-procedural care.

A Bundle Team Built to Last: Selecting the Best Partners

Creating a bundled arrangement program can be a bit daunting at first, and will require dedicated representatives from multiple teams to collaborate on analyzing data and establishing benchmarks and standards of care.

Before entering a bundled arrangement, the risk group must identify which providers will make the best partners. Assess your care continuum providers for volume, quality, access to data, and historical working relationship. Identify who among your community providers are willing to partner with you and will actively participate in efforts to reduce costs and improve quality.

Provider Collaboration and Integration

In the context of a fee-for-service model, only patients and their families experience the entire patient journey. Although systems may be in place for communication and follow-up between providers, there is very little influence for quality or cost at another healthcare setting. Data sharing through IT integration is a critical component to establishing a successful bundle program and can prove to be a significant initial hurdle. These challenges may exist even within affiliated organizations. In fact, hospitals and their affiliated long-term care centers often use different patient identifiers due to non-integrated IT silos. Providers are simply not equipped to track patient services, quality, and costs beyond their own setting and may require outside assistance to initially structure an integrated data platform to support the bundle. In addition to IT integration, this elevated level of collaboration and monitoring of the patient care continuum will require patient navigators, integrated care systems, tracking software, and dedicated administrative support.[6]

Episode of care models force organizations and their providers to rethink their role in the care continuum. It is important to identify which potential partners are ready for such a cultural shift, and recognize if their leaders can motivate clinicians and staff toward a new episode of care model.

Commercial Payer and Employer-Funded Plans

Selecting the right payer for your bundled program is as essential as choosing the best provider partners. Commercial bundles require OIG guideline adherence and careful consideration as to the legal structure, particularly if you plan to adopt bonus incentive programs for physicians.[7] These programs do not benefit from the same blanket approval as Medicare for shared savings or gainsharing programs. You may consider partnering with a commercial payer and legal counsel with previous bundled program experience to help navigate through these complex legal requirements. Payer analysis of demographic composition, case volumes, medical severity and financial indicators must also be considered for feasibility of program success.

Just as hospitals and physician groups will undergo cultural shifts for a new payment structure, health insurance organizations will have to position themselves to analyze and monitor benchmarks and to work with their bundled payment partners. Since payers stand to reduce their costs significantly, they should be open to discuss bundled arrangements and be willing to provide support in establishing a successful program.

Providers may also consider working with large community employer health plans. These employers can be very motivated to reduce costs for their self-funded plans, often passing savings along to their members. Some companies pay for travel expenses for members and their families to other cities for top-quality care not provided locally.[1] Alternatively, employers may choose to partner with local providers to improve quality of care and costs for the community, and encourage patients to receive care locally.

Building a Solid Foundation

It is important to create a solid foundation for your bundled payment program. Identify opportunities for cost reduction and quality improvement, and recognize what elements are out of your control. Hospitals are not accustomed to reviewing aggregate episode of care costs, and making financial and quality improvements outside the hospital will be challenging. The best way to prepare is to conduct a comprehensive review of historical data which follows two paths: financial/operational analysis and quality/outcomes analysis.

Financial and Operational Review

Form a committee with representatives from the payer-hospital-physician triad to include clinicians, finance, data analysts, and a dedicated administrative team. Their objectives will be to identify episodes of care opportunities and to establish appropriate durations of care. This requires examining at least two years of historical data to identify variances in cost for like-cases, cost distribution among all providers of care, and cost distribution for hospital stay and readmissions. Mapping pathways of care will help to find patterns in cost and outcomes associated with various steps in the care continuum. The American Hospital Association issue brief "Moving Towards Bundled Payment" (PDF) provides a roadmap for walking through each cost discovery point.[8]

Quality and Outcomes Review

Form a quality committee with representatives from each payer-hospital-physician member, including a team of clinicians. The team's objectives are to establish agreed-upon best standards of care and processes of care, and to develop quality matrix and benchmarks. They will also be tasked with establishing physician eligibility for shared incentive bonus programs, and setting individual improvement plans for each physician in order to gain eligibility. This committee should be called on as needed to create action plans for quality and outcomes issues that may arise.

Bundle Models and Payment Structure

Each program must also determine the appropriate bundle model and payment structure. Review the Medicare bundle models offered by CMS. Should your bundle include the entire episode of care and all post-acute care providers? Again, this goes back to understanding what services may be out of your control. If your market has several long-term rehab centers operated by other organizations, you may be able to influence quality by referring patients to the best quality centers, but what can you do to reduce or even monitor costs at those facilities?

"You may be able to influence quality by referring patients to the best quality centers, but what can you do to reduce or even monitor costs at those facilities?"

Most payment structures are set up for retrospective payment, meaning all parties are paid fee-for-service payments, then the payer reconciles payments for the entire episode of care to pre-defined benchmarks. Either the payer will be making an additional payment to the hospital or the hospital will be making a payment back to the payer for exceeding targets. If the bundle involves a hospital-physician partnership and a shared savings program, those payments are retrospective as well, pending a periodic reconciliation.

Shared Savings Incentive Models: Aligning Risk Group and Physician Goals

Physicians have significant influence over costs and it makes sense to partner with them for shared savings. A shared savings bonus incentive is one of the best models for aligning risk group and physicians goals. The bonus incentive promotes awareness and accountability for the entire care continuum as participants work together to achieve the same objectives.

Studies of shared incentive models show that all or the majority of physician participants earned incentive payments.[9] Those who are not eligible to participate or did not earn shared savings payments are motivated to study their own outcomes and work toward improvement and participation.[10]

The Pitch: Approaching the Board, Payers, and Providers

Come to the Meeting Prepared

Be prepared to outline the program as you see it working for your organization. Identify the payer-hospital-provider team and highlight past working relationships and arrangement success stories. Perform a preliminary data review for feasibility of case volumes and financial scenarios. Summarize methods for cost reduction and quality improvement based on what you know about your past cases. Demonstrate a shared savings model and incentive pool scenarios for physicians. Finally, outline possible risk factors for the hospital, physicians, and payer.

Initial Strategic Direction: Start Small, Aim High

A good strategy for first-time bundlers is to start with your orthopedic or cardiovascular procedures known to have some of the highest costs and greatest variability, mainly major joints and heart surgeries. Plan to phase in additional procedures and then medical conditions for the service line. This phase-in approach allows for program review and improvements along the way. However, be mindful of the medical severity of your cases. Too few episodes of care may result in a greater percentage of high-risk cases, and adding more episodes of care may help to smooth outlier risk.

You may also consider a two-phased approach where Phase I of your program focuses on the quality portion of the arrangement, and Phase II incorporates episode cost targets. A phase-in approach allows the hospital and risk-adverse physicians to get comfortable with monitoring quality targets before adding the financial risk portion.

Phase II of the gainsharing program should allocate a greater portion of the bonus pool to cost reduction. For example, 50% of the shared savings incentive pool ties to achieving cost targets, 30% to quality and 20% patient satisfaction. In both phases, certain quality and outcomes measures will be required for bonus payment.

Share your Vision for the Future

Outline a timeline for adding second and third service lines and the major player physician groups for each. Show a plan that can incorporate additional physician groups and individuals as the program progresses. Replicate your pilot bundled payment programs at other hospitals and post-acute care providers within your system. Continue moving IT systems toward integration across episodes of care for future analysis.

Bundle Payment Successes

The Geisinger Story

Geisinger Health System in Pennsylvania initiated a CABG bundled program in 2006 called ProvenCare. The first year they had 181 procedures, and 34% eligible cases under the Geisinger Health Plan. The following improvements are cited at after 18 months of implementation (shown as % of improvement/reduction)[11]:

- ALOS dropped by 0.5
- 30-day readmission rate 44%
- Patients w/complications 21%
- Patients with less than 1 complication 28%
- Incidence of atrial fibrillation 17%
- Neurological complication 60%
- Pulmonary complication 43%
- Blood products used 22%
- Re-operation for bleeding 55%
- Deep sternal wound infection 25%

Blue Cross Blue Shield

Blue Cross Blue Shield has been very active in implementing commercial bundle payments across the country, and is reporting substantial cost savings and quality improvement.

Horizon BCBS New Jersey began with total hip and total knee replacement episodes of care in 2013, with 10 providers. The next year they expanded to add knee arthroscopy, pregnancy, adjuvant breast cancer, and colonoscopy cases with 10 providers.[12]

BCBS North Carolina teamed up with Triangle Orthopaedic Associates to offer total knee and hip replacement bundles in North Carolina. Payments are 10% to 20% less than the state's average cost for the same procedure. Their first bundle was for total knee replacement, reporting cost reduction of 22%, better-than-national outcomes, a reduction in avoidable complications, and a 97% patient satisfaction score.[13]

> "We have such disparities in New Jersey that, honestly, we could in some places put a patient and his or her family into a limousine and drive them into New York City, and send them to a Broadway show and out for a wonderful dinner and put them up in a hotel and drive them to the hospital and still have it cost less than it might cost at the nearest hospital to them."
>
> *--Lilli Brillstein, Director of Episodes of Care, Horizon BCBS NJ*

Getting Started

- ✓ Outline your goals and objectives for creating a bundled payment arrangement.
- ✓ Begin with comprehensive analyses: financial, operational, quality, outcomes, payer and market.
- ✓ Target high-cost, high-variation procedures first (major joints and heart surgeries may be good candidates).
- ✓ Select strong, innovative partners who will be dedicated and engaged throughout the process.
- ✓ Evaluate the level of data integration necessary to service the bundle and ensure partners can support.
- ✓ Identify leaders who can motivate and move their groups forward toward new reimbursement models.
- ✓ Form teams represented by all parties to investigate historical data and set the course for your program.

If your organization is considering entering into a bundled payment arrangement and you need assistance with preliminary data analysis, data integration, payment structures, contract negotiations, and implementation, call HealthGroup West at 888-459-2692 to schedule an initial consultation to discuss your vision and next steps.

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References:

1. Bob Herman, "Where Commercial and Employer Bundled Payments Stand in Healthcare Right Now," *Becker's Hospital Review* (2013).

2. Robert Mechanic, "Post Acute Care – The Next Frontier for Controlling Medicare Spending," *New England Journal of Medicine* 370;8 (2014): 692-4.

3. "Bundled Payments for Care Improvement (BPCI) Initiative," Centers for Medicare and Medicaid Services, accessed July 2014, http://innovation.cms.gov/initiatives/bundled-payments/.

4. Bob Herman, "Which Providers and Employers Have Commercial Bundled Payments?" *Becker's Hospital Review* (2013).

5. "Commercial Bundled Payment Tracker," Advisory Board, accessed July 24, 2014. http://www.advisory.com/research/health-care-advisory-board/resources/2013/commercial-bundled-payment-tracker.

6. Jessica Zigmond, "Early Bundled Payment Projects Test Positive," *Modern Healthcare* (2014).

7. Jill Gordon, David Martland, Michele Masucci, Jason Chimon, Jennifer Cormano, et al. "Legal Issues in Designing Bundled Payments and Shared Savings Arrangements in the Commercial Payor Context," Nixon Peabody LLP, The Camden Group and Robert Wood Johnson Foundation.

8. "*Issue Brief: Moving Towards Bundled Payment*," American Hospital Association (2013).

9. Lindsey Dunn, "Bundled Payment Trends: 10 Findings on Arrangements Across the U.S.," *Becker's Hospital Review* (2014).

10. Joseph Burns, "Hospitals and Physicians Prepare for Bundled Payment," *Hospitals & Health Networks* (2013).

11. "ProvenCare by the Numbers," Geisinger Health System, accessed July 24, 2014, http://www.geisinger.org/provencare/numbers.html.

12. Steve Davis, "Ark. N.J. Blues Bundled Payments are Reducing Costs and Improving Quality," *AISHealth* 13;5: (2014).

13. "Expanded Collaboration Provides BCBSNC Customers with 10-20 Percent Savings on Hip Replacement Surgeries," Blue Cross Blue Shield, accessed July 25, 2014, http://mediacenter.bcbsnc.com/news/expanded-collaboration-provides-bcbsnc-customers-with-10-20-percent-savings-on-hip-replacement-surgeries.

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