

Bundled Payments: What are the Essentials You Need to Know?

White Paper



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Abstract: Bundled payments are likely to become more commonplace in the healthcare industry. Bundled payment methodologies are being used to incentivize improved care coordination, quality, patient safety, and cost efficiency in a system that is badly in need of improvements in these areas. This paper outlines the mechanisms underlying bundled payments and helps guide providers who may be considering this payment model to optimize their performance by mastering certain key capabilities. Readers gain an understanding of bundled payment methodologies, how their uses affect healthcare organizations, and how to incorporate the needed capabilities to maximize effectiveness and efficiency under this payment model.

Key Words: Bundled Payments, Centers for Medicare & Medicaid Services (CMS), Affordable Care Act (ACA), Bundled Payment Care Improvement (BPCI), CABG, potentially avoidable complications (PAC), coronary artery bypass grafting (CABG), time-driven activity-based costing (TDABC), capitation payments, value-based care, care delivery, payment methodologies, Lean Value-stream Mapping

INTRODUCTION

Bundled payments are rapidly becoming a common form of reimbursement for services in the American healthcare system. Bundled payment methodologies are being used by government, specifically the Centers for Medicare & Medicaid Services (CMS), and commercial payers alike to incentivize improved care coordination, quality, patient safety, and cost efficiency in a system that is badly in need of improvements in these areas.

This paper will outline the underlying mechanisms of bundled payments and offer guidance to providers who may be considering this payment model. We will review the past successes and deficiencies of bundled payment pilot programs and discuss predictions about the possible expansion of this reimbursement methodology into other arenas.

Please note that at the time this paper goes to press, President Donald J. Trump was recently inaugurated as President of the United States, and the newly elected Republican Congress will be voting to repeal the Affordable Care Act (ACA). How the new administration and the repeal of the ACA will affect the use of bundled payments by CMS and commercial payers alike is an open question. However, it seems likely that this payment mechanism will stay; thus, the information presented in this paper will be useful to those who work within the healthcare economy.

UNDERSTANDING BUNDLED PAYMENTS

In 2009, the Brookings Institution studied multiple payment mechanisms for their effect on the inexorable rise of the cost curve in the healthcare industry. This study clearly showed that bundles were superior to other methods considered, such as accountable care/shared savings plans, capitated payment models, and others, in bending this cost curve.¹ Since that time, CMS

has piloted the bundled payment model extensively. The 2009 acute care episode project, a small study involving orthopedic and cardiac care in five organizations, achieved 3% savings for Medicare.ⁱⁱ In 2011 a much broader initiative known as the Bundled Payment Care Improvement (BPCI) initiative was introduced to cover 14,000 bundles across 24 surgical and 24 medical conditions.ⁱⁱⁱ The BPCI achieved savings in order of a magnitude higher than Accountable Care Organizations (ACOs), and in 2016, it was converted from a voluntary program to a mandatory program related to the comprehensive care of patients undergoing total joint replacement. This program has now been expanded to include hip fracture repair, coronary artery bypass grafting, and heart attacks. Future bundled payment programs on the horizon include ambulatory bundled payments for cataracts and colonoscopy.^{iv}

Fundamentally, bundled payments work by bundling together the payments for a single healthcare service (procedure or treatment of a clinical condition over a period of time), including the professional and technical payments for any single service.

The usual methodology is to add the fee-for-service payments for all services being bundled to determine an overall bundled budget. These payments are then reduced by eliminating payments for services deemed by expert panels to be unnecessary or non-value-add to the bundle under question. Next, some payments are added in for what are deemed potentially avoidable complications (PACs). PACs are payments for services that under ideal conditions would not be necessary, such as payments for services used to treat complications. However, since ideal conditions rarely exist in the delivery of healthcare services, some payment for such services is allowed under most bundled payment models. After this, the budget is discounted, usually by 3 to 5%. This discount is used to anticipate some of the expected savings that can occur through bundling of services and the incentivizing of more coordinated and efficient care delivery. Finally, quality and patient satisfaction goals are set that must be met for any providers to receive shared savings incentives under most bundled payment plans.

Once the bundled budget/price is set, then providers who come together to deliver services under such arrangements are paid the bundled price, which they are expected to divide, per pre-determined allocation methods, as determined by the providers. Further, if quality and patient safety goals are met, and savings against the budget are achieved, then these savings are shared between payers and providers. If, however, spending exceeds the budget, then the cost overruns are also shared between providers and payers via penalty payments. The split between providers and payers of either savings or cost overruns is also determined up front by the parties engaged through a bundled payment agreement. These arrangements can vary widely from one agreement to another; however, the most usual is a 50-50 split between providers and payers. Finally, the providers (hospitals, physicians, and others) must determine how they divide their share of the savings, which can also vary greatly between contracts.

Further analysis of bundled payments can reveal some interesting aspects of these models.

First, appropriate care and thus the inclusion of fee-for-service payments for services that are deemed to be appropriate can depend greatly on who determines whether or not a service is appropriate. In most circumstances, payers are making these determinations. While they usually rely on expert panels of experienced clinicians, the objectivity of these determinations cannot always be assured and may or may not be free of conflicts of interest.

Second, the up-front discounts to the bundled payments may or may not accurately reflect the actual savings to be gleaned through coordination of care and clear communication of roles and responsibilities between the various providers. Since these discounts are also usually dictated by the payers, there is an inherent tendency for providers to feel that these cuts are too severe.

Next, PACs are very difficult to circumvent. Here, providers and payers may differ on how much should be left in the budget to cover these events.

Finally, the quality and patient safety goals that are used to trigger most bundled payments need to be set so that all parties to these agreements can agree that these measures are accurate and valid to reflect high-quality care delivery. Again, providers and payers often disagree in this area.

Let us now look at an example of a bundled payment, such as coronary artery bypass grafting (CABG). In this case, we can divide the bundle into the following services and their average contribution to the bundled budget:

- **Physician/Surgeon Services - \$6,183**
These services may include professional fees for the referring primary care physicians or cardiologists, the cardiac surgeons themselves, anesthesiologists, hospitalists, and even post-op specialists in cardiac rehabilitation.
- **Hospital Services - \$33,913**
These services include all the technical services surrounding a complex surgery like coronary artery bypass grafting. These include inpatient nursing, surgical, imaging, pharmacy, rehabilitation, and other services. Unsurprisingly, this category represents the largest share of the bundled budget, and hospital inefficiencies and non-value-added costs are the prime targets for those who wish to use this payment model to lower overall costs of care.
- **Post-Acute Care - \$3,286**
These services include any home care, skilled nursing care, or rehabilitation (outpatient or inpatient) care provided to post-CABG patients after discharge from the hospital. This category is also a prime target area for savings, and organizations that can improve coordination of care across the continuum from pre-acute to acute to post-acute care will fare best under bundled payments.

- **Readmissions - \$3,393**

This cost is a good example of a PACs that ideally should never happen. But since readmissions, unfortunately, do occur frequently, it is listed here as a part of the overall bundled price. Naturally, this then incentivizes providers to avoid this complication and turn this cost into a savings.

As the above example shows, bundled payments have a way of turning profit centers for any specific service provision into cost centers. Therefore, the providers are incentivized under this model to deliver highly-coordinated, cost-efficient care, which is regrettably not often the way care delivery is provided today in the American healthcare system.

BUNDLED PAYMENTS VS CAPITATION

Two payment models are used in today's healthcare economy as ways to drive quality improvement and cost reduction simultaneously. As mentioned, bundled payments are increasingly becoming the favorite reimbursement method of CMS, while other payers are pushing to resurrect capitation payments. Capitation was the favored model of most commercial payers in the first era of heavily managed care, during the 1980s and 1990s.

Thus, it is illustrative to compare these two competing payment models to understand how each works and under which situations one or the other might be preferable.

We have discussed bundled payments extensively, and, to reiterate, this model pays providers for the care of a patient's medical condition across the entire care cycle. There can be primary care bundles, which usually involve patient populations (adults, elderly, children) or specialty care bundles, which usually are organized around a specific clinical condition or service offering (total joints, transplants). The perception is that bundles set up competition around value, usually defined as quality per unit of cost and have been proven to bend the cost curve in pilot projects ranging from the BPCI to the transplant programs (renal, heart) that are common in the industry.

Perhaps the bundled payment's best aspect is its ability to gear efforts toward each patient's specific condition and what matters most, such as avoiding complications and returning to baseline health status. Providers tend to like that while bundled payments do put them at some risk, these are risks that the providers feel they can control. Further, in a bundled payment model, the risk adjustments are easier to make since they involve risk adjusting around single conditions or single patients. Finally, bundles tend to drive competition, innovation, integration, and multi-disciplinary care, which is very popular with patients who are frustrated at trying to maneuver through a healthcare system that often seems disjointed, uncoordinated, and not patient-centric.

Capitation, on the other hand, involves paying a healthcare organization a fixed payment per year per covered life and then asking the provider organization to meet all the needs of a broad patient population for that single payment. During the 80s and 90s, this payment method was not found to change the cost trajectory significantly within the healthcare industry. Also, it was unpopular with patients, who felt that cost savings were commonly achieved by denying care. Capitation is usually used to pay for population health management services and puts providers at risk for overall spend, readmission rates, and length of stay. Providers tend to feel that this puts them at risk for things they cannot control, such as utilization of the emergency department. Finally, it is acknowledged that it is harder to risk-adjust a population than an individual patient or condition.

The trend seems to be for certain payers, particularly CMS, to favor bundled payments, especially when paying for procedural services like total joint replacement or coronary artery bypass grafting. Other payers, such as commercial payers, are more partial to capitation payments, especially when paying for population health management services.

In summary, bundled payments are rapidly becoming the favored reimbursement model for those payers interested in simultaneously driving reliably high-quality care delivery and cost efficiency. It is becoming evident that the essential elements within any bundled payment must include the following.

The payment must:

- Cover the overall care required to treat the condition
- Be contingent on delivering good outcomes
- Be adjusted for risk
- Provide a fair profit for effective and efficient care
- Relieve the providers of responsibility for unrelated care or catastrophic cases

While the future of bundled payments is yet to be determined, it seems likely that this method will become more prevalent in the industry. Thus, providers should do all they can to learn how to operate optimally within this reimbursement system.

OPTIMIZING PERFORMANCE UNDER BUNDLED PAYMENTS

Optimizing performance under bundled payments will require providers to master certain key capabilities to include:

- **Understanding care processes and procedures.** Unfortunately, although many providers perform certain care processes and procedures several times a day, they may not have an in-depth understanding of how these processes are structured and whether or not they are designed to be optimally effective and efficient. Therefore, it is recommended

that providers use well-described process mapping techniques, such as Lean Value-stream Mapping, to understand their frequently utilized processes and procedures.

- **Designing or redesigning care processes and procedures according to best-practice, evidence-based guidelines.** Once care processes and procedures are mapped and well-understood, they should then be scrutinized as to whether they incorporate best practices as informed by the scientific evidence base (when available) and the knowledge and experience of the frontline providers themselves. It also should be understood that the majority of the activities performed in the healthcare delivery system have never been, and never will be, subjected to randomized prospective clinical trial. Therefore; while evidence-based medicine is indeed the ideal, most of care delivery will need to be designed according to less rigorous standards.
- **Measuring clinical outcomes (quality and patient experience).** Most commonly used quality measures today are process measures as opposed to true outcome measures. Over time, it is recommended that true outcomes be used to guide clinical care delivery as these metrics truly reflect the end-goals of care processes. Further, they do not have to rely on an intermediary “leaps of faith” that delivering care via standardized processes will result in quality outcomes.
- **Measuring true costs of care delivery.** Most organizations use proxies for the true cost of care delivery, such as charge-to-cost ratios, instead of more accurate cost accounting methods, such as time-driven activity-based cost accounting (TDABC). In fact, it can be argued that those who do not understand their true cost of care delivery will have a difficult time accurately pricing or negotiating bundled payment prices with payers.
- **Practicing data-driven process improvement.** Once quality and cost measures are implemented, they should be used to drive process improvement so that care delivery processes and procedures can be modified and refined over time and higher value (quality/cost) can be delivered to the patients served.

OPTIMIZING CONTRACTING UNDER BUNDLED PAYMENTS

In addition to operational capabilities, optimizing contract terms within a bundled payment agreement can significantly determine a provider organization’s success or failure with this type of reimbursement model.

Key points to remember about bundled payment contracts include:

- Many contracts, such as those from CMS, are nonnegotiable, and success will be determined by a provider’s ability to deliver high-quality clinical outcomes and, simultaneously, to cut costs within the care delivery system. Thus, the operational capabilities reviewed become crucial, especially the removal of non-value-added costs from well-designed care processes and procedures. This assessment should be done by those best prepared to make these decisions, i.e., frontline caregivers who are most familiar with the clinical processes at hand.

- Where pricing is negotiable under bundled payment agreements, knowing the true costs of care delivery can be paramount. Providers should invest in learning and in applying sophisticated cost accounting techniques to their workflows that are most likely to be included in a bundled payment.
- The market for bundled payments may extend beyond traditional payers, such as Medicare, Medicaid, and commercial payers, and include large self-insured employers who are interested in contracting directly with provider groups who can reliably deliver high-value care to their self-insured employee populations. These bundles may include primary care bundles, where the provider is at risk for all members of an employee population or specialty care bundles, where specific procedures or clinical conditions are carved out for direct contracting under a bundled payment method.

To summarize, successful contracting for bundled payments depends greatly on provider groups acquiring key capabilities that are not necessarily required in fee-for-service agreements. These include care process design, continuous data-driven process improvement, accurate cost accounting, and marketing of bundled services directly to self-insured employers.

CONCLUSION

Bundled payments are likely to become increasingly commonplace in the healthcare industry. Providers who do not understand bundles or how to optimize their performance under this model do so at their peril. The key to this understanding involves an in-depth study of the most common bundled payment models in use today. Providers must also acquire capabilities previously not needed under more traditional payment methodologies. Care process mapping, systematic elimination of waste and inefficiency, and accurate pricing of bundles are just a few of these capabilities that providers must learn. Improvements in both quality and cost are sorely needed in the American healthcare system, and the ultimate promise of bundled payments is that they can drive higher quality, cost efficiency, and ultimately better value for the patients served. Time will tell whether this change in the payment system can accomplish these lofty goals. So far, the results are promising and warrant further utilization of this novel reimbursement mechanism.

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