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Bundled Episodes-of-Care Payments

It is no secret that the rise in Medicare spending, and the overall U.S. health care spend, is unsustainable. The U.S. Government Accountability Office and other fiscal experts continue to issue warnings to that effect. As the nation's largest healthcare payer, the Centers for Medicare and Medicaid Services (CMS) has sent clear signals that Medicare Part B compensation, which doesn't foster improved quality or care collaboration, will soon be a thing of the past. Medicare's reduced physician reimbursement rates, applied to an already-lean fee schedule, challenge physicians to pay close attention to payment reform models.

One such payment reform model that has garnered national attention is bundled episode payment, a method of healthcare reimbursement which sets a fixed rate for a patient's entire episode of care for a particular procedure or condition. This payment combines reimbursement for the multiple providers and other services involved in providing care for the patient throughout the episode. Bundled episode payments are already in play with active pilot programs, such as the Integrated Healthcare Association's (IHA) three-year Bundled Payment Demonstration, funded by the Agency for Healthcare Research and Quality. This demonstration is testing the feasibility and scalability of bundled payments among a range of payors and providers in California, including the implementation of bundled payments for commercially insured patients receiving total hip and knee replacement at Hoag Orthopedic Institute (HOI). HOI is a joint venture between Newport Orthopaedic Institute and Hoag Memorial Hospital located in Newport Beach, CA.

In addition, the Center for Medicare and Medicaid Innovation (CMMI) is due to announce the approval of applications for Bundled Payments for Care Improvement, its national program to implement bundled payments for hospitals and physicians serving Medicare fee-for-service beneficiaries. To incentivize providers to participate in this program, CMMI provides safe harbor from federal and state laws which otherwise prohibit gainsharing. This paves the way for physician bonuses to be paid under bundled payment arrangements as an incentive to integrate care delivery, improve quality, and reduce costs. The Bundled Payments for Care Improvement initiative sends a strong signal that, in the future, bundled payment may become a more common form of payment in the public sector.

Background

Bundled payment involves a single price for a patient's care across a defined episode of treatment. As distinguished from traditional fee-for-service medicine, under bundled payments, doctors, hospitals and other health providers share one fee for treating all aspects of an episode of care, such as a hip replacement. The approach is intended to encourage various disciplines of health providers and hospitals to work together to efficiently coordinate care, control costs, eliminate unnecessary care, and improve quality and outcomes. Bundled payments may be clinical episode of care-related or concern a specific condition over a defined time period.

Medicare's prospective payment system for Part A services (hospital services) is a form of bundled payments, reimbursing a single provider (the hospital) for all services provided in a particular patient stay with a single payment amount. Hospitals have been paid under Part A's diagnosis-related group (DRG) system for many years and are more accustomed to the concept of a bundled payment system as a result.

In contrast to DRGs, bundled payments cover *all* costs associated with the specific procedure and include the full range of providers involved in an episode of care. A bundled payment for a hip replacement, for example, might cover pre-surgical preparation and diagnostic tests, facility fees, anesthesiology, the surgical procedure, the hip implant, intro- and post-operative radiological examinations, laboratory tests, and rehabilitation.

How do bundled payments differ from capitation payments?
Bundled payments are sometimes described as a hybrid fee-for-service payment and capitation payment; and they do fall between those extremes. Fee-for-service payment programs leave all the risk with the payer, while capitation agreements shift almost all of that risk to the provider. Bundled payment programs, however, offer middle ground between these approaches since they involve shared risk between the payer and providers. They typically will target specifically defined health care procedures or conditions. Providers who participate in bundled payment programs usually incur the "performance risk" only, that is the risk that the procedure will be more difficult than usual, or the patient will experience excessive complications or require a greater intensity of services. Those risks are inherent in any medical procedure, but combining many different providers and services in the "bundle" increases the performance risk that something unexpected may occur.

Fundamental to the concept of bundled payment programs is that if the costs of care for the bundled episode are less than the bundled rate, the providers keep and share the difference. By the same token, costs exceeding the bundled rate result in a shared loss among all bundled payment participants. Therefore, an accurate and sophisticated analysis of costs is essential to a successful bundled payment program.

Steps to Implementing Bundled Payments

Providers interested in implementing a bundled payment program should consider the following steps.

1. **Convene the right clinical team**
A key step of implementing bundled payments is to identify the physicians and ancillary providers who are involved in delivering care for the proposed episodes and will agree to participate in a bundled payment arrangement. These should be providers that work well together and/or are familiar.

2. **Define the episode**
Next, the diagnosis-related groups (DRGs) or specific disease conditions/procedures (CPT codes) must be identified and analyzed. Physicians should focus on those particular procedures or conditions where they and their potential partners have expertise. From this analysis, care pathways are developed that target areas of cost within that episode that can be better managed, reduced or eliminated. The best structure will not just bundle all providers and reduce the costs by a certain percentage, but work to improve and coordinate the patient's care. These plans will support the development of a budget for the episode of care.

   In some episodes, such as hip replacement, duties and assigned tasks are predictable. The surgeon should have primary accountability for the patient. Physical therapy regimens can dramatically affect outcomes. In other disease conditions, however, it is more difficult to predict critical tasks. For example, a hip fracture might involve three or four facilities and prolonged treatment by numerous providers. Age and weight affect outcomes, and comorbidities are less predictable. A successful bundled payment program should only include well-defined and predictable episodes of care, with provider responsibility and involvement carefully delineated for each.

3. **Develop the quality metrics**
Quality metrics should be developed with input from the providers and use nationally accepted evidence-based treatment guidelines that are measurable for each provider/entity that participates in the bundle.

4. **Price the bundle**
Pricing the bundle requires a detailed financial analysis and review of providers' history of costs and reimbursements. Use of financial analysis/data analytics is then needed to choose a price point for the bundle reimbursement.

Evaluating catastrophic costs is a necessary component of an accurate bundled payment budget. It may be easy to analyze the average costs of a knee replacement, but few cases are average. How can one analyze outliers? Variations in length of stay and the probability of infections or serious complications are key components of that analysis. The group may wish to fund such outliers through stop-loss coverage. Also, because payments due to the participating providers under a bundled payment arrangement may involve a situation in which an intermediary receives the bundled payment directly from the payer and then, in turn, pays the physician, hospital, or other health professionals, you may find that payments may not always readily "flow downhill" from the payer to the entity rendering the service. To protect against the contingency of payment delays, all providers participating in a bundled payment arrangement should have a clear understanding of when payments will be received. Participants may wish to establish sufficient credit or acquire other financial resources to ensure practice financial viability if the bundled payment arrangement is likely to constitute a significant portion of total practice revenue.

5. Develop mechanisms to monitor and/or reduce costs

Financial management of the bundled payment requires participants to identify cost reduction opportunities through standardization or product substitutions. Groups should define the key cost metric indicators that will measure cost reduction progress for the bundled episode. Lowering infection and readmission rates, improved discharge to home care, and decreasing some of the post-acute rehabilitation with home exercise programs are all potential ways to lower costs and improve the overall quality of care, while lowering costs.

6. Plan the gainsharing incentives

Participants should plan the gainsharing incentives strategies and methodologies and develop a performance scorecard for all involved in delivering care under the bundled payment arrangement. All provider incentives need to comply with Stark, anti-kickback, and anti-trust laws.

7. Determine who administers the bundled payment

A central organization typically holds and administers bundled payments and claims. It may be an existing hospital financial department, an Independent Practice Association (IPA) or other third-party administrator. Not every physician may feel comfortable with the hospital partner receiving and apportioning the bundled payment. In communities where a good working relationship exists between the hospital and physicians, physicians may have sufficient trust in the hospital as a business partner so that allowing the hospital to receive and distribute the bundled payments is acceptable.

The administrative entity should be capable of receiving, storing, and transmitting information on pricing of cases, payments, types of providers, contracts, master codes for bundled cases, including rules, and length of stay data. The organization should carry out some or all of the following steps:

- Receiving and storing information about a bundled case episode;
- Generating a unique case ID for the bundled case episode;
- Receiving claims for services which are generated by providers, both facility and professional;
- Identifying a specific claim with procedural and diagnosis codes that triggers a specific case rate or bundle price and then automatically matching all other claims as either inclusive or to be excluded from the bundle to the case ID of the identified bundled case;
- Matching each claim associated with the bundled episode or case to determine whether it is inclusive or exclusive of the length of stay for the bundled case rate; and,
- Determining whether the case exceeds the fixed length of stay for the identified bundle.

This same organization also calculates accounts payable to providers on the case, calculates net margin per case prior to potential risk pool claims; submits the single, reprised bundled claim to a third-party payer and/or other responsible party, and automatically provides claim status to each provider on the case, including whether the bill is billed, in process, denied for more information required, or paid. Finally, they need to provide appropriate reporting to the entities that are part of the group so everyone is aware of how the group is performing.

8. Develop a continuous process improvement plan
It is important to include a process improvement plan that continually looks at ways to improve care and efficiencies.

9. Build in transparency to the bundled payment arrangement
Each entity involved in a bundled payment arrangement must have complete, accurate and transparent information, including:

- How payments will be made, e.g.to a single entity, such as a hospital, from which the physicians and providers would receive payment;
- How each episode of care or condition is defined, including, but not limited to, each item or service included in the bundle, identified by CPT, HCPCS, ASA and ICD-9-CM codes, and any applicable modifiers;
- The duration of the bundle, including the extent to which the risk window may be increased to enhance payer and patient satisfaction;

- How the basic bundled payment is calculated;
- Whether the physician will be given sufficient information to enable them to independently audit revenue for their cases;
- How responsibility for items and services will be assigned to the physician;
- How the payment will be apportioned between the participating entities;
- The percentage that the payment received by the physician represents of the entire bundled payment amount;
- The identities of each physician or provider that is involved in the bundling arrangement; and,
- The methodology's use of cost and quality benchmarks, risk adjustment and other mechanisms – the kind of considerations that are common to the other risk arrangements.

Case Studies of Bundled Episode Payments in California

Integrated Healthcare Association's (IHA) Case Study

The IHA Bundled Payment Demonstration's joint replacement bundled episodes include the pre-admit work-up, all physician and facility fees, the medical implant device, and charges for related complications and readmissions during a 90-day warranty period (global surgical period) that begins on the day of surgery. Diagnostic radiology, skilled nursing, DME, outpatient pharmacy, and rehabilitation are excluded. A health plan, hospital, ambulatory surgery center establishes a contract and a price for the bundled episode. The health plan pays the hospital for an authorized case -- and the hospital in turn pays all claims for care delivered during the episode – to surgeons, anesthesiologists, radiology, pathology, and for the implant device.

IHA's Demonstration has defined a total of six episodes of care, primarily in the areas of orthopedics and cardiology, with the support of two committees. Their Technical Committee, comprised of physicians and other clinicians, developed the clinical elements of the episode, and Optum (formerly Ingenix) incorporated billing, procedure and diagnostic codes using its national claims data base. The Steering Committee, made up of contract and operational administrators from physician groups, hospitals and health plans, verified that the definition could be operationalized, and ultimately approved the definitions.

Hoag Orthopedic Institute Case Study

70 bed inpatient hospital with two Ambulatory Surgery Centers

An early leader in implementation of this payment methodology, Hoag Orthopedic Institute (HOI) in Newport Beach, CA, developed the infrastructure to accept bundled payments with the 2008 roll-out of its Medical Travel Program (MTP). Through this program, Hoag draws

patients from self-insured employers beyond their traditional service area, including outside of California. The MTP also establishes a fixed rate, but with an employer, for an employee's specific procedure - such as a total hip replacement. The rate includes professional and facility fees, implants, surgical support, and 3-5 days of physical therapy at a local hotel, where the patient recovers and prepares for travel. The MTP bundle also excludes diagnostic radiology. Claims for bundled services are paid by a separate holding company, established to receive and distribute MTP funds according to the terms of the bundled payment contracts.

The Hoag's MTP's early roots grew from the physician side of the delivery system – providing the momentum for securing the hospital's endorsement of the program. The front-end work to implement this bundled payment model involved the negotiation of professional, facility, and new medical implant device contracts. In lieu of a fully automated software solution, bundled claims are processed manually, and additional operational modifications were necessary to manage bundled cases. For example, a MTP patient face sheet includes "Ortho Cal" as the payer designation – an alert for the billing office not to send bills to the patient or the payer. An operational team manages the revenue cycle, to trouble-shoot issues, and generate awareness of and compliance with the unique aspects of the MTP.

A key tool that guides the bundled procedure is the "Episode Definition" or which specific procedures are bundled. Within this definition, procedure details—including related readmissions during a postoperative period—are described using billing, procedure and diagnostic codes. It is important to include eligibility requirements of a patient in the definition of a procedure since such factors may drastically alter the outcome of a surgical procedure. Eligibility requirements include patient age, and excluded clinical conditions, such as end stage renal disease, are also outlined in the definition.

Other clinical and administrative adjustments are needed to execute bundled episode contracts, manage authorizations, and conduct claims payment/reconciliation. Orthopedic surgeons must develop or redesign evidence-based care pathways that improve outcomes and lower costs – ultimately creating value within a pre-established budget. A patient navigator program may need to be developed or enhanced to support a positive experience for the patient, and to identify possible complications and avoid treatment or readmissions outside of the bundled network. This is made possible with the navigator's early and ongoing communication with the patient, family and caregivers.

How do I Implement Bundled Payments?

Before deciding whether or not you and/or your hospital should pursue bundled payment contracts, you must first determine whether or not a bundling arrangement would be beneficial to you and your group.

Think about these questions the AMA Practice Management Center poses for those considering bundled payments:

1. Are you affiliated with an organization that has sufficient infrastructure to administer successfully a bundled payment arrangement or try to build one from scratch?

   In some cases, physicians may benefit from partnering with an institution or larger physician organization that has requisite administrative expertise, as physicians may find it challenging to create that expertise from scratch. When looking for a partner, however, a physician should ensure that the partner and physician have common goals and that the partner has recognized physician leadership and administrative expertise.

2. To what clinical conditions or procedures should bundled payments be applied?

3. Are you already a community leader in a particular procedure or disease state?

4. Do you have sufficient historical clinical and financial data to assess the risk?

5. Which providers and services should be included or excluded in the arrangement?

6. How can provider accountability be measured and ensured?

7. What should be the timeframe of a bundled payment?

8. What administrative capabilities are needed to administer a bundled payment? Do you have a staff and infrastructure capable of administering the program, or do you have to build it from the ground up?

9. What financial and cash flow backing is available?

Payments do not always readily flow downhill. If the arrangement is a significant portion of your business, do you have enough credit and other resources to ensure success?

10. How should payments be set and allocated among participants?

Once the overall rate is determined, transparency and equity among participants is key. Achievable financial incentives built into the arrangement will help foster a cooperative work ethic.

If you have thoughtfully reviewed the above questions and decided bundled payments would be beneficial, consider the suggestions below on how to successfully implement a bundled payments program:

1. Propose a bundled arrangement to your payors/hospital/other members in your group. Be prepared to show data on where the cost savings could be through cooperation and coordination of care with the various specialties. You must also decide which procedures you want to bundle and what services are included/excluded in the bundle.

2. Decide administrative structure of the program
   Will the hospital be paid first and then disseminate the payment to the various subspecialties? Or will the physician be paid for their services directly and later pay the hospital their facility fee?

Benefits and Risks

Like any other program, bundled payments have both risks and benefits. Remember to take in account both sides before making a decision on bundled payments in your practice.

Benefits

- Consistent amount of reimbursement for a specific procedure.
- No need to justify clinical choices of treatment for payors “second guessing” decisions.
- Shared risk split between physician and payors
- Middle ground between the physician incurring all the risk of a procedure with capitation payments (i.e. a patient costs more than reimbursed) and a payor incurring all the risk by overpaying a physician more than a procedure costs.

Risks

- Physician will incur full responsibility for a procedure for a flat fee. Not all procedures are “cookie cutter” and some may require additional treatment/rehabilitative, diagnostic testing, etc. then originally budgeted.
- There may be incentive for a physician to “cut corners” on a patient’s treatment in order to pocket additional reimbursement.
- Payment to physicians may be slower than usual due to payment initially going to an administrative center before flowing out. In other words, the more hands the payment touches, the slower the payment will travel.

Conclusion

Physicians are well-positioned to play an important role as leaders in driving payment reform efforts, otherwise, hospitals are more in control to implement (or not implement) a bundled episode payment model in their community. Capturing a hospital’s interest in this emerging model requires the knowledge of how the concept works, coupled with ‘a pitch’ that the model cultivates efficiencies, alignment of physicians and hospitals, and accountability by all providers for the entire episode of care all of which contribute to the delivery of the best care and outcomes, in a highly cost-effective manner. Clearly, bundled payments are an attractive proposition for hospitals, patients, employers and payors, and one that can drive increased volume.

No doubt, the initial implementation of bundled payment is a challenging process. It involves the desire and energy to design, implement and adapt to change. It requires the courage to participate in a fresh dialogue between providers, clinicians and hospital administrators -- parties that operate in different worlds, and frequently struggle to understand one another.

Physicians must lead the charge in developing closer working relationships with their hospital(s) and other physician colleagues that are part of the treatment team for bundled payment cases. Ultimately, the challenge is to identify, or develop physician champions, build a culture that embraces innovation, inspires clinicians and administrators, improves quality outcomes, and provides an early opportunity for physicians to shape these payment reforms, and influence payors – ahead of impending payment reforms.

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