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Are You Ready for Bundled Payments?

By John Maher

Bundled payments have increasingly become a reimbursement option that hospitals should consider to reduce the cost of care through better care coordination by providers. Hospitals and other providers must weigh the pros and cons to decide whether and how to participate in this and other alternative payment models.

Are You Ready?

Whether bundled payments are right for an organization or not, it is strategically important to prepare now for this dramatic shift in how hospitals will be reimbursed. Centers for Medicare and Medicaid Services (CMS) and other major payers are continuing the migration to global payments. The shift is toward shared risk among patients, providers and insurers. The transition from fee-for-service reimbursement models has led to the growth of bundled payments around the nation. Targeted for rapid growth, on Feb. 2, 2015 the Secretary of Health and Human Services (HHS) announced a goal of linking 30 percent of Medicare payments to quality and value through alternative payment models by 2016 and 50 percent by 2018.

Medicare is actively conducting a voluntary pilot program and recently began to add new entrants to its bundled payment initiative. In fact, more than 2,000 providers applied to participate in the program and roughly 4,100 additional providers are exploring the possibility of using bundled payments. While data suggests another year is needed to measure the long-term value, early signs indicate that bundled payments are working.

Commercial payers are also moving toward this alternative payment model to pay for episodes of care. Payers, employers and State and Federal government policymakers view bundled payments as a way to control healthcare spending through increased provider competition and care coordination across providers. If hospitals do not prepare, they may risk exclusion from payer networks and decreased market share.

Even further evidence of policy makers' eagerness to expand bundled payments is demonstrated with proposed legislation to implement bundled payments in certain post-acute care services provided within 30 days of patient discharge. In addition, CMS's Center for Medicare and Medicaid Innovation (CMMI) is seeking input to develop a bundled payment model for outpatient speciality procedures. Currently, outpatient surgeries and procedures are typically exempt from the programs.

Finally, many hospitals have, or may soon have, acquired a physician enterprise. Some hospitals also own and operate sub-acute care providers, rehabilitation centers, skilled nursing facilities, inpatient rehabilitation units and home health agencies. A system with physicians and providers involved in an episode of care as well as acute care services, provides an operational opportunity to enter into bundled payment type contracts. A recent Sg2 report indicated that only 55.7 percent of costs for an episode of care occurs during the acute care phase of treatment. The first 30 days of post-acute discharge care generated average revenue equal to 76.6 percent of the acute care-generated charges. In this study, over $7,300 was expended on outpatient care per discharged patient. To retain revenue for all providers, hospitals should direct care coordination for the discharged patient.

What is a Bundled Payment?

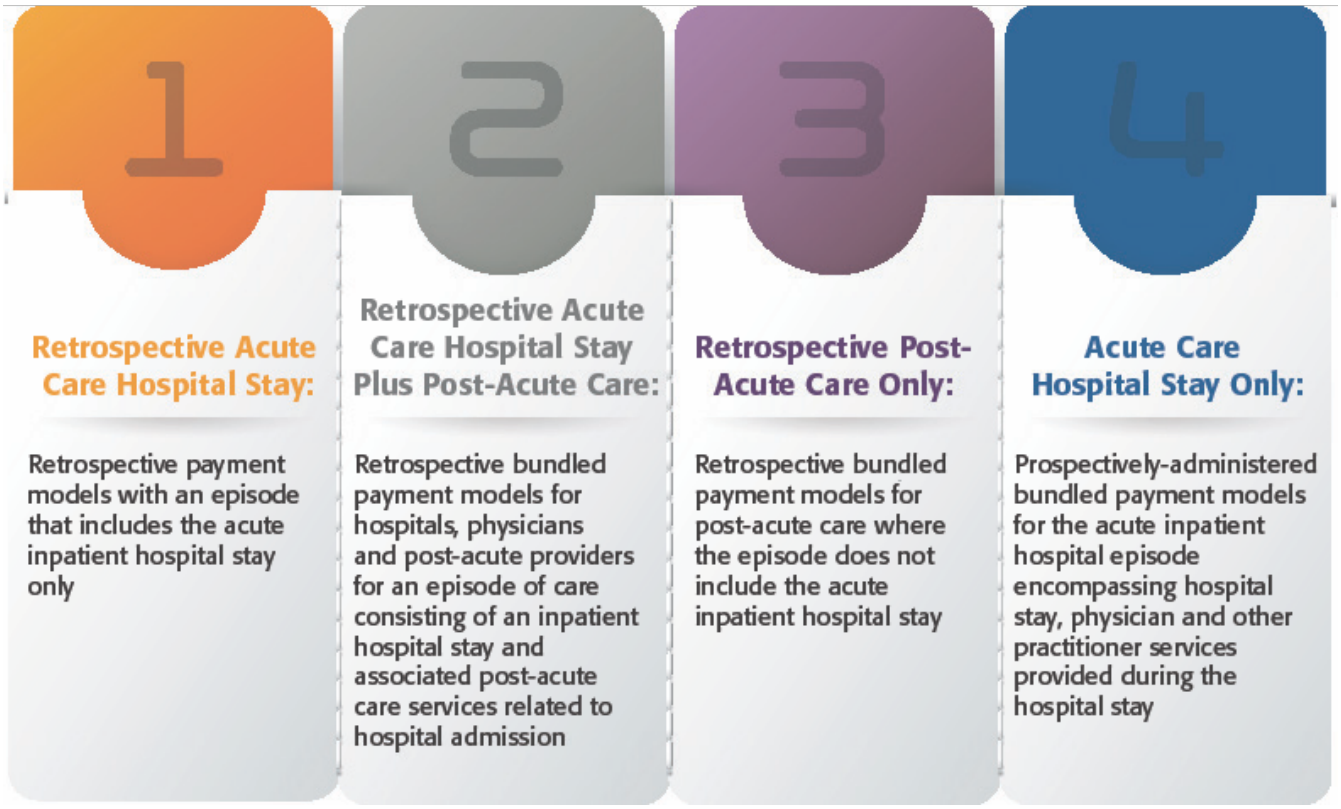
The general design of bundled payments inherently leads to decreased reimbursements compared to the fee-for-service reimbursement system. Congress' goal is to use bundled payments to control healthcare spending. Under this type of reimbursement system, organizations enter arrangements with payers and other providers to offer patients the ability to make a single payment for an entire episode of care. Typically, quality indicators also impact the bundled payment reimbursement.

An episode of care is an exclusive event with a distinct endpoint. For instance, fee-for-service Medicare reimbursement system pays each provider separately (hospital/physician/ physical therapy/home health) for a total knee replacement. In a bundled payment reimbursement system, the hospital, physician, physical therapist and home health agency make a contractual agreement to determine

> In a nutshell, patients or insurers are charged one overall price for everything involved in one episode of care. Similarly, hospitals and participating providers receive one payment for the entire episode of care.

the price and time period to cover the services in this single episode of care. The time period for one episode of care is typically 30 to 90 days. In this scenario, the hospital receives a single payment for the total knee repla cement and then distributes the agreed upon amounts to each provider.

Medicare Use of Bundled Payments



The voluntary Bundled Payments for Care Improvement (BPCI) initiative was announced by CMS on Aug. 23, 2011 as a result of the Affordable Care Act (ACA). To participate in a BPCI initiative, hospitals must submit a detailed application (by one of CMS' filing deadlines). Organizations can choose to participate in one of four bundled payment models (below). Please see Appendix 1 for more information.

Bundled Payment for Uninsured Patients

Quorum client Wooster Community Hospital (Wooster, OH) offers up-front bundled prices for many services to its self- pay patients. The hospital's most popular bundled services include: vaginal delivery (including one ultrasound, prenatal care, 48-hour inpatient stay and six weeks of postpartum care); bilateral ear tubes; and MRI diagnostics. Each service is priced to include all hospital, physician and ancillary fees. Scott Boyes, CFO of Wooster Community Hospital explains how the bundled pricing offers peace of mind to its patients: "Regardless of the exact discount, the customer usually perceives it as a better value because this eliminates the unknown. When they walk out after their services are rendered, they are finished and they are not going to get a bill."

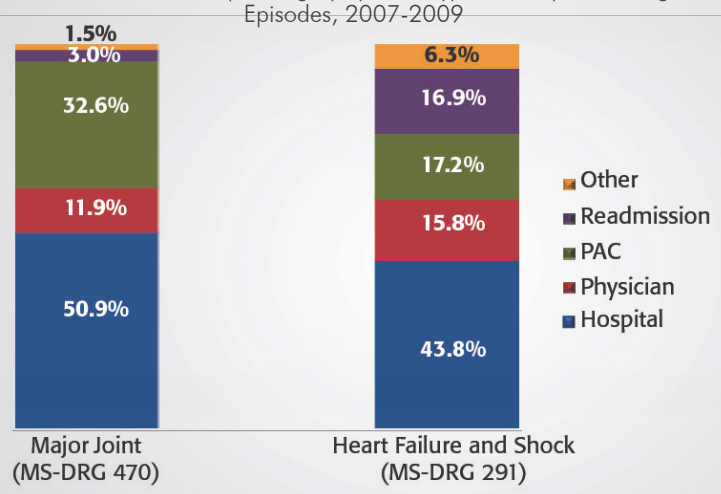
To determine pricing, Boyes checks what Medicare pays the hospital and physicians for a given service or procedure. "We set our first price at the lowest margin that will cover our costs," Boyes says.

Private Insurance Payers and Provider Partnerships

Today, payers and providers are utilizing bundled payments to align incentives. Payers can control expenditures to providers and in turn, providers can control market share and improve revenue streams. Modern Healthcare recently covered a bundled payment collaboration between five oncology groups and the insurer UnitedHealthcare. In a pilot launched in Oct. 2009, the collaboration explored an alternative to the fee-for-service-method, tying financial incentives to billing for chemotherapy drugs. By Dec. 2012, the use of the episode payment model for treatment of breast, lung and colon cancers in 810 patients led to a net savings of more than $33 million, when compared to anticipated costs, according to the study published in the Journal of Oncology Practice. This dramatic change demonstrates how the net savings can be turned into lower premiums for the employees served by the insurer.

Understanding the distribution of costs will help identify savings opportunities.

Chart 1: Percent of Spending by Episode Type, 30-day Fixed-length Episodes, 2007-2009



Source: Dobson | DaVanzo (2012). Medicare Payment Bundling: Insights from Claims Data and Policy Implications.

Lowering Costs of Bundled Payments

Utilizing a bundled payment model is a strategic decision that should be based upon the needs of the hospital and its community. If a bundled episode of care is delivered for less than the stated price, the provider and payer share the savings. Bundled payments also require improved hospital/ physician alignment to coordinate care at a lower cost. However, bundled payments may not be the right choice for some hospitals at this time, if they are not able to effectively coordinate care across multiple providers.

It is critical for hospitals to carefully determine options for pricing bundled payments. The American Hospital Association (AHA) chart to the right shows the difference between a major joint procedure, for which 32.6 percent of the cost is for post-acute care (PAC), while only 17.2 percent of the cost for a heart failure and shock episode is for PAC.

Early findings have identified a significant difference in the share of patients enrolled in both Medicare and Medicaid. Among providers participating in the bundled payment initiative, 14 percent of their patients were dual eligible, compared with 25 percent for non-participants. In addition, the average length of stay (LOS) for the hospitalization in surgical orthopedic in BPCI providers declined from 4.6 days to 4.4 days in the year immediately before BPCI. Significantly, the study also found initial evidence that participating providers might be able to reduce costs for the Medicare program. For example, providers participating in the bundled payments program were less likely to refer patients to skilled nursing facilities and more likely to rely on home health agencies, which is a lower cost and reimbursement setting.

Assessing Readiness

The questions below can help assess whether an organization is ready to offer bundled payments. Asking these questions can prepare for other care coordination initiatives beyond bundled payments, including medical homes, readmission reduction programs and accountable care organizations (ACOs).

Similar to bundled payments, ACOs are also showing early signs of success. According to CMS' Office of the Actuary Study (OACT), there are also early signs that pioneer ACOs may lead to cost savings and enhanced quality. ACOs generated more than $384 million in savings for Medicare over the first two program years (2012 and 2013), compared to expenditures that would have occurred in their absence. In terms of quality, pioneer ACOs collectively had "statistically significant reductions in acute hospital admissions for COPD, older adult asthma, or heart failure in 2013" and significantly increased rates of post-discharge physician follow-up in the week immediately following an inpatient discharge in 2012 and 2013."

To succeed under the bundled payment reimbursement scheme and other care coordination initiatives, hospitals must focus on improving cost structure, patient care delivery models and increasing market share. The ultimate goal of a bundled payment is to enhance quality, reduce costs across all provider settings and improve market share.

Generally, hospitals need to identify:

- All associated costs surrounding bundled payment contracting with private payers, uninsured patients and within the Medicare program;
- Which services will be provided under bundled payments;
- The costs of services under the bundle (including applicable physician services and post-acute care);
- Reimbursement amounts for the bundled services; and
- How reimbursement and savings will be shared between providers.

Detailed Questions To Ask About Bundled Payments

Governance and Strategy

- What are the strategic and financial benefits to the organization?
- Do we have relationships with physicians and pre- and post-acute providers to bundle our services and coordinate patient care and delivery?
- What does our hospital have to do to become a desirable partner with others to provide services under a bundled payment?
- How will bundled payments affect our strategy – have we covered this potential option in our strategic plan?
- How will we decide if bundled payments make sense to our organization?
- Do we think bundled payments will improve market share?
- Do we have the ability to adjust our current operational infrastructure and information system capabilities, including a robust Electronic Medical Record system?
    - Changes to billing structure?
    - Payment distribution mechanisms?
    - Tracking and monitoring patients in bundled payment DRGs?
- Which episodes of care will we bundle and what is the physician's role in those episodes?
- Are our physicians willing to collaborate to help meet our quality goals and coordinate care with

other providers in the community?
- Who will collect and distribute the funds in the bundled payment? What agreements have to be in place to effectively manage this process?
- Will we ultimately improve financial performance or not?
- Have we compiled robust financial pro forma projections?

C-Suite

- What could be the financial and operational impact of bundled payments on our hospital?
- Are our commercial payers implementing bundled payment models in our market or in other markets?
- What are our competitive advantages and opportunities to increase market share through offering bundled payments?
- Who are our partners up and down the continuum of care who provide all components of a single episode of care?
- What are the legal issues for the hospital to develop relationships with components of continuous care to participate in a bundled payment?
- What will happen if we are left out or choose not to participate in bundled payments?
- What are our opportunities for clinical integration and improving care coordination throughout the community?
- What impact will bundled payments have on our service lines?
- Have we established organizational goals and reporting mechanisms for payer affiliations?
- Have we analyzed our data to determine cost of care by service line and revenue stream?
- Should we pursue agreements with commercial payers and enter into the Medicare pilot program?
- Have we benchmarked our performance on key indicators (e.g., potentially avoidable admissions, length of stay, cost per case and 30-day readmissions) for the episodes of care being considered for bundling, and viewed our data at the DRG or physician level?
- Is there a strong market demand for specific episodes of care that might yield volumes? Which episodes of care will we bundle?
- Have we reviewed fragmentation patterns at the zip code level to understand the number of competitors and their relative share of the disease market?
- Who are the high-volume providers that treat the disease in the outpatient arena?
- Have we conducted preliminary market research by tracing the geographic submarkets that are primary sources for patients with diseases being considered for bundled payment?

Finance and Revenue Cycle

- How will bundled payments impact electronic health record (EHR), case management, computerized provider entry (CPOE) and clinical documentation?
- What are the potential shared savings or cost reduction opportunities?
- How well will our revenue cycle management team systems support bundled payments, distribution allocations and performance monitoring?
- Is case management and utilization oversight and review functions prepared to work across multiple providers and physicians during an episode of care?
- Are systems in place to monitor and evaluate the care provided within and outside of the hospital's four walls?

Physicians

- How will physicians be impacted by bundled payments?
- What is the physician's role in bundled payments?
- How can we achieve physician buy-in to bundled payments?
- Are physicians willing to agree on standard protocols for each treatment?
- Are physicians committed to the same quality goals as the hospital and payer?
- How will bundled payments impact electronic health record (EHR), case management, computerized provider entry (CPOE) and clinical documentation?
- Who will decide how much of the bundled payment will go to the physician and how physicians will be paid?

Bundled Payment Contracts

Once these questions are answered, crafting a bundled payment contract is the next step. Hospitals should consider entering into the Medicare BPCI program or should work with major payers within their markets. Some key elements that can impact the profitability of a bundled payment program include: implementation costs, pricing of services, increased market share and reduced supply costs.

Summary of CMS Bundled Payment Models — Appendix 1

	Model 1: Retrospective Acute Care Hospital Stay Only	Model 2: Retrospective Acute Care Hospital Stay plus Post-Acute Care	Model 3: Retrospective Post-Acute Care Only	Model 4: Acute Care Hospital Stay Only
Entities eligible to be awardees:	• Physician group practices • Acute care hospitals • Health systems • Physician hospital organizations • Conveners of participating healthcare providers	• Acute care hospital • Health systems • Post-acute providers • Physician hospital organizations • Physician group practices • Conveners of participating health care providers	• Physician group practices • Acute care hospitals • Health systems • Long-term care hospitals (LTCH) • Inpatient rehabilitation facilities (IRF) • Skilled nursing facility (SNF) • Home health agency (HHA) • Physician hospital organizations • Conveners of participating health care providers	• Acute care hospitals • Health systems • Physician group practices • Physician hospital organizations • Conveners of participating health care providers
Episode definition				
Criteria for beneficiary inclusion in episode:	• Admission to an acute care hospital for a claim paid under the IPPS under any MS-DRG	• Organized around reason for hospitalization (MS-DRG). • Exact identification criteria to be proposed.	• Organized around reason for hospitalization (MS-DRG). • Exact criteria to be proposed.	• Organized around reason for hospitalization (MS-DRG). • Exact criteria to be proposed.
Episode anchor:	• Acute care hospital admission at awardee or Bundled Payment participating organization for any MS-DRG	• Acute care hospital admission at awardee or Bundled Payment participating organization for included clinical conditions (identified via MS-DRG).	• Initiation of SNF, IRF, HHA, or LTCH services with awardee or Bundled Payment participating organization within 30 days following discharge from an acute care inpatient hospital for an included MS-DRG.	• Acute care hospital admission at awardee or Bundled Payment participating organization for included clinical conditions.
End of episode:	• Acute care hospital discharge	• Option 1: Minimum 30 days post-hospital discharge; maximum of 89 days post-hospital discharge. • Option 2: Minimum 90 days post-hospital discharge.	• Minimum 30 days following the episode anchor. • Exact duration to be proprosed.	• Acute care hospital discharge.
Types of services included in bundle:	• Part A inpatient hospital services.	• Physicians' services • Inpatient hospital services (episode anchor) • Inpatient hospital readmission services • Long-term care hospital services (LTCH) • Inpatient rehabilitation facility services (IRF) • Skilled nursing facility services (SNF) • Home health agency services (HHA) • Hospital outpatient services • Independent outpatient therapy services • Clinical laboratory services • Durable medical equipment • Part B drugs	• Physicians' services • Inpatient hospital readmission services • Long-term care hospital services (LTCH) • Inpatient rehabilitation facility services (IRF) • Skilled nursing facility services (SNF) • Home health agency services (HHA) • Hospital outpatient services • Independent outpatient therapy services • Clinical laboratory services • Durable medical equipment • Part B drugs	• Physicians' services • Inpatient hospital services (episode anchor) • Inpatient hospital readmission services

Summary of CMS Bundled Payment Models

(Continued from Page 7)

	Model 1: Retrospective Acute Care Hospital Stay Only	Model 2: Retrospective Acute Care Hospital Stay plus Post-Acute Care	Model 3: Retrospective Post-Acute Care Only	Model 4: Acute Care Hospital Stay Only
Payment fro CMS to providers:	• Acute care hospital: Traditional FFS with a predetermined discount included in prospective payment • Physician: Traditional FFS	• Traditional FFS (ultimate reconciliation with predetermined target price).	• Traditional FFS (ultimate reconciliation with predetermined target price).	• Acute Care Hospital: Prospectively-established bundled payment for identified MS-DRGs • Physicians: Paid by acute care inpatient hospital. Claims for included services are submitted to Medicare as "no-pay."
Expected discount provided to Medicare:	• Year 1: Minimum 0% for start date through month 6; minimum 0.5% for months 7-12 on all Part A allowed charges • Year 2: Minimum 1% on all Part A allowed charges • Year 3: Minimum 2% on all Part A allowed charges • Exact amount to be proposed.	• Option 1: Minimum 3% discount on included Part A and Part B allowed charges for episodes that include a post-hospital discharge period of 30 days to 89 days • Option 2: Minimum 2% discount on included Part A and Part B allowed charges for episodes that include a post-hospital discharge period of 90 days or longer • Exact discount rate to be proposed under either option	• To be proposed	• The prospectively-established bundled payment will incorporate a minimum 3% discount on included Part A and Part B allowed charges; more for ACE MS-DRGs • To be proposed
Reconciliation, spending calculation, disbursement and post-episode monitoring:	• Episode reconciliation: A discount on Part A payments will be incorporated prospectively. Medicare spending for the inpatient hospital stay will not be reconciled against a set target price.	• Episode reconciliation: If aggregate FFS payments for included services during the episode are less than the predetermined target price, Medicare will pay the difference to awardee. If aggregate FFS payments for included services during the episode exceed the predetermined target price, awardee must repay Medicare.	• Episode reconciliation: If aggregate FFS payments for included services during the episode are less than the predetermined target price, Medicare will pay the difference to awardee. If aggregate FFS payments for included services during the episode exceed the predetermined target price, awardee must repay Medicare.	• Episode reconciliation: The Bundled Payment participating acute care hospital where the beneficiary is treated will be paid a single prospectively established bundled payment for the episode, including related readmissions. Professional services furnished during the episode and covered under Part B would be billed to Medicare as "no-pay" claims and paid for through the bundled payment made to the hospital. If any Part B claims for professional services
Reconciliation, spending calculation, disbursement and post-episode monitoring: (Continued)	• Episode monitoring: Medicare Part A and Part B payment for the inpatient hospital stay that exceeds trended historical aggregate Part A and Part B payment beyond a risk threshold (taking the discount into consideration) must be paid by the awardee to Medicare. • Post-episode monitoring: Medicare Part A and Part B payment during the post-episode monitoring period that exceeds trended historical aggregate Part A and Part B payment beyond a risk threshold must be paid by the awardee to Medicare.	• Post-episode monitoring: Medicare Part A and Part B payment for included beneficiaries during the post-episode monitoring period that exceeds trended historical aggregate Part A and Part B payment beyond a risk threshold will be paid by the awardee to Medicare.	• Post-episode monitoring: Medicare Part A and Part B payment for included beneficiaries during the post-episode monitoring period that exceeds trended historical aggregate Part A and Part B payment beyond a risk threshold will be paid by the awardee to Medicare.	furnished during the episode, any claims for Part A for a related readmission, or any claims for related Part B professional services furnished during any readmission (related or unrelated) are submitted and paid separately by Medicare, the awardee must repay Medicare for those expenditures. • Post-episode monitoring: Medicare Part A and Part B payment for included beneficiaries during the post-episode monitoring period that exceeds trended historical aggregate Part A and Part B payment beyond a risk threshold (taking the prospectively established bundled payment with the discount into consideration) will be paid by the awardee to Medicare.
Post-episode monitoring period:	• 30 days post-hospital discharge	• 30 days following the end of the episode	• 30 days following the end of the episode	• 30 days post-hospital discharge
Gainsharing; other payment arrangements between participating providers (i.e., non-hospital care settings):	• Consult with Legal Counsel • CMA allows in certain circumstances	• Consult with Legal Counsel • CMA allows	• Consult with Legal Counsel • CMA allows	• Consult with Legal Counsel • CMA allows

Source: CMS, Quorum Health Resources

Resources:

- *CMS:* Request for Information on Speciality Practitioner Payment Model Opportunities, February 2014
- *CMS:* Bundled payments for care improvement initiative: general information, http://innovation.cms.gov/initiatives/bundled-payments/
- *HHS.gov:* Affordable Care Act payment model saves more than $384 million in two years, meets criteria for first-ever expansion, May 4, 2015
- *HFMA:* Creating package prices for self-pay patients: Lola Butcher, June 5, 2014
- *Forbes:* Though Obamacare pays less, providers flock to 'bundled' Medicare payments, February 1, 2013
- *Sg2:* Bridging the infrastructure gap for bundled payment initiatives: Bradley Helfand, April 9, 2014
- *HFMA:* At the forefront of payment reform: Lola Butcher, June 6, 2013
- *Quorum Health Resources:* CMS Bundled Payments, John Waltko, 2011
- *HealthLeaders Media:* Transitioning to Bundled Payments: Rene Letourneau, June 2014
- *The Wall Street Journal:* Hospitals push bundled care as the billing plan of the future: Melinda Beck, June 8, 2014
- *The Advisory Board:* Considering a Bundled Payment Contract? 2013
- *Modern Healthcare:* Early bundled payment projects test positive: Jessica Zigmond, Feb. 1, 2014
- *American Hospital Association:* Moving towards bundled payment, 2013
- *Modern Healthcare:* Reform update: CMS to expand bundled-payment initiative, June 30, 2014
- *Modern Healthcare:* New payment model saved oncology groups $3.3 million, study finds, July 8, 2014

About the Author

As President of Quorum Health Resources' Intensive Resources, John Maher is focused on enabling systems to develop networks as they prepare to transition to value based care. Maher has more than 20 years of experience in healthcare management, consulting and leadership. His experience includes strategic planning, client engagement management, business plan development and execution, market research and analysis, revenue and market expansion and financial management and improvement. Prior to joining Quorum, Maher held a variety of roles in The Advisory Board Company and Premier, Inc.

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For more information on QHR's Consulting Services for Bundled Payments, contact Rick Drake at (615) 371-4914 or Rick_Drake@qhr.com.