

Integrating bundle payments for long-term reimbursement strategy success

The concept of receiving a lump sum payment for a single episode of care — rather than multiple payments submitted and paid throughout the episode — is decades old. Bundle payments have risen and fallen in popularity over the past 30 years. Most recently, bundles gained prominence in 2010 with the passage of the Affordable Care Act. As a result, the Centers for Medicare and Medicaid Services (CMS) Bundled Payments for Care Improvement (BPCI) initiative began in 2013.

More flexible reimbursement programs are becoming an important tool to manage costs and improve quality as organizations move from fee-for-service to fee-for-value. Regardless of how regulatory bundles change, bundle arrangements between all types of payers and providers are here to stay.

The impact of CMS and other regulations

Regulatory bundles continue to evolve. Rather than requiring hospitals and health systems to engage in bundle programs such as the Comprehensive Care for Joint Replacement (CJR) program, CMS is using new bundle model designs to entice organizations to join. Participants in the new BPCI Advanced model will qualify for Advanced Alternative Payment Model (APM) participation in Medicare's Quality Payment Program (QPP). CMS also scaled back the CJR program, canceled two other episode payment programs and generally signaled its intention to make bundles voluntary rather than mandatory.

Involvement was limited to hospitals in previous iterations of BPCI, but physicians and ambulatory surgery centers can now take a more prominent role with BPCI Advanced. Additionally, participation in the BPCI Advanced program provides a credit toward MACRA's APM program. While scaling back CJR-led CMS to anticipate a savings decrease of more than \$100 million, broadening the scope of BPCI could significantly increase participation.

As CMS places increased emphasis on bundle payments, employers and employer groups continue to be the catalysts for providers and payers to expand their bundle strategies. They know they have the purchasing power and volume to support specific bundles. They see bundle adoption as a smart business decision because it can result in healthier, happier, more productive employees. Rather than approaching providers and payers with a simple edict — raise your quality and lower my costs — they tell them to use bundles to lower readmission rates, decrease the length of stay and reduce complications, knowing that those improvements will result in lower costs. Providers continue to leverage their areas of expertise to find new ways to align with the evolving needs of health care purchasers. Bundles require well-defined care pathways with a heavy emphasis on best practices and clinical efficiencies. Successful organizations will align their bundle strategies with their particular strengths and overall objectives.



“We’ve often talked about a tipping point in the movement from fee-for-service to alternative payment models, and I believe **today is the day.**”

Dr. Susan Nedza,
*former CMO at CMS*¹

¹What to know about Medicare's big bundled-payment expansion", Modern Healthcare, July 25, 2016.

Expand bundles to be a broader part of your of reimbursement models

Bundles are a versatile, indispensable reimbursement method. They have a place in any provider's reimbursement strategy, whether that strategy is focused on fee-for-service, fee-for-value or somewhere in between.

If an organization's plan is to move toward advanced alternative payment models, bundles should be an integral part of the plan. Bundles help organizations think about episodes more broadly. They promote clinical engagement by incentivizing them to more closely align to best practice protocols.

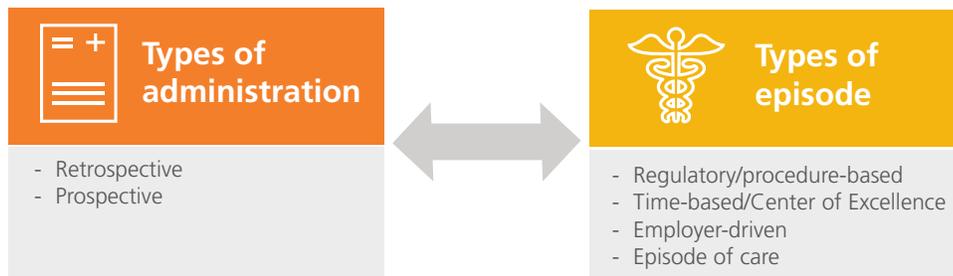
But bundle payment programs differ from typical value-based models in key ways. Value-based contracts reward providers for meeting specific quality, utilization or cost metrics. Bundles, on the other hand, pay a set amount for defined elements and procedures. They help guide and encourage performing care a specific way so that it helps improve quality, utilization and costs, which is valuable in any reimbursement arrangement.

Bundles can be thought of as levers to help organizations meet their strategic goals. Whether the goal is to be a Center of Excellence, to customize programs for targeted employers or to better manage specific diseases states, bundle payments help reinforce the care pathways that lead to success.

Common bundled payment models and the impact on quality and cost of care

Organizations that have participated in successful regulatory bundles are prepared to pursue bundle contracts that align with their strengths and long-term goals. One organization may align to regulatory bundles and take the fullest advantage of Medicare and Medicaid programs. Another organization may focus on a Center of Excellence or destination medicine strategy to align to targeted volumes and/or cost targets. Another organization may need to build a bundle program that positions itself relative to a specific employer group or an emerging market need.

Bundle payment arrangements can be grouped into these general categories:



Retrospective bundles are the most common form of bundle payment arrangement; the BPCI model is an example of a retrospective bundle program. In a retrospective bundle, organizations are paid on a fee-for-service basis. Once an episode ends, a reconciliation process based on a predetermined payment threshold begins. If claims are under that threshold, the provider earns a percentage of the savings and the payer keeps the rest. If claims go over that threshold, the provider pays a percentage of the overrun.

Reconciliation is where things get complicated. The reconciliation process typically does not start until at least six months after the beginning of an episode. Most reconciliation processes allow for discussion and some disagreement between provider and payer. Resolving those disagreements can take significant time. Most retrospective bundle agreements don't reach reconciliation until 8–12 months after the initial episode.

Prospective bundles are growing in popularity, but they are less common than retrospective bundles. In a prospective bundle, claims are still submitted as services are provided, but they are not paid for every service. Payment happens in a lump sum after a sentinel event occurs, such as a surgery. Services such as pre- and post-operative consults, lab work, radiology and rehabilitation are not paid by the payer. It is up to the paid provider to distribute the payments to the various clinicians and facilities that are part of the episode.

Providers are interested in prospective bundles because they can receive payments earlier. In retrospective arrangements, they may need to give back some of their fee-for-service revenue months after the service is provided. In many cases, providers in prospective bundles receive the total amount before the full episode is complete. By participating in a prospective bundle, providers have also noticed that they can focus more on providing the best care rather than providing care based on a payer's assessment of medical necessity.

The following bundle episode types can be either retrospective or prospective:

Procedure-based bundles are based on major surgical events. BPCI bundles can all be considered procedure-based. They are an effective way of controlling readmissions and other events that can result in a breakdown of post-acute care. The BPCI models that CMS has rolled out have also proven that procedure-based bundles are a great way to control spend for some expensive episodes.

Time-based/Center of Excellence (COE) bundles align well with destination medicine, where an organization is known for their excellence, efficiency and patient satisfaction and thus attract patients from across a region. Time-based bundles are procedure-based, but do not cover a full episode. Rather, they cover a shorter period, typically when the patient is under the direct care of the COE provider.

Employer-driven bundles are procedure-based arrangements that are driven by the volume that an employer can provide. The employer works closely with the provider to develop the bundle because the employer's analysis shows their employees and their bottom line will benefit.

Episode of care bundles are a form of capitation for a disease state/chronic condition. For example, most providers know they are going to see their diabetes or cancer patients a certain amount of times a year. Episode of care bundles include those expected visits, associated lab work and sometimes radiology. Episode of care bundles also define the negative financial consequences for a defined set of negative outcomes. These bundles help providers and payers come to agreement on the right treatment for specific conditions.

How to succeed with bundles

Bundles are increasingly an essential part of a reimbursement portfolio. When provider organizations leverage their unique areas of expertise, bundles can be positioned as a key differentiator in the market place, with an emphasis on lower costs and better outcomes.

Bundle arrangements do not work if there are winners and losers; payers, providers and patients all need to benefit. Implementing a program that considers the impact that bundle elements can collectively have on providers, payers and patients leads to success.

There are five key elements to setting up and operationalizing a bundled payment program:



1. Get strategic. Upfront analytics and modeling will help provider organizations determine which type of bundle program will work best for their organization before they develop contracts.



2. Centered around clinicians. Organizations need strong clinicians that will practice with the bundle definition in mind. Including a clinical champion in bundle definition, along with governance and workflow personnel, will help clinicians get on board.



3. Invest in administrative technology. Because bundles are a new administrative model, not having the right tools can lead to errors, slow turnaround times and workflow inconsistency. Having solutions to help manage the financial and operational elements of bundles helps reduce errors and increase consistency. Technology that allows for clinical and financial analysis can also help organizations find the right models for bundle success.



4. Tune and evolve bundle programs. Organizations should not allow the pursuit of absolute perfection to get in the way of implementing a bundle program. Even if they do not have all the capabilities they believe they need, there is value in deploying a program. Developing a perfectly tuned bundle program is an iterative process that takes time. Bundle programs get better with experience.



5. Consistently monitor and measure. One of the biggest complaints providers have about bundles is not knowing how they are performing against bundle definitions throughout the bundle period. Issuing ongoing bundle dashboards and/or scorecards can help clinicians know if they need to course correct and iteratively refine and improve their performance.

Navigate bundle payment complexities with the right experts

An experienced partner can help organizations get their bundle programs up and running. A variety of organizations provide services from simple claims processing to full-program orchestration.

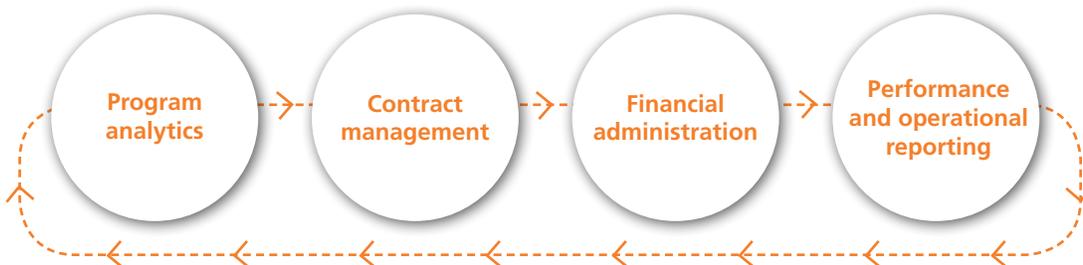
Full-service programs will offer the following:

Program analytics: Full-service bundle programs can help providers take advantage of ready-made bundle definitions. By using “what if” bundle modeling, consultants can help providers tune bundle definitions that pinpoint the right episodes at the right price.

Contract management: Every contract is different, and bundles can be complex. A full-service bundle program can help a provider store and manage bundle contracts for each payer, product and line of business.

Financial administration, including claims and exception management: A full-service bundle program will create a financial workflow that manages the process from claim receipt through payment for both retrospective and prospective programs. Exception management allows for unusual episode situations (for example, patient enrollment changes and provider specific exceptions) to be queued for resolution while automated episodes are processed.

Performance and operational reporting: A full-service bundle program will provide reporting that allows organizations to confirm they are on track, course correct or target program growth areas as they manage program operations.



Perhaps the most important advice regarding bundles is to get started on your bundle payment program today. Partnering with an external expert can help providers start their program quickly. Once a bundle program is in place and running smoothly, layering on other alternative payment programs can help an organization make more significant inroads to improving quality of care and outcomes while still managing costs. Bundle programs also help foster stronger collaboration across providers, payers, and employers enabling longer-term, value based clinical and financial benefits for patients and health care organizations, alike.



David Mauzey
General Manager, Optum Payment Innovation

David leads the development of financial administration platforms used to execute value-based contracting programs. Prior to joining Optum, David spent 17 years working with an enterprise network administration and claim pricing organization. Serving as both COO and CIO, David gained a great appreciation for finding the right operational and technical balance that align to organizations' visions. Today, David focuses on enabling organizations to better deploy their payment innovation strategies.

Contact Optum to learn more about bundle payment strategies and administration.

Email: info@optum.com

Phone: 1-800-347-0845

Visit: optum.com



11000 Optum Circle, Eden Prairie, MN 55344

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