A Real-World Look at Bundled Payments

A TALE OF TWO BUNDLES

Bundled payments allow care coordination from the point of view of the patient and allow all clinicians the opportunity to work together to create common metrics, share protocols, and drive to a collective outcome. They are gaining tremendous momentum across all lines of business, and on a national scale. Why?

The Centers for Medicare and Medicaid, employers and payors are all extremely interested in bundled payments because they create an opportunity to focus care on patients that have historically been tough to manage, and have driven significant costs.

Bundles also offer the chance to improve market share in more profitable commercial business. For many, they create an opportunity to start down the value-based reimbursement path. For organizations that have already begun that journey, bundles can further leverage integration initiatives and accelerate improvements in cost, quality and patient experience.

The programs are indeed gaining momentum, and there is now some urgency about moving forward. Medicare has introduced the Comprehensive Care for Joint Replacement program, the first time that bundled payments will be mandatory in the Medicare space. As healthcare leaders know, where Medicare goes, most everyone follows.

Initially, provider organizations will see upside incentives when they deliver agreed-upon outcomes, but eventually, downside risk will be part of the equation. So there's a first-mover advantage for organizations that can get into programs, understand how to manage them correctly, organize physicians to deliver the right outcomes, and understand their own data in terms of optimal pricing, cost and care design.

How to Design, Implement and Operate a Bundled Payment Program

Data analytics is crucial to succeeding in bundled payments. Knowing which parts of your business are most profitable and which are poised for growth will help you identify the best candidates for bundled payments.

Just a couple examples of what's needed includes benchmarking data, comparing your system or hospital's performance within your market, region or nationally; and cost breakouts on a DRG level. "We've seen clients who have this kind of data at their fingertips, and others who took six months to build something," said Brent Hill, vice president at Valence Health.

To accept lower margins, as is required with bundled payments, organizations must latch onto two strategies: strict control of costs and

Stakeholders' Bundled Payment Benefits

	Savings	Efficiency	Accountability
Patient	• Lower or no out of pocket expenses	• Fewer bills • Better care experience	• Warranty for 60-90 days post procedure
Public and Private Payors	• Reduced price for common services	• One bill	• Access to the highest quality providers • Reporting on outcomes • Warranty provides protection for unnecessary services
Provider	• Increased volume and market share • Reduced expenses through panel selection	• Pre-qualified patients • Increased volumes • Expanded geographic coverage	• Controlled provider panel reduces variation of costs and margin • Greater consistency in care delivery

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predictability. These are especially important when deciding which physicians will participate in the bundle. "Outcomes and quality take center stage here," Hill said. For example, surgeons with higher readmission rates should not see bundled patients—at least initially. "Once you decide who's in and who's out, and how they can get in over time, you'll see other benefits outside this initial group of approved physicians," Hill said.

A Tale of Two Bundles: Government Payor

A Valence Health partner, a health system, took part in the Bundled Payments for Care Improvement (BPCI), Medicare's bundled initiative for total hips and knee replacements. The government set up the program: indexing admissions, looking at 30 days post-acute trends and setting prices based on historic spend.

While the government took its savings right off the top, it also provided a number of waivers and an opportunity for gain sharing, so providers could share in the savings.

Medicare provided the data set, "rich with insights," to review how patients are arrayed and how services are rated across the episode of care, setting a standard level of care. Based on those standards, the system was able to pinpoint the quality and efficiency opportunities for improvement.

When the program was administered, selection of the patient was critical: Does this patient actually need this procedure? Have we managed risk factors upfront so readmission or adverse event likelihood was reduced?

The results: Medicare saved money, the health system generated significant additional savings that could be used for new incentives for physicians as well as reinvestment, and every measure of quality and efficiency improved. "Most importantly, this coordinated approach created an opportunity to improve across the board by measuring every aspect important to the outcome," said Michael McMillan, senior vice president of strategic solutions for Valence Health.

This is an excerpt from a webinar recorded on Nov. 18, 2015.

Download the slides and watch the complete webinar at ModernHealthcare.com/Bundled

A Tale of Two Bundles: Commercial Payor

A different Valence Health partner took part in a commercial bundle. This hospital had strong support from its board to move into value-based reimbursement, and saw a commercial bundle program as a viable route.

After many months of cost variation analysis, the hospital was able to identify which services to include based on market data. Then it set a price target based on the margins it was comfortable giving up and what volume it was expecting to gain. The design included limiting which physicians were allowed in the bundle.

This hospital started working directly with employers, and along the way invited payors to get involved. The results were positive and in the end, the bundle:

- Sparked a major boost in quality and greater cost management
- Delivered significant market share increases in specific service lines
- Attracted net new cases
- Increased patient satisfaction and eliminated out-of-pocket costs
- Built stronger relationships with payors and employers
- Helped advance value-based contracting