



Ready, Risk, Reward: Keys to Success in Bundled Payments

This white paper discusses bundled payments as a key strategy for providers to leverage as part of their overall journey toward value-based care. It provides an overview of the types of bundles that can be created; results from the various models; benefits associated with shifting to an episode-focused incentive structure; and the capabilities health systems need to ensure financial and organizational success.

Executive Summary

Fee-for-service pressures are pushing health systems to pursue new, alternative payment options for economic survival. Bundled payment models represent an attractive alternative to fee-for-service, creating new opportunities to work to improve quality and manage costs, all while earning new income in the form of shared savings.

Bundled payments have a long, diverse history, going back to the 1980s. Through numerous tests of change, research has shown that creating financial incentives for care across an episode is an effective strategy for improving outcomes, enhancing care coordination and aligning providers behind shared performance improvement goals. While the Medicare program was an early leader promoting adoption of bundled payments, many commercial payers are interested in contracting using alternative payment as a core structure to incent change.

Bundled payments also can be a vital strategic tool for health systems that are just beginning the journey toward value-based care. For instance, while global payments or ACOs require an organization-wide mobilization and assumption of risk that many find daunting, bundled payments can be tested within a few services lines, and expanded gradually if successful. Bundled payments also can be aligned with evidence-based clinical guidelines for cost and quality improvements, making the effort more focused than many population-based efforts with limited scholarship behind them. Last, bundled payment models create incentives to bring in providers that are traditionally left out of ACO or primary-care based models, including specialists and post-acute care that can have a major impact on total spending, as well as patient outcomes.

Despite its appeal as an early, less intensive test of change, bundled payment models are not without risk. There are a myriad of program participation options and care episodes that can be selected, requiring a careful analysis of data to identify episodes that provide the best, most viable options to improve patient outcomes and ensure financial success. Moreover, bundled payments also require an ability to align with partners across the continuum, so engagement and incentive structures that promote the right amount of change at the right pace

must be initiated and refined on an ongoing basis. Infrastructure is also required to measure cross-continuum performance through analysis of claims, provider performance, financial and outcomes data. Last, care management needs to be integrated into an overall program of clinical transformation, with full leadership backing.

While bundled payments do require very specific clinical, technical and administrative capabilities across the continuum, when executed properly, they create opportunities for providers to leverage greater financial incentives, while improving care delivery practices. At the same time, payers and employers reduce expenses by avoiding unnecessary services and healthcare complications, while realizing better patient outcomes. As these models continue to take hold, providers must be skilled at assessing opportunities and managing risk. Evaluating readiness, identifying opportunities, implementing cross-continuum changes to the delivery system and creating an infrastructure for ongoing management and measurement are keys to success.

Bundled Payment Options in Medicare

Bundled payment models officially went nationwide in 2013 with the Center for Medicare and Medicaid Innovation's official launch of the voluntary Medicare Bundled Payment for Care Improvement (BPCI) initiative. This model allows hospitals, post-acute providers, physician group practices and other organizations to assume risk for total spending relative to a target price for up to 48 clinical episodes that account for about 70 percent of total Medicare spending. Providers in the model could choose from among four different models, as well as variable episodes and measurement periods (i.e., 30-, 60- to 90-days after the initial acute care admission).

This model was subsequently followed by the Comprehensive Care for Joint Replacement (CJR) for hip and knee surgeries, which began on April 1, 2016, and the Oncology Care Model (OCM) for cancer treatments shortly thereafter. Most recently, on Jan. 9, 2018, Medicare announced a new BPCI Advanced model. As the name would suggest, BPCI Advanced builds on the earlier BPCI program, but includes new outpatient episodes for high-volume, high-costs procedures, and a pathway to leverage bundled payments as part of a health system's overall approach to two-sided, risk-based contracting.

How Medicare Bundled Payments Work

EPISODE DEFINITION

Since bundled payments pay for all care within a defined episode, most models begin by defining the diagnoses and services to include in the bundle. Episodes are generally grouped into procedure families that include almost all services provided to patients with these diagnoses.

TARGET PRICE

The target price is the methodology for calculating spending per episode. Target price calculations usually include the organization's historical spending, but additional modifiers/adjustments can be included depending on the model.

PAYMENT

Providers are typically paid via traditional fee-for-service reimbursement up front. After a period of time to allow for claims run out, payers look back on actual costs and quality outcomes. If quality metrics are met and the total spend is less than the target price, the payer will send a certain percentage of the savings to the participants to distribute among themselves as a bonus. If total spend is not less than the target price, providers may have to pay back the difference to the payer.

RISK CORRIDORS

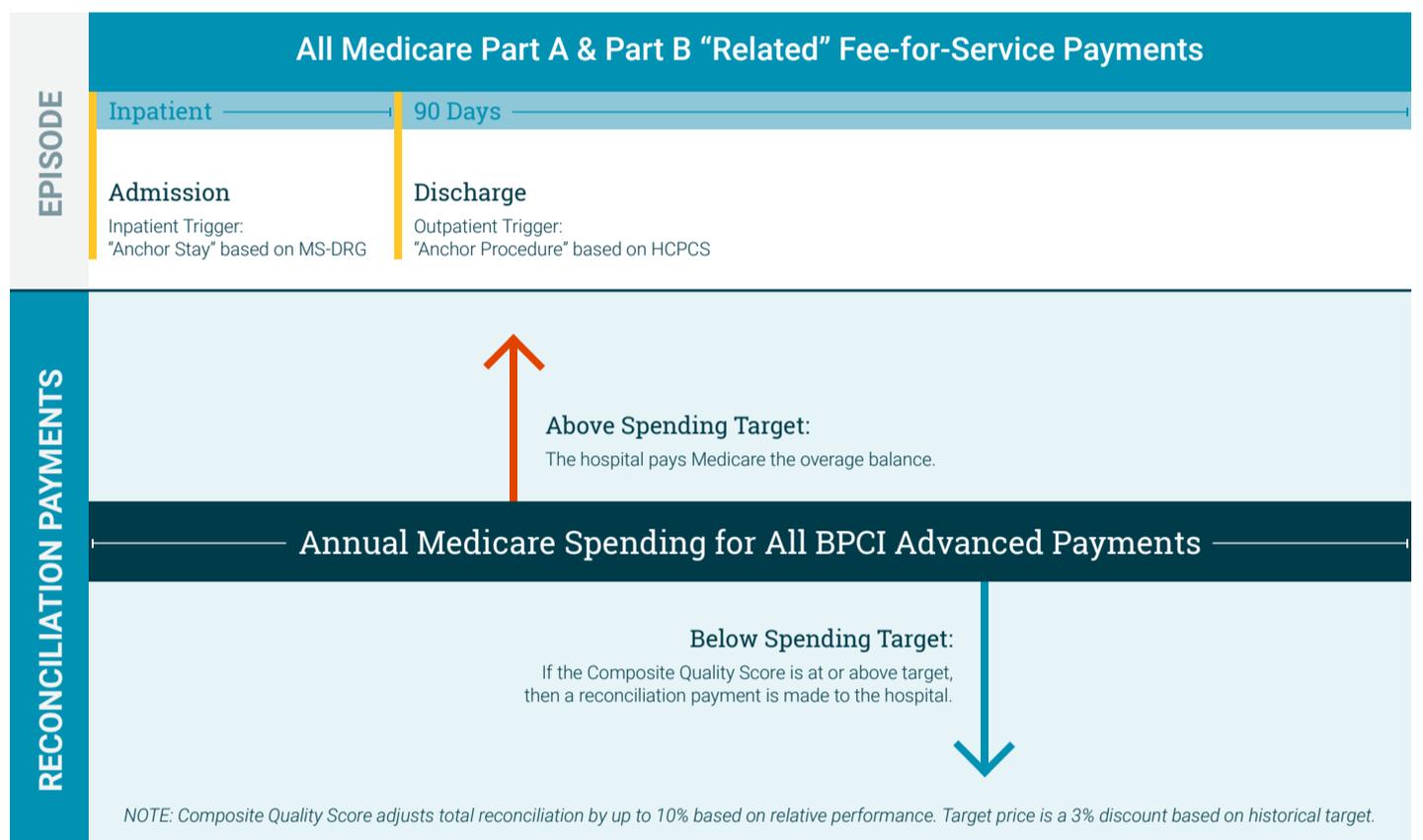
Most of the Centers for Medicare & Medicaid Services' (CMS) bundled payment models include stop-loss and stop-gain limits at an aggregate level, which give participants and payers financial protection.

QUALITY REQUIREMENTS

The latest bundled payment models (i.e., CJR and BPCI Advanced) require achievement of certain quality metrics in order to be eligible for savings payments through reconciliation. This aspect, along with satisfying Certified Electronic Health Record Technology (CEHRT) requirements, also allows for the models to be eligible as MACRA Advanced Alternative Payment Models (APMs).

FIGURE 1: BUNDLED PAYMENT MODEL

This diagram is representative of the latest bundled payment model, BPCI Advanced, though BPCI, CJR and OCM follow this construct very closely.



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Growth of Bundled Payment Models

MEDICARE BUNDLED PAYMENT MODELS

Today, more than 1,600 organizations participate in BPCI, taking on risk for more than 14,000 clinical episodes.¹ An additional 465 are participating in the Medicare CJR program² and 187 practices have joined OCM.³ The latest model, BPCI Advanced, will further grow bundled payment participation on a national level, giving both existing and new entrants experience in the value-based payment environment.

This growth is being driven by the significant savings that bundling has been able to generate. BPCI evaluations indicate that bundling has been effective in improving quality and reducing overall costs. According to current program analysis, Medicare payments for joint replacements decreased an average of \$1,273, or 4.5 percent, per case among BPCI participants.⁴ Similarly, congestive heart failure

spending also dropped by an average of \$970 per case, or 3.6 percent lower than the baseline.⁵ Similarly, 47 percent of all participants in CJR program achieved savings through their participation in joint bundles, earning \$37.5 million in added Medicare shared savings payments.⁶

FIGURE 2: PREMIER BUNDLED PAYMENT COLLABORATIVE PARTICIPANTS LEAD THE NATION

In just the first two quarters of Performance Year 1 (PY1), CJR reconciliation results showed:



OVER \$8


MILLION




Total program savings for first two quarters of PY1* Annualized, that's \$16.1M.



Premier members who **achieved savings** for Medicare.



Premier members who achieved **at least 10% savings**.



Premier members who **will receive savings payments from Medicare** due to their episode costs being below target (that's 35% better than the nation).



Premier members who achieved **"good" to "excellent"** quality ratings.

*PY = April 2016 – December 2016.
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NON-MEDICARE BUNDLED PAYMENT MODELS

Outside the Medicare program, hundreds of other bundled payment initiatives exist in the private sector, with more than 20 percent of employers contracting for bundled payments directly with providers⁷ through their private health plans, including organizations such as Boeing, Walmart, Kroger, Lowe's and PepsiCo.⁸ Commercial payers also have bundled payment models in place, with dozens of bundling initiatives across the country, particularly among Blue Cross Blue Shield plans.⁹

In addition, organizations can experiment with bundled payments through the concept of a "shadow bundle." Shadow bundles are a way for ACOs to extend their population health management work to specialists and post-acute providers, experimenting using nationally recognized bundled payment models as a blueprint. Organizations

that already have established population health infrastructure and access to claims data through the ACO can define their episode(s) within the shadow bundle for a defined duration, centered on either chronic or surgical episodes, and customize incentives and distribution of gains without the risk associated with formal participation.

Benefits of Participating in Bundled Payment Models

Providers considering participation in a bundled payment model can expect a range of revenue, cost, quality and patient care improvements.

ALIGNED INCENTIVES

The driving factor steering provider interest in bundled payments is the alignment it creates between hospital, physicians and other providers. Traditionally, hospitals paid under the MS-DRG system were highly motivated to reduce any unnecessary expense in order to optimize margin, while physicians paid under fee-for-service had little exposure to the cost of their services. A similar phenomenon exists among post-acute and other providers, leaving very few caregivers accountable for total costs. Bundled payments inject the same level of price sensitivity into all clinical decision-making, and promote shared accountability for costs, quality and outcomes. Bundled payment models that are supplemented with gainsharing or other bonus programs for eligible physician providers create greater incentives for active physician participation, while raising awareness of episode costs.

IMPROVED CLINICAL PERFORMANCE

Because financial consequences are attached to errors or deviations from evidence-based practices, many bundled payment participants begin their journey by standardizing care guidelines and post-discharge procedures, hardwiring them into every clinical interaction. As best practice becomes the standard for care, clinical quality typically improves across the board. In particular, standardized care has been shown to improve clinical quality in a number of high-visibility areas, and are particularly effective at reducing complications, infections and readmissions.¹⁰

IMPROVED FINANCIAL PERFORMANCE

For many procedures, there is wild variation in total costs. For instance, research shows that per episode, payments to highest-cost hospitals were higher than those to the lowest-cost facilities by up to \$2,549 for colectomy and \$7,759 for back surgery.¹¹ Bundled payments incent providers to work together to compress that variation by allowing providers to receive a portion of the episode savings generated – funds that can go straight to the bottom line.

EXTENDS VALUE-BASED PAYMENT TO SPECIALISTS AND POST-ACUTE CARE

Many value-based or population health models, like ACOs and patient-centered medical homes, are heavily focused on optimizing disease prevention and overall health to avoid costly healthcare utilization. As such, the focus is heavily skewed toward primary care services. Bundled payments, however, target surgical services and recovery and/or exacerbations of medical conditions, creating participation incentives for specialists and post-acute care providers, adding to the total cost savings potential. For instance, post-acute care and readmissions account for nearly 40 percent of Medicare spending for 30-day cardiac care episodes and 37 percent of spending for joint replacement episodes.¹² Better management of post-acute utilization represents a major savings opportunity for bundled payment participants, and can help optimize performance across all value-based care contracts.

ALIGNMENT TO OTHER TRANSFORMATION INITIATIVES

Bundled payments can be a strategy for success within a range of clinical and financial improvement initiatives. For providers who are still predominantly in the world of fee-for-service, optimizing performance in surgical procedures, for instance, can simultaneously help them avoid financial penalties tied to complications or overall system readmission rates. For those in an ACO, bundles can help reduce overall spending among specialists and post-acute providers, generating further cost savings that return to the providers in the form of percentage-based shared savings payments. In addition, bundles can be an effective strategy to ensure alignment and successful performance under the MACRA quality payment program (QPP), which ties physician payment to quality indicators and provides additional upside payment to those that participate in two-sided, risk-bearing bundles.

COMPETITIVE DIFFERENTIATION

Because bundled payments have the potential to generate significant savings, participation in the models can be a competitive differentiator. Particularly in crowded, competitive metro markets, providers are increasingly being driven into alternative payment arrangements in order to manage margin with additive shared savings payments, and retain high-value physicians by enabling their success within MACRA. Providers that aren't preparing to take advantage of these opportunities risk losing market share to competitor organizations, as well as inclusion in narrowed payer networks that increasingly only contract with high-value organizations.

“Bundled payment is one of the foundations for a value-driven market. Bundles brought our system valuable synergies.”

- Shawn Rhodes

Director of Project Management, Clinical Integration, The Medical Center at Bowling Green

How They Did It: Lessons from Successful Health Systems

The Medical Center at Bowling Green joined the BPCI program in 2015, focusing on two cardiac care bundles. Analyzing data, the health system opted to focus improvement efforts in several areas where they experienced the widest variations in care: lowering overall cardiac readmission rates, more care coordination/navigation services post-discharge, and reducing the length of stay in post-acute settings like inpatient rehab and skilled nursing facilities. After a focused effort to redesign their care management program and engage community resources in the care of patients with these conditions, they began to realize savings. Their efforts to improve chronic disease management and reduce barriers to care transitions resulted in a progressive reduction in post-acute spend. Patient navigators were key to this reduction in post-acute cost, as barriers to care transitions between levels of care and care settings could be proactively identified and addressed.

Core Capabilities Needed for Success in Bundled Payment

Premier's Bundled Payment Collaborative is one of the largest collaboratives of healthcare systems in the nation focused on episode-based care.

Through this work, Premier has helped hundreds of hospital organizations and physician groups develop and implement successful bundled payment models in both the Medicare and commercial markets. Based on Premier's extensive experience with bundled payments, we have developed a set of core capabilities essential for implementing and sustaining a successful bundled payment program. These capabilities are listed below:

LEADERSHIP, GOVERNANCE AND INFRASTRUCTURE

An organization or health system interested in bundled payments should have a governance structure that provides oversight and support for the bundled payment program and the various work streams associated with transforming care delivery. Before diving into the nuts and bolts of program design, strong executive sponsorship and the commitment of physician/clinical champions are essential. Organizations that show positive outcomes and cost savings develop aligned goals for their bundled payment initiatives and invest in structure and resources designed to facilitate high-performance within an episode of care. One layer down, leadership generally creates a multidisciplinary oversight or steering committee to manage the day-to-day work and optimize performance. Successful bundled payment models need to be a core strategic goal of the organization, and treated as such, in order to garner savings (i.e., increased revenue opportunities)– they are not isolated projects.

PROGRAM AND EPISODE DESIGN KNOWLEDGE

Whether a Medicare-sponsored bundle or a commercial or employer contract, having a point person(s) who understand the details about the program is essential. This includes an overall understanding of the operational processes and practices of the organization, as well as knowledge of bundled payment program elements: how to define the bundle and determine the target price, how to negotiate or manage the overall stop gain/stop loss cap and how to describe the impact on overall volume of beneficiary inclusions/exclusions. In addition, the point person(s) must also understand program precedence, reconciliation

rules and repayment practices. This individual(s) should be a member of the steering committee and help inform that group's activities.

SMART EPISODE SELECTION

A great, well-structured bundled payment program could still be financially unsuccessful if the episodes selected don't have both a strong savings opportunity and the providers involved don't have an ability to influence change. To begin, leadership needs to collect and analyze financial and clinical data to determine those episodes that have the widest variation in terms of cost and quality, thereby representing the greatest opportunities for savings. Most successful choices tend to be episodes with significant overutilization of post-acute care. Additionally, high-volume, high dollar procedures that rely on expensive resources (such as physician preference items like implants), have variable outcomes in terms of quality (such as higher than expected complication or readmission rates that can add up to 80 percent in added expense¹³), and those that typically involve multiple physicians can be good choices. Similarly, the providers in the bundle have to have an influence over the cost and quality outcomes. Episode choices are most successful when there are pre-existing evidence-based quality and efficiency metrics that align with bundling's goal, as well as procedures that can be easily modified to reflect the most appropriate needs of the patient as they move to the next step in their care journey (e.g., post discharge/ procedure).

TECHNOLOGY, ANALYTICS AND REPORTING

The ability to measure, monitor and evaluate current bundle performance, as well as forecast for the future, is critical for sustaining a bundled payment program. Detailed claims and eligibility data is complex, but also a very rich resource, providing information about care across the continuum (inpatient, professional visits and post-acute care). Claims analytics capabilities, as well as the ability to enhance an EMR for patient tracking, clinical protocols/order sets, and the ability to provide data to key stakeholders (e.g., surgeons, physicians) is key.

LONGITUDINAL CARE MANAGEMENT

Due to the cross-continuum nature of bundles, the ability to assess and redesign care across the episode (i.e., find and close care gaps) and to execute continuous improvement processes to achieve both low-cost and high-quality outcomes is a core program capability.

Historically, providers have been narrowly focused on the procedure(s)/ interventions that will be done, along with the immediate pre-operative and post-operative care. However, organizations successful in bundles have invested in care management and patient navigators that can develop a plan for pre-hospitalization care all the way through rehabilitation that coordinates handoffs between providers and minimizes use of more expensive resources. For example, the care plan may involve utilizing home health or outpatient care to avoid placement in a skilled nursing facility that can often cost four times as much¹⁴, or education on exactly when (and when not) to present to the emergency room for care.

How They Did It: Lessons from Successful Health Systems

Central Florida Health, a 636-bed, not-for-profit, community-based health system has more than 400 medical staff physicians across two hospitals. Less than a dozen physicians are directly employed. A total of 55 cardiologists are spread across 15 different group and private practices. Half of these cardiologists participate in their cardiovascular co-management company. According to Chris Wood, Director, Co-Management Companies, "This structure empowers physicians to lead change efforts and initiatives, and bundled payment fits in nicely with our co-management strategy." With experience gained as a participant in the CJR Bundled Payment Program, Central Florida Health analyzed several data sources to uncover significant opportunities in cardiac procedures, particularly AMI, and also helped to identify variation in care between hospitals related to cardiac episodes. Clinical documentation improvement and the development of a preferred post-acute network were two major focus areas that helped the system realize performance gains.

POST-ACUTE CARE PARTNERSHIPS

Post-acute care is perhaps the most significant contributor toward total per-episode spending.¹⁵ For example, post-acute care and readmissions account for nearly 40 percent of Medicare spending for 30-day heart failure episodes and 37 percent of spending for joint replacement episodes.¹⁶ Therefore, a narrowed network of high-quality, low-cost post-acute care providers is an essential component of success in bundled payment. An evaluative process is suggested to strategically identify and select partners for in-network inclusion, leveraging on-site assessments of post-acute providers,

as well as public data sets such as star ratings, readmission rates, patient satisfaction scores, etc., to ensure only those with demonstrable cost and quality outcomes are selected for inclusion. Partners must also be willing to agree upon and adopt practice tools and processes that standardize patient experience and promote quality outcomes. Note that not all post-acute providers are equally high-quality across all bundles. Therefore, there may be different narrow networks depending on the patient's needs.

PROVIDER ALIGNMENT AND ENGAGEMENT

Provider alignment and engagement typically involves a two-pronged approach: one based on structures that promote transparency and continual communication, the other on incentives to influence behavior change. Engagement structures need to allow physicians and other leaders to meet regularly on shared discussion topics, such as progress to goals, quality, redesign efforts and data sharing/transparency. In addition, providers need to use established communication channels, such as clinician champion communication trees, provider meetings, newsletters, emails, one-on-one discussions, etc., to inform and disclose information among participants or supplement with new communication channels. Providing support for clinical champions with project management, change management and leadership training is also crucial, yet often under-valued.

Alignment structures often come in the form of incentives contingent upon hitting quality and outcomes goals and savings targets. By choosing performance measures and corresponding productivity targets carefully, hospitals and physicians can find themselves in a win-win scenario with better compensation tied to improved patient outcomes delivered at a lower cost. Key strategies include consideration of both financial and non-financial incentives for physicians, such as increased transparency of outcomes across the continuum, improved patient access to appropriate providers, Advanced APM qualification and exploration (or development) of gainsharing opportunities.

Conclusion

Bundled payments represent a key strategy for health systems to explore on the journey toward value-based care. Bundled payment models have been in operation for decades, and numerous tests of change have shown that these

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models can be leveraged to generate both cost and quality improvements for a range of clinical episodes. Bundled payments can also help providers accelerate their movement toward risk-based contracting, while allowing time to optimize performance before building advanced capabilities.

In addition, bundled payments can yield significant margin opportunities to health system, offering the chance to earn over 100 percent of all Medicare payments with the addition of savings if successful.

However, not everyone achieves success.

To build a successful program, providers need to commit to change, and recruit partners and participants that are willing to take the journey toward continuous performance improvement. Leadership must support the effort with a total commitment of time and resources, including management structures and infrastructure to oversee the program and monitor performance. Episodes must be carefully selected based on data analysis to uncover the greatest opportunity areas, and care design must be considered all along the continuum to ensure optimal performance. Lastly, incentives need to be managed to encourage the right behaviors at the right pace of change.

An organization that can hone in on the capabilities outlined in this white paper and successfully collaborate with their care teams and hospital leadership will start seeing accelerated performance improvement within their bundled payment work.

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