Potential rewards justify efforts to create bundled payment programs

Physician alignment is a key element of current hospital strategy. Last month, we looked at how hospital ORs can use co-management agreements to build strong collaboration with surgeons. Payment reform has created an even more sophisticated option—participation in a bundled payment program.

Bundled payment initiatives are more complex than most other alignment strategies. Hospital and OR leaders must perform upfront analysis, manage provider contract negotiations, and work continually with surgeons and other clinicians to manage costs. Yet bundled payment offers strong potential rewards.

Two avenues

The basic idea of bundled payment is simple—healthcare providers receive a single payment for a defined episode of care. Overall, healthcare organizations have two distinct opportunities to pursue bundled payment contracts.

The first opportunity is the Centers for Medicare & Medicaid Services (CMS) Bundled Payments for Care Improvement (BPCI) program. With four different payment models and a broad choice of care episodes, the BPCI creates multiple opportunities for partnership between provider organizations.

When an organization enters the BPCI, CMS sets a target price for each contracted patient continuum or episode of care. The target price is the historical average cost of the episode, minus a discount. Historical costs are based either on the hospital’s own data or a blended state/hospital average.

Under Models 1, 2, and 3, participating providers bill CMS and the government pays all claims at the usual reimbursement level. Then, on a quarterly basis, CMS reconciles claims against the contractual target price. There is risk associated with the BPCI program. If the organization’s total claims are less than the target price, the organization can keep the difference. If total claims exceed the target price, however, the organization must pay the difference to CMS.

The second opportunity is to negotiate bundled payment contracts with private payers. Private or commercial insurance payers are at an earlier point on the adoption curve with regard to bundled payments, and pursuing this avenue requires additional preparatory work and negotiation. But private payer contracts may offer some advantages over the federal bundled payment program.

Evaluating opportunities

When evaluating bundled payment alternatives, “speed to market” is an important consideration. “CMS has been overwhelmed with applications for the federal bundled payment program,” says Thomas Blasco, MD, medical director of the Illinois Sports Medicine and Orthopedic Surgery Center in Morton Grove and medical director at Surgical Directions, a national perioperative consulting firm in Chicago.

“A large percentage of applicants have had their applications delayed,” Dr Blasco notes. In contrast, private payers may be ready to move forward more quickly on bundled payment negotiations.
There is also an important structural difference between private/commercial insurance and CMS bundled payment opportunities. “CMS rules say that if you are going to enter the BPCI program, all the surgeons on your medical staff must participate,” Dr. Blasco says. “So when you sign up one surgeon, you have to sign up all of them.”

In contrast, private bundled payment arrangements can give OR leaders the chance to be selective about which surgeons they can partner with.

Whether a hospital pursues federal or private payer opportunities, the first step is careful analysis of procedure types, costs (all professional and technical fees), and outcomes data. BPCI participants receive extensive data from CMS on all applicable procedures (within the DRGs for which the organization is participating) in the organization’s primary and secondary markets. The additional value of these data is that they allow the applicant organization to accurately gauge market demand and competitive costs.

The most important question is: “Can we reduce costs enough to make an episode profitable?” Keep in mind that cost reduction goals must be large enough to cover the contractual discount and any gainsharing payment for surgeons. The main goal of the initiative is to improve value in terms of the equation “clinical outcomes divided by costs.” Patient safety and clinical outcomes are paramount to the long-term success of the program and the hospital.

**Gainsharing contracts**

“The BPCI plan provides a waiver within Stark guidelines to allow gainsharing that is with merit and legal,” says Bob Dahl, senior vice president and chief operating officer of Surgical Directions. “Surgeons have the opportunity to receive up to 150% of Medicare professional fee schedule per procedure, should outcomes and cost reductions be achieved.”

“The beautiful part of the CMS bundled payment program is that it provides an avenue for hospitals to do gainsharing in a preapproved manner,” says Chad Beste, a partner in PBC Advisors, LLC, Oak Brook, Illinois. “Unfortunately, there is still some confusion about what is and what is not acceptable.”

Under existing guidance, organizations have broad leeway for structuring gainsharing contracts. According to CMS, gainsharing arrangements must:

- support improved quality, improved patient experience, and cost savings
- include a methodology and a comprehensive plan for sharing gains among contracted parties, notably frequency and criteria
- support quality improvement and include minimum quality thresholds, a process for monitoring quality, and metrics for improving quality of care.

In addition, arrangements must be transparent and auditable by the government. Gainsharing payments cannot be based on referral volume or value (although “payments based on achieved savings are permitted”). Overall, gainsharing payments cannot exceed 50% of physicians’ normal fee-for-service reimbursement for services.

The guidance does not set specific quality standards or metrics for bundled payment contracts. “CMS is allowing organizations to propose their own quality criteria,” Beste says. “Most organizations are using things like PQRS [Physician Quality Reporting System] measures and readmission rates.”

**Working with surgeons**

“The key to controlling costs under bundled payments is to develop a consistent, repeatable, relatively uniform model of care for a given procedure,” Dr. Blasco says. “The hardest part is getting surgeons to agree on one single approach.”
According to Dr Blasco, it is relatively easy to get surgeons to agree on preoperative screening and risk stratification protocols. “But getting surgeons to reach consensus on a common technique or single-source implant is very daunting,” he says. “Even standardizing the recovery phase is a challenge, since many surgeons are more comfortable with one approach or another.”

The entire effort requires extensive planning and facilitated discussion. Supply costs are an obvious starting point. OR leaders can use multiple strategies to address supply expenses, including preference card standardization, value analysis, vendor control, and better inventory management (see OR Manager August 2013, pp 21-23). In addition, single source or capitated pricing for consigned implants should be a consideration for the OR.

OR leaders should also use a bundled payment initiative to look at supply costs from a holistic perspective. Customized patient-specific joint implants are an often neglected option.

“These joints are more expensive than standard implants, but you need to look at the issue of time and OR instrument costs as well,” Dr Blasco says. “When you consider the additional time as well as the costly and numerous implant trays it takes to measure and fit an implant during surgery, noncustom hardware can often end up being more expensive.”

Surgeon collaboration is also important for addressing non-OR hospital costs. The inpatient room and surgical floor coverage can account for one-third or more of total episode costs. Surgeons can move the dial on these costs by adopting clinical care pathways that can reduce inpatient length of stay.

Direct costs are not the only issue. Efficiency is an underappreciated factor in bundled payment management. For example, a hospital might control costs associated with a bundled episode and generate a profit from the point of view of reimbursement. But if the OR has low overall utilization, its high department cost structure will erase any profit generated.

Given this pitfall, ORs must also collaborate with surgeons on efficiency issues such as increasing utilization (OR Manager, May 2013, pp 21-22, 24) and decreasing case times (OR Manager, May 2014, pp 25-27).

**Postacute reboot**

For most hospitals, the major opportunity to reduce episode costs will be in postacute care. According to Beste, there are three principal areas to focus on:

**Readmissions.** “Each hospital readmission adds about $20,000 to the total spend,” Beste says. In his experience, readmission rates for joint replacement range from about 7% to 20%. “If your rate is closer to 7%, you obviously don’t have a lot of room to reduce spending. Hospitals that are starting at 20%, on the other hand, have a big opportunity to cut episode costs.”

**First postacute setting.** “Where patients start in postacute care is significant because we find that each setting—long-term care, inpatient rehab, SNF [skilled nursing facility], and home health—adds about $10,000 in costs,” Beste notes. For patients discharged directly to home health, postacute costs are typically under $10,000. For patients who start out in a SNF, costs are about $15,000 to $20,000. “Say 75% of your joint patients are discharged to skilled nursing and 15% to home health. There may be an opportunity to reduce costs significantly just by increasing home health discharges from 15% to 25% of all the patients.”

**Postacute length of stay.** Patients discharged to a SNF tend to stay through most of the Medicare 100% coverage period. “Plan design is the issue here, and many facilities try to maximize their reimbursement,” Beste says. “The question is whether there is an opportunity to reduce utilization.”
According to Dr Blasco, surgeons can take a greater role in optimizing postacute care. For example, some surgeon groups have put home health at the center of joint replacement postacute care. “For the right patients, home health with tightly controlled physical therapy and visiting nurse support is very successful,” he says. “Patients do just as well or better. There is also greater patient satisfaction.”

The key to success is data-driven proactive patient triage and management. “If you are going to take part in bundled payment, you have to monitor and manage patients very closely,” Dr Blasco says. He recommends creating information systems that follow patient care throughout the perioperative period, from scheduling to discharge and follow-up care. Additionally, patient data analysis can be used as the basis for risk stratification, patient selection, and management algorithms.

**Market strategy**

“The BPCI program incentivizes surgeons to perform contracted procedures at an approved facility,” Dahl says. “This incentive can provide a strategic competitive advantage for hospitals that are ‘first to market’ with a bundled payment opportunity.”

Physician engagement is another factor. Surgeons who have entered into a bundled payment contract with a hospital assume personal responsibility for a service line, becoming highly invested in the long-term success of the OR.

A successful bundled payment program can also help an OR develop a center of excellence that wins case volume from both referring physicians and patients, Dr Blasco believes. “Bundled payments give hospitals the opportunity to create a sustainable competitive advantage by partnering with surgeons to create ‘best in class’ service lines.”

This column is written by the perioperative services experts at Surgical Directions (www.surgicaldirecions.com) to offer advice on how to grow revenue, control costs, and increase department profitability.

**Reference**