Four questions to help healthcare providers assess their readiness for bundled payment programs.

The decision to start bundled payments may not be simple for many health systems. Modern efforts to bundle a payment for a single episode of care, such as the Medicare Participating Heart Bypass Center Demonstration,[1] date back to at least the 1990s. But as movement toward value-based arrangements (e.g., risk arrangements, performance incentives, accountable care organizations) has accelerated in the past 10 years, and been recently spurred on by Medicare’s introduction of the Bundled Payments for Care Initiative in 2013, bundled payments are getting a deeper look by the healthcare industry. Bundled payment products have been found to offer several benefits to a health system:

- Lower risk than a fully capitated or total-cost-of-care type of arrangement.
- Opportunity to drive operational improvements (e.g., standardized processes, cost-effective supply chain, higher patient satisfaction) by creating an organizational goal.
- Better alignment with physicians through shared financial incentives.
- Potential for additional incremental volume to boost a service line.
- Minimize variation in surgical and follow-up protocols to reduce acute-care costs.
- Standardize supplies to keep costs low and maintain margins.
- Follow post-acute care treatment protocols to reduce readmission rates and unnecessary utilization of emergency department services, as well as ultimately avoid extraneous costs.
- Can bundle performance be accurately measured and monitored?
- Will the care quality level be high enough to attract the patients?
- Can the variables be controlled to mitigate the risk?
- Is the technology available to appropriately flag bundle patients and ensure care management?

However, not all providers are good candidates to offer such a program. For health systems considering a bundle, there are...
several issues to consider before presenting a product to the market.

1. **What is the appropriate market for the bundled product?** When an organization begins the process of crafting a bundle, an initial concern often is what the potential market will be (e.g., local, regional, national, international) – but the most important factor is the potential incremental volume to the organization. Bundle programs require a critical mass of patients to participate in order to maximize the value. High-volume, standardized procedures (e.g., primary joint replacement, cardiac angioplasty) are ideal targets for bundled payments. Understanding the market for these services and identifying market opportunities (e.g., direct-to-employer, health plans) are the first steps toward making the decision to pursue a bundle.

   The necessary volume required for success varies and will depend on the bundle type, discount or shared savings offered and the system’s ability to reduce costs and increase the margin. Financial projections are required to determine if the addressable market is sufficient. For most providers, there is more than enough patient volume to target locally through collaboration with either a health plan or area self-insured employers.

   Recent surveys have indicated patients are often willing to travel some distance to obtain high-quality services and have a positive experience at a reasonable price, so the geographic target market might be larger than previously determined. Although attracting patients from a wide geography can garner headlines, health systems should not overlook the fact that there is often more than enough volume to be gained by targeting patients within a 60-minute drive. The key is to balance the factors of distance, volume, price and margin as you consider building your bundle.

2. **Is the organization sufficiently aligned with the appropriate physicians to successfully execute the program?** A crucial element to the success of a bundled payment is ensuring buy-in and participation of the appropriate physicians. A bundle will be most successful when the physicians are fully aligned because they can directly impact care management and drive cost savings in several areas:

   Alignment is typically achieved through financial incentives where the physicians share in a portion of the dollars saved or the margin generated. A physician’s actions can even impact a hospital acute-only or a post-acute-only bundle by virtue of his or her position among the clinical team and influence on the patient. Without this alignment, the delicate balance of generating savings while providing high-quality care can be disrupted. For example, just a few patients with a $15,000 readmission, an extra day in the hospital or duplicative ancillary services or unnecessary higher-cost post-acute care can significantly erode any shared savings that might be generated by the program. A successful bundle will have the support of high-quality physicians and include aligned financial incentives.

3. **Does the organization possess the operational skills?** Executing a bundle requires an organization to approach patient care in a way that may not be consistent with historical practice. An organization must evaluate its ability to operationalize a bundle and conduct robust care management. These skills are important to manage the financial risk associated with variation in care and avoid expensive negative outcomes.

   To implement a bundle, a health system must be able to track and monitor bundle patient utilization. Appropriate patient-tracking will often require some adjustment to EHR and financial accounting systems in the form of new financial codes and proprietary procedure codes for
care management. These adjustments will allow for the accurate reporting of metrics to physicians, administrators and health plan partners. Regular monitoring of processes and utilization provides opportunities to change behavior and make cost-saving adjustments.

Further, a higher level of care management is required to sufficiently mitigate the risk of the bundled payment patients. Successful bundle programs implement a set of strict clinical protocols and supplement them with active care management. Patient navigation and care management programs that deploy well-educated staff to manage patients in coordination with physicians are services that many organizations must create. Strong care management will guide patients to appropriate providers and vendors, as well as oversee the services used (e.g., transportation, home durable medical equipment) and the level of care (i.e., a skilled nursing facility versus home health).

Alignment with post-acute care providers (e.g., rehabilitation, physical therapy, SNF, DME, subspecialty providers) is also frequently required to facilitate optimal care management and ensure desired protocols are being followed. This alignment may take the form of contractual arrangements or simply an agreement to follow care protocols in exchange for being the preferred provider. Each respective bundle will dictate the need for these arrangements which are required to mitigate the risks and manage limited financial resources.

4. What is the risk profile of the targeted patients, and what is the organization’s risk tolerance? Depending on the type of bundle you are considering, the patient risk profile may differ greatly. For example, the risk associated with orthopedic patients could range significantly between a young healthy patient with no comorbidity to a patient with multiple comorbidities such as obesity and cardiac complications.

A provider needs to manage the financial risk that is associated with a bundle to generate savings. Management of this risk incorporates the direct cost of the episode of care, as well as any follow-up care. Some organizations generate their own volume and cost reports; others obtain a significant amount of claims and utilization information from the health plan. Tracking an array of clinical outcome and financial metrics, especially the cost components, is a critical success factor. An organization must be able to understand the underlying costs associated with a bundled service to inform pricing and track improvement in costs.

Bundled payments can be executed within an array of market conditions. They do not necessarily involve attracting patients from across the nation or require an organization to accept discounts on current fee-for-service rates. Building a bundled payment program does require strategic vision, operational competence and clinical alignment. The above considerations can help organizations determine their willingness to embrace the financial risk and take the necessary operational steps to produce a successful bundle.

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