Five Steps for Successful Initiation of Bundled Payments and Episodes of Care

written by Theresa Hush | August 2, 2018

Everything about health care is complicated—its rules, science, service delivery, organizational systems, financing, and the relationship between all participants. So too will be the solutions for measuring and managing its value as determined by quality, outcomes and cost. To imagine that we can simply change one part of health care and effect change throughout the entire system is naïve, even ridiculous.

Nonetheless, a recent analysis of how bundled payments failed to lower costs is being used as an example of why such reimbursements aren't effective in changing incentives for high medical costs. While the analytical results show little difference in Medicare costs associated with bundled payments, that is not the lesson we need to take away. In fact, we must take great care not to erect a straw man argument against bundled payments by assuming that reimbursement alone can change costs and behavior.

Without altering behaviors by providers, facilities and patients, a payment mechanism cannot accomplish much. At the level of health care delivery, most providers—and certainly

patients—are not aware of changes in how services are reimbursed, nor what it means for their wallets. How can we reduce the cost outcome if we don't do anything to alter the inputs to care? If there is no reengineering of care delivery, if physician compensation remains the same, if nursing and operational staff are uninvolved, and if patients don't understand or can't see costs in medical decision-making, we cannot expect savings to result.

Bundled Payments Are Economic Vehicles but Require Clinician Involvement to Achieve Savings

To be sure, the intent of bundled payments has always been cost control through creating a package price and putting providers at risk for managing within a global fee. But much more has to take place for it to work.

Bundled payments are built on the concept that care can be broken into time-bound packages of health care services provided to a patient—"episodes" based on procedures, diagnoses or other causative health care elements. But episodes can include services of multiple providers, and this is where the financial concept becomes significantly complicated. To reconfigure both price and quantity of services, the distribution formula must also be negotiated, often across specialty lines.

Unfortunately, episodes of care and bundled payments are rarely initiated by physicians or clinicians; rather, they are initiated by administrators. And when these approaches are negotiated with health plans or as part of a Medicare or Medicaid initiative, the analytics to identify cost variations, cost drivers and specific clinical issues are often unavailable. Indeed, organizations typically initiate bundled payments lacking significant data on volume, cost and variations of care. The providers can be impacted without fully understanding the implications to their practice of medicine, yet still be held responsible for results.

The successful implementation of episodes as a savings initiative depends on agreement among every care team member, including those not named in the specific episodic arrangement (such as nurses and facility staff) regarding key aspects of service delivery. Issues such as facility scheduling and staffing, waiting time before or after procedures, and technology available at the time of care, all present issues for both quality and cost.

Information about the patient must be shared with all clinicians, who may need to adjust care accordingly. Learning of potential for complications at the time of the procedure can cause delays or revision of care, costing precious time and expensive resources.

Trickle Down Economics Have Little Power to Affect Cost, Unless Orchestrated

Bundled payments are trickle-down economics applied to health care. Business tax cuts are the most well-known example of trickle-down economics, but with positive rather than negative potential. The theory is that cutting taxes will stimulate spending by businesses and consumers, and thereby create jobs. That end result will depend on specific actions by business to expand their enterprises by reinvesting and hiring more people, as well as passing more money to employees as higher wages.

Politics aside, however, the economic stimulus from business tax cuts is not a given. The organization must have the leadership and confidence in the long view to engage in business expansion strategies. Otherwise it will just return any extra income to its investors, owners and executives. Most importantly, organization leaders must have the desire and existing resources to execute expansion strategies, which are very time consuming and expensive to undertake.

Health care has an even greater challenge to make trickle-down economics work. To achieve real cost savings, providers must address the specific services and elements of care that are driving cost, not the total cost alone. Focus on total costs will result in denying care to patients who can benefit because they may exceed the bundled payment price. That practice was apparent during the height of HMOs, when consumer complaints of denied services peaked and essentially killed the HMO movement. Unless provider organizations can engage consumers in new methods of providing optimal care delivery with fewer inputs into such services—and to voluntarily avoid some care altogether if outcomes promise to be poor—they will not achieve cost savings.

Providers who participate in an episode need historical information that reveals costs associated with historical episodes and how costs varied by type of service. Patient selection must be a part of this evaluation, since patient outcomes will vary by age and other factors, driving costs higher or lower. Careful design of care to deliver services that are appropriate for patient risk will reduce the perverse incentives of financial risk in episodes of care.

The following five essential steps can help provider organizations get on the right track and develop episode-based bundled payments as a successful growth strategy:

Five Essentials for Making Bundled Payments Really Work for Providers, Consumers and Cost Savings

Understand the current service mix, volume and variation in costs through analytics. Even specialty-heavy organizations have had little reason historically to analyze their services along episodic lines. But looking at both procedural and medical episodes and estimating costs based on source system data is revealing. This review is the first step toward understanding where to focus, especially if payer-specific data is evaluated. Claims data is valuable, not essential, to this process.

Share data with providers by specialty or type of care that could be involved in initial episodic payment initiatives. This ensures that, at the very least, a leadership group of physicians participate in the initial cost evaluation of services, and that a few specialties and episodes can be used to delve deeper into the experience of an episode. One caveat: avoid selection of outliers and high cost cases exclusively for the drill-down, since it will be equally constructive to review cases where cost was low and everything went well.

Select a handful of specific episodes across specialties to use as pre-bundled payments. Establish groups that will design optimal care delivery and the changes required to make that care happen. The groups should be representative of the provider-facility-administrative team involved in services, as well as finance department and/or contracting staff (who may also wish to involve health plans for support and/or data at this point).

Identify patient-reported outcomes and quality outcomes to be captured along with the episodes. Rather than traditional quality measures, these should be focused on complications, cost drivers and patient decision-making, so that cost and outcomes can be more easily correlated.

Broadly educate clinicians and administrators on the effort and create ongoing communication tools and events to keep channels open. As most quality directors know, initiatives have a way of "dying" because momentum flags and communiqués become more infrequent, killing enthusiasm. Change always demands a steady supply of rocket fuel, energy and urgency to keep moving.

Episodic Payments Can Differentiate Competitive Providers

Episodic payments offer specialty providers a mechanism for accomplishing two critical objectives in Value-Based Health Care. First, they create a mechanism for reasonably evaluating costs of care according to procedures and medical conditions. It is essential that the inquiry be constructive, investigatory and collaborative with clinicians. Analytics that compare costs across clinicians too early or without assessing risk and cost drivers will doom the effort

to failure.

Second, the construction of episodes of care with transparent pricing has market appeal for health plans, employers and patients. This approach will differentiate innovative and customer-focused health systems that are responsive to the latest trends and will help them cultivate the data for further analysis and actual savings in health care costs.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

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