

# Building Your Automated Bundled Payment for an Episode-of-Care Initiative

Douglas Moeller, MD

Medical Director, McKesson Health Solutions, Malvern, PA

Payers and providers are looking to “bundled payments” as the payment reform most likely to deliver cost-savings and drive positive outcomes. Bundled payment generally refers to a lump sum paid to providers for a predefined episode of care. Several pilot projects are under way to test and refine this innovative payment model, initially focusing on a handful of surgical procedures but with an eye toward expanding to other services and chronic conditions. The intent is to reward value, not volume, by providing incentives to providers across settings to coordinate their efforts toward evidence-based care while reducing complications and duplicated services.

Projections have pointed to bundled payment as one of the more promising approaches for controlling health-care spending, largely by reducing avoidable complications. A 2009 report from The Commonwealth Fund projected that bundling payments for acute care episodes could potentially reduce health expenditures in the United States by as much as \$300 billion between 2010 and 2020.<sup>1</sup>

In the same year, an estimate from a team at RAND projected that one model of bundled payments for 6 chronic and 4 acute conditions could reduce the national health spending by 5.4% between 2010 and 2019.<sup>2</sup> More than a decade earlier, in the early 1990s, the Centers for Medicare & Medicaid Services (CMS) initiated its experiment in bundling payments in Medicare for coronary bypass surgery, which showed savings of roughly 10%.<sup>3</sup> The question is then, why is the use of bundled payments fairly limited today?

## The Implementation Challenge

As a physician participating in that early-1990s Medicare project, I saw firsthand the potential of bundled payments but also the challenges of implementation. Small projects have shown their worth with manual claims processing and reconciliation. However, a program large enough to deliver meaningful impact requires a supporting infrastructure to offset the administrative burden. Bringing a program to scale requires clinical and financial automation, which until recently was not available.



The complexities of bundled payments create “substantial implementation challenges” and “the need for reliable software to automate bundled payment,” according to Robert E. Mechanic, of the Heller School for Social Policy and Management at Brandeis University, and Executive Director of the Health Industry Forum.<sup>4</sup> Mr Mechanic calls for immediate investments “to develop administratively feasible, economically sus-

tainable, scalable programs,” and describes ongoing development of software to “automatically convert fee-for-service claims into episode-based payments—an extremely complex endeavor but one that could greatly reduce insurers’ administrative barriers.”<sup>4</sup>

Our experience has shown that technological innovations provide health plans with the flexibility to manage bundled claims even in the loosely organized networks of physicians and hospitals that characterize the majority of US healthcare delivery systems.

## The 4 Key Areas for Technology Support

Our experience in pilot projects with health plans and other payers has led us to define 4 areas of automation for a successful bundled payment program. At a minimum, technology must be able to support health plans (and subsequently providers) with these key activities:

**1. Define a care episode and recognize the starting and stopping points (front-end).** Defining included and excluded services is probably the single most important determinant of success. This requires payer-provider collaboration to itemize components for every step in the bundle (eg, clinical laboratory, imaging, anesthesia services). The beginning and end of a care episode must be defined and recognizable to the claims payment process (ideally during a care episode preauthorization or registration process), with a signal that a care episode is under way or will start at some future time.

The wide range of possibilities poses a challenge to many systems. Urgent procedures, such as cardiac catheterization for new chest pain, may have a minimum preintervention period, and the starting point may be the surgery itself. Elective surgeries, by contrast, will have a starting point (such as 30 days before a total

knee replacement) and a trigger point (decision to initiate a care episode) sometime after the diagnosis, when the decision for surgery is made, and surgery may occur weeks later.

A follow-up period (such as 90 days after surgery) must also be defined. For chronic conditions, such as chronic heart failure, chronic obstructive pulmonary disease, or cancer, the episodes of care will typically be defined as a fixed time interval.

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**2. Resolving the care episode with accurate financial management (back-end).** The claims submission process generally is used to track resources used in a bundled care episode, and a claims-processing system must be able to recognize excluded and included services and pay them according to the compensation model. Preventable complications must be clearly defined at the outset, so the stakeholders understand their risk. Once the episode is under way, electronic notifications from the health plan to providers can help in the financial management of bundling claims. Enhanced claims processing and management must be able to look across claim types to autoadjudicate contract terms.

**3. Managing clinical care.** This is the core of the bundled payment process and is essential to moving care toward best practices while using resources efficiently. An ideal solution helps care coordination across multiple sites and integrates expert decision-support content. The care episode definition that triggers financial management can also be used to generate provider alerts and reminders to drive care through appropriate pathways and keep the patient “on track.”

**4. Providing analytics for action.** Powerful analytics are essential to creating the information feedback loops that drive program refinement. Clinical and financial performance metrics must be able to identify variances from best practices in (or near) real time to trigger alerts that can help modify care, either for an individual patient while a care episode is under way, or for a provider overall.

Whether the bundled payment amount is tied to services used by a single patient or tied to average utilization, knowing what resources were used for each

patient is important, because it can point to variations in care or utilization that signal opportunities for improvement. Shared information between payers and providers helps them to align their efforts to achieve a common goal.

### **Fast-Forward to Success**

Many organizations are closely watching current CMS projects, particularly its Acute Care Episode demonstration project that bundles Medicare Part A and Part B for orthopedic and cardiac inpatient surgical services at 5 sites.<sup>5</sup> Results are not expected until 2013, but early positive reports include cost reductions, shared cost-savings, and greater use of evidence-based medicine.<sup>4,6</sup>

Another program, announced this summer, invites providers to define and build episodes of care with 4 different models of bundled payments, selecting for themselves which episodes and services will be bundled.<sup>7</sup>

Organizations setting out on this path may feel stymied by the many choices they have to manage. One challenge is to define the network of providers. Highly integrated delivery systems, notably Geisinger Health System and Kaiser Permanente HMO, have shown successful results for episode-based payments. A pilot program through California’s Integrated Health Association is taking the model to a broader group of payers and providers and independent practice associations more typical of care delivery throughout the country.<sup>8</sup>

Payers also face a range of compensation options, including (1) a lump sum paid before or after the episode; (2) a reconciliation process that aggregates claims for all included services and pays based on a targeted goal; and (3) a modified fee-for-service payment at the start, before moving to a lump sum. One model may work well for an elective surgery, another may make more sense for a diagnostic procedure, and a hybrid may work best for a third type of care episode. Varied compensation models are viable if the payer’s technology for automating payments has the flexibility to adapt to varied compensation models.

For most health plans, bundled payments represent new territory. Many will need assistance—first, in determining which episodes, which regions, and which providers are most suited for collaboration. But plans need not wait to get started. The necessary technology and experience are currently available to help plans move ahead now in creating their own episode-of-care programs.

To jump-start the first episode of care, packaged options of predefined bundles with industry-standard content are available now (or custom-made care episodes can be purchased). When the right workflow technology is then applied to manage the administrative

burden, a bundled payment program can be on the fast track toward meaningful results. ■

#### Author Disclosure Statement

*Dr Moeller is an employee of McKesson Health Solutions, which provides software programs for bundled payments.*

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