Change in reimbursement isn’t waiting for tomorrow. It’s happening right now. Rather than paying for each procedure and office visit, government and private health plans are moving toward a payment model based on the health of an organization’s patient population. During this transition, an organization’s success depends on its ability to manage a variety of payment models. Health care organizations must successfully administer these payment models — which continue to evolve and grow more complex — while optimizing quality, outcomes and patient satisfaction. In short, they must manage “fusion reimbursement” or risk significant cuts in revenue.

**Aggressive timelines**
The Centers for Medicare & Medicaid Services has been very clear in its intent to move payment models away from fee for service, and quickly. Having set an ambitious goal of 30 percent of payments under an alternative model by the end of 2016, CMS plans to increase that goal to 50 percent by the end of 2018.

It is not just CMS that is embarking on this transition. Health & Human Services Secretary Sylvia Burwell says, "Whether you are a patient, a provider, a business, a health plan or a taxpayer, it is in our common interest to build a health care system that delivers better care, spends health care dollars more wisely and results in healthier people."

Commercial carriers and state Medicaid plans across the country also are experimenting with alternatives to fee-for-service reimbursement. Large self-funded employers like Wal-Mart and Lowe’s have started to employ these strategies, as they continually look for ways to reduce their health plan expenses.

**Alternative payment models**
Bundled payments are one of the alternative payment models that CMS, Medicaid plans, commercial carriers and employers are piloting. A bundled payment is the process of making a single payment for all of the care and services for a specific procedure or episode of care. It offers an easier entry point to clinical and actuarial risk management than moving straight to a total-cost-of-care or capitated arrangement. In such an arrangement, providers would be held accountable for providing all of the care necessary for patients for a predetermined fixed budget amount. The bundled payment model offers a shorter time frame (a 30-, 60- or 90-day episode) than a one-year global capitation contract. In addition, the populations are smaller under bundles, some pilot initiatives may offer physicians gain-sharing without risk-sharing, the services are well-defined and, typically, there are exclusion criteria for highly complex patients.

The most recent bundled payment announcement came from CMS about the Comprehensive Care for Joint Replacement program that began Jan. 1, which mandates participation for 800 hospitals in 75 metropolitan statistical areas. The program covers total hip and total knee replacements and includes all professional and facility services during the inpatient stay and for 90 days post-discharge. The program is modeled on the previous voluntary Bundled Payments for Care Improvement initiative, which covers 48 episodes of care (both medical and surgical) that can last up to 90 days post-discharge.

The state of Arkansas has the largest statewide multipayer bundled payment initiative in the country, and it includes both commercial payers and Arkansas Medicaid.
ers have been participating “at risk” since 2013, and the results are telling: Bundled payment programs, when properly constructed, have the power to change provider behavior almost immediately. As a result, Tennessee, Ohio and New York are implementing similar programs.

Bundled payment programs can provide a springboard that helps to standardize care, create efficiencies, and improve both quality and patient satisfaction. The behavior change is the result of the transparency and financial incentives. In many cases, the physicians who appear to be “outliers” in terms of cost or certain practice patterns are unaware that they differ from their peers. But once presented with credible data that identify the source of the variation and point to a standard method of practice, these physicians typically are willing to change.

**Follow the money**

Initially, the natural candidates for bundles are high-cost, high-volume procedures such as joint replacement; in fact, the literature shows that bundles work for elective surgical procedures. However, the demand for bundles continues to grow and is expanding rapidly beyond joint replacements. High-volume procedures that have a lower cost, such as colonoscopies and tonsillectomies, also are being bundled. Market demand also exists for bundling high-cost, lower-volume procedures where there is significant variability in practice, such as spinal fusion.

Because Medicaid plans are spending a significant amount on maternity services, there is a lot of interest in developing and implementing perinatal bundles. Commercial payers and employers easily can adapt such bundles.

**Beyond inpatient services**

Medicaid plans are considering bundles for behavioral health, particularly in children, because of the expense. But implementing behavioral health bundles requires the development and deployment of standard care protocols, including medication for conditions like attention deficit disorder and oppositional defiant disorder. Plans also are looking at the post-discharge period. Avoiding readmissions, coupled with discharging patients to the most appropriate level of care, saves money and improves patient satisfaction.

Health systems that embrace bundled payments have identified partners, from primary care to home care and other post-acute venues, to maximize value.

**Data as strategic asset**

Effectively navigating fusion reimbursement relies on access to data and using data in a new way. But many organizations are struggling to locate the data necessary to conduct analysis and model the impact of shifts in contract provisions.

It is time to evaluate the available data sources and the reporting that is in place. Moving toward a more formalized data governance structure is essential. What is your level of comfort regarding the accuracy of the data? If it is low, what is your plan and time frame to fix it? How current are the data, and does the data lag impact your ability to use it for the purposes you’ve identified? Chances are good there are a number of reports that run automatically on a daily, weekly, monthly or quarterly basis. Who, if anyone, is using the reports, and do they contain information that is actionable? If not, get rid of them.

Commit to improving the availability, timeliness, accuracy and usefulness of the data your organization shares; then make sure you follow through on that commitment and share it transparently and on a regular basis. That process doesn’t happen overnight, but it is absolutely necessary to survive payment transformation and to support alternative reimbursement strategies.

**Leading the conversations**

Forward-thinking provider organizations aren’t waiting for someone to make them an offer. They are reviewing their data and creating a value proposition to take directly to employers and commercial carriers. This proposition has been developed on the providers’ terms, not those of payers.

Providers are looking to direct the conversation and to take on additional risk if they are offered the chance for reward. Because there isn’t yet a national standard model for bundles, payers, employers and providers can develop creative solutions collaboratively.

**Operationalizing bundles**

Successful support and operational implementation of bundles requires organizational commitment from leaders, clinicians and staff alike. Having a dedicated resource — a nurse navigator or clinical coordinator responsible for monitoring patients, educating patients and their families, acting as an advocate to help overcome roadblocks to compliance, triaging clinical issues, and serving as a liaison to the physician...
Bundled payment programs can provide a springboard that helps to standardize care, create efficiencies, and improve both quality and patient satisfaction.

— is key to implementing bundles. Nurses with a background in home health or care management are well-positioned to serve in this capacity.

Ensuring strong physician leadership and active participation in monitoring the results and providing feedback to outliers is critical, as is agreement between clinical and administrative leaders on expected outcomes.

The reporting that supports bundled payment programs allows for easy comparison of important data points like cost, compliance with quality metrics, length of stay, and complication and readmission rates.

New normal
Bundled payments will be a part of any health system or medical practice, regardless of the site of care or specialty. Implementing bundles to establish new care patterns within your organization can make a positive difference in both quality and cost outcomes.

Learning to manage the risk now and improve efficiency along the way is essential for successfully navigating fusion reimbursement. We are a long way from the supposed end game of widespread total cost of care methodology and global budgets, but bundled payments are one element of the transition that can enable success for the future.

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**TRUSTEE TAKEWAYS**

7 Questions to Consider

1. Is your organization ready to face mandated bundled payment programs successfully?
2. Are you leveraging your data as a strategic asset to turn it into actionable information?
3. Are you truly tracking and reporting what it costs to deliver care?
4. Are you making investments in data and technology that will support alternate payment models?
5. Are you developing a post-acute strategy and choosing collaborative partners interested in shared success?
6. Are you using or planning to use clinical coordinators like a nurse navigator to help monitor, educate and assist patients in their care?
7. Are you taking a wait-and-see approach to payment transformation or looking to actively manage the conversation?

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