Bundled Payment Contracting Strategies and Guidelines for Health Plans

Introduction

Health plans seeking to contract with providers around bundled payments are faced with a variety of issues and challenges. This guide will describe some of the most pertinent issues and provide some strategies for surmounting them.

Role of the Health Plan

The first issue to address is the exact role of the health plan in contracting for episodes of care. Health plans may contract with existing provider organizations that decide to accept financial risk for complete episodes or the plan may serve as a “virtual integrator” for providers not otherwise affiliated with each other but willing to participate together for bundled payment. Whether a health plan chooses to serve as a virtual integrator depends on the availability and willingness of existing provider organizations to accept the financial and clinical risk associated with episodes of care and the resources of the plan to undertake the development of “virtual” provider organizations.

Contracting with Existing Provider Organizations

Many different types of provider organizations may desire to contract with a health plan for bundled payment including Accountable Care Organizations (ACOs), Physician Organizations (POs), Integrated Delivery Systems (IDSs) or Physician Hospital Organizations (PHOs). Before contracting with a health plan, these organizations, similar to the health plan, have likely conducted an analysis or assessment of opportunities for clinical and financial improvement utilizing episodes of care. Ideally, the episodes of care the health plan and provider organization would like to contract around overlap. Once the plan and provider organization have agreed on a set of episodes, they must negotiate and agree on the terms for pricing and administering the episode contracts. Often, plans and providers will develop pilot programs whereby they will “operate” the contracts for a specified pilot term (perhaps one year), and limit downside and/or upside risk to each other while they work out administrative and methodological issues associated with entering into contracts using the new payment units.

Prospective or Retrospective Payment?

A fundamental question in contracting for an episode of care with an existing provider organization is whether payments for the bundle are made prospectively or retrospectively. Episode of care contracting has long been seen as a potentially effective way to transfer manageable financial risk to providers through a single (global) case rate. This “technical” or “performance” risk transfer
enables a provider organization to recognize the financial reward for delivering a complete case for less than the negotiated price. It is commonly perceived that bundling payment along an episode of care requires calculating the total case fee or payment in advance and also paying this total fee upfront or prospectively to the “integrated” provider so the provider organization may distribute the funds internally. However, the payment does not have to occur upfront – it can be tracked during the course of the episode of care and reconciled once the episode has closed. As a first step in bundled payment contracting, health plans will need to weigh the pros and cons of prospective versus retrospective payment.

Prospective Payment

Under prospective payment, an episode budget is established once the episode trigger criteria are met and a fee is paid out to either an existing provider organization (such as an ACO) or to a fiscal intermediary, which is in charge of distributing payments to all subcontracted providers. We recommend that a withhold be applied under prospective payment to guard against overpayment when patients seek services outside contracted providers, or in the event that a patient in an episode dies or is found to have a more intense medical problem such as AIDS or cancer (in which cases the episode will have to be terminated).

As the episode unfolds, claims incurred are zeroed out but tracked against the bundled price to help inform future pricing and potential severity adjustment reconciliations. This process can either be done manually or it can be automated via some of the emerging technology solutions that are quickly becoming available. Even under prospective payment, we strongly recommend a reconciliation process. Claims incurred are reconciled against the initial fee and the withhold is then balanced out. The health plan performs these reconciliations and then determines the distributions of withhold balances.

The key to prospective payment is accurately pricing the bundle. There are two ways to do this. The first is a flat average payment and the second reflects patient severity with risk adjustment. The attraction of a flat average bundle is that it is simple to grasp and is based purely on past claims experience that could be calculated on an Excel spreadsheet. So long as payer and provider agree to the elements of care bundled into the package (i.e. what’s in and what’s out), the terms of the bundle become the contract price for the unit of care.

Despite it's simplicity, there are some complexifying factors that need to be kept in mind. A flat price generally requires or assumes some threshold of volume to smooth out patient-to-patient variability. This is how CMS approached the original ACE pilots. If large numbers are not expected, then it is extremely important to define risk corridors using stop-loss, and case outliers for catastrophic reinsurance, otherwise, providers can be exposed to managing too much volatility.
Because the perception of volatility may dominate the provider’s view of the bundle, there can also be a definite danger of risk-shifting or gaming the bundle. Physicians have a good sense of patient complexity and can be especially adroit at steering more easily managed patients into the bundle and referring the complex patients to other centers.

Risk adjustment solves this problem, but it also introduces the question of methodology and physician skepticism; so long as providers understand and accept the method, they generally see risk adjustment as a fair way to price the bundle. One way to ensure viability is to employ already available models like Prometheus that have been generated and vetted in a non-biased environment, or, with a little patience, wait for CMS to publish its public domain model that will have a solid risk adjustment method. In addition, another plus to the CMS model is that it will form the basis of a public standard for defining bundles. Thus, a good deal of the potential conflict between plans and providers over who defines the bundle and risk adjustment model will be removed.

One of the attractive features of prospective payment is that it makes patient responsibility for co-pays or co-insurance far more consumer friendly. A defined price for a bundled package of care allows for a defined co-pay, meaning that a beneficiary can know upfront what the out-of-pocket cost will be and only have to make one payment. In order for this to work, however, contracted providers operating under the bundle must be aware that the benefit model has changed. If they are still billing FFS charges to the plan under the bundled contract, for which the plan has the ability to zero pay, then correspondingly, the providers working under the bundled stream of care must also be able to discern these patients and turn off their nominal co-pay mechanisms. This also suggests that the plan will have to develop a new kind of EOB that is specific to the contracted bundle.

Moreover, plan and provider must determine which provider entity under the bundle will be responsible for collecting the co-pay and make sure that all other provider elements operationally honor the bundled benefit. In previous episode of care experiments, consumer satisfaction has risen or fallen based on whether providers could discriminate between episode of care patients and FFS patients. This puts an extreme responsibility on the plan network managers and contracting people to make sure that this is communicated to provider office staff and to perform adequate due diligence in the contracting process – with a commitment to ongoing monitoring of the process.

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Retrospective Payment

An alternative approach to paying the entire bundle up front to the provider and having the provider distribute the bundle accordingly, is to determine or calculate the fee in advance and reconcile it against fee-for-service claims on a retrospective basis—after the case is completed. The key conceptual element of retrospective payment is that the prospective “budget” can be calculated at the start of an episode of care, against which normal fee-for-service (FFS) billings and payments can be compared during and upon episode completion. Under this implementation method, if the dollars associated with the fee-for-service claims assigned to the provider’s case total less than the pre-established fee or budget, there is a “surplus.” If the actual dollars on a FFS basis at the completion of the case exceeds the pre-established budget, then a “loss” to the risk-bearing entity occurs. Thus, these existing provider organizations can be put at financial risk and be paid on an episode of care basis without the need for intense system integration and complex legal agreements between the providers. The point of these retrospectively reconciled budgets is that the plan continues to be the financial integrator of the dollars paid as opposed to delegating that responsibility to a single provider who would act as the financial intermediary for all of the other providers engaged in the provision of care for the episode.

This “actual versus predicted” retrospective payment method solves a number of problems presented by prospective payment. First, this methodology allows a payer to theoretically work with more provider organizations and cover more cases than only being able to work with provider organizations that are already fully integrated legally, clinically, informationally and financially to operate prospective payment. Second, even with well-researched and vetted bundled payment models, plans will want to test these payment methods on a retrospective basis to identify and address any issues associated with a new payment approach—especially for complex patients. Such a testing or pilot period allows payers and providers to become comfortable with bundled payment while limiting each party’s exposure to financial and business risk. For example, “risk corridors” may be put in place to ensure the surplus or loss does not exceed a certain amount for a particular episode. Third, patient behaviors may be difficult to predict and more difficult to control. A patient may select and initiate a contracted episode of care provider, but then choose to opt out to seek another provider as the care pathway proceeds. The so-called “patient leakage” problem presents tricky subrogation issues if the complete bundled fee has been paid in advance. Fourth, most payer claims transaction systems are not set up to detect a triggered episode of care contract, pay a bundled fee, and subsequently turn off FFS processes (although there are emerging solutions from MedAssets and TriZetto that address this). These potential system constraints may cause such issues as double billing or payment whereby the payer remits a bundled check and still ends up being billed through contracted provider billing systems. The retrospective payment method—while having its own drawbacks—solves these
problems and creates a pathway to prospective payment. This methodology may be implemented leveraging existing systems and can create a smooth transition path allowing provider groups to manage the transition from FFS medicine to accountable care over time. Furthermore, even in prospective payment there is an important (almost essential) component of retrospective reconciliation. For example, some episodes might terminate unexpectedly because of a patient’s death or changing coverage. These terminations will need to be reconciled against other episodes to ensure the prospectively paid provider was not overpaid. Similarly, many risk arrangements are contingent on the provider’s performance on quality metrics. In these arrangements a portion of the prospective payment is withheld and made subject to the scorecard. As such, it’s unclear to us that any episode of care payment system will effectively be managed without a degree of retrospective reconciliation.

Retrospective Payment: How it Works

As described above, there are at least two scenarios for health plans to contract with existing provider organizations for episodes of care:

1. Contract with one “risk-bearing” organization for the full episode (that organization may or may not choose to share the risk with other providers) under the retrospective model; or
2. Serve as a “virtual integrator” and help facilitate the sharing of risk among a number of provider organizations for the episode.

In the first scenario, the health plan contracts with a single existing provider organization such as an ACO or large physician group for episode case rates to be administered using a retrospective payment methodology. Under this model, providers that are part of or affiliated with the ACO or group and/or other providers that may not be affiliated with the ACO or group may perform medical procedures and services associated with the episode. Because fee-for-service claims are tracked against the budget, the episode can operate “across” multiple provider types and providers that operate under normal FFS claim flows. The actual performance for each episode of care is reconciled retrospectively, at the end of the episode time period. In this implementation, FFS remains the actual cash transaction process and the episode of care system converts the fundamental unit of account from FFS codes such as CPT-4, NDC and UB04 codes with negotiated fees to a new unit of account: the episode of care with a negotiated bundled fee. Coupled with accompanying clinical outcomes measures, the prospective budget functions as a financial target against which contracted providers can measure progress towards accountable care.

For each episode that is started or “triggered”, a prospective credit for a bundle of patient care is established for a specified time period. During the course of care, as claims are received for that patient, for that specific episode, they are
“debited” or counted against the established budget - similar to drawing down a bank account. If at the conclusion of the episode the FFS claims total more than the established budget a “loss” to the risk-bearing organization or “overdraft” results. If at the end of the episode the FFS claims are less than the budget then there is a “surplus.” Under this type of implementation, FFS payments, therefore, function as a cash flow mechanism to support ongoing provider operations and debit amounts. Because it does not require full delivery system integration, nor does it require health plans to alter their network fee schedules, this implementation method can be scaled out across many current provider settings in the very near term leveraging existing core claims processing systems.

Defining a Stop-loss

A stop-loss can be defined in just about any manner that payers and providers are comfortable with. It can be set in aggregate and/or at the individual episode level. Stop-losses can be defined in hard set numbers after looking into the details of the episode of care data analyses, or simply as some multiple of the average prospective budget within a patient cohort. One of the advantages of retrospective payment is that once a stop-loss is hit, the episode can be terminated and payment reverts to regular FFS, fully protecting at risk providers. Think of this as the equivalent of the “donut hole” in Medicare Part D. The provider would get reimbursed for costs up to the prospective budget, but then would be at risk for a certain amount (the donut hole) up to the point when full stop-loss is triggered. Stop-loss is a powerful tool in negotiating bundled payment contracts and in the end, determines the amount of downside risk imputed to the provider or held by the plan in the contract.

Further, as payers go through the process of contracting around bundled payment, the key negotiable questions are:

1. At what point does the stop-loss get triggered?
2. What is the total size of the “donut hole” for the provider? Is that a financially manageable amount?
3. Are there any reserves that should be created to cover the donut hole either by applying withholds to on-going FFS payments or the posting of a bond?

Summary

There are several important questions to consider when embarking on bundled payment contracting:

1. Who will you contract with around bundled payments: an existing provider organization or multiple providers?
2. How will you pay the bundle: prospectively or retrospectively? If prospectively, will you apply a withhold?
3. Will there be both upside and downside risk on the part of the provider? If there is both, where and how will you define the stop loss provisions?