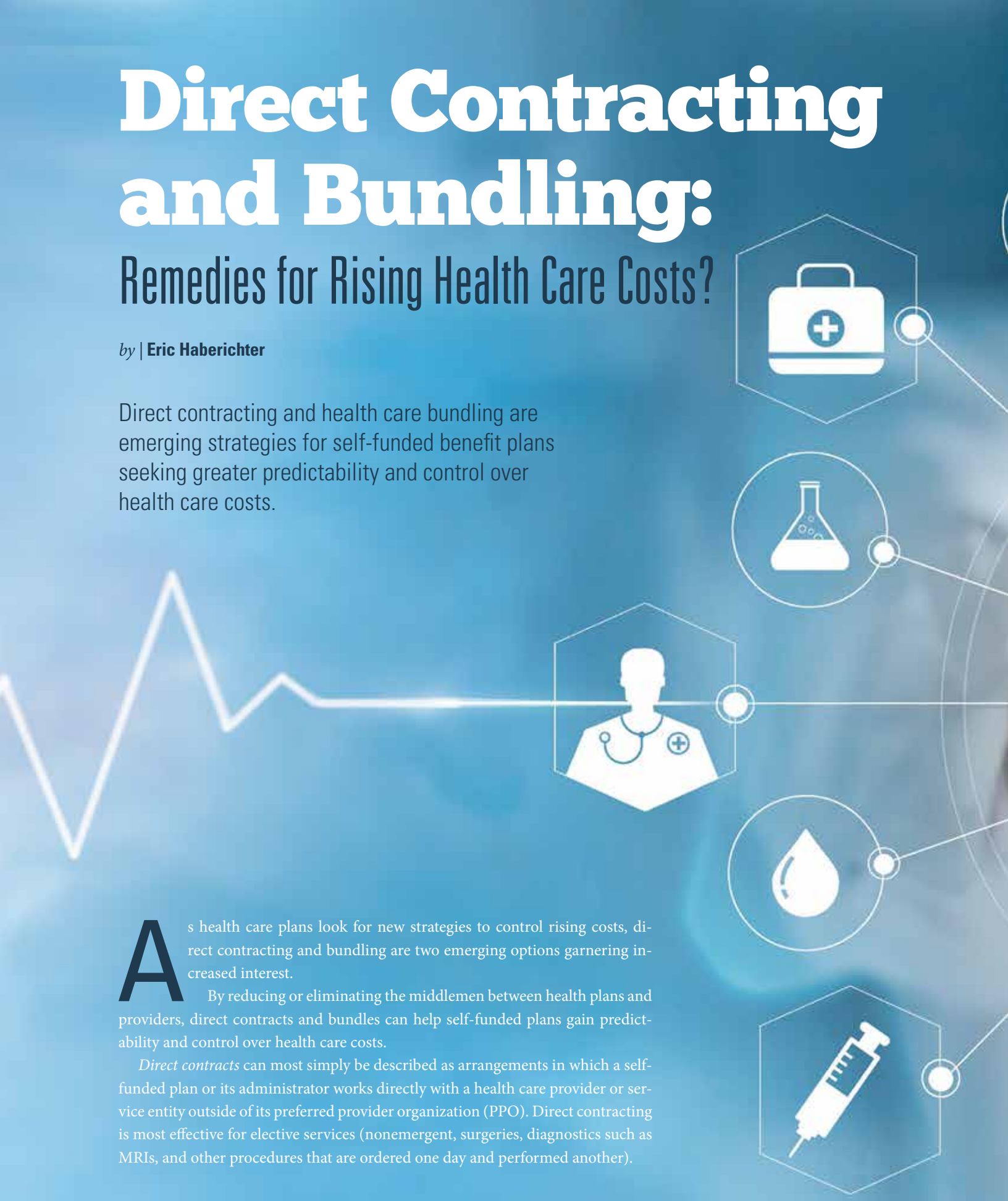
Direct Contracting and Bundling:

Remedies for Rising Health Care Costs?

by | **Eric Haberichter**

Direct contracting and health care bundling are emerging strategies for self-funded benefit plans seeking greater predictability and control over health care costs.



As health care plans look for new strategies to control rising costs, direct contracting and bundling are two emerging options garnering increased interest.

By reducing or eliminating the middlemen between health plans and providers, direct contracts and bundles can help self-funded plans gain predictability and control over health care costs.

Direct contracts can most simply be described as arrangements in which a self-funded plan or its administrator works directly with a health care provider or service entity outside of its preferred provider organization (PPO). Direct contracting is most effective for elective services (nonemergent, surgeries, diagnostics such as MRIs, and other procedures that are ordered one day and performed another).

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Establishing a Price

Most health plans that enter into direct contracts do so because they know the cost of a particular medical procedure or test in their market and believe that the cost is too high. But they face issues determining what a "fair" price is and whether they will they be able to contract for enough services to make direct contracting efforts pay off.

Establishing the fair price for a given service could be relatively easy or extremely difficult. Numerous publicly available transparency sites, such as Guroo and Healthcare Bluebook, offer information on average allowed or fair prices in major markets. Both sites offer public information on local prices for episodes of care ranging from basic lab work to relatively complex surgeries. Another method of determining how much to reimburse under a direct contract is to evaluate how much the plan has historically spent on procedures. A third-party administrator (TPA) should be able to assist in this process, or there are companies that help analyze historical spending.

Making It Count

Obtaining enough direct contracts to provide a return on investment (ROI) on their efforts is likely the biggest obstacle for most plan sponsors. Getting contracts from a handful of providers willing to offer better prices when paid directly is typically not that difficult. However, generating enough direct contracts to provide meaningful savings for an organization and plan participants might prove next to impossible. Why? Providers are just entering the world of direct contracts, and many of them remain unsure of how put such efforts into operation.

takeaways

- *Direct contracts* are arrangements in which a self-funded health plan or its administrator contracts with a health care provider for health services at an established fair price. Plans typically must provide a monetary or volume guarantee to the provider.
- Obtaining enough direct contracts to provide a return on investment is one of the biggest obstacles for plan sponsors.
- Another challenge of direct contracting is the potential for double billing.
- With *bundling,* plan sponsors pay health care providers an agreed-upon lump-sum payment for all of the services provided in an episode of care.
- Plan members must be educated, and incentives typically are needed to encourage use of direct contracts and bundled services.

The easiest way to obtain direct contracts is likely to work with contracting experts that can ensure plans are receiving quality services. Most companies that direct contract or that work with contracting experts can obtain discounts above those offered by their PPOs, but plans typically must provide some sort of monetary or volume guarantee to the provider in order to seal the deal. Contracting experts come in a variety of forms, but the most common are consultants or connectors that can work with employers on building a network of direct, value-based contracts.

Claims Administration and Processing

The tasks of processing and administering claims from direct contracts likely will fall on the plan sponsor. This has the potential to be both good and bad. Paying claims directly is good for plan sponsors because they know exactly how much they are paying and have real-time information on the utilization of contracts and the savings achieved. The downside is that payments made by the plan may not flow to participants' deductible or maximum out-of-pocket expense limits as easily or cleanly as they do within a PPO's standard operations.

Many TPAs, however, have set up programs that allow direct contracts to aggregate with PPO claims. If a plan's TPA does not have that capability or refuses to assist the plan sponsor with direct contracting, the plan sponsor will need to process and pay the claims either on its own or with the assistance of a vendor. It is critical under these circumstances to clearly communicate the process to plan participants so they will be aware that there could be some confusion around billing. The key is to let everyone know the objective of direct contracting and to assure plan participants that they are in it together to win for the both the plan and the plan member.

Billing

Direct contracts can and will save money, but they can also lead to plans being billed twice for the same episode of care. It's important to remember that participants will have their insurance card regardless of the direct contract and that it remains entirely likely that the providers the plan contracts with will obtain the participant's insurance information at the time of service. This can result in both the plan sponsor and the PPO receiving a bill. It's important to work with the TPA to catch any overlap, or savings will turn into overspending.

TPAs that are supportive of direct contracting are a big help, and there are software and service solutions that can further aid plan sponsors in taking control of direct contract billing. Regardless of the solution, plan sponsors should be vigilant about monitoring billing. Provider billing systems are designed to maximize revenue, so the potential for additional charges through a PPO is always present.

Bundling—Direct Contracting Evolved

Direct contracting, like all medical contracting, can take a variety of forms. Within PPOs, most services are paid for on a fee-for-service basis. The essence of this is that providers are paid for every item they are able to code (bill for). The disadvantage of fee for service is that providers are systemically motivated to bill for more. This can result in overtreatment. Ultimately, fee for service drives increased reimbursement for poorer outcomes. How? Efficient high-quality providers inherently code for less care. Here's an example: Highly experienced and skilled Surgeon A completes an orthopedic surgery in one hour with no complications, while less experienced and skilled Surgeon B completes the same surgery in 1.5 hours with some complications. The result? The less skilled surgeon with a poorer outcome generates 200% more reimbursement. Why? Because operating room fees, skilled nursing fees and anesthesia costs were increased by 50%, and the extended hospitalization, increased medication and additional followup care is paid for on a per unit basis.

One way to combat fee-for-service overpayment is by limiting the amount that will be paid for that surgery. The surgery is treated as an "episode of care," which covers the entire cost of the surgery and is determined beforehand. This payment methodology rewards the skilled surgeon and reduces the likelihood of patients being directed to the less skilled surgeon because their employer would lose money. In the world of contracting, payment via episodes of care is called *bundling*.

Paying for medical services as episodes of care has the potential to both simplify billing and increase savings, but bundling methodologies vary in effectiveness at lowering costs and participant experience.

Bundles are a new way of thinking about health payment. With bundling, the plan pays for an episode of care, typically an elective service, in its entirety with a lump sum. Medicare has paid for most hospitalization and extended treatment in this manner for a very long time, through a payment methodology called a diagnosis-related group (DRG). DRGs are a form of bundling that capitates the reimbursement a provider receives for treating a patient with a particular diagnosis, for example, acute chest pain. Some PPOs have adopted this payment method as well for similar conditions. The new bundling, or prospective bundling, is a more appropriate tool for plan sponsors and working-age individuals because they are defined by the treatment received rather than the underlying chronic condition, which could have a variety of treatments with highly varied costs. The treatment bundle is agreed upon by both parties in advance, with no variation in billed costs.

The most recent advances in bundling clearly define all of the elements of an episode of care, such as physician fees, tests, hospital costs and physical therapy, that would typically be paid for under fee-for-service and lumps them together into a single charge. Hospitals, physicians and other providers in a health plan network and geographic area agree to provide their best price for an episode of care.

Plans typically waive copays and deductibles for participants and family members who get care from providers that have agreed to the bundles.

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The incentive for health care providers for participating in bundles is that they get more patients and, if the plan has waived copays and deductibles, the health plan pays the bills in full, so providers don't have the hassle and expense of collecting from patients.

Bundling allows for a level of variability in the actual services performed, leaving the provider in a limited risk position that increases performance and improves outcomes.

Bundles can be a great way to hold down costs, but not all bundles are created equal.

Essentially there are two types of bundles—those that providers agree to in advance and those that are established after services are performed. Working proactively and collaboratively with providers gives plan sponsors and participants transparency and assured value. For example, a plan could determine a benchmark price for an episode of care using a transparency service. The plan then approaches providers and asks them to quote a fixed price for all of the services contained in that episode of care.

Savings can be achieved retrospectively, but the process is highly adversarial and may result in plan members being billed for services they would not otherwise be billed for, which of course makes them very unhappy. Working out the price for services in advance makes the most sense for providers and allows them to compete for the plan's business by offering the best price and service. It also makes communicating the value of the bundle and the participant's responsibility for payment predictable and straightforward. Retroactive or reference-based repricing can save money, but the amount of savings and participant portion are not known until weeks or months after services have been provided.

bio

Eric Haberichter is the co-founder and chief executive officer of Access HealthNet and has more than 25 years of health care, management and entrepreneurial experience. He previously founded Smart Choice MRI, a flat-rate imaging center. He is a graduate of the St. Joseph Hospital School of Radiation Therapy and studied medical microbiology in the premedical studies program at Marquette University.

Utilization

Engaging participants in using direct contracts and bundled services is essential to generating meaningful savings. Educating plan members about direct contracts and bundle options is the first step, but incentives, shared savings or "penalties" will likely need to be applied as well in order to achieve maximum utilization and savings.

The strategies for success are determined by corporate culture, market and health plan design. Most plans find a carrot-and-stick methodology to work the best. In short, the *carrot* is some form of financial reward for making a value-based decision via plan design or incentive, and a *stick* is a penalty for making a non-value-driven choice to spend more.

Another important strategy for implementation is crafting a wellness environment that reassures participants that direct contracts and bundling allow the company to save money without compromising quality of care. Plan sponsors that are the most successful establish trust with participants so they know any changes or additions in their health care offerings could only be in their best interest.

Plan sponsors with high-deductible health plans in place have inherent disincentives for overspending. Highlighting the positives of direct contracts, such as reduced out-of-pocket costs and equal or better outcomes, builds trust with plan participants and will likely have the greatest impact. The portion of a staff that is most likely to initially champion plan sponsor efforts will do so for positive reasons rather than to avoid the penalties.

Engaging participants in any health savings program takes time. Sharing positive (and a few negative) stories can go a long way in creating awareness, but communication needs to be regular and consistent since health care savings information is only of high interest to most employees when they actually need—or believe they or a family member will need—care imminently or are struggling with a recent medical bill. Perpetual marketing is key to success.

Conclusion

Every plan struggles with the widely varying costs in a PPO network. Self-insured employee benefit plans—large and small—looking to control their health care costs and bring year-to-year predictability on their health care spending may need to consider alternative payment models for sustainability. Direct contracting and bundling could be two of the most promising solutions.

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