Bundle Conveners FAQs



With the shift to value-based care payment arrangements, anesthesiologists are increasingly finding themselves in practice environments interacting with entities called **bundle conveners**. It is important for anesthesiologists to understand what role these entities play and how to engage with them. This document answers the most common questions related to bundle convener entities.

What is the forecast for bundled payment arrangements?

Despite pauses and delays, the shift continues away from fee-for-service and towards value-based care. The percentage of health care payments tied to quality and value continues to grow. More than a third of all US health care payments are already flowing through alternative payment models.[1] The Centers for Medicare and Medicaid Services (CMS) have set a goal to get 100% of people with traditional Medicare into a care relationship that includes accountability for quality and total cost of care by 2030. They are also focused on expanding the reach of Accountable Care Organizations (ACOs) into rural and other underserved communities.[1]

Advanced Alternative Payment Models (APMs) operating during the 2023 Quality Program (QP) Performance Period, as well as some Advanced APMs anticipated to be operational during the 2023 QP Performance Period, include: All-Payer Combination Option and Bundled Payments for Care Improvement Advanced Model; Comprehensive Care for Joint Replacement Payment Model (CEHRT Track); ACO REACH (formerly Global and Professional Direct Contracting) Model; Kidney Care Choices Model (Kidney Care First; Professional Option and Global Option); Maryland Total Cost of Care Model (Care Redesign Program; Maryland Primary Care Program); Medicare Shared Savings Program (Basic Track Level E and the ENHANCED Track); Primary Care First (PCF) Model; Radiation Oncology Model; and Vermont All-Payer ACO Model (Vermont Medicare ACO Initiative).[2]



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Alternative Payment Models

What are Alternative Payment Models (APM)?

Our current payment model is complex and creates uncertainties in predicting the cost of anesthesia care for third-party payers. To create financial predictability and easier budgeting, third party payers have presented different forms of payment models to mitigate financial risk when contracting with an anesthesia group. Therefore, understanding these principles will make anesthesiologists better negotiators when it comes to contracting third-party payers.

How many alternative payment models can anesthesiologists participate in?

In the commercial space, this varies by region, plan, and local payment arrangements. In Medicare, for the 2023 QP Performance Period, the Advanced APMs most applicable to anesthesiologists include: the All-Payer Combination Option and Bundled Payments for Care Improvement Advanced Model; Comprehensive Care for Joint Replacement Payment Model (CEHRT Track); ACO REACH Model (formerly Global and Professional Direct Contracting); Maryland Total Cost of Care Model (Care Redesign Program; Maryland Primary Care Program); Medicare Shared Savings Program (Basic Track Level E and the ENHANCED Track); and Vermont All-Payer ACO Model (Vermont Medicare ACO Initiative).[2]

See page 5 for examples of APMs for anesthesia services.

See page 6 for an example of a bundle convener.



Bundle Conveners

What are bundle conveners?

In Medicare's Bundled Payments for Care Improvement (BPCI), a Convener Participant is a type of APM participant that brings together multiple downstream entities referred to as "Episode Initiators"—which must be either Acute Care Hospitals (ACHs) or Physician Group Practices (PGPs)—to participate in BPCI Advanced. The function of the Convener Participant is to facilitate coordination amongst the Episode Initiators and to accept and apportion financial risk under the payment model. Episode Initiators may be either Acute Care Hospitals (ACHs) and/or Physician Group Practices (PGPs). Convener Participants must enter into formal agreements with Episode Initiators to participate in BPCI Advanced and to comply with all the applicable requirements under the Model.[3]

More than 57% of hospitals participating in a BPCI Model 2 hire a bundle convener. These participating hospitals tend to select a larger range of clinical conditions than providers who choose to take on the risk alone.[2]

Why do I need to be familiar with bundle conveners?

Due to the important role that bundle conveners play in apportioning financial risk, anesthesiologists need to know who they are, how to best position themselves, and how to work with them. Physicians and other health care providers have extensive experience with the fee-for-service (FFS) system. With value-based care, providers are being tasked with caring for patients for longer periods of time. Bundle conveners are key in value-based care models because they can be contracted to point out providers' risks as well as provide access to working capital. Additionally, bundle conveners provide useful expertise, technology, and management to the health care provider.[4]

What role do bundle conveners play in health care?

Bundle conveners frequently play the role of apportioning financial risk. They are key in value-based payment and population care models because they can identify providers' risks. Bundle conveners can also access working capital that may be required for data infrastructure and other implementation needs. Additionally, bundle conveners provide useful expertise, technology, and management to the provider.[5] They have claims analysis capabilities that allow them to forecast performance in quality and utilization metrics that drive financial outcomes in APMs. Furthermore, they can use claims analysis to identify broad areas for clinical focus, such as post-acute care and readmissions, that can impact utilization. Some conveners also employ clinicians and case managers to help with care coordination workflows. Strive HEALTH is an example of a convener for total care of chronic kidney disease and end stage renal disease in value-based settings. Physicians have hired STRIVE to facilitate care coordination.

Who pays bundle conveners and what incentives do they have, if any?

Conveners may be hired by hospital administration. Part of their contractual arrangement includes sharing the risk and a percentage of savings earned by the client.

What is the training/education/background of the people who work for bundle conveners?

This varies widely between private consulting firms. The team dedicated to a client can include a physician, nurse, social worker, and other staff with master's or bachelor's degrees and backgrounds in business, health care management, data analytics, or population health.

Do the companies that serve this function often serve other functions or serve only as bundle conveners?

Some of these entities' business portfolios are expansive and include products and services beyond the health care sector.





Do we have a sense of how much value hiring a bundle convener adds and how much one costs?

The costs vary depending on the services being provided for the organization. The value added also depends on the hospital's or physician group's existing data analytics and population health capabilities. Hospitals or groups with lower capabilities in the aforementioned domains will probably perceive more value in hiring a bundle convener.

How much influence do these third-party entities have on health care decisions?

From recent literature, conveners have significant influence over hospital decisions. For example, a 2021 study[6] found that:

- Non-teaching and for-profit organizations had a higher probability of partnering with a convener in Medicare's BPCI program.
- Among hospitals participating in at least one inpatient clinical episode, hospitals that partnered with third-party conveners were more likely to select episodes with higher target prices. A $1,000 increase in episode target price was associated with a 1.66-percentage-point increase in the probability of episode participation in BPCI Advanced compared with a 0.72-percentage-point increase for participating hospitals without third-party conveners.
- Hospitals with conveners were more likely than those without to select inpatient clinical episodes with greater opportunities to reduce spending on post-acute care and readmissions.

What else do I need to know when approached and/or negotiating with bundle conveners?

It is recommended that you have a good understanding of alternative payment models/ methods.

What negotiation tips are there for anesthesiologists?

- Be persistent and regularly follow up with both phone calls and emails. Sometimes it may take up to several weeks to get a response.
- Explain and discuss fee structure in terms that third-party payers understand.
- If working with professional management or negotiators, always have regular oversight meetings.
- Always review the contract yourself besides having a professional review.
- Always be courteous.
- Always check the math in the contract.
- Always be ready to discuss the 33% Medicare problem with anesthesia reimbursement.



APM Examples

Here are examples to illustrate APMs for anesthesia services:

Health Maintenance Organization/Accountable Care Organization

When HMO contracts with physicians, physicians are sharing financial risk with the third-party payer. The payment is usually a fixed monthly check based on the number of members for that month. Therefore, physicians usually get regular monthly checks regardless of the number of patients seen in the office or number of surgeries performed. More patient visits lead to less remuneration per visit, and thus, less profit. Therefore, in the anesthesia contract, to achieve reasonable reimbursement, innovative solutions must be considered. First, we have to figure out the number of cases and the kind of cases performed with the particular HMO contracted surgeon. If there is historic data, analysis will be much easier to conduct. However, if there's no such data available, we must make the best estimate. This may involve some guessing. Once we have the data on the billing amount and actual received amount, we may calculate the high and low per member per month by dividing the dollar amount per month by the number of members. Sometimes, this average amount may fluctuate from month to month; therefore, it is reasonable to take the average of the data over a year.

Example: $\textit{Capitation Payment Per Member Per Month} = \dfrac{\textit{Total HMO Collection Over A Year}}{\textit{(Number of Members Per Year)/12)}}$

Since we are bearing the risk of overutilization, it is reasonable to build a risk corridor for the contract. To alleviate the risk, both parties may want to reconcile the utilization data at a fixed period of time. A fixed payment or percentage of monthly capitation payment may be considered during the contract negotiation.

Ancillary procedures like arterial line, central line, TEE, etc. should be negotiated separately and billed at fixed price. This also holds true for the postoperative pain blocks.

Specialists Directly Contracting to Employers

When employers contract with surgeons for the performance of specific procedures, they are looking for fixed and reduced health care payments. Our current anesthesia payment model can make that kind of budgeting difficult and potentially create ballooning payments. These specific procedures tend to involve total joint replacement surgery. Thus, it would be easier to come up with fixed prices for individual procedures. A reasonable approach would be taking the average of all the surgeries over six months. Certainly, other methods of calculating the case rate can also be used during the contract negotiation. Sometimes discounts may be provided to facilitate the deal.

Cash Paying Patients

This usually applies to GI and plastic procedures. It is always reasonable to set the cash price at the market rate or the rate that is acceptable to the surgeons, as the surgeon will be the person presenting the anesthesia fee to the patient. Therefore, setting a cash rate can be an art and should ensure that the services provided are not at a loss. In the case of a surgeon collecting on behalf of anesthesiologists, reconciliation should be considered during contracting if the fee is based on surgery time. Fixed payment is easier for all parties involved. It is usually based on the relationship with the surgeon or the surgery center and pre-negotiated terms between both anesthesiologists and surgeons. Finally, fees are usually collected ahead of commencement of the procedure.

Bundle Convener Example

Here is an example from an ASA member that has engaged with a bundle convener:

Case 1

My health system contracted with a third party to serve as a non-risk bearing facilitator for Medicare's Bundled Payments for Care Improvement (BPCI) program. Under BPCI, my organization entered into payment arrangements that included financial and performance accountability for episodes of care. The chief quality officer (at the time) and I completed the application. Our contracted third party helped us create the gain sharing contracts between physicians and the hospital, they also helped us obtain, review, benchmark, query, and submit our data. It was helpful to have an organization that could breakdown the different components of care in an episode and let us know specifically where we needed to focus to reign in cost or quality outliers. I know several organizations that perform these services and I have heard good things about them. Some organizations will gain share with the organization (episode initiator) to mitigate down-side risk.



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