

BUNDLED PAYMENT ACROSS THE U.S. TODAY: *Status of Implementations and Operational Findings*

BUNDLED PAYMENTS: THIS WAY TOWARD A CHALLENGING YET BETTER PLACE

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A few years ago, RWJF and the Commonwealth Fund helped develop and refine the promising PROMETHEUS Payment project. RWJF supported the project's efforts to build evidence informed case rates—or episodes—and manage several local pilot payment projects. This report includes interviews from those PROMETHEUS pilots.

RWJF also funded a RAND study regarding progress in three PROMETHEUS pilots. That study found, not surprisingly, that pilots attempting to launch a fairly radical and complicated bundled payment reform like PROMETHEUS in active, dysfunctional and fragmented health care settings would obviously encounter significant delays and major challenges. The RAND authors also though correctly noted that virtually any payment or delivery system reform applied to our current dysfunctional health care settings would encounter similar challenges. So, the question then is not whether a payment reform can avoid major implementation challenges. The question should be—do we have promising payment alternatives that help us save health care dollars? If we do, how can we quickly and practically address the predictable challenges? What have we learned about implementing promising payment models like bundled payments? Arguably, we now have sufficient experience to understand that at least in certain limited care settings bundled payment approaches can take hold and can help garner precious savings.

This issue brief provides a helpful snapshot of that current real world state of bundled payment attempts in the United States. The authors reviewed all 19 of the first bundled payment arrangements. Their report discusses the medical conditions these efforts address, the way they define bundles, how they parse risk and, importantly, how they make payments. American health care and our nation are at a pivotal, difficult time. Most now understand that we cannot go back—that way leads to more cost escalation, fragmentation and unaffordable mediocrity and waste. That way is madness. We must press into unknown and challenging yet better territory. This issue brief provides some practical mapping of the bundled payment part of that new place.

Can we stipulate that the way we have collectively chosen to pay for health care is mad? Would you mind too much if we just agreed that our fee for service approach is unsustainable? Perhaps it made some sense to someone at some time in the past, but those quaint days are over. The authors of this issue brief on bundled payments note that their interviewees agreed on that point. We can no longer rely on the predominant way we pay for care. It leads to perversely high service volume and inexorably rising health care costs. Our task now is not to stay put or go back, but rather to decide which way to proceed. In some ways we are fortunate. We have the urgency of now on our side. Our ongoing health reform debate, as well as national attention to our ballooning federal deficit and the central role that rising health care costs plays in that deficit problem, all are prompting us to, as they say, “bend the health care cost curve”. How should we do that?

At the Robert Wood Johnson Foundation (RWJF) we, like many, have been working for years to help in just such a national moment. We have devoted enormous resources to our centerpiece effort, an initiative called Aligning Forces for Quality, in which communities across the nation learn how to improve both the cost and quality of their health care. In that nearly 10 year effort local consumer, employer, health professional and health plan leaders have been working together to improve the value of their health care. They are doing many things to make that happen—including importantly experimentation with new payment reforms like bundled payments. The authors of this paper included several of these Aligning Forces communities in their study.

“But I don’t want to go among mad people,” Alice remarked.

‘Oh, you can’t help that,’ said the Cat. ‘We’re all mad here. I’m mad. You’re mad.’

‘How do you know I’m mad?’ said Alice.

‘You must be,’ said the Cat. ‘or you wouldn’t have come here.’”ⁱ



Fair, Evidence-based Solutions. Real and Lasting Change.

ⁱ Carroll, Lewis, *Alice’s Adventures in Wonderland*, Chapter 6, 1865.

Hussey, Peter, M. Susan Ridgely, and Meredith B. Rosenthal. “The PROMETHEUS Bundled Payment Experiment: Slow Start Shows Problems in Implementing New Payment Models.” *Health Affairs* November 2011, vol. 30, no. 11 2116-2124.

“Analysis of Medicare claims data has suggested that considerable savings could result from the widespread implementation of bundled payments¹. Limited early results from selected initiatives analyzed in this report also show savings coupled with improvements in the quality of care.”

INTRODUCTION

Health policy discussion across the United States during the past few years has placed significant attention on the adverse effects of fee-for-service payment, the predominant method of paying for health care services in the country. Fee-for-service payment has been widely criticized for financially motivating providers to focus on increasing volume of services and thereby contributing to the nation’s high rate of health care cost growth. Fee-for-service payment has also been faulted for contributing to fragmented and sometimes harmful care.

Bundled payment is one alternative to fee-for-service payment. A bundled payment is a fixed dollar amount that covers a set of services, defined as an episode of care, for a defined time period. The fixed dollar amount can be used to cover two different types of bundles:

- 1) professional and facility charges for a discrete episode of acute care over a defined time period, and
- 2) professional and facility charges for treatment of a chronic condition over a defined time period.

Analysis of Medicare claims data has suggested that considerable savings could result from the widespread implementation of bundled payments¹. Limited early results from selected initiatives analyzed in this report also show savings coupled with improvements in the quality of care. Interviewees in some cases pointed to reductions in lengths of stay and readmissions. These savings and improvements in care suggest there is value in a continued focus on bundled payments as an alternative to fee-for-service payment.

EARLY BUNDLED PAYMENT INITIATIVES

Bundled payment is not a new payment strategy. It has been employed in the past in applications with generally more limited scopes of services than those arrangements being used today. For example, the longstanding diagnosis-related group (DRG) payment methodology for hospitals bundles facility-only services for a given inpatient stay, and global obstetrical fees that include prenatal, delivery and post-partum obstetrical physician services have been in common use for decades. These older bundled payment methods have not grouped services of multiple providers, but rather have done so for single providers.

The first large scale evaluated pilot of bundled payments that included both professional and facility services was Medicare’s Heart Bypass Center Demonstration (1991-1996) in which four hospitals each received a single payment covering both Part A (hospital) and Part B (physician) services for coronary artery bypass graft surgery. CMS did not permit any outlier payments. The amount of the combined payment was negotiated between 10% and 37% below the then-current payment levels. The hospital and physicians were able to decide how to split the combined payment. A formal evaluation² revealed that the participating providers, patients and Medicare all benefited. Physicians were able to identify ways to reduce length of stay and unnecessary hospital costs, resulting in cost decreases of two to 23% in three of the four hospitals. While the payments did not incorporate post-discharge care, those costs also decreased likely due to advancements in discharge planning. A subsequent evaluation³ found that, after controlling for preoperative risk factors and postoperative outcomes, all four hospitals had significant reductions in total direct variable costs (those costs that vary with the number of patients treated) over the entire period of the demonstration. These cost reductions came primarily from the nursing intensive care unit, the routine nursing unit, pharmacy, and the catheter lab. Furthermore, this study found that the cost reduction increased over time. Medicare also tested bundled payment in the outpatient setting in the Medicare Cataract Alternative Payment Demonstration, but with very limited provider participation⁴.

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Continued on page 3

Continued from page 2

Despite the positive results of the demonstration, additional efforts to advance the payment methodology did not occur until several years later with four well-publicized initiatives bringing widespread attention to the strategy:

- In 2006 the PROMETHEUS Payment model was launched with the support of the Robert Wood Johnson Foundation through four initial pilots. PROMETHEUS now includes 21 bundles that can potentially impact payment for almost 30 percent of the insured adult population⁵.
- In 2007 Geisinger Health System began offering a bundled payment rate for CABG surgery, including preoperative evaluation and work-up, inpatient facility and physician services, routine post-operative care, and any required treatment of complications⁶. Geisinger also guaranteed adherence to a set of 40 clinical performance standards specific to the bundle. Geisinger subsequently added additional bundles.
- In 2009 the Centers for Medicare and Medicaid Services (CMS) implemented another bundled payment demonstration, this one titled the Acute Care Episode (ACE) Demonstration. This demonstration expanded upon the Heart Bypass Demonstration by including three joint replacement bundles and five cardiovascular procedure bundles. Five health systems were chosen for participation⁷. One health system has self-reported positive results⁸.
- In 2011 CMS launched the Bundled Payments for Care Improvement Initiative under the authority of the Affordable Care Act, with implementation scheduled for 2012. The initiative utilizes four different models:
 - ◇ *Model 1*: Inpatient stay only (discounted IPPS payment);
 - ◇ *Model 2*: Inpatient stay plus post-discharge services (retrospective comparison of target price and actual FFS payments);

- ◇ *Model 3*: Post-discharge services only (retrospective comparison of target price and actual FFS payments), and
- ◇ *Model 4*: Inpatient stay only (prospectively set payment)

PURPOSE AND SCOPE OF THIS STUDY

All of the above activity, combined with a growing national consensus that movement away from fee-for-service payment is imperative if health care cost growth is to be slowed and quality improved, has generated a flurry of experimentation with bundled payment. Little is known about the design decisions faced by these early initiatives, nor of the challenges they have encountered in implementation. This report was created in order to convey the experience of a sample of payer and provider organizations that have initiated bundled payment arrangements in the past few years. Their experience will help to inform others seeking to implement bundled payments.

To assess recent experience with and trends in bundled payment, Bailit Health Purchasing, LLC identified and researched 19 non-federal bundled payment initiatives during the first quarter of 2012. The initiatives included all of the PROMETHEUS Payment pilots, as well as other initiatives identified through an Internet search, those known by the authors, and those identified for the authors by professional colleagues. For each of the 19 initiatives, Bailit conducted telephone interviews with payer, provider and/or employer organizations involved in currently operating or planned bundled payment arrangements⁹. Additional interviews were also conducted with organizations that had convened and were facilitating multi-provider, multi-payer bundled payment pilots. (For a full list of interviewed organizations, please see Appendix 1.)

Of the 19 studied initiatives, nine have fully operationalized at least one bundled payment, two are conducting observational studies with no payment involved and eight are in the process of developing a bundled payment.

“Bundled payment requires a deep commitment and very strong provider relationships. You can’t impose this on providers—you need to do it with them and not to them.”

—Payer

Continued on page 4

“To implement bundled payment, you need to tie the billing portion and clinical portion together...you need to have a nurse and an accounting person, it can’t just be managed by finance.”

—Provider

“We currently pay for waste. This is a payment model that will require doctors to think differently and get rid of waste.”

—Payer

Continued from page 3

RESEARCH FINDINGS

Why are bundled payments being pursued?

There was a common recognition among the interviewees that fee-for-service payment is not sustainable as a primary payment model and a new payment model is necessary to pay for health care services. The majority of interviewees stated a desire to achieve one or more components of the Institute for Health Care Improvement’s (IHI) Triple Aim, with a desire to control costs being the most commonly cited reason for exploring the payment model, particularly on the part of the payers.

Many bundled payment initiative participants initially approached bundled payment as a methodology to explore and test before facing a decision of whether to make a broader commitment. Payers, the initiators of most initiatives, often cited the need to have a strong provider partner(s). They emphasized that they were selective in finding a provider organization(s) that a) had already spent time defining clinical pathways for the episode of care that was the focus of the bundle, b) enjoyed a good relationship with the payer, and c) had a strong organizational leader with interest in the pilot. A strong physician leader is reported to be a desirable quality for any bundled payment pilot as such an individual helps ensure the clinical perspective is considered and can help support efforts to achieve buy-in among other providers¹⁰.

When providers initiated the bundled payment arrangement, however, the reasons and motivation were slightly different. Some providers, especially those with integrated networks, had a greater focus on clinical care

redesign and alternative payment methodologies were a secondary thought. Two studied providers in particular, cited their desire to focus on improving the value of health care services as a win-win strategy regardless of whether their future payment methodology was one of bundled or global payments. Those providers that did not initiate the bundled payment arrangement often spoke to their desire to gain early exposure to and experience with bundled payment so that the provider would not be harmed when payment reform of a broader scope became mandatory. Those providers wanted to gain experience to “get ahead of the curve.”

What conditions are most commonly bundled?

Reasons for choosing a condition with which to experiment bundled payment varied among the studied initiatives. The majority of interviewees cited the cost of a procedure or condition as the top reason for targeting it for an alternative payment. Yet the simplicity of a bundle’s definition and the ease of implementation were also important considerations, as payers in particular sometimes wanted to limit the scope of their administrative systems investment while testing the concept. Alignment with existing provider initiatives was also a strong consideration for bundle selection. Payers sometimes cited providers who were well prepared for a specific bundle as the main reason for choosing a particular bundle. Finally, there were some indications that bundle selection in the future, as well as its methodology, will be influenced by the bundles Medicare adopts. Some interviewees acknowledged that they were likely to follow CMS, at least in part, in the adoption of future bundles.

Table 1. Number of Studied Bundled Payment Initiatives by Types of Conditions Subject to Bundling and Operational Phase of Bundle¹¹

BUNDLE TYPE	OPERATIONAL	PLANNING / OBSERVATIONAL ¹²
Inpatient Procedural Conditions	9	4
Outpatient Procedural Conditions	1	2
Chronic Medical Conditions	1	6
Acute Medical Conditions	0	1

Continued on page 5

Continued from page 4

While there are four different categories of bundles (chronic medical conditions, acute medical conditions, inpatient procedures and outpatient procedures), inpatient procedures were most frequently selected in the studied initiatives, with chronic medical conditions second in prevalence. A description of observed patterns in bundle selection follows below. (For a complete listing of bundles, see Appendix 2.)

Inpatient procedures

Hip and knee replacement surgeries clearly appear to be the most common inpatient procedures actively subject to or planned for bundled payments. Among the interviewees, seven initiatives¹³ were actively paying providers bundled payments for joint replacement, one payer-provider dyad was in the observational phase and three were in the planning phase.

Interviewees reported that joint replacement is relatively easy to define, as are most procedural bundles. Some interviewees also reported that since the costs of care occur mainly during the inpatient stay, providers have the ability to exhibit more control over costs. Finally, it was reported that joint replacement procedures and the aftercare can be easily standardized, which helps providers to apply some control over the outcome of care.

Some interviewees noted that for joint replacement surgery variation in cost appears to be primarily due to implant device price. Yet, this view was not universally held. Others cited realized opportunities to reduce average length of stay and readmissions.

Outpatient procedures

Among the interviewees, there were far fewer initiatives actively paying for or developing bundles for outpatient procedures despite the work some are doing in creating definitions. Only one interviewee reported active work to implement outpatient procedure bundles, in this case for Percutaneous Coronary Intervention (also known as PCI or “coronary angioplasty”), cataract removal and perinatal care. Two other interviewees were considering perinatal care or another form of bundled care for maternity care.

Maternity bundles may increase in popularity as payers make more efforts to decrease elective pre-term caesarian deliveries, which tend to be more expensive and have poorer outcomes than vaginal deliveries.

Chronic medical conditions

In contrast to outpatient procedure bundles, there is growing movement toward experimenting with chronic medical condition bundles. Bundling chronic medical conditions is more difficult than the bundling of procedural conditions. The cost of chronic medical conditions for any given patient can fluctuate from year-to-year, or from bundle episode to bundle episode. Defining when a bundle begins and ends and what services are included can be challenging when considering chronic conditions such as diabetes. Yet analysis also indicates that the greatest opportunity to reduce avoidable complications and generate savings is with chronic medical condition bundles, and not procedure bundles¹⁴.

Diabetes care was the most common chronic medical condition that is being actively considered for or paid under a bundled payment arrangement among interviewed payers and providers. Asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), coronary artery disease (CAD) and others were also being considered, but less so than diabetes care. Among the interviewees, only six payer-provider dyads were actively designing a chronic medical condition bundle and only one had actively begun making payments.

Uniquely, one large public payer is actively working to develop bundled payment methodologies for developmental disabilities (specific to Medicaid since the bundled services include some only covered by Medicaid) and for attention-deficit hyperactivity disorder (ADHD).

Acute medical conditions

No payer-provider dyads were actively engaged in bundling acute medical conditions, though one was creating a bundle for an inpatient stay related to congestive heart failure.

“We chose high volume surgical services with large variation in payments with an opportunity for increased clinical standardization.”

—Payer

Continued on page 6

“There is a benefit to developing clinical pathways even if there is no payment model.”

—Provider

Continued from page 5

One general challenge identified by several interviewees was identifying procedures with adequate payer-specific volume to make the bundled payment initiative worthwhile. The challenge was most significant in a rural state where the prevalence of small Critical Access Hospitals made procedural bundled payments untenable, particularly at the individual payer level. While the issue of bundle volume is somewhat less of a challenge for condition-based bundles, most interviewees were not currently engaged in such bundled payment activity.

How are bundles defined?

Defining a bundle can require a significant investment of effort. Some payers and providers have turned to pre-defined bundles, like those offered by the PROMETHEUS Payment model. PROMETHEUS has been working on defining bundled payments since 2006 and has defined seven chronic condition bundles, three acute medical bundles, five inpatient procedural bundles and six outpatient procedural bundles. Other third-party organizations, including information technology companies (e.g., 3M, McKesson), nonprofit health care improvement organizations, and consulting firms have also worked to develop operational bundle definitions. Some payers have created bundle definitions on their own, or have considered existing bundle definitions and used them as a starting point in creating their own. These are often large multi-state commercial insurers that benefit from the use of corporate resources to develop and implement a methodology that has potential use across many different markets.

The definition of a bundle is largely comprised of three components:

- (1) service inclusion criteria;
- (2) the episode time window, and
- (3) patient inclusion and exclusion criteria.

The following section will highlight the key considerations for each of the three components.

What services are included within a bundle?

A crucial element to any bundled payment methodology is defining exactly what services are included within a bundle and whether any services for an episode of care could be excluded. The services included within a bundle varied by payer-provider dyad and by bundle type. In order to determine whether a service should be included, many payers, providers and third parties who define bundles consider the clinical relevance of the service to the central procedure or condition when deciding whether the service should be included. For example, physical therapy following joint replacement is almost always included within a joint replacement bundle because it's critical to post-operative recovery and occurs in the majority of cases. In some cases where a payer and provider are developing their own bundle definition, the bundle may be limited to a smaller scope of services (e.g., inpatient portion of the stay only) to simplify the administration of the bundle or, in the case of one provider organization, to reflect only the services over which the providers have direct influence. However, more often than not, inpatient procedural bundles included both the professional and facility fees directly related to the procedure in addition to post-procedure outpatient services.

The one interviewed payer actively engaged in bundling payment for diabetes used the PROMETHEUS-defined approach, which includes both medical and procedural services, but limits the provider's exposure to procedural conditions where diabetes is a comorbidity, but not a cost driver (e.g., hip replacement would be excluded, but foot amputation would be included.)

Continued on page 7

Continued from page 6

When does the bundle start and stop?

After the included services are defined, payers and providers must define the time period for when agreed upon services are considered part of the defined payment. Procedural bundles were found to begin between 2 and 30 days prior to the procedure and extend beyond the procedure by 90 to 180 days. In some cases, pilot sites were considering beginning the bundle on the day of the procedure.

In order for payers and providers to choose a timeframe appropriate for their bundle, some are estimating the amount of spending that occurs during the proposed time period to understand what proportion of typical costs the bundle will capture. Some payers and providers have observed that very little spending related to an outpatient joint replacement happens after 90 days post-procedure and therefore are limiting the post-procedure period to 90 days.

Other providers discussed the natural administrative lag time (i.e., the time period a provider has to submit a claim to the time period a payer has to remit payment) and how it can extend the administrative life of a bundle much longer than desired. For example, if a bundle is 180 days post-procedure, with an administrative lag time of 90 days, a retrospectively adjusted bundle would not be settled until at least 270 days after the initial procedure. This extended time period can make it difficult for providers to make real-time adjustments to their processes as they may not have a complete sense of the results of their efforts until three-quarters of a year later.

Bundles for chronic conditions, in contrast, are typically defined using a standard time period (e.g., one year) and do not have the same considerations for time period as do the procedural bundles. The time period can begin with first diagnosis on a claim or simply include the entirety of the time period for someone with a diagnosis on a claim.

What patients are included within the bundle and are there any factors that would exclude them from a bundle?

Not all services provided to patients who undergo a procedure or who have a condition that is subject to bundling are automatically paid under a bundled payment. Among the interviewed arrangements, patients with comorbid medical conditions who require significant health care services beyond the bundled condition or procedure are excluded from the bundle (e.g., ESRD, HIV). In addition, bundles can be limited to certain patients by placing restrictions on the age of included patients. Lastly, it is common to see bundles exclude patients who have gaps in health insurance coverage during the bundle time period.

What is the process for reaching agreement on the bundle definition?

Despite the availability of pre-defined bundles, payers and providers can spend a great deal of time working on defining the bundle to ensure all parties are comfortable with and agree to the definition. Bundle definitions are often complex and take a great deal of effort and data analysis for providers and payers to understand the definition and its potential impact on provider behavior and provider finances. Providers inherently want to ensure the bundle definition includes services for which the provider can exhibit some control in utilization or occurrence (e.g., pre-surgery imaging or complications) while payers seek to maximize efficiency and motivate improved quality through the use of this type of payment. This means that data modeling and scenario testing may be required before the parties become comfortable.

Payers and providers described multiple rounds of discussion with one another, with support from external consultants, before reaching agreement. This process was generally described as a positive one that helped develop trust between the parties.

“This is where the rubber hits the road. We want to provide a fair deal, but we don’t want to preserve the status quo.”

—Payer

Continued on page 8

“Organizational culture and relationships between payers and providers played a key role in the speed at which bundle definitions were established.”

Continued from page 7

Organizational culture and relationships between payers and providers played a key role in the speed at which bundle definitions were established. In instances in which some distrust existed, certain organizations were successful at narrowly defining the bundle to be limited to a small group of homogenous patients which in effect, limited exposure to high-risk patients and high-cost outliers. In doing so, however, the payers and providers significantly reduced the case volume that would fall under a bundle and the opportunity for each party to financially benefit. In some instances, the bundles became so narrowly defined they were little different than Medicare’s DRGs.

How do payers formally qualify providers for bundled payment arrangements?

Some payers set qualifying criteria for participation in bundled payment arrangements, rather than adjusting the bundle for performance. For example, one interviewee cited facility accreditation, physician credentialing requirements, use of specific surgical safety and verification processes, documentation of how the provider was preventing venous thrombosis, and documentation of a surgical infection program as examples. At the outset, one large employer only sought proposals for a bundled payment arrangement from provider groups that had demonstrated quality on key performance metrics and received accreditation by nationally-recognized organizations. Notably, the large employer also took into account internal brand recognition so as to encourage employee use of the provider for the bundle service.

How are rates set for the bundle?

Upon agreement on the definition of a bundle, it is necessary for payers and providers to develop and negotiate its price. Payers and providers typically take into account historical spending when creating the rates. Many initiatives also analyzed the amount of dollars paid for care that can be defined as “potentially avoidable.” Even for common bundles, participants identified different opportunities for providers to generate savings. For example, in some markets the opportunity to reduce implant device costs was viewed as a prime opportunity for

joint replacement surgery, whereas reducing readmissions and complications and reducing average length of stay were identified as potential and/or realized opportunities elsewhere.

There are two types of rates for bundled payments: risk-adjusted rates that vary with the patient’s severity and flat-fee rates which remain constant for every patient.

Risk-adjusted rate

Risk-adjusted rates using a software program like PROMETHEUS were the most common type of bundled payment rates among initiatives interviewed for this brief. PROMETHEUS uses a multivariate regression model based on claims data and takes into account patient age, comorbid conditions and clinical severity. It also factors in regional differences in the use of health care to further refine the budget to the unique circumstances of each patient. PROMETHEUS is not the only available software for developing risk-adjusted rates - other third-party risk adjustment software vendors (e.g., OptumInsight, 3M, McKesson) are being used or considered for use in risk-adjustment.

Flat-fee rate

While risk-adjusted rates are most common, four studied initiatives reported planning for or using flat-fee, non-risk-adjusted rates. The reasons for choosing a flat-rate bundle varied. Some organizations have adopted substantial exclusion criteria that limit the age and comorbid conditions of a patient, making the eligible patients relatively homogenous and thereby limiting if not eliminating the need to risk-adjust the payment for each bundle. In other organizations, quality improvement efforts to standardize clinical treatment of certain procedures have resulted in consistent service delivery that does not significantly vary based on patient characteristics.

Flat-fees are appealing to payers because they are considerably easier (and less expensive) to administer. In one case a flat-fee rate was employed because the payer had no administrative resources that it was able to commit to a risk-adjusted methodology, and so a flat-fee rate was the only option available to the provider.

Continued on page 9

Continued from page 8

What is the time period from planning to implementation?

The duration of the planning period ranged from six months to a year. In some cases, the planning period was immediately followed by pilot implementation. In other instances, particularly with more complex designs, the planning period was followed by an observation or testing period of six to 12 months, and then by implementation. While criticized for being slow in implementation¹⁵, the first PROMETHEUS sites were in some cases testing alpha and beta versions of the methodology and identifying ways to improve the model. Other PROMETHEUS sites that benefited from the lessons learned have moved to payments and contracts more quickly and in some cases were able to be live with payments within 6 months of first considering implementation.

For initiatives with testing periods, there was sometimes a delay between the end of the testing period and the start of implementation. The causes of the delay included the need to complete the claims run-out period after the end of the last bundle period in order to finalize an analysis of performance, the need to obtain technological solutions to administer the bundled payments, and the time required for negotiation of payment terms.

The pace of planning, testing (if any), and implementation varied for multiple reasons including the level of leadership commitment of the participating parties. One interviewee acknowledged that a two-year ramp-up period could have been completed in six months if all three parties (payer, hospital and physician group) were really focused and made the initiative a priority. Nearly all interviewees described the importance of having a strong commitment among senior leaders within the organization to fully implement a bundled payment. In some cases, senior leaders within the organization were the main drivers to testing bundled payment in the first place. One successful initiative was motivated by a charge from the organization’s CEO.

Does insurer claim data support implementation of bundled payment rates?

While interviewees seldom identified claim data quality as a considerable barrier to their efforts, in one case it proved a large stumbling block. In this instance the payers were not large carriers, but rather self-insured employers using third-party administrators (TPAs). The TPA data was reportedly lacking sufficient detail for use with the PROMETHUES “engine” (i.e., the algorithm used to identify potentially avoidable complication and price bundles). This required significant effort to improve the completeness of captured claim data by the TPAs.

How are payments made?

Payments can be made prospectively or retrospectively. The most common approach to payment administration is by continuing traditional fee-for-service payments and then adding an administrative budget reconciliation process at the conclusion of each episode. While some observers and organizations do not consider fee-for-service payments with retrospective reconciliation to represent true bundled payment, this payment administration method is currently in use for several reasons.

First, the technical and administrative structure to support fee-for-service payments is already in place for both the payers and the providers. Conversely, administering a prospective bundled payment can require changes in billing practices for the provider and always requires a significant investment in technology for the payer. While technology vendors have recently been developing modules to add to conventional claims payment systems, claims payment systems today can seldom administer payments that bundle multiple professional and facility services.

Second, in many definitions of bundled payment, certain procedures, conditions or events can disqualify a patient from a bundle. For patients who are terminated from the inclusion of a bundled payment episode, the health plan would likely default provider payment back

“Data integrity is essential”

—Payer

Continued on page 10

“The folks who do best with bundles are those who think about it before getting into it.”

Continued from page 9

to fee-for-service. In this case, it would be necessary to track the fee-for-service claims to pay the provider for the services covered prior to termination from the bundle. In addition, in the event a prospective payment was made for a terminated bundle, the provider would then have to remit payment back to the health plan.

While fee-for-service with retrospective reconciliation is by far the most common approach, two of the studied initiatives were currently employing prospective payment, and a third initiative was planning on proceeding with prospective payment. In the last case the payer consisted of a coalition of self-funded employers. The large number of plan administrators, and their lack of enthusiasm for administering prospective payments, led the coalition to partner with a technology vendor that would allow for prospective payment administration. As of the time of the interview, the payer was awaiting the completion of the technology vendor’s work with a goal of implementation in the second half of 2012.

How do plans track and report spending within the bundle?

Tracking and reporting spending during the episode of care

For providers to understand the spending for which they are accountable during an episode of care, payers must provide them with a means to track the bundle-related claims—especially those claims that occur outside of their purview. Among interviewed initiatives, payers send reports on either a monthly or quarterly basis to help providers get a sense of spending to-date on the bundle. In one case, a third-party vendor uses a secure website to display how providers are faring against their budgeted bundle rate for claims that have been processed through the payer.

Not all providers are satisfied with the amount of information they receive and some are seeking more real-time information to help manage their costs. Unfortunately, claims are never sent or paid for on a real-time basis and there will always be a time lag between a health care event and notifying the provider of its costs, especially for those events that happen outside of the provider’s health care organization.

Reconciliation

Regardless of whether bundle payments are made on a prospective basis or not, the budgets need to be reconciled at the conclusion of an episode to determine whether all of the patient claims were associated with the bundle, to administer any performance adjustments, administer any risk-arrangement, and make any risk-adjustment.

The reconciliation process for the majority of interviewed payers and providers is a manual process and can take up to a few FTEs of personnel to complete the task. In some cases, as mentioned above, reconciliation occurs up to nine months after the start of the episode.

Since most payers and providers are still operating in a fee-for-service claims-based system, the reconciliation process includes a review of all fee-for-service claims to identify the appropriate treatment for each claim. A set of complex rules must be applied to each claim to determine whether it should be “zeroed-out” (i.e., not paid and applied to the bundle) or if it is unassociated with the bundle (e.g., emergency department visit unrelated to a knee replacement) and paid under the normal operating payment system. In addition, rules must be applied to identify exclusionary events that could revert the payment of care for that patient back to fee-for-service. For example, if a patient changes health insurance during the episode of care (even if it is during the last few days), the bundled rate would not apply and all claims for that patient would be paid as fee-for-service.

This complex reconciliation process has been automated by a few different vendors (i.e., HCl3, MedAssets, TriZetto and 3M, for example) who have recently entered the market with software products to assist payers with administering bundled payments. To date, only a few payers have engaged with a third-party vendor to administer bundled payments due to the costs associated with the vendor and the fact that many payers are still testing the bundled payment concept. Some payers voiced concern that the savings achieved through this new payment system may be spent on administration, resulting in no net savings to the health care system as a whole. Still, multiple interviewed payers described exploration of

Continued on page 11

Continued from page 10

the capabilities of vendors and see them as resources for expanding the use of bundled payments beyond the pilot phase.

Are the bundles adjusted for performance in any fashion?

Among interviewed payers and providers, only one pilot reported that it was adjusting the bundled payment amount to account for performance on quality measures at the present time, although several were using quality measures in other ways. This one payer made a pay-for-performance payment in addition to the bundled payment for providers who performed well on quality and efficiency measures, or in some cases, just efficiency measures (e.g., ambulatory care-sensitive ED visits).

Some payers and providers cited the challenge in finding acceptable procedure bundle-specific quality measures. A specific concern voiced by those payers and providers engaged in joint replacement bundles was the lack of nationally recognized performance measures for hip and knee replacement. In addition, a concern among orthopedists is that the use of hospital-based surgical outcome metrics (e.g., Medicare’s Surgical Care Improvement Project (SCIP)) do not adequately hold the surgeon accountable for individual performance and can be tarnished by performance elsewhere in the operating room.

In other instances, the decision to not use quality measures to adjust payment seemed to reflect the fact that the bundled payment initiative was at an early stage of testing rather than payer and provider strategic intent. When asked about performance adjustments, one interviewee noted his desire to “keep it simple” and focus on ensuring the definition was accurate before the addition of quality metrics. That same interviewee foresaw that quality metrics would have a future purpose as a minimum threshold for participating in a bundled payment arrangement.

In one case a provider created physician report cards to help track performance relative to clinical care protocols established for the bundles. This measurement was performed for quality improvement purposes, and not to influence payment.

In some instances, a payer negotiated minimum quality thresholds the provider had to meet to be eligible to share in any savings that the provider generated. For example, one interviewee explained that providers had to be fully compliant with data collection for key measures, antibiotic administration and timing (for surgical bundles) and complete pre and post-operative functional assessments in order to qualify for any shared savings. The use of measures reported for other purposes (e.g., in provider incentive programs or existing hospital report cards) was a desirable way to avoid creating added administrative burden for quality measurement.

What types of risk arrangements are in place?

Among the interviewed bundled payment initiatives, many are progressively increasing provider-borne risk over a period of years, by transitioning from shared-savings to full-risk. This is a common strategy used to help engage providers in trying bundled payments in that it gives providers time to study and change their care processes to have a greater chance of being successful under this new payment model. The following section will highlight the key considerations for each of these three risk-arrangements:

- (1) shared savings;
- (2) shared risk, and
- (3) full risk.

Shared savings

Shared savings is a payment strategy that in combination with bundled payment offers an incentive for the provider to reduce health care spending to be below the negotiated bundled payment rate by allowing the provider to share in any of the savings realized. In addition to the ability to share realized savings, the provider bears no responsibility for costs that occur above and beyond the bundle price. Protecting providers against “down-side” loss was a common first step approach among interviewees toward full-risk bundled payments.

Details of shared-savings arrangements were not obtained during the interview, because many interviewees had not finalized the details of the arrangement and because the interviewee

“From the beginning we said this was as much about quality as efficiency.”

—Payer

Continued on page 12

Continued from page 11

wished to keep its methodology confidential. A broader study of shared-savings arrangements not limited to bundled payments found that a 50/50 split between the payer and the provider is most common¹⁶. As mentioned above, some initiatives required providers to meet a minimum quality threshold in order to be able to share in any savings they had achieved. This type of quality threshold helped to ease concerns that providers could “game the system” by withholding important tests or delaying treatments in order to come under budget.

Shared risk

Shared risk is a payment strategy that in combination with bundled payment offers an incentive for the provider to reduce health care spending to below the negotiated bundled payment rate by putting the provider at-risk for some of the costs above the negotiated rate and by allowing the provider to share in some of the savings realized. The percentage of costs above the negotiated rate for which the provider is responsible varies from arrangement to arrangement and is usually the result of a negotiation.

Only one interviewed payer reported the desire to use this approach during the first year of its bundled payment arrangement. It was more commonly reported that payers and providers currently engaged in shared-savings arrangements desired to move to a shared-risk arrangement after the first year of using bundled payment.

Full risk

Full risk is a payment strategy that in combination with bundled payment offers an incentive for the provider to reduce health care spending to below the negotiated bundled payment rate by putting the provider at full risk for all of the costs above the negotiated rate, but also by allowing the provider to retain all of the savings realized as a results of their efforts.

While most interviewees reported the desire to move toward full-risk over time, a number of initiatives have jumped directly to a full-risk arrangement. However, among those who reported using a full-risk bundled payment approach, there were limitations associated with that risk. For example, some providers negotiated to have outliers excluded from their responsibility or to have a stop-loss in place to prevent them from being exposed to rare, but high-cost cases. In one instance, a high-cost outlier was defined as two and half times the negotiated rate. In another initiative, the provider was held fully responsible for all costs, with the exception of those associated with readmissions outside of the provider’s system.

How many patients are involved in bundled payment arrangements?

While bundled payments are becoming more popular, the volume of the studied bundled payment initiatives was still relatively small – often 10-50 bundles per year for a provider and payer. While many payers and providers chose high-volume procedures or conditions to bundle (e.g., joint replacement and diabetes), the volume of qualifying patients was low for a variety of reasons. In more than one example, providers negotiated so many exclusions into the bundle to not only make the population homogenous, but to also reduce the financial risk. In other cases, the problem of continuous enrollment (i.e., when a patient keeps the same health insurance during the period of the bundle) caused an unexpected drop in patient volume. A recent study suggests that this problem is common—26 percent of all adults experienced a gap in coverage in 2011 due to the loss or change of job¹⁷. For one payer and provider, this lack of continuous enrollment caused a 40 percent drop in expected paid bundles. Despite the low volume, payers and providers are using these early experiences to test the waters of alternative payment and risk-sharing arrangements and prepare themselves for likely market changes down the road.

Continued on page 13

Continued from page 12

What results have been produced by the existing initiatives?

Very few studied initiatives had a formal evaluation of their bundled payment arrangements and, as noted earlier, many of the interviewed payers and providers were too early in the development of the bundled payment to make any clear conclusions about the impact of bundled payment on cost or quality. Despite this, the preliminary results showed some modest savings on cost. One large provider system reported a modest savings of \$600 per bundle and another reported reducing the average length of stay by ½ day. One well-studied interviewee reported a 40 percent decrease in readmissions, a 50 percent decrease in complications and a reduction in mortality to nearly zero. These reported savings, plus the savings reported in the Medicare demonstrations, suggest the value of continued testing of bundled payment by providers and payers.

How did interviewees view the future of global payments?

The number of bundled payment pilots is on the rise, but whether they auger a widely employed permanent reimbursement strategy or a transitional one remains to be seen. While some interviewed providers and plans thought that their experience with bundled payments would transition into contracting using global payments, the majority of interviewees was taking a “wait and see approach” and reported using their pilot experience to gain deeper insight into the payment strategy. Many are waiting with a watchful eye to see the results of Medicare’s experience with Bundled Payment for Care Improvement Initiative.

Whether bundled payments can coexist with global payments is unclear. Most interviewees confessed to not having considered the question. For provider organizations that are transforming into Accountable Care Organizations (ACOs), bundled payments could be an internal means

for managing care under a global payment with the providers associated with the ACO. On the other hand, bundled payments may lose popularity among payers if they decline to administer a bundled payment for a service that is covered under a global payment.

CONCLUSION

Our research identified significant and growing bundled payment activity in the United States. Payers feel compelled to pursue alternative payment models to fee-for-service payment and at least some providers see a need to prepare themselves for a changing reimbursement landscape. Those who we interviewed were in many ways pioneers, often proceeding at the outset without a clear understanding of how bundled payments operated and what was required administratively and clinically to use bundled payment as a new way of transacting business. With a couple of notable exceptions where there was a payer commitment to making bundled payment a core business strategy, the studied initiatives were exploratory in nature, with the participants awaiting additional experience before deciding whether bundled payments were advantageous and worthy of long-term commitment. Despite this uncertainty of the long-term, there were some for whom initial experience had been sufficiently positive that they were choosing to expand their use of bundled payment arrangements to additional bundles and contracting partners.

This brief has described the path and the decisions followed by providers and payers involved in 19 of the first bundled payment arrangements. Their experience, and specifically how they have responded to choices that they have faced, should help to inform those who are following them to explore and implement bundled payments.

“We’re worried about the operational investment so we won’t take it to scale until it has proven value.”

—Payer

APPENDIX 1.
INTERVIEWED ORGANIZATIONS

ORGANIZATION	ORGANIZATIONAL TYPE
Aetna	Payer
Aligning Forces for Quality (AF4Q) in South Central Pennsylvania ¹⁸	Multi-stakeholder payment reform collaborative
Anthem Blue Cross and Blue Shield of Missouri	Payer
Anthem Blue Cross and Blue Shield of Wisconsin	Payer
Arkansas Medicaid	Payer
Blue Cross and Blue Shield of North Carolina	Payer
Cigna	Payer
Colorado Business Group on Health	Employer coalition
Colorado Choice Health Plan	Payer
Crozer-Keystone Health System	Provider
Employers' Coalition on Health	Payer
Geisinger Health System	Provider
HealthNow New York, Inc.	Payer
Horizon Healthcare Innovations of New Jersey	Payer
Independence Blue Cross	Payer
Integrated Healthcare Association (IHA)	Multi-stakeholder quality improvement collaborative
integrated Physicians Network (iPN)	Provider
Johns Hopkins Health System	Provider
Massachusetts General Hospital	Provider
Massachusetts Medicaid	Payer
Partnership for Healthcare Payment Reform	Multi-stakeholder payment reform collaborative
PCD Partners	Consultant to St. Johnsbury, VT pilot
PepsiCo	Payer
Priority Health	Payer
Swedish American Medical Group	Provider
Vermont Green Mountain Care Board ¹⁹	Multi-stakeholder payment reform collaborative

APPENDIX 2.
DETAILED LISTING OF CONDITIONS SUBJECT TO OR PLANNED FOR BUNDLING

BUNDLE TYPE	CONDITION
Inpatient Procedural Conditions	<ul style="list-style-type: none"> • Knee Replacement • Hip Replacement • Hip and Knee Replacement Revisions • Hip and Knee Arthroscopy* • Coronary Artery Bypass Graft (CABG) • Percutaneous Coronary Intervention (PCI) • Bariatric Surgery • Colon Resection* • Prostatectomy²⁰ • Diagnostic Cardiac Catheterization*
Outpatient Procedural Conditions	<ul style="list-style-type: none"> • Cataract Removal • Perinatal Care • Cervical Spine Implant* • Hysterectomy²¹* • Percutaneous Coronary Intervention (PCI) • Maternity²²
Chronic Medical Conditions	<ul style="list-style-type: none"> • Asthma • Chronic Obstructive Pulmonary Disorder (COPD) • Diabetes • Coronary Artery Disease (CAD) • Congestive Heart Failure (CHF) • Developmental Disabilities* • Attention Deficit Hyperactivity Disorder (ADHD)* • Oncology*
Acute Medical Conditions	<ul style="list-style-type: none"> • Upper Respiratory Infection (URI)*

* Denotes that the condition is under consideration, but has not yet been implemented as bundled payment by any payers or providers.

- 1 Cutler D and Kaushik G. "The Potential for Cost Savings through Bundled Episode Payments." *New England Journal of Medicine* 366;12 March 22, 2012.
- 2 Cromwell J, Dayhoff DA and Thoumaian AH. "Cost Savings and Physician Responses to Global Bundled Payments for Medicare Heart Bypass Surgery" *Health Care Financing Review*, 9(1): 41-57, fall 1997, available at www.ncbi.nlm.nih.gov/pubmed/10180001.
- 3 Liu CF, Subramanian S and Cromwell J. "Impact of Global Bundled Payments on Hospital Costs of Coronary Artery Bypass Grafting" *Journal of Health Care Finance*, Vol. 27, No. 4, Summer 2001, pp. 39-54, available at www.ncbi.nlm.nih.gov/pubmed/11434712.
- 4 Abt Associates Inc., *Medicare Cataract Surgery Alternate Payment Demonstration: Final Evaluation Report*, Cambridge, MA 1997.
- 5 PROMETHEUS Payment. What is PROMETHEUS Payment? An Evidence-Informed Model for Payment Reform. 2009, available at www.rwjf.org/qualityequality/product.jsp?id=43951.
- 6 Lee TH. "Pay for Performance, Version 2.0?" *The New England Journal of Medicine*, Vol. 357, No. 6, August 9 2007, pp. 531-533.
- 7 Medicare Acute Care Episode Demonstration or Orthopedic and Cardiovascular Surgery, available at www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads//ACE_web_page.pdf and Acute Care Episode Demonstration, available at www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads//ACEFactSheet.pdf.
- 8 In 2011 Baptist Health System reported reducing spending by \$4.3 million since the program's inception, or approximately \$2,000 per case in the ACE demonstration. CMS also reduced costs through discounted bundled fees, and physicians added \$280 in gain-sharing payments per episode. Participating beneficiaries have earned approximately \$320 each through reductions in their Part B premiums. See The Health Industry Forum. "Episode Payment: Private Innovation and Opportunities for Medicare" Conference Report, Brandeis University, May 17, 2011, Washington, DC, available at <http://healthforum.brandeis.edu/meetings/materials/2011-17-may/Final%20cr5-17-11.pdf>.
- 9 Two of the initiatives (Aligning Forces for Quality (AF4Q) in South Central Pennsylvania and the Vermont Green Mountain Care Board) were represented by the direct experience of Bailit facilitating the initiatives.
- 10 Herzlinger, Regina. "Note on Bundled Payment in Health Care." *Harvard Business School*, N1-312-032, October 2011.
- 11 The total sum does not add up to 19 (the total number of studied initiatives) as some are operational with one or more conditions while planning for others.
- 12 "Observational" refers to the time period when payers and providers engage in real-time analysis of potential episodes of care, in some cases shadowing the process of administering a bundled payment, but with no bundled payments made and no budget reconciliations resulting in a payment transfer.
- 13 One payer limited its bundled payments to revisions of joint replacement only.
- 14 de Brantes F., et al. "Sustaining the Medical Home: How PROMETHEUS Payment can Revitalize Primary Care." *Robert Wood Johnson Foundation* <http://www.hci3.org/sites/default/files/files/PROMETHEUS%20-%20Medical%20Home%20-%20full%20packet%20-%20FINAL.pdf>
- 15 Hussey, Peter., M. Susan Ridgely and Meredith B. Rosenthal. "The PROMETHEUS Bundled Payment Experiment: Slow Start Shows Problems in Implementing New Payment Models." *Health Affairs* November 2011, vol. 30, no. 11 2116-2124.
- 16 Bailit M. and Christine Hughes "Key Design Elements of Shared-Savings Payment Arrangements." Commonwealth Fund, August 2011. Available at: www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/Aug/1539_Bailit_key_design_elements_sharesavings_ib_v2.pdf
- 17 Collins, Sara R. et al. "Gaps in Health Insurance: Why So Many Americans Experience Breaks in Coverage and How the Affordable Care Act Will Help." *The Commonwealth Fund*. April 2012.
- 18 This organization was represented in this brief by Bailit's direct experience facilitating its bundled payment initiative.
- 19 *ibid*
- 20 The definition of this procedure is still in development and could be bundled as inpatient or outpatient.
- 21 *ibid*
- 22 *ibid*