ISSUE brief

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KEY PAYER AND PROVIDER OPERATIONAL STEPS

to Successfully Implement Bundled Payments—May 28, 2014

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INTRODUCTION

This is the third in a series of annual issue briefs that have tracked the development and implementation of bundled payments in the public and private sectors. This brief builds upon the two previous issue briefs[1] by providing a more in-depth review of the operational steps health plans and providers are taking to be successful under bundled payment. Our findings are based on interviews with seven payers, seven providers, and one organization selected as a convener.[2]

We found two emerging trends for payers implementing bundled payments:

- A limited number of public and private payers are now committing to bundled payment as a core payment and delivery reform strategy and, therefore, they are significantly expanding the scope of their efforts to include more providers and more episodes. Bundled payment is no longer a payment method assigned only to pilot status.

- These same payers are automating what have been manual, resource-intensive processes and are making significant investments to do so. They are also simplifying their bundled payment methodologies to make them easier for the payer and its contracted providers to administer.

The predominant trend among providers embracing bundled payments is their commitment to developing and implementing comprehensive systems of care that continue for the duration of the bundle, and that include all caregivers. Although the providers we interviewed are predominantly implementing orthopedic bundles (i.e., knee and hip replacement bundles), many of their approaches to building systems of care are applicable to other types of bundled payments. With the Centers for Medicare and Medicaid Innovation's (CMMI) Bundled Payment for Care Improvement (BPCI) initiative, the types of services to which bundled payment models are being applied have greatly expanded.

While the number of providers and payers implementing bundled payments is relatively small, we observed growth in the adoption of bundled payment initiatives. In Arkansas, implementation of the Arkansas Healthcare Payment Improvement Initiative propelled much broader bundled payment implementation within the commercial and Medicaid markets, and across a variety of procedures and conditions. The Ohio and Tennessee Medicaid programs are also in the process of implementing bundled payment programs that are modeled, at least in part, on Arkansas' work. With the Medicare BPCI initiative, and three state-based programs implementing bundled payment programs on a large scale, a movement towards broader adoption of bundled payment may be on the horizon.

PAYER FINDINGS

We first identified a number of payer organizations that either are involved in bundled payment activity, or have been in the past. Of these, we interviewed seven payer organizations, including six in depth interviews, to understand how they are currently operationalizing bundled payments. (See Appendix A for a listing of the interviewed payer organizations.) We chose not to interview payers that had been participating in pilots in prior years, but whose efforts did not continue or were stalled. We also did not interview organizations that were still planning new pilots or were continuing existing pilots.

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1 Burns ME and Bailit MB "Bundled Payment Across the U.S. Today: Status of Implementations and Operational Findings." Health Care Incentives Institute, Newtown, CT, May 2012 (see www.hci3.org/sites/default/files/files/HCI-IssueBrief-4-2012.pdf) and Burns ME, Houy, MH, Bailit MB. "Bundled Payments One Year Later: An Update on the Status of Implementation and Operational Findings." Health Care Incentives Institute, Newtown, CT, May 2013 (see www.hci3.org/sites/default/files/files/IB.BundledPayment-June2013-L3_0.pdf).

2 Awardee convener organizations are entities that assume a portion (or all) of the risk on behalf of an episode-initiating bundled payment organizations (e.g., hospitals.) A case study of an awardee convener is provided in Burns ME, Houy, MH, Bailit MB. "Bundled Payments One Year Later: An Update on the Status of Implementation and Operational Findings." Health Care Incentives Institute May 30, 2013 (see www.hci3.org/sites/default/files/files/IB.BundledPayment-June2013-L3_0.pdf).

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Episodes: Number, Type and Definition

Table 1. Immediately below provides summary descriptive information on the bundled payment programs of the six payers that we interviewed in depth.

PAYER	BUNDLES IMPLEMENTED	START DATE
Payer A	1. ADHD 2. CABG 3. Cholecystectomy 4. Colonoscopy 5. Congestive heart failure 6. Developmental disabilities 7. Hip replacement 8. Knee replacement 9. Oppositional defiant disorder 10. Perinatal care 11. Tonsillectomy 12. Upper respiratory infection (URI) *Five more planned for 2015 implementation.*	2012
Payer B	1. Hip replacement 2. Knee replacement	2012
Payer C	1. Bariatric surgery 2. CABG 3. Cataract removal 4. Congestive heart failure 5. COPD 6. Hip replacement 7. PCI 8. Perinatal care *Two more planned for 2014 implementation.*	2006
Payer D	1. Hip replacement 2. Knee replacement *One more planned for 2014 implementation.*	2012
Payer E	1. Cholecystectomy 2. Congestive heart failure 3. Hip replacement 4. Knee replacement 5. Perinatal care 6. Tonsillectomy	2013
Payer F	1. Adjuvant breast cancer 2. Arthroscopy 3. Colonoscopy 4. Hip replacement 5. Knee replacement 6. Pregnancy	2011

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The numbers of providers contracting with the payers under these arrangements range from one to thousands. Not surprisingly, the annual volume of episodes also varies from "10 to 15" to approximately 125,000 (Arkansas Medicaid's upper respiratory infection episode).

Some of the payers have adopted a standardized approach to episode definition and contracting or have set of goal of doing so, whereas others are open to variation. One of the payers with a higher degree of variation in terms of bundle definition and contracting provider type stated, "you have to be flexible."

Payers are also making changes in bundle definition to streamline operations for the payer and its providers. One payer reported having previously used risk-adjustment factors, but more recently discarding them after finding risk-adjustment complicated and manually intensive to administer. Another shortcoming of risk-adjustment is that the contracted provider does not know its actual budget at the outset of the episode, which is challenging to the provider.

The payer that discarded risk-adjustment factors now develops a budget using two years of historical data. The payer sets an episode budget target based on each provider's mean historical experience, with a cap on the provider's financial exposure of 115% of the episode budget. As a result, the provider is in essence "competing against itself." The payer said because of this change, it is now possible for a provider to know its episode budget up front. Payer modeling reportedly revealed a negligible financial impact from moving away from patient-level risk adjustment.

"While some of the pilots we studied in prior years involved a physician group and a hospital, there appears to be a certain trend towards contracting with just one provider entity for an episode."

Provider Contractors: Partners and Financial Terms

The interviewed payers reported two different approaches to contracting:

- specifying bundled payments as the sole payment model for providers delivering selective episodes of care, and
- contracting using bundled payment with only selected, high-volume providers who are interested in bundled payment, and with whom the payer enjoys a strong working relationship.

For those payers that contract selectively for bundled payments, approaching provider organizations whose leaders are visionary and want to be "ahead of the curve" is critical to the formation of successful arrangements. Conversely, success seems to be limited with providers for whom the payer offers small market share, and with providers who are risk averse.

Contracting partner

While some of the pilots we studied in prior years involved a physician group and a hospital, there appears to be a certain trend towards contracting with just one provider entity for an episode – even when multiple providers have a role in care provision during the episode. Payers explained that they have made this design decision because a) there are few if any providers who are able to contract in a manner that supports aggregated risk across provider organizations and b) it is simpler for the payer to administer such an arrangement. In addition, some payers observed that in most cases it is the physician who most influences care decisions, and thus it makes sense to hold the physician accountable. For this reason, most (but not all) of the studied bundled payment arrangements are characterized as payer-physician relationships,[3] with only one physician specialty involved. No hospital or post-acute care providers are involved.

Payment and risk

All but one of those interviewed pay fee-for-service claims to the provider and then retrospectively reconcile paid claims to a prospectively-defined budget. One payer, however, described a couple of prospective payment arrangements that it maintains[4] in addition to retrospective payment models. The payer expressed a desire to do more prospective payment contracting in the future. A second payer also expressed a desire to move to prospective payment. The other interviewed payers explained that they had opted for retrospective reconciliation because many providers aren't able or willing to accept a prospective payment. One payer, in fact, said that it initially sought prospective payment arrangements and backed off when it received negative provider feedback.

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3 One payer shared that it has contracted with both a surgical group practice and an anesthesiology group practice for the same bundle – although not at the same hospital.

4 This payer has a prospective payment arrangement that pays a fixed percentage of the contracted bundle to the hospital and a fixed percentage to a physician group. In another arrangement, the payer pays a prospective bundled payment to a medical group which then divvies up the money with partnering hospitals.

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The terms of financial risk vary across the arrangements, with some payers only entering agreements that have shared upside and downside risk, and others willing to enter upside-only risk agreements. Those payers with shared upside and downside risk arrangements make it clear that they will only contract on these terms. One payer not only insists on shared risk, but also on a budget that reflects a percentage discount off of historical episode costs.

Shared risk arrangements sometimes compare provider performance to a normative benchmark (e.g., average network cost), and sometimes to prior years' provider experience. The former approach can have the effect of penalizing the accountable provider if other providers involved in services included within the episode budget (e.g., hospitals, post-acute providers, other professional providers) are inefficient and/or have unit costs that are higher than the network average. One payer using this model shared an anecdote involving a surgical group that changed hospital affiliation due to the relatively high contracted rates received by its former admitting hospital.

Some of the payers described variably structured arrangements to accommodate provider interests and concerns, while others described current and planned efforts to standardize bundled payment arrangements, particularly as they expand the number of participating providers and the number of episode types. A desire to standardize and simplify is rooted in a goal of reducing both payer and provider administrative costs to operate bundled payment, and to improve clarity and understanding. As described later in more detail, one payer justified its move away from patient-specific risk adjustment because calculations are simplified and physicians will know their episode budgets a priori.

Payment Reconciliation

Automating payment reconciliation is a major focus for the payers. Those that still maintain a manual process describe it as resource-intensive and burdensome. While manual reconciliation appears to be simpler when bundled payment arrangements are standardized, none of those interviewed who have manual reconciliation processes were happy with them.

Most payers are studying automation options, are in the midst of automation implementation, or are already automated. While automation seems to be working well for those who have selected that direction, those going through implementation described it as a long process. Two interviewees are implementing automation with a common vendor's new product, and one said the process would take over two years – and will still require some manual processes. Others with automation in place with support from different vendors, however, described a much less arduous process. Payers reported using MedAssets, Optum and Trizetto for bundle calculation and reconciliation.

Payment reconciliation, whether manual or automated, is performed within varying timeframes. Payers differ in practice in two respects:

1. **Whether reconciliation of costs to budget is performed after each completed episode, or a batching protocol is used.** Three of the payers reconcile after the completion of each individual bundle, and three batch reconciliations. Of those that batch, one does it quarterly, and two at the end of the year.

2. **The timing of reconciliation after episode completion.** Under either reconciliation process, payers require a lag of 60, 90, or 120 days after the end of an episode before considering an episode ready for reconciliation. In addition, one payer conducts an interim reconciliation and then a final reconciliation much later.

Reporting and Technical Assistance

Two payers that have automated their payment reconciliation processes described the process of report development and automated production as being more challenging than automation of payment reconciliation.

One payer that has not automated explained that its largest provider partner had purchased software to analyze performance against the bundled payment budget using data in the provider's clinical system. While such analysis does not include care delivered by other providers participating in the bundle, the limited information it provides has proven a useful tool for the provider.

Most of the payers interviewed produce quarterly reports for provider partners that inform providers of their performance against bundled payment budgets and, to varying degrees, break down paid claims into service categories.

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One payer produces such reports monthly, and one does not produce any at all.

Reports are generally posted on a payer web portal and are static reports. One payer is planning on providing dynamic reports in the future.

Payers supplement these reports with various other forms of communication and technical assistance, including the following:

- Two payers inform providers in shared risk arrangements that are "running in the red" of their status during the course of the year, so that the provider might take corrective action.
- Two payers have regular face-to-face meetings and telephone calls with providers to review performance, one doing so just with newly-participating providers.
- One payer maintains a physician advisory committee for one type of bundle. The payer is considering creating more such committees for other bundle types, or expanding the scope of the current committee.
- One payer is considering sharing performance information not just with the contracted provider, but more broadly, potentially for other providers and the public to see.

One payer stood apart from the others when describing the close partnership it tries to forge with its "episode partners," and the ways it seeks to help these providers identify and address opportunity in care delivery. This payer said, "having the incentives doesn't mean knowing what to do differently." The payer representative went on to say, "I'm looking to help them transform the practices; they don't necessarily know what to do to develop an episode approach."

"Most payers place an emphasis on simplification and minimizing administrative demands on contracting providers."

Staffing

Not surprisingly, staffing resources vary depending upon the scale of the payer's program. The large-scale programs have integrated the responsibility for supporting bundled payments operations into informatics, provider relations and network contracting activities. Smaller programs more often have limited stand-alone teams that dedicate part or all of their time to the program. Demands are reported to be greatest for analytics and reporting staff. Payers that have instituted large-scale programs report having made significant investments in provider outreach and education.

Quality Measurement

All of the payers have defined measures of quality to assess provider performance relative to the episode. Payers use general, non-episode-specific measures and/or episode-specific measures. In addition, the measures are sometimes generated by the payer using claims data, and are sometimes generated by the provider and reported to the payer.

Examples of general, non-episode-specific measures include:

- readmissions
- avoidable complications
- adverse events
- Surgical Care Improvement Project (SCIP) Core Measure Set
- care coordination with the primary care physician
- patient education
- patient satisfaction

Examples of condition-specific quality measures include:

- colonoscopy: rate of abnormal detections
- obstetrics: early induction, pre and post-natal care, C-section rate
- joint replacement: pre and post function assessment

As with other aspects of their programs, most payers place an emphasis on simplification and minimizing administrative demands on contracting providers. Strategies to decrease provider burden include maximizing use of payer-generated measures, and reducing the number of data elements that providers need to report. In some cases the measures are specified for the provider by the payer, while in others there is a joint payer-provider measure selection process.

Payers also vary in the implications of quality performance. Interviewees reported the following approaches:

- **Qualifying "gate" for the provider to obtain savings.** One payer allows the provider to retain 50% of any generated savings, with the remaining 50% contingent on quality

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performance meeting a minimally acceptable threshold level. Another payer puts the entire earned savings at risk for achieving threshold-level performance.

- **Qualification for continued provider participation in the program.** Two payers use this approach. One of them requires corrective action which, if not achieved, results in provider removal from the program.

Employer Market Response

The five commercial payers shared their challenges in gaining employer customer support for bundled payment arrangements. They spoke of the skepticism that employers have towards value-based payment models in general. Some employers have said, in essence, "I want to stay on the sidelines while you work this out." Still, some payers reported great success in obtaining self-insured employer buy-in. Most treat the shared savings or shared risk bundled payment arrangements as covered by standing ASO agreements, with an allowance for self-insured employers to opt out. The payers report very few employers opting out.

A couple of payers have expressed interest in developing network products around the bundled payment providers, with one going so far as to project a 2015 product introduction.

Impact

Five of the six payers interviewed reported at least partial results from their assessment of the impact of bundled payment arrangements on cost and quality. All five reported positive impact on cost, although for one the impact was described as "slight." Three of the payers concluded their programs were cost effective because they had paid out shared savings to their providers. Either they paid shared savings to all of their providers, or the percentage of providers who earned shared savings exceeded the percentage that went over the episode budget.

One payer reported savings of 10-30% because the payer won't enter a bundled payment arrangement with a provider if the provider won't agree to "take a haircut" (i.e., accept an episode budget below historical episode cost) and take downside risk. This payer sees providers succeeding financially, despite the discounted budget, because "they are cutting out the fat and maintaining or improving their margins."

With respect to impact on quality, the same five payers had positive findings to share, albeit with limited information. Some of the reported findings included:

- a decrease in unnecessary use of antibiotics for URI, and an increase in strep tests to diagnosis pharyngitis;
- increased compliance with ACOG standards;
- reduction in the percentage of patients with avoidable complications;
- superior and faster post-surgical mobility and range of motion relative to national norms following joint replacement surgery, and
- high patient satisfaction.

It appeared that the attention and scrutiny given to quality measurement varied across payers. For those payers with limited scope programs, low volume may have been an influencing factor.

Challenges and Future Direction

We asked each of the interviewed payers about their greatest operational challenges. As with everything, the payer perspectives varied. Still, for those payers that had not automated their financial reconciliation processes, that challenge was commonly cited.

As noted earlier, payers have been moving towards contracting with just one provider, rather than trying to aggregate risk across multiple providers. For those payers still interested in aggregating risk across providers, the difficulties in doing so represent a vexing challenge. Those difficulties include federal statutory limitations (Stark Law and anti-kickback laws) and the legal and operational challenges of bringing providers together.

Two payers with voluntary programs spoke to the difficulty of attracting provider participation in bundled payment arrangements. They identify multiple barriers, including lack of engaged and forward-thinking leadership in some provider organizations; provider financial success under existing fee-for-service payment arrangements;

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provider aversion to risk; and size limitations in an individual payer's episode volume with providers – especially when plan sponsors won't agree to steer patient volume.

Finally, other important challenges individual payers noted include the following:

- correcting problems in episode definitions;
- losing patient volume from bundled payment arrangements due to exclusionary episode-definition rules;
- the need for intensive provider outreach and education;
- maintaining open communication and strong relationships with participating providers;
- helping providers see what they can do to improve performance, and
- state insurance department restrictions on provider downside risk assumption.

"Some payers recognize that they have more work to do to determine how these programs might complement each other."

As payers look ahead, they anticipate future trends. First, many of the payers are maintaining and/or creating medical home and ACO contractual arrangements simultaneously with bundled payments. Bundled payment is not considered to be an exclusive payment model. Some payers recognize that they have more work to do to determine how these programs might complement each other. One payer acknowledges that it may currently be paying out shared savings to some providers twice, through both bundled payment and ACO shared savings arrangements. While stating that the payer was comfortable doing this, the individual also noted that the payer is evaluating what to do in the future.

Second, payers are certainly looking at how to increase the scale of bundled payment activity, both in terms of the numbers of episodes, and the numbers of participating payers. Increased automation of reconciliations and reports, simplified bundled definitions, and streamlined quality reporting requirements are likely to follow.

Finally, expansions of scope, coupled with market trends towards narrow and tiered network products, may produce new products that are informed by provider bundled payment performance. This trend may take a few years to develop.

PROVIDER FINDINGS

Provider findings are based on in-depth interviews with seven provider organizations and one CMMI BPCI awardee convener. We interviewed a variety of types of providers, including physician practices, hospitals and post-acute care providers. However, five of the seven providers run highly integrated, single-specialty programs (e.g., separate joint replacement units) that enable all staff to become specialists at what they do, thus maximizing efficiencies and quality. The key characteristics of the providers are summarized in Table 1, below.

The number of completed episodes varied significantly, from less than 10 to several hundred a year. We found the most experienced providers to be those implementing orthopedic episodes with commercial payers for several years. The provider participating in a mandatory Medicaid episode of care initiative also had significant volume. Providers participating in the CMMI initiative generally had fewer episodes because of recent launch dates.

Joint replacements remain the predominant type of service covered by bundled payments among the interviewees. The providers participating in commercial bundled payment initiatives, as well as two of the providers and the convener participating in CMMI's BPCI initiative, are focusing on orthopedic services. CHF episodes were being implemented by two of the other providers participating in the CMMI BPCI initiative. One provider is participating in a tonsillectomy episode.

While we tried to pair practices and payers, it proved difficult to do so. Two of the seven providers who were interviewed have bundled payment arrangement with two of the payer interviewees. The perspectives of the other provider interviewees reflected their orientation towards the hospital-centric Medicare Bundled Payment for Care Improvement (BPCI) program. As a result, several trends identified from payer interviews – not sharing risk with post-acute providers, and contracting with physicians and not hospitals – were evident in the two commercial arrangements for interviewed providers, but not for those participating in the Medicare CMMI BPCI initiative.

Despite these limitations, we focused on identifying key characteristics for the successful

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implementation of bundled payments, some or all of which may be applied to different provider configurations and episode types. For example, as episodes expand to cover outpatient conditions, such as upper respiratory infections, the lessons already learned around the need to develop a clear understanding of disease processes, and processes to identify deviations, may be applied.

Finally, we have not included a list of providers interviewed in order to respect their wish for anonymity.

Systems of Care

The systemization of care—or providers organizing and coordinating services to create a comprehensive and interconnected system of care—is the most important impact of bundled

Table 2. Characteristics of Participating Provider Interviewees

TYPE OF PROVIDER	EPISODES IMPLEMENTED	START DATE	TYPE OF PAYER	EPISODE PARTICIPANTS
Orthopedic practice with own physical therapy staff	Total knee Total hip Uni-compartmental knee	2011	Commercial	Practice only. Contracts with hospital for IP services
Private ENT practice	Tonsillectomies	2014	Medicaid	Practice only. Owns free-standing surgi-center
Fully-integrated post-acute care provider	Total knee Total hip Hip fractures	2013/ 2014	BPCI Models 2 and 3[5]	Practice only. Assuming only post-acute risk
CMMI BPCI Awardee Convener	Multiple, but predominantly total knee, total hip, CHF, COPD and pneumonia	2014	BPCI Model 3	Shares risk with participating hospitals and physicians
Hospital with dedicated joint replacement unit	Total knees Total hips	2011	Commercial	Hospital and physicians share risk
Hospital with dedicated joint replacement unit	Total knees Total hips	2013	BPCI Model 2	Hospital and physicians share risk
Community Hospital	CHF	Planning since 2011 Implemented 2014	BPCI Model 2	Risk shared proportionately based on billings among hospital and all post-acute providers
Community Hospital with employed physicians	CHF	2013	BPCI Model 2	Hospital, physicians and post-acute providers share risk proportionately based on Medicare allowed

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5 CMS' Bundled Payment for Care Improvement Initiative offers participating providers four risk-assumption and payment models: Model 1 – inpatient only with discounted IPPS payment; Model 2 – inpatient plus post-discharge services with fee-for-service payments and retrospective reconciliation; Model 3 – post-discharge services only with fee-for-service payments and retrospective reconciliation, and Model 4 – inpatient only with prospective payments.

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payments on delivery of care. Providers who understand the implications of bundled payments systematize the delivery of care for the entire length of time covered by the episode. The providers we interviewed are, to varying levels of success, working on creating systems of care by taking key steps to:

1. value leadership that articulates a unifying patient care vision and challenges participants to creatively develop strategies to realize the vision;
2. map the arc of patient progress across the episode timeframe and implement processes to quickly identify patients who are deviating from the expected path;
3. track costs and utilization in real time, to the extent possible;
4. use a quality improvement (QI) model to improve delivery of care processes and patient outcomes;
5. integrate unaffiliated post-acute providers into the systems of care;
6. build the organizational structure to support and sustain the change in the design of care delivery, and
7. continually communicate with patients involved in the episode to maximize their engagement and levels of satisfaction.

"Effective leaders challenge episode participants to be creative in developing strategies to achieve their shared vision."

While it is clearly easier to develop and implement a system of care if all participating providers are situated at the same physical location, all interviewees, regardless of their structure, are involved in efforts to address each of these key activities. The following is a description of how the various providers are building their systems of care.

1. Value leadership that articulates a unifying patient care vision and challenges participants to creatively develop strategies to realize the vision

Creating an inspiring vision

Consistent with the findings from the payer interviews, providers successfully embracing bundled payments are forward thinking and have strong senior leadership. Two specific areas of leadership were evident among the providers that are furthest along the continuum of systemizing care delivery. First, the leaders articulate a defined and bold vision of a successful system of care, and that vision serves as a unifying 'north star' for all bundled payment providers. An example of such a vision comes from two different providers implementing joint replacement episodes. Their vision is to create a system of care under which the vast majority of patients may be safely and appropriately discharged to home with few readmissions. These visions serve to both challenge and focus the practices in their transformation efforts. An example of a less impactful vision from another orthopedic practice was to place patients in the most appropriate post-acute care setting.

Moreover, by setting specific targets for care, all participants can track progress and challenge themselves if goals are not being met. Both orthopedic practices mentioned above, for example, set a target that 3% to 7% of their joint replacement patients are to be discharged to skilled nursing facilities or to rehabilitation hospitals.

Developing creative solutions

Effective leaders also challenge episode participants to be creative in developing strategies to achieve their shared vision. For example, to reduce the risk of post-operative infection, one provider practice performing joint replacements has patients apply a disinfectant to the surgical site, at home, on each of three days prior to surgery. This provider practice also substitutes an individual physical therapy visit with a less expensive group visit, in order to reduce the cost of rehabilitation services while maximizing the number of patient rehabilitation contacts. Another practice purchased its own ultrasound machine to diagnose deep vein thrombosis, a life- threatening complication of surgery, to provide the service within the office setting, rather than the more expensive hospital setting.

The leadership of one hospital-guided CHF initiative develops shared accountability by involving all post-acute providers in an extended pre-implementation planning process. This allows all providers to understand how care is currently delivered, and to identify gaps to address to reduce readmissions. The planning process has created buy-in among all participants and has resulted in a series

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of interrelated improvements. Changes that have been implemented include increased use of palliative care to reduce end-of-life cost; increased use of home health services to support community placements; and increased use of tele-monitoring services to expand home health service capacity.

Spreading improvements

Several providers report that their longer term goal is to apply systematic service delivery models to all patients, whether the patient is reimbursed under a bundled payment or not. One practice reports having achieved this goal prior to entering into a bundled payment arrangement, describing the payment model as the right model for how they do business. More commonly, providers use the bundled payment as an opportunity to transform their delivery system. Once a defined process is proven to reduce costs and improve quality, it is spread across the practice or to other conditions.

The most aggressive practices are never satisfied with their performance and believe that they can always improve. They have the clinical and administrative leadership to challenge their teams of providers to do so.

2. Map the arc of patient progress across the episode timeframe and implement processes to quickly identify patients who are deviating from the expected path

Creating a baseline

In systematizing care, the most advanced providers have developed processes for determining and documenting how each individual patient should progress through the timeframe covered by the episode. For providers performing joint replacements, the progress is usually delineated in terms of number of days in the hospital, and dates by which the patient's functional capabilities have reached targeted levels.

Since CHF is a progressive and terminal condition, the recovery tracking paradigm is different than what is used for procedure-based episodes. One CHF initiative focused on understanding the disease progress and tailored interventions based on the stage of CHF experienced by each patient. This provider uses the ACC Foundation/American Heart Association guidelines for assessing heart failure stages to understand the patient's disease progress. This was a new way of assessing CHF patients, so the initiative leadership spent the time necessary to train all participants on how to understand the terminology, and how to use the schema to determine appropriate levels of intervention.

Standardizing care and identifying variations

Having a common way of understanding patient care serves several purposes. First, it creates a common vocabulary for assessing the patient throughout the duration of the episode. Second, understanding the care or disease progression allows the providers to standardize care. The interviewed providers who specialize in CHF have developed and implemented clinical pathways and protocols which address patient disease progressions, delineate appropriate interventions, and detail intervention steps. One provider describes implementing "power orders" that are a comprehensive and consistent set of orders covering every facet of inpatient care, such as medications and therapy services.

Third, it enables the providers to develop an individual longitudinal care plan for each patient, and to identify patients who are deviating from the expected norm. For example, one orthopedic practice estimates hospital days and functional status goals throughout the episode timeline for each patient. Patients who stay in the hospital longer than expected or fall behind in functional capabilities are quickly identified, and additional resources are put in place to provide support to bring the patient back on track. For one CHF initiative, changes in a patient's condition will trigger a reassessment of the disease stage assignment, which in turn prompts the provision of additional services, such as home health services or prescription medications, to support the patient within the community setting. For another CHF initiative, when delivered care varies from the "power orders," the case is examined to determine if the variation was warranted. If it was not, the providers determine what went wrong, why, and how to avoid the same situation in the future.

Maximizing patient contacts

Several of the providers have created processes to maximize the number of contacts a patient experiences with care team members, so that the patient is repeatedly assessed. For example, one joint replacement initiative has eliminated physical therapy co-payments; once

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patients are discharged, they can be cared for by physical therapists multiple times a week for the duration of the episode, without additional out-of-pocket costs. In addition, the physical therapists know which patients miss their appointments and will arrange for an outreach call. Most initiatives use case managers or patient navigators to regularly check on patients both telephonically and in-person, providing increased contacts for those patients at greatest risk. They are trained to ask questions in areas known to signal potential clinical issues so that problems are identified early and quickly addressed.

3. Track costs and utilization in real time to the extent possible

To be successful under bundled payments, providers report that they need to understand the costs generated during an episode of care. Generally, they do so by relying on two sources of data: provider-generated data and payer-provided claims data. Each source is discussed below.

Provider-generated data

Several integrated practices have developed very sophisticated data collection processes and tracking reports which produce near real-time information. For example, one orthopedic provider has developed a system for assigning expected costs for each patient's episode based on expected length of hospital stay, and type and number of post-acute rehabilitation services to be provided throughout the timeframe of the episode. The expected patterns and costs for patients with different characteristics were developed by examining longitudinal data to identify clusters of patients with key similarities. The provider then standardized the care process and calculated total service delivery costs.

Each new patient being paid for under the episode is assigned to a "patient cluster" that correlates to an anticipated pattern of care. As the patient receives services, such as inpatient hospital services, post-acute physical therapy services, pain management consultations, ultrasounds, etc., the cost of each service received is entered into a web-based program. Reports are then produced that assign a color code (red, yellow and green) to each patient based on the extent of the patient's deviation from what is expected. The care team focuses on the patients assigned the red color to identify issues and provide additional support services to get the patient back on track. These reports are updated frequently.

Providers implementing episodes with non-affiliated providers face significant challenges in building the capability to collect and share cost and utilization data among episode participants. Providers without sophisticated systems focus on collecting limited real time data from their own systems that are tied to their key cost containment strategy. For example, the CHF providers use their own hospital data to obtain real-time information on inpatient admissions in order to track and frequently report readmission rates, but they are unable to determine whether a patient was readmitted to another hospital. To combat that problem, one CHF initiative accesses real-time inpatient admissions information from a community Health Information Exchange where they can see their patient readmissions at other competing hospitals, albeit, not the associated costs. Several of the hospitals report being in the early stage of developing real-time reporting capacities with affiliated skilled nursing facilities, to collect SNF costs associated with the patient's utilization of services.

Payer-provided claims-based reports

Providers working with commercial payers reported receiving regular (usually monthly) reports that convey cost information about each patient under the episode, and a listing of all claims associated with each patient. The reports are used for a variety of purposes including determining care by providers other than the participating providers, and identifying which claims are assigned to the episodes. Payers using analytical software, such as that offered by PROMETHEUS Payment, also provide regular reports on potentially avoidable complications. Providers use this information to identify delivery system issues and make modifications to the care processes. One provider reported using the data to compare performance across providers (both those participating and not participating in risk sharing), and using it to improve performance consistency.

Two providers participating in the CMMI BPCI reported that they have not been able to receive timely data from Medicare in the same fashion that providers working with commercial payers have, due to a significant time lag (e.g., in March 2014 the most recent claims provided by CMS were through September 2013). One provider participating in the CMMI BPCI initiative that chose not to use a data aggregator expressed frustration with the difficulty of manipulating the data. This initiative, which ran a pilot in 2013 and went "live" in 2014, reported

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"Several integrated practices have developed very sophisticated data collection processes and tracking reports which produce near real-time information."

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that it was still working on a way to provide claims-based reports to the participating providers. Another provider participating in the CMMI BPCI is reporting an estimated 5% to 14% "error" rate. That is, episodes that are not bundled payment are included in the data, and episodes that the provider thinks should be part of the bundle are not including. These data challenges create barriers to expanding the number of conditions under bundled payments and making real-time changes to enhance the care being provided to patients.

Some providers have engaged BPCI aggregators, which offer sophisticated analytic capabilities. While they do not receive Medicare claims any faster than providers not using aggregators, they use their extensive databases to develop patient risk assessment systems, performance benchmarks and cost reports. Some are also marrying the claims data with provider-supplied patient assessment data and patient satisfaction data to provide a richer picture of patient care against benchmarks.

Impact of data sharing on participating providers

The interviewees universally reported that physicians are genuinely surprised by the data they receive, and that data are acting as a catalyst for provider commitment to the transformation process. Inpatient providers, who have historically had little knowledge of post-discharge activities, report gaining new appreciation for the need for coordinated, integrated, systematic care processes. In several instances, data have served to inspire participating physicians to become strong leaders in driving the systematization of care across the duration of the episode. For example, one administrator reported that providers were amazed to learn that the least intensive CHF DRG bundled payment assumed no post-acute services. Providers then understood that discharge to any location other than home, and any ED visit or readmission, would result in a financial loss. This information solidified the providers' commitments to work closely on transitions-of-care processes with the ambulatory care manager who would be supporting the patients post discharge.

4. Use a quality improvement (QI) model to improve delivery of care processes and patient outcomes

All interviewees emphasized the importance of using clinical outcomes and patient and provider experiences to improve their patient care processes and to develop an effective system of care. Several examples are informative.

- One provider tests defined QI initiatives throughout the year and reports results on a monthly basis. Each initiative could last as short as a month or as long as a year. For example, during one month the provider tested more effective use of ice therapy for reducing inflammation.
- One provider hires patient coordinators who have clinical trial and research backgrounds in order to maximize data integrity, believing that their skill set can help systemize data collection and accurately interpret patient data.
- All providers have established interdisciplinary committees to review unexpected patient events, such as patient readmissions, and they report using the findings from those assessments to improve care.
- Some providers report constantly tracking performance against goals and creating dashboards as a vehicle to widely share the performance results. Performance measures are usually based on key success factors that relate to the nature of the episode (e.g., surgical site infection), but also include more global measures such as patient and physician satisfaction measures, average length of stay, and discharge disposition.

5. Integrate unaffiliated post-acute providers into the systems of care

Because the interviewees are implementing procedure-based episodes, they realize the importance of working with post-acute providers as partners in building a system of care. The degree of integration varies based on the organizational structure of the lead provider.

Working with integrated health care providers

Integrated health care providers that include post-acute providers, such as physical therapists and skilled nursing facilities, engage post-acute leaders on the project team and incorporate their services within care pathways, protocols and data collection systems. For example, at one practice the functional assessments performed by any affiliated provider, at any time throughout the duration of the episode, are captured and reported. The assessments are

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then included in the analysis of the how closely the patient is tracking to the expected pattern of care, and in determining whether additional services are required.

Working with unaffiliated providers

Providers that are not part of a fully integrated health system are at various stages of creating closer working relationships with their high volume post-acute providers. One hospital system has started to develop preferred skilled nursing facility and home health agency relationships. Interestingly, since most of their bundled payment patients are discharged home, the impetus for creating preferred relationships is coming from their creation of an ACO, and not from the bundled payment initiative.

Another hospital has invited selected high-volume skilled nursing facilities to join the episode and has provided financial incentives to do so. The hospital has established cardiology and nurse practitioner rounding in the preferred facilities and works closely on implementing best transitions-of-care practices with them. These facilities, however, do not yet participate in the project team meetings. Moreover, standard treatment protocols have not yet been developed for these services.

The most extensive efforts at integrating hospital and unaffiliated post-acute providers have been undertaken by a hospital that involves its community partners, including SNFs, home health agencies, their regional quality improvement organization, and high volume PCPs, in the risk sharing model. Working together, they started planning for bundled payments by reviewing two years of data to understand current practices and to identify improvement opportunities. They continued to work together as a team, building infrastructure to manage a bundled payment project, and piloting their systems for a year prior to implementing the bundled payment methodology. During that time, the team worked on developing a common language to describe patients and services to be provided. They improved real-time communication by creating EMR access for all providers, and by instituting email alerts from the hospital to the patient's care team when a patient with CHF arrived at the ED. They standardized care across the providers by developing a shared treatment protocol, and implementing standard transitions-of-care processes.

This hospital and its community partners meet regularly to jointly identify problems and solutions to increase the success of the initiative. For example, through this meeting process the cardiologists learned how often CHF patients were visiting the emergency department because they could not see their physician promptly. To address this issue, the participating cardiologists created open slots in their daily schedule of office visits, and they made themselves available to consult with the emergency department physicians.

Representatives from all participating providers participate on the project team and its subcommittees. All participating providers are required through a written agreement to participate in meetings, adopt the initiative's protocols and implement lessons learned throughout the initiative.

6. Build the organizational structure to support and sustain the change in the design of care delivery

Providers implementing bundled payment initiatives are developing new organizational structures on four levels:

- executive leadership;
- project management;
- quality improvement/problem identification and resolution, and
- payer-level interaction, if working with commercial payers.

Meeting with executive leadership

Recognizing the importance of active leadership engagement to achieving success, all the providers have regularly scheduled meetings with key executive leaders. Meetings with physician practice leaders are held either weekly or monthly to review performance data including cost and utilization measures and improvement strategies. Several hospital-driven initiatives that contract with non-affiliated, post-acute providers do not include non-affiliated leaders in meetings, but recognize the need to do so.

One exception is a CHF initiative that encompasses a community hospital and multiple community providers and social service agencies. In this initiative the executive leadership from all participating organizations

"Meetings with physician practice leaders are held either weekly or monthly to review performance data including cost and utilization measures and improvement strategies."

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and physician practices meet quarterly for updates. The meetings are designed to retain these leaders' active commitment to the initiative, recognizing that they each need to make the episode initiative a priority within their organizations. Without their commitment, such basic support as providing staff release time to work on the initiative would not happen.

Holding project management meetings

To promote buy-in, accountability and a unified implementation of processes, each initiative established a project management team. All but one is interdisciplinary, and most initiatives include clinical staff and administrators of key departments and practices. One initiative includes leaders from every department that touches the patient, including the director of environmental services, since workers in that department have contact with patients on a daily basis.

Most interdisciplinary project management meetings occur monthly and include reports on available clinical, utilization and financial performance measures. None, however, report performance measures by provider. Participants also have an opportunity to discuss issues and solicit ideas on possible solutions. Interviewees emphasized the importance of these meetings to reinforce the value of and need for all participants' involvement.

Holding quality/process improvement team meetings

Each initiative has a clinical committee that addresses quality and process improvement issues. Most meetings include the care managers and a physician leader conducting case reviews of "problem" patients. The key purpose of the reviews is to identify why the patient's progress varied from what was expected, and what care process could be changed to prevent the same issues from arising for similarly situated patients in the future. Each initiative then uses the QI findings to implement improvements to their care processes. One hospital also holds bi-weekly meetings with cardiologists, emergency doctors and hospitalists, during which individual patients are reviewed to identify what could have been done differently, and to develop care pathways.

Meeting with payer representatives

As previously discussed, providers working with commercial payers have established regular, usually monthly, meetings with payers to review claims-based information in detail. These practices find the payer-provider meetings to be essential in understanding costs and care delivery, since most providers are not fully integrated and must rely on payers for the complete view of services delivered to the episode of care patients. These meetings also enhance the trust and working relationships between the parties.

7. Continually communicate with patients involved in the episode to maximize their engagement

The interviewees universally recognized the importance of maintaining high patient satisfaction levels as one key to increased patient engagement and better clinical outcomes. Several highly performing providers believe that an increased number of contacts results in better outcomes due to quicker identification of problems, and in increased patient satisfaction because of the additional support and attention received. One provider specifically stated that his practice has added extra contacts to improve patient experience and outcomes.

All but one provider reported relying on care managers or patient navigators to increase patient contacts, and to assist the patients throughout the duration of the episode. This role serves as the single point of contact for the patient and patient's family. Having a "go-to" person reportedly increases patient comfort with care being received because they have a trusted person to approach with questions or concerns. The care managers/patient navigators are responsible for understanding the patient's "story" and identifying what is most important to him or her (often a non-health-related matter such as caring for a pet or riding a bike again), as well as fears or concerns about the patient's surgery or condition. By creating a trusting relationship through frequent patient contacts, the care manager or navigator serves as an early warning system to identify and intervene when problems arise. In this role, the care managers/patient navigators function as the "glue" that holds the system together across the continuum of time and care.

Increased patient communication achieves several different purposes related to improved outcomes and increased patient satisfaction including:

- creating a baseline assessment against which to measure recovery progress;

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- setting realistic patient expectations regarding the patient's care and condition;
- training patients and families on post-discharge care;
- training patients and families on signs and symptoms of potential problems;
- assessing the patient's mental attitude towards the state of his or her post-acute condition and how much support the patient will likely need to prevent avoidable ED visits or readmissions;
- assessing patient adherence to the care plan;
- assessing the patient's level of satisfaction with the care he or she is receiving, and
- assuring the patient makes a smooth transition back to care by the PCP.

Challenges and Future Direction

We asked the interviewed providers about their greatest operational challenges. Those identified most commonly are discussed below.

Lack of timely data

Providers identified the lack of timely data, particularly for those involved in the CMMI BPCI initiative, as a key barrier to quickly identifying problems and improving their systems of care. To compensate, the providers are moving in three related and complementary directions. One direction is for providers without timely payer data to develop or purchase third-party capability to analyze large amounts of historical data, and to develop best practices and care benchmarks. With this information, providers can identify in real time patients who are not following the best practices and move into problem identification/resolution mode.

The second direction is for providers to develop close-to-real-time reporting capabilities within the scope of the provider community that they control, even if relatively small. In one example, a hospital estimated that it only controls 40% of the total patient costs, but it is building timely reporting capabilities relating to its own data, with the intention to gradually add in information from contracted, post-acute providers. When available, providers are also accessing real time HIE information regarding patient ED visits and inpatient admissions.

Finally, one community-based initiative has created access to the hospital's EHR for community-based providers. It was a major project because different levels of access must be provided to protect patient confidentiality and because of the variety of medical record systems providers and community agencies were using.

Timely identification of qualifying patients

Another data-related barrier is the timely identification of patients who will fall within the bundle. This is most problematic for providers pursuing non-procedure-based bundles, such as CHF. Eligibility depends on DRG assignment, which often cannot be made until the third or fourth day of an inpatient stay. The providers who are managing the care under the bundle feel that they are losing valuable time to implement standardized care processes developed for these patients. Both of the interviewed CHF bundle providers reported getting better at identifying eligible patients earlier, but they said that early identification remains an issue.

Managing the patient's right to choose

Several providers noted that building a closed system of care, as is required to be successful under a bundled payment methodology, is inconsistent with the requirement of Medicare and some commercial payers that patients have the freedom to choose the providers they wish to use. Several interviewees shared that they encourage patients to use participating providers by describing the coordinated care and better outcomes the patient may experience as a result of using post-acute providers with which the provider has developed working affiliations.

One post-acute care provider that receives a prospective payment from health plans has developed an effective approach to aligning incentives by providing financial incentives for patients to stay within the affiliated provider group. This provider requires all patients participating in the bundle to pre-pay to the practice all applicable plan deductibles, including hospital pharmacy and outpatient deductibles. The practice, in turn, pays all providers for services rendered, including the patient's deductible. This creates a financial bond between the patient and the practice. The alignment is reinforced because the practice also waives the health plan's co-pay for services rendered by affiliated providers,

"Providers identified the lack of timely data, particularly for those involved in the CMMI BPCI initiative, as a key barrier to quickly identifying problems and improving their systems of care."

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but not for non-affiliated providers. This provider is completely transparent with the patients about how bundled payments function and has trained its business staff on how to explain the bundled payment arrangement to its patients so they understand and accept it.

CONCLUSION

There is a small cadre of state and private payers that are committing to bundled payments as a core strategy. These payers are dramatically expanding the types of episodes that are being implemented to include chronic conditions (e.g., developmental disabilities) and conditions primarily treated in outpatient settings (e.g., upper respiratory infection), as well as more procedure-based episodes (e.g., tonsillectomies and cataract removal). To bring the payment model to scale they are simplifying their administrative processes by contracting with a single risk-bearing entity (usually a practice) and automating resource-intensive settlement processes. They are also simplifying their payment models by removing risk adjustments factors and creating budgets that enable the provider to know the target budget at the outset of the episode. However, all payment models incorporate quality measurement standards that must be met either to obtain savings or to qualify to continue participating in the program. Fee-for-service with a retrospective reconciliation process remains the predominant payment methodology because of provider preference.

Payers continue to play a vital role in supporting contracted providers by supplying claims payment reports on a regular basis, either monthly or quarterly. Some payers provide technical assistance to practices on how to best transform.

All interviewed payers report cost savings, some at significant levels, and most report at least some impact on quality. However, employers are generally remaining on the sidelines, waiting for more definitive evidence of cost and quality impact.

For providers to be successful under bundled payment models, they must continue to build highly integrated systems of care that focus on increasing efficiencies in areas of greatest cost savings. To do so, they need creative leadership, committed provider partners, dedicated time and reliable data. However, as they work to build systems of care, they face major challenges to obtain and disseminate real-time cost and utilization information. Many providers are building their own data reporting systems that include information from affiliated and unaffiliated providers. Hospital-dominated bundles will also need to be more expansive in providing incentives to unaffiliated providers to participate in building their systems of care. Successful practices have strong leaders that have visions of new delivery systems and the ability to challenge their team to creatively implement that vision.

With the adoption of bundled payment methodologies by major public payers and with the efforts by commercial payers to bring the programs to scale, we anticipate a rapid growth in use of bundled payment methodology over the next few years. How payers and providers expand these efforts in concert with growing medical home and ACO contracting arrangements remains to be determined.

APPENDIX A
List of Interviewed Payers

Aetna
Arkansas Medicaid
Arkansas Blue Cross and Blue Shield
Blue Cross Blue Shield of North Carolina
Geisinger Health Plan
HealthNow New York
Horizon Blue Cross Blue Shield of New Jersey

HEALTH CARE INCENTIVES IMPROVEMENT INSTITUTE®
Fair, Evidence-based Solutions. Real and Lasting Change.