



THE BUNDLED PAYMENT GUIDE FOR PHYSICIANS



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County / Regional Medical Societies

Cleveland County Medical Society
Craven-Pamlico-Jones County Medical Society
Durham-Orange County Medical Society
Mecklenburg County Medical Society
Forsyth-Stokes-Davie County Medical Society
New Hanover-Pender County Medical Society
Pitt County Medical Society
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Western Carolina Medical Society
Wake County Medical Society

Specialty Societies

Carolinas Chapter, American Association of Clinical Endocrinology
North Carolina Academy of Family Physicians
North Carolina Chapter of American College of Cardiology
North Carolina Chapter of the American College of Physicians

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North Carolina College of Emergency Physicians
North Carolina Council on Child and Adolescent Psychiatry
North Carolina Dermatology Association
North Carolina Neurological Society
North Carolina Obstetrical and Gynecological Society
North Carolina Orthopaedic Association
North Carolina Pediatric Society
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North Carolina Society of Eye Physicians and Surgeons
North Carolina Society of Gastroenterology
North Carolina Society of Otolaryngology – Head and Neck Surgery
North Carolina Oncology Association
North Carolina Society of Pathologists
North Carolina Society of Plastic Surgeons
North Carolina Spine Society
North Carolina Urological Association

State Societies / Organizations

Community Care of North Carolina
Carolinas Center for Hospice and End of Life Care
North Carolina Academy of Physician Assistants
North Carolina Association of Local Health Directors
North Carolina Community Health Center Association
North Carolina Foundation for Advanced Health Programs
North Carolina Healthcare Quality Alliance
North Carolina Medical Group Managers
North Carolina Medical Society

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I. Introduction

As detailed in the Toward Accountable Care (“TAC”) Consortium’s companion document, *The Physician’s Accountable Care Toolkit*®, to control spiraling health care costs, we are moving toward a health care payment system that rewards value, not volume. That is, we are shifting away from rewarding utilization, toward rewarding the highest quality at the lowest appropriate cost. This shift must align the incentives of payers, physicians and hospitals.

“Bundled payment” is one such experiment. Bundled payment refers to a single predetermined payment to multiple providers for an entire episode of care. These teams are jointly accountable for clinical costs, quality, outcomes and coordination. The payment is apportioned across providers. An episode can relate to a particular procedure, sometimes including post-acute care, or all treatment of a chronic condition for an extended period of time.

Realizing the dearth of physician-oriented guidance in this field, the purpose of this *Guide* is to acquaint physicians with this emerging health care reform model and to provide non-technical guidance specifically for physicians. The *Guide* will outline the elements essential for a successful bundled payment program, including what procedure(s) to pick for bundled payment, who to team with, how to budget, the “low-hanging fruit” opportunities that will drive value, and the necessary infrastructure. After showing you how to be in a position to succeed, the next sections show you how to legally protect those interests. This *Guide* was prepared for actively practicing physicians, by physicians and their advisors. The authors hope that this will serve as your roadmap for bundled payment success.

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II. HOW IS THIS DIFFERENT FROM OTHER VALUE-BASED PAYMENT REFORMS?

There is a common theme in all the payment reforms, including the Medicare reforms contained in the Patient Protection and Affordable Care Act (“ACA”), that payers will no longer pay for avoidable costs stimulated by financial incentives, such as fee-for-service, which rewards cost overruns and promotes our “siloed”, fragmented system.

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“The difference between bundled payment and other reimbursement models is that these bundles represent a fairly sound segment of total care, so you can really focus in and analyze to a greater degree what risk is involved in that episode.”¹ Bundled payment also has been viewed as a “stop in the road” to full provider risk.²

A. Not Capitation – Capitation is not a bundled payment model. Capitation payments are actuarially determined insurance risk payments for patients attributed to a provider who gets the same amount regardless of whether the patient needs medical care. In contrast, with bundled payment, the team of providers will get paid, usually less overall, for an identified medical episode.

B. Not an ACO – Some call accountable care organizations’ (“ACOs”) population management a form of bundled payment, but applying to all assigned patients for all of their medical conditions. Others disagree, as the health status and needs of the attributed patients are unknown, thus adding a component of insurance risk.

III. WHAT HAVE BEEN EXAMPLES OF THE DIFFERENT MODELS OF BUNDLED PAYMENT?

A. Public Payers

1. 1991-1996 Medicare Experiment – From 1991 through 1996, Medicare experimented on bundled payment with seven hospitals. Medicare provided a single payment to hospitals and physicians for coronary artery bypass graft (“CABG”) surgery. Forty-two million dollars was saved on 10,000 procedures through lowered length of stay, better pharmaceutical drug management, and lower post-discharge care costs. There also was a three-year cataract bundled payment demonstration for 4,500 procedures. Only \$500,000.00 was saved.

Strategic Tip: The lessons learned from this experiment included prioritizing specific inpatient procedures, those with variability of care subject to standardization, and those which use expensive resources.

¹ T. Schwartz, S., *Physicians Practice, Bundled Payments: What Physicians Need to Know*, p. 2, (Nov. 2012).

² Doug, L., et al., *Milliman, Evaluating Bundled Payment Contracting*, p. 1, (Dec. 2011).

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2. **“ACE” Program** – The now expired Medicare Acute Care Episode (“ACE”) demonstration project tested bundled payment for inpatient care, skilled nursing care and hospice care, physician’s fees, and hospital outpatient visits in five hospitals for nine orthopaedic and 28 cardiac inpatient surgical services and procedures.³

3. **The ACA’s Bundled Payment for Care Improvement Initiative (“BPCI”)** – The ACA called for a demonstration around defined episodes, which is being implemented through the Center for Medicare and Medicaid Innovation (“CCMI”). There are several models of care addressing most prominently retrospective versus prospective payment and bundling acute with or without post-acute care.⁴ Retrospective payment may mean that all providers of patient care bill fee-for-service as usual, but that a “true-up” will occur later with the holder of the bundle. To align incentives, “gainsharing” (more on that later; see Section V.C.4.) with physicians is specifically allowed but regulated.

4. **State Medicaid Experimentation** – Arkansas was the first state to identify bundled payment as a Medicaid priority in 2011, partnering with Arkansas BlueCross and BlueShield and QualChoice. There is no shared risk among providers, with sharing up to 50 percent of savings subject to a cap. Ohio and Tennessee have received planning grants from CMS to design bundled payment initiatives for their Medicaid programs.

B. Commercial Payors

1. **PROMETHEUS Model** – Numerous commercial payers employ the PROMETHEUS Model in their bundled payment programs.

a. **The PROMETHEUS Model bundles services with three components:**

- Evidence-informed base payment;
- Patient-specific severity adjustment; and
- Allowance for potentially avoidable complications.

b. **Blue Cross and Blue Shield of North Carolina’s (“BCBSNC”) Bundled Payment Initiative** – BCBSNC uses the PROMETHEUS Model, including software. BCBSNC prioritized bundled payments as providing a competitive advantage of preparing for the future, lowering costs and building alliances with providers through performance incentives. BCBSNC started with hip and knee replacements, and is moving to CABG. BCBSNC seeks high-volume practices that are committed to care transformation and are viewed as centers of excellence by reputation. The plan is for BCBSNC to be transparent

³ <http://www.cms.hhs.gov/demoprojectsevalrpts/downloads/ACESolicitation>.

⁴ <http://innovation.cms.gov/initiatives/bundled-payments/>.

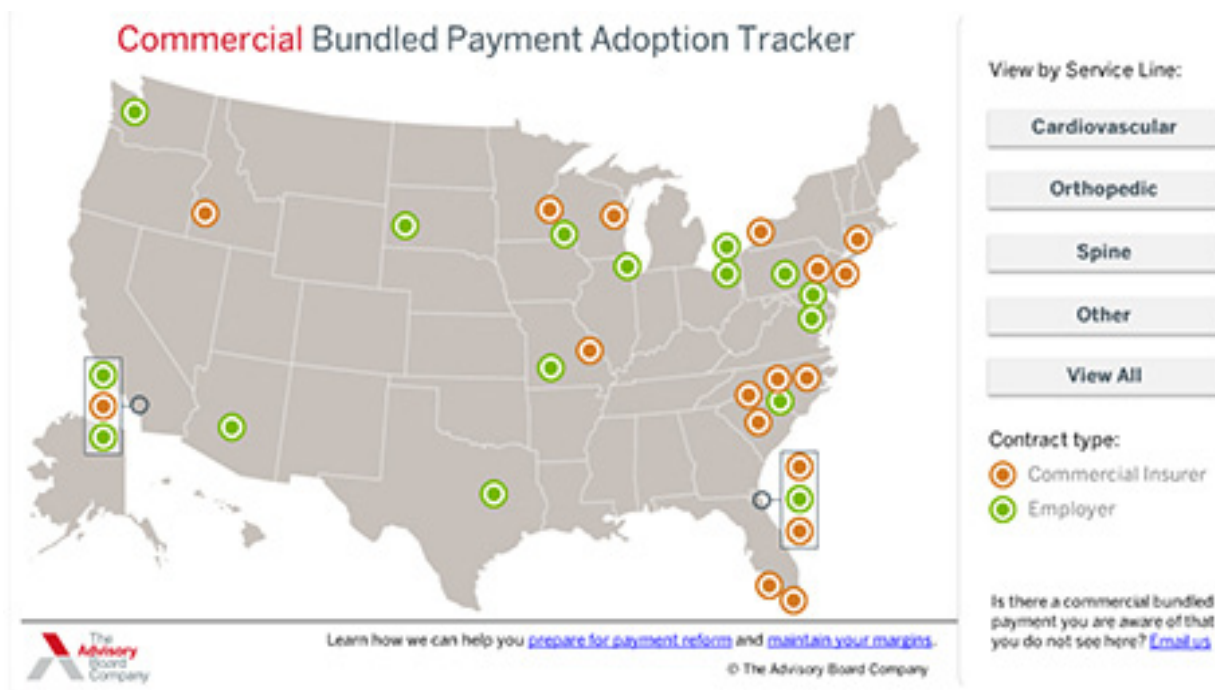
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with data sharing, offer prospective payment, retrospective reconciliation process, and embed quality data into the program. BCBSNC uses the Surgical Care Improvement Project (“SCIP”) and Hospital Consumer Assessment of Health Care Providers and Systems (“HCAHCPS”) measures along with measures co-developed with the providers. It uses Prometheus’ potentially avoided complications calculations to rank providers. It will contract with a medical practice showing sufficient administrative expertise to hold the bundle.⁵ Patients have a choice whether to participate, and our panel noted that unless there is a Patient Navigator involved, the patients may not readily perceive a benefit.

2. **Geisinger’s ProvenCare “Warranty”** – ProvenCare started with the clinically integrated Geisinger Health System providing a “warranty” on elective CABG surgery. It included in the single bundled payment: preoperative workup, hospital and provider fees, routine discharge care, rehab and any complications for 90 days. It proved successful and has been extended to percutaneous angioplasty, bariatric surgery and non-small cell lung cancer.

C. Prevalence of Bundled Payment Programs

The following map shows the general number and location of bundled payment programs around the country:



⁵ Baillitt, M., *Health Care Incentives Improvement Institute, Bundled Payments One Year Later*, pp. 4-7, (May 30, 2013).

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IV. PROS AND CONS: ARE BUNDLED PAYMENTS OPPORTUNITIES OR THREATS FOR PHYSICIANS?

A. Pros

- “Where else can we actually sit down with our hospitals and other caregivers and help define all that is absolutely necessary to provide for the best possible outcomes for our patients?”⁶
- Bundled payment programs prepare physicians for broader value-based care models. “With bundled payments, we’re not at population health but we’re at the step before that... You’re taking control of patients for a certain length of time.”
- Payers will steer patients to high-value teams, and bundled payment opens the door for direct-to-patient marketing (e.g., Geisinger’s “warranty” program).
- The Congressional Budget Office predicts that bundled payments for Medicare would reduce expenditures by \$19 billion between 2010-2019.⁷ A California study showed an unjustified variation in cost for knee replacement devices of \$3,321.00-\$8,987.00, for lumbar fusion of \$6,969.00-\$14,689.00, and for cardiac defibrillator of \$19,229.00-\$29,496.00.”⁸
- Physician leadership is essential to bundled payment success. This may be an historic opportunity for physicians to improve patient care and receive professional and financial rewards for so doing.
- “Bundled payments present opportunities for reducing expenses, improving delivery system integration, gainsharing between hospital and physician, increasing profit margin and increasing patient volume.”⁹

B. Cons

- Physicians have neither the time to do it ourselves nor the war chest to hire consultants or lawyers. Redesigning care requires substantial investment of physicians and care team time, energy and data and process analysis.
- We just want to see patients.

⁶ *Id.*, p. 7.

⁷ <http://bit.ly/CBObundling>.

⁸ Lazerow, R., The Advisory Board Company, Health Care Advisory Board, *Succeeding Under Bundled Payment*, p. 29 (Dec. 2010).

⁹ Doug, L., Milliman, *Evaluating Bundled Payment Contracting*, p. 1, (Dec. 2011).

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- This too shall pass.
- Some costs in the bundle may not be under the direct control of physicians responsible for the bundle.
- This is still “pay for volume” since the more bundles ,the more payments, and all still are paid fee-for-service. The incentive remains to promote volume, such as physicians being incentivized to “cherry pick” low risk patients who may not truly require the procedure in question.
- Bundled payment starts with a discount to the payer and will surely go downhill from there.
- In many cases, the discounts have been steep, the gainshare reduced year over year, and the hoped-for increased market share never happened.
- Bundled payments are complicated and national standardization is lacking. The same practice may have widely different bundled payment programs for the same procedure depending on what hospital they go to.
- Payer-driven steerage was less than expected.
- In some cases, the hospital may receive the bundled payment and be in control of its distribution. Physicians lack the foundation of trust and experience in collaboration.
- Hospitals are essential because they hold the reins to clinical and utilization data but want to hold onto fee-for-service as long as possible and don’t want to give up control.
- “The hospital industry is generally unprepared to manage increased episode performance risk. At present, organizations simply lack the relationships and infrastructure.... [Mere] employment isn’t enough; they must ensure functional integration and strategic alignment.” ¹⁰
- There has often been poor hospital transparency actually eroding hospital relationships. ¹¹
- Payers and employers are struggling with bundles and how they work.
- Nearly half of the initial 450 provider organizations that participated in the 2013 BPCI program decided not to go forward with it in 2014.

¹⁰ Lazelow, R., The Advisory Board Company, Health Care Advisory Board, *Succeeding Under Bundled Payment*, p. 20, (Dec. 2010).

¹¹ Teske, K., The Advisory Board Company, Expert Insight, *What Independent Medical Group Leaders Are Saying About Bundled Payments*, p. 2, (Feb. 21, 2014).

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- Many physicians see co-management and accountable care as better types of models for them.¹² And, will Medicare disallow gainshare payments if the physician is also in the Medicare Shared Savings Program, which disallows “double dipping” on savings for the same patients? This may not be an issue since Medicare will allow a set amount upfront under bundled payments, regardless of possible subsequent savings below that amount.
- Oncologists surveyed reported that defining the bundle’s scope on certain advanced cancer patients was “almost impossible.”¹³
- “In spite of the fact that we were doing the much-needed work to create patient health care value, the legal obstacles were extensive, time consuming and costly.”¹⁴
- Bundled payment is more difficult to manage for chronic disease patients.

V. HOW TO CREATE A SUCCESSFUL BUNDLED PAYMENT INITIATIVE

The main goal of this Guide is to demystify bundled payments by giving physicians a non-technical roadmap to follow and by giving you strategies so you can avoid the potential pitfalls and maximize opportunities along the way. We will set forth a more or less chronological process of bundled payment initiative development with liberal use of strategic tips and examples- all from the physician’s perspective. Most of the keys to success transcend payer or contract details such as development of a clinically integrated structure and culture, but for such things as gainsharing, scope of the episode, and other matters, the distinction controls design and options. CMS has specific requirements, and, in some cases, waivers from the application of health regulatory requirements. While remaining faithful to the overview approach, the notable differences influenced by payer type will be flagged.

A. Preplanning Understanding – Ideally, every decision maker of every stakeholder will become familiar with the bundled payment process. All participants will need to become aware later of the fundamental changes required for success under bundled payment.

We are all busy, want quickly to get to “the bottom line,” and to get back to seeing patients. However, a quick approach, not grounded in an understanding of care-redesign or payment reform, would be a big mistake. Without an understanding of value-based health care reform, and the dos and don’ts of

¹² L. Id., p. 3.

¹³ Id.

¹⁴ American Academy of Orthopaedic Surgery, The Reality of Bundled Payments, <http://www.aaos.org/news/aaosnow/nov12/advocacy1.asp>, (Nov. 2012, p. 3).

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bundled payment, stakeholders apply the problem-solving skills and attitudes they have been using successfully in the fee-for-service system, but which are inapplicable in pay-for-value thinking, such as win/lose versus win/win, silos versus teams, etc. The purpose of this Guide is to supply that necessary understanding in a matter of hours, not weeks. Though written from the physician's perspective, it lays out win/win strategies for all stakeholders and the principles that work for all in the long run.

Know what your roles are financially and clinically throughout the entire episode of care. What timeframes are covered? How do reinsurance programs factor into the program? Work with a third party to analyze CPT and DRG information throughout the entire continuum so you will know what is paid to each provider. Look at payment structures for all providers, making sure they are fair.

However, a quick approach, not grounded in an understanding of care-redesign or payment reform, would be a big mistake.

It is useful to create or purchase a financial and care continuum database tracking tool for care planning payment and analysis.

B. Committed Leadership – The MITRE Corporation was hired by CMS to provide information to help organizations fashion effective bundled payment contracts. They felt that before diving into the nuts and bolts of contracting, it was important to emphasize the requirement for committed leadership. They write, “Organizations and physician leaders will design, drive, and manage bundled payment program planning and implementation. Leadership commitment is essential.... The process of establishing and mobilizing this commitment consists of identifying leaders, obtaining their commitment, and then establishing committees to carry out essential functions.”¹⁵ Physician leaders emerge and respond well when exposed to data-driven case study examples that show how the bundled payment will achieve better outcomes and lower costs. A focus on common goals fosters the commitment of informed champions. Committee composition should be determined by the competencies needed to accomplish its purpose, not politics or historic referral power.

As an example, it is reported that the physician CEO of Hoag Orthopedic Institute attributes the success of their bundled payment program (profiled in Chapter IX) primarily to two things: 1) site of service differential, and 2) leadership and participation of all orthopaedists across the board.

C. Communication Process – Communication is key. Define the roles and responsibilities for all those involved in the process. Implement weekly calls/meetings to ensure handoffs are flowing smoothly and patients and processes are not falling through the cracks. The physicians, hospital and payers should all be included.

¹⁵ The MITRE Corp., *Contracting for Bundled Payment*, p.11 (Dec.16, 2011).

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D. Organizational Infrastructure – During this transition in health care from individual stakeholders practicing separately in siloes to interdependent seamless teams, the choices on organizational structure, decision-making, governance, data transparency, financial distribution policies, and risk attribution are very important.

1. **Structure** – As outlined in more detail in the companion *The Physician's Accountable Care Toolkit*, there is much flexibility on the form of multispecialty value-based model teams, whether ACOs or for bundled payment. The two most common approaches are the network model, with stakeholders remaining independent but contracting through a “hub” entity, perhaps an existing physician-hospital organization (“PHO”), or a “NEWCO,” newly formed for this purpose. The other common structural approach is through a single legal entity, with all individual participants employed, or, if including facilities, owned in one system.

2. **Governance and Decision Making** – If a basic commitment by all parties to common goals is not present, no amount of board configuration, super-majority votes, appeal rights of disputes, etc. will fix it. Too many beginning hospital/physician partnerships focus on reserving rights in legal documents and too little on culture. All integrated care will fail without some competency and trust, and bundled payment is no exception. That said, special care should be given to foster a sense of fairness and meaningful input in designing the governance structure.

E. Readiness Assessment – Care redesign under bundled payment involves people and things. The organization should confirm the commitment, not only of leaders, as mentioned at C.1. above, but whether the workforce has a culture of collaboration and care improvement and the necessary new skills. Do you have the appropriate data collection and analysis horsepower or administrative infrastructure? Experts recommend “batting practice” of two or three bundled payment pilots to test readiness.

All integrated care will fail without some competency and trust, and bundled payment is no exception.

F. A Plan for Merit-Based Gainsharing – A bundled payment initiative is not sustainable if the participating physicians do not feel that their contributions will be respected and extra effort and skill rewarded somehow. Everyone needs to be aligned and incentivized to achieve the common goals of the bundled payment program. That is why they call them “incentive” payments. A value-based bonus is recommended if possible. In the bundled payment setting, this is often termed “gainsharing.”

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Gainsharing is the most legally sensitive aspect of the bundled payment model and must meet regulatory guidelines.

A Word About “Gainshare”

“Bundled payment arrangements that include the cost of hospital services involve what is sometimes referred to as ‘gainsharing.’ Different from, but a close cousin to bundled payments, gainsharing typically refers to an arrangement in which a hospital gives physicians a percentage share of any reduction in the hospital’s costs for patient care attributable in part to the physicians’ efforts. Gainsharing has the potential to align hospital and physician incentives to realize cost savings. For example, gainsharing arrangements can encourage more appropriate use of imaging and testing services, more careful choice among available generic and brand name drugs, reductions in medication errors, use of outpatient rather than inpatient services, use of disease management services to preclude the need for hospital admission, and reduction of avoidable readmissions. Currently, a federal law, frequently referred to as the Civil Monetary Penalty statute, imposes financial penalties on hospitals that make payments to physicians as an inducement to reduce or limit services to Medicare or Medicaid beneficiaries. The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services has interpreted the Civil Monetary Penalty statute as prohibiting such payments even if the services being reduced are not medically necessary or appropriate. Consequently, gainsharing programs that are designed to reward physicians for reducing unnecessary services or unnecessary elements of services may be determined by the OIG to violate the Civil Monetary Penalty statute and may in some circumstances implicate the federal Anti-Kickback statute.

Notwithstanding its general prohibition concerning gainsharing arrangements, since early 2005, a number of gainsharing arrangements have been reviewed and favorably approved by OIG in a series of advisory opinions. These approved arrangements have used cost-reduction mechanisms such as limits on use of certain supplies; product standardization; and using certain supplies and services only on an “as needed” basis, in order to curtail waste.”¹⁶

“From a practical standpoint, a commercial bundled payment program could find it more efficient to comply with these federal requirements if the participants are running a concurrent government-payer bundled payment program. Currently, CMMI has several bundled payment programs under the BPCI

¹⁶Morrison, E., American Medical Association, Practice Management Center, *Evaluating and Negotiating Payment Options, Chapter 6: Bundled Payments*, p. 6 (2012.)

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initiative. The Patient Protection and Affordable Care Act ('ACA') granted CMMI the authority to waive federal health care fraud and abuse laws as may be necessary for purposes of carrying out CMMI initiatives such as the BPCI initiative. Applicants may propose waivers in their application and explain why waivers are necessary for their BPCI-model design. Any such waiver, if granted, would be included in the terms and conditions of the agreement between the Centers for Medicare and Medicaid Services ('CMS') and BPCI participants. It is important for all BPCI participants engaging in gainsharing to request and obtain a waiver.”¹⁷

Another note of caution to physicians is to be careful about inadvertent “double-dipping.” Make sure that any gainshare from, say, a hospital service line co-management agreement does not charge the physician for the same outcome under a bundled payment program. Some good news—bundled payment gainsharing for a Medicare Beneficiary does not trigger the Medicare Shared Savings Program’s prohibition on paying twice for the same shared savings. Remember, under bundled payment, CMS receives its discounted payment upfront.

Example: In the bundled payment project employed at Continuum Health Partners in a four-hospital health system in New York, physicians became entitled to 50 percent of the savings if they met or exceeded the 75th percentile in cost reductions, zero if not. The bonus was capped at 25 percent of physician income. Seventy-five percent of the eligible physicians participated. The program saved \$20-million over 11 quarters through implant cost reductions and a 9 percent length of stay reduction. The cost per case was reduced 12.6 percent, resulting in an average bonus of \$7,100.00 per physician.¹⁸

Example: A bundled payment initiative started by looking at historical total knee cost data (86 percent hospital, 10 percent orthopaedists, and 4 percent anesthesiologists). To establish the bundled payment budget, they pegged costs at 100 percent of “typical costs” (evidence-informed guidelines define “typical case”) plus 50 percent of the “average of complication costs” across the board rather than individually severity adjusted. These “typical costs” and “average of complication costs” (an allowance for potentially avoidable complications) definitions are terms of art utilized under a Prometheus-type model. By separating typical care from care of complications, the portion of costs of care caused by patient factors is bifurcated from the costs of care caused by project management failures.

Sustainable Merit-Based Gainsharing Model – Keeping in mind the gainshare legal compliance minefield noted above, start with the fee-for-service hospital, surgeon and anesthesiologist old ratios modified by allocation based on responsibility for the “compressible portion of the episode,” measuring

¹⁷ Nixon Peabody LLP, *Legal Issues in Designing Bundled Payments and Shared Savings Arrangements in the Commercial Payor Context*, p. 21 (2013).

¹⁸ Lazerow, R., The Advisory Board Company, Health Care Advisory Board, *Succeeding Under Bundled Payment*, pp. 40-42, (2010).

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which provider has greater influence on reductions in costs and utilization.¹⁹ Allocation should not depend solely on historical distribution of costs among the participants, but instead should be correlated to the participant's impact on costs at no compromise to patient satisfaction or quality. As a physician, you know that the changes and extra effort being required of you to make this successful will not be sustainable if you do not feel fairly treated.

How to Allocate Gainshare Based on Relative Contribution to Cost Reductions – Cost reductions stem primarily from six areas listed in order of impact: (1) complication rates²⁰; (2) reduced device, pharmaceutical and care variation; (3) perioperative management; (4) optimum site of service; (5) post-acute care management; and (6) patient-focused interventions (follow-up communications). Depending on the bundled payment initiative, a facility or physician's ability to impact quality improvements and cost reductions will vary. The principles of allocating performance incentives among providers based on relative contributions to quality and savings found in the *Toward Accountable Care Consortium's A Merit-Based Accountable Care Shared Savings Model* also should serve as a useful roadmap for bundled payment gainshare allocation. As noted, most of the desirable behaviors for ACO and bundled payment success are the same, with the most notable distinction being the limitation to discrete episodes of care for bundled payment.

G. Create a Bundled Payment Implementation Plan

1. Selecting the Episode – Collect and analyze financial and clinical data. What will give you the biggest bang for the buck? Where are waste bottlenecks and gaps in outcomes relative to the norm? Target episodes which:

- Have a wide variation in provider costs that could be subject to standardization;
- Use expensive resources;
- Are high-volume, high-expenditure;
- Present a significant opportunity to reduce complications such as procedures involving patients with chronic medical conditions;
- Are risk adjustable—the less severity adjustment the more insurance risk is shifted to the providers;
- Include multiple physicians;

¹⁹ Baillitt, M., Health Care Incentives Improvement Institute, *Bundled Payment One Year Later*, (May 30, 2013).

²⁰ Potentially avoidable complications can have a huge impact on Bundled Payment costs. One study showed that 61 percent of historical costs paid for diabetes were for preventable outcomes and they constituted 80 percent of costs for congestive heart failure 80 percent. Gosfield, A., Health Law Handbook, *Bundled Payment: Avoiding Surprise Packages*, (2013).

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- Have measurable data;
- Have leadership buy-in;
- Have established evidence-based quality and efficiency metrics that align with intended purposes; and
- Do not have many variables beyond the control of the bundled payment team.

We profile the seasoned bundled payment strategies of the Hoag Orthopedic Institute later in this *Guide*. Here is what they recommend that you look for in designing your bundled payment program: “[Y]ou have to pick high volume and predictable procedures. Hip and knee replacements, for example. You must also pick the right patients and the right surgeon. The patients need to meet predetermined selection criteria. The surgeons need to stay within the metrics of a standardized delivery program and meet quality metrics. Then, you have to have great data and know what things cost.”²¹ Grace Terrell, MD, President of Cornerstone ACO reminds us that, “Like much else in value-based payment models, the acuity of the patient population needs to be understood because it is critical to understanding costs and profit. It will be important to identify outliers and complex patients and create cost-effective management strategies ‘a priori.’”

Using similar criteria, the American College of Surgeons’ General Surgery Coding and Reimbursement Committee study found that the following tended to grade out the highest—colon resection for colon cancer and mastectomy for breast cancer.²²

Using these filters to target “low-hanging fruit,” the AMA likes maternal care, total joint replacement, and disease management.²³

2. Creating the Bundled Payment Budget – An actuarial analysis of historic claims data will provide the foundation for budget-setting. What were the historical costs? What group of service naturally bound by a medical condition should be included? What co-morbidities or other factors (altering the actuarial analysis or beyond the provider’s control) should be excluded? Consider the American Society of Anesthesiologists’ severity classifications. What are potential cost improvements through such things as standardization, care redesign, reduced complications, moving procedures to lower cost facilities, process improvement and post-acute care management? The budget or payment will be less than the unmanaged historic costs, otherwise the payer will not be interested. You will not be interested if the amount agreed upon is more than expenditures you think you can obtain using the collaborative best practices to be performed. Some recommend using historical costs less 50

²¹ A Survivor’s Guide to Bundling, Orthopedics Hub, <http://orthopedicshub.wordpress.com/2014/05/20/a-survivors-guide-to-bundling> (May 2014).

²² American College of Surgeons, Surgeons and Bundled Payment Models: A Primer for Understanding Alternative Physician Payment Approaches, p. 11 (April 2013).

²³ Morrison, E., American Medical Association, Practice Management Center, Evaluating and Negotiating Payment Options, Chapter 6: Bundled Payments (2013).

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percent of the complication costs. “Bundling doesn’t mean you have to charge less for what you do. You might even add a percentage to cover the risks and costs of the warranty.”²⁴

3. Selecting the Timeframe – “A staggering percentage of patients are readmitted while receiving post-acute care. With 43 percent of heart failure patients returning to the hospital from post-acute care providers, integrating with these providers and facilities is a problem hospitals cannot afford to ignore under episode bundling.”²⁵ Similar “post-discharge care and readmissions accounted for large variations in cost” when episodes were expanded from 30 to 90 days from discharge. A recent CMS Request for Information shows increasing interest in capturing the post-acute care period within the bundled payment episode.²⁶ The time deadline for proposals expired April 10, 2014. Interestingly, this is the first time CMS has been interested in episodes controlled primarily by physicians. They are interested in extending the time period for chronic disease management beyond the 60 to 90 days normally associated with surgical procedures. CMS is interested in episodes in which specialist services are involved over a period of days or weeks, such as colonoscopies, cataract removal, radiation therapy, and management of complex diseases. “[I]n the commercial space, acute-care episode bundles typically begin between two and 30 days prior to the procedure and extend afterwards for 90 to 180 days.”²⁷ Episode timeframes regarding chronic disease management may be tied to a 12-month period or indefinite, until the management ceases.²⁸ In planning your episode’s timeframe, you will need to balance the security of a more controllable and less complex situation with a short timeframe—against the higher potential quality, savings potential, and consequential payer interest in having a longer episode timeframe. It is important to set triggers and end-points.

4. Who Is On the Team? – Such things as compressing variability and standardizing devices and processes without compromising quality and engaging in multi-disciplinary care redesign call upon both clinical and collaborative skills. As with ACOs, even if you do everything

It is not about working harder or cheaper; it is about reducing complications, readmissions, and gaps in care.

perfectly, if others on the team drop the ball, you will fail under bundled payment. So, it is important that all involved understand what is involved and are committed to do this properly. It is not about working harder or cheaper; it is about reducing complications, readmissions, and gaps in care. Your teammates must “get it.” Participating providers can include hospitals, physicians of different specialties, imaging centers, home health, hospice, skilled nursing facilities, physical therapists, etc.

²⁴ A Survivor’s Guide to Bundling, Orthopedics Hub, <http://orthopedicshub.wordpress.com/2014/05/20/a-survivors-guide-to-bundling> (May 2014).

²⁵ Lazerow, R., The Advisory Board Company, Health Care Advisory Board, *Succeeding Under Bundled Payment*, p. 71, (Dec. 2010).

²⁶ <http://innovation.cms.gov>.

²⁷ Nixon Peabody, LLP, *Legal Issues in Designing Bundled Payments and Shared Savings Arrangements in the Commercial Payor Context*, p. 8, (2013).

²⁸ Id.

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Payers are beginning to tier provider teams based on quality and efficiency criteria and to steer patients accordingly through provider performance reports to patients, reduced co-pays and reduced premiums. Our physician Bundled Payment Workgroup advised obtaining copies of order sets used by all the physicians. “Know what is currently in play.” Determine the high cost, low quality providers, and vice versa. Who determines the order sets used going forward? Spend time defining them. How will scientific evidence be reviewed? “Flow out process and handoffs for each step of the care continuum.” Define responsibilities for the Patient Navigators. Determine how they work with hospital navigators. Some organizations have separate financial and clinical navigators.

Measure and monitor:

- Outcomes
- Teamwork
- Handoffs
- Cost
- Patient satisfaction
- Provider engagement

Determine baselines for all process, outcome and engagement data so improvements can be identified and tracked.

Providers not on the team also can influence your success. “[T]o the extent a provider can reduce services that ‘work’ outside its system [or network] (e.g., skilled nursing services or rehabilitation unaffiliated with the care provider), it can retain a greater portion of the revenues [and better manage care].”²⁹

5. Who Holds the Bundle? – Who holds the bundle—the provider network, the ACO or the hospital? Data analytics capabilities are essential. What episode? What providers? What DRGs and procedures? What are the catastrophic cost outliers? What variability in care? What probability of infection and other complications?

²⁹ Doug, L., et al., Milliman, *Evaluating Bundled Payment Contracting*, p. 1, (Dec. 2011).

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If the insurance company is making a single payment to one entity: The entity needs to be able to receive and store information on the episode, generate a unique case ID for the bundled payment episode, receive claims for services by all providers, identify claims with codes that trigger the bundled payment case rate and automatic matching of all other claims to the case ID number of the identified bundled care. It must be able to calculate accounts payable to providers, submit claims to payers, provide claim status to each provider on the case, and be transparently responsive to all providers.

Strategic Tip: The other simpler option for smaller organizations is to have the payer pay fee-for-service to all providers and then perform a “true up” at the end of the episode to determine if additional payment is due to the provider, or vice versa. If this option is chosen, there needs to be frequent meetings with the payer and data transparency so providers can discover early avoidable “leakage.”

Who Holds the Bundle? – It’s About Trust, Transparency and Capability

As noted above, there are extensive administrative and financial capabilities required of the entity receiving and distributing the bundled payment. But without a requisite baseline of trust and willingness to go from being independent to being interdependent, success in the bundled payment initiative will be challenged.

Trust and transparency are yoked together. “Transparency is an essential component to physician success under bundled payment arrangements...”³⁰ Physicians must have clear and transparent information on such things as: single entity or “virtual” bundling, timing of payments, definition and duration of the episode, assignment of responsibilities, payment allocation methodology, identity of other physicians, metrics, risk management, and the method of data collection. “Not every physician may feel comfortable with the hospital partner reviewing and apportioning the bundled payment. ... In situations where relationships between physicians and hospitals are not conducive to that, it is imperative that physicians be given...transparent information...but physicians must also play a role in administering the bundled payment arrangement.”³¹

³⁰ Morrison, E., American Medical Association,, Practice Management enter, Evaluating and Negotiating Payment Options, Chapter 6: Bundled Payments, p. 4 (2012).

³¹ Id. at p. 5.

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VI. HOW TO MAXIMIZE YOUR SUCCESS

Considering a Bundled Payment Contract?

Six Factors That Drive Profit—or Loss

1 Price Discount

Right-sizing pricing is critical to profitability and requires a solid understanding of costs including baseline, labor, physician, device, and supplies

2 Program Costs

Implementation and start-up costs often include staff to process claims, marketing outreach to physicians, outside counsel or consultants, and IT improvements

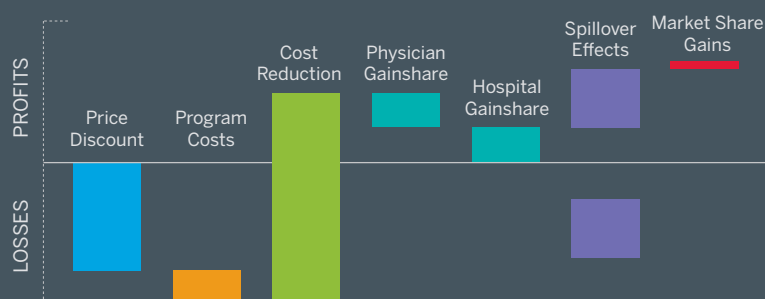
3 Cost Reduction

Implant and device costs account for the majority of savings. Depending on baseline practice, you may also expect reductions in LOS, consults, and supply costs

4 Gainsharing

Most hospitals split savings with specialists on a 50/50 basis

Key Factors Driving Bundled Payment Profitability



5 Spillover Effects

Cost savings for patients not directly covered by the bundled payment contract will be a net positive for patients reimbursed on a case rate basis and net negative for patients covered under percent-of-change contracts

6 Market Share Gains

Some hospitals may see market share shifts, but we recommend that these scenarios be considered 'best case' and not included in profitability models



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Regardless of the bundled payment episode, physicians usually can exert the most influence over the “compressible portions of the episode” with which they are involved by following proven strategies in the top six (6) high-impact categories within the bundled payment episodes.

A. Reduce Complication Rates – While this tends to be the result of following best practices, improved process management, better patient engagement, and other recommendations noted below, it is given

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a priority designation because of its overriding influence on bundled payment success or failure and the lack of awareness many physicians have of its significance. Physicians must be intentional about reducing complications, infections and readmissions. Inattention to reducing complications when in a bundled payment design discussion will be a bell-weather of failure, or at least mediocrity. Physicians drive this all-important variable.

B. Reduce Variation (Equipment, Drugs, Care) – Standardize equipment and supplies. Reduce medication costs. Our panel suggests particular attention be given to implants and to be mindful of the influence of vendors on equipment and device selection process. Use lower cost procedures and screenings consistent with evidence-based best practice. Agree among the physicians on the clinically-valid best practices and reduce variability. Physicians are always shocked to learn of the high degree of unjustified variability among accomplished peers.

C. Perioperative Management – This is sometimes called “care redesign.” You are freed from your silo and the fragmented health system. Virtual workstations with actionable information that follows the patient, transition management, and better informed patients are new tools for improved perioperative management. Simple things like better scheduling and pre-op readiness will benefit. The workflow management efficiencies fee-for-service discouraged, bundled payment encourages. Physician leadership to chart this new path is obviously essential. Do not default on this opportunity.

D. Optimize Site of Service – Physicians should always seek to move procedures to lower-cost facilities or outpatient sites. You should employ lower-cost procedures when consistent with best practices. Avoiding the emergency department will reap dividends. Will the hospital be hesitant to move the site of services if it will lower its fee-for-service reimbursement?

E. Post-Acute Care Management – Patient engagement, discharge planning, active follow up and communication, managing complex high-risk, high-cost care with post-acute care providers, have been shown to present significant opportunities for care improvement, reduced complications and readmissions and cost savings.

Strategic Tip: For elective surgical conditions, consider assigning a “Patient Navigator” to assist the patient in developing a care plan outlining the anticipated recovery and minimize use of more expensive resources. For example, the care plan may involve utilizing home health care to avoid placement in a skilled nursing facility. During the recovery, the care plan should be updated and monitored, including feedback to the treating physician.

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Bundled payment patients post-acute who use of the emergency department for non-emergency care can cause significant cost increases, but create an opportunity for care management. Combining palliative care with post-acute medical care has been shown to generate increased quality of life, better health and lower costs. Available and oftentimes underutilized community health resources can help tackle chronic disease management.

Our panelists caution to be mindful of divided incentives if the host hospital also owns the participating post-acute care facilities. They also caution that whereas a commercial payer might allow use of best practice justifications before referral to a nursing home, Medicare approves a 20-day stay as long as the patient has been hospitalized for three days. Nursing homes are still incentivized to keep their beds full. One member of our Work Group stressed that “physicians need to buy into continuity of care.”

Strategic Tip: Our physician Bundled Payment Workgroup emphasizes that care plan creation is crucial, particularly hand-offs. Who will oversee the care plans?

F. Patient-Focused Intervention – Patient education is absolutely essential for success, according to our panel. The Patient Navigator is key. Patients need to know when it is appropriate to present to an Emergency Department. A detailed patient handbook and journal are recommended. Better physician-patient communication is the best way to engage a patient. The hospitalist can coordinate better with the primary care providers. A transition health coach or “Patient Navigator” can actively follow up, including home visits.

Patient education is absolutely essential for success.

Strategic Tip: Physicians involved in bundled payment need to monitor all expenses related to the negotiated bundle and to document “leakage” such as Emergency Department visits, diagnostic studies such as lung scans, readmissions, excessive physical therapy visits, SNF placement and unscheduled home health usage. The Patient Navigator, besides being intimately involved in developing the care plan as noted in VI.E. above, should be an easily reachable point of contact for the patient. With hospital payment a “fixed” DRG, the biggest “leakage” variables are in post-hospitalization spending.

The patient can sign a patient compact to promise to be a responsible partner in his or her care. Social media, websites and email should be employed. Telemonitoring of identified high-risk patients is recommended. Transfer forms and other hand-off techniques with post-acute care facilities are recommended.

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VII. LEGAL ISSUES

Though there are significant legal issues surrounding bundled payment, and great care must be used in navigating this legal minefield in fashioning a successful program, these issues can be addressed through use of experienced health law counsel. The main issues are:

- Federal and State Antitrust Laws;
- Federal Civil Monetary Penalty Law;
- Federal and State Self-Referral Laws;
- Federal and State Anti-Kickback Laws;
- Federal and State Tax Laws;
- State Corporate Practice of Medicine Law;
- State Fee-Splitting Laws;
- State Insurance Laws; and
- Federal Self-Funded Employee Health Plan Laws.

VIII. BUNDLED PAYMENT NEGOTIATION ROADMAP

A. **Introduction** – You now know how to optimize the chances for bundled payment success, to improve patient outcomes, and to maximize your entitlement to financial contribution therefrom. Now, here is a roadmap to enable you to protect those interests in bundled payment contract negotiations.

B. **Negotiating With the Entity Holding the Bundled Payment**

1. **Have Your Due Diligence Done** – The entity holding the bundled payment may be an IPA, PHO, ACO, physician group, or hospital. As noted, this entity and its competencies and capabilities should have been vetted before you negotiate. You should have been in the loop enough to feel good about the game plan and team for the bundled payment as outlined in prior chapters of this Guide.

2. **Fee-for-Service or Flat Fee Rate** – While the novelty of bundled payment is the collaboration, process improvement, care management and reduction of complications, there are still the underlying individual clinical services for which you should be adequately compensated. Significant antitrust considerations come into play in these types of collective fee negotiation situations and should be carefully observed.

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3. **“Gainsharing” Amount** – As discussed, “gainsharing” is a financial arrangement between the holder of the bundled payment and the bundled payment participants wherein the bundled payment holder shares with a participant a portion of the cost reductions attributable to the participant. A gainsharing arrangement has the benefit of aligning incentives of participants to make cost-effective choices. Important gainsharing structural considerations include:

- Legal constraints.
- With whom?
- Method for calculating overall savings.
- Method for calculating the physician’s attributed portion.
- Timing.
- What data, who collects, who measures?

4. **Logistics** – The holder of the bundled payment acts as a hub. It contracts with the payer, receives the funds, and arranges for delivery of all the services included in the bundled payment episode through contracts/employment with all the entities that vary state-by-state providing care for the patient. Absent insurance law issues, the shift of risk of loss and chance for gain may be negotiated among the parties within reason, so long as the payments are at fair market value.

The parties must develop a logistical and financial framework to distribute the “unbundled” payment among themselves. The contract should describe the allocation of revenue, including gainshare.

5. **Amend, Don’t Start From Scratch** – Unless there has been no prior relationship, it is usual to amend a pre-existing ACO, IPA, PHO, or other fee-for-service or value-based payment underlying agreement. The agreement needs to address the following:

- Define the episode (i.e., is congestive heart failure in the bundle or not?);
- Define type of patients.
- Carve out bundled payment population from fee-for-service pool.
- Be clear regarding the contractually binding duty to provide services, follow protocols, and be accountable. Define quality, data, risk and role responsibility.
- Exclusions – catastrophic cases, high-risk cases, low-volume, “BMI very important.” Again, in commercial plans, there is often leeway, but with Medicare, not so.

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- Reinsurance.
- Termination: As one Bundled Payment Workgroup member said, “Every contract needs an exit.” Another said, “Have an out that is reasonable should processes fall apart.”

C. Negotiating With the Payer – The payer usually will be making a single bundled payment of a pre-determined amount to the central entity, which assumes financial risk. The payer may have the option to include post-acute activity, use the “virtual” bundled payment model and different episode terms and different payment amounts. Alternatively, the payer may contract directly with the providers. This is often driven by state corporate practice of medicine and fee-splitting considerations. The fixed amount is almost always a discount from historical fee-for-service sums, so it is crucial to the prospect of obtaining any gainshare that the payment amount is not unrealistically discounted.

IX. PUTTING IT ALL TOGETHER—CONCRETE EXAMPLES

There are obviously many moving parts to a well-executed bundled payment initiative with uncharted change adaptation, relationship building and team building going on simultaneously. It may be useful to see how two projects came together. The first is [Attachment A](#) concerning the Hoag Orthopedic Institute, equally owned by physicians and a hospital, and the second is at [Attachment B](#) concerning Triangle Orthopaedic Associates, P.A., a medical practice. Due to confidentiality agreement constraints, the latter is limited to a press release.

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X. SUMMARY

Sifting through the many things physicians need to keep in mind when approaching bundled payments, the AMA provides a fitting summary to The Bundled Payment Guide for Physicians by highlighting the following top 10 takeaways:

“1. Are you affiliated with an organization that has sufficient infrastructure to administer successfully a bundled payment arrangement or try to build one from scratch.

Note: Success in bundled payment systems depends upon having sufficient infrastructure and administrative expertise to manage the bundled payment arrangement.

In some cases, physicians may benefit from partnering with an institution or larger physician organization that has the requisite administrative expertise, as physicians may find it challenging to create that expertise from scratch. When looking for a partner, however, a physician should ensure that the partner and the physician have common goals and that the partner has recognized physician leadership and administrative expertise.

2. To what clinical conditions or procedures should bundled payments be applied?

Note: Are there obvious common and predictable procedures to start with?

3. Are you already a community leader in a particular procedure or disease state?

Note: Go with your strengths. What are you known for? What do you do the most of?

4. Do you have sufficient historical clinical and financial data to assess the risk?

Note: Anecdotal evidence is not sufficient. Access to adequate and sophisticated historical data, and the resulting due diligence, is critical to ensure success.

5. Which providers and services should be included in the arrangement?

Note: Who is essential for the success of the procedure or the treatment? Who do you routinely communicate with in that course of treatment? Who do you wish you could communicate with? Who drives costs?

6. How can provider accountability be measured and ensured?

Note: What role does each provider play? What can they contribute to a successful outcome, and more importantly, what problems can they create? Can those be objectively measured?

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7. What should be the timeframe of a bundled payment

Note: Surgeries typically have a 90-day surgical window. Can increasing the risk window be reasonably done to enhance payer and patient satisfaction?

8. What administrative capabilities are needed to administer a bundled payment?

Note: Do you have a staff and infrastructure capable of administering the program, or do you have to build it from the ground up? How will you provide feedback and communication among participants?

9. What financial and cash flow backing is available?

Note: Payments do not always readily flow downhill. If the arrangement will be a significant portion of your business, have you credit and other resources to ensure success?

10. How should payments be set and allocated among participants?

Note: Once the overall rate is determined, transparency and equity among participants is key. And achievable financial incentives built into the arrangement will help foster a cooperative work ethic.”

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Attachment A

Issue Brief

No. 11 • September 2013

Care Redesign: An Essential Feature of Bundled Payment

Jett Stansbury

Director, New Payment Strategies, Integrated Healthcare Association

Gabrielle White, RN, CASC

Executive Director, Ambulatory Services and Network Development, Hoag Orthopedic Institute

Successful implementation of bundled payment requires physicians and other providers to redesign care so that it aligns with the episode of care definition.



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ABSTRACT: The Integrated Healthcare Association conducted a demonstration of bundled episode of care payment between health plans and hospitals in California. Hoag Orthopedic Institute was an early adopter, providing orthopedic care for total knee and hip replacement procedures through bundled payment contracts with three health plans. This brief outlines the process of care redesign, an important step toward the successful implementation of a bundled payment model.

INTRODUCTION

The Integrated Healthcare Association (IHA) completed a three-year bundled payment demonstration in September 2013 funded by the Agency for Healthcare Research and Quality (AHRQ). The goal of the project was to encourage the use of bundled payment contracts as a means to align incentives between hospitals and physicians by providing care through a single, pre-determined payment amount for all services provided in an episode of care with a procedure or condition. In bundled payment for joint replacement, the hospital acts as the "bundler," accepting the fixed fee from the health plan and paying all professional, facility and medical implant device fees during the episode of care.

One of the initial participants in IHA's demonstration, Hoag Orthopedic Institute (HOI), is a specialty hospital for inpatient and outpatient surgical care, equally-owned by a group of 35 medical specialists and Hoag Memorial Hospital Presbyterian in southern California. Participating surgeons from HOI accepted joint replacement cases from three health plans: Aetna, Blue Shield of California, and CIGNA.

EPISODE DEFINITION—THE FIRST STEP TOWARD CARE REDESIGN

As part of the demonstration project, IHA developed ten bundled episode definitions, including five orthopedic procedures.¹ The episode definition is the heart of a bundled payment model, and is used as a tool to guide providers as they deliver care. The definition describes what is included in the episode using billing codes

In September 2010, IHA was awarded a 3-year, \$2.9 million grant from the Agency for Health Research and Quality (AHRQ) to implement a bundled payment strategy in California. The project, titled *Bundled Episode Payment and Gainsharing Demonstration*, aimed to test the feasibility and scalability of bundling payments to hospitals, surgeons, consulting physicians and ancillary providers in the California delivery system and regulatory environment. Issue briefs, practical tools such as episode definitions and contract language, and other resources are available at www.ihc.org.

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and DRGs, as well as patient qualification and exclusion requirements. The IHA episode definitions for total knee replacement (TKR) and total hip replacement (THR) include facility, professional and medical implant device charges for the inpatient stay; a 90-day post-surgical warranty for related complications and readmissions are included, but other post-acute care is excluded.

Once the episode is defined, an essential next step in the bundled payment implementation process is for physicians and other providers to redesign care so that it aligns with the episode definition.

CARE REDESIGN AND BUNDLED PAYMENT

Bundled payment creates a strong motivation for hospitals and physicians to collaborate to manage a patient's care within an established budget. Successful implementation requires care coordination, an organized effort to reduce unnecessary care, readmissions, and—with joint replacement procedures—revisions (repeat surgeries). Care delivery improvements can be achieved through a process known as care redesign. For the purposes of this issue brief, the care redesign process is defined as the intentional effort to standardize the way care is delivered using best practices, evidence-based clinical practice guidelines, and literature reviews; the goal is improving efficiency and quality by reducing risks and complications, and enhancing patient function and outcomes. The end product of this work is captured in what are commonly known as care protocols. Provider variation in care delivery requires more resources—staff, supplies, equipment and associated costs—and also generates inefficiencies for the medical staff and other providers. Standardization reduces these factors; it streamlines and simplifies the care process, and bolsters a provider's ability to stay within the negotiated bundled price.

Large payers, such as the Centers for Medicare & Medicaid Services (CMS), are piloting bundled payment models that mandate the inclusion of care redesign. CMS's Center for Medicare and Medicaid Innovation (CMMI), established under the Affordable Care Act (ACA), is charged with the development and evaluation of innovative models of payment and care service delivery. In keeping with the ACA mandate, CMMI launched the Bundled Payments for Care Improvement initiative (BPCI), a three-year pilot developed to test different bundled payment models and align care delivery incentives for hospitals, physicians

and other providers for fee-for-service Medicare beneficiaries. The program includes four models designed to improve care coordination across multiple settings. CMMI requires that all models include care redesign; the most ambitious of the four from a care redesign perspective, Model 2, creates episodes of care that include the inpatient stay and post-acute periods ranging from 30-90 days after hospital discharge. Implementation of this model requires coordinating care across multiple settings, including skilled nursing facilities and home health agencies—a challenging proposition given the fragmented state of the current health care delivery system.

THE CARE REDESIGN PROCESS AT HOAG ORTHOPEDIC INSTITUTE

The bundled payment model sparked the implementation of new practice patterns at HOI, moving surgeons away from a fee-for-service payment model that does little to foster care collaboration to one that requires ongoing coordination. HOI physician leadership understood that without a care redesign plan, the bundled payment model would falter, and cause fiscal failure for all parties. HOI opened in 2010, initially without bundled payment contracts. As HOI began to develop the capability to accept bundled payment for hip and knee replacements, practice variations among surgeons and hospital staff became evident, with the potential to become a financial liability. The infection prevention and performance improvement committees evaluated physician performance on quality and outcomes and generated comparative data, all of which pointed to the need to reduce practice variation through care redesign.

During the start-up phase of HOI, five orthopedic surgeons convened a series of meetings to begin the process of drafting a care redesign plan, including developing and refining care protocols for TKR and THR procedures. Pre-admission, surgical, and post-surgical phases of the procedures were identified, and clinical steps from each were captured in process flow maps. Next, the physicians discussed each stage by comparing historical practice patterns, often consulting references for current evidence-based clinical practice guidelines such as the Joint Commission's Surgical Care Improvement Project (SCIP) measures. Once the physicians completed drafts, other HOI stakeholders—including anesthesiologists, hospitalists, and staff from infection prevention, rehabilitation,

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nursing and administrative departments—reviewed their work and provided input on the protocols. While standardization is important, most of the final care protocols offer more than one pathway to allow for variances in patient needs. For example, the pain management protocol provides several care delivery options, depending on the patient's individual needs. All care protocols for TKR and THR were completed after several physician meetings, totaling approximately 50 hours of time and effort to plan, develop and finalize these tools. Information technology staff built the protocols electronically, making them available in real time to physicians and other medical staff who carry out orders. Training sessions were conducted for all medical staff, including physicians and mid-level practitioners.

On an ongoing basis, HOI has monthly performance improvement meetings with orthopedic surgeons, anesthesiologists, hospitalists, hospital administration and front line staff. Quality and outcomes data are reviewed through the metric dashboard at these meetings, along with comparative benchmark and patient satisfaction scores, and any process improvement needs. New physicians complete mandatory two-hour training for compliance with care protocols, usually held on a one-to-one basis. A wide range of staff are involved with quality and process oversight of the protocols, with review and updates by physicians, hospitalists, nurses, pharmacists, physical therapists, case managers, and dietary staff. Onsite and online training on content or process updates are widely communicated. HOI's significant and ongoing investment of effort in care redesign helped to establish a culture that contributed to the broad acceptance and consistent use of care protocols.

STANDARDIZING CARE AT HOI

Two priorities for HOI emerged to ensure that the bundled payment rate could cover the cost of TKR and THR—a medical implant device purchasing strategy and the development of care protocols. The protocol shown in Figure A is one example from HOI's protocol set that provided an important path toward standardizing care.

Care Processes—Infection Protocol

Prior to the development and implementation of care protocols, some HOI surgeons varied in their approaches to management of patients needing surgery who tested positive via nasal culture for Methicillin-resistant

Staphylococcus aureus (MRSA), a virulent staph infection. Instead of decolonizing a positive MRSA patient with an antibiotic nasal ointment regime and subsequent re-testing, some physicians would schedule surgery for a MRSA-positive patient but pre-operatively order Vancomycin, a strong antibiotic known to help reduce risk for MRSA-positive patients. HOI's review of the evidence pointed to decolonizing the patient of MRSA and performing surgery on a negatively-tested patient as the best approach for reducing the risk of surgical site infections (SSI). The final MRSA protocol calls for screening and decolonization, and is now used by HOI surgeons. As shown in Figure B, SSI rates have fallen since the implementation of the care protocol, dropping from 1.01% in fiscal year 2011 to 0.42% in fiscal year 2012 and < 0.25% in fiscal year-to-date 2013.

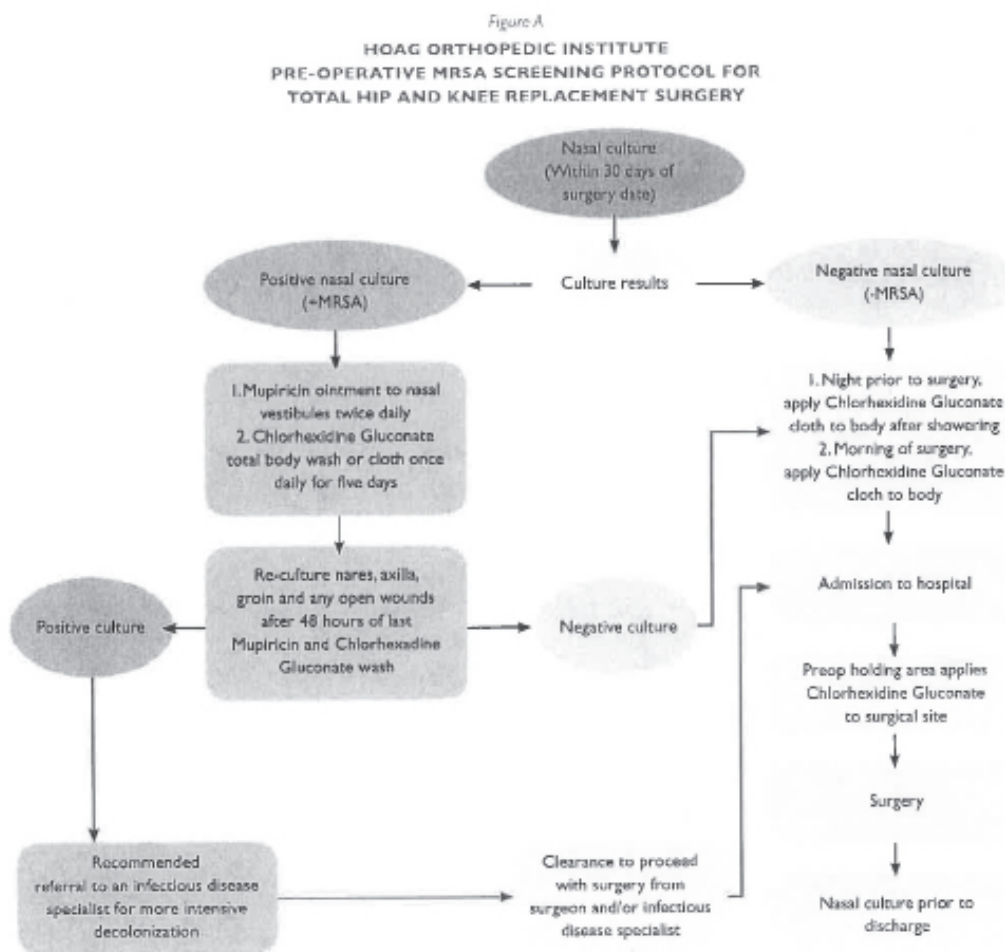
Purchasing—Medical Implant Device

Medical implants can be a significant component of the total cost of joint replacement procedures. In a fee-for-service environment, physicians have little need to pay attention to the device cost. By contrast, bundled payment includes the device, motivating physicians to reduce the number of implant options to generate more competitive vendor pricing. For HOI, a crucial aspect of effective care redesign for TKR and THR involved an assessment of medical implant devices used for procedures. During the care redesign process, comparative data were used to make decisions to narrow the number of vendors and medical devices used for joint implants. Once there was consensus, contracts were negotiated between the device vendors and the hospital, under the direction of the surgeons and with the support of the hospital supply chain team. By decreasing the number of device vendors, HOI was able to streamline the inventory and quality control process, case set up, and training—efficiencies that further reduced the procedure cost.

LEADERSHIP AND COMMUNICATION

HOI physician leadership strategies were necessary to drive the redesign process with the orthopedic surgeons, other medical providers, and hospital administrators—entities that have historically operated in distinct health care domains with long-standing cultural differences and divergent business models. As outlined below, communication played a central role—both among physicians, and

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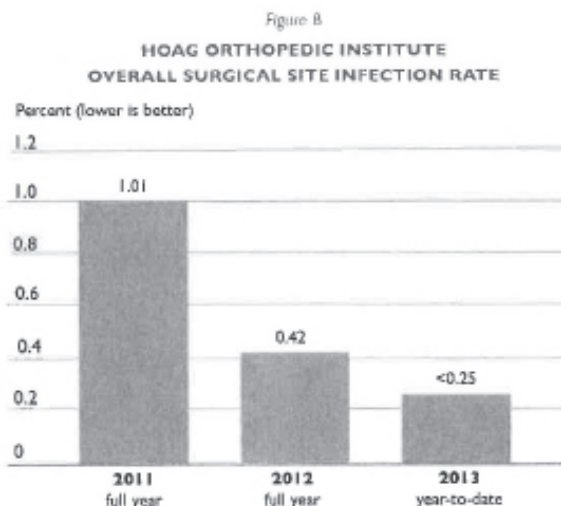
between physicians and the hospital—as did comparative data on provider performance.

Physician-Hospital Communication—To stimulate interest in care redesign, the physician leadership launched a continuous stream of formal and informal communication between the physicians and hospital administrators and arrived at a shared understanding of the bundled payment model, its value, and the key elements of successful implementation. Hospital and physician collaboration, especially around the medical implant device purchase strategy, created pricing transparencies across care settings and provided participating surgeons access

to claims data, payer reimbursement and outcomes data that supported care redesign.

Physician-to-Physician Communication including the review of data for outliers, was particularly effective in generating support for process changes. For example, after HOI care protocols were approved and adopted, physician compliance was initially inconsistent, as some surgeons did not immediately alter their existing practice patterns, and early data on infection rates (see Figure B) demonstrated variations in compliance with the SCIP measure for pre-operative antibiotic ordering. In response, physician leaders regularly engaged in peer-to-peer

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discussions and interventions, along with HOI's infection prevention medical director as needed, and often used physician comparative data to support discussions.

CONCLUSION

Successful implementation of bundled payment—risk-based reimbursement in the form of a single payment for all services provided in an episode of care—requires careful attention to care processes. Focusing solely on operational and administrative changes, such as claims adjudication and contracting, misses a core element of the model—coordination of care across all providers involved in the episode of care. Physician champions are well positioned to drive a bundled payment strategy, as the model requires that providers pivot from the more traditional approaches to practicing medicine in a fee-for-service environment to a more collaborative approach that emphasizes standardization of care processes.

As an early implementer of bundled payment, HOI leaders engaged in frequent and spirited discussions, bringing along surgeons, hospital administrators and staff—and ultimately leading to the full adoption of care protocols. The financial alignment of shared risk and reward through HOI's joint venture reinforced the coordination incentives inherent in the bundled payment model. For other business models, gainsharing can incentivize physicians through bonus payments when program benchmarks are met or exceeded.

As bundled payment initiatives gain momentum through the CMMI Bundled Payments for Care Improvement initiatives and private programs, those undertaking or considering an episode of care approach would be well-advised to integrate care redesign into implementation planning.

1. See IHA Issue Brief #7, May 2012 Commercial PPO Episode Selection and Definition in IHA's *Bundled Episode Payment and Gainsharing Demonstration* for more information on episode definition development. IHA episode definitions are publicly available at www.ihainc.org

Acknowledgements

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Attachment B

Expanded Collaboration Provides BCBSNC Customers with 10-20 Percent Savings on Hip Replacement Surgeries

New Coordinated Care Arrangement Expected to Lower Costs and Improve the Quality of Orthopedic Surgeries

06 Feb 2014



CHAPEL HILL, N.C. – Blue Cross and Blue Shield of North Carolina (BCBSNC) and Triangle Orthopaedic Associates (TOA) are expanding their efforts to provide better quality and cost options to BCBSNC customers through a coordinated care arrangement. The two organizations today announced the first bundled payment model for total hip replacement surgeries in North Carolina. Effective Nov. 1, 2013, BCBSNC customers, including State Health Plan members, became eligible to pay a flat fee for hip replacement surgeries performed at North Carolina Specialty Hospital in Durham. The one-time payment will be 10-20 percent less than the average cost of hip replacements in North Carolina.

"The cost of a hip replacement surgery and follow-up care in North Carolina can range from \$22,000 to \$52,000, and the prices of many surgeries aren't always available to patients when surgeries are scheduled," said Brad Wilson, BCBSNC president and CEO. "This lack of transparency drives up health care costs more than \$100 billion in the U.S. each year.^[1] Our new agreement with TOA takes the guesswork out of paying for hip replacements, allowing our customers to save money and make better-informed decisions about their health care."

Under the new agreement, BCBSNC customers will pay TOA a one-time fixed rate for hip replacement surgeries rather than receive multiple bills from the surgeon, hospital, physical

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therapist, anesthesiologist and others. This approach, known as coordinated care, improves efficiency, reduces unnecessary paperwork and ultimately lowers health care costs. The agreement between BCBSNC and TOA covers:

- All appointments and care occurring during the inpatient stay, including the total hip replacement surgery and care related to any complications
- All related post-operative care for 90 days after surgery, including physical therapy and follow-up care received at TOA

BCBSNC and TOA launched a similar agreement for knee replacement surgeries in 2012. To date, more than 120 BCBSNC customers have benefited from the agreement. Overall results show:

- An average cost saving of more than 22 percent in the Triangle for knee replacement surgeries*
- Peer-based outcome measures that are trending better than national benchmarks*
- A reduction in potentially avoidable complications as compared to other total knee replacements performed in North Carolina*
- Patient satisfaction with the care team carries 97 percent rating*

"We know this approach to care works from the results we're already seeing from our knee replacement agreement," said Thomas A. Dimmig, MD, President of Triangle Orthopaedic Associates. "We are pleased to work with BCBSNC again to bring another high quality, lower-cost orthopedic surgery option to BCBSNC customers."

BCBSNC customers who are interested in taking advantage of this payment model can contact TOA at 1-800-359-3053 for more information.

***BCBSNC customers under FEP and Blue Medicare do not qualify for this payment model.*

About BCBSNC

Blue Cross and Blue Shield of North Carolina is a leader in delivering innovative health care products, services and information to more than 3.74 million members, including approximately 1 million served on behalf of other Blue Plans. For generations, the company has served its customers by offering health insurance at a competitive price and has served the people of North Carolina through support of community organizations, programs and events that promote good health. Blue Cross and Blue Shield of North Carolina was recognized as one of the World's Most Ethical Companies by Ethisphere Institute in 2012 and 2013. Blue Cross and Blue Shield of North Carolina is an independent licensee of the Blue Cross and Blue Shield Association. Visit BCBSNC online at bcbnsnc.com. © Marks of the Blue Cross and Blue Shield Association. All other marks are the property of their respective owners.

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About TOA

Triangle Orthopaedic Associates, P.A., is the Triangle's largest physician-directed medical practice, caring for patients through state-of-the-art medical treatment, orthopedic surgery, physical medicine and rehabilitation, rheumatology, general surgery, physical therapy, occupational (hand) therapy, and other medical and diagnostic services responsive to the needs of patients living within the counties TOA serves. For more information, visit triangleortho.com.

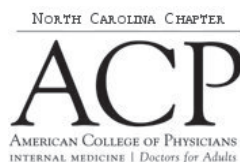
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[1] U.S. Government Spending, 2012

*These results are based on the results of 100 knee surgeries performed in 2013.

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