ISSUE brief

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BUNDLED PAYMENTS ONE YEAR LATER:
An Update on the Status of Implementations and Operational Findings—May 30, 2013

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Foreword

Form drives function and incentives drive function. That's the basic principle that is driving so many to focus on moving away from fee for service to alternative payment models. In March, Catalyst for Payment Reform issued a scorecard showing that barely 89% of total health plan payments were still fee for service. That means the prevailing incentive in health care is to produce more volume (the function), and health care providers are optimally organized to do just that (bad form). A year ago we asked Bailit Health Purchasing to provide an overview of some of the national activities related to bundled payments, essentially focusing on a part of the 11% not being paid fee-for-service. What they found was a number of health plans and providers engaged in pilots, trying to get through proof of concept. Since then, some of those pilots have closed up shop, preferring to either continue to focus on the prevailing incentive, or engaging payers in other payment alternatives. However, others have filled in the ranks, leaving the total number of active pilots stable, at 19. While that number seems paltry, there is an underlying shift that merits a closer look.

To do so, Bailit focuses on two case studies. One is about two Blue Cross Blue Shield plans that have moved resolutely to full, scalable implementations. The other is about a new model of financially integrating providers to accept financial risk from the new Medicare bundled payment pilot. Each offers important lessons. First, payment reform requires the adoption of new operating platforms that are not endogenous to health plans. That's a big hurdle because most of the plan CFOs will look at the cost of adopting these new platforms as an incremental cost when they should, instead, look at it simply as a cost of doing business in a the new world of value-based healthcare. Clay Christensen teaches us that most of these CFOs will get it wrong and jeopardize the future of their organizations. Second, non-integrated providers can band together to accept financial risk and improve their collective performance. Remedy Partners has facilitated that process for hundreds of physicians and hospitals across the country. Their analytic support and push to clinical integration assures that the financial integration will work. This is an essential lesson to payers everywhere. They keep looking for integrated systems that can take full risk, when in fact efficiencies are far better optimized by integrating service lines and taking performance risk instead of insurance risk. Again, the CFOs of many provider organizations will get this wrong, for the same reasons the health plan CFOs will get it wrong.

But for every one that gets it wrong, some will get it right, and this year's report shows us that the momentum continues to build strongly towards thoughtful payment reform. We'll know for sure next year whether the tide has turned, but if I were you, I wouldn't bet against the innovators. I'd bet against the incumbents.

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INTRODUCTION

In May 2012, Bailit Health Purchasing, LLC (Bailit) wrote *Bundled Payment Across the U.S. Today: Status of Implementation and Operational Findings* to convey the experiences of a sample of 19 payer and provider dyads that had initiated or were planning to initiate bundled payment arrangements. Since that report, payers and providers continue to experiment with compensating health care providers for a bundled set of services in lieu of a traditional fee-for-service or other payment approach. In some areas, experimentation with bundled payments has given way to permanent reimbursement change. As the pace of payment reform continues to accelerate, more providers are being paid in value-based methodologies designed to reward quality and reduce waste. While only about 11 percent of commercial in-network payments are characterized as "value-oriented" today, bundled payment has been reported to be one of the leading alternative payment methodologies currently employed by purchasers to shift financial performance risk to providers.[1]

In addition to commercially-driven bundled payment initiatives, significant experimentation is underway in the Medicare program (the Bundled Payments for Care Improvement Initiative) and in several state-organized efforts. With regard to state-based activity, the Arkansas Medicaid program partnered with two commercial insurers on a large scale bundled payment implementation. Ohio and Tennessee proposed pursuing bundled payment as a multi-payer innovation under each state's State Innovation Model grant from the Centers for Medicare and Medicaid Innovation (CMMI).

PURPOSE AND SCOPE OF THIS STUDY

This report provides a status update on the original 19 payer-provider dyads studied in the May 2012 report and highlights the motivations of payers and providers that have made bundled payment part of their permanent reimbursement strategy. In addition, this report reflects on key state agency and Medicare bundled payment developments and their influence on the commercial market's use of bundled payments.

To assess the most recent experience with bundled payments, Bailit interviewed either the payer or the provider partner of the original 19 non-federal bundled payment initiatives studied in the May 2012 report. Bailit conducted additional interviews with a sample of organizations that intend to participate in Medicare's Bundled Payments for Care Improvement (BPCI) Initiative. (For a full list of interviewed organizations, please see Appendix A.

RESEARCH FINDINGS

Of the 19 originally studied bundled payment initiatives, nine fully operationalized and have committed to expanding bundled payments. Two of the original initiatives studied are conducting observational pilots and three are still in the process of developing a bundled payment program. Five dyads from the 2012 report have concluded (or never started) pilots and have opted to not move forward with bundled payment.

In the original issue brief, Bailit reported that nine of 19 initiatives fully operationalized at least one bundled payment. While that number remains the same, the composition of the nine dyads has changed over the past year. Two dyads originally reported as having operationalized payment, concluded their pilots and elected not to move forward with bundled payments. Both dyads reported success with their bundled payment pilots, though neither reported statistically significant financial gains. In both cases, the dyads defined success in terms of provider initiating efforts at innovative care redesign.

While the lack of financial gains may have influenced the payer's decision to not move forward, the participating payers and providers are pursuing other alternative payment methodologies. The payer of one dyad elected to put its resources and energy into a different alternative payment methodology. The providers

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1 National Scorecard on Payment Reform. Catalyst for Payment Reform, March 2013. See www.catalyzepaymentreform.org/images/documents/NationalScorecard.pdf.

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of the other dyad focused on alternative payment methodologies of a different insurer with a larger share of the market than its initial bundled payment pilot partner.

Of the nine dyads that fully operationalized at least one bundle (including two dyads in the planning phase the prior year), all reported the desire to continue and expand to additional bundles, additional providers or additional covered populations (e.g., ASO clients). Most dyads studied view bundled payments as a key payment methodology of a value-based payment system. However, these dyads also recognize that bundled payments will not be the exclusive payment method.

Despite some challenges, payer and provider dyads have successfully made bundled payments operational and are working toward making them a permanent change in reimbursement.

Commonly Bundled Conditions

Bundled payments in the non-Medicare market continue to focus on inpatient and outpatient procedural conditions as noted in Table 1 below. Since the original study, the number of operating inpatient procedural conditions among the 19 studied dyads has increased 122 percent (from 9 to 20) and the number of operating outpatient procedural conditions has increased 200 percent (from 1 to 3). Chronic medical conditions are considered to have the potential for the greatest savings,[2] and bundled payments for these medical conditions have increased 300 percent (from 1 to 4).

Challenges

Certain challenges continue to plague bundled payment efforts, including lack of data, lack of engaged leadership, lack of resources to implement alternative payment methodologies and lack of engagement in local efforts by national plans. However, these challenges are no different than those affecting alternative payment reform efforts across the country.[5] Three of the 19 studied dyads failed to implement bundled payments beyond the observational time period and one dyad in the planning phase is at risk of not launching a pilot. Two of the dyads that failed to launch pilots were challenged by data issues that continued to the point that leadership engagement waned and the pilots eventually fell apart. One provider previously reported to be in the planning phase never moved forward with the pilot phase. This provider decided to focus its limited resources on developing an Accountable Care Organization (ACO) structure instead. Lastly, a provider currently reported to be in the planning phase is struggling to obtain payer support in a marketplace with many national insurers, all of which have alternative payment methodology pilots underway.

Success Factors

Despite some challenges, payer and provider dyads have successfully operationalized bundled payments and are working toward making them a permanent change in reimbursement. In this issue brief, Bailit highlights two plans from the original study committed to making bundled payments part of everyday plan operations.

Table 1. Number of Studied Bundled Payment Initiatives by Types of Conditions Subject to Bundling and Operational Phase of Bundle[3]

BUNDLE TYPE	OPERATIONAL	PLANNING / OBSERVATIONAL[4]
Inpatient Procedural Conditions	20	13
Outpatient Procedural Conditions	3	4
Chronic Medical Conditions	4	8
Acute Medical Conditions	1	0

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2 de Brantes F., et al. "Sustaining the Medical Home: How PROMETHEUS Payment can Revitalize Primary Care." *Robert Wood Johnson Foundation.* See www.hci3.org/sites/default/files/files/PROMETHEUS%20-%20Medical%20Home%20-%20full%20packet%20-%20FINAL.pdf

3 The total sum does not add up to 19 (the total number of studied initiatives) as some are operational with one or more conditions while planning for others.

4 "Observational" refers to the time period when payers and providers engage in real-time analysis of potential episodes of care, in some cases shadowing the process of administering a bundled payment, but with no bundled payments made and no budget reconciliations resulting in a payment transfer.

5 Bailit Health Purchasing, LLC. "Facilitators and Barriers to Payment Reform." *Robert Wood Johnson Foundation.* Report forthcoming summer 2012.

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BLUE CROSS BLUE SHIELD NORTH CAROLINA / HORIZON HEALTHCARE SERVICES, INC. (NEW JERSEY) CASE STUDY

By the end of 2013, Horizon is planning to add additional procedures to their bundled payment initiatives. BCBSNC will be adding PROMETHEUS-defined CABG bundles in the same time period. This expansion to additional conditions is one proof of their commitment to bundled payments as a permanent reimbursement strategy.

Blue Cross Blue Shield of North Carolina (BCBSNC) and Horizon Healthcare Services, Inc. (Horizon) have both been successful in moving bundled payments from a pilot stage to a permanent reimbursement strategy. While not all studied bundled payment efforts do so, these two payers utilize PROMETHEUS Payment definitions and associated analytic software.[6] The following case study looks at the factors that help explain BCBSNC's and Horizon's success with bundled payments, with a goal of identifying best practices helpful to other organizations interested in using bundled payment methodologies.

Engaged and Committed Leadership

Both health plans report very strong and committed leadership support for their bundled payment initiatives. The plans' leadership identified bundled payments as an essential strategy to promote broader-based and long-term delivery system transformation. Leaders at each of the plans view bundled payments as creating a competitive advantage through strengthening provider alliances and lowering costs. In other words, BCBSNC and Horizon consider bundled payments as a wave of the future, not a side endeavor. Similarly, both plans see bundled payments as a vehicle to achieving clinical integration among multiple providers. Horizon considers bundled payments as one of three integrated transformation strategies it is pursuing; the other two being the patient-centered medical home (PCMH) and the development of ACOs. Within that strategic framework, Horizon believes bundling payments enables specialists to improve and streamline care, activities essential for the successful development and execution of population based health programs such as PCMHs and ACOs.

BCBSNC emphasizes the transformational outcomes of bundled payments as being strategically important. In addition to clinical integration, the plan's desirable outcomes for bundling payments include: 1) providing a transparent methodology to compare performance across providers, 2) better collaboration among all participants—including the payer—within the bundled payment, and 3) shifting performance risk to providers while BCBSNC retains the insurance risk.

BCBSNC and Horizon's staff commitment to develop and implement the reimbursement strategy offer further evidence of plan leadership support for bundling payments. The plans provide data analytics and contracting expertise, and invest in key software that defines the bundles and automates the reconciliation process.

Implementation Approach

Bundles. Both BCBSNC and Horizon started bundled payments with knee and hip replacements because these are well-defined, high-volume procedures with opportunity for savings through care redesign. By the end of 2013, Horizon is planning to add additional procedures to their bundled payment initiatives. BCBSNC will add PROMETHEUS-defined coronary artery bypass grafts (CABG) bundles in the same time period. Expanding bundled payments to additional conditions is one proof of these plans' commitment to bundled payments as a permanent reimbursement strategy.

Provider selection. The approach to selecting providers is dependent on the structure and competitive dynamics of the locale in which the plan operates. For example, up until recently Horizon partnered only with orthopedic practices. In a new partnership, Horizon is working to share savings garnered from bundled payments with two orthopedic practices and a hospital. Plan representatives explained that New Jersey has a limited number of integrated delivery systems; therefore, the plan did not view including hospitals in the initial pilot phase as appropriate at that time. BCBSNC, on the other hand, consistently contracts jointly with practices and hospitals to be accountable for the bundled payment.

As a first step, both plans start a search for bundled payment partners by identifying high-volume providers. Horizon vets practices internally, examining their quality profile, contractual relationship with the plan, and level of practice sophistication. Horizon seeks partners who are looking to the future, understand that they must transform their practices to be successful,

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6 The Evidence-informed Case Rate (ECR) Analytics are a SAS-based episode of care analytic tool available from the SAS Institute

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and have physician champions to lead the change. BCBSNC describes the high-volume practices it seeks as those that are willing to think outside the box, have leadership that understands the importance of practice transformation to reducing costs, and are early adopters of innovation. These practices also see themselves as "destination providers"—practices that patients view to be leaders in the field. Both plans evaluate practices by using the ECR Analytics software to identify potentially avoidable cost savings opportunities. While high levels of potentially avoidable costs indicate higher potential for savings, Horizon notes that practices with a low level of potentially avoidable costs can be good partners too because they believe there may be cost savings opportunity in the typical portion of the bundles as well.

Budget Development. To build its original budgets BCBSNC analyzed several years' worth of potentially avoidable claims (PAC) data. In its analysis, the plan found very little PAC variation and felt comfortable developing a flat-rate budget for each practice, meaning that the plan reimbursed each bundled procedure at the same level within a practice. Payment levels for each bundle varied by practice. However, BCBSNC left patient-level risk-adjustment methodologies on the table for future consideration. Horizon implemented risk-adjusted budgets for each patient covered by a bundle.

Contracting. The two plans contracting philosophies differ due to underlying market factors. BCBSNC considers a key part of the contract negotiations to be reaching and agreeing on a flat-rate budget. BCBSNC is flexible with its negotiations depending on which providers participate in the bundled payment. For example, if anesthesiologists are at the table, the plan includes their services in the bundled payment; if anesthesiologists are not at the table, the plan develops a financial The two plans contracting philosophies differ due to underlying market factors. BCBSNC considers a key part of the contract negotiations to be reaching and agreeing on a flat-rate budget. BCBSNC is flexible with its negotiations depending on which providers participate in the bundled payment. For example, if anesthesiologists are at the table, the plan includes their services in the bundled payment; if anesthesiologists are not at the table, the plan develops a financial model that excludes their services. As a result, BCBSNC emphasizes the need for flexibility regarding the included provider services, the financial model, the budget amount and the contracting structure. For example, depending on the local dynamics, BCBSNC either contracts with a single provider that subcontracts with downstream providers or the plan develops contracts with each participating provider separately.

BCBSNC describes the contracting discussions as part of the process of team building. All parties need to be open to others' points of view during contractual discussions. These discussions provide an opportunity for providers to see situations differently, and an opportunity for the plan to see what the providers view as challenges. BCBSNC believes an open and flexible approach is essential to successfully negotiating a bundled payment contract. Depending on the motivation and time commitment of the partnering providers, the bundled payment contracting process can take as little as four months or as long as two years.

Horizon's approach to contracting is also very collaborative. The plan reviews historical data with prospective partners and develops budgets by using the ECR Analytics, and risk adjusts at the member level. Because of the successful execution of the hip and knee replacement program, Horizon is expanding its bundled payment program and preparing to scale the model. The plan expects that 'on-boarding' a new practice will occur within 12 weeks of initial discussions.

Data sharing. Both plans emphasize the importance of transparent data sharing to obtain provider buy-in, build trust, and motivate transformation. Data sharing is essential during the contracting process to demonstrate to the providers the logic and fairness of the bundle definition, the appropriateness of the budget and the opportunities for cost savings. Plan representatives report that physicians are often surprised at the total cost of care and find the data to be eye-opening. Both plans hold monthly meetings with providers to keep them abreast of claims data for contracted bundles. The data sharing has helped providers begin to build a better understanding of care provided by downstream providers and the cost of those services. Plans indicated that these monthly sessions offer participants the opportunity to discuss new practice improvement ideas

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and ways to better coordinate with other providers. BCBSNC's monthly meetings focus on analyzing where care was rendered, and looking for leakage (services provided by providers not part of the bundle). The plan shares data to providers at an aggregate level and not at the CPT code level.

When asked to identify factors that have been key to success so far, the plans commonly identified three factors:

1. *Commitment to the initiative by top leaders;*
2. *Adequate resources for program design and administration and provider contracting, and*
3. *An open mind to new ideas*

Data analysis. Both health plans developed internal capabilities to perform complex claims analysis to build budgets, analyze provider care patterns, identify opportunities for savings, report bundle activities and conduct reconciliations. Representatives from both plans emphasized the importance of having analytic capabilities to be successful at internal program monitoring and in sharing actionable data with providers.

Reconciliation. Both plans currently offer a retrospectively reconciled bundle administered by the plans making traditional fee-for-service payments and then going through a manual reconciliation process. BCBSNC also offers a prospective bundle administered by the plan paying the entire budget amount up front. All claims filed by providers covered by the bundle are zero paid since they are included by definition as part of the single bundle payment. A key step in the reconciliation process for both BCBSNC and Horizon involves both the plans and the providers reviewing claims to determine whether a claim is covered by the bundle or not. BCBSNC's reconciliation process for the prospective bundle focuses on leakage claims, which are claims from providers not participating in the bundle. If there is a disagreement regarding the inclusion or exclusion of a claim from the bundle, BCBSNC has arranged with HCI3 to arbitrate the final decision, a service that has not been needed to date.

The manual reconciliation process is quite time consuming. BCBSNC originally chose to administer its bundles manually because it needed to demonstrate that a bundled payment was a win/win strategy for itself and providers before moving to automate the process. Now that both plans are ready to make bundled payments a viable permanent reimbursement strategy, both have decided to engage a claims adjudicator to automate the reconciliation process. The claims adjudicator, TriZetto[7](in both cases), is able to re-price claims and assign them to the bundle using definitions set forth by the plans. In addition, TriZetto can implement bundled payments that are either prospectively paid or retrospectively reconciled. BCBSNC is currently working with TriZetto and HCI3 to ensure that TriZetto has the appropriate PROMETHEUS Payment algorithms and the health plan's provider contracts. The plans described the process of readying TriZetto as time consuming and involving months of work.

Use of quality data. BCBSNC and Horizon each built quality data into their bundled payment program. Horizon used a provider advisory council composed of participating physicians to identify and define performance measures that the plan collects and reports back to the practices. The data collected is a "toll gate" meaning that it must be reported before any savings that results from the bundle is distributed to the providers. The data includes functional analyses relating to hip and knee replacements, such as range-of-motion capabilities in a specified number of days after surgery. The plan is also analyzing the incidence of "Never Events" and readmissions, and monitoring the occurrence of pulmonary embolisms. If Never Events or readmissions occur, the plan and providers conduct a major review to determine what could be done in the future to avoid such an event. Horizon reports zero Never Events and very few readmissions in 1,000 surgeries.

Recently, Horizon added patient experience measures into its quality assessment, allowing the plan to monitor how well the patients perceive their care. Plan representatives report that patient satisfaction levels for patients whose case is subject to a bundle are higher than for those who are not. The quality improvement staff at the plan also uses the measurement results to identify areas of improvement and work with all participating practices to implement them. One example of a successful quality improvement initiative is that all participating orthopedic practices have scales and can calculate and report body mass index (BMI) for each joint-replacement patient.

BCBSNC is using Surgical Care Improvement Project (SCIP) and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPHS) measures, as well as outcome measures related to the condition developed in conjunction with the providers. The plan also tracks return-to-work times. The plan shares results with participating

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7 Other claims adjudicators include McKesson.

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providers. BCBSNC uses CMS benchmarks wherever possible, such as the CMS rate of post-operative sepsis. In addition, the plan uses PROMETHEUS Payment's potentially avoidable complications (PAC) calculations to rank providers in its tiered network product, placing providers with low PAC rates in a preferred tier.

Key Success Factors

When asked to identify factors that have been key to success so far, the plans commonly identified three factors:

1. Commitment to the initiative by top leaders;
2. Adequate resources for program design, administration and provider contracting, and
3. An open mind to new ideas.

Horizon believes that by standardizing its model, it will successfully scale up the bundled payment methodology to the point where it will represent a significant portion of total provider payments. BCBSNC sees the automation of the reconciliation process and offering both prospective and retrospective bundled payment methodologies as critical to success. Finally, both plans view patient engagement as key. Patient agreement to use the participating providers assures more coordinated and efficient care, two goals driving both of these plans adoption of bundled payments. Horizon collects patient satisfaction information and is reporting high satisfaction rates. Both plans are still in the early stages of addressing the challenge of patient engagement.

In January 2013, CMS announced that 450 providers were accepted into the BPCI—nearly twice the number of organizations that have to date been accepted into the Medicare Shared Savings Program.

MEDICARE EXPERIMENTATION WITH BUNDLED PAYMENTS

As reported in our original study, CMS launched the Bundled Payments for Care Improvement Initiative (BPCI) under the authority of the Patient Protection and Affordable Care Act. CMS originally scheduled BPCI implementation for late 2012, but pushed the start back to June 2013, with an observation period that started in January. CMS accepted approximately 450 providers into the BPCI[8]—nearly twice the number of organizations CMS accepted into the Medicare Shared Savings Program. BPCI offers four different payment models:

- **Model 1:** inpatient only (discounted Inpatient Prospective Payment System (IPPS) payment)
- **Model 2:** inpatient stay plus post-discharge services (retrospective comparison of budget with actual FFS payments)
- **Model 3:** post-discharge services only (retrospective comparison of budget with actual FFS payments)
- **Model 4:** inpatient stay only (prospectively set payment)

There are 48 episodes available to providers, all of which are triggered by an inpatient stay. CMS generally organized the available BPCI episodes around procedures (e.g., amputation, knee replacement, spinal fusion), but also included chronic conditions for common inpatient diagnoses (e.g., diabetes, sepsis, pneumonia).

It is not clear whether this bundled payment initiative will be successful for Medicare or the hospitals that participate. Based on early research and analysis of Medicare claims data related to episodes of inpatient care, Brandeis University made three important conclusions,[9] all of which will impact whether and which type of hospitals commit to the program.

First, Medicare typically spends as much or more in the 90 days post-hospitalization than it does for the hospitalization itself. The episode-initiating organizations are hospitals—which control half or less than half of the cost of a total bundle. Under BPCI, hospitals are at substantial risk for the care provided-post discharge. Without an integrated network of post-acute care providers or sophisticated coordination among providers, hospitals could face losses under the program's financial arrangements.

Second, Brandies found wide variation in average post-acute care spending. The researchers attributed the majority of this variation to differences in readmissions and in the use of post-acute care. These findings suggest an opportunity for providers to better coordinate care, which can be difficult to achieve when providers are not affiliated. However, Medicare recently announced several waivers that may help improve post-acute care coordination. Under new rules, BPCI

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8 See http://innovation.cms.gov/initiatives/map/index.html#model=bpci-initiative-model-1+bpci-initiative-model-2+bpci-initiative-model-3+bpci-initiative-model-4

9 Mechanic R and Tompkins C. "Lessons learned preparing for Medicare bundled payments." *New England Journal of Medicine.* November 15, 2012.

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participants will be reimbursed for home-based physician office visits for non-homebound Medicare patients. In addition, BPCI will reimburse participants for telehealth visits, which previously were reimbursed only in rural areas.

Third, Medicare built 48 different episodes of care, and Brandies found that each hospital may not always have a statistically significant number of patients within each bundle, which can lead to wide variation in patient-severity, and therefore cost. This lack of statistically valid groupings can lead to significant financial risk for providers year-over-year. Providers can mitigate this risk by limiting the number of bundles it chooses to join. However, since CMS released the final Bundle Payment Pricing data set just prior to the publication of this study, many providers have been unable to make those decisions. In addition, CMS' reliance on DRGs as the determinant for classifying the bundle, places providers at significant risk simply due to the heterogeneity of diagnoses included in a DRG, especially the procedural ones.[10]

Consequently, non-integrated hospitals may view the BPCI program too difficult to manage successfully outside of an ACO structure given the barriers identified by Brandies. Despite this, CMS did accept a number of smaller, not well-integrated hospitals into this Medicare bundling program. Financial intermediaries that can help manage the financial risk and the relationships between providers are assisting a number of smaller, non-integrated hospitals participating in the bundled payment program. The following case study on Remedy Partners provides an example of what role such a financial intermediary can play in supporting providers pursuing bundled payments.

Remedy has teamed up with nearly 100 different providers across the country to implement Models 2 and 3, with a focus on providers in the Northeastern part of the United States. The company offers several key services to its partner organizations including program financing & management, pricing and data analytics, technology to link the various care providers to the patient, and care coordination and redesign services.

REMEDY PARTNERS CASE STUDY

Remedy Partners ("Remedy") is one of several awardee convener organizations[11] assisting providers in operationalizing CMMI's BPCI Model 2 bundle. Awardee convener organizations are entities that assume a portion (or all) of the risk on behalf of episode-initiating bundled payment participation organizations (e.g., hospitals). Awardee conveners can be parent companies, health systems, non-profit or for-profit organizations. They may partner with providers that will initiate the episode (i.e., inpatient hospitals in the case of Model 2) and with non-episode initiating organizations that may care for the patient during the duration of the bundle (e.g., skilled nursing facilities, home health providers).

Remedy teamed up with nearly 100 different providers across the country to implement Models 2 and 3, focusing on providers in the Northeastern part of the United States. The company offers several key services to its partner organizations including: 1) program financing and management, 2) pricing and data analytics, 3) technology to link the various care providers to the patient, and 4) care coordination and redesign services.

Data Analysis

To succeed in bundled payments (and most alternative payment arrangements) providers must have access to and the expertise to analyze complex data sets. Providers interested in bundled payment must analyze their past performance and identify where potential efficiencies and savings can occur through care redesign or the elimination of waste. In addition, providers can reduce risk exposure in bundled payments by better managing patients through transitions of care. Remedy, and other software-focused organizations such as SAS and MedAssets, built episode groupers and/or analytic platforms specialized in managing episode-based payments. On behalf of its 46 Model 2 hospital partners, Remedy manages and reports Medicare claims data from 2008-2012. In addition, by early summer, Remedy will analyze the recently released Medicare pricing data and recommend which bundle(s) may have the most opportunity for each hospital. One hospital interviewed for this report cited data analytics as being the most important consideration for working with an outside awardee convener organization because such analyses were beyond the hospital's internal capabilities.

As part of its data analytic package, Remedy offers technology that combines various data streams of treatment information into one software platform allowing the at-risk provider to get a full picture of the health care claims that occur within the episode,

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10 See HCI3 comments on BPCI at http://www.hci3.org/content/cms-cmmi-bundled-payments-care-initiative-pilot-resources

11 Including Optum, Geisinger Health Systems & Clinic, NaviHealth and others.

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including those outside of the episode-initiating organization (e.g., home health visits, skilled nursing facility stay, etc.). Without seeing the entire picture, provider organizations cannot proactively manage inefficiencies within the episode. Both Remedy and private technology firms in the commercial market offer this capability, but usually at a significant cost to health plans or providers (i.e., $250,000 and up). Prior to the BPCI and the emergence of entities like Remedy Partners, this cost is one of the reasons smaller, not well-integrated providers were typically not engaging in bundled payments. The other reason was the unavailability of the complete claims data.

Risk Assumption

Remedy Partners believes there is a significant opportunity to create a more efficient and effective system with episodes of care. Coupled with its leadership experience in bundled payment[12], Remedy Partners' belief in its own technology and care coordination offerings has led the firm to assume substantial financial risk in its business model. Remedy's data analytics efforts have identified approximately 30 percent waste in the system due to poor transitions of care. Remedy's initial analysis of 2008-2009 data revealed that almost 1 out of every 2 acute care hospital discharges resulted in a readmission within 90 days. Consequently, Remedy focuses on more effective transition management and prevention of unnecessary readmissions.

Second to data analytic capabilities, interviewed providers cited risk assumption as a top reason for partnering with Remedy Partners. Remedy will customize the risk parameters for each episode-initiating partner depending on their risk tolerance. Table 2 illustrates risk sharing between Remedy and the episode-initiating organization where Remedy Partners assumes roughly two-thirds of the downside risk and shares in one-third of any potential savings. (See Table 2 for an example of the risk sharing model.)

Table 2. Example of Remedy Partners Risk Sharing Model–*Fictitious Numbers*

SAVINGS ACHIEVED—90 DAY BUNDLE *(Fictitious Scenario)*	DOLLARS FOR ONE CASE *(Rounded)*
CMS Historical Cost Amount for All Services within the Bundle	$100,000
Medicare's Guaranteed Discount on Historical Costs (2% of historical FFS rate)	($2,000)
CMS Active Bundle "Target Price"	**$98,000**
Bundle Savings (6% of target price)	$5,880
Program Management Costs (2% of target price)	($1,960)
Total Net Savings (Savings minus Program Management Costs)	$3,920
LOSS OCCURRED—90 DAY BUNDLE *(Fictitious Scenario)*	
CMS Historical Cost Amount for All Services within the Bundle	$100,000
Medicare's Guaranteed Discount on Historical Costs (2% of historical FFS rate)	($2,000)
CMS Active Bundle "Target Price"	**$98,000**
Programmatic Loss (3% of target price)	($2,940)
Total Net Loss (Programmatic loss + Medicare's guaranteed discount)	($4,940)
Remedy Partners' Share (2/3 of loss)	($3,293)
Episode Initiating Partner's Share (1/3 of loss)	($1,646)

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12 Remedy Partners Executive Chairman and Co-Founder, Steve Wiggins, was Founder, Chairman and CEO of Oxford Health Plans and one of the original bundled payment pioneers.

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Many providers are generally risk averse. Remedy Partners offers providers a safer risk arrangement for providers not ready to risk substantial financial penalties for their performance and the performance of other entities with which the provider may or may not have an existing relationship. Remedy Partners does not recoup any of the program management costs from participants unless the program achieves savings of more than two percent.[13]

The company's financial model and technology is a promising and attractive offering for providers, but whether it is successful remains to be seen as the Medicare BPCI program is fully launched later in 2013.

Care Coordination

Central to Remedy Partners' program offering are patient navigators that deliver care coordination services. Patient navigators supplement the existing care managers / coordinators within a hospital and will act as a resource for the patient and other care providers throughout the episode time period. Remedy Partners and the partnering hospital jointly hire patient navigators—identified as the "connective tissue" between the hospital and care provided in the 90 days post-discharge bundle timeframe. One example of the role of the patient navigators is to assist patients in adhering to their home health care plans after Medicare-funded home health services have concluded (typically 45 days post-discharge, according to Remedy) or when the patient is discharged with no home health services. In addition, the patient navigators can assist patients by providing traditionally non-covered services such as picking up prescription medications or transporting patients to medical appointments. Remedy partners has yet to test its care coordination function with partnering hospitals and will commence once the BPCI goes live.

Technology Offering

To assist all providers caring for the patient during the episode, Remedy Partners developed a web/tablet/mobile-enabled software application connecting all relevant data from each site of care and patient-reported information. Data is transmitted into the software portal through direct data feeds or provider entry. The software, called "Episode Connect," allows post-discharge care providers and patient navigators to see what care has been provided earlier in the episode and the results of testing. This glimpse into previously provided care is one way Remedy Partners hopes to reduce the "waste" of duplicative testing and improve the transitions of care between providers.

In addition to the provider view, Remedy Partners built a portal for the patient and family caregivers to provide education and to transmit clinical data from the patient back to navigators and other providers. Remedy Partners is pursuing a waiver to allow the distribution of iPads (or other mobile device) to patients to allow them to respond to structured questionnaires that assess their wellbeing and treatment compliance (e.g., a pain scale or adherence to medication). With these mobile devices, Remedy Partners hopes to offer applications to assist patients in staying healthy, including healthy eating tips, information on their medication, and educational videos relevant to their medical condition.

The Future of Remedy Partners

The future success of Remedy Partners will largely depend on its success in managing the risk it has assumed with many providers. The company's financial model and technology is a promising and attractive offering for providers, but whether it is successful will remain to be seen.

STATE EXPERIMENTATION WITH BUNDLED PAYMENT

State Medicaid programs tend to trail payment and delivery innovations introduced by commercial payers and Medicare, and that has been the case with bundled payment. It appears that adoption of bundled payments may expand and, in the context of multi-payer efforts, may bring bundled payment to a large scale, at least in selected states.

Arkansas

Arkansas was the first state to identify bundled payment as the primary instrument that it wished to adopt to drive out waste and generate improvement in health care. Governor Beebe made bundled payments an administration priority in 2011:

> "Rather than make the deep program cuts seen in other states, our goal is to align payment incentives to eliminate

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13 The first two percent of savings is recouped by Medicare.

14 August 10, 2011 letter from Governor Beebe to Secretary Kathleen Sebelius as reported in "Ark. gov. zeroes in on 9 areas for Medicaid reform" Associated Press, August 22, 2011

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> inefficiencies and improve coordination and effectiveness of care delivery," Beebe wrote. "We will do this, in large part, by moving away from a fragmented, volume-driven, fee-for-service system to one that pays teams of providers for episodes or bundles of care."
>
> *-Governor Mike Beebe*[14]

While Arkansas is the only example of a state-initiated wide scale adoption of bundled payment in a state, similar efforts may follow.

Arkansas chose to pursue the strategy in partnership with two commercial insurers, Arkansas Blue Cross and Blue Shield and QualChoice. The three payers agreed to use common bundle definitions and quality measures developed with support from consulting firm McKinsey & Company. As part of what Arkansas is now calling the Arkansas Health Care Improvement Initiative, the state makes fee-for-service payments to what it terms Principal Accountable Providers and then conducts retrospective reconciliations for bundles attributed to those providers. Unlike all the other studied implementations, which began with pilots or demonstrations with limited numbers of providers, this payment model is being implemented with all network providers.

The Arkansas bundled payment initiative commenced in July 2012 with providers reporting via web portals. The state's first payment performance period commenced in October 2012 with five bundles: attention deficit hyperactivity disorder (ADHD), congestive heart failure (CHF) (hospitalization only), joint replacement (total hip and knee), perinatal care and upper respiratory infection. In addition, the plans have been approved to pay for additional bundles, including for developmental disabilities (all services for waiver and facility-based beneficiaries, including health home supplemental payments), tonsillectomy, cholecystectomy, colonoscopy, oppositional defiant disorder, inpatient chronic obstructive pulmonary disorder (COPD), inpatient asthma, CABG, percutaneous coronary interventions (PCI) and neonatal intensive care. Unlike other bundled payment initiatives, the Arkansas model does not require providers to share performance risk with other providers. The arrangement exists solely between the payer and the contracted Principal Accountable Provider.

The payment arrangement is one of shared risk. Providers may share in up to 50% of savings with a cap, but may also be responsible for downside financial risk. Some payers may use a withhold to recoup payments. A provider's shared risk responsibility is 50% up to 10% of the provider's total fee with the payer.

The model uses quality measures to qualify providers for shared savings distributions, and another set for reporting and tracking. The measures are generally claims-based, but the payers have allowed for provider reporting through a web portal.

Each payer provides contracted providers with a quarterly report depicting performance against budget for closed episodes with a breakdown by cost category.

Other States

Arkansas is the only example of a state-initiated wide scale adoption of bundled payment, but similar efforts may follow. CMMI released State Innovation Model testing and planning grants in February 2013. Arkansas received a large testing grant to support its ongoing work. At least two other states, Ohio and Tennessee, received planning grants and intend to pursue bundled payment as a principle strategy. Ohio contracted with the same consultant that assisted with Arkansas's design. The State Innovation Model grants require multi-payer engagement, so the states will need to attempt to align their efforts with commercial insurers.

CONCLUSION

Over the past year, payers and providers in both the public and commercial sectors have increased their experimentation with bundled payments. While some early commercial-sector adopters have abandoned the payment methodology, others are making bundled payments part of their permanent reimbursement strategy. Lessons learned from two payers adopting the payment approach, BCBSNC and Horizon, indicate that leadership, adequate resources and flexibility are the most important contributors to bundled payment adoption, and likely to adoption of any alternative payment strategy.

While small, non-integrated providers may have leadership and flexibility, they often lack the adequate resources to implement non-fee-for-service methodologies. With the

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emergence of financial intermediaries like Remedy Partners willing to take on financial risk, and assist in data analytics and care redesign, smaller non-integrated providers can gather the appropriate resources needed for Medicare's grand bundled payment experiment—and perhaps with other payers.

Not to be forgotten are the efforts taking place within state Medicaid agencies. While they trail the commercial sector and Medicare in experimentation, bundled payments are taking a foothold in Medicaid agencies as a viable alternative to fee-for-service. In the case of Arkansas, a Medicaid-commercial multi-payer approach resulted in a faster spread of bundled payment than anywhere in the U.S.

While the extent of any savings and care improvement achieved through application of bundled payment remains uncertain, payers and providers continued experimentation in all sectors is a growing sign that many view bundled payment as a viable alternative to fee-for-service payment.

APPENDIX A
Interviewed Organizations

ORGANIZATION	ORGANIZATIONAL TYPE
Aetna	Payer
Aligning Forces for Quality (AF4Q) in South Central Pennsylvania[15]	Multi-stakeholder payment reform collaborative
Anthem Blue Cross and Blue Shield of Missouri	Payer
Arkansas Medicaid	Payer
Blue Cross Blue Shield of North Carolina	Payer
Colorado Choice Health Plan[16]	Payer
Crozer-Keystone Health System	Provider
Geisinger Health System	Provider
HealthNow New York	Payer
Horizon Healthcare Services, Inc.	Payer
integrated Physicians Network (iPN)	Provider
Jersey City Medical Center	Provider
Johns Hopkins Medical Center	Provider
Lifespan	Provider
Priority Health	Payer
Remedy Partners	BPCI convening organization
Swedish American Medical Group	Provider
Vermont Green Mountain Care Board	State convener
Wisconsin Payment Reform Initiative	Multi-stakeholder payment reform collaborative

15 Information for this organization was obtained through Bailit's direct experience facilitating its bundled payment initiative.

16 Information for this organization was obtained through HCI3.

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