Aligning Forces for Quality | Improving Health & Health Care in Communities Across America

Robert Wood Johnson Foundation

PRIMER/BRIEF

Bundled Payment: The Quest for Simplicity in Pricing and Tying Payment to Quality

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Summary

While fee-for-service remains the dominant approach to paying for health care in the United States, multiple local and regional initiatives have sought to demonstrate that other payment schemes can do better—that they can achieve higher quality and better overall outcomes, greater efficiency, and lower or at least controlled costs. Bundled payment (BP) is one such alternative. Bundled payment is the concept of paying a fixed dollar amount to cover a set of services, as an episode of care over a defined period. Because of the fixed price, providers are encouraged to hold variable costs down; yet BP programs usually require providers to satisfy a minimum set of quality metrics in order to receive payment, thus ensuring providers do not skimp on care. Aligning Forces for Quality (AF4Q), the Robert Wood Johnson Foundation's signature effort to lift the overall quality of health care in targeted communities, has made payment reform one of its distinct quality improvement goals in its 16 communities. As such, several AF4Q communities are considering or implementing BP initiatives. This paper examines issues confronted by two of these communities.

About Aligning Forces for Quality

Aligning Forces for Quality (AF4Q) is the Robert Wood Johnson Foundation's signature effort to lift the overall quality of health care in targeted communities, as well as reduce racial and ethnic disparities and provide real models for national reform. The Foundation's commitment to improve health care in 16 AF4Q communities is the largest effort of its kind ever undertaken by a U.S. philanthropy. AF4Q asks the people who get care, give care and pay for care to work together to improve the quality and value of care delivered locally. The Center for Health Care Quality in the Department of Health Policy at George Washington University School of Public Health and Health Services serves as the national program office. Learn more about AF4Q at www.forces4quality.org. Learn more about RWJF's efforts to improve quality and equality of care at www.rwjf.org/goto/quality-equality.

I. Introduction

The method by which we pay for health care in the United States has been widely criticized—a criticism that is, in large part, deserved. The "fee-for-service" framework around which U.S. health care payment is built rewards providers for volume of services provided without regard to their quality or even their necessity. This payment approach is inefficient and expensive. Worse, the care that results from it is fragmented, sometimes dangerous, and too often of poor overall quality.[i]

Today's system therefore enjoys few advocates. Stakeholders from every sector and of all political persuasions are advocating for change. Fortunately, alternative options exist.

While fee-for-service remains the dominant approach to paying for health care in the United States, multiple local and regional initiatives have sought to demonstrate that other payment schemes can do better—that they can achieve higher quality and better overall outcomes, greater efficiency, and lower or at least controlled costs. Some communities have pursued initiatives on their own or with the assistance of national partners. Many of these initiatives have gained steam under payment reform provisions of the Patient Protection and Affordable Care Act of 2010.[ii]

Bundled payment (BP) is one such alternative. BP is the concept of paying a fixed dollar amount to cover a set of services, as an episode of care over a defined period.[iii] It defines an episode of care for a common procedure (e.g.,

orthopedic surgery, coronary angioplasty) or, sometimes, a chronic condition (e.g., diabetes) and sets a single payment for all health professional and facility charges for that care. Because of the fixed price, providers are encouraged to hold variable costs down; yet BP programs usually require providers to satisfy a minimum set of quality metrics in order to receive payment, thus ensuring that providers do not skimp on care.

"Bundled payment is an attractive option under certain circumstances because it meets the 'Triple Aim' goals of improving the quality of care, improving the health of populations, and controlling spending," says Robert Graham, MD, program director of the Aligning Forces for Quality (AF4Q) National Program Office.

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Bundled payment isn't a new concept. In fact, it underlies Medicare's DRG (diagnosis-related group) approach to paying for care. (There are important distinctions, chief of which being that under Medicare DRGs, only the hospital and not the physician receives a bundled payment—but conceptually, they are similar.) Medicare pursued it more directly with a 5-year demonstration project with BP for coronary artery bypass graft (CABG) in the early 1990s, saving the program $42 million on CABG patients treated in the demonstration hospitals, an average discount of approximately 10 percent from anticipated spending.[iv] Yet BP's application for the commercial population is more recent.

Today, 19 bundled payment initiatives are under way across the country. The most prominent private-sector example is PROMETHEUS Payment®, an RWJF-supported initiative that debuted in 2006. PROMETHEUS ties payment, determined by an "evidence-informed case rate," to recommended care.[v] Another widely cited BP initiative is ProvenCare™ at Geisinger Health System, the Pennsylvania integrated delivery system. Under ProvenCare, which began in 2006, payment is bundled for all non-emergency CABG procedures including the preoperative evaluation, all hospital and professional fees, and management of any complications (including readmissions) occurring within 90 days of the procedure.[vi]

What does a BP program look like?

BP offers simplicity. It's one price for one episode of care. In application it's not quite that simple, but BP does simplify the pricing structure for payers, providers, and patients alike.

Take, for example, hip replacement surgery. A BP program starts by defining the episode (e.g., from initial physician consultation to 30 days following hospital discharge). Then it establishes a case rate—the amount of money that should be paid to all providers, including physician, hospital, pharmacy, medical device, and rehabilitation facility fees. This rate is usually determined by gauging average or mean pricing for a hip replacement—i.e., what "should" be paid to a fiscally responsible provider. Providers, often working together, negotiate fees with health plans. A margin is built in to the case rate to incentivize providers.

But it isn't quite that simple. To ensure both fair payment and high quality, BP programs often include a severity adjustment (to account for potential complications or patients who are problematic for any reason) and a quality incentive payment, to encourage high-quality care. Still, the end result is a payment mechanism that, arguably, rewards high-value results significantly more than the fee-for-service approach.

So far, BP initiatives have been tried in only a few clinical areas, including orthopedic procedures, certain heart procedures (e.g., CABG), and cataract surgery. Those conditions with a defined time frame from diagnosis to recovery may be best suited for BP,[vii] in part because there are fewer variables outside the provider's control and therefore the provision of services often is easier to predict. However, there is nascent interest in using BP to cover care for certain chronic conditions.

There are many initial challenges, including garnering buy-in from enough providers and payers to make a program viable and persuading consumers that care under a BP program can be as good as (or better than) care paid for in the traditional manner. And there are technical challenges, such as setting case rates, establishing definitions of an episode, and overcoming technological barriers. (Legacy data systems and electronic health records often do not collect or organize data in ways that facilitate BP.) These barriers are significant and in many cases could prove too challenging to overcome. Yet the simplicity and confidence in pricing that BP promises, together with promised quality improvements, are tantalizing.

"At its essence, bundled payment is a mechanism to pay for all services in a specified episode of care," says Francois de Brantes, who led the PROMETHEUS Payment design team from its inception in 2006 and now is advising AF4Q communities on their implementation of BP initiatives. "For payers, it's important because it creates more certainty about payment for an episode of care. For providers, it's an opportunity to generate a margin when they do a good job of managing the patient. And for patients, it creates pricing transparency, so patients can better predict and manage their out-of-pocket expenses."

II. Case Study: Wisconsin

Wisconsin enjoys both a rich history of interest in payment reform and a long tradition of bringing together disparate stakeholders to collaborate for higher quality, controlled spending, and transparency. Its all-payer claims database, managed by the Wisconsin Health Information Organization, is envied by many for its voluntary nature and its comprehensiveness. This spirit of cooperation allowed the Wisconsin Collaborative for Healthcare Quality (WCHQ), which leads the state's AF4Q alliance, to pursue payment reform with a high degree of credibility.

"Wisconsin has a fairly collaborative health care environment," says Karen Timberlake, JD, director of Wisconsin's Partnership for Healthcare Payment Reform (PHPR), which the Wisconsin Health Information Organization established, with the support of WCHQ and many other organizations, to lead Wisconsin's payment reform initiatives. "We have competition as any state would have, but we also have a history of working together when we need to."

Timberlake is a former secretary of the state's Department of Health Services and also directs the Population Health Institute at the University of Wisconsin School of Medicine and Public Health. As such, she understands that payment reform must serve a broader overall objective of improving health, not just saving money. "We've got too much variation and too much waste, and we're not delivering enough high-quality care," Timberlake says. "But right now we have an opportunity to talk about quality, cost, and efficiency in the same conversation, and that creates a conversation about value."

In April 2010, following passage of the Affordable Care Act, Wisconsin's health care community held a meeting led by Harold D. Miller, then-president and CEO of the Network for Regional Healthcare Improvement and executive director of the Center for Healthcare Quality and Payment Reform. Miller's sessions, which have been replicated around the country, are effective in encouraging disparate stakeholders to overcome parochial concerns and find areas of common ground, and then identify concrete steps to take to pursue reform locally. In Wisconsin's case, stakeholders voiced concern about "the big 3"—chronic disease, preventive care, and acute conditions—and established working groups to devise initiatives in each area.[viii]

On the acute conditions side, the work group, composed of health providers, health plans, employers, and state organizations, decided to focus on total knee replacement (TKR) and opted for a BP approach. There were four reasons for the decision: 1) the procedure is occurring with increasing frequency among the commercially insured population; 2) while TKRs are performed more frequently than before, they still account for only a small fraction of overall spending, so Wisconsin could attempt an initiative and learn from it without causing too great a disruption initially; 3) there is broad agreement on what constitutes a standard of care and clinical guidelines; and 4) there were good models on how to build a TKR BP program.

An analysis of data from the Wisconsin claims database revealed that the need was there. It found wide variation in spending for total knee replacement (TKR)—from $17,000 to $55,000 per procedure. These figures are calculated based on billed amounts and the mix of services provided, not allowed amounts, and therefore are not the "true" price of care. These "standard prices" are nevertheless instructive because they demonstrate the variation in pricing and in resource use for procedures of comparable risk and severity.

Next, Wisconsin leaders looked for an existing model from which to build a BP program. They selected the Bundled Episode of Care Pilot from the Integrated Health Association (IHA), the California multi-stakeholder leadership group that promotes health care quality improvement and accountability. Using a grant from the Agency for Healthcare Research and Quality, IHA is pursuing a BP program for TKR and total hip replacement, expanding a small pilot project. Ultimately, the IHA demonstration will expand the effort over three years to 10 acute conditions and procedures, 20 physician-hospital teams across California, and to HMO, Medicare Advantage and Medi-Cal Managed Care populations, and will expand conditions covered to include diagnostic cardiac catheterization, cardiac angioplasty with stents, and knee arthroscopy with meniscectomy.[ix]

Based on the IHA model, PHPR designed its BP program. Parameters are: start date the day of admission for surgery, end date 90 days post-discharge, with a single payment to providers covering all relevant services, including complications and readmissions. The amount of the payment is negotiated at the local level and is considered proprietary.

Then came the hard part—signing up providers and finding willing payers. While the program is still in its early phases, this is an area where Timberlake wishes she had more success: five providers are participating at the outset, including two in Madison, but none in Milwaukee. "That's been one of our biggest disappointments to date," Timberlake says. A challenge has been competition in the reform space: PHPR is simultaneously conducting a shared savings program in diabetes, and some Milwaukee systems, and their major payers, are conducting their own payment reform initiatives. Other providers are focused on accountable care organization (ACO) implementation. Others have expressed interest in participating but have had to focus on internal issues related to electronic health record implementation.

With such a disappointment, it could have been easy for Wisconsin to walk away—to declare that the state wasn't ready for BP. But instead, PHPR decided to work with what they had. "It all boils down to will—is there enough willingness in a community to do this," de Brantes says. "You've got to find people who are willing to work on this, and in Wisconsin they did." Thus, even in its initial phases with limited participation, Wisconsin expects to cover 150 to 200 TKRs in 2013, and PHPR expects to add more providers and payers as the initiative demonstrates value. So far, two hospitals and an ambulatory surgery center are live under the project, with two more hospitals working toward a launch in 2013.

Another early challenge for all pilot participants has been establishing confidence in their data. "It's not like there's a ton of science out there on this," Timberlake acknowledges. "But providers and payers want the data they rely on to make decisions to be as good as possible." Data on the results of the pilots, in turn, will be particularly important in demonstrating success and recruiting more participants. PHPR's task is to demonstrate quantitatively that quality is improving (through approximately 10 TKR quality metrics, comparing baseline performance to performance after the BP program is established) and spending is controlled (through analysis of cost trend data). More participants will bolster the dataset and mitigate the "tyranny of small numbers."

Timberlake is frank about the challenge. "If we do this and our cost trend data don't change, I don't think we'll succeed," she says. "But I think that won't happen. Providers and payers report that they are finding bundling to be a path toward focus and simplicity, and when you think about all the complexity that we struggle with in health care, this is something that everyone wants to see work."

III. Case Study: South Central Pennsylvania

Wisconsin is very different from York and Adams counties in Pennsylvania. They are different markets, with different demographics and a different health care environment. But the two counties, which together comprise the South Central Pennsylvania region of AF4Q, face the same pressures as Wisconsin does. "We've seen health care inflation at double or triple the rates of overall inflation for so many years, and that's just not sustainable over the long term," says Matthew L. Vogel, vice president of provider relations and contracting for Highmark Blue Cross Blue Shield, the region's largest health plan.

Interest in the region for payment reform has been high, but stakeholders didn't know where to start. People were aware of PROMETHEUS, but the concept didn't catch fire immediately.

As in Wisconsin, stakeholders in South Central Pennsylvania started with a series of meetings to secure buy-in. These began in earnest in February 2012, convened by the local AF4Q alliance. And, as in Wisconsin, the community had to go without full participation from all providers and payers; Highmark and South Central Preferred (the health plan affiliated with WellSpan—which houses the South Central Pennsylvania alliance) are participating, but other plans aren't involved yet. Five local provider organizations have participated in planning, although it is unknown how many will join once the program is introduced.

Next came the task of picking a model. Rather than follow Wisconsin's lead and use IHA, South Central Pennsylvania selected PROMETHEUS, in part because the community could receive technical guidance from someone who had already been through it: Crozier Keystone Health System, the integrated delivery system based in suburban Philadelphia, had already pursued a BP initiative with Independence Blue Cross, and officials there were willing to offer assistance.

Over the course of the planning meetings, providers and payers in South Central Pennsylvania selected conditions for BP. They chose both total hip and total knee replacement and CABG. They set standard criteria, choosing a population between 18 and 71 years old, defining the bundle as covering three days before admission to 90 days following discharge. For CABG, National Quality Forum-endorsed quality metrics from the Society of Thoracic Surgeons[x] will be used. For the orthopedic procedures, the WOMAC (Western Ontario and McMaster Universities) Orthopedic Index,[xi] which assesses pain, stiffness, and physical function in patients with hip or knee osteoarthritis, has been proposed, but regional orthopedists' input is being sought before settling on this metric.

Reliance on a successful example has been helpful for planning purposes. "If you want to get into this, the PROMETHEUS model makes it such that there really aren't a lot of decisions you have to make," Chodroff says. "They've already made a lot of the decisions for you. It reduces the transaction friction and eliminates a lot of potential barriers." The exception is the quality metrics for orthopedic procedures, because there is not yet full comfort with the WOMAC Index.

Another reason PROMETHEUS has been attractive to South Central Pennsylvania providers is that it explicitly creates incentives for avoiding adverse events (or, as PROMETHEUS terms them, Potentially Avoidable Complications, or PACs). These incentives can preserve provider margins and even increase them if quality improves. For instance, with a fixed price set for TKR, a provider avoiding PACs with TKR under a BP program will make money by avoiding having to pay the cost of fixing the PACs.

However, there are some limitations and hurdles. For instance, many providers feel that the model favors integrated delivery systems that can provide care across the continuum, putting smaller providers at a comparative disadvantage, and providers often are at risk for all related costs of care, even if they did not provide those services themselves. Insurers maintain some risk, but providers assume some risk as well, which can be new territory for them.

Yet South Central Pennsylvania has taken to the model well. "It hasn't been so difficult to determine how a bundle should be constructed," Vogel says. Deciding what quality measures and time frames should be used has not been problematic, in part because the past experience of PROMETHEUS lights the way, and Vogel describes local conversations between providers and payers as "collegial and friendly" with respect to designing the BP program—much more so than usual. "It's been much more collaborative rather than a pure negotiation—at times, it's a little uncomfortable for all of us," he jokes. "It takes us to a much higher level of trust and requires us to let our guard down a little bit."

Vogel acknowledges, however, that the waters may get choppy when it's time to negotiate actual payment rates. That's where the community stands today: determining rates and readying providers and plans for implementation. The program rolled out in January 2013, but with no payment attached for a period while providers grow accustomed to the arrangement and can gauge how their reimbursements will be affected under BP.

As they negotiate case rates, finalize implementation plans, and encourage providers to participate, the BP group has spent a great deal of energy on a communications plan to educate providers, plans, employers, and the public. These plans remain in the development phases, and the community is working with RWJF technical assistance providers to develop materials. In the meantime, Chodroff describes the current environment among potential participants as neutral. "People are not resistant to this, but they're not embracing it either," he says. "This is a political exercise as much as anything else."

IV. Conclusion: Action Steps for Communities

The common recognition that the fee-for-service model is not sustainable is leading to a great deal of innovation. Bundled payment is one such innovation—a new method of paying for health care in a way that aims to raise quality and control costs. But as the Wisconsin and South Central Pennsylvania experiments demonstrate, payment reform can't be achieved on a "plug-and-play" basis. It takes time, effort, and commitment on the local level, and potential pitfalls abound.

The good news is many lessons have already been learned, and models—including IHA, PROMETHEUS, and Medicare demonstration projects—exist to guide communities. "I don't foresee communities making mistakes out there, because we already made all the mistakes at PROMETHEUS," de Brantes says. "We figured out a lot of the problem areas, and we readjusted accordingly, and now communities are able to take those lessons into account when they plan their own initiatives."

Drawing on the PROMETHEUS work, de Brantes offers the following steps that communities should follow when considering a bundled payment program:

1. **Define the focus.** Is your community ready for a big project? Would it prefer a small one? Can a BP program start in your community with just one or a few providers, or is widespread participation necessary? Do you want to look at one or two procedures or conditions, or do you want to attack many procedures and conditions at once? (This is the stage at which the impact of a BP program should be considered within the context of other payment reform initiatives in your community, e.g., accountable care organizations, shared savings programs.)
2. **Analyze the data.** Understand utilization and price/cost patterns in your community. Use these data to identify opportunities for cost control and quality improvement. For instance, if costs vary wildly in your community for orthopedic procedures, try to understand why. Are certain hospitals charging more? Are physicians using more expensive devices—and could savings be found based on standardizing the devices used in your community? And, have other payment reform programs under way in your community indicated a certain area in which BP would be particularly appropriate?
3. **Negotiate the deal.** Determine a case rate. Allow room for a provider margin. Make it a "fair" price, so that both providers and payers have incentive to participate. Build in an extra payment (or a penalty) for meeting (or not meeting) quality goals based on measurable results.
4. **Figure out the small stuff.** There are details to be considered—issues like stop-loss levels and communications plans. These need to be dealt with at the front end, before a program rolls out, if possible.

Wisconsin's Timberlake, with the experience of getting her program up and running, offers similar advice, but adds the following lessons she has learned over the course of building her program:

- Secure stakeholder commitment. This "buy-in" from all of those affected should start with building relationships and bringing in experts from outside the community if necessary.
- Participants must commit resources necessary to drive a pilot and should make the decision as to whether to commit such resources before agreeing to participate.
- Designing a program and establishing definitions can be time consuming, so use publicly available definitions when available.
- Make sure local participants are on board and are validating the process at every step.
- Integrate the BP program into ongoing quality improvement initiatives in your community if possible.

It's important not to lose sight of a bigger picture with respect to BP—that it aims not only to control costs but also to improve care, according to BP expert Michael H. Bailit, MBA, president of Bailit Health Purchasing. "Care has to be customized to each individual patient—to what that patient is seeking and his or her individual characteristics," Bailit says. "But in general, we know that for some conditions and some procedures, there is evidence of better ways to deliver care that results in better outcomes and is more efficient. So, with the need to be patient-centric very much in mind, bundled payment programs can achieve better results when we apply those evidence-based processes."

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