Robert Wood Johnson Foundation

Reforming Payment in an Evolving Environment: A Brief on Bundled Payment Successes and Challenges

Partnership for Healthcare Payment Reform's Total Knee Replacement Pilot Project

EXECUTIVE SUMMARY

Bundled payment models hold the promise of driving down health care costs while improving health care quality. As pilot projects have been conducted in the field, common barriers and themes have emerged, including administrative implementation hurdles, data and technology challenges, new emphasis on engaging patients in their care, and questions of whether true costs savings can realistically be achieved. This brief addresses the successes and challenges encountered in a recent bundled payment pilot project in Wisconsin, as well as the underlying transformative effects on patient care.

INTRODUCTION AND BACKGROUND

Since 2010, the Partnership for Healthcare Payment Reform (PHPR), a Wisconsin-based multi-stakeholder collaborative, has worked to pilot a bundled payment project for total knee replacement (TKR). The Wisconsin Collaborative for Healthcare Quality (WCHQ), a regional healthcare improvement collaborative and leader of the Aligning Forces for Quality initiative in the state, has actively participated in PHPR's efforts from the beginning and tracks quality outcomes for the TKR Pilot. PHPR is an initiative sponsored by Wisconsin's all-payer claims data organization, the Wisconsin Health Information Organization (WHIO). PHPR supports the engagement of health care stakeholders in assessing, designing, testing, and implementing approaches to health care payment reform.

PHPR selected TKR as an acute care pilot program in part because it is a common surgical procedure, with costs that frequently vary from provider to provider. In addition, there is evidence that a bundled payment program could improve both quality and efficiency of care provided to total knee replacement patients. The goal of the overall project was to foster and support the use of bundled payments to align incentives between payers and providers by agreeing to a single payment amount for specific services related to a defined episode of care. The goals of the TKR pilot program are aligned with the mission of PHPR—to improve the quality and affordability of health care, and to improve health outcomes for patients.

One of the initial steps in initiating a bundled payment is to decide which services are included, and which are not. This process is called *bundle formation* and is often cited in case studies as a major challenge for involved parties.[1]

[1] *Cary, Weslie. 2013. Bundled Episode Payment and Gainsharing Demonstration Technical White Paper. IHA.*

PARTNERSHIP FOR HEALTHCARE PAYMENT REFORM TOTAL KNEE REPLACEMENT PILOT DESIGN

- Three-year pilot period targeted
- Commercially insured population, ages 18-64
- Bundled payment for total knee replacement of one knee
- Bundled payment may include any services provided for 90 days post-discharge (a "warranty period") as a result of any complications arising from surgery
- Bundled payment also includes rehabilitation services 90 days post-discharge, excluding skilled nursing facilities
- Excluded services: Unrelated services, outpatient prescription drugs, outpatient durable medical equipment, and facility and professional fees for non-participating facilities involved in a readmission
- Publicly reported quality measures, including:
  - Beta blocker during preoperative period
  - Venous thromboembolism (VTE) prophylaxis
  - Length of stay
  - Readmission rates related to knee replacement as well as all-cause readmissions
  - Revisions within 90 days of discharge
  - Complications, including infection, deep vein thrombosis, and pulmonary embolism within 30 days of discharge
  - Patient satisfaction
  - Functional outcomes measures (e.g., WOMAC, Knee Society Score, etc.)

However, the Wisconsin TKR project simplified bundled formation by building on the bundle definition that had been established by the Integrated Healthcare Association in California. PHPR also enlisted a highly credible and credentialed multi-stakeholder planning committee to refine and validate this definition. Once the committee agreed on the definitions, PHPR recruited payer-provider pairs, or dyads, that expressed interest in attempting to create and bring to market a bundle for TKR. The bundle parameters were an essential component of the implementation materials PHPR provided to the pilot sites.

CUSTOMIZED IMPLEMENTATION

The payer-provider dyads that chose to participate were given guidelines and limited technical support by PHPR, but ultimately made key decisions about final bundle formation, payment amounts, and other contract arrangements independently. The project implementation was similarly left to the payer–provider dyads, although PHPR coordinated periodic conference calls to facilitate shared learning across the pilot sites. The dyads included: (1) Manitowoc Surgery Center and Anthem Blue Cross Blue Shield of Wisconsin; (2) University of Wisconsin Hospital and Clinics and Unity Health Insurance; and (3) Meriter Health Services and Physicians Plus Insurance. Throughout the pilot, quality metrics were tracked.[2] All three dyads began with a high level of performance on the quality metrics that was maintained throughout the pilot.

Each dyad made some modifications to the bundle. Some dyads chose to include rehabilitation services

[2] *Quality measure information is available at the WCHQ website at: http://www.wchq.org/measures/initiatives/phpr.php.*

QUALITY MEASURES

The PHPR pilot program tracked and publicly reported the following quality measures:

1. Beta blocker during preoperative period
2. Venous thromboembolism (VTE) prophylaxis
3. Length of stay
4. Readmission rates related to knee replacement as well as all-cause readmissions
5. Revisions within 90 days of discharge
6. Complications, including infection, deep vein thrombosis, pulmonary embolism within 30 days of discharge
7. Patient satisfaction
8. Functional outcomes measures (e.g. WOMAC, knee society score, etc.)

for patients after their surgeries, but others chose to exclude these services or offer longer periods of rehabilitation. Pilot participants reported the modifications were made relatively easily, owing in part to the relatively small scale of the pilot and the mature, high-trust relationships between the payers and providers who participated. In two out of three dyads, the provider group was closely affiliated with the payer.

Claims administration was a challenge, to greater and lesser degrees, for all three participants in this project. All experienced challenges with the manual processes required to implement the bundled payment. These challenges are not unique to Wisconsin: previous projects in bundled payment have found it difficult to determine what unanticipated services were related to the bundle. For example, if a patient was admitted to the same hospital twice within 30 days, there would be many claims made using different billing codes. Untangling which services should be included in the bundle is challenging, and providers reported having to do this manually. Legacy software systems currently in use by providers and payers, by and large, cannot be easily modified to accommodate bundled payments.

In the Wisconsin experience, the initial struggle of adjusting billing and claims processing to be responsive and functional to a bundle remains a significant barrier to widespread expansion of bundled payment, notwithstanding the pilot participants' reports of the positive impact of the bundled pilot on quality, cost effectiveness, and care transformation.

TRANSFORMING PATIENT CARE, ACHIEVING COST SAVINGS

The fundamental value of bundled payment is derived from re-engineering the delivery of care and the patient's experience.[3] These benefits are realized through reductions in unnecessary supplies and services, fewer avoidable readmissions, lower complication rates, and improved outcomes—that is, higher-quality care. Better-coordinated care also saves in total costs with bundles designed to enhance the patient-doctor relationship. Pilot leaders reported that the physicians and other care team members with whom they worked were enthusiastic about the chance to review their own quality data, compare it to other providers' data within the project, and use the data to drive improvements in patient care processes. Physicians felt that viewing their quality data enabled them to ensure they were providing optimal care to patients. Closer working relationships between medical teams and patients, as well as medical teams and rehabilitation facilities, correlated with notable savings in two out of the three dyads.

[3] *Williams, Tom, and Jill Yegian. 2014. "Bundled Payment: Learning from Our Failures." Health Affairs Blog. http://healthaffairs.org/blog/2014/08/05/bundled-payment-learning-from-our-failures/.*

Provider groups further attributed the savings to better care coordination. Anecdotally, providers reported redirecting patients who did not require admission to a skilled nursing facility to home care, which accrued savings. Additionally, patients who were engaged in and informed about their post-operative care required fewer rehabilitation visits. Patients were grateful and enthusiastic about knowing the upfront costs of their surgery and rehabilitation.

Each payer and provider had different expectations and motivations to participate in the pilot project. Some providers viewed bundled payment as a necessary next step in care transformation, one that would benefit patients and physicians alike with greater transparency of cost and quality information. Other payers approached the pilot as a learning experience and expressed a desire to be "ahead of the curve" in payment reform. Building market share—using bundles as an appeal to potential customers—was also mentioned as a motivation for providers. One provider wanted to appeal directly to patients by emphasizing that a bundled payment enables patients to know all the costs before their surgery. Transparency was a way for this provider to advertise and differentiate itself in the market. All participants felt that payment reform is inevitable, and they would be well served to be prepared to shift away from traditional fee-for-service approaches.

Two out of three dyads were able to track and report cost savings from the PHPR project. Savings were derived in part from renegotiating and standardizing the implant options available for surgeons to use, creating some greater efficiencies. Rehabilitation services seem to be another area with opportunities for accruing savings; a successful surgery and rehabilitation will not require a revision or readmission, which add to the total costs associated with a TKR.

CONSIDERING POTENTIAL RISKS

Wisconsin TKR participants noted that marketing and awareness strategies could be considered in future bundled payment efforts in order to maximize efficiencies gained from bundle creation as also found in the Integrated Healthcare Association bundled payment demonstration.[4] Other bundled payment projects have reported issues with lower-than-expected patient volume, adding complexity to the cost-benefit analysis that has to be conducted by payers and providers contemplating bundled payment as part of their payment reform strategy.[5]

Bundled payment transfers some of the financial risks from payers to providers. If a patient's recovery goes poorly and he or she requires additional services from the provider the physician would not be paid for additional treatments under the bundled payment. Risk transfer has been a difficulty for other payers and providers attempting to form and offer bundled payments. It is helpful for providers to have historical data on their quality outcomes; this analysis helps providers estimate how many revisions, or second surgeries, may occur and allows them to account for these in their financial calculations. None of the Wisconsin participants noted this feature of bundled payments as a significant concern. By contrast, all reported the shift in financial risk and incentives as catalyzing improvements in care processes.

At the end of the PHPR pilot, two dyads are expanding their work in bundled payments into additional areas of care. The other dyad is pursuing an accountable care organization (ACO) strategy to drive down costs and improve quality. The individual experiences, motivations, and challenges of the three dyads are described on the following pages.

[4] *Ridgely, M. Susan, David de Vries, Kevin J. Bozic, and Peter S. Hussey. 2014. "Bundled Payment Fails To Gain a Foothold in California: The Experience of the IHA Bundled Payment Demonstration. Health Affairs 33(8):1345-1352. http://content.healthaffairs.org/ content/33/8/1345.full.html.*

[5] *Ibid.*

1. DYAD: MANITOWOC SURGERY CENTER AND ANTHEM BLUE CROSS BLUE SHIELD OF WISCONSIN

Manitowoc Surgery Center, along with the Ortho-Manty LLC physician group, found a willing partner in Anthem Blue Cross Blue Shield of Wisconsin. Together, the provider and payer embarked upon the PHPR TKR bundled payment pilot. This payer-provider dyad was the only one in the PHPR pilot in which the payer did not function as a subsidiary of the provider group or hospital. It was also the only dyad that included an outpatient ambulatory surgery center.

Motivation

Before the bundled payment pilot, Manitowoc Surgery Center (Center) had tracked cost, quality, and service, paying special attention to value as a core operating principle. The Center was motivated to participate in this pilot to enhance its commitment to patient satisfaction and experience. "Fee-for-service has eroded the patient-doctor relationship. With [the total knee replacement bundle], we saw a strong relationship emerge again, one with shared decision-making," said Kate Willhite, executive director of the Center at the time of the pilot program launch. The Center offered "joint camp," a one-day event required for all patients and a family member or other caretaker. Patients were taught steps they could take to ensure their best possible outcome after surgery. Patients met with a nurse, who worked with that specific patient to ease their care transitions throughout their surgery and recovery. Anthem, as the payer partner, was also invested in improving quality.

Another motivator was a desire to position itself at the forefront of health care payment; many employers are now interested in bundled payment as a cost-savings strategy, according to Willhite. John Foley, vice president of provider engagement and contracting with Anthem Blue Cross Blue Shield of Wisconsin, echoed this sentiment from the payer perspective. "Bundled payment has the ability to create greater margin through better and more efficient care."

A third motivator for the Center was the desire to expand market share through differentiation on transparency. "We wanted to make the choice easy for patients," added Willhite. Patients were told all costs upfront, before the surgery and rehabilitation. Willhite reported that patients were delighted to know all associated costs before any treatments or surgery. Patients were also assured of high-quality care on the basis of past patient outcomes.

Bundle Implementation

The bundle formation was not a barrier to bringing the TKR bundle to market. As an outpatient surgery center, Manitowoc had an excellent grasp on its fixed and variable costs and was well aware of its margins. Two bundles were created: one with rehabilitation services included for those patients who lived in proximity to the Center, and one excluding those services for patients who traveled for their surgical procedure. The Center offered patients a one-time co-pay for all rehabilitation services rather than a co-pay at the time of each visit.

Both payer and provider recognized the cost of the knee implant itself as a significant driver of cost. Transparency in the cost of implants would be advantageous to providers and patients in the future.

Notably, Anthem did not have to share any data with the Center to facilitate the bundled payments. The Center used its own cost and quality data to make projections about risk and the overall costs of surgery, including facility, physician, rehabilitation, and implant costs. According to Foley, there is usually a 3 percent chance of a revision with a provider for a total knee replacement. He believes that the risk-sharing element is overplayed. "Risk sharing is not a problem if you have the data," added Willhite. Although the Center reported a learning curve regarding the billing process, it was a small hurdle

that was overcome. The Center advises that similar outpatient surgery centers undertake cost accounting to understand their fixed and variable costs, understand risk, and make bundled payment projects feasible.

Challenges

The Manitowoc Surgery Center reported a lower volume of TKR surgeries than initially expected; only 24 were completed, as opposed to the expected 150. This was attributed to the level of marketing and lack of community awareness. Both Manitowoc and Anthem noted that it is important to define who will take on the role of marketer in a bundled payment arrangement to achieve optimal volume and efficiencies.

Outcomes

One outcome of the pilot project was more efficient, tightly coordinated care. Because the bundled payment structure included patients as an essential partner and enhanced the physician-patient relationship, care was more tightly coordinated to ensure quality and good outcomes. Patients reported enjoying knowing the straightforward cost for every aspect of care before the surgery. Physicians also reported having positive feelings about being innovative and providing high-quality care.

As far as costs, Anthem realized a 10 percent savings on TKR costs per case, compared to the non-bundled historical costs per unit for the same services, according to Foley. Anthem had anticipated a 17 percent savings (related to both unit costs and volume), but did not attain the savings goal because of a lower volume of TKRs than anticipated.

Looking to the Future

The Center expanded upon the bundled payment pilot in the second year, applying the same basic approach to total hip replacements. In the future, Willhite sees continued expansion of the bundled payment model into coronary artery bypass graft (CABG). Chronic disease care bundles are another possibility. Foley expressed a desire for national benchmarks to track quality outcomes for TKR, as none currently exist. The next step in health billing technology is to automate the claim/billing functions to accommodate bundled payment. Both payer and provider in this dyad felt that a market was created for bundled payment—not just in Manitowoc, but also in eastern Wisconsin through this project—and that bundled payment will continue to have a presence and role in health care in the region.

2. DYAD: UNIVERSITY OF WISCONSIN HOSPITAL AND CLINICS AND UNITY HEALTH INSURANCE

UW Health is comprised of the academic health care entities of the University of Wisconsin Hospital and Clinics and the University of Wisconsin Medical Foundation. These two organizations collaborated with their partner payer, Unity Health Insurance, and joined the PHPR bundled payment project to align efforts by physicians and the hospital to maximize effectiveness in orthopedics. As a large provider in the region with an affiliated partner payer, this dyad entered into the pilot with a high level of trust and integration. Unity has capitated contracts with UW facility and professional services groups, adding a layer of complexity to the bundled payment pilot.

Motivation: Accrue Experience for the Future

Rapid implementation of a TKR bundled payment was possible because of shared expectations and open communication between payer and provider. The provider and payer reported building on their close and unique partnership arrangement and the high level of trust underlying this as well as other innovative projects. Both reported being motivated additionally by an opportunity for shared cost savings, although cost savings were not the primary goal. University of Wisconsin Hospital and Clinics believed that transitions in payment were apparent in the marketplace, and chose to join the pilot to gain experience. Unity also

expressed an interest in providing new information to benefit the patient directly while also better engaging patients in their care.

Bundle Implementation

The dyad adopted many of the guidelines and bundle definitions PHPR suggested, including the total knee replacement flat fee for medical professional and facility fees and readmissions for certain diagnostic codes. Exclusions were made based on the age of the patient and termination of insurance before 90 days post-discharge. Outpatient services, notably, were not included in the bundle; UW Health draws patients from a broad geographic area and found including rehabilitation services provided by distant, unaffiliated providers to be too difficult to administer.

Challenges

The UW Health-Unity dyad noted initial administrative challenges with the bundle formation and processes related to payment. In the initial stages of the bundle billing process, it was difficult to identify claims related to the bundle and manual identification of charges related to the TKR. Sean Jindrich of UW Health said, "The challenge of identifying and attributing charges never went away. The labor hours were insurmountable." To work around this challenge, UW created an algorithm to compute costs for all TKR patients, not just those participating in the pilot. UW Health and Unity expressed optimism that bundles would be more easily automated in future versions of their electronic medical record and billing systems, and in fact are collaborating with software developer Epic to automate bundles in the future.

Outcomes

UW physicians hoped to learn from the experience of the pilot by reviewing and comparing quality data on patient outcomes within their own dyad and from other participating dyads. This dyad reported ease of reporting on quality measures, since they aligned with common Centers for Medicare & Medicaid Services measures already being reported for TKR and other surgical patients.

The dyad found it difficult to estimate cost savings in light of the pre-existing capitated contracts between the payer and the facility and the professional services group. "The verdict is still out on costs and savings. We may have bent the curve," said Jindrich. UW took the opportunity to renegotiate its contracts with vendors on implants. "UW relied on easily accessible modeled costs, whereas less accessible actual costs would have been preferred for some aspects of the improvement process. Working across silos has improved, but it is still a work in progress for the organizations," Jindrich observed. UW would have welcomed a higher volume of patients to economize further on the newly created administrative processes. The dyad also made the conscious choice to exclude rehabilitation from the bundle coverage, which may have been a lost opportunity for additional cost savings.

For UW Health, the success of this pilot was achieving greater standardization of services, regardless of the surgeon overseeing the TKR procedure.

Looking to the Future

UW Health and Unity both reported learning from the pilot and felt that their experiences with the pilot allowed them to create a model that is ready to implement again in the future. Said Jindrich, "Now we're waiting on the market—will bundled payment be the next big thing?" UW is now pursuing an ACO strategy to drive down costs and improve quality.

3. DYAD: MERITER HEALTH SERVICES AND PHYSICIANS PLUS INSURANCE

Meriter Health Services and insurer Physicians Plus joined together to participate in the PHPR TKR pilot project. As close affiliates, the mature relationship removed issues of trust and allowed for sharing cost savings through improved efficiencies. Physicians Plus as a payer operates on a capitation agreement with Meriter Hospital.

Motivation: Position for the Future

Meriter wanted to strengthen its ability to succeed with payment reform in the future. "We know that moving forward, these types of initiatives will not be voluntary," said Phil Swain, director of orthopedics and rehabilitation, Meriter Health Services. "We believe that eventually it will be mandatory." In this first foray into bundled payment, Meriter wanted to start with a project that featured a clearly identifiable population and a relatively manageable and predictable amount of risk. A pilot with an easily defined bundle was an ideal first step into payment reform. Physicians Plus Insurance had a similar motivation: "We wanted to see if we could do it. The goal was feasibility," said Tim Jackson, informatics analyst with Physicians Plus.

Greater physician engagement was also an area of interest for Meriter. Once physicians had a better understanding of what their implants and supplies cost and identified viable options for making changes to drive down those costs, they were largely receptive to making the necessary changes, including standardizing the types of implants used in surgery.

Physicians Plus saw the pilot as an opportunity to support an existing focus on quality. "If we proceed with a bundle, that forces quality to a certain extent because we're going to monitor the case. The idea being, if we see that someone's utilizing a lot of services that would mean we should check on that physician case. We did not see that, though," said Jackson.

Bundle Implementation

The Meriter-Physicians Plus dyad largely adopted the guidelines and bundle definitions suggested by PHPR, which excluded certain complications and comorbidities. The dyad included 30 days of post-operative rehabilitation and care. Reconciliation of the costs was done by Meriter retrospectively, and so all risk was placed upon the provider rather than the payer. Meriter assessed baseline costs based on two years of data, working with vendors who scoured claims data. This was important to capturing the true cost of a full TKR episode. Physicians Plus and Meriter chose to include only 30 days post-surgery for a greater degree of control over associated rehabilitation services and greater ease of associated claims processing.

Meriter found that supporting bundle implementation with project managers and clinical care managers was key to moving the pilot forward. Project leaders, including clinical and operational champions, took the opportunity presented by the pilot to standardize supplies and renegotiate implant costs with suppliers. Meriter also worked with physicians to streamline the implant purchase process. Before the pilot, Meriter was using multiple knee implant systems based on physician preference. Now, only one knee implant system is being used, with a significant cost savings from improving implant purchasing practices. "Bundled payments present a great opportunity to look at the process, and they serve as a vehicle to drive improvement," said Tracy Bailey, project manager for Meriter's Bundled Payments Initiative.

Physicians Plus operates on a capitation agreement with Meriter. "The actual dollars that are associated with an inpatient admission—we don't actually pay those dollars. We pay the capitated rate," said Jackson. This project was not going to affect the rate paid to Meriter Hospital by Physicians Plus, but Meriter did take this opportunity to identify areas to streamline and increase efficiency.

Meriter was the only provider to examine the use of skilled nursing facilities after a TKR. While some patients require discharge to skilled nursing facilities after a TKR, others do not need this level of care and can be discharged to their homes. Skilled nursing facilities provide a high level of inpatient care and can be costly. Meriter implemented a chart review process and concluded that some patients could be discharged to their home. Meriter also met with skilled nursing facilities to collaborate on the shared goals of increasing value through shorter length of stay while maintaining good patient outcomes.

Challenges

"Planning was the easy part—operationalizing was a challenge," said Swain. Driving standardization in processes for claims and identifying charges was a hurdle. Meriter believes that it has a granular and specific understanding of hospital operations costs, but a limited view of post-acute processes. Swain observed that it took time for Meriter to examine post-surgical care for patients covered by the bundle; however, a new focus on post-surgical care with an emphasis on ensuring patients are prepared for discharge and have appropriate follow-up appointments has been a significant development. "That was eye-opening. The hospital has influence on post-acute care, even without direct control. There are ways to influence cost containment in post-acute care with what is explained to the patient pre-operatively," Swain noted.

Jackson of Physicians Plus noted that working with claims data was a struggle initially because there was no "grouper," or a way to automate the grouping of all claims related to the total knee replacement. "This was a bit more of a challenge for us," said Jackson. The internal process was to create software code to identify the surgery within the claims data. That software code would also associate post-surgical experiences with the surgery, such as rehabilitation. Jackson and his team checked the accuracy of the software code with a manual analysis. "We chose to go with a 30-day post-surgery period because we could be more certain that all rehab during that time period was associated with that surgery," said Jackson.

Patient engagement and communication remains an area of learning for pilot participants. In Meriter's experience, some patients declined participation in the bundle because patients didn't connect the bundle to out-of-pocket savings for themselves, nor to the prospect of more affordable, high-quality care over time.

Outcomes

Physicians Plus reported having saved on average about 20 percent as compared to the target price of a TKR. Over the span of the PHPR TKR pilot, the savings each quarter have varied between 17 and 23 percent. These results show decreasing costs across the whole episode of care. The number of rehabilitation visits required on average per patient decreased, according to Jackson. The cost savings were a pleasant surprise for Physicians Plus; cost savings in this pilot were not expected. Jackson reported that the savings were "dramatic" and attributed the majority to the renegotiation of the knee implant contracts.

Now that some of the "low-hanging fruit" has been addressed to decrease costs, including knee implant contracts, surgical supplies, and redirecting patients who did not require admission to a skilled nursing facility after surgery, Meriter will move on to other areas to continue to bend the cost curve. Meriter hopes to address length of hospital stay and readmissions to reduce costs and provide better patient outcomes.

Looking to the Future

Meriter and Physicians Plus are considering expanding bundles to other service lines. Meriter will continue to focus on orthopedics, notably by choosing to participate in the Centers for Medicare & Medicaid Innovation's Bundled Payment for Care Improvement Initiative. Meriter reports interest in moving into other areas of care once it feels more confident in its abilities to execute bundled payment successfully. Meriter's future efforts will continue to focus on improving value in health care. "We know the transition will be from volume to value," said Swain.

Physicians Plus intends to use its experience as a learning tool with large employers. Now that Physicians Plus has attained the ability to perform the analysis and properly code claims, it is in a good position to replicate this work in the future. No changes in the software are needed because of the code Physicians Plus analysts wrote at the beginning of this project. Physicians Plus is also looking at expending bundles into other service lines.

CONCLUSION

Bundled payment gives provider organizations responsibility for the number and types of services within an episode of care.[6] Providers and payers have the flexibility to decide which services should be included, and can work together to eliminate unnecessary and/or redundant care. The most attractive element of undertaking a bundled payment pilot for many payers and providers may be the opportunity to develop readiness for future demands of health care transformation. All dyads in this project expressed a desire to be ready for the future of health care payment reform, and all observed that their experience with this pilot had provided considerable opportunities for learning.

On the surface, bundled payment appears to be about health care financing. Beyond a change in the flow of dollars, however, bundled payment is truly about the transformation of care through a focus on improving quality and reducing costs. The Wisconsin experience has demonstrated that relatively modest changes in reimbursement methodology can drive significant changes in data analysis and delivery redesign, notwithstanding administrative and logistical challenges. By aligning incentives through a single payment, patients receive care that is better coordinated across multiple providers, and costs are reduced. When coupled with quality data tracking and reporting, bundled payment has significant potential to drive down costs and improve value in health care.

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[6] *Miller, Harold. http://content.healthaffairs.org/content/28/5/1418.full.pdf+html.*

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