

Bundled Episode-of-Care Payment for Orthopedic Surgery: The Integrated Healthcare Association Initiative

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Episode-of-care payment has been endorsed by many practitioners and policymakers as a means to align incentives and promote efficiency, but the design and implementation has proven far more difficult than anticipated.

INTRODUCTION

In recent years there has been strong interest in episode-of-care (EOC) payment for physicians and hospitals as a replacement for fragmented, fee-for-service reimbursement. Medicare's DRG method for hospitals can be interpreted as the nation's first bundled payment, though it covers neither physician services nor post-acute services administered after discharge. Medicare's Acute Care Episode (ACE) demonstration project built directly on DRGs, combining Part B physician services with Part A hospital payments. Most recently, the Center for Medicare & Medicaid Innovation (CMMI) launched the Bundled Payments for Care Improvement initiative (BPCI), pursuing several models of episode-of-care payment for Medicare fee-for-service beneficiaries. Several large employers and private insurers have experimented with bundled payment as well.

The Integrated Healthcare Association (IHA) is a multi-stakeholder association with a commitment to collaborative initiatives among insurers, physician groups, and hospital systems in California. Its core competencies lie in performance measurement and payment incentives for these three organizational stakeholders. IHA's key programs include the statewide pay-for-performance program, in which health plans have paid over \$450 million since 2004 to 180 medical groups based on their clinical quality, patient satisfaction, information technology adoption, and appropriate use performance.

IHA's involvement in bundled payment began with an earlier initiative, the Value Based Purchasing of Medical Devices, which brought together hospitals across the state to evaluate the purchasing of high-cost medical devices in orthopedics and cardiology. During 2006-2010, the variance in medical device costs was measured across similar hospitals, leading to an interest in realigning financial incentives for more efficient purchasing using a bundled payment approach. The initial effort, to develop bundled payment for orthopedics, was funded by the California HealthCare Foundation and it established the groundwork to launch IHA's three year bundled payment demonstration, funded by the Agency for Healthcare Research and Quality (AHRQ).

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



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This initiative was titled the Bundled Episode Payment and Gainsharing Demonstration (BEPGD).

The payment demonstration was launched in September of 2010, and included five key objectives—test the feasibility and scalability of bundled payment episodes in a multi-payer environment; develop ten bundled episode definitions; recruit physicians, hospitals, ambulatory surgery centers, and health plans, and facilitate contracting among them; conduct an evaluation led by the RAND Corporation and the University of California at Berkeley; and disseminate key lessons learned and best practices.



IMPLEMENTATION AND EVOLUTION OF THE INITIATIVE

The IHA project began with six commercial health plans and eight hospital systems. Many of these stakeholders participated in committees to develop episode definitions and guiding principles. It was agreed that health plans and hospitals would conduct price negotiations individually. There was no desire for joint negotiations that potentially would violate anti-trust guidelines. All participating insurers and hospitals would use the IHA episode definitions. For orthopedic knee and hip surgery, the episode definition included all hospital services, the surgical implant, all physician services (surgery, anesthesia, other specialists), and costs incurred for related readmissions within 90 days of hospital discharge.

A lively debate developed around the health plans' desire to expand the episode length to include services provided before admission and after discharge from the hospital, with providers expressing concerns about taking on too much risk and an overambitious clinical process redesign. The parties ultimately struck a balance by excluding pre-admission services and post-discharge services aside from related complications and readmissions. Some health plans expressed concern over lack of incentive for appropriateness and even perhaps a perverse incentive for physicians and hospitals to increase the volume of procedures. Ultimately, the parties agreed

not to include appropriateness or a shared decision-making component, despite their obvious value, because of administrative complexity and the absence of agreed-upon clinical appropriateness criteria.

It was decided that bundled payment would take the form of a prospective payment between a health plan and a lead provider entity (often the hospital) playing a prime contractor role. The lead provider entity would distribute the bundled payment among participating physicians and hospitals. This approach contrasts with those taken by bundled payment initiatives that establish spending targets for each episode but otherwise continue paying physicians and hospitals separately. In these retrospective bundled payment initiatives, actual spending is compared to the spending target at the end of each year, and bonuses are distributed retrospectively if savings were achieved, but no provider entity manages the bundled payment on behalf of other providers.

HMOs in California contract on a capitation basis with physician organizations for professional services and separately with hospitals for institutional services. It was not administratively feasible to carve out of the professional services capitation the amounts to be paid to the surgeons and other physicians involved in orthopedic surgery. Therefore, the bundled payment initiative could not include commercial HMO and Medicare Advantage enrollees. As a result, contracting development focused on commercial PPO plans. Initial participants included all the major commercial PPOs in California: Aetna, Anthem Blue Cross, Blue Shield of California, CIGNA, Health Net, and United Healthcare. The initial set of hospital systems included Cedars Sinai Medical Center, Hoag Memorial Hospital Presbyterian, Huntington Memorial, Memorial Care Health System, Providence Health & Services, St. Joseph Hospital of Orange, Sutter Health, Tenet Healthcare, and UCLA Medical Center.

IHA developed detailed episode definitions, contract templates, gainsharing webinars, and communication materials to support the project. It engaged Optum, a data analytics vendor, to identify billing and procedure codes and to calculate historical costs for the episodes. In some cases, this required a customized approach to align with different legacy systems, facilitating the flow of data necessary for the negotiating parties to understand their own historical cost information.

The process of negotiating the new payment method proved to be challenging, as it required both the health plan and hospital to devote considerable staff and resources even though the number of patients was modest. Over time, plans and providers focused on other strategic priorities, such as mergers or ACO development, which competed for limited organizational resources. Constituents involved in the demonstration viewed ACOs as having a higher potential return on investment than bundling individual procedures. These obstacles, coupled with low volume of orthopedic procedures for commercial PPO populations, contributed to the erosion of plan and provider interest in bundled payment. This led several large health plans to drop out of the demonstration, followed by several hospitals.

Aetna, Blue Shield of California, and CIGNA continued with the project. They executed contracts with Hoag Orthopedic Institute and Alta Bates Summit Medical Center. Blue Shield also executed contracts with four ambulatory surgery centers operated by a single entity (Surgery One) and another independent ambulatory surgery center (Monterey Peninsula Surgery Center). However, PPO patient volumes were very low, and only 25 orthopedic cases were completed, with an additional 150 cases performed at the ambulatory surgery centers by August, 2013.

The IHA demonstration funding period ended in late September 2013. However, the health plan contracts will not end as a result. Some health plans continue to develop bundled payment contracts, including possible expansion to other episode definitions hospitals, and ambulatory surgery centers.



LESSONS FROM THE INITIATIVE

A. Savings Now or Later?

An early and persistent challenge facing the initiative was the opposing perspectives by health plans and providers on the level of pricing to be used in the transition to bundled payment. The health plans sought immediate savings in

the form of payment reductions, compared to what the hospitals would have earned under fee-for-service. They held the view that the providers would realize meaningful cost reductions from the care redesign process required for the bundled payment model and should share those savings with the insurers and the insurer's employer customers through lower payment rates. For their part, the hospitals were concerned about the administrative cost of implementation and unanticipated medical service costs, and sought a higher level of payment than what they received under fee-for-service reimbursement.

The compromise position was that the level of payment in the first year should be equal to payment levels that existed prior to bundled payment (adjusted for inflation). In years two and three the level of payment would be inflated at the rate of the general consumer price index (CPI). Nonetheless, differing views continued to prevail in negotiations between the parties and rendered the negotiations at times difficult and slow.

B. Information Systems and Claims Payment

Health plans had concerns about 'paying twice.' Their claims systems were not set up to pay on an episode basis, as distinct from the traditional fee schedule for physicians and per diem payments for hospitals. Some health plans decided to postpone contract negotiations with hospitals until information technology solutions could be identified externally, or existing claims systems were modified. Others decided that contracts could be handled manually for an interim period due to low case volume. Many hospitals lacked the information technology capability to pay claims to physicians covered by the bundled payment method. IHA approached two of its member organizations, McKesson and TriZetto, to enhance claims payment software for insurers and to develop new payment technology for hospitals. Within a year, McKesson was involved in pilot testing a new bundled claims payment module for Aetna, and TriZetto developed new software programs for hospitals to pay physician claims for services within the episode bundle. Despite these efforts, claims payment continued to be a significant concern, since bundled payment is a substantial change for health plans and providers from standard claims payment. There

were also challenges to accurately identify, authorize, and pay the small number of cases. Limited volume inhibited the ability to rapidly test these claims payment solutions.

C. Regulatory Constraints

California law prohibits the employment of physicians by organizations that have not been licensed to practice medicine. This “corporate practice of medicine” prohibition prevents hospitals from employing physicians. Hospitals involved in the IHA initiative raised the concern that paying physicians for the services they independently provided to the patient might violate the corporate practice prohibition. To address this concern, IHA developed contract templates that established that the relationship between parties was that of prime contractor to subcontractor rather than employment. Under IHA’s structure, the hospital accepts payment for the entire episode of care but acts only as an agent of the physician subcontractors in dispersing payment for professional services. In the end, the dominant model adopted by the health plans and providers was to split the episode services and payments into two components—a bundled payment for all professional services and a bundled payment for all facility services.

The California Department of Managed Healthcare (DMHC) requires approval of any provider contract involving risk arrangements, such as capitation payment. DMHC staff considered episode payment a risk transfer from the insurer to the hospital, as the hospital would be required to make payments to physicians. The DMHC expressed concern for the level of oversight by the health plan over the hospital’s payment to subcontracting physicians. What steps was the health plan taking to ensure that the hospital had adequate financial reserves to cover these payments? How did the health plan intend to communicate to the enrollee about the provider risk transfer? How would the health plan assure that bundled payment would not have negative consequences to the enrollee in terms of deductible or coinsurance requirements? To assure regulatory compliance, DMHC subsequently required the health plan to submit every new bundled payment contract for review and approval. This significantly slowed down the implementation of the bundled payment initiative.

D. Episode Definitions

IHA focused on orthopedic procedures, giving additional attention to cardiac and maternity episode definitions. It convened committees to develop the clinical and administrative framework of the definitions, which included health plan, hospital and provider members. Procedures were selected based upon patient volume and insurer expenditures, the potential for quality improvement, cost reduction, and opportunity in physician-hospital alignment. These criteria led the participating health plans, hospitals, and physicians to select total knee and hip replacement surgery as the primary target. Health plans were interested in broad inclusion criteria in order to expand the number of patients covered by each bundle. They also favored lengthier episode definitions to incorporate more services, such as post-acute care, within the bundle. Hospitals sought to limit the length of the episode definitions to focus on the admission, since the addition of pre-admission or post-discharge services greatly added to the burden of coordination and the number of providers who would be included.

Criteria for exclusion: broad versus narrow patient eligibility—IHA made an early decision not to adopt or develop a risk-adjustment methodology for episodes. Instead, the initiative included episode definitions that were limited to patients with low risk, for whom complications were less likely to be due to underlying clinical conditions that were present on admission. Narrow episode definitions involved identifying clinical indicators that would exclude high-risk patients, such as those with morbid obesity, or certain medical conditions such as end stage renal disease. Exclusions also included readmission to another hospital.

Episode duration: long versus short episode timeframes—Longer episodes of care increase the need and incentive for care coordination but shift more risk to the lead provider entity. The hospitals did not want to extend the payment bundle beyond the primary admission except for admissions that were clearly linked to complications caused in the first admission. The IHA episode definitions for hip and knee replacement—which include physician and hospital services, the medical device implant, and a 90 day warranty period including related complications and readmissions—represent compromises that allowed the initiative to move forward.

E. Insurance Benefit Design and Consumer Cost Sharing

Although the health plans envisioned implementing only methods of provider payment, they were unable to avoid discussions of insurance benefits and consumer cost sharing. Since bundled payment rates are calibrated to a historical average cost for the procedure, it was possible for patients who used fewer services under bundled payment (due to efficiencies obtained by hospitals from care redesign with physicians) to owe more in coinsurance as a share of total costs than they would have owed when the individual services were paid fee-for-service. The health plans decided to require patients to pay the lesser of what they would have paid on the fee-for-service bills and the nominal coinsurance rate due under bundled payment.

The hospitals wanted the health plans to steer higher patient volume to their facilities. The addition of incentives for channeling to participating hospitals would have required the health plans to restrict network access and to file new benefit options. The typical cycle-time for regulatory approval and implementation of new benefit plans with purchasers is close to two years, making these changes impossible within the demonstration period. As a result, the IHA project did not include incentives for consumers to use the participating hospitals. This reduced the enthusiasm for participation on the part of the hospitals.

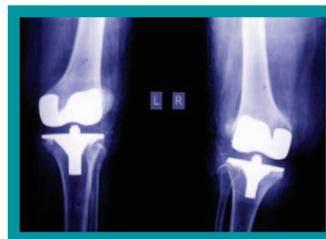
F. Patient Volume

Patient volume proved to be a key consideration influencing the commitment of health plans and hospitals to the demonstration. Will there be enough patient volume to offer health plans meaningful savings and/or quality improvements? Is the number of episodes adequate for a hospital to spread the costs across a high volume of patients and justify the operational challenges of implementation? Is volume adequate to incentivize physicians to change their practice patterns? Unfortunately, the inability to include Medicare patients (a large population, particularly for total knee and hip replacements), and loss of several major commercial health plans meant the answer to these questions was negative.

G. Population-based Payment versus Episode-of-Care Payment

Questions were raised by health plans and hospitals as to whether episode payment was a step towards global payment and Accountable Care Organizations,

or a distraction from it. Global payment is especially strong in California, which never migrated fully away from capitation after the managed care era. California hospitals have focused on the acquisition of physician practices to compete in the new health reform environment. Their initial enthusiasm and ability to devote resources to implementation of bundled payment diminished as their enthusiasm for a commitment to global payment increased.



CONCLUSION

Episode-of-care payment has been endorsed by many policymakers, insurers, and providers as a means to align incentives and promote efficiency in the health care delivery system. The design and implementation of episode payment has proven far more difficult than anyone anticipated, however. To date, none of the various private sector initiatives, including that of the IHA, has been able to cover more than a small number of insurers, hospitals, and patients.

The transition from fee-for-service to bundled payment requires substantial administrative effort, the re-design of claims payment systems, the navigation of legal and regulatory hurdles, and culture changes for physicians and hospitals. It will not be undertaken unless potential savings are significant. This requires that many patients have their care reimbursed under the new payment method. The health insurance markets in some states are dominated by one commercial plan. In these concentrated markets, collaborative initiatives between the dominant private plan and the state's Medicaid program potentially can drive the shift from fee-for-service to episode-of-care payment; Arkansas is one promising example. Most states, however, have more fragmented insurance markets. In those states, which include California, even the largest plan accounts for only a small fraction of any one hospital's admissions; hospitals are unwilling to change payment methods for the sake of any one plan. Likewise, health plans are unwilling to implement a unique payment

arrangement for a solo hospital. Medicare accounts for a large share of every hospital's admissions, and CMS could require the use of episode payment as it did with the original DRG hospital payment system. In turn, this likely would inspire private insurers to follow suit. However, given that CMMI has launched the Bundled Payment Care Improvement initiative as a voluntary model for testing and evaluation, mandatory use of episode payment by Medicare is unlikely in the short term.

The full benefit of episode payment will be realized only when episode definitions include the patient's entire course of care, from pre-admission testing through inpatient care to post-acute services. However, extending episode definitions increases the complexity of coordinating services and providers, and true prospective payment requires one provider to take on functions usually assigned to insurance firms. This raises concerns by regulators as well as hospitals. The success of Medicare's ACE demonstration may have derived in part from its truncated episode definition, which began with hospital admission and ended with hospital discharge. An incremental approach to implementing bundled payment may be more palatable to insurers, hospitals, and regulators. Bundled payment initiatives could begin with short episode durations and expand these as the operational, regulatory and clinical challenges are resolved.

The goal of episode payment is to encourage collaboration between physicians and hospitals in the care received by particular patients. Moving from fragmented payment to a bundled payment gives all participants the incentive to reduce waste, duplication of services, and overcharging. However, bundled payment is not the only means to this laudable end. Many hospitals are pursu-

ing development of an Accountable Care Organization (ACO), and are now engaged in building fully integrated health systems, employing physicians, and purchasing ambulatory clinics. In this scenario, there is no need for the insurer to bundle specific episodes of care for payment purposes because the ACO is responsible for the total cost of care; bundled payment just adds another level of administrative complexity. But in markets such as Arkansas, where integrated delivery systems are not prevalent, episode payments potentially offer an attractive alternative.

Despite great initial support, enthusiasm and effort, episode-of-care payment does not offer an easy fix to the nation's health care financing problems. The IHA initiative in California began with a collaborative culture among private health insurers and the largest hospital systems. It received generous funding from private foundations and AHRQ. Yet it was able to bring only a few insurers and hospitals to the point of actually signing episode-of-care contracts and changed the method of payment for only a small number of patients. In this the IHA program encountered the same difficulties encountered by other private sector initiatives.

Nonetheless, these early experiments have broken important new ground in resolving the practical barriers to bundled payment implementation. The project successfully specified definitions, navigated legal and regulatory approvals, developed payment administration, and designed gainsharing arrangements. Lessons learned and resources developed through this initiative will be valuable to an array of private sector bundled payment efforts, as well as to CMMI and the participants in its Bundled Payment for Care Improvement initiative.

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