



BRANDEIS UNIVERSITY // THE HELLER SCHOOL FOR SOCIAL POLICY AND MANAGEMENT

THE HEALTH INDUSTRY FORUM

EPISODE PAYMENT: PRIVATE INNOVATION AND OPPORTUNITIES FOR MEDICARE

CONFERENCE REPORT / MAY 17, 2011 / WASHINGTON, D.C.



Table of Contents

Session Title	Speaker(s)	Page
Key Themes		3
Overview of "State of the Art" Episode Payment Programs	<p>Robert Mechanic, M.B.A., Executive Director, Health Industry Forum, Brandeis University</p> <p>Michael Zucker, Senior Vice President, Baptist Health System</p> <p>Richard Afile M.D., President and CEO, Hoag Memorial Hospital Presbyterian</p> <p>James Robinson, Ph.D., Professor, UC Berkeley School of Public Health</p> <p>Tom Williams, Dr.Ph., Executive Director, Integrated Healthcare Association</p> <p>Betty Herbert, Director, Managed Care, CaroMont Health</p> <p>Joseph Fifer, Vice President for Finance, Spectrum Health System</p> <p>Jim Byrne, Vice President, Priority Health</p>	5
Key Issues in Expanding Medicare Episode Payment Policies	<p>Francois de Brantes, President, Healthcare Incentives Improvement Institute</p> <p>Christopher Tompkins, Ph.D., Associate Professor, Brandeis University</p>	8
Automating Episode Payments Through a "Claims Engine"	<p>Gilbert D'Andria, Vice President, MedAssets</p> <p>Sheila Stewart, Director, Data Analysis, Trailblazer Health Enterprises</p> <p>Jay Sultan, Associate VP Applied Analytics, The TriZetto Group</p>	10
Opportunities for New Federal Episode Payment Initiatives	<p>Robert Mechanic, M.B.A., Executive Director, Health Industry Forum, Brandeis University</p>	12

The Health Industry Forum is based at Brandeis University, chaired by Professor Stuart Altman, and directed by Robert Mechanic. The Forum brings together public policy experts and senior executives from leading healthcare organizations to address challenging health policy issues. The Forum conducts independent, objective policy analysis and provides neutral venues where stakeholders work together to develop practical, actionable strategies to improve the quality and value of the US healthcare system.

Conference presentations and other background materials are available at www.healthforum.brandeis.edu.

Health Industry Forum ♦ Heller School for Social Policy and Management ♦ Brandeis University
415 South Street, MS035, Waltham, MA 02454 ♦ (781) 736-3903 (Tel) ♦ (781) 736-3306 (Fax)

Key Themes

Overview

The current healthcare system is fragmented, in part because fee-for-service payment contains few incentives for care coordination or high quality. Episode-based payment – an approach that bundles payments for all services provided during a defined episode of care – has the potential to change that. Establishing episode payments (or a bonus system based on performance relative to episode-based budget targets and quality goals) changes provider financial incentives, potentially leading to greater clinical, operational, and financial alignment. Case studies of episode payment pilot programs indicate that they can lead to improved care coordination, better outcomes, and reduced costs. Based on these experiences, meeting participants made recommendations to the Center for Medicare and Medicaid Innovation about designing programs that will be administratively feasible and economically sustainable for a reasonably wide range of healthcare organizations.

Context

On May 17, 2011, the Health Industry Forum brought together a diverse group of stakeholders, including representatives from the Center for Medicare and Medicaid Innovation (CMMI), to discuss real-world experiences with episode payment and perspectives about how to make these systems more widely attractive to payers and providers. Three case studies of private episode programs and one case study from Medicare's ACE demonstration were shared, with lessons extracted from each.

One objective of this meeting was to provide input to the Center for Medicare and Medicaid Innovation about how to best incorporate episode payment into its portfolio of new pilot programs. CMMI's Acting Director, Dr. Richard Gilfillan, invited participants to help articulate a strategy for the industry to redesign care and to create new payment incentives. He also asked for input about CMMI's immediate and longer-term priorities.

Key Themes

▪ Episode payment can drive care redesign.

Many leading healthcare experts view care coordination as a key to improving healthcare quality and reducing spending. The current fee-for-service payment model has helped sustain a system of fragmented patient care with few incentives for eliminating unnecessary services. Once incentives are better aligned, they argue, dramatic improvements in quality and efficiency can occur very quickly, especially when physicians and hospitals work together.

The concept of episode payment—making a single payment (or setting a target budget) for all services provided during a defined episode of care that includes multiple providers and settings — can fundamentally change provider financial incentives. For example, at Baptist Health System in San Antonio, Texas, aligning incentives between the hospital and physicians in Medicare's ACE program has resulted in better outcomes and savings of more than \$2,000 per case.

While presenters indicated that initial savings came from improved purchasing practices, much of the benefit from episode payment was derived from redesigning care processes. Episode payments combined with opportunities to share savings with physicians provided an impetus for physicians and hospitals to work together to develop care guidelines and clinical coordination. As Francois de Brantes said, "Incentives drive function, which drives form." Across the four case studies, the redesign process ranged from 90 days to three years, based on each organization's readiness, sense of urgency, and leadership commitment. Participants believed that by sharing best practices the speed of such clinical redesign could be accelerated.

▪ Episode payments are extremely complex to administer; technology is needed.

Presentations by software vendors highlighted the complexity of administering episode payments. New software must be integrated with current fee-for-service claims systems and determine 1) when episodes are triggered, 2) which claims are part of the bundle and which are not, and 3) how much to reimburse based on patient-specific risk factors. Payment can be prospective or structured as retrospective performance bonuses.

Due to this complexity, new technology solutions are essential for any large-scale effort to implement episode payment. The effectiveness of new software depends to a large degree on the ability to integrate with existing claims systems. Many organizations, including Medicare Administrative Contractors have older systems that must be updated before they will be able to integrate effectively. Furthermore, robust real-time reporting systems will be needed to help providers monitor and improve on their performance.

▪ Participants offered multiple suggestions to inform CMMI's episode payment strategy.

- *Join or expand existing bundled payment projects.* CMMI should rapidly join existing private sector episode payment initiatives. It should also immediately expand the ACE demo to give more hospitals experience with episodes.
- *Focus on both acute procedures and chronic conditions.* The 2013 national payment bundling pilot mandated by the ACA focuses on hospital-based episodes. But, patients with chronic conditions incur the majority of potentially avoidable healthcare spending. Based on Spectrum's experience in Michigan, CMMI was encouraged to consider longer-term episodes of perhaps one year related to chronic diseases.
- *Have flexibility in structuring episode payments.* Different providers have different capabilities. Instead of forcing providers to adopt one approach, CMMI should consider a portfolio of episode payment options, including different rates for different types of episodes over different durations. Rather than dictate specific configurations, provide a clear policy goal for different levels of sophistication.
- *Don't just identify promising innovations - spread them.* The industry has done a poor job of disseminating successful delivery system innovations. CMMI has a great opportunity to drive broader adoption of demonstrated best practices.

Overview of "State of the Art" Episode Payment Programs

Moderator: **Robert Mechanic, MBA**, Executive Director, Health Industry Forum, Brandeis University

Overview

Across the country only a few health systems actually have experience with episode payment programs. These experiences show that aligning payer and provider incentives can improve the quality of care delivered while lowering costs. Bundled payment can also serve as a catalyst to motivate clinical, operational, and financial alignment.

Successful performance in a bundled payment environment requires leadership, culture change, clinical redesign, and effective performance-measurement systems. These case studies illustrate that bundled payment models can be effective in a variety of different delivery system environments and can be adapted for both acute episodes and chronic conditions. Experimenting with episode payments can also help organizations prepare for more comprehensive payment reforms that may accompany the development of accountable care organizations.

Context

Four healthcare organizations presented case studies describing their experience developing and implementing episode payment programs and shared key lessons learned. Rob Mechanic led off the discussion by noting that the majority of US healthcare organizations that have actually implemented episode-based payments were represented in this forum. To maximize lessons based on real-world experience, presenters were asked to discuss success factors, challenges, and examples of how barriers were overcome.

Case Study 1: Prospective Payment for Medicare Parts A and B During Hospitalization (ACE Demo)

Michael Zucker, Senior Vice President, Baptist Health System (BHS)

Baptist Health System, a five-hospital health system in San Antonio, Texas, was one of the first participants in Medicare's Acute Care Episode (ACE) demonstration project. ACE's purpose is to determine if quality improvements could result from a greater alignment of financial incentives between hospitals and physicians. The ACE program included competitive bidding where hospitals proposed discounted bundled prices that combined hospital and physician services for 28 cardiac and 9 orthopedic DRGs; an ability for hospitals to share cost savings ("gain-sharing") with participating physicians with bonuses of up to 25% of their regular fees; and financial incentives for Medicare beneficiaries that select participating hospitals. Participants in the ACE demo explicitly measure quality. In the BHS program, the system must meet specified quality targets before physicians are eligible for any gain-sharing.

- **For BHS, ACE has been a tremendous success.**

According to Mr. Zucker, BHS had to overcome initial resistance from its independent physicians, including some who walked out of meetings in protest, fearing that the hospital wanted to micromanage their practices. But the alignment of financial incentives quickly changed provider attitudes and produced

outstanding results. Patient outcomes have improved significantly as physicians are focused on improving quality and reducing waste in order to participate in gain-sharing. Previously, there were dozens of different order sets for orthopedics; now there is a single uniform order set across the entire system, which is used in more than 90% of cases.

"Quality always trumps costs savings. If we do not achieve the quality results there is no gain-sharing."

— Michael Zucker

Financially, BHS reduced spending by \$4.3 million since the program's inception, or approximately \$2,000 per case in the ACE demonstration. CMS has also saved money through the discounted bundled fees, and physicians are earning roughly \$280 in gain-sharing payments per episode on top of previously low-margin Medicare cases. The financial alignment has helped BHS generate improved margins beyond Medicare, as the clinical protocols also reduce costs associated with private payers. Beneficiaries participating in the program have also earned approximately \$320 each through reductions in their Part B premiums.

- **Physician alignment has been critical to this success.**

Physicians were initially concerned that the episode payment would result in even lower margins. But eventually physician support was achieved by:

- *Keeping physicians whole.* BHS decided the health system would take all of the financial risk and would ensure that physicians would receive the same compensation per procedure. BHS also agreed to be responsible for all billing and collections. So, physicians had no downside risk and the potential for gain-sharing. To date, physicians have received more than \$500,000 in gain-sharing payments.
- *Securing early wins and physician champions.* Once ACE began, BHS distributed reports of its physician gain-sharing payments. In the first month, about six physicians received extra payments. Participation quickly grew and today about 85% of eligible physicians are participating in ACE.
- *Building trust.* To share savings, BHS had to be completely transparent about its costs and open its books to physicians. Doing so helped physicians understand the system's costs, and participate more effectively in initiatives to manage spending. For example, once physicians agreed to standardize the devices used in orthopedic and cardiac procedures, BHS engaged in aggressive negotiations to lower device costs. In the first 60 days of the program, BHS generated \$2 million in savings through lower device costs plus another \$800,000 in savings in year two. BHS had previously tried and failed to achieve such standardization. Now physicians are more actively engaged as partners in looking for additional cost-savings opportunities, including reducing unnecessary imaging services, laboratory costs, and length-of-stay.

“When incentives are aligned, it’s amazing the partnership that can develop, and develop fast.”
 — Michael Zucker

▪ **With its success in ACE, Baptist is looking to expand use of episode payments.**

One of Baptist’s concerns is what will happen when ACE ends. While they are looking to leverage their experience with commercial payers, BHS recommended further developing the concept of episode payments:

- Expanding the number of procedures.* With successes in orthopedics and cardiology, BHS would be interested in testing more bundles for high-volume, high-cost procedures in other specialties.
- Expanding ACE to the outpatient setting.* For BHS, episode payments have been much more successful in orthopedics than in cardiac services. Mr. Zucker believes this is because so much cardiac care is delivered on an outpatient basis. He would like CMS to consider including outpatient services in the episode payments – an opinion shared by his physicians.
- Expanding gain-sharing.* In the ACE demo, physician gain sharing is capped at 25%. Once physicians reached the maximum amount they were less focused on producing additional savings. Had there been a higher ceiling, costs savings might have been greater. CMS should consider increasing or removing this limitation.

Discussion

- Sharing gains with beneficiaries.* In the ACE demo, Medicare beneficiaries had no responsibilities yet they received incentive payments of approximately \$325 each while nothing was expected of them. Most didn’t understand what this money was or why they received it. While increasing the engagement of beneficiaries is important, it is not clear that sharing saving is the best way to engage them. (Mr. Zucker believes that commercial enrollees would find such an incentive engaging if tied to selection of high-quality efficient providers).
- Manual program administration.* Due to its legacy system, BHS administers the episode payments primarily by hand, with six or seven FTEs at a total cost of around \$400,000.
- Case mix and cherry-picking.* While some are concerned that episode payment can create financial incentives for patient “cherry picking,” Mr. Zucker has no data showing whether the case mix at BHS has changed based on physicians bringing in lower-risk cases and steering higher-risk cases to other facilities.

Case Study 2: Prospective Episodes for Hip and Knee Surgery Plus 90 Days Post-Discharge

Richard Afable, M.D., *President & CEO, Hoag Memorial Hospital Presbyterian*
James Robinson, Ph.D., *Professor, UC Berkeley School of Public Health*
Tom Williams, Dr.Ph., *Executive Director, Integrated Healthcare Association*

While the ACE bundle ends at discharge, Dr. Williams described an episode payment initiative in California being led by the Integrated Healthcare Association (IHA) that encompasses the admission plus 90 days of outpatient care post-hospitalization. Dr. Afable then explained why Hoag Orthopedic Institute is participating in this program and how it is positioning for episode payment. Professor Robinson focused on the role of consumers and benefit design.

▪ **IHA is trying to change the healthcare ecosystem through payment redesign and benefit changes.**

IHA, based in California, is a group whose members include health plans, physician organizations, and providers. IHA projects involve multiple payers and providers, and attempt to aggregate a sufficient population of patients to send a strong signal to the market.

Backed through a grant from AHRQ, IHA has initiated a statewide episode payment project for ten acute procedures, starting with hip and knee replacement. The program will soon expand to also include diagnostic cardiac catheterization, cardiac angioplasty with stents, and knee arthroscopy. The knee and hip bundles include both the inpatient and outpatient services that are provided over a 90-day period. The bundles will be paid immediately following the procedure itself (prospectively to the warranty period). Three commercial payers and 20 provider groups have signed on. IHA would like to include Medicare Advantage plans and possibly Medicare. One participant went live in the summer of 2011, but has been slowed by state regulatory review. Important next steps include:

- Securing support from multiple payers.* Providers want to be assured of a significant sample size before they make the investments needed to participate. This hasn’t been easy as payers have been distracted by the initial excitement around ACOs. They are also concerned over the problems of adjudicating claims stemming from episodes, which will have to be done manually until automated software can be implemented.
- Standardizing definitions of each episode* so protocols and processes can be developed, data from providers can be systematically gathered, and reports of costs and outcomes returned.
- Working to get software vendors in place* to help manage the administration of this program.

▪ **Hoag Orthopedic Institute has positioned for an environment with bundled or episodic payment.**

Hoag was the first provider to commit to IHA’s episode payment project. Hoag’s attributed its enthusiasm for the project to work that it began in 2004 to transform its operations. At that time, the hospital’s board directed it to create value by building a system that creates superior outcomes per dollar spent. The board concluded that under the existing payment system it could at least deliver better care, but that the best-case scenario would be a change in the payment system that would reward organizations for delivering more efficient care.

Hoag decided to create a new entity: Hoag Orthopedic Institute, a joint venture that is owned 50% by the hospital and 50% by physicians. The Institute focuses solely on the treatment of musculoskeletal disease, specifically knee, hip, and spinal

procedures. The Hoag Orthopedic Institute is a 70-bed orthopedic hospital with nine operating rooms. It was designed and built specifically for orthopedic procedures, and all care processes were completely redesigned to maximize effectiveness and efficiency. The key to the Institute's success is complete operational, financial, and clinical alignment.

"The key is alignment: operational, financial, and clinical alignment."
 — Richard Afile

Since opening in November 2010, the Institute has performed 1,800 surgical cases. Its quality ratings are well ahead of national averages and the cost of care is 30% lower than it was at the Hoag hospital. About 50% of the cost savings is attributable to savings on devices/ impacts, but 50% of the cost savings is due to efficiencies from care redesign from pre- and post-hospital services.

▪ **Benefit changes can enhance episode payment.**

Professor Robinson discussed how benefit design changes can complement episode payments. In most cases, episode payment is an arrangement between a payer and a provider, with no defined role for consumers. However, benefit changes could be adopted to drive patient volume to providers that operate under episode payments. For example, an employer (or a payer) could commit to paying a fixed amount (say \$10,000) for a certain procedure. Consumers could use providers that charged more, but would be obligated to pay the difference in price. In this scenario, consumers must have information about both the cost and quality of available providers for the complete episodes. Alternatively, payers and employers could establish centers of excellence and limit coverage to services provided at these facilities. Such a narrow-network benefit design is commonly used for major procedures like organ transplantation.

Discussion

- Patient notification.* Several participants felt that patients should be notified if their provider is involved in a gain-sharing arrangement, to provide full transparency for patients who might be concerned about potential financial incentives for providers to skimp on care. Other participants countered that DRGs and other prospective payment arrangements are already a form of bundling and do not require notification. Nevertheless, health plan participants are working with the state of California to develop a policy on notification. Furthermore, IHA requires that gain-sharing formulas be based on quality performance as well as on spending.
- Appropriateness.* While bundled payments generate incentives for efficiency within episodes of care, it does not ensure that those episodes are truly warranted. Currently neither IHA nor Hoag Orthopedic Institute is dealing with "appropriateness." Both assume that all care being delivered is appropriate. However, Hoag sees a longer-term opportunity to establish processes that determine whether specific procedures are appropriate for a specific patient.

Ms. Herbert characterized CaroMont Health as "representing America." CaroMont is a single community hospital in North Carolina with 200 employed physicians and a broad network of independent physicians.

Two years ago, under the leadership of a new CEO, CaroMont began to transform itself from a hospital-centric to a community-centric organization. Under its "Triple Aim Framework", CaroMont focused on: 1) enhanced patient experience, 2) improved population health, and 3) reduced per capita cost of care.

▪ **CaroMont's focus on bundled payment fits with its community-centric vision.**

CaroMont's decision to proceed with episode payment for knee replacement was consistent with the idea of helping local payers and employers control spending while providing better care for patients. CaroMont's objectives for this initiative were to:

- Develop core competencies to implement the Triple Aim.*
- Lay a foundation for larger ACO development with episode payment serving as an initial catalyst for enhanced performance measurement and accountability.*
- Build the foundation for future performance-based product opportunities.*

With these objectives, CaroMont partnered with BlueCross BlueShield of North Carolina to develop an episode payment for knee replacement that covered the hospital admission and all related services over a 210-day period (30 days pre-admission and 180 days during hospitalization and recovery) based on the Prometheus model.

▪ **CaroMont and BCBSNC implemented this program in just 90 days.**

CaroMont's CEO pushed to implement this program in 90 days with the following five phases:

- Phase 1: Assess episode cost and utilization.* CaroMont gathered and analyzed data to understand cost variation for knee replacement across the 210-day episode. Through this analysis CaroMont found significant variation and identified major cost drivers. Patient comorbidities such as obesity, osteoarthritis, or long-term antiplatelet use led to unforeseen complications and readmissions, requiring CaroMont to better design and implement a standardized risk score. In addition, the organization saw the variation in post-discharge rehabilitation care across outpatient physical therapy, home health services, and skilled nursing facilities as a key opportunity to standardize care and lower overall costs.
- Phase 2: Understand the clinical operating environment.* CaroMont staff conducted extensive interviews with front-line clinicians and staff to understand the key factors affecting the quality and efficiency of patients' care. This included socioeconomic barriers that might prevent patients from being discharged directly to their home.
- Phase 3: Redesign the care pathway for knee replacement surgery.* CaroMont developed a detailed process map laying out every step in the 210-day treatment and recovery process. Once they understood the current care pathway, they initiated a redesign process to take advantage of opportunities for improvement.

Case Study 3: Budgeted Episodes for Total Knee Replacement Plus 180 Days Post Discharge

Betty Herbert, Director, Managed Care, CaroMont Health (Gastonia, NC)

An important aspect of this process was building a simulation model to estimate the impact of process changes on cost and quality. The simulation model allowed CaroMont to answer the “what if” questions posed by clinicians and was essential for gaining the buy-in needed to completing the redesign process in just 90 days.

—*Phase 4: Establish metrics and incentives.* CaroMont developed a plan to track and monitor both cost and quality during the episodes.

—*Phase 5: Implement the plan and document lessons.* CaroMont established multiple workgroups that were responsible for different aspects of implementation.

This phased approach enabled CaroMont to use extensive modeling to redesign its care processes and ready the organization to start down the path of episode payment. Building on strong leadership support and collaboration across the organization, CaroMont identified five improvement initiatives necessary for a successful program: patient engagement and patient-based contract for care; risk screening and optimization; accelerated return to wellness; reduced variable supply costs; and an increased use of outpatient physical therapy.

Discussion

—*Appropriateness.* When the issue of appropriateness criteria was re-introduced, Stuart Altman pointed out that while appropriateness is important, most of the recent growth in private healthcare spending has been due to increased prices, not utilization. By creating a standardized bundle, episode payments also provide a mechanism to constrain price inflation.

Case Study 4: Preparation for Implementing Five Chronic Care Episodes

Jim Byrne, MD, Vice President, Chief Medical Officer, Priority Health
Joseph Fifer, Vice President, Finance, Spectrum Hospital Group
 (Grand Rapids, MI)

Spectrum Health is an integrated system in Western Michigan with three components: 1) Priority Health, a health plan with 636,000 members; 2) Spectrum Health Hospitals; and 3) Spectrum Health Medical Group, with 500 employed physicians. The Chief Medical Officer of the health plan and the CFO of the health system agreed that even though they are part of the same organization, there were major opportunities to improve integration by changing incentives.

- **Spectrum has focused on chronic conditions because they present the greatest savings opportunities.**

Unlike the other case studies that focused primarily on orthopedic and cardiovascular procedures, Spectrum looked at where money was being spent and decided to focus on chronic conditions. Spectrum’s analysis showed that CHF, COPD, diabetes, and asthma represented the system’s largest areas of spending and presented the greatest opportunities for savings. Episodes for each of these conditions had a large number of potentially avoidable complications. Spectrum is now working with its own plan, Priority Health, to develop bundled payments

for these conditions, which will include all related costs over a one-year period. This effectively creates a risk-adjusted, capitated rate for these conditions.

- **Moving to bundled payment will require a more team-based delivery system.**

The decision to accept bundled payment will force Spectrum to deliver chronic care in a much more integrated fashion. Underlying the complexity of this undertaking, Spectrum has embarked on a three-year process for development and implementation of episode payments including care process redesign. Spectrum has termed its integrated care delivery system for chronic conditions “Team-based Healthcare Energizes Management of Illness and Sickness (THEMIS).” In Greek mythology, Themis was the mother of Prometheus.

Spectrum has established teams to manage different diseases. This has resulted in creation of integrated clinical processes and in some instances, additional resources, like care managers.

- **Bundled payment is a game-changer that comes with risks, rewards, and challenges.**

Mr. Fifer called episode payment a “game-changer” that requires material changes in the financing and delivery of care that are extremely complicated. The complications include the need for accurate risk adjustment. It also will require a change in culture that could have implications for the health system’s capacity if admissions are reduced. The chronic care episodes have stimulated important conversations about Spectrum’s goals. The system has determined that bundled payment is an important step in readying for accountable care.

Discussion

—*Bundled payment provides focus.* Since Spectrum is defining chronic care episodes as covering an entire year, Rob Mechanic asked why Spectrum chose that approach over global capitation. Mr. Fifer said that Spectrum has some global risk contracts; however, such arrangements are so broad that they have not driven changes in care delivery. Spectrum’s belief is that a few defined episodes of payment can serve as a catalyst for more integrated care.

—*Disease management outside of an integrated system.* A participant asked if it is possible to provide coordinated disease management if the providers are not all under one roof. Dr. Byrne believes that it is possible. He noted that even though Spectrum is under one roof, much of the care it previously provided had been highly fragmented. He believes that through contracts and coordination it is possible for multiple providers to work together to deliver effective chronic disease management under a bundled payment model.

—*Other payers getting a free ride.* Only 20% of Spectrum Hospital’s admissions are enrollees in their own Priority Health plan. Mr. Fifer admits that if his physicians are successful in significantly reducing the complications of chronic diseases, it would create a “windfall” for Medicare, BCBS, and other private payers through reduced utilization and spending across the system.

Key Issues in Expanding Medicare Episode Payment Policies

Panelists: **Francois de Brantes**, *President, Healthcare Incentives Improvement Institute*
Christopher Tompkins, Ph.D., *Associate Professor, Brandeis University*

Moderator: **Robert Mechanic, MBA**, *Executive Director, Health Industry Forum, Brandeis University*

Overview

Stakeholders believe CMS should join existing private episode payment programs to add scale and credibility to these efforts. CMS should also quickly expand the ACE program to cover new markets and additional services. The Innovation Center should establish multiple episode payment pilots that include both prospective payment and more flexible retrospective models that allow a wider range of providers to participate. It should drive experimentation across a wide range of providers, and then rapidly diffuse findings about what's working to the broader community.

Context

Rob Mechanic facilitated a conversation among two panelists: Chris Tompkins and Francois de Brantes and Forum participants to examine key themes raised in the earlier case studies in greater detail. Particular attention was focused on specific actions that the new CMS Innovation Center could take to facilitate expansion of episode payment.

Key Themes

- **Aligning incentives is what makes delivery system innovation possible.**

Rob Mechanic observed that actors in today's healthcare system are often in conflict. Payers battle with providers, hospitals battle with doctors, and patients—who seem to want nearly unlimited services at no cost—feel like they don't receive the support they need. Yet all want better, safer, more coordinated medical care that leads to superior health outcomes. But if each constituent only looks out for their own financial interest, it will be virtually impossible to change healthcare delivery.

"These actors shouldn't be at each other's throats, but misaligned financial incentives drive a whole host of conflicts."

— Rob Mechanic

Mr. de Brantes argued that incentives drive function, and function drives form. Thus, changing how the healthcare system operates starts with changing the incentives. Baptist Health System's Michael Zucker added that for years his health system has been trying to reduce costs, but that the physicians weren't interested. The ACE demo changed this by creating an alignment of incentives that did not previously exist. The mindset of physicians has completely changed, evidenced by physicians now actively suggesting ideas to reduce costs.

- **Episode definitions must balance the desire to completely align care against more incremental bundles that may be easier to administer.**

Paying for comprehensive care bundles will drive integration, but may be too difficult for many providers, especially when it includes post-acute care. Participants debated the merits of

whether to bundle post-acute care together with hospitalizations, separately as unique care episodes, or not at all. Stuart Altman described a similar debate when developing the DRG payment system in the 1980s. But he emphasized that ignoring post-acute care altogether "seems too small." We need to expand beyond the ACE model.

The argument for a comprehensive bundle is that it would better align delivery across settings and reduce variation in the cost of services delivered after discharge. According to the panelists, post-acute services represent approximately half of Medicare's total cost of care for the orthopedic procedures discussed in the case studies. A comprehensive episode payment would drive better coordination at discharge and potentially lead to infrastructure investments like EMRs in rehab and skilled nursing facilities.

Other participants advised a more incremental approach. Many hospitals are not ready to form partnerships with post-acute facilities. The mix of providers and services is different in every region, and a national Medicare policy that bundles post-acute care with inpatient DRGs and Part B physician payments would result in highly divergent outcomes across local communities, placing great financial pressure on areas with concentrations of more expensive institutional providers. Consumer advocates worry that bundled payments could limit patient choice: what happens when a Medicare patient travels to a regional medical center for care, but wants to recuperate in a local post-acute facility that is not affiliated with that hospital?

- **Participants believe Medicare should develop pilots with prospective episode payments as well as others that simulate episodes with retrospective settlements.**

Many people envision episode payments as a single lump-sum payment made to a specific provider organization (typically a hospital, medical group, or third-party administrator). Critics argue, however, that most provider organizations are not prepared to distribute a bundled payment to all providers that treat patients during the course of an episode, something that would require them to establish a payer-like relationship with other providers.

A prospective episode payment system should work well for integrated delivery networks with employed physicians. It is also relatively straightforward for payers like Medicare to administer. But focusing only on a prospective model may limit the number of groups that are willing to participate. As one participant put it, "My docs would say, 'I'll be damned if I have to wait for the hospital to pay me.' And the converse is also true."

Another approach is to establish prospective episode budgets but to continue paying providers fee-for-service with a retrospective settlement process. Providers would continue billing for services throughout the episode and receiving payments. Payers would periodically aggregate claims and calculate whether there is a net surplus or deficit compared to pre-

established episode budgets. Payers would then distribute surpluses or collect deficits from individual providers based on their contribution to the episodes.

This retrospective payment method has the advantage of allowing a broader range of provider organizations to participate in episode payment without individual contracts for each provider—just an agreement on how to handle the net differences. Critics argue that such a process is complex to administer and can be politically challenging—especially if groups generate deficits. In comparison to prospective payment, this approach may create weaker economic incentives if bonus payments occur long after the conclusion of episodes. While participants expressed different preferences, most believe that CMS should make both options available, with providers choosing the best option based on their situation and preference.

▪ **The CMS Innovation Center can act immediately to expand what is already working.**

Professor Tompkins argued that Medicare is almost insolvent. Because of this, CMS should feel a sense of urgency for using payment policy to drive health system change. This includes advancing new policies, re-training physicians to accept alternative forms of payments, and putting pressure on prices in Medicare fee-for-service. Panelists and participants offered numerous suggestions for the CMS Innovation Center, including:

—*Expand ACE.* Mr. de Brantes and other participants see expanding the ACE programs to other markets as a “no brainer.” CMS could also expand the number of DRGs eligible for episode payment within ACE. Greater participation will lead to competition in local markets, help drive system change, and acclimate more providers to episode payment.

“There are many things that are not difficult to scale. This is not about innovation. It is about saying, ‘It’s about time.’”
— Francois de Brantes

—*Provide options for all providers, not just the head of the class.* Different organizations are in different places in their ability to prepare for episode payment; some could be ready to participate in 90 days while other organizations might take a few years. However, Mr. de Brantes believes that CMS should be able to determine best practices and provide a toolkit that enables organizations to move relatively quickly.

“If you want to go fast, start where people are now and show them how to grow and evolve.”
— Francois de Brantes

Rather than promulgating a one-size-fits-all approach, CMS should develop several episode programs with different structures to allow providers of all levels of sophistication to participate. Dr. Tompkins said that scaling episode payment widely isn’t about creating a program that applies to those at the very head of the class; it is about getting broad participation from all types of providers, from stand-alone medical groups to integrated delivery systems. Rob Mechanic termed this a “portfolio approach” with different structures for different types of players.

“The Innovation Center should meet the world where it is at right now.”

— Christopher Tompkins

Another participant suggested that CMS could define small, medium, and large episodes (for different types of procedures) and set different time periods for each bundle, ranging from perhaps 30 days to one year. The rates for each would differ. Providers could then determine which bundle and time period they were comfortable with. Such a program could probably be implemented quickly.

—*Focus on the diffusion of what works.* Several participants commented that the role of the Innovation Center should not be limited to just identifying what works. CMS should also focus resources on actively disseminating these lessons across the healthcare system, something the industry has historically not done well. Best practices from innovators and early adopters should be shared broadly.

▪ **Participants encouraged the Innovation Center to think and act both big and small.**

Participants want to see the Innovation Center focus on activities that are broad, scalable, and have potential for fundamentally changing healthcare delivery. However, major changes often start with small experiments. CMS should work with private payers to enroll Medicare beneficiaries into existing episode-payment programs.

Mr. de Brantes suggested that the IHA program in California, Spectrum’s bundled payment initiative in Michigan, and CaroMont’s project in North Carolina would welcome Medicare fee-for-service patients. Adding Medicare patients would provide these programs with far greater scale and would send a strong signal to the market. Mr. de Brantes sees little reason why this couldn’t happen quickly. (Representatives from CMS indicated their interest in partnering with commercial plans.)

Therefore, the Innovation Center should be actively involved in seeding experiments, seeing which ones are working, and rapidly expanding and scaling those that are working. A participant said there should be a divergence of experiments across the country, followed by a convergence: “Let’s have a thousand flowers bloom, but not all in one place.”

Other Important Points

▪ **Transferring lessons to the rest of Medicare.** One participant observed that three of the episode payment case studies dealt with orthopedic procedures. These programs generated lessons about improving quality and lowering costs that CMS could help disseminate across Medicare providers. Examples include having device vendors engage in competitive bidding, having a pre-operative assessment process, and ensuring that patients receive an appropriate level of post-acute care. While episode payment sets a price for the episode and aligns incentives, CMS could take the lessons learned and create new orthopedic guidelines that would go into practice immediately. CMS could tie reimbursement for orthopedic procedures to compliance with specified guidelines.

Automating Episode Payments Through a “Claims Engine”

Presenters: **Gilbert D'Andria**, Vice President, MedAssets
Sheila Stewart, Director, Data Analysis, Trailblazer Health Enterprises
Jay Sultan, Associate VP Applied Analytics, The TriZetto Group

Overview

For provider organizations and health insurers to engage in episode payments beyond small pilots, they need a software platform that can aggregate claims for the multiple services and providers that occur during an episode of care into a single bundled payment. Automating these systems requires careful design choices. The software examples that were shared are layered on top of existing fee-for-service claims payment systems, but provide users with flexibility to implement different bundling logic along with robust reporting.

Context

Representatives from two software companies and a Medicare Administrative Contractor (MAC) described how their systems are helping payers and providers administer episode payments. MedAssets is a software company that provides products to more than 4,000 hospitals and health system-owned payers in the United States; TriZetto's claims software processes more than 60% of all commercial insurance claims; and Trailblazer administers Medicare claims, as well as payments for providers in the ACE demonstration. The panelists discussed current efforts to establish scalable claims engines for the private sector, as well as the implications of these experiences for Medicare payment initiatives.

Key Themes

- **The wide-scale adoption of episode payments requires a software platform that is readily scalable across multiple organizations.**

While each company represented on the panel primarily serves a different customer segment within the healthcare system, all see the need to develop technology to enable episode payments. Fundamentally, a “claims engine” automates the process of identifying episodes, accounting for all of the services that are part of each episode, and calculating payments. Both MedAssets and TriZetto have invested millions of dollars creating software systems specifically for this purpose. While these two organizations have developed different products with different feature sets, they both agree that product-design decisions must solve several issues:

- Building on the existing fee-for-service payment system.* Rather than require payers and providers to completely redesign core claims systems, episode payment software must be layered on top of the current systems that reimburse providers based on submitted claims for each visit, procedure, or service.

“The technology has to fit with the existing fee-for-service system”

— Gilbert D'Andria

- Determining if a specific service is part of a bundle.* Episode payment logic must recognize which services trigger the start

of an episode and separate related services from the other care a patient may receive. For each claim, the system automatically determines whether or not it is part of a defined episode. Several private organizations have developed episode definitions for commercial payers; CMS recently contracted with several such firms as well as academic organizations to develop a public domain episode grouper that will work for more medically-complex Medicare beneficiaries.

- Determining a price for a bundle.* For a knee transplant, the cost of providing the surgery and rehabilitation is quite different depending on whether the patient is a relatively healthy 30-year-old athlete or a 65-year-old retiree. Some software systems set a patient-focused, risk-adjusted budget when each new episode is created. Other algorithms define an episode narrowly to ensure a homogenous patient population. With the proper budget set, all subsequent claims can be assigned to that bundle as care is provided.
- Tracking payment prospectively or retrospectively.* These technologies must give users the flexibility to track, monitor, and reconcile payments prospectively or retrospectively. Prospective payment can be made to a single entity once the episode is triggered, or multiple case rates can be sent to multiple providers for the future care of a specific patient.

In retrospective systems, insurers can use the software to continue to pay individual claims and debit each payment against a virtual budget. Withholds can be implemented to help ensure that there is money remaining in the budget at the final settlement. Alternatively, pre-determined algorithms can make settlement payments based on attribution logic.

- Giving users robust reporting capabilities.* Providers need to know how they are performing within each episode. Reporting enables providers to monitor if the claims for specific types of episodes are greater or less than the budget, both at a patient and a provider level. Reports must also include information on services provided by non-integrated physicians and facilities. For example, the recipient of a bundled payment should quickly know if the patient is re-admitted for complications at a different hospital or sees a specialist outside the network. And reports should also include utilization and quality metrics, which may even be used to modify payments based on a performance or quality scorecard.

Importantly, episode payment systems must offer users great flexibility to suit the circumstances and contracts of each provider. This includes flexibility in defining and configuring bundles, deciding if payment is prospective or retrospective, customizing payment adjustments and attribution, and providing specific operational reports.

▪ **The speed in which payers can implement an episode claims engine depends largely on the capabilities of existing software systems.**

The panelists estimated that commercial claims engine software can be implemented in as little as a few months. But the sophistication of the current infrastructure and the availability of IT staff can substantially affect the speed of adoption. The implementation of these systems is greatly aided by the receipt of claims in a standard format. Insurers need to have complete and accurate eligibility information, as well as a unique identifier for each patient (family IDs will not work with patient-specific bundles). Full medical and pharmacy data also significantly improves the ability to risk-adjust episode payments. Also, coding inaccuracies in fee-for-service claims can get amplified in episode payment models.

For the private insurers serving as Medicare Administrative Contractors (MAC) on behalf of CMS, the software systems used to pay Medicare fee-for-service payments have become customized over the past 20 years to serve the unique characteristics of Medicare payment. The speakers worried that the limitations of the current MAC claims-processing capability will prove to be a barrier to progress, not just for episode payments, but for all areas of innovative contracting.

▪ **CMS must update current claims-processing technology or develop a compatible claims engine in order to implement large-scale episode payment programs.**

The panelists offered the following recommendations to CMMI:

- Focus on the process and behavioral barriers to innovation within the federal government.
- Create incentives for MACs to update the technology used to process traditional Medicare claims.
- Provide commercial plan applicants waivers to regulations inhibiting payment innovation, such as the OIG prohibition on gain-sharing.
- Allow Medicare Advantage and managed Medicaid populations to be included in the commercial initiatives for payment bundling. Mr. Sultan commented that the commercial payers are already experimenting with bundled payments. CMMI should move quickly to include Medicare and Medicaid patients in these experiments.

"Including CMS in [bundled payment] pilots would make a big difference."

— Jay Sultan

- Use CMMI resources along with the resources of commercial plans to studiously measure quality.

Participant Discussion

- **Working from existing claims.** One participant argued that bundled payment systems have to work from existing claims because that is where member eligibility information, as well as other important data, resides. Just paying the entire bundle prospectively could result in a loss of visibility. Mr. Sultan responded that even in prospective systems, claims are important to generate individual encounter data; no one is advocating any system that removes or suppresses existing claims systems.
- **Providers' cash flow.** In contemplating bundled payments, physicians, hospitals, and other providers are extremely concerned about their cash flow, as it can impact their bond ratings. This may be one reason why they would prefer prospective payments or prospective budgets and retrospective reconciliation while maintaining fee-for-service payment.

Opportunities for New Federal Episode Payment Initiatives

Moderator: **Robert Mechanic, MBA**, Executive Director, Health Industry Forum, Brandeis University

Context

Rob Mechanic reminded participants of the initial charge from Dr. Gilfillan, reiterated several key themes that emerged during the course of this Forum, and asked for additional input from participants about strategies and key considerations for the Center for Medicare and Medicaid Innovation as it begins to develop new episode payment programs.

Charge from CMMI's Acting Director

At the beginning of the meeting, Dr. Richard Gilfillan asked participants to articulate strategies for the industry to redesign currently fragmented care processes and to create new payment initiatives that would be feasible and economically sustainable. In addition, Dr. Gilfillan asked for input regarding CMMI's priorities for designing new payment initiatives and invited participants to identify mechanisms for the industry to work together with the Innovation Center.

What Should CMMI Do?

During the course of the day, the following themes emerged on actions that CMMI should take related to episode payment:

- Send a strong signal to the market that CMS plans to pursue episode payment on a large scale. This will help motivate providers by signaling that business as usual will not continue
- Join existing private sector bundled payment projects. Bringing CMS in as a partner will bring significant patient volume to these programs and motivate significantly more private sector participation.
- Immediately expand the current ACE demonstration and rapidly develop an extended ACE program that includes post-acute care.
- Conduct an immediate comprehensive review of MAC capabilities to implement episode payments and initiate an RFI for solutions that would enable both an expanded ACE program and other new episode payment programs.
- Coordinate CMS initiatives and regulation with other regulatory agencies, particularly around gainsharing and antitrust.
- Make targeted R&D investments in activities that will facilitate standards that will help guide the industry – in such areas as episode design, episode-based quality metrics, and new patient engagement models.
- Develop a series of different episode payment pilots with sufficient flexibility to allow organizations at different stages of readiness to participate.
- Invest in capacity to produce more timely Medicare data to support participants in upcoming payment pilots.
- Create incentives for transparency of cost and best practices.
- Reduce regulatory barriers for participants by coordinating CMS initiatives with other regulatory agencies and create a process for rapidly improving waivers and safe harbors for gain sharing in private sector programs.

Additional Comments From Participants

- Incentivize alignment and clinical integration.
- Design new technologies for administering episode payments that are unencumbered by existing legacy systems.
- Design pilots with the intent of scaling them.
- Pursue the tremendous opportunity that exists in chronic care as this is where most money is spent.
- Educate physicians about the economics of healthcare and where opportunities exist for savings.
- Expand the use of reference pricing. Its use in California has made a big difference in a short period.
- Drive change both top down (with leadership support and incentives) and bottom up (through cultural change).
- Focus on how fast, with CMMI's help, an organization can get to where the early adopters are in accepting episode payment.
- Establish metrics to be achieved by providers who participate in episode payment and then give providers flexibility in how to achieve these metrics.
- Offer a phased set of episode payment options for providers of different sizes and levels of sophistication.
- Test both prospective episode payment and episode-based pay-for-performance with FFS payments combined with potential bonuses based on retrospective analysis of performance on episode-based budget targets and quality measures.
- Be aware that those who are doing well in the current system will fight to oppose change.
- Think about how to create pockets of engaged, motivated physicians on a local level. The success of these physicians will spread and others in the same geographies will then also want to participate in bundles. Through word of mouth enthusiasm will grow organically.