With the Supreme Court’s upholding of the Affordable Healthcare Act (ACA), all eyes have now turned to the industry to see whether this law can truly improve the health status of our nation. In 2014, major changes are expected to occur, including state health insurance exchanges and Medicaid expansion. Thus, many observers have remarked that the ACA’s focus is more about improving access to health care, as opposed to the delivery of that care. By providing more Americans with access to a healthcare system that rewards volume instead of quality or value, there are valid concerns the ACA may exacerbate the problem of rapid cost growth. In response to the challenge of paying for public programs and private health insurance, several initiatives have already emerged to improve value in our health care delivery system. We believe that bundled payments are a critical piece of the solution that can provide a framework for high-value providers to be awarded for quality and cost efficiency, rather than being penalized as a FFS system would do.

Our payment system is primarily fee-for-service (FFS), which is designed to reward more volume and has been effective in driving more services. While FFS is in many ways dysfunctional, it is familiar to providers, employers and members. It is well supported by current claims systems and processes and does not require providers to assume any degree of risk. Therefore, while we think these new paradigms are superior in many ways, it is likely that FFS will exist for some time to come.

1. Transforming provider payment – P4P vs. global budgets

The challenge now is about how best to transform our system to one that rewards value. This challenge is exacerbated by fragmentation in the delivery system, in which each participant, whether physician, hospital, laboratory or drug or device maker, seeks to maximize its own piece of the pie while ignoring consequences for other participants. Also, there will be new losers in a transformed system, namely those who provide duplicate tests, care that is shown to be ineffective, or treatment of avoidable complications. So, it is not surprising to see some resistance to change. And while integrated systems like Kaiser, Mayo and Geisinger have well deserved reputations for providing care that is both clinically excellent and high value, many of these institutions have employed physicians on staff. These models are not representative of where the rest of the country stands today or where it is likely to be over the next decade. Past attempts at major payment reforms, such as capitation, focused primarily on shifting risk from payers to providers. Many people have memories of the 1990s version of capitation in which patients had insufficient access to appropriate care and a tremendous backlash emerged.1

Fortunately, it is a new world in 2013: not only have healthcare leaders learned from their past experiences, but Electronic Health Records and informatics tools have improved the ability to “risk adjust” payments. These did not exist a decade ago and allow for both more sophisticated and more timely evaluation of new care delivery models so that both quality and cost can be measured and optimized on an ongoing, versus purely retrospective basis. We care about cost certainly, but no one wants to compromise on quality. As a result, virtually all of the clinical initiatives in today’s world of outcome-based payment include meaningful quality metrics that must be met in order for the providers to receive their full compensation. There are also national and even international initiatives underway, such as the recent inception of the International Consortium for Health Outcomes Measurement (ICHOM). Founded in 2012 by Michael Porter’s Institute for Strategy and Competitive-ness at Harvard Business School, Sweden’s Karolinska Institute, 1 Frak AB, Mayes R. Beyond capitation: how new payment experiments seek to find the ‘Sweet Spot’ in amount of risk providers and payers bear. Health Affairs 2012;31(9):1951–1958.

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and the Boston Consulting Group, the ICHOM’s goals include providing a global resource of current outcome measures and risk-adjustment factors by medical condition so that those undertaking new care delivery models can learn from others’ work across the globe.2

As we attempt to move the system away from fee-for-service, most efforts have focused on one of the two frameworks: enhanced fee-for-service with incentives, or global population-level models such as capitation. The former, frequently referred to as Pay-for-Performance (P4P) has the benefit of being relatively easy to implement, built on the current “fee-for-service chassis”, but has met with mixed success. These programs have been hampered by a number of challenges including failure to put a sufficient proportion of the dollars at risk, the use of convenient and generally easy-to-measure targets like process measures versus true outcomes that matter to the patient, and even more so by the fact that the same elements that influence the overall negotiations between payer and provider also impact the choice of metrics. So, it should not come as a surprise that many of these tactics have failed to truly drive the delivery of high value care.3 More recent efforts, such as the movement around primary care practices transforming to become Primary Care Medical Homes, also build on fee-for-service payments,4 generally through the addition of a population-based care coordination fee; and of note, there are a number of published studies attesting to their impact on quality (generally positive) and cost (mixed results to date).5

At the other extreme, many sophisticated systems have entered into agreements that reward them for managing populations. There are a number of varieties, including full risk (accepting a fixed payment for providing services to a population), partial risk (sharing the risk with the payer, commonly 50%), and shared savings models (which reward the provider entity with half of the financial savings, versus what is experienced in a control population and which may not penalize the provider if expenses exceed those in the control setting). While there are many examples of provider systems effectively managing patient care in these types of models, meeting both savings and quality targets, there are a number of constraints as well. Many highly respected provider entities do many things well, but there are few if any that can legitimately claim to do all things well, particularly for uncommon conditions where it may be impossible for more than a few select provider systems to maintain sufficient volume to maintain both expertise and cost effectiveness (which can depend on having sufficient capacity utilization of high cost specialists and equipment). And, integrated systems that are receiving a global payment may be loathe to effectively outsource elements of care to competing organizations, regardless of whether they deliver higher quality, more cost effective care than the “home team.”

Many have touted the benefits of “bundled payments” that provide a fixed payment for an agreed-upon episode of care, although there has been more talk than action. While systems like Geisinger have shown that this framework can be effective through their much publicized efforts, the Geisinger ecosystem possesses characteristics that facilitate their ability to execute (i.e., having a wholly owned health plan, as well as provider organization and a strong organizational culture that seeks to maximize outcomes versus dollars). Despite the challenges, interest runs high for a number of reasons. First and foremost, physicians participating in a global payment agreement have an opportunity to evaluate the entire clinical pathway; and by taking actions to make changes that eliminate inputs that do not add value, unnecessary pre-operative laboratory tests for example, they have the ability to redirect dollars to other areas, which may include professional fees. In the fee-for-service world, physicians have little incentive to reduce utilization of low value inputs that are paid for by someone else, particularly if doing so would take effort on their part, but in the bundled payment world, they are able to share in the benefits of reducing post-operative ER visits or readmissions. In addition, it is well established that institutions that have focused on bringing together disparate provider types (such as the Cleveland Clinic, which has moved from traditional departments to Institutes that bring together all of the providers involved in a specialty area, such as cardiovascular medicine or ophthalmology) can frequently demonstrate both high quality and low cost. These systems are arguably positioned best to benefit from moving to global payments. Furthermore, provider systems are generally focused on growing, particularly in those service lines in which they excel, and many have therefore shown interest in this approach as a way to reach more patients.

2. Implementation of bundled payments

While there are other pockets of experimentation, we have yet to see broad implementation of bundled payments, in part because of the need to work differently with the payer community. For example, an attempt by Prometheus, now known as HC13, to develop a financial modeling approach to support the development of bundled payments, was widely criticized for its complexity and “black box” approach, after initially receiving a great deal of attention within the provider community. It has also become apparent that payers’ support is critical, given not only the necessity of changing how claims are paid to allow providers to benefit from focusing on quality, but also to inform its members of the availability and desirability of these care delivery sites. Without a health plan willing to pay differently, improvements that result from the provider-led improvements will accrue to others. Health plans generally understand the benefit of these care delivery models, but they are hamstrung by limitations such as claims systems that were set-up to handle individual claims and not global payments, as well as a contracting mindset that may not be open to new ways of collaborating. Plan designs that tie co-pays to individual interactions further complicate matters as well, but these can be managed through tactics such as waiving member liability for those who choose to seek care from these high-value providers. The operational challenges, while real, may be easier to surmount than cultural barriers, given that implementing these types of programs requires a high degree of collaboration between provider and payer, as well as a degree of trust. In many cases, there are long histories of contentious negotiations over fee schedules and the existence of “win-lose” mentalities that must be overcome if we are to, together, move beyond fee-for-service.

At Harvard Pilgrim Health Care, a regional, not-for-profit payer serving over one million members in New England, in an environment that is noted not only for both its outstanding qualities, but unfortunately also for high cost,6 the provider system here is fairly

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2 This information may be found at [www.ichom.org](http://www.ichom.org) and is available to interested parties without charge.

3 As examples, consider recent negotiations in which provider groups who perceived themselves to be in positions of strength argued for measurement targets that were below their current rates or proposed measures that were clearly ludicrous (such as a proposal – very quickly rejected – that called for a quality incentive payment if 97% of primary care visits contained documentation of blood pressure having been recorded – not controlled, simply recorded!).

4 A small number of PCMH pilots have utilized a primary care capitation payment and therefore are not fee-for-service based, but these have been in the minority.


6 Massachusetts is ranked number one among the 50 states for per capita healthcare expenditures. Refer [http://kff.org/other/state-indicator/health-spending-per-capita/](http://kff.org/other/state-indicator/health-spending-per-capita/).
sophisticated, with 65% contracted through global budget/shared savings arrangements, with the remainder under FFS contracts, but with approximately two-thirds of those having pay-for-performance incentives. Despite the challenges, we have chosen to make implementing bundled payments an area of strategic focus and are in various stages of discussion and/or implementation with a number of provider systems, with respect to episodes of care involving conditions such as coronary artery bypass surgery, total joint replacement, rotator cuff repair, colonoscopy and pediatric surgical procedures. We are also in the early stages of developing bundles for chronic care, including care of the diabetic patient and an innovative care model that provides home care to chronically ill pediatric patients, with significant physiologic impairment, whom are cared for primarily in the home setting, many on ventilators. While each bundle has its own nuances, such as the time period for the warranty (during which additional care – including surgery – is provided at no additional cost), each of these efforts is characterized by a high degree of collaboration with physician leadership and a shared accountability for defining the bundle as well as the quality, cost and satisfaction metrics. While it is our expectation that data generated from these endeavors will support expansion of this approach more broadly across our network, there needs to be an explicit understanding that these early initiatives are pilot programs requiring some element of “course correction” as providers and payers both learn from shared experience. When we face challenges such as what element of risk the provider system is undertaking by, for example, taking clinical and financial responsibility for ER visits related to the course of care, we frequently remove barriers by agreeing to proceed, but agreeing also in principle that if we find that one side is being financially disadvantaged because of unanticipated utilization patterns we will re-open the bundle definition. Another tactic used to limit risk is to agree upon a specified time period or number of cases before an assessment – and potential bundle revision – is scheduled to take place.

The build-up of these care delivery models is fairly complex and requires a significant time commitment, particularly the first time one seeks to evaluate a new clinical area; from a six to nine month time period is probably realistic, and that is with biweekly or even more frequent meetings taking place. It should also be noted that agreeing on a bundle involves not only more than just determining the trigger event, such as a decision to perform surgery, and agreement on a time interval (such as 30 days preoperatively to 365 days postoperatively), but also discussion of a host of other elements. For example, there needs to be an approach to adjusting payment, based upon underlying severity. Some techniques that have been employed are (1) excluding any patient that falls outside of a precisely defined set of characteristics, (2) dynamically adjusting the case rate to reflect co-morbidities, or (3) having multiple categories, even with a different reimbursement amount. Of these, we favor the third approach with no more than two or three categories for a given bundle, and continuing to pay on a fee-for-service basis for those with less common, high acuity conditions or risk factors. In practice, it is generally useful to begin with the less severe patient population and expand once experience has been gained. It is also worth acknowledging that providers generally don’t want to become insurers and therefore need to be protected from catastrophic risk, such as in the case of a patient who suffers from a pulmonary embolus or neurologic event following a surgical procedure. Again, there are many ways to address these situations, but we generally seek to establish a cut-off point two standard deviations from the mean, above which cost is shared (with the health plan potentially assuming full risk at a certain level of spend). Other points to consider include characteristics of a warranty (a rotator cuff bundle currently under discussion is likely to include a one-year warranty, but only if the patient gets all of his or her physical therapy from a designated provider, for example) and how to treat related care that occurs at nonaffiliated practice sites (which most philosophically agree should be included in the bundle, but which adds some degree of uncertainty based upon patient behavior).

Ultimately, we believe that the use of bundled payments to reimburse providers for both procedures and chronic care is the best means to drive value in healthcare. However, this will not be an easy task and many challenges remain. Acquiring a comfort level with the framework for defining episodes of care, managerial skills on the part of the provider entity, data analytic capability, and claims payment infrastructure will take a focused and sustained effort on the part of both health plans and providers. For those who can adapt to these changes and learn how to work together in a collaborative fashion, the rewards will be significant.