

Alternative Payment Models: Bundled Episodes of Care

Request for Information Findings Report



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Purpose of this Report

On April 21, 2017, the Washington State Health Care Authority (HCA) released Request for Information (RFI) 2232 for Bundled Episodes of Care Programs. The intent of the RFI was to seek input from the Washington State provider community to help inform future value-based purchasing and payment strategies, specifically, those related to bundled episodes of care models. HCA hoped to gather information from the provider community regarding their knowledge, experience, and expertise in creating, implementing, and offering bundled episodes of care. The information gathered, including input from the provider community, will inform HCA's VBP purchasing roadmap, which will guide HCA's procurement and implementation efforts over the next few years.

HCA created this report to engage the purchaser, payer, and provider communities in the discussion around bundled payments for clinical episodes of care and how bundled payment strategies play a key role in value-based purchasing. HCA wants to provide purchasers, payers, and other stakeholders with information gathered from the responses to the "Bundled Episodes of Care Programs" Request for Information number 2232.¹

In this report you will learn:

1. Which providers (those who responded to our RFI) have experience and/or plan to offer bundle product to purchasers
2. The current state of bundled episodes of care in Washington
3. Common trends amongst responders
4. The Health Care Authority's next steps in developing bundled payments

Introduction to Bundled Payments

For more than 30 years, bundled payments have been attempting to transform the way clinical episodes of care are paid. Throughout those years, bundled payments have emerged in a variety of different approaches; each had their own successes, as well as areas for improvement. Regardless of the outcome of the different bundles, one thing is clear, the health care community was able to learn something from each one and capitalize on those experiences in creating the next bundle. Since Medicare's nation-wide introduction of diagnosis related groups (DRGs) in the early 1980s, there have been a number of episodic targeted bundles created.

Catalyst for Payment Reform defines a bundled payment, also known as, "Episode based payment" as, "[a] single payment to providers or health care facilities (or jointly to both) for all services to treat a given condition, or, to provide a given treatment. Providers assume financial risk for the costs of services for a particular treatment or condition as well as costs associated with preventable complications." Ultimately, bundled payments creates a tie between providers assuming financial and clinical risk for the services they provide under the bundled episode of care, and the need for providers to implement evidence-based care best practices and eliminate unnecessary services. There are many variations in defining a bundled episode of care. In creating a bundle, it's important that the different components are clear and the parties involved agree to them.

HCA released a Request for Proposal (RFP) in November 2015 in solicitation of one or more health care providers and or network of providers to become the contracted Center of Excellence for knee and hip replacements for Uniform Medical Plan Classic and Consumer-Directed Health Plan (CDHP) Members. HCA's expectation was for the contracted provider(s) to have the capability and demonstrated experience to deliver a high-quality, evidence based knee or hip replacement bundled episode of care and warranty based on the Dr. Robert Bree Collaborative recommendations. The contractor(s) also needed to have the capability to produce and report on health outcomes, and be financially and clinically accountable for the complete total knee or hip replacement bundled episode of care to include physician and hospital care.

¹ See Washington State Health Care Authority in the Works Cited for a link to RFI 2232 and related materials.

HCA Paying for Value

HCA, the largest health care purchaser in Washington State purchases care for over 2.2 million individuals through Apple Health and for state employees and their families. As directed by the Washington State Legislature through ESSB2572 in 2014, HCA has increased the use of value-based purchasing and payment in the pursuit of increasing access to high-quality, high-value care to Apple Health and state employees. HCA has an ambitious purchasing goal: move 90 percent of provider payments in state-financed programs and 50 percent of commercial insurance to value-based payment arrangements by 2019, as defined by HCP-LAN Framework 2c-4b. HCA is also using its purchasing power to drive health transformation statewide, by inviting other purchasers to implement alternative payment strategies like bundles for their employees.

The Bree Collaborative

To accomplish its purchasing goal of “Paying for Value,” HCA is implementing evidence-based purchasing strategies including alternative payment models developed by the Bree Collaborative. The Bree Collaborative is a multi-stakeholder group in Washington State that was established in 2011 by the Washington State Legislature through passing Engrossed Substitute House Bill 1311 to, “...provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State.”

All of the Bree surgical bundles include clinical and quality components. These components are used to ensure:

- a. The patient is appropriate for surgery based on the documentation of their disability;
- b. Meets the fitness requirements prior to surgery;
- c. The surgical team is using evidence-based practices to avoid complications; and
- d. There is a standard process in place post-surgery to continue to avoid complications and unnecessary readmissions, and help the patient have a rapid return to function

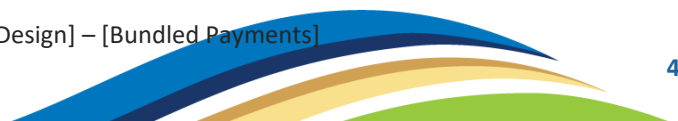
All of the Bree surgical recommendations also include a 90-day post-discharge warranty. Each warranty is specific to the clinical episode and is based on complications that are related to the episode of care that arise during specific time periods post discharge (7 days, 30 days, 90 days).

Retrospective vs Prospective Payment

Most health care providers have experience with retrospective payments based on a fee-for-service reimbursement system, mostly through bundle initiatives led by the Centers for Medicare and Medicaid Services. Under the retrospective payment model, providers are paid on a fee for service basis for services related to the bundle. At the end of the year, there is normally a financial reconciliation with the potential for shared savings depending on whether claims costs were above or below an established target.

Prospective payments require health care providers and payers to agree on a fixed price up front for a set of procedures that are identified as being included in the episode of care

In the context of a bundled payment, prospective payments would require the provider(s) to determine which services are covered under the bundled episode of care and what the total cost of care for providing those services is. If not all services are necessary as part of the bundled episode of care, and the cost of care is less than the agreed upon price, the provider is still paid the full agreed to amount. The same applies if the services the provider renders end up costing more during the episode of care, the provider is still paid the same amount, but, the provider might lose money. This is one reason why having set criteria for appropriateness and fitness for surgery, such as those found in the Bree recommendations are so important in determining whether or not a patient qualifies to participate in a bundled episode of care. Prospective payments also allow providers to build in an outlier threshold to provide some protection, while still holding providers accountable for the quality of care they provide.



Request for Information Findings

HCA released a RFI on April 21, 2017; responses were due June 15, 2017. In the RFI, HCA reiterated the goal to continue its efforts to transform the state’s health care purchasing strategies, and their focus on high-quality care focused on patient safety and outcomes. The RFI sought to gain knowledge and experience from the provider community within Washington State and included 6 sections pertaining directly to information around bundled episodes of care: Development and Experience; Process; Clinical; Outcomes; Payment and Finances; and Feedback for HCA.

Respondents

HCA received a total of fifteen (15) responses from providers, health plans, and vendors:

Figure 1: Responders

Responders	
EvergreenHealth	Kaiser Permanente Washington*
Overlake Medical Center	Community Health Plan of Washington
Providence St. Joseph Health	Washington State Hospital Alliance
University of Washington Medicine	McKesson
Virginia Mason Medical Center	Navigant
Skagit Regional Hospital	Vestica Healthcare
Seattle Cancer Care Alliance	Liberty Health Partners
Northwest Medical Specialties, PLLC	*cover letter only; no submission

Current State of Bundles

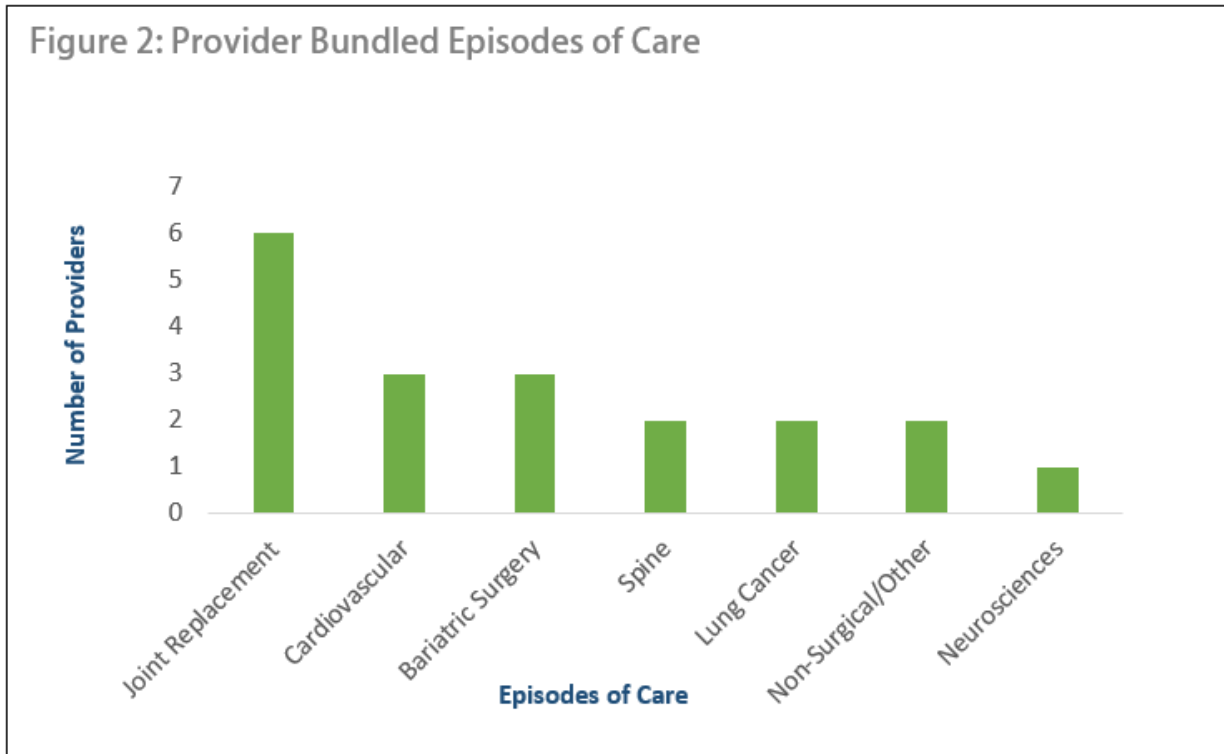
Disclaimer: All of the information in this section is based on the information received from responses to the RFI, and is not an indicator of bundled episodes of care that other providers, health plans, and vendors are developing, implementing, or have available. Due to proprietary and confidentiality requests, not all information received is included in this report. For additional details on any bundle, please reach out directly to the respondent.

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The Episodes of Care

Figure 2 depicts the number of provider respondents participating in each bundled episode of care. Most providers responding to the RFI indicated that they had experience with bundles for total joint replacement, which has been the focus for Centers for Medicare and Medicaid Services (CMS) bundles for a number of years and these bundles are fairly well-defined. Cardiovascular episodes of care are less common, and are not as prevalent, even for CMS.



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Figure 3 shows the spectrum of bundles, the definition (CMS or Bree) payment type, and the types of payers involved. Providers are looking to Bree as well as CMS to provide national guidelines to define the bundles and their clinical quality criteria.

Figure 3: High-Level RFI Findings

Bundled Episodes of Care	Number of Provider Respondents	Criteria	Payment Type	Payers
Joint Replacement	5 fully implemented, 1 preparing to implement	Bree and CMS recommendations	Retrospective & Prospective	Commercial and Medicare
Cardiovascular	3	Bree and CMS recommendations	Retrospective and Prospective	Commercial and Medicare
Bariatric Surgery	3	Bree	Retrospective and Prospective	Self-pay
Spine	1 fully implemented, 1 preparing to implement	Bree	Prospective	Commercial
Lung Cancer	2**	Nationally recognized evidence-based guidelines	Retrospective	Commercial and WA Apple Health
Non-Surgical/Other	2 – Some bundles are fully implemented, others are being developed by the two providers, but are not market ready.	N/A	Prospective	Commercial
Neurosciences	1	Clinical collaborative	Retrospective	Self-pay
Bone Marrow Transplant	1	Varies by network, but each participating facility must meet criteria.	Case rate contracts	Not provided
Oncology Models	1	Nationally recognized evidence-based guidelines; some Bree.	Retrospective, but has features to support the next phase of bundled price development.	Commercial and Medicare

*One provider is preparing to implement

**One provider has bundled the screening for lung cancer



Trend Findings

Improving Care

A clear trend among the respondents regarding their rationale for developing bundled episodes of care is their desire to improve quality:

“Our participation allows us to develop strategies to further improve the health and well-being of a patient population and pursue our goal to transform healthcare.”

“... every patient deserves a high quality experience with the best possible outcome.”

“Bundles replace opinion-based variation among providers with evidence-based standards.”

“... [bundled episodes of care] create standardized best practice pathways for high-volume, low-variation, and repeatable episodes of care.”

Providers' improvement strategies include using established evidence-based care, leveraging their system expertise to create standardized best practice pathways, identifying gaps and inefficiencies, collaborating with different providers who participate in the patient's care, and focusing on ways to improve the patient experience.

Payment

Providers were varied in their feedback regarding the value of bundled payments. They see benefits in maintaining their current retrospective payment structures due to the infrastructure and lead time needed to create successful prospective payment bundles. However, they also understand that for the sake of accountability on the provider's side, a prospective payment allows the provider the opportunity to better define the services that are included and excluded from the bundled episode of care payment upfront, *“... in the longer term, we feel a prospective rate is better for the sake of managing a budget and allowing the accountable party (the one receiving the funds) to then work with subcontractors on their responsibilities and payment terms in regards to services covered by the bundle. This also allows the accountable party to better define what is included and excluded from the sake of taking on the associated risk.”* Some providers mentioned the difficulty of implementing prospective payments outside of an employed model; that is, when the physicians, hospital and other components of the care continuum are not in the same organization:

“Prospective payment is difficult since we do not employ all components of the bundle. It would not be impossible to set-up a process to administer a prospective bundled payment model although it would require additional infrastructure and lead time to be successful.”

“The infrastructure [for prospective payments] required increases with the complexity of the episode: number of external partners, length of episode, etc. Unless a provider has an integrated health plan, they will need to partner with a third party, or create their own infrastructure to register beneficiaries, adjudicate claims from all providers within the bundle, negotiate case rates, and implement third party reimbursement mechanisms.”

If a prospective payment is desired by a payer or purchaser, there are two critical components which were identified by a respondent which HCA agrees with: *“1) a discrete starting point and ending point of the bundle; and 2) a process for handling extreme outliers if and when they occur.”*

Challenges

The most frequently mentioned barrier to creating a bundled episode of care is the need to create a new infrastructure to support it. This infrastructure includes active and ongoing participation from within the organization as well as providers who

work outside of the organization (“The process to implement and operationalize bundled procedures requires active, ongoing participation from the institution, and participating providers, both employed and private practice.”), staff time, new IT systems, or the need to configure current claims and billing systems, and care navigators. More than one provider indicated the importance of volume in order to justify the resources dedicated to creating and working within the bundled episode of care:

“With any new initiative a significant amount of infrastructure and volume is required to be successful. If enough volume is not created through a bundled payment program it becomes difficult to ensure appropriate infrastructure.”

“A minimum threshold is set at 100 cases per year. Risk adjustments and/or guarantees are required if number fall below the threshold.”

“Again, it is important to make sure volumes and reimbursement are sufficient to cover these additional infrastructure needs.”

Conclusion

Experience from CMS, private purchasers, and HCA show a bundled payment model can be effective in improving the quality of care provided and the patient experience, while helping to lower costs. While there are hurdles in implementing bundled episodes of care, purchasers have an important role in ensuring that providers are appropriately rewarded for improving the care and outcomes of their members.

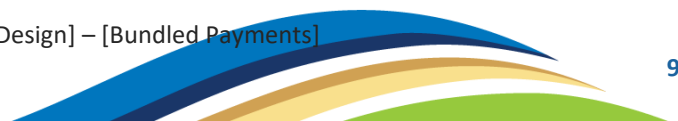
The RFI findings show there are providers in Washington State that have dedicated themselves to developing bundled products. However, without the support of other purchasers and commercial payers, providers and health systems face an increased risk of bundled payment episodes becoming an example of how underlying initial investment without support cannot sustain progressive design demands (i.e. Washington State Health Services Act; failed efforts to broadly implement managed care).

Next Steps

The Health Care Authority, being the largest purchaser of health care services in Washington State is continuing its pursuit in paying for value through bundled payments. In the future, HCA would like to take a collaborative approach to this purchasing strategy to help in developing its value-based road map. In doing so, HCA hopes to gain a better understanding of the opportunities and challenges within the local community.

HCA intends to release a procurement during the first quarter of 2018. The clinical episode of care will be determined based on Public Employees Benefits Board Program data for one of the Bree recommended episodes of care.

Over the next year, HCA will work with providers on adding bundled payments to HCA’s value-based purchasing roadmap.



Works Cited

Catalyst for Payment Reform. "Definitions of Payment Model Terms." *National Compendium on Payment Reform*, 2016, <http://compendium.catalyzepaymentreform.org/compendium-search/definitions-pmt>. Accessed 7 November 2017.

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