Bundled Payment Options in the 2020 Marketplace: A Guide for Employers and Other Health Care Purchasers

A comprehensive report for purchasers seeking to advance effective bundled payment strategies.

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INTRODUCTION

The cost of health care in America is rising at twice the rate of the national GDP.[1] As a result, employers and other purchasers of health care (hereafter "purchasers") are constantly searching for strategies that improve affordability without compromising access, patient experience or outcomes. Although costs are rising across all provider types and settings, inflation is most acute in facility-based care (inpatient and outpatient), where costs have increased by 15% over the past 3 years, versus 10% for all other services combined.[2] What's more, studies have consistently found that approximately one-quarter of health care spend in the United States is due to waste or inefficiency.[3] Given health care's ever-rising price tag and the system's failure to deliver high-quality, well-coordinated care reliably, it's no wonder that purchasers have increasingly sought solutions that utilize episode bundled payment.

Bundled payment programs give providers a single target budget or price for an "episode" of care. The Centers for Medicare and Medicaid Services (CMS) defines an episode as "a set of services provided to treat a clinical condition or procedure, such as a heart bypass surgery or a hip replacement." Bundled payments can be either prospective or retrospective. Within a prospective bundled payment model, program administrators pay providers in advance, essentially capitating payment for the procedure or services to treat a condition; while in retrospective payment models, administrators pay providers incrementally through fee-for-service, then reconcile the total episode cost against a predetermined budget at the end of the episode. Under either format, bundled payment programs are intended to improve cost and quality outcomes by:

1. Holding providers financially accountable to a cost target for the episode of care, and

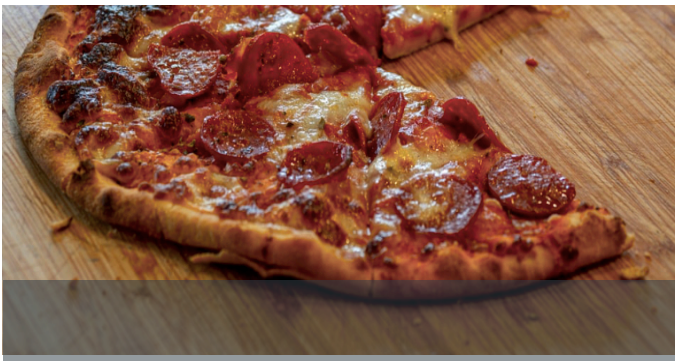
2. Encouraging care coordination and efficiency through a single payment that encompasses all physician and facility services.

"Bundled payment is replacing the inefficient and waste-prone fee-for-service payment model in health care and this disruption has parallels with other industries. For example, **e-commerce disrupted the brick-and-mortar retail model** and Amazon led the charge in the '90s, starting with books. Now, they sell everything online. **We're evolving similarly in bundled payment** in that more procedures and conditions are and will be paid through bundles."

– Sach Jain, CEO, Carrum Health

[1] Milliman (2020). Milliman Medical Index. Available at: https://us.milliman.com/en/insight/2020-Milliman-Medical-Index
[2] Milliman (2020). Milliman Medical Index. Available at: https://milliman-cdn.azureedge.net/-/media/milliman/pdfs/articles/2020-milliman-medical-index.ashx
[3] JAMA (2019). Available at: https://jamanetwork.com/journals/jama/article-abstract/2752664

Catalyst for Payment Reform (CPR) was founded on the principle that we must change how we pay health care providers, holding the health care delivery system accountable for health care outcomes, patient experience and efficiency. Over the past ten years, we've seen a seismic shift in the growth of alternative payment models. When CPR began tracking payment reform among commercial health plans in 2010, only 1-3% of their health care spend was attached to a payment model that rewarded quality. The good news is that, by 2017, more than 50% of health plan payments to doctors and hospitals in the commercial sector were value-oriented; but episode bundled payment had not gained momentum, accounting for only 2% of commercial health plan dollars.[4]



"The fee-for-service market isn't rational. When I sit down at a restaurant and order a pizza, I **don't get a separate bill from the chef, the waiter, and the dishwasher.** I get a single price for the pizza I ordered and they even tell me the price ahead of time."

– James Millaway, Co-Founder & CEO, The Zero Card

Recently, through the Center for Medicare and Medicaid Innovation's Bundled Payments for Care Improvement (BPCI) initiative, there is renewed focus on bundled payment as an alternative payment model. Several factors recently led CPR to want to support purchasers in advancing bundled payment and implementing their own bundled payment strategy, including:

- Promising evidence for effective bundled payment arrangements showing higher quality care at the same or lower cost;
- Health plans were making so little progress with bringing bundled payment to scale;
- A crop of new vendors entering the marketplace offering bundled payment programs;
- More purchasers have an increased appetite to implement a direct or semi-direct contracting arrangement with a health care provider.

We brought a group of sophisticated purchasers (including 32BJ Health Fund, Qualcomm Incorporated, San Francisco Health Service System and Self-Insured Schools of California) together in a small group collaborative to discuss how purchasers could advance effective bundled payment in the marketplace. During the collaborative, we heard from various stakeholders and developed questions and criteria by which to evaluate programs offered by health plans and other vendors. The goals were to signal the interest among purchasers, communicate what purchasers want from these programs, and to help purchasers understand the various options in the market that would enable them to bring bundled payment to their populations.

The final output of this effort is a hands-on toolkit with standard evaluation questions and specifications that purchasers can use to assess health plans and vendors offering bundled

[4] Catalyst for Payment Reform (2019). National Scorecard on Payment Reform, Lookback Edition. Available at: https://www.catalyze.org/product/national-lookback-payment-reform/

payment programs. CPR has piloted this tool by evaluating several health plans and vendor solutions. We intend for this Report to educate purchasers and other stakeholders by sharing the state of the evidence and outlining considerations for a purchaser-led bundled payment strategy.

THE EVIDENCE BEHIND BUNDLED PAYMENT

> A full scientific consensus on the effectiveness of bundled payment programs has not yet been established - most implemented programs are small and less than eight years old. CMS first developed its BPCI model in 2011, and most commercial or Medicaid models have emerged more recently. However, independent researchers have analyzed individual pilots and programs, and even more programs have been self-evaluated. One must examine both quality of care and cost of care when studying a bundled payment program to ensure that the care being delivered is high value.

Published studies suggest that bundled payment initiatives may bring about higher-quality care than traditional fee-for-service payments. These improvements include declines in readmissions, declines in need for post-acute care, and shorter hospital stays. Among participants in the BPCI initiative, a 2017 article shared that readmissions declined 1.4%, emergency room visits declined 0.9%, and episodes with prolonged length of stay decreased 67.0%.[5] Private and Medicaid payers saw similar improvements in quality under bundled payment models. For example, Horizon Blue Cross Blue Shield of New Jersey reported 37% fewer hospital readmissions for hip replacement and 22% fewer hospital readmissions for knee replacement in its episodes of care program.[6] Similarly, Arkansas implemented an episode of care model among Medicaid recipients that covered fourteen

"Historically speaking, American workers rejected the full-risk HMO model. The alternative is episodes of care that create competition among providers, offer transparency in price to consumers, choice among competing providers, and allow for benefit design selection and differentials. **The combination of these factors offers the highest probability of reshaping the delivery system** in an efficient manner that consumers can understand."

– François de Brantes, Senior Vice President, Episodes of Care, Signify Health

[5] JAMA Internal Medicine (2017). Available at: https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2594805
[6] American Journal of Managed Care (2016). Available at: https://www.ajmc.com/focus-of-the-week/njs-horizon-bcbs-pays-3m-in-shared-savings-for-episodes-of-care-readmissions-c-sections-reduced-

episodes, ranging from maternity care to congestive heart failure (CHF) to attention deficit hyperactivity disorder (ADHD). Quality results were largely mixed within each category, though some (such as the overall reduction in cesarean section delivery rate from 38.5% to 31.8% in three years) were very positive.[7]

"There shouldn't be a plan sponsor right now paying more than $25,000 for total hip or total knee replacements, given the availability of public information and the availability of multiple willing providers in a lot of markets."

– Chip Burgett, Senior Vice President, Payer Partnerships, Global One Ventures, LLC

Reductions in length of stay, readmissions and complication rates generate cost savings, so bundled payments that increase the quality of care can also reduce costs. Published studies suggest that bundled payments can bring about significant cost savings for payers, depending on the care episode, and the price they pay for the episode. In a 2016 JAMA publication, authors indicated that mean Medicare episode payments declined by an estimated $1,166 more for BPCI episodes than for comparison episodes (a decline they attribute primarily to reduced use of institutional post-acute care). A 2017 paper found a decrease of $5,577 (20.8%) in total spending per uncomplicated joint replacement.[8] Among Medicaid programs, Tennessee found that episodes of care reduce cost by 3.4% for perinatal episodes, 8.8% in asthma exacerbation and 6.7% in total joint replacement. In total, episodes of care have reduced costs in Tennessee by at least $38.3 million since 2015.[9] In Arkansas, between 2014 and 2015, Medicaid average episode costs fell by 8 percent for Chronic Obstructive Pulmonary Disease (COPD), and decreased by 4 percent for total joint replacement.[7] In the commercial sector, the Pennsylvania Employees Benefit Trust Fund pilot found that non-inpatient claims within the identified episodes were under budget by an average of $4,189 per patient in 2015. These savings were attributed to process improvements for pre-operative and post-discharge services.[10] Due to the overall "newness" of bundled payment, however, nothing in these studies can be interpreted as consistently generalizable. Additionally, several studies have shown results to be mixed or inconclusive with regards to the impact of bundled payment on health care costs and quality, though few have published proven negative findings.

One challenge bundled payment cannot address is whether every episode of care is appropriate in the first place. Providers still have a volume incentive – with each episode of

[7] Arkansas Health Care Payment Improvement Initiative (2017). Available at: https://achi.net/wp-content/uploads/2018/10/Arkansas-Health-Care-Payment-Improvement-Initiative-State-Tracking-Report-Year-3-Full-Report.pdf
[8] CMS (2016). Available at: https://innovation.cms.gov/Files/reports/bpci-models2-4-yr2evalrpt.pdf
[9] TennCare (2019). Available at: https://www.tn.gov/content/dam/tn/tenncare/documents2/EpisodesOfCare2018PerformancePeriod.pdf
[10] Health Care Incentives Improvement Institute. Available at: http://prometheusanalytics.net/sites/default/files/attachments/PEBTF-Case-Study_0.pdf

care comes more revenue. However, these published studies do suggest more bundled payment would be beneficial, though additional experimentation and research will be important over time.

TYPES OF BUNDLED PAYMENT ADMINISTRATORS AND INSIGHTS FROM CPR'S EVALUATION

> Despite the evidence suggesting bundled payment produce cost savings and higher quality care, bundled payment has been slow to gain traction in the marketplace. Multiple factors can explain the lack of momentum from health plans, including limitations in claims processing technology, provider hesitation to accept downside risk, a perceived lack of purchaser demand, and any number of other operational and strategic challenges.

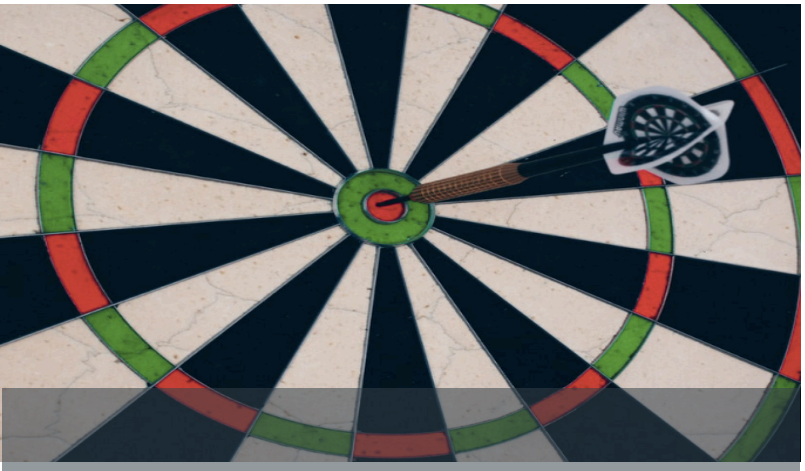
Regardless, the lack of momentum among commercial health plans created an opportunity, paving the way for new entrants to gain traction in the marketplace. Over the course of our research, CPR identified three "species" of bundled payment administrators within the marketplace with whom purchasers may contract: health plans, centers of excellence (COE) vendors, and "hybrid" vendors. Although all three administrators pay providers using bundled payment, they differ significantly in their cost of care strategies, use of quality data, and operational models.

"Implementing bundles is complex. There are many barriers. It takes a lot of work to roll out and operationalize bundles, and change is hard. **Implementation requires different collaboration approaches with providers.** In recent years, providers have been experiencing change fatigue around technology, payment and quality. Market-share of health plan members within a provider practice also presents a challenge to attract and retain attention."

– Erin Keitel, Program Manager, Payment Innovation, Blue Shield of California

HEALTH PLANS

Health plans were first to implement bundled payment programs, but they have been slow to deploy and spread them. Health plans who execute bundled payment contracts with providers may offer prospectively paid bundles, retrospectively paid bundles, or both. Health plan bundled payment programs operate under the assumption that by setting a total cost target for an episode of care, providers will be compelled to communicate with each other, coordinate care more efficiently and implement practices that improve quality and reduce the risk of complications.



"The administrative changes a payer needs to make to implement an episode of care program can be very expensive. **The direct benefit of those changes goes to self-funded purchasers who pay them less than a third of what they make on their insured business**. It also creates a tension in the provider network, which is what they view as their last remaining asset. It's a double negative for a payer to do it."

– Roger Francoline, Executive Vice President, Episodes of Care, Signify Health

To stimulate and encourage quality improvement efforts, health plan bundled payment models usually offer financial incentives for performance on quality. In retrospective bundles, quality performance determines whether a provider is eligible for shared savings and calibrates the size of the shared savings bonus. Under prospectively paid bundles, health plans withhold some portion of the provider's fees. The provider can earn these dollars back at the end of the episode, contingent on how they perform against pre-determined measures of quality. Health plans can rely on existing care management and navigation infrastructure to support patients across an episode of care. In fact, under a health plan-administered bundled payment program, most members will never realize that their care is paid for through a bundled payment contract. This speaks to the fact that health plan bundles exist primarily as a contracting tool, rather than a product or network strategy. Consequently, purchasers who want to guide members to providers who are paid by bundle will struggle to find that information or option available through most major carriers.

CENTERS OF EXCELLENCE (COE) VENDORS

Centers of excellence vendors operate as a carve-out from a purchaser's primary health plan or third-party administrator (TPA). These vendors identify high-quality providers and hospitals and prospectively pay them a bundled payment for elective procedures. COE vendors' base their formula for success on the beliefs that:

1) High-quality providers, if offered a bundled payment for elective procedures prospectively, will accept deep discounts yielding significant cost-savings for purchasers and their members.

2) In many markets, it is less expensive to pay for a patient to travel to a low-cost COE in another market; consequently, most COE vendors offer a travel benefit that covers air travel and accommodations for both the patient and a companion.

3) Many elective procedures – particularly in orthopedics – are unnecessary, and patients are better served through low-intensity treatment options like physical therapy. Therefore, most COE vendors offer evaluations for "appropriateness of care," paying COE providers a fee separate from the bundle to evaluate whether surgical intervention is necessary. Vendors cite that anywhere from 10 to 40 percent of patients avoid surgery through these upfront evaluations.

COE bundled payment programs use quality criteria to identify high-performing providers, often selecting individual physicians within a group practice; however, they generally do not offer providers incentives for quality outcomes or utilization as part of the payment model. Instead, the COE model makes inclusion in the COE network conditional on sustained quality performance - providers whose quality declines are removed from the network. COE vendors have built robust infrastructure to assist with patient navigation and smooth the transition back to the patient's primary care team. Most offer care navigation and coordination through multiple modalities – online and telephonic – and services range from assistance in provider selection, to appointment scheduling, to support managing travel logistics.

"We will never be, nor is it our desire to be, the local PPO network. **Quality does not exist everywhere,** so a large part of our value proposition is helping members find and access high-quality surgeries. Today, we have contracted with high quality orthopedic surgeons within 100 miles of 80% of the U.S. population, and we intend to achieve that proximity for all our categories."

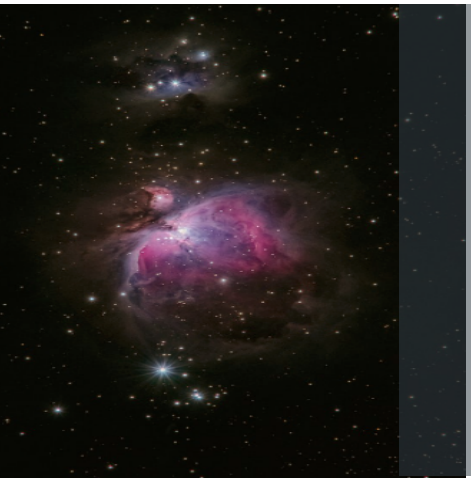
– Jamie Hall, President, BridgeHealth

Because COE vendors transport patients from their home market to another location where prices are lower and quality is high, the consequential risk for patients and purchasers under a COE model is that an unexpected and unrelated event occurs during a hospitalization at a facility that is out-of-network for the purchaser's primary carrier. For example, a patient goes into cardiac arrest following a knee replacement surgery. Under this circumstance, the patient may be balance billed for care that falls outside of the bundle definition and for receiving care in an out-of-network hospital. Some COE administrators have built provisions in their provider contracts that protect purchasers and patients under these circumstances, but this practice is far from universal. COE vendors must also contend with the risk that their contracted providers may inadvertently or reflexively bill the purchaser's health plan, even though the COE vendor has already paid for care prospectively. COE vendors should have policies in place to prevent double-billing and commit to resolving billing issues if they arise.

HYBRID MODELS

This "amphibious" classification of bundled payment vendor can either operate through a health plan, accelerating the scope and operational efficiency of the health plan's bundled payment program, or contract directly with purchasers using an alternative TPA. Like health plans, hybrid model bundled payment programs focus on helping providers improve care coordination and operational efficiency; they embed quality incentives into their provider contracts and use robust data and analytics for process and performance improvement purposes. In fact, some hybrid vendors have joint venture ownership of freestanding ambulatory surgery centers.

CPR found significant variation among the business models of the hybrid vendors. Some offer a broad menu of condition and procedural-based episodes, while others focus narrowly on a few types of bundles. Additionally, some offer a full suite of clinical coordination and navigation services, while others prefer to operate under the infrastructure of a health plan, and, if this is not possible, sub-contract their patient coordination and navigation services to third-party vendors.



"The challenges for self-insured entities have been **the lack of experience in negotiating directly with the providers and provider consolidation**. Both make it hard for self-insured entities to get affordable, high-quality care. And that creates frustration on where to direct their plan members. They're beholden to the higher-cost providers."

– Mike Caponetto, Chief Operating Officer, Global One Ventures, LLC

CONSIDERATIONS FOR EMPLOYER-PURCHASERS

The concept of bundled payment holds great promise for purchasers seeking greater value for specific episodes of care, but there are important considerations when selecting an administrative partner. In the course of CPR's bundled payment collaborative, purchasers raised a series of core concerns and considerations that inform their selection of a bundled payment administrator. Some of these considerations are catalogued below.

PATIENT / MEMBER CARE AND OUTCOMES

"How do benefits teams figure out which providers are high quality? Tackling this challenge requires subject matter expertise that most benefits teams don't have. **It is extremely complex to define quality, source the data and analyze it for each provider and specialty.** This is why Carrum formed a world-class clinical advisory board and developed what we believe is the most comprehensive quality methodology in the industry, featuring a deep focus on appropriateness of care."

– Brent Nicholson, Co-Founder & Chief Customer Officer, Carrum Health

First and foremost, purchasers want assurance that a bundled payment program will improve their plan members' health and well-being -- that they receive the right care from qualified providers, and that they will be protected from adverse outcomes and financial harm. To this end, here are central questions regarding patient/member care and outcomes for purchasers to consider when selecting a bundled payment administrative partner:

1. *How can I be assured that my members will receive high-quality health care?*

Purchasers naturally want to make sure that their members receive care from providers with a proven track record of excellence within their specialty. They will want to know what criteria and which metrics the program administrator uses to select providers, whether the administrator evaluates the facility versus provider practices in aggregate versus providers individually, and how often evaluations recur. Administrators should use nationally recognized indicators of quality, utilization and experience of care data, and ideally, should assess both individual physicians and facilities.

"We look at bundles as more than just an economic relationship. We also offer access to a surgery that results in good outcomes, fewer complications and better member satisfaction. It's a good financial bundle accentuated through high quality providers, and the people who use us really like the service. So, **a bundle is more than just a contract; it's a new way of creating value** for all of health care's stakeholders."

– Terry Fouts, Chief Medical Officer, BridgeHealth

2. *How can I be assured that my members will receive appropriate care – particularly for procedures where low-intensity care options are available?*

A common – and fair – critique of bundled payment programs is that while they may reduce the cost of individual procedures, the payment model by itself does not prevent unnecessary episodes of care. Obviously, this is more relevant for some episode types (like spine surgery) than others (like maternity). But for many elective surgical procedures, checks for appropriateness of care that result in avoided intervention drive greater cost savings than the bundle itself. Therefore, many bundled payment programs include a surgical consultation, paid separately from the bundle, as an incentive toward conservative treatment. Purchasers should ask what checks the administrator has in place for appropriateness of care (beyond standard utilization management protocols) and seek data about the administrator's rate of avoided procedures.

3. *How will my members be protected from poor outcomes that arise post-surgically?*

By offering a single payment for an episode of care, bundled payment programs create incentives for providers to work in concert, coordinating with each other to improve efficiency. Purchasers rightly want assurance, however, that "improved efficiency" does not amount to "cutting corners" such that members require revisions, readmissions or that the procedure leads to other complications later. For this reason, many bundled payment programs offer "warranties" for surgical procedures. These warranties cover all care related to the procedure for an interval of time. Moreover, purchasers will want to ensure that non-payment for "never events" (serious medical errors) is part of the administrator's contract with the provider.

"**When there aren't financial barriers to care, there's a concern that people will seek unnecessary care.** We follow members who have been previously told they need surgery to determine how many of them actually end up getting surgery when matched with our providers. One of our orthopedic practices has a 34% surgery avoidance rate. We're going to make it easy for members to access that facility, because their outcomes are the best and they're only operating on people who need surgery."

– James Millaway, Co-Founder & CEO, The Zero Card

4. *How will my members be supported throughout the bundled payment journey? What tools will they have to identify providers, understand their benefits, and navigate their care through recovery?*

Purchasers who choose to partner with an external vendor to administer a bundled payment program will want to make sure that the logistics of carving out an episode of care from the purchaser's primary health plan to another TPA can operate seamlessly. They will want to pay close attention to the tools, resources and support the administrator provides to help members:

- Identify participating providers and estimate their share of the cost of care
- Manage the logistics of booking travel (if necessary), complete pre-operative assessment and complete post-operative care
- Coordinate care between the member's primary care team and the providers responsible for the episode of care
- Answer questions members have at any point during their care through multiple communication channels (e.g., phone, app, website)

Purchasers will want to confirm that these support systems are in place and should ask for product demonstrations to confirm their usability.

"No one wants to spend more time in a doctor's office or hospital than is necessary nowadays. **This trend is only going to accelerate further in the post-COVID-19 world.** The way we have virtualized every step in the surgical care delivery minimizes the time a patient spends at a provider facility. The consultation, form completion, medical record collection and post-discharge care communications are all virtual through our app. The only thing a patient needs to do is show up at the provider facility for the surgery. That's it."

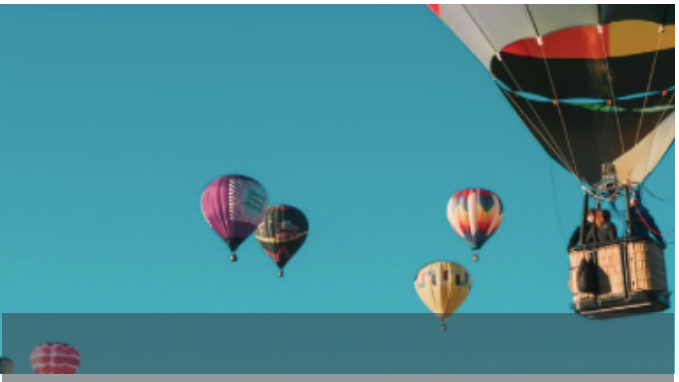
– Sach Jain, CEO, Carrum Health

EMPLOYER / PURCHASER EXPERIENCE

In addition to assurances that their members will receive high-quality, low-risk care through a bundled payment program, purchasers want to ensure that the program will function effectively and ensure that they understand the size of the lift of implementation.
Here are some questions regarding the employer/purchaser experience to consider when selecting a bundled payment administrative partner:

1. *How much will it cost to contract with a bundled payment vendor? How will I know how much of the cost goes directly to patient care vs. administrative overhead?*

Purchasers who select external vendors to administer a bundled payment program will incur some form of additional administrative fees. Even health plans may charge additional fees if the bundled payment program is offered as a separate benefit design product, or if the health plan charges a per member per month fee to fund provider bonus payments or clinical infrastructure. In either case, purchasers should demand transparency into the administrative costs of the program, how they are structured (per procedure, per member per month, flat fee, etc.) and whether the program administrator offers flexibility into their fee structure according to purchasers' needs.



"In any marketplace, there will be high-performing and low-performing health systems and surgeons. **We liberate that data because health care needs to be democratized.** Then, members can access health care based on cost, quality and convenience and leverage our team of Personal Health Assistants for support."

– James Millaway, Co-Founder & CEO, The Zero Card

2. *What will be required of me to implement a contract with a new vendor? What resources and infrastructure will be necessary?*

As with any new product or program, bundled payment requires work in the areas of program implementation, communication and management. Purchasers who select an external vendor or a separate product offering from their health plan should probe into how much of this labor will fall on the purchaser's shoulders and how much will be borne by the program administrator. For example, does the program administrator offer communications campaign templates and tutorials for plan members? Does the administrator provide dedicated client success staff, and what is their availability? These questions will help purchasers assess up front how much they must invest to launch, and ultimately manage, a bundled payment vendor.

3. *How much agency will I have as a purchaser to customize the bundled payment program?*

This is a double-edged sword. Some purchasers will want discretion over the scope and structure of the bundled payment program, including the episode definition, warranty length and provider network.

While some program administrators may be willing to accommodate these types of requests, purchasers should be advised that customizing episode definitions can present challenges for providers who must accommodate multiple sets of bundle parameters while maintaining consistent clinical operations. Purchasers should seriously consider aligning with external industry standards or the vendor's standard for the definition of the episode.

4. *What benefit design options are available to guide my members to providers in bundled payment contracts?*

Benefit design options vary across bundled payment program administrators. Many COE models require purchasers to waive all cost sharing for services rendered through the bundled payment program; some also require a travel allowance that includes transportation, lodging, and food for patients and their companions. Other vendors take a more flexible approach and are willing to modulate benefit designs according to purchaser preferences.

Health plans, on the other hand, have historically treated bundles as primarily a provider contracting strategy and have been slower to create *any* benefit design products anchored around providers in bundled payment contracts. Purchasers who take an active interest in a bundled payment strategy may need to push health plans to accelerate a bundled payment product strategy, if one isn't already in place.

5. *How will I know if this program is working? What kind of reporting will I receive from my contracted vendor or health plan, and what kind of insights will I glean?*

All bundled payment program administrators should provide purchasers with reporting that is accurate, timely, and comprehensive, offering insights into cost, utilization, quality outcomes and member experience. If the administrator offers checks for appropriateness of care (which they should!), they should also report on the rate of avoided procedures. Purchasers should expect administrators to benchmark results against their book of business, supplemented with external data, and trend results over time.

Note that this summary represents a high-level overview of some of the primary concerns of purchasers. CPR's Bundled Payment Toolkit includes many other questions and recommended specifications developed by the purchasers who participated in CPR's collaborative, which CPR then updated after evaluating 10 bundled payment solutions.

"When we began looking to establish a bundle methodology, we did a lot of research. We thought it would be **particularly impactful to go to a provider practice and propose an industry-standard methodology**, one that aligns with others versus creating something custom."

– Laura Fox, Senior Manager, Innovation, Blue Shield of California

NEXT STEPS AND ADDITIONAL RESOURCES FOR PURCHASERS

"Our **payment strategies are part of our broader Health Reimagined strategy**, which includes community transformation, as well as technological tools and support to help practices excel in implementing these payment models."

– Laura Fox, Senior Manager, Innovation, Blue Shield of California

"I think that one of the main problems in health care is that too often our default is to incrementally improve what's fundamentally broken, rather than getting to the core issue and fixing it. What we do at BridgeHealth is **attack the core issue of cost and quality at its foundation.** By using bundled payments and direct contracts, we eliminate administrative waste and create a more equal, balanced and effective solution for employers, employees, and their providers."

– Jamie Hall, President, BridgeHealth

"The market is still very much at a transactional level. Purchasers are looking for point solutions to solve a specific problem. **It's not for everyone, but for those who understand the potential value of a larger episodes of care program**, that's how we position ourselves in the market."

– François de Brantes, Senior Vice President, Episodes of Care, Signify Health

After nearly a decade of slow, incremental progress, bundled payment programs are now rapidly gaining traction and notoriety. Purchasers searching for strategies to improve quality and affordability through a bundled payment program have many potential partners at their disposal. Purchasers can exert pressure on health plans to develop products anchored around providers in bundled payment contracts, or partner with an external bundled payment vendor. Moreover, given the expansion of procedures and conditions available for bundled pricing, purchasers have agency and choices around how to implement a program and bring it to scale. Purchasers can opt for narrow implementation with a single procedure and a specific provider or jump in with both feet and implement several episodes with multiple providers.

At the time of this report's publication, the United States is still deep in the turmoil wrought by the COVID-19 pandemic. Consequently, in the short term, demand for elective procedures (and the supply of hospitals willing or able to provide them) may be low. That said, there are several advantages to launching a bundled payment program now. For example, introducing a change in benefit design for elective procedures while demand is low buys time for purchasers to roll out an implementation strategy with lower risk of member disruption. Also, offering benefit design change through a COE model is less likely to cause member abrasion if the alternative is to raise premiums or otherwise increase employees' share of the cost.

"In 10 years, I believe that **every elective surgery will be in some sort of value-based bundle.** There's just too much data out there to not be engaging on this movement."

– Scott Leggett, Co-Founder & Co-Principal, Global One Ventures, LLC

For purchasers seeking more information from CPR regarding bundled payment program administrators and standards of excellence, CPR offers the following resources:

- **Bundled payment evaluation questions and specifications:** Purchasers seeking to hold health plans accountable for progress on bundled payment and/or explore innovative carve-out solutions can download CPR's bundled payment evaluations questions and specifications at no cost. Health plans, vendors, providers and others can also access this resource for a nominal fee.
- **Bundled payment solution summary scorecards:** CPR evaluated 10 bundled payment administrator offerings and produced summary scorecards for use by CPR's member organizations. The administrators we evaluated include:

  - Aetna
  - Best in Class Care
  - Blue Shield of California
  - BridgeHealth
  - Carrum Health
  - Global 1
  - Signify Health
  - UnitedHealthcare
  - ValueHealth
  - The Zero Card

  Purchasers who want access to CPR's summary scorecards can contact Ryan Olmstead to discuss membership.

- **Bundled payment Reform Evaluation Frameworks:** Built on the shoulders of CPR's Standard Plan Accountable Care Organization Report for Customers (SPARC), CPR offers Reform Evaluation Frameworks (or REFs) that give purchasers a standardized tool to evaluate health plan and vendor-administered bundled payment programs.

Finally, other resources for purchasers to get on the road to a bundled payment strategy include:

- CMS' BPCI Advanced: Provides a list of CMS's clinical episodes, payment methods, quality measures and participating providers.
- Prometheus' Episodes: Provides a list of clinical episodes. Note, episode definitions require a license to access.
- TennCare's (Tennessee Medicaid) Episode Technical Documents: Provides a list of clinical episodes, definition guide, file with medical codes to define the episode and cost and quality thresholds; offers a roadmap for purchasers to replicate TennCare's implementation of bundled payment

APPENDIX: KEY TERMINOLOGY

Balance billing: According to Healthcare.gov, a bill received by a patient for the difference between the provider's charge and the allowed amount under the patient's health plan. A preferred provider generally does not balance bill a patient for covered services.

Centers of excellence (COE): Designated groups of providers that meet high standards for both the quality and the cost of care for a particular service or set of services. Employers and payers typically create COE programs to address variations in quality and costs for particular high-cost or highly-specialized services. This enables patient members to select care from a site offering high-quality, more affordable care.

Elective procedures: According to Johns Hopkins Medicine, elective or non-emergent procedures can be scheduled in advance and generally treat pain, immobility, and other quality-of-life concerns. These procedures can be delayed or postponed without serious health risk.

Fee-for-service: A payment model where providers receive a negotiated or payer-specified payment rate for every unit of service they deliver without regard to quality, outcomes or efficiency.

Payment Reform: A range of health care payment models that use payment to promote or leverage greater value for patients, purchasers, payers, and providers.

Prospective bundled payment: Prospective bundled payment is a single upfront 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 cost of services for a particular treatment or condition as well as costs associated with preventable complications.

Providers: Providers include physicians, non-physician clinicians (e.g., nurse practitioner), independent physician associations (IPAs), medical groups, and inpatient or outpatient facilities (e.g., hospitals), including ancillary providers.

Retrospective bundled payment: Retrospective bundled payment requires bundled payment administrators and providers to set a target budget for all services to treat a given condition or to provide a given treatment in advance. Providers are usually paid for each service (i.e., fee-for-service). Once the episode of care is complete, payers and providers reconcile the fee-for-service claims to determine if the provider delivered services at or below the target budget. If providers' total claims for the episode are under the target budget, they may receive additional payments. If providers' claims for the episode are over the target budget, they may have to refund the amount that exceeded the target budget. Providers assume financial risk for the cost of services for a particular treatment or condition as well as costs associated with preventable complications.

CONTACT INFORMATION

If you are an employer or other health care purchaser interested in learning about CPR's bundled payment evaluation process, seeking support with bundled payment strategies, or inquiring about CPR membership:

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