



Pursuing Bundled Payments Lessons from the ACE Demonstration

Providers involved in the Centers for Medicare & Medicaid Services' ACE demonstration project share lessons learned from their experiences in developing and managing episode-based care bundles.

Through its new Center for Medicare & Medicaid Innovation, the Centers for Medicare & Medicaid Services (CMS) is inviting healthcare organizations to develop episode-based care bundles and, through a request-for-application process, offer CMS a target price for these bundles that represents a discount on the combined fee-for-service prices of the procedures and services covered in the bundle (see "The CMS Innovation Center's Bundled Payments for Care Improvement Initiative," page 2).

The CMS Innovation Center's bundled payment initiative represents a "next step" from CMS's Acute Care Episode (ACE) demonstration, launched in 2009. The ACE demonstration also uses bundled payments for select orthopedic and cardiovascular inpatient procedures, and has other similarities to the new bundled payment initiative (see "About the ACE Demonstration Project," page 4).

To help healthcare organizations anticipate issues and prepare for implementation of bundled payment arrangements with the CMS Innovation Center, HFMA sat down with a group of providers involved in the ACE demonstration to discuss lessons learned from the demonstration and to see how they are responding to the new bundled payment opportunities with the Innovation Center.

The Business Case for Participating in Bundled Payment Initiatives

All the organizations participating in the ACE demonstration saw the program as an opportunity to prepare for reform and to position themselves for additional opportunities in both the public and private sectors. Beyond experience with assembling and costing bundled episodes of care, the demonstration offered potential opportunities with respect to:

- *Improved volume*, either through physician referrals or through marketing of "Value-Based Care Center" status to Medicare beneficiaries
- *Improved margins*, as the hospital and physician groups worked to identify cost-saving opportunities

As noted in the discussion below, the ACE demonstration participants had the most success with margin improvements.

Impact on volumes. Participants in the ACE demonstrations anticipated possible improvements in volume based on several factors. Recognition as a "Value-Based Care Center," which indicated that the hospital had achieved improvements at or above certain quality

thresholds, could help drive both physician referrals and beneficiaries' provider selection. The opportunity for physicians to participate in gainsharing might also affect volumes, especially with respect to physicians who had historically "split" referrals. The opportunity for Medicare beneficiaries to participate in shared savings could also

help improve volumes. In general, however, participant hopes for improved volumes have not been realized, an outcome that can be attributed to several factors.

On the beneficiary side, the biggest problem was that most beneficiaries simply did not know about the program. CMS efforts to publicize the program were well-intentioned,

THE CMS INNOVATION CENTER'S BUNDLED PAYMENTS FOR CARE IMPROVEMENT INITIATIVE

Beginning in 2012, CMS will be experimenting with four different bundled payment models through its Innovation Center, an entity established by the Affordable Care Act. To participate in the initiative, provider organizations apply to the CMS Innovation Center, proposing which conditions they would like to bundle and setting a proposed target price determined by applying a discount to total costs for a similar episode of care as determined from historical claims data.

The four models for the bundled payment initiative include:

- > *Model 1: Inpatient only (retrospective).* Hospitals are paid a discount on all Medicare severity DRGs (MS-DRGs) based on payment rates established under the inpatient prospective payment system. Physicians are paid separately under the Medicare Physician Fee Schedule, but are permitted to share gains arising from better coordination of care with the hospital.
- > *Model 2: Inpatient plus postacute episode.* This retrospective payment model includes inpatient hospital and physician services, related postacute services, and related readmissions for episodes ending a minimum of either 30 or 90 days postdischarge. Traditional fee-for-service payments are reconciled with a predetermined target price. Savings below the target price can be shared among participating providers.
- > *Model 3: Postacute care episode.* Model 3 episodes exclude the acute inpatient hospital stay. Episodes would begin at discharge and extend at least 30 days postdischarge.
- > *Model 4: Inpatient only (prospective).* The hospital where the beneficiary is treated is paid a single prospectively established bundled payment for the episode, including related readmissions. Physicians and other practitioners submit "no-pay" claims to Medicare and are paid by the hospital out of the bundled payment. This model most closely resembles the model used in the ACE demonstration.

Under all four models, CMS intends to ensure that total Medicare expenditures will decrease relative to what they would have been absent this initiative. CMS will determine a baseline for aggregate Medicare Part A and Part B fee-for-service expenditures based on historical data for the applicant provider organization, as well as a risk threshold to account for random variation. Provider organizations that participate in the initiative will be expected to pay Medicare for any expenditures above this threshold.

As in the ACE demonstration project, gainsharing payments to physicians are allowed, but are capped at a higher amount of up to 50 percent above what the physician would typically be paid for the case. Unlike the ACE demonstration, gainsharing with Medicare beneficiaries is not part of the bundled payment initiative.

Among the ACE demonstration participants interviewed for this report, Model 4 has the most interest, as it is focused on inpatient procedures and is the only model to use a prospective payment system; in the retrospective payment models, participants question whether claims data would be received within a time frame (at least every 30 days) that would enable them to identify high-cost physician outliers and intervene as appropriate. The retrospective payment model does have an advantage, however, in that CMS, not the hospitals, pays physicians and other providers.

Of the retrospective payment models, Model 1 is least favored, as it requires hospitals to take an across-the-board discount on MS-DRGs. Some ACE demonstration participants are considering applications for Model 2, depending in large part on their relationship with postacute care providers. Model 3, which focuses on postacute care episodes only, was not being considered by hospital-based ACE demonstration participants because this model excludes the inpatient hospital stay.

but started late and never fully penetrated the ACE participants' local markets. Participants' own marketing efforts were subject to restrictions by CMS—the use of the word *rebate*, for example, was not allowed—and did not prove very successful. Participants also had to deal with a few public relations issues when beneficiaries who did anticipate shared savings did not receive them because of claims disputes regarding their inpatient—and thus “ACE-eligible”—status.

Participants also noted that for cardiac events, patients will almost always go where their physician advises; there typically is not time to weigh the benefits of different providers as there might be in orthopedic cases. Perhaps most fundamentally, however, “shared savings is a very difficult concept for patients to understand,” says Nancy Harrison, director of the Acute Care Episode Project at Ardent Health Services. A beneficiary shared-savings component has not been included in the CMS Innovation Center's bundled payment initiative.

On the physician side, several factors may be at work. Federal laws and regulations have traditionally put heavy restrictions on gainsharing, and some physicians refused to participate in gainsharing—even if they referred patients to the ACE participant—because they did not want their patients to think that they were receiving any money from Medicare as a result of their referral. Physicians who had significant split referrals between hospitals were also less likely to partner with the hospitals and invest the time necessary to identify cost-saving opportunities.

Impact on margins. Although gainsharing opportunities for physicians did not increase volumes, they had a significant impact on margin improvements within the ACE demonstration hospitals.

The greatest gains came from standardization of high-cost supplies, such as stents and joint implants. Baptist Health System in San Antonio started the demonstration with more than 20 different order sets for just one of the demonstration Medicare severity diagnosis-related groups (MS-DRGs). Baptist assigned an analyst to physician teams working on standardizing order sets to provide

them with cost and quality data as provided. The physicians also built a grid for implants comparing the similarities and differences of the various devices that were currently in use. Over the course of a six-month process, the 20 different order sets for the MS-DRG referred to above were replaced by one order set in 95 percent of all cases.

Both Baptist and Ardent Health Services report an approximately 10 to 12 percent decrease in materials costs during year one of the ACE demonstration, and no corresponding price increases (typically an estimated 5 percent) in subsequent years. Exempla, which implemented the demonstration later than other facilities, has also achieved significant cost savings during the program's first year. Savings have been matched with increases in quality. ACE participants have also seen some positive spillover effect from cost reductions on implants in non-Medicare cases.

Given that savings have been driven largely by supply costs, participants found more consistent savings on orthopedic bundles than on cardiovascular bundles. “If no implant is required for a cardiovascular procedure, it's harder to keep costs below the discounted bundle price,” says Tom Bieterman, controller at Baptist Health System.

The ACE demonstration participants believe that there are additional opportunities for cost savings and that increasing the cap on physician gainsharing (not to exceed 125 percent of normal payment in the ACE demonstration) will provide the physician incentives necessary to push for these savings. The gainsharing cap has been raised in the CMS Innovation Center's bundled payment initiative up to 150 percent of normal reimbursement.

Opportunities with other payers. All the ACE demonstration participants interviewed for this report have submitted letters of intent to the CMS Innovation Center and, based on the data they receive, plan to apply for Model 2 and, particularly, Model 4 payment models. (Model 2 applications will depend on the availability of an appropriate post-acute care provider partner.) Their cardiovascular and orthopedic ACE bundles will likely form the basis of their applications, but they are also interested in such areas as oncology and general surgery MS-DRGs.

ABOUT THE ACE DEMONSTRATION PROJECT

The Centers for Medicare & Medicaid Services (CMS) launched the Acute Care Episode (ACE) demonstration in 2009. The demonstration pays prospective global payments for acute care episodes within Medicare fee-for-service, focusing on select orthopedic and cardiovascular inpatient procedures. CMS's stated goals for the ACE demonstration are to:

- > Improve quality for fee-for-service Medicare beneficiaries
- > Produce savings for providers, beneficiaries, and Medicare using market-based mechanisms
- > Improve price and quality transparency for improved decision making
- > Increase collaboration among providers

The ACE demonstration asked eligible providers to voluntarily submit competitive bids that bundled prices for Part A and Part B services around designated orthopedic and cardiovascular diagnosis-related groups (DRGs), with the intention of aligning payment incentives between hospitals and physicians to encourage care coordination. Cost savings below the baseline are shared with physicians, as long as quality targets were met and physician gainsharing did not exceed 25 percent above what the physician would typically be paid for the case, and help the hospital offset the financial risk represented in the discounted DRG.

The ACE demonstration was also designed to let Medicare beneficiaries share up to 50 percent of the savings CMS achieved through the providers' competitive bids, which beneficiaries could use to offset their Medicare cost-sharing obligations. Provider participants were allowed to market

their participation in the ACE demonstration as "Value-Based Care Centers," and CMS also indicated its intention "to take an active role in publicizing the demonstration to Medicare beneficiaries and providers in the relevant geographic locations."

The ACE demonstration was limited to entities that

- > Included an affiliation between at least one physician group and at least one hospital
- > Met particular procedure volume thresholds
- > Had established quality-improvement mechanisms
- > Were located in Medicare Administrative Contractor (MAC) Jurisdiction 4 (comprising Texas, Oklahoma, New Mexico, and Colorado)

Five such entities were identified for participation in the demonstration. Representatives of four of these five entities participated in interviews for this report, including:

- > Baptist Health System, San Antonio (part of Vanguard Health Systems)
- > Hillcrest Medical Center in Tulsa, Okla. (part of Ardent Health Services)
- > Lovelace Health System in Albuquerque, N.M. (also part of Ardent Health Services)
- > Exempla Saint Joseph Hospital in Denver

Baptist, Hillcrest, and Lovelace participate as both cardiovascular and orthopedic Value-Based Care Centers. Exempla participates as a cardiovascular Value-Based Care Center only.

Exempla is pursuing another bundled payment opportunity with the PROMETHEUS Payment project, and both Ardent and Baptist have initiated discussions with commercial payers. A significant barrier to commercial opportunities at this time is scalability—there has to be sufficient volume of bundled payment cases to justify automation of administrative functions that would make

processing claims cost-effective. Other barriers include concerns with existing legal barriers to building gainsharing arrangements with physicians through commercial payers, and a lack of willingness for employers or payers to create closed or limited networks to increase volume. On the provider side, a proliferation of bundled payment arrangements could cause other administrative issues.

“There’s the possibility that providers could create a lot of bundled ‘fiefdoms’ without any of the benefits of population management,” says Debbie Welle-Powell, vice president for payer strategies and legislative affairs at Exempla Healthcare.

Physician Selection and Relationship Management

Physicians are key to the success of any bundled payment initiative, as they make the decisions that affect costs of care and efforts to redesign care delivery. Participants in the ACE demonstration emphasize the need to identify and partner with physician champions who are willing to invest their time and efforts in the project.

ACE demonstration participants identified the following issues as key in selecting and managing relationships with physicians involved in a bundled payment initiative:

- Determining whether it is appropriate to ask physician partners to assume a portion of downside financial risk
- Creating project management bodies that balance opportunities for knowledge sharing and best-practice adoption across service lines with respect for the time physicians are asked to commit to project management
- Establishing guidelines and procedures for determining individual physician or practice group participation in gainsharing opportunities
- Ensuring timely and accurate physician payments

Exposure to risk. Because the ACE demonstration uses a prospective payment model, the participants’ physician-hospital organizations (PHOs) contracted with physician groups to pay them 100 percent of the Medicare physician fee schedule (PFS). Physicians participating in the demonstration, in other words, did not assume any downside risk. Their incentive for identifying care redesign and cost improvement opportunities was defined by the opportunity for gainsharing up to 25 percent above their normal reimbursement for the cases.

When considering the CMS Innovation Center’s bundled payment initiative, particularly Model 4, Exempla

plans to continue to bear all the downside risk. Its rationale is that the gainsharing bonus opportunity is what has driven physician engagement, and that interest may weaken if physicians are exposed to downside risk. Baptist has broached the topic of downside risk with its physicians and has found them open to taking on some risk (around 2 to 3 percent of their normal payment). They understand that their willingness to take on this risk will likely give the organization a stronger application, and also recognize that it is unrealistic to expect up to 150 percent of the Medicare PFS when there is no chance of a downside risk. The working relationship between the physicians and the hospital forged during the ACE demonstration has built trust, which also contributes to their willingness to accept some risk. Ardent is also considering sharing some risk with its physicians.

Management of bundled service lines. The ACE demonstration participants have used an arrangement resembling a co-management model to manage the bundled service lines, with representation on the board that oversees the lines split between physicians and facility administrations (with the addition of a community representative, as mandated by CMS).

One significant difference among the ACE demonstration participants was the number of boards used to manage the bundled service lines. Baptist and Exempla use a single board to oversee management of both the cardiovascular and orthopedic bundles, while Ardent uses two oversight boards, one for the cardiovascular and one for the orthopedic bundles. There are pros and cons to both models.

The single board fosters knowledge sharing and best-practice adoption across service lines, and leverages physicians’ competitive nature to show quality improvement. On the negative side, a single board is more time-consuming, as issues relating to both service lines are discussed in meetings. To mitigate this downside, Baptist used subboards for cardiovascular and orthopedics for discussion and resolution of details, with high-level issues reserved for full board discussion.

Dual boards make more efficient use of board members' time. On the negative side, opportunities are lost for knowledge sharing across service lines; however, informal conversations did transfer knowledge between cardiovascular and orthopedic physicians at Ardent.

If the ACE demonstration participants pursue both Model 2 and Model 4 under the CMS Innovation Center's initiative, separate boards will most likely be required for the different models, as Model 2 will require the participation of representatives from post-acute care facilities.

Gainsharing arrangements. Under the ACE demonstration, participants chose their own quality and cost metrics and set their baselines for quality, utilization, and costs, subject to CMS's review and approval. Ardent stressed the importance of working with front-line clinicians for the establishment of metrics and baselines to understand where there were significant opportunities to achieve savings and improve quality to ensure that these areas were included in the measurements.

Establishing baselines and metrics is part of the first step in Exempla's four-step gainsharing protocol:

- *Step one: Define terms.* In addition to determining baselines and metrics, the first step involves defining the DRG groupings included in the bundle, as well as the patient populations to which the bundles apply (i.e., Medicare inpatients in fee-for-service program with Part A and Part B).
- *Step two: Validate quality.* The quality baselines and metrics defined in step one establish quality parameters for physicians. Those who fail to meet these parameters are not eligible for gainsharing. Those who do qualify for gainsharing up to 125 percent of the resource-based relative value scale (RBRVS).
- *Step three: Calculate savings.* Savings are calculated by collecting the physician's actual billing records for patients included in the program. The PHO then determines if the overall costs for the specific DRGs decreased (every DRG has a cost baseline). An important aspect of the ACE demonstration was that there could be no cost increases in other areas, so the PHO also validates that no cost-shifting has occurred.

- *Step four: Make payments.* After applying any appropriate adjustments to savings, the PHO calculates the difference between the cost baseline and the weighted average costs for all participating physicians, which sets the cap on the amount available for gainsharing payments. Payments are allocated based on a physician's or medical group's volume and practice pattern. Exempla calculates payments within 90 days of calendar quarter end. Payments are not cumulative, and start anew each quarter.

Ardent and Baptist follow a similar process, although Baptist differs in its approach to step four, using a "four-hurdles" approach. Each month, Baptist determines whether all physicians in a given service line meet hospital quality and cost-saving targets (hurdles one and two) before any physicians in the service line qualify to participate in gainsharing. In addition, individual physicians must meet individual quality and cost-saving targets (hurdles three and four) to qualify for gainsharing.

CMS allowed, but did not require, annual adjustments of baselines if needed or desired. Baptist used a "year zero" baseline that was not adjusted, which was particularly effective in maintaining savings on supplies. The downside of this approach is that other costs—such as labor—might creep up even if implant costs continue to go down, so in MS-DRGs that aren't as supply-intensive, adjustments might be required. So far, however, these non-supply cost increases have not justified a resetting of the baseline for Baptist; they have managed to maintain baselines by making a few adjustments within the gainsharing agreement.

The organizations interviewed for this report agree that gainsharing was an effective method to both engage physicians in the project and focus their attention on opportunities to reduce clinical variations and bring down costs, and believe that the increased limit on gainsharing in the CMS Innovation Center initiative will encourage even greater efficiencies. But participants also noted that physicians participating in the demonstration clearly wanted to do the right thing to deliver care more efficiently. "It's encouraging

what physicians have proved willing to do,” says Baptist Health System’s Tom Bieterman.

Ensuring timely, accurate payments. For prospective payments, it is important to pay physicians on time and accurately. Most providers involved in the ACE demonstration set up a third-party administrator (TPA) or “TPA-like” mechanism. Functions of the TPA include:

- Claims processing
- Check and explanation of benefits processing
- Enrollment and benefits
- Physician 24/7 online access
- Administrative and financial capabilities
- Reporting capabilities
- ERISA/HIPAA compliance
- Complete IRS 1099 reporting
- Clinical protocols

The TPA also plays a key role in receiving data in a timely fashion to support care reengineering and performance monitoring efforts. The ACE demonstration participants noted, however, that they would not ask physicians and post-acute care providers participating in a retrospective bundle to submit no-pay claims to a TPA for data warehousing and analysis, because the inconvenience would most likely discourage physician participation.

The ACE demonstration participants did encounter some issues with the MAC’s processing of claims, particularly Part B payments for physicians. Although approximately 95 percent have processed without difficulty, the remaining 5 percent had some type of error that typically traced back to a few root causes, relating primarily to the notice of admission (NOA) process used in the ACE demonstration. If claims were originally submitted with an NOA attached, but the DRG was later determined to be non-ACE or the patient had something else done that took away ACE status, for example, ACE funds needed to be recovered and providers needed to be repaid under fee-for-service. Baptist also notes that crossover claims have not paid as expected, particularly with its state Medicaid program and, to a lesser extent, with commercial payers. CMS and the MAC are aware of these issues and are working to resolve them.

Resource Requirements for Managing Bundled Payments

Participants in the ACE demonstration estimated that they spent approximately \$150,000 to \$200,000 in start-up costs for participation in the project, and an additional \$350,000 annually in ongoing costs. Updates to cost accounting and materials management systems are another potential area of cost for providers considering participation in a bundled payment pilot.

Cost accounting and materials management. Accurate costing data are essential, both to establish baseline costs and pricing for the bundle and to track ongoing cost savings following implementation of the bundled payment program. Providers will likely need to significantly modify their cost accounting systems to allow tracking of discrete implant costs and pharmaceutical costs per patient.

Ardent Health Services has a materials management system that links to the cost accounting system. However, there can be timing issues relating to rebates and other discounts (for example, system discounts based on volume) that need to be incorporated into the data, and it is necessary to perform manual audits to ensure that the data are accurate. “Even with significant automation, it takes a lot of people doing their job well to get this right,” says Ardent’s Nancy Harrison.

Start-up costs. The \$150,000 to \$200,000 start-up costs incurred by ACE demonstration participants were spent primarily on marketing and legal costs. Participants agreed that the marketing allowed in association with the demonstration had little impact. Funds spent on marketing could be better redeployed elsewhere, participants agreed. One possibility worth exploring is the use of provider representatives to visit physicians and describe the benefits of using a facility that participates in a bundled payment initiative.^a

Ongoing program costs. Of the estimated \$350,000 in annual ongoing costs associated with the ACE demonstration, just under half of the costs went to employment of

a. For use of such representatives, see “Hospitals Adopt Drug Industry Sales Strategy,” *Kaiser Health News*, Dec. 13, 2011, www.kaiserhealthnews.org.

patient navigators or case managers to screen lists of patients who will be or have been admitted to, first, identify patients who are eligible for the ACE demonstration and, second, educate those patients about ACE. (Participants generally used three such navigators at a cost of \$50,000 each, for a total of \$150,000 per year.) Participants also found that they needed to dedicate patient financial services staff to resolve claims issues with the MAC. Remaining costs went to the TPA and opportunity costs of management time spent on the initiative. Some of these costs—including patient navigators and TPA-associated costs—may be scalable as organizations expand into additional MS-DRG bundles; others will not be.

Lessons Learned

For other provider organizations—and payers—considering bundled payment options, key lessons learned from the ACE demonstration include the following:

- Opportunities to improve margins may be greater than volume-improvement opportunities.
- Appropriately structured gainsharing is a significant incentive to encourage physician engagement in improving the cost-effectiveness of care.
- Hospitals and health systems must be willing to absorb downside risk until they have been able to develop physician trust in the viability of bundled payment models.
- There can be significant administrative costs associated with bundled payments, which should be balanced against any expected shared savings from a bundled payment arrangement.

Despite some inevitable difficulties in implementing the ACE demonstration, participants generally agreed that it was a positive experience in terms of both improving the cost and efficiency of care and preparing for fuller engagement with value-based payment opportunities. Most are planning to apply for bundled arrangements under Model 4 of the CMS Innovation Center's bundled payment initiative, and to a lesser extent, Model 2. ■