



# Bending the Health Care Cost Curve in New York State:

Implementation Plan to Adopt  
Bundled Payment Methods

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Prepared by The Lewin Group



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# Overview

The following high-level implementation plan is presented as a follow-up to the New York State Health Foundation's (NYSHealth's) July 2010 report, "Bending the Health Care Cost Curve in New York State: Options for Saving Money and Improving Care." The report was designed to inform a State-level discussion of health care savings opportunities in New York, and outlines the estimated impact of 10 scenarios that could help to contain escalating health care costs in New York State over the next decade while also improving health care quality.

While the report demonstrates that New York State's health care cost curve can be bent through policy options that better coordinate care and improve health care outcomes, significant effort on the part of a variety of stakeholders is required to actually achieve these savings. With the assistance of a Technical Advisory Panel, four of the modeled scenarios were selected for high-level planning to identify the action steps, timeframes, and resources required for implementation. The following four scenarios were selected based on a combination of their savings potential, feasibility, and impact on quality of care:

- ▶ **Expanding Palliative Care.** Require hospitals to establish a palliative care program to promote better coordinated, higher value care where appropriate.
- ▶ **Integrating Care for Dual Eligibles.** Enroll New York's Medicaid/Medicare dual eligibles into a fully integrated coordinated care setting.
- ▶ **Adopting Bundled Payment Methods.** Make prospective payments for entire episodes of care, potentially encompassing inpatient care, physician services while hospitalized, and post-acute care services, including short-term rehabilitation and home health care.
- ▶ **Rebalancing Long-Term Care.** Restructure New York State's Medicaid programs for long-term care, examining both residential and community-based settings for a large population of beneficiaries with extensive functional and cognitive impairments, and behaviorally and medically complicated needs.

With the exception of the managed care for the dual-eligible population scenario, each of these opportunities can be advanced by the State of New York through the Medicaid and the State employee benefit programs, with minimal Federal involvement other than routine program oversight. While more significant savings are associated with adoption of these scenarios beyond these State-operated programs, implementation by New York State is a major first step toward more widespread adoption. In the case of managed care for the dual-eligible population, however, full implementation of the modeled scenario requires a change to Federal Medicare statute, which guarantees "freedom of choice" under the Medicare program.

For each of the four scenarios, we convened a group of stakeholders that included New York State officials, policy experts, and representatives of payers, providers, and patients. Stakeholders were not asked to endorse any of the scenarios, but were asked to comment on implementation requirements necessary to achieve each of the scenarios. Those involved in the planning process acknowledged that implementation of these scenarios will require a great deal of effort.

It is our hope that the following implementation plans can serve as a roadmap for policymakers seeking to contain costs while improving care coordination and quality. Achieving substantial improvement in the delivery of health care is neither quick nor easy, and requires active participation by government, providers, and payers working together, and not shifting costs. The potential improvements in efficiency and quality of care associated with these initiatives make it worthwhile to initiate implementation efforts as soon as possible.

# Adopting Bundled Payment Methods Implementation Plan

## SCENARIO SUMMARY

Under the modeled policy scenario, New York State would adopt a bundled payment methodology, providing a single payment amount for all services provided to a patient during an episode of care. Hospitals would be paid a single bundled rate that covers hospitals' inpatient stays and any readmissions occurring within 30 days of admission for select procedures and conditions. Conditions/procedures would include commonly provided hospital services and those included in an upcoming Centers for Medicaid and Medicare Services (CMS) payment demonstration.

As modeled, total savings under this scenario are estimated at \$24.2 billion if implemented across all payers, and \$6.2 billion if implemented for Medicaid (fee-for-service and managed care) and public employees, phased-in over the 2011–2020 period.

## CURRENT ENVIRONMENT

Inpatient hospital care is commonly reimbursed based on diagnosis-related groups (DRGs) under which a hospital receives a predetermined rate for a hospital admission based on a patient's diagnosis and other characteristics.<sup>1</sup> The State recently implemented hospital outpatient prospective payment, a type of bundled payment system for hospital services provided during a single outpatient visit, also known as ambulatory patient groups (APGs). Post-acute care, even if related to the same episode as the original admission, is typically reimbursed based on the volume of services provided. State payment rates and methodologies are set in statute, regulation, and in the State Medicaid Plan, depending on the provider or facility type.

Section 3023 of the Patient Protection and Affordable Care Act (PPACA) encourages bundled payment demonstrations for Medicare and Medicaid. CMS is currently in the preliminary stages of outlining the program and funding requirements for these demonstrations, and expects to be ready by 2013. The bundled payment concept is also compatible with accountable care organizations and medical homes, both of which are also encouraged by PPACA.

The Health Care Incentives Improvement Institute (HCI3) has developed evidence-informed case rates for 21 medical conditions and procedures, which are pending endorsement by the National Quality Forum. It is working to demonstrate its "Prometheus" bundled payment model at two sites in New York. In addition, hospitals have been working to identify ways to reward providers for eliminating variation in costs for similar episodes. For example, Continuum Health Partners, a New York City hospital system, has demonstrated cost savings by standardizing surgical devices, and has been able to share the savings with surgeons. This type of "gainsharing" demonstration is a useful foundation for bundled payments.

Bundled payment demonstrations have previously demonstrated the potential to produce savings. An evaluation of the Medicare Participating Heart Bypass Demonstration, which was one of the largest bundled payment demonstration programs, found that it saved the Medicare program

<sup>1</sup> Effective December, 2009 New York Medicaid began using modified DRGs known as 3M™ All Patient Refined Diagnosis Related Groups (APR-DRGs).

## Adopting Bundled Payment Methods Implementation Plan *(continued)*

an average of 10% for bypass surgery patients in demonstration hospitals compared with the predicted Medicare payments in the absence of the demonstration.<sup>2</sup> Also, The Geisinger Health System in Pennsylvania implemented a bundled payment program for non-emergency Coronary Artery Bypass Graft procedures (ProvenCare) in 2006. The bundled services included hospital and professional fees, pre-operative evaluations, and post-acute care and management of any complications that occur for the 90-day period following surgery. A study of slightly more than 100 patients found that hospital costs had dropped by 5% compared to the year prior to the program.<sup>3</sup>

### **OBSTACLES TO IMPLEMENTATION**

The most significant obstacle to a widespread bundled payment methodology is likely to be resistance from providers that anticipate a potential reduction in revenue. Ultimately, buy-in from physicians will be critical to a successful implementation. In addition, hospitals, physicians, and other post-acute providers will need to organize into networks capable of sharing payments and adhering to uniform policies and procedures. Unless financial relationships already exist, this is expected to be particularly difficult to implement. Throughout the process of designing and implementing a bundled payment methodology, all stakeholders will need to be sure to avoid any restrictions imposed by antitrust requirements.

The primary technical obstacles to implementing a bundled payment methodology are lack of consensus over the definition of an episode and—assuming the payment was truly made as a single bundle—which entity would receive the payment and how would it be divided among providers.

Additional obstacles are related to the complexities of implementing bundled payments. For example, bundling payments will require extensive revisions to reimbursement policies and billing procedures for Medicaid, as well as managed care organizations. It will also require major changes to programmatic and financial relationships between hospitals and other providers. One approach to addressing this type of issue, which would likely be a substantial impediment to timely implementation, would be to consider a “virtual” bundle. Under a “virtual” bundle approach, providers would continue to be paid separately under existing reimbursement processes and then share in rewards or recoupment through a reconciliation process.

Implementing changes to the State Employee Health Plan is also very complex. Any changes to the benefit levels provided to employees would require negotiation with the collective bargaining units representing State employees. While the current agreements expire in April 2011, it is unlikely that the various collective bargaining units would agree to waive their members’ right to choose any provider, which might be incompatible with a bundled payment methodology that relies on pre-established provider relationships. In addition, each of the four major service categories under the Empire Plan is provided under a separate insurance contract. Bundling payments across these categories would entail significant contract changes that would require negotiation with the respective vendors.

<sup>2</sup> J. Cromwell, D.A. Dayhoff, et al, “Medicare Participating Heart Bypass Demonstration: Final Report,” CMS, (1998).

<sup>3</sup> Casale A, Paulus RA, Selna MJ, Doll MC, Bothe AE Jr, McKinley KE, Berry SA, Davis DE, Gilfillan RJ, Hamory BH, Steele GD Jr, “ProvenCareSM: A Provider-Driven Pay for Performance Program for Acute Episodic Cardiac Surgical Care,” *Annals of Surgery*, October 2007.

## Adopting Bundled Payment Methods Implementation Plan *(continued)*

### **ACTION PLAN**

The Action Plan for this option will be driven by a number of major program design decisions (e.g., whether payments will actually be bundled or be “virtual”). These design decisions will have a major impact on the steps that need to be taken, as well as the length of time it will take to implement the option. The scope and timing impacts of these decisions will need to be addressed during the implementation phase itself.

### **Program Design**

#### **Department of Health Activities**

- ▶ Establish stakeholder group to assist in development and vetting of program design and related activities.
  - Identify potential members
    - ▶ Medicaid representatives
    - ▶ Department of Civil Service representatives
    - ▶ CMS representatives
    - ▶ Hospital representatives
    - ▶ Physician representatives
    - ▶ Representatives of other post-acute providers that may be included in a bundle
    - ▶ Private health plan representatives
    - ▶ Patient advocacy groups
  - Consider a third-party facilitator that may be helpful in gaining consensus, first to proceed, and later around program design elements.
- ▶ Identify relevant statutory and regulatory provisions in the Medicaid State Plan and/or waiver provisions.
  - Identify, for each, the steps that would need to be taken should changes be required, as well as projected timeframes for initiating such changes (e.g., statutory change to define episodes will likely require drafting a Governor’s Program bill; regulatory changes will likely require approval of the Public Health and Health Planning Councils).
- ▶ Begin discussions with CMS as early as possible to facilitate the amendment process.
- ▶ Determine whether to pursue a joint pilot program with Medicare.
- ▶ Begin to develop provider buy-in.

## Adopting Bundled Payment Methods Implementation Plan *(continued)*

- Share success stories from previous bundled payment demonstrations.
- Emphasize the amount of potential waste in the system that could be eliminated and the expected improvement in the quality of care that would be promoted with this change.
- Promote potential provider benefits of being able to share in the savings associated with eliminating that waste and improving care.

### Stakeholder Group Activities

- ▶ Determine the scope of the program.
  - Decide whether to initially limit the program to Medicaid only or to include the State employee health system in initial program change.
  - Consider whether private plans should be included.
    - ▶ Including more payers may help achieve a critical mass of support.
  - Assess the relative “readiness” of providers to participate and decide whether to:
    - ▶ Limit the initial program to one or more geographic areas.
    - ▶ Limit the initial program to selected bundled payments.
- ▶ Determine the episodes that will be bundled and how the bundle will be defined.
  - Questions that will need to be considered include, but are not limited to, the following:
    - ▶ What type of episodes should be bundled? For example, should the program be limited to relatively simple episodes, such as joint replacement, or will chronic care be bundled as well?
    - ▶ What services should be included in the bundle? Should payment be included for post-acute care?
    - ▶ How long after the trigger episode should services be included in the bundle?
    - ▶ Can emergency room visits trigger an episode?
    - ▶ Would patients be restricted to providers that are included in the bundling arrangement?
- ▶ Determine whether the bundles will be “real” with payments made in one bundled sum to a provider to be further distributed to other providers, or “virtual” bundles applied to existing payment systems (where individual providers continue to be paid separately under the existing reimbursement processes and share in bonuses or recoupment through a reconciliation process), or whether both options should be available depending on each provider’s legal and financial relationships with other providers.

## Adopting Bundled Payment Methods Implementation Plan *(continued)*

- Determine mechanisms and timing for sharing savings through bonuses or recouping overpayments if the payment methodology is to be “virtual.”
- Determine the approach and timeline for incorporating savings if using “real” bundles. For example, would the State build savings into the rate up-front or following cost reporting?
- What quality/performance metrics should be used to gauge performance and pay bonuses?
- Develop a methodology for sharing revenue among providers if the bundled payments are to be “real.”
  - ▶ Identify which provider receives the payment initially (e.g., hospitals) and how the providers are related (e.g., common ownership, affiliation, etc.).
- ▶ Consider ways to link a bundled payment program with other emerging payment models, such as medical homes and/or accountable care organizations.
- ▶ Identify data collection, reporting approaches, and tools needed to assist the State and providers to understand how the new payment mechanism is working, where program improvements can or should be made, etc.

### **Payment Modeling**

#### **New York State Department of Health Activities (performed in conjunction with provider associations)**

- ▶ Collect data, link claims to determine an episode, and conduct modeling to determine payment amounts (based on highly predictable patterns of care) and bonuses.
  - Incorporate risk adjustment.
    - ▶ Consider whether it is necessary and feasible to account for the socioeconomic status of patients to avoid unduly penalizing safety net providers.
  - Determine whether a stop-loss mechanism or outlier policy is necessary to protect providers from unexpected declines in revenue, particularly if a high degree of predictability cannot be achieved.
- ▶ Department of Civil Service will conduct similar activities if decision is made to implement a bundled payment methodology for State employee health plans.

#### **Commercial Health Plan Activities (if participating)**

- ▶ Conduct modeling activities based on actual patient data to bundle payments for particular procedures.
  - Medicaid health plans would most likely use the payment rates established by the State.
  - Consult Department of Civil Service if including civil service health plans.



## Adopting Bundled Payment Methods Implementation Plan *(continued)*

### Implementation

#### New York State Department of Health Activities

- ▶ Amend State statutes, regulations, and Medicaid State Plan, as necessary, including developing Medicaid waiver if necessary.
  - Prepare informational materials and briefing sessions for involved legislative staff and legislators, as well as Public Health and Health Planning Council members.
- ▶ Update capitation rates and contracts for Medicaid and Child Health Plus.
- ▶ Develop technical assistance materials to help guide providers and health plans through the implementation process (e.g., seminars, training sessions, website, and frequently asked questions).
- ▶ Develop informational campaign to make patients, providers, and advocacy groups aware of the program changes and any changes in choice of particular providers.
- ▶ Update State data systems and program integrity and quality assurance procedures to monitor and evaluate the bundled payment program.
  - Enhance quality assurance procedures to ensure that increased system efficiencies are not gained at the expense of quality.
  - Ensure that revised data collection procedures still allow plans to measure quality (i.e., they should not disrupt plans ability to use encounters).
- ▶ Develop tools/system coding/etc. to ensure that payments that are determined to be part of a bundled payment cannot be billed individually.

#### Civil Service Department

- ▶ Negotiate the adoption of the bundled payment methodology under the Empire Plan and update contracts for the State employee health plans as necessary to reflect the impact of bundled payments.

#### Health Plan Activities

- ▶ Negotiate new payment methodologies and approaches with providers, hospitals, etc.
- ▶ Determine whether additional provider types need to be included in network to meet payment requirements related to bundled payments; engage if necessary.
- ▶ Update systems and contracts with providers as needed.
- ▶ Inform patients and providers of program changes and any changes in ability to choose particular providers.
- ▶ Assess role of health plans in facilitating bundling, collecting and sharing data among providers, etc.
- ▶ Update operational protocols as necessary to promote and enhance quality of care and efficiency.

## Adopting Bundled Payment Methods Implementation Plan *(continued)*

### Provider Activities

- ▶ Establish or strengthen relationships and contracts among hospitals and non-hospital based providers.
- ▶ Implement coordinated data systems that facilitate the sharing of patient data and financial transactions, if necessary.
- ▶ Update billing systems as needed to account for episode-based payments.
- ▶ Update patient care and operational protocols.
  - Identify opportunities to enhance efficiency while improving quality.
  - For example, related providers may choose to standardize and aggregate the purchasing of supplies and streamline the continuum of care to minimize costs.

### Required Resources

As with any new program, resources will be required to achieve implementation and to sustain the program into the future. The following resources are expected to be needed:

#### New York State

- ▶ Actuarial analysis to determine appropriate capitation rates
- ▶ Staff/other resources for modeling, data collection, and analysis
- ▶ Staff/other resources for modifying billing systems
- ▶ Increased efforts to monitor quality
- ▶ Staff/other resources to develop program education and technical assistance materials

#### Health Plans

- ▶ Actuarial analysis to determine appropriate capitation rates
- ▶ Staff/other resources for modeling, data collection, and analysis
- ▶ Staff/other resources for modifying billing systems
- ▶ Increased efforts to monitor quality

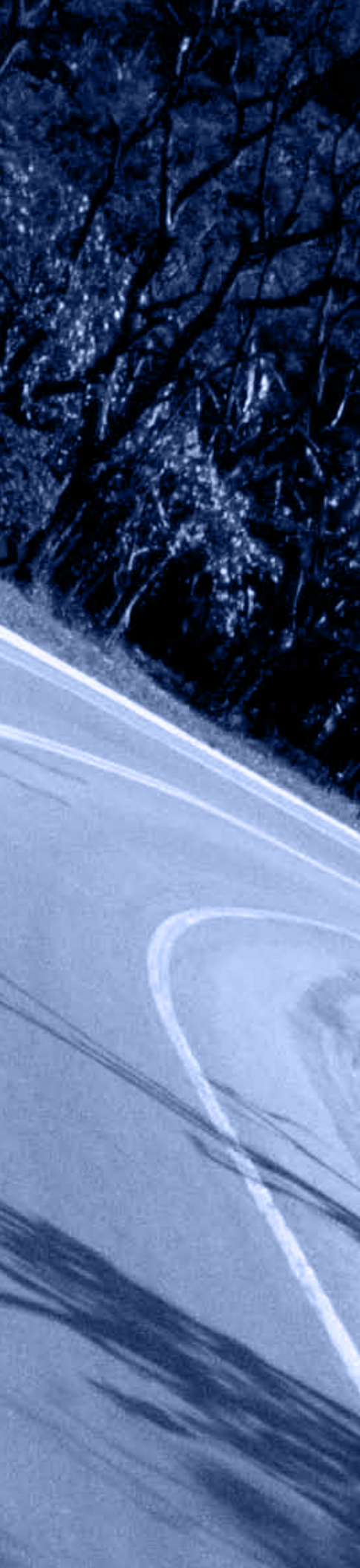
#### Providers

- ▶ System development resources
- ▶ Staff/other resources to assess and revise operating protocols
- ▶ Staff/other resources to enhance internal reporting capabilities

## Adopting Bundled Payment Methods Implementation Plan *(continued)*

ESTIMATED IMPLEMENTATION TIMELINE FOR ADOPTING BUNDLED PAYMENT METHODS <sup>4</sup>													
Policy Option: Adopting Bundled Payments	2010	2011				2012				2013			
ACTION STEP	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Work with stakeholders to gain buy-in for program	Program Design	Program Design											
Identify all Federal and State statutes/regulations/waiver provisions that need to be amended for both Medicaid and employee health plans	Program Design												
Assess need to discuss possible bundled payment approval as part of collective bargaining negotiation	Program Design	Program Design											
Design program through stakeholder involvement and CMS discussions, including scope of program, definition of episodes, real and virtual bundles, incentives, risk-adjustment, and quality/performance metrics	Program Design	Program Design	Program Design	Program Design	Program Design								
Providers develop revenue sharing methodology			Program Design	Program Design	Program Design	Program Design	Program Design						
Conduct modeling to develop program parameters, including payment rates (to providers and plans)		Payment Modeling	Payment Modeling	Payment Modeling	Payment Modeling	Payment Modeling	Payment Modeling						
Establish and strengthen relationships and contracts among hospitals and non-hospital based providers		Implementation	Implementation	Implementation	Implementation	Implementation	Implementation						
Draft and codify proposed changes to statutes/regulations/Medicaid amendments/waivers		Implementation	Implementation	Implementation	Implementation	Implementation	Implementation						
Develop guidance to assist plans with transition					Implementation	Implementation							
Modify current hospital information technology systems (e.g., billing)						Implementation	Implementation	Implementation	Implementation				
Modify Medicaid and Child Health Plus managed care contracts						Implementation	Implementation	Implementation	Implementation				
Amend, if necessary, contracts related to the State employee health plan						Implementation	Implementation	Implementation	Implementation				
Plans determine bundled rates to providers										Implementation	Implementation	Implementation	Implementation
Modify patient care and operational protocols and procedures										Implementation	Implementation	Implementation	Implementation
Expand existing provider networks										Implementation	Implementation	Implementation	Implementation
Identify/implement other quality assurance approaches as needed										Implementation	Implementation	Implementation	Implementation
Go live										1/1			

<sup>4</sup> Overall project scope and magnitude of the included bundles will have a significant impact on the timeline for implementation.



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