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January 31, 2011

The Honorable Dave Camp  
Chairman  
Committee on Ways and Means  
House of Representatives

The Honorable Frank Pallone, Jr.  
Ranking Member  
Subcommittee on Health  
Committee on Energy and Commerce  
House of Representatives

The Honorable Pete Stark  
Ranking Member  
Subcommittee on Health  
Committee on Ways and Means  
House of Representatives

The Honorable John Shimkus  
House of Representatives

Subject: *Medicare: Private Sector Initiatives to Bundle Hospital and Physician Payments for an Episode of Care*

In recent years, we and other federal fiscal experts—including the Congressional Budget Office (CBO) and the Medicare Trustees—have noted the rise in Medicare spending and expressed concern that the program is unsustainable in its present form.<sup>1</sup> Concerns about the rising cost of health care are particularly pressing in light of evidence that suggests that greater spending does not necessarily translate to better health outcomes or higher-quality care. Medicare's fee-for-service (FFS) payment system may contribute to spending growth because it rewards volume of services regardless of the appropriateness, cost, and quality of those services. Under FFS, a payment is made for each unit of service based on the expected costs of delivering that service.<sup>2</sup> For example, Medicare makes multiple separate payments

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<sup>1</sup>GAO, *The Federal Government's Long-Term Fiscal Outlook: January 2010 Update*, [GAO-10-468SP](#) (Washington, D.C.: Mar. 2, 2010); CBO, *Budget Options, Volume 1, Health Care* (Washington, D.C.: December 2008); and The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, D.C.: Aug. 5, 2010).

<sup>2</sup>In most instances, the unit of service is narrowly defined, such as a single office visit or a single test. However, in some instances, Medicare provides a single payment for multiple services furnished by a provider. For example, the hospital outpatient fee schedule includes payment for a primary service as well as other integral services and ancillary items related to that service, such as intraoperative services and imaging supervision/interpretation.

for the services associated with a complex medical procedure performed in a hospital. It pays the hospital for the initial admission and any related readmissions; each physician involved in the patient's care, such as the surgeon and the anesthesiologist; and the skilled nursing facility for any related care immediately after hospitalization. Payments made in isolation in this way may give providers little incentive to coordinate the provision of care or to control the volume of services; in fact, each admission and readmission increases revenue for hospitals, and each visit and procedure increases revenue for physicians.

“Bundling,” under which a single payment is made for a group of services related to an episode of care,<sup>3</sup> may promote closer integration of health care providers and hold them jointly responsible for the cost and quality of services. An episode of care may refer to all services, including hospital, physician, and other services related to a health condition with a given diagnosis from a patient's first admission, including any readmissions, through the last encounter for the condition, including postacute services such as home health, skilled nursing facility, and rehabilitation. Bundled payment arrangements effectively hold providers collectively responsible financially for the health care they provide to a patient. As such, these arrangements seek to promote coordination among providers and the integration of health care delivery.<sup>4</sup> To the extent that bundled payment arrangements encourage providers to become more efficient in the delivery of care, these arrangements can also benefit providers financially. Any reductions in unnecessary care that result from bundling can improve the quality of care.

Some studies of bundled payments in the private sector suggest that for certain services and in certain settings, bundling may lower costs and improve efficiency. For example, one private sector pilot project conducted in the early 1990s looked at the impact of bundling hospital and physician payments for knee and shoulder arthroscopic surgery, including a 2-year warranty from the surgeon. This pilot resulted in a decrease in total costs to the payers.<sup>5</sup> A more recent study of Geisinger Health System's bundled hospital and physician payments for cardiac bypass surgery procedures found that 30-day clinical outcomes improved. For example, there was a reported statistically significant 12 percent increase in patients discharged to their home. Financial outcomes were also reported to improve, including a 5 percent drop in hospital charges.<sup>6</sup>

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<sup>3</sup>For purposes of this report, the term bundled payment refers to payment for services delivered by multiple providers for an episode of care that goes beyond a single day. Other types of bundled payments may exist, including a single payment for multiple services delivered by a physician to a patient on the same day.

<sup>4</sup>The Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*; and Robert E. Mechanic and Stuart A. Altman, “Payment Reform Options: Episode Payment Is a Good Place to Start,” *Health Affairs* 28, 2, Web Exclusive (Jan. 27, 2009), <http://content.healthaffairs.org/cgi/content/abstract/28/2/w262>.

<sup>5</sup>Lanny L. Johnson and Ruth L. Becker, “An Alternative Health-Care Reimbursement System—Application of Arthroscopy and Financial Warranty: Results of a 2-Year Pilot Study,” *Arthroscopy* 10, 4 (1994): 462-470.

<sup>6</sup>Other outcomes also improved although these improvements were not statistically significant: readmissions dropped 9 percent and in-hospital mortality rates dropped by 100 percent. See Alfred S. Casale et al., “Proven Care: A Provider-Driven Pay-for-Performance Program for Acute Episodic Cardiac Surgical Care,” *Annals of Surgery* 246, 4 (October 2007): 613-623.

Medicare first explored the use of bundled payments almost 20 years ago, implementing two demonstrations that lowered the cost of services provided to beneficiaries.<sup>7</sup> Most recently, in 2009, the 3-year Acute Care Episode (ACE) Demonstration implemented bundled payments for selected inpatient high-cost cardiac and orthopedic surgery in four states in the Southwest. To improve the coordination, quality, and efficiency of services provided to Medicare beneficiaries, in the Patient Protection and Affordable Care Act (PPACA), the Secretary of Health and Human Services (HHS) is required to implement a national pilot program by January 1, 2013,<sup>8</sup> for integrating services provided to beneficiaries during an episode of care. An episode of care may include inpatient, physician, and related services provided prior to, during, and following an admission to a hospital. The Secretary must develop payment methods that may include bundled payments for episodes of care. Medicare provider entities including a hospital, a physician group, a skilled nursing facility, and a home health agency may apply for participation in this pilot program subject to standards to be set by the Secretary. In setting the standards, the Secretary must ensure adequate beneficiary choice of providers under the pilot program.

You asked us to examine private sector initiatives to bundle payments for an episode of care.<sup>9</sup> We examined

- types of services for which private payers have bundled payments for an episode of care,
- how private payers administer bundled payments, and
- the views of national payers, physician specialty societies, and experts on the feasibility of more extensive use of bundled payments in Medicare.

### **Scope and Methodology**

To describe types of services for which the private sector has bundled payments and how the bundled payment arrangements are administered, we interviewed the five largest national payers—Aetna, Cigna, Humana, UnitedHealth Group, and Wellpoint—and reviewed relevant materials provided to us by officials from these organizations.<sup>10</sup> We also interviewed representatives of medical professional societies that had taken a public position on bundled payments, as well as representatives of other organizations that were identified in the literature as having experience with bundled payments to hear about their experience and get

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<sup>7</sup>The Medicare Participating Heart Bypass Center demonstration, which ran from 1991 to 1996 in seven sites nationwide, implemented bundled hospital and physician payments for cardiac bypass graft surgery as well as all related readmissions to the hospital. The Medicare Cataract Surgery Alternative Payment Demonstration, which ran from 1993 to 1996 in three states, implemented bundled payments for outpatient cataract surgery procedures, including all follow-up care for 120 days after surgery.

<sup>8</sup>Pub. L. No. 111 – 148, §§ 3023, 10308, 124 Stat. 119, 399-403, 941-942 (2010).

<sup>9</sup>You also asked us to explore options to ensure that the physician fee schedule appropriately reflects efficiencies occurring across all types of services that are commonly furnished together. We examined efforts by the Centers for Medicare & Medicaid Services (CMS) to set appropriate fees, and additional opportunities for it to avoid excessive payments, when services are furnished together on the same day, in GAO, *Medicare Physician Payments: Fees Could Better Reflect Efficiencies Achieved When Services Are Provided Together*, [GAO-09-647](#) (Washington, D.C.: July 31, 2009).

<sup>10</sup>Our preliminary research with local payers in several states showed that while efforts were under way to develop bundled payments in several markets, local payers had not implemented them yet. We therefore limited our study to bundled payment initiatives by the five largest national payers.

their views about the feasibility of bundled payments for Medicare.<sup>11</sup> To learn about bundled payment initiatives developed by the Centers for Medicare & Medicaid Services (CMS)—the agency that administers the Medicare program—we interviewed agency officials and reviewed relevant CMS policies. Our findings are based on interviews with selected national payers and physician groups, and therefore they cannot be generalized to all payers and physicians.

We conducted this performance audit from March 2010 through December 2010 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform our work to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our research objectives. We believe that the information obtained, and the analysis conducted, provide a reasonable basis for any findings and conclusions in this product.

## **Results in Brief**

The five largest national payers stated that they have routinely bundled payments for solid organ and bone marrow transplants for over 20 years, and a few had bundled payments for other services. The bundled payment for transplants generally included all hospital, physician, and ancillary services for the transplant episode, from evaluation through follow-up care. Two of the five national payers also have begun using bundled payments on a limited basis for other procedures. In 2009, one payer implemented bundled payments for bariatric surgery with providers in 22 states, and another payer implemented bundled payments for cardiac bypass surgery and other cardiac interventions in one hospital.

All five national payers told us they generally signed a single contract with the hospital and physicians to bundle payments for transplants, and they processed bundled payments manually. The payers contracted with high-quality transplant centers that first met minimum volume and quality criteria established by national transplant organizations and were then willing to accept a competitive bundled payment rate. The payers typically signed a single contract, usually with large, urban teaching or tertiary hospitals and physicians who were either hospital employees or in hospital-affiliated practice plans. Payers paid the hospital, which then paid physicians and other providers. In addition, all five payers told us that both payers and providers processed claims for bundled payments manually because their claims systems were not designed to group hospital and physician claims related to an episode of care.

Payers, representatives from physician specialty societies, and experts we interviewed stated that while bundled payments were feasible for Medicare, there were several obstacles to overcome. Among the factors noted that contributed to the feasibility of bundled payments in Medicare were that the ongoing Medicare bundled payment demonstration had increased providers' acceptance of bundled payments; and that bundled payments for transplants at the payers' centers of excellence resulted in savings—an important consideration in light of Medicare's financial challenges. Factors that could hinder wider use of bundled payments for

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<sup>11</sup>The medical professional societies included the American College of Cardiology (ACC), American Academy of Orthopedic Surgeons (AAOS), and the Society of Thoracic Surgeons (STS). The other organizations included the Center for Studying Health System Change; the Commonwealth Fund; Health Care Incentives Improvement Institute, a nonprofit organization that developed a bundled payment model known as the PROMETHEUS Payment for selected services; the Integrated Healthcare Association in California (IHA), a nonprofit, statewide multistakeholder group that was in the process of developing bundled payments for selected surgical procedures; the Rand Corporation; and the Urban Institute.

Medicare included manual claims processing, which all five payers told us would be less viable for higher-volume services; that standard definitions for an episode of care do not exist; and that limiting provider choice under the selective contracting used for transplant networks may pose problems for Medicare FFS beneficiaries, who are used to a wide choice of providers since Medicare generally allows participation by all willing providers that meet certain standards.

In its written comments, HHS stated that the report provided useful information for CMS as it takes steps to expand bundled payment programs. CMS added that it has already begun to address some of the challenges we noted, such as manual claims processing, in the ACE demonstration for bundled payments.

### **Largest National Payers Bundled Payments for Transplants, and Some Have Started Bundling Payments for Other Services in Specific Locations**

The five largest national payers told us that bundling payments for transplants is standard procedure and has been the industry norm for more than two decades. The five payers bundled payments for solid organ transplants—including heart, liver, kidney, and pancreas—and for bone marrow transplants. The payers told us there were several reasons they selected transplants for bundled payment arrangements. Transplants are high-cost procedures, which increases the potential for achieving substantial savings; they have clearly defined start and end points, which is a necessity in defining an episode of care; and they have well-established clinical protocols for care and well-defined outcome measures.

The five national payers told us that the bundled payment for transplants generally included all hospital, physician, and ancillary services for all phases of the transplant episode: evaluation; organ procurement; hospital admission for the procedure; readmissions; and follow-up care, which varied from 30 to 365 days. The payers told us that they typically did not adjust for the severity of the patient's condition beyond the inherent severity adjustment included in the Medicare diagnosis related group.<sup>12</sup> Four of the five payers also told us that they had established outlier provisions to limit the financial risk to providers.<sup>13</sup> The payers provided additional per diem payments when outlier thresholds, which were based on a limit of total days or a threshold of total charges for the episode, were reached.

Two of the five national payers were moving toward expanding bundled payments to additional procedures. For example, one payer told us that in 2009 it had implemented bundled payments for bariatric surgery in selected hospitals in 22 states. This payment included all hospital, physician, and ancillary services: evaluation for surgery, hospital admission, and follow-up care for 180 days after discharge. The payer told us it had selected bariatric surgery for a bundled payment arrangement for reasons similar to those for transplants: it is a high-cost procedure with clearly defined start and end points, and well-established clinical protocols for care. Another payer began using bundled payment arrangements in 2009 for cardiac bypass surgery and other cardiac interventions in one

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<sup>12</sup>Inpatient admission cases are classified into relatively homogeneous categories, called Medicare severity diagnosis-related groups (MS-DRG), that are based on a patient's diagnoses and treatment procedures, and may also take into account the severity of the condition. For example, MS-DRG 1 is a heart transplant with major comorbidities and complications, and MS-DRG 2 represents a heart transplant without major comorbidities or complications.

<sup>13</sup>The payer that did not establish outlier provisions included in its bundled payment 30 days of follow-up care after the transplant compared with longer periods for the four other payers.

hospital. This payer told us that the bundled payment included hospital, physician, and ancillary services for the surgical procedure and follow-up care for 30 days after discharge.

Four of the five payers told us that they were exploring bundled payments for other high-cost services, including cardiac and orthopedic surgery. Three payers told us that, as a first step in that direction, they had developed a “centers of excellence” approach to identify high-quality hospitals that provide these services. In this approach, health plan members are encouraged to use hospitals that meet volume, quality, and efficiency criteria specified by the payers. The payers told us they are interested in developing bundled payments for these additional services but certain implementation challenges would need to first be considered.

### **National Payers Generally Contracted Jointly with Selected Hospitals and Physicians for Transplants, and Processed Claims Manually**

All five national payers told us that they selected hospitals for their transplant network on the basis of criteria including volume and quality, experience, and availability of ancillary services. The payers said that to identify hospitals to include in the transplant network they first relied on minimum volume and quality criteria endorsed by national transplant organizations like the United Network for Organ Sharing (UNOS) and the Scientific Registry of Transplant Recipients (SRTR).<sup>14</sup> Payers told us that the data included in these public registries on each hospital’s transplant experience are risk-adjusted, that is, differences in patient demographics and severity of condition are considered so that fair comparisons can be made across hospitals. Payers also told us that they used their own additional criteria, such as evidence of an experienced transplant team; availability of ancillary and 24-hour support services; hospitals’ quality assurance programs; and participation in clinical data registries, such as UNOS and SRTR.<sup>15</sup> The payers told us that only about half or fewer transplant hospitals qualified for their national transplant networks; these were typically large teaching or tertiary hospitals located in urban areas. Payers examined hospitals’ volume and quality data annually.

After identifying hospitals that met volume and quality criteria, the five payers said they usually signed a single contract with hospitals and physicians, and that the hospitals and physicians determined how the payment would be disbursed. The payers said they contracted with hospitals that were willing to accept a competitive bundled payment rate.<sup>16</sup> They said that a single contract could be negotiated because the physicians were either employees of the hospitals or were organized into hospital-affiliated practice plans. Payers generally made payments to the hospital in installments after each phase of the transplant

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<sup>14</sup>UNOS is a private, nonprofit organization that manages the nation’s organ transplant system under contract with the federal government. UNOS maintains the database that contains all organ transplant data for every transplant event that occurs in the United States. The UNOS database contains current and historical data for individual transplant centers, such as annual transplant volume by organ. The SRTR is a national database of organ transplantation statistics developed by a nonprofit research organization to support ongoing evaluation of the scientific and clinical status of the continuum of transplant activity from organ donation and wait list candidates to transplant recipients and survival statistics.

<sup>15</sup>A clinical data registry is a data warehouse used to collect information about patient demographics and clinical outcomes. In this correspondence, we refer to clinical data registries as registries that collect performance data on hospital-level performance for procedures such as transplants, cardiac interventions, and orthopedic surgeries.

<sup>16</sup>These hospitals may be willing to accept lower payments because they are assured of higher volume with a limited network of providers.

episode; the hospital then paid the physicians. Payers did not typically get involved in decisions about how payments were allocated among participating providers.

All five national payers said they had established financial incentives for patients to use the hospitals in the transplant network. Some payers reduced patients' copayments or coinsurance if they used hospitals within the network. One payer covered only the transplants performed at designated centers of excellence; if patients chose hospitals outside the network, they would have to pay out of pocket for the entire cost of the transplant. Because designated centers of excellence could be far from a patient's home, payers also usually helped pay travel expenses for patients and at least one family member.<sup>17,18</sup>

All five national payers told us that both payers and providers processed claims for bundled payments manually, not with an automated claims processing system, because automating the process would be difficult. Payers said that their claims systems were not designed to group hospital and physician claims related to an episode of care and to make a bundled payment for these claims instead of paying them individually. To facilitate manual processing of the claims for bundled payments, payers had a dedicated claims unit that identified and flagged all transplant-related claims as 'no-pay' to avoid paying twice for them. Several payers told us that they required providers to submit the claims for transplant services because payers needed to capture all encounter data to record and track the types of services being provided during the episode and determine how the bundled payment compared to billed charges. Payers also reviewed the claims to identify any potential quality problems such as stinting on care.

All five national payers told us that the case managers they hired were key to ensuring the successful implementation of bundled payments. Payers assigned a dedicated case manager, typically a registered nurse experienced in transplant care, to patients throughout the transplant episode to help them navigate through their transplant experience. For example, the case manager explained the patient's transplant benefits, how the transplant network was structured, and the advantages of using a designated transplant center. The case manager also helped patients select the most appropriate center for their needs and medical condition, and explained the expenses covered by the travel benefit, if applicable. In addition, the payers told us that the case manager acted as the liaison between the patient and providers, coordinated services, and helped resolve any claims issues that arose.<sup>19</sup>

### **National Payers, Physician Specialty Societies, and Experts Described Factors Enhancing and Factors Impeding Medicare's Broader Use of Bundled Payments**

Payers, representatives from physician specialty societies, and experts we interviewed told us that more extensive use of bundled payments in Medicare was feasible but that there were several obstacles to overcome. They described factors such as providers' growing acceptance of bundled payments that they believe enhance the potential for more extensive use as well as factors that may hinder it, including manual claims processing.

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<sup>17</sup>Travel benefits had to be authorized by the employers with whom the payers contracted.

<sup>18</sup>For example, one payer's travel benefit included up to \$10,000 if the transplant center was at least 60 miles from the patient's home. The benefit covered expenses such as transportation costs, housing assistance for visits or hospital admissions, and meals.

<sup>19</sup>Hospitals may also employ transplant case managers; however, these managers are only able to coordinate care once the patient is assigned to their hospital. They would not be able to explain patients' transplant benefit coverage or help patients choose a transplant center.

Providers' Growing Acceptance of Bundled Payments, Medicare's Market Power, and the Potential for Savings Indicate Potential for More Extensive Use of Bundled Payments

**Provider Acceptance of Bundled Payments and Increased Collaboration between Hospitals and Physicians.** Some respondents we interviewed told us that providers were more accepting of bundled payments, and that increased collaboration between some physicians and hospitals was conducive to bundling. Some payers, researchers, and specialty societies' representatives told us that the ongoing ACE demonstration and the national pilot program in PPACA had increased providers' receptiveness to bundled payments because providers believe that bundled payments are likely to be implemented broadly in the future. Several payers and specialty societies also noted that some hospitals and physicians were collaborating to develop bundled payment arrangements. For example, a representative from the ACC stated that physicians at a major Ohio hospital had developed bundled payments for selected high-cost cardiac surgery procedures and were in the process of marketing the bundled payment arrangements to private payers. Similarly, a representative from AAOS told us that orthopedic surgeons at a hospital in southern California had collaborated with the hospital to develop bundled payment arrangements for certain high-cost orthopedic surgeries, which had been successfully implemented for a large employer group.

**Medicare's Market Power.** Respondents mentioned Medicare's size as a plus in facilitating bundled payments. Several payers and some researchers and specialty society representatives told us that Medicare's size enables it to effect change, such as facilitating provider integration and encouraging provider investment in infrastructure to manage bundled payments. As one payer noted, Medicare alone can represent over half of a hospital's business, while all private payers combined would represent less than one-third, and any single payer a much smaller share. As such, providers may be more willing to make changes to support bundled payments for Medicare than for any single private payer. Respondents also noted that hospitals may be eager to contract in order to boost their volume, particularly if CMS contracted selectively with only high-volume, established centers.

**Potential for Savings.** Interview respondents noted that bundled payments, coupled with their selective contracting approach, have the potential to produce savings—an important consideration in view of the financial challenges facing Medicare. Most of the five national payers stated that bundled payments for transplants at their centers of excellence resulted in savings and efficiencies. For example, one payer noted an average 4 percent reduction in total costs for transplants performed at its designated centers of excellence compared to a 15 percent increase at nondesignated centers, and several payers noted efficiencies such as reductions in total length of stay. Some specialty societies told us that there is potential for significant reductions in hospital costs—which is where most of the costs are concentrated—if bundled payment arrangements are used for cardiovascular care.<sup>20</sup> In addition, a representative from one hospital in the Medicare ACE demonstration reported a 10 percent reduction in costs for orthopedic procedures stemming largely from the purchase of lower-priced medical devices such as orthopedic implants. This representative stated that the hospital and orthopedic surgeons were looking for ways to streamline their costs and improve their efficiency to maximize their potential for success under the bundled payment.

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<sup>20</sup>It has been noted that physicians also may provide potentially unnecessary services and that bundled payment arrangements help reduce such services.



Claims Processing System Limitations, Current Degree of Provider Integration, and Ongoing Management Requirements among Factors Impeding Medicare's Broader Use of Bundled Payments

**Manual Claims Processing.** All five national payers told us that manual claims processing would represent a significant challenge for any payer, including Medicare, particularly for high-volume services. The payers told us that automated claims processing systems do not exist. Payers have found it difficult to group hospital and physician claims related to an episode of care. The five payers stressed that the reason manual claims processing has worked for transplants is that transplants are relatively low volume. If bundled payments are used more widely and for higher-volume services, manual claims processing would be less viable for payers, including Medicare, and providers.

**Provider Integration.** Most of the respondents told us that it was difficult to establish a single contract for bundled payments with hospitals and physicians. Most of the five national payers, specialty societies, and researchers told us that successful implementation of bundled payments requires that a single entity, composed of the hospital and its physicians, contract with payers to receive and distribute the bundled payment.<sup>21</sup> Large tertiary or teaching hospitals likely have physicians who are either employees or in practice plans affiliated with the hospital, but respondents told us that most other physicians practice alone or in small groups making it more difficult to involve these physicians in bundled payment arrangements. One payer also noted that generally hospitals are not affiliated with the full range of postacute care providers such as rehabilitation, home health, and skilled nursing facilities and may be unwilling to accept risk in the bundled payment for care they do not provide.

**Standard Definition for Episode of Care.** Respondents told us that standard definitions of an episode of care do not exist for the types of services that lend themselves to a bundled payment approach, and payers and providers are looking to Medicare to develop such definitions.<sup>22</sup> All five national payers, the specialty societies, and some researchers we interviewed noted that bundled payments may not work well for all conditions because the services that make up an episode of care must be unambiguously defined. The five payers told us that one reason bundled payments have not been implemented more widely for other services is because the episode of care and the start and end points cannot be as clearly defined as they are for transplants. When patients have comorbidities, episodes may overlap, making it difficult to distinguish services that should be included in one bundle from those to be included in another. Some payers noted that providers have to tailor their systems to each payer's definition of an episode, which makes them reluctant to take on bundled payments, but if Medicare developed standard definitions, payers would adopt them.

**Case Management.** The five national payers told us that the case managers they used to help patients navigate the transplant process and resolve any claims issues were essential for bundled payment arrangements, and that Medicare does not have case managers. They said

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<sup>21</sup>Notably, for the Medicare ACE demonstration, CMS limited potential applicants to physician-hospital organizations, with at least one physician group and at least one hospital that routinely provide at least one of the two main procedures included in the demonstration.

<sup>22</sup>Under PPACA, as part of the Physician Feedback Program, the Secretary must provide reports to physicians that compare their patterns of resource use to their peers beginning in January 2012. For purposes of these reports, the Secretary must develop an episode grouper that combines separate but clinically related items and services into an episode of care for individual patients, as appropriate. See Pub. L. No. 111 – 148, § 3003, 124 Stat. 119, 366-368 (2010).

that Medicare would need a similar case management function to implement bundled payments successfully.

**Public Data Registries.** Some respondents we interviewed told us that reliable, publicly available data on the quality of transplants that help them identify high-quality providers do not exist for other types of cases but that Medicare could facilitate the development of these data sources. All payers told us that they relied on public patient registries developed by specialty societies or other organizations to identify high-quality transplant hospitals. Since the data are risk adjusted, it is possible to compare outcomes across hospitals. Specialty societies stressed that Medicare should rely on their data registries, where they exist, rather than Medicare claims data for risk adjustment. For example, representatives from the STS told us that Medicare should use their registry of cardiac bypass patients rather than claims data to develop risk adjustment for bundled payments because their registry is a comprehensive database, started in 1989, that includes data from more than 90 percent of cardiac surgery programs nationwide. The clinical data are collected from patient charts and include information on patient severity, complications, and mortality. These and representatives from other specialty societies believed that Medicare should facilitate the development of registries where they do not yet exist and require physicians to participate in existing registries.<sup>23</sup> For example, a representative from the ACC stated that all physicians now participate in the registry they have developed on patients with cardiac defibrillators because Medicare will not pay physicians who do not participate in the registry.

**Benefit Structure.** Some national payers and researchers we interviewed told us that Medicare's benefit structure and program characteristics may present challenges because a bundled payment is made up of both hospital and physician services, but the Medicare program makes payments separately for these services and has different deductibles and copayments for each. A Medicare bundled payment may therefore be more complicated for HHS to administer and track. Some payers told us that the financial incentives they offered—such as lower copayments and deductibles, and travel benefits—to encourage use of centers of excellence would be more difficult for Medicare to offer.

**Provider Choice.** Some payers we interviewed also told us that their selective contracting approach may be problematic for Medicare, since Medicare generally is required by law to allow all willing providers that meet certain requirements and standards to participate in the program.<sup>24,25</sup> Payers told us that for bundled payments they contracted with only the top-tier hospitals based on volume and outcome data, but some payers and researchers said that 'leakage' of bundled payment services to noncontract providers, particularly for follow-up care, could occur in a FFS environment where beneficiaries are used to a choice of providers.<sup>26</sup>

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<sup>23</sup>For the Medicare ACE demonstration, applicants that participated in clinical improvement programs or registries were given preference.

<sup>24</sup>42 U.S.C. §1395cc.

<sup>25</sup>For example, in March 2007, CMS issued standards that transplant hospitals would need to meet to participate in Medicare. Among other criteria, the standards included minimum volume and outcomes, based in part on standards from UNOS and the SRTR.

<sup>26</sup>Although participation in Medicare's transplant network is limited to certain hospitals that meet its minimum standards, HHS has not bundled Medicare payments for hospital and physician services for the entire transplant episode at these centers as the national payers have done. Thus, the issue of 'leakage' is not currently as critical for the Medicare program since Medicare beneficiaries are not required to obtain all their follow-up care at selected centers.

## Agency Comments

We obtained written comments from the Department of Health and Human Services (HHS) which are reprinted in enclosure 1. In its written comments HHS stated that the report provided useful information for CMS as it takes steps to expand bundled payment programs. While CMS agreed with the report's finding that manual claims processing is a factor that hinders Medicare's ability to expand bundled payment programs, it stated that it had worked with the Medicare Administrative Contractor (MAC) for the ACE demonstration to develop an electronic bundled payment claims processing system within the MAC's existing operation and plans to transfer this processing program to other MACs as it expands bundled payment programs. CMS added that electronic processing was possible for existing bundled payment programs implemented under Medicare because fixed payments, with identical Part A deductible and Part B coinsurance amounts, were set for each patient per hospital per diagnosis-related group. This also helped overcome the challenges presented by Medicare's benefit structure. In addition, CMS stated that its evaluation of prior bundled payment initiatives indicated that bundled payment programs themselves do not automatically result in increased volume to hospitals because patients tend to use hospitals where their physicians have privileges. However, as we stated in the report, respondents told us that bundled payments coupled with a selective contracting approach could increase volume for participating hospitals.

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If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or [cosgrovej@gao.gov](mailto:cosgrovej@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in enclosure II.



James C. Cosgrove  
Director, Health Care

Enclosures – 2

**Comments from Department of Health and Human Services**

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DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation  
Washington, DC 20201

JAN 14 2011

James Cosgrove  
Director, Health Care  
U.S. Government Accountability Office  
441 G Street N.W.  
Washington, DC 20548

Dear Mr. Cosgrove:

Attached are comments on the U.S. Government Accountability Office's (GAO) draft correspondence entitled, "Medicare: Private Sector Initiatives to Bundle Hospital and Physician Payments for an Episode of Care" (GAO-11-126R).

The Department appreciates the opportunity to review this correspondence before its publication.

Sincerely,

A handwritten signature in black ink that reads "Jim R. Esquea".

Jim R. Esquea  
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT CORRESPONDENCE ENTITLED, "MEDICARE: PRIVATE SECTOR INITIATIVES TO BUNDLE HOSPITAL AND PHYSICIAN PAYMENTS FOR AN EPISODE OF CARE" (GAO-11-126R)**

The Department appreciates the opportunity to review and comment on this draft correspondence. This correspondence provides a summary of findings from private sector bundling initiatives that the Centers for Medicare & Medicaid Services (CMS) will find useful as we engage in efforts to expand our bundled payment programs.

CMS agrees with the GAO finding that processing claims manually is one of several factors that hinder Medicare's ability to conduct expansive bundled payment programs. During the initial Medicare bundled payment demonstrations for coronary artery bypass grafts and cataract procedures, we realized that continuing to process claims by hand would preclude a widespread application of the concept. A major goal of the current Acute Care Episode (ACE) Demonstration has been to develop an electronic bundled claims processing system that could be incorporated into the existing Medicare system. For that very reason, we restricted the solicitation of ACE applicants to the four States serviced by the Jurisdiction 4 Medicare Administrative Contractor (MAC), worked closely with that one MAC to develop an electronic bundled payment claims processing system within their existing operation, and continue to cooperate with them to refine the process. We then plan to transfer these electronic claims processing programs to other MACs as we expand bundled payment programs.

In reference to the statement in the report that "...hospitals may be willing to contract (a bundled payment with Medicare) in order to boost their volume, particularly if Medicare contracted with only high-volume, established centers," we would like to note that the evaluation of prior CMS bundled payment initiatives indicated that bundled payment programs, by themselves, did not automatically lead to increased volume from expanded market share for program participants. Also, to date, shared savings payments to beneficiaries under the ACE Demonstration have not led to significant volume increases for program participants. The fact remains that patients tend to go where their physicians advise them, and patients tend to choose hospitals where their physicians have admitting and practicing privileges, regardless of incentives available under bundled payment programs. However, as noted in the report, bundled payment program participants still have significant opportunities to implement efficiencies and increase their own savings.

In the report, it was stated that "Medicare's benefit structure...may present challenges because a bundled payment is made up of both hospital and physician services, but the Medicare program makes payments separately for these services and has different deductibles and copayments for each." Although this statement is true of Medicare in general, we have addressed the challenges noted in the report for purposes of the bundled payment demonstration programs already implemented under Medicare. For those programs, the bundled payment is a fixed amount per

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hospital per diagnosis related group from which both the Part A deductible and the Part B coinsurance are deducted. The Part A deductible is a fixed amount while the Part B coinsurance is 20 percent of the designated Part B portion of the set bundled payment. Thus, the deductible and coinsurance are the same for every patient served in the particular hospital in the particular bundled payment episode, enabling the MAC to incorporate the processing of these payments into their electronic claims processing system. We would also like to note that bundled payment initiatives under Medicare are largely invisible to Medicare beneficiaries. While participating sites must meet specific program requirements including quality monitoring, they are not designated as centers of excellence. Fee-for-service beneficiaries remain free to choose any provider they wish regardless of whether the provider is participating in a bundled payment initiative.

We look forward to expanding the application of the bundled payment concept within the Medicare program. An upcoming challenge will be the incorporation of post-acute services into the bundle. Post-acute services are an area where accountable care organizations with established relationships among various types of providers may play a key role.

We would like to thank the GAO for all of its efforts and for their valuable insights provided in this report.

Enclosure II

**GAO Contact and Staff Acknowledgments**

**GAO Contact**

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