

# Organizational Capacity Among Hospitals in Medicare and Commercial Bundled Payments

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**D**riven by a decade of policy and efforts by public and private payers to shift the United States toward value-based reimbursement, bundled payments have become a prominent nationwide alternative payment model. CMS has been at the forefront of this shift.

Between 2013 and 2018, CMS implemented the Medicare Bundled Payments for Care Improvement (BPCI) initiative, in which hospitals voluntarily accepted bundled payments for care episodes spanning hospitalization and up to 90 days of postacute care.<sup>1</sup> As the largest completed US bundled payment program to date, BPCI has been associated with cost savings and stable quality for both surgical and medical episodes.<sup>2,3</sup> Medicare has used these successes to model subsequent bundled payment programs, such as the Comprehensive Care for Joint Replacement<sup>4</sup> and BPCI Advanced programs.<sup>5</sup>

Over this period, a number of commercial insurers also developed bundled payment programs.<sup>6</sup> These initiatives shared the same underlying foundation as their Medicare counterparts: Hospitals voluntarily chose to accept financial accountability for the quality and costs of defined care episodes. However, commercial programs differed from Medicare's BPCI program in several ways, including incentive design, extent of financial risk sharing, and covered populations.<sup>7</sup>

In both Medicare and commercial bundled payment programs, hospitals must invest in new organizational capacities to help transform care delivery in response to value-based payment incentives.<sup>8</sup> Unfortunately, little is known about the strategies adopted by hospitals in Medicare vs commercial bundled payment programs.<sup>9</sup> In this study, which is to our knowledge the largest survey of hospital experiences in bundled payments to date, we examined the organizational capabilities of these 2 groups of hospitals in 4 domains: physician performance feedback, care management, postacute care provider coordination, and health information technology.

## METHODS

### Survey

We analyzed survey data from the AHA-Penn LDI National Bundled Payment Survey, an online survey conducted between October

## ABSTRACT

**OBJECTIVES:** Hospitals must strategically build organizational capacities to succeed in bundled payment arrangements. Given differences between Medicare and commercial arrangements, capacities may vary between hospitals in Medicare vs both Medicare and commercial bundled payment programs. This study compared organizational capacities between these 2 hospital groups.

**STUDY DESIGN:** National survey of American Hospital Association (AHA) member hospitals with experience in bundled payment programs.

**METHODS:** We analyzed data from October 31, 2017, to April 30, 2018, collected from AHA member hospitals with bundled payment experience in only Medicare (Medicare-only hospitals) or in both Medicare and commercial insurers (multipayer hospitals). Survey questions examined capacity in 4 areas: (1) physician performance feedback, (2) care management, (3) postacute care provider utilization, and (4) health information technology.

**RESULTS:** Our sample included 114 hospitals reporting experience in Medicare or commercial bundled payment programs. Both Medicare-only and multipayer hospitals reported high organizational capacities in performance measurement of physician-level quality and cost feedback and in incorporation of health information technology. More multipayer hospitals reported high capacity for coordinating hospital to postacute care settings (88% vs 52%). Although nearly all hospitals in both groups reported formalized relationships with skilled nursing facilities (98%), fewer hospitals reported such relationships with long-term acute care hospitals (83%) and inpatient rehabilitation facilities (80%).

**CONCLUSIONS:** Although they have similar capacity in a number of areas, Medicare-only and multipayer hospitals differed with respect to other aspects of organizational capacity.

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31, 2017, and April 30, 2018, among American Hospital Association (AHA) member hospitals identified by the AHA as having experience in voluntary bundled payment programs. The overall survey response rate was 38% (160/424), with 114 hospitals reporting experience with Medicare or commercial bundled payment programs and included in this analysis.

As described previously,<sup>10</sup> the survey included questions about 4 domains relevant to an organization's performance in value-based payment models. The domains were (1) physician performance feedback, (2) care management, (3) postacute care provider utilization, and (4) health information technology. Within each domain, respondents were asked to assess specific aspects of hospital capacity via 5-point Likert ("little to no ability" to "near complete to complete ability") and other ("yes" vs "no" vs "unsure") formats. The survey was pretested among study team members, AHA leadership, and several hospital executives.

**Statistical Analysis**

We focused our analysis on hospitals reporting participation in Medicare's BPCI program. Among BPCI hospitals, we used hospitals' survey responses about participation in commercial bundled payment programs to distinguish between multipayer hospitals (those reporting participation in both BPCI and commercial bundled payment programs) and Medicare-only hospitals (those reporting participation in BPCI only). Survey results were combined with 2017 AHA Annual Survey data to capture information about hospital characteristics.

Survey responses were summarized using percentages. We used  $\chi^2$  tests to compare categorical variables and *t* tests to compare continuous variables. For 5-point scale questions in each of the 4 organizational capacity domains, hospitals were deemed to have high capacity in a particular area if they reported a 4 or 5 on the 5-point scale; otherwise, they were deemed as having nonhigh capacity.<sup>10</sup> Non-Likert questions about capacity were dichotomized (yes vs no/unsure). Statistical tests were 2-tailed and significant at the 0.05  $\alpha$  level. Analyses were performed using SAS version 9.4 (SAS Institute). The survey was approved by the institutional review board at the University of Pennsylvania.

**RESULTS**

There were 88 Medicare-only and 26 multipayer hospitals in our sample. Multipayer hospitals tended to be larger than Medicare-only hospitals,

**TAKEAWAY POINTS**

A national survey demonstrated differences in organizational capacity between hospitals participating in Medicare bundled payment programs and those coparticipating in both Medicare and commercial bundled payment programs.

- ▶ Medicare-only and multipayer hospitals both have high capacity for quality and cost feedback, as well as for incorporation of health information technology.
- ▶ Compared with Medicare-only hospitals, more multipayer hospitals have high capacity for coordinating transitions from hospital to postacute care settings.
- ▶ Nearly all hospitals in both groups have formalized relationships with skilled nursing facilities, but fewer hospitals have such relationships with long-term acute care hospitals and inpatient rehabilitation facilities.

**TABLE 1.** Hospital Characteristics

Characteristic		Medicare-only hospitals (n = 88)	Multipayer hospitals (n = 26)	P
Hospital size, %	Small (< 100 beds)	6	0	.025*
	Medium (100-399 beds)	70	50	
	Large (≥ 400 beds)	24	50	
Geographic region, %	Northeast	23	50	.0019*
	Midwest	10	23	
	South	34	23	
	West	33	4	
Ownership, %	Government	9	0	.27
	Not-for-profit	78	88	
	For-profit	13	12	
Urban/rural, %	Urban	95	92	.53
	Rural	5	8	
Safety-net hospitals, %	Safety net	32	50	.09
	Non-safety net	68	50	
Teaching status, %	Nonteaching	24	12	.40
	Minor teaching	56	65	
	Major teaching	20	23	

\**P* < .05.

and they were more likely to be located in the Northeast (Table 1). No differences were observed in ownership, urban/rural setting, teaching status, or safety-net status between the 2 hospital groups.

**Physician Performance Feedback Capacity**

Multipayer and Medicare-only hospitals did not vary with respect to most facets of performance measurement, monitoring, or feedback capacity (Table 2). More multipayer hospitals reported high capacity for monitoring clinical quality data compared with Medicare-only hospitals (81% vs 55%; *P* = .016), but there were no significant differences in the content of information that was provided to physicians. Most hospitals in both groups reported providing physicians with clinical quality data across all levels of care (health system, hospital system, practice group, and individual levels). Across both groups, the majority of both multipayer and

## TRENDS FROM THE FIELD

**TABLE 2.** Organizational Capacity Domains, Medicare-Only vs Multipayer Hospitals

Survey question		Medicare-only hospitals (n = 88)	Multipayer hospitals (n = 26)	P
<b>A. Physician performance feedback</b>				
To what extent is your hospital able to monitor and provide timely feedback to physicians about their performance on clinical quality measures?				
Nonhigh capacity, %		45	19	.016*
High capacity, %		55	81	
What level(s) of information about performance on clinical quality measures is/are provided to physicians?				
Health system level, %	Yes	77	76	.79
	No	15	12	
	Unsure	8	12	
Hospital level, %	Yes	98	96	.56
	No	1	4	
	Unsure	1	0	
Physician practice or group level, %	Yes	80	92	.26
	No	8	0	
	Unsure	13	8	
Individual physician level, %	Yes	82	92	.26
	No	9	0	
	Unsure	9	8	
Are the following types of data used to monitor and/or provide feedback to physicians about performance on clinical quality measures?				
Insurance claims data, %	Yes	77	81	.91
	No	13	12	
	Unsure	10	8	
Clinical or electronic health record data, %	Yes	98	100	.74
	No	1	0	
	Unsure	1	0	
Patient care experience survey data, %	Yes	94	96	.74
	No	2	0	
	Unsure	3	4	
Patient-reported outcomes data, %	Yes	36	46	.60
	No	41	31	
	Unsure	23	23	
Other quality data, %	Yes	11	8	.55
	No	47	38	
	Unsure	42	54	
To what extent is your hospital able to monitor and provide timely feedback to physicians about their performance on cost measures?				
Nonhigh capacity, %		38	35	.79
High capacity, %		63	65	

(continued)

Medicare-only hospitals also reported using insurance (81% and 77%, respectively), electronic health record (100% and 98%), and patient survey (96% and 94%) data to monitor clinical quality.

There were no observed differences in either reporting capacity or content of monitored cost data. The majority of both multipayer and Medicare-only hospitals reported high capacity with respect to

cost monitoring, more commonly via hospital-level data (73% and 81%, respectively) than individual-level data (72% and 58%). Less than 50% of hospitals in both groups used patient-reported outcomes data (46% and 36%).

### Care Management Capacity and Postacute Care Utilization Capacity

The 2 hospital groups varied in reported capacity for care management and postacute care utilization (Table 2). Whereas the majority of both multipayer and Medicare-only hospitals reported having integrated care management programs to target high utilizers and high-cost conditions (69% and 58%, respectively), more multipayer hospitals reported care management processes in place to ensure smooth transitions after discharge to postacute care settings (88% vs 52%;  $P < .001$ ). Additionally, more multipayer hospitals reported efforts to reduce preventable utilization, including preventable postdischarge emergency department visits (77% vs 40%;  $P < .001$ ), compared with Medicare-only hospitals.

Uptake of several strategies across multipayer and Medicare-only hospitals was high, notably following up with patients within 48 hours of discharge via telephone (92% vs 91%), appointing patient navigators or care transition coaches (88% vs 84%), and using home visits (69% vs 70%). However, compared with Medicare-only hospitals, more multipayer hospitals provided discharge summaries to primary care physicians (96% vs 63%;  $P = .004$ ). Telemonitoring for patient follow-up was more common among Medicare-only hospitals (38% vs 27%;  $P = .002$ ).

Nearly all multipayer and Medicare-only hospitals reported formalizing some type of relationship with skilled nursing facilities (100% vs 98%, respectively) and home health agencies (100% vs 99%), but fewer reported analogous relationships with inpatient rehabilitation (88% vs 77%) and long-term acute care (88% vs 82%) facilities. Although both hospital types reported highly developed systems for determining patients' postdischarge need for skilled nursing

facilities, it was more common for multipayer hospitals to report similarly developed systems for home health (77% vs 50%;  $P = .02$ ).

### Health Information Technology Capacity

Hospital groups did not differ in health information technology capacity. The majority of multipayer and Medicare-only hospitals

used single electronic health records (73% and 77%, respectively), whereas a minority used multiple electronic health records (27% and 20%). Less than half of each (35% vs 43%) had the ability to apply risk stratification models to their patients using their electronic health record. Multipayer and Medicare-only hospitals did not differ with regard to ability to manage discrete bundles or episodes of care (42% vs 63%;  $P = .07$ ), access outside provider data (65% vs 81%;  $P = .10$ ), or conduct risk stratification and predictive risk assessment (35% vs 43%;  $P = .44$ ).

## DISCUSSION

This analysis demonstrated that although they have similar organizational capacity in a number of areas, Medicare-only hospitals and multipayer hospitals differ in key aspects of their institutional capacities. As these represent early descriptive data of organizational capacity among hospitals accepting bundled payments through multiple payers, several findings are noteworthy.

First, multipayer hospitals tended to have more developed systems to coordinate postdischarge care. Not only were multipayer hospitals more likely to have formal systems in place aimed at reducing preventable readmissions and postdischarge emergency department utilization, but they were also more likely to have programs designed to determine patients' postacute care needs, proactively coordinate postacute transitions in care, educate patients prior to discharge, and reach out to primary care providers.

These capabilities may reflect increased salience of the incentives under commercial programs or greater alignment or integration between hospitals and postacute care providers. Alternatively, observed differences may indicate a dose-response relationship through which participation in programs through multiple payers drives greater innovation in postacute care management. Any differences in postacute care capabilities are particularly salient as lower levels of postacute care have been identified as a key driver of dropping out of bundled payment programs.<sup>11</sup> Given the early descriptive nature of this study, however, future work should employ both quantitative and qualitative methods to further elucidate differences in postacute care between the 2 groups.

Second, compared with Medicare-only hospitals, multipayer hospitals reported greater capabilities related to providing physicians

with real-time feedback on quality performance. Although all hospitals are incentivized to achieve certain quality performance under bundled payments, observed differences may reflect the fact that incentives are stronger when applied across multiple payer segments. Alternatively, trends observed in this analysis could reflect larger potential savings or stronger incentives in the commercial

**TABLE 2.** (Continued) Organizational Capacity Domains, Medicare-Only vs Multipayer Hospitals

Survey question		Medicare-only hospitals (n = 88)	Multipayer hospitals (n = 26)	P
What level(s) of information about performance on cost measures is/are provided to physicians?				
Health system level, %	Yes	64	46	.27
	No	25	38	
	Unsure	11	15	
Hospital level, %	Yes	81	73	.38
	No	13	23	
	Unsure	7	4	
Physician practice or group level, %	Yes	72	65	.83
	No	19	23	
	Unsure	9	12	
Individual physician level, %	Yes	72	58	.39
	No	17	23	
	Unsure	11	19	
Are the following types of data used to monitor and/or provide feedback to physicians about performance on cost measures?				
Insurance claims data, %	Yes	73	77	.79
	No	17	12	
	Unsure	10	12	
Hospital billing data, %	Yes	76	81	.60
	No	14	15	
	Unsure	10	4	
Hospital cost accounting data, %	Yes	73	69	.80
	No	16	15	
	Unsure	11	15	
<b>B. Care management and postacute care utilization</b>				
To what extent are care management processes or programs in place to manage patients with high utilization or high-cost illnesses? (%)	Nonhigh capacity	42	31	.30
	High capacity	58	69	
To what extent is your hospital engaged in reducing preventable hospital readmissions? (%)	Nonhigh capacity	16	4	.11
	High capacity	84	96	
To what extent is your hospital engaged in reducing postdischarge emergency department use? (%)	Nonhigh capacity	60	23	.0009*
	High capacity	40	77	
To what extent are care management processes or programs in place to assure smooth transitions of care from the hospital to the postacute setting? (%)	Nonhigh capacity	48	12	.0009*
	High capacity	52	88	

(continued)

## TRENDS FROM THE FIELD

**TABLE 2.** (Continued) Organizational Capacity Domains, Medicare-Only vs Multipayer Hospitals

Survey question		Medicare-only hospitals (n = 88)	Multipayer hospitals (n = 26)	P
Please indicate whether the following approaches are utilized at your hospital to manage care transitions from the hospital to the postacute setting.				
Identifying patients who transition between care settings, %	Yes	95	100	.27
	No	0	0	
	Unsure	5	0	
Following up with patients within 48 hours of discharge via telephone, %	Yes	91	92	.93
	No	6	4	
	Unsure	3	4	
Using telemonitoring to follow up with patient, %	Yes	38	27	.0019*
	No	57	42	
	Unsure	6	31	
Assigning patients to care transition coaches or patient navigators, %	Yes	84	88	.54
	No	11	12	
	Unsure	5	0	
Using home visits to follow up with patients, %	Yes	70	69	.99
	No	23	23	
	Unsure	7	8	
Notifying patients' outpatient providers of discharge from hospital, %	Yes	80	69	.46
	No	8	15	
	Unsure	13	15	
Providing discharge summary to PCP and other outpatient physicians, %	Yes	63	96	.0043*
	No	5	0	
	Unsure	33	4	
Providing discharge summary to other providers (eg, rehabilitation facilities), %	Yes	89	88	.55
	No	3	0	
	Unsure	8	12	
Sharing clinical information between care settings, %	Yes	92	96	.54
	No	5	0	
	Unsure	3	4	
Educating patients prior to admission about expected hospital and postdischarge care plans, %	Yes	65	77	.35
	No	6	8	
	Unsure	30	15	
Educating patients during admission about postdischarge care plans, %	Yes	75	96	.061
	No	1	0	
	Unsure	24	4	
Other methods for postacute care transition, %	Yes	7	4	.51
	No	27	38	
	Unsure	66	58	

(continued)

programs, or greater experience at multipayer hospitals with quality incentives—and, in turn, investments that can contribute to bundled payment success (eg, in data sharing capabilities).<sup>12</sup> Future work is needed to investigate these potential dynamics.

Our data also suggest potential areas of capacity building for both hospital groups. Neither group reported uniformly developing formal relations with inpatient rehabilitation centers and long-term acute care hospitals (as they have with skilled nursing facilities). Given the

considerable costs associated with both types of facilities, greater emphasis on formalizing institutional protocols and discharge criteria may become more important with time. Additionally, a plurality of hospitals in both groups had yet to provide physicians with real-time cost data on the individual or group practice level, instead favoring hospital-level data, which are less directly actionable for the individual. Although both hospital groups incorporated survey data about patient experience in physician feedback on quality performance, less than half in both groups reported incorporating patient-reported outcomes data.

### Limitations

Our study had limitations. First, as with all surveys, it was subject to self-report and potential recall bias, as well as differences in how respondents may have interpreted questions or quantified capacity. Second, results may also have limited generalizability due to sampling strategy, focus on AHA member hospitals with known bundled payment experience, a 38% overall survey response rate, and inclusion of a subset of hospitals with bundled payment experience. Data availability precluded comparison of respondents with nonrespondents or non-bundled payment hospitals.

Third, our findings reflect a description of trends rather than an assessment of causal relationships. Additional analyses should be conducted to evaluate the relationship between organizational capacity and patient outcomes. Fourth, due to data limitations, this analysis could not compare and contrast differences between hospital groups with respect to value-based payment models or overall hospital incentive structures as wholes. These should be focus areas in future work.

## CONCLUSIONS

Although they reported similar organizational capacity in a number of areas, Medicare-only and multipayer hospitals differed with respect to other areas of capacity. Future work should build on these descriptive data and use a range of methods to evaluate the implications of observed capacity differences. ■

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## REFERENCES

1. Bundled Payments for Care Improvement (BPCI) initiative: general information. CMS. Accessed March 3, 2021. <https://innovation.cms.gov/innovation-models/bundled-payments>
2. Navathe AS, Emanuel EJ, Venkataramani AS, et al. Spending and quality after three years of Medicare's voluntary bundled payment for joint replacement surgery. *Health Aff (Millwood)*. 2020;39(1):58-66. doi:10.1377/hlthaff.2019.00466
3. Rotnick JA, Liao JM, Emanuel EJ, et al. Spending and quality after three years of Medicare's bundled payments for medical conditions: quasi-experimental difference-in-differences study. *BMJ*. 2020;369:m1780. doi:10.1136/bmj.m1780
4. Comprehensive Care for Joint Replacement Model. CMS. Accessed April 11, 2021. <https://innovation.cms.gov/innovation-models/cjr>
5. BPCI Advanced. CMS. Accessed June 3, 2020. <https://innovation.cms.gov/innovation-models/bpci-advanced>
6. Glickman A, Dinh C, Navathe AS. The current state of evidence on bundled payments. *LDI Issue Brief*. 2018;22(3):1-5.
7. Song Z, Chokshi DA. The role of private payers in payment reform. *JAMA*. 2015;313(1):25-26. doi:10.1001/jama.2014.15904
8. Corrigan J, McNeill D. Building organizational capacity: a cornerstone of health system reform. *Health Aff (Millwood)*. 2009;28(2):w205-w215. doi:10.1377/hlthaff.28.2.w205
9. Peiris D, Phipps-Taylor MC, Stachowski CA, et al. ACOs holding commercial contracts are larger and more efficient than noncommercial ACOs. *Health Aff (Millwood)*. 2016;35(10):1849-1856. doi:10.1377/hlthaff.2016.0387

**TABLE 2.** (Continued) Organizational Capacity Domains, Medicare-Only vs Multipayer Hospitals

Survey question		Medicare-only hospitals (n = 88)	Multipayer hospitals (n = 26)	P
To what extent are there formal systems for determining which patients are discharged to:				
SNFs, n (%)	Low (≤3)	22 (25)	6 (23)	.84
	High (4 or 5)	66 (75)	20 (77)	
Inpatient rehabilitation facilities, n (%)	Low (≤3)	41 (47)	8 (31)	.15
	High (4 or 5)	47 (53)	18 (69)	
Home health agencies, n (%)	Low (≤3)	44 (50)	6 (23)	.015*
	High (4 or 5)	44 (50)	20 (77)	
Long-term acute care hospitals	Low (≤3)	44 (50)	9 (35)	.17
	High (4 or 5)	44 (50)	17 (65)	
Has your hospital established formal contractual relationships, nonownership written agreements (eg, preferred network list), or informal relationships with the following postacute care providers?				
SNFs, n (%)	Yes	86 (98)	26 (100)	.44
Inpatient rehabilitation facilities, n (%)	Yes	68 (77)	23 (88)	.21
Home health agencies, n (%)	Yes	87 (99)	26 (100)	.59
Long-term acute care hospitals, n (%)	Yes	72 (82)	23 (88)	.42
<b>C. Health information technology</b>				
To what extent are there health information technology systems for applying risk stratification and predictive risk assessment to patients and their care? (%)	Nonhigh capacity	57	65	.44
	High capacity	43	35	
To what extent is your hospital able to use health information technology processes to access data from providers with which it has no formal relationship (eg, outpatient or postacute care providers)? (%)	Nonhigh capacity	19	35	.10
	High capacity	81	65	
To what extent is your hospital able to use health information technology processes to specifically manage discrete bundles or episodes of care? (%)	Nonhigh capacity	38	58	.07
	High capacity	63	42	

PCP, primary care physician; SNF, skilled nursing facility.

\*P < .05.

10. Liao JM, Clodfelter RP, Huang JJ, et al. Organizational capacity of hospitals co-participating in accountable care organizations and bundled payments. *Am J Med Qual*. 2022;37(1):39-45. doi:10.1097/01.JMQ.0000741980.70096.ce
11. Joynt Maddox KE, Orav EJ, Zheng J, Epstein AM. Characteristics of hospitals that did and did not join the Bundled Payments for Care Improvement - Advanced program. *JAMA*. 2019;322(4):362-364. doi:10.1001/jama.2019.7992
12. Freeman R, Coyne J, Kingsdale J. Successes and failures with bundled payments in the commercial market. *Am J Manag Care*. 2020;26(10):e300-e304. doi:10.37765/ajmc.2020.88503

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