CATALYST FOR PAYMENT REFORM

Implementing Bundled Payment

Action Brief

WHAT IS BUNDLED PAYMENT?

Bundled payment, sometimes referred to as "episode-based payment," entails reimbursement for all of the services needed by a patient, across multiple providers and possibly multiple care settings, for a treatment or condition.

Bundled payment received a boost when the 2010 Patient Protection and Affordable Care Act (PPACA) included Medicaid demonstration (2012) and Medicare pilot (2013) bundled payment programs.

WHAT PROBLEM DOES BUNDLED PAYMENT TRY TO SOLVE?

Bundled payment seeks to address the problem of the cost of an episode of care for a particular condition being unnecessarily high and/or where there is high variation in the cost and quality of episodes of care among similar patients and across regions. Unlike global payment, bundled payment does not address the potential problem of *too many* episodes of care being delivered. As a result, it works best where there are not concerns about excessive volume of episodes of care, but instead concerns about the performance for each episode.[1]

Bundled payment requires providers to assume risk for the efficient and effective delivery of a bundle of services, but not for the occurrence of a patient's condition. This makes bundled payment more attractive to some providers than global payment which, while risk-adjusted, transfers more financial risk to providers because it represents payment for a more comprehensive array of services, if not all services.

A RESPONSE TO FFS

Bundled payment responds to some of the problems with the existing predominant fee-for-service (FFS) payment, including:

- FFS does not create incentives for, or reward, superior care delivery or outcomes, nor does it incent or reward efficient resource use or care coordination across providers or settings.
- FFS creates a financial incentive for each provider to shift costs onto other providers involved in separately-paid portions of a patient's care.

How does bundled payment work?[2]

Two key design decisions for bundled payment are:

1. the duration of the episode of care comprising the bundle; and,
2. which providers and which services are included within the definition of a given bundle.

Bundled payments can be structured in two different ways, depending upon whether the payment is for a specific treatment or for a chronic condition.

Bundled Payment for a Specific Treatment

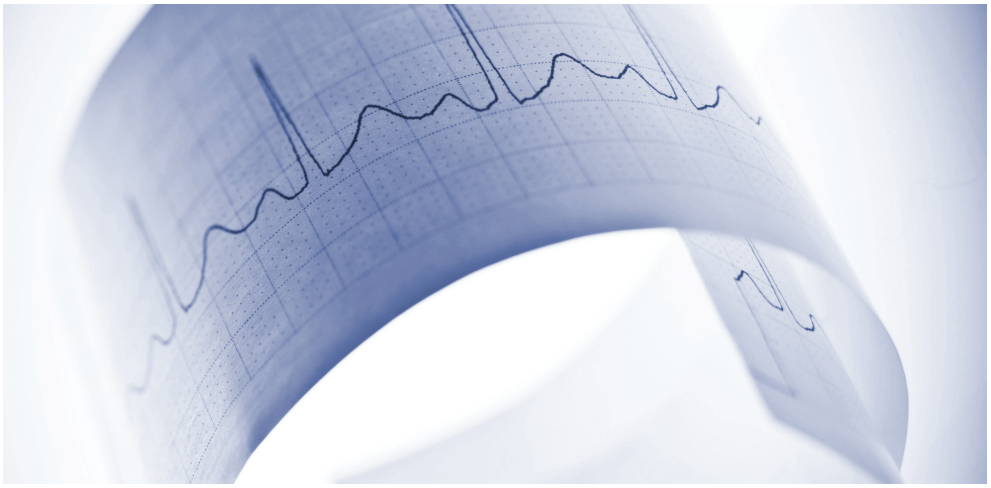
In this application, the bundled payment is often oriented around an inpatient surgical procedure, and incorporates any anticipated post-discharge services, including home health and rehabilitation. The payment is made for all services which the patient is anticipated to use based on evidence-based guidelines, including physician, hospital and other professional services. If the incurred costs exceed the payment, the participating providers are financially at risk for the difference. Conversely, they experience a financial gain if costs are less than the value of the payment.

Bundled Payment for a Chronic Condition

Bundled payment can also be applied to payment for chronic conditions, such as diabetes and congestive heart failure. In this case the payment is made in anticipation of all services to be received for treatment of that condition over the course of a defined time period, typically a calendar year. Some view this form of bundled payment as equating to condition-specific global payment.

Whether the bundled payment is for a specific treatment or a chronic condition, payment covers the average cost of a bundle of services, giving providers an incentive to keep their costs below the bundled payment amount. More specifically, there are incentives to reduce the number of services that have no or minimal benefit, and to encourage coordination of care by holding multiple providers, across care settings, jointly accountable.

Bundled payment can be combined with pay-for-performance incentives, so that providers have complementary incentives to perform well on access, clinical quality, patient experience and/or efficiency metrics.



HAS BUNDLED PAYMENT BEEN TRIED BEFORE?

Medicare has tested the concept on a larger scale with some success. There are also limited additional bundled payment examples.

- The Medicare Participating Heart Bypass Center Demonstration (1991-1996) selected four hospitals to receive a single payment covering hospital and physician services for coronary artery bypass graft surgery. CMS did not permit any outlier payments. The amount of the combined payment was negotiated between 10% and 37% below the then-current payment levels. A formal evaluation revealed that physicians were able to identify ways to reduce length of stay and unnecessary hospital costs, resulting in cost decreases of two to 23% in three of the four hospitals. Furthermore, this study found that the cost reduction increased over time.[3]
- The Medicare Acute Care Episode Demonstration began in 2009 with five hospitals for cardiac care and orthopedic care and has yet to report any results.
- Geisinger Health System in PA began in 1996 to offer a fixed price for non-emergency coronary artery bypass (CABG) surgery through a program named ProvenCare®. The fixed price includes all professional and hospital fees, and any costs associated with readmissions within 90 days of discharge. The price for the bundle of services was set at a level calculated to cover average routine treatment costs plus half of the historical average costs for treating complications. Geisinger also guarantees adherence to 40 quality process measures for CABG surgery. An evaluation found a 5% reduction in hospital costs, as well as drops in average length of stay in the hospital and in readmissions.[4] As of October 2010 ProvenCare® was offered for a total of eight procedures and other services.[5]
- PROMETHEUS Payment, Inc. has developed a bundled payment system for multiple treatments and conditions, and began to implement pilots in three sites in 2009. The payments are risk-adjusted and are based on the resources required to provide care as recommended in well-accepted clinical guidelines. The system specifies that a portion of the payment be withheld and re-distributed based on provider performance on measures of clinical process, outcomes of care, and patient experiences.[6] As of October 2010 there were PROMETHEUS "episode treatment groups" established for 21 treatments and conditions.[7] Reported pilots included two in New York, three Colorado, and pilots in New Jersey, North Carolina, Missouri and Oregon.[8]

Limited applications of bundled payment have been in place for years. For example, Medicare has paid for hospital services on a limited bundled basis (i.e., bundling only hospital services) through the DRG system since 1983. In addition, obstetricians are often paid a bundled payment for prenatal, delivery and postpartum care.

What problems could it produce?

Provider interest and readiness to contract on this basis varies. The Employers Coalition on Health (IL) is in the process of piloting the PROMETHEUS model and reports that while providers were receptive, they were not without reservations. Selecting an initial set of bundles for chronic care conditions focused on underuse (and not overuse) was helpful in gaining provider support.

There is currently enthusiasm regarding the potential of bundled payment to restrain cost growth and improve quality. There are, however, challenges and potential problems related to the application of bundled payment. These include:

WHAT PROBLEMS COULD IT PRODUCE?

There are challenges and potential problems related to the application of bundled payment. These include:

- Administrative challenges with performance measurement, insurer and TPA claims administration, and provider financial systems to support billing and receipt of payment for bundled services.
- Episodes of care need to have clear start and end dates, and condition-defined bundled payments need tight definitions so that it is clear which patients are eligible, and which are not. Lack of clarity could result in conflict between providers and payers.
- Distribution of clinical and financial accountability across the providers involved needs to be well-defined if the providers are to coordinate efforts effectively.
- Consumers might be distrustful if they know that their providers are managing within a budget for a service or treatment of a condition.
- Providers may avoid serving expensive patients if payments are not adequately risk-adjusted.

What steps can a purchaser take?

- ENCOURAGE your insurer or TPA to enter bundled payment arrangements that:
  - make provider reimbursement contingent, in part, on performance on access and quality measures to protect against an incentive to undertreat;
  - protect providers against catastrophic financial loss through risk-adjustment of payment and other means;
  - allow for participation by self-insured employers;
  - support testing and/or use of for broad network products (if desired by the employer in response to a consumer preference for a broad choice of provider); and,
  - make the quality performance of providers receiving bundled payment transparent as Geisinger has done,[9] and share it with employees.
- CONSIDER modifying the benefit plan to provide incentives for employees to seek care from highly performing providers being reimbursed with bundled payments for specific services or condition.
- ANTICIPATE a multi-year transition, and encourage your TPA or insurer to phase in implementation, allowing providers to assume gradually increasing responsibility for more services within the bundle, and for more financial risk.[10]

1."Which Payment System is Best?", Center for Healthcare Quality and Payment Reform. See www.chqpr.org/downloads/WhichPaymentSystemisBest.pdf
2. "Bundled Payment: AHA Research Synthesis Brief", American Hospital Association Committee on Research, May 2010 and "Overview of Bundled Payment", RAND Corporation, see www.randcompare.org/policy-options/bundled-payment.
3. Cromwell J, Dayhoff DA and Thoumaian AH. "Cost Savings and Physician Responses to Global Bundled Payments for Medicare Heart Bypass Surgery" *Health Care Financing Review*, 9(1): 41-57, fall 1997.
4. Casale AS et. al. "'ProvenCareSM': A Provider-Driven Pay-for-Performance Program for Acute Episodic Cardiac Surgical Care," *Annals of Surgery*, Vol. 246, No. 4, October 2007, pp. 613-623.
5. See www.geisinger.org/provencare/portfolio.html.
6. de Brantes F and Camillus JA. "Evidence-Informed Case Rates: A New Health Care Payment Model", The Commonwealth Fund, April 2007.
7. http://hci3.org/Content/ContentDisplay.aspx?ContentID=109
8. Health Care Incentives Improvement Institute, Inc. Newsletter, Issue 7, October 15, 2010.
9. See www.geisinger.org/provencare/numbers.html.
10. See "Transitioning to Episode-Based Payment," Center for Healthcare Quality and Payment Reform. See www.chqpr.org/downloads/TransitioningtoEpisodes.pdf.