catalyst FOR PAYMENT REFORM

Action Brief
Implementing Bundled Payment

WHAT IS BUNDLED PAYMENT?

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

Bundled payments can be thought of as two dimensional: the clinical dimension representing the services or conditions included in the episode of care, and a time dimension representing the duration of the episode. For example, if a patient undergoes surgery, payers traditionally reimburse each aspect of the service separately- the surgeon, facility, anesthesiologist, etc. Using bundled payment, the payer collectively reimburses for all aspects of an episode of care, using a set price.

WHAT PROBLEMS DOES BUNDLED PAYMENT TRY TO SOLVE?

Bundled payment seeks to address unnecessarily high costs of an episode of care for a particular condition and/or 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 payments incentivize care coordination and efficiency by providers, potentially reducing the use of medically unnecessary services or tests. Clinician and/or facilities receiving a bundled payment share a common financial interest to control the cost of each bundle of care because they are eligible to keep the savings, or conversely bear the cost if treatment costs exceed the episode's fixed price.

A RESPONSE TO FFS

Bundled payment responds to some of the problems with 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 case 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.

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 capitation, which, despite being risk-adjusted, transfers more financial risk to providers because it represents payment for a more comprehensive array of services, if not all services.

Implementing bundled payments can be seen as a pathway between volume-based payments and population-based payments, such as global capitation. Bundled payments allow clinicians and organizations to phase into broader payment reforms, creating an opportunity to evaluate changes in quality and cost.

Two key design decisions for bundled payments 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.

HOW DOES BUNDLED PAYMENT WORK?

Bundled payments can be structured in two different ways, depending on 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 that 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 delivered 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 or capitated 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.

HOW EFFECTIVE IS BUNDLED PAYMENT?

Results on bundled payments to date are mostly promising but not consistent.[2] While most program results appear to trend in a positive direction, many studies may not capture the full picture and overlook the unintended consequences associated with bundled payment implementation.

Generally, bundled payments have led to lower episode costs, though the results fail to address whether number of episodes performed may have increased given the incentive to perform more episodes of care. Packaging several services into one also creates the potential for providers to cut back on patient care.

So far, the majority of studies focus on positive cost savings and reductions in utilization of medically unnecessary tests or procedures. To assess bundled payment programs critically moving forward, it's important to pay attention to quality improvement efforts, appropriateness of care assessments (to avoid skimping on care or overtreating), and the volume and pricing of services not related to bundled payments as providers may see these as areas to cost-shift in order to compensate financially for the implementation of bundled payments.

EXAMPLES OF BUNDLED PAYMENT MODELS IN ACTION:

CMS' Bundled Payments for Care Improvement (BPCI) Initiative - Ongoing [3]

- In 2011, CMS introduced a bundled payment initiative to transition away from traditional FFS models of payment to value-based care.
- The BPCI program has offered participating providers four models of bundled payments to choose from for 48 different episodes of care.
- As of July 2015, 1,025 health care organizations were participating in the initiative.
- The organizations are in the process of rolling out bundled payment models and have seen mixed results to date: [4,5,6]
  - Total spending per episode for joint replacements without complications decreased by 20.8%, or $5,577;
  - Readmission and ED visits declined 1.4% and 0.9%, while episodes of prolonged length of stay decreased 67.0%; and
  - Across the models, quality was generally maintained or improved, but changes were mostly neutral.

Total hip and knee replacement surgeries can range from $16,500 to $33,000 in different geographic areas. CMS is using episode-based care to standardize payment and hold providers more accountability for the quality and cost of these procedures.

CMS' Comprehensive Care for Joint Replacement (CJR) Model[7]

- Introduced in 2016, hospitals participating in the CJR are providing total hip and knee replacements for Medicare beneficiaries using episodes of care payment structure.
- Hip and knee replacements are the most common inpatient surgery for Medicare beneficiaries. Despite a high volume of these surgeries, quality and cost vary widely across providers and geographic areas, ranging from $16,500 to $33,000.
- The model began operating in 2016 and is slated to run for five years in 67 geographic areas.
- Medicare estimates that the bundled payment initiative will lead to $153 million in savings.
- In the first year, out of 799 hospitals participating in CJR, 48% received a reconciliation payment and 52% did not. To be eligible for a reconciliation payment, hospitals had to both generate savings and achieve a certain level of quality performance.[8]

UnitedHealthcare's Value-Based Care Program for knee, hip and spine surgeries has demonstrated improved health outcomes and generated $18 million in total savings.[9, 10]

- The program began as a small pilot in 2016 and has expanded nationally to 46 health care facilities, contracting with 115 employers to cover 3 million employees.
- The program gives employees access to providers and facilities that UnitedHealthcare deems Centers of Excellence accepting bundled payments.
- To date, the program has reduced hospital readmissions by 22 percent for joint procedures, 10 percent for spine procedures and has led to reduced complications for both.
- Since the program's initiation, employers have generated average savings of $18,000 per operation, and participating employees have saved more than $3,000 in out-of-pocket costs per procedure.

WHAT PROBLEMS COULD BUNDLED PAYMENT PRODUCE?

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:

- 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-specific 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 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 or skimping on care in a fixed-episode payment approach if the set price is not 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 and share it with employees;
- CONSIDER modifying the benefit plan to provide incentives for employees to seek care from high-performing providers receiving bundled payments for specific services or conditions, such as centers of excellence.
- 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. See CPR's Total Joint Replacement Bundled Payment Toolkit for guidance (https://www.catalyze.org/product/tjr-bp-toolkit/).
- LEARN about independent vendors that arrange for employers to carve out particular episodes of care and use bundles to pay for them.[11]
- PARTICPATE in state-based efforts led by Medicaid programs to implement bundled payments, if applicable.
- ENSURE that your insurer or TPA gets its bundled payment programs approved by CMS as an advanced alternative payment model under the MACRA program to encourage additional physicians to participate in bundled payment programs administered by the insurer or TPA.

ABOUT US

Catalyst for Payment Reform (CPR) is an employer-led, national nonprofit on a mission to catalyze employers, public purchasers and others to implement strategies that produce higher-value health care and improve the functioning of the health care marketplace.

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