White Paper

Bundled Payments 101

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Introduction

The bundling of payments to healthcare providers is not new. Medicare's diagnosis-related groups (DRGs), which were introduced in 1983, are essentially bundled payments for hospital services, categorized by diagnosis and severity. But in recent years, bundled payments in both the public and private sectors have expanded to include physicians and post-acute care (PAC) providers as well as hospitals. Some bundling arrangements include multiple care settings, such as hospitals, ambulatory care offices, PAC facilities and home with or without nursing help.

According to a report on alternate payment models from the Bipartisan Policy Center (BPC), "Bundled payment is a system under which a provider or group of providers are paid based on an episode of care, rather than independently receiving individual payments for each service."[1]

A bundled payment can be a single, fixed payment, based on historical spending, for the services in the bundle. This is known as a *prospective* payment, because it is determined before the services are rendered. In contrast, a *retrospective* bundled payment is determined relative to a benchmark based on either national or regional spending or the historical spending of the participants. In this model, participating providers are paid fee for service, and the cost of the episode is measured against the benchmark after the episode ends. If the episode costs less than the benchmark, the providers keep the difference, as in the Centers for Medicare & Medicaid (CMS) case, after a stipulated discount. If it costs more than the benchmark, they must refund the difference to the payer.

Most bundled payment contracts are retrospective. Providers grasp the idea of being paid the traditional way—setting up the payer at the end of the episode—because it can be more difficult to receive a sum of money in advance and figure out how to provide appropriate care for that sum. Moreover, the hospitals or physician groups that receive the money may lack the infrastructure they need to distribute any bonuses fairly among the bundling participants.

Even retrospective bundling has not gotten many voluntary takers. In fact, just 1.6 percent of healthcare payments in 2013 involved bundling.[2] But the uptake of bundled payment contracts by accountable care organizations (ACOs) has been considerably higher. A 2015 survey found bundled or episode-based payments in 13.5 percent of physician-led ACOs, 33 percent of physician-hospital-led ACOs, and 47.5 percent of ACOs led by integrated delivery systems.[3]

No risk adjustment

One reason that bundling has gotten off to a slow start is that CMS has not adjusted the payments for the risk involved in particular cases beyond the severity-based payment differences between DRGs.[4] As a result, if a hospital or a physician group has sicker-than-average Medicare patients, they are less likely to profit from bundling than are providers with healthier patients.

Providers and payers are also conflicted as to how to properly define a bundle. If the definition is too broad, the providers are likely to lose; if the definition is drawn too narrowly, the payer loses. Failure to agree on bundle definitions was a major reason why the three-year Integrated Healthcare Association pilot in California didn't succeed. In addition, the health plans in the pilot wanted to offer providers a per-episode price below the historical benchmark, while the hospitals wanted a higher price to justify their risk.[5]

The BPC report made a few recommendations on how to create viable episodes of care for bundling. To begin with, the report said, the episodes should involve conditions or procedures for which the cost of care varies widely. They should be episodes that require coordination across a fairly small number of providers, especially ones that already have relationships with each other. Patient variation should be low enough, or patient volume high enough, to help ensure the benchmark is meaningful to the bundle. If too many cases are outliers in terms of cost, the risk to providers can be too great.

BPC also said that episodes for acute services that best lend themselves to a bundle are those that have distinguishable start and end limits and do not have many co-morbidities. Hip and knee replacements, glaucoma management and chemotherapy are a few examples of episodes that are more primed to implement as bundles. Additionally, there is significant potential for bundles that combine inpatient and post-acute care, which would encourage better coordination, quality improvement and cost-containment efforts across a variety of care settings. In Medicare cases, we know that much of the geographic variation in spending per beneficiary results from variation in post-acute-care utilization.[6]

Other than chemotherapy for cancer, and high-risk respiratory ailments such as chronic obstructive pulmonary disease (COPD), chronic diseases are generally not the basis of bundled payments. "Much chronic disease management remains difficult to reimburse as an episodic payment," especially if it involves comorbidities, BPC noted. ACOs and Patient-Centered Medical Homes (PCMH) are better suited to managing these conditions, it said.

An analysis of the Bundled Payments for Care Improvement (BPCI) Initiative found that in phase 2, where hospitals had to begin taking risk, 50 percent of the remaining participants enrolled for just one clinical condition, and 72 percent enrolled for three or fewer conditions. Hospitals tended to have a large volume in the conditions that they selected, which suggests they felt they could perform well in those bundles.[7]

The five most common conditions chosen for bundled payments were major joint replacement of the lower extremity (72.9 percent); congestive heart failure (35.5 percent); chronic obstructive pulmonary disease, bronchitis, or asthma (25.2 percent); simple pneumonia or respiratory infections (20.6 percent); and hip and femur procedures apart from major joint replacement (18.7 percent).[8]

Quality measures

Observers caution that bundled payments can lead to two types of unintended consequences. First, providers may increase the number of episodes that qualify for bundled payments. The BPC report, for instance, warns against including supply-sensitive conditions such as back pain in the list of bundles, because that might incentivize providers to perform unnecessary procedures.[9]

Second, bundled payments can lead to skimping on care. The best way to guard against that, experts say, is to include quality measures in bundling contracts. "When designed to improve value, bundled payment should include clear quality metrics focused on desired clinical outcomes that providers must achieve to maximize their payment," Suzanne Delbanco argued in a Health Affairs blog post.[10]

All of CMS's reform initiatives are designed to improve quality as well as lower costs, but the agency hasn't always followed through in that respect. For example, while CMS monitors quality in the BPCI initiative, it does not require participants to meet quality thresholds in order to receive bonuses.[11] In contrast, the Comprehensive Care for Joint Replacement (CCJR) program "holds participant hospitals financially accountable for the quality and cost of a [CCJR] episode of care and incentivizes increased coordination of care among hospitals, physicians, and post-acute care providers," according to CMS.[12]

Government programs

Except for inpatient DRGs, CMS' first bundled payment demonstration project was its coronary heart bypass graft (CABG) initiative, which ran from 1991 to 1996. While small in scope — just seven hospitals were involved — the project cut Medicare's CABG costs in those hospitals by 10 percent and reduced mortality rates and post-surgical complications.[13]

In 2009, CMS launched the three-year Acute Care Episode (ACE) demonstration, testing prospective bundled payments for cardiac and orthopedic surgery. The services covered by bundling included inpatient care and physician services during a hospital stay. Five hospitals and health systems participated in ACE. In the first two years, Hillcrest Health of Tulsa, OK, saved US$ 1.59 million, and its quality of care did not decline, according to one analysis. Quality remained high or improved at Hillcrest and at Lovelace Health in Albuquerque, NM, because the physicians had to meet quality thresholds to participate in gainsharing with the hospitals.[14]

The BPCI, which kicked off in 2013, includes four different models. The first model, which was sunset in March 2016[15] involved bundling of inpatient services only, with hospitals and physicians paid separately for care provided under any DRG. For the other models, hospitals can choose among 48 clinical episodes. In model 2, the episode includes an inpatient stay plus post-acute care and related services for up to 90 days after discharge. In model 3, the episode is triggered by a hospital stay but begins with transfer to a post-acute-care facility or home health services. Both of these models include a retrospective payment method in which the episode cost is later reconciled against a benchmark. In model 4, CMS makes a single, prospective payment to a hospital for all hospital services, including those provided by physicians and other clinicians during the episode of care. The hospital distributes the money due to other participants in the bundling arrangement.[16]

As mentioned earlier, BPCI includes two phases. In the first phase, hospitals can look at Medicare's data and decide whether they want to go onto phase 2, which requires them to enter a bundled payment contract. As of April 1, 2016, BPCI had 1,522 phase 2 participants, including 321 awardees that are taking financial risk. Among the participants are acute care hospitals, skilled nursing facilities, physician group practices, home health agencies, inpatient rehabilitation facilities, and a long-term care hospital. The maximum amount that a hospital can gain or lose under BPCI is 20 percent.[17]

The CCJR Model, a mandatory program that covers about 800 facilities in 67 hospital service areas, began April 1, 2016. The five-year demonstration bundles payments for hip and knee surgery. Episodes of care begin with a hospitalization and end 90 days after discharge. All Medicare Part A and Part B services and items are included in the bundle, with certain exclusions. The differences between benchmarks and actual costs form the basis for retrospective payments by or to CMS.[18]

In an analysis of CCJR, health policy expert David Mechanic noted that a major goal of the initiative is to reduce the cost of post-acute care, which varies greatly from one PAC provider to another. While hospital costs for hip and knee replacements cost Medicare more than US$ 7 billion in 2013, he pointed out, the program also spent about US$ 6 billion for post-acute care of patients recovering from those procedures.[19]

CCJR presents a major financial challenge for hospitals, Mechanic observed. One reason is that average spending per episode can vary greatly, depending on patient differences and other factors. A few outliers can have a big financial impact. CMS has tried to mitigate this problem by capping each hospital's annual gains and losses. Hospitals have no downside risk in 2016; losses are capped at 5 percent and 10 percent of spending in years two and three, and at 20 percent thereafter.[20]

The quality measures in CCJR include 30 day all cause readmission rates, complication rates, and patient experience scores. Hospitals will have to score above the 30th percentile on all these measures to keep CCJR savings, Mechanic observed, adding that most hospitals will likely fail on at least one. He also questioned the lack of risk adjustment, which he said would cause a lot of pushback from hospitals.

Private sector programs

Bundled payment programs are also found in the private sector. Some of these health-plan programs are based on a forerunner of today's bundling initiatives called Prometheus Payments. Created by the Health Care Incentives Improvement Institute (HCI3), Prometheus bundles payments for all services related to a single illness or condition during an episode of care. The costs of treatment are funded out of a risk-adjusted, patient-specific budget for the care episode. Using evidence-based practice guidelines, HCI3 developed *evidence-informed case rates* for a number of acute and chronic conditions and inpatient procedures. Prometheus gave clinicians incentives to collaborate and to avoid complications in order to do well financially.[21]

Although HCI3's own pilots with several health plans did not go well, the concept was carried on by insurers such as Horizon Blue Cross Blue Shield of New Jersey and BlueCross Blue Shield of North Carolina (BCBSNC).

Unlike CMS' bundling approach, which gives hospitals the central role, Horizon's *episodes of care* program focuses on the role of physicians. In each episode of care, a single practice or physician orchestrates the full spectrum of care related to a specific service, procedure or diagnosis within a defined time period. Among these bundles are hip and knee replacement, knee arthroscopy, pregnancy and delivery, colonoscopy, breast cancer, heart failure, and CABG.[22]

In the pregnancy and delivery episode, for example, obstetricians and gynocologists lead and organize all care related to pregnancy, delivery and post-delivery recovery. The doctors are paid an agreed-upon amount and can get shared savings if they meet program goals.[23]

BCBSNC started using the Prometheus Payment model in 2011. In its initial foray, the insurer worked with CaroMont Health, a healthcare system, and its physicians on a knee replacement episode, including the 30 days before hospitalization and six months after discharge. Community doctors played a key role in developing the program, but the hospital system took the financial risk.[24]

BCBSNC later made knee replacement bundling deals with OrthoCarolina, a large orthopedic group; Duke University Health System (now Duke Medical); and Novant Health, a major healthcare system. These contracts covered the procedure plus 90 days of either post-surgical or post-discharge care.

Some employers have also made bundling arrangements with large providers. The Advisory Board Co., a healthcare consulting firm, has identified more than a dozen such contracts across the country.[25]

As can be deduced from this brief summary, private sector bundling efforts are on a much smaller scale than those of CMS. But if CMS' current initiatives succeed, they could be expanded to all of Medicare.[26] According to a September 2016 study in the Journal of the American Medical Association, "In the first 21 months of the BPCI initiative, Medicare payments declined more for lower extremity joint replacement episodes provided in BPCI-participating hospitals than for those provided in comparison hospitals, without a significant change in quality outcomes." If further research confirms such results, it would be reasonable to expect private payers to follow CMS' lead, as they have historically done.

Footnotes

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