

Issue Paper
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Bundled Payment

As the healthcare industry seeks to improve efficiency and outcomes, and control spiraling costs, payment reform is a key focus. Among the many drivers of payment reform, three considerations stand out:

- The industry has recognized a need to shift away from rewarding utilization toward paying for good outcomes, finally heeding providers' decades-long plea to look at their results. This is part of a paradigm shift from providing 'sick care' to promoting wellness.
- Any reform must bring about greater alignment between payors and providers, with appropriate incentives for hospitals and physicians to improve quality, efficiency and outcomes.
- Reducing variability in care, not just reducing cost, must be inherent to any initiative.

Until now, we have experimented primarily with two payment approaches. The fee-for-service approach that leaves the full insurance risk with the payor is now regarded as a root cause for poor coordination of care and system overutilization. Capitation, at the other extreme, provides a lump sum for the care of each individual – thus transferring the full insurance risk to the provider. In between is a system of “bundled payment,” an approach that is now the focus of great interest.

“Bundled payment” refers to a single payment for all care related to a treatment or condition – a payment that is then apportioned to multiple providers across many settings. Also called “episode-based payment” or “case rate” payment, bundled payment is being looked to as a mechanism for improving both cost and quality. An “episode” can take many forms – such as a single rate for all services relating to a particular procedure (as already is done with global payments for certain surgeries), or combining hospital care and post-acute care, or all treatment of a chronic condition for a defined period of time.

Compared with fee-for-service, a bundled payment system requires providers to bear more of the financial responsibility for outcomes. This creates an additional incentive to use resources wisely. The payment mechanism is constructed to address overutilization by discouraging duplication or services that provide minimal or no benefit. When multiple providers in multiple settings are jointly accountable for the total cost of care, through shared payment, they have an incentive to coordinate care.¹ Because providers would not receive additional payment for extra treatment due to an unintended consequence of care — such as a hospital-acquired infection, or a readmission — providers have incentive to improve quality and to avoid costly complications.

The Congressional Budget Office has projected that bundling hospital and post-acute care for Medicare patients alone would save \$18.6 billion (.05%) by 2019.² A recent RAND report concluded that bundled payment was the most promising approach for controlling US health care spending. Applying bundled payment for all patients for six chronic and four acute conditions requiring hospitalizations would lead, optimistically, to a spending reduction of 5.4% across ten years, mostly by reducing avoidable complications, the RAND researchers projected.³

BUNDLED PAYMENT: CURRENT MODELS AND PILOT PROJECTS

Experiments in bundled payment have been keenly watched since Medicare piloted them for a handful of surgical procedures in the 1990s. Some integrated health systems accept a single payment for non-emergency procedures, as Geisinger in Pennsylvania does for non-emergency CABG (coronary artery bypass graft) and hip replacement surgery. In these scenarios, physician payment may be tied, in part, to adherence to process-of-care performance measures.⁴ Similarly, the much-watched Acute Care Episode (ACE) demonstration project, now underway, is testing bundled payment for Medicare Part A (for inpatient hospital care, skilled nursing care, hospice care) and Part B (includes doctors' fees, outpatient hospital visits) services in five hospitals in Texas, New Mexico, Oklahoma and Colorado for 9 orthopedic and 28 cardiac inpatient surgical services and procedures.⁵

¹ RAND: Health COMPARE: Policy Options: Overview of Bundled Payment Policy Options, 2009.
www.randcompare.org/options/mechanism/bundled_payment

² CBO Report “Budget Options, Volume 1: Health Care,” 2008 p. 62.
<http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf>

³Hussey P, Eibner C, Ridgely M, McGlynn, E. Controlling U.S. Health Care Spending – Separating Promising from Unpromising Approaches. *New England Journal of Medicine*, Nov 26, 2009, pages, 2109-2111.
<http://healthcarereform.nejm.org/?p=2301&query=home>

⁴ RAND: Health COMPARE: Policy Options: Overview of Bundled Payment Policy Options, 2009.
www.randcompare.org/options/mechanism/bundled_payment

⁵ A complete list of procedures and services is available at
<http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/ACESolicitation.pdf>

Another approach is the Prometheus Payment Model, which has served as the basis for other ongoing pilot projects and is used in many savings projections in bundled payment. The model bundles services with three components: evidence-informed base payment, patient-specific severity adjustment, and an allowance for potentially avoidable complications.⁶ A hypothetical case of a bypass surgery for a patient with uncontrolled diabetes provides an example of how savings can be achieved, ideally because shared accountability would lead to fewer complications: In this scenario, fee-for-service payment would entail \$47,500 to the hospital and \$15,000 to the surgeon for the surgery; another \$12,000 for the hospital and \$2,000 for the physician for uncontrolled diabetes that requires an additional 3 days in the hospital; and another \$25,000 for readmission one week after discharge to treat an infection from the vein harvest. The total is \$101,500. Under Prometheus, the severity-adjusted budget would be \$89,300: \$61,000 for the hospital, \$13,000 for the physician, and a \$15,300 allowance for “Potentially Avoidable Costs.” The cost to the insurer under Prometheus is \$12,200 less than under fee-for-service. If the readmission were prevented, the hospital and physician would be paid \$12,800 more under Prometheus than fee-for-service.⁷

	Fee-for Service	Prometheus
Hospital	\$47,500	\$61,000
Surgeon	\$15,000	\$13,000
Diabetes Care	\$14,000	
Readmission	\$25,000	
PAC Allowance		\$15,300
Total	\$101,500	\$89,300

Source: De Brantes F, Rosenthal M, Painter M, Building a Bridge from Fragmentation to Accountability – the Prometheus Payment Model. *New England Journal of Medicine*, Sept 10, 2009, p. 1035.

⁶ De Brantes F, Rosenthal M, Painter M, Building a Bridge from Fragmentation to Accountability – the Prometheus Payment Model. *New England Journal of Medicine*, Sept 10, 2009, pages 1033 – 1036.

⁷ De Brantes F, Rosenthal M, Painter M, Building a Bridge from Fragmentation to Accountability – the Prometheus Payment Model. *New England Journal of Medicine*, Sept 10, 2009, p. 1035.

BUNDLED PAYMENT: CHALLENGES TO IMPLEMENTATION and ADOPTION

While a strong case can be made for bundled payment in theory, implementation presents very real challenges. These include:

- Defining the “episode of care” that is appropriate for a bundled payment, and creating case definitions that are consistent enough to be applied across varying payment arrangements. The AMA has expressed concern that the science of developing reliable episode groupers is in its infancy and that little data exists to identify services where consistency of care across patients would lend itself to this approach.⁸
- Persuading physicians and other providers to adopt changes and alter behavior. The collaboration that is necessary may occur more readily in integrated systems, where bundled payment is likely to gain a foothold first. The growing employment of physicians by hospitals will help.
- Current organizational models of disparate stakeholders will pose challenges for bundled payment, especially in community-based care. Physicians may distrust a hospital to be in charge of administering their payments.⁹
- Reconciling bundled payment with regulations against self-referral.¹⁰
- Accounting for patients changing insurance or geographic location during the defined treatment episode.

The biggest immediate challenge, though, is putting in place the contracting and claims infrastructure to handle a new payment model. For example, contracting systems will need to specify episodes and claims systems will need to recognize and correctly handle submissions for episode services versus services that are outside of episodes and should be paid separately.

BUNDLED PAYMENT: THE TOOLS TO MAKE IT WORK

With bundled payment on the horizon, organizations need technology that is robust, yet flexible enough to manage a complex and changing environment. A strong IT partner is crucial to any organization exploring or implementing episodes of care payment.

⁸ American Medical Association, “Health System Reform, Get the Facts and Get Involved,” October 7, 2009 . <http://www.ama-assn.org/ama1/pub/upload/mm/399/resource-use-outliers.pdf>

⁹ Jennifer Lubell, “Paying By the Bundle.” Modern Healthcare, April 6, 2009.
<http://www.modernhealthcare.com/article/20090406/REG/904039970>

¹⁰ Jennifer Lubell, “Paying By the Bundle.” Modern Healthcare, April 6, 2009.
<http://www.modernhealthcare.com/article/20090406/REG/904039970>

Many hospitals, physicians and post-acute providers may look to solidify their relationships with partners who seem to offer quality, efficiency and cost-effectiveness. They will need the data and analytic tools that can help lead to informed decisions. Ongoing data-driven assessment of whether bundled payment is returning the expected quality and efficiency will require powerful and configurable analytics.

Operationally, contract management, claims processing and fraud/abuse functions all must be able to integrate new payment rules. At the same time, minimizing manual functions through automation is critical for optimizing the gains of reform efforts. Doing this requires:

- Episodes of care that are defined so that a logic framework can be built and applied in an automated fashion.
- Dynamic contracting that incorporates episodes of care terms and definitions.
- Systems that automatically convert contract terms to terms in the payment system.
- Claims processing technology that can look across claims and time to associate all services that should be included or excluded as part of an episode of care. Slow response may result in inappropriate payment, which could jeopardize payor confidence.
- Auto adjudication of complex contracts with multiple payment arrangements.
- The ability to apply clinical knowledge to claims payment decisions to ensure defensibility of payments to providers.
- Fraud and abuse systems that can detect new means of inappropriate optimization of payment that may spring up in response to a new payment model.
- Interoperability between payment and quality data.
- Systems with the flexibility to adapt as new payment mechanisms evolve.

Organizations experimenting with bundled payment likely will begin with small and clearly-defined episodes of care – specific surgical procedures for which a hospital and physicians agree to accept a single payment for hospital and physician services. Over time, with scalable systems in place and fine-tuning, programs may eventually be expanded to chronic care and multi-facility episodes of care.

Bundled payment meets many of the government’s goals for value-based purchasing, including payment incentives that are linked to quality and efficiency, joint accountability (clinically and financially) between clinicians and providers, and payment systems that support smooth transitions across providers and settings.¹¹ If incentives are truly aligned and processes well-integrated, bundled payment may present a “win-win” for health systems. Organizations that are prepared to work collaboratively and have the tools to do so will be at the forefront for implementing and reaping the benefits of this new initiative.

¹¹ CMS Roadmap for Implementing Value Driven Healthcare in the Traditional Medicare Fee-for-Service Program, http://www.cms.hhs.gov/QualityInitiativesGenInfo/downloads/VBPRoadmap_OEA_1-16_508.pdf