Bundled Payment in Medicare: Promise, Peril, and Practice

A DISCUSSION FEATURING:

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The Commonwealth Fund

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RAND Corporation

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Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services

FORUM SESSION ANNOUNCEMENT

FRIDAY, APRIL 20, 2012
8:45AM–9:15AM—Breakfast
9:15AM–11:00AM—Discussion

LOCATION
Reserve Officers Association
One Constitution Avenue, NE
Congressional Hall of Honor
Fifth Floor
(Across from the Dirksen Senate Office Building)

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Under fee-for-service Medicare, in which separate payment is made for each service, providers are rewarded for delivering more services. Moreover, no single entity is responsible for ensuring the efficient delivery and mix of services for a given episode of care for a procedure, such as a joint replacement, or a condition, such as a stroke. These features of fee-for-service Medicare are blamed for duplication of services, the provision of unnecessary care, failure to coordinate services for the patient, and excess spending and poor quality related to unnecessary or duplicate services and lack of coordination.

Some advocate bundled payment models as an alternative to fee-for-service payment to promote more efficient, coordinated care across providers or settings. By making a single payment to one entity for the entire episode of care, bundling makes that entity responsible for the care delivered during that episode. The entity receiving the bundled payment would arrange for the array of services to be provided and would distribute the bundled payment amount among the providers involved in the patient’s care. The theory underlying bundled payment is that providers would achieve lower costs and better care through improved care coordination and more efficient care delivery if payment systems reward them for doing so. The primary financial incentive for providers under a bundled payment system is to reduce the costs of care provided during the episode because they will keep any difference between the payment and episode costs; conversely, they would be responsible for any costs above the payment amount. In general, bundled payment models leave the means of achieving efficiency improvements to the entity receiving the payment rather than specifying precisely how costs could be reduced or quality improved.

While bundling has the potential to improve the care experience for the beneficiary and make care delivery more efficient for the Medicare program, a number of policy and operational concerns related to bundled payment have been raised. Understanding the risks can help to design bundled payment programs with features that may mitigate some of those risks, where possible, and establish realistic expectations for what bundling can achieve in the Medicare program. One commonly cited limitation of bundled payment is that it does not eliminate incentives for providers to increase the volume of services in a population, particularly high-margin services, which are significant drivers of Medicare spending. While bundling may create incentives to reduce unnecessary hospital readmissions, it does not address the problem of whether the initial admission is appropriate.
Establishing a bundled payment system also presents several critical design choices that must balance fairness to providers with promoting responsibility for an entire episode at a price that is adequate to ensure access. These choices include: which conditions or services and providers to include in the bundle; the initiation, duration, and termination of the episode covered by the payment; and how to set and distribute payment. If the right balance is not struck in these decisions, the program could overpay for bundles of services, providers may not participate, or beneficiaries may not receive adequate care. Because providers could potentially achieve savings by stinting on or delaying care or by avoiding expensive patients, another related concern is whether the program has adequate quality measures to safeguard the health of beneficiaries and sufficient risk adjusters to ensure providers are not financially rewarded for simply avoiding higher cost patients.

A number of operational issues could also make implementing bundled payment difficult for providers, even those who are highly motivated to participate in new payment models. These include: problems determining accountability within the bundle and distributing payments, problems implementing quality measurement, difficulty engaging all necessary providers in the effort to reengineer care delivery, and countervailing payment incentives from the prevailing fee-for-service payment environment.

NEW BUNDLED PAYMENT MODELS IN MEDICARE

Some of Medicare’s existing fee-for-service payment systems already bundle payments for multiple services. For example, Medicare payments for hospital discharges, physician surgical services, dialysis treatments, and home health services are for a bundle of services, rather than a single procedure or service. Unlike these current bundled payments, however, the bundling option contemplated under Patient Protection and Affordable Care Act of 2010 (PPACA) and the Center for Medicare & Medicaid Innovation (CMMI) Bundled Payments for Care Improvement (BPCI) initiative (see below) extends beyond individual providers. The PPACA-mandated pilot and the BPCI initiative aim to pay for more comprehensive episodes and encompass multiple provider types such as hospitals, physicians, and post-acute care.

PPACA includes a requirement for the Secretary of the Department of Health and Human Services to conduct a Medicare pilot program
to test whether bundling the payments for a hospitalization and subsequent post-acute care can “improve the coordination, quality, and efficiency of health care services.” The law outlines general parameters of the pilot: for beneficiaries with designated conditions, Medicare would pay an entity for covered services, including inpatient hospital, physician, outpatient therapy, and post-acute care services delivered during an episode of care that is initiated with a hospitalization and continues for 30 days after discharge. According to PPACA, the pilot will be evaluated on whether it improved quality of care, health outcomes, and access, and whether it reduced spending. If this pilot is successful it could be expanded in the Medicare program without any additional legislative action.

CMMI in the Centers for Medicare & Medicaid Services (CMS) is currently in the process of implementing the BPCI initiative. Under this initiative, CMS would combine payments for multiple services that patients receive during an episode of care. For example, instead of a surgical procedure during an inpatient stay generating multiple claims from multiple providers, the entire team is compensated with a bundled payment in some of the models. The goals of the BPCI are to:

* align payment with how patients experience care,
* foster quality improvement while decreasing the cost of an episode of care,
* support and encourage providers who are interested in continuously redesigning care,
* give providers as much flexibility as possible in redesigning care to meet the needs of their community, and
* remove barriers and provide opportunity for partnerships among providers and other stakeholders.

CMMI announced in August 2011 that it would be seeking applications for four broadly defined bundled payment models (Table 1, page 6). Three of the models would involve a retrospective bundled payment arrangement, with a target payment amount for a defined episode of care involving a hospitalization and possibly post-acute care. In the BPCI context, retrospective means participants will be paid for their services under Medicare’s fee-for-service (FFS) system. In the fourth model, payments will be determined prospectively, which means that a negotiated lump sum payment amount is made for the bundle of services in lieu of fee-for-service payment.
In all four models, applicants will propose a target price for the bundled services. In model 1, where the “bundle” is solely the acute care hospital stay, the target price would be set by applying a discount to Medicare’s MS-DRG (Medicare severity-diagnosis related groups) payment. In models 2 through 4 the target would be set by applying a discount to total FFS costs, determined from historical data, for a similar episode of care. At the end of the episode for models 2 and 3, the total payments made for the episode would be compared with the target price. Participating awardees receive the difference between the target and total payments or must refund payments exceeding the target to Medicare. In models 1 and 4, there is no reconciliation with the target price at the end of the episode. In model 1, although the bundle payment is only for the Part A inpatient payments, if aggregate Part A and Part B payments during the inpatient stay exceed the historical average plus a risk threshold, the awardee pays the excess to Medicare. In model 4, the awardee bears full risk for the price of the episode and accepts the negotiated, prospective lump sum payment as payment in full for the episode. In all four models, spending for 30 days after the end of the episode will be compared to historical spending levels and awardees pay the excess to Medicare to ensure that participation in the initiative does not increase Medicare spending after the episode ends. Awardees may be allowed to share any gains with other providers involved in care delivery during the episode.

Providers will have some flexibility to determine which episodes of care and which services would be bundled together and to propose quality metrics and risk adjustment methods to be applied within the four models outlined in the initiative. CMS has indicated that it is seeking proposals that:

- affect broad categories of conditions,
- reach many beneficiaries,
- offer significant savings to Medicare,
- are designed to be scalable and replicable by similar health systems around the country,
- already or could rapidly involve participation by other payers, and
- could be implemented on aggressive timelines.
### TABLE 1: Bundled Payment for Care Improvement Models

<table>
<thead>
<tr>
<th>Eligible Services</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Acute care hospital admissions for any MS-DRGs</td>
<td>Acute care hospital admissions for selected MS-DRGs, plus post-acute care</td>
<td>Post-acute care after acute care hospital stay for selected DRGs</td>
<td>Acute care hospital admissions for selected DRGs</td>
</tr>
<tr>
<td>Episode definition</td>
<td>Acute care hospital stay for any MS-DRG</td>
<td>Acute care hospital stay for selected MS-DRGs, plus post-acute care for period proposed by awardee (Minimum of 30 days)</td>
<td>Services from a SNF, IRF, HHA, or LTCH initiated within services within 30 days following acute care inpatient discharge for selected MS-DRG and received during a period proposed by the awardee (Minimum of 30 days)</td>
<td>Acute care hospital stay for selected MS-DRG</td>
</tr>
<tr>
<td>Services included in the bundle</td>
<td>All Part A inpatient services</td>
<td>Part A and B services during the initial inpatient stay, the post-acute period, and readmissions</td>
<td>Part A and B services during the post-acute period and readmissions</td>
<td>All Part A and B services and readmissions</td>
</tr>
<tr>
<td>Payment</td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Prospective</td>
</tr>
<tr>
<td>Expected discount to Medicare (actual discounts to be proposed by the awardees)</td>
<td>Minimum discount on Part A allowed charges of 0% for first 6 months increasing to 2%</td>
<td>Minimum 3% discount on Part A and B allowed charges for episodes of less than 90 days after hospital discharge</td>
<td>Minimum 3% discount on Part A and B allowed charges for episodes of less than 90 days after hospital discharge</td>
<td>Minimum 3% discount on included Part A and B allowed charges; more for ACE MS-DRGs</td>
</tr>
<tr>
<td>Reconciliation with target price</td>
<td>None; Discounted PPS payment made for Part A Inpatient Services</td>
<td>Awardee receives difference between aggregate FFS payments and predetermined target price. Awardee pays Medicare excess of aggregate FFS payments and predetermined target price. Awardee receives difference between aggregate FFS payments and predetermined target price.</td>
<td>Awardee pays Medicare excess of aggregate FFS payments and predetermined target price.</td>
<td>None, except awardee pays Medicare for any Part B claims for services during the hospitalization or readmission that are submitted separately and paid by Medicare</td>
</tr>
<tr>
<td>Comparison to historical spending trend</td>
<td>If aggregate Part A and B payments during the inpatient stay, or in the 30 days following discharge, exceed the historical average plus a risk threshold, awardee pays the excess to Medicare.</td>
<td>If aggregate Part A and B payments in the 30 days following the episode exceed the historical average plus a risk threshold, awardee pays the excess to Medicare.</td>
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</tbody>
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SESSION

This Forum session will describe the rationale for Medicare to move toward episode or bundled payment; examine the policy and operational challenges that a bundled payment approach presents for providers and payers, particularly Medicare, and ways those could be addressed; and provide the audience with an understanding of the CMMI’s Bundled Payments for Care Improvement (BPCI) Initiative.

KEY QUESTIONS

- What are the potential benefits of bundled payment for the Medicare program? Beneficiaries? Providers?
- What services or episodes are suitable for bundling, in terms of defining what belongs in the bundle and the existence of sufficient quality measures and adequate risk adjusters?
- What are the limitations of bundling, in terms of its ability to reduce spending and improve care? What have past Medicare pilots and demonstrations shown regarding the potential of bundling to reduce costs and improve quality of care?
- Why would different types of providers (hospitals, physicians, post-acute care providers) participate in the BPCI? Why might they choose not to participate?
- How does the BPCI initiative relate to the PPACA-mandated bundling pilot program?
- What types of providers can apply to participate in the BPCI initiative? Who decides which entity receives and distributes the payments?
Given that the BPCI provides flexibility to applicants within its four-model framework, how will the initiative be evaluated? How will the program determine the intervention that led to success or failure? What are the plans to replicate successful models?

SPEAKERS

Stuart Guterman is vice president, payment and system reform and executive director of the Commission on a High Performance Health System at the Commonwealth Fund. Mr. Guterman will provide an overview of incentives of prevailing fee-for-service payment models and provide an overview of bundled payment and the problems that bundling has the potential to address. Peter Hussey, PhD, a policy researcher at the RAND Corporation, has conducted research on topics such as episode-based payment and performance measurement approaches, health care efficiency measurement, and quality improvement. He will discuss some of the important policy challenges that bundling presents and will draw on his research to present lessons learned about the bundled payment’s operational and implementation challenges for payer and provider organizations. Valinda Rutledge, MBA, is director, Patient Care Models Group at the Center for Medicare & Medicaid Innovation in the Centers for Medicare & Medicaid Services (CMS). Ms. Rutledge will discuss details of the CMS Innovation Center’s Bundled Payments for Care Improvement Initiative.

ENDNOTES


4. For a deeper discussion of implementation difficulties encountered by participants in one private-sector bundled payment pilot project see, Peter S. Hussey, M. Susan Ridgely, and Meredith Rosenthal, “The PROMETHEUS Bundled Payment Experiment: Slow Start Shows Problems in Implementing


7. Physician participation in gainsharing must be voluntary. CMS expects applicants to provide evidence of physician participation in the initiative according to Center for Medicare & Medicaid Innovation (CMMI), Bundled Payment for Care Improvement Initiative Request for Application, August 22, 2011, p.11, available at www.innovations.cms.gov/Files/xx/Bundled-Payments-for-Care-Improvement-Request-for-Applications.pdf.

8. CMMI, Bundled Payment for Care Improvement Initiative Request for Application, p. 7.