



FORUM SESSION

Bundled Payment in Medicare and Private Insurance: Version 2.0

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Bundled payment combines payments for health care services that have traditionally been reimbursed separately into a single fee. Because it provides incentives for better-coordinated, high-quality care, bundling is viewed as a promising strategy for slowing the growth of health care costs. Many view bundling as an appealing intermediate step in the transition from fee-for-service payment to some form of population-based or global payment for health care services. Both Medicare and commercial insurers participate in bundled payment initiatives.

Experience with bundling services, especially those delivered by multiple providers, is still very limited, however, and the challenges of defining bundles are considerable. Even when care is delivered efficiently, episodes of care can involve highly variable mixes of services and lengths. Because of these difficulties, the list of currently defined episodes is relatively short. In addition, some worry that, in shifting from the “do more” incentive inherent in fee-for-service payment to a “do less” incentive with bundled payments, the pendulum will swing beyond improved efficiency and reduction of unnecessary services to stinting on care. A balance must be struck to both protect patients with adequate quality measurement and monitoring and ensure that appropriate services have been delivered.

Both Medicare and private insurers mostly rely on retrospective reconciliation of fee-for-service payments against a target price or budget, suggesting that there are significant operational challenges inherent in moving to prospective payment in today’s fragmented health care system. Few entities may be prepared to accept responsibility for a complete bundle of services or to receive a prospective payment that will then be divvied up among independent providers who deliver care during the episode.

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The health care delivery landscape is changing rapidly, however, and it seems likely that new business relationships will continue to emerge to facilitate the payment of prospective bundles.

BUNDLED PAYMENTS IN MEDICARE

Paying for services in a bundle is not new to the Medicare program. Payments are currently bundled for hospital stays, home health episodes, dialysis and related services for end-stage renal disease (ESRD) patients, in-patient rehabilitation facility (IRF) stays, long-term care hospital (LTCH) stays, and pre- and post-operative surgical care. In all of these cases, Medicare makes its payment to a single provider for a bundle of its services.

The Centers for Medicare & Medicaid Services (CMS) has also used its demonstration authority to pay for bundles of services delivered by multiple providers, such as hospitals and physicians. An early example is the Medicare Participating Heart Bypass Center Demonstration that, in 1991, provided a single payment for all inpatient hospital and physician services for coronary artery bypass graft surgeries performed at seven hospitals. In 2009, the Medicare Acute Care Episode (ACE) demonstration bundled payment for certain orthopedic and cardiovascular procedures. In this demonstration, hospitals received a single payment for both Part A hospital services and Part B physician services provided in the hospital.¹

The Bundled Payments for Care Improvement (BPCI) initiative, which began in January 2013, is CMS's newest and most ambitious experiment with bundled payment. According to the Center for Medicare and Medicaid Innovation (CMMI), which administers the initiative, the BPCI initiative links "payments for multiple services beneficiaries receive during an episode of care"² in an effort to test how payment policies can be used to realign provider incentives. Providers—hospitals, physicians, post-acute care providers—in this initiative are expected to redesign care processes and improve coordination in ways that reduce costs while maintaining or enhancing quality of care.

Under BCPI, CMS enters into agreements with "awardees" who accept risk for episode costs. Awardees can include hospitals, physicians, various post-acute care providers, and "conveners"—organizations that bring together a group of providers and accept risk on their behalf. Multiple models of bundling can occur in BPCI.³ One version retrospectively bundles hospital and post-acute

services for 48 clinical episodes; another retrospectively bundles only post-acute services, including hospital readmissions, for the same 48 clinical episodes. Providers are all paid for their services under current Medicare payment systems. Total expenditures are reconciled against a target price for the episode; savings are paid to the awardee taking risk for the provider initiating the episode, but the awardee must repay expenditures above the target to Medicare. In still another model, a discounted lump sum is paid prospectively to cover Part A and B services during an initial inpatient hospital stay and any readmissions. Spending in the post-episode period is monitored and the responsible awardee must repay Medicare for costs that exceed a threshold.⁴ Awardees can choose to be at risk for one or more of the 48 clinical episodes.

The BPCI initiative currently has 105 awardees in the risk-bearing Phase II, including 67 independent providers and 38 conveners of health care organizations representing 243 Medicare providers. Another 870 awardees are in Phase I, an exploratory period in which participants receive patient-based episode data from CMS to help them decide whether to move to Phase II. Phase I awardees include 732 independent providers and 138 conveners representing an additional 6,424 Medicare providers.⁵

BUNDLING AND PRIVATE INSURERS

Some date the beginning of bundled payment in private health insurance to 1984, when the Texas Health Institute included all services associated with cardiovascular surgery under a single global fee.⁶ Major commercial insurers now have two decades of experience bundling payment for organ transplants.⁷ In 2006 Geisinger Health System launched ProvenCare®, which today sets a single price for a variety of episodes that includes pre-operative care, hospital and professional services, routine post-discharge care, and management of any related complications occurring within 90 days after discharge.⁸ Numerous insurers have implemented bundles for bariatric surgery, coronary bypass surgery, and more recently, joint replacement.⁹ Although surgical episodes, especially orthopedics, tend to dominate the types of services that get bundled, insurers are beginning to venture into other kinds of episodes, such as adjuvant breast cancer therapy and asthma. Of the 13 episodes being bundled by Medicaid and private insurers through the Arkansas Healthcare Payment Improvement Initiative, two are for behavioral health conditions.¹⁰

Insurers have entered into a variety of bundled payment arrangements with providers, but most appear to be similar to the BPCI initiative, with retrospective reconciliation against a target price or budget based on historical experience. Using historical data, each payer in the Arkansas Healthcare Payment Improvement Initiative sets thresholds against which providers are evaluated. Providers delivering care at or below the Arkansas BlueCross BlueShield “commendable” threshold, for example, share in savings whereas those exceeding an “acceptable” threshold will have a portion of excess payments recouped over a one year period.¹¹

Looking at bundled payment initiatives across the country, there are very few cases in which providers receive a *prospective* payment for all services associated with an episode of care. And unlike the BPCI initiative, which has a heavy emphasis on bundling services from providers such as hospitals and post-acute care providers, most insurers have focused their attention almost solely on entering into bundling arrangements with physicians who play a significant role in influencing the total cost of care. This is especially true for bundles that involve hospitalization, as physicians determine where post-acute care is provided: in community outpatient settings, at home from home health providers, or in a skilled nursing or rehabilitation facility.¹²

SESSION

This Forum session looked at bundled payment initiatives in both the public and private sector. **Amy Bassano, MA**, acting director of the Patient Care Models Group at the Center for Medicare and Medicaid Innovation, Centers for Medicare & Medicaid Services, provided an overview of CMMI’s BPCI initiative. **Charles A. Wiggins, MHA**, president of the Tri-State Region at Remedy Partners, Inc., described Remedy’s participation as an awardee convener in the BPCI initiative and discussed bundled payment initiatives with other payers, such as private insurers and self-insured employers. **Steven A. Spaulding**, senior vice president, Enterprise Networks, Arkansas BlueCross BlueShield, gave an overview of the Arkansas Healthcare Payment Improvement Initiative and described his organization’s participation as the state’s largest commercial insurer.

KEY QUESTIONS

- What are the challenges in defining episodes and in setting and adequately risk-adjusting payment rates to reflect efficient care delivery?
- How do Medicare and insurers monitor quality and outcomes to ensure that providers are not stinting on care? Does a lack of quality measures inhibit bundling of episodes of care for some conditions?
- Are there episodes of care for some conditions that are not suitable for bundled payment? Could that change over time?
- How are providers responding to bundled payment or the prospect of bundled payment? Is bundling spurring mergers or other affiliations across different provider types?
- How do convening organizations assist providers in dealing with bundled payment?

ENDNOTES

1. Lyle Nelson, "Lessons from Medicare's Demonstration Projects on Value-Based Payment," Congressional Budget Office, Working Paper 2012-02, January 2012, www.cbo.gov/sites/default/files/cbofiles/attachments/WP2012-02_Nelson_Medicare_VBP_Demonstrations.pdf.
2. Centers for Medicare & Medicaid Services (CMS), "Bundled Payments for Care Improvement Initiative Fact Sheet," updated July 31, 2014, pp. 1-2, www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2014-Fact-sheets-items/2014-07-31.html.
3. The models described in this section are Models 2, 3 and 4, respectively. Model 1, a nominal part of the initiative, involves a discount on all hospital DRGs.
4. For more information about Models 2 through 4, see the descriptions available at <http://innovation.cms.gov/initiatives/Bundled-Payments/>.
5. CMS, "Bundled Payments for Care Improvement Initiative Fact Sheet."
6. Mark I. Froimson *et al.*, (AAHKS Bundled Payment Task Force) "Bundled Payments for Care Improvement Initiative: The Next Evolution of Payment Formulations," *Journal of Arthroplasty*, 28, suppl. 1 (2013): 157-165, www.aahks.org/wp-content/uploads/2014/02/joa-bundled-payments-care-improvement.pdf.
7. Nelson, "Lessons from Medicare's Demonstration Projects on Value-Based Payment," p. 16.
8. Ronald A. Paulus, Karen Davis, and Glenn D. Steele, "Continuous Innovation In Health Care: Implications Of The Geisinger Experience," *Health Affairs*, 27, no. 5 (September 2008): pp. 1235-1245, <http://content.healthaffairs.org/content/27/5/1235.full>.

9. Michael Bailit and Margaret Houy, "Key Payer and Provider Operational Steps to Successfully Implement Bundled Payments," Health Care Incentives Improvement Institute, May 29, 2014, www.hci3.org/content/key-payer-and-provider-operational-steps.
10. Episodes include: asthma, attention deficit/hyperactivity disorder, coronary artery bypass graft, cholecystectomy, colonoscopy, congestive heart failure, total joint (hip/knee) replacement, oppositional defiance disorder, perinatal care, tonsillectomy, upper respiratory infection (three separate episodes).
11. Arkansas Health Care Payment Improvement Initiative, "Frequently Asked Questions," www.paymentinitiative.org/referenceMaterials/Pages/faqs.aspx.
12. Bailit and Houy, "Key Payer and Provider Operational Steps to Successfully Implement Bundled Payments," p. 3.