

Implementing Episode and Bundled Payments

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Implementation Issues for Episode and Bundled Payment

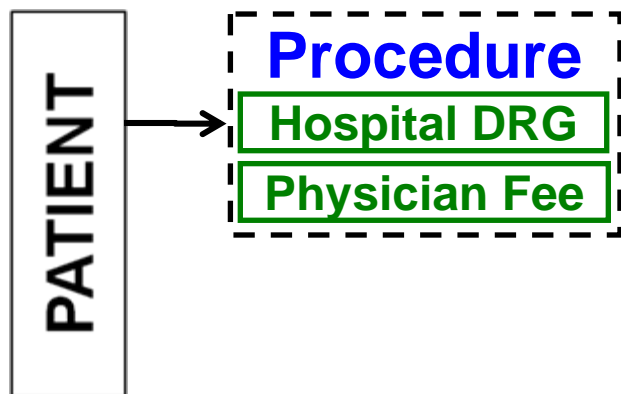
- What's in the Bundle, Why, and Who Decides?
- Who Gets the Check?
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- Is Bundling Worth It?

Implementation Issues for Episode and Bundled Payment

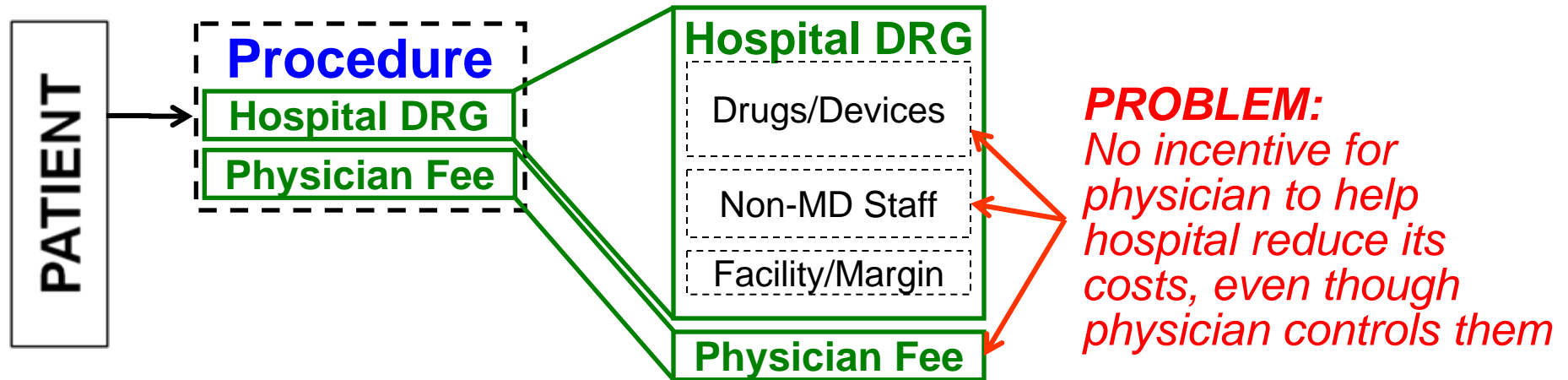
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Most Obvious “Unbundled”

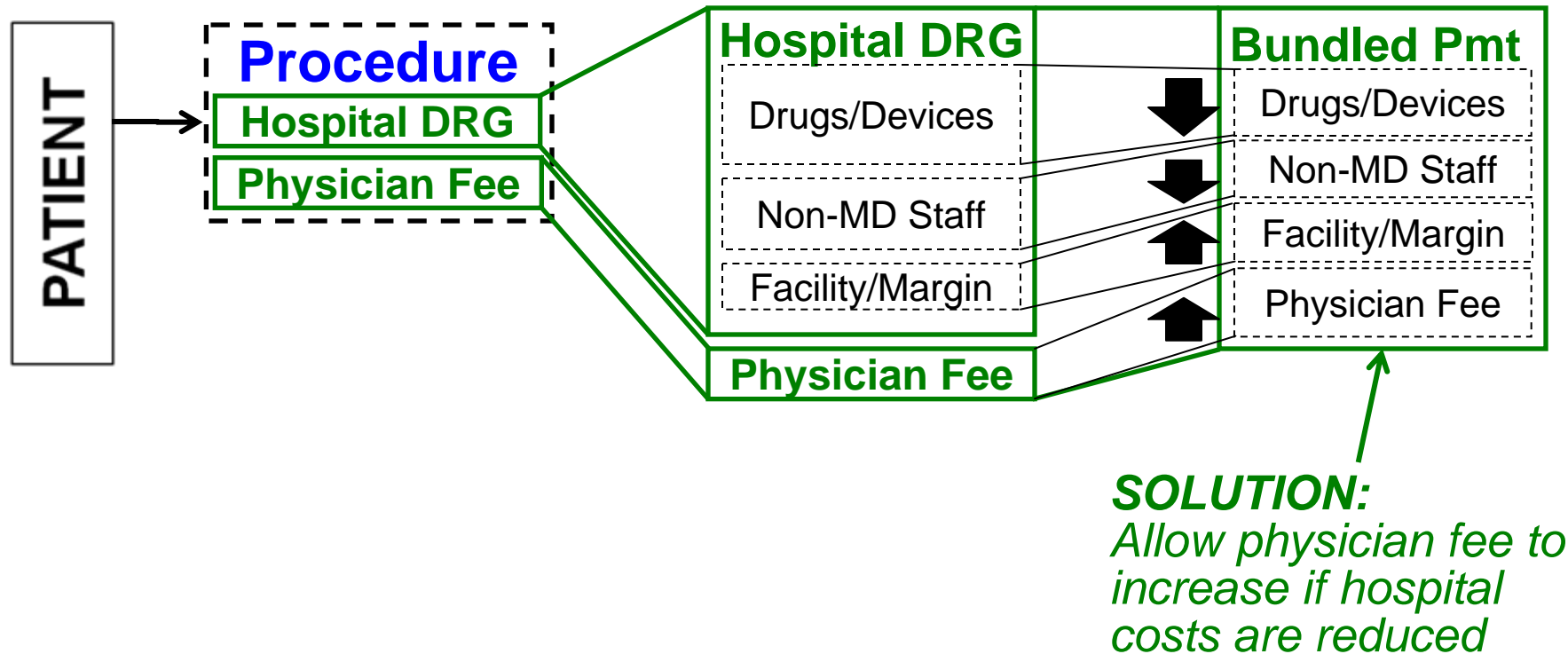
Payment Today: Hospital & Doctor



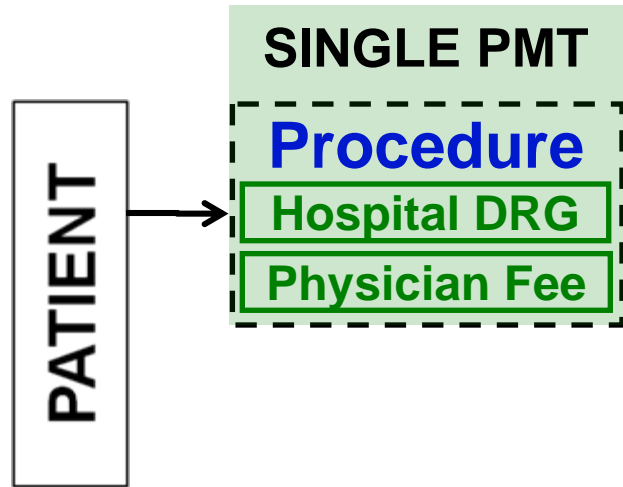
Hospital Payment Was Already “Bundled,” But Narrowly



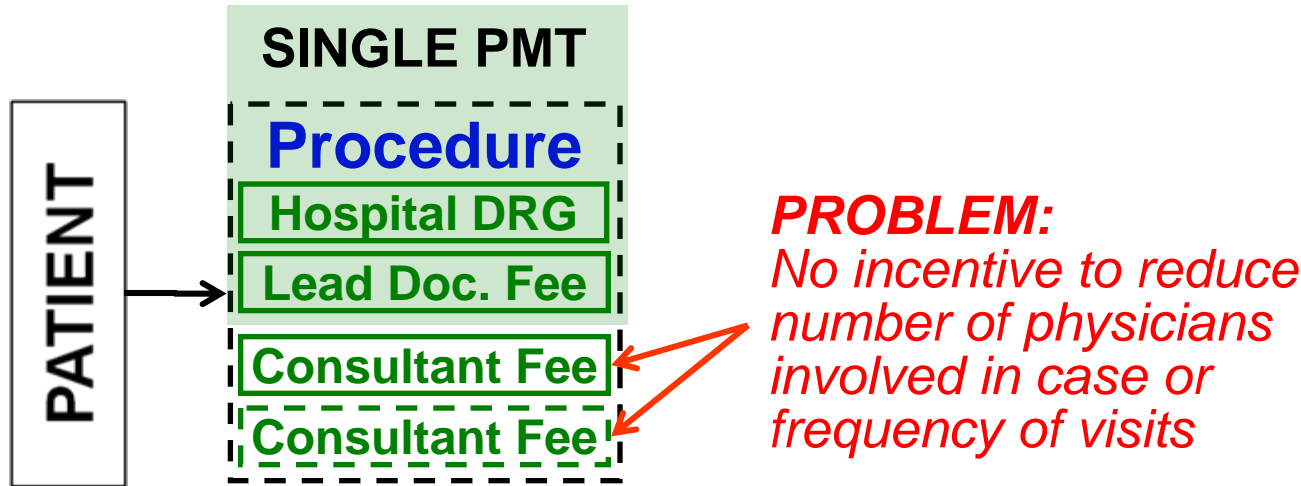
Adding Physician in Bundle Can Lead to Win-Win Savings



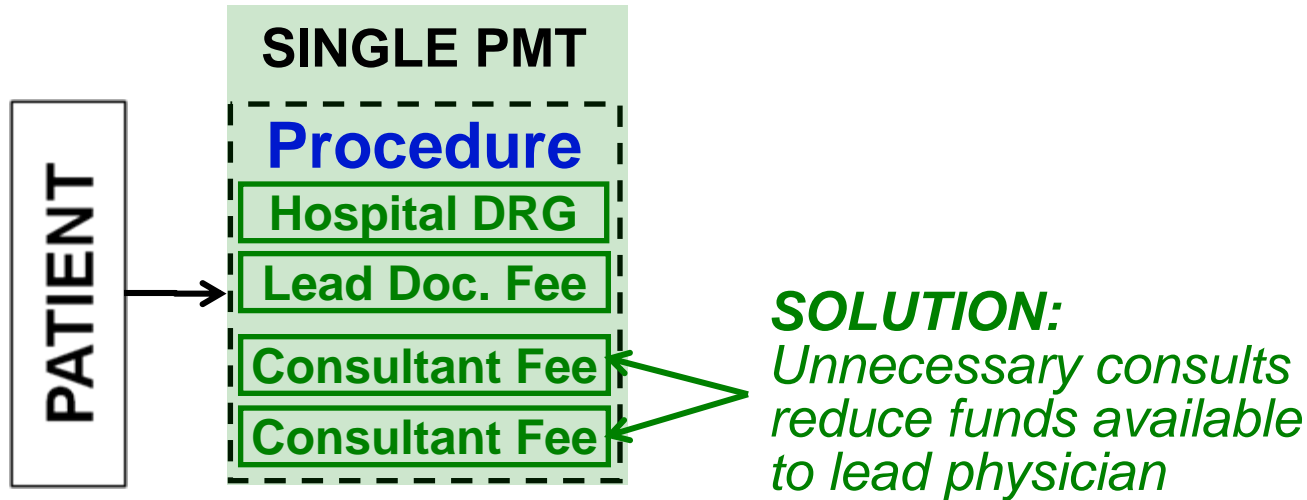
Simplest Bundle, Already Working in CMS Demonstrations



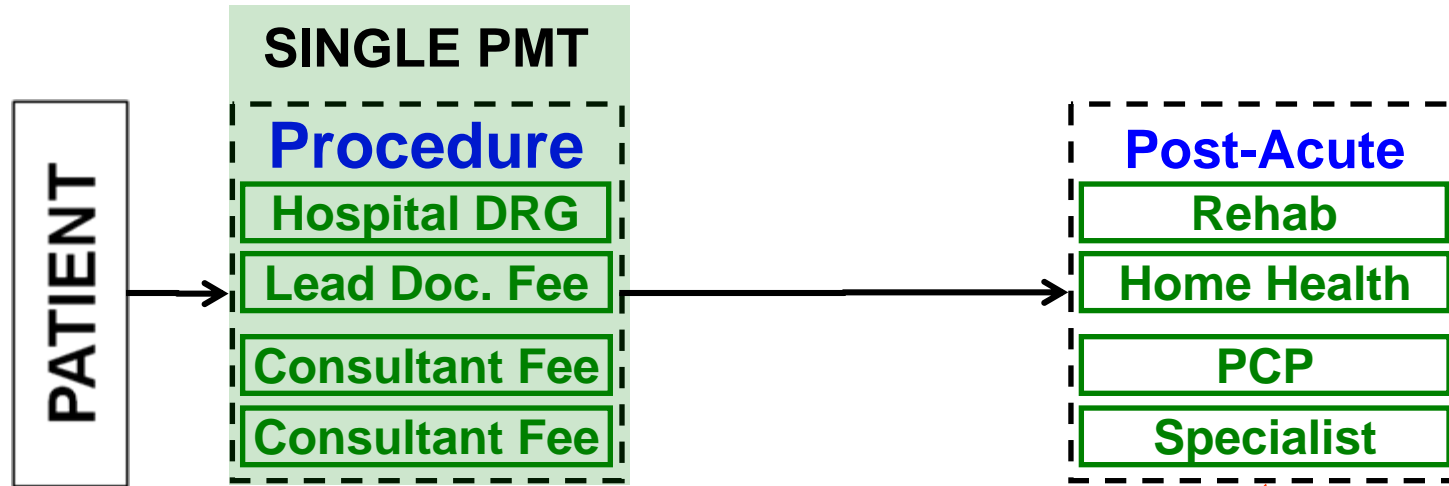
In More Complex Cases, Many Physicians Are Involved



Bundling All Physicians Promotes More Care Coordination

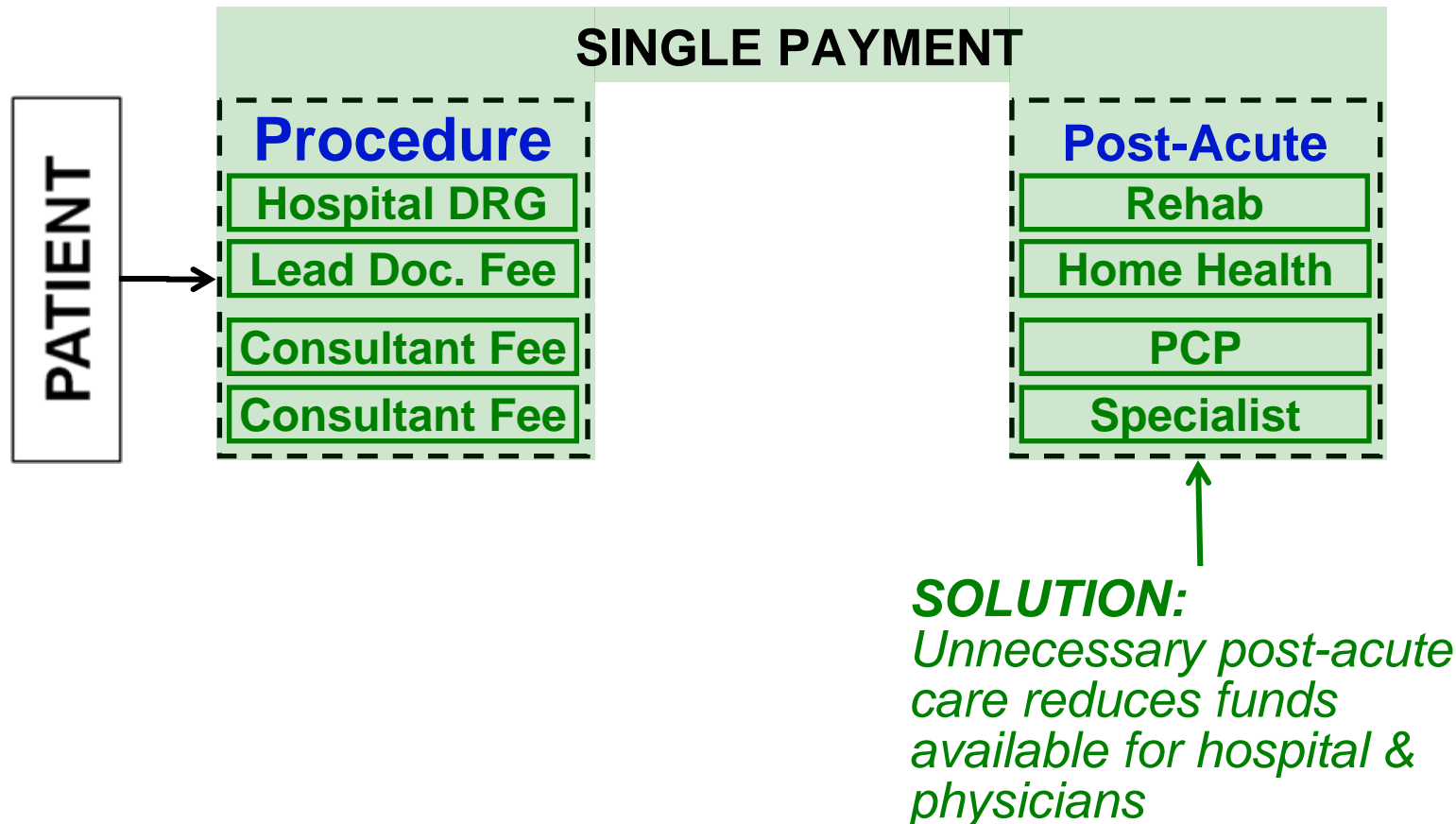


Not All Care Providers Are Inside the Hospital Walls

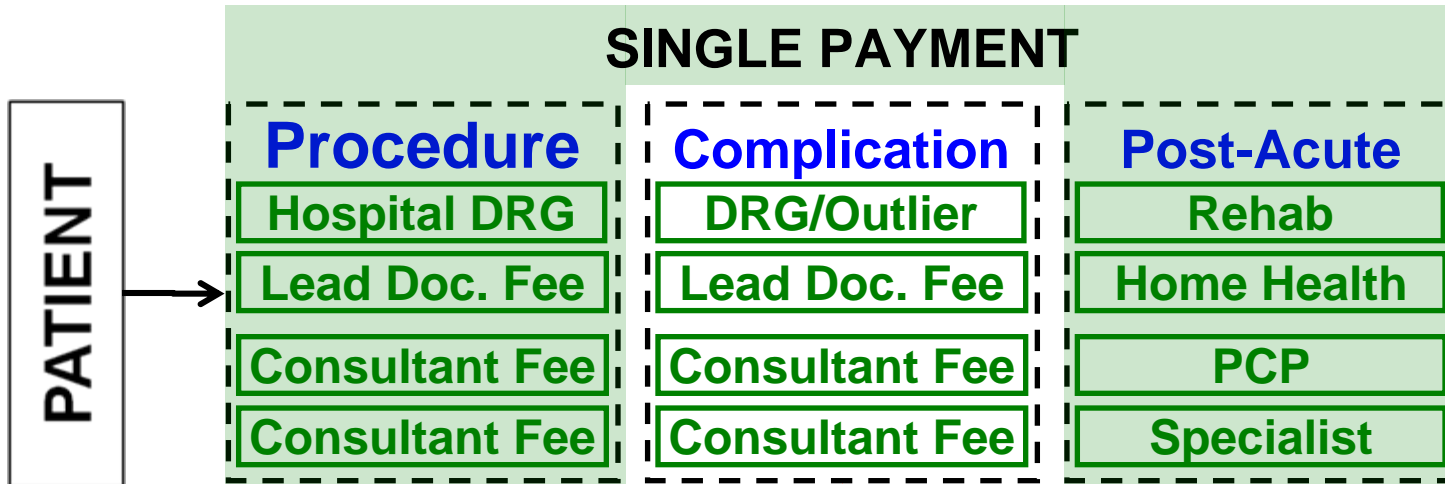


PROBLEM:
*No incentive to reduce
unnecessary use of
expensive post-acute care*

Bundling Inpatient and Post-Acute Care Promotes Coordination

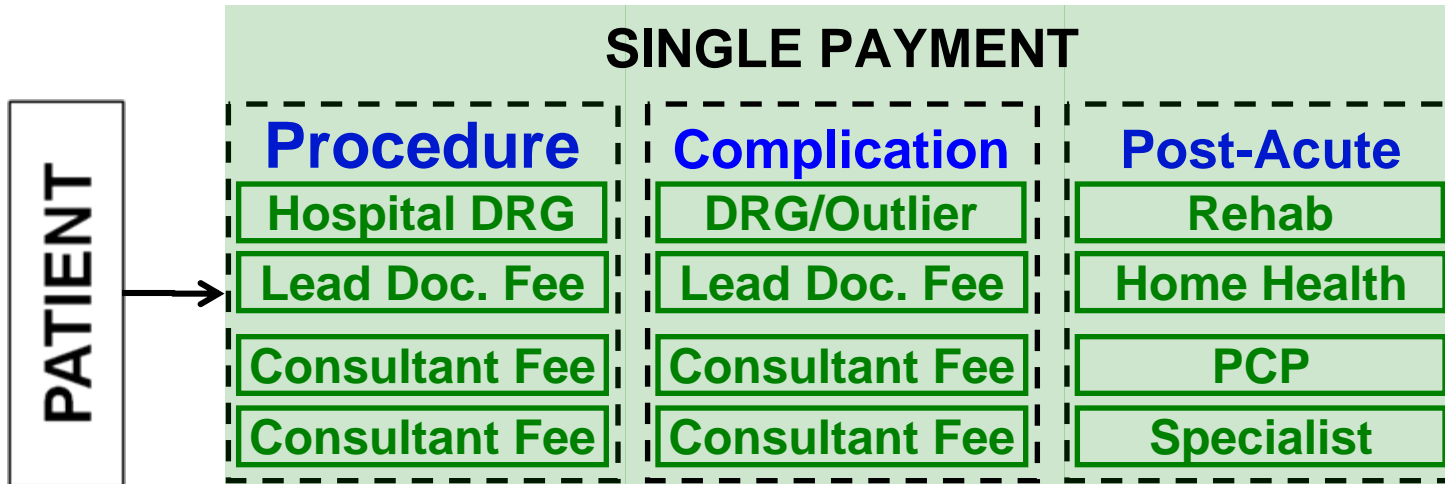


Does the Bundle Stop When Things Go Bad in the Hospital?



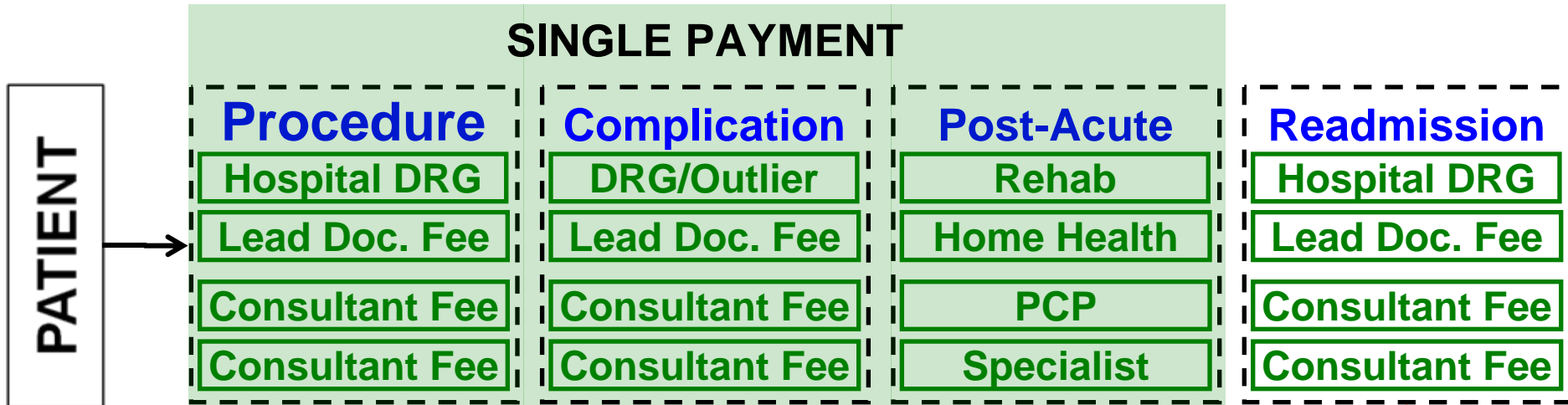
PROBLEM:
*Hospital and physicians
 are paid more to treat
 expensive infections and
 complications*

Including a Warranty for Complications in the Bundle



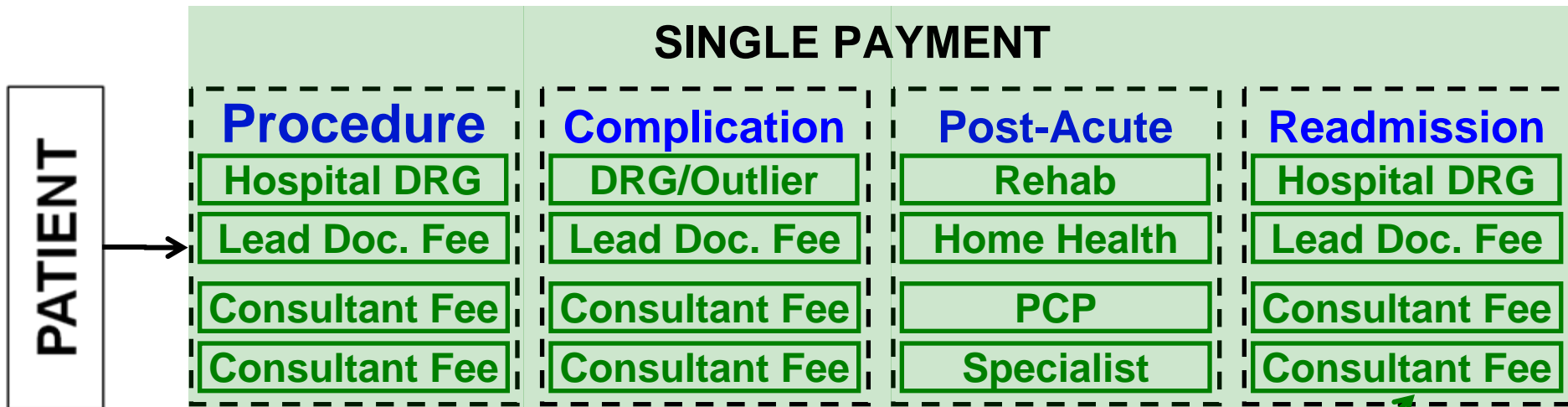
SOLUTION:
Infections and complications increase costs but not revenues for hospitals & physicians

What About Complications That Occur After Discharge?



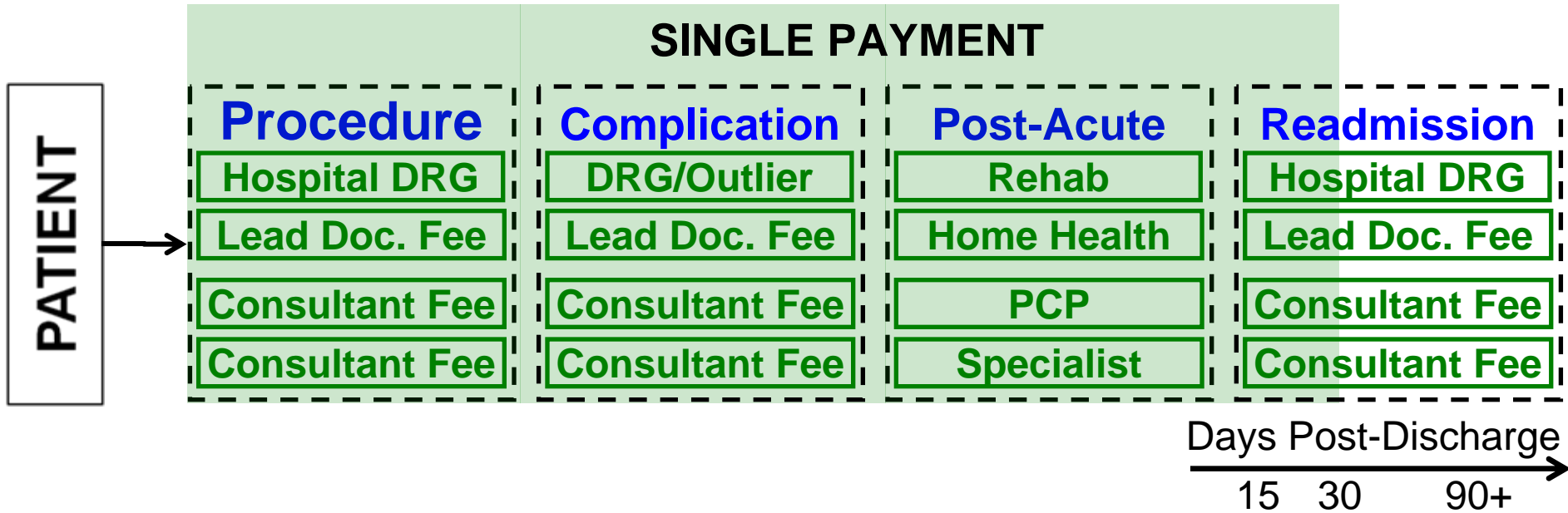
PROBLEM:
Hospitals and physicians
make more money when
patients are readmitted

Adding a Warranty for Post-Discharge Events

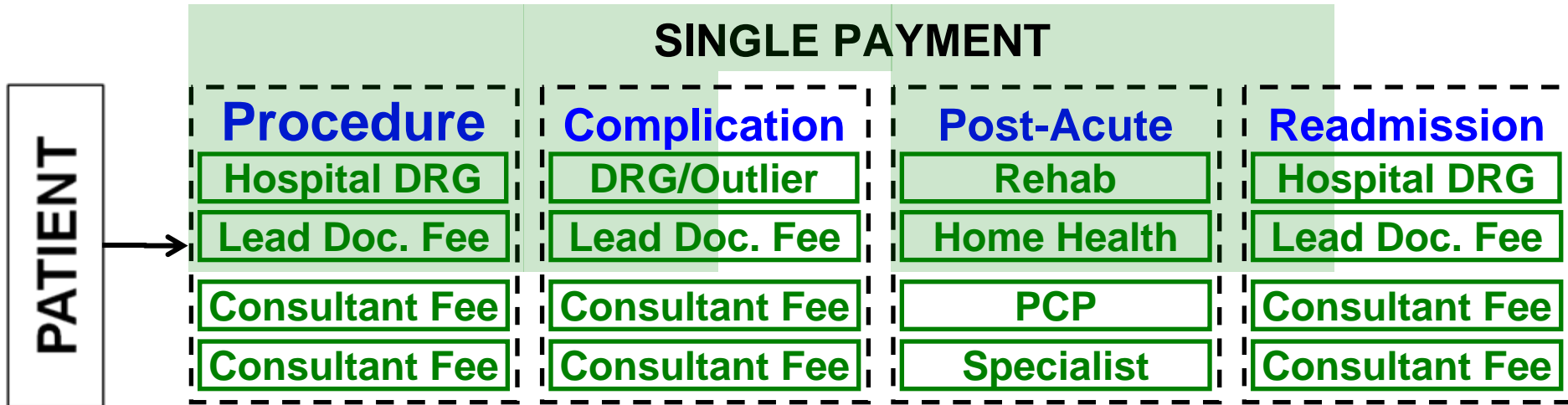


SOLUTION:
Readmissions increase costs but not revenues for hospitals and physicians

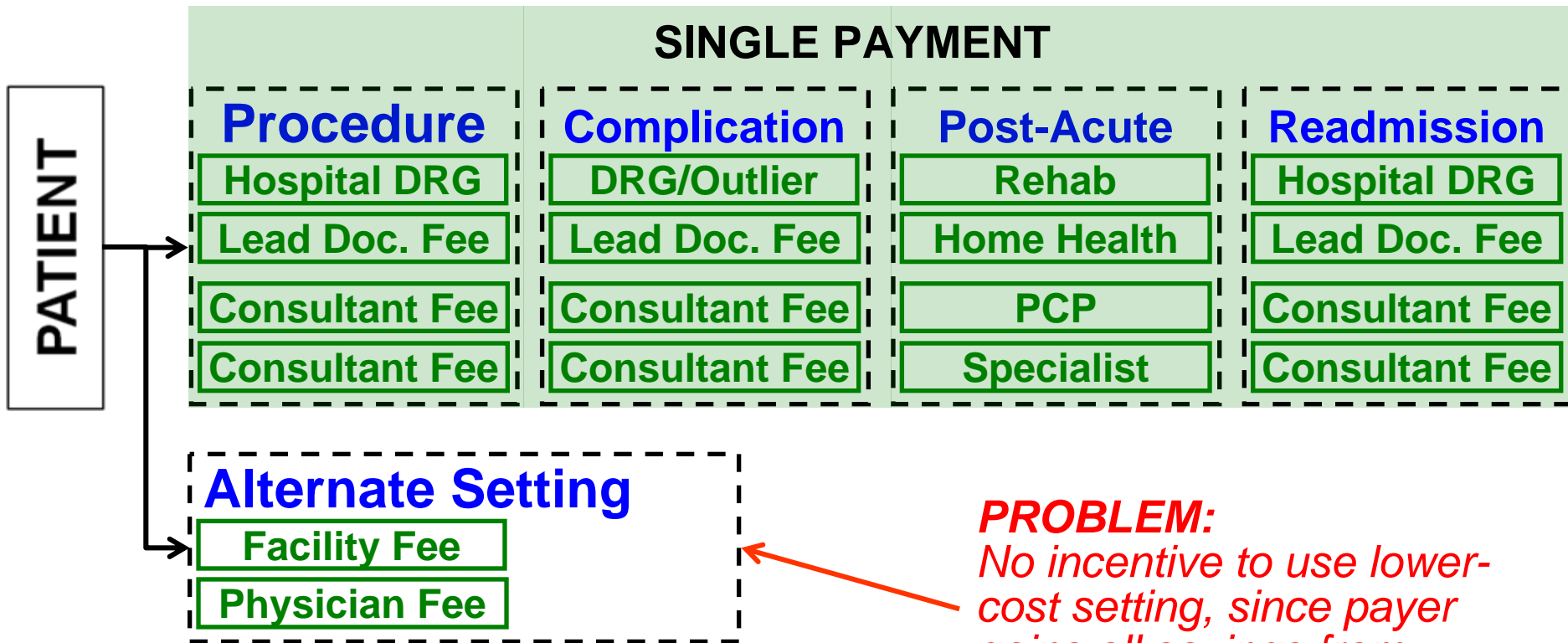
How Long Does the Warranty Last?



Partial Bundles Could Exclude Some Providers, Complications

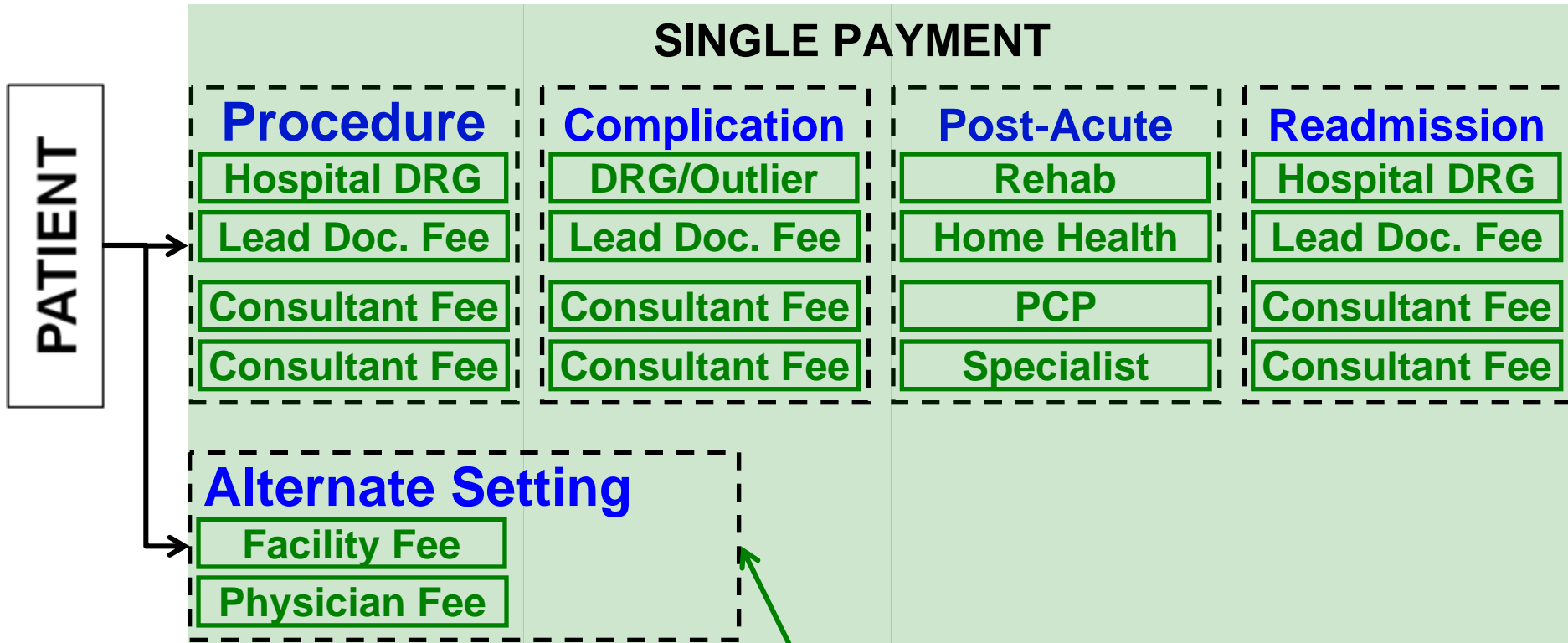


What If The Procedure Could Be Done Outside the Hospital?



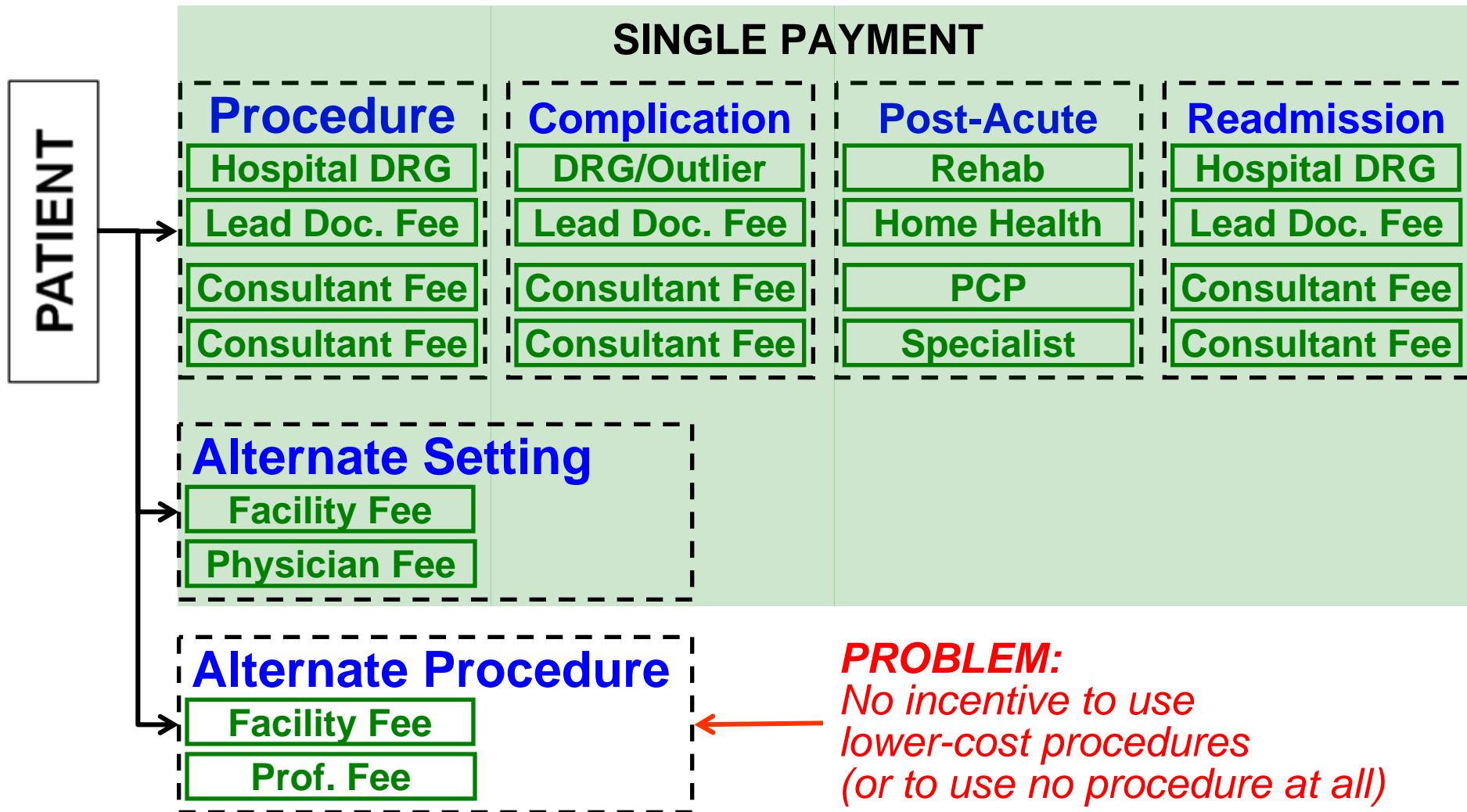
PROBLEM:
No incentive to use lower-cost setting, since payer gains all savings from lower facility fees

A Facility-Independent Bundle

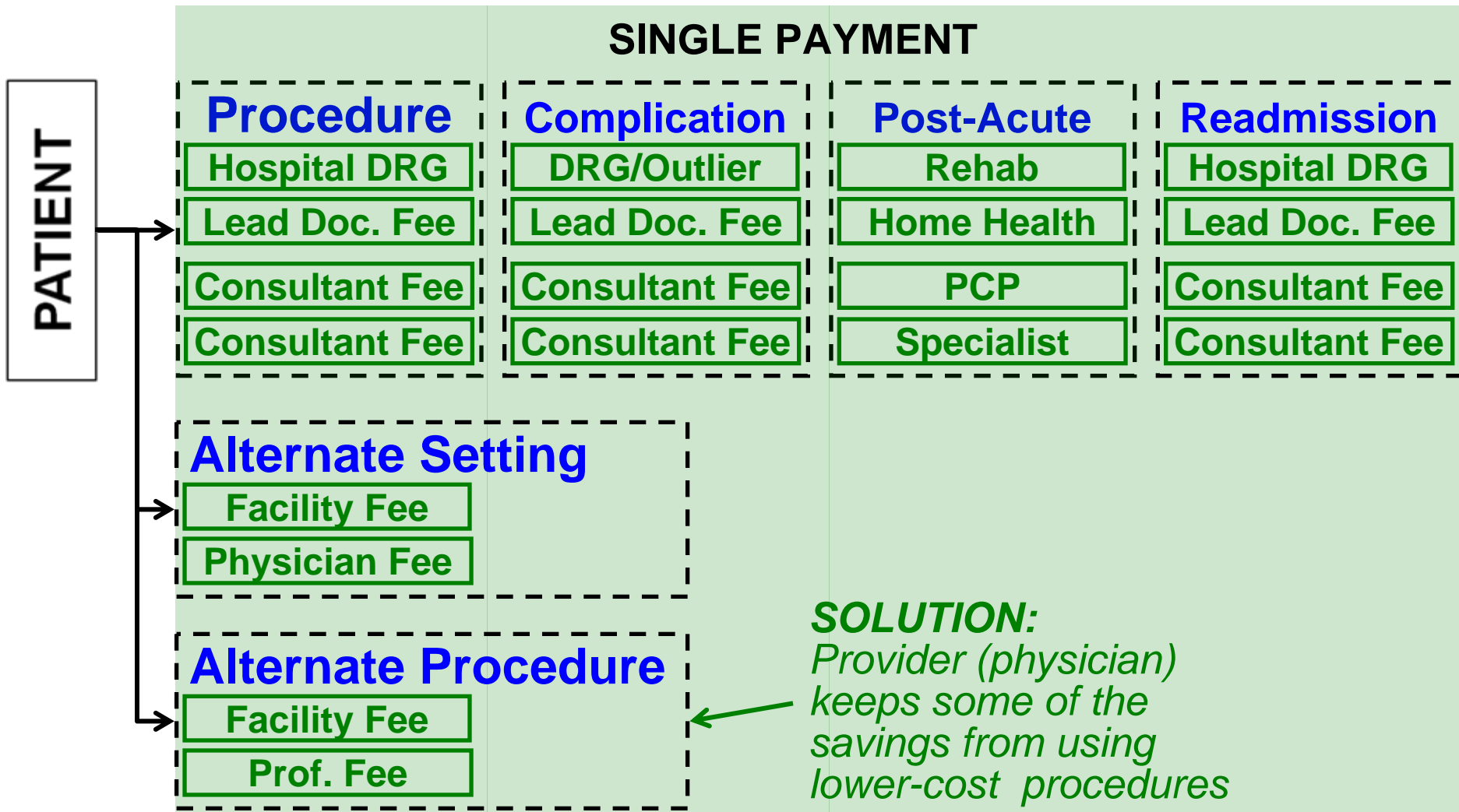


SOLUTION:
Providers keep some of the savings from moving procedures to lower-cost settings

What if An Alternative Procedure Would Be Better or Cheaper?



A Condition-Based (Not Procedure-Based) Bundle



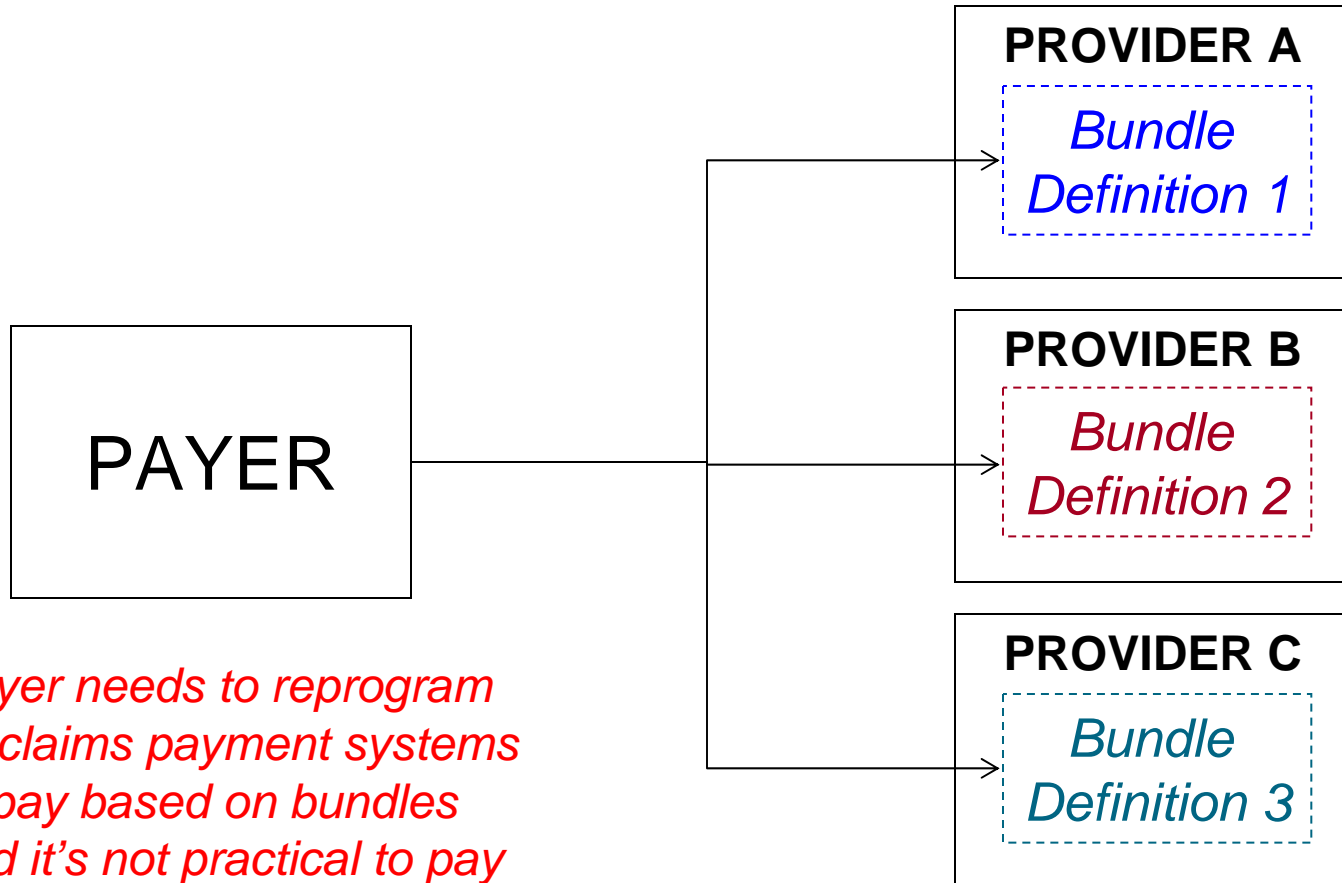
Different Episode/Bundling Concepts for Different Problems

PROBLEM/OPPORTUNITY	WHAT TO BUNDLE
Savings on medical devices or reduction in inpatient inefficiencies	Hospital + Lead Physician
Variation in consulting physicians	Hospital + All Physicians
Reducing infections, complications	Procedure + Complications
Efficient use of post-acute care	Inpatient + Post-Acute Care
Preventable readmissions	Initial Admission + Readmits
Availability of lower-cost facilities	Any Facility for Procedure
Option for lower-cost procedures	Any Procedure for Diagnosis
None of the above	Nothing: Not Worth the Effort

Focus Bundle Definitions on Condition-Specific Opportunities

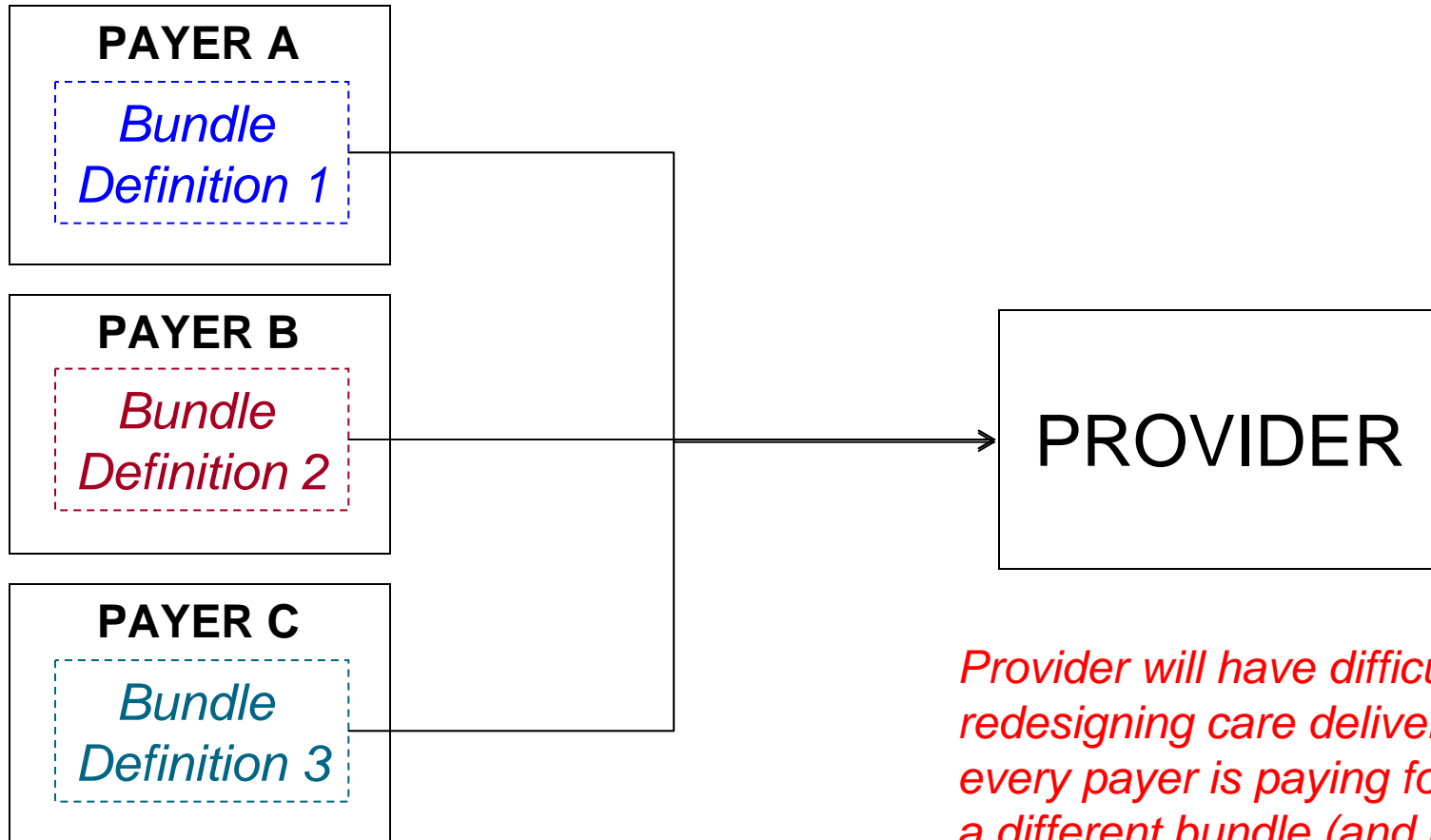
Condition/Procedure	Likely Opportunities	Episode/Bundle Definition
Surgery	Reduce Device Costs if Multiple Vendors Exist	Hospital + Surgeon
Surgery	Reduce Infections	Hospital + Complications
Chronic Disease	Reduce Readmissions	Hospital + Readmission
Chronic Disease	Reduce Initial Admissions	Condition-Based Pmt (Year-Long Episode)
Maternity Care	Reduce C-Sections	Pay for Childbirth, Not Delivery Method
Maternity Care	Increase Use of Birth Centers	Pay Physicians, Not Facility

Who Decides What's in a Bundle? Each Provider?



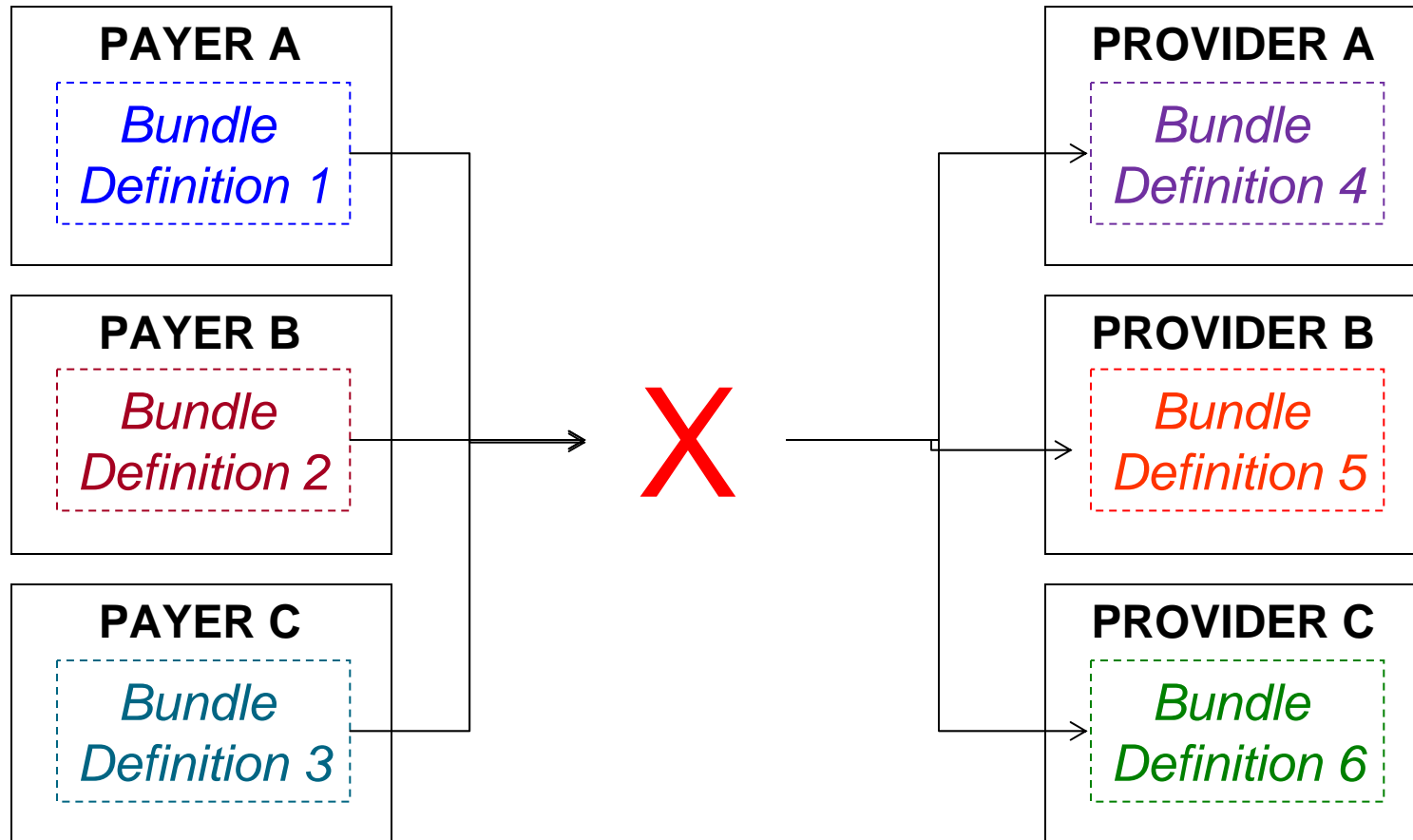
Payer needs to reprogram its claims payment systems to pay based on bundles and it's not practical to pay every provider differently

Who Decides What's in a Bundle? Each Payer?



Provider will have difficulty redesigning care delivery if every payer is paying for a different bundle (and if some are still paying FFS)

What If Payers Won't Buy What Providers Offer (& Vice Versa)?



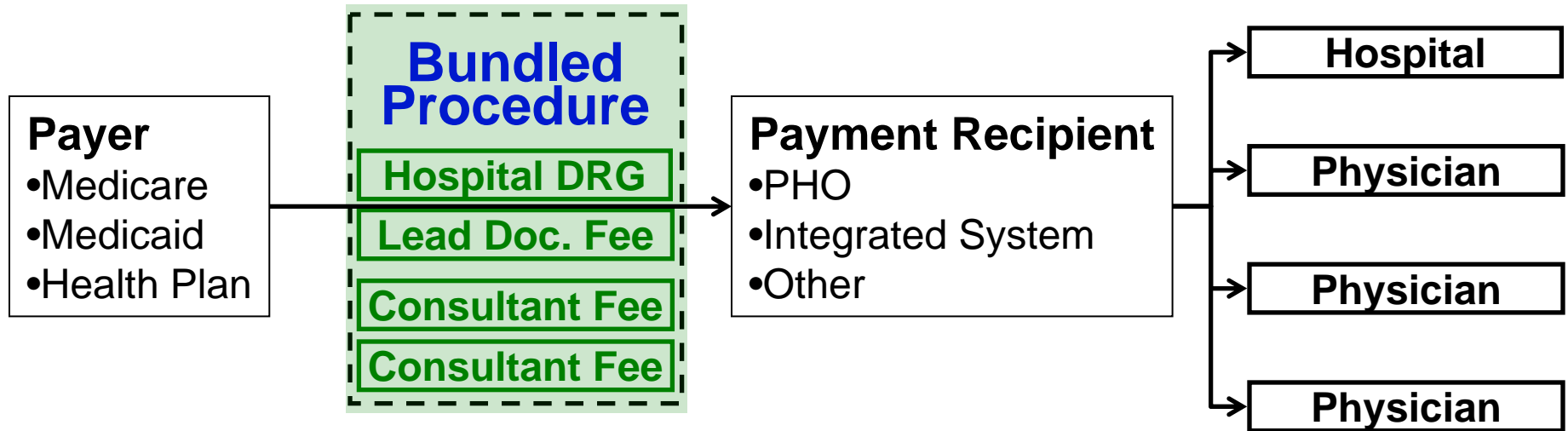
What's the Solution?

- **Data:**
Physicians and hospitals need the ability to analyze current data to determine where the opportunities for lower cost and improved quality exist
- **Neutral Facilitator:**
Providers and payers need a neutral third-party (with shared, trusted data) to agree on bundle definitions that will benefit both sides
- **Willingness to Collaborate:**
All payers and all providers need to agree to use bundles with the same definitions (competition on performance, not on definitions)

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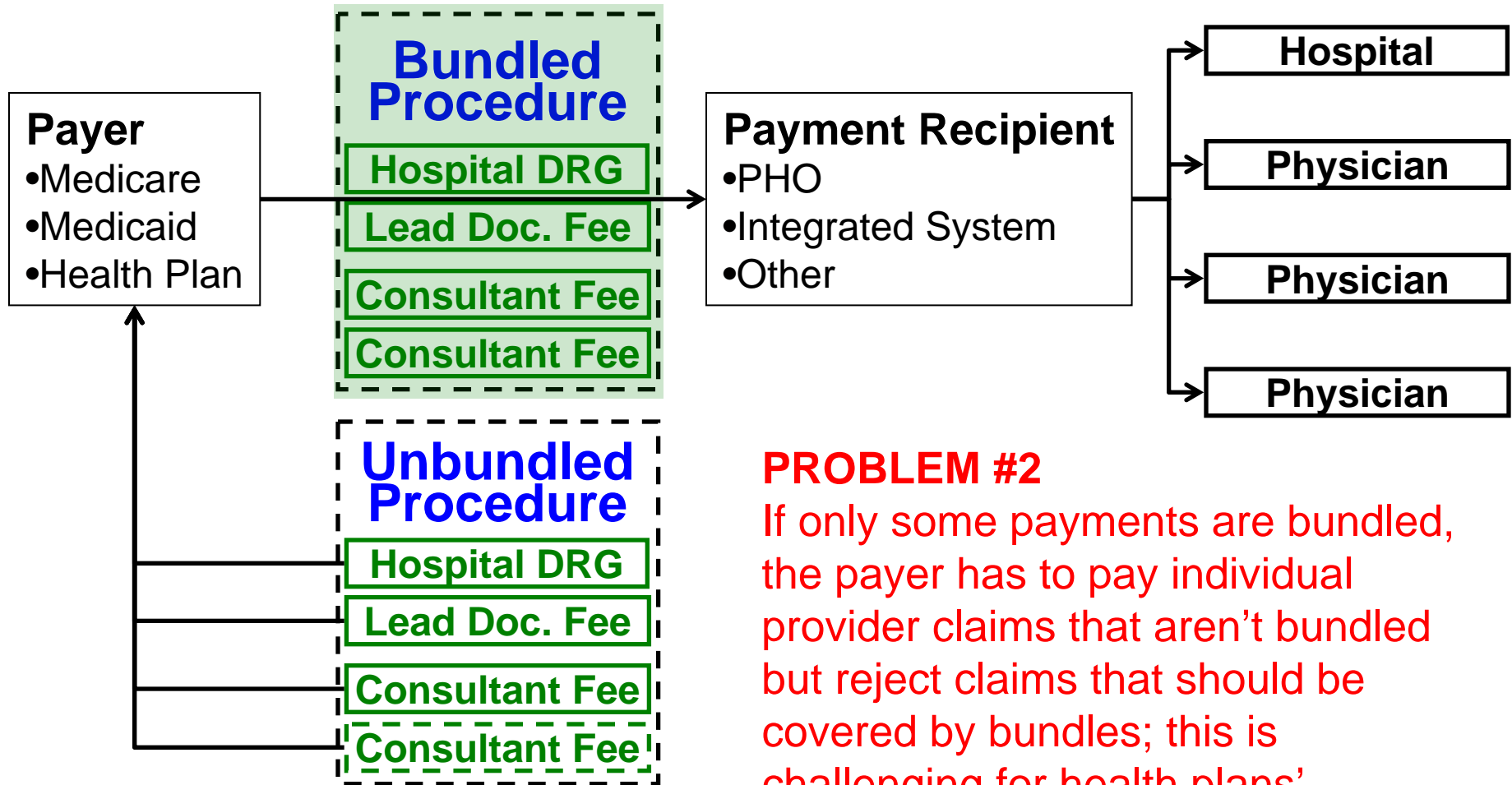
Who Gets the Check?



PROBLEM #1

Making a single payment to two (or more) providers who are currently paid separately requires designating some entity to take the single check and divide it up among participating providers

Which Claims Should Be Ignored And Which Should Be Paid?



PROBLEM #2

If only some payments are bundled, the payer has to pay individual provider claims that aren't bundled but reject claims that should be covered by bundles; this is challenging for health plans' claims payment systems

“Virtual” Bundling Solves Some Implementation Challenges

- **Problem #1: Who gets the check?**
 - Making a single payment to two (or more) providers who are currently paid separately requires designating some entity to take the single check and divide it up among participating providers
- **Problem #2: Which claims shouldn't be paid?**
 - If only some payments are bundled, the payer has to pay individual provider claims that aren't bundled but reject claims that should be covered by bundles; this is challenging for claims payment systems
- **Solution: Treat the bundle as a budget, not a payment**
 - Individual providers bill and get paid for services under standard FFS
 - Total FFS claims compared to bundled payment amount; payer pays providers bonus if total < budget; providers refund \$ if total > budget

“Virtual” Bundling Solves Some Challenges, But Reduces Benefits

- **Problem #1: Who gets the check?**
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- **Solution: Treat the bundle as a budget, not a payment**
 - Individual providers bill and get paid for services under standard FFS
 - Total FFS claims compared to bundled payment amount; payer pays providers bonus if total < budget; providers refund \$ if total > budget
- **Weaknesses:**
 - No upfront flexibility for the providers to cover costs of currently unreimbursed services or to change payment amounts quickly
 - Bonus/refunds occur in future, creating cash flow and solvency issues
 - Providers still need a way to divide up the bonus/refund amounts

CMS “Bundling” Initiatives

Reflect Range of Opportunities

- **Model 1 (Inpatient Gainsharing, No Warranty)**
 - Hospitals can share savings with physicians
 - No actual change in the way Medicare payments are made
- **Model 2 (Virtual Full Episode Bundle + Warranty)**
 - Budget for Hospital+Physician+Post-Acute+Readmissions
 - Medicare pays bonus if actual cost < budget
 - Providers repay Medicare if actual cost > budget
- **Model 3 (Virtual Post-Acute Bundle + Warranty)**
 - Budget for Post-Acute Care+Physicians+Readmissions
 - Bonuses/penalties paid based on actual cost vs. budget
- **Model 4 (Prospective Inpatient Bundle, No Warranty)**
 - Single Hospital + Physician payment for inpatient care

What's the Solution?

- Partnerships Among Providers
 - E.g., physician-hospital organizations
 - E.g., joint contracting arrangements
 - Acquisition of physician practices or consolidation of providers is not necessary
- Neutral Facilitator
 - Helping all “sides” develop a mutually beneficial arrangement
- Reduce Legal Barriers
 - Anti-trust rules and other laws make it challenging for independent providers to collaborate on offering bundles/episodes

Implementation Issues for Episode and Bundled Payment

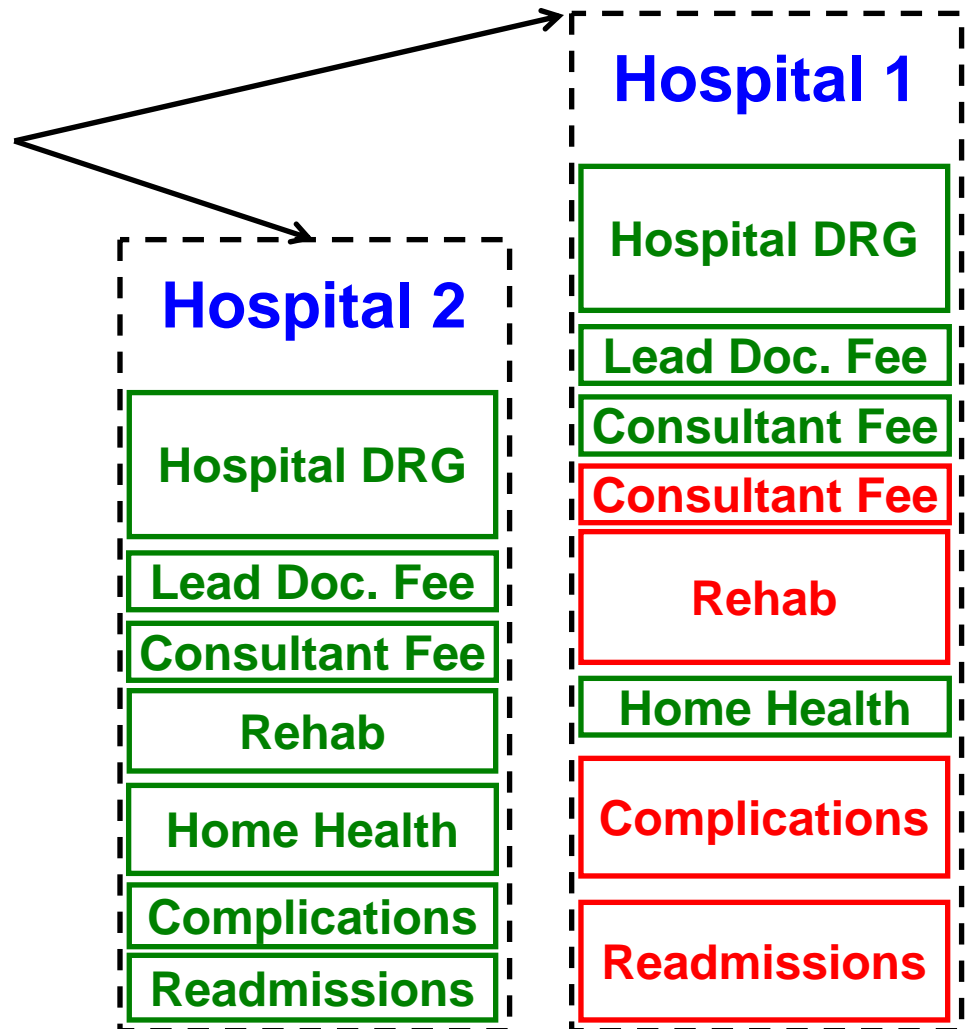
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Payment Reform Helps Control Utilization But Not Prices

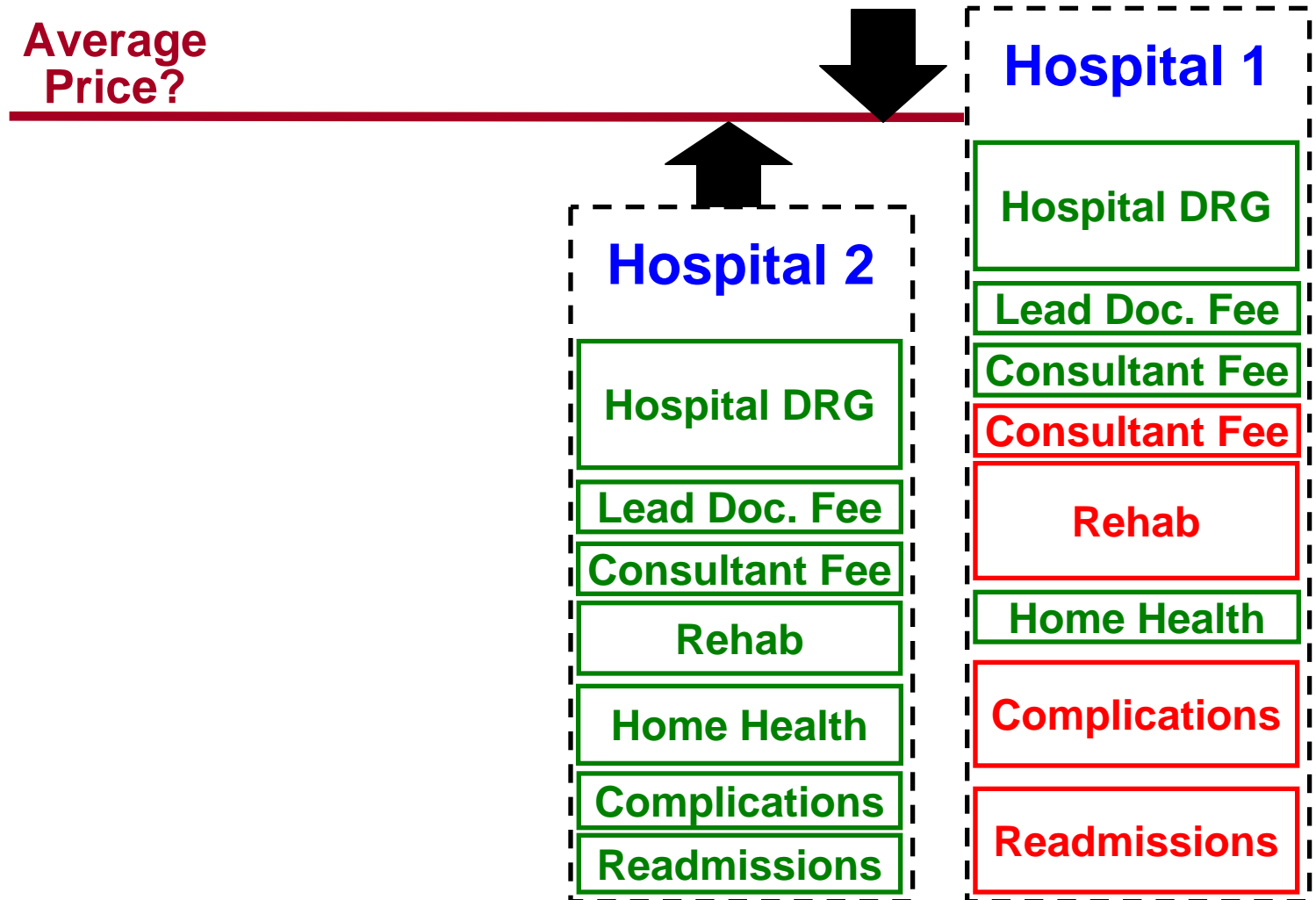
- Changing the payment *method* removes the incentives to increase volume and removes barriers to reducing costs
- But under any payment method, prices may be too high or too low
 - If the price is (too) high, there are no savings and no incentive to transform care
 - If the price is too low, providers will be unable to deliver high-quality care and risk financial disaster

Variation Today Among Providers on Components of Bundles

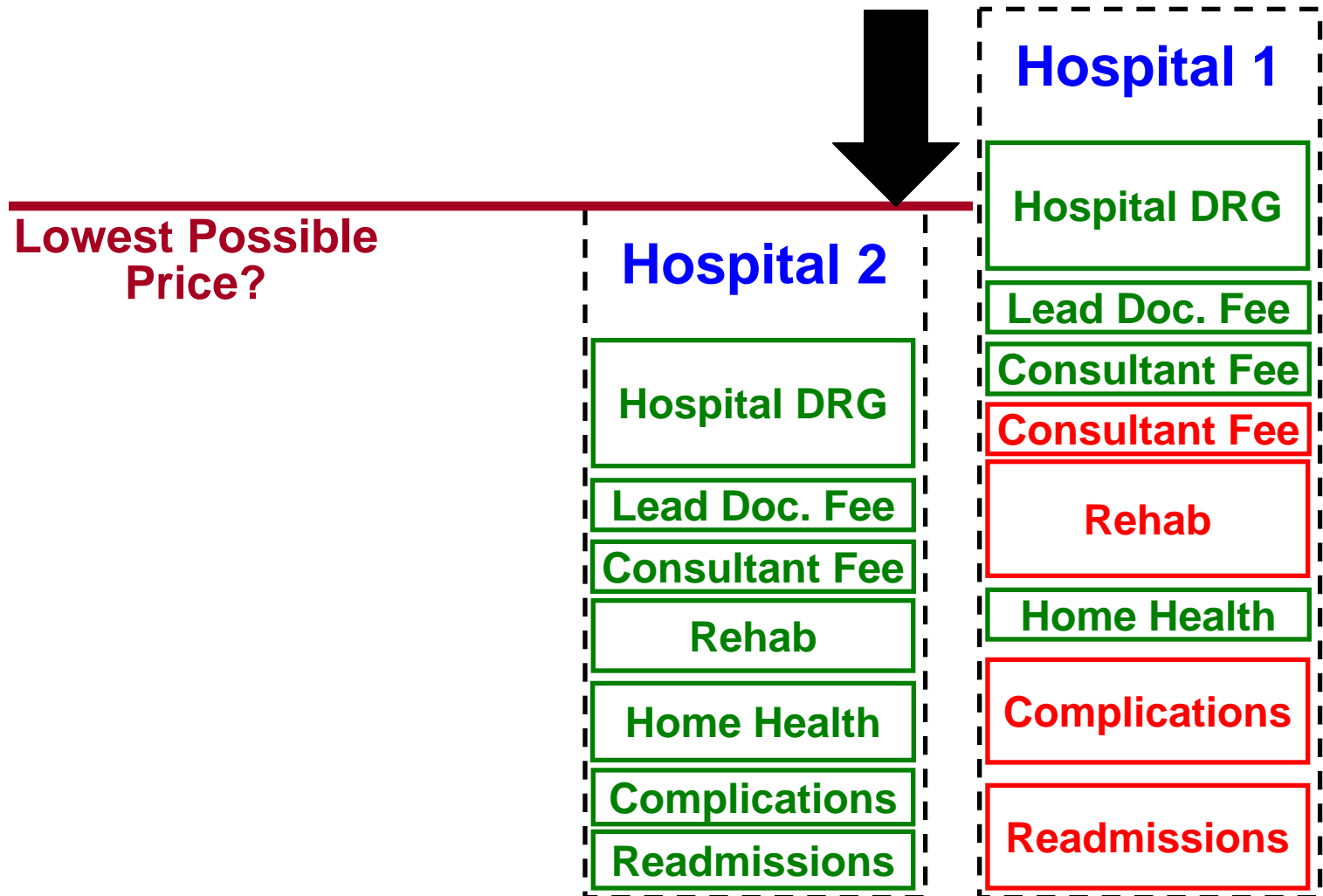
What's the
"Right" Price?



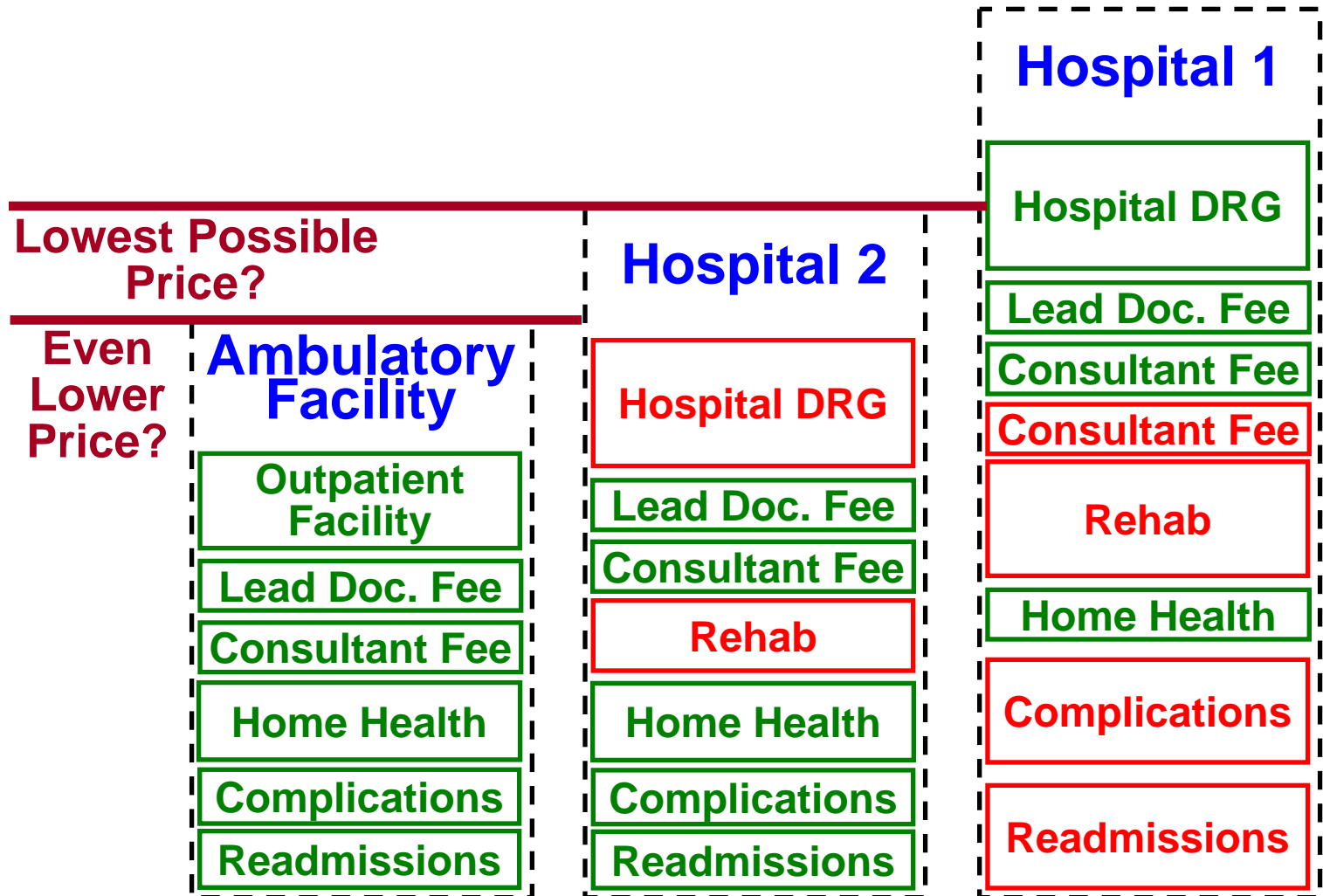
Using the Average Price Doesn't Benefit Payers



Lowest Price Benefits Payers But Hurts Most Providers

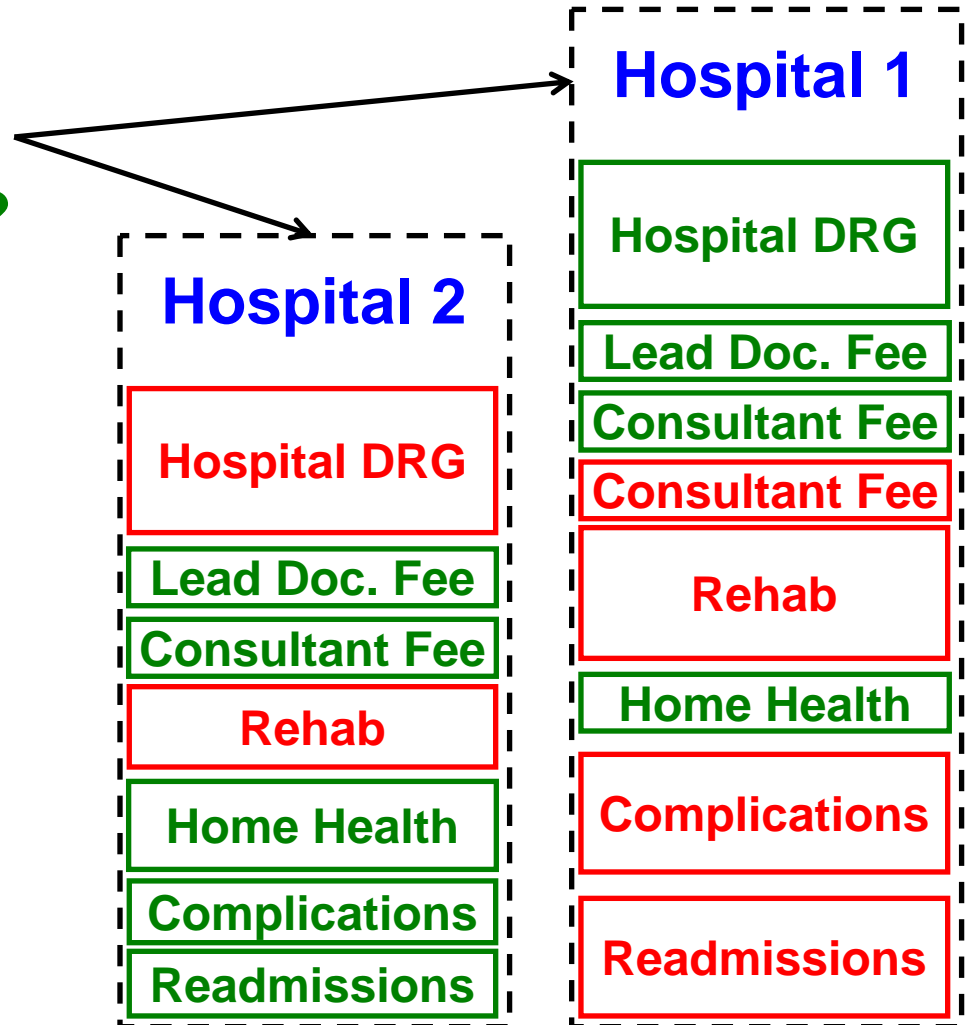


Broader Bundle Definitions Could Encourage Even Lower Costs



Distinguishing Variation Due to Patient Needs vs. Inefficiency

Inefficiency?
or
Sicker Patients?



What Are the Solutions?

1. Risk Adjustment (Pay More for More Complex Patients)
 - Difficult to do without a better understanding of which variation is appropriate and inappropriate; regression-based models adjust for unwarranted as well as warranted variation
 - Depends heavily on accuracy of coding patients, and creates potential for gaming in coding
 - Need to distinguish conditions present on admission versus those acquired during a procedure
2. Risk Limits (Pay More for Unusually Complex Patients)
 - Outlier threshold would need to be lower for smaller providers & less common procedures
3. Risk Exclusions (Pay Bundles Only for Lower-Risk Patients)
 - Reduces potential benefit of bundling by limiting number of patients/procedures included
 - Potentially leads to “upcoding” patients to move them out of the bundle, reducing potential savings

Risk Limits/Exclusions May Be An Easier Way to Start

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Can a Provider Lower Its Prices? Is There an Incentive to Do So?

- **Medicare sets its prices unilaterally/uniformly, so there is little ability/incentive for a provider to charge less**
 - Competitive bidding initiatives have had rough sledding
 - Bundling demonstrations have sought provider-defined discounts
- **Health plans typically negotiate conversion factors, not individual procedure prices**
 - Health plans can't easily change prices on individual procedures
 - Most providers are not prepared to lower prices on everything at once
- **Patient cost-sharing requirements don't reward use of lower-cost providers**

Where Will You Get Your Knee Replaced?

Knee Joint Replacement



	Price #1 \$23,000	Price #2 \$28,000	Price #3 \$33,000
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Copayment?

Use High Price Provider

Knee Joint Replacement



Consumer Share of Surgery Cost	Price #1 \$23,000	Price #2 \$28,000	Price #3 \$33,000
\$1,000 Copayment:	\$1,000	\$1,000	\$1,000 ✓

Coinsurance?

Use High Price Provider

Knee Joint Replacement



Consumer Share of Surgery Cost	Price #1 \$23,000	Price #2 \$28,000	Price #3 \$33,000
\$1,000 Copayment:	\$1,000	\$1,000	\$1,000 ✓
10% Coinsurance w/\$2,000 OOP Max:	\$2,000	\$2,000	\$2,000 ✓

High Deductible? Use High Price Provider

Knee Joint Replacement



Consumer Share of Surgery Cost	Price #1 \$23,000	Price #2 \$28,000	Price #3 \$33,000
\$1,000 Copayment:	\$1,000	\$1,000	\$1,000 ✓
10% Coinsurance w/\$2,000 OOP Max:	\$2,000	\$2,000	\$2,000 ✓
\$5,000 Deductible:	\$5,000	\$5,000	\$5,000 ✓

Pay the Difference in Price? Use the High-Value Provider

Knee Joint Replacement



Consumer Share of Surgery Cost	Price #1 \$23,000	Price #2 \$28,000	Price #3 \$33,000
\$1,000 Copayment:	\$1,000	\$1,000	\$1,000 ✓
10% Coinsurance w/\$2,000 OOP Max:	\$2,000	\$2,000	\$2,000 ✓
\$5,000 Deductible:	\$5,000	\$5,000	\$5,000 ✓
Highest-Value:	\$0 ✓	\$5,000	\$10,000

Today: Hard to Know if Better Price Means Better Value

Payment for Procedure

Provider 1:

\$10,000

Provider 2:

\$9,500

-5%

What Hidden Costs Accompany the Lower Price?

Payment for Procedure	Added Payment for Infection	Rate of Infections
Provider 1:		
\$10,000	\$20,000	5%
Provider 2:		
\$9,500	\$19,000	10%
-5%		

Total Spending May Be Higher With the “Lower Price” Provider

Payment for Procedure	Added Payment for Infection	Rate of Infections	Average Total Payment
Provider 1:			
\$10,000	\$20,000	5%	\$11,000
Provider 2:			
\$9,500	\$19,000	10%	\$11,400
-5%			+4%

Provider 2 has a lower starting price, but is more expensive when lower quality is factored in

Bundled/Episode Payments Allow Comparing Apples to Apples

Payment for Procedure	Added Payment for Infection	Rate of Infections	Bundled/Episode Payment
Provider 1:			
		5%	\$11,000
Provider 2:			
		10%	\$11,400
			+4%

Bundled prices show that Provider 1 is the higher-value provider

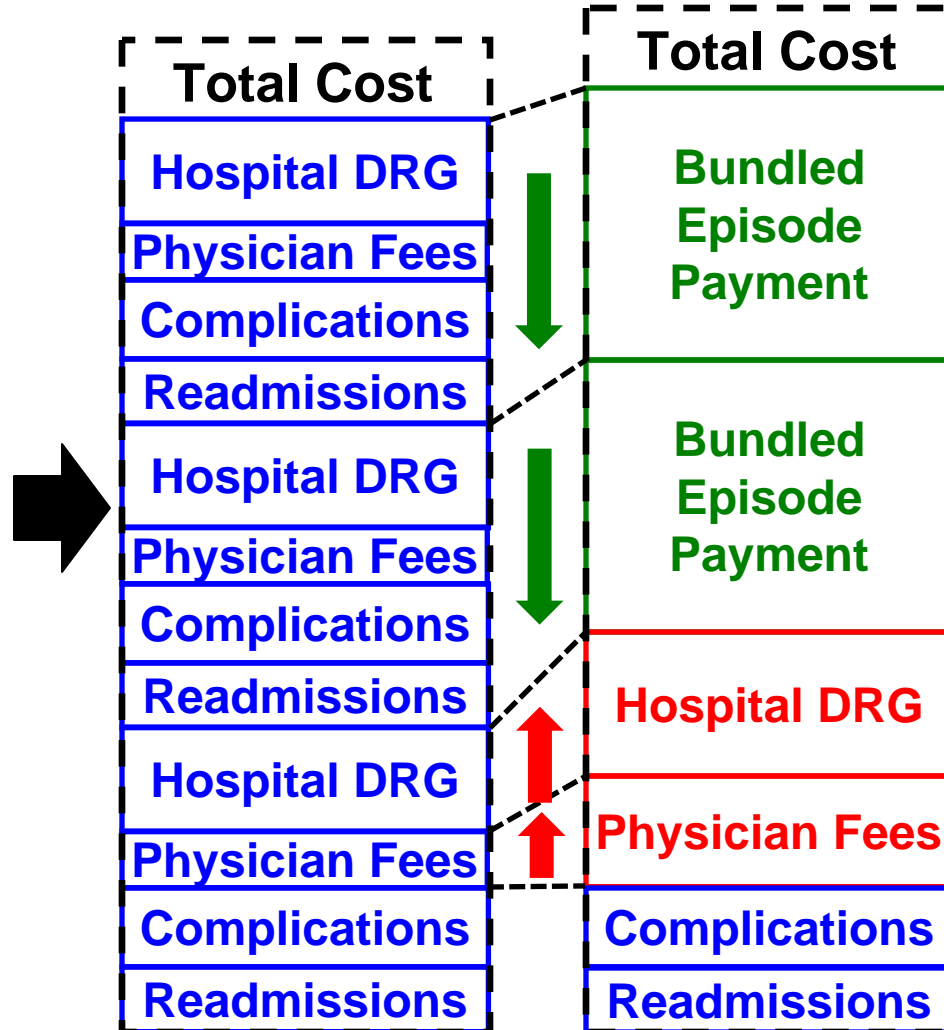
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What Stops Cost-Shifting to Unbundled Procedures?

Payer

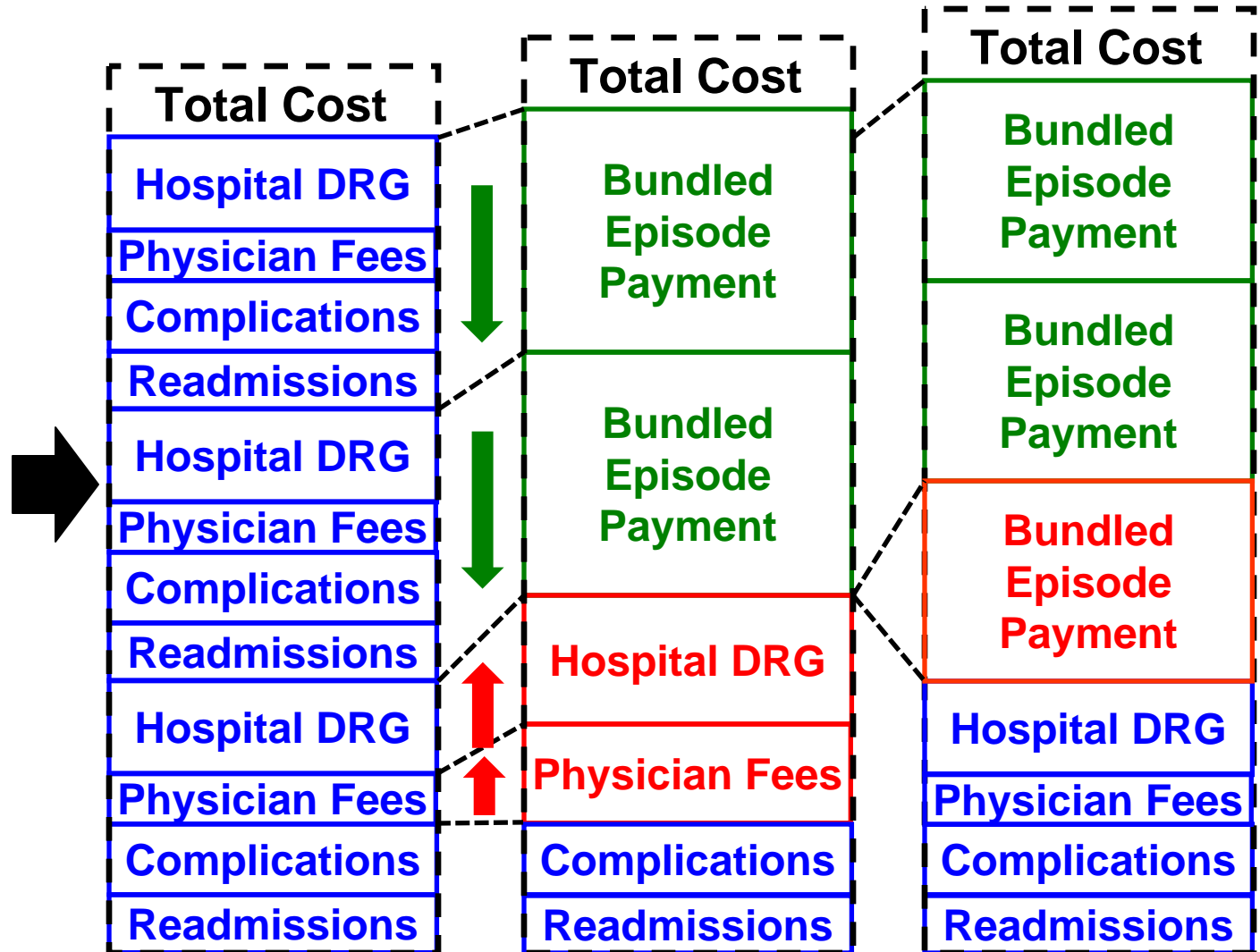
- Medicare
- Medicaid
- Health Plan



What Stops Increases in Number of Episodes?

Payer

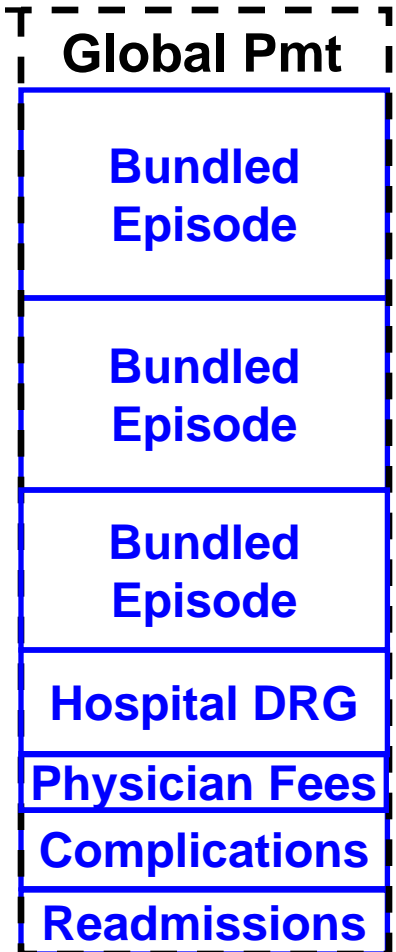
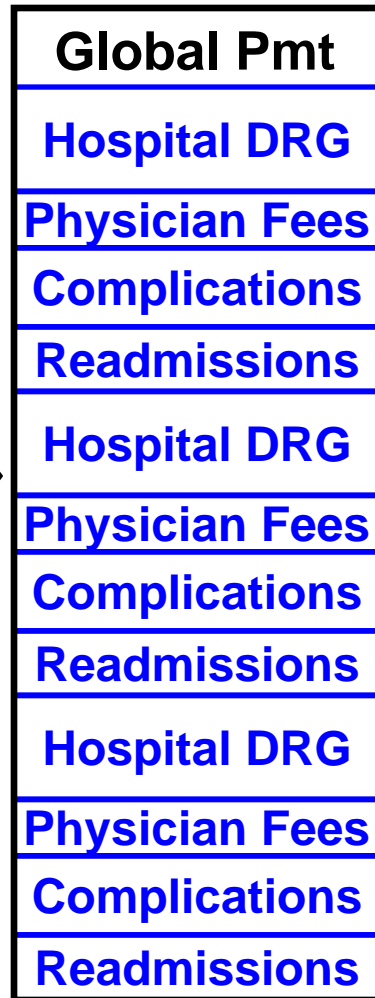
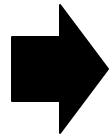
- Medicare
- Medicaid
- Health Plan



Solution: Global Payment

Payer

- Medicare
- Medicaid
- Health Plan



Global Payment Has Most of the Same Implementation Challenges

- Who gets the check?
- What's the right “global price?”
- How do you appropriately limit the provider's risk?
- What's the incentive to be lower-priced?

MANY Other Issues

- Improved Cost Accounting Systems
 - Providers need to know the true cost of an episode
 - Hospitals need to know how costs will change as volume declines
- Methods of Redesigning Care Processes
 - Bundling only “works” if the provider redesigns care to reduce costs
- Revised Physician Compensation Systems
 - Paying physicians based on productivity no longer works if the organization is being rewarded for quality/efficiency
- Reforms to Fraud & Abuse and Other Laws
 - Stark, Anti-Kickback, Civil Monetary Penalty, Anti-Trust laws all create impediments to gainsharing and bundling
- Revised Patient Benefit Structures
 - Patients need to “choose” all the providers who jointly deliver care
 - Patient cost-sharing amounts need to be recalculated for the bundle
 - Patients need the ability and incentive to adhere to treatment regimes
- Better/Different Quality Measures
 - Current measures focus on what FFS disincentivizes, but bundled payments create different incentives and different potential quality problems

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Is It Worth It?

- Yes, to align payment with care improvements where there are known opportunities for savings
 - Many opportunities to reduce costs by redesigning care
 - Rather than imposing bundles on providers, help create them for providers that want to create higher value
- Yes, as a transitional step to help organizations build the capacity to accept global payments
 - Focus delivery system redesign on specific areas without being expected to manage total costs all at once
- Yes, as an internal mechanism within organizations accepting global payments for allocating resources and responsibility to individual provider teams
 - Even if you accept a global payment, you still have to manage the costs and quality of individual episodes of care

For More Information on Payment and Delivery Reforms

nrhi Network for Regional Healthcare Improvement Robert Wood Johnson Foundation

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From VOLUME to VALUE

Transforming Health Care Payment and Delivery Systems to Improve Quality and Reduce Costs

NRHI Healthcare Payment Reform Series

BETTER WAYS TO PAY FOR HEALTH CARE

A Primer on Healthcare Payment Reform

Transitioning to Accountable Care

CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

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Harold D. Miller www.CHQPR.ORG

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Setting Payment Levels

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Transitioning to Episode-Based Payment

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PATHS TO HEALTHCARE PAYMENT REFORM

Which Healthcare Payment System is Best?

There is broad agreement that episode-based payment systems are needed to drive more services to more people, but often financial incentives are not aligned to deliver better services and improve health. The two papers address a payment system currently being discussed:

- Episode Payment** (i.e. paying a single price for all of the healthcare services needed by a patient for an entire episode of care, including all of the patient and outpatient care they need after leaving the hospital)
- Comprehensive Care Payment** (also called condition-adjusted capitation, or risk-adjusted global fees) (i.e. paying a single price for all of the services needed by a specific group of people for a fixed period of time (e.g. all of the care needed during the course of a year by the people who work for a particular employer or people who have chronic disease)).

There are many reasons why the best payment system is a fixed approach, particularly in the early stages of healthcare reform. Episode Payments are better for certain kinds of conditions and patients, and Comprehensive Care Payments are better for other kinds of conditions and patients, and the best approach is probably using a combination of both. Which one should be used depends on the characteristics of the cost and quality problems to be solved.

Two Different Kinds of Cost/Quality Problems to be Solved

There are (at least) two different reasons why the cost of treating people with a particular condition may be higher than it needs to be:

- The cost and quality of care for a particular condition is unusually high and/or there is high variation in the cost and quality of episodes among similar patients and across regions.** For example, the cost of coronary artery bypass graft surgery is generally higher in some states than in others, depending on the mix of which delivery system or hospital are used, how frequent visitors are included before 30-day post-discharge, how frequently Cesarean sections are used, etc. Also, problems that are difficult to solve through the use of quality improvement are more likely to be solved by adjusting for case severity and outcomes.
- Episodes occur more frequently than necessary for a particular condition and/or the frequency of episodes varies significantly among similar patients and across regions.** For example, the type of care that chronic disease patients receive in the community can significantly affect the rate at which they are hospitalized for exacerbations of their disease. Also, research by the Dartmouth-AHA project has shown wide variations in the frequency of cardiac surgery and other types of procedures across the country, with no evidence that higher frequency delivers better outcomes for patients.

Different Payment Systems Solve Different Cost/Quality Problems

Amount Variation of Cost Per Episode	High	Episode Payment Examples: Hip Fracture, Labor & Delivery	Episode Payment Examples: Heart Disease, Back Pain
	Low	Free for Service Examples: Immunizations, Simple Injuries	Comprehensive Care (Flat or Year-Long Episodes) Examples: Chronic Disease, Complex Heart Failure
		Low	High
		Low Variation in Frequency of Episodes Per Condition	High

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