Implementing Episode and Bundled Payments

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Executive Director
Center for Healthcare Quality and Payment Reform
and
President and CEO
Network for Regional Healthcare Improvement
Implementation Issues for Episode and Bundled Payment

- What’s in the Bundle, Why, and Who Decides?
- Who Gets the Check?
- What’s the Price of the Bundle?
- What’s the Incentive for a Provider to Be Low-Priced?
- Will It Actually Lower Costs?
- Is Bundling Worth It?
Implementation Issues for Episode and Bundled Payment

- What’s in the Bundle, Why, and Who Decides?
- Who Gets the Check?
- What’s the Price of the Bundle?
- What’s the Incentive for a Provider to Be Low-Priced?
- Will It Actually Lower Costs?
- Is Bundling Worth It?
Most Obvious “Unbundled” Payment Today: Hospital & Doctor
Hospital Payment Was Already “Bundled,” But Narrowly

**PROBLEM:**
No incentive for physician to help hospital reduce its costs, even though physician controls them.
Adding Physician in Bundle Can Lead to Win-Win Savings

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Hospital DRG</th>
<th>Bundled Pmt</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Drugs/Devices</td>
<td>Drugs/Devices</td>
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<tr>
<td></td>
<td>Non-MD Staff</td>
<td>Non-MD Staff</td>
</tr>
<tr>
<td></td>
<td>Facility/Margin</td>
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</tr>
<tr>
<td></td>
<td>Physician Fee</td>
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**SOLUTION:**
Allow physician fee to increase if hospital costs are reduced
Simplest Bundle, Already Working in CMS Demonstrations

- Procedure
- Hospital DRG
- Physician Fee
In More Complex Cases, Many Physicians Are Involved

**Problem:**
No incentive to reduce number of physicians involved in case or frequency of visits
Bundling All Physicians Promotes More Care Coordination

SOLUTION: Unnecessary consults reduce funds available to lead physician
Not All Care Providers Are Inside the Hospital Walls

**SINGLE PMT**

**Procedure**
- Hospital DRG
- Lead Doc. Fee
- Consultant Fee

**Post-Acute**
- Rehab
- Home Health
- PCP
- Specialist

**PROBLEM:**
No incentive to reduce unnecessary use of expensive post-acute care
Bundling Inpatient and Post-Acute Care Promotes Coordination

**SINGLE PAYMENT**

**Procedure**
- Hospital DRG
- Lead Doc. Fee
- Consultant Fee
- Consultant Fee

**Post-Acute**
- Rehab
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**SOLUTION:** Unnecessary post-acute care reduces funds available for hospital & physicians
Does the Bundle Stop When Things Go Bad in the Hospital?

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**PROBLEM:**
Hospital and physicians are paid more to treat expensive infections and complications
Including a Warranty for Complications in the Bundle

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**SOLUTION:**
Infections and complications increase costs but not revenues for hospitals & physicians
What About Complications That Occur After Discharge?

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<th>Readmission</th>
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**PROBLEM:** Hospitals and physicians make more money when patients are readmitted.
Adding a Warranty for Post-Discharge Events

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**SOLUTION:**
Readmissions increase costs but not revenues for hospitals and physicians
How Long Does the Warranty Last?

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Days Post-Discharge

15 30 90+
Partial Bundles Could Exclude Some Providers, Complications

<table>
<thead>
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<th>SINGLE PAYMENT</th>
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What If The Procedure Could Be Done Outside the Hospital?

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<td>Specialist</td>
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</tbody>
</table>

**SINGLE PAYMENT**

**PROBLEM:** No incentive to use lower-cost setting, since payer gains all savings from lower facility fees
## A Facility-Independent Bundle

### SINGLE PAYMENT

**Procedure**
- Hospital DRG
- Lead Doc. Fee
- Consultant Fee
- Consultant Fee

**Complication**
- DRG/Outlier
- Lead Doc. Fee
- Consultant Fee
- Consultant Fee

**Post-Acute**
- Rehab
- Home Health
- PCP
- Specialist

**Readmission**
- Hospital DRG
- Lead Doc. Fee
- Consultant Fee
- Consultant Fee

**Alternate Setting**
- Facility Fee
- Physician Fee

### SOLUTION:
Providers keep some of the savings from moving procedures to lower-cost settings
What if An Alternative Procedure Would Be Better or Cheaper?

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<td>Consultant Fee</td>
<td>Specialist</td>
<td>Consultant Fee</td>
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<tr>
<td>Alternate Setting</td>
<td>Facility Fee</td>
<td></td>
<td>Facility Fee</td>
<td>Prof. Fee</td>
<td></td>
</tr>
<tr>
<td>Alternate Procedure</td>
<td>Facility Fee</td>
<td></td>
<td>Facility Fee</td>
<td>Prof. Fee</td>
<td></td>
</tr>
</tbody>
</table>

**PROBLEM:**
No incentive to use lower-cost procedures (or to use no procedure at all)
A Condition-Based (Not Procedure-Based) Bundle

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</table>

**Alternate Setting**
- Facility Fee
- Physician Fee

**Alternate Procedure**
- Facility Fee
- Prof. Fee

**SOLUTION:**
Provider (physician) keeps some of the savings from using lower-cost procedures.
## Different Episode/Bundling Concepts for Different Problems

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

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

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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)?

PAYER A
- Bundle Definition 1

PAYER B
- Bundle Definition 2

PAYER C
- Bundle Definition 3

PROVIDER A
- Bundle Definition 4

PROVIDER B
- Bundle Definition 5

PROVIDER C
- Bundle Definition 6
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).
Implementation Issues for Episode and Bundled Payment

• What’s in the Bundle, Why, and Who Decides?
• **Who Gets the Check?**
• What’s the Price of the Bundle?
• What’s the Incentive for a Provider to Be Low-Priced?
• Will It Actually Lower Costs?
• Is Bundling Worth It?
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

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• **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

• What’s in the Bundle, Why, and Who Decides?
• Who Gets the Check?
• **What’s the Price of the Bundle?**
• What’s the Incentive for a Provider to Be Low-Priced?
• Will It Actually Lower Costs?
• Is Bundling Worth It?
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?

Hospital 1
- Hospital DRG
- Lead Doc. Fee
- Consultant Fee
- Consultant Fee
- Rehab
- Home Health
- Complications
- Readmissions

Hospital 2
- Hospital DRG
- Lead Doc. Fee
- Consultant Fee
- Consultant Fee
- Rehab
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- Complications
- Readmissions

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Using the Average Price Doesn’t Benefit Payers

Average Price?

Hospital 1
- Hospital DRG
- Lead Doc. Fee
- Consultant Fee
- Consultant Fee
- Rehab
- Home Health
- Complications
- Readmissions

Hospital 2
- Hospital DRG
- Lead Doc. Fee
- Consultant Fee
- Consultant Fee
- Rehab
- Home Health
- Complications
- Readmissions
Lowest Price Benefits Payers But Hurts Most Providers

Hospital 1
- Hospital DRG
- Lead Doc. Fee
- Consultant Fee
- Rehab
- Home Health
- Complications
- Readmissions

Hospital 2
- Hospital DRG
- Lead Doc. Fee
- Consultant Fee
- Consultant Fee
- Rehab
- Home Health
- Complications
- Readmissions

Lowest Possible Price?
Broader Bundle Definitions Could Encourage Even Lower Costs

Even Lower Price?

Ambulatory Facility
- Outpatient Facility
- Lead Doc. Fee
- Consultant Fee
- Home Health
- Complications
- Readmissions

Hospital 1
- Hospital DRG
- Lead Doc. Fee
- Consultant Fee
- Rehab
- Home Health
- Complications
- Readmissions

Hospital 2
- Hospital DRG
- Lead Doc. Fee
- Consultant Fee
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- Complications
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Lowest Possible Price?
Distinguishing Variation Due to Patient Needs vs. Inefficiency

Inefficiency? or Sicker Patients?

Hospital 1
- Hospital DRG
- Lead Doc. Fee
- Consultant Fee
- Consultant Fee
- Rehab
- Home Health
- Complications
- Readmissions

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- Readmissions

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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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• What’s the Incentive for a Provider to Be Low-Priced?
• Will It Actually Lower Costs?
• Is Bundling Worth It?
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?

<table>
<thead>
<tr>
<th>Knee Joint Replacement</th>
<th>Price #1</th>
<th>Price #2</th>
<th>Price #3</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>$23,000</td>
<td>$28,000</td>
<td>$33,000</td>
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## Copayment?
### Use High Price Provider

#### Knee Joint Replacement

<table>
<thead>
<tr>
<th>Consumer Share of Surgery Cost</th>
<th>Price #1 $23,000</th>
<th>Price #2 $28,000</th>
<th>Price #3 $33,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000 Copayment:</td>
<td>$1,000</td>
<td>$1,000</td>
<td>$1,000</td>
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**Coinsurance?**  
Use High Price Provider

### Knee Joint Replacement

<table>
<thead>
<tr>
<th>Consumer Share of Surgery Cost</th>
<th>Price #1</th>
<th>Price #2</th>
<th>Price #3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$23,000</td>
<td>$28,000</td>
<td>$33,000</td>
</tr>
<tr>
<td>$1,000 Copayment:</td>
<td>$1,000</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>10% Coinsurance w/$2,000 OOP Max:</td>
<td>$2,000</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

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# High Deductible?

Use High Price Provider

## Knee Joint Replacement

<table>
<thead>
<tr>
<th>Consumer Share of Surgery Cost</th>
<th>Price #1 $23,000</th>
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<td>$1,000</td>
<td>$1,000 ✓</td>
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<td>$2,000</td>
<td>$2,000</td>
<td>$2,000 ✓</td>
</tr>
<tr>
<td>$5,000 Deductible:</td>
<td>$5,000</td>
<td>$5,000</td>
<td>$5,000 ✓</td>
</tr>
</tbody>
</table>
## Pay the Difference in Price?
Use the High-Value Provider

### Knee Joint Replacement

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<td>$2,000 ✓</td>
</tr>
<tr>
<td>$5,000 Deductible:</td>
<td>$5,000</td>
<td>$5,000</td>
<td>$5,000 ✓</td>
</tr>
<tr>
<td>Highest-Value:</td>
<td>$0 ✓</td>
<td>$5,000</td>
<td>$10,000</td>
</tr>
</tbody>
</table>
Today: Hard to Know if Better Price Means Better Value

<table>
<thead>
<tr>
<th>Payment for Procedure</th>
<th>Provider 1:</th>
<th>Provider 2:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$10,000</td>
<td>$9,500</td>
</tr>
<tr>
<td></td>
<td>-5%</td>
<td></td>
</tr>
</tbody>
</table>
# What Hidden Costs Accompany the Lower Price?

<table>
<thead>
<tr>
<th>Provider 1:</th>
<th>Payment for Procedure</th>
<th>Added Payment for Infection</th>
<th>Rate of Infections</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10,000</td>
<td>$20,000</td>
<td>5%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider 2:</th>
<th>Payment for Procedure</th>
<th>Added Payment for Infection</th>
<th>Rate of Infections</th>
</tr>
</thead>
<tbody>
<tr>
<td>$9,500</td>
<td>$19,000</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>-5%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Total Spending May Be Higher With the “Lower Price” Provider

<table>
<thead>
<tr>
<th>Payment for Procedure</th>
<th>Added Payment for Infection</th>
<th>Rate of Infections</th>
<th>Average Total Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider 1:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$10,000</td>
<td>$20,000</td>
<td>5%</td>
<td>$11,000</td>
</tr>
<tr>
<td>Provider 2:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$9,500</td>
<td>$19,000</td>
<td>10%</td>
<td>$11,400</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Payment for Procedure</th>
<th>Added Payment for Infection</th>
<th>Rate of Infections</th>
<th>Bundled/Episode Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider 1:</td>
<td></td>
<td>5%</td>
<td>$11,000</td>
</tr>
<tr>
<td>Provider 2:</td>
<td></td>
<td>10%</td>
<td>$11,400</td>
</tr>
</tbody>
</table>

Bundled prices show that Provider 1 is the higher-value provider.
Implementation Issues for Episode and Bundled Payment

• What’s in the Bundle, Why, and Who Decides?
• Who Gets the Check?
• What’s the Price of the Bundle?
• What’s the Incentive for a Provider to Be Low-Priced?
• Will It Actually Lower Costs?
• Is Bundling Worth It?
What Stops Cost-Shifting to Unbundled Procedures?

Payer
- Medicare
- Medicaid
- Health Plan

<table>
<thead>
<tr>
<th>Total Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital DRG</td>
<td>Bundled Episode Payment</td>
</tr>
<tr>
<td>Physician Fees</td>
<td>Bundle Episode Payment</td>
</tr>
<tr>
<td>Complications</td>
<td></td>
</tr>
<tr>
<td>Readmissions</td>
<td></td>
</tr>
</tbody>
</table>

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What Stops Increases in Number of Episodes?

Payer
- Medicare
- Medicaid
- Health Plan
Solution: Global Payment

Payer
- Medicare
- Medicaid
- Health Plan

Global Pmt
- Hospital DRG
- Physician Fees
- Complications
- Readmissions

Bundled Episode
- Hospital DRG
- Physician Fees
- Complications
- Readmissions

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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 disincents, but bundled payments
    create different incentives and different potential quality problems
Implementation Issues for Episode and Bundled Payment

- What’s in the Bundle, Why, and Who Decides?
- Who Gets the Check?
- What’s the Price of the Bundle?
- What’s the Incentive for a Provider to Be Low-Priced?
- Will It Actually Lower Costs?
- Is Bundling Worth It?
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

www.PaymentReform.org
For More Information:

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President & CEO, Network for Regional Healthcare Improvement

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www.CHQPR.org
www.NRHI.org
www.PaymentReform.org