CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

nrhi Network for Regional Healthcare Improvement

Implementing Episode and Bundled Payments

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Center for Healthcare Quality and Payment Reform
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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?

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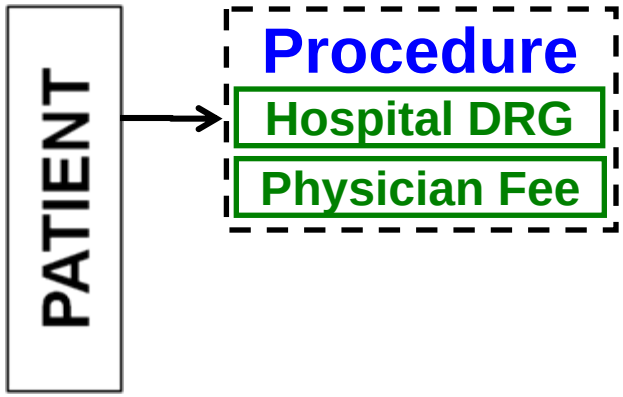
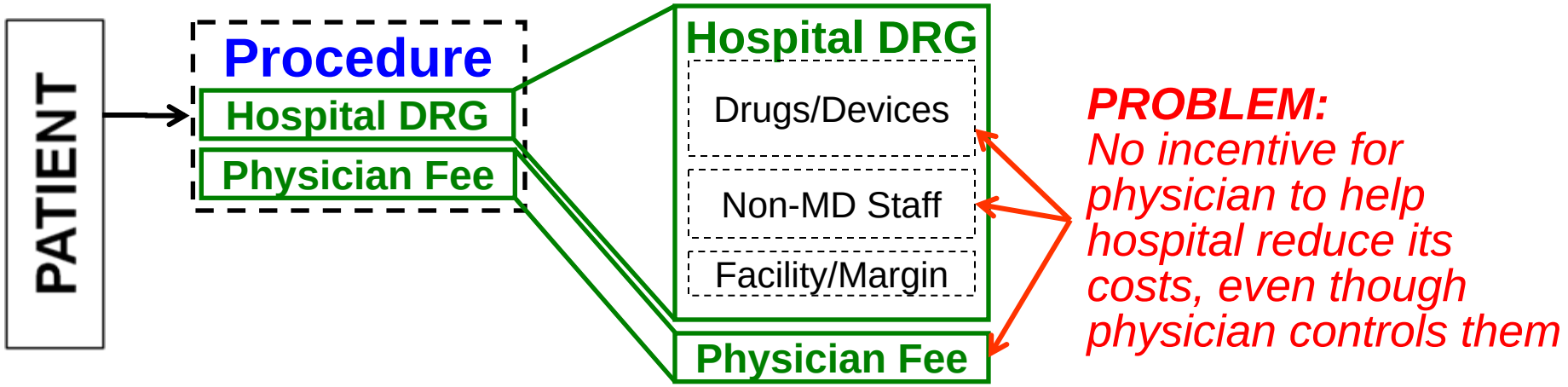
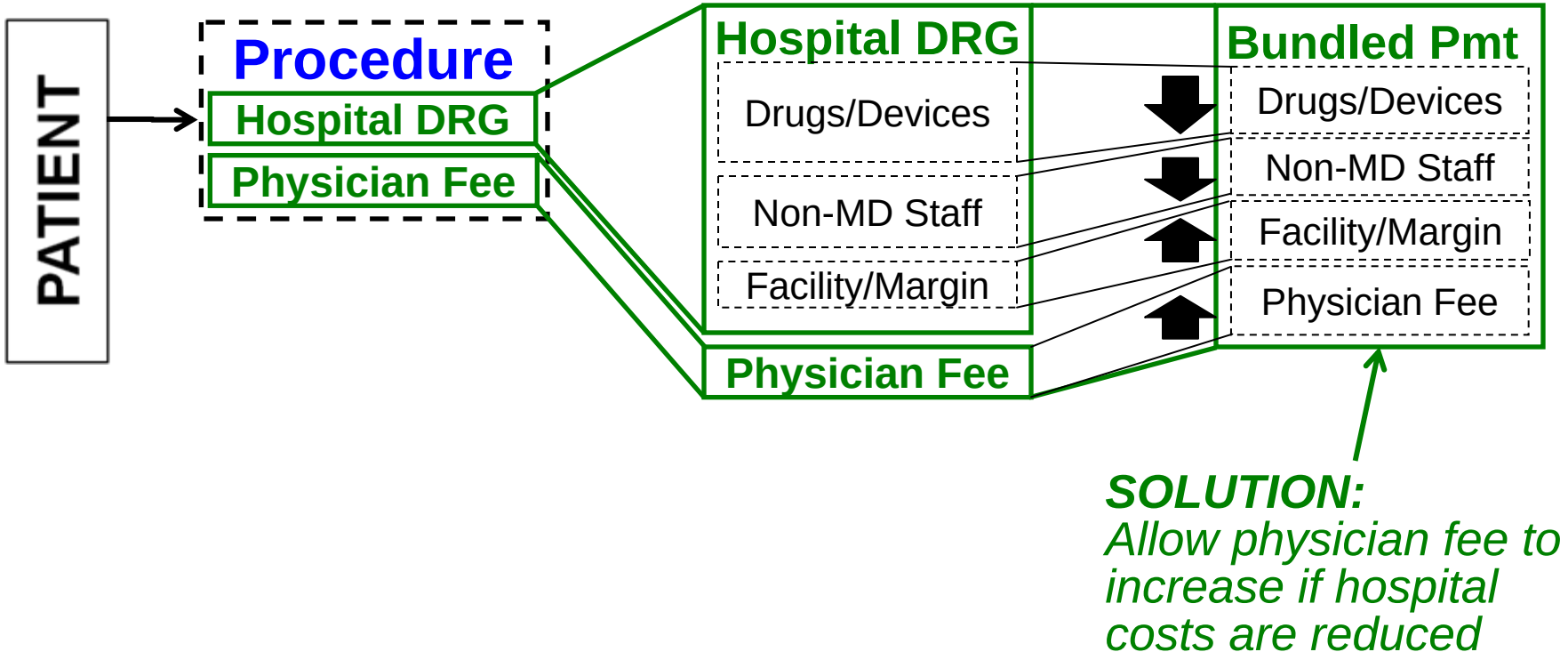
Most Obvious "Unbundled" Payment Today: Hospital & Doctor



Hospital Payment Was Already "Bundled," But Narrowly

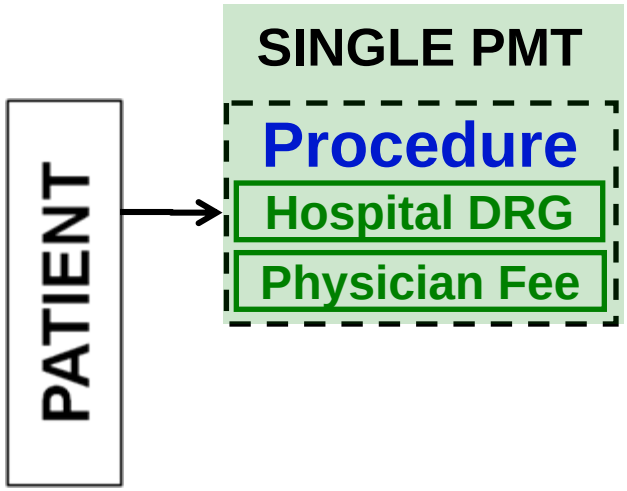


Adding Physician in Bundle Can Lead to Win-Win Savings

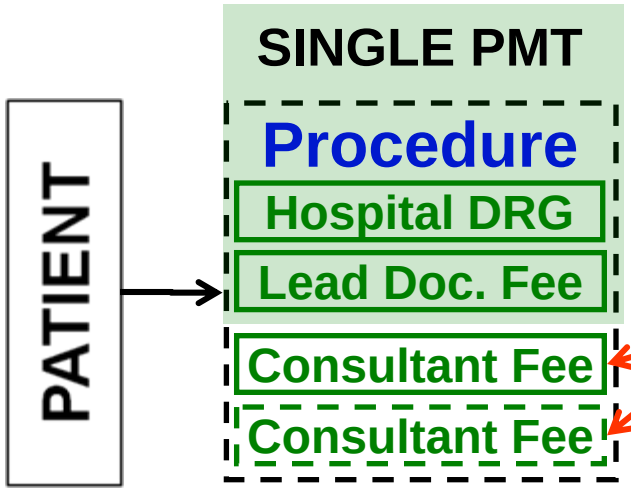


SOLUTION:
Allow physician fee to increase if hospital costs are reduced

Simplest Bundle, Already Working in CMS Demonstrations

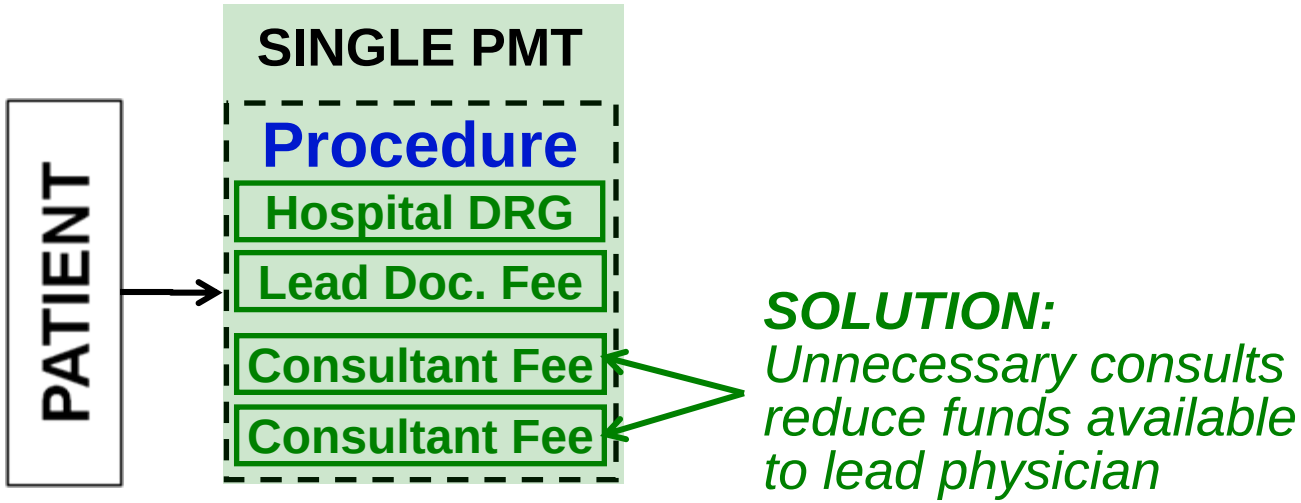


In More Complex Cases, Many Physicians Are Involved

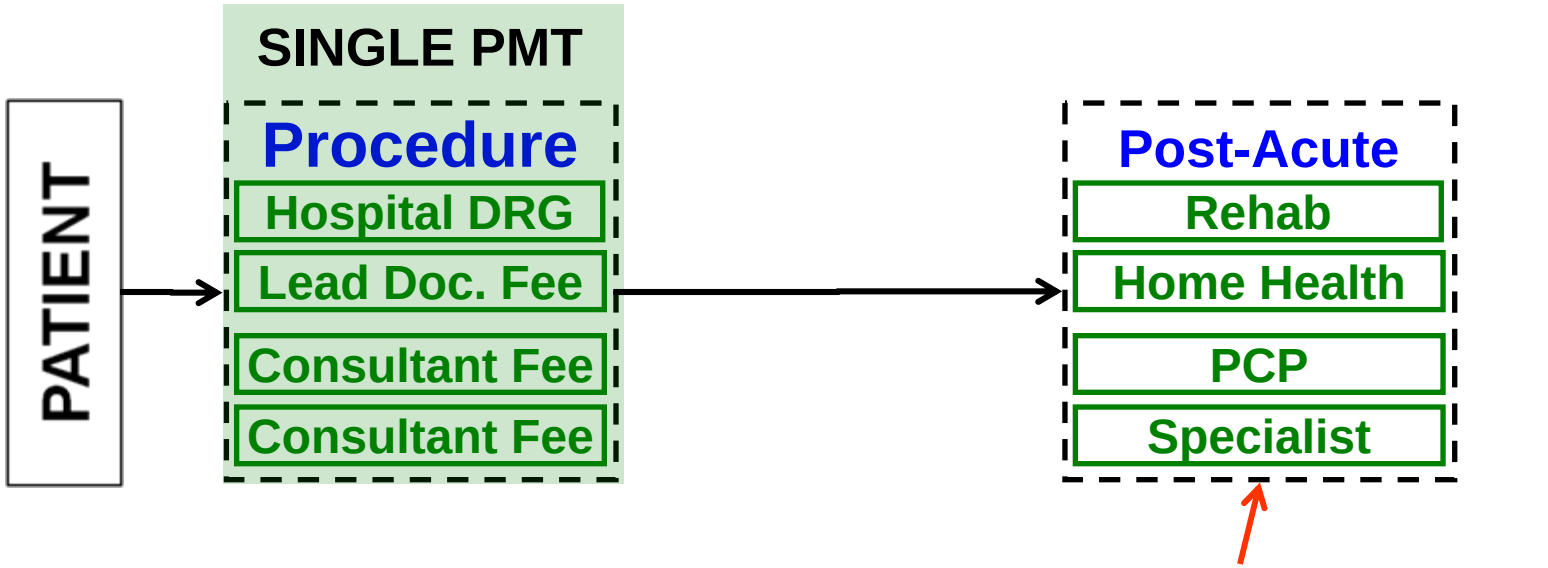


PROBLEM:
No incentive to reduce number of physicians involved in case or frequency of visits

Bundling All Physicians Promotes More Care Coordination

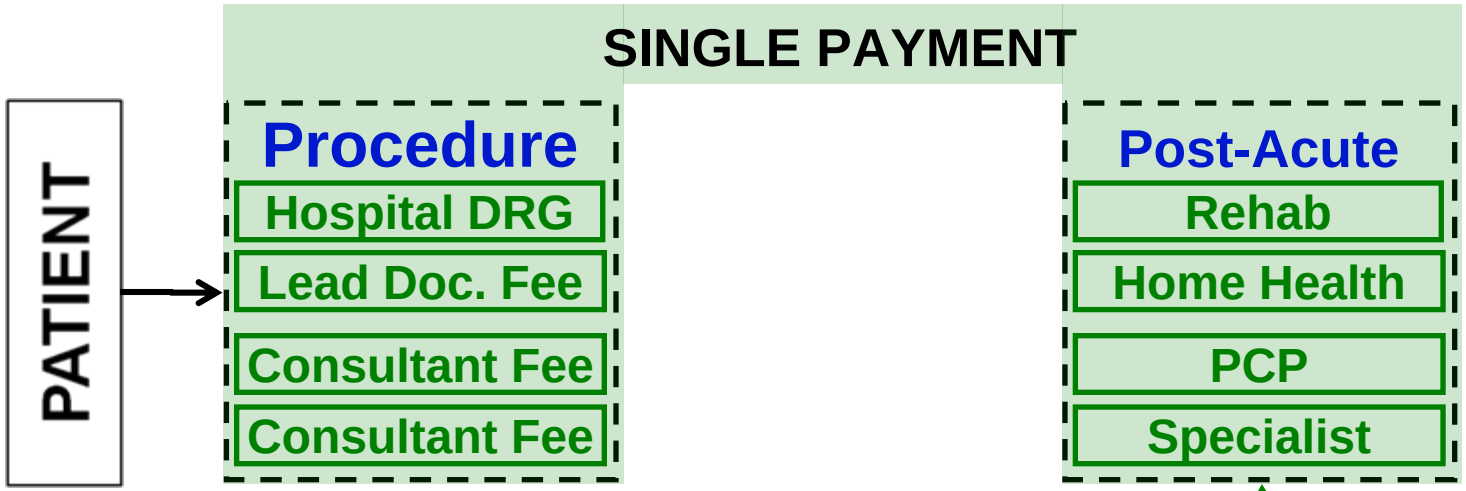


Not All Care Providers Are Inside the Hospital Walls



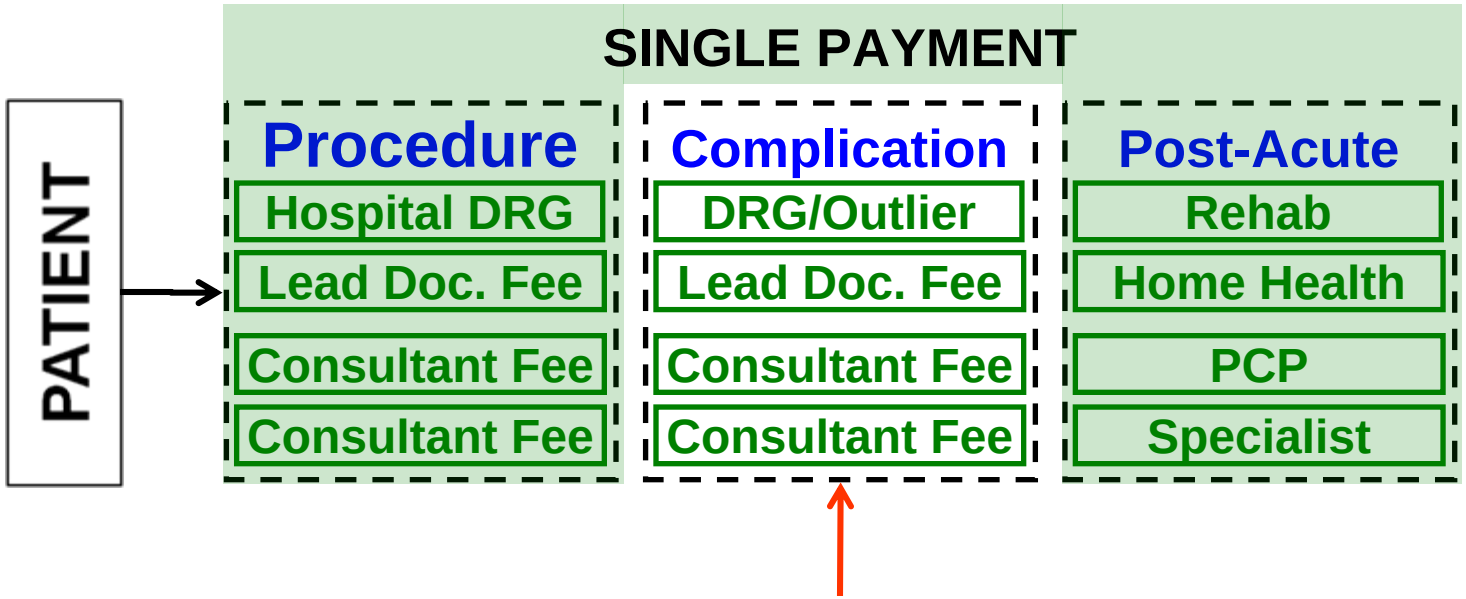
PROBLEM:
No incentive to reduce unnecessary use of expensive post-acute care

Bundling Inpatient and Post-Acute Care Promotes Coordination



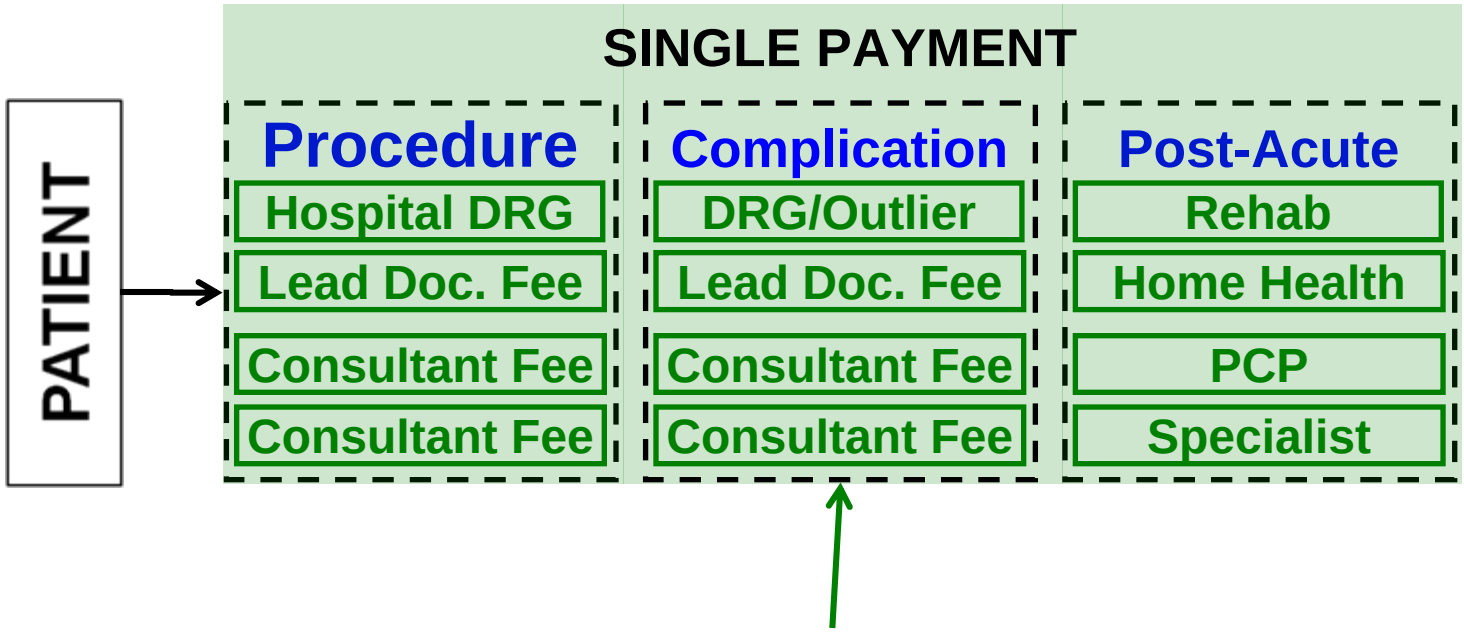
SOLUTION:
Unnecessary post-acute care reduces funds available for hospital & physicians

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



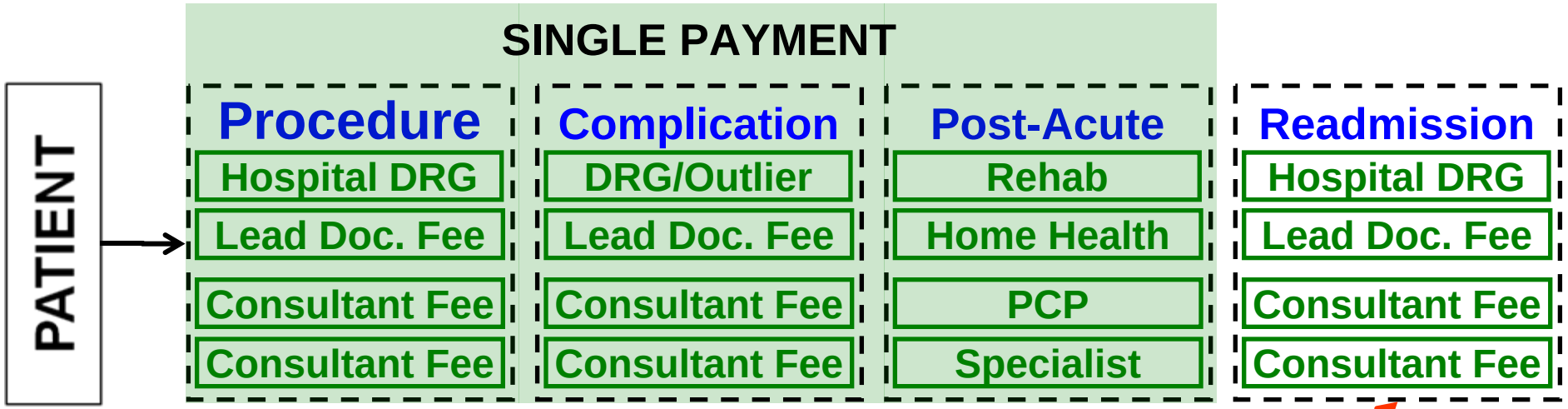
PROBLEM:
Hospital and physicians are paid more to treat expensive infections and complications

Including a Warranty for Complications in the Bundle



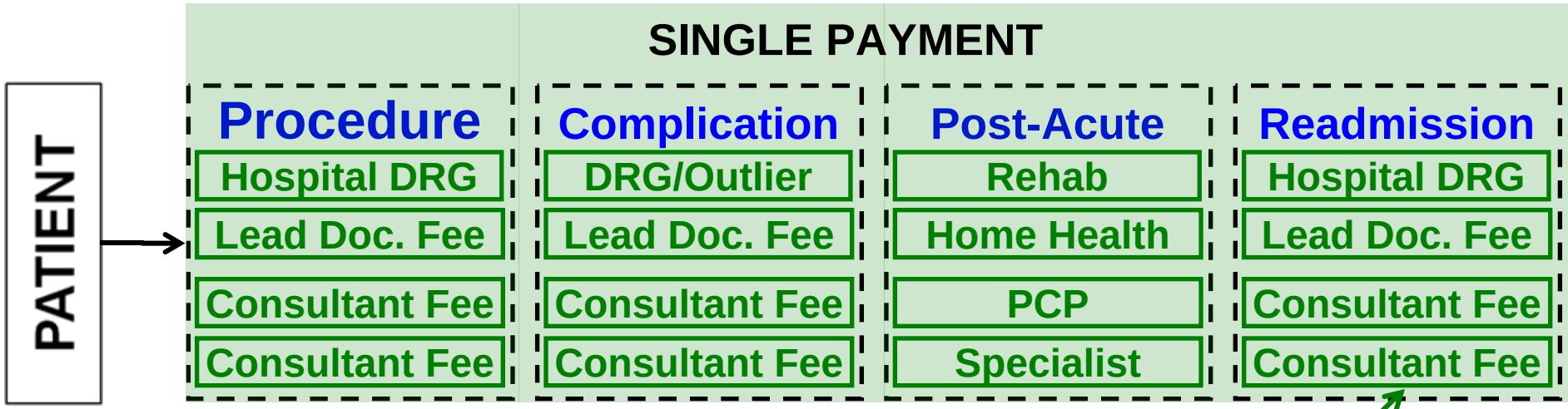
SOLUTION:
Infections and complications increase costs but not revenues for hospitals & physicians

What About Complications That Occur After Discharge?



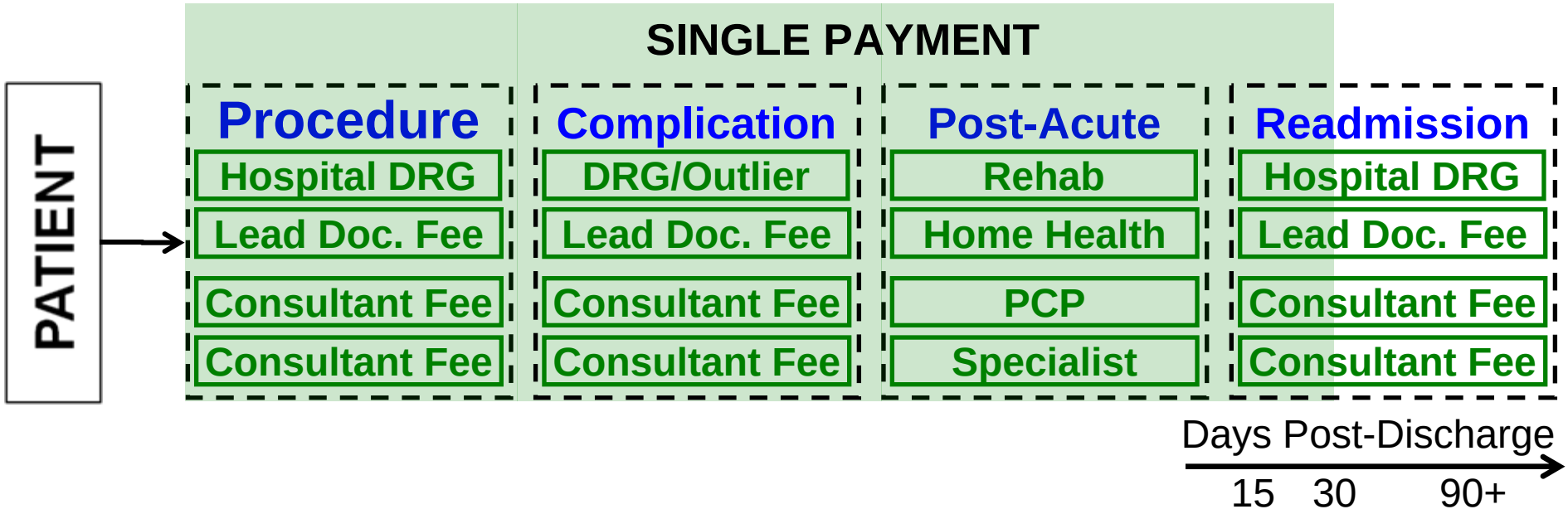
PROBLEM:
Hospitals and physicians make more money when patients are readmitted

Adding a Warranty for Post-Discharge Events

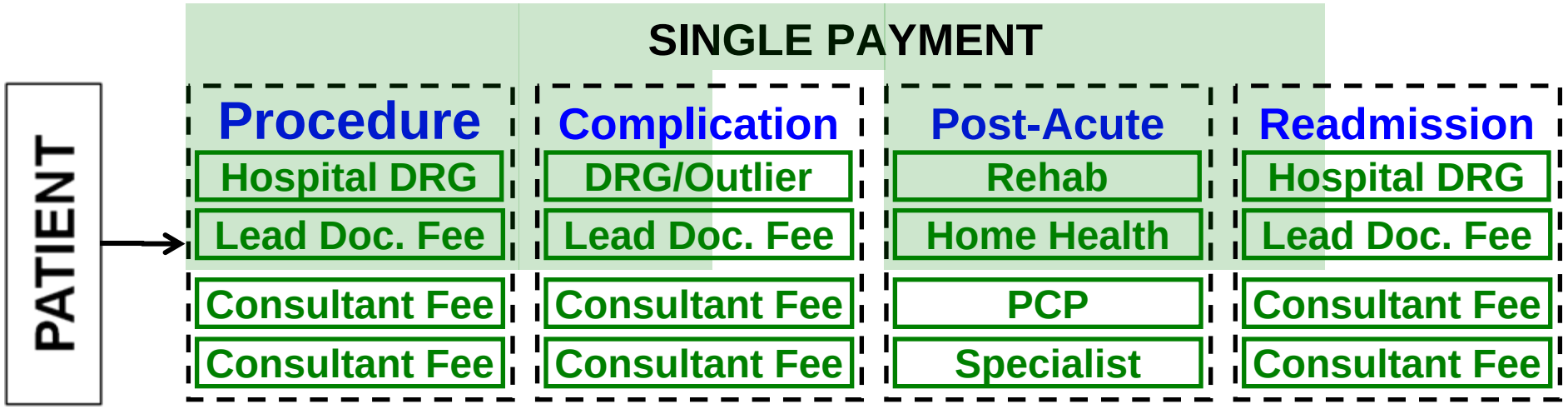


SOLUTION:
Readmissions increase costs but not revenues for hospitals and physicians

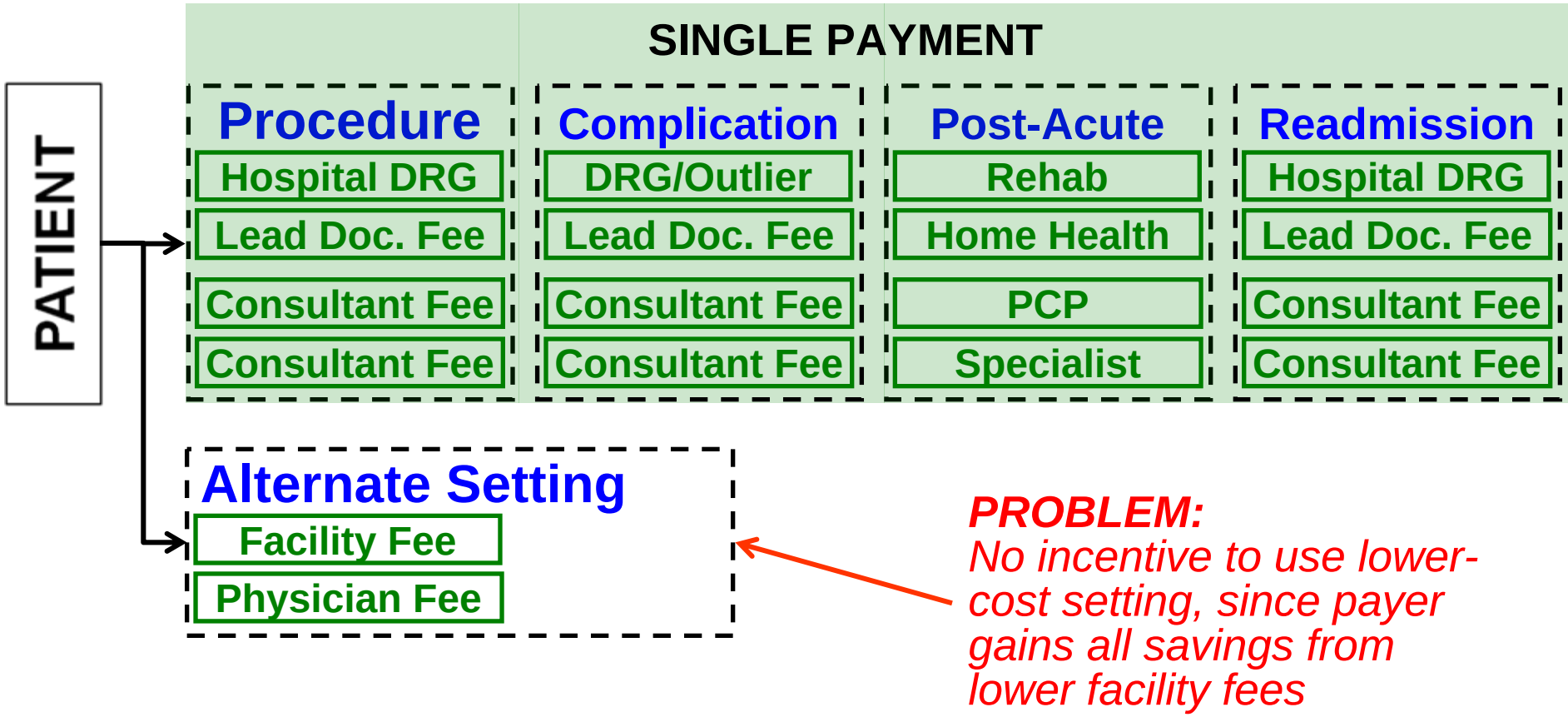
How Long Does the Warranty Last?



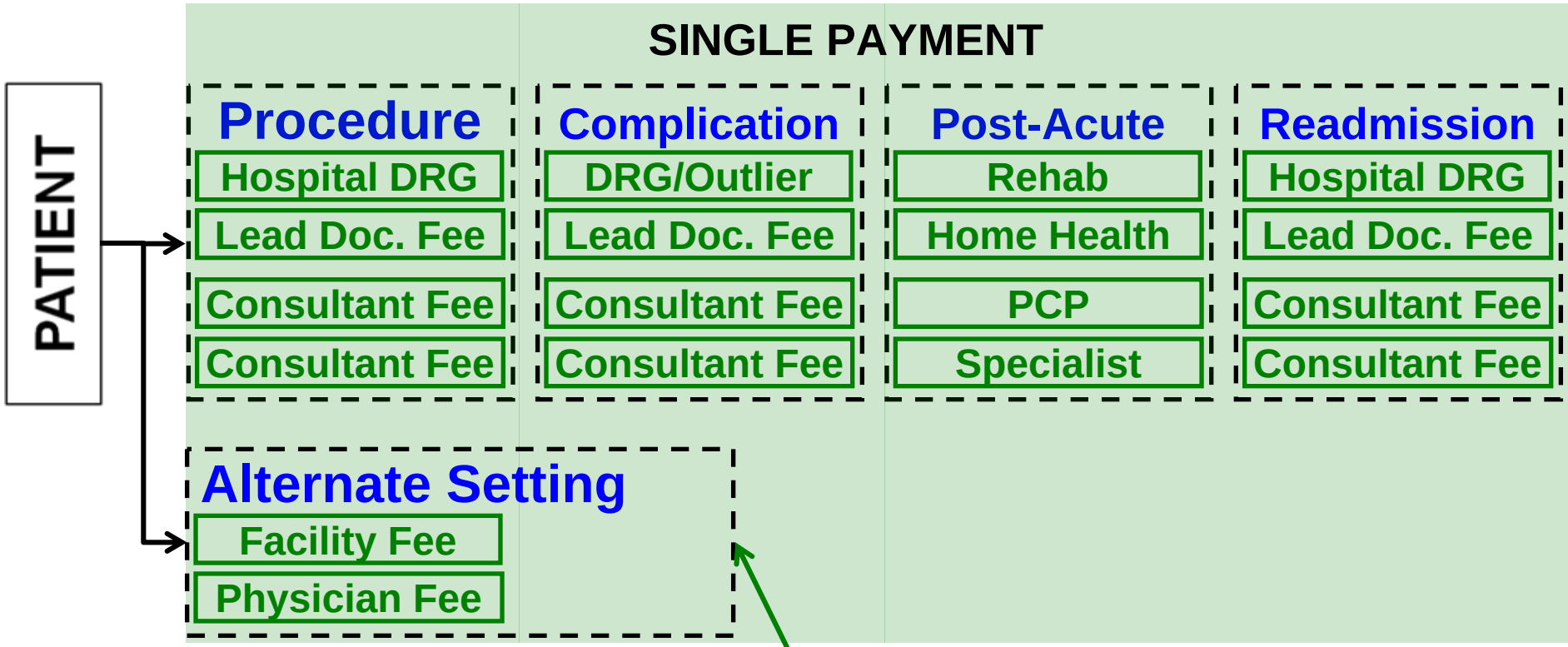
Partial Bundles Could Exclude Some Providers, Complications



What If The Procedure Could Be Done Outside the Hospital?

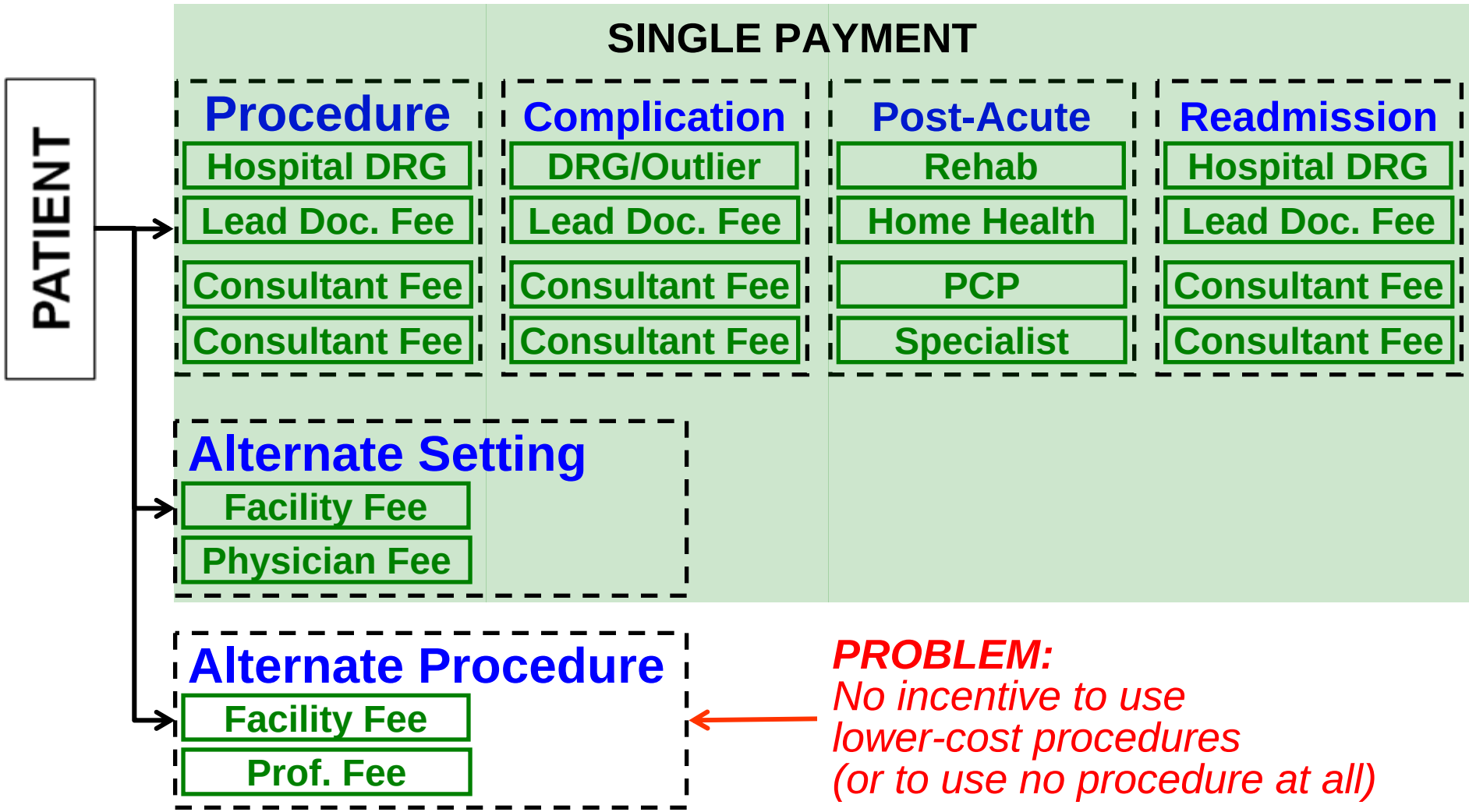


A Facility-Independent Bundle

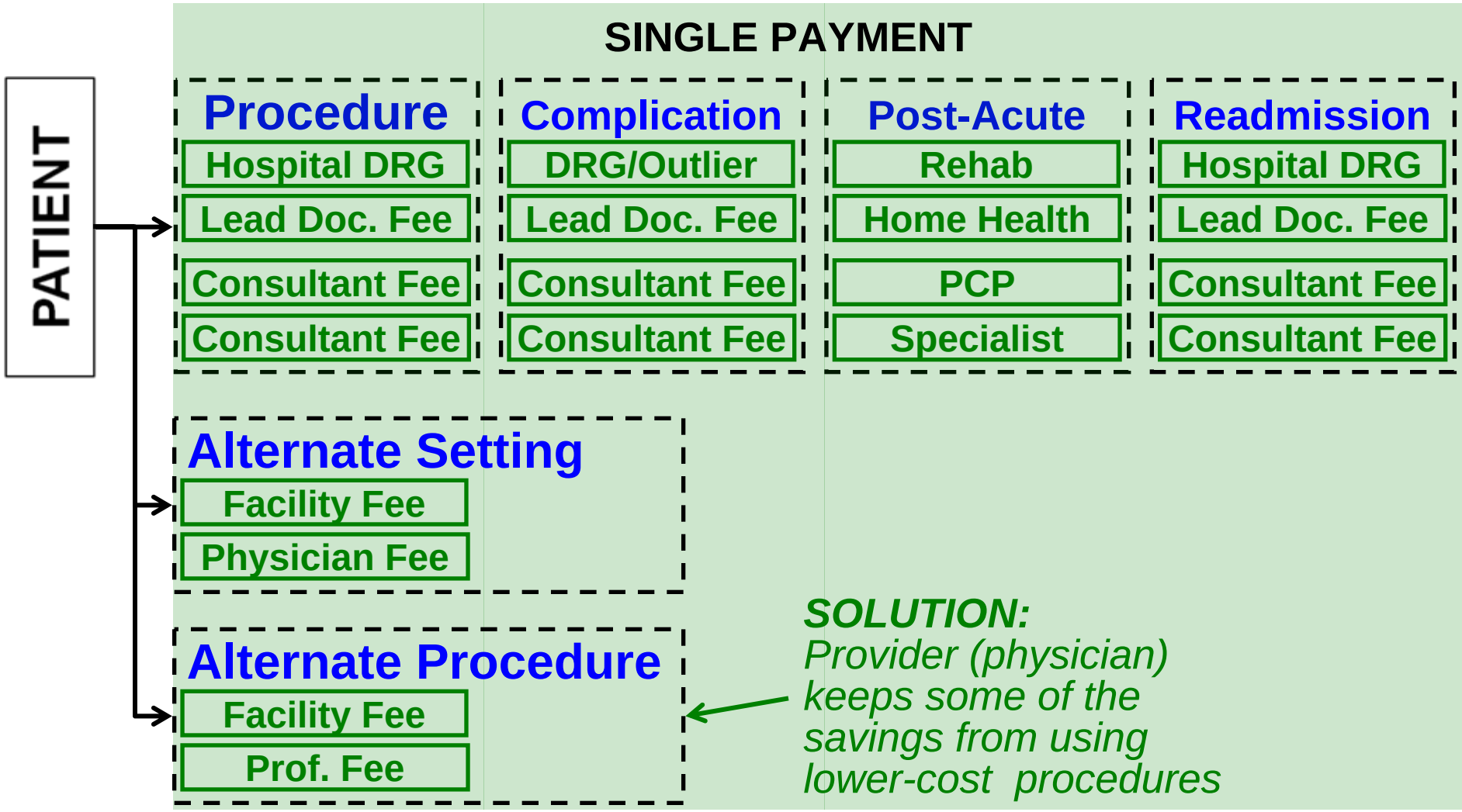


SOLUTION:
Providers keep some of the savings from moving procedures to lower-cost settings

What if An Alternative Procedure Would Be Better or Cheaper?



A *Condition*-Based (Not Procedure-Based) Bundle



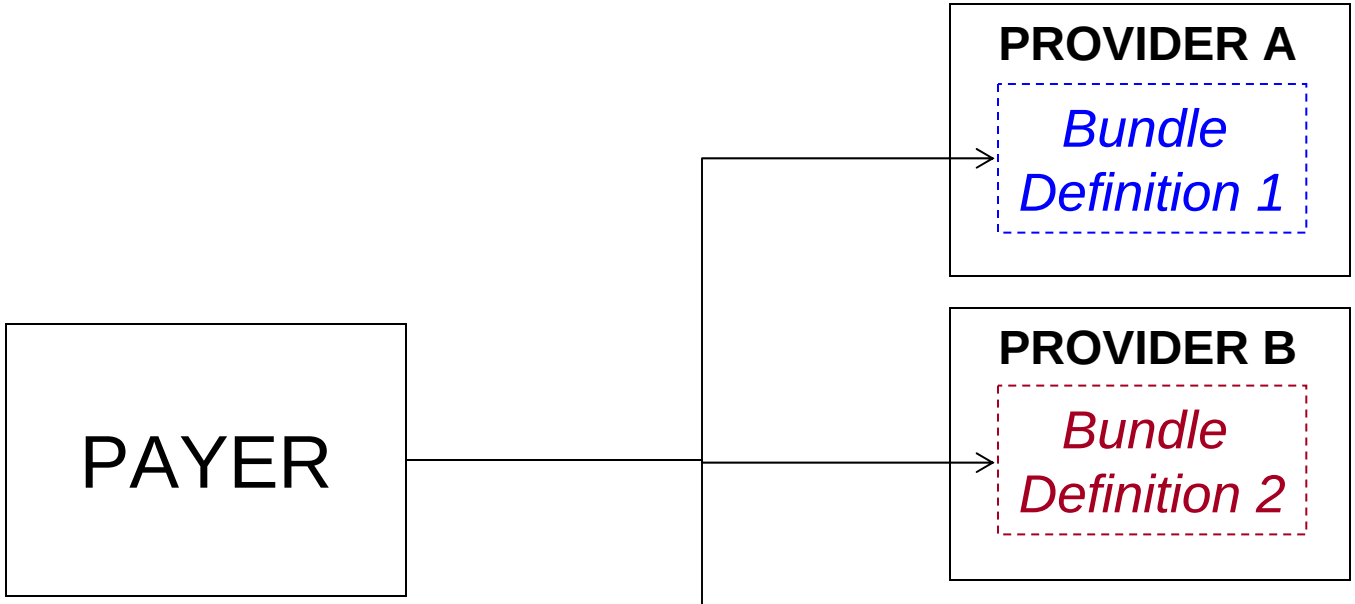
Different Episode/Bundling Concepts for Different Problems

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

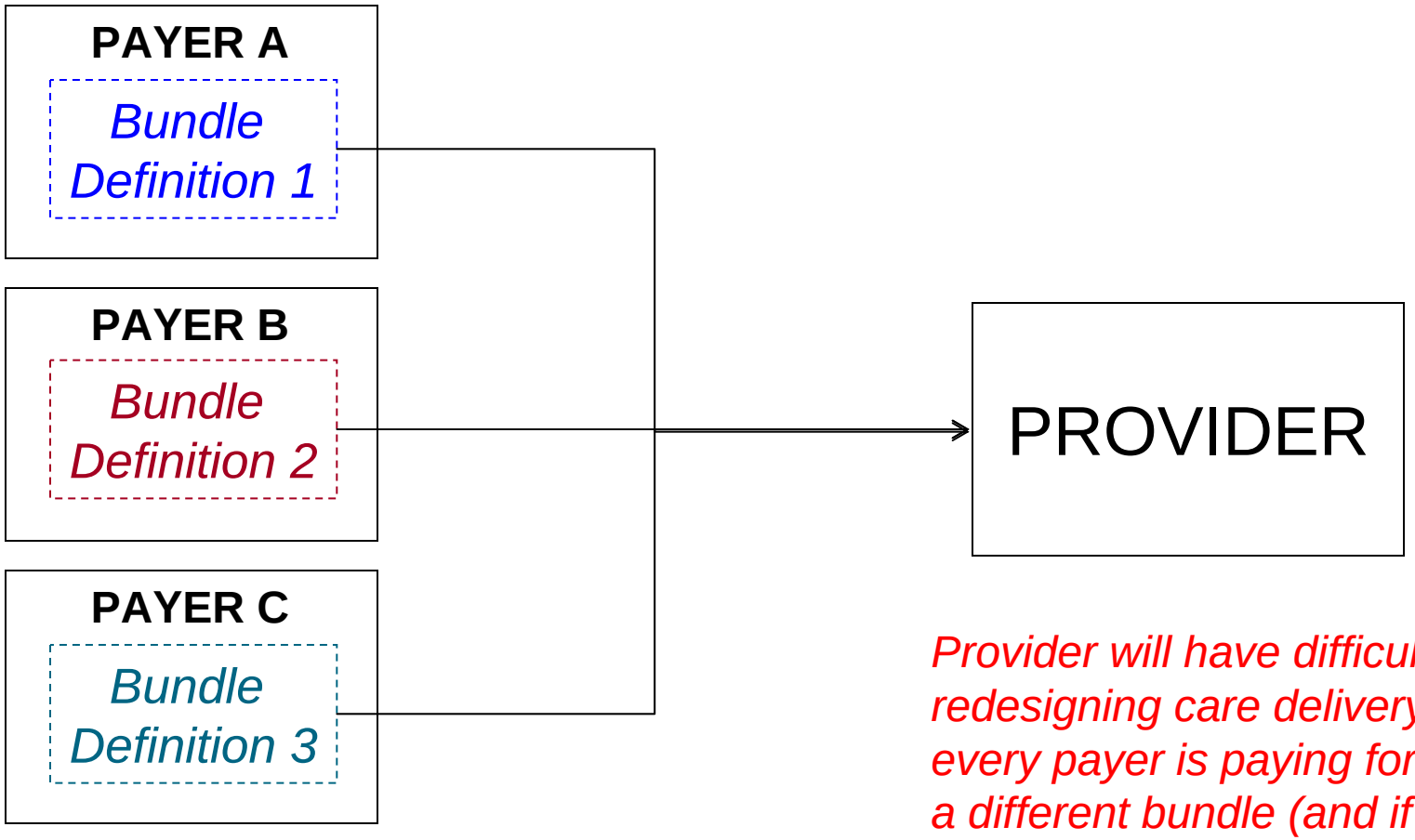
Condition/Procedure	Likely Opportunities	Episode/Bundle Definition
Surgery	Reduce Device Costs if Multiple Vendors Exist	Hospital + Surgeon
Surgery	Reduce Infections	Hospital + Complications
Chronic Disease	Reduce Readmissions	Hospital + Readmission
Chronic Disease	Reduce Initial Admissions	Condition-Based 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?



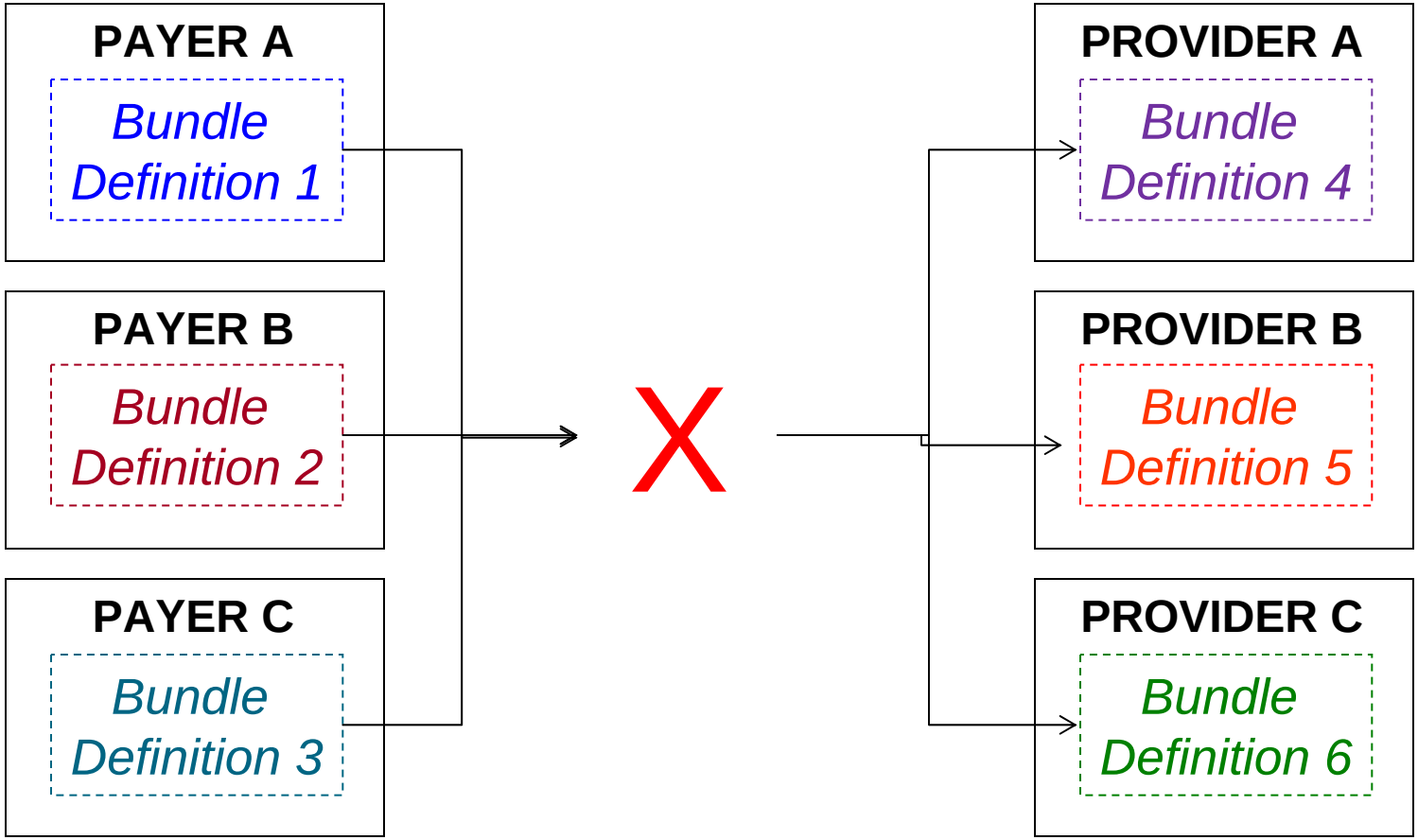
Payer needs to reprogram its claims payment systems to pay based on bundles and it's not practical to pay every provider differently

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)

Implementation Issues for Episode and Bundled Payment

- What's in the Bundle, Why, and Who Decides?
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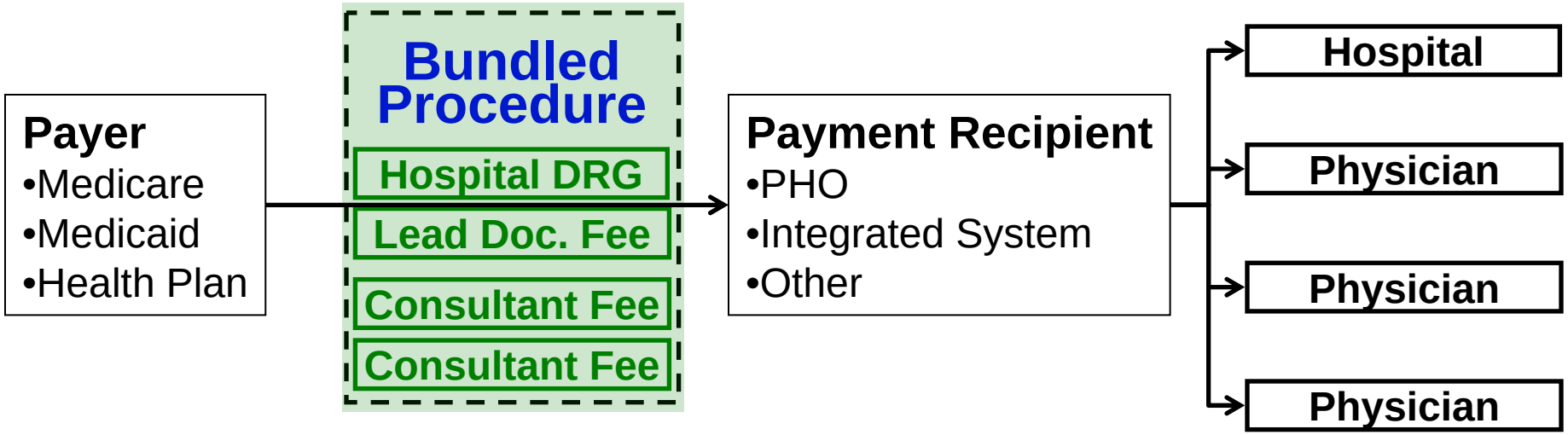
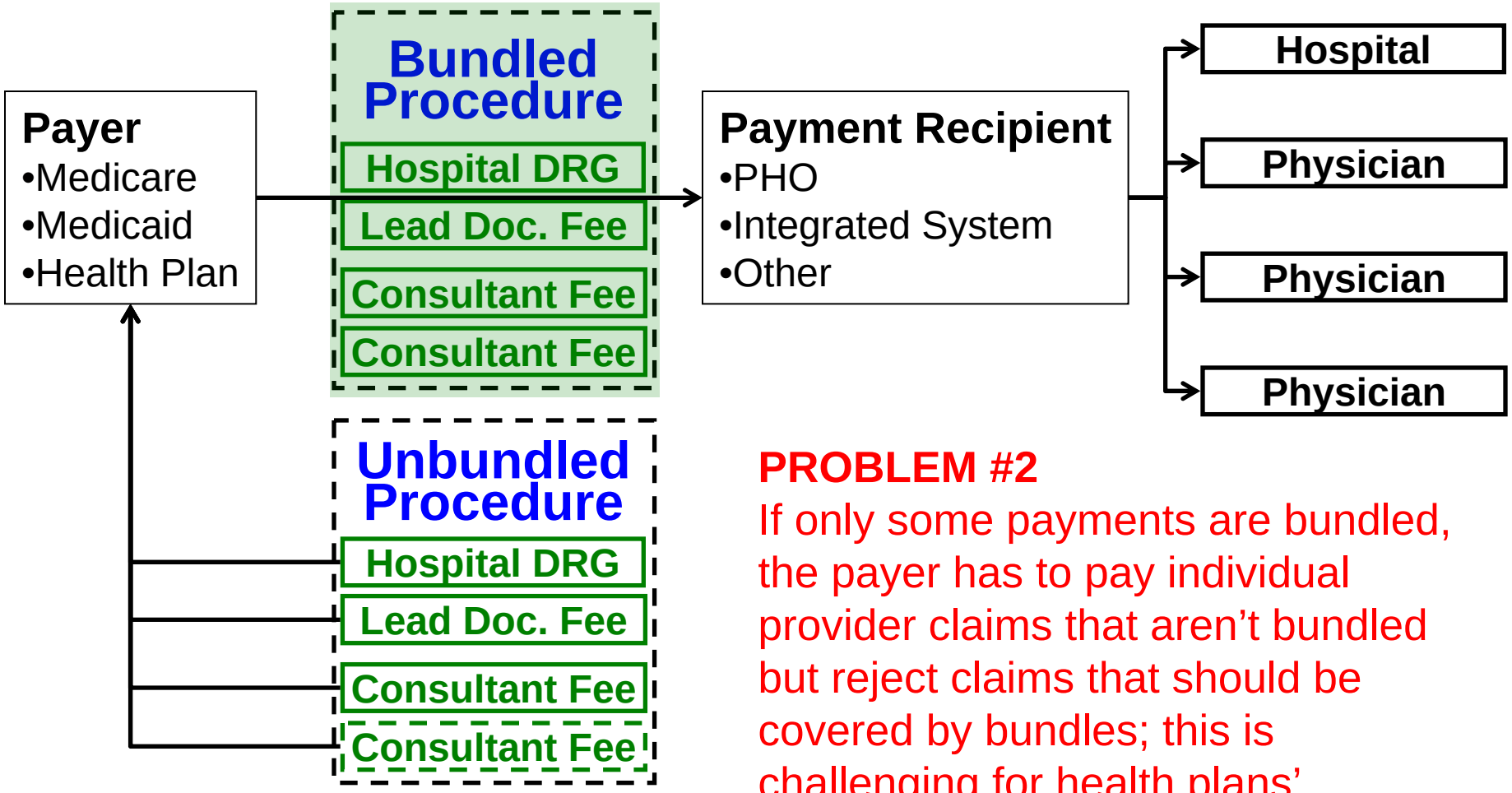
Who Gets the Check?



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

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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

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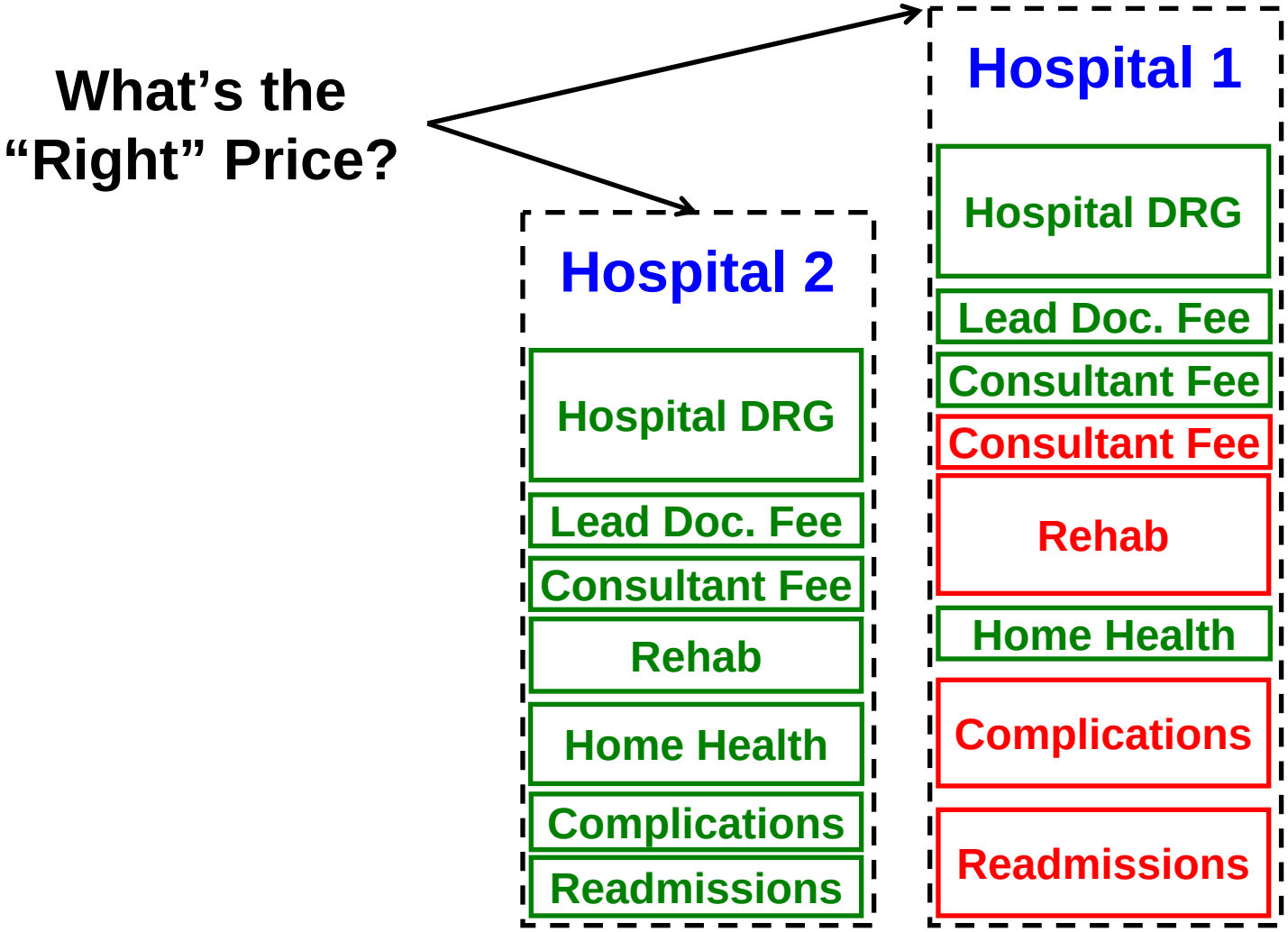
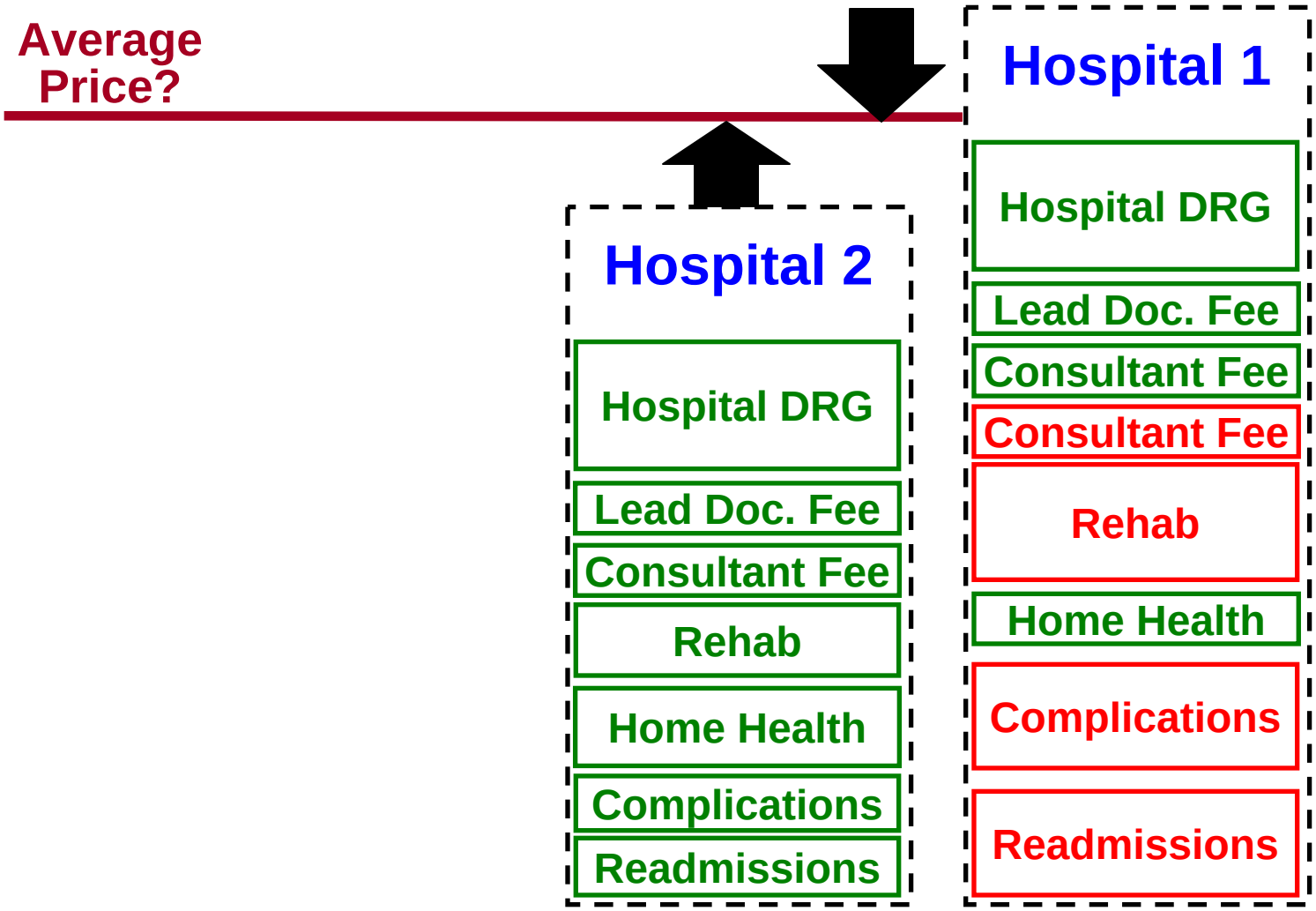
Payment Reform Helps Control Utilization But Not Prices

- 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

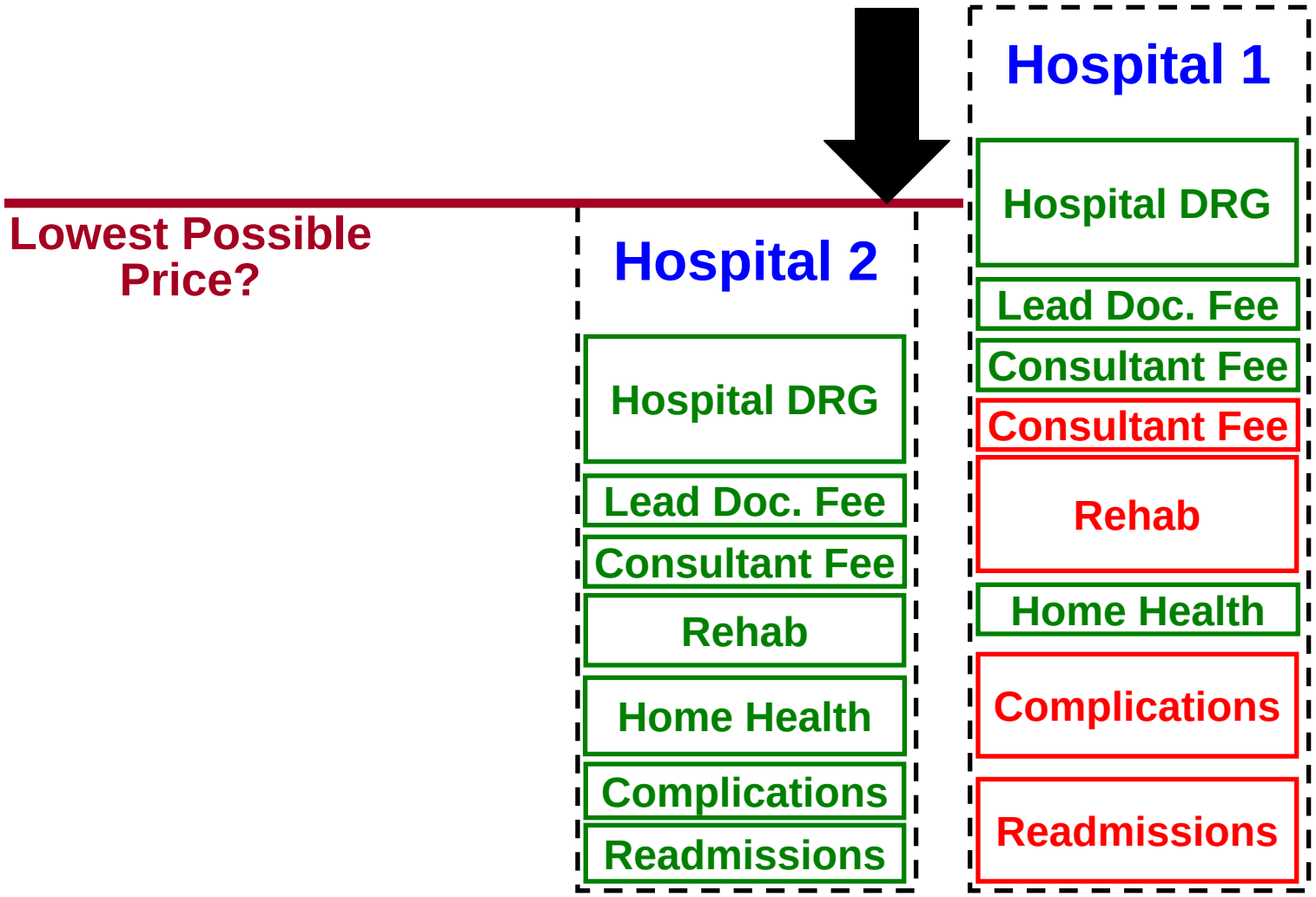
Variation Today Among Providers on Components of Bundles



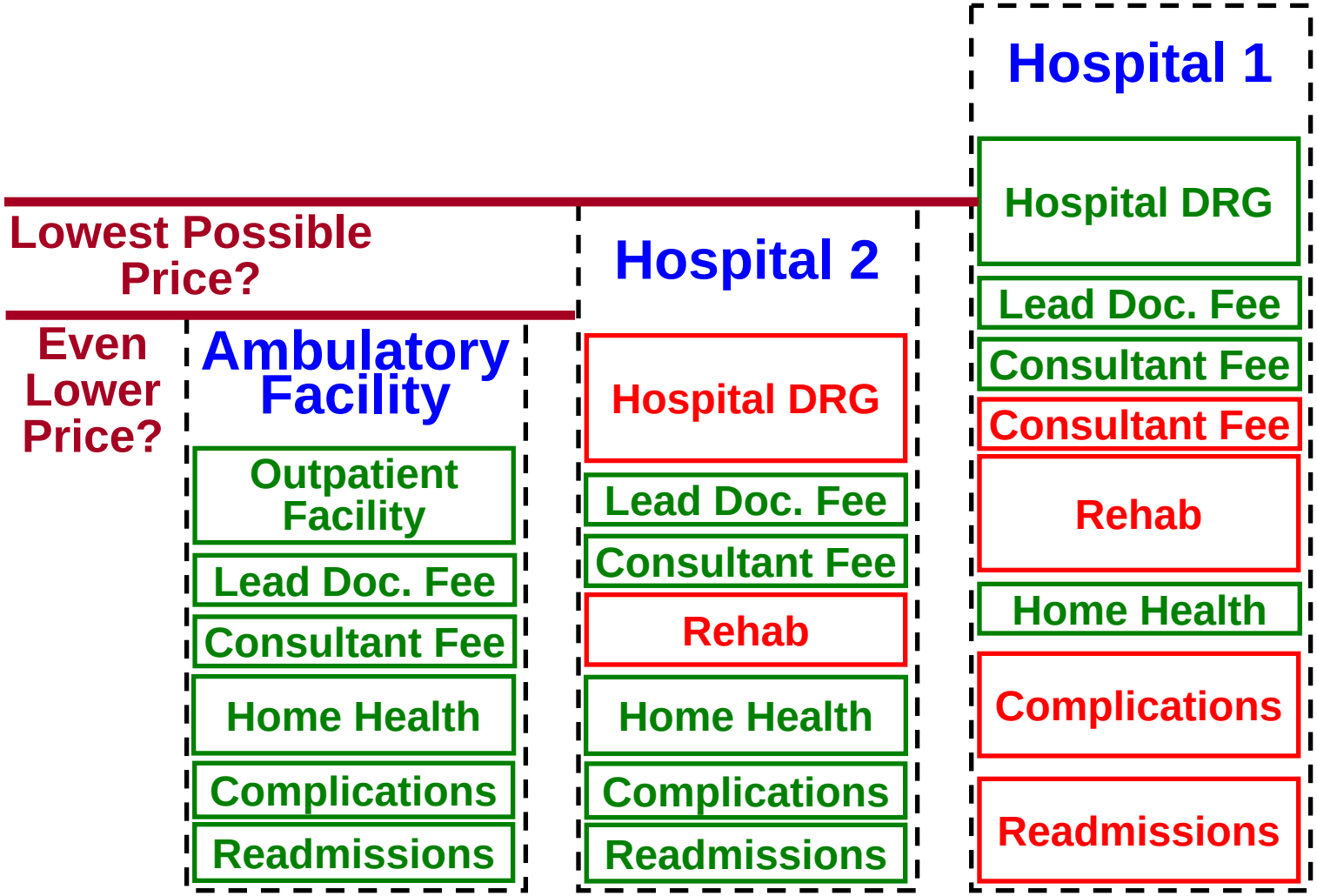
Using the Average Price Doesn't Benefit Payers



Lowest Price Benefits Payers But Hurts Most Providers



Broader Bundle Definitions Could Encourage Even Lower Costs

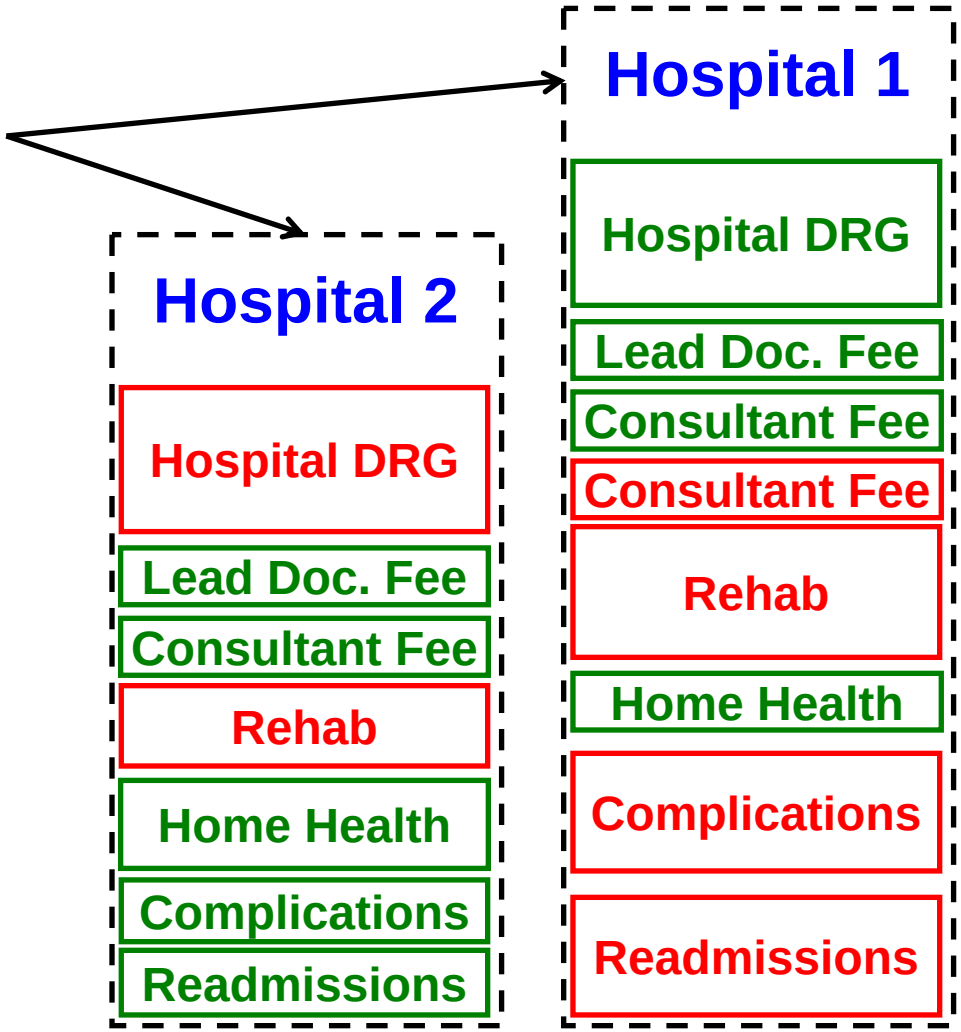


Distinguishing Variation Due to Patient Needs vs. Inefficiency

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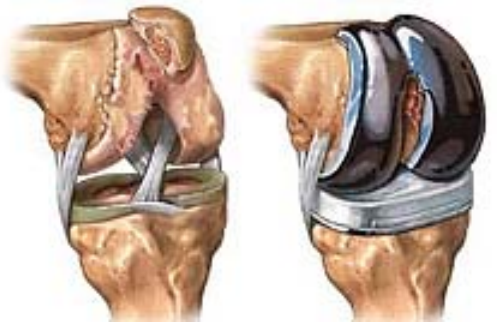
Can a Provider Lower Its Prices? Is There an Incentive to Do So?

- **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?

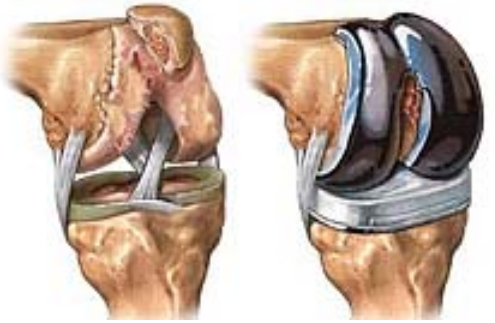
Knee Joint Replacement



	Price #1 $23,000	Price #2 $28,000	Price #3 $33,000

Copayment?
Use High Price Provider

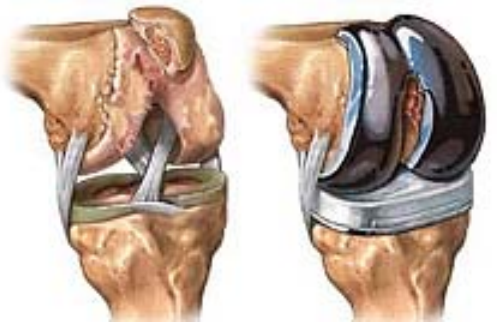
Knee Joint Replacement



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

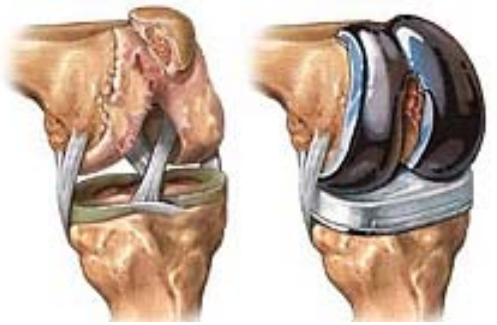
Knee Joint Replacement



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



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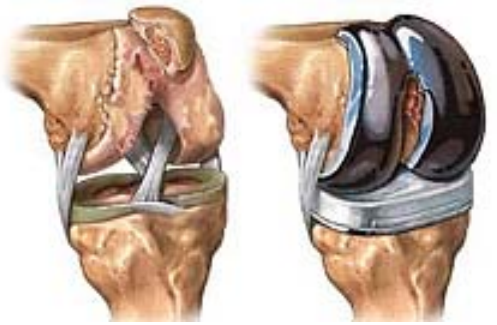
Pay the Difference in Price? Use the High-*Value* Provider

Knee Joint Replacement



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$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%

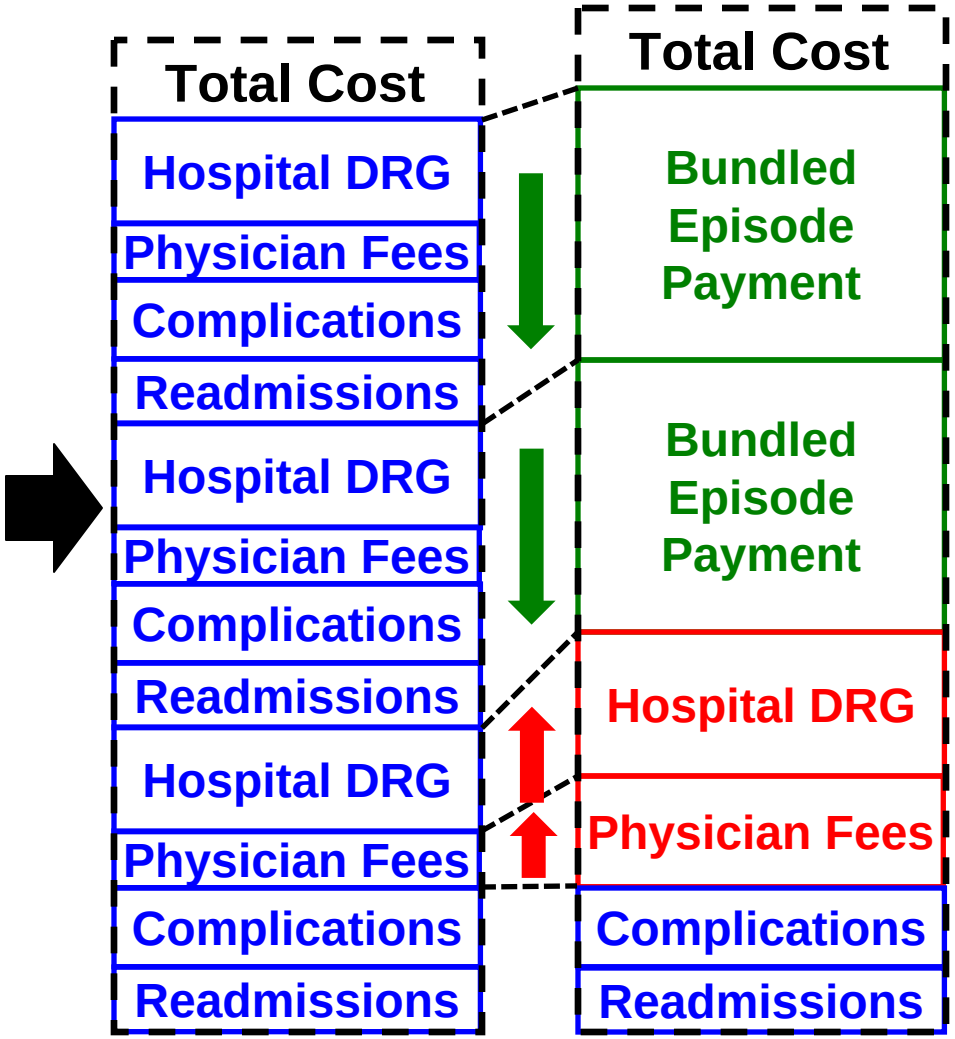
Bundled prices show that Provider 1 is the higher-value provider

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?

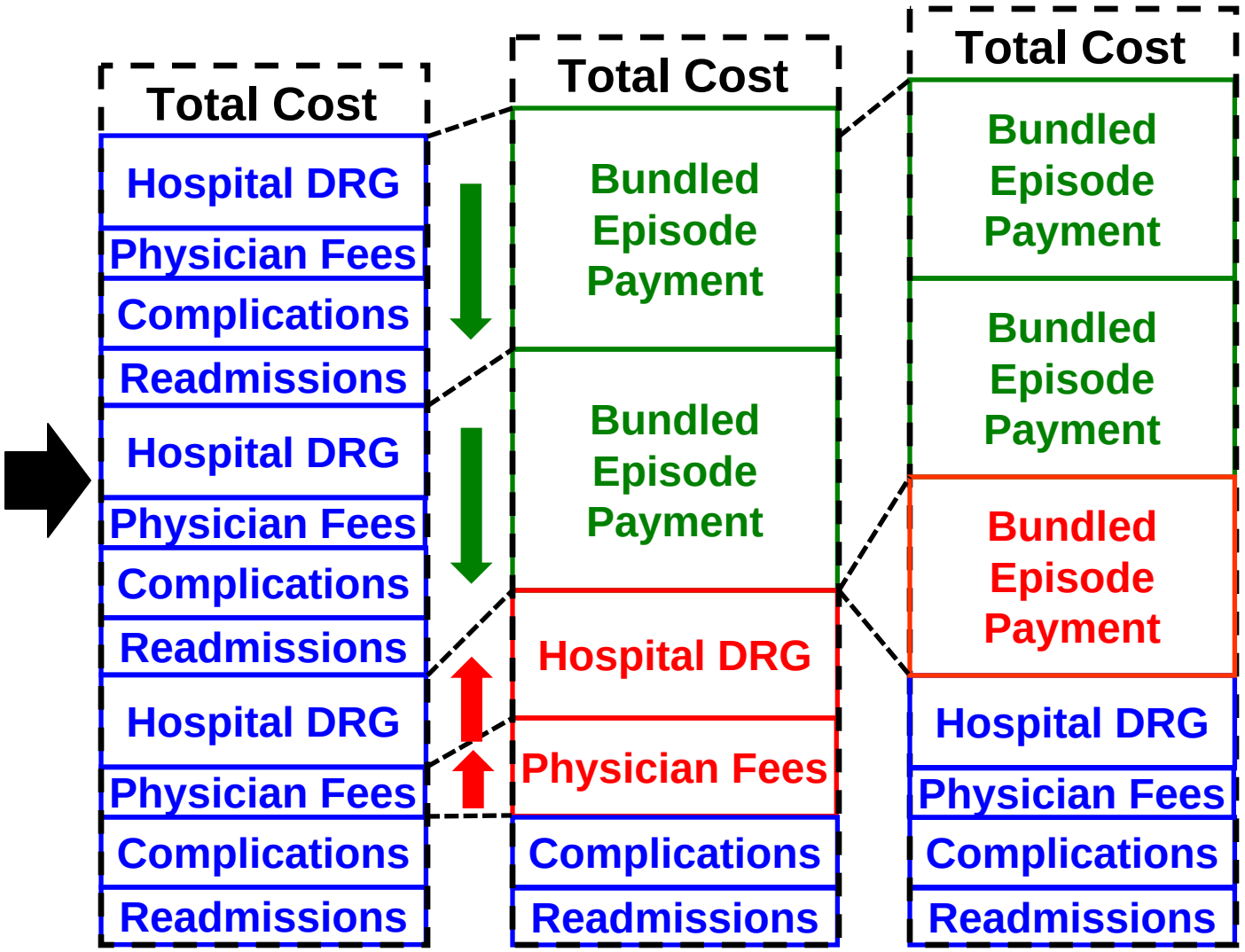
What Stops Cost-Shifting to Unbundled Procedures?

Payer
- Medicare
- Medicaid
- Health Plan



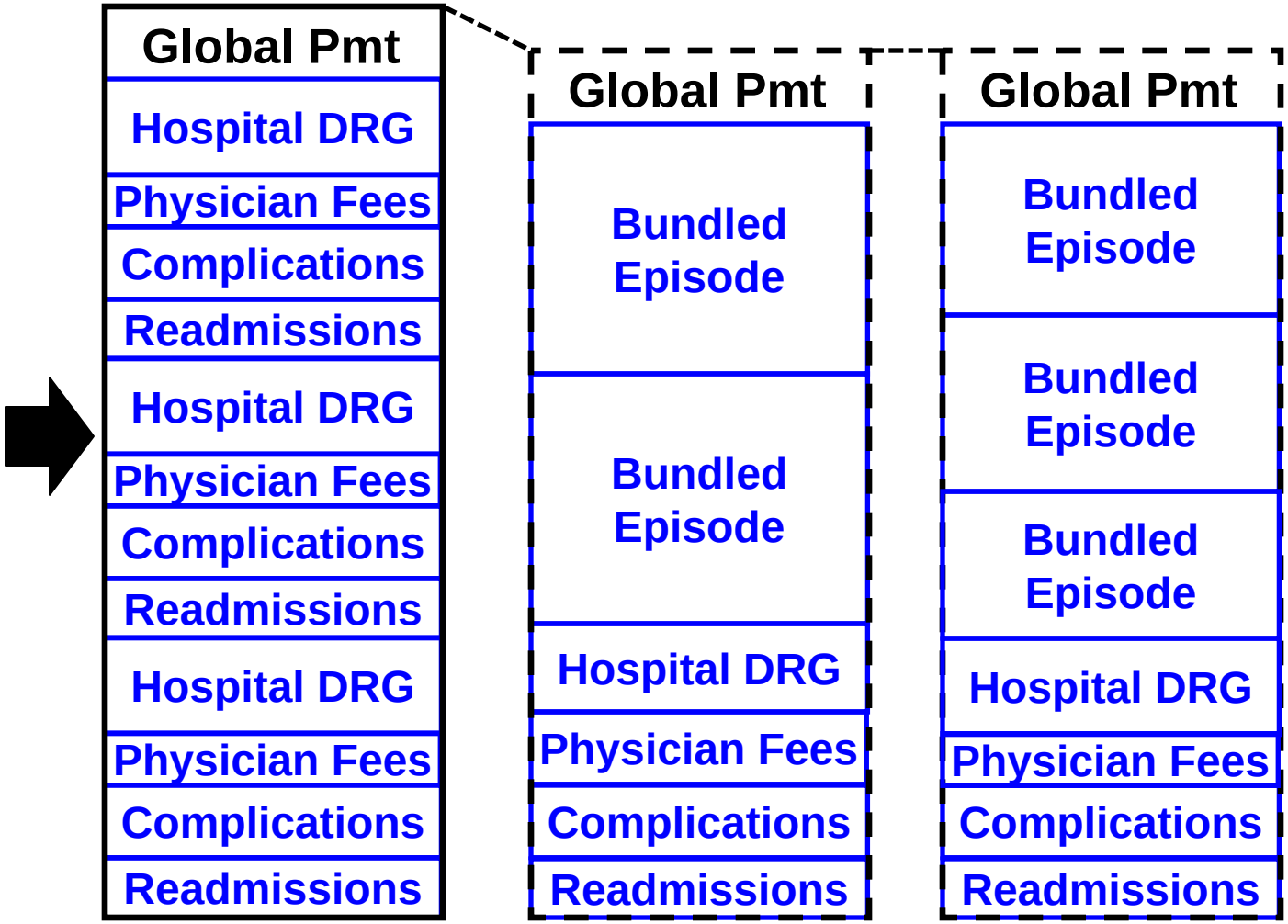
What Stops Increases in Number of Episodes?

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 disincents, but bundled payments create different incentives and different potential quality problems

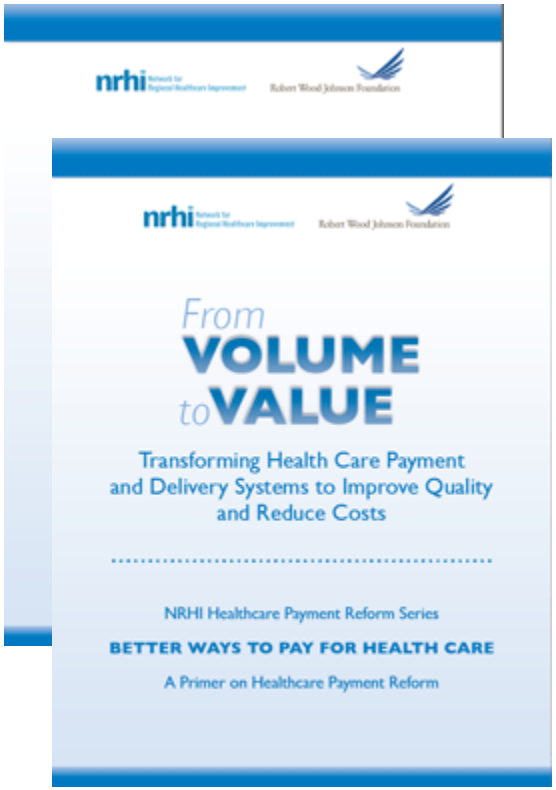
Implementation Issues for Episode and Bundled Payment

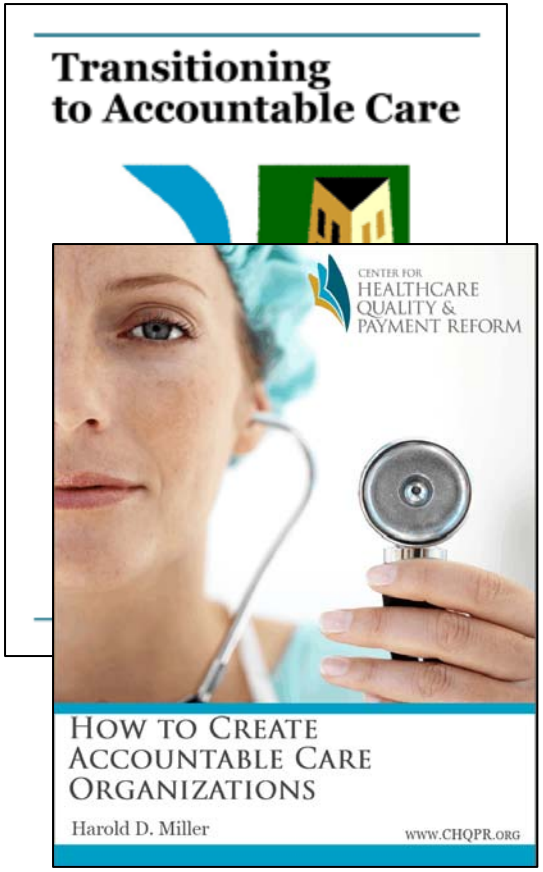
- What's in the Bundle, Why, and Who Decides?
- Who Gets the Check?
- What's the Price of the Bundle?
- What's the Incentive for a Provider to Be Low-Priced?
- Will It Actually Lower Costs?
- **Is Bundling Worth It?**

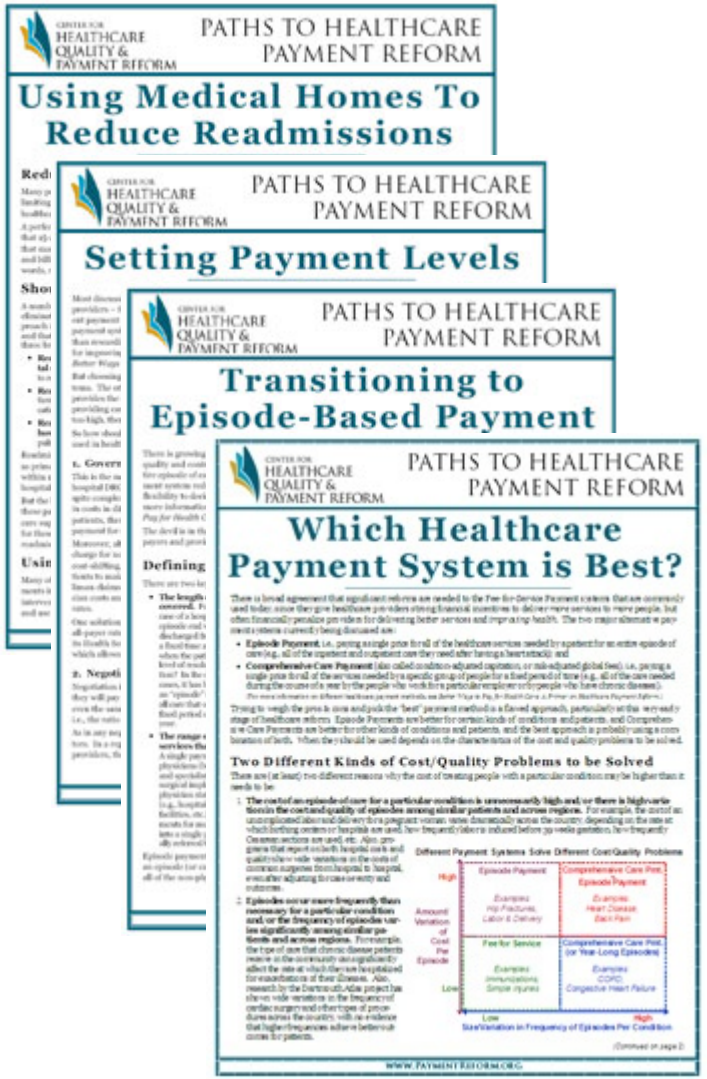
Is It Worth It?

- 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

CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

nrhi Network for Regional Healthcare Improvement

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