JOHNS HOPKINS BLOOMBERG SCHOOL of PUBLIC HEALTH

Bundling in Context of the Spectrum of Value-Based Payment

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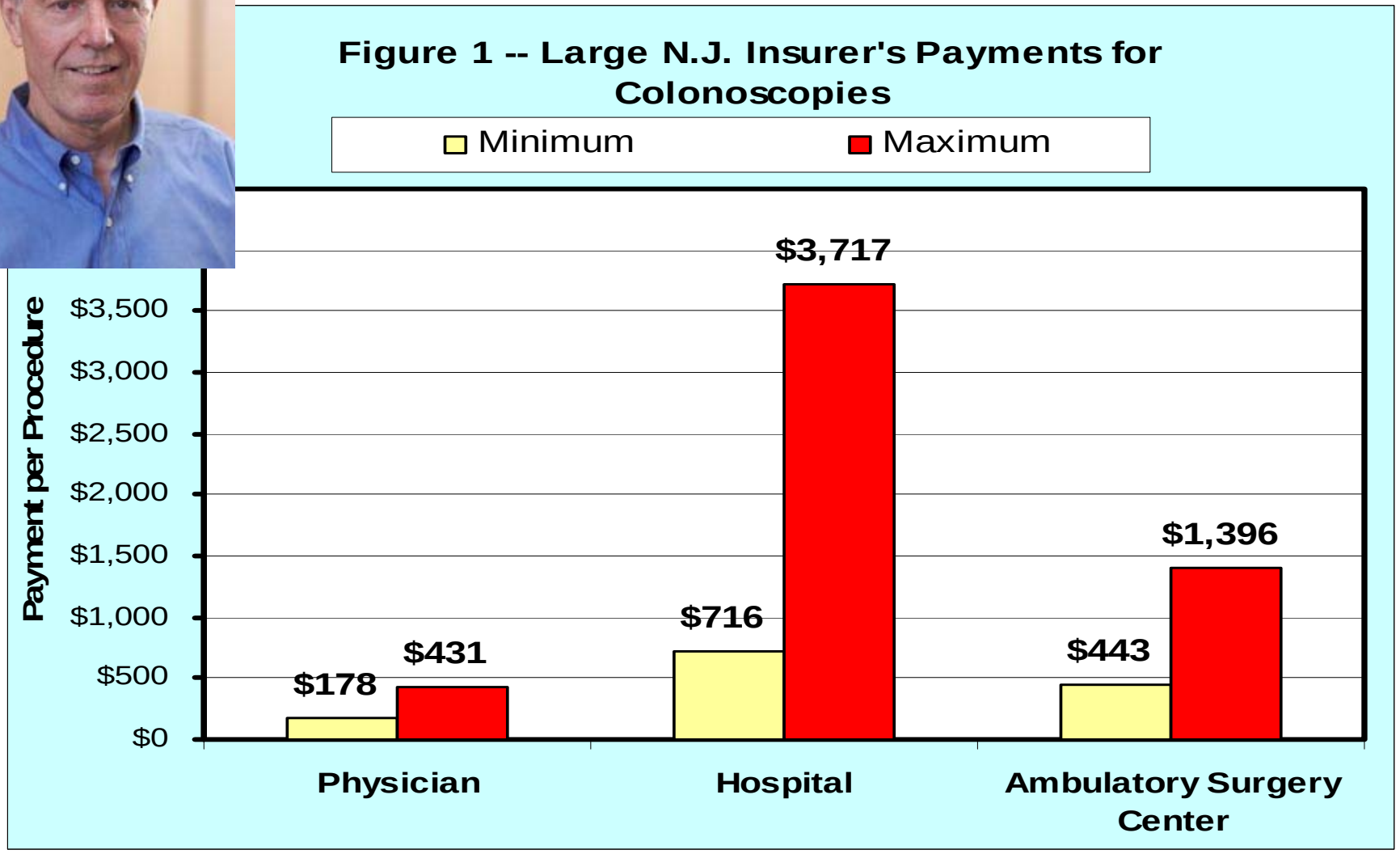
CURRENT PRICING SYSTEM

Irrationality of Current Health Care Pricing System

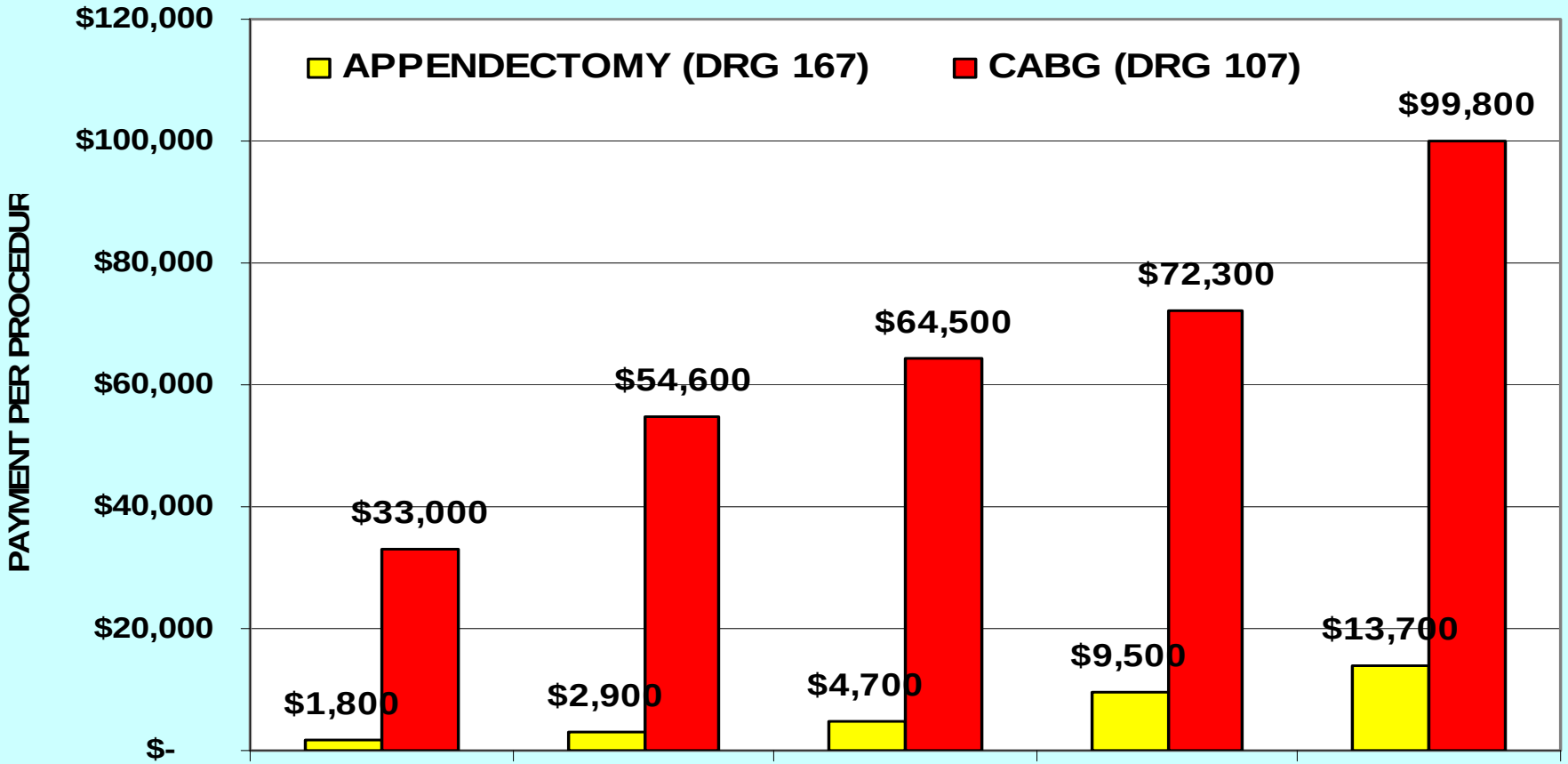
- **Highly variable prices charged by providers and paid by commercial insurers within and across markets**
- **Little transparency or ability for patients to compare total charges for procedure (e.g. hip replacement) or treatment of acute or chronic condition (e.g. breast cancer treatment; diabetes)**
- **Higher payment for more specialized services and procedures without respect to benefit or value to patients**
- **Medicare has leverage to obtain lower payment rates generally; commercial insurer charges also lower when Medicare payments are tighter**



SOURCE: N.J. Commission on Rationalizing Health Care Resources, Ch. 6.

Reinhardt UE. "Price variation in U.S. health care: Opportunities for fairness and cost control?" PowerPoint Presentation. Bipartisan Congressional Health Policy Conference. 2012.

Figure 2 -- ACTUAL PAYMENTS MADE BY ONE CALIFORNIA INSURER TO VARIOUS HOSPITALS, 2007 (WAGE ADJUSTED)



SOURCE: N.J. Commission on Rationalizing Health Care Resources, Ch. 6.

Reinhardt UE. "Price variation in U.S. health care: Opportunities for fairness and cost control?" PowerPoint Presentation. Bipartisan Congressional Health Policy Conference. 2012.

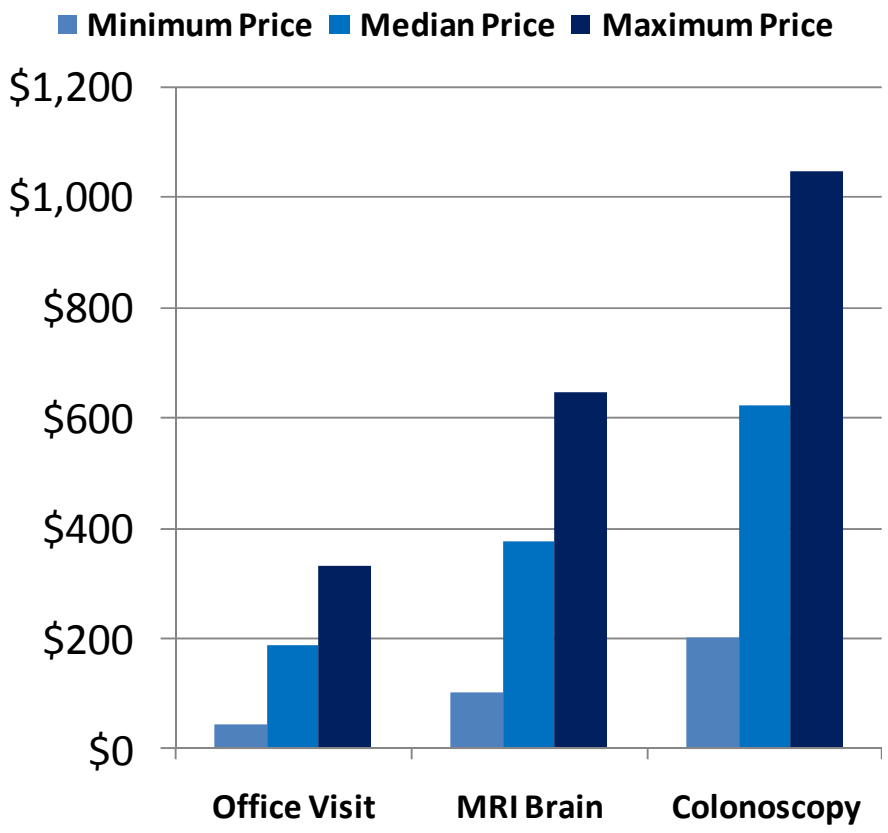
Payment Variation Among Oregon Hospitals

	State Average	Oregon State		Portland Area	
		Average Low	Average High	Average Low	Average High
Balloon angioplasty (no heart attack)	$26,161	$18,553	$53,810	$18,721	$32,201
Coronary artery bypass (without angioplasty)	$63,985	$33,302	$64,427	$54,764	$67,528
Uncomplicated childbirth	$6,424	$2,969	$8,765	$4,974	$6,628
Laparoscopic gallbladder removal	$16,834	$10,540	$28,816	$10,952	$18,320
Knee replacement surgery	$28,682	$18,472	$45,547	$18,472	$29,123

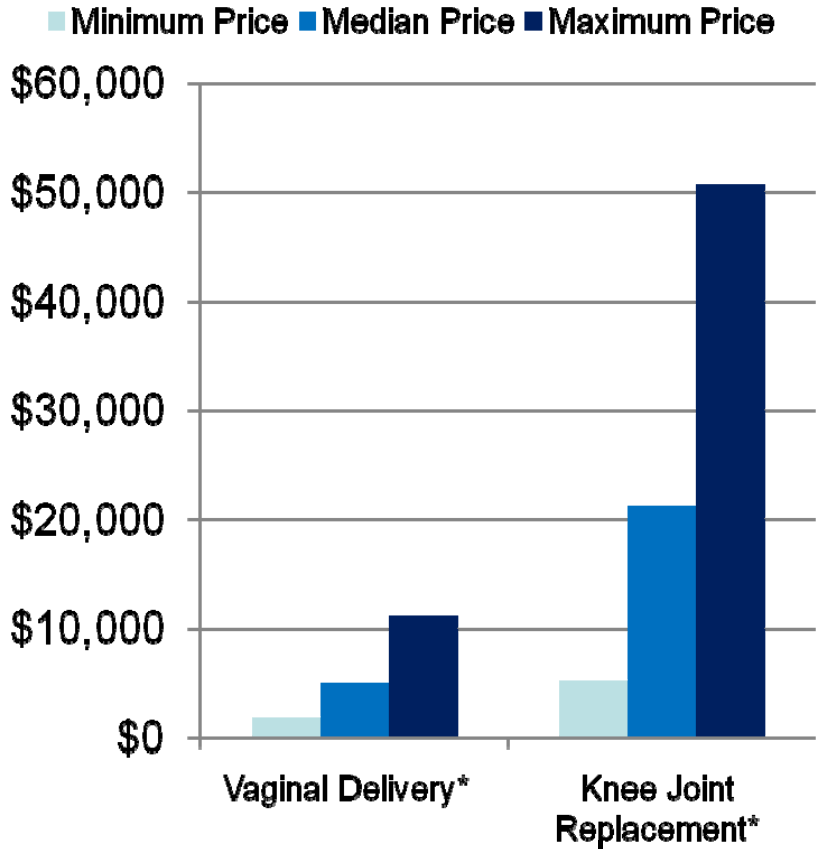
Schoen S. "Price Variation, Cost Increases and Implications for Policy" PowerPoint Presentation. Bipartisan Congressional Health Policy Conference. 2013.

Massachusetts: Private Payment Variation for Professional Services and Hospital Care

Private $ Variation, Professional Services



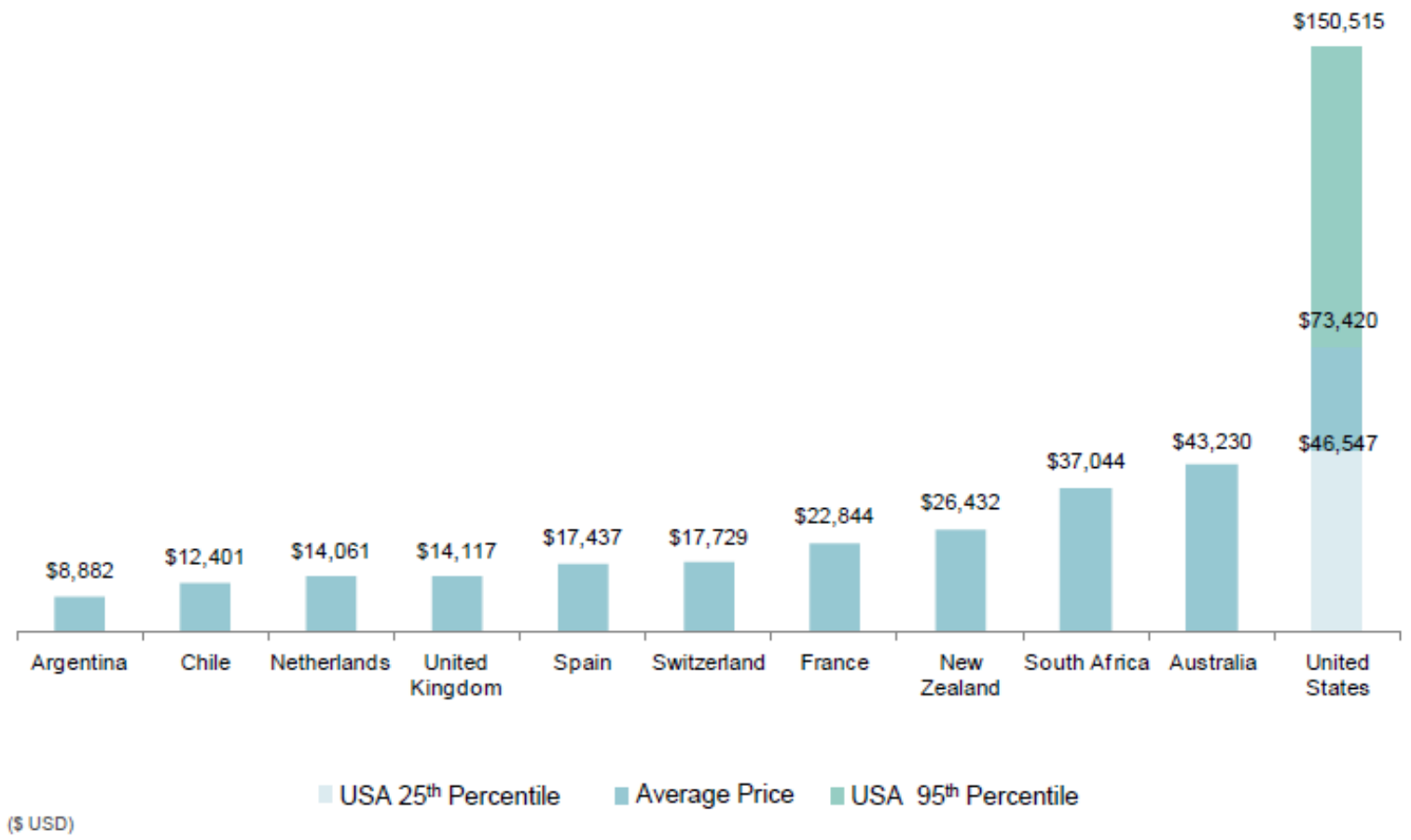
Private $ Variation Across Hospitals



Schoen S. "Price Variation, Cost Increases and Implications for Policy" PowerPoint Presentation. Bipartisan Congressional Health Policy Conference. 2013.

Total Cost Comparisons: Bypass Surgery

2012 Total Hospital and Physician Cost: Bypass Surgery



2012 Comparative Price Report: Variation in Medical and Hospital Prices by Country. International Federation of Health Plans; 2012.

NEW PAYMENT METHODS

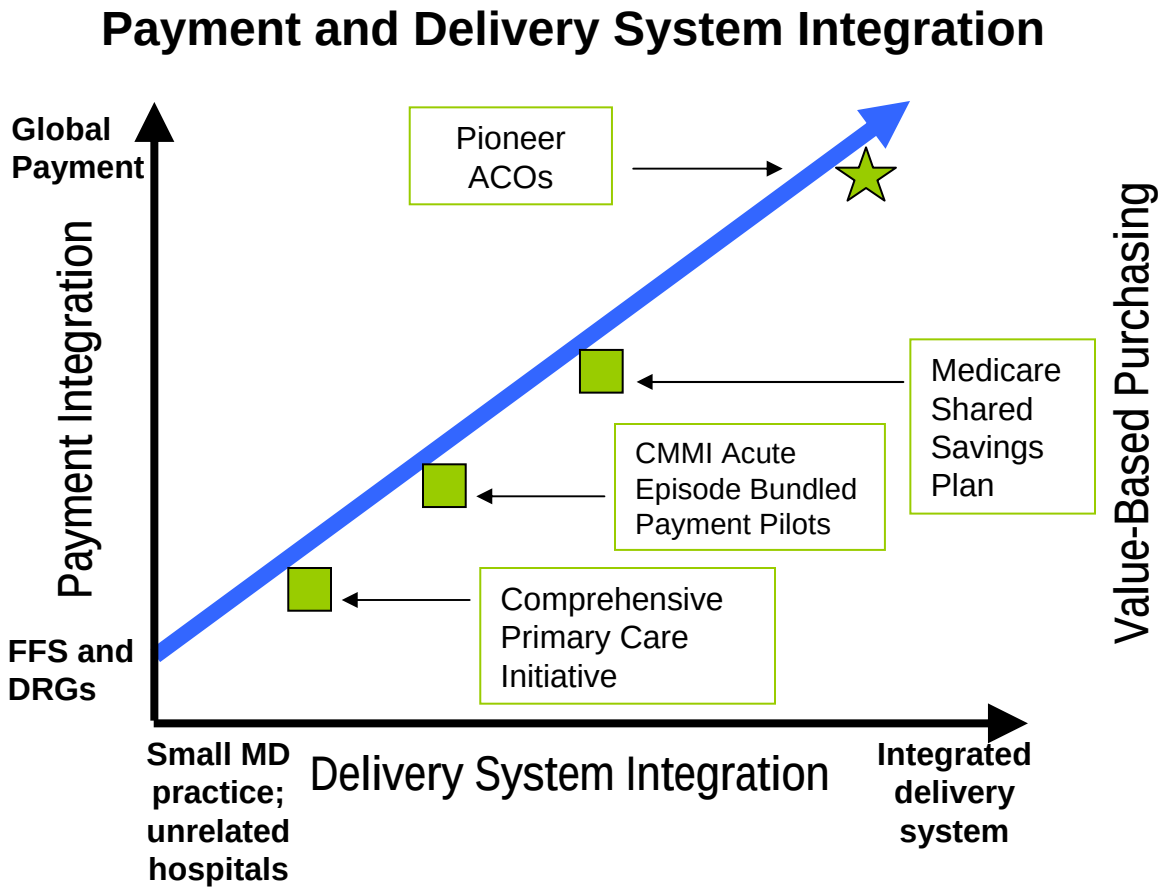
Rationale Guiding New Payment Methods

- **Reward lower cost of total care for a patient, procedure, condition, or episode by creating incentives to:**
  - **Emphasize prevention and primary care, prompt intervention before exacerbation occurs; team approach to care**
  - **Ensure 24/7 access and reduce emergency room use**
  - **Use generic prescribing or lower cost treatment alternatives**
  - **Reduce hospitalization and readmissions, improve transitions in care, avoid complications**
  - **Develop post-acute plan of care and contract with lower cost, higher quality post-acute care providers**
  - **Better manage chronic conditions**
  - **Avoid waste, duplication, and use of low-value services**
  - **Better integrate care across care continuum**
- **Reward higher quality**
- **Public information on quality and total charges; promote competition among providers by facilitating patient and payer comparison of total charges and quality**

Payment Innovation to Support Care Coordination and Integration

- **Tools: Primary care, payment reform, health information technology, data on comparative performance, technical assistance**
- **Innovative Payment Methods:**
  - **Patient-Centered Medical Homes**
  - **Accountable Care Organizations**
  - **Value-Based Purchasing**
  - **Bundled Payment for Care Improvement**

Payment and Delivery System Reforms Support a High Performance Health System



Source: Modified from The Commonwealth Fund, *The New Wave of Innovation: How the Health Care System Is Reforming*, (New York: Columbia Journalism Review, November 2011); A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, *Organizing the U.S. Health Care Delivery System for High Performance* (New York: The Commonwealth Fund, Aug. 2008

Overview of CMS Primary Care Payment Innovations

Demonstration	Multi-Payer Advanced Primary Care Practice Demonstration	Federally Qualified Health Centers (FQHC) Advanced Primary Care Practice Demonstration	Comprehensive Primary Care Initiative (CPCI)
Geographic Scope	ME VT, RI, NY, PA, NC, MI, MN	500+ clinic sites In 44 States	7 "Markets" : Statewide: AR, CO, NJ,OR; Mid-Hudson/Capital (NY); Cincinnati-Dayton (OH); and Greater Tulsa (OK)
Participants	Up to 1,200 practices (MD & NP) participating in state health care reform initiatives promoting APCP	FQHCs (and "look-alikes") serving relatively large numbers of Medicare beneficiaries	• 45 payers (commercial, states, unions) • 500 primary care practices • 2,144 providers serving an estimated 313,000 Medicare beneficiaries
Practice Qualifications	Dependent on state program	> 200 Medicare beneficiaries per site	High performing practices
Targeted Beneficiaries	Dependent on state program	Medicare beneficiaries	Medicare beneficiaries
Payment	Care management fee. Established by state multi-payer reform initiative	Medicare all-inclusive rate plus $6.00 PMPM care management fee	• Avg $20 PMPM (risk-adjusted) Years 1-2 • Avg. $15 Years 3-4 • Opportunity for shared savings starting Yr. 2

Accountable Care Organizations

- **Local entity, comprised of a group of providers that are accountable for the cost and quality of services delivered to a defined population of patients**
- **260 ACOs now enroll over 4 million Medicare beneficiaries; CMS estimates up to 270 ACOs with up to 5 million beneficiaries will participate between 2012 – 2015**
- **Payments for quality reporting and meeting quality standards**
  - **33 measures with 4 domains: patient/caregiver experience (7); care coordination/patient safety (6); preventive health (8); at-risk populations (12)**
  - **ACO must achieve threshold on 70% of measures within each domain**
- **ACO programs offered**
  - **Pioneer ACO Program**
    - Began January 1, 2012 with 32 organizations http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/index.html
    - Designed for more advanced ACOs willing and able to assume full or partial risk for meeting target spending level
  - **Medicare Shared Savings Program (MSSP)**
    - Began April 1, 2012 with 27 organizations; additional 193 started as of January 10, 2013 https://www.cms.gov/sharedsavingsprogram/
    - Eligible for savings if Medicare outlays below target
  - **Advance Payment ACO Model**
    - Began April 2, 2012 with 35 organizations http://innovation.cms.gov/initiatives/Advance-Payment-ACO-Model/index.html
    - Designed for physician-based and rural providers to receive upfront and monthly payments, which they can use to make important investments in care coordination infrastructure

Source: M. Zezza and S. Guterman, Accountable Care Organization Final Regulations Give Health Care Providers More Flexibility, (New York: The Commonwealth Fund blog, October 2011); M. Zezza, The Pioneer Accountable Care Organization Model: An Alternative to the Medicare Shared Savings Program, (New York: The Commonwealth Fund blog, November 2011). Accountable Care Organization 2013 Program Analysis, Centers for Medicare and Medicaid Services. December 2012.

Shared Savings Offers a Wide Range of Approaches

One-Sided

- Continue operating under current insurance contracts/coverage models (e.g., FFS)
- No risk for losses if spending exceeds targets
- Most incremental approach with least barriers for entry
- Attractive to new entities, risk-adverse providers, or entities with limited organizational capacity, range of covered services, or experience working with other providers
- **MSSP** –Can participate in one-sided model, sharing up to 50% of savings for 1st 3 years.
- **Pioneer**: Offers a 1-sided option for one year

Two-Sided

- Payments can still be tied to current payment system, although ACO could receive revenue from payers and distribute funds to members
- At risk for losses if spending exceeds targets
- Increased incentive for providers to decrease costs
- Attractive to providers with some infrastructure or care coordination capability and demonstrated track record
- **MSSP** – Offers a 2-sided track, sharing up to 60% savings. Must participate in 2-sided model after 3rd year
- **Pioneer** – Offers greater potential (up to 75%) for shared savings earnings

Capitation

- ACO receives prospective fixed payment
- If successful at meeting budget and performance targets, greater financial benefits
- If ACO exceeds budget, more risk means greater financial downside
- Only appropriate for providers with robust infrastructure, demonstrated track record in finances and quality and providing relatively full range of services
- Ultimate goal for most ACOs
- **Pioneer** – in 3rd year, high-performing ACOs have option for partial capitation for Part B services or full capitation, including Part A and Part B

CMS Hospital Value-Based Purchasing Program (VBP)

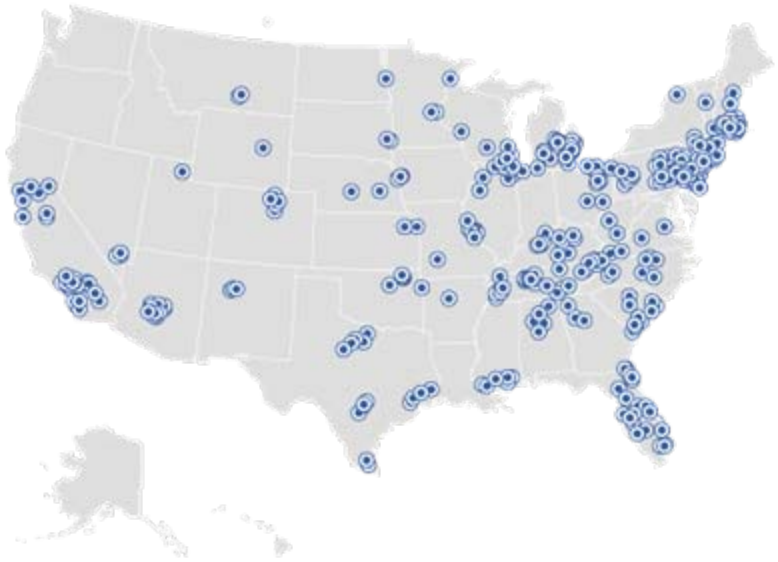
- **Rewards hospitals that meet a set standard of clinical quality measures and penalizes those that do not**
- **Levies fines on hospitals that have too many patient readmissions because of complications within 30 days of discharge**
- **Participants began to receive incentive payments on October 1, 2012**
- **More than 3,400 acute-care and 400 long-term care hospitals across the country are eligible to participate, with >99% participating**
  - **For the FY 2013 Hospital VBP program, CMS will measure hospital performance using two domains: the clinical process of care domain, which is comprised of 12 clinical process of care measures, and the patient experience of care domain, which is comprised of Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey measure**
  - **Hospitals participating in the program will have their base operating DRG payments for each patient discharge across all hospitals reduced by a small percentage each year in order to fund incentive payments**
  - **CMS estimates that roughly half of participating hospitals will receive a net increase in payments, while the rest will receive a net decrease in payments. CMS estimates that no participating hospital will receive more than a net 1-percent decrease in payments in FY 2013.**

Source: Hospital Value-Based Purchasing. Center for Medicare and Medicaid Services. Accessed on February 21, 2013. Accessed from http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html

BUNDLED PAYMENT FOR CARE IMPROVEMENT

CMS Bundled Payment for Care Improvement (BPCI) Initiative

- **3-year program started January 31, 2013**
- **>500 organizations participating**
- **Test 4 different models of care, allowing physicians, hospitals, and post-acute care to participate**



Source: Centers for Medicare & Medicaid Services

Sources: M. Zezza, S. Guterman, and J. Smith, The Bundled Payment for Care Improvement Initiative: Achieving High-Value Care with a Single Payment, (New York: The Commonwealth Fund blog, January 2012); Bundled Payments for Care Improvement Initiative Fact Sheet. Centers Medicare and Medicaid Services. Released January 31, 2013. Access from http://www.cms.gov

Key Components of BPCI

- **Minimum discounts of 2-3%**
- **Detailed bundled payment design, including list of DRGs, inclusion and exclusion criteria, episode trigger and window, and risk adjustment mechanism**
- **Detailed action plan to redesign care to maximize coordination, patient-centeredness, efficiency, and improved quality**
- **Detailed physician gain sharing model (up to 50% of professional fees), including criteria for participating, methodology and frequency of sharing gains, and safeguards and quality control mechanisms to ensure that medically necessary care is not reduced**

Motoney M. Lessons Learned and Opportunities Ahead for Bundled Payment. Powerpoint presentation. Medical Quality 2013. Accessed from http://www.acmq.org/natlconf/2013/presentations/Montoney%20-%20MQ2013%20Presentation.pdf

The 4 Models

- **Model 1: Hospitalization with gain-sharing for physicians**
- **Model 2: Inpatient hospital (including readmissions), physician services, post-acute-care, and other related services**
- **Model 3: Post-hospitalization services**
- **Model 4: Inpatient hospital and physician services including readmissions, but not post-acute-care services**

Types of Services by Model

Type of Services Included in Bundle	Model 1: Acute Hospital Stay Only	Model 2: Acute Hospital Stay + Post-Acute Care	Model 3: Post-Acute Care Only	Model 4: Acute Hospital Stay + Readmissions
Inpatient hospital and physician services	✓	✓		✓
Related post-acute care services		✓		
Post-acute care services		✓	✓	
Related readmissions		✓	✓	✓
Other services defined in bundle (Part A & Part B)		✓	✓	

Gong J, Fuller B. "CMS Announces Bundled Payments for Care Improvement Initiative Awardees—Lessons for Post-Acute Care Providers." Health Dimensions Group. Accessed from http://www.healthdimensionsgroup.com/pdfs/CMS%20Announcement%202.1.13.pdf

Type of Episodes Covered

- **48 clinical condition episodes by DRG groupings**
  - **Coronary artery bypass surgery (CABG) – DRG 231-236**
  - **Acute myocardial infarction – DRG 280-282**
  - **Stroke – DRG 61-66**
  - **Chest pain – DRG 313**
  - **Urinary tract infections – DRG 689, 690**
  - **Chronic obstructive pulmonary disease (COPD) – DRG 190-203**
  - **Diabetes – DRG 637-639**
  - **Revision of the hip or knee – DRG 466-468**
  - **Amputation – DRG 239-241, 255-257, 474-476, 616-618**
  - **Simple pneumonia and respiratory infections – DRG 177-195**
  - **Nutritional and metabolic disorders – DRG 640-641**

Bundled Payment Model Designs

	Model 1: Acute Hospital Stay Only	Model 2: Acute Hospital Stay + Post-Acute Care	Model 3: Post-Acute Care Only	Model 4: Acute Hospital Stay + Readmissions
Episode	All acute patients, all DRGs	Selected DRGs, hospital plus post-acute period	Selected DRGs, post-acute period only	Selected DRGs, hospital plus readmissions
Services included in the bundle	All Part A services paid as part of the DRG payment	All non-hospice Part A and B services during the initial inpatient stay, post-acute period and readmissions	All non-hospice Part A and B services during the post-acute period and readmissions	All non-hospice Part A and B services (including the hospital and physician) during initial inpatient stay and readmissions
Payment	Retrospective	Retrospective based on preset target price	Retrospective based on preset target price	Prospective
Number of initiatives	32	193	166	76

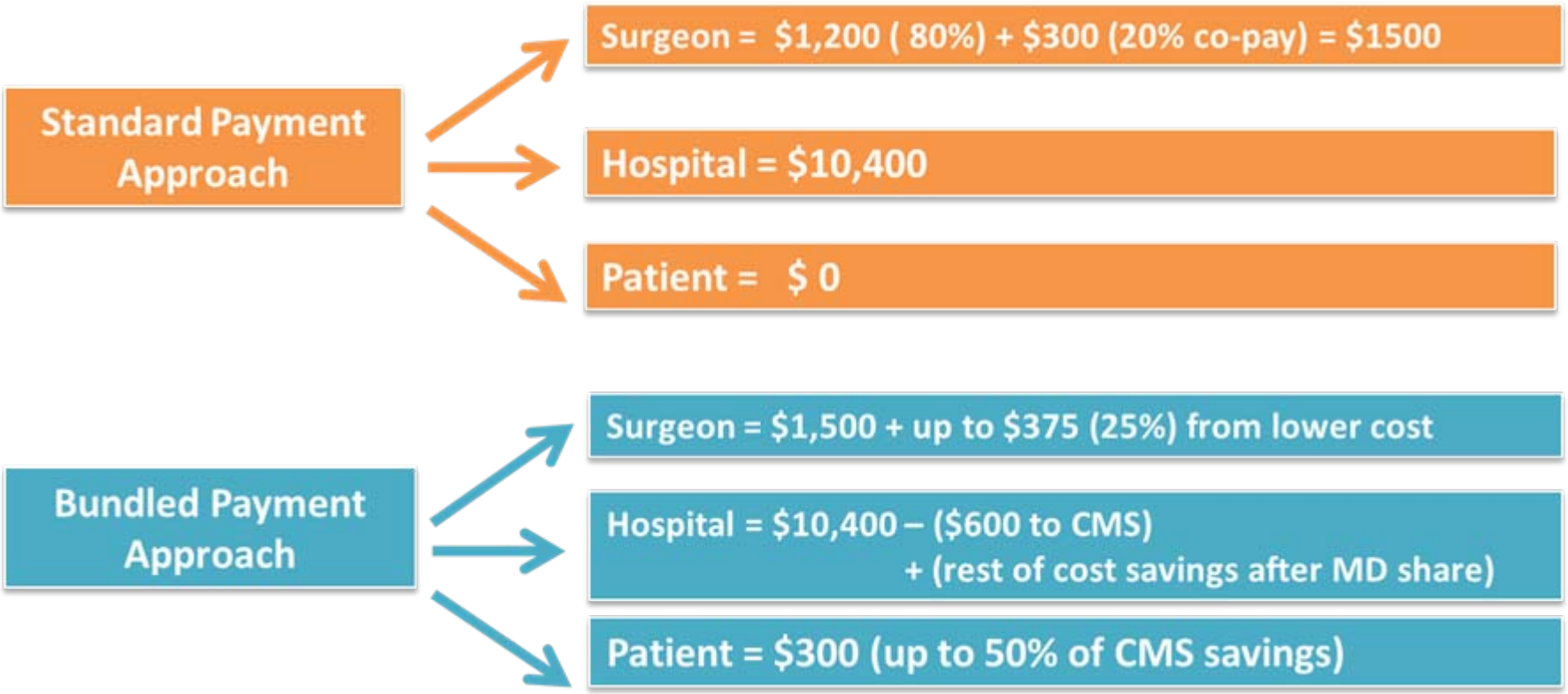
Bundled Payments for Care Improvement Initiative Fact Sheet. Centers Medicare and Medicaid Services. Access on February 21, 2013. Access from http://www.cms.gov

From Michael C. Zucker, Chief Development Officer of Baptist Health System

INNOVATIVE PAYMENT MODELS DRIVING DELIVERY SYSTEM REFORM

Gain Share Example

DRG 470 – Major Joint Replacement or Reattachment of Lower Extremity w/o MCC



Zucker MC. “Innovative Payment Models Driving Delivery System Reform.” PowerPoint presentation. Bipartisan Congressional Health Policy Conference. 2013

Cost Savings under ACE
June 2009-May 2012

Volume

4,750 Medicare Patients

Hospital Savings

$9,500,000

Shared Savings to Patients

$1,341,198

Gain Share to Physicians

$1,109,415

Zucker MC. “Innovative Payment Models Driving Delivery System Reform.” PowerPoint presentation. Bipartisan Congressional Health Policy Conference. 2013

Walmart "Centers of Excellence" Program

- **Provide employees with quality health care with no out-of-pocket cost for heart, spine, and transplant surgeries at six hospital and health systems in the U.S**
- **Use exclusive and unique bundled pricing arrangements for these types of procedures**
- **Projected to save employees $5,000 to $12,000**
- **"Triple win" for hospitals and employers - improve quality, improve value, and eliminate out-of-pocket costs for employees**
- **Program started January 2013**

Walmart Expands Health Benefits to Cover Heart and Spine Surgeries at No Cost to Associates. Access from http://news.walmart.com/news-archive/2012/10/11/walmart-expands-health-benefits-to-cover-heart-spine-surgeries-at-no-cost-to-associates; Wohl J. "Wal-Mart to pay for heart and spine surgery for U.S. employees." Reuters; October 11, 2012. Accessed from http://www.reuters.com/article/2012/10/11/us-usa-walmart-surgery-idUSBRE89A1GR20121011; Young J. "Walmart Workers To Get No-Cost Surgery At Mayo Clinic, Other Top Hospitals." Huffington Post; October 11, 2012. Accessed from http://www.huffingtonpost.com/2012/10/11/walmart-surgery-workers_n_1958673.html.

Walmart "Centers of Excellence" Procedures

- **Cardiac surgeries including open-heart surgery, CABG, heart valve replacement/repair, closures of heart defects, thoracic and aortic aneurysm repair**
  - **Cleveland Clinic in Cleveland, Ohio**
  - **Geisinger Medical Center in Danville, Pa.**
  - **Scott & White Memorial Hospital in Temple, Texas**
  - **Virginia Mason Medical Center in Seattle**
- **Spinal procedures including cervical and lumbar spinal fusion, total disk arthroplasty, spine surgery revisions**
  - **Mercy Hospital Springfield in Springfield, Mo.**
  - **Scott & White Memorial Hospital in Temple, Texas**
  - **Virginia Mason Medical Center in Seattle**
- **Transplant surgeries**
  - **Mayo Clinic sites in Arizona, Florida, and Minnesota**

Walmart Expands Health Benefits to Cover Heart and Spine Surgeries at No Cost to Associates. Access from http://news.walmart.com/news-archive/2012/10/11/walmart-expands-health-benefits-to-cover-heart-spine-surgeries-at-no-cost-to-associates

Other Private Sector Collaborations

- **Cleveland Clinic has similar programs for cardiac surgeries with**
  - **Lowe's Corporation**
  - **Kohl's**
  - **Rich Products**
  - **Alliance Oil**
- **Johns Hopkins Hospital and PepsiCo for cardiac and joint replacement surgeries**
  - **Rates tend to be set at the national average for a certain procedure**
- **Programs tend to have higher than expected participation from employees**

Spector H. "Lowe's will bring its workers to Cleveland Clinic for heart surgery." Cleveland.com; February 17, 2010. Accessed from http://www.cleveland.com/healthfit/index.ssf/2010/02/post_27.html; Young J. "Walmart Workers To Get No-Cost Surgery At Mayo Clinic, Other Top Hospitals." Huffington Post; October 11, 2012. Accessed from http://www.huffingtonpost.com/2012/10/11/walmart-surgery-workers_n_1958673.html; Walker AK. "PepsiCo to pay for employee surgeries at Hopkins: Cardiac and joint replacement covered under the deal" Baltimore Sun; December 11, 2011. Accessed from http://articles.baltimoresun.com/2011-12-11/health/bs-hs-hopkins-pepsi-20111209_1_surgeries-pepsico-mercer-health-benefits

MEDICARE ESSENTIAL: REINFORCING PAYMENT REFORM WITH BENEFICIARY INCENTIVES

Medicare Essential: A New Option to Enhance Value

1. **Single plan with comprehensive benefits, one premium, and lower administrative costs (replaces Part A, Part B, Part D, and supplemental coverage); default option beginning in 2014; Medicare Advantage and traditional Medicare continue; Medi-Gap minimum $250 deductible**
2. **Comprehensive benefits with reduced and rationalized cost-sharing; single deductible ($250) for hospital, physician, and other A/B services; $20/$40/$50 copayment for primary care, specialty care, ED use; limit on patient costs ($3400)**
3. **Single Rx formulary and pharmaceutical benefits manager negotiating drug prices; lower cost-sharing for generic and essential medications**
4. **Provider payment reform – blended/bundled/global provider payment options with value based-purchasing, shared savings**
5. **Reduced beneficiary cost-sharing for selecting high-value patient-centered medical homes and health systems.**

Medicare Essential Incentive Benefit Design

	Medicare Essential Core Benefits	Medicare Essential Incentives: Lower Cost-Sharing for High-Value
Deductible	Hospital/physician: Unified $250 deductible ($500 family). Does not apply to preventive care (including prescription drugs).	Deductible does not apply to primary care if registered with primary care practice or a patient-centered medical home (PCMH). Deductible does not apply if referred to specialist by PCMH or high-cost care team.
Coinsurance Co-payment	$20 primary care visit. $40 specialist visit. 10% lab/diagnostic outpatient. 10% other Part B services currently subject to 20% cost-sharing (outpatient surgery, durable medical equipment, etc.). $50 emergency department visit unless urgent, accident.	$10 co-pay for primary care if PCMH practice Co-insurance lowered to 5 percent for lab, diagnostic if PCMH, high-cost care team, or accountable care organization (ACO) network. No cost-sharing for care management. Health home networks covered for dually-eligible where available.
Prescription drugs	25 % cost sharing for non-preferred brand. (Out of pocket limit includes Rx)	Use reference pricing – pay up to level of equivalent drugs (lowest cost two drugs) – patients pay the difference unless doctor specifies reference drug not appropriate for patient. Nominal co-payment for generic. No deductible.
Home health **Skilled nursing**	Home health: no cost-sharing (same as current). Skilled nursing: $80/day for days 21-100.	If in ACO network or high-cost care teams, expanded benefit as needed to avoid hospitalization.
Ceiling on Out of Pocket (OOP) Costs	$3,400 annual.	$2,000 if high-cost care team or certified ACO network. $2,000 OOP limit if low-income.
Other provisions		
Low-Income : Up to 150% poverty	Medicaid eligible: Current provisions for Medicaid supplement; Medicaid pays additional Medicare Essential premium. Other under 150%: Out of pocket limit of $2,000 per year.	
Medigap	Starting in 2014, Medigap does not cover the $250 deductible and all plans must include at least $20 co-payment per physician and emergency room visit (similar to current Medigap Plan N).	
Medicare Advantage	Limit out-of-pocket maximum to no more than $3,400 (lower limits permitted). No cost-sharing for home health if part of care plan (to avoid risk selection).	

Estimated Total Monthly Out-of-Pocket Costs for a Typical Medicare Beneficiary with Medicare Essential (Using Standard Providers and Using High-Value Providers), Compared with Traditional Medicare with Medigap and Part D, 2014

Estimated Monthly Expense	(1) Current Law: Medicare Plus Medigap Plan F Plus Part D	(2) Medicare Essential (Standard Providers)	(3) Net Difference [(2) – (1)]	(4) Medicare Essential (High-Value Providers)	(5) Net Difference [(4) – (1)]
Out-of-Pocket Costs for Medicare Covered Services:					
--Medical Care (Parts A and B)	$0	$80	$80	$40	$40
--Prescription Drug (Part D)	$48	$36	-$12	$8	-$40
Premiums:					
--Part B	$127	$127	$0	$127	$0
--Part D	$35	$0	-$35	$0	-$35
--Medigap Plan F	$217	$0	-$217	$0	-$217
--Medicare Essential	$0	$111	$111	$79	$79
Monthly Cost: Premiums plus Out-of-Pocket	**$427**	**$354**	**-$73**	**$254**	**-$173**

Notes: Estimates reflect full implementation of Medicare Essential in 2014.
Source: Estimates provided by Actuarial Research Corporation based on ARC Medicare micro-model.

Changes In Health Expenditures with Medicare Essential Compared To Projected Spending, By Payer Source, $ Billions

	2014-2018	2014-2023
National Health Expenditures	-$12.9	-$179.9
Federal Government	32.6	0.0
State and Local Government	-8.1	-27.0
Private Employers	-27.1	-89.9
Households/Beneficiaries	-10.3	-63.1

Notes: Projected spending under current law assumes replacement of sustainable growth rate formula with freeze of Medicare physician fees throughout the ten-year period. Assumes increased participation in Medicare Essential over time compared to traditional Medicare, with 90% of those in Medicare core program selecting the option by the end of the decade. Share of Medicare Advantage enrollment is assumed unchanged.

Source: Estimates provided to authors by Actuarial Research Corporation based on ARC Medicare micro-model.

Benefits of Medicare Essential

- **Potential to simplify and lower costs for beneficiaries**
- **Lower administrative costs and complexity**
- **Better financial protection for beneficiaries**
- **Creates incentives for beneficiaries to choose lower-cost, higher quality care**
  - **Supports spread of care system innovation**
- **Potential to reduce retiree-benefit costs for employers**
- **New choice to compete on level playing field with Medicare Advantage plans**
- **Inefficient Medigap plans likely to decline overtime**

Incentives for Better Care

- **Provides incentives for wise choice of care, choice of less expensive diagnostic and treatment options with comparable or better outcomes**
  - **No cost-sharing for preventive services; rationalized cost-sharing of $20 per visit for primary care, $40 for specialty care and $50 for emergency department care; encourages use of lower-cost primary care**
  - **Eliminates deductibles for beneficiaries choosing high-performing patient-centered medical homes and accountable care organizations**
  - **Reduces cost-sharing for obtaining specialty care within ACO networks and through health systems accepting bundled payment**
- **Promotes coordinating care, improving medical adherence, and reducing hospitalization and emergency department cost by having all services in a single plan**
- **Incentives for shared decision-making, information for patients**

Incentives for Providers

- **Incentives for providers to participate in innovative payment methods, meet high standards of performance, be accountable for better care, better outcomes, lower cost**
    - **Blended payment for patient-centered medical homes (FFS, care management fee per beneficiary, performance bonuses)**
    - **Bundled payment for health systems (bundled case rate for selected conditions and procedures including inpatient hospital, inpatient physician, post-acute care for 30 days for selected conditions and procedures)**
    - **Global payment for ACOs (full or partial risk or shared savings)**
- **Bonuses for high performance, shared savings**
- **Contribute to lower-cost care, better care and outcomes for patients; eliminate incentives for overuse by providers**

THE PROMISE AND THE CHALLENGES OF BUNDLED PAYMENT

The Promise and the Challenges

- **Promise:**
  - **Simplicity, transparency in costs, transparency in benefits**
  - **Potential for promoting competition, lower prices**
  - **Better rewards for efficiency and quality**
- **Challenges:**
  - **Assumption of risks**
  - **Implementation**
  - **Administrative claims systems**
  - **Evaluation**
  - **Spread**

Thank You!

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