Bundled Payments: The Rationale for Early Preparation

By Catherine DiNardo

Indeed, bundled payment is not a new idea, having been around for a number of years; but, this concept is of late garnering increasing attention as a result of the passage of the Patient Protection and Affordable Care Act in March 2010. This law, the PPACA, included the Bundled Payments for Care Improvement Initiative (BPCI) program, which is a voluntary program that pays a single agreed-upon price for all services provided by two or more providers to Medicare patients for an “episode of care.”

As providers across the country evaluate the potential impact of adopting a bundled payment methodology for their organizations, Corazon is working to assist hospital and service line leaders with preparations should this new payment paradigm become the standard payment system for Medicare or other insurers.

Physician and hospital services are the typical components combined under a bundled payment approach, but other providers (long-term care, skilled nursing, home health, and other such facilities) can also be included. Under BPCI, the definition of the “episode of care” changes from model to model (as explained below). The episode of care can include just the inpatient hospital stay, just the post-acute care, or it can include both along with up to 90 days of post-acute care. Cardiac services are often considered for a bundled payment because of the high volume of cases and the relatively high costs associated with cardiac procedures across the continuum.

The Bundled Payments for Care Improvement Initiative (BPCI) program, set to launch in 2013, will give even more hospitals and physicians an opportunity to experience the benefits (and challenges!) of a bundled payment program. Even though the initial application process to be part of the BPCI program has passed, hospitals and insurers are free to develop their own bundled payment models as the concept gains momentum in the industry.

In fact, given the high cost of healthcare, at some point in the future, it is very likely that Medicare – and possibly other insurers – will demand a bundled pricing option from providers, especially for high-cost and high-volume services – like most cardiac procedures.

Corazon recommends that all hospitals that have a significant portion of the bottom line driven by cardiac care explore the bundled payment method…without proactive planning, organizations will be scrambling to achieve the efficiencies necessary to obtain positive margins should a bundled payment system become a mandated approach in the near future.

Most Common Acute Care Bundled Approaches

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<th>Inpatient Only</th>
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<td>Single Payment for a Hospital Admission</td>
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Background

The Centers for Medicare & Medicaid Services (CMS) that administers the Medicare program, the federal agency formerly known as the Health Care Financing Administration (HCFA), has been contemplating bundling payments as a way to curb the rate of Medicare expenditures since the early 1980s. In 1983, the DRG system was put into place, effectively limiting the payments to hospitals, but the payment system for physicians remained as a fee-for-service structure. By 1988, Coronary Artery Bypass Graft surgery was one of the most expensive procedures for the Medicare program, but the hospital costs were under control because regardless of how long the patient stayed or how much the hospital charged, Medicare was liable only for the set DRG payment with the exception of those few cases that qualified as ‘outliers.’

Although the surgeon received only one payment for the inpatient surgery and the visits, the other physicians involved in the case were paid for every service, including routine daily visits and consultations. HCFA launched the Medicare Participating Heart Bypass Center Demonstration project in 1988 to study the feasibility of paying a single negotiated price that included both hospital and physician services. The seven hospitals that participated in the study for a number of years proved that the bundled payment method was feasible.

In 2009, CMS again launched a bundled payment program called the Acute Care Episode (ACE) Demonstration. Five hospitals are still participating in this study that bundles payment for both hospital and physician services for selected orthopedic and cardiovascular procedures. The study again includes Coronary Artery Bypass Graft Surgery, along with Cardiac Valve Replacement Surgery, Cardiac Pacemaker Implantation and Replacement, Cardiac Defibrillator Implantation, Coronary Artery Angioplasty, Hip replacement, Knee replacement, and other lower extremity joint replacements. Even though the ACE project is not yet completed, some participants have already been reporting positive results from the approach.
The Bundled Payments for Care Improvement Initiative (BPCI) Program

On August 23, 2011, CMS invited hospitals and other providers to participate in one of four different models of bundling payments. The involved providers determine how payments will be allocated among participating providers. While previous bundled payment programs have focused on only hospital and physician services for acute hospital stays, under the BPCI program, post-discharge services such as skilled nursing care and home care are included in the ‘bundle.’

For the first three models, the providers of the services propose to CMS a discounted price compared to similar episodes of care from historical data. The providers of the services would be paid as usual by Medicare, but at a discount. At the end of the episode, the total payments from all providers would be compared to the agreed-upon price. Any savings would be shared by the participating providers.

In Model 1, the episode of care is defined as the inpatient stay with all DRGs included. CMS pays the hospitals at a discount from their current Medicare payment rates, while physicians are paid their usual fees under the Medicare Physician Fee Schedule. Hospitals and physicians are permitted to share gains arising from better coordination of care.

In Model 2, the episode of care includes the inpatient stay and post-acute care, ending at the applicant’s option, either a minimum of 30 or 90 days post-discharge. The hospital proposes which DRGs they wish to include in the project. This model includes physician services, post-acute care provider services, durable medical equipment, and related readmissions. In this model, traditional payments are made to all providers and suppliers, but at the end of the episode, the total payments would be compared to the agreed-upon price and any savings would be shared by the participating providers.

In Model 3, the episode of care begins at discharge from the inpatient stay, so hospitals are not eligible to participate.

The next relevant option is Model 4, under which CMS makes a single, prospectively determined bundled payment to the hospital that would encompass all services furnished during the inpatient stay by the hospital, physicians, and other practitioners. The hospital proposes which DRGs they wish to include, and the episode of care includes any related readmissions. Physicians and other practitioners submit “no-pay” claims to Medicare and are paid by the hospital out of the bundled payment amount. The hospital and the physicians choose how to split the single payment based on a previously agreed-upon calculation.

Benefits and Challenges

Whether your organization decides to participate in a bundled payment arrangement or not, Corazon recommends preparing for the possibility now. Savvy hospitals can get ready for a potential movement to bundled payments in the future, without having to completely change or modify current pay structures. Instead, hospitals should focus on areas that will have the greatest impact on reducing costs and improving quality and efficiency to make up for any potential discounted reimbursement that accompanies a bundled payment approach. For example, the list below outlines the items that hospitals will need to proactively prepare for in order to enter a bundled payment arrangement.

- Integrated Information Systems
  - EMR
  - Cost Accounting System – accurate patient-level cost data

- Detailed Cost Records
  - Equipment costs
  - Device costs
  - Drug costs

- Dedicated Team of Physicians & Hospital Staff
  - Quality Outcomes
  - Ancillary Utilization
  - Consult Utilization
  - Length of Stay

Strategies to Prepare

Undoubtedly, as payment rates decline, managing costs is increasingly important – at all levels of an organization, from the Cath Lab through all clinical (and other) departments. A global payment arrangement that includes both hospital and physician services encourages physicians to use hospital resources and any consulting physicians in a more cost effective manner. Since physicians under the current payment systems do not bear the cost of keeping patients in the ICU longer or of using the most expensive drugs, testing modalities, implantable devices, Corazon recommends that hospital managers establish creative ways to encourage more efficient physician use of hospital resources.

Before any plan can be implemented, we advise hospitals to determine the true cost of care and where resources are being ‘wasted.’ Then, once the cost analysis is complete, the hospital must then involve the physicians in process improvement initiatives. Corazon has worked with a number of hospitals that were able to trim their cath lab supply costs by meeting with physicians and encouraging them to limit the number of different types of supplies, pacemakers, and defibrillators, thereby allowing the hospital to negotiate volume discounts with vendors. Even a relatively simple change could result in thousands of dollars of savings to the bottom line.

Not just a cost-savings strategy, some organizations may consider a bundled payment arrangement as a means to capture market share. Entering into a bundled payment arrangement with an insurer may persuade that insurer to direct beneficiaries to that hospital ahead of others...Indeed, bundled payments for cath lab services could significantly increase cath lab volume and hospital profits when considered in the context of relationship-building with insurers. In this case, having a set price for high-cost, high-volume services is especially attractive to insurers, which are also seeking ways to improve margins.

Preparing for entry into a bundled payment arrangement will no doubt expose shortcomings in a hospital’s infrastructure. Even with the advent of the electronic medical record, hospitals still have difficulty reporting meaningful data from their information systems. Without such data, it becomes nearly impossible to perform an accurate analysis and calculate a reasonable bundled price.

For instance, Corazon has found that hospital systems are often unable to report all the consulting physicians involved in a patient’s care. This is a crucial piece of information should the hospital enter into a bundled payment arrangement in which the hospital is responsible for dividing the bundled payment between the hospital and all the physicians who participated in the episode of care. The hospital may eventually discover that they underestimated the payment due to the physicians, thereby reducing their own portion of the bundled payment.

Even if your organization is not prepared to offer bundled pricing today, it is no doubt beneficial to prepare for the possibility in the future. Taking the proper steps to prepare NOW for bundled payment (even in small, incremental changes) will likely expose many ways to deliver high-quality care more efficiently and effectively at a lower cost overall — a valuable effort to undertake, regardless of the payment methodology currently in use.
To Bundle or Not to Bundle?

Procedural-based cases such as cardiac artery bypass graft surgery, percutaneous coronary intervention, and defibrillator implantation are ideal for a bundled payment program because these services fit well into a defined clinical pathway. Due to the limited number of physicians involved in these cases and an industry-wide focus on standardization and proper supply cost management, the cost for the care for each patient will not vary greatly from the average within each DRG. Therefore, it is somewhat easier to predict whether the hospital can profit under a bundled payment program.

On the other hand, a bundled payment program may not be as profitable for complex medical cases where there is a lot of variation from patient to patient, as with congestive heart failure. The key for cost savings success with the HF population typically lies in preventing readmissions, along with better primary care management – which won’t largely impact a bundled payment arrangement in any positive way.

References


B. Herman: 2 Major Lessons from CMS’ Bundled Payment ACE Demonstration; Becker’s Hospital Review, April 3, 2012.

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