Bundled Payments: What Physicians Need to Know

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For OrthoTennessee in Knoxville, Tenn., the switch to bundled payments could not come soon enough. After an initial unsuccessful attempt to negotiate payment reform with BlueCross and BlueShield of Tennessee, the medical group managed to reach agreement with the plan in May 2012 to begin using a bundled payment system for total knee and hip replacements starting in the fall. The model will provide a fixed payment for the entire episode of care — from surgery to post-care to physical therapy — creating a financial incentive for the providers to deliver better care more efficiently.

"We opened dialogue because we recognize the need for new forms of payment in response to the Affordable Care Act (ACA) and we wanted the opportunity to influence some of these payment models," says Teresa Copeland, director of managed care for OrthoTennessee. "We feel there's a great incentive to have hospitals and providers work together to deliver quality care. In addition, whatever dollar amount we can save above the negotiated payment is an opportunity for gain sharing."

Bundled payments are being hailed, by many, as the most promising solution to the problem of rising healthcare costs in the United States. CMS and commercial health insurers are currently testing a variety of episode-based payment models in their quest for a reimbursement system that rewards physicians for value, rather than volume. Under the bundled approach, two or more providers receive a single payment based on the expected cost of a defined episode of care, such as a hip replacement or heart bypass surgery. The provider pool might include the physician, hospital, anesthesiologist, and rehabilitation specialist.

The idea, of course, is to motivate providers across the healthcare continuum to control costs by coordinating care, while maintaining or improving the quality of that care for patients. If the cost of delivering services is less than the negotiated bundled payment, the provider team keeps the savings. If the cost is greater, they absorb the loss. Bundled payments would replace the traditional fee-for-service model, in which providers are paid separately for each patient encounter — a system long-criticized for breeding inefficiency and fragmented care.

While sound in theory, however, the concept of bundled payments has a great many hurdles to overcome. Echoing the criticism of earlier risk-based reimbursement models, for example, some providers fear the move to bundled payments forces them to assume too much financial risk. Others suggest the infrastructure required to process bundled claims would be cost prohibitive for smaller practices. And patient advocate groups are voicing concern that cost incentives may compel physicians to limit pricey, but necessary, patient care. As healthcare stakeholders weigh in on the national debate, we explore the challenges and opportunities that bundled payments present for your practice.

First, some background. Many physicians have already tested the concept of shared risk contracting via capitation: a payment model introduced in the 1980s in which doctors were paid a fixed rate per patient, regardless of how much care that patient received. Capitation, however, was never fully embraced by providers who felt it penalized them for treating patients who required expensive therapies — and put them on the hook for the majority of financial risk.
Another attempt at reimbursement reform, shared-savings programs, rewards providers who deliver care to a defined patient population for less than the projected cost, by allowing them to receive a percentage of the savings. Some models require practices that exceed their projected cost of care to pay a portion of the difference. Others do not. The chief complaint of shared savings initiatives is that the provider groups that gain the most from such arrangements are those that generate the most operational waste. Practices and hospitals that already emphasize efficiency have less opportunity to benefit from such cuts.

Bundled payments seek to remedy those problems by enabling physicians to collect a base level of reimbursement (like fee-for-service) for the clinical episodes they select, and generate additional revenue by delivering care to those patients for less than the projected cost. The BlueCross and BlueShield of Tennessee contract also builds quality incentives into its contract, reserving a small percentage of the bundled payment for provider teams that improve patient outcomes and score well on patient satisfaction surveys.

"The difference between bundled payments and other reimbursement models is that these bundles represent a fairly small segment of total care so you can really focus in and analyze to a greater degree what risk is involved in that episode," says Jeffrey B. Milburn, a consultant with the Medical Group Management Association Health Care Consulting Group.

Nationally, a number of pilot programs are underway to address some of the lingering questions over bundled payments and create a blueprint for implementation. They include the Health Care Incentives Improvement Institute's PROMETHEUS Payment project, and the multi-payer, multi-hospital demonstration of episode-based payment being conducted in California by Integrated Healthcare Association (IHA). But the real proving ground rests with CMS, which was authorized by the ACA to initiate a pilot program called "Bundled Payments for Care Improvement." CMS is currently working with providers to help test and develop different models of bundled payments, all of which grant doctors flexibility in selecting conditions to bundle, developing the healthcare delivery structure, and determining how payments will be divvied up among participating providers.

Advocates of bundled payments insist the system is a win for payers, providers, and patients alike. When providers collaborate clinically, supporters say, they are less likely to deliver unnecessary care, authorize duplicate tests, or let post-operative care slide, which can lead to preventable readmissions. Thus, they argue, the cost savings derived from bundled payments stem from wringing inefficiency out of the system, not denying patients the care they need. Just how much does the healthcare system stand to save? The Congressional Budget Office projects that bundling hospital and post-acute care for Medicare patients alone would reduce federal outlays by almost $19 billion over the period from 2010 to 2019 (see http://bit.ly/CBObundling).

Reimbursement mechanisms that bundle and fix prices also provide patients with previously unavailable cost and quality metrics, enabling them to make a more informed, value-based selection of a provider team, according to IHA. Under the fee-for-service regime, patients receive a trickle of bills from their doctor, hospital, and specialists for months to years after their treatment is complete.

As for providers, the primary benefit of episode-based payment models is the opportunity for enhanced revenue. It may also grant smaller practices more purchasing power with suppliers. "Physicians have a lot of impact on hospital costs so if everyone in the provider pool agrees on one type of prosthesis we can use our collective market share to secure lower rates through economies of scale," says Copeland, noting such savings would be shared by the group.

Whether that proves to be rhetoric or reality, however, remains to be seen, says Glen Stream, president of the American Academy of Family Physicians (AAFP). "For primary-care doctors, the challenge is making sure their contribution is compensated fairly when the bundle is divvied up," he says. An added challenge for family physicians, he notes, is that compensation is based on relative value units (RVUs), which the AAFP believes has long undervalued their services. Under a bundled payment system, Stream says, the successful management of financial risk hinges largely on the initial medical evaluation and follow-up treatment provided by a primary-care doctor.

Milburn agrees that bundled payments may not lift all boats. "The problem is that costs are not entirely under the physician's control," he says. "You've got a number of different providers participating in the
bundle, and if any one of them fails to control costs that impacts the risk to everyone.” Take facility fees. Some hospitals run a highly efficient operating room that can complete a procedure in one hour to two hours, while others take twice as long. "The idea of bundled reimbursement sounds good, but the complexity of putting different providers together and trying to anticipate costs is going to take a lot of hard work," says Milburn.

If you're contemplating a switch from fee-for-service to bundled reimbursement, either by choice or payer request, you'll need to get your ducks in a row to ensure its success — and protect your practice against loss. For starters, the AMA suggests physicians familiarize themselves with the minutia on how each episode of care is defined, what services are included in the bundle, how the bundled payment is calculated, the duration of each episode, and how the bundled payment will be divided among the various participants in the group. Some insurers pay a single entity, like a hospital or accountable care organization, and allow them to apportion the payment among the providers. In a concept known as "virtual bundling," other insurers pay each individual physician separately and adjust that payment based on the negotiated contract.

In the interest of due diligence, you should also identify every provider who is participating in the bundle and get it in writing what percentage of the bundle your service represents. "If you aren't organized it's a huge risk and it's doomed to fail," says Peggy Crabtree, vice president of The Camden Group, a practice-management consulting firm in Los Angeles. "Practices would lose out financially and it would also impact patient care." Indeed, she says, providers considering a bundled arrangement should decide together what services deliver the most value to patients, including any laboratory or diagnostic tests, the number of visits per episode, and the type of follow-up care that patients will need post discharge to prevent complications. "We want to ensure we do what the patient needs in the most appropriate setting, not do less," says Crabtree.

From an operational standpoint, you must also analyze your claims history, so you can identify episodes of care that make the most sense to bundle, which may include procedures with reliable outcomes or the least amount of cost variability. "Look at your claims history for the last 12- to 24-month period so there's enough volume to evaluate what your costs have been in the past for an episode of care," says Crabtree. Here's where smaller practices may be at a disadvantage, says Stream, as they may lack the level of management expertise found at larger networks.

Of course, you'll need to evaluate your existing processes and screen for opportunities to add value, while maintaining or improving patient outcomes. That may include prepping patients better on the front end for surgery, or using patient education tools and follow-up appointments to minimize complications. There is often the most opportunity for cost savings in post-acute care, says Crabtree. "Typically, when patients are discharged from the hospital they fall through the cracks," she says. "You want to establish a very organized evidence-based protocol for patients to follow after a hospitalization so they keep their follow-up appointments and prevent readmission. You reduce costs by managing the patients in that bundle."

Lastly, your contract with the payer should include a stop-loss provision in the event one of your patients experiences a catastrophic event that causes you to exceed your costs by a significant margin, says Taylor Moorehead, a regional partner with revenue cycle management company Zotec Partners, based in Carmel, Ind. "You have to build in an adjustment mechanism of, say, 5 percent, into the contract," he says. "If your costs go outside that range you want to see an adjustment for downside protection."

Milburn suggests practices that are considering a move to bundled payments "get their feet wet" by selecting one or two cases for bundled payments and performing a test run. If possible, sign a six-month contract with your insurer to see how it works, he says, "but make sure you have an escape clause." Above all else, though, remember that your practice holds the most cards during the negotiation process, says Moorehead. "Before signing, you need to have your eyes wide open and build a contract that makes you feel protected," he says. "The negotiation process is really the only point where you have any leverage. Once the contract is in place, if you realize, 'Uh oh, I should have done it differently,' you're hosed."

As health plans seek to align incentives across the healthcare system for better patient outcomes and increased cost control, practices need to prep their business models for the inevitable shift toward risk-
based reimbursement. Bundled payments, in particular, may create growth opportunities for physicians who project costs accurately and manage future risk. But don’t rush in until you’ve carefully considered the pros and cons. "Practices really need to exercise caution," says Stream. "Each practice is going to have to do a careful business analysis of the potential upside and downside of bundled payments."

**In Summary**
Before you bundle, here are some key considerations for your medical practice:

- Bundled payments reimburse a team of providers a single payment for a defined episode of care.
- Episode-based payment models reward for value, rather than volume.
- Practices benefit from the opportunity for gain sharing and from better purchasing power with suppliers.
- Smaller practices may lack the management expertise to analyze prior claims, necessary to negotiate fair compensation.
- Practices can protect themselves by building in a stop-loss provision

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