Implementing Bundled Payments for Health Care Services

Co-Sponsored by Aetna Inc.

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Conference Report
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*The Health Industry Forum* is based at Brandeis University, chaired by Professor Stuart Altman, and directed by Robert Mechanic. The Forum brings together public policy experts and senior executives from leading healthcare organizations to address challenging health policy issues. The Forum conducts independent, objective policy analysis and provides neutral venues where stakeholders work together to develop practical, actionable strategies to improve the quality and value of the US healthcare system.

Conference presentations and other background materials are available at [www.healthindustryforum.org](http://www.healthindustryforum.org).

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Key Themes

Overview

Fee-for-service reimbursement has helped sustain a fragmented, inefficient health care delivery system. Instead of paying providers based on the volume of services, reimbursement systems need to reward quality, efficiency, care coordination, and value. Episode payments reimburse a set fee for all medical services associated with defined episodes of care, and are a potentially important step towards more systematic payment reform.

Although relatively few providers or health plans currently use episode payments, an expanding number of pilot programs are testing this approach. Episode payments have potential appeal for providers if they are designed based on the services specified in evidence-based guidelines, and if providers have opportunities to increase margins by reducing rates of avoidable complications. There are still significant barriers to widespread adoption of episode payments, particularly provider readiness and the administrative complexity of these systems. Nevertheless, lessons learned from these early pilots will provide valuable guidance for implementing future payment system changes.

Context

On April 29, 2009, the Health Industry Forum gathered leading policy analysts, industry executives, healthcare practitioners, and federal officials to discuss practical considerations for implementing episode-based payment models. Through case studies of insurers and provider systems experimenting with episode payments, participants examined opportunities and challenges of these approaches. Participants also discussed options for establishing episode payments under Medicare, and discussed the role of payment reform in driving meaningful delivery system reform.

Key Themes

• **Episode-based payments are a promising approach for improving provider incentives for efficiency, quality and care coordination.**

  Fee-for-service payment rewards volume with no incentive for quality, efficiency, or care coordination. New payment systems that focus on quality and value are needed to drive the delivery system towards greater efficiency and more integration. Episode payments represent one important strategy for moving towards these objectives.

  Episode payment systems reimburse for all relevant services provided during a defined episode of care by consolidating payments for multiple categories of service into a single fee. For example, an episode payment might encompass a hospitalization, physician care, post-acute services, and any re-admissions for a surgical procedure like a knee replacement. Episode payments are potentially attractive to payers because they contain strong incentives for providers to increase efficiency, coordinate care, and reduce preventable complications. They are also potentially attractive to providers because they create opportunities for providers to increase margins by improving quality and reducing preventable complications.

  • **Early-adopting health systems and plans are testing new episode-based payment models.**

    Although there are no large-scale examples of episode payments, several pilot projects are now underway. Some providers like Geisinger Health System bundle hospital inpatient payments with physician fees for surgical procedures including the costs of complications and readmissions. Groups like PROMETHEUS and Fairview Health Services are also developing bundled payments for chronic conditions that would encompass all the primary and specialty care required to treat patients with CHF or diabetes over the course of a year.

    These pilot programs are beginning to validate the feasibility of episode payments in real-world settings. They have answered key questions in translating the theoretical concept of bundled payment to realistic payment policy, and demonstrate the kinds of episodes that can be bundled, the ways in which reimbursement rates are set, and the methods to compensate the multiple providers that contributed to a patient's care within the episode.

  • **Bundled payment systems must overcome significant operational hurdles prior to widespread adoption.**

    Broader adoption will probably require industry standards that create common episode definitions. Episode payments also will require credible risk adjustment; otherwise physicians and hospitals will have strong incentives to avoid more complex patients. Providers will also need to track the services their patients receive in close to real time in order to manage them effectively under episode payments. Better health information systems and episode-focused quality measures will help facilitate this process.

    Critics of episode payments argue that providers still have strong incentives to increase volume, and that these incentives may even be increased by aligning the interests of hospitals and physicians. Appropriateness criteria are needed to guard against over-utilization.

  • **Most health plans are cautious about episode payments because of potential administrative costs and concerns about provider and consumer acceptance.**

    Although health plans are interested in the concept of episode payments, they express concern about the viability and scalability of these systems. Insurer claim systems are designed for fee-for-service. Under global capitation, health plans can pay FFS for individual services and reconciling payments against a global budget at the end of the year. In contrast, procedure-based episode payments (like the care of all services associated with a hip or knee replacement) are more challenging because claims systems must determine which services are bundled into episodes and which are paid separately through FFS. While not
impossible, these programming changes are expensive and time-consuming. Payers are reluctant to invest in major system changes unless they are confident that episode payment systems can deliver value and can be brought into widespread use.

Even if they wanted to implement episode payments broadly, most payers would find it impossible to do so without significant local market share. In markets where payers control less than 10 or 15 percent of individual hospital or physicians’ market share, they will have difficulty finding interested providers. Enrolling physician practices into a new approach requires significant education and training at the practice level in each market. Moreover, many providers currently lack the technical infrastructure, clinical pathways, and care coordination tools to prosper under episode payments.

Consumers may also resist bundled or capitated payment if these changes limit their choice of providers. As physicians and hospitals integrate care, they are likely to develop semi-exclusive partnerships. For example, hospitals may align with specific skilled-nursing and rehabilitation facilities, limiting a patient’s choice to specific organizations that may not be their preferred option. Employers and other healthcare leaders will need to play a role in educating consumers and explaining the tradeoffs.

**Medicare could be a catalyst for expanded use of episode payment, but “one-size-fits-all” approaches are problematic.**

Because of its size, Medicare implementation of episode payments will affect the landscape for private payers and providers. Bundled payment approaches are not new to Medicare. It has successfully implemented prospective payment for inpatient stays, home health visits, and renal dialysis. However, national implementation of episode payments under Medicare will be difficult. While some markets and select accountable care organizations may be able to quickly adapt to episode payments, much of the delivery system remains highly fragmented and is likely to oppose these reforms. Another option for Medicare would be to implement a series of voluntary pilot programs with the ability to rapidly expand the programs as they demonstrate positive outcomes.

Yet, the prospect for the successful implementation of episode payments is buttressed by a common motivation for change. All Forum participants agreed that the current inflationary fee-for-service system is a “burning platform” that is unsustainable. The level of interest and sense of urgency is high. Episode payments have the potential to improve efficiency, increase quality, and improve margins for providers who are able to reduce complication rates. As such, episode-based payment systems offer a promising new model, whose continued adoption must be monitored carefully to ensure success.
Overview

There is growing interest in the concept of episode-based payment as a mechanism for driving beneficial delivery system changes. Payment for an episode would focus providers on reducing complications, coordinating care, and managing spending across the continuum of care. But episode payments face significant implementation challenges. These include a lack of standardized definitions, limited provider care coordination infrastructure, and the significant cost of overhauling claims payment systems. Physicians and hospitals must develop capabilities to better coordinate care and determine ways to divide the bundled payment across a fragmented delivery system. Migrating to this approach will require a concerted, sustained effort of pioneering payers, providers, and employers.

Context

Mr. de Brantes described the PROMETHEUS payment system and its approach for developing evidence-informed case rates. He also addressed common “myths” about episode-based payment. Ms. Peters and Mr. Stapleton, representing major insurers, shared their perspectives on bundled payment.

Key Takeaways (de Brantes)

- **PROMETHEUS payment has been designed to be practical and feasible for a range of health care organizations - not just integrated systems.**

  Mr. de Brantes outlined the principles and objectives that guided the development of PROMETHEUS payment.

  - **Payment incentives must drive delivery system reform.** Too often, desired changes in care delivery are obstructed because they are not supported by necessary reimbursement changes. To make progress, policymakers must first realign payment to create incentives for delivery system change.

    “First change payment and incentives; then change the delivery system.”

    — Francois de Brantes

  - **Tie effectiveness to efficiency.** Effectiveness and efficiency are linked; it is possible to achieve both better quality and lower costs by reducing preventable complications, which in any other industry would be labeled “defects”.

  - **Help providers improve their margins.** Providers need incentives that foster continuous improvement in care delivery. These incentives should come in the form of improved margins. Physicians and hospitals that provide higher quality and more efficient care should be paid more, as is not often the case under fee-for-service reimbursement.

    — **Encourage team-based care.** Changing the delivery system doesn’t require consolidation. Under PROMETHEUS, it isn’t necessary (nor is it practical in many communities) for care to be delivered by integrated organizations. Rather physicians, hospitals, and other healthcare providers must work more closely to deliver coordinated care. With improved information technology, this is increasingly possible without consolidation.

    — **Don’t unduly disrupt current operations.** Migration to a new delivery system won’t happen overnight. During this migration, it is important to ensure that there are not major disruptions in provider revenues.

- **“Evidence-informed case rates” hold providers accountable for potentially avoidable complications.**

  PROMETHEUS has developed a model for episode payments based on dissecting historical episode costs into two major categories:

  - **Costs of base care.** These include the costs of all necessary care (physician visits, prescriptions, lab tests, imaging, etc.) over the course of an episode based on established clinical guidelines. In PROMETHEUS, the overall bundle includes the full costs of base treatment, risk adjusted for the patient’s severity of illness.

  - **Costs of potentially avoidable complications (PACs).** Complications are expensive and there is significant variation in costs due to errors, oversights, and failure to utilize evidence-based guidelines across providers. Recognizing that some complications are not in the control of treating physicians, and that it is impossible to avoid all complications, the price of each episode includes half of the statistical cost of PACs (though the percentage can be varied for individual contracts). Thus, Prometheus seeks to hold delivery systems accountable for reducing PACs and their associated costs.

    “We have to hold the delivery system accountable for potentially avoidable complications.”

    — Francois de Brantes

The model assumes cost savings in two ways. First, it assumes that providers will reduce potentially avoidable complications. If these defects could be reduced to zero, the US healthcare system could save $500 billion annually. Second, episode payment provides incentives to continually improve care; the more effectively a physician manages the patient and reduces PACs, the more money she can make.
Implementing Bundled Payments

Mr. de Brantes described and then refuted commonly-held assumptions about bundled payment.

— Myth #1: Episodes can only be used for procedures or acute events. Mr. de Brantes contends that "episodes" can encompass acute events, procedures, and chronic care. Traditionally episodes centered on procedures like hip or knee replacement and payment included pre-admission testing, hospitalization, surgery, and post-discharge rehabilitation and follow-up care. But increasingly, episodes are also being developed for chronic conditions, such as all primary and specialty care required to treat a CHF patient over a defined time period.

Different episodes have different triggers and different time windows. In PROMETHEUS, an acute episode like a stroke or heart attack is triggered by a hospital admission and includes the admission cost plus all related care provided 3 days prior to and 30 days following a hospitalization. In comparison, non-urgent, procedure-based episodes, such as CABG, hernia repair, or bariatric surgery, cover the period 30 days prior to and 180 days after the procedure. Chronic care for conditions like asthma, diabetes, or COPD, typically include all related care provided over an entire year and are renewed annually.

— Myth #2: Episodes have to be priced the same for all patients. Pricing patients the same encourages cherry picking. Episodes must be severity adjusted and budgeted at the patient level, which can significantly impact the final dollar figure. Mr. de Brantes demonstrated how the price for treating a CHF patient could range from $7,000 to $41,400 annually.

— Myth #3: You need Accountable Care Organizations (ACO). Mr. de Brantes argued that ACOs are only needed if episodes are paid for prospectively. However, it is possible to prospectively budget for an episode, but pay providers on a fee-for-service basis. At the end of the episode, the insurer can retrospectively reconcile the budget with actual payments. For example, a diabetic patient might see a PCP, a nephrologist, a cardiologist, and an ophthalmologist over the course of an episode. If these doctors are not contractually linked, each physician can bill the insurer under FFS arrangements (potentially using withholds). Year-end surpluses or shortfalls can be reconciled at the end of the episode based on the proportion of care delivered. The key message: episode of care payment is not synonymous with prospective payment. In addition, complicated legal agreements aren’t necessary to divvy up the rewards. All that is needed is a formula for sharing the surplus.

Mr. de Brantes emphasized that the PROMETHEUS model is more than just a blueprint or academic ideal; the organization is now working with payers and provider groups to implement the model in several pilot sites.

Key Takeaways (Peters and Stapleton)

— Two of the nation’s largest payers support the concept of episode-based payment. Representatives from Aetna and UnitedHealthcare expressed general support for the concept of episode-based payment. For many years both organizations have employed episode-based thinking for transplants. Mr. Stapleton commented that he likes the verticalness and disease focus of episode-based payment.

Ms. Peters said Aetna has analyzed provider performance around episodes to help it select specialists for its contracted networks. Among the reasons she supports PROMETHEUS: it is extremely consumer focused as providers are incented to do the right things in the right way; it demands meaningful communication between providers; it will drive adoption of health IT; it rewards value and not volume; and it fits with the medical home concept.

— Insurers emphasized that there are significant challenges to implementing episode-based payments on a large scale. Payer representatives raised a number of issues that must be addressed for episode payments to expand beyond the pilot testing. Among them:

— Industry standards. It is critically important to characterize episodes consistently, both in terms of time frames and services covered. Evidence-based industry standards are needed that define episodes along with associated quality measures.

— Scalability. Many providers, especially those in small practices, are not ready to accept episode-based payments. They lack the clinical pathways, technical infrastructure, and coordination capabilities to manage prospective episode payments. This is particularly true where multiple providers interact with a patient. Scaling episode-based payment in today's highly-fragmented delivery system is extremely challenging. For this reason it may make sense to start episode-based payment in specific markets and provider groups that can support it.

— Claims administration. Administering episode claims will be complex. Payers will have to continue to maintain a fee-for-service payment system while also administering episode payments - a complicated (but not impossible) task.

Participant Discussion

— Consensus on the need for payment reform. An informal poll of meeting participants found that nearly all attending this meeting agreed with the statement, “No serious delivery system reform will occur unless payment reform proceeds it.” Those who disagreed held the view that payment and delivery reform need to occur simultaneously.

— Concern about getting it right. Some participants expressed skepticism that policymakers could implement comprehensive payment system reforms and “get it right.” These individuals expressed the view that continued
experimentation is needed across a wide range of payment systems and provider settings.

- **Incentive for change.** In the absence of a strong governing entity and with no assurances of a surplus to share, providers could simply continue to operate in a fee-for-service system as they always have. If there is no credible threat to the existing payment system, many providers will resist change. Mr. de Brantes commented that an incremental step could be to continue to use fee-for-service, but withhold a certain proportion of each reimbursement. Funds that were withheld could be used as part of reconciliation payment for providers with strong performance. Participants commented that such a policy would be considered aggressive, and would be very difficult to implement in practical terms, especially when Medicare is involved.

For providers, if each payer represents only a small portion of their revenue, and if each payer has a different episode payment model, there will not be enough critical mass to get providers to change care delivery. One participant stressed the need to define “where you want to go”, and to then provide a glide path for getting there.

- **Flexible versus uniform payment systems.** A question was raised about whether payers should have flexible payment systems that allow providers to participate based on their capabilities, or if they should impose a uniform payment system. Stuart Altman suggested that it may make sense to afford greater flexibility in the short term, but a consistent approach is probably desirable in the longer term.

- **No scrutiny on “appropriateness.”** While PROMETHEUS aims to reduce potentially avoidable complications, it doesn’t deal with the appropriateness (or lack of appropriateness) of certain episodes. For example, an episode payment for knee replacement does not address whether the procedure was necessary or appropriate in the first place.

- **Gaming the system.** Many are concerned about potential gaming with a new payment system. Because they share the gains of less-expensive care, it could focus providers on cost savings without necessarily reducing PACs. This would help lower costs but wouldn’t decrease defects. While this kind of gaming might be acceptable to reduce costs, Mr. de Brantes suggested that gain sharing will ultimately be tied to decreasing defects.

- **Emphasis on data needs.** Representatives from the insurance industry stressed that timely information is critical to make these programs a success. Most physicians do not have real time data indicating the services other doctors are providing or recommending for their patients. In order to manage episodes, physicians will need near real time reports about necessary, unnecessary and omitted care. Insurers are often the only central resource for this information and can support effective patient management by sharing data. Furthermore, payers can generate data to help physicians (and providers in their virtual care team) are performing compare with others in the area.

- **Creating episode definitions.** In response to questions about standardizing the services covered within episodes, Mr. de Brantes estimated that a government initiative to define about 400 episodes could be created in 12 to 18 months for three to five million dollars. Then, they could be made public, and all payers could use them like DRGs.
Overview
Forward-thinking providers believe that the fee-for-service era is drawing to a close. Future payment models will reward value and outcomes rather than volume. This is leading providers to experiment with episode-based payment and global capitation. They believe that experimenting with new payment models will help them modify organizational incentives, physician-hospital alignment, culture, and ultimately improve care delivery. However, organizational capabilities differ across providers, and participants emphasized that there are no one-size-fits-all solutions.

Context
In this panel providers from across the country described their initial experiences with bundled payments.

Key Takeaways (Zucker and Martin)
Mr. Zucker described Baptist Health System's participation in CMS's Acute Care Episode (ACE) Demonstration Project, which will begin June 1, 2009. Baptist Health System, a vertically and horizontally integrated health system in San Antonio, has five acute care hospitals, and is part of the 15-hospital Vanguard Health Systems.

- **Participation in the ACE demonstration has helped the Baptist system align financial incentives and care coordination between the hospital and its surgeons.**
  
  Under the ACE demonstration, Baptist is paid a single rate for hospital and physician care provided during the hospitalization for 28 cardiac DRGs and 9 orthopedic DRGs based on bids it set forth in its application. Under the demonstration, the system is able to share financial gains from savings with its physicians.

  The hospital decided to carry all the financial risk under ACE and “keep the physicians whole.” This means surgeons are paid the same as they would have been previously from CMS. However, the physicians receive a significant portion of any gains realized from more efficient practices. This upside potential got physicians’ attention, and helped align physician and hospital efforts to improve efficiency.

- **Gainsharing has focused physicians on reducing costs through product standardization and improved care processes.**
  
  For years Baptist had tried unsuccessfully to get surgeons to agree upon a limited set of standard implants. Once physicians were able to share in the savings—and saw that savings could be significant—they drove the standardization process, which has improved margins for Medicare and non-Medicare patients alike. Baptist has used this demonstration project as a way to create better relationships with local cardiologists and orthopedists.

  Mr. Zucker emphasized that it is important to enlist physicians in negotiating how any surplus will be divided, and to develop quality metrics. Physician involvement is critical for their participation and ownership of the program. He is optimistic that the cultural changes and alignment of incentives that ACE is bringing about will extend broadly.

Key Takeaways (Carroll and Valdivia)
Dr. Carroll and Dr. Valdivia described financial and economic pressures affecting health care systems in Minnesota and actions being taken by government, providers, and employers to implement new payment models and develop more efficient delivery models.

- **Healthcare stakeholders in Minneapolis/ St. Paul have formed a Healthcare Innovation Initiative to build capabilities for a new delivery model.**
  
  In Minnesota, the recession has created an untenable state budget shortfall and the governor has proposed substantial cuts in Medicaid reimbursement. Employers are also suffering from high health care costs despite Minnesota’s reputation as a low-cost state. State government, major payers, health systems, and employers, have concluded that the current activity-based, fee-for-service model has run its course and that future reimbursement must evolve towards global payment. However, navigating the transition process will be challenging.

- **Episode-based payment is a necessary step on the road to global payment.**
  
  Carol, Inc. has worked with several of Minnesota’s largest self-insured employers to develop more than 50 “care packages” for diabetes, asthma, coronary artery disease, and chronic back pain. Individual provider group have define their own “bundles” including the specific services provided, outcomes measures, and price.

  Employers and patients can then use online tools to “buy” a package that best fits their needs. Patients take the time to learn about these care packages and review independent measures of quality for the different providers. Experience to date has shown that what consumers care most about what services are included in each package, rather than the overall price.

  Working with Carol, Fairview Health Services will be operationalizing ten care packages by the end of September 2009. Fairview
will incorporate gainshare contracts with physicians, an outcomes-based compensation model, and an outcomes-centric technology platform.

This effort allows Fairview to get started now and to begin capturing the financial value associated with quality and efficiency improvements. It delivers value to employers in the near term and doesn't disrupt the current fee-for-service model, but prepares Fairview for future reimbursement changes.

Key Takeaways (Zane)

Ms. Zane discussed Tuft’s Medical Center’s decision to enter into a new “Alternative Quality Contract” (AQC) with Blue Cross Blue Shield of Massachusetts (BCBSMA).

- Payment reform will require multiple strategies to match the needs and abilities of different markets.
  
  Many health care policymakers are trying to develop a single payment methodology to replace fee-for-service. Ms. Zane believes that this is a naive and uninformed perspective, and that no “one-size-fits-all” solution will work given the diversity of the provider community. A range of experiments are needed to develop experience with different approaches. A long-term solution will require dedication among all payers and providers to sustainable change.

  “There is not a quick fix and there is no one-size-fits-all silver bullet. What we need is a thoughtful transition.”
  — Ellen Zane

- Tufts Medical Center and BCBSMA are making a big bet on a new payment model to replace the inflationary fee-for-service system.
  
  Earlier this year Tufts Medical Center became the first academic medical center in Massachusetts to enter into the AQC—a new kind of managed care contract that is essentially “budget-based capitation on steroids.” However, the AQC has been designed to avoid many of capitation’s earlier mistakes by:

  - Emphasizing quality. There are significant financial incentives to improve quality along 32 measures. The contract’s emphasis on quality gives providers strong incentives to do the right thing for patients, as opposed to a traditional capitation that theoretically created incentives for undertreatment. As part of this contract, BCBSMA will make significant infrastructure funding available to enable Tufts to design programs that will assist physicians in meeting the quality targets. The quality measures are fixed over the period of the contract – rather than as “moving targets.” Real improvement will result in considerable rewards.

  - Adjusting for risk. To prevent cherry picking AQC is health-status adjusted. AQC isn’t perfect, but it aims to prevent gaming by providers, which is especially important for Tufts high-acuity enrollees.

  - Providing data to monitor the program. BCBSMA has committed to providing Tufts with extensive data to monitor the program. Since the contract has been signed, the amount of cooperation and data sharing has been extensive.

  - Changing attitudes around wellness. Money to keep patients well is intended to shift the mindset of providers from “more treatment is better” to “appropriate treatment is better.” The expectation is that this contract will decrease overuse and misuse.

  - While the AQC represents the compelling start of a long-term strategy, it must be flexible to overcome challenges as they arise.

  Recognizing existing fee-for-service reimbursement as a “burning platform”, Tufts views ACQ as a strong first step. It recognizes that there will be bumps along the road. Some of the issues that have been flagged include:

  - Declining HMO enrollment. Currently, the ACQ applies only to BCBSMA’s HMO product, which is declining in popularity. While the PPO market is growing, there is currently no accepted way of connecting global payment to these members. This situation highlights the fact that consumers prefer open-architecture products with out-of-network benefits, while the business community seems unwilling to talk with employees about the tradeoffs between cost and freedom of choice.

  - Penalizing efficient providers. The AQC bases its first year global payments on historic levels. While this makes many provider groups more willing to contract (i.e., the AQC focuses on trend rather than baseline spending), it also essentially rewards high-cost providers and penalizes those with lower costs and may cement inefficiencies in the system. Some balancing and redistribution based on performance over time is needed.

  - Locus of control at the margins. While providers only want to be at-risk for what they control, financial incentives for teamwork and integration are necessary. Bundled payments and global capitation create a motivation for referring to a network of efficient specialists. However, this may be challenged by patients who want to decide which doctors to see. More extensive integration is also needed, moving away from solo and small practice environments, but these transitions will take time.

  - Transferring risk from payers to providers. Payment methods that shift financial risk from payers to providers raises questions about the proper use of insurer financial reserves, and whether these reserves should be available to protect community providers. In addition, forcing providers to purchase reinsurance from their global capitation funds strikes Ms. Zane as unfair “double dipping.” Finally, the products designed and offered by payers must enable global payment to work; providers must have a seat at the product design table, striking a balance between unlimited patient access and ability to control cost.
Participant Discussion

- **Capitation free-rider effect.** As providers enter into episode-based payment schemes and global capitation for BSBS-MA patients, it is likely that the changes that result will lower the costs and improve the quality of care for other patients that Tufts treats as well. Ms. Zane believes that changes made for one insurer will prepare them to work with others when fee-for-service payments become untenable.

- **Post-acute bundling.** The savings opportunities discussed as part of the ACE demonstration project all relate to improved purchasing practices during the hospitalization. Because the payment is only for the admission, ACE sites have no additional incentive to manage post-acute care or prevent readmissions. Mr. Zucker envisions the ACE project as an incremental step toward greater bundling of care and envisions the next phase to include 30 days post-discharge, including re-admissions.

- **Appropriateness of care.** The focus on episode-based payment assumes that there are “appropriateness” indicators for specific treatments and a process for ensuring that patients want the treatment. However, these are lacking for many episodes. Thus a major concern is that the payment structure has no explicit protections against unnecessary episodes.

- **Social issues.** Episode payment will focus attention on creating a more efficient healthcare delivery system, but may overlook other avenues for improvement. For example, the fact that a significant portion of all health care spending takes place in the last year of life (often in the last days of life) is largely a cultural issue that episode-based payment cannot address. Cultural and social interventions, like social media, should not be overlooked.
Is Medicare Ready for Bundled Payments?

Moderator: Stuart Atman Ph.D., Professor, Brandeis University
Panelists: Keith Fontenot, Associate Director for Health Programs, Office of Management and Budget
Robert Reischauer Ph.D., President, Urban Institute
Robert Berenson, M.D., Institute Fellow, Urban Institute

Overview

Episode payments are part of the Administration's proposed Medicare budget and interest is high regarding their long-term potential. But before fully embracing bundled payments, many critical questions need to be addressed and decisions made.

Context

Mr. Fontenot described the Administration’s proposal for episode payments in Medicare. Dr. Reischauer laid out critical questions related to episode payments that need to be addressed, and Dr. Berenson shared his perspective on why episode payments may be the wrong direction.

Key Takeaways (Fontenot)

Mr. Fontenot outlined the Administration’s view of episode payments, discussed the goals of episode payments, and talked about the future role of episode payments.

- Episode payments are an important element of the Administration’s current budget with a focus on bundling hospital and post-discharge services.
  
  The current budget includes about $300 billion in Medicare savings proposals over the next ten years. Its episode payment proposal is projected to save $1 billion over the next five years and $18 billion over the next ten years. The Administration defines episode payment as a single payment to a provider or multiple providers for an array of services related to one episode of care. Most of the government's attention has focused on expanding the DRG payment to include post-hospital services. Proposed episodes would include both the acute care received in a hospital and post-acute care following discharge.

- Episode payments are part of the Administration’s overall goal of reducing readmissions and rationalizing post-acute care.
  
  Data showing a 19% readmission rate for Medicare beneficiaries has led the Administration to propose testing episode payments for select conditions. The Administration believes that episode payments provide incentives for better discharge planning and for choosing more efficient post-discharge care settings. He emphasizes that the Administration’s interest in episode payments is high and believes they will increase collaboration, improve quality, and create greater transparency and cost savings.

Key Takeaways (Reischauer)

- Key questions must be addressed and decisions made before Medicare can proceed with episode payments.
  
  Dr. Reischauer raised eleven critical questions about episode payments that must be addressed before Medicare can move with this concept. He emphasized that these questions do not have right or wrong answers.

  “Moving to episode payments will not be easy. A lot of difficult decisions will have to be made which will engender pushback from providers and patients. Ultimately this will end up in front of Congress.”

  —Robert Reischauer

1. How should episode payments be characterized to Congress, the public, and providers? How episode payments are portrayed will affect the acceptability and the degree of opposition. For example, are episode payments positioned as an incremental step along the path started with DRGs or are they a revolutionary step to transform the delivery system?

2. What is the primary public policy objective of bundling? Is it to improve quality, enhance efficiency, or reduce costs? Should episode-based payment be used to reorganize the delivery system or develop clearer lines of accountability? Advocates of episode payments will say that these are all objectives. But these objectives have tradeoffs and decisions need to be made about what to emphasize in the short and long term.

3. How inclusive should episodes be? An episode could include hospital fees, physician fees during the hospitalization, physician fees for a period after discharge, and a host of possible outpatient services. Defining the breadth of services in each episode will be critical.

4. How long should the episode be? It could be a hospital stay plus two weeks, 30 days, or 60 days. Perhaps the length of the episode should vary based on the DRG, with longer episode lengths for chronic conditions.

5. How many and which DRGs should receive episode payments? Medicare data document the need to address readmissions and post-acute care, especially among selected conditions. Should these DRGs be targeted first,
and how should these policies evolve over time? There will be a fundamental tension between the flexibility and simplicity of Medicare regulations.

6. Should Medicare’s episode payments program be voluntary or mandatory? There are huge differences in provider circumstances, capabilities, and attitudes regarding episode payments. A voluntary program (which is favored by MedPAC) would have less resistance but would produce fewer savings.

7. How should the initial payment level be set? (and how should this level change over time?) An option put forward by the CBO would set the payment at the hospital DRG rate plus the average post-acute spending for the DRG. But post-acute rates vary across the country and using average costs to set rates would give some providers huge windfalls and cause others to struggle.

8. Who should get the episode payment and how should it be divided? Should the hospital receive and then divide up the payment? Should new entities be created to receive and allocate payment? This could cause a shift in power and would be highly divisive.

9. Is our ability to measure the quality of care during an episode up to task? Measuring quality across an entire episode is complicated and isn’t yet occurring. Are our risk-adjustment tools sufficient to prevent cherry picking? It will be difficult to adjust episode payments if a patient develops a comorbidity during the episode.

10. How would a episode payment approach fit with medical homes and accountable care organizations? Would these concepts fit well together or undermine each other?

11. How will patients react to the changes that episode payments would bring in the delivery system? Medicare beneficiaries (and their elected representatives) may resist reform due to the unavoidable reduction in patients’ ability to choose their providers. As hospitals and post-acute facilities align and coordinate care under episode payments, patients are likely to see restrictions on their choice of rehabilitation or skilled nursing facility. True reform can not happen until employers and government are willing to put the financial consequences of open access on beneficiaries.

Mr. Reischauer emphasized that given the cautious nature of CMS, payment system changes may be slow and incremental.

Key Takeaways (Berenson)

Dr. Berenson expressed a contrarian view on episode payments.

- **Episode payments may not move the health care system in the right direction.**
  
  Most people agree it is desirable for health care delivery to evolve from solo practitioners to multi-specialty group practices and ultimately to integrated delivery systems. However, Dr. Berenson doesn’t believe that episode payments help move the system in this direction. His issues with episode payments include:
  
  - **Proliferation of service line strategies.** Hospitals have hired doctors to develop strategies for increasing revenues along specific service lines. These strategies focus on increasing service line admissions and profitability, and to perform discretionary procedures that may not be needed. Even if payment is bundled, these hospitals will continue working to drive volume growth.
  
  - **Lack of appropriateness criteria.** Without good appropriateness criteria, the health care system will continue to be driven by number of episodes. Payment for episodes is essentially aggregated fee-for-service.
  
  - **Perpetuation of a specialist focus.** The focus on service lines and episodes is not helpful in evolving toward primary-care-oriented systems and accountable care organizations.
  
  - **An episode focus is not holistic.** Many patients have multiple chronic conditions. Yet episode payments are based on pre-defined packages for chronic conditions diabetes or CHF, potentially diminishing care coordination for the sickest Medicare beneficiaries. As Dr. Berenson notes, “By the time one aggregates chronic conditions that ‘travel together’—e.g. CHF, chronic renal failure, hypertension, diabetes—one may as well bite the bullet and call it capitation.”

- **Capitation is the right long-term payment approach and all efforts should focus on migrating toward it.**

  Dr. Berenson sees capitation using enhanced approaches including health status based risk adjustment, risk sharing, quality and patient experience reporting as the preferred long-term payment model. Instead of episode payments, which he describes as a cul-de-sac that doesn’t get us to our destination, he suggests focusing on the pathway toward capitation, albeit with a new name.

  “We just need to capitate and risk adjust. Episode payment is not a step along the way.”
  
  —Robert Berenson

Aligning incentives is important. Accountable care organizations could use episode grouping methodology internally to organize care. Gainsharing may be worthwhile, but can take place without episode payments.
Participant Discussion

- **Positives from service line strategies.** Service line strategies aren’t just about revenues and marketing. An organizational focus on specific service lines can increase quality and efficiency.

- **Forcing change.** One participant, noting the high quality of health care in low spending regions like Salt Lake City Utah, Danville Pennsylvania, and Minneapolis, suggested that the federal government set out a five-year target for high spending regions to move towards the performance of those regions. After five years, significant Medicare payment reductions would go into effect. This would give health systems significant time for change, but also a hard target if spending was not reduced.

- **Benefits from care coordination.** Bundling hospital and post-acute services will dramatically increase discharge planning. The hand-off from acute to post-acute care has been notoriously bad. New evidence has demonstrated that there are proven approaches to improving the effectiveness of post-acute care. These approaches should be developed further and incentives developed to spur their use.

- **Finding middle ground.** Many expressed during the discussion were presented as either/or options. For example, either episodes or capitation; either payment reform or delivery reform. There are many ways to move forward in the near term that represent compromises and combinations of different options.