Bundled Payments Gain Traction in Health Care

Top Ten List - Part I

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Bundled payment arrangements involving providers and payors are rapidly gaining traction in the health-care industry. Championed by the federal Center for Medicare and Medicaid Innovation (commonly known as the "Innovation Center"—a center created by the Affordable Care Act, the future of which remains uncertain), the model has also been implemented by commercial and self-funded insurance plans.

This article, divided into two parts, introduces the rationale for bundled payment reimbursement models and then lists the top ten items to consider when structuring such an arrangement. Part I discusses items 1 through 5; Part II discusses items 6 through 10.

Bundled Payment: What Is It?

A bundled payment is a single, lump-sum payment for treating a specific medical episode. Historically, under the traditional fee-for-service system, a knee replacement, for example, would generate numerous claims for payment by a variety of providers, including multiple claims from the same provider in some instances (e.g., claims for lab work, orthopedic physician professional services, radiologist professional services, radiology facility fees, hospital/ambulatory surgical center facility fees, physical therapy, etc.). Under a bundled payment system, the payor—for example, an insurance company or government program—makes a single payment, set in advance, which is distributed among providers that have agreed to be included in the bundled payment arrangement.

Why Have It?

Because provider income is not correlated with the volume of services rendered, bundled payments reverse the historical financial incentive of health-care providers to increase volume. Accordingly, bundled payments are designed lower the total cost of health-care expenditures. Additionally, improved quality of care may be a residual effect, because to be successful, health-care services must be highly integrated among various types of providers, and integration among health-care providers is believed to correlate with improved quality of care.

(See, e.g., "The Value of Provider Integration," TRENDWATCH, American Hospital Association, March 2014; Claffey, T.F., Agostini, J.V., Collet, E.N., Reisman, L. and Krakaur, R., "Payer-Provider Collaboration in Accountable Care Reduced Use and Improved Quality in Maine Medicare Advantage Plan," Health Affairs 31, No. 9: 2074-2083, 2012.)

Does It Work?

Numerous reports of demonstration projects indicate that bundled payment models can reduce the total cost of care for the conditions included in the program, such as knee replacements and coronary artery bypass grafts. (See, e.g., "Analysis of Bundled Payment," Rand Corporation, Technical Report TF-562/20, 2010.) Accordingly, the Center for Medicare and Medicaid Services (CMS) launched a Bundled Payments for Care Improvement (BPCI) initiative in 2013, which has reported savings in some areas. (See, "CMS Bundled Payments for Care Improvement (BPCI) Initiative Models: 2-4, Year 1 Evaluation & Monitoring Annual Report," Prepared for CMS by The Lewin Group, February 2015; and "CMS Bundled Payments for Care Improvement Initiative Models: 2-4, Year 2 Evaluation & Monitoring Annual Report," Prepared for CMS by The Lewin Group, August 2016.)

Caveat: Not for the Faint of Heart

The failure of a three-year, $2.9 million, multi-hospital bundled care demonstration project was attributed to administrative breakdowns and inadequate patient volume rather than health-care delivery issues and economic matters. (Ridgely, M.S., et al., "Bundled Payment Fails to Gain a Foothold in California: The Experience of the IHA Bundled Payment Demonstration," Health Affairs, 33:8, 1345-1352, Aug. 2014.) This widely reported failure provides a cautionary tale that initiating bundled payment arrangements is not for the faint of heart.

Essential Top Ten Items

1. Temporal Boundary

Agreeing on when the bundled payment period begins and ends is fundamental to any bundled payment arrangement. Once a case has been identified, the starting point can be, for example, the date of a particular lab test, or the date of hospital admission. The end point can be fixed at, say, 30, 60, 90, 180 or any other number of days from the starting point. For example, under CMS's current large-scale Comprehensive Joint Replacement bundled payment program, the

episode begins on the date of hospital admission and ends 90 days following discharge. (42 CFR 510.210(a)).

2. Exclusions

Equally important is explicitly identifying which patients and which services will be excluded. The pool of patients who may potentially be included must be clearly defined; for example, inclusion may be based on MS-DRG and/or ICD-9/10 codes, type of insurance coverage, demographics and other factors. However, it may be appropriate to exclude patients with certain co-morbidities that could skew utilization costs. Also, patients should be excluded who, during the episode period, cease coverage by the payor involved in the program.

Another cause of unintended high utilization can arise from health-care expenditures that are not intended to be captured in the bundled payment, such as hospitalizations for trauma, acute disease surgery such as appendectomy, other illness and chronic diseases unrelated to the bundle.

Whether to include prescription drugs must be considered. This is particularly important because prescription drugs account for approximately 10 percent of overall health-care spending. (Peterson-Kaiser Health System Tracker, "What are the recent and forecasted trends in prescription drug spending?" Henry K. Kaiser Family Foundation.) Curiously, the cost of prescription drugs actually increased when those costs were included in the bundle in a demonstration project involving UnitedHealthcare. (Polite, B., Ward, J.C., Cox, J.V., Morton, R.F., Hennessy, J., Page, R. and Conti, R.M., "A Pathway Through the Bundle Jungle," Journal of Oncology Practice, Vol. 12, Issue 6, June 2016, 504-509, at 506.)

3. Early Termination

Under certain circumstances, early termination of the episode is warranted, in which case billing and payment typically revert to a standard fee-for-service model. For example, under the BPCI in which hospitals mandatorily participate in a lower extremity joint replacement bundled payment model, episodes are removed from the reconciliation if: (1) patient ceases to meet inclusion criteria; (2) patient is readmitted to another participating hospital for treatment of a condition included in the BPCI program; (3) patient initiates a lower extremity joint replacement episode under the BPCI program; or (4) patient expires. (42 CFR 510.210(b)). The model may

also consider other circumstances that would terminate an episode, such as: (a) patient leaves hospital against medical advice; or (b) patient transfers to another facility.

4. Participating Providers

While it may be obvious that hospital and physician charges would be included, charges generated by other types of providers must be clearly identified, such as those by intermediate rehabilitation facilities, skilled nursing facility, home health agencies, ambulatory surgery centers, certified nurse practitioners, physician assistants, physical therapists, occupational therapists, dieticians, clinical social workers and others. (For example, see 42 CFR 510.2 for definitions of "CJR Collaborator" and "Nonphysician practitioner" under CMS's BPCI program.)

5. Financial Operations

Whether the bundled payment is made prospectively (upon identification of a triggering event) or retrospectively (pursuant to a reconciliation process), identification of the payee must be specified. For example, in a bundled payment pilot study involving UnitedHealthcare and five volunteer oncology groups, the single bundled payment was made by UnitedHealthcare to the oncology group at the initial visit. (Newcomer, L.N., Gould, B., Page, R.D., Donelan, S.A. and Perkins, M., "Changing Physician Incentives for Affordable, Quality Cancer Care: Results of an Episode of Payment Model," American Journal of Clinical Oncology, July 8, 2014.) On the other hand, CMS's BPCI program is structured so providers bill Medicare as if the program were not in place, and the economic result of the bundled payment is calculated retrospectively pursuant to a reconciliation process. (42 CFR 510.305(b).)

Bundled payment programs that involve hospital systems can be structured so the hospital is the holder of the initial payment, which would ultimately be distributed among the network of providers involved in the program pursuant to contractual agreements involving those providers. Other scenarios could involve an IPA or PHO holding the initial payment. Alternatively, it may be possible to form a new entity that would receive the initial payment and handle distributions to participating providers. In any event, the receipt and distribution of payments must be structured carefully to comply with all applicable state and federal laws.

Part II - Items 6 through 10

Part II of this article is forthcoming in the next issue of the *New Jersey Law Journal* and discusses the remaining five items on the list: (6) Allocation of the Bundled Payment; (7) Clinical Integration and Anti-Trust; (8) Fraud & Abuse/Civil Monetary Penalty Laws; (9) Corporate Practice of Medicine; and (10) Local Analysis.