Medicare to Begin Testing Bundled Payments

BY MARY ELLEN SCHNEIDER

Physicians and hospitals now have the chance to test out bundled payments on a range of conditions under a new Medicare initiative.

In August, officials at the Centers for Medicare and Medicaid Services released a request for applications (RFA) inviting physicians, hospitals, and other health care providers to participate in the Bundled Payments for Care Improvement initiative. The program, which was mandated under the Affordable Care Act, offers a variety of options for bundling payments for a hospital stay, for postdischarge services, or for both the hospital stay and the postdischarge care.

The move toward bundled payments is a major shift in how the government pays for medical care. Instead of paying hospitals, physicians, and other providers separately, this initiative would combine the payment over an episode of care for a specific condition. The aim of the program is to incentivize clinicians to work together and provide better continuity of care, resulting in better quality and lower costs.

"Today, Medicare pays for care the wrong way," Health and Human Services Secretary Kathleen Sebelius said during a teleconference to announce the bundling program. "Payments are based on the quantity of care, the amount of services delivered, not the quality of that care. And that leaves us too often with a system that actually can punish the providers that are most successful at getting and keeping their patients healthy."

The new bundling program offers four ways that health care providers can receive a bundled payment, three of which provide payment retrospectively, and one that offers a prospective payment. For example, under some of the retrospective payment models, CMS and the providers would agree on a target payment amount for the episode of care and providers would be paid under the original Medicare fee-for-service system, but at a negotiated discount of 2%-3% or greater. At the end of the care episode, the total payment would be compared with the target price and providers would be able to share in the savings, according to CMS.

The prospective payment model would work differently. Under that option, CMS would make a single bundled payment to the hospital to cover all services provided during the inpatient stay by the hospital, physicians, and other providers. That payment would offer at least a 3% discount to Medicare. Under this option, physicians and other providers would submit "no pay" claims to Medicare and the hospital would pay them out of the single bundled payment.

In addition to the options of prospective or retrospective payment, providers could choose how long the episode of care will be and what conditions they want to bundle payment for, and what services would be included in the payment. CMS officials said they wanted to make the program flexible so that a range of hospitals, physicians, and other providers could participate.

Organizations interested in applying for Model 1 had to submit a letter of intent by Sept. 22. Nov. 4 is the deadline for those interested in Models 2, 3, and 4. More information on the program and how to apply is available at www.innovations.cms.gov/areas-of-focus/patient-care-models/bundled-payments-for-care-improvement.html.

Dr. Richard Gilfillan, the acting director of the CMS Innovation Center, which is overseeing the bundling initiative, said he expects that hundreds of organizations will apply. CMS will consider a number of factors in choosing participants for the program including the best proposals for care improvement, the number of patients involved, and the conditions addressed, and the price discounts offered, he said.

The program is a unique opportunity for hospitals to redesign their systems to promote better care coordination, Dr. Gilfillan said, and have that effort supported through Medicare payments.

The idea is to eliminate the traditional barriers between physicians and other providers – both inpatient and outpatient – all of whom may be involved in the care of a single condition, said Dr. Nancy Nielson, senior adviser to the CMS Innovation Center and past president of the American Medical Association. "I do believe that both physicians and hospitals will find this [to be] an opportunity that's flexible enough to give them the opportunity to begin to learn how to get paid for care differently," she said.

The AMA praised CMS for making the program flexible. Dr. Cecil B. Wilson, AMA immediate past president, said the organization will urge federal officials to encourage applications for physician-led bundling projects.

"For this to be successful, and for physicians to participate actively, then they need to be a part of that process rather than just some larger corporation or larger hospital system or health plan that's organizing these," he said.

"We think those are important as well, but we also think it's important that physicians be a part of that leadership." ■

ADVISER'S VIEWPOINT

Look Before You Leap

Within the past year, major developments have occurred that will have a significant impact on the future of medicine. The Patient Protection and Affordable Care Act (ACA) was signed into law by Congress in March 2010. On March 31, 2011, the Centers for Medicare and Medicaid Services released the proposed rules and guidance regarding the development and implementation of accountable care organizations (ACOs). Almost a month later, on April 23, the CMS announced the Bundled Payments for Care Improvement Initiative (BPCII) as a reimbursement model in which the fees of multiple providers are bundled into a single, comprehensive payment that covers all of the services involved in the patient's care.

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The BPCII payment system appears to be somewhere between fee-for-service and capitation. The fee-for-service approach puts the full insurance risk on the payer. There is much criticism that fee-for-service ties reimbursement directly to the volume of services provided instead of quality, and is the root cause for poor coordination of care and overuse of expensive, and sometimes unnecessary, services. Capitation provides a lump sum for the medical care of each individual which transfers the full insurance risk to the provider. Bundled payments focus on a single payment for a defined group of services rather than paying separately for each item or service. A bundled payment system will also require providers to bear more of the financial responsibility for outcomes.

This kind of bundled payment model will need to have some type of integrated delivery system consisting of an administrative structure to determine the continuing medical needs of patients and how much each participating provider should be reimbursed for care. ACOs are being considered as one appropriate entity to manage bundled payments on behalf of providers and to develop collaborative and contractual relationships with facilities such as hospitals in providing patient care coordination.

The ACO/Medicare Shared Savings Proposed Rule, which outlined the statutory framework of ACOs, is rather limiting and allows a narrow scope of providers who can apply, but the BPCII is more flexible and allows applications from not only physicians and hospitals but also from other health care providers, including rehabilitation facilities, home health agencies, and skilled nursing facilities.

In the three retrospective models for episodes of care, applicants would set a target payment amount for a defined episode of care. That price would be negotiated at a discount of 2%-3% off the original Medicare fee-for-service rate. Total payment would then be reconciled against the predetermined target price. For models involving inpatient stay and posthospital care, any profit or shared savings beyond the target price would be paid to the participants. This would be synergistic with the ACO concept of better outcomes for less cost. Costs above targets would be paid back to the CMS.

Presumably, by introducing different options of involvement, it should be easier for providers of different sizes and readiness to participate in the BPCII initiative.

There are numerous concerns as well as multiple potential operational and design issues which must be addressed before bundled payments are universally implemented. Examples of questions neurologists may have include:

► Are neurologists willing to have a hospital be in charge of administering their reimbursements and developing an equitable agreed-upon fee for both the hospital and physician group?

► How will bundled payments be divided among various physicians including procedural and nonprocedural specialists? Who will make that decision?

► Will neurologists be willing to make an expensive investment in a new contracting and claims infrastructure to handle the new payment model, and which disease entities and services should be included in a bundled payment?

► Will bundling with hospitals require an integrated health care system with hospital-based neurohospitalists?

► In the absence of integration and existing contractual relationships, would a general neurology practice be expected to provide neurohospitalist services?

Neurologists would be well advised to exercise due diligence before entering into an agreement such as an ACO or bundled payment contract without appropriate professional and legal counsel.

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