Advisory Board member’s top 10 questions on the Bundled Payments for Care Improvement Initiative

Since CMS’s Innovation Center announced the new Bundled Payments for Care Improvement Initiative on August 23, 2011, Advisory Board members have asked a range of excellent questions about the new program. I have compiled the top 10 questions for further discussion below.

1. What is the Bundled Payments for Care Improvement Initiative? Is this program the same as the 2013 National Pilot Program on Payment Bundling or the Acute Care Episode Demonstration?

The Bundled Payments for Care Improvement Initiative is voluntary program, offering providers an unprecedented opportunity to increase their accountability for specific portions of patient care across the continuum. The hospitals, physicians, and post-acute care providers who apply for the initiative will have free range to define and price care bundles for fee-for-service Medicare beneficiaries, enabling providers to collaborate to improve both the quality and efficiency of individual episodes of care.

The bundling initiative was developed by CMS’ Innovation Center through its statutory authority established by the Patient Protection and Affordable Care Act (PPACA). As a result, this initiative is neither an expansion of the ongoing Medicare Acute Care Episode (ACE) Demonstration nor part of the upcoming 2013 National Pilot Program on Payment Bundling, also created by the PPACA.

2. What are the major differences among the four models offered through the bundling initiative? Would providers need to apply for just one model?

Taken together, the four models included in the bundling initiative allow providers to enter a world of selective accountability, as each model includes a different scope of services spanning across the care continuum. These tables provide detailed comparisons of the four bundling models and the services included within each model.

In addition to the varying scope of services included in the bundles, the four models have a few key differences.

- Model 1 includes all inpatient admissions, while Models 2-4 allow applicants to select specific DRGs for bundling. Given the more expansive nature of Model 1, CMS has established a lower minimum discount rate for Model 1 than Models 2 or 4 to help balance risk and reward.
- Models 2 and 3 utilize retrospective bundling, while Model 4 is a true prospective bundle.
- Models 1, 2, and 4 include inpatient care, encouraging participation of a hospital or health system, while the exclusive post-acute bundle in Model 3 could potentially be managed by post-acute care providers and physicians without involvement of a hospital partner.

The Innovation Center has encouraged providers to apply for multiple bundling models in this initiative. If providers ultimately participate in multiple models, for example Models 1 and 2, then Model 1’s across-the-board price cut would apply only to the admissions that are not selected for Model 2; all DRGs selected for Model 2 would be discounted according to the Model 2 application.

3. What is the difference between prospective and retrospective bundling?

The key difference between prospective and retrospective bundling is the method Medicare uses to reimburse providers for the bundled episode of care.

Under a prospective bundling model, the hospital would receive a single, lump sum payment from Medicare and then distribute that payment among all of the providers involved in the episode of care. As a result, the hospital, surgeon, anesthesiologist, radiologist, pathologist, hospitalists, consulting physicians, and any other providers eligible under the bundle definition would all share the single prospective payment. If providers spend more than the bundled payment rate during the episode, they
would take a loss on the case. To implement a prospective bundling model, the hospital would need to develop “banker competencies” to successfully manage the funds flow.

Under a retrospective, or “virtual” bundling model, all providers would continue to receive individual fee-for-service payments at their standard Medicare reimbursement rates. After an episode concludes, Medicare would complete a reconciliation process, calculating the total reimbursement paid out to providers for the episode and comparing that aggregate amount to the pre-established, discounted bundle price.

If the aggregate provider reimbursement amount were less than the bundled rate, Medicare would pay the providers the difference. If, however, providers were reimbursed more than the stated bundled rate, they would need to repay the overage amount to Medicare. The retrospective bundling model allows providers to experiment with bundling without altering existing revenue cycle practices, which may be attractive to independent physicians wary of having their reimbursement flow through the hospitals.

Ultimately, prospective and retrospective bundling models represent the two sides of the same budgetary coin. Regardless of the method of payment, both prospective and retrospective bundling models require providers to reduce the cost of care below the bundled rate to maintain profitability. The only practical difference is whether providers receive the full payment upfront or complete the reconciliation process after the episode concludes.

4. Why would a hospital or health system want to potentially participate in the bundling initiative? What is the strategic benefit?

The prime benefit of participating in the bundled payment initiative is the opportunity to strengthen hospital-physician alignment. Specifically, participating hospitals gain the ability to develop CMS-sanctioned gainsharing models that reward physicians for successfully improving quality and reducing input costs. According to the Innovation Center, CMS will use its authority to waive the regulations that typically hinder development of gainsharing programs, including Fraud and Abuse, Stark, and Anti-Kickback regulations.

For hospitals and health systems considering various methods of aligning with independent physicians around quality and efficiency improvement, a bundled payment program may be an attractive option, especially when compared to other relationship models, such as co-management, joint ventures, or even full employment.

One of the key benefits of the performance improvement efforts fueled by a bundling program is that they will likely extend beyond just the bundled cases. Once physicians standardize care processes for the bundling program—especially device selection—they will begin to apply those standards to all cases. As a result, hospitals are likely to enjoy margin and quality improvement across all payers. Early adopters have referred to this positive externality as either the “halo” or “spillover” effect, and it is central to the economics of bundling. All breakeven analyses should include the “halo” effect to account for the true cost savings potential.

Finally, some hospitals and health systems may consider participating in the bundled payment initiative as a means of building a business case for readmission prevention. Currently, providers have limited ability to capture the value of successful readmission prevention efforts. Under the new Hospital Readmission Reduction Program, hospitals can at best avoid a penalty—and forfeit revenue along the way.

Under an episodic bundle, however, hospitals can create an arbitrage opportunity by pricing their bundles based on their historic readmission rates and then successfully improving readmission performance. Ultimately, episodic bundled payments allow providers to capture the value created by readmission reduction efforts.

5. What are the major risks of participating in the bundling initiative?

Hospitals and health systems that participate in the bundled payment initiative will likely face three major types of risks: financial risk, design risk, and operational risk.

- Hospitals and health systems will bear the direct financial risk of offering Medicare a voluntary price cut on all bundled cases. If these providers cannot successfully reduce input costs and/or grow volumes to offset the revenue loss, they will ultimately lose money on the bundling program. Outside of this direct risk, however, Medicare will also conduct post-episode monitoring to ensure that providers do not drive up Medicare spending outside of the bundle; any providers who contribute to cost shifting beyond “a risk threshold” will need to reimburse Medicare for this cost growth.
- Providers will face design risk. All applicants must successfully construct and price their bundles based on historical cost data provided by Medicare. Further, hospitals and health systems must develop effective
gainsharing models to drive the physician performance improvement. If hospitals and health systems fail to accurately price bundles or develop effective gainsharing models, they may face financial losses.

- **Hospitals and health systems will bear ongoing operational risk.** Participating providers will need to standardize care processes, coordinate care across the continuum, and engage patients as partners in care. Further, participants in Model 4 will need to develop the “banker competencies” necessary to manage the bundled payment revenue cycle. Failure in any of these operational functions could be costly.

6. What types of quality metrics would participating organizations need to track and report?

The bundling initiative will utilize a range of quality measures to ensure that beneficiaries receive high-quality care through the program. The Innovation Center will combine existing inpatient and outpatient quality measures with new initiative-specific metrics. A full list of the existing metrics outlined below measures is available on pages 42-45 of the initiative's Request for Application.

- **Existing inpatient quality measures**: For Model 1, programs must submit all FY11 Hospital Inpatient Quality Reporting Program (IQR) measures, including those classified as “Required,” “CMS Voluntary,” “CMS Informational,” or “automatically captured via claims.” For Models 2-4, programs must submit the Hospital IQR measures classified as “Required.”
- **Existing outpatient quality measures**: For all Models, programs must submit all CY 2011 measures from Hospital Outpatient Quality Data Reporting Program (HOP QDRP).
- **New quality measures**: In addition to the existing quality measures, applicants must propose new quality measures. The Innovation Center and bundling programs will ultimately agree upon a standardized set of these new quality metrics.

7. How are patients “assigned” to a bundling program? If a hospital or health system applies for the program but some of the physicians do not want to participate, would that hinder patient assignment?

Medicare patients are “assigned” to a bundling program if they receive care for a qualifying admission at a hospital participating in the bundled payment initiative. As a result, physician participation does not factor into patient assignment. If physicians decline to participate in the initiative, they would forfeit any gainsharing bonus opportunity; however, the hospital would still be paid according to the design of the bundling program—which includes taking the bundle discount on all eligible cases. Under Model 4, non-participating physicians will still receive their reimbursement out of the lump sum payment made to the hospital.

8. Does the bundling initiative include any financial incentives to encourage patients to receive care at hospitals participating in the bundling initiative?

No, the bundling initiative does not include any financial incentives to attract patients to bundling programs. Conversely, Medicare’s current bundling experiment, the ACE Demo, includes patient incentive payments; Medicare shares up to half of the discount it receives from providers, capped at $1,157 per beneficiary. Despite the initial attractiveness of this patient incentive, ACE Demo sites report numerous challenges with the incentives and struggled to effectively incorporate these payments into marketing collateral without causing any misconceptions about the quality of care.

Further, none of the leaders of ACE sites we interviewed believed that the patient incentive payment led to volume growth. Given all of the challenges associated with the patient incentive payment, we were not surprised when the Innovation Center ultimately decided to exclude patient incentives from the new bundling initiative.

9. If a hospital or health system applies for a model that includes post-acute care, can the organization require that patients receive their post-acute care from owned or affiliated post-acute care providers?

No, the Innovation Center has explicitly stated that that bundling programs cannot restrict patients’ choice of providers, especially for post-acute care. Bundling programs may want to emphasize the benefits of selecting care from an owned for affiliated post-acute care provider, but they cannot restrict access to a limited set of aligned providers.

10. Would participation in this bundling initiative prevent an organization from also participating in other voluntary payment programs, such as the Pioneer ACO Model or Medicare Shared Savings Program?
No, participating in the bundled payment initiative does not prevent providers from also joining ACO programs, including both the Pioneer ACO Model and the Medicare Shared Savings Program. The Innovation Center has encouraged providers to apply for both the bundled payment initiative and ACO models. That said, Medicare may choose to modify the payment structures for organizations that participate in both bundling and a Medicare ACO model to prevent double payments.

What Are Your Questions?

Do you have additional questions about the new bundling initiative? Please feel free to email me at LazerowR@advisory.com with any questions you may have about bundling or any other emerging provider payment models.

Wealth of Bundling Resources

Are you evaluating the bundled payment initiative? Make sure to read our *Succeeding Under Bundled Payments* publication, evaluate potential bundles with our *Inpatient Bundled Payment Impact Calculator*, and listen to our recent webconference highlighting the key details and implications of the Bundled Payments for Care Improvement Initiative.