

Improving Care: A Primer on Bundled Payments

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Imagine you are renovating your house and want to modernize the kitchen. Would you rather pay the contractor a single price, agreed upon in advance, or pay an open-ended price for time and materials, with the total determined only at the end? Increasingly, health care is using the former fixed-price approach—the chief example being the “bundled payment.” Given the growth of the bundled payment in health care today, it is important that physicians understand its history, structure, and goals.

The bundled payment sets a fixed price for all services during a single *episode* of care. It is a middle ground between “fee for service,” in which all services are billed separately (e.g. the contractor who charges for time and materials), and capitation, in which the insurer pays a fixed amount per patient each year, regardless of what services are performed.

For example, a typical bundle may cover hip replacement, providing a single all-inclusive payment for physician fees, hospital fees, and rehabilitation. If providers coordinate care as efficiently as possible, the savings accrues to them (i.e. the difference between the bundled price and the actual cost). Likewise, providers bear any costs in excess of the bundled price. By using a fixed payment, the payer thereby incentivizes the provider to manage costs.

The bundled payment is not a new concept. In 1983, Medicare introduced the Prospective Payment System (PPS), a hospital payment system based on the diagnosis-related group (DRG). While formerly hospitals were reimbursed for each item or service they provided, the

PPS provided a single predetermined “bundled” price for all services a patient received during a hospital encounter, with the exception of physician fees, which were billed separately. This bundled structure had profound effects. First, it gave hospitals a direct incentive to manage costs. Second, in turn, it led to substantial savings for Medicare. Once the PPS system was implemented, hospital expenses went from growing faster than all other Medicare spending to growing slower than Medicare spending.¹

In the 1980s, PPS was considered a success in terms of cost containment, but its scope was narrow. The bundles included hospital fees but did not include physician fees or services occurring after hospitalization. Because hospitals were incentivized to lower costs, many shortened length of stay by shifting care to the post-acute care setting, which was outside of the scope of PPS. From the mid-1990s to 2009, post-acute spending became the fastest growth area for Medicare.²

Today’s bundles cover more categories of spending than before: hospital fees, physician fees, and post-acute services. With this widened scope, the goal is to lower costs and improve coordination across the entire episode, including post-acute care.

Implementation of bundled payment is growing quickly. In the public sector, the Center for Medicare and Medicaid Innovation (CMMI) launched a *voluntary* version of bundled payment called the Bundled Payment for Care Improvement (BPCI), which offers bundles across 48 clinical conditions.³ Practice bundles are implemented differently de-

pending on the payer and provider. In the BPCI, for example, there are four models of bundled payment. “Model 2” bundles the index hospitalization, physician professional fees, and the post-acute period.

Further, in April 2016, CMMI launches its first *mandatory* bundled payment program—Comprehensive Care for Joint Replacement (CJR)—for major lower extremity joint replacement. CJR will apply to hospitals not participating in BPCI in 67 metropolitan statistical areas.⁴ If successful, it is estimated that bundled payment initiatives could save Medicare \$4.7 to \$29 billion.⁵ The private insurance sector is pursuing bundled payments as well. For example, the Employers Centers of Excellence Network, a coalition of large employers that includes Walmart, Lowe’s, and McKesson, has partnered with hospitals around the country on hip and knee replacement bundles.⁶ Having seen the cost savings of government-led initiatives, private employers are hoping to achieve similar results.

The first question physicians ask is whether the bundled payment can both lower costs and provide high quality care. Early results suggest the answer is yes to both. Regarding costs, an evaluation of the BPCI initiative demonstrates that widening the bundle to include the hospital stay and post-acute care can decrease expenditures.⁷ Regarding quality, physicians had concerns about the effect on readmissions. A recent study from NYU Langone Medical Center provides evidence to the contrary. In that study, NYU reduced its rate of discharge to post-acute facilities by

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34% for lower extremity joint replacement and 49% for cardiac valve surgery with no corresponding increase in readmission rates.⁸ This finding is not surprising given how bundled payments are structured. Typically, a bundle encompasses complications related to the condition, such as revisions, infections, or readmissions. If such complications occur, providers are required to treat them with no additional payment. As a result, providers are incentivized to promote high quality and reduce complications in addition to lowering costs.

While these early results are promising, further research is needed if we are to transition more of health care to this payment model. Moreover, how we measure quality achieved under bundled payments is itself an open question. Today, quality assessment is commonly based on hospital-focused measures such as readmission and complication rates. Many are advocating that we should broaden the assessment to include more patient-centered measures such as functional outcomes and quality of life. Future evaluation of bundled payment is an opportunity to include patient-centered measures in addition to traditional measures of quality.

Looking to the future, physicians are key players in leading positive change under bundled payment. This is especially true for internal medicine physicians. Many of the clinical conditions for which hospitals receive bundled payment are medical and rely on the general internists or hospitalists who provide inpatient care. In addition, successful transition of the patient to the community after a hospitalization is typically dependent on a patient's primary care physician. If physicians lead the way and outcomes continue to improve, bundled payment could prove to be an early success of 21st century health care reform.

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