



Health Program

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Transitioning to Organized Systems of Care:

Medical Homes, Payment Bundles, and the Role of Fee-for- Service

January 2015



BIPARTISAN POLICY CENTER



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ABOUT BPC

Founded in 2007 by former Senate Majority Leaders Howard Baker, Tom Daschle, Bob Dole, and George Mitchell, the Bipartisan Policy Center (BPC) is a non-profit organization that drives principled solutions through rigorous analysis, reasoned negotiation, and respectful dialogue. With projects in multiple issue areas, BPC combines politically balanced policymaking with strong, proactive advocacy and outreach.

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The findings and recommendations expressed herein do not necessarily represent the views or opinions of the Bipartisan Policy Center's founders or its board of directors.

DELIVERY SYSTEM REFORM INITIATIVE

In April of 2013, BPC issued A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment, a report which laid out a comprehensive set of policy recommendations for lowering costs, improving quality, and reducing inefficiency across the health care system. As a continuation of that work, the Delivery System Reform Initiative's four co-chairs – former Senate Majority Leaders Tom Daschle and Bill Frist, former White House and Congressional Budget Office Director Dr. Alice Rivlin, and former Ways and Means Health Subcommittee Chair Jim McCrery – are developing meaningful policy solutions to facilitate and accelerate the transition to a value-based health care system.

AUTHORS

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Background

The Bipartisan Policy Center (BPC) Delivery System Reform Initiative leaders and staff, in collaboration with a diverse set of health care experts and stakeholders, are developing solutions to meaningfully facilitate and accelerate the transition to higher-value, more coordinated systems of health care payment and delivery.

This work builds on comprehensive policy recommendations in BPC's 2013 report, [*A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*](#), such as Medicare Networks¹ in which providers are accountable for quality, cost, and satisfaction for a defined population of patients.¹ Since its publication, experts and officials have had nearly two years of additional experience with reformed payment in Medicare, Medicaid, commercial insurance, and self-insured plans. What's more, in early 2014, an agreement was forged among leaders of the congressional committees of jurisdiction (Senate Finance, House Ways and Means, and House Energy and Commerce) on long-term physician payment reform legislation that would, among other provisions, establish clear incentives within the physician fee schedule for the adoption of alternative payment models (APMs).² While final action on this tri-committee bill has not occurred, it represents an important bipartisan step toward transitioning from fee-for-service payment to new models that reward value, including improved health outcomes, patient experience, and cost. The recommendations in this series are intended to build on this framework and early APM implementation, improve the viability of APMs, and make progress toward the long-term vision for the health care system presented in *A Bipartisan Rx*.

1. [*Transitioning from Volume to Value: Opportunities and Challenges for Health Care Delivery System Reform*](#) discusses progress and next steps toward payment and delivery systems that increase provider accountability for health outcomes, patient experience, and cost. [August 2014]³
2. This paper, [*Transitioning to Organized Systems of Care: Medical Homes, Payment Bundles, and the Role of Fee-for-Service*](#), addresses early implementation of two APMs in Medicare, bundled payment and patient-centered medical homes, as well as adjustments to the Medicare fee schedules. [January 2015]⁴

¹ In *A Bipartisan Rx*, BPC proposed accelerating the transition to value-based payment models by creating an enhanced version of ACOs, called "Medicare Networks," which would be provider-led and feature an enrollment model and stronger incentives for beneficiaries and providers to participate.

3. *Transitioning to Organized Systems of Care: Near-Term Recommendations to Improve Accountable Care Organizations in Medicare* reviews implementation of accountable care organizations in Medicare and offers near-term recommendations to improve this model. [January 2015]⁵
4. *Up Next:* The fourth paper in this series will address the imperative to have a more workable number of user-friendly, meaningful, and outcomes-oriented quality measures integrated within all alternative payment and delivery reform models.

The Role of Fee-for-Service: The Rationale for Refining Payment

In today's health care system, fee-for-service (FFS) remains the dominant payment model for both public and private payers. Retrospective, individual payments for each office visit, procedure, and other health service can and often does result in higher utilization—leading to more, though not necessarily better, care. BPC's leaders believe that providing incentives to move to organized systems of care will both improve quality and slow the rate of growth in health care cost, as well as improve accountability and facilitate the transition to population health.

BPC's Health Project is focused on advancing models of care that improve quality and value; at the same time, changes to the underlying fee schedules are necessary. Indeed, FFS payment rates frequently serve as the basis for assessing utilization and cost by assigning a value to services delivered. As a result, the success or failure of alternative payment models (APMs) is based on whether the model improves quality and slows cost growth relative to FFS. BPC has previously identified that inefficiencies, misaligned incentives, and fragmented care delivery inherent in the current FFS payment system have ultimately undermined quality and increased costs.⁶ While many providers and payers have taken significant steps to move away from FFS, many other providers throughout the country have not, and in some areas APM adoption is especially low. In those areas, it is important to incentivize provider migration to organized systems of care while recognizing that some providers may ultimately remain in the FFS system, even if less financially attractive.

Indeed, the widespread transition to new models of care will be difficult without stronger incentives for providers to adopt them, such as the enactment of legislation to establish higher annual fee-schedule payment-rate updates for providers participating in APMs. As part of *A Bipartisan Rx*, BPC recommended congressional action to establish differential updates in payment to accelerate that transition across all provider groups, now reflected, at least for physician-fee-schedule providers, in the tri-committee physician payment reform legislation (fixing the Medicare Sustainable Growth Rate, or SGR). Higher Medicare reimbursement for APM participation, including patient-centered medical homes, bundled payments, and accountable care organizations (ACOs), relative to FFS, will accelerate the transition to new, organized systems of care. Incentives in Medicare will increase participation

in APMs; however, broader delivery system reform will concurrently require broader alignment across payers. While many employers and private insurers have provided leadership in transitioning to organized systems of care,⁷ the success of these payment models will depend on broader private- and public-sector engagement. Without these changes, many providers will not have sufficient incentive to move away from FFS.

Physician Payment in Medicare: The Relative Value Scale (RVS)

Recommendation: The Centers for Medicare & Medicaid Services (CMS) should continue to devote resources to identify and revalue incorrectly valued codes under the physician fee schedule, prioritizing the rebasing of the value of services in a way that does not add to federal spending.

For decades, Congress and the U.S. Department of Health and Human Services (HHS) have struggled to assign appropriate value to physician services. In 1989, Congress overhauled Medicare physician payment by replacing an approach that screened charges for “reasonableness” with a fixed fee schedule based on a large-scale study of relative time, work, and practice expenses for each physician service. Initially, this legislation led to substantial increases in payments for office visits at the expense of payments for surgery and other procedures. One intentional result was higher revenue for primary-care physicians.⁸ However, many have observed that this shift has gradually been reversed over time by a flawed updating process in which the Centers for Medicare and Medicaid Services (CMS) delegated much of the responsibility to the RVS Updating Committee, which is felt to have disproportionate representation from the various specialty societies.⁹ A particular shortcoming of the process is the small number of downward adjustments in relative values for services in which physician productivity has increased over time. For example, new, technically complex procedures sometimes become more routine and less demanding over time, and there has been a lack of effort to identify and review incorrectly valued payment codes that no longer reflect the complexity of the service provided.

The current Medicare fee schedule for clinicians is widely viewed as undervaluing primary care and unsupportive of care-coordination efforts that primary-care providers often undertake.¹⁰ In response, the Affordable Care Act (ACA) temporarily increased payment rates by 10 percent for primary-care services provided by primary-care clinicians. This bonus program expires at the end of 2015 and should be continued for those primary-care clinicians who remain in FFS. Since the mid-2000s, Congress has enacted a number of measures to reduce payment for specific “over-valued” services. Sections 3102 and 3134 of the ACA took a more comprehensive approach, directing CMS to systematically review the relative values of large numbers of services, prioritizing services with rapidly increasing volumes

and those that have not been reviewed since the inception of the fee schedule. While CMS has long had the authority to review such services for possible adjustments, the law requires CMS to make these changes, which are often politically challenging. Because new models of care are based on the Medicare physician fee schedule and other payment schedules, CMS should prioritize the revaluation of incorrectly valued codes.

The Patient-Centered Medical Home (PCMH)

For a number of years, health policy experts have argued the merits of paying a single primary-care provider or practice to better coordinate patient care, noting opportunities for improved quality and efficiency. This approach facilitated the formation of patient-centered medical homes, a term that describes clinician practices that demonstrate defined capabilities to provide coordinated primary care. The PCMH payment approach used most often in Medicare demonstrations is a fixed per member, per month (PMPM) payment in addition to FFS reimbursement, with the participating practices accepting these enhanced reimbursements in exchange for expanded responsibilities, such as care-coordination services, extended hours, e-mail access to clinicians, and expanded health IT requirements. This bonus payment is intended to cover the costs for the practice to serve as a central point of contact for the patient, as well as coordinating their care across the broader health system.

Historically, payment and delivery demonstration programs were congressionally mandated on an individual basis or launched by CMS under its administrative authority. Many demonstrations were criticized for failing, in part due to the difficulty in overcoming volume-driven incentives of the current FFS payment model.¹¹ Section 1115A of the Social Security Act, as added by section 3021 of the ACA, established a Center for Medicare and Medicaid Innovation (CMMI, or “Innovation Center”) at CMS, and awarded it \$10 billion to test innovative payment models. Under this provision, CMS was given the authority to expand nationally those models determined to reduce health care costs while preserving or improving quality.¹² It is through the Innovation Center that PCMH models are currently being tested and evaluated under several programs and initiatives. The Comprehensive Primary Care Initiative (CPCI) is a multi-payer initiative that includes Medicare, Medicaid, and privately insured patients.¹³ PCMH-type models also operate within the Federally Qualified Health Center Advanced Primary Care Practice Demonstration for Medicare beneficiaries, as well as within several Health Care Innovation Awards and State Innovation Models (SIM) operating out of CMMI.^{14,15} Though there are many PCMH models in the private market, there are gaps in available information on their implementation due to private insurers’ hesitancy to share information they view to be proprietary.

While there have been many private and public approaches to the PCMH model, the CPCI and an implementation of SIM in Arkansas appear particularly promising. These approaches not only provide a PMPM payment in addition to FFS reimbursements, but also hold participating practices accountable for quality and offer the opportunity

to share in savings. This essentially creates a global, upside-risk payment arrangement with the PCMH, allowing CMS to capture some of the savings associated with better-coordinated care while also rewarding practices. In the Arkansas SIM, providers receive the PMPM payment in order to facilitate better care coordination within the practice. After meeting quality standards, practices are then “shared-savings eligible” in one of two ways (providers receive whichever is the greater of the two methods):

- 1) Spending below the established statewide threshold for risk-adjusted average per beneficiary spending (in 2014, the medium spending threshold is set at \$2,032 annually per beneficiary)¹⁶ or
- 2) Spending below pre-set, practice-specific benchmarks, or spending targets, based on historical spending.^{ii,17}

The inclusion of the second option motivates even high-spending practices to participate, as they are still able to share in savings by improving care coordination and decreasing spending as compared with their previous year. Key to both the CPCI and Arkansas SIM initiatives is that practices are held accountable for quality in order to become eligible for shared savings. Examples of quality measures used in the CPCI include rates of breast and colorectal cancer screenings, measures related to diabetes management, and rates of influenza immunizations. In Arkansas, quality measures are consistent with those used in the CPCI with the addition of pediatric measures, are adjusted annually and evaluated as a portfolio. By including these quality and practice transformation targets, the PCMH payment structure is elevated to more than just a bonus payment on top of FFS and holds practitioners accountable for better, integrated care.

The CMMI demonstrations and initiatives in the private market are appropriate first steps in highlighting the importance of primary care in delivery system reform. They offer an approach to paying providers for certain services that historically have been under-reimbursed or uncompensated and have the potential to improve care coordination and quality of care. While many argue that PCMHs also have the ability to lower costs, particularly through lower utilization of inpatient services, CPCI began late in 2012 and a final evaluation of the program is not yet available. The following recommendations are therefore made with the expectation that the results from these global-risk PCMH models result in savings and improved quality.

ⁱⁱ In this “performance improvement” model, the participating practice is categorized in one of three strata (high, medium-to-high, or below medium spending) based on its practice-specific, risk-adjusted performance in the previous year. If the practice achieves at least a 2 percent minimum savings rate during the performance year compared with the historical benchmark, then the practice will receive a bonus payment of 10 percent, 30 percent, or 50 percent of the savings, based on their strata. In this approach, practices that were relatively efficient to begin with are allowed to keep a larger percentage of any savings.

Potential for Improved Quality and Value

Recommendation: Congress should specify that the upside-risk PCMH model would be considered an APM eligible for higher fee-schedule payment-rate updates proposed as part of SGR reform legislation, recognizing it as a useful mechanism to improve the patient experience and accelerate the transition away from FFS.ⁱⁱⁱ

Congressional efforts to increase payment for primary care while reducing the utilization of other services in an appropriate manner promotes the success of organized systems of care with the expectation of reducing costs overall. In addition to extending the existing higher payments for primary-care office visits, the PCMH model should be considered as another way to increase payment to primary-care practitioners, as recommended by MedPAC in their [June 2014 report](#).¹⁸ CMS should pursue a PCMH program similar to the global, upside-risk model (ability to share in savings, but no accountability for spending growth over the target) in the CPCI and Arkansas SIM, as long as these current pilots show improved quality and cost savings. The CPCI model should be incorporated as a routine, program-wide element of Medicare through a per-beneficiary fixed monthly payment for PCMH services. So as not to simply distribute a bonus payment without incentivizing the coordination of care, participating practices should also be able to share in savings. Advancing this global, upside-risk-only approach to the PCMH model would reward a patient-centered, coordinated approach to primary care, and help providers build infrastructure that would assist in the transition to APMs.

ⁱⁱⁱ If the CMMI, CPCI, and SIM PCMH initiative in Arkansas are shown to both improve quality and reduce costs, this upside-risk PCMH model could be integrated as a standard element in the Medicare program using CMMI authority and made available as an option to providers nationwide. This model includes both a PMPM payment and upside risk, though it also requires accountability in quality in order to become shared-savings eligible.

Bundled Payment

Bundled payment is a system under which a provider or group of providers are paid based on an episode of care, rather than independently receiving individual payments for each service. There are two general approaches to setting the payment amount when implementing bundles. An administratively straightforward way involves a fixed, single payment made to providers based on historical spending for the services included in the particular episode of care. Another approach assigns participants a benchmark that reflects the average spending for the services covered by the bundle, either for the providers involved or for all providers in a geographic area.^{iv} In both cases, the difference between the benchmark and actual spending under FFS can be shared between the payer and the providers.

For complex episodes, bundled payments can involve multiple physicians, a hospital and/or freestanding facility, post-acute-care providers (such as home-health agencies and skilled-nursing facilities), durable-medical-equipment suppliers, medical devices, and prescription drugs. In these cases, the goal is to align incentives across providers. Clinicians within the bundle are accountable to each other through shared financial risk based on performance. If an individual clinician were not seen as contributing positively to the bundle, colleagues would have incentives to exclude them from future participation.

In 2013, the Innovation Center launched Bundled Payments for Care Improvement (BPCI), a three-year initiative in which awardees are reimbursed based on bundled arrangements triggered by inpatient stays.¹⁹ With four models to choose from, totaling 48 distinct episode types, each bundle includes financial and quality accountability measures. Though the initiative is still too new to evaluate, CMS has shown success in the past with bundles implemented through the ACE Demonstration and Heart Bypass Center Demonstration. According to the evaluation by Health Economics Research, Medicare saved roughly 10 percent of the \$438 million in expected spending on bypass procedures on those patients treated in the demonstration hospitals.²⁰ These hospitals were shown to provide services more efficiently, improve quality, and reduce costs.

In addition to public efforts, some private payers have demonstrated savings from implementing bundled payment. For example, BlueCross BlueShield of North Carolina reported it saved about 8 to 10 percent on average per-episode cost for their knee-replacement bundle.²¹ State Medicaid programs have also initiated bundling

^{iv} This benchmark roughly reflects what spending would have been under continuation of FFS, and the provider assumes risk for a portion of the difference between actual spending for services included in the bundle and this benchmark.

programs, most notably Arkansas,²² which mandated bundled payments for selected episodes and did so in concert with private payers.

Importantly, one of the major limitations of bundles is that they do not lead to accountability for overall costs and quality, as ACOs do, but rather only address delivery and payment incentives within the episode. Because of this limitation, much of the interest surrounding bundles today is whether the approach should be managed as a long-term component of alternative payment or as a transition to, or complement of, population-based APMs, such as ACOs. The following examines the role of bundled payment in delivery system reform, recommends criteria for assessing the appropriateness of an episode, and discusses how to structure the bundled payment.

Prioritizing Among and Defining Episodes of Care for Bundled Payment

Recommendation: To ensure success of bundled payment approaches, CMS should—among other criteria—prioritize the establishment of bundled payment for episodes of care that have statistically meaningful clustering of costs, providers, utilization, and patient characteristics.

Responding to congressional interest in the 2000s, CMS carefully analyzed the prospects for grouping claims into episodes of care and using the resulting groupings to inform Medicare reimbursement. That research highlighted key challenges associated with creating broadly applicable groupings of claims based on episodes of care.^{23,24,25} Because some episodes of care are more suitable for bundled payment approaches, CMS should be selective about the episodes for which to create bundles, rather than attempting to apply bundled payment to all episodes of care.

The complexity and variety of medical conditions exhibited by Medicare beneficiaries, along with the sheer number of their claims, precludes a single, standard approach to designing bundled payments. For example, bundles for chemotherapy will have elements that do not appear in bundles for joint replacement, and oncology and joint-replacement episodes may vary significantly from episodes involving patients with chronic diseases. More generally, some episodes either involve a small number of providers, facilities, and suppliers, or the affected entities already frequently interact with each other when treating patients, possibly to the point of having formal or contractual relationships. In contrast, other episodes either involve many providers or ones that do not routinely interact. Some episodes have relatively clear start and end points, while others do not. The need to customize the bundle for the specific characteristics of each episode is another reason why CMS should be selective in choosing the episodes for which the bundled payment approach is made available.

The following proposed criteria should be used for assessing where bundling is appropriate.

- Especially during the early stages of implementing bundled payment, priority should be given to episodes that require coordination across a smaller number of providers, because they are more likely to succeed. For example, bundles for the management of glaucoma or macular degeneration have the advantage of usually only involving one provider and no facilities. Bundles that involve providers, facilities, and suppliers who commonly work together and potentially already have a formal relationship also pose less of an organizational challenge (such as joint replacements, where surgeons, anesthesiologists, and hospitals regularly work together and potentially already have established, formal relationships). Subsequent bundling efforts can pursue episodes that involve greater numbers of distinct provider types or unrelated entities that do not typically work together, where the potential gains might be larger.
- An episode must result in a statistically meaningful clustering of costs, utilization, and patient characteristics. Patient variation should be low enough, or patient volume high enough, to assure the benchmark is meaningful to the bundle. When considering potential episodes for bundled payment, careful attention should be paid to the frequency of outlier cases involving high-cost complications. If such outliers are prevalent, the episode may no longer be appropriate for bundling. Otherwise, substantial variations associated with patient characteristics (e.g., co-morbidities) must be effectively explained to establish appropriate payments for the characteristics of the patient population.
- Current spending for the episode should show substantial variation from provider to provider. For an acute episode, variation could come from testing, prescription-drug use, complications, or rehabilitation services.
- Bundles are more suitable for episodes where there are relatively clear, objective clinical guidelines identifying the triggering event and where the episode type is not excessively supply-sensitive. Episodes may not be appropriate for conditions where providers have substantial discretion in triggering treatment, such as back pain. These types of bundles could perversely incent providers to induce additional episodes. For selected episodes, CMS should continue to monitor for possible increases in episode rates. Bundles should also be closely monitored for quality-of-care issues in order to limit the financial incentives for providers to underutilize items and services for an individual patient.

Episodes for acute services that best lend themselves to a bundle are those that have distinguishable start and end limits and do not have many co-morbidities. Hip

and knee replacements, glaucoma management, and chemotherapy are a few examples of episodes that exhibit these characteristics and are more primed to implement as bundles. The private sector already has concrete offerings in these areas, most notably in the oncology field^v and joint replacement. Additionally, there is significant potential for bundles that combine inpatient and post-acute care, which would encourage better coordination, quality improvement, and cost-containment efforts across a variety of care settings. Indeed, in Medicare, we know that much of the geographic variation in spending per beneficiary results from variation in post-acute-care utilization.²⁶

While we recognize the potential opportunities in expanding bundled payment across multiple care settings, much chronic disease management remains difficult to reimburse as an episodic payment. Chronic conditions with high rates of co-morbidities may not be appropriate for inclusion in this payment model. These types of care often are better addressed in the ACO and PCMH models, and bundles should not preclude the movement toward coordinated, high-quality care within a population-health model. The use of bundled payments for procedural services delivered by specialists may be an ideal use of the model as both a standalone payment system for areas that do not have ACOs as well as a means to incorporate specialists within ACOs.^{vi}

The Role of Bundles in Delivery System Reform

Recommendation: While not a complete payment-reform solution, bundles should be developed as both an alternative to FFS reimbursement and a mechanism for engaging specialists in ACOs.

As an isolated payment mechanism, some health policy experts have suggested that the utility of bundles is limited to transitioning health care providers to accepting risk and that the ultimate goal is more comprehensive systems of care. It is important, however, to consider their potential contribution to alternative systems of care and population health. Under the tri-committee physician payment reform legislation, bundled payments would likely be considered an APM and would qualify for higher physician-fee-schedule payment-rate updates, along with the PCMH model. By design, selected bundles would limit incentives to increase the volume and intensity of services provided within the episode. One of the primary benefits to bundles and their greater role within delivery system reform is their potential to engage more specialists in APMs. Providers may find it easier to participate in bundled payment

^v United Healthcare bundled treatment for breast, colon, and lung cancer. Medical oncologists were paid a single fee, in lieu of any drug margin, resulting in reduced costs and maintained outcomes. More information can be found at:

<http://jop.ascopubs.org/content/early/2014/07/08/JOP.2014.001488.abstract>.

^{vi} The United Healthcare oncology bundle is a good example of using bundles in specialist care. More information can be found at:

<http://jop.ascopubs.org/content/early/2014/07/08/JOP.2014.001488.abstract>.

arrangements in areas where other APMs, such as ACOs, do not exist or have low penetration. In these settings, the bundle may be an especially important tool for improving the efficiency and quality of care available to patients in rural areas.

Again, an important limitation of bundles is that the methodology does not address the volume of episodes as a whole, but rather the volume of services within the selected episode. Indeed, some observers fear that it could lead to higher rates of episodes, especially if bundles prove more financially attractive than FFS for providers through the shared-savings payments. While not a global solution, bundled payment is a valuable tool, providing both an alternative to FFS reimbursement and a means of expanding the ACO model.

Bundles as a Tool for Engaging Providers in ACOs

As will be discussed in subsequent publications, ACOs are built around primary care and accountability for improved population health and lower total cost of care. With regulatory modification to address current concerns, ACOs have significant potential to improve care coordination and more effectively manage chronic disease. But involvement of specialists in many ACOs under the model adopted by Medicare and some private payers is very limited. Many costly episodes that are clinically important to patients could be suitable for bundled payment. Bundles can facilitate the ability of ACOs and participating providers to better manage selected episodes, for example, by aligning incentives in joint replacement or chemotherapy to specialists and other providers involved in those episodes.

Given the potential for overlap among providers and patients involved in ACOs and bundles, it is important to establish clear rules to provide appropriate incentives and avoid double counting. Bundles could operate independently in situations where the patients are not part of an ACO. Where the patients do belong to an ACO, the bundled payment could be used in both setting the ACO spending target and reconciling actual spending. Depending on the ACO arrangement with Medicare or another payer and the physician's relationship with the ACO, the bundled payment could either be made to the providers (in lieu of the previous FFS reimbursement) or to the ACO for distribution to participating providers. In either case, the bundled payment would be counted when assessing eligibility for shared savings or, if the ACO has assumed two-sided risk, financial penalties.

In developing alternative payment systems, policymakers should consider interactions and unintended consequences that may inadvertently harm the overall objective of coordinated care. Likewise, provider participation in multiple payment mechanisms that are not integrated could result in perverse incentives that would inhibit the viability of both models of care. Lack of coordination among payment models within a geographic area has the potential to create problems regarding how to allocate resources among bundled payment approaches and other reforms such as

ACOs. Whether integrated or standalone, bundles should never undermine the ACO (or other APM) models, which would inhibit the development of more comprehensive patient-centered, integrated care. That being said, there is little question that bundled payments present important opportunities for payment reform and can play a foundational role in moving toward population-based payment approaches.

Voluntary or Mandatory Participation in Bundles

Recommendation: In an effort to encourage the transition to alternative systems of care, providers should receive differential updates in fee-schedule payment rates as they adopt more advanced payment and delivery models, so that bundled payment participants would over time access higher fee-schedule payment rates than those not participating in APMs.

Encouraging participation in bundled payment is critical, as increasing the share of reimbursements paid under any APM is more likely to transform how providers are organized and practice. BPC called for mandatory bundled payment for selected episodes in its 2013 report, asserting that the uncertainty with bundled payment was manageable and that the gains from bundled payment could be realized more rapidly. Mandatory approaches permit rewards for good performance—rather than only *improved* performance—and create a much stronger business case for provider investment in improved processes of care. Indeed, the Arkansas Medicaid bundled payment program is mandatory for providers that accept Medicaid.²⁷ While recognizing that bundles are most effective if mandatory, this option is most likely too aggressive to be politically feasible for broad implementation at this time. In order to obtain high provider participation in bundles without making them mandatory, it is necessary to establish clear incentives for providers.

We are now proposing an intermediate approach in which participating in a bundled payment system is voluntary, but providers have incentives to participate in bundled payment as an alternative to FFS for those episodes of care. Fee-schedule payment-rate updates for APM participants, including bundled payment, would be higher than for providers not participating in APMs to encourage this transition. Providers who accept the enhanced update for participating in bundled payments would be committed to bundles for all qualifying episodes and could not vacillate between them and FFS, preventing providers from cherry-picking the payment structure based on the patient.

Though this approach would not mandate bundling, it would create strong incentives for providers to move away from FFS. As long as these incentives to participate in bundled payment are reasonably strong in this differential update system, it will also be possible to move away from historical FFS benchmarks and establish a community experience benchmark, as discussed below.

Setting the Benchmark for Bundled Payment

Recommendation: Transition from a benchmark based on provider-specific, historical experience at the beginning of the contract toward a community-experience benchmark. Updates based on historical experience should not be rebased for experience under bundled payment.

When bundled payment programs are completely voluntary, the benchmark for any provider must be based on its historical spending. Otherwise, the program would only attract providers with lower-than-average spending, who would be rewarded for continuing their performances. Indeed, CMMI's initiatives all use a voluntary and historical benchmark approach.

The problem with provider-specific benchmarks is that they are unfair to already-efficient providers who would find it more difficult to improve. Another downside is that the benchmark for a provider will need to be updated in the future. If the updated benchmark is based on more recent spending by the provider, it means that there is no reward in the future for continuing the efficiency gains that have been achieved to date under bundled payment. This undermines the providers' business case for participating in bundled payment approaches. The alternative is continuing the original benchmark for many years. Although this is an improvement over frequent rebasing, over time its suitability inevitably erodes.

Unfortunately, CMMI has exacerbated the problem by updating benchmarks on a quarterly basis. The current CMMI moving-target benchmark is unworkable because it makes it almost impossible for providers to succeed economically over time. It also creates uncertainty, with providers not knowing the new baseline until the retrospective reconciliation of reimbursement. For this reason, CMS should not update benchmarks except to transition to community experience. One approach would be a five-year, blended transition from provider-specific spending during the year before implementation, updated by a market-basket index, to a benchmark based on actual spending of all providers in a geographic area. Ideally, community benchmarks would be set by Metropolitan Statistical Area or by grouping rural counties within a state (e.g., Bureau of Economic Analysis Economic Areas), which would be large enough to encompass substantial patient variation.

In order to be able to incorporate community experience, bundles would either have to be mandatory or attractive enough that provider participation would become widespread in a given area. While not mandatory, our recommended differential update approach could likely result in sufficient provider participation into the bundled payment system to allow viable community benchmarks. This is in line with the overall principle of moving from practice-specific experience to regional benchmarks, while providing certainty to providers and rewarding the faster transition to organized systems of care.

Prospective versus Retrospective Payment

Recommendation: CMS should offer more options for prospectively paid bundles, while retaining retrospective bundles as a default payment mechanism.

As discussed in the challenges section, defining an episode with a single, fixed payment rate presents the issue of how to calculate benchmarks and fairly distribute payment across providers. As for benchmarks, the current CMMI method is ineffective in providing certainty for participating clinicians and, though initial provider interest in the program has been high, will inhibit participation over the long term. The moving benchmark also causes providers to drop out in cases where the benchmark is lowered frequently in response to successful cost savings on the part of the provider. Furthermore, the combination of retrospective payment of bundles and frequently updated benchmarks means that providers might not become aware of the new target until well after they have rendered the services. As a guiding principle for bundles, benchmarks should be certain and known, which requires targets to be established in advance. This is most effectively done through a prospectively paid bundle, in which a single, prospectively determined bundled payment is established, leaving the flexibility in distribution of payment to the involved providers who have already organized themselves to deliver the episodic services.

CMMI currently offers four models of bundled payment in Medicare. Models 1-3 use retrospective payment, meaning each participating provider receives payment, based on the Medicare fee schedules, for each individual service provided during the episode of care. After all services within the episode are rendered, CMS then reconciles the total amount paid to the individual providers with the pre-set bundle amount, distributing savings or recouping losses. In this retrospective approach, providers receive payment in a manner that is familiar, with Medicare handling all of the administrative tasks of payment reconciliation for the bundle. These retrospectively paid models are useful in attracting providers who are not yet ready to take on the organizational challenges of payment distribution.

The fourth Medicare bundled payment model uses prospective payment, in which CMS makes one lump-sum payment per episode to one party, which is then responsible for distribution of payment to all other providers involved in the episode of care. Model 4 thereby requires providers to establish business relationships and negotiate payment contracts before rendering services.

There are advantages to each payment approach. Retrospective bundled payment allows providers to accept risk with relatively low administrative burden, since CMS continues to handle all payment reconciliation. Prospective bundled payment is ideal for providers with more advanced administrative capabilities, who are eager and ready to form their own contractual relationships among providers involved in the episode.

In the current BPCI offerings, Model 4 includes only hospital and inpatient care and excludes any post-acute care, a notable limitation in the scope of the bundle. By limiting the episode to inpatient care only, CMMI provides fewer opportunities for improved coordination and cost savings across the care continuum. For providers who have been or are eager to form their own arrangements and have standing formal relationships across the episode of care, CMMI should offer more opportunities for prospectively paid bundles that include post-acute care. In this way, providers will have more certainty in payment and will gain greater experience with administrative relationships and shared risk.

Conclusion

As stated in *A Bipartisan Rx*, BPC leaders believe that the most promising approaches to delivery system reform include an enhanced, enrollment-based ACO model called Medicare Networks and enhanced, competitively priced Medicare Advantage plans. That said, we recognize that not all providers, particularly small group practices or those operating in rural areas, are ready to assume risk and that structuring a role for specialists in this model has been challenging. We believe that other APMs, such as PCMHs and bundled payment, can serve as a means to transition provider groups to assuming risk, especially in the context of stronger incentives for providers to adopt APMs. Further, bundles, where appropriate, might be a way that ACOs could contract with specialists to better coordinate the care they provide. Policymakers should continue to build on existing bipartisan efforts, such as the tri-committee physician payment reform legislation, to incorporate these models and accelerate the movement toward more comprehensive, integrated care.

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