

Bundled Payments: Brilliant Idea or Boondoggle?

By Lola Butcher

In this article...

Take a look at the pros and cons of making bundled payments to hospitals and physicians.

Brian Jack, MD, was staffing the clinic at Boston Medical Center one evening when a patient came in suffering from metastatic cancer.

“We ended up putting him back in the hospital—even though it was totally unnecessary— because I just didn’t know what had been done,” Jack said. “I later found out all the plans for his care had been put in place but he didn’t know and I didn’t know.”

Of course he did not know. In all but a handful of places across America, inpatient care and outpatient care are distinct points on a patient’s continuum of care, delivered by two (or more) separate businesses that have different financial incentives and measures of success. Communication is spotty and incomplete, resulting in rework and inadequate patient care.

Recognizing that the bifurcated care system is to blame for poor health outcomes and billions of dollars of wasted money, health care policymakers and payers are seizing on that lack of coordination as a primary culprit in America’s health care crisis. They believe that health care reform starts with payment reform that encourages coordination between physicians, hospitals and others on the caregiving continuum.

After the medical home model to improve primary care, one idea getting a great amount of attention is bundled payments for physicians and hospitals. Both require physicians and hospitals to work together in ways they previously have not, an idea that makes so much sense it is difficult to argue against it.

Bundles and bundles

The general idea for bundled payments, as proposed by the Medicare Payment Advisory Commission, is that Medicare would pay a single provider entity—composed of



a hospital and affiliated physicians—one amount for the full range of care over a hospitalization episode.

Providers would not necessarily have joint ownership but they would determine how to allocate the money among themselves. Thus, they would be motivated to contain their own costs and would have a financial incentive to work together to improve their collective performance.

The Center for Payment Reform (CPR), recently founded by Robert Galvin, MD, General Electric's executive director of health services and chief medical officer, and others, is working to coordinate private-sector payment reform initiatives with the proposals being advanced by the Obama administration. Galvin sees bundled payment as an idea with broad support.

"I believe Congress is going to move forward on this," he said.

Physician executives who work in those rare situations in which physicians and hospitals are economically aligned think bundled payment is—or at least should be—the future of the health care industry.

For example, Dean Health System, a group of multispecialty clinics and ancillary services based in Madison, Wis., is 95 percent owned by physicians and 5 percent owned by St. Louis-based SSM Health Care. SSM owns St. Mary's Hospital in Madison. Dean Health System and SSM Health Care are 50-50 owners of a health plan that covers 250,000 lives.

"For every health plan patient we have, the hospital system and the physician group co-own that life," said Craig Samitt, MD, president and CEO of Dean Health System. "So we are essentially receiving a bundled payment, which means we are incented and are aligned to provide the best care for that patient at the lowest cost."

That is just one way to organize hospitals and physicians so they share incentives to work together. Others—such as the tightly integrated Kaiser

High Readmission Rates Could Result in Reduced Pay



An improved hospital discharge process developed at Boston Medical Center has been shown in a randomized trial to reduce bounce-backs—either hospital readmissions or emergency department visits within 30 days of discharge—by about 30 percent.

Brian Jack, MD—the physician behind the re-engineered discharge, or RED—won big awards from two federal agencies. The government is enthusiastically promoting RED, and several of the 14 “reducing avoidable hospitalizations” pilots recently funded by the Centers for Medicare & Medicaid Services are using the process. And many insurers are calling him to find out how RED techniques can help them.

But at Boston Medical Center, birthplace of RED, the discharge process is being used in just two services.

“Everybody understands how important this is, and we’re working on it,” Jack said. “But changing hospital culture is very difficult. It’s not a matter of ‘let’s just do it.’”

Change is especially difficult when a reduction in readmissions means a reduction in revenues. And the extra cost of providing the enhanced discharge is paid by the hospital. And the savings from fewer readmissions accrue to an insurance company or Medicare, not the hospital.

Those are just some of the reasons that, despite wide consensus that many readmissions can be avoided, exactly how to make that happen is not at all clear.

Although many hospitals have long tried to improve discharge planning processes, the issue first got big-time traction in 2007 when the Medicare Payment Advisory Commission called out avoidable readmissions as an expensive waste of health care dollars.

President Barack Obama apparently was reading. Keying directly to MedPAC’s recommendation, he has proposed that, by reducing pay rates for readmissions to hospitals with high readmission rates, the Medicare program could save \$36 billion over 10 years.

Actually, it might be even more than that. Writing in the *New England Journal of Medicine* (Apr 2, 2009; Vol. 360: 1418-1428), Stephen F. Jencks, MD, MPH, and his co-authors reported that nearly 20 percent of Medicare beneficiaries discharged from a hospital in 2004 bounced back within 30 days, and 34 percent were rehospitalized within 90 days. Estimating that about 10 percent of rehospitalizations were probably planned, the researchers found that unplanned bounce-backs cost Medicare \$17.4 billion in a single year.

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The first reason that patients return, of course, is that their health has deteriorated. But the underlying reason is that the DRG system stops paying hospitals the moment a patient is discharged—and starts paying the moment he or she returns. No one is accused of actively churning patients to make money, but the payment system does not pay hospitals to keep patients away, and it does pay hospitals when they bounce back.

Amy Boutwell, MD, MPP, a hospitalist at Newton-Wellesley Hospital in Newton, Mass., and policy specialist at the Institute for Healthcare Improvement in Cambridge, estimates 25 percent of avoidable readmissions could be eliminated if hospitals took relatively simple steps that have been proven to be effective.

“There’s no incentive for providers to change the processes that we currently use to keep the patients out of the hospital, to invest in that extra patient education or post-acute care coordination or additional home visit services that could very easily keep the patient out of the hospital,” she said.

The delivery system is designed to serve patients who are readmitted rather than reward proactive, effective care coordination and management.

The MedPAC recommendation—tying reimbursement rates to a hospital’s track record for readmissions—would create an incentive for reducing bounce-backs, but it does not address the bigger problem it would create for hospitals. Some hospitals have shut down successful quality improvement programs because they could not cope financially with the empty beds they created, said Boutwell, the primary investigator at the Institute for Healthcare Improvement for its multi-state initiative to reduce avoidable rehospitalizations.

“The recommendations ... to decrease avoidable re-hospitalizations need to be coupled with a payment policy strategy to facilitate this,” she said. “Otherwise, it is going to be very, very difficult for hospitals to handle decreasing their volume in this current economic climate, and it’s going to be a hard sell.”

Meanwhile, keeping patients from bouncing back is new work that deserves new pay and requires new systems be put into place, in the view of Robert Wachter, MD, chief of the medical service at University of California-San Francisco Medical Center.

“Somebody needs to do this work, and if my only three choices are hospital, primary care doctor or patient, I would choose hospital,” said Wachter, who coined the term “hospitalist” and is past president of the Society of Hospital Medicine. “But if the pressure is put on the hospital to fix this and it requires an extra expenditure—say, \$300 per hospitalization—and there are hospitals that are already in the red, then you have a big problem.”

Bruce Bagley, MD, medical director for quality improvement for the American Academy of Family Physicians, thinks the answer to preventable admissions is making sure patients connect with their “usual source of care,” the primary care physician or other caregiver who is responsible for the patient.

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Permanente system, Mayo Clinic and Geisinger Health—often surface as examples of high-quality care delivered efficiently.

“There are many examples of working models throughout the country,” Samitt said. “If we believe that integrated practice of hospital and physicians provides better care at a lower cost, then we need something to catalyze the expansion of that model, and I think (bundled payments) will do that.”

Out of alignment

Of course, the vast majority of hospitals and physicians are not aligned, presenting the bundled payment idea with one big hurdle.

“Providers don’t know how to do this yet,” said Amy Boutwell, MD, an internist at Newton-Wellesley Hospital and a content director and policy specialist at the Institute for Healthcare Improvement.

For that matter, many hospitals are so overwhelmed by multiple challenges of staying afloat, they are taking a wait-and-see approach. Boutwell said the concept gets much more enthusiasm from pundits and policymakers than providers.

“What we’re hearing is that this is such a radical proposition that we’re not going to do anything about it until it becomes a reality,” she said. “There is a substantial majority of hospitals that don’t believe that this will become reality.”

Guy Clifton, MD, a neurosurgeon turned health policy analyst, points out another challenge for bundled payments: The Center for Medicare & Medicaid Services does not know how to pull it off.

“This is all pie-in-the-sky talk,” said Clifton, a recent Robert Wood Johnson Foundation health policy fellow. “It turns out there is no actionable plan at the federal level to implement the things they’re talking about.”

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He advocates for a quality measure for which, to receive a positive score, a hospital must make sure that the discharged patient is seen by his or her usual source of care within seven days of discharge.

In today's reality, he acknowledges, hospital staffers would be reluctant to take that responsibility since they are not involved in the follow-up appointment. Likewise, outpatient physicians would not want to be held responsible, since they frequently are unaware their patients have been hospitalized.

"A measure like that would force them to cooperate and, instead of 'I-did-my-thing, you-do-your-thing,' it would actually force them to develop systematic solutions to a difficult problem," Bagley said. "The downstream result would be fewer readmissions."

His comment points to a possible controversy about which physician—the patient's usual source of care or the hospitalist who provided care during the inpatient stay—should be the point person in the immediate post-discharge period.

When Bagley's own father was hospitalized, Bagley was pleased with the care delivered by the hospitalist—but he believed that physician did not know his father or the care that had been provided before he entered the hospital.

By contrast, Wachter believes that, if a physician is going to be assigned responsibility for keeping a patient from bouncing back, the hospitalist may be the obvious choice.

"The hospitalist is in a better position to do that than the primary care doctor if the primary care doctor was not involved in hospital care," he said.

Clifton believes the bundled payment model is essential to salvaging the health care system but, having spent a year working with Sen. Orrin Hatch's health policy staff, he is doubtful that it can happen. Those who could figure it out—physicians—are not at the table, and that is not entirely Washington's fault.

"The professional societies are not very helpful to people in Congress because all they do is come in and say, 'We need more money,'" he said, explaining that their credibility is diminished. "Their function is to keep doctors' fees up every year, so (policy-makers) can't listen to them."

Clifton, writing in *Flatlined: Resuscitating American Medicine*,

advocates for creation of a new entity—he calls it the American Medical Quality System—to overhaul the health care system. Modeled after the Federal Reserve System, AMQS would, among other things, figure out the details for bundled payment and provide the information to CMS as well as state and private payers. Unless all payers use the same payment system, providers will have to respond to the varying incentives of each system, whittling away the efficiencies that payment reform can bring.

Galvin is also concerned about the complexity of episode-based payment. For that reason, he wants to see reform legislation passed soon—but with a timetable that allows changes

to be carefully thought out so as to avoid unintended consequences. For example, unless the details of new payment schemes drive cost savings, hospitals and physicians may create organizations that have the market power to raise prices.

While the complicated details of bundled payments and other payment reforms are worked out, he believes immediate action should be taken to improve the fee-for-service system by, for example, increasing primary care pay.

"As enamored as we all are of new models, I think we would be doing a disservice to not move forward with fee-for-service," Galvin said. "So we should improve fee-for-service while waiting for episode-based payment to be worked out."

The ultimate solution, Clifton believes, requires physician executives to step up and lead. They are the only ones who can really understand how medical care influences the business of medicine and vice versa.

"It's a little scary because it involves creation of new entities, new structures, some reforming of how Medicare works," he said. "So it's not trivial. But we're talking about reforming the largest single component of the U.S. economy. If this doesn't require a plan and a scope, I don't know what does."



Lola Butcher

Writes about the business of health care for several trade publications.

lola@lolabutcher.com