Bundled Payments

Why they are doing it

- Give doctors/hospitals an incentive to better coordinate; reduce costs of preventable readmissions
- Currently, providers have no incentive to improve care, just provide more
- Studies have shown that patient outcomes were poorest in areas providing the most high-tech services. Meaning more care could actually be harmful.
- Health care accounts for 16% of GDP and are rising at 6.7% per year
- Institute of Medicine has estimated that 30 to 40 cents of every health care dollar is spent on inappropriate, duplicative, or ineffective care – costing 600-700 billion annually
- Bundled payments are described as a middle ground between fee-for service reimbursement and capitation (providers are paid a lump sum per patient regardless of number of services)

Benefits

- Health care providers will need technical support to adopt new technologies such as EMRs to promote coordination and collaboration
- Unlike capitation, does not penalize providers for caring for sicker patients (debatable)
- Could give hospitals and doctors an incentive to provide more efficient care and reduce unnecessary hospitals readmissions since they won't get paid for doing more
- Could save U.S. healthcare system about a billion dollars a year

Potential issues for billing companies

- Because 1 provider may outsource part of the care of a patient to other providers, it may be difficult to assign financial accountability for a given bundled payment
- Difficulty in establishing fair compensation rates
- Patients may have multiple bundles that overlap each other

Potential issues for medical providers

- Physicians worry that sending the lump payments to hospitals would give them too much control over physician rates, provide an incentive to skimp on needed care/specialist to maximize profits, and that a focus on acute care episodes would leave primary care doctors left out
- Restructuring of malpractice needed
- Providers assume financial risk if cost of care exceeds bundled payment for a particular treatment or condition, as well as costs associated with preventable complications
- Some illnesses may not fall neatly into "episodes"
- Providers risk large losses, for example it a patient experiences a catastrophic event
- Uncertain how hospitalists will fit into program
    - Phoenix Group released a white paper that warns that "bundled fees may result in a slowdown or even a reversal" of compensation for hospitalists
    - Concern that inpatient savings generated will simply be shifted to primary care

How it is going to be implemented

- Proposal would bundle payments for acute inpatient care and post-acute care occurring or initiating 30 days following a patient's discharge, including home health, skilled nursing, rehabilitation, and long-term hospital services
- Payment bundling would occur in 3 stages
    - 2014: Include only those conditions accounting for the top 20% of post-acute spending
    - 2016: Include the next 30% of conditions that require post-acute spending
    - 2018: Include all remaining conditions
- Beginning on January 1st, 2011, CMS will provide a single, bundled payment ($229.63) for outpatient dialysis treatment, supplies, related clinical lab tests, and certain related drugs (some oral drugs won't be included into 2014)
- The following year, CMS wants to begin a value-based purchasing system that would tie reimbursement to performance on 3 quality measures related to end-stage renal disease.