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Bundled Reimbursement: A Step in the Right Direction, or Another Flawed Idea?

By Todd Lueders

In the current environment of technological advances in claims processing and data modeling systems, along with the flood of new ideas regarding how to improve issues in the health care system, some advocates view the idea of "packaged" or "bundled" payments to providers as a move toward improving quality and lowering costs.

Some opponents, however, view bundled payments as merely another idea full of administrative complexities with little hope for any real long-term improvement in quality and cost. In addition, opponents feel that this is not true population health management and thus would not actually bend trend.

Below is a discussion of the potential advantages a bundled payment structure can offer, as well as issues and concerns that may prevent bundled payments from becoming a mainstream reimbursement methodology.

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What is Bundled Reimbursement?

Bundled reimbursement refers to a single payment for all services rendered during a clinically defined episode of care. This payment would cover all hospital, professional and ancillary services performed by a variety of providers relating to that specific episode. Many discussions and pilot programs on the potential benefits

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of bundled reimbursement center on an acute inpatient admission and the skilled nursing, follow-up visits, and home health services that would occur afterward.

The philosophy behind bundled reimbursement is that providers would be given the proper incentives to provide efficient and effective care, resulting in the elimination of unnecessary tests, reduction in readmission rates, etc. Additionally, since there remains a link between the needs of members and provider revenue, health care providers would not be subject to undue insurance risk as they would under a full-risk capitation arrangement.

Under a single-episode payment system, it is generally up to the hospital or overarching provider entity to disburse payments to the individual providers. Determining the amount of these payments and the administrative process for disbursing them is a significant hurdle to overcome. For an integrated system such as a Physician-Hospital Organization (PHO), this process may be possible without large administrative changes. For individual physicians and hospitals not part of any integrated system, however, this represents a major change from current practices, with many issues to be addressed.

Improvements in data quality and the widespread availability of episode-grouping software has made episode-based reimbursement a very real possibility. In the past, this type of information and level of analytical sophistication was not available.

Advantages Over Today's Fee-for-Service Environment

Proponents of bundled or episode-based reimbursement point to the bundled-payment approach as a way to improve on the cost and quality concerns under current fee-for-service (FFS) based methods, including:

- Efficient use of resources
- Quality incentives
- Collaboration between providers

Efficient Use of Resources

Under the FFS system, revenue to providers is directly linked to the number of services they perform. There is little incentive to determine and implement a patient care plan that makes the most efficient use of limited resources. From a purely financial perspective, bringing a patient back to full health quickly and efficiently could mean lost revenue for the provider.

Under an episode-based reimbursement system, there is no extra revenue for additional visits or tests, so providers would have the incentive to bring patients back to full health quickly and efficiently. This type of system provides incentives for eliminating unnecessary physician visits during and after a hospitalization, along with the incentive to use fewer hospital resources.

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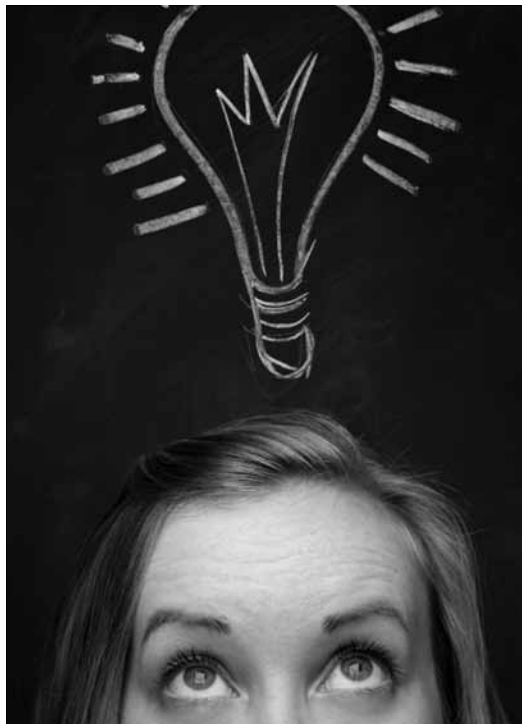

Quality Incentives

Unlike a quantity-based payment system, the episode-based reimbursement system inherently creates quality incentives. Although we generally believe health practitioners always act in the best interest of their patients to determine the best way to bring a patient back to health as quickly and efficiently as possible, removing the financial incentive to provide unnecessary services is likely to have an impact. This is the primary philosophy behind capitation arrangements; however, in the case of episode-based reimbursement, providers are not enduring the high level of insurance risk that most are not ready and/or willing to handle.

Collaboration between Providers

One of the major problems in today's system impacting both cost and quality is the lack of collaboration between the many providers interacting with a patient for a given episode. The financial and operating independence across providers can again lead to unnecessary visits and services, confusion and frustration for the patient, increased costs, and potentially harmful outcomes.

An episode-based system requires that providers come together (both financially and operationally) to provide the best and most efficient care for the patient. This type of collaboration is not unlike the provider collaboration theory discussed around patient-centered medical homes, where care for a patient is more closely coordinated across various health care professionals.

Criticisms/Obstacles

While the potential cost and quality improvements in episode-based reimbursement are intriguing, there are many roadblocks and pitfalls that may prevent this type of system from becoming a widespread methodology, including:

- Delay in final payment
- Distribution of funds
- Concerns regarding incentives

Delay in Final Payment

Since a patient episode may last several months, the ultimate payment may not be made until well after all services have been provided, which could be a very long time from when the initial services were rendered. Thus, some form of interim FFS-type payment with a final settlement would be needed to avoid provider cash flow issues.

This type of payment could cause significant administrative and financial problems for a health plan, since plans rely on timely and accurate claims data for reserving, underwriting, budgeting, and product pricing. Plans would need to know (or be able to accurately estimate) the net impact of the ultimate episode payment over the interim FFS payment, which could prove to be a difficult exercise.

Distribution of Funds

Under an episode-based system, it would likely be up to the hospitals to distribute the funds to each individual provider. This would be a serious administrative task that most hospitals today are not equipped to handle. Aside from the operational issues of distributing funds, there are several undesirable consequences that may occur:

- Hospitals may reward physicians who create more hospitalizations or episodes.

- In an effort to attract physicians, hospitals that are financially strained may be forced to keep physician payments high, limiting critical funds needed to cover their own operating costs.
- Hospitals may give physicians a financial incentive to code in such a way as to maximize revenue for the episode. In the FFS environment, physician reimbursement is generally not linked to the coding/intensity of the hospital admission; thus, there is currently not as much incentive for upcoding as there would be under episode-based payments.

Concerns Regarding Incentives

While the comments at the beginning of this article discussed how episode-based reimbursement may correct incentive problems in today's FFS world, episode-based reimbursement may produce its own set of incentive problems.

Rather than having an incentive to render more services (as with FFS), episode-based reimbursement would merely shift the incentive to create more episodes. This could result in providers delaying needed care until an episode end date was reached, which would then trigger a new episode. If manipulation like this occurs, it would likely result in a deterioration in the quality of care to the patient. Note that some plans have dealt with this issue using rigorous definitions of episode triggers.

Another potential quality-related concern is the incentive to withhold or limit needed follow-up care after the hospital admission. This is the same concern that exists with capitation agreements.

An additional capitation-related concern is the issue of providers "cherry-picking" the healthiest patients, with low risk of complication and readmission. Ideally, an episode-based approach would include appropriate risk adjustment to account for the likelihood of complications. Nonetheless, providers will likely be able to determine which patients are high-margin versus low-margin, and plans and patients would run the risk of providers acting on this information.

Can It Really Work?

Episode-based reimbursement's success is yet to be fully proven. There are various pilots and trial programs in place, some showing early signs of success. Whether or not this type of reimbursement will be successful and widely adapted over the long-term will depend on many factors, including:

- The ability of physicians and hospitals to become more fully integrated
- Resolution of issues pertaining to the distribution of funds
- Ability of episode-reimbursement programs to limit undesirable incentives

Of course, the largest factor in determining whether episode-based reimbursement will be widely accepted will be if and how the Centers for Medicare & Medicaid Services (CMS) implements this type of methodology to pay providers for Medicare patients. CMS has already conducted acute care episode (ACE) pilots for invasive cardiac and orthopedic procedures, which contain well-defined treatment patterns. Without specific and far-reaching government or CMS mandates, it is unlikely that the private sector will have the incentive to tackle all of the administrative issues necessary to implement episode-based payments on a large scale.

This is not to say that there may not be a place for episode payments. Certainly within integrated systems and for select types of medical conditions (e.g., CABG), there may continue to be a niche for this type of reimbursement methodology.

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