THIRD WAY

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Executive Summary: Bundled Payments, a Stable Foundation for Medicare Financing

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Brian Stickley, a 60-year-old real estate agent in Charlotte, NC, limped due to severe pain in his right knee and gained weight because the pain made him stop taking his daily four mile walk. He needed a knee replacement, but that normally would have involved dealing with many different care providers—as well as a bill from each one. Instead, a Charlotte-based orthopedic practice gave him a "patient navigator" who helped him every step of the way and figured out all of the services he needed—all for one combined price.

A combined price—or bundled payment—gives patients a single price for a given treatment like a knee replacement. Instead of separate bills for the surgeon and other physicians, the hospital, and physical therapists, Brian received one bill covering his entire episode of care, including rehab. With bundled payments, the provider is accountable for any problems patients might encounter with care because it cannot bill for extra services. And patients are happier with a simpler process and have better outcomes because the doctors and the care team use consistent methods to deliver care. If Medicare adopted bundled payments, patients like

Brian would receive better care and the federal government would save $206.5 billion over ten years.

This idea brief is one of a series of Third Way proposals that cuts waste in health care by removing obstacles to quality patient care. This approach directly improves the patient experience—when patients stay healthy, or get better quicker, they need less care. Our proposals come from innovative ideas pioneered by health care professionals and organizations, and show how to scale successful pilots from red and blue states. Together, they make cutting waste a policy agenda instead of a mere slogan.

What is Stopping Patients from Getting Quality Care?

More than half of physician revenue is based on fee-for-service payments, which incentivize physicians to perform more tasks rather than overseeing a patient's overall care from beginning to end. These à la carte payments have led to substantial, and troubling, variation in price and quality for the treatment of similar conditions. This unstable, fee-for-service foundation for health care payment is set to remain in place for the foreseeable future, as even alternative payment models are built on this base.

Where are Innovations Happening?

The innovative concept of "bundled payments" attempts to reward value over volume by offering providers a fee for an episode of care. Often this set fee is a single payment to one provider or organization that is then responsible for compensating the other clinicians who have agreed to work together, rather than payers reimbursing unlimited claims for each of them. Bundled payments can save money over the fee-for-service system because the single payment encourages providers to think beyond their own role to the broader quality, value, and coordination of care a patient receives. Innovations include:

- In the early 1990s, Medicare first experimented with bundled payments under the Medicare Participating Heart Bypass Center Demonstration, which was implemented at seven hospitals for up to five years, and saved about 10% compared to a baseline, while reducing length of stay and maintaining high quality. The Ohio State University Hospital in Columbus was one of the original participants and continues its involvement in bundled payments today, participating in the Bundled Payments for Care Improvement initiative for both coronary artery bypass graft and cardiac valve procedures.

- Medicare's Bundled Payment for Care Improvement (BPCI) Initiative, rolled out in August 2011, offers providers a choice of four bundled payment models. Among the models are one that focuses on care only within a hospital, two models that include inpatient care and care following discharge for a specific time period, and one that focuses directly on care after a hospitalization at nursing homes, community settings, or in the hospital if a patient is readmitted. For the last three models, Medicare has identified 48 episodes of care, which include 180 Medicare Severity Diagnosis Related Groups (MS-DRGs) and encompass 70% of all possible Medicare episodic expenditures. Medicare defined which services are included in the bundle for each episode and established a target price based on each provider's historic costs for that bundle of services, minus a discount taken by Medicare.

- Planning for the PROMETHEUS (Provider payment Reform for Outcomes, Margins, Evidence, Transparency Hassle-reduction, Excellence, Understandability and Sustainability) payment model began in 2007, and it is used today by health plans and large self-funded employers. This model bundles payments around "a comprehensive episode of medical care that covers all patients services related to a single illness or condition" in an effort to encourage provider collaboration for effective, efficient care.

How Can we Bring Solutions to Scale?

Over the next 10 years, policymakers should make bundled payments the new foundation for Medicare reimbursement, replacing the current fee-for-service system. To accomplish that will require four changes in Medicare policy:

1. Congress should establish a goal for basing a specific percentage of Medicare fee-for-service payments on bundled payment rates.

2. Policymakers should direct CMS to use alternative payment models as a cap for payments under fee-for-service.

3. Wherever possible, Medicare should use market-based pricing to set prices for bundles.

4. Medicare should partner with states and private insurers to accelerate the adoption of bundled payments by all patients and payers.

Potential Savings

Based on a phased-in approach to implementing bundled payments in Medicare, the ten-year savings would be $206.5 billion. The savings under this approach would come from lower prices for the bundled payments compared to current fee-for-service payments. Physicians would have a strong financial incentive to prevent patient complications from

medical care, reduce duplicative tests and procedures, and coordinate care to prevent a patient's health problems from worsening. Fully implemented, the savings would equal 5.4% of Medicare spending for physician and hospital care in traditional fee-for-service Medicare over ten years.