THIRD WAY

REPORT *Published June 27, 2013 • 9 minute read*

Reduce Poor Quality and Duplicative Care through Physician Teamwork

David Kendall
Senior Fellow for Health and Fiscal Policy
@DavidBKendall

Our a la carte, fee-for-service health care payment system encourages physicians to perform more tasks rather than overseeing a patient's overall care from beginning to end. That has led to expensive, disjointed, and often mediocre-quality service as well as wide price variation to treat similar conditions. Bundled payments, by grouping a set of services over a given period into one payment, gives providers an incentive for efficiency and coordination that is absent in the fee-for-service model. Medicare savings from a phased-in approach to bundled payments would be $114 billion over ten years.

Current behavior: Each specialist works separately and seeks payment for their individual services.

New behavior: Specialists work as a team to continuously improve quality and lower costs.

How to change behavior: Pay medical specialists a set and bundled payment for each episode of care.

What's The Problem?

For decades, Medicare physicians have been paid under a "fee-for-service" model: a set payment for a set service regardless of its necessity or efficacy. The model has set in place two very problematic behaviors: (1) it only allows providers to operate in silos, offering no coordination of a patient's care between practitioners; and (2) it allows providers to be effectively insulated from patient outcomes, with little to no incentive to engage in a host of quality-improving activities.

The fee-for-service model has resulted in extraordinary variation in cost and quality across the country. Dartmouth Atlas data shows "more than a two-fold variation in per

capita Medicare spending in different regions of the country" and also indicates that these differences do not have an overall effect on quality. [1] In fact, if all areas of the country could reduce their costs to equal those of low-cost areas, while maintaining quality, the health care system could save between 20 and 30%. [2]

What Can Fix It?

Fee-for-service is an expensive model because there is no limit on volume. Providers can deliver, and bill for, largely unlimited services regardless of the efficiency or efficacy of the care. In fact, the provider's financial incentive is to generate very high volumes of services since he or she is being reimbursed a specific amount for each individual service—but not on the outcome. Bundled payments, in comparison, attempt to reward value over volume by offering providers a fee for an episode of care—"a defined set of services delivered by designated providers in specified health care settings, usually delivered within a certain period of time, related to treating a patient's medical condition or performing a major surgical procedure," like a knee replacement. [3]

Bundled payments can save money over the fee-for-service system because the single payment encourages providers to think beyond their own care delivery to the broader quality, value, and coordination of care a patient receives. In other words, instead of conducting a battery of tests (each of which earns the provider a payment under the fee-for-service system), the provider has an incentive to find out which tests have already been performed and not duplicate them. Or, in the case of a bundled payment for surgery, providers have an incentive to coordinate effective post-operative care such as checking on implants, coordinating physical therapy, and monitoring each patient's rehabilitation. In other words, bundled payments reward the successful treatment of a health problem and not the number of services performed.

Medicare has two pilot programs for bundled payments for hospital-related health care services: the Medicare Acute Care Episode (ACE) Demonstration for Orthopedic and Cardiovascular Surgery and the Bundled Payment for Care Improvement initiative through the Innovation Center. Under the ACE Demo, hospitals are given a single payment for both Part A and Part B services delivered during an inpatient stay. [4] This payment covers a patient's admittance to discharge, and also includes a provider incentive, a patient incentive, and quality reporting requirements. The demo currently includes both orthopedic and cardiovascular procedures.

With Medicare silos broken down and Part A and Part B incentives aligned, costs have dropped mostly due to better contracting for devices and supplies. Costs are also lower because physicians are following stricter evidence-based protocols that prevent mistakes, eliminate duplication, and allow physicians to share a portion of the savings they create.

The Bundled Payment for Care Improvement initiative, rolled out in August 2011, offers providers a choice of bundled payments that are adjusted either retrospectively or prospectively for how sick each patient was or will be. [5] In this initiative, providers are invited to propose a target price for an episode of care, which may include follow-up care after a hospitalization. This price will be reconciled with total payments at the end of the episode and providers can share in any savings.

Other types of bundled payments are possible for non-hospital based care such as diabetes treatment. In this example, the bundle would include all the services related to a patient's diabetes such as blood tests, eye exams, and foot exams over several months. The Health Care Incentives Improvement Institute in Newton, Connecticut is sponsoring the development of these bundled payments at several locations throughout the country. [6]

Where Is It Working?

Medicare first experimented with bundled payments that combined payments to physicians and hospitals in the 1990's under the Medicare Participating Heart Bypass Center Demonstration. The bundle included inpatient hospital and physician care for coronary artery bypass graft patients including readmissions up to 72 hours after discharge. [7] The demonstration was implemented at seven hospitals for up to five years, and saved about 10% compared to a baseline, with quality unchanged.

Geisinger Health System in Pennsylvania has made progress more recently with its ProvenCare program for elective coronary artery bypass graft surgery. [8] Geisinger charges a set rate for the surgery, all related services, and any care required within 90 days of the acute stay. The program reduced hospital costs by 5%, the average length of stay dropped by .5 days, and the 30-day readmission rate dropped by more than 44% over 18 months. [9]

Potential Savings?

Based on a phased-in approach to implementing bundled payments in Medicare, the ten-year savings would be $114 billion. [10] Here are the key steps for achieving those savings:

- Over the next four years, Medicare administrators would complete ongoing demonstration programs for bundled payments. This timeframe is consistent with the Medicare Physician Payment Innovation Act of 2013 proposed by Reps. Allyson Schwartz (D-PA) and Joe Heck, D.O. (R-PA) for physician payment reform. [11]

- Medicare administrators would implement about 40 new bundled payments each year over a period of six years starting in fiscal year 2018.

- Medicare administrators would cap the national payment rate for each bundle at the current average of the fee-for-service costs for that bundle of services. This cap would reduce regional variation in costs that exceed the cap.

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 3.9% of Medicare spending for physician and hospital care in traditional fee-for-service Medicare. Greater savings could be achieved with a faster implementation schedule, by extending bundled payments to more health care services such as chronic care, and by tighter caps on regional variation in costs.

Other estimates of savings are more optimistic. For example, RAND estimates that implementing bundled payments for ten common conditions or procedures * would reduce health care spending by as much as 5.9% depending on the extent of adoption. [12]

* The condition/procedures are: knee replacement, hip replacement, bariatric surgery, acute myocardial infarction, diabetes, congestive heart failure, chronic obstructive pulmonary disease, asthma, hypertension, and coronary artery disease.

Questions & Responses

Are hospital and physician costs being bundled today?

Medicare already pays hospitals a bundled payment for the hospital's portion of a patient's health care bills. Each hospital payment is called a diagnostic related group (DRG). Medicare adopted this payment system in the 1980s, and it has been credited with saving Medicare money. [13] Many private insurance plans have adopted DRGs, saving employers and employees money as well. But a DRG does not include the physicians' fees as we propose.

What does a bundled payment look like?

Under the existing bundled payment system for hospitals, each DRG has its own code. For example, the code for a heart

transplant without complications is 002. [14] Hospitals submit a bill to Medicare based on hundreds of DRG codes. Their payment is for all the hospital's costs, ranging from the operating room staff to the patient's stay in the hospital. Physician fees, however, are separate. Under bundled payments, the physician and hospital costs would be paid together in order to encourage the physicians and hospital staff to work together to control costs and improve quality.

What about payments to physicians who see sicker patients?

Bundled payments could be adjusted based a physicians' mix of simple and complicated cases. These adjustments would be similar to the system in place for adjusting payments to hospitals under DRGs. The extra payments for sicker patients ensure that physicians don't try to avoid seeing sicker patients who have higher costs for reasons like pre-existing health problems.

What ensures that patients will get all the services they need?

Although physicians will have an incentive to reduce the amount of services under a bundle payment, patients can be assured that only unnecessary services will be weeded out for three reasons. First, physicians will have to report on their patients' outcomes. Quality measures will expose poor performance. Second, physicians can still face legal recourse from patients if they don't provide all the necessary care. Third, physicians will work as a team to prevent gaps in care that occur when specialists practice alone and no one coordinates a patient's care.

How will the federal government determine which services should be included in a bundled payment?

The technical work of determining the details of bundled payments has already begun. Medicare administrators are conducting demonstration programs to see how bundled payments can work in practice. [15] They will use the results of

these programs and an earlier acute care episode demonstration [16] to set new payment policies. Given the complexity of the work, it will take several years to create all the bundled payments.

What about other payment reforms like accountable care organizations?

Physicians may wish to use other new payment systems that are being developed, like accountable care organizations, through which Medicare and providers share in cost savings from improving the efficiency of all the services that a patient needs. Such a choice is important because it is not clear which payment reform will produce the best quality of care for the least cost. This is the kind of choice envisioned in the Schwartz-Heck bill. [17] Under the Third Way version of this proposal, bundled payments would establish a new overall budget for provider payments. Payments to accountable care organizations (or any other kind of new payment system) would be set such that if all providers participated in ACOs, then those reimbursements would not exceed the cost of bundled payments. In other words, bundled payments would set the standard for payments that other systems would try to beat through lower costs and higher quality.

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END NOTES

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