



RESEARCH REPORT

Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care

Bundled Episode Payments

Robert A. Berenson
URBAN INSTITUTE

Divvy K. Upadhyay
URBAN INSTITUTE

Suzanne F. Delbanco
CATALYST FOR
PAYMENT REFORM

Roslyn Murray
CATALYST FOR
PAYMENT REFORM

April 2016





ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is dedicated to elevating the debate on social and economic policy. For nearly five decades, Urban scholars have conducted research and offered evidence-based solutions that improve lives and strengthen communities across a rapidly urbanizing world. Their objective research helps expand opportunities for all, reduce hardship among the most vulnerable, and strengthen the effectiveness of the public sector.

Contents

Bundled Episode Payments	4
Key Objectives	6
Procedure-Based Bundled Episodes	6
Strengths	6
Weaknesses	7
Design Choices to Mitigate Weaknesses	9
Condition-Specific Bundled Episodes	9
Strengths	9
Weaknesses	10
Design Choices to Mitigate Weaknesses	10
Compatibility with Other Payment Methods and Benefit Designs	11
The Focus of Performance Measurement	12
Potential Impact on Provider Prices and Price Increases	13
Acknowledgments	14
Statement of Independence	15

Payment reform promises to substitute value for volume. Yet, value- and volume-based approaches typically are implemented together. All payment methods have strengths and weaknesses, and how they affect the behavior of health care providers depends on their operational design features and, crucially, on how they interact with benefit design. Those seeking greater value for their health care dollar are also turning to innovation in benefit design, which also typically involves the implementation of more than one approach at a time—each with its own strengths, weaknesses, and effect on consumer health care behavior. Although payment and benefit design each has received significant attention independently, the intersection between the two has received little if any. The Urban Institute partnered with Catalyst for Payment Reform to explore how established and proposed payment methods and benefit design options work on their own and together. We also examined how payment and benefit design can be blended to improve health care delivery. This chapter is one of the nine payment methods discussed in the report *Payment Methods: How They Work*. All reports and chapters can be found on our project page: [Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care](#).

Bundled Episode Payments

With the bundled episode approach, a prospective payment is made for all care a patient receives over the course of a defined clinical episode or period of management, instead of for discrete services (as with a fee schedule) or for all care a patient receives (as in global capitation). The episode of care has two dimensions: a clinical dimension, which can represent either the set of services or the clinical conditions that compose the episode, and a time dimension that reflects the beginning and the end of the episode. In essence, the approach is designed to transfer financial responsibility for the technical risk (i.e., risk related to care production) that is under the included providers' control, but not the probability (or insurance) risk that relates to the burden of illness and injury in any large patient population. The bundled providers—clinicians and facilities—have common financial incentives to control the cost of the bundle, because they keep the savings or bear the cost of overruns if costs differ from the fixed payment.

Here we distinguish bundled episode payment from episode payment. The former refers to payment that covers all care for a defined clinical condition *across* various providers of patient care, whereas the latter refers to the duration of service the payment covers, whether or not provided by a

single provider or by providers working together. Even in the United States, with its reliance on fee schedules, individual physicians sometimes receive payment for a care episode, for example, for costs associated with professional services for a pregnancy. However, in this example, hospitals would be paid separately for the facility costs associated with the actual delivery.

Bundling separate payment streams into a single one is a unique challenge with bundled episodes. Extending the length of the episode, for example, beyond a hospital discharge, also can be an important strategy to promote care coordination, depending on the providers included in the episode.

Many, though not all, proposals for bundled episode payments involve the care around a hospitalization. For example, in the Medicare Acute Care Episode demonstration, payment was made for bundled episodes triggered by joint replacements and particular cardiac procedures. Medicare is currently testing other approaches under the Bundled Payments for Care Improvement (BPCI) initiative, which includes models that bundle various combinations of physician and hospital inpatient services during the hospital stay, as well as postacute care services within 30 to 90 days after discharge. Preliminary evidence suggests that extending the episode to the postacute care period produces savings, as home health care is substituted for more costly institutional postacute care and readmission rates decrease.

Recently, the Centers for Medicare & Medicaid Services Innovation Center has launched two additional bundled payment models: comprehensive care for joint replacement, mandatory for all hospitals in the demonstration areas, and an oncology care model that bundles services for patients receiving chemotherapy.

These demonstrations, as well as many private sector efforts, focus on more efficient production of procedures—usually performed on an inpatient basis—but there is also interest in condition-based bundled episodes. In this approach, an episode for a reasonably well-defined chronic condition would be the focus of the payment model; for example, the bundle would include services for patients with ischemic heart disease or diabetes for a period of time, perhaps as long as a year. Compared to procedure-based episodes, bundled episodes for conditions could affect much more health care spending and could create much stronger incentives for care coordination across health professionals and providers. Condition-based bundled episodes also could counter the volume-inducing incentives of procedure-based episodes, as discussed below. However, particular challenges associated with chronic condition-based episodes must be addressed—particularly for patients with multiple chronic conditions.

Key Objectives

The primary objective of a bundled episode model is to promote better coordination among clinicians, hospitals, and other providers. These entities respond to the efficiency incentive of the fixed prospective amount they receive for providing all the patient’s services during the episode of care.

In addition, whereas most other payment and delivery reform approaches—including patient-centered medical homes and ACOs—prominently emphasize primary care physicians’ role in spending reductions, bundled episodes rely more on specialists (who provide the most costly services). *Procedure-based* bundled episodes provide specialists with an opportunity to assume primary, risk-based responsibility for producing lower-cost care with high quality. *Condition-based* bundled episodes can permit physicians to manage care over extended periods, without creating a bias toward performing procedures, by rewarding managing physicians for avoiding costly complications.

Because the incentives, designs, and operational mechanics of procedure-based and condition-based bundled episodes differ substantially, we consider their strengths, weaknesses, and design features separately.

Procedure-Based Bundled Episodes

Strengths

- Procedure-based bundled episodes internalize the incentive for efficiency to affected providers. The contracted party receiving the bundled payment, often the hospital, earns a higher margin if patients are discharged earlier. Yet the party also bears the financial risk of both readmissions and the cost of postacute care for episodes extended beyond hospital discharge, providing a counter-balance to premature discharge.
- Procedure-based bundled episodes provide an incentive for acute and postacute care providers to communicate and coordinate, to both improve patient outcomes and reduce costs. For common inpatient procedures, a typical area for such cooperation is purchasing equipment and supplies, such as expensive artificial joints, using combined market leverage to negotiate better prices from manufacturers.

- Hospitals would likely develop close relationships with physicians and postacute-care facilities more willing to participate in a cooperative venture, and follow care guidelines to achieve quality and cost targets (again, assuming there is a posthospital portion of the defined episode). Providers in acute and postacute settings are encouraged to communicate about ensuring continuity of care for the patient.
- Bundled episodes can be viewed as partway between volume-based payment and true population-based payment (e.g., global capitation), allowing clinicians and organizations to ease into broad payment reform with increased accountability for quality and costs.
- Bundled episodes are more consistent with the service-line strategies hospitals have adopted over the past decade than with population-based payment approaches. Thus, the approach could be more readily undertaken without major change in business models and complex organizational cultures.
- Bundled episodes are seen as providing an “on-ramp” toward value-based payment for some procedural specialties, comparable to medical homes for primary care physicians.
- Because the approach requires providers to cooperate but not to integrate, it can reduce the potential for provider consolidation that can raise transaction prices.

Weaknesses

- Procedure-based bundling remains firmly a volume-based payment method in that it rewards providers for initiating more episodes. The approach might result in high-quality, efficiently produced, but unneeded procedures.
- Arguably, combining various providers’ separate payments into the same bundled payment promotes—and perhaps even heightens—opportunities for providers to increase volume of services. That is, providers together could brand and market their now jointly produced services.
- Incentives to skimp on care or to avoid sicker patients are inherent in any fixed-episode payment approach, if there is no risk-adjustment mechanism that pays for additional services provided to sicker individuals.

- Hospitals and other providers have a logical impulse to narrow their referrals to favored postacute care providers, which might compromise patients' choice of provider.
- Although procedure-based bundling is, in some ways, less of a change from the usual payment approaches, it may lack the simplicity of a fixed capitation payment, generating additional administrative expense to adjudicate claims at scale.
- Determining which specific claims for payment belong in a bundled episode is operationally challenging, especially for posthospital services for patients with multiple conditions. Ensuring that services in the bundled episode are paid one time, and one time only, can be difficult. In Medicare's BPCI initiative, recipients are accountable for all spending by the patient addressing claims-related challenges but raising other concerns.
- Where health professionals and other providers, such as hospitals, remain legally independent, sustaining relationships among multiple providers may be difficult. Of particular concern is that a hospital, typically the dominant cost center in a procedure-based bundled episode, may dominate the collaboration and act in its own interests, which may not be congruent with the others'.
- Relatively few procedures may be amenable to a bundled episode approach—payment for less common and for complex procedures may be difficult to bundle, thereby limiting the potential impact of the payment method.
- Even assuming procedure-based bundling is successful, hospitals and physicians in noncompetitive markets may be able to increase volumes and prices for other services to make up for reduced revenues on the bundles. This is more likely if basic payment, except for the bundled episodes, remains volume-based through fee schedules for physicians and either per diems or DRGs for hospitals.
- Only by obtaining discounts off the legacy payment equivalent can payers (and possibly consumers) benefit financially from more efficiently produced episodes. Such discounting may be difficult to negotiate where provider partners have market power, especially with integrated hospital-physician entities.
- A potential barrier to providers' participation is their assumption of risk for large losses. These can result from catastrophic medical events or from patients covered under bundled payment requiring additional services.

Design Choices to Mitigate Weaknesses

Several operational policy options would address both the problem of excessive financial risk and the incentive to stint on care. These include (1) an outlier policy that exempts some amount of payments from the bundle, (2) risk corridors in which payers would share both upside and downside risk with providers, and (3) requirements that payment recipient organizations purchase reinsurance for spending above a certain threshold.

The strongest candidates for bundled payment are episodes for which current costs vary substantially and for which well-established practice guidelines (that can form the basis for normative standards) determine reasonable costs. Payers, however, should want to ensure each procedure is appropriate. Appropriateness may be better ensured by a centers of excellence approach than by broad application of the bundled episode payment approach to participating providers. Other approaches might include reconsideration of second-opinion programs and external precertification determination by the payer. Yet, there is often a large “grey zone” of appropriateness for common procedures.

Giving an entity funds that otherwise would flow directly to a different provider via a prospective payment raises concerns. One approach is to continue paying individual providers in a bundle separately and retrospectively, using standard payment methods that reconcile payments at the end of the episode (and perhaps withholding a portion of payments to cover overspending, if that occurs). In this case, the collaborative group would only have to agree on how to distribute surpluses or pay back deficits, while a flow of core funding for each entity would be assured. However, the approach of maintaining separate payment streams may to some extent undermine the goal of true collaboration across health professionals and other providers.

Condition-Specific Bundled Episodes

Strengths

- Condition-specific bundling could involve a larger percentage of health care spending than procedure-specific bundled episodes.
- This approach directly counters the possible bias in procedure-based bundled episodes toward unnecessary procedures, by focusing on all components of care rather than each procedure.

- Condition-based episodes could provide a significant role for specialists, who may be functioning as principal physicians for patients with chronic health conditions, without encouraging them to perform procedures or refer their patients to other providers. .
- Evidence-based, clinical guidelines are typically condition based and may be more practical to use with condition-specific episodes than with capitation for all services under a provider’s control.

Weaknesses

- Many conditions—even common ones—are not well defined, offering providers an incentive to “find” conditions in order to receive a prolonged payment for a condition-specific episode. Current variations in ICD diagnosis coding, even for common conditions such as congestive heart failure, suggests a lack of standardization with the potential for gaming (although definitions of conditions for episodes are improving).
- Although condition-specific bundling is not likely as complex as the risk adjustment needed for global capitation, there would still be a need for case-mix adjustment for chronic conditions.
- Many patients, especially in Medicare, have multiple chronic conditions. Paying on a condition basis, perhaps to different groups of providers, would not be holistic, possibly counteracting the goal of better care coordination.
- Alternatively, holding a particular provider who has accepted payment for a particular condition-based episode accountable for total health spending as in Medicare’s BPCI can generate conflicts among different physicians caring for different conditions.
- In managing a chronic condition, the cost of a procedure typically dwarfs the cost of medical management absent the procedure. A single condition-specific payment, then, would perhaps create a powerful incentive for its primary recipient to not refer the patient for necessary procedures.

Design Choices to Mitigate Weaknesses

To address the potential for patients with coexisting conditions to receive “nonholistic,” separate episodes of care, payers could combine conditions that often “travel together” (e.g., hypertension,

congestive heart failure, diabetes, chronic renal failure) into a single payment that providers would be responsible for managing collaboratively. However, this approach is akin to capitation and undermines the simplicity condition-specific episode payment is meant to achieve.

To address the concern that clinicians will make questionable diagnoses to trigger an episode payment, strict criteria can be required. These criteria can include demonstrating positive test results or providing patients with multiple encounters and documenting diagnoses via claims forms (thus demonstrating a minimum level of persistence or verification of the diagnosis by one or more other clinicians). Although the testing requirement will likely help confirm diagnoses, it might also generate unnecessary, sometimes invasive, tests. This perverse result would see tests ordered to qualify the patient for payment instead of to meet clinical need. Relying on persistence of the same diagnosis on multiple claims is less intrusive for patients, but may be gamed.

The challenges described here are not unique to condition-specific episodes; they also are present in diagnosis coding as the basis for risk-adjusting capitation payments. For private insurance bundles, the common approach to avoiding false-positive diagnoses is to consider newly diagnosed conditions as being in an observation period until the next benefit year begins. At that point, the diagnosis would trigger a condition episode, assuming confirming claims document the condition.

Compatibility with Other Payment Methods and Benefit Designs

Procedure-specific bundled episodes are compatible with reference pricing approaches, as both rely on a fixed, predetermined price for complete procedures and applicable postprocedure days, rather than rely on fee-for-service physician billing. Reference pricing might also improve the likelihood that procedure-based episodes are appropriate, if the payer's approach requires that providers able to perform an intervention at its reference price also meet basic standards, including commitment to evidence-based guidelines and other basic quality standards. Variable cost-sharing, such as with V-BID, varies by individual services and so would seem inapplicable to procedure-specific episode payments; the procedures for which this payment method is being tested do not generally fall within the V-BID ambit.

Narrow and tiered provider networks are typically determined by hospitals and employed or affiliated professionals. Yet, bundled episodes are determined at the hospital and specialty level. The provider collaboration best able to manage a bundled episode might not correspond to the providers

selected in a narrow or favored tier. At the same time, for selected or favored providers within the network, a bundled episode approach might be complementary.

Payment for a condition-specific inpatient treatment episode is quite compatible with DRGs, but not with per diem payment. Indeed, some jurisdictions have expanded the duration of a DRG case to extend beyond hospital discharge, so that the hospital takes responsibility for improving discharge planning and transitioning patients back to other facility-based or community-based providers. The approach may also complement various approaches to capitation or population-based payment: the primary care physician at risk or, especially, the ACO-like group would have reason to better assure a procedure is appropriate.

The Focus of Performance Measurement

Procedure-specific and condition-specific bundled episodes present different challenges for measurement. Procedure-specific bundles remain volume based, with incentives to generate perhaps unneeded services. As with other approaches to addressing concerns about provision of unnecessary bundles, it would be useful to measure rates of inappropriate services. At this time, such measures are in a formative state.

Condition-specific episodes, on the other hand, have inherent, strong incentives for providers to avoid costly procedures, which could lead to stinting on care that would benefit patients. We may count on professionalism to protect against denial of referral in clear-cut situations when a procedural intervention is needed. Yet, there is usually a “grey zone” of discretion in which financial incentives may have a large influence. Here, measures of denial of appropriate services would be useful to monitor performance. However, without a population base as the denominator for calculation of procedure rates, it is hard to determine whether needed procedures are being denied

For both versions of bundled episodes, a fixed payment raises concerns about short cuts in quality. Payers could develop specific procedure and condition measures for common bundled episodes, such as joint replacements and deliveries. These measures would not be broad-based core metrics but, rather, would be relevant to the specific procedures and conditions paid under the episode approach. Metrics might include patient-reported outcomes that are currently being developed, which would inform consumers’ and payers’ choice of providers that are to be offered bundled episodes. Indeed, narrowly focusing the episode to a procedure or condition makes available quality metrics more relevant for facilitating individual patient choice. Further, given the incentives inherent in bundled episodes, the

Centers for Medicare & Medicaid Services are including measures of shared decision-making, patient-reported outcomes, and clinical appropriateness.

Potential Impact on Provider Prices and Price Increases

As with some payment approaches, if the bundled episode fee is based on historic costs, the payer will build in current pricing disparities that result from variable negotiation leverage. Basing payment on normative pricing, such as the community average, would directly penalize higher-priced providers and make their voluntary participation less likely. A specific concern is that putting hospitals, clinicians, and, perhaps, postacute care facilities together into a recognized “focused factory” could produce, in effect, a “bargaining unit.” This could raise prices higher than they would be if the parties were negotiating separately, without their ongoing joint participation in providing services.

Acknowledgments

This report was funded by the Robert Wood Johnson Foundation. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at www.urban.org/support.

A [technical expert panel](#) advised the project team and reviewed the reports at different stages.

STATEMENT OF INDEPENDENCE

The Urban Institute strives to meet the highest standards of integrity and quality in its research and analyses and in the evidence-based policy recommendations offered by its researchers and experts. We believe that operating consistent with the values of independence, rigor, and transparency is essential to maintaining those standards. As an organization, the Urban Institute does not take positions on issues, but it does empower and support its experts in sharing their own evidence-based views and policy recommendations that have been shaped by scholarship. Funders do not determine our research findings or the insights and recommendations of our experts. Urban scholars and experts are expected to be objective and follow the evidence wherever it may lead.



2100 M Street NW
Washington, DC 20037

www.urban.org