

Payment Reform: Bundled Episodes vs. Global Payments

A debate between Francois de Brantes and Robert Berenson

Timely Analysis of Immediate Health Policy Issues

September 2012

Moderated by Rachel Burton

Introduction

There is widespread agreement that the current fee-for-service approach to paying for health care is problematic, since it incentivizes volume over value, but there is a lack of consensus on what should replace it.

One option, *bundled episode payments*, is about to be piloted nationally in the Medicare program as a way of paying for certain high-volume, high-cost procedures. Proponents like **Francois de Brantes** cheer such developments, and have been busy laying the technical groundwork for implementation. But other payment experts, such as **Robert Berenson**, worry that the current interest in bundled payments will distract policymakers from moving more forcefully away from fee-for-service. At best, he views bundled payments as a waypoint on the road to capitation, but at worst, he worries it could turn into a cul-de-sac from which we never emerge. Dr. Berenson would prefer to see more experimentation with capitation, also called *global payments*, which is a payment approach currently used by health maintenance organizations (HMOs), including in Medicare Advantage plans. This gives providers a stronger incentive to reduce unnecessary care and bring spending under control. (These and other terms are defined in the “Glossary” on p. 13.)

To debate the merits of these two payment models, we brought these two experts together for a frank assessment of the benefits and drawbacks of bundled payments and global capitation. (The debate begins on p. 3.) Some of their views may surprise you. While Mr. de Brantes believes globally capitated payments are a “blunt tool,” and says “if I had cancer, you couldn’t pay me enough to be insured through such a model!” he nevertheless thinks capitation could make sense, but only for patients with routine sick and preventive care needs. Meanwhile, Dr. Berenson argues that “that’s not where the costs are.” He thinks bundled payments could prove to be counterproductive, since any benefit from bundled services being performed more efficiently could be outweighed by the increased number of bundled episodes this approach could generate (in what would still essentially be fee-for-service).

Who’s right? Read on to decide for yourself and find out which design features and incentives they share concerns about for both approaches.

The Debaters

Francois de Brantes, MS, MBA, is the executive director of the Health Care Incentives Improvement Institute, and has previously led various employee health care initiatives for General Electric. He is a proponent of bundled episode payments, in general, and his organization’s PROMETHEUS Payment model, in particular (described on p. 2).

Robert Berenson, MD, is a former official with the Centers for Medicare & Medicaid Services, commissioner of the Medicare Payment Advisory Commission, and primary care physician. He is currently a fellow at the Urban Institute. He is a proponent of global payments, as well as hybrid mixes of fee-for-service with capitation, such as partial capitation.

The Payment Models

Among the various payment models available for consideration by reformers, each approach varies in its allocation of financial risk between payers and providers. At one end of the spectrum is fee-for-service, which requires payers to foot the entire bill for patients' care while putting providers at no risk of losing any money. At the other end of the spectrum is global payment, which requires providers to take on considerable financial risk, since they must deliver whatever care a patient may need, even if the cost of this care exceeds the value of the capitated payment they've received. In between these two is the bundled episode payments model, which typically requires providers to take on financial risk for certain designated procedures, while leaving the fee-for-service payment system intact for all other services.

Bundled episode payments combine two key concepts: these payments are “episode-based” because they cover the cost of all services delivered during a defined episode of care (e.g., beginning three days prior to a knee replacement surgery and extending 30 days past a patient's discharge from the hospital for this procedure). These payments are also “bundled,” since payments for services delivered by multiple providers can be combined into a single payment, which is then divided up between these providers as they see fit. Alternatively, a budget can be established for the bundle up front, which can then be reconciled against actual spending once the episode is closed.¹

The combination of these two concepts is relatively new in the United States, but each has been separately employed by U.S. payers for years. Technically, Medicare's diagnosis-related group (DRG) payments to hospitals are *episode*-based payments, since they are pre-set, lump-sum payments for diagnoses or procedures, which do not vary based on what services are actually provided. And *bundling* has been used for decades by HMOs, which typically pay a provider organization a lump sum to cover the cost of care delivered by a variety of different providers.

The goal of combining these two approaches into *bundled episode payments* (which is sometimes abbreviated as “bundled payments,” though this term is a bit of a misnomer) is to give providers an incentive to coordinate their services and to find more efficient ways to deliver care. A recent study by Bailit Health Purchasing identified 19 sites across the U.S. implementing private sector bundled payment initiatives (see the “Current Bundled Payment Arrangements in the Private and Public Sectors” box on p. 6).²

The PROMETHEUS Payment Model of Bundled Episode Payments

The PROMETHEUS Payment model for calculating and paying for bundled episodes uses an evidence-based, ground-up approach. To construct bundles, researchers at the nonprofit Health Care Incentives Improvement Institute (HCI³) review the best available clinical evidence and determine what services should be delivered during a given episode; the cost of these services is summed, then the total price for the episode is risk-adjusted to reflect the clinical complexity of a given patient and an allowance is added to cover the cost of treating potentially avoidable complications that may arise. If a group of providers can deliver care at a cost that is lower than the price of the bundled payment—primarily by closely monitoring a patient to avoid the onset of costly complications—they can generate profits to share among themselves. PROMETHEUS differs from other bundled episode payment approaches which set the price of bundles using a top-down approach based on historical costs for treating a given condition. The PROMETHEUS Payment model's basic operational framework has been adopted by CMS in its forthcoming bundled payment pilots.

Since 2006, HCI³ has created algorithms for calculating the price of 21 episode bundles, which are made available to participating payers and providers through a software application called the PROMETHEUS Payment Model ECR Analytics. The analytical package uses historical claims data from a payer to establish prospective budgets for contracted providers and those budgets are then reconciled against paid claims.

PROMETHEUS is an acronym for **P**rovider Payment Reform for **O**utcomes, **M**argins, **E**vidence, **T**ransparency, **H**assle-Reduction, **E**xcellence, **U**nderstandability and **S**ustainability.ⁱ

ⁱ Health Care Incentives Improvement Institute. *What's the Most Rational and Sustainable Pathway to a New Health Care Payment System?* Newtown, Conn.: Health Care Incentives Improvement Institute, 2010, www.hci3.org/sites/default/files/files/Prometheus%20Brch-F6.pdf (accessed August 2012).

Global payments (sometimes called “global capitation”) differ from bundled payments in that they are usually paid to a single health care organization, and cover a wider array of services for a larger population of patients over a longer period of time (for example, all of a population of patients’ health care needs over the course of a year, instead of only the services associated with a given condition or procedure). Global payments are currently used by private HMOs, including in publicly financed products like Medicare Advantage plans and Medicaid managed care plans. If a patient insured through a globally capitated plan uses services that cost less than the amount paid to her provider organization, the organization keeps the leftover funds as profit. To ensure providers do not withhold needed care, globally capitated providers often have to report on quality and utilization measures, which can be linked to performance bonuses or publicly reported.³ The amount of the global payment can be based on normative standards (e.g., the average risk-adjusted payment for the population in the community) or based on historical spending for the population cared for by the capitated organization, trended forward. (Other forms of capitation—*primary care capitation* and *professional capitation*—share some of the same features as *global capitation*, but encompass far fewer services. In particular, neither includes the costs of hospitalization, which represents a major source of spending and corresponding opportunities for spending reductions.)

The Debate

Moderator: The two of you are staunch proponents of payment models that would move us away from our current fee-for-service system. Can you each give me your best 30-second elevator pitch for your preferred payment model?

de Brantes: There are really two broad functions in the health care market: one is insurance, and the other is care delivery. Insurance is typically managed by actuaries and risk managers, whereas care delivery is typically managed by clinicians. The people performing each function need to understand the types of risk they’re managing, and need to have incentives to do a good job. Bundled payments focus clinicians on the appropriate management of patients, yet still maintain an essential role for insurers to manage financial risk. Also, one of the appeals of bundled payments is that it’s an approach that translates into an effective purchasing mechanism for consumers. They can look at something like a knee replacement bundle and calculate their portion of the bundled price up front. This can allow patients to engage in value-based purchasing.

Berenson: I don’t think moving to episodes gets us far enough away from fee-for-service—there are still strong incentives to do unnecessary, inappropriate interventions to get an episode payment for them. And once you start paying providers using bundled payments, you have brought the doctors and the hospital together to develop a dedicated service line around doing knee replacements. I will concede that they are likely to do them more efficiently and perhaps with higher quality—they’ll become what in business is called “focused factories”—but they’ll also now have an incentive to brand and market their joint activity, contributing to a “medical arms race”⁴—which means that providers compete not over price but over the newest and best technology, sometimes providing it to patients who don’t need the intervention. I don’t see how performing an unnecessary procedure more efficiently is helping us get control over health care spending.

I think to really change the current system, physician-led organizations (which may or may not include a hospital) should be responsible for a patient population. This would fundamentally change incentives: physicians would have to figure out how to provide the best care to keep that population healthy within budgetary constraints. Since the provider organization would now essentially be working within a budget, the next unnecessary coronary intervention would be a *cost* to the group, rather than a *profit*. If we have concerns about small groups taking on too much financial risk, we could do risk corridors—share the risk with the payers, whether they are Medicare or private insurance companies. Providers don’t have to take on 100 percent of the financial risk, they can split it 50-50 or even 20-80. To me, the key thing is that unnecessary services would now be a *cost* rather than a *profit* for providers. This represents a much more fundamental break with the current fee-for-service payment system than other payment models, including bundled episodes. Unfortunately, in the U.S., at this point, fee-for-service has become unsustainable. Physicians are just abusing it too much, so we need to move fundamentally away from it—at least to where physician organizations are able to take responsibility for the populations under their care.

de Brantes: But physicians could end up abusing global capitation, as well. Depending on how the incentives are designed within the capitation model, the value of each additional service delivered by the organization is negative. That's just an economic fact. So you always have that challenge—if you're a patient on the 30th of December asking for that additional service that's going to put the organization underwater—you might be completely out of luck.

Moderator: Let's deal with bundled payments first. Mr. de Brantes, is it true that bundled payments could lead to increased utilization of unnecessary services?

de Brantes: There's no evidence to date in any of the studies on bundled payments that they lead to increased use of unnecessary services.

Berenson: There is evidence that episode-based payments, in the form of Medicare DRGs, leads hospitals to “upcode” – to claim payment for a more complex condition – and in some circumstances, to increase admissions.⁵ Aligning hospitals with physicians could well increase the ability to do both. One might be able to adjust payment amounts for volume increases or require prior authorization for particular procedures; but inappropriate overuse of procedures and some imaging is a real problem that bundled episodes may make even worse.

de Brantes: Well I feel very strongly that, rather than simply and only putting pressure on the *supply* of health care services, which occurs in capitation, the *demand* for services also needs to be controlled—mainly at the consumer level. If you look at the proliferation of consumer-directed health plans with high deductibles and high co-insurance, we know that these types of benefit designs create a brake on consumption. I believe patients' insurance benefits should have a continuous, thin cost-sharing—somewhere between 5 and 10 percent—to remind patients there is a cost associated with each incremental service they receive. It makes the discussion of the appropriateness of a service more tangible to them, rather than a right or an expectation.

But I want to distinguish between two populations that we sometimes co-mingle in these discussions: one is the commercial patient population, and the other is the Medicare population. With the commercial population, there are mechanisms in place to dampen demand for services—mainly because now, about 20 percent of people with private insurance have high co-insurance and high-deductible health plans, and the number is expected to continue to rise rapidly.⁶ And even for people who are not in such plans, deductibles have gone up across the board. But on the Medicare side, unless you are covered by a Medicare Advantage plan, the likelihood of fundamental benefit design change that would convert the Medicare beneficiary into a more active shopper is unlikely.

Berenson: I agree. In Medicare, 90 percent of beneficiaries have supplemental insurance and most have virtually no co-pays.⁷

de Brantes: So yes, I am concerned about the over-production of bundles, but only in the Medicare world—because the population is very different and you don't have the natural restraint on the demand for services that you can create on the commercial side through co-pays. And there might be different solutions for these two populations.

Moderator: I've read that bundled payments are administratively complex to implement⁸. A 2011 study found that at the end of a three-year pilot, none of the five payers who had signed up to use the PROMETHEUS Payment model had managed to enter into agreements with providers to begin paying them using bundled payments.⁹ Are bundled payments too complicated to be implemented?

de Brantes: I'm not going to get into the multiple reasons why there weren't any agreements entered into in those sites, but suffice it to say, today that's a changed story. More importantly, beyond those sites, there are now many other sites pursuing bundled payment—a total of 19 groups of payers and providers (see the “Current Bundled Payment Arrangements in the Private and Public Sectors” box on p. 6).¹⁰ In many of these newer sites, they went from design to contracts in six months or less. So the barriers to implementation have changed dramatically in recent years.

Influential Bundled Payment Demonstrations in Medicare

Participating Heart Bypass Center Demonstration. In this demonstration, which ran from 1991 to 1996, Medicare paid seven hospitals bundled payments for inpatient hospital and physician services associated with coronary artery bypass graft (CABG) surgery. Over the course of the demonstration, participating hospitals lowered CABG mortality rates by 8 percent per year and the Medicare program saved 10 percent compared to what it would have otherwise spent.ⁱ

Acute Care Episode (ACE) Demonstration. In this demonstration, Medicare is paying five hospitals bundled payments for a larger set of services, which includes certain cardiovascular and/or orthopedic procedures. In addition, CMS will share up to 50 percent of the savings that are generated for the Medicare program with beneficiaries, up to a maximum of the annual Medicare Part B premium, which is currently \$1,199. Hospitals began their three-year participation in the demonstration between May 2009 and November 2010.ⁱⁱ

ⁱ Cromwell J, Dayhoff DA, McCall NT, et al. *Medicare Participating Heart Bypass Center Demonstration*. Baltimore: U.S. Health Care Financing Administration, 1998, www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/oregon2_1998_3.pdf (accessed August 2012).

ⁱⁱ Centers for Medicare & Medicaid Services. *Medicare Acute Care Episode Demonstration for Orthopedic and Cardiovascular Surgery*. Baltimore: Centers for Medicare & Medicaid Services, www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/ACE_web_page.pdf (accessed August 2012); Centers for Medicare & Medicaid Services. *Acute Care Episode Demonstration*, Baltimore: Centers for Medicare & Medicaid Services, www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/ACEFactSheet.pdf (accessed August 2012).

Part of the issue has been technology. The operational systems in many health plans are built on legacy systems that manage fee-for-service billing. So you need IT solutions that will allow you to implement this type of payment—you need an operational structure at either the payer level or the provider level to effect those contracts and manage them. You can't do that with the legacy fee-for-service transaction systems. Today there are at least three IT companies that have either developed or are in the process of developing new bundling modules for claims adjudication purposes. So I would say the technical piece is, if not 100 percent resolved, then about 90 percent resolved. Of course, for all payers (including Medicare), changing or making improvements to their current claims adjudication systems is a significant undertaking, and many will take time to evaluate the need to make such an investment.

Once these technical issues are resolved, what's left are human issues. The human piece is a challenge—whether talking about an accountable care organization (ACO) or a bundled payment. You're taking players in the delivery system that have had a core incentive to produce volume, and now getting them to think about delivering care in a different way. To get them to bind together through a financial agreement—and to now work together to figure out a different, more efficient way of delivering services—requires clinical collaboration, clinical exchange of data, and different forms of gainsharing and contractual relationships between them. The core issues of how you get folks who have never worked together to collaborate is a problem for any incentive program other than fee-for-service—not just bundled payments. And a key ingredient to success is actionable data, which some episode analysis programs provide. So, for example, it's a lot easier for orthopedic surgeons to manage the cost of total knee replacement surgeries if you can provide them with comparative information on the episode costs—how much different inpatient facilities cost, or what portion of the episode costs were the result of readmissions or medical errors. In other words, good data analysis can identify a lot of the current waste in health care, and bundled payments can help focus clinicians on reducing that waste.

Moderator: Is the human piece harder to wrap people's heads around than the technology piece? Is that what the hold-up has been in getting bundled payment agreements implemented?

de Brantes: For many payers and providers, a central issue—and this is a big one—has been trust. When payers and providers have had a historically rocky relationship, it can take a tremendous amount of time to bridge that trust gap. If one party is holding the books and the other doesn't have the opportunity to look at them, there is no trust. I think that's true no matter what type of contract you sign (other than fee-for-service), because you are shifting financial risk from one party to another. If I do not trust you as a payer and you are the one setting the rate—whether it's a bundled payment or a capitation rate—and if I have no way of validating whether or not the calculation is accurate, I'm not going to accept it.

Moderator: Recently, bundled payments have been developed for chronic conditions, not just specific procedures. Dr. Berenson, is this beginning to sound like capitation to you?

Berenson: I find bundled payments for chronic conditions conceptually more attractive than bundled payments for particular interventions, because the group of providers now has an incentive to not do unnecessary procedures during the course of the chronic condition. I'm not sure it can work practically, but conceptually, I can understand the change in incentives.

de Brantes: The beauty of bundles for chronic conditions is that you can start achieving the goal of encouraging a reduction in the provision of certain procedures, without putting too much insurance risk on the backs of clinicians. An example is heart disease. If you create a bundle for heart disease that doesn't just include the ambulatory services associated with the disease, but also includes the treatment pathways—such as coronary artery bypass graft surgery or normal medication therapy—you are now holding the physicians responsible for the entire cost of care, and the selection of treatment. You can “bake into” the overall bundle an average level of utilization of procedures. That creates an incentive to reduce overutilization of these types of procedures. However, since you're only creating a bundled payment for heart disease, the providers continue to be insulated from forms of insurance risk. For example, providers wouldn't be held financially responsible for the cost of services to treat newly diagnosed cancer in a patient with a heart condition; the treatment of the cancer is outside the boundaries of the heart disease bundle.

Moderator: Dr. Berenson, you said bundled payments for chronic conditions are “more attractive” to you—are they equally attractive to you as global capitation?

Berenson: Well, no. For one thing, it seems to be non-holistic. We would pay separately for episodes of diabetes and congestive heart failure and renal failure—possibly even to different groupings of providers? By the time you cluster all the conditions that many people have concurrently, you might as well bite the bullet and pay capitation.

Current Bundled Payment Arrangements in the Private and Public Sectors

According to a 2012 study, 19 groups of providers and payers (which are mostly private payers, but include some states) are interested in paying providers using bundled payments—including three groups that are interested in the PROMETHEUS model, specifically. Nine of these groups have moved out of the planning stage and have begun paying providers using this approach. Many of the bundled payment agreements that have been implemented so far do not put providers at financial risk if the cost of the services they provide exceeds the price of their bundled payment; however, these payers and providers generally agree that the end-goal of their partnerships is to have providers take on some financial risk for the cost of services provided in an episode. Meanwhile, among the agreements that already require providers to take on financial risk, providers' exposure is usually limited, such as by excluding outlier patients who generate particularly high costs (e.g., two-and-a-half times the cost of a bundled payment). So far, the number of patients whose episodes of care have been paid for through a bundled payment has been relatively small (typically 10-50 per year per payer-provider agreement).¹

CMS is also experimenting with bundled episode payments. In August 2011, its new Innovation Center released a call for applications to participate in its new Bundled Payments for Care Improvement initiative. Through this pilot, participating provider groups can take on financial risk for providing services to Medicare beneficiaries for certain defined episodes of care. They can choose between four bundled episode payment models. Under Model 1, hospitals receive bundled payments covering the cost of both hospital care and professional services provided during an inpatient admission. Under Model 2, the cost of care post-discharge would *also* be added in, and the episode period would end a minimum of 30 or 90 days post-discharge. Model 3 would *only* include such post-discharge services. Bundled episode payments in these three models would all be made *retrospectively*, meaning CMS would pay all regular medical claims as they occur but would settle-up periodically through a reconciliation process. By contrast, under Model 4, CMS would make *prospective* payments covering all costs associated with an inpatient stay.

¹ Bailit MH, Burns ME, and Painter MW. *Bundled Payment Across the US Today: Status of Implementations and Operational Findings*. Newtown, Conn.: Health Care Incentives Improvement Institute, 2012, www.hci3.org/sites/default/files/files/HCI-IssueBrief-4-2012.pdf (accessed August 2012).

Also, I am worried about the “woodwork effect”—lots of diagnoses coming out of the woodwork, now that a provider has an incentive to find more chronic conditions and get paid for each one. You pay me for treating low back pain with an episode payment, and I will find a lot of low back pain. So you’ve got a real oversight issue. How do you make sure you’re paying for a real diagnosis and not a made-up condition the patient doesn’t actually have? (Or, more likely, does have but is not worthy of a full-episode payment.)

de Brantes: Well, to lessen the incentive for providers to gin up fake diagnoses, what we’ve done—in the newer version of the PROMETHEUS Payment model, at least—is to split the cost of the services amongst different episodes. Let’s say you have an office visit, and in that office visit, the physician codes the claim for diabetes, coronary artery disease, asthma, and Lord knows what else. So that patient has all those open episodes. Well that visit—let’s assume it costs \$75—is actually going to get split into all the underlying episodes. So the more episodes you have, the lower the expected cost per episode. As such, a provider gains nothing by over-diagnosing a patient or artificially opening new episodes.

Berenson: Overlapping or concurrent episodes, like you’re talking about, sound like they could be complicated operationally. When any service is provided, who decides which episode it belongs to? Often a diagnosis is made after a service is delivered, and some services reasonably can be allocated to more than one episode—like lab tests and x-rays.

de Brantes: An excellent point, and one that is best answered by focusing on the level at which you want to measure provider performance. If you want to measure performance for providers treating Medicare patients with a cluster of chronic conditions, then where the lab test or x-ray ends up isn’t important; this is the approach we’ve focused on in our PROMETHEUS Payment implementations, since it reduces operational complexity and the arbitrariness of service assignments. Or if you want to measure performance of providers treating patients with a specific condition, then yes, the devil is in the details.

Moderator: *Mr. de Brantes, what would happen if a patient with diabetes and hypertension shows up in the hospital with a heart attack? Do the costs of that heart attack get assigned to the diabetes episode, or do you create a new episode?*

de Brantes: Well, there are different methodologies and ways of doing this. In the PROMETHEUS Payment model, we would call that heart attack a “potentially avoidable complication.” If you’re a payer, you can contract with a hospital to treat heart attacks, in addition to contracting with them to treat chronic condition episodes. You want to create an incentive for the appropriate management of the heart attack, and not overutilization of services during treatment—and you want to instill a sense of warranty, post-discharge, so that you don’t end up with a repeat heart attack. And when the heart attack bundle closes, the costs associated with that bundle immediately get reassigned to the diabetes episode, because it is considered a potentially avoidable complication. So you can have bundles within bundles, but at the end of the day, the cost of treating the heart attack would come out of the bundled payment for whatever chronic condition the patient had to begin with.

Berenson: But wouldn’t the hospital costs for treating a heart attack overwhelm the standard costs of the chronic care bundle?

de Brantes: Of course it does. So if you have a patient with a heart attack, you’re going to have a huge problem because episode costs for the patient with diabetes-plus-comorbidities are going to be completely eaten up by that avoidable complication.

Berenson: In fact, most of the costs associated with chronic conditions are for those acute events.

de Brantes: Absolutely, they are.

Berenson: Obviously, providers want to prevent a heart attack—but there is random chance. A patient could have a heart attack even though her diabetes was under control. So, one needs large numbers of patients, so that random events don’t highjack the providers’ financial performance.¹¹

de Brantes: That's right. In the bundles we've designed, we create allowances for expected costs of complications. But you need numbers; if you have only two or three patients for which you are getting bundled payments for chronic conditions—even if you have allowances for avoidable complications—if a heart attack occurs, you're wiped out. So you have stop-loss provisions; as a payer, you limit the providers' risk of financial losses by creating a loss ceiling per episode and, potentially, overall. Actually, stop-loss works for capitation as well.

Berenson: The problem I'm having here is that the likelihood of a diabetic having a heart attack is largely a function of what's happened over the last 30 years—not what's happened in the last six months under a clinician's or medical home team's good care. Due to chance, your whole financial performance is going to be based on spending you had no control over. It strikes me that that's the problem with putting *all* the spending associated with a chronic disease into that chronic disease bundle.

de Brantes: But this is a problem with any budget-based payment, including global capitation.

Berenson: But with global capitation, risk adjustment attempts to alter the payment amount based on patients' baseline conditions. Does your system have risk adjustment?

de Brantes: Yes. But risk adjustment, as you know, only gets you so far; these things are imprecise. If you're a medical group that's under a capitation formula, what's the incentive to grab that next patient with a chronic illness? I actually think your incentive to try to get that patient is far lower under capitation than under bundled payments.

Berenson: I agree with that, I understand. But now you have an incentive to *create* a chronic illness for payment. Under global payment, identifying a minor, but real condition won't do much to increase the risk score of a patient for purposes of risk adjustment, but under a bundled episode approach it might produce a new 365-day bundled payment—not bad! MedPAC showed that while Miami has less expensive coronary artery disease episodes than Minneapolis, they have many more episodes per Medicare beneficiary, producing much higher per-capita spending.¹² And that is *without* a new incentive to produce episodes...

Moderator: *Dr. Berenson, do you have other concerns with bundled payments?*

Berenson: I think operationally, there are issues as to what fair payment would be, and how to divide up payments between providers. I think we could accomplish the objectives of bundled episodes without their complexity by just liberalizing the use of gainsharing—which allows hospitals to financially reward desired cost-cutting physician behavior. Why are there greater concerns about compromising quality under gainsharing¹³ than under bundled episodes? The operational problems seem to me quite daunting for bundles that are defined on the basis of a disease, as opposed to an intervention. For example, it's easy to identify an intervention or a hospitalization, but who confirms the presence of a disease?

Of course, this is also an issue in global capitation, but you're not creating *ad hoc* groupings based on different diagnoses—you are creating an integrated organization that is supposed to work together for all diagnoses. And we have a lot of experience with how to do that. I think that makes capitation easier to administer than the numerous and changing groupings of providers that are required for bundled payments, although I agree that the organizational structures for bundled episodes need not be as formal and elaborate as the provider agreements that would have to be in place in a global capitation arrangement.

Also, I'm concerned that if bundled payments focus on acute care events in a hospitalization, you haven't engaged the primary care doctor, who seems to be pretty crucial in changing the culture of how medical care is provided. Ultimately, you have a very technology-oriented, specialty-oriented delivery system. Episodes that have a post-hospital component, say 30 days afterward, should bring primary care into the equation, but then that complicates the incentives. If you go too far out from the hospitalization, patients' problems—and their associated costs—may have less and less to do with the hospital's role in assuring a safe passage through the hospital stay and a proper discharge with medication reconciliation, communication to community physicians, etc.

Moderator: We've talked a lot about bundled payments so far; I want to turn to global capitation now. Mr. de Brantes, what are your concerns with this payment model?

de Brantes: If you go back to the 1990s, when HMOs started, the primary incentive of the capitated arrangements was to create a natural dampening effect on the supply of services. Yet, to attract people to these plans, the benefit design created almost no co-pays. In fact the advertising campaigns for the HMOs was “stop paying 20 percent co-insurance for the cost of your care, and go into these wonderful products where you can go and see any physician for \$5, have no co-pay to go to emergency departments, and have no co-pays if you're hospitalized.” So you had a rush of people who went to these types of products, and faced physicians whose primary incentives were to reduce the supply of services. That creates a clash of demand and supply, because the design of the incentives on both sides is fundamentally opposed. That's a challenge for Medicare. As it moves to more ACO- and global payment-type formulas in the Medicare population—which I believe is worth pursuing—you have that same challenge. The beneficiaries' primary mindset is “most of this stuff is free,” so there shouldn't be a reason for any barrier to consumption, and yet now you're creating an incentive for providers to restrain supply. I don't know how you manage that inherent conflict.

Berenson: Let me disagree a little bit. It seems to me there is a growing literature base that documents that, when truly informed about their treatment options, people actually ask for less than they're getting. In the mid-1990s, the Robert Wood Johnson Foundation had the SUPPORT project looking at people at the end of life, and pretty conclusively demonstrated that people wanted less heroic end-of-life care than they actually received because they were largely not adequately informed of their prospects and realistic choices.¹⁴ I think the literature sustains that finding that patients often want less than offered, even for interventions that are not associated with the end of life.¹⁵ What's lacking is getting the information. That's why I think the primary target of reform should be on providers to actually be engaging patients more with education, information, and true consent—that would change the demand curve fairly significantly. Right now in the fee-for-service system, I'm convinced—from the literature¹⁶ and my own experience—that physicians create demand, and that's promoted then by marketing. Only by fundamentally changing that incentive, so providers are responsible for population health rather than generating interventions, would we change the providers' attitudes to encompass candor and shared decision-making.

I know a lot of people say the managed care backlash during the '90s demonstrated that people don't want physicians to have this “double agent” problem, where they have an interest in providing services to their patients (as the patient's doctor) but they also have an interest in withholding services (to increase their profit margin). But I don't think the backlash was about that; I think it was mostly about the intrusion of managed care companies into a fee-for-service environment—requiring doctors to get prior approval for everything they wanted to do.¹⁷ I don't think there was any fundamental backlash to the California model¹⁸—which is alive and well today¹⁹—of medical groups taking capitation and being responsible for managing a budget. Obviously there can be tension when a patient wants more and the clinical guideline that the group is using says they don't need more, but I think that can be managed.

I think the basic problem here is that we have been so volume-generating that the physicians have created demand. If that's the only situation we have—fee-for-service driving too much demand—then I understand the need to have co-pays and deductibles in trying to give patients “skin in the game.” I think a better way to do that, though, would be to have the clinicians no longer have that incentive to create demand for services, and to instead engage their patients in shared decision-making. In those instances when a patient wants something that they don't really need according to the literature, give it to them; but the predominant care would have a whole different context to it. The family who wants to keep someone alive on a respirator with less than 1 percent chance of a miracle—I think we can tolerate that, if in the large majority of cases, patients are given the information any reasonable person should want, since I think many of them would select a less-intrusive, less-costly alternative. That seems to be what the experience is.

de Brantes: But global capitation is a blunt tool, which says all costs associated with all services for a patient are encompassed under this single global fee. That payment drives a very specific incentive, which is to find a way to manage all the costs associated with the patient under that global budget. The trick becomes: “How do you manage that?” The organizations that have been successful, such as Kaiser Permanente, have said: “We're going to bring all

these providers together under our roof, salary them, and give them some internal incentives around production, but not too much.” But the question then becomes, from a consumer’s perspective: “Is that how I want to receive my care? Do I want to go to that single brand, that single box?” There are folks who love the Kaiser model; there are lots of people who don’t—the majority of people. My sense is, generationally, there has been such a shift in the way consumers—who are patients occasionally—purchase goods and services in the marketplace, that the idea that you’re going to get all your services from a single brand, which is going to deliver excellence in anything you need at any moment in time, just doesn’t hold water. You have cancer, you want to go to the Memorial Sloan-Kettering Cancer Center; you don’t want to go to some random hospital. You can’t pay me enough to lock me into that system, you just can’t do it.

Berenson: I understand the point that when something bad happens to people, they want choice. And that is one of the barriers that I think prevents some people from signing up with a closed-network model like Kaiser. Medicare is going to be testing whether there can be an ACO with full freedom of choice for beneficiaries to go where they please—but I’m somewhat skeptical that one can successfully combine risk-taking with full freedom of choice for beneficiaries. However, there are probably some intermediary approaches that private insurers are using—tiered pricing and PPO-type products—where you pay somewhat more to go out of network, but are not prohibited from doing so. I think there are potentially more flexible models. But I agree that patients’ natural desire to seek out the “best” needs to be addressed in global payment.

de Brantes: Another challenge to capitation is it creates an incentive to create large provider organizations, which in turn can convert a normal market into an oligopoly, where there are only a few sellers who can drive up the prices they charge. Medicare might not care because it is setting the price, but when you are a commercial payer, it’s much more challenging.

Berenson: Well, it’s one of the potential Achilles heels of capitation—these oligopolies that amass market power. I co-authored one of the papers that put this policy problem on the table.²⁰ But this problem is not confined to global payment; for any group that’s delivering wonderful care and doing it appropriately, what prevents them from using market power to raise their prices? What’s preventing providers from doing exactly the same thing for services they deliver as part of a bundled episode payment?

de Brantes: Nothing. But the barriers to entry are lower than when you are dealing with a massive health system paid through capitation. If you are competing at the episode level, the barrier to entry for the new entrant, from a capital investment perspective, is far lower. In fact, some health plans are now becoming a little creative: if they see a fair amount of market concentration in an area like orthopedic care, they’re starting to think about how they can encourage new entrants in the marketplace. One mechanism is to reduce the capital investment by, for example, becoming the sourcing agent for implants. Think about an ambulatory surgery center for orthopedic care: one of their significant ongoing capital expenses is the inventory cost. Well, what if the health plan carried the inventory or financed that inventory, as opposed to the surgeons? Barriers to entry are lower, which means you get more competition at the bundled level.

Berenson: My concern is, then, for a new entrant to compete, they will now have an incentive to generate volume; it could lead us into a “medical arms race” kind of competition. So I would maintain some antitrust law here; there is a point at which a provider organization is too big and shouldn’t be permitted. Ultimately, I think we need to do something on the price-regulation side. We now have hospitals that are developing market power and driving up prices. I think it is something that will plague bundles, ACOs, the current fee-for-service system—all payment methods. I would argue for taking price regulation—as is done in Maryland, where you have all-payer rate-setting for hospitals—and extending it to ambulatory surgery. It actually promotes competition, by no longer rewarding those with more market power. Or at least consider having some price ceilings or regulatory oversight over price increases.

de Brantes: As long as the prices are ceilings and not floors, to allow price competition below that ceiling.

Berenson: I think that's right, we're talking ceilings. Maryland has been relatively creative in moving to new payment methods.²¹ Clearly most of the country isn't ready for that role for government—to get involved in rate-setting. But I think market power is a problem both for ACOs and for “focused factories” providing a bundled episode.

de Brantes: The basic rule of any going concern is to amass as much market power as possible. Ask any company in any industry and they'll tell you the more market share we can grab, the better off we'll be—so we'll need regulation to avoid that from happening.

Moderator: What are examples of countries that have implemented global payments or bundled payments?

de Brantes: You know, what's interesting is when people say things like “bundles have never been implemented on a large scale”—because actually they have: in the Philippines, Singapore, and India.

Berenson: Is that mostly for hospital-based interventions?

de Brantes: Yes. Also, the Netherlands has moved to a bundled payment for procedures. It actually has a dual system, where primary care is capitated, but most specialty care is bundled. There are a fair number of countries that have done this.

Berenson: In Europe, it's very common to do a bundled episode payment because specialists are often salaried employees of hospitals—they are not getting a separate payment stream. The UK and Germany actually offer a 30-day warranty covering any complications that arise after a procedure in exchange for an episode-based payment—which I think is a great idea.²² That's the interesting thing. Bundled payments are sort of new here, whereas capitation is pretty well established here. Yet in most other countries, it's the reverse—there's a fair amount of experience with episodes, but not so much with global capitation.

Moderator: Dr. Berenson, what are good examples of countries that have pursued global capitation?

Berenson: It's been well established for decades in the U.S., which is why I like it. Instead of working on developing a new model, we actually have a model. But I'm not necessarily attached to global capitation. I would suggest something in between pure capitation and ACO-style shared-savings models that are based on historical performance.

Moderator: Mr. de Brantes, if we were to fast-forward to 20 years from now, do you think bundled payments will be adopted on a widespread basis here in the U.S.?

de Brantes: My best guess is 70 percent of care will be paid for under bundled payment arrangements.

Berenson: You don't think that bundled payment arrangements will evolve into capitation?

de Brantes: No, I think the administrative and organizational weight of the capitated organizations trying to manage the total cost of care will make them uncompetitive in the marketplace. On the flip-side, I think integrated medical groups who don't necessarily have the burden of providing patients with the full spectrum of care should do fine. I just can't see how these other larger organizations will be able to compete. I just don't see it.

Berenson: Would you expect anything to still be paid fee-for-service?

de Brantes: Honestly, the only thing I would continue to pay for using fee-for-service is immunizations and preventive care. And then I think some form of a partial capitation for when healthy people get sick and need care, because it just doesn't make sense to put the flu or a rash in a bundle.

Berenson: The Netherlands and Denmark have that kind of system: 40 percent capitation and 60 percent fee-for-service, and it strikes me as a nice balance. This is a form of Joe Newhouse's partial capitation approach.²³

Moderator: So do you see fee-for-service being phased out in the future?

Berenson: Actually, I think we could get a long way by reforming our current fee-for-service system. Yes, it generates volume, and has that inherent incentive—but by changing the relative prices of things, you can encourage or discourage certain kinds of volume. I know there's this simplistic notion that if you ratchet down on price you automatically get a volume increase, so it's self-defeating, but that's not right. With the Deficit Reduction Act of 2005, where Congress said: “We’re not going to pay more for an MRI in a doctor’s office than we’re paying in the outpatient department”—you saw a dramatic impact.²⁴ The reduced price led to reduced growth in volume of those services; it was a perfect result. In that instance, we had too much imaging going on. If you take out the profitability in services that aren’t producing much value, you can affect the volume; you decrease the incentive for self-referral to generate unnecessary volume. I don’t think we’ve paid enough attention to fixing fee-for-service.

Fixing fee-for-service would also help produce more accurate bundled episode payments. In a calculation of a bundled payment amount, the existing fee-for-service payment levels are used for the services included in that bundle. If you are paying two times too much for a service that’s part of a bundle, then you’ve put too much money into that bundle. If you’re underpaying for primary care coordination, you are paying inappropriately in that bundle. Fixing fee-for-service is not inconsistent with moving on; in fact, I think it’s a requirement.

The same is true with capitation. Capitated rates are calculated by taking current fee-for-service prices and multiplying them by the volume of services you expect patients to use to come up with a total capitation amount for medical services.

Of course, the providers who are currently big winners in fee-for-service won’t be interested in moving to new payment models. So what I think you want to do is put pressure on fee-for-service reimbursements for both hospitals and doctors—to a point, but not below costs—so the innovative doctors and hospitals will be interested in moving to these new models.

de Brantes: Fee-for-service will be phased out if we make it less appealing than the alternative. Most primary care physicians are ready to move to another payment form, because fee-for-service is so unappealing. We should welcome them with bundled payments, which can greatly increase their income levels by getting them to reduce the frequency of big-ticket items that are now peppering the costs of chronic conditions. And I agree with Bob that we need to readjust some specialty and other service costs that have been inflated beyond reason. But after that, let the physicians and other providers organize themselves into whatever organizational structure they see fit to deliver patient care, taking on financial risk at a level they feel they can manage. Most importantly, let’s free them up to provide the mix and intensity of services they feel is most appropriate and remove the tyranny of fee-for-service fee schedules. Bundled payments provide that alternative and the faster we move to them, the faster we phase out fee-for-service.

Glossary

Bundled episodes—A payment approach in which a single payment is made to cover the cost of services delivered by multiple providers over a defined period of time to treat a given episode of care (e.g., a knee replacement surgery, or a year’s worth of diabetes care).

Fee-for-service—A payment approach in which health care providers receive a separate fee for each service they deliver.

Financial risk—When an entity assumes liability for the financial loss that could occur if actual costs exceed expected costs.

Gainsharing—When a hospital shares with non-employed physicians savings that the hospital generates as a result of the physicians’ actions (e.g., when all of a hospital’s physicians agree on a certain stent to use, thus allowing the hospital to negotiate bulk discounts on the stents).

Global capitation—A single payment made to a provider organization to cover the cost of a pre-defined set of services delivered to a patient (e.g., an amount paid per member per month to cover the cost of all of a patient’s health care needs). In many cases, the provider organization is responsible for reimbursing other providers for care they deliver to the patient.

Partial capitation—When a payer pays for some types of services on a capitated basis (e.g., by contracting with a group of providers to deliver all of their enrollees’ outpatient care) and pays for other services on a fee-for-service basis (e.g., reimbursing any hospital in their network for inpatient care delivered to their enrollees).

Risk adjustment—A process of adjusting payments to providers to reflect patient characteristics, especially health status, age, sex, and other demographic characteristics.

Risk corridor—A provision in a risk-sharing agreement whereby a provider’s financial losses or profits are limited to a specified percentage above and below their break-even point, to prevent them from experiencing excessive profits or catastrophic losses.

Shared savings—A payment approach whereby a provider or provider organization shares in the savings that accrue to a payer when actual spending for a defined population is less than a target amount. (Typically, performance targets on quality measures must be met to qualify for shared savings.) If actual costs are higher than projections, there are no financial repercussions for providers (unless “shared losses” are also part of the payment agreement).

Warranty—In exchange for a single episode-based payment, a provider promises to deliver all needed services associated with a procedure, including treatment of complications that arise after the procedure (e.g., Geisinger Health System’s warranty covers the 90 days following bypass surgery).

Adapted from: Delaware Healthcare Association. “Delaware Healthcare Association Glossary of Health Care Terms and Acronyms.” Dover, Del.: Delaware Healthcare Association, www.deha.org/Glossary/GlossaryA.htm (accessed August 2012).

The views expressed are those of the authors and should not be attributed to the Robert Wood Johnson Foundation or the Urban Institute, its trustees, or its funders.

About the Authors and Acknowledgments

Francois de Brantes, MS, MBA, is the executive director of the Health Care Incentives Improvement Institute. Robert A. Berenson, MD, is an institute fellow and Rachel Burton is a research associate at the Urban Institute. The authors thank Robert E. Mechanic at Brandeis University for his helpful comments on this paper, and Arnav Shah at the Urban Institute for his research assistance. This research was funded by the Robert Wood Johnson Foundation.

About the Urban Institute

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic, and governance problems facing the nation.

About the Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to health and health care, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, measurable, and timely change. For 40 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit www.rwjf.org. Follow the Foundation on Twitter [www.rwjf.org/twitter](https://twitter.com/rwjf) or Facebook [www.rwjf.org/facebook](https://www.facebook.com/rwjf).

Notes

- ¹ An example of how this might work in practice is a payer could provide regular fee-for-service payments to a hospital, a surgeon, a primary care physician, a physical therapist, and perhaps a home health agency, and then once a knee replacement episode finishes, the payer could reconcile the expenses that were generated with the agreed-upon price of the bundle, and disburse any surplus savings to the providers.
- ² Bailit MH, Burns ME, and Painter MW. *Bundled Payment Across the US Today: Status of Implementations and Operational Findings*. Newtown, Conn.: Health Care Incentives Improvement Institute, 2012, www.hci3.org/sites/default/files/files/HCI-IssueBrief-4-2012.pdf (accessed August 2012).
- ³ Alguire P. *Understanding Capitation*. Philadelphia: American College of Physicians, 2012, www.acponline.org/residents_fellows/career_counseling/understandcapit.htm (accessed August 2012).
- ⁴ Robinson JC and Luft HS. "Competition and the Cost of Hospital Care, 1972–1982." *Journal of the American Medical Association*, 257(23): 3241–3245, 1987; Berenson RA, Bodenheimer T, and Pham HH. "Specialty-Service Lines: Salvos in the New Medical Arms Race." *Health Affairs*, 25(5): w337–w343, 2006.
- ⁵ Cots F, Chiarello P, Salvador X, et al. "DRG-based hospital payment: Intended and unintended consequences." In *Diagnosis-Related Groups in Europe: Moving towards transparency, efficiency and quality in hospitals*, Busse R, Geissler A, Quentin W, and Wiley M (eds). Berlin: European Observatory on Health Care Systems, 2011.
- ⁶ Hancock K. "The New Normal in Health Insurance: High Deductibles," *Kaiser Health News*, June 3, 2012, www.kaiserhealthnews.org/stories/2012/june/04/high-deductible-health-insurance.aspx (accessed August 2012).
- ⁷ Cubanski J, Huang J, Damico A, et al. *Medicare Chartbook, 4th edition*. Washington, DC: The Henry J. Kaiser Family Foundation, 2010, <http://facts.kff.org/chartbook.aspx?cb=58> (accessed August 2012).
- ⁸ Mechanic RE. "Opportunities and Challenges for Episode-Based Payment." *New England Journal of Medicine*, 365 (9): 777–779, 2009.
- ⁹ Hussey PS, Ridgely MS, and Rosenthal MB. "The PROMETHEUS Bundled Payment Experiment: Slow Start Shows Problems In Implementing New Payment Models." *Health Affairs*, 30(11): 2116–2124, 2011.
- ¹⁰ Bailit MH, Burns ME, and Painter MW. *Bundled Payment Across the US Today: Status of Implementations and Operational Findings*.
- ¹¹ Tompkins C, Ritter G, Mechanic R, et al. *Analysis of Financial Risk and Risk Mitigation Option in the Medicare Bundled Payment For Care Improvement Program*. Waltham, Mass.: The Schneider Institutes for Health Policy, The Heller School for Social Policy and Management, Brandeis University, 2012, <http://sihp.brandeis.edu/ihs/publications/Bundled%20Payments%20White%20Paper.docx> (accessed August 2012).
- ¹² Medicare Payment Advisory Commission. *Report to the Congress: Increasing the Value of Medicare*. Washington, DC: U.S. Medicare Payment Advisory Commission, 2006, www.medpac.gov/publications%5Ccongressional_reports%5CJun06_Ch01.pdf (accessed August 2012).
- ¹³ Wilensky GR, Wolter N, and Fischer MM. "Gain Sharing: A Good Concept Getting A Bad Name?" *Health Affairs*, 26(1): w58–w67, 2007.
- ¹⁴ Teno JM, Fisher F, Hamel MB, et al. "Decision-Making and Outcomes of Prolonged ICU Stays in Seriously Ill Patients." *Journal of the American Geriatric Society*, 49(5): S70–S74, 2000; Wenger NS, Phillips RS, Teno JM, et al. "Physician Understanding of Patient Resuscitation Preferences: Insights and Clinical Implications." *Journal of the American Geriatric Society*, 49(5): S44–S51, 2000.
- ¹⁵ Volk RJ, Cass AR, and Spann SJ. "A Randomized Controlled Trial of Shared Decision Making for Prostate Cancer Screening." *Archives of Family Medicine*, 8(4): 333–340, 1999; O'Connor AM, Stacey D, Rovner D, et al. "Decision Aids for People Facing Health Treatment or Screening Decisions." *Cochrane Database of Systematic Reviews*, (2): CD001431, 2003.
- ¹⁶ The Dartmouth Institute for Health Policy and Clinical Practice. *Supply-Sensitive Care: A Dartmouth Atlas Project Topic Brief*. Hanover, N.H.: The Dartmouth Institute for Health Policy and Clinical Practice, Dartmouth College, 2007, www.dartmouthatlas.org/downloads/reports/supply_sensitive.pdf (accessed August 2012).
- ¹⁷ Robinson JC and Casalino LP. "Re-evaluation Of Capitation Contracting In New York and California." *Health Affairs*: w11–w19, 2001, <http://content.healthaffairs.org/content/early/2001/05/17/hlthaff.w11.suppl/DC1> (accessed August 2012).
- ¹⁸ Hammelman E, Ipakchi N, Snow J, et al. *Issue Brief: Reforming Physician Payments: Lessons from California*. Oakland, Calif.: California Health Care Foundation, 2009, www.chcf.org/publications/2009/09/reforming-physician-payments-lessons-from-california (accessed August 2012).
- ¹⁹ 42 percent of California residents are insured through an HMO. See: Kaiser Family Foundation, "California: State HMO Penetration Rate, July 2010," www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=7&rgn=6&ind=349&sub=85 (accessed August 2012).
- ²⁰ Berenson RA., Ginsburg PB, and Kemper N. "Unchecked Provider Clout in California Foreshadows Challenges to Health Reform." *Health Affairs*, 29(4): 699–705, 2010.
- ²¹ Sommers AS, White C, and Ginsburg PB. "Addressing Hospital Pricing Leverage through Regulation: State Rate Setting," *Policy Analysis*, (9): 1–9. Washington, DC: National Institute for Health Care Reform, 2012, www.nihcr.org/11192 (accessed August 2012).
- ²² Berenson RA, Paulus RA, and Kalman NS. "Medicare's Readmissions-Reduction Program—A Positive Alternative." *New England Journal of Medicine*, 366 (15): 1364–1366, 2012.
- ²³ Newhouse J. "Patients at Risk: Health Reform and Risk Adjustment." *Health Affairs*, 13(1): 132–146, 1994.
- ²⁴ Levin DC, Rao VM, Parker L, et al. "The Disproportionate Effects of the Deficit Reduction Act of 2005 on Radiologists' Private Office MRI and CT Practices Compared With Those of Other Physicians." *Journal of the American College of Radiology*, 6(9): 620–625, 2009.