

Bundled Payments: An Examination of a New Payment Reform Model from a Physician's Perspective

*Melissa M. Redondo**

I. INTRODUCTION

The fragmented state of healthcare delivery in the U.S. calls for changes and reforms. Among recent reforms, bundled payment programs propose to align physician and hospital incentives to result in higher quality care at lower cost. Challenges, however, are brought to light when feasibility and implementation of bundled payment systems are considered. Although legislators believe in the effectiveness of bundled payment programs, physician compliance and acceptance is essential for its success. This article will examine the proposed bundled payment system from the physician's perspective. Part II provides a brief history on the background of healthcare payment systems in the United States. Part III examines bundled payment programs. Part IV explores potential benefits of adopting a bundled payment system. Finally, Part V describes challenges associated with bundled payment programs, specifically physicians' concerns and resistance to implementation to such a program.

II. BACKGROUND ON HEALTHCARE PAYMENT SYSTEMS

Currently, hospitals and physicians are paid separately.¹ Hospitals assign charges for a patient's entire hospital stay into diagnostic related groups (DRGs).² Physicians are then paid separately.³ The most common method of physician payment is a fee-for-service system, where a third party or a patient pays for each service separately.⁴ Each blood

* Juris Doctor Candidate, Loyola University Chicago School of Law, Class of 2011. Ms. Redondo is a staff member of *Annals of Health Law*.

1. Manoj Jain, *Bundled Payments Might Cut Hospital Costs Without Reducing Quality of Care*, WASH. POST, Mar. 9, 2010, <http://www.washingtonpost.com/wpdyn/content/article/2010/03/08/AR2010030802421.html>.

2. *Id.*

3. *Id.*

4. RAND COMPARE, *Overview of Bundled Payments: Increase the Use of "Bundled" Payment*

test, urine sample, or other test conducted during a traditional office visit constitutes a separate “service” and is priced and billed individually.⁵ This system creates an incentive for physicians and hospitals to perform more complex and expensive procedures when simpler, cheaper options are available.⁶ Furthermore, fee-for-service payment adds to the lack of coordination across providers⁷ (i.e. physicians and hospitals) and blurs the lines of accountability in the healthcare.⁸

Although much less common, capitation is another healthcare payment method.⁹ Capitation calls for a lump sum payment in exchange for all of a patient’s care.¹⁰ The provider assumes all financial risk in the event that the cost of care exceeds the lump sum paid for treatment.¹¹ An obvious concern is that providers withhold necessary care because high costs exceed payment.¹²

In a society that functions on incentives, the aforementioned payment methods fail to align provider and patient incentives. A bundled payment system is a proposed solution that hypothetically aligns those incentives, thus, enhances patient care and reduces costs.

III. BUNDLED PAYMENT PROGRAMS

Bundled payment, also known as episode-based payment, is a reimbursement model that bundles all costs associated with a particular condition or episode into one payment.¹³ As with the capitation method, financial risk lies with the provider.¹⁴ Unlike capitation, however, risk is mitigated because providers do not assume the risk that the patient will acquire a condition.¹⁵ Capitation payments are most commonly made prospectively and account for all care-related costs that the patient may need.¹⁶ In contrast, bundled payment programs, as described in Section 3023 of the Patient

Approaches, <http://www.randcompare.org/policy-options/bundled-payment> (last visited Jan 23, 2011).

5. *Id.*

6. Stuart Guterman & Heather Drake, *DEVELOPING INNOVATIVE PAYMENT APPROACHES: FINDING THE PATH TO HIGH PERFORMANCE*, ISSUE BRIEF, June 2010, at 2.

7. RAND COMPARE, *supra* note 4.

8. Guterman & Drake, *supra* note 6, at 2.

9. RAND COMPARE, *supra* note 4.

10. *Id.*

11. *Id.*

12. *Id.*

13. *Id.*; AM. HOSP. ASS’N. COMM. ON RESEARCH, *BUNDLED PAYMENT: AHA RESEARCH SYNTHESIS REPORT*, 3 (2010) [hereinafter *AHA RESEARCH SYNTHESIS REPORT*].

14. RAND COMPARE, *supra* note 4.

15. *Id.*

16. *Id.*

Protection and Affordable Care Act (PPACA), only cover specific clinical episodes or a defined period of time.¹⁷ An “episode of care” is the period: (a) three days prior to hospital admission for the condition, (b) the length of stay in the hospital, and (c) the thirty days following discharge from the hospital.¹⁸ If the cost of care is less than the bundled payment, the provider keeps the difference.¹⁹ Ideally, this should incentivize health care providers to coordinate amongst each other to provide the most direct and cost efficient care. The converse, however, may prove to be true as well. Potential cost savings may create an incentive for doctors to withhold necessary services, thus, affecting overall quality of care. Actual and widespread demonstration programs are extremely important to test whether this seemingly ideal situation can become a reality or if quality of care will be compromised.

IV. POTENTIAL BENEFITS OF A BUNDLED PAYMENT SYSTEM

As previously mentioned, the main benefit sought through a bundled payment system is a reduction in total spending for an episode of care so that all parties (providers, payers, and patients) benefit.²⁰ Factors contributing to reduced spending include: provider adherence to guidelines, elimination of waste and utilization reduction, and physician-hospital alignment.²¹

Pursuant demonstration program grants, several institutions implemented bundled payment systems to determine its effectiveness.²² It should be noted, however, that the results of these programs cannot truly be generalized to the entire health care system because they are either very narrow in scope or implemented in large, integrated systems.²³ Baptist Health System (Baptist) in San Antonio, Texas is one such institution that conducted a demonstration program.²⁴ During the three-year demonstration at Baptist, Michael Zucker, Senior Vice President and Chief Development Officer, found

17. AHA RESEARCH SYNTHESIS REPORT, *supra* note 13, at 4.

18. Maria T. Currier & Morris H. Miller, *Medicare Payment Reform: Accelerating the Transformation of the U.S. Healthcare Delivery System and Need for New Strategic Provider Alliances*, 22 HEALTH LAW, no. 3, 4-5, Feb. 2010.

19. AHA RESEARCH SYNTHESIS REPORT, *supra* note 13, at 4.

20. *Id.* at 6.

21. *Id.*

22. J. Thompson, *Bundled payments demonstration shows early promise*, HEALTHCARE FINANCE NEWS (July 16, 2010), <http://healthcarefinancenews.com/print/17236>.

23. AHA RESEARCH SYNTHESIS REPORT, *supra* note 13, at 4-5.

24. Thompson, *supra* note 22.

specific benefits for participating physicians.²⁵ Benefits included:

Improved patient outcomes, enhanced care coordination, being on the leading edge of global pricing, increased Medicare and non-Medicare volumes, potentially increased reimbursement through provider-incentive program and increased local and national recognition.²⁶

Doctors at Baptist agreed to use a smaller range of orthopedic devices.²⁷ This is an example of one of their practices that resulted in nearly \$2 million in savings.²⁸

The implementation of bundled payments in the U.S. healthcare system will not stop with localized demonstration projects, such as Baptist's program. The PPACA²⁹ calls for the establishment of a national Medicare five-year pilot program beginning in 2013³⁰ that will test bundled payments.³¹ If successful, the PPACA authorizes the Secretary of Health and Human Services to expand bundled payment programs.³² Furthermore, the private healthcare sector is also testing the bundled payment method.³³ For example, in California, several healthcare providers will begin charging bundled fees for hip and knee replacements.³⁴

V. CHALLENGES TO THE IMPLEMENTATION OF A BUNDLED PAYMENT SYSTEM AND THE PHYSICIAN REACTION

Although the legislature continues to encourage the implementation of bundled payment programs, and demonstration programs resulted in positive outcomes, many still harbor deep-rooted concerns. Among these concerns include questions about: defining an "episode of care" for chronic conditions, preventing providers from avoiding riskier patients, legal and structural arrangements needed for implementation, dividing money fairly, and the overall effect on the quality of care.³⁵

Expanding the definition of "episode of care" to conditions requiring coordination

25. *Id.*

26. *Id.*

27. S. Reese, *Physician Payment Reform: What it Could Mean to Doctors – Part 3: Bundled Payments*, MEDSCAPE BUSINESS OF MEDICINE (Aug. 23, 2010), http://www.medscape.com/viewarticle/727115_print.

28. *Id.*

29. Patient Protection and Affordable Care Act (PPACA), Senate Amendment of H.R. 3962, 111th Cong. §3023 (2009).

30. *Id.*

31. AHA RESEARCH SYNTHESIS REPORT, *supra* note 13, at 4.

32. H.R. 3962, 111th Cong. at §3023.

33. Reese, *supra* note 27.

34. *Id.*

35. *Id.*

among multiple providers over an extended period of time is one challenge impeding the full implementation of a bundled payment system. Acute care episodes are the most appropriate for bundled payment programs because they have a clear beginning and end.³⁶ Defining an “episode of care” for chronic conditions that span a longer period of time, such as diabetes, hypertension, asthma, congestive heart failure, and coronary artery disease, presents more of the challenge.³⁷ The Prometheus Payment model presented a possible solution to this issue. In its demonstration program, Prometheus divided episodes of care for chronic illnesses into year-long units.³⁸ Therefore, the bundled payment amount for diabetes was broken down into payment for care for one year of diabetes. More experimentation is necessary to determine whether this is an effective manner for treating all chronic illnesses.

A key element to the success of bundled payment programs is provider readiness to participate. Studies show, however, that provider willingness to partake is varied.³⁹

Under bundled payment systems, physicians are faced with a multitude of both opportunities and challenges. A presentation by the American Medical Association (AMA), entitled “Pathways for Physician Success Under Healthcare Payment and Delivery Reforms,” identified challenges faced by physicians.⁴⁰ These challenges include: inadequate payments or reduced payments, unreasonably high performance standards, payment based on problematic measures of quality or cost, higher administrative, and insufficient capital to install new infrastructure or successfully manage financial risk.⁴¹ Furthermore, the AMA also found that reduction in revenue through fewer referrals or lower utilization of services, and reduced utilization prior to the establishment of a baseline for rewards also present challenges to physicians.⁴²

Despite these aforementioned obstacles, however, some physicians are optimistic. Dr. Manoj Jain, an infectious disease specialist in Memphis and assistant professor at Emory University, presented a positive analysis and outlook for bundled payments.⁴³ Under a

36. AHA RESEARCH SYNTHESIS REPORT, *supra* note 13, at 8.

37. Reese, *supra* note 27.

38. *Id.*

39. AHA RESEARCH SYNTHESIS REPORT, *supra* note 13, at 7.

40. Harold D. Miller, *Executive Summary to Pathways for Physician Success Under Healthcare Payment and Delivery Reforms*, AM. MED. ASS'N., at iii (June 2010).

41. *Id.* at iii-iv.

42. *Id.* at iv.

43. Jain, *supra* note 1.

fee-for-service model, low reimbursement leads to an inclination for physicians to increase the number of patients and procedures.⁴⁴ These actions, however, are not solely motivated by greed.⁴⁵ Rather, physicians' motivation is dually based on patient and financial concerns.⁴⁶ Under the bundled payment approach, the need to increase patient volume is nullified. A Medicare study during the 1990's showed that a fixed payment method, similar to bundled payments, produced savings from shorter hospital stays, substituting generic for brand name prescription drugs, and reducing unnecessary testing.⁴⁷ Furthermore, physicians exhibited an increased effort to implement protocol and checklists when using bundled payment programs.⁴⁸ Dr. Jain believes that the use of bundled payments is the most efficient way for physicians and hospitals work together.⁴⁹ Salaried physicians at widely acclaimed institutions, such as the Mayo Clinic, provide low-cost, high-quality healthcare because of the alignment of interests among hospitals and physicians.⁵⁰

Although some physicians, such as Dr. Jain, are optimistic about the bundled payment approach, the majority of U.S. physicians still earn their income through fee-for-service payments and are uncomfortable with change.⁵¹ Some of the qualms expressed by doctors to the bundled payment system include: the overall effect on the healthcare system, the affect on quality of patient care, and the bundling of outpatient services that require multiple visits to multiple physicians.⁵²

A specific gray area in a bundled payment program that has garnered much physician concern is the question of how costs and payments are divided amongst providers and hospitals.⁵³ Dr. Felix Aguirre, Vice President for IPC The Hospital Company, the largest hospitalist provider in the U.S., harbors a number of fears if bundled payments are given to hospitals for distribution.⁵⁴ For example, hospitals may opt to work solely with

44. *Id.*

45. *Id.*

46. *Id.*

47. *Id.*

48. *Id.*

49. Jain, *supra* note 1.

50. *Id.*

51. *Id.*

52. *Id.*

53. Phyllis Maguire, *Sounding and Alarm on Bundled Payments*, TODAY'S HOSPITALIST (Oct. 2009), http://www.todayshospitalist.com/index.php?b=articles_read&cnt=882.

54. *Id.*

hospital-owned groups due to convenience instead of with private, non-hospital owned, physician groups, thus putting those private groups at a serious economic and professional disadvantage.⁵⁵ Additionally, hospitals may attach conditions to reimbursement, such as limiting the number of patients a hospitalist may treat.⁵⁶ Dr. Aguirre commented, “Under the private practice model, [private physicians] might not be able to break even. [They] could be left without the potential to earn more money or the incentive to work harder.”⁵⁷ Similarly, physicians fear becoming “slaves to the hospital.”⁵⁸ Lori Heim, MD, FAAFP, President of the American Academy of Family Physicians, shares fears similar to Dr. Aguirre’s and worries that bundled payments will become primarily hospital based.⁵⁹ She expressed concerns stating, “[t]he private practice physician is saying, ‘I do not have an entity to be able to participate in a bundled payment unless I am part of a hospital system or some other integrated system.’”⁶⁰ The development of proper methods for distributing bundled payments is important to protect hospitalist reimbursement.⁶¹ Dr. Aguirre proposed placing an umbrella organization, such as CMS, in charge of payment distribution to hospitals and physicians as a mitigating solution.⁶²

Another principal question of physician concern regarding bundled payment programs lies in the crux of the purpose of health care. How will bundled payments affect the quality of care provided to patients? The bundled payment system is intended to align physician and hospital incentives to produce high quality care at low-costs. To many, realignment of incentives is an idealization that may have serious, unintended repercussions when put into practice. For example, when a doctor is paid by a hospital, temptation will arise for the doctor to put financial incentives for the hospital ahead of patient care.⁶³ Physicians may fail to order certain tests or procedures that are necessary fearing they will drive up costs beyond the allotted bundled amount. Furthermore, pressure to cut costs may lead to a culture of cutting corners when providing care.

55. *Id.*

56. *Id.*

57. *Id.*

58. Jain, *supra* note 1.

59. Reese, *supra* note 27.

60. *Id.*

61. Maguire, *supra* note 53.

62. *Id.*

63. Jain, *supra* note 1.

Doctors bear the financial risk and are likely to be on the short end of payments,⁶⁴ possibly creating rationing problems,⁶⁵ or deterring physicians from accepting high-risk cases. These concerns mirror those associated with the capitation method of payment. Under this payment method, a lump sum of money is paid to the provider for the requisite care for the patient.⁶⁶ Similar to bundled payment, concerns with capitation include the incentive on the part of physicians to provide fewer services in an effort to hedge financial risk.⁶⁷

Even medical students express concerns over a potential bundled payment system. A student at the University of Chicago, Pritzker School of Medicine, stated, “[t]he potential savings are outweighed by the risks of cutting corners. I want every option at my disposal and not to be handcuffed by meeting the bottom line.”⁶⁸

Prior demonstration projects have attributed cost reduction to the substitution of generic for brand-name drugs,⁶⁹ or by limiting the range of orthopaedic devices used in a hospital.⁷⁰ Commenting on such a cost-cutting method, a Chicago-based orthopaedic surgeon said,

You need all the technology available to you in order to produce the best outcome for the patient. Using older and cheaper devices may reduce costs in the short-run, but that increases the risk that the patient will have to have a revision because the longevity of older products is not up to par. Revisions can be complicated and updated technology and availability of products is key to success rates.⁷¹

Physicians are concerned that these and other similar practices will impede the research and development of new technologies in both the pharmaceutical and medical device fields.⁷²

These are some of the many challenges associated with the impending implementation of a demonstration bundled payment program. Physician compliance with the program is one of the key factors for its success. Physician concerns, however, are well founded and

64. David Gorn, *New Payment Method May Help Curb Costs, Improve Care*, CALIFORNIA HEALTHLINE (June 3, 2010), <http://www.californiahealthline.org/features/2010/new-payment-method-may-help-curb-costs-improve-care.aspx>.

65. *Id.*

66. RAND COMPARE, *supra* note 4.

67. *Id.*

68. Interview with Anonymous Medical Student, in Chicago, Ill. (Sept. 20, 2010).

69. Jain, *supra* note 1.

70. Reese, *supra* note 27.

71. Interview with Anonymous Orthopaedic Surgeon, in Chicago, Ill. (Oct. 8, 2010).

72. *Id.*

still remain unanswered. Hopefully, the Medicare demonstration program implemented in the coming years will provide answers and solutions to these physician concerns.

VI. CONCLUSION

Any change in the healthcare payment system will be met with resistance. The best way to ensure physician acceptance is with thorough testing before implementation. Dr. Aguirre encouraged the expansion of current demonstration projects to include more sites, medical Diagnosis-Related Groups, and post-acute care to fully gauge the impact of bundled payments.⁷³

Many in the healthcare industry, however, remain optimistic about bundled payment systems. Doug Emery, Implementation Manager of Prometheus, concedes that implementation of this program may be difficult but is not a “stumbling block.”⁷⁴ Mr. Emery’s position is:

[A]s a rule, structural solutions that retrofit payment aren’t right. We’re saying if you get the payment structure right and centered on each episode of care, the delivery system will ultimately figure out the best way to configure it. We’d like to set up a system where incentives drive innovation.⁷⁵

His proposition is, of course, ideal.

Bundled payment systems do have advantages, but are still fraught with concerns and challenges. The difficulty in defining “episodes of care” and determining fair reimbursement for physicians and the overall effect on the quality of care for patients are real concerns that legislators must bear in mind when instituting legal and structural framework for bundled payment systems. Of utmost importance is the implementation of quality assurance programs and systems that do not deter advances in research and development in exchange for lower costs. Only time will tell whether this new payment system is the much-needed reform the healthcare system has been seeking.

73. Maguire, *supra* note 53.

74. Reese, *supra* note 27.

75. *Id.*