Bundled Payment for Gastrointestinal Hemorrhage

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The Medicare Access and Chips Reauthorization Act (MACRA) is now law; it passed with bipartisan, virtually unanimous support in both Houses of Congress. MACRA replaced the Sustainable Growth Rate formula for physician reimbursement and replaced it with a pathway to value-based payment. This law will alter our practices more than the Affordable Care Act and to an extent not seen since the passage of the original Medicare Act. Practices that continue to hang on to our traditional colonoscopy-based fee for service reimbursement model will increasingly be marginalized (or discounted) by Medicare, commercial payers, and regional health systems. To thrive in the coming decade, innovative practices will move towards alternative payment models. Many practices have risk-linked bundled payments for colonoscopy, but this step is only an interim. Long-term success will come to practices that understand the implications of episode payments, specialty medical homes, and total cost of care. Do not wait for the finances to magically appear–start now to build infrastructure. In this month's "Road Ahead" article, Dr Mehta provides a detailed description of how a practice might construct a bundled payment for a common inpatient disorder. No one is paying for this yet, but it will come. Now is not the time to be a "WIMP" (Allen JI, et al. Gastroenterology 2016;150:295–299).

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In January 2016, the Center for Medicare and Medicaid Services (CMS) launched the Comprehensive Care for Joint Replacement (CJR) model. This payment model aims to improve the value of care provided to Medicare beneficiaries for hip and knee replacement surgery during the inpatient stay and 90-day period after discharge by holding hospitals accountable for cost and quality.[1] It includes hospitals in 67 geographic areas across the United States and marks the first time that a post-acute bundled payment model is mandatory for traditional Medicare patients. Although this may not seem to be relevant for gastroenterology, it marks an important signal by CMS that there will likely be more episode-payment models in the future.

It is well-known that the government and policymakers have been promoting a shift to value-based reimbursement, most notably through the Affordable Care Act. In 2015, the Department of Health and Human Services announced goals for shifting Medicare reimbursement from fee-for-service to payments that are based on the value of care.[2] In addition, the Medicare Access and CHIP Reauthorization Act consolidated pay-for-performance programs for physician reimbursement and will direct more rewards and penalties for alternate payment models.[3] Most of the public discussion has been around outpatient-focused models such as Accountable Care Organizations, but post-acute bundled payments have also been proliferating across the country, initially through voluntary participation by hospitals.

Gastroenterologists have not been primary drivers or participants in these models, but gastrointestinal (GI) hemorrhage is included as 1 of the 48 clinical conditions for the post-acute bundled payment program. In addition, CMS recently announced that clinical episode-based payment for GI hemorrhage will be included in hospital inpatient quality reporting (IQR) for fiscal year 2019.[4] This is an opportunity for the field of gastroenterology to take a leadership role in an alternate payment model as it has for colonoscopy bundled payment,[5] but it requires an understanding of the history of post-acute bundled payments and the opportunities for and challenges to applying this model to GI hemorrhage. In this article, I will describe insights from our health system's experience in evaluating different post-acute bundled

Abbreviations used in this paper: **BPCI, Bundled Payment for Care Improvement; CJR, Comprehensive Care for Joint Replacement; CMS, Center for Medicare and Medicaid Services; DRG, diagnosis-related group; GI, gastrointestinal; IQR, inpatient quality reporting; MS-DRG, Medicare Severity-Diagnosis Related Group; SNF, skilled nursing facility.**

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PRACTICE MANAGEMENT: THE ROAD AHEAD, *continued*

payment programs and participating in a GI bundled payment program.

Inpatient and Post-acute Bundled Payments

Bundled payments in health care are not a new phenomenon. A bundled payment refers to a situation where hospitals and physicians are incentivized to coordinate care for an episode of care across the continuum and eliminate unnecessary spending. In 1983, Medicare initiated a type of bundled payment for Part A spending on inpatient hospital care by creating prospective payment that is based on diagnosis-related groups (DRGs). This was a response to the rising cost of inpatient care resulting from retrospective payment that is based on hospital charges. Because hospitals would get paid the same amount for similar conditions, it resulted in shortened length of stay and reduction in the rise of inpatient costs, along with no measurable impact on quality of care.[6] This was followed by prospective payment for outpatient hospital fees and skilled nursing facility (SNF) care as a result of the Balanced Budget Act of 1997. Medicare built on this by bundling physician and hospital fees through demonstration projects in coronary artery bypass graft surgery from 1991 to 1996 and orthopedic and cardiovascular surgery from 2009 to 2012, both resulting in reduced costs and no measurable impact on quality.

The Bundled Payment for Care Improvement (BPCI) program built on these results in 2013 by expanding to include Part A and B services rendered up to 90 days after discharge, and as of January 2016, it includes 1574 participants across the country. On a voluntary basis, hospitals, physician groups, and post-acute providers and conveners were able to participate in 1 of 4 bundled payment models that were anchored on an inpatient for any of 48 clinical conditions that were based on MS-DRG (Table 1).

- Model 1 defined the episode as the inpatient hospital stay and bundled the facility and physician fees, similar to prior demonstration projects.
- Model 2 is a retrospective bundled payment for Part A and B services in the inpatient hospital stay and up to 90 days after discharge.
- Model 3 is a retrospective model that starts after hospital discharge and includes up to 90 days. (Models 1–3 maintain the current payment structure and retrospectively compare the actual reimbursement with target values that are based on historical data for that hospital with a 2%–3% payment reduction.)
- Model 4 makes a single, prospectively determined global payment to a hospital that encompasses all services during the hospital stay.

Orthopedic bundles have had the greatest adoption, and this is reflected by the CJR model, which includes hospitals in 67 geographic areas across the country for hip and knee replacement surgery, and is similar to model 2 of BPCI. These bundled payment models have also been proliferating in the commercial insurance markets, because payers have similar value-based goals to Medicare, and there are economies of scale for both providers and payers.

Opportunities in Inpatient and Post-acute Bundled Payments

Participation in bundled payments requires a new set of analytic and organizational capabilities.

Table 1. Medicare BPCI Improvement Models

	Model 1	Model 2	Model 3	Model 4
Episode	All DRGs; all acute patients	Selected DRGs; hospital plus post-acute period	Selected DRGs; post-acute period only	Selected DRGs; hospital plus readmissions
Services included in the bundle	All Part A services paid as part of the MS-DRG payment	All non-hospice Part A and B services during the initial inpatient stay, post-acute period, and readmissions	All non-hospice Part A and B services during the post-acute period and readmissions	All non-hospice Part A and B services (including the hospital and physician) during initial inpatient stay and readmissions
Payment	Retrospective	Retrospective	Retrospective	Prospective

Reference: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-08-13-2.html.