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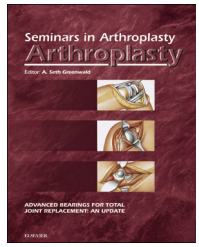

Bundled payment care initiative: How this all started

John P. Andrawis, MD, MBA[a], Karl M. Koenig, MD, MS[b], and Kevin J. Bozic, MD, MBA[c,*]

[a]Department of Orthopedic Surgery, Harbor-UCLA Medical Center, Torrance, CA
[b]Department of Surgery and Perioperative Care, Dell Medical School at the University of Texas at Austin, Austin, TX
[c]Department of Surgery and Perioperative Care, Dell Medical School at the University of Texas at Austin, 1400 Barbara Jordan Blvd, Suite 1.114, Austin, TX 78723

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ABSTRACT

For the past 40 years health care policymakers have attempted to come up with creative ways to deal with uncontrolled medical inflation. Medicare has enacted multiple changes to their reimbursement system and experimented with different payment models. Bundled payments were first implemented for hospital in 1984. Since then experimental models that bundled both hospital and physician payments have been attempted with moderate success. With the passage of the Affordable Care Act, CMS was required to pilot a bundled payment model. As a result the Bundled Payments for Care Improvement Initiative was announced and piloted at multiple hospitals around the country.

1. 1980s: The First Bundled payments-Hospitals

In the late 1970s, health care policymakers were forced to deal with uncontrolled rising medical inflation and a deep economic recession [1]. To keep Medicare solvent, Congress and the Reagan administration turned to an alternative reimbursement system that academicians at Yale had studied and tested with reported success in New Jersey [2]. The new system paid hospitals a prospectively predetermined case rate based on a patient's diagnosis or procedure, called Diagnosis Related Groups (DRGs). New Jersey's state-regulated hospital payment scheme served as evidence that prospective payment could be implemented without upheaval. This new payment system was applied to Medicare and became the Medicare Prospective Payment system. Unnoticed by the general public, this dramatic change was the first time the federal government shifted the risks associated with the cost of providing care onto hospitals [1]. The goal was to alter the incentives for hospitals to improve their efficiency and reduce the growth of health care expenditures [3].

In reaction to needed changes, the first hospital bundled payment system was signed into law with the passage of The Tax Equity and Fiscal Responsibility Act (TEFRA) on September 3, 1982. This law mandated the development of the Inpatient

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*Corresponding author.
E-mail address: kevin.bozic@austin.utexas.edu (K.J. Bozic).

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Prospective Payment System (IPPS) to reimburse hospitals. With this mandate, the Social Security Amendments Act of 1983 created a new Medicare payment system for hospitals. Medicare shifted from paying hospitals their reported costs, to paying hospitals a fixed cost per inpatient stay based on DRG Coding. For example, Pre-TEFRA if a hospital charged $40,000 for a hip replacement, Medicare paid $40,000. With the introduction of IPPS, Medicare created a fee schedule to pay a fixed amount for a hip replacement, subject to geographic and teaching hospital adjustments. This set rate was what Medicare reimbursed the hospital regardless of the charge. The new prospective payment system had the tandem goals of altering the behavior of affiliated physicians and to act as a monitor of physician financial performance [3]. The DRG system ultimately had limited success in influencing physician behavior, as hospital administrators did not put pressure on physicians because the hospitals viewed physicians as key professionals who supplied patients, revenue, and prestige to the hospital [3].

In 1984, with the adoption of the prospective payment systems for hospitals, the Medicare Economic Index (MEI) was instituted for physicians. The MEI required congressional legislation to change the fees yearly because physician fees were rising faster than projected. This was the first time Medicare began using a separate payment system for Medicare Group B (physician payments) compared with how Medicare paid for other types of services [4]. Gradually, the use of bundled payments was extended to outpatient care, renal care, home care and nursing care. The payments were adjusted based on inflation and productivity increases as well as legislative changes. Physician payment models took a different course.

Physician fee schedules continued on a fee-for service system, based on “usual and customary charges,” even after the implementation of hospital bundled payments. Physicians were paid for discreet services using a fee schedule with thousands of billing codes. Over time, there were attempts to change the system. In 1989, to assess the value of work effort by physicians, the Resource Based Relative Value Scale was adopted. This change was to correct the perceived undervalue of services provided by primary care physicians and other so-called “cognitive” physicians. Although this effort created acrimony between and among physician specialties, it did little to curb spending. In the end, Medicare’s physician payment policy history has resulted in a disaggregated system with charge-based billing that has led to concerns about inappropriate volume increases. Current incentives do nothing to promote or reward appropriate utilization. Policymakers continue to express concern that fee-for service payments incentivize providers to increase their income by increasing volume for patients, without consideration of the appropriateness of those services [4].

2. 1980s: Other experimental models

In reaction to many of the health care financing challenges at that time, a few health care systems began bundling reimbursement options for an entire patient care episode. The Texas Heart Institute created CardioVascular Care Providers, Inc., and offered a single package price for cardiovascular services. All services (Hospital and Physician) were covered under one global fee. This global fee of $13,800 was lower than average Medicare payment of $24,588 for the same condition. The program was deemed a success as the plan lowered cost, improved access and streamlined the billing and forecasting of expenses while still maintaining high quality of care [5].

The first bundled payment in orthopedic surgery was also being attempted for knee arthroscopy. One of the large concerns for insurers at that time was the cost of repeat services for the management of complications. Managed-care systems were trying to identify preferred providers and control cost. In response to this, a single private practice orthopedic surgeon in Lansing Michigan collaborated with his principal hospital, Ingham Medical Center, and contracted to become the sole provider for an HMO. The surgeon evaluated each patient for free, and if a patient needed surgery he provided a 2-year warranty, promising to cover any post-surgery expenses. The surgeon and hospital charged a single flat fee for the surgery and they covered any repeat surgeries needed [6]. By the end of the study pilot, all parties benefitted financially, with the hospital and surgeon earning more than the existing reimbursement system, and the HMO reducing their cost outlays for knee arthroscopy [6].

3. The 1990s: Medicare participating heart bypass center demonstration

By the early 1990s, Medicare expenditures continued to increase. The early changes enacted in the 1980s did little to curb the continuing growth in health care costs. In 1980, the federal government spent $36.4 billion on the Medicare program [7]. By 1991, the figure had reached $120.2 billion, an average increase of 11.4% annually [8]. For hospital care alone, the federal Medicare Program spent $73.3 billion in 1991, versus $26.4 billion in 1980 [8]. Spending on physician services rose even faster, from $7.9 billion in 1980 to $32.8 billion in 1991 [8]. At that time, the Health Care Financing Administration (HCFA), now known at the Center for Medicare and Medicaid Services (CMS), had been active in responding to high costs and were attempting to find ways to contain costs.

Medicare Part A (hospital insurance) was capped at an annual growth rate through the implementation of the IPPS and reduced the expenditure per enrollee per hospital admission from what it would have been [9]. However, the growth of Medicare Part B (medical insurance) remained uncontrolled even though physician reimbursements were limited by the MEI. The HCFA was particularly concerned about expenditures on heart bypass surgery as the government was spending several billion dollars on inpatient care alone for bypass patients. It was estimated that Medicare allowed charges (after adjustments) grew 12–14% annually for bypass surgery from 1985 to 1988 [10]. Thus, hospital and policymakers at that time realized the large financial incentives physicians had related to complex procedures. It was felt physicians were paid for every additional service and the hospital inputs were “free” to physicians, as they bore none of the financial risks associated with using more expensive