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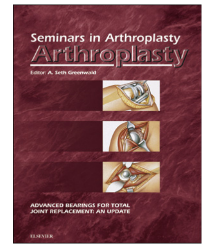

Private payer bundled payment arrangements

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ABSTRACT

In 2015, the Centers for Medicare & Medicaid Services (CMS) began a mandatory bundling initiative to cover all services for hip and knee replacements. Broader expansion of alternative payment and delivery models has recently been introduced in the private sector. Bundled payments incentivize providers to appropriately reduce spending without compromising quality of care. Establishing market size, competitive pricing, and care coordination are integral to ensure the viability of a bundled payment model. The purpose of this study is to address key considerations for providers who plan to create an effective bundle in the private sector.

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1. Overview

In 2014, the United States spent nearly 17.5% of its gross domestic product (GDP) on health care; this number is expected to rise to 20.1% in 2025 [1]. This is 1.5 times higher than the percentage of GDP that the next highest country, Netherlands, spent on health care [2]. The aggregate costs of total hip and knee replacements represent the highest of any operative intervention for both commercial and governmental payers. The volume of total joint arthroplasty (TJA) procedures has, and continues to, increase. As a result of increased activity expectations and improved component durability, the fastest growing joint replacement segment of patients is those 50 years and younger [3]. The predicted burden of such spending places significant economic strain on the US health care system. Traditionally, the burden of non-governmental health care costs falls on the employers and these rising costs have made it difficult for US employers to compete in the international marketplace. Outside of the United States, per capita health care costs are much lower and frequently born by the government and not the employer. Additionally, the increase in high deductible insurance plans requires the patient to bear a significant amount of health care costs. Thus private payers, employers, and patients have taken significant steps to explore alternative payment strategies to reduce the cost of TJA.

Traditionally the fee-for-service (FFS) model incentivized providers based on volume rather than value which resulted in increased use of services and health care spending. Alternatives to FFS known as value-based strategies, such as episode of care or bundled payments, have been proposed as a mechanism to improve quality and reduce costs of TJA. Bundled payments are designed to incentivize greater communication and coordination among providers with the goals of enhanced quality and efficiency of care. The goal of bundled payments is to shift the financial incentives from volume of services toward high-quality care with an established target payment for the episode of care. This achieves the aims of reducing costs and increasing quality. Equally as important, bundled payment arrangements provide cost transparency so that the health care consumer can make financially informed, educated decisions as to where to get their care.

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Table – Principal Elements of Medicare CJR Versus Commercial Bundles

	Medicare CJR	Commercial Bundle
Payment methodology	Retrospective	Prospective
Availability of data	Historical data (20+ years)	Limited (5–8 years)
Participation	National	Local
Episode length	90 days	Variable
Quality	Mandatory threshold required for payments	Not required
Convener	Hospital	Any provider
Conditions	Lower-extremity joint replacement (LEJR)	Any condition (TJA, ACL, etc.)

2. History of private bundled payments

Private bundled payments began as early as 1984, when the Texas Heart Institute developed a pricing plan for cardiovascular surgery—where all services were covered under one global fee. At that time, a study centered on the efficacy of this payment system demonstrated that the payment system effectively reduced costs and increased patient access, without negatively affecting the quality of care [4]. In 2006, the Geisinger Health System announced ProvenCare—a pay-for-performance approach that initially focused on coronary artery bypass surgery. The program had the following three objectives: to establish best practices, to develop risk based pricing, and to engage patients. A patient's preoperative, inpatient, and postoperative costs of care (within 90 days from surgery) were packaged into one fixed price. A study showed that 117 patients who received ProvenCare had a significantly shorter total length of stay (5.3 days versus 6.3 days), increased likelihood of being discharged to home (90.6% versus 81.0%), and a lower readmission rate (7.1% versus 6.0%) compared with 137 patients who received conventional care in 2005 [5]. ProvenCare's early success has now expanded to include total joint arthroplasty (TJA) and many other health systems use their approach as a framework for health care delivery.

In 2006, another private bundled payment project, Provider payment Reform for Outcomes, Margins, Evidence, Transparency, Hassle-reduction, Excellence, Understandability, and Sustainability (PROMETHEUS) was developed by PROMETHEUS Payment Inc. After adjusting for severity and complexity of illness, evidence-based case reimbursement rates (ECRs) were assigned to different conditions [6]. An ECR was designed to cover all inpatient and outpatient care associated with the condition in order to set a fixed budget. If actual spending was below the target budget, health care providers would receive the difference. However, if actual spending was in excess of the budget, payment was partially withheld. These programs demonstrated the effectiveness of bundled payments in reducing health care costs, but also highlight the difficulties providers encountered as these models were implemented. Moreover, employers are now more interested in selecting centers of excellence hospital sites for their employees based on high performance and quality levels, safety ratings, and reputation for consistently delivering quality care. For example, Walmart selected six hospital and health systems for heart, spine, and transplant surgeries: Cleveland Clinic; Geisinger Medical Center; Mayo Clinic; Mercy Hospital Springfield; Scott & White Memorial Hospital; and Virginia Mason Medical Center. This highlights the importance in controlling cost and quality within a clinical episode when developing a care redesign structure.

3. Medicare versus private bundles

In 2009, CMS launched a 3-year acute care episode (ACE) demonstration to test bundled payments for cardiac and orthopedic procedures, including TJA. A study of this intervention revealed that Medicare saved about $585 per case [7]. In 2013, CMS officially launched its Medicare bundled payment for care improvement (BPCI) initiative. Under BPCI, providers and organizations assume risk for total spending relative to a target price for up to 48 clinical episodes that begin with an acute-care hospital stay. Bundling for Medicare fee-for-service TJA became mandatory in 2016 when CMS released its final rule for a new Comprehensive Care for Joint Replacement (CJR) [8]. The goal of CJR is to create financial incentives that encourage providers to coordinate care across treatment settings and reduce unnecessary services. Under CJR, hospitals will be accountable for the cost of episodes of TJA, beginning from the time of surgery through 90 days after discharge.

Although the central concepts of bundled payments are similar between Medicare and commercial payers, important differences do exist (Table) [8]. The first difference that arises between commercial bundles and Medicare bundles is their clinical cost levers. Under Medicare's bundle, 52% of the 90-day bundle is spent on post-discharge costs. In comparison, only 12% of commercial bundle costs occur in the post-discharge period. Younger, non-Medicare patients tend to use less post-acute services than their Medicare counterparts. Additionally, they tend to have lower rates of readmission [9]. For private bundles, the prosthesis cost is not contained in any DRG payment. This is different from Medicare bundles where the prosthesis cost is included in the DRG. Additionally, younger, more active non-Medicare patients tend to require higher cost and higher performance (at least theoretically) components. Thus, the cost of joint prosthesis is an important cost lever for commercial bundles. Also, in CJR, the only entities allowed to manage the bundles are hospitals. Bundle managers are termed conveners. In private bundles, any provider, including physicians, third party companies and/or hospitals can be bundle conveners.

Perhaps the most significant difference between Medicare and private bundles comes in their method used to reimburse providers for the bundled episode of care. The CJR and most of the BPCI uses a retrospective reconciliation method to pay

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