Incentivizing Physicians to Deliver High-Value Care in a Bundled Payment Setting

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"Bundled payments" is a phrase being used with greater frequency these days by a variety of healthcare stakeholders, but the concept is nothing new. The idea of a "flat fee" has been around a long time, and the familiar "90-day global period" for procedures is nothing but a bundling of professional services in the perioperative period.

In the spectrum of payment models, with fee-for-service on one end and capitation on the other, bundled payments is somewhere in the middle. No single payment model has been completely successful in the past, but there is no dispute that cost reduction must be one of the primary goals of any model that all stakeholders can agree on.

While "bundled payments" is a generic term that includes a variety of concepts, such as episode-based payment models and global payments, the Center for Medicare & Medicaid Services (CMS) has developed multiple bundled payment models, including Comprehensive Care for Joint Replacement (CJR), Episode Payment Models, such as the Acute Myocardial Infarction (AMI) Model, Coronary Artery Bypass Graft (CABG) Model, Surgical Hip and Femur Fracture Treatment (SHFFT) Model, and Cardiac Rehabilitation (CR) Incentive Payment Model, and a number of Bundled Payments for Care Improvement (BPCI) Initiatives.[1] In addition, custom-designed bundles have become recently popular between providers and private payers or directly with large employers by leveraging quality and improved patient outcomes to drive down total costs of care.

One of the premises driving these programs is the idea that variation in healthcare delivery adds cost without improving outcomes, and in fact, variation has been shown to increase risk of harm to patients. Despite the evidence supporting standardization of medicine, however, there is lack of support from physicians because of the fear of loss of autonomy. Because of the huge amount of variation in physician training techniques and lack of strong clinical evidence, little consensus exists in how to treat even the most common and expensive conditions. For example, despite the lack of evidence, there is still significant regional variation in the diagnosis, imaging, treatment and decision for surgery in treating low back pain, along with the associated variation in cost.[2]

Past failures and conflicts over capitation models have also turned physicians against the idea of bundling, which may be seen as restriction of care and interfering with the doctor-patient relationship by disregarding the voice of the patient.[3] Improving quality and outcomes by practicing "evidence-based medicine" is also not universally accepted as a standard because of the controversial nature of much of the clinical evidence available today.[4]

However, with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) clearly in sight, physicians are responding with initiatives designed to create standardized, reproducible patient experiences with predictable outcomes while reducing costs by eliminating waste and improving complication rates. One such program is the Perioperative Surgical Home (PSH), "a patient-centric, team-based model of care created by leaders within the American Society of Anesthesiologists to help meet the demands of a rapidly approaching healthcare paradigm that will emphasize value, patient satisfaction and reduced costs."[5]

The PSH model is based on the concept that a patient's perioperative journey should be personalized and coordinated so that the patient receives the exact care needed at the right time based on the best evidence available. This requires collaboration and alignment between the patient, physician, the hospital, and numerous other care providers and stakeholders. Previous attempts at this type of model failed financially because many elements of care were not funded by payers (e.g., perioperative visits outside the global period), but new bundled

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payment models would include episode-related perioperative care that is also incentivized by better outcomes, such as reduced 30-day readmissions, which are costly. Because of these bundles, physicians are now financially motivated to deliver better outcomes and including care elements into protocols that have been shown to improve these bundle-specific metrics.

A popular example of these outcomes-based protocols within a PSH model is the colon surgery enhanced recovery program (ERP). These protocols have existed for decades but have recently resurged due to the increasing need for hospitals and physicians to collaborate to reduce costs and complications. The colon surgery ERP is basically an all-inclusive list of evidence-based care elements beginning from preoperative risk assessments to the post-discharge period and recovery. The protocol includes not only physicians but pharmacists, dieticians, physical therapists, care managers and other care providers who follow the patient's path throughout the perioperative period, in and out of the hospital. The adoption of ERPs by large organizations has uniformly been shown to decrease length of hospital stay, surgical site infections, and 30-day readmission rates.

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The PSH is also the ideal venue for supply expense reduction initiatives that are driven by patient-centered clinical programs. For example, by defining each step using evidence and standardizing the products used at each of these steps, the hospital can simultaneously reduce the variation of products available while encouraging appropriate utilization of the product. One example is a wound protector device used during colon surgery. While the product itself adds significant cost to the single procedure, when used in a limited fashion as part of a surgical site infection bundle, the hospital may see improved outcomes and reduction in overall episodic cost that would justify the added item cost.[6]

The current healthcare system is highly complex and often affected by political turbulence, but what remains constant is the ultimate goal of improved patient outcomes and cost efficiency (i.e., value-based care). While the structure of bundled payment models may always remain controversial, incentivizing physicians to deliver high value to patients is the key component to their engagement and the success of these programs.

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