

Will Bundling Work in Rural America? Analysis of the Feasibility and Consequences of Bundled Payments for Rural Health Providers and Patients

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Key Findings

- Bundled payments may improve the quality of care in rural areas; however, the impact is likely to be unevenly distributed across geography and care systems.
- Bundled payments may lead to increased provider consolidation and fewer provider options in rural markets.
- Incorporating Critical Access Hospitals into a bundled payment mechanism may not work.
- Under a bundled payment system, safeguards may need to be implemented to protect rural consumer choice and patient/provider relationships.

Background

The Medicare Payment Advisory Commission (MedPAC) and the Centers for Medicare and Medicaid Services (CMS) have long recognized the misalignment of incentives across the payment sectors within Medicare. Many health policy analysts and organizations are now advocating moving CMS towards a bundled payment strategy that re-aligns hospital, physician, and post-acute care provider incentives to better coordinate and improve inpatient and post-acute care, thereby reducing readmission rates, improving patient outcomes and reducing costs (MedPAC, 2007; Pham et al., 2010; Hussey et al., 2009; Mechanic and Altman, 2009; Fisher et al., 2009).

The rationale behind bundling acute care and post-acute care (PAC) payments is straightforward: The structure of provider payments affects incentives for organizing care and also affects the quantity and quality of that care (Town et al., 2004). Currently, inpatient episode payments are fragmented across providers. We define an inpatient episode as the inpatient stay (including both the hospital and physician payments) plus the 30-day

period after discharge (the period in which the patient is likely to receive significant post-acute care services). The PAC services include post-op follow-up, rehabilitation services, outpatient care, skilled nursing facility and home health services.¹ Most hospitals are paid on a diagnosis-related group (DRG) basis, which is a form of bundling. Inpatient physician (e.g., surgeons) and rehabilitation services are paid on a fee-for-service (FFS) basis. Nursing home care and home health services are paid on a per-diem basis. All of these services are billed separately.

Under bundled payments, a hospital would receive one payment that would cover inpatient and post-acute care (and, potentially, physician services) for a defined episode of care from admission to a pre-specified number of days post-discharge. Organizational relationships that emerge out of this new reimbursement environment may alter current pathways that rural patients traverse as their recovery progresses. This new environment may also challenge the financial viability of rural providers that deliver post-acute care.

The impact of moving to a bundled payment system will depend upon several factors, including the organizational structure and density of providers, the scale and types of services offered by providers, and the population density. Assessing the implications of such a policy change from the perspective of urban communities at the exclusion of consideration of the rural context raises the risk of unintended negative consequences for rural patients and providers. These issues are particularly timely given the bundling model proposed in the national pilot program authorized under the Patient Protection and Affordable Care Act (PPACA, 2010).

Purpose of the Study and Approach

This report assesses how a change in payment structure (i.e. bundling reimbursement payments for acute and post-acute care episodes) may affect existing and

¹ Follow-up physician office visits are excluded from the bundled payment in some proposals but, in principle, could be included in the bundle.

emerging relationships between rural and urban-based providers. Most discussions of the benefits of bundling post-acute care payment focus primarily on the desirable incentive properties of this type of payment reform.

There is little doubt that a bundled payment strategy creates some desirable incentives for coordinating care and containing costs. However, bundling payments may have other consequences for the health care infrastructure, especially in rural areas. Such consequences have not been well articulated. Therefore, this report:

1. Assesses the financial and quality challenges – and potential unintended consequences for rural providers and patients – of implementing bundled payments for acute and post-acute care episodes.
2. Explores the possible impact on quality of care delivered under a facility-physician bundled payment system, and suggests measurement opportunities to assess the quality of care delivered under a facility-physician bundled payment system.
3. Describes potential modifications to current bundling proposals (plus additional steps CMS could take) that will help address rural-specific issues.

Our analysis relies on two sources of information. First, we turn to the economics, quality measurement and organizational literature to understand the theoretical and broad practical issues associated with bundled payments and the implications of those issues in the rural context. We then supplement that information with structured stakeholder interviews, exploring pertinent issues with a select group of ten rural health care leaders, including administrators, agency heads, and physicians.

Results

The effective implementation of a bundled payment system faces several challenges, including ensuring that hospitals can form the necessary agreements with other providers on how a single payment will be allocated, measuring quality in implementing quality improvement initiatives and the construction of risk-adjusted payments. Implementing bundled payments in rural settings raises several additional potential consequences that need to be addressed.

Finding #1: Bundled payments may improve the quality of care in rural areas; however, the impact is likely to be unevenly distributed across geography and care systems.

Bundled payments are likely to work best in integrated health care systems, where it is easier to align incentives across providers. Several of the PAC stakeholders we interviewed noted that the consolidation of services from tertiary care centers into rural areas (while presenting a number of challenges for local providers) would also provide opportunities for disseminating cutting-edge information technology (e.g., investment of urban and large rural health system resources into health technologies through ownership and management contracts). Stakeholders also expected health care quality to improve through enhanced care coordination as bundled payments better aligned provider incentives.

While there are several large integrated health systems in rural areas, much of the rural health care infrastructure is fragmented. Making bundled payments work in non-integrated environments requires addressing several specific challenges, including a) allocation of payment across providers, b) disincentive for urban centers to refer back to rural areas for PAC services, c) vulnerability of rural post-acute providers, and d) monitoring challenges due to lack of health information technology infrastructure.

Potential Strategies to Address These Issues

Based on our assessment of challenges, we suggest that CMS consider the following proactive steps:

- Design optimal contractual arrangements that provide rural providers with templates. Such templates would reduce the cost of negotiating contracts across providers and help redress the potential imbalance of provider bargaining power.
- Develop risk- and volume-adjusted performance criteria to facilitate contract monitoring and selection of PAC providers for contracting.
- Provide contract guidance and technical support for small rural providers as they negotiate contracts with larger urban and rural referral centers.
- Design measurement and reporting mechanisms that adapt to both integrated and non-integrated care delivery models (e.g., HIT capacity, inter-platform compatibility, and design/protocol differences).

Finding #2: Bundled payments may lead to increased provider consolidation and fewer provider options in rural markets.

Since bundled payments are well suited for integrated systems, there will be incentives for rural providers to consolidate vertically and horizontally. A number of survey respondents noted that providers are already engaged in this type of strategic activity. For example, a health care system could become owner of a local rural hospital and thus integrate the physicians quickly to create payment and operational efficiencies. In another scenario, a rural hospital could remain independent but have a contractual relationship with a large physician provider group. More of these arrangements are growing now because of the opportunity for provider-based billing.

Potential Strategies to Address This Issue

- Adjust the criteria for monitoring the anti-trust implications of provider mergers and acquisitions (such as the Hart-Scott-Rodino thresholds²) to increase their sensitivity to scale differences found in rural health care markets.
- Assure that rural providers are fully aware of Department of Justice/ Federal Trade Commission anti-trust enforcement policies regarding service delivery integration.
- Where feasible, require larger hospitals to establish multiple PAC contracts to accommodate consumer choice in health care providers and settings.

Finding #3: Incorporating Critical Access Hospitals (CAHs) into a bundled payment mechanism may not work.

CAH respondents commented that their cost-based reimbursement status has placed them in a position where Prospective Payment System (PPS) hospitals consider them unfair competition. It can be difficult to negotiate a contract, because there is less flexibility to underbid competitors. Many Critical Access Hospitals are freestanding facilities; that status further undermines their strength at the bargaining table.

Potential Strategies to Address This Issue

- Exempt CAHs from the bundled payment methodology.
- Carve out PAC services provided by CAHs for bundled payments under the same methodology used for PPS providers.
- Create a “fixed-bonus” payment to support the continued operation of CAHs and avoid loss of access to needed services in rural communities that have no alternative sources of care. Performance incentives can be incorporated into the bonus payment methodology to encourage service delivery efficiencies and quality.

Finding #4: Under a bundled payment system, safeguards may need to be implemented to protect rural consumer choice and patient-provider relationships.

There is considerable agreement that integrated delivery systems (IDSs) provide a suitable environment for a bundled payment scenario. Such systems also have several options for patient care. Discharged patients could be kept within the corporate umbrella or local contractual relationship of the tertiary care facility in order to achieve greater control over the level of financial and performance risk.

The potential loss of access to post-acute care providers in a rural patient’s own or nearby community threatens consumers’ ability to choose their care setting. Without sufficient safeguards, patient choice may be lost, support for patient self-management and treatment compliance may be compromised, and the well-being of rural residents could be jeopardized.

Potential Strategies to Address This Issue

- Implement contract requirements that encourage patient choice. One approach would be to document that a specific percent of rural residents discharged from referral hospitals can obtain PAC services within a reasonable distance from the resident’s home community (e.g., within 30 miles).

² The Hart-Scott-Rodino Act established the federal pre-merger notification program, which provides the Federal Trade Commission and the Department of Justice with information about mergers and acquisitions before they occur. The reporting process is intended to allow the agencies to determine whether a merger or acquisition would violate anti-trust laws and to seek an injunction in federal court if it does. Only a very small portion of rural health care providers would meet the guidelines for initiating an anti-trust review (e.g., when the assets of the deal are greater than \$63.4 million or when one party has assets totaling \$126.9 million or more). (<http://www.ftc.gov/bc/hsr/index.shtml> accessed July 2011)

- Foster communication to assure care coordination during the transition between hospital discharge and transfer back to the patient's community. Communication would include treatment plans for PAC providers, plus medication reconciliation and care plans sent to the patient's primary care provider. Require transfer communication documentation and reporting.
- Specify a split payment methodology (as with split DRGs) so that each set of providers does not re-create the wheel.

Policy Implications

Rural residents often travel to urban hospitals for their inpatient treatment but typically seek to have their PAC near their home (Probst et al., 2007). The bundled payments framework may discourage urban hospitals from discharging to a rural PAC facility. Rural facilities may be less likely to be part of the urban hospital's integrated network for the bundled service.

If rural residents who are treated in urban hospitals cannot return to their communities for PAC services, the patient, family and rural provider may all suffer:

- First, rural residents may not be able to recuperate near their home and that would increase the burden on them and on their social support network.
- Second, if rural residents return to a PAC service provider near their home but these facilities are not part of the urban hospital's integrated network, the coordination of care that the bundled payment strategy seeks to influence will likely suffer.
- Third, the resulting reduced demand for rural PAC facilities, in turn, may lead to closure and more fragmentation of an already thin network of rural health care providers.

In addition, any diminution of rural provider capacity resulting from closures and increased system fragmentation may place rural providers at a disadvantage even when the list of bundled conditions begins to expand and includes services typically provided in rural settings. The Secretary is required to submit a plan for expanding the Pilot Program by January 2016. Although the legislative language does not define the nature of expansion, the Senate Finance Committee proposal upon which the Pilot design was largely based provided for the eventual expansion of bundled conditions to include all services to Medicare beneficiaries (Senate Finance Committee, 2009).

Disbursing bundled payments through a single entity (hospital) over an episode of care is a significant shift from the current payment methodology. It is difficult to predict if this change will be more likely to create competitive or collaborative facility-physician relationships. Physicians may find themselves facing situations of increasing competition or collaboration, depending on both the nature of their role in the episode and the resources available to support their activities. For example, in the case of increased competition, two entities or two departments within a given entity may attempt to justify their proportion of the reimbursement by exerting greater control over the process and thereby limiting the participation of their collaborating partners in care. On the other hand, it could prove advantageous for some physicians to allow their partners in care to assume more responsibility for care and in doing so limit those physicians' time commitment for post-op care management.

The bundled payment arrangement can have particular implications for independent primary care physicians treating patients with chronic conditions such as diabetes. As long as the physicians are doing their jobs, patients are not recalcitrant, and nature does not conspire against the patient, there won't be an inpatient admission due to uncontrolled blood sugar. However, once there is an admission, the relationship between the independent practitioner and hospitalist/specialist could just as easily become competitive. The organizational relationships established prior to implementing a bundling strategy will greatly influence the nature and extent of competition or collaboration.

The implementation of the National Pilot Demonstration for Payment Bundling authorized under the Patient Protection and Affordable Care Act is scheduled for no later than January 2013. The Secretary of Health and Human Services has been given broad latitude to ensure that the demonstration will use: a patient assessment process to determine the most clinically appropriate site for care; an adequate choice of providers of services for beneficiaries; site-neutral quality measures; and payment for care coordination, discharge planning, and transitional care services.

The Secretary is also directed to consult with small rural hospitals, including CAHs, on issues related to their participation in the program. This provision for consultation with rural stakeholders has not occurred in past legislation. It represents a significant opportunity for improving rural provider participation.

Accommodating issues related to low-volume services is critical for the evaluation, monitoring, and improvement of quality and operational performance. However, the existing language in the Act does not provide any indication that other issues are recognized as important for program implementation (e.g., CAHs' inability to aggressively negotiate because of cost-based reimbursement). The issues we identify represent other important factors that could impact the ability of rural providers to participate in a bundled payment strategy. Addressing these issues is critical for assuring the continued operation of many rural health delivery systems as the bundled strategy payment strategy is expanded nationwide.³

Since participation in the pilot demonstration appears limited to IDS-like entities, it will be difficult to determine the implications of bundling for providers that are not part of such an entity. It would be useful for CMS to develop quality measurement and reporting processes that would be applicable in non-integrated collaboration models as well as in the integrated models that will exist in the demonstration. In this way expansion of the strategy could be facilitated in those areas where formal integration is not possible or desirable. There will also be a high demand for contract guidance and technical support, especially for non-integrated providers. It would be far more effective for CMS to either develop or contract for development of universal contract support that could be readily adapted to multiple market settings. Useful contract support could include decision-making processes, factors important for specifying payment rates, performance measures for individual providers and provider teams, and mechanisms for monitoring resource utilization and patient outcomes.

Implementation of a bundled payment strategy will drive consolidation and regionalization of services both horizontally (e.g., physician groups) and vertically (e.g., hospitals, nursing homes, and home health care). The degree to which this may evolve will depend on a variety of factors, including supply and demand for services, relative levels of competition, the pre-existence of integrated systems of care, and Medicare Conditions of Participation. There is no doubt that providers that are part of an integrated delivery system will encounter a far different experience under bundled payments than independent providers, since the latter must establish contracts with other providers to successfully pursue the same quality and operational performance goals. Rural hospitals, physicians, and other post-acute care providers may elect to remain independent and seek to establish contractual relationships with other providers in transfer, referral, and treatment efforts, or they may opt for affiliation with or ownership by a larger provider or system.

For rural providers to be meaningful participants in bundled payment strategies, they will need to be fairly reimbursed for the services they provide. "Success" in a bundled payment strategy should not be totally based on financial factors, but should also reward quality outcomes and patient choice, including selection of the best site for the most appropriate inpatient and post-acute care for rural as well as urban patients.

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³ The Secretary is required to submit a plan for the implementation of an expansion of the pilot program no later than January 1, 2016.

Additional Information

The information in this policy brief is based on Upper Midwest Rural Health Research Center Final Report #13 by Robert Town, PhD, Walter Gregg, MA, MPH, Ira Moscovice, PhD Shailendra Prasad, MBBS, MPH and Jill Klingner, PhD, RN.

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