Global and Episodic Bundling: An Overview and Considerations for Medicaid

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Introduction

State Medicaid agencies are under particular scrutiny as health care costs continue to rise and the need for Medicaid-funded health care services for increasing eligible populations far exceeds available funding. This scrutiny will only intensify given the impact of the economic downturn on state revenues. Commercial payers face the same health care cost increases and deal with cost-shifting as providers seek higher reimbursement to make up for lower public program rates and care for the uninsured. Taxpayer tolerance for additional public program funding is limited, and the state funding shortfall will widen when the federally mandated Medicaid expansion takes effect in 2014, even with the federal government taking on the majority of the costs for the newly eligible. Medicaid agencies are particularly challenged by the costs of serving the elderly and people with disabilities, who account for over half of Medicaid expenditures.[1] This population will continue to increase due to U.S. population age trends.

Effectively managing health care cost increases involves addressing challenges inherent in the entire health care system to ensure delivery of the right care, in the right amount, at the right time. The current system encourages volume over value, with little financial reward for improving outcomes or delivering preventive care. Hospitals', physicians', and other providers' income depends on delivering more services to more people, which increases health care costs without any guarantee of improved outcomes. Consumers have little information about relative quality and appropriateness of care to guide them and, if insured, are often shielded from the actual costs of care.

Many policymakers are taking a renewed look at Medicaid payment strategies to determine how to slow cost increases and incent providers to deliver more efficient and effective care to the growing number of beneficiaries. Two payment strategies, while not new in concept, have been promoted of late: global bundling (also referred to as risk-adjusted global fees and comprehensive care payment[2]) and episodic bundling. Recent federal legislation (The Patient Protection and Affordable Care Act, or ACA) promotes these strategies through Medicare and Medicaid. The new law authorizes implementation of Medicaid global and acute care episode bundled payment demonstration projects in selected states beginning in 2011. Medicare has already been experimenting with episodic payment approaches through various pilot programs, and the ACA requires Medicare to implement a national pilot program on bundled payment by 2013. This brief describes global and episodic bundling and outlines considerations for state Medicaid agencies when evaluating potential implementation, including the relevance of these strategies for Medicaid agencies employing managed care strategies.

Overview of Global and Episodic Bundling

Global and episodic bundling payment strategies are payment approaches under which a group of providers receives a set payment amount per patient for a predefined time period for a predefined set of services. Both strategies go beyond current bundling approaches as they include multiple providers and services. Current approaches, most notably Diagnosis Related Groups (DRGs) and ambulatory payment classifications (APCs), cover only hospital care.

Under *global bundling*, a provider or group of providers receives a single payment per person to cover a wide range of services over a period of time (typically prorated over a year). Payment is risk-adjusted based on a patient's health and other key characteristics, such as age and gender, that may affect the level of needed services. Strong outcome and performance measures are incorporated into the payment structure.

What Is Bundling?

Bundling is the process of grouping services for payment purposes—either for a particular person over a predefined period of time or for a particular clinical diagnosis or procedure. Instead of providers receiving payment for each individual service performed, they receive one payment amount for a group of services related to either a particular person or a particular diagnosis or procedure.

Under episodic bundling, a provider or group of providers receives a single payment per person and health event (e.g., hip fracture or knee replacement), with payment adjusted for the severity of the presenting patient's condition. The time period is more limited than in global bundling, lasting from the beginning of the health event to, in general, 30 days after the related hospital discharge. Although episodic bundling may include a wide range of providers and services—for example, hospitals, physicians, physical therapists, and long-term care facilities—it typically focuses on hospital and physician care along with some ancillary services.

The differences among global bundling, episodic bundling, and historical provider capitation approaches have been the subject of much debate. For purposes of this paper, historical provider capitation refers to traditional capitated arrangements between payers and providers that typically do not include strong risk-adjustment features or performance/outcome measures. The lack of risk adjustment under historical provider capitation meant that providers took on both insurance risk (the risk of whether or not a patient has an illness or condition requiring care) and performance risk (the ability of a provider to address an illness or condition in a high-quality and efficient manner). When historical provider capitation used risk adjustment, the approaches were

relatively simple compared with (1) the risk-adjustment strategies currently used by some states to risk-adjust Medicaid capitation rates paid to managed care organizations (MCO) and (2) more recent commercial capitation strategies.

Under historical provider capitation, providers made money if patients stayed healthy, but they did not receive additional revenue for taking on sicker patients. In addition, providers were paid regardless of quality of care and related outcomes. In contrast, global and episodic bundling strategies employ a strong risk-adjustment component; the strategies call for payers to take on the insurance risk (the risk of whether a patient has an illness or condition requiring care) and for providers to assume responsibility for performance risk (the ability of a provider to address an illness or condition in a high-quality and efficient manner).[3] Global and episodic bundling also includes bonuses or penalties based on quality measurement. Figure 1 summarizes some of the key differences among global bundling, episodic bundling, and historical provider capitation models.

Global and episodic bundling strategies are not mutually exclusive, and episodic bundling does not necessarily precede global bundling as a building block. The two strategies serve different goals and therefore may be implemented either separately or together as a part of a larger service delivery strategy. For example, a state could use global bundling for care and management of individuals with chronic conditions in order to control avoidable hospitalizations but could use episodic bundling for labor and delivery care for pregnant women (including prenatal care) or for hip or knee replacements (including post-surgery recovery and therapy).

While episodic bundling provides a tool for managing cost and the variation of costs across similar episodes, it may not discourage future episodes (e.g., the number of hospitalizations in a year for chronic disease patients) because the time period for payment is limited to the single episode. Accordingly, episodic bundling may be well suited to conditions in which the rate of occurrence of episodes is less of a concern, and there is unnecessary variation across different providers in the cost of an episode of care (e.g., labor and delivery). Global bundling, on the other hand, intends to affect the number of unnecessary episodes in addition to the cost of episodes. Global bundling may be particularly well suited for patients with conditions involving a high rate of hospitalizations and a potential for preventable re-admissions.

Global and episodic bundling can both help reduce avoidable hospital re-admissions—a key area for cost reduction and improved outcomes—albeit in different ways. Episodic bundling's inclusion of a period of time after the health event for follow-up care—typically 30 days—incents providers to reduce the number of re-admissions after the initial hospitalization so as to achieve net income. Global bundling's structure of paying for all services for a longer time period covers all hospitalizations and re-admissions, not just those related to a particular health event. Accordingly, providers have a similar incentive to reduce re-admissions, but that incentive is not tied to a specific health event.

Example of an Episode of Care

Under Geisinger Health System's ProvenCare program, payment is bundled for all non-emergency coronary artery bypass graft (CABG) procedures, including the pre-operative evaluation, all hospital and professional fees, and management of any complications (including re-admissions) occurring within 90 days of the procedure.

Figure 1: Key Differences among Episodic Bundling, Global Bundling, and Historical Provider Capitation

Feature	Episodic Bundling	Global Bundling	Historical Provider Capitation
Time period	Health event, including additional time to encompass related re-admissions	One year, paid monthly or via fee-for-service with periodic reconciliation with global budget	One year, prorated by month
Target population	Tailored to each payer's goals	Tailored to each payer's goals	Tailored to each payer's goals
Providers and services to be bundled	Services related to health event for a particular person • Hospital and physician services • Other services and providers only as necessary to treat the health care event	All services related to care for a particular person (carve-outs may apply) • Hospital and physician services • All other services necessary to provide covered services	All services related to care for a particular person (carve-outs may have applied) • Hospital and physician services (may have been capitated separately) • All other services necessary to provide covered services
Performance and outcome measures	Yes	Yes	Sometimes
Risk-adjustment feature	Yes	Yes	Less sophisticated methods
Assignment of risk	Split between payer and provider	Split between payer and provider	Provider accepts financial risk

Global and episodic bundling strategies can be useful in states already using managed care approaches to deliver care. Approximately 70 percent of Medicaid enrollees receive some or all of their care through some form of managed care.[4] Typical Medicaid managed care arrangements include full-risk capitated contracts for all covered services; pre-paid, partial-risk contracts for a subset of services; and primary care case management (PCCM). PCCM is not capitation; the state pays Medicaid beneficiaries' primary care physicians an administrative fee to provide basic care and to coordinate and authorize any needed specialty care or other services. States using PCCM may find global and episodic bundling strategies particularly helpful as PCCM primary care providers are typically not at risk for hospitalizations. States already using partial or full-risk capitation may achieve a more limited benefit from global or episodic bundling strategies as they already bundle services.

Generally speaking, under a global or episodic bundling approach, a Medicaid agency would contract directly with an integrated provider group (e.g., an accountable care organization [ACO][5] or a hospital or hospital system that has either established employment relationships with physicians or entered into some other type of exclusive contractual arrangement with a physician group(s) for the majority of services). However, it is possible for Medicaid agencies that use MCOs or other similar clinically integrated entities to work through those entities to implement global or episodic bundling. We discuss this issue in more detail later under "Medicaid Considerations."

Despite significant benefits to implementing a global or episodic bundling approach, Medicaid agencies and their contracted providers would require significant resources to do so. Medicaid agencies, for example, would need to restructure their provider or MCO contracts (or both), develop sophisticated analyses of utilization and costs across providers for specific populations and diagnoses, and employ a robust risk-adjustment methodology. In global and episodic bundling approaches, payers also typically provide reports to providers as part of an ongoing feedback loop. These reports might include, for example, data on re-admission rates, emergency department utilization, and discretionary ambulatory procedures. Medicaid agencies, or the MCOs with which they contract, would need to develop this analytic capacity and work closely with providers to gain a common understanding of the results of the analyses.

To be successful under global and episodic bundling, providers must be highly integrated. Accordingly, Medicaid agencies might initially look to highly integrated provider systems, including emerging ACOs and other similar entities. There is also a recent trend across the country toward increased hospital and physician integration. A wide range of providers would need to perform population-level care management jointly, predict and manage financial risk, and integrate service delivery. These activities would, for example, require all providers to use a common electronic medical record and perform "real-time" analyses of utilization and cost (as opposed to the "look back" approach that claims data provide). While the federal and state governments have made significant investments to improve health information technology, additional provider investment would be required to make the needed changes to information systems, including the use of electronic medical records.

Medicaid Global Bundling Key Implementation Issues

When developing a global bundling approach, several key issues warrant consideration across payers:

- *Target population.* While global bundling theoretically could, if appropriately tailored, be implemented for most populations, Medicaid agencies should first determine which covered populations could most benefit from increased coordination and integration of services. Detailed analysis of health care costs and utilization by subpopulation could help identify, for example, which populations have the most unexplained variance in health care costs and utilization across providers.
- *Providers and services to be bundled.* Current global and episodic bundling payment strategies typically include hospitals, physicians, and prescription drugs. Depending on the covered services, the strategy might also include behavioral health, nursing facility care, home health, hospice, and other services. A payer could decide to pay for certain services and providers outside of the bundle. For example, similar to some current managed care approaches, Medicaid could include all acute care, primary care, behavioral health, and prescription drugs under a global payment and pay separately for extended long-term care services.
- *Risk adjustment.* Adjusting payments based on types of conditions, severity of conditions, and other characteristics of the patients cared for reduces the incentive for providers to avoid less healthy patients. Medicaid agencies

would need to specify which factors to include in risk-adjusting payments and determine if the patient population is sufficient to diversify risk adequately. Risk adjustment has some notable limitations, however, as discussed later under "Medicaid Considerations."

- *Payment levels.* If a global payment rate is set too low, providers may be incented to restrict needed care. However, a global payment rate should reflect a reduction in current expenditures resulting from improved outcomes and a more coordinated application of services and related resources. In this regard, careful analysis of historical expenditures and utilization data is necessary, along with a collaborative planning process with providers. Payment rates can be set, for example, by using the historical costs of services (e.g., average fee-for-service rates minus a predetermined percent) or guideline-based standards (estimated costs of care determined by using a set of recommended services).[6] Medicaid agencies could consider using commercially available groupers to inform analyses and payment rate determination, although these may not fully address issues related to disability services (particularly developmental disability) and long-term care. The groupers use data such as diagnosis and procedural codes to assign individuals to predefined episodes of care or clinical risk groups. Given historical payment levels that reflect significant state budget constraints, Medicaid faces unique challenges when setting payment levels, as discussed later under "Medicaid Considerations."

- *Distributing payments.* In theory, a Medicaid agency (or its contracted MCO) would provide one global payment amount to a provider organization for services for a particular patient, and that provider organization would be responsible for distributing the payment as necessary to the individual providers responsible for care for the patient. Payment distribution has been a notable challenge to the global payment approach as few providers are integrated enough or have the administrative capacity and health information technology infrastructure necessary to accept and distribute payments, although physician and hospital integration is on the rise. As a result, it may be necessary to look at alternative payment administration arrangements. For example, according the Center for Healthcare Quality and Payment Reform, the Patient Choice system in Minnesota, which serves self-funded employers, uses the standard fee-for-service claims payment system and adjusts fee levels based on the severity-adjusted total cost of care.[7] Blue Cross Blue Shield of Massachusetts (BCBSMA) pays providers in its global payment system (Alternative Quality Contract, or AQC) on a fee-for-service basis until the end of the year, at which time BCBSMA performs a reconciliation with the predetermined global budget (based on total estimated medical expenses and adjusted for patient health status).

- *Building in safeguards for underutilization.* As with traditional provider capitation, there is some concern that providers may skimp on care, particularly preventive services for improved outcomes that may not occur in the short term. In addition to developing severity-adjusted rates, other safeguards can be considered, including use of outlier payments, tying incentives or penalties to outcomes of care, requiring the delivery of specific services for payment to be received, and public reporting of quality measures.[8] For example, BCBSMA's AQC includes performance-based incentives for a broad set of quality and outcome measures for ambulatory and inpatient care. By meeting defined targets on these measures, AQC organizations can earn up to an additional 10 percent of their global budget.

Implementing a global bundling payment approach requires a great deal of preparation, even for Medicaid agencies already familiar with capitation approaches. For example, a state Medicaid agency would need to:

- Improve analytics to identify avoidable costs and complications by population and episode;
- Assess provider networks' ability to reduce avoidable costs and increase quality through the use of health care information technology and clinical protocols;
- Determine how state health information technology strategies may be modified to support providers' efforts to integrate and coordinate care, particularly the implementation of electronic medical records; and
- Develop or strengthen pay-for-performance approaches, for example, public reporting of quality-of-care indicators.

As with other payment strategies, Medicaid agencies can tailor the global bundling concept to ease implementation and allow providers time to adjust to the new payment system. For example, states could consider implementing a physician practice–specific global payment with performance incentives for hospital services[9] similar to partial capitation. Under such a strategy, a physician practice or health system would receive a single severity-adjusted payment per patient to cover services provided through that practice or system. Other outpatient and inpatient hospital services would be paid separately, but the practice or system would receive a pay-for-performance-style bonus or penalty based on the level of utilization of all outpatient and inpatient services.

Current Examples of Global Bundling Approaches

Blue Cross Blue Shield of Massachusetts (BCBSMA) Alternative Quality Contract (AQC)

Blue Cross Blue Shield of Massachusetts uses a per-patient global budget (based on total estimated medical expenses adjusted for patient health status) with significant performance incentives based on quality measures for its health maintenance organization product. The AQC covers all services and costs (primary care, inpatient, outpatient, pharmacy, behavioral health, among others), with participating providers paid on a fee--for-service basis until the end of the year, at which time BCBSMA performs reconciliation with the predetermined global budget. Provider participation is voluntary, and BCBSMA offers different levels of risk-sharing arrangements with provider organizations according to the size of the group, the degree of integration, and the ability to assume risk for utilization and variations in care.

Source: Blue Cross Blue Shield of Massachusetts. *Blue Cross Blue Shield of Massachusetts The Alternative Quality Contract*. May 2010. Available online (October 14, 2010) at www.qualityaffordability.com/pdf/alternative-quality-contract.pdf.

Patient Choice Care System

The Patient Choice Care System groups health care providers and facilities into customized networks called Care Systems and is available to self-funded employers in Minnesota, South Dakota, and limited areas of North Dakota and western Wisconsin. The Care Systems are tiered into three cost groups based on their risk-adjusted total cost of care combined with their performance on a variety of quality and efficiency measures. Employers offer a choice of Care Systems, and consumers have access to comparative information as well as the option to contribute less toward the cost of their premium when selecting Care Systems in lower tiers. Once enrolled, participants obtain care from providers affiliated with their selected Care System in order to be eligible for in-network benefits. According to the Center for Healthcare Quality and Payment Reform, Patient Choice pays providers the equivalent of a global bundled payment by using its standard fee-for-service claims payment system and adjusting fee levels based on the severity-adjusted total cost of care.

Sources: Patient Choice Web site. Available online (December 31, 2010) at www.patientchoicehealthcare.com/physicians/products.html; Center for Healthcare Quality and Payment Reform. *Transitioning to Comprehensive Care Payment*. Available online (December 20, 2010) at www.chqr.org/downloads/TransitioningtoComprehensiveCarePayment.pdf.

Medicaid

The ACA authorizes the implementation of a state global payment demonstration project for up to five states that would adjust the current Medicaid payment structure for safety-net hospitals from fee-for-service to capitated payment (PPACA, Section 2705). As of February 2011, the Center for Medicare and Medicaid Innovation had not released guidance on the projects, and it is not known which states will pursue this option.

Implementation of Global Bundling to Date

While global bundling has not been widely implemented, two large commercial payers have implemented it, and the ACA authorizes Medicaid global payment pilot projects for states (see box above).

Medicaid Episodic Bundling Key Implementation Issues

As with global bundling, some of the key issues associated with episodic bundling include defining the target population, identifying included providers and services, selecting a risk-adjustment approach, determining payment levels, and administering payments. Episodic providers and services may be more limited than global bundling providers as the former are identified on the basis of the particular type of services required for the chosen health care event. Determining payment levels may require a different type of analysis than that required for global payments because of the desirability of developing a payment rate based on a specific protocol of care for the particular episode. For example, Geisinger Health System bases its payment rates for cardiac surgery episodes of care on 40 best-practice steps developed from the American Heart Association and the American College of Cardiology guidelines for cardiac surgery.

Additional issues pertaining to episodic bundling include the following:

- *Establishing period of time covered.* It is necessary to establish a clear beginning and end to each episode of care so that providers' responsibilities within the fixed payment are clear. For example, when bundling services for an episode that would typically require inpatient hospitalization (e.g., knee replacement surgery), decisions must be made regarding how long after the procedure services will be provided under the bundled payment and if they will include subacute care facilities and physical therapists for rehabilitation needs and physician follow-up visits.
- *Identifying diagnoses or clinical procedures.* Episodes of care hinge on specific health events, which may be defined by using diagnoses and/or procedure codes.
- *Use of clinical protocols and quality-of-care standards.* Basing payment on established clinical protocols and guidelines for the specific episodes of care and providing such information to providers assists them in improving quality of care and reducing unnecessary costs (e.g., Geisinger's 40 best-practice steps).

As with global bundling, preparation for an episodic bundling payment strategy requires state Medicaid agencies to perform sophisticated analyses of patient expenditures and utilization (specifically by episode of care), analyze current provider networks, support health care information technology innovations, and strengthen pay-for-performance measurement/recognition approaches.

Implementation of Episodic Bundling to Date

Episodic bundling approaches have been tested more than global bundling approaches, although primarily for services largely requiring hospital and physician services.

Global Bundling Issues That Apply to Episodic Bundling

- Defining the target population
- Identifying included providers and services
- Selecting a risk-adjustment approach
- Determining payment levels
- Administering payments

(Refer to Medicaid Global Bundling Key Implementation Issues section for more details about these issues.)

The box at right describes different episodic bundling approaches in effect or to be implemented in the near future.

Medicaid Considerations

Medicaid agencies face additional challenges when considering global or episodic bundling approaches. Given the amount of resources that state Medicaid agencies and providers would need to dedicate to the successful implementation and ongoing use of either strategy, Medicaid agencies will need to identify populations and/or health events that clearly offer opportunities for reasonably achievable improvements in costs and outcomes. Even in these cases, it may be prudent for a state to consider if its current payment approach may be modified to achieve similar cost and outcome improvements (particularly if full- or partial-risk capitation is already used). Starting on a smaller scale through pilot programs may help Medicaid agencies determine how best to structure global or episodic payment approaches and assess to what extent providers are able to coordinate and effectively manage the risk.

Impact of State Budget Constraints on Setting Payment Levels

Often Medicaid agencies aim to maintain budget neutrality when changing payment strategies. As many providers already perceive that Medicaid rates are too low,

Examples of Current Episodic Bundling Approaches

Provider Groups or Commercial Payers

- Geisinger Health System in Pennsylvania's ProvenCare. ProvenCare offers one bundled payment for all non-emergency coronary artery bypass graft (CABG) procedures, including the pre-operative evaluation, all hospital and professional fees, and management of any complications (including re-admissions) occurring within 90 days of the procedure. ProvenCare now also includes bundled payments for hip replacement and cataract surgery, among other services.
- Carol, The Care Marketplace, a for-profit company in Minnesota. This employer-sponsored program offers employees 53 care packages designed around four chronic conditions (pediatric asthma, chronic low back pain, coronary artery disease, and Type 2 diabetes). Care packages are evidence-based and include traditional outpatient services, along with some non-traditional services. Participating providers set their own prices for the care packages, and employers decide how much coverage they will provide under their existing benefit plans for each care package.
- The Integrated Healthcare Association (IHA). IHA began work on an episodic bundling pilot in 2010 for total knee and hip replacements in Southern California and is now expanding the program to providers across California and other clinical areas and episodes of acute treatment that may include surgical procedures. IHA was awarded a three-year, $2.9 million grant from the Agency for Healthcare Research and Quality (AHRQ) in September 2010 to demonstrate bundled episode payments for physicians, hospitals, and other providers and to evaluate their effectiveness versus current payment methods in California.
- PROMETHEUS. Payers such as Health Partners in Minnesota, Independence Blue Cross (Pennsylvania) in partnership with the Crozer-Keystone Health System, and the Employers Coalition on Health in Illinois are using the PROMETHEUS payment model. Under the model, providers are paid evidence-informed case rates (ECR) to care for a patient diagnosed with a single condition. The ECR is a single, risk-adjusted payment—based on historical information from a large commercially insured population database—that covers health care services delivered in both inpatient and outpatient hospital settings.

Medicare

Acute Care Episode Demonstration. The project began 2009 and now includes five sites targeting orthopedic and cardiovascular services. Medicare will continue testing episode-of-care approaches; the ACA authorizes a five-year, national, voluntary pilot program starting in 2013 that includes hospital services, physician services, and post-acute care services for an episode of care that begins 3 days before hospitalization and extends for 30 days following discharge.

Medicaid and Other Publicly Developed Approaches

- Minnesota's Department of Health is developing seven baskets of care—collections of health care services—designed to treat particular health conditions or episodes of care. The baskets of care include quality measures and are aimed at addressing asthma (children), diabetes, low back pain, obstetric care, preventive care (adults and children), and total knee replacement. Although providers and payers (including Medicaid and Medicare) are not required to use baskets of care, the objective of the baskets-of-care concept is to encourage providers, payers, and consumers to be innovative and think differently about health care service delivery.
- The ACA authorizes the implementation of an integrated care hospitalization demonstration for up to eight states to use bundled payments to promote integrated care (PPACA, Section 2704). As of February 2011, the Center for Medicare and Medicaid Innovation had not released guidance for the projects, and it is not known which states may pursue this option.

it may be difficult to obtain provider buy-in if providers must invest additional resources in coordinating care and developing their health care information technology infrastructure, especially with additional cuts in states' Medicaid funding on the horizon. State policymakers will need to assess carefully whether payment levels would appropriately meet the additional upfront and ongoing resources expended by providers, even when considering increased efficiencies and improved outcomes associated with provider integration and coordination. Medicaid agencies may want to consider conducting a program-wide assessment of payment levels to identify how Medicaid might adjust payment levels across service types to meet state goals and provider needs.

Given funding constraints, it may be best to pilot global or episodic bundling approaches through existing integrated provider organizations; such organizations will likely have already made many of the changes needed to help ensure success under a global or episodic bundling approach (e.g., use of electronic medical records). Some Medicaid agencies may find that there is already a movement by providers to create ACOs or other clinically integrated entities and that these providers may be interested in exploring Medicaid pilot programs.

Coordinating with Other Payers

Public payers have limited influence on the extent to which providers are sufficiently integrated to coordinate care at the level required by episodic and global bundling. While Medicaid will represent a much larger share of the health care market in 2014 under the ACA provisions for Medicaid coverage expansion, Medicaid agencies may need to be aware of what other payers are doing to make sure that the incentives they create are consistent with and do not conflict with those of other payers.

Limitations of Risk Adjustment

One of the main benefits of global bundling is its emphasis on risk adjustment, which in theory should allow providers and payers to share risk more equitably. For many years, Medicaid agencies have been using and refining their Medicaid or condition-based risk-adjustment systems for Medicaid risk-based managed care—for example, the University of California's Chronic Illness and Disability Payment System (CDPS) and Johns Hopkins University's Adjusted Clinical Groups (ACG). Nonetheless, risk-adjustment methodologies, while much improved over the last two decades, are still a work in progress, and even the most sophisticated approach explains only a portion of the risk. Medicaid agencies and providers should consider this an area of particular focus, given the risk to which Medicaid and their contracted providers are exposed. Some solutions to address the limitations with risk adjustment might include stop-loss payments, outlier payments, or reinsurance.[10]

Should risk-adjustment approaches prove insufficient, providers may end up taking on more risk than they expected, potentially resulting in significant financial hardships for providers and potential disruption to provider networks for beneficiaries. The risks may be higher for Medicaid populations than for commercial populations, given some of the unique characteristics of Medicaid programs (discussed above) as well as the regulations governing how Medicaid patients can or cannot be billed for services, ease of communication (i.e., reading levels, transient nature of covered individuals, and so forth), and patient compliance. Medicaid agencies should carefully monitor the extent to which providers take on risk and develop their own assessment of whether the amount of risk is excessive (even if the provider is willing to move forward). Depending on how the provider accepts risk, Medicaid agencies may want to open discussions with the state insurance department to make sure that proper oversight is in place. Given the above concerns, it may be particularly important to start with small pilot programs that carefully analyze how the payment structure affects providers.

State Demonstrations to Integrate Care for Dual Eligibles

The Centers for Medicare & Medicaid Services plans to award contracts to up to 15 states of up to $1 million each to implement a demonstration program that would improve the quality, coordination, and cost-effectiveness of care for dual eligibles. The federal government particularly encourages the testing of new and emerging models (e.g., health homes or ACOs) and building on existing vehicles (e.g., PACE or SNP). State applications were due on February 1, 2011, with implementation beginning after an 18-month design period.

Considerations for States Using MCOs to Deliver Care

Many states already use MCOs to provide services to the majority of their beneficiaries. The feasibility and palatability of states promoting global and episodic bundling strategies through these MCOs depend in large part on the goals of the state and insurance and provider market characteristics (e.g., number of integrated health systems in the state, number of insurers in the state, and whether they already contract with Medicaid).

States could require MCOs to implement global or episodic bundling strategies as a condition of doing business with the state (using request-for-proposal and contract requirements) and then oversee those strategies. However, such a requirement could conflict with existing goals of using MCOs to reduce the state administrative burden as well as with reluctance to dictate internal reimbursement strategies to MCOs.

Alternatively, states could choose to provide start-up funds for plans to implement pilot programs, offer extra points during the MCO proposal review process to MCOs that implement these strategies, or offer enhanced MCO payments for implementation. Using global or episodic bundling strategies could also be built into a state's pay-for-performance initiative with MCOs. Maine, for example, is planning to issue a managed care request for proposals in May

2011 that will include incentives for payers that develop contracts with providers to move in the direction of severity-weighted capitated payments or shared risk.

In states where the health plans that serve Medicaid recipients offer a wide variety of products and command a large market share, Medicaid agencies may have a particularly useful opportunity for cross-payer coordination of global and episodic bundling approaches. States might also consider implementing episodic bundling strategies in geographic areas where traditional capitation has not been possible.

Relevance of Global and Episodic Bundling Strategies for the Elderly and People with Disabilities

States' service delivery systems for the elderly and people with disabilities vary widely, e.g., available funding, number and size of community-based service networks, and the integration of care between Medicare and Medicaid for dual eligibles (individuals qualifying under both programs). Whether a state uses global or episodic bundling for these populations should be considered within the context of existing delivery systems. For example, in the case of dual eligibles, fundamental administrative and payment policy changes to integrate Medicare and Medicaid services would likely need to take place before implementing bundled payment methodologies.

Global bundling may hold particular promise as compared with episodic bundling for the elderly and people with disabilities due to the likelihood that these individuals have several diagnoses or needs. Dual eligibles, for example, are more likely to have mental health needs and to live in nursing homes compared with other Medicare beneficiaries.[11] Under global bundling, providers would be responsible for all the needs of a patient, whereas episodic bundling would focus on a particular health event.

The PACE model—which provides dual eligibles with all needed Medicare and Medicaid supportive services for a per member per month capitation rate from Medicare and Medicaid—is similar to global bundling and has often been held up as an example of well-executed integration between payers and providers. States could choose to build on this approach but expand it to a broader population.

Some states contract with Special Needs Plans (SNP) for Medicaid acute and long-term supports and services.[12] The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) increased SNP integration by requiring new plans or those expanding into new service areas to contract with state Medicaid agencies and establish new standards in the provision of care.[13] States using SNPs for a full range of services could consider global bundling for all or a portion of these services or episodic bundling for specific events. Before using this approach, however, Medicaid agencies should carefully assess the degree to which SNPs fully integrate Medicare and Medicaid funding within their own administrative structure.

Medicaid agencies might also want to consider serving as the integrated entity for delivering care to dual eligibles. This is a new model under which the Medicaid program would receive an agreed-upon amount of Medicare funding for participating dual eligibles and would assume responsibility for the Medicare benefit. States would be able either to manage the integrated benefit themselves or establish contracts or other arrangements with health plans or administrative entities to do so. States could choose to integrate global or episodic bundling strategies into this model.

Dually eligible populations will quickly increase as the 80 million baby boomers become eligible. Advanced Medicaid planning, including new payment methodologies, is critical given the disproportionate costs associated with the co-morbidities inherent in this population. The challenges of modifying payments to care for this population will be significantly complex.

Options for States Not Moving Immediately to Global or Episodic Bundling

Depending on state-specific goals, the provider market, current Medicaid payment approaches, or available resources, some Medicaid agencies may not immediately implement global or episodic bundling approaches. Many options are available to these states to move toward increased bundling while achieving cost savings. For example, for acute care services, states could choose to implement the following:

- *Enhanced payments to hospitals that demonstrate reductions in avoidable re-admissions.* Similar to DRGs, enhanced payments help reduce re-admissions and produce real cost savings. With many re-admissions generated by events outside of the hospital in ambulatory settings, an investment in transition coordinators may be critical. If payment increases are available for improvements and/or if grants are available for interventions, then there is an increased likelihood that hospitals will focus resources on care improvement and cost reduction resulting from reduced re-admissions. As states begin to focus on medical homes and other patient-centered approaches, they will also find that the transition of care coordination required to reduce re-admissions will be an important resource for enhancing care coordination of patients with chronic conditions and their care teams.
- *Increasing bundling in current inpatient and outpatient hospital reimbursement systems.* For example, Medicaid could transition to Medicare's risk-adjusted All Patient Refined DRGs or other similar products for inpatient hospital services or to Enhanced Ambulatory Patient Groups (EAPG) for outpatient hospital services, which is more bundled than Medicare's APCs.

- *Increases in the time period around payment for specific DRG.* For example, bundling could be increased over time, e.g., implement Medicare's 72-hour window payment policies.[14]
- *Reducing or eliminating payment for the treatment of preventable complications.* In going beyond ACA's requirements that states do not pay for certain hospital-acquired conditions, state Medicaid agencies, for example, could adopt ACA's provision that reduces Medicare payments to hospitals for preventable re-admissions.

Conclusion

Variations on global and episodic bundling strategies are likely to become more common in the future, and states are well advised to consider how their features may help provide higher-quality care to the sharply rising number of Medicaid enrollees. The provider landscape is also shifting, with a recent and notable trend across the country toward increased hospital and physician integration. Given these trends, pilot programs targeting areas where current analyses of cost and utilization suggest positive results may be particularly useful in determining if an expanded use of these strategies is warranted.

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Endnotes

1 Kaiser Commission on Medicaid and the Uninsured. Slide "Top 5% of Enrollees Accounted for More Than Half of Medicaid Spending, FY 2008." Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from the Centers for Medicare and Medicaid Services. Available online (January 2, 2011) at http://facts.kff.org/chart.aspx?ch=471.

2 Miller, Harold. "Transition to Comprehensive Care Payment." Center for Healthcare Quality and Payment Reform. Available online (December 16, 2010) at www.chqpr.org/downloads/TransitioningtoComprehensiveCarePayment.pdf.

3 The definition of insurance and performance risk may be found at Network for Regional Healthcare Improvement. "A Primer on Healthcare Reform." January 2009. Available online (January 9, 2011) at www.nrhi.org/downloads/NRHI-PaymentReformPrimer.pdf.

4 Kaiser Commission on Medicaid and the Uninsured. *Medicaid and Managed Care: Key Data, Trends and Issues.* February 2010. Available online (October 10, 2010) at www.kff.org/medicaid/upload/8046.pdf).

5 An accountable care organization may be defined as "a set of providers associated with a defined population of patients accountable for the quality and cost of care delivered to that population. The providers could include a hospital, a group of primary care providers, specialists, and possibly other health professionals who share responsibility for the quality of care and cost of care provided to patients." AcademyHealth. "Medical Homes and Accountable Care Organizations: If We Build It, Will They Come?" Available online (January 9, 2011) at www.academyhealth.org/files/publications/RschInsightMedHomes.pdf.

6 American Hospital Association. "Bundled Payment." May 2010. Available online (January 10, 2011) at www.hret.org/bundled/resources/BundledPayment.pdf.

7 Center for Healthcare Quality and Payment Reform. "Transitioning to Comprehensive Care Payment." Available online (December 20, 2010) at www.chqr.org/downloads/TransitioningtoComprehensiveCarePayment.pdf.

8 Miller, Harold D. "From Volume to Value: Better Ways to Pay for Health Care." *Health Affairs*, Volume 28, Number 5, September/October 2009, pp. 1424-1425.

9 Center for Healthcare Quality and Payment Reform. "Transitioning to Comprehensive Care Payment." Available online (December 20, 2010) at www.chqr.org/downloads/TransitioningtoComprehensiveCarePayment.pdf.

10 Reinsurance and stop-loss strategies seek to provide protection against aggregate losses for a group over a preset level or a loss per insured person exceeding some threshold. Outlier payments provide additional reimbursement for cases with extraordinarily high costs.

11 Kaiser Commission on Medicaid and the Uninsured. "Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries." December 2010. Available online (January 2, 2011) at www.kff.org/medicaid/upload/4091-07.pdf.

12 Arizona, Minnesota (Minnesota Senior Health Options), New Mexico, New York (Medicaid Advantage Plus), Texas (STAR+PLUS), and Washington (per the Center for Health Care Strategies' "Options for Integrating Care for Dual Eligible Beneficiaries." March 2010).

13 New standards include evidence-based models of care; interdisciplinary care teams; and individual care plan identifying goals, objectives, measurable outcomes, and specific benefits.

14 Under Medicare's 72-hour rule, outpatient department services related to a hospital admission that were delivered in the three days before the admission are included in the payment for the inpatient stay and may not be separately billed.