

# Hospitalists Assess the Impact of Bundled Fees

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## Background

A group of the nation's leading hospitalists has emerged to actively engage in issues that significantly impact the future of hospital medicine, particularly as it applies to the private practice model. The authors of this white paper convened March 25-26, 2009 in Dallas, Texas as an organization known as The Phoenix Group. Formed as an action-oriented think tank, The Phoenix Group's mission is to provide executive leadership to address the most serious challenges facing private practice hospitalists in the U.S. today. Collectively, The Phoenix Group membership represents more than 3,000 hospitalists, which according to Society of Hospital Medicine (SHM) statistics, comprise more than 30% of hospitalists practicing in some form of a private practice setting.

The recent meeting was The Phoenix Group's fifth gathering, and this white paper is the fourth published by the group since its founding. The group plans to continue to meet for a retreat each spring and fall, while maintaining active dialog and discussion throughout the year.

One of the key topics of the meeting was the issue of the bundled fees between hospitals and physicians for inpatient acute and post-acute care. It is clear that a bundled payment plan is under active consideration by Congress as an integral part of the new healthcare legislation being formed at the time of this writing. Therefore, we will focus this white paper on our examination of this topic.

## A hopeful but uncertain outcome for hospitalists

As the national debate rages over the future of healthcare policy, the rallying cry for reform can be heard from all corners of the healthcare industry. The Phoenix Group approached the public policy issue from the perspective that there will indeed very likely be a major healthcare reform bill introduced to Congress by the end of summer or early fall of this year, and a bill is expected to be passed before the end of the year. It appears that the new legislation will usher in the most significant reforms to healthcare in a generation—with changes so sweeping that its ultimate impact will be difficult if not impossible to predict.

Meanwhile, the many stakeholders in healthcare reform jockey for position to secure their interests. Curiously, the issue of bundling has remained largely outside the main theatre of debate, largely neglected by the mass media if not by the professional healthcare community. Overshadowed by the higher profile aspects of healthcare reform, debate and discussion on bundling seems muted. Nevertheless, the potential impact of bundling on hospital medicine is large indeed, and a consensus on what the position of hospitalists should be is not yet within sight.

Details coming out of Washington have been slow to emerge as the Obama administration seeks to gauge stakeholder reaction. But one thing is clear: healthcare reform legislation holds the potential for an uprooting of the traditional fee-for-service payment system. The plan that finally emerges, perhaps by the end of this year, holds the potential to leave hospital medicine in a position of vulnerability, particularly with respect to the security and reliability of compensation. In some scenarios no longer would even a portion of a hospitalist's revenues remain independent of the hospital.

### **Will the Medical Home be funded from inpatient care savings?**

Bundled payments are just one component of what will likely be very comprehensive legislation with various elements linked through a system where some reforms will pay for others. For example, to see the potential impact of bundled fees one has to look at reforms planned for primary care, specifically the Patient-Centered Medical Home (PCMH). As the latest nostrum for rebuilding the country's atrophied primary care system, the Medical Home offers the patient and their family a continuous relationship with a physician coordinating care for both wellness and illness. Currently there are several dozen sites testing the PCMH concept to determine its impact on cost and quality of care. It remains to be seen if results to date are compelling enough to justify inclusion in the reform package, although Congress can choose to include PCMH whether or not the evidence materializes.

The Medical Home concept would seem to hold many potential advantages for primary care. It may serve as the vehicle by which the compensation of primary care physicians is increased, with the further goal of making primary care more financially attractive to residents joining the physician community. With the prospect of nearly 50 million Americans obtaining access to

healthcare insurance it seems as if the Medical Home initiative would be a welcome addition if it effectively served this purpose.

Championed by the American Academy of Family Practitioners and the American College of Physicians and enjoying the support of many physician societies (including SHM), the Medical Home is emerging as a centerpiece for rebuilding the position of primary care, signaling a newly elevated role for preventative medicine in future healthcare policy. Moreover, the Medical Home appears attractive as a vehicle to improve the coordination of care both among and between medical specialties, a theme that is likely to be present in various parts of the new legislation. Primary care physicians generally embrace the PCMH initiative since it will positively impact their compensation. Whether or not these gains are achieved at the cost of reduced compensation to other providers, including hospitalists, remains an open question.

There can be little doubt that the rise of hospital medicine over the last 15 years has had the unintended consequence of reducing the ranks of primary care physicians. However, support for additional funding for primary care must not be allowed to become a source of contention between outpatient primary care physicians on the one hand and hospitalists on the other. Healthcare dollars moving into primary care must be allocated in a way that does not create the impression, either real or perceived, that gains in payment for outpatient care are expected to be generated from cost savings achieved through cuts in inpatient care. The Phoenix Group would be most comfortable in supporting the Medical Home with the reassurance that the newly increased compensation platform for primary care is not perceived as part of a zero-sum game at the expense of hospitalists.

### **Bundled payments: a potential game-changer**

Congress intends to pay for healthcare reform, including the Medical Home, by addressing inefficiencies and cost-saving opportunities that pervade the entire healthcare system. Therefore, it is not unreasonable to expect that funding for the Medical Home will be connected directly or indirectly with cost savings associated with the bundling fees of inpatients during the hospital stay as well as their post-acute care. The potential exists for cost savings to be identified and extracted from the acute and post-acute patient care and redirected toward improvements in the outpatient system.

Eliminating improper or unnecessary over-utilization of inpatient services is of great interest to the hospitalist community, and we would welcome the opportunity to deploy the understaffed hospitalist workforce to greater effect. However, justification of bundled fees for the purpose of lowering admission rates is a tenuous rationale at best. In a white paper released in April 2009, the Senate Finance Committee looked to bundled payments as a driver for reducing 30-day readmission rates. Moreover, in its effort to connect bundled fees to readmission rates the Committee seeks to tie post-acute care into a bundled fees scheme even though an evaluation of post-acute care is not within the scope of the Acute Care Episode (ACE) demonstration project. (The House Tri-Committee would rectify this oversight as it seeks to upgrade the ACE initiative from a “demonstration” to a “pilot” project.)

Unfortunately, hard evidence of the positive impact of bundling on readmission rates is, at the moment, rather thin. The antecedents to the ACE project may be found in a relatively obscure study completed in 1998 which evaluates the impact of bundling on cataract surgeries performed in the mid-to-late 1990s. The cataract study is what the Centers for Medicare & Medicaid Services (CMS) relies upon as evidence for undertaking the current bundling project for inpatient care. It is interesting to note that the Health Care Financing Administration (HCFA), the predecessor to CMS, characterized the cataract project at the time as a success “despite its modest savings impact.”

The Phoenix Group will be watching with keen interest the ACE project in five western cities; at least one Phoenix Group member is included in the project. CMS states that, “The Acute Care Episode (ACE) Demonstration will test the effect of bundling Part A and B payments for episodes of care to improve the coordination, quality, and efficiency of that care.”

In the absence of energetic opposition, Congress seems to be on a path toward including a bundling program in the new healthcare reform legislation. However, the new bundling program would not take effect until 2014, although the timetable remains uncertain. Presumably, the delay in implementation would be for the purpose of evaluating the results of the ACE project, but this may or may not be the case. Meanwhile, the rationale to include a bundling program prior to evaluation of the evidence and ensuing public discussion of the ACE project (currently scheduled to run through 2011) remains unclear, leaving the awkward impression of healthcare legislation that is not evidence-based.

### **The mechanics of bundling: details to follow...when?**

While the Senate Finance Committee white paper holds some attractive provider incentives through gainsharing, it remains non-committal as to what formula will be used to determine how physicians will be paid for inpatient services in a bundled fee arrangement.

Perhaps the lack of detail has allowed the bundling plan to avoid too much scrutiny while it garners support. But to the extent that support is there, it will remain shallow until details emerge that are in alignment with the goals and interests of hospital medicine. For example, a comprehensive payment structure for hospitalists under a bundled fee structure has yet to emerge. This naturally raises the concern that bundled fees may result in a slowdown or even a reversal of recently positive compensation trends. Bundled fees hold the potential to trigger an internecine battle for funds not only among the medical specialties but also between medical facilities and providers. The holders of the bundled purse strings—itsself a big unknown—will be parsing out payments according to cost-savings and efficiency guidelines that have yet to be agreed upon and hospitalists’ approbation of such guidelines is far from certain.

Who would be the holder of the payment bundle? Several scenarios are in contention, but on the short list are the hospitals themselves. For hospital executives, absorbed in a protracted struggle for the economic viability of their institutions, the task of effectively managing bundled payments may well prove overwhelming. Taking on responsibility for the coordinated operations of large groups of inpatient and outpatient providers, while ensuring that their own facility is compensated in a way that is perceived as equitable, is a prospect for which many hospitals are ill equipped and in any event lies beyond the scope of their institutional experience.

### **Making a difference in healthcare reform: the time is now**

Some hospitalists contend that it is too early to voice misgivings about the potential impact of bundled fees on the future of hospital medicine. Meanwhile, momentum builds for healthcare reform legislation which in all likelihood will make bundling a reality.

As the healthcare reform legislation continues to make its way through the political process, The Phoenix Group recommends the following issues related to bundling receive more thorough consideration:

1. Explore ways to migrate the fee-for-service system to becoming more DRG-specific in a manner that promotes physician-hospital alignment.
2. Maintain responsibility for physician payments with CMS rather than a hospital or another third-party payer.
3. Allow the ACE project to run its course and undergo a thorough, evidence-based evaluation

prior to inclusion of bundling into healthcare reform legislation.

4. As soon as feasible, include post-acute care to current and future ACE demonstration sites, and evaluate their impact prior to inclusion in any bundling program.

The Phoenix Group wants to see a more vigorous debate on bundling get underway before 30,000 hospitalists are sidelined from the formulation of policy on this critical issue. Time is beginning to run short for hospitalists to speak out with a reasonable prospect of making a difference in the outcome.

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