

# hospitalist leadership

A SUPPLEMENT TO  
MEDICAL STAFF BRIEFING

# Advisor

## Helpful or hurtful?

### Proposed bundled payments make waves

You've probably engaged in heated debate with a colleague about the Centers for Medicare & Medicaid Services' (CMS) proposal to offer bundled payments to hospitals and physicians for certain acute care episodes (ACE) and whether it will help or hurt.

As they say, the devil is in the details, and no one yet knows whether a bundled payment system will prove viable. CMS is currently overseeing three-year ACE demonstration projects (<http://tinyurl.com/CMSACEDemo>) in five hospitals across the country, and the healthcare community is waiting for results. HLA spoke with several experts to answer your most pressing questions.

#### How will bundling be differ from the current payment system?

The current payment system is based on DRGs. Under this system, which has been in place since the 1980s, Medicare pays hospitals a fixed amount per diagnosis regardless of the methods practitioners used to treat the patient. Physicians are paid separately for the services they provide, which often creates tension between a hospital and the hospitalists that work there, says **Richard E. Rohr, MD, MMM, FACP, FHM**, director of hospitalist programs at Guthrie Healthcare System in Sayre, PA.

Because Medicare provides hospitals a lump sum, they get the most bang for their buck when patients stay in the hospital for the shortest possible time, Rohr

explains. However, physicians get paid a collective sum for every day the patient is in the hospital, so they benefit from longer lengths of stay.

"Bundling the payment basically removes that tension so that both sides are oriented in the same direction," says Rohr. "It requires the hospital to work with its medical staff to treat patients most efficiently so the maximum benefit is obtained from that bundled payment."

#### How will the bundled payments be split?

To accept bundled payments, each hospital and its physicians will need to create entities to accept and distribute payments from Medicare. Although this entity doesn't have to be a physician-hospital organization (PHO), it is certainly the most likely candidate, says **Richard A. Sheff, MD, CMSL**, chair and executive director of The Greeley Company, a division of HCPPro, Inc., in Marblehead, MA.

Each facility participating in the ACE demonstration project, also known as a value-based care center, has created its own system for distributing funds, says **Felix Aguirre, MD**, vice president of medical affairs and a hospitalist at IPC The Hospitalist Company, which provides services at Baptist Health System in San Antonio, TX, a participating ACE facility.

At the conclusion of the demonstration projects, CMS will review the sites' methodology and make recommendations for future value-based care centers.

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## Bundled payments

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### Will bundled payments favor physicians who perform procedures more than inpatient care?

The ACE demonstration currently focuses on select orthopedic and cardiovascular inpatient procedures, so it is unclear how, in the future, hospitalists will be compensated for the efficiencies they bring to the table.

Historically, cognitive work and inpatient hospital codes have been undervalued compared to procedural codes, says **Jack Percelay, MD, MPH, FHM**, a Society of Hospital Medicine board member. “There is no CPT code for quality improvement,” Percelay says.

For that reason, hospitalists will need to work even harder to demonstrate their value to hospital administrators. “It will require hospitalists to have the management skills and leadership to negotiate and advocate effectively for their programs within any group that receives a bundled payment,” Percelay says.

If these negotiations go well, non-procedure-based hospitalists may eventually enjoy higher salaries to compensate for their quality improvement efforts, says Rohr.

“Hospitals are going to start receiving some extra payment for better performance on clinical indicators and should put some of that money into the hospitalists’ compensation pool,” he says.

### Is bundling close cousins to gain sharing?

As hospitals and physicians collaborate to allocate funds appropriately, they can work in rewards for physicians for creating additional efficiencies. This is close to gain sharing, an approach in which a specific group of physicians creates financial savings for a hospital, and the hospital shares a portion of those savings with the physicians. However, gain sharing has been debated, given the Medicare rules that prevent hospitals from paying physicians to limit patient services.

“Bundled payments allow the hospital to basically engage in gain sharing right out in the open, by adjusting the division of payments. They get you out from underneath the Medicare rule,” says Rohr.

Hospitalists who are members of the entity that distributes the funds may eventually participate in a gain sharing program if the expanded scope of DRGs also includes medical DRGs and not only surgical or procedural-based DRGs, says Aguirre. Nonemployed or contracted hospitalists may not be able to enjoy this luxury because they will not be part of the entity.

“IPC is not part of the PHO, so we are considered a contracted vendor, and the hospital pays us 100% of the Medicare rate for the hospitalist services provided during the demonstration project,” Aguirre says.

### Haven’t we already been there and done that?

Talk of bundled payments may bring back memories of managed care and capitation, efforts that were launched and subsequently crashed in the 1990s. Capitation is a method of paying physicians a fixed amount for each person served regardless of the services provided, explains Sheff. That, paired with managed care, which encouraged providers to limit the care rendered and control medical spending, was unpopular with patients, who resented the limits put on the care they could receive.

The proposed bundled payment system is similar to capitation in that physicians receive a lump sum regardless of what services are required. However, under capitation, those payments were calculated on a yearly basis rather than for an individual episode of care.

“Some of the challenges that led to the demise of capitation and tightly managed care in the ‘90s must also be faced with any bundled payment system,” says Sheff. “This has been done before. Let’s go back and figure out what worked and what didn’t.”

Regardless of whether bundled payments make it off the ground, a crying need for incentive payment reform exists. “Given that the reimbursement for inpatient care does not cover the cost of a quality hospital medicine program, there are clear reasons for us to redesign these systems so we can work collaboratively,” says Percelay. ■