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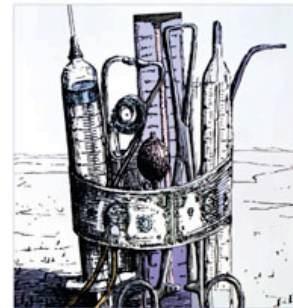
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## Contemporary Topics in Health Care: **Bundling**

*An alternative to today's reimbursement models*

By Jim Romeo



In today's health care reform debate, attention often focuses on provider reimbursement. However, the two most common reimbursement models—fee-for-service and capitation—both have their critics.

Fee-for-service, in which each service provided is priced and paid for separately, often is blamed for contributing to the lack of coordination of care across providers and settings and the provision of services that have little or no health benefits.<sup>1</sup>

The alternative, capitation, allocates to an entity a lump sum, usually prospectively, to provide all the needed care for an individual. But capitation may offer an incentive to provide fewer services than a patient might need. Further, it can be difficult to adjust the lump sum amount to account for varying levels of illness among patients.

Being proposed as a middle ground is the concept known as bundling (or "bundled payment systems," "case rates," or "episode-based payment"). Bundling would make a single payment for all services related to a treatment or condition, possibly spanning multiple providers in multiple settings. For example, bundling already has been tested or evaluated with cataract treatment, knee and shoulder arthroscopic surgery, hip replacement, and more. (See "What Is Bundling?")

But does bundling combine the best elements of fee-for-service and capitation...or the worst?

It depends on whom you ask.

Tim Fox, PT, DPT, GCS, executive director of Fox Rehabilitation in Cherry Hill, New Jersey, acknowledges that, as part of health care reform, there is a concerted effort to create a post acute care bundling payment system. Fox is wary of this approach, concerned that patient outcomes can be vulnerable if early patient discharge is promoted. He also stresses the importance that care providers bring to the bundle of services for it to be truly effective for patient outcome.

"I am okay being grouped with other providers working toward excellence in patient care. But I'd only want to be grouped with other high-caliber providers," he says. "Bundling has the potential to be effective if bundled providers use verifiable evidence to justify their interventions and outcomes. They must be like-minded, with similar clinical values and philosophies. The reimbursement also must be fair and compensate providers for meeting and maintaining targeted health care outcomes."

Kevin Basile, PT, OCS, MTC, director of clinical services of MedRisk in King of Prussia, Pennsylvania, echoes Fox's concerns. He says that one challenge of bundling is the fair and appropriate distribution of reimbursement among all providers involved in the care. For example: In the case of total joint replacement, there is a higher risk and skill for surgery. However, one also could argue that the postoperative rehabilitation is equally important for optimal recovery and best functional outcome. Surgery may require 2 hours of the physician's time with periodic 15-minute follow-up office visits, whereas the rehabilitation provider may work with the patient 10-15 hours over the course of treatment and follow-up appointments.

Fox's colleague, Matthew Mesibov, PT, GCS, is the director of regulatory affairs and compliance at Fox Rehabilitation. He believes that the outcome of bundling can go in different directions, positive or negative. "We must be careful to let intentions drive actions and not the opposite. Allowing actions to drive intentions can contribute toward unethical behavior and not placing the patient's interest first," he says.

## Eve of Destruction?

Sara Morrison, PT, owner of Total Body Therapy and Wellness in Lillington, North Carolina, has concerns about bundled services-particularly with reference to payment and compensation for such services.

"Bundling services usually occurs in a skilled nursing home environment," says Morrison. "It provides the facility a lump sum of money based on the category a patient falls into." The category, and payment amount, depend on such factors as the need for physical therapy, occupational therapy, and/or speech therapy, and the extent of each that's required, and other services such as medication monitoring. If a patient needs more services, bundling may or may not place him into a higher-paid category. This means that a patient may benefit from an additional service, but the facility will not be reimbursed for providing it. "In this case, what incentive does the facility have to provide this service? Some will provide the service since it is beneficial to the patient. Others may omit this service if it is beneficial, but not necessary."

Morrison also says that bundled services may place extra pressure on the health care provider. "For example," she says, "Mr. Jones will be reimbursed for all of his services at the maximum level if he receives one hour of speech, occupational, and physical therapy each day, 5 days a week. During the course of the day, therapists need to coordinate with each other as well as with nurses, doctors, radiologists, and anyone else who may treat Mr. Jones. Remember, the patient also needs to be bathed, fed, taken to the bathroom multiple times a day, and so on. That can be a problem when one patient needs many services.

"Let's say Mr. Jones has an unexpected test that requires him to be transferred to the hospital. He is gone for 4 hours. Now he still needs to undergo 3 separate hours of therapy. If Mr. Jones is too tired and can only perform 1 1/2 hrs, an extra 1 1/2 hours of therapy needs to be added into his already busy week. Suppose this happened on a Friday. The facility now must find an available person to come in on Saturday to complete the therapy. The patient may or may not want to participate in therapy on the weekend, but it is necessary if the facility is to be reimbursed the needed amount. This often results in 'unproductive' sessions, just to obtain the needed minutes."

Morrison says, "Bundled services are a good idea in theory, but do not work well in practice. Most patients need to be examined on a case-by-case basis. By placing patients into categories, some people tend to assume they know exactly what the patient needs without fully listening to all the facts. This also places stress on the health care providers, because if they need to deviate from the predetermined plan this may place a financial burden on their place of employment."

That concern is seconded by Edmond Cleeman, MD, an assistant clinical professor of sports medicine, arthroscopic knee and shoulder surgery at Mount Sinai Hospital in New York, and the founder of TRIARQ-an organization that focuses on collaborative efforts among care providers. He believes that bundling poses a dire threat to physical therapists.

"It will destroy physical therapy private practices," he predicts. "Bundling will favor hospitals or medical/orthopedic practices that have physical therapy in house. The private PT practices will suffer huge financial losses. Many will be forced to close."

Cleeman explains, "One: they will have to wait to get paid because the insurance will pay [the physician] the bundled fee. Two: If the decision by government or private insurance is a bundled reimbursement, then what happens in a difficult case that requires more physical therapy sessions? You can't pigeon hole patients and say they all need 8 sessions. Some may need 16. The PT will have two choices: provide treatment for free or cut the patient off . . . I don't see how that can be good for the patient."

But not everyone agrees that the drawbacks outweigh the benefits. Looking forward, Mesibov is optimistic. "I would hope that bundling causes acute care providers to form partnerships with top-notch, outcome-driven, quality providers across the entire health care continuum. Bundled providers who communicate well will bring about better health care through efficiencies. They will create a shared and accessible medical record to provide accurate and timely information on a patient's condition, medications, and medical and functional histories."

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## What Is Bundling?

Bundling is often described as a middle ground between fee-for-service and capitation. Bundled payment systems make a single payment for all services related to a treatment or condition, possibly spanning multiple providers in multiple settings.

Several bundled payment approaches addressing Medicare alone currently are within the health care debate. According to think-tank Rand Corporation's Rand Health Compare Project, one proposal, supported by MedPAC (Medicare Payment Advisory Committee), would bundle services related to hospitalization for common diagnosis related groups. Bundled payment approaches also could be implemented by individual states via Medicaid and the State Children's Health Insurance Program, by the U.S. Office of Personnel Management in the Federal Employees Health Benefits Program, and by private payers.

Rand Health Compare gives this example of bundling: "A single payment could be made for coronary artery bypass graft surgery, including presurgical services, facility and physician fees for the inpatient surgical procedure, and follow-up care, including monitoring and cardiac rehabilitation. Providers would assume financial risk for the cost of services for a particular treatment or condition as well as costs associated with preventable complications, but not the insurance risk (that is, the risk that a patient will acquire the condition, as is the case under capitation).

"Since providers would receive a set payment covering the average cost of a bundle of services, there would be an incentive to reduce the number of services that have no or minimal benefit. Providers with higher-than-average costs would be financially penalized, and providers with lower-than-average costs would profit. Another effect would be to encourage coordination of care by holding multiple providers in multiple settings jointly accountable, through shared payment, for the total cost of care for a given treatment or condition."<sup>1</sup>

Rand Health Compare cites a number of evaluations of bundled payments. The largest, it says, was the Medicare Participating Heart Bypass Center Demonstration. The program, conducted in the early 1990s, tested payment for an episode that included all inpatient and physician services during hospitalization, readmissions within 72 hours, and related physician services during the 90-day global period, but not other pre- and post discharge physician services.<sup>2</sup> Payment was made to the hospital, with the hospital and physicians free to divide the payment as they chose. The payment rate was determined through a competitive bidding process.

Medicare also tested bundled payment in the outpatient setting in its Medicare Cataract Alternative Payment Demonstration. The episode included physician and facility fees for cataract removal surgery, intraocular lens costs, and selected preoperative and postoperative tests. Episode payment rates were negotiated with 3 participating providers.<sup>3</sup>

Rand Health Compare also identifies several private sector initiatives, including those involving shoulder arthroscopic surgery and coronary artery bypass graft surgery.

President Obama endorsed the concept of bundling in a 2009 speech before the American Medical Association. Addressing the need to reform the way health care providers are compensated, he said, "We need to bundle payments so you aren't paid for every single treatment you offer a patient with a chronic condition like diabetes, but instead paid well for how you treat the overall disease. We need to create incentives for physicians to team up, because we know that when that happens, it results in a healthier patient."<sup>4</sup>

Estimates of the cost savings resulting from bundling vary widely. The Congressional Budget Office (CBO) estimated that \$19 billion could be saved over the 2010-2019 period if hospitals received a single bundled payment from Medicare for both the hospital services they provide and the care that their patients receive in a postacute setting in the 30 days following discharge.<sup>5</sup> However, the CBO report cites a "considerably more aggressive" bundling option offered by The Commonwealth Fund, which estimated a savings of over \$200 billion between 2010 and 2020.

Although bundling is still largely a concept that may or may not be implemented, some see bundling itself as only a stepping stone to health care reform. Health CEOs for Health Reform, a coalition of health care leaders, says, "Linking provider payment to quality and patient outcomes within an episode or continuum of care delivery and allowing clinicians to share in the potential savings (and financial risk) will encourage care coordination, increase quality and efficiency, and refocus health care on the patient . . . . The development of bundles should be an interim step to accountable payments."<sup>6</sup>

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