

Paradigm Shift in Health Care Reimbursement: A Look at ACOs and Bundled Service Payments

SWEEPING CHANGE IS underway concerning health care reimbursements, and getting involved is the best way to secure an advantage in the coming paradigm shift. The creation of Accountable Care Organizations (ACOs) was among the many reforms born with passage of the Patient Protection and Affordable Care Act (HR 3590) in March 2010. And with those ACOs, officials see clearly a system trending toward bundled payment models for reimbursement, away from the traditional fee-for-service approach.

With ACOs only coming into effect January 1, 2012, the long-term impact this will have on registered dietitians (RDs) and other providers is yet to be determined. Likewise, the benefits and drawbacks offered by bundled payments are still up for debate. In the meantime, these moves offer significant opportunity for health care providers able to demonstrate quality, and could open the doors for RDs by way of team participation and expanded referrals. A thorough understanding of what these models entail can give RDs a significant advantage in securing a place at the table.

Marsha Schofield, MS, RD, LD, director of Nutrition Services Coverage for the Academy of Nutrition and Dietetics, said individual RD's awareness of these changes differs widely, particularly with regard to the concept of bundled payments, as most health care professionals have spent their entire careers in the fee-for-service model. Shifting from one model to the other will not happen overnight, she said. However, the push toward bundled payments is being made at so many levels that those

who remain uninformed risk being left behind.

A MIDDLE WAY

The concept behind bundled payments is not new and many describe it as a compromise between the fee-for-service model and capitation.

“Bundled payment’ refers to a single payment for all care related to a treatment or condition—a payment that is then apportioned to multiple providers across many settings. Also called episode-based payment or case rate payment, bundled payment is being looked to as a mechanism for improving both cost and quality.”¹

These episodes can take a variety of forms, ranging from a single rate for all services involved in a particular procedure to combining payment for all hospital and post-acute care, or all treatment of a chronic condition for a defined period of time.¹ The primary difference between this and capitation is that bundling is a payment applied to a cluster of services, whereas capitation implies an annual payment over the course of a year for all services required for one individual.²

The ideas driving the Patient Protection and Affordable Care Act are that health care needs to shift away from rewarding utilization and toward inducing good outcomes, and more alignment must be brought about between payors and providers. These moves are hoped to reduce variability in care, not just reducing cost.¹ However, cost savings are in the mix as the Congressional Budget Office has projected that bundling hospital and post-acute care for Medicare patients alone will save \$18.6 billion by 2019.¹

Both Schofield and Sharon McCauley, MS, MBA, RD, LDN, FADA, director of Quality Management for the Academy of Nutrition and Dietetics, expect resistance to bundled payments from some physicians who fear that it will reduce their income. Other physicians will support it in hopes that overall quality

of care can be increased given the quality orientation. Schofield and McCauley predict that in general, private practitioners and smaller groups will most likely feel the greater financial pinch, as opposed to professionals employed by large institutions.

The Centers for Medicare and Medicaid Services (CMS) has been studying pilot programs of bundling models since the 1990s, including the Acute Care Episode demonstration project¹ in testing payments for Medicare Parts A and B. The Prometheus Payment Model has served as yet another basis for study, mapping out the contrast between fee-for-service and bundling.¹

In the hypothetical case of a bypass surgery for a patient suffering uncontrolled diabetes, the fee-for-service payment would entail \$47,500 to the hospital and \$15,000 to the surgeon; \$12,000 for the hospital and \$2,000 to the physician for uncontrolled diabetes management. This case assumes an additional 3 days in the hospital and another \$25,000 for readmission 1 week after discharge to treat an infection from the vein. The grand total for that under the fee-for-service model would be \$101,500. In contrast, under the Prometheus model of bundling, the overall budget for the case would be set at \$89,300. This would allow for \$61,000 for the hospital, \$13,000 for the physician and an allowance of \$15,300 for potentially avoidable costs.

In comparison, the cost to the insurer is \$12,200 less under Prometheus, and if readmission is prevented, the hospital and physician would be paid \$12,800 more. Providers are thus financially rewarded for good outcomes rather than number of visits. However, the provider bears the risk of negative outcomes, as complications arising afterward will not be reimbursed, nor will follow-up visits.

Schofield acknowledged this model puts the providers at more risk, while simultaneously offering a reward for quality. Whether providers make more

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or less with bundled payments largely depends on the individual outcome of each case. The specific payment for individual procedures and services has yet to be established, making it difficult to predict profit gains or losses, she said. Each provider within the ACO or delivery model will need to negotiate their piece of the total payment, making for an ongoing series of ever-changing calculations. RDs need to become fluent in the language of business, and adept at negotiating on their own behalf.

Meanwhile, the initial concern of RDs is that they're not listed by profession in these models.

"I think all of the concerns involve being left out of the equation," Schofield said. RDs might feel vulnerable to encroachment by other professionals, including physicians and nurses, who might choose to provide services themselves to keep the set amount of money rather than split the "pie" up with others.

These concerns are not necessarily justified, she said, explaining that if institutions and providers have financial

STEPS TO GET INVOLVED IN AN ACCOUNTABLE CARE ORGANIZATION (ACO)

- Speak with physicians in your community to determine who is establishing an ACO and what roles are available.
- Identify key leaders and decision-makers within the organization and arrange a meeting to discuss opportunities for participation and/or membership.
- Provide evidence for the benefits that an RD can bring to wellness issues in the target population of the ACO.
- RDs can consult their state's Public Policy Coordinator to determine what developments are occurring in their area.
- RDs can consult their dietetic practice group (DPG) about the potential for collaboration or membership in ACOs.
- RDs should contact their affiliate or DPG Reimbursement Representative by visiting the Academy Leadership Directory and looking under Policy Initiatives and Advocacy Leader Groups at <http://www.eatright.org/members/leadershipdirectory.aspx>.

incentives to prevent issues such as re-admission, including RDs will be seen as an investment. Speaking the language of quality outcomes, data management, demonstrated results, and evidence-based protocols will make RDs welcomed members of those teams. If those same RDs become fluent in the language of business, and adept at balancing financial concerns with regard to quality, then they will, in fact, become invaluable. Using RDs costs less per hour than nurse practitioners, and with a determined budget for every case, that too makes them an attractive component, she pointed out.

POTENTIAL DISADVANTAGES VARY

Both agreed that change in this direction is more likely to negatively impact the private practitioner, as opposed to institutional professionals and those working with a group. Any change in reimbursement models will most likely entail more administrative work and, therefore, time and money. Large groups

and institutions already have the support staff in place to manage such changes, whereas independent practitioners will have to either hire staff or do it themselves. Also, independent practitioners, both physicians and RDs, have likely built their business around the idea of reimbursement per visit or service. The big question of how much money will be paid for individual services has not been established yet, leaving revenue predictions to guess. Meanwhile, increases in overhead and administrative cost seem a certainty.

“With bundled payment on the horizon, organizations need technology that is robust, yet flexible enough to manage a complex and changing environment. A strong IT partner is crucial to any organization exploring or implementing episodes of care payment.”¹

McCauley said the issue of technology dominates the entire topic of health care reimbursement. Passage of the Patient Protection and Affordable Care Act brought with it federal funding for health care institutions to upgrade electronic health records systems. By 2015, the federal government hopes to have a standardized system of health care records in place throughout the nation, from nursing homes to hospi-

tals and physicians’ offices, she explained. Once that model is in place, and all computer systems can “talk” to one another using the same “vocabulary,” the process of measuring quality across all spectrums will be possible. And that’s a key ingredient for the move to bundled payment systems, she said. But for independent practitioners, whether physician or RD, this could pose significant financial barriers.

“How can they afford these electronic health records systems?” she posed rhetorically. Large institutions and practice groups have the buying power to shift into this model with greater ease, but the pool of true private practitioners will most likely continue to shrink, she predicted.

Ready or not, movement in that direction won’t be stopped, she said. Institutions want and need the funding available for the technology upgrades, and universities are already beginning to train students that way. Vendors ranging from hardware manufacturers to software programmers are likewise following suit.

This increase in up-front costs comes in conjunction with the risk imposed by a lump sum payment. Whereas most professionals have tailored their prac-

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New models for health care delivery and payment are emerging, including patient-centered medical homes, accountable care organizations, and value performance-based payment systems. As the paradigm shifts, registered dietitians (RDs) and dietetic technicians, registered (DTRs) need to shift marketing messages and practice management models to align with 21st century health care. This session will assist the RD and DTR in rethinking how to adjust to the times to integrate nutrition services into these new models and achieve a healthy bottom line.

tices to having multiple follow-up visits, each billed separately, the future will be one where payment is all-inclusive.

“They’re really going to crack down on costs,” McCauley said, extending that to other perks such as the products and funding provided by medical device and pharmaceutical companies for use of their products. Stricter regulations governing, such “uses” as samples, training, experimental devices, and pharmacy products, will narrow the potential revenue streams of practitioners as payors demand quality over quantity and results-oriented work.

What long-term impact this could have on quality is also a question, as it’s conceivable that practitioners could figure their expenses and revenue based on the bundled payment and simply provide less treatment, she noted. But those groups not achieving high enough standards of care won’t last long in the quality-based outcomes model of reimbursement, as proposals have been made to reduce reimbursements to those practitioners not in the 90th percentile of national utilization rates.

Meanwhile, those professionals, such as RDs, who can demonstrate outcome improvement, will become invaluable players on health care teams at every level. Schofield advises RDs to embrace the changes and move with them as they present an opportunity to shine. RDs have strong documentation skills and a proven track record of improving outcomes, she pointed out, adding these assets can help them rise above competitors from other fields.

Reconsider the Prometheus Payment Model pilot that maps out fee-for-service vs bundling.¹ In the proposed case of a bypass surgery for a patient with uncontrolled diabetes, the grand total for that under the fee-for-service model would be \$101,500. In contrast, under the Prometheus model of bundling, the overall budget for the case would be set at \$89,300. If readmission is prevented, the hospital and physician are paid \$12,800 more than the fee-for-service model. RDs lead the field in diabetes management and wound treatment. The role RDs can play, and the potential for revenue tied back to their performance, seems clear. However, this case has to be articulated by RDs in the language of business as they market themselves to their fellow health care professionals and administrators.

THE ROLE OF THE ACO

With passage of the Patient Protection and Affordable Care Act has come the creation of ACOs, organizational vehicles hoped to incentivize improvements, managed through CMS on behalf of the US Department of Health and Human Services. ACOs are effectively teams of doctors, hospitals, and other health care providers and suppliers working collaboratively to coordinate a patient’s care. This teamwork approach lends itself to the bundled payment model and is hoped to save Medicare as much as \$960 million over 3 years.³ According to fact sheets published by CMS, patient and provider participation in ACOs is voluntary.⁴ However, membership in these groups is necessary to participate in the Medicare Shared Savings Program, which will reward ACOs that lower growth in costs. These bonus payments will be determined by outcome quality. Government officials believe this path will lead to more efficient treatment.

On March 31, 2011, the CMS established this program to coordinate care for beneficiaries of the original Medicare Parts A and B. ACOs are held against higher quality benchmarks, but those that perform higher than the goals are eligible for bonuses. Those that fail to achieve the benchmarks might be required to reimburse Medicare.⁵

In a statement announcing the creation of ACOs, US Department of Health and Human Services Secretary Kathleen Sebelius stated: “For too long, it has been too difficult for health care providers to work together to coordinate and improve the care their patients receive. This has real consequences: patients have gaps in their care, receive duplicative care, or are at increased risk of suffering from medical mistakes. Accountable Care Organizations will improve coordination and communication among doctors and hospitals, improve the quality of the care their patients receive, and help lower costs.”³

According to the CMS, the agency proposes to use a number of quality measures to establish the performance standard ACOs must meet to share in savings, provided they also meet the program’s cost saving requirement. These 65 measures span five quality domains: Patient Experience of Care, Care Coordination, Patient Safety, Preventa-

tive Health, and At-Risk Population/ Frail Elderly Health. Performance will be scored on a linear points scale advancing five scores for each of the five domains. The percentage of points for each domain will be aggregated using weighting methods to generate a single percentage applied to the maximum sharing rate for which the group is eligible.

The triple-aim goals to be met by the ACO are improving the health of the targeted population, improving the patient experience, and improving the affordability of health care. The Medicare Shared Savings Program launched in January 1, 2012.

Schofield explained that ACOs will target specific populations, defined by characteristics such as geographic boundaries, utilization patterns, and age. RDs employed by institutions might already be included in the model through their employer, but getting involved and making that determination is preferable to waiting, she added. ACOs are new enough that RDs need to get in at the right time so as to help determine the structure and goals. Quality bonuses from Medicare will be dependent on patient outcomes. Therefore, all members will share some of the risk created by their colleagues’ performance. RDs should check whether any ACOs are forming near them, Schofield said. ACOs could be formed by a group of local physicians, or through a hospital, she explained, adding that the best way to find out is to get involved and ask around.

In its June 2011 edition of MNT Provider, the Academy of Nutrition and Dietetics outlined a number of steps RDs could take to contribute to the initiation and development of ACOs.⁵ By consulting with the physicians in their communities about group formation, RDs can tap into a new network of potential referral business. Evidence demonstrating the value of MNT is readily available to RDs through such resources as the MNT Works Kit at www.eatright.org/members/mntworks, as well as the Evidence Analysis Library at www.adaevidencelibrary.com. Another source for information on the topic is the Public Policy Coordinator in an RD’s home state.

McCauley said the RDs’ ability to monitor habits and report data will make them valuable members of an

ACO, particularly when it comes to reducing a patient's dependency on medications for issues such as diabetes, cholesterol, and blood pressure.

"If you can get people off their medications, that can save money," she said, adding the best way to participate is to get involved. "All health care is local. RDs have to get into their communities and communicate their worth."

TIDES ALREADY SHIFTING

Both Schofield and McCauley agreed that the lead taken by CMS is certain to be followed by private payors, and in some cases, it's already happening. In February, Hoag Memorial Hospital Presbyterian, with locations in Newport Beach and Irvine, CA, announced it would be working with Blue Shield of California to create a 3-year ACO.⁶ Joining into that endeavor will be the Greater Newport Physicians medical group, which hopes to serve 11,000 Blue Shield HMO members in Orange County. That insurer already works with St Joseph Health System in the same county, covering 30,000 Orange County members.⁶ That initiative is slated to launch in July 2012.

That move is part of Blue Shield of California's development of Blue Groove, a three-tiered, value-based program for employers, planned for a pilot launch in 2012.⁷ Three levels will include the basic, main, and "care+groove," all of which provide a variety of health and wellness benefits and opportunities to earn incentives for quality. Participants can earn cash and reduced rates for compliance with evidence-based protocols outlined in customized plans. Meanwhile, provider teams will be provided, including primary care physicians and affiliated professionals.⁷

The move toward bundled payments and team-based care, such as ACOs, is not so much a matter of if but when, Schofield said. Given the pace at which such changes occur, it's not likely to be completed overnight, or in any kind of regimented fashion. More alterations and new ideas are likely to emerge as data are received. But being informed is always preferable to the alternative, and RDs should begin investigating opportunities to participate, securing themselves a seat at the table.

References

1. McKesson Health Solutions. Position paper: Bundled payments. http://www.mckesson.com/static_files/McKesson.com/MHS/Documents/Issue-Paper-Bundled-Payment0210.pdf. Accessed February 2, 2012.
2. Lubell J. Paying by the bundle. Modern Healthcare website. <http://www.modernhealthcare.com/article/20090406/NEWS/904039970/>. Accessed January 28, 2012.
3. US Department of Health & Human Services. Affordable Care Act to improve quality of care for people with Medicare. <http://www.hhs.gov/news/press/2011pres/03/20110331a.html>. Accessed January 28, 2012.
4. US Department of Health and Human Services, Centers for Medicare & Medicaid Services. Improving quality of care for medicare patients: accountable care organizations. https://www.cms.gov/MLNProducts/downloads/ACO_Quality_Factsheet_ICN907407.pdf. Accessed February 2, 2012.
5. American Dietetic Association. *MNT Provider*. 2011;10(2):1-4. <http://www.eatright.org/publications/mntprovider/june2011/index.html>. Accessed February 26, 2012.
6. Reed V. Blue Shield, Hoag in "accountable care" partnership. Orange County Business Journal website. <http://www.ocbj.com/news/2012/feb/28/blue-shield-hoag-accountable-care-partnership/>. Accessed January 19, 2012.
7. Edlin M. "Value" in health insurance acquires new meaning. California Healthline website. <http://www.californiahealthline.org/features/2012/value-in-health-insurance-acquires-new-meaning.aspx#ixzz1j7M4ocSC>. Accessed February 26, 2012.