Bundled payments are commonly associated with a single clinical event, such as cardiac bypass surgery. But payers are increasingly using the payment model for a broader array of services, so defining when an episode of care begins and ends is no longer as obvious as it once was.

This topic and others are covered in the AMA resource, “Evaluating bundled or episode-based contracts,” which answers questions about model design and accountability. It also provides guidance on formulating strategies for engaging in episode-based agreements.

Bundled payments could be considered among the oldest of the “new” risk-based payment models that are becoming more common as payers shift more financial risk onto physicians. The roots of the payment model go back to the Medicare inpatient prospective payment system that was launched in 1983.

By 2016, almost 35 percent of physicians responding to an AMA survey reported receiving some payment from a bundled-payment agreement. On average, these physicians received 8.8 percent of their practice revenue from such contracts.

A 2015 AMA-Rand Corp. report, Effects of Health Care Payment Models on Physician Practice in the United States, had mixed findings on bundled-payment agreements.

“Although interest in bundled-payment programs is high among private-sector payers, early adopters have faced significant, and sometimes insurmountable, hurdles,” the report states, citing a previous Rand study published in Health Affairs.

These hurdles include defining the bundles in terms of which services are included or excluded and determining accountability for each episode of care when many providers care for a patient.

The watchword is specificity
When defining the length of an episode, the AMA recommends identifying a specific diagnosis or procedure code that triggers the start of an episode as well as identifying which services will be covered until it ends. Even with seemingly obviously defined episodes such as hip-fracture treatment, specificity is recommended.

“It is important to include specific contractual language to specify whether the episode includes follow-up care or surgery, management of complications from surgery,” the AMA resource says. The contract should also specify whether health conditions not related to the initial episode—such as developing community-acquired pneumonia within 30 days of the surgery—are considered part of the episode of care included in the bundled payment.

“In general, more detail is better than less when defining the episode in the agreement,” the resource advises.

Defining the beginning and end of episodes are particularly important in scenarios where services are provided by multiple physicians and providers in multiple settings.

“An episodic, bundled payment for a patient who has experienced chronic heart failure might be limited to the time period of an inpatient admission for a heart attack, or may extend to include the initial inpatient admission, follow-up outpatient care, and cardiac rehab (including the services of multiple physicians and non-physician practitioners within each setting),” the resource states.

Plan for the unexpected

Physicians also should include a contract provision that protects them against unforeseen events that could create a dramatic increase in care costs beyond their ability to control.

“Uncontrollable, game-changing events, such as the introduction of a high-cost specialty drug or a national drug shortage, can adversely affect the financial benefit of participation in a bundled or episode-based model,” the AMA resource states. The resource’s model contract language includes a provision terminating the agreement if such circumstances occur.

“Physician shall have the right to immediately terminate this Agreement,” the model contract states. “For purposes of this agreement ‘substantially exceeds’ shall mean an increase of 100 percent or more of the stated episode payment.”