

Editorial:

Global Bundling

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In the Middle Ages, the word *mace* referred to a spiked club which was used to penetrate the armor of an opponent in battle. It has also been used to refer to the sword of state, a symbol of authority and power.

How fitting, then, that the government's most recent assault on physicians is a demonstration project whose initials spell MACE—Medicare Acute Care Episode.

The ultimate goal of the government's MACE attack, like other bundling schemes implemented by Medicare, is cost containment. The government will wield its MACE in the hope of piercing the Hippocratic armor of physician autonomy, and will force the wounded survivors into a structured environment where physicians can be more easily and strictly controlled, by either a Physician Hospital Organization (PHO), or physicians who are employees of a hospital. Those who favor government-controlled medicine know that it is far easier to control a small number of PHOs or hospitals than a large number of independent physicians.

The MACE demonstration is a 3-year project started in 2009. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 authorized the Secretary of Health and Human Services to approve demonstration projects "...that examine health delivery factors that encourage the delivery of improved quality in patient care, including the provision of incentives for improving the quality and safety of care and achieving the efficient allocation of resources."¹ According to the Centers for Medicare & Medicaid Services (CMS), the vision that motivated MACE included, among other things, "...unsustainable growth in health care spending in the United States health system overall."¹

The MACE demonstration is currently at seven hospital sites (five health care systems) in Oklahoma and Texas.² More sites will be added in 2010. A PHO-type structure or other hospital-physician collaborative arrangement is required for participation in the project. MACE provides a bundled payment for Part A (hospital) and Part B (physician) services for episodes of hospital care involving certain cardiovascular and orthopedic procedures.

Bundled payment is sent directly to hospitals, and hospitals distribute payment to physicians. Thus, the mechanism of payment resembles the medieval feudal system, in which the lord of the land ruled the serfs and determined what, if any, of the fruits of their labor the serfs would be allowed to keep.

Participating hospitals submitted bids with discounts for each applicable diagnosis related group (DRG), "...expressed as a discount off the entity's base DRG payment amount."¹ Initially, it is likely that hospitals will adhere closely to the current Medicare physician fee schedule in distributing the physician's portion of the bundled payment, so as to get physicians to submit to and accept the PHO/hospital authority and structure. Eventually, however, if MACE becomes a permanent entity, it is likely that hospitals will pressure physicians to provide discounts to already inadequate fees so that the PHO can submit a competitive bid. Physicians who oppose steep discounts in their fees may find themselves terminated from, or forced out of the PHO, or may be subject to retaliation through a career-ending sham peer review.

Physicians, who face periodic cuts in Medicare fees (physicians currently face a 21 percent cut in Medicare fees), may naively view the hospital PHO as a source of income security, and some may even view the PHO as a larger entity which will have more clout in negotiating fees with the government. However, as government has made clear in the Medicare program, one does not "negotiate" fees with the government; government simply sets fees and physicians must accept them or opt out of the Medicare program. The adequacy of payments, in terms of meeting the expense of providing medical services, and the need to make a reasonable living from one's labor, are of no consequence to government bureaucrats who set fees.

Bribes will be offered to Medicare patients to induce them to receive care from MACE providers. Medicare will share 50 percent of any savings realized under the program, up to the full annual Part B premium, with Medicare beneficiaries who agree to go along with the program. Bribes, which are referred to as "gainsharing," will of course be subject to taxation, and individuals who have both Medicare and Medicaid will not be eligible to receive the government bribes.²

MACE hospitals will have the option, but no obligation, to reward physicians "...who succeed with measurable clinical quality and efficiency [cost containment] improvements."¹ Of course the threshold that physicians must meet to be eligible for gainsharing bonuses can easily be manipulated and adjusted by a hospital-dominated PHO so as to favor the hospital, while simultaneously limiting the number of physicians who qualify for a gainsharing bonus.

In order to achieve cost savings, MACE hospitals will need to enforce strict physician compliance with so-called "evidence-based" treatment protocols, employ vigorous utilization review to ensure the shortest length of stay (LOS) possible, and utilize supercharged Health Information Technology (HIT) systems to track and monitor the performance of individual physicians. Thus, physicians in the MACE PHO system may not be free to exercise their best clinical judgment in treating patients, but will have to submit to the dictates of the PHO if they wish to survive and make a living. One-size-fits-all treatment protocols, and an institutional mantra that shorter LOS equals quality care, of course, do not bode well for patients whose individual circumstances may not fit the protocol, and who may need more time than the "average length of stay" to recover from procedures.

Meanwhile, the Robert Wood Johnson Foundation (RWJF) has provided \$6.4 million in grants for a global bundling initiative known as the PROMETHEUS Payment® System—Provider payment Reform for Outcomes, Margins, Evidence, Transparency, Hassle reduction, Excellence, Understanding and Sustainability.³ Two test sites, one in Rockford, Ill., and one in Minneapolis, became operational in 2009, and two more sites are planned. In addition to the \$6.4 million in grants, two sites are already receiving additional RWJF grants under the "Aligning Forces for Quality" program.

The PROMETHEUS Payment project is similar to MACE in that a bundled payment is provided for hospital and physician services. In addition to providing bundled payment for treatment of

certain types of cancer, and for cardiology and orthopedic procedures, PROMETHEUS seeks to bundle payments for routine and preventive care (i.e. outpatient and chronic care) as well.⁴

PROMETHEUS also shares the same cost containment goal of MACE—"The PROMETHEUS system attempts to put a lid on runaway costs that are associated with unnecessary or complicated care and at the same time through a separate performance scorecard ensures that high quality care is provided."⁴ Patients, who may require "complicated care," should note that they are basically placed in the same category of cost containment as "unnecessary" care.

PROMETHEUS has a fee-setting system similar to the government price-fixing scheme known as the Resource Based Relative Value Scale (RBRVS) system. The PROMETHEUS scheme, called Evidence-Informed Case Rates (ECRs), purports to base payment on "...a case rate that encompasses what science indicates are the resources all providers should consider in treating a patient's condition."³ The project has even developed a "playbook" to show how ECRs can be constructed and used to determine "...global fees for care of 'typical' episodes."⁴ Compliance with one-size-fits-all treatment protocols may place patients at risk who do not fit the "typical care" model. The PROMETHEUS system will "...explicitly base payment on adherence to clinical guidelines and patient outcomes, which by necessity will require tight coordination among an entire care team."³ Thus, PROMETHEUS transforms "pay for performance" into "pay for outcomes."

And, although capitation proved to be a miserable failure in the 1990s, PROMETHEUS borrowed a page from the capitation playbook in establishing a withhold/bonus system identical to that used in capitation schemes: "Finally, there is a 'withhold'—a portion of the total payment that is held back, to be paid at a later date, based on how a provider performs on a scorecard of quality metrics [i.e. compliance]."³

PROMETHEUS even has its own ECR tracking engine: "The PROMETHEUS Payment program has contracted with Innovative

Resources for Payors (IRP) to help design the ECRs and establish the operational processes with the pilot plans. IRP will use its Claimshop® contract management and pricing engine to develop and operate the ECR Tracker—the project's tracking engine."³

No centrally controlled, price-fixing or bundling scheme, of course, would be complete without "evaluators" to affix their stamp of approval. In this case, the RWJF has provided funding to the RAND Corporation and to the Harvard School of Public Health to evaluate the PROMETHEUS project.⁵ Given that RBRVS was developed at Harvard University, and the PROMETHEUS ECR was made in the image of RBRVS, favorable assessment by such evaluators seems assured.

Ultimately it is our patients who suffer under centrally controlled price-fixing and bundling schemes in which cost containment is the priority. Attempts to distort the meaning of quality care, and disingenuous claims that the patients' individual needs will be met by the fixed bundled payment, are nothing more than deception to conceal the harmful bureaucratic rationing of care.

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