

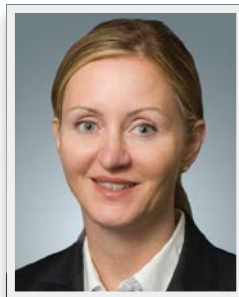
Bundled Payments: How Seemingly Small Innovations in Care Delivery Can Lead to Big Financial Rewards

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As part of the healthcare reform law, on January 31, 2013, CMS announced that nearly 500 healthcare organizations will participate in the Bundled Payments for Care Improvement (BPCI) initiative beginning in spring 2013.

Ready or not, with the passage of the Affordable Care Act (ACA), new payment methods such as bundled payment enable CMS to move away from traditional fee-for-service, which CMS says has encouraged over-utilization. Since 2008, with the Medicare Acute Care Episode (ACE) Bundled Payment Pilot, nearly one-half of the country has moved to some form of bundling. The mounting evidence demonstrating that bundled payments has the ability to meet the Triple Aim is in part why 2013 will see continued interest in this reimbursement methodology, particularly in the private sector. While the context may be payment reform, as we have seen in the past, changes in reimbursement policy become the impetus for *care delivery reform*.

Rapidly following CMS' lead, commercial payers are demonstrating heightened interest in bundling payments to providers in an effort to rein in costs, particularly in the areas of post-acute care and avoidable readmissions. The degree to which these forms of risk-based reimbursement require hospitals and providers to integrate across the enterprise is unprecedented. Organizations may not be ready for population risk; however, a smaller test such as bundles may be a manageable next step toward full risk for a population. Healthcare



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What Are Hospitals and Post-Acute Providers Bundling?

The ACA calls for new bundles that go beyond elective surgical procedures to include not only medical conditions but also post-acute services and avoidable readmissions, expanding the episode of care to three days prior to inpatient admission to 30, 60, or 90 days post discharge.

As with prior tests of bundling, BPCI applicants appear to view high-end elective procedures as a logical starting point. In addition, while staying within cardiovascular services, applicants have increasing interest in more challenging bundles, which may aid in mitigating risk related to CMS' Value-Based Purchasing initiative.

The top five most commonly proposed episodes as indicated by percent of applications are:

- Major joint replacement of lower extremity (78 percent)
- Congestive heart failure (58 percent)
- Coronary artery bypass graft (51 percent)
- Chronic obstructive pulmonary disease—bronchitis/asthma (49 percent)
- Percutaneous coronary intervention (48 percent)

Since 2008, commercial bundles have included services such as bariatrics, oncology, and pediatrics; however, most commonly, orthopedics tends to be the place commercial payers have started bundling.

Key Considerations for Board Members and Senior Executives

Medicare versus Commercial Bundling

Beyond the required discount CMS imposes on participants (2 percent to 3.25 percent depending on the episode), the new round of Medicare bundles may pose considerable challenges for some participating hospitals and post-acute providers including readmission risk, risk related to the Medicare beneficiary population (which has a higher incidence of comorbid conditions and also a higher number of comorbidities per enrollee), outlier risk, and out-of-network readmission risk. Most commercial bundling efforts to date have been more flexible between hospitals and commercial payers as they negotiate the scope of bundle and the price and how to share risk for outlier cases. In general, commercial payers are not expecting a discount upfront; however, many have expressed interest in having hospitals take on readmission and post-acute risk and are willing to pay hospitals to manage the post-acute phase of a bundle.

Defining the Scope of the Bundle

Bundling is a process that must initially be defined as those services and procedures directly related to the primary condition. Defining bundles more broadly than an organization is capable of managing today presents considerable risk. Top executives need to look at areas of the enterprise that are well-developed and have strong physician leadership in place when considering which services to bundle. Expensive conditions such as cardiac and orthopedic procedures

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with adequate prevalence and a predictable course of treatment are well-suited to bundling. Conditions amenable to evidence-based care protocols enable the balancing of risk to providers with the opportunity to reduce variation and waste.

New Care Delivery Models

Real and sustainable care delivery reform will not be achieved by incremental change and conventional mandates from the top. The nearly 500 healthcare organizations that recently signed on to bundle with CMS will need innovations that will upend the status quo. What makes bundled or episodic reimbursement a game changer is that redesign of our care delivery system is both required and incented. Board members and executive leaders will need to say “yes” to requests for support and resources and ensure that care redesign makes it through the corporate-approvals gantlet unscathed.

Healthcare organizations that combine new and innovative care delivery models with an understanding of which incentives best motivate physicians will not be left behind in the redesign of healthcare.

Innovating off the Grid

Medicare has been quietly testing proof of concept for bundled payments for more than 20 years, mostly under the radar. The stamina required in this work is very real. For care redesign teams, innovating under the radar de-emphasizes the distraction of internal resistance and provides care teams the space to truly innovate, testing and retesting ideas that will deliver the highest level of healthcare value. Conventional tinkering at the edges will not yield the level of change required to compete on value. Board members and top executives who have a sophisticated understanding of the past will understand and support creative and sustainable methods for improving quality and reducing costs.

Aligning Physician Incentives

A February 2013 report from CMS reveals that gainshare programs can reduce hospital costs by an average of 10 percent. Gainsharing, a feature of both Medicare and commercial bundles, is critical to achieving the level of physician engagement required for rapid and meaningful change. The work of care redesign is both labor-intensive and requires a level of standardization and consensus that physicians have historically struggled with. With ACE, we learned firsthand that when financial incentives are aligned, physicians will consolidate vendors and adhere to disease-specific care protocols.

The “Do Nothing” Approach Comes with Considerable Risk

While bundling can be a manageable step toward reducing costs and improving quality, it is not the only game in town. What is most important for 2013 is that we are taking steps toward the greatest levels of integration across care settings in anticipation of risk-based reimbursement. Board members and senior executives need to challenge assumptions about institutional constraints, seek out opportunities to listen to a variety of perspectives, and ensure the organization’s vision and focus in 2013 is on creating unique value for patients, payers, and physicians via differentiated models of care.

In summary, Medicare and commercial payers have signaled a strong intention to move to bundles and population management, particularly in urban areas across the United States. CMS has spent the last several years consolidating fiscal intermediaries so that all providers in a region are on a single fiscal intermediary for Part A and B billings, thereby enabling CMS to make a single prospective bundled payment. This



transition illustrates CMS’ continued interest in this area of payment reform as an alternative to traditional fee-for-service.

The healthcare landscape today poses both complex challenges and tremendous strategic opportunity to be at the forefront of reengineering the U.S. healthcare delivery system. The redesign required to be successful offers hospitals the ability to compete on price and quality by redesigning the way care is provided. If industry reform offers top executives and board members anything it offers us *focus*. Hospital executives who understand that 2013 is about new care models that deliver higher quality at appreciably lower costs and focus their efforts to that end will thrive in the evolving reimbursement environment. ●

The Governance Institute thanks Deirdre Baggot, M.B.A., RN, vice president, and Cleo Burtley, M.B.A., manager, with The Camden Group for contributing this article. In 2012, Ms. Baggot, served as an applicant reviewer and panel expert for the CMS Bundled Payment for Care Improvement. As the former lead for the Acute Care Episode Demonstration at St. Joseph Hospital in Denver, Ms. Baggot is a leading national expert on bundled payments. She can be reached at dbaggot@thecamdengroup.com.