Bundled Payments Show Early Promise in the Payment Reform Mash-Up

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Today, more than 2,000 organizations around the country are piloting some form of payment transformation, and that number will more than double within 2015.

One of the most promising elements of the Affordable Care Act (ACA)—that is, the *payment reform* provisions—offers our best chance at "getting it right" in lowering healthcare costs and improving quality. The concepts present a measure of what *New York Times* best-selling author Malcolm Gladwell describes as "stickiness," which determines whether a great idea succeeds or fails.[1]

Over the last two years, with the passing of the ACA, we have witnessed unprecedented interest in one of the "big ideas" of the ACA aimed at reducing healthcare spending. With more than 60 published studies on bundled payments, conceptually it is not new. Bundled payments is a pricing strategy (i.e., a fixed price for a set of predefined procedures/services) and in most cases, offers a "warranty."

Bundled payments aim to reduce cost and improve quality by reducing fragmentation and making medicine a team sport using payment reform as the lever. What we know for sure is that aligning financial incentives for hospital and physician providers can become, almost overnight, the impetus for care delivery transformation.

The Next Frontier of Bundled Payments

The skyrocketing interest among hospitals and physicians to test bundled payments has resulted in an expansion both in terms of episode length and also the types of healthcare services being bundled. Over the last 18 months, we have seen heightened interest among all sectors of the payer market to expand bundles to include outpatient procedures and infusion services such as chemotherapy, and to further expand post-acute bundles.

This article proposes 10 new ways of looking at bundled payments, introducing the concept of "fusion reimbursement" as we are seeing emerge during this time of industry disruption.

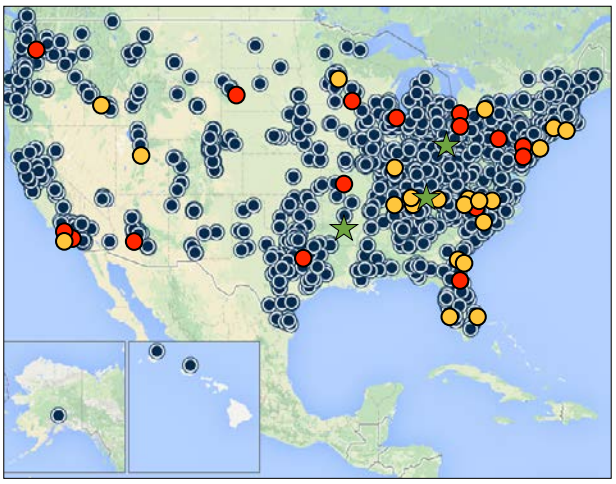
Key Board Takeaways

The ACA's focus on reducing healthcare spending has led many hospitals and health systems to pilot some form of payment transformation, including bundled payments. As we enter into the next frontier of bundled payments, boards should keep in mind:

- Fee-for-service will not be replaced with a single payment construct; rather, it will be a fusion of multiple reimbursement models on the risk continuum.
- Not all bundles are created equal in terms of economic risk.
- Smart leaders will take a portfolio approach to payer contracting.
- Leaders need to find innovative solutions to eliminate waste and duplication.
- Regional partnerships with post-acute care providers bring opportunities for savings.

Exhibit 1: Where Are Bundled Payments Happening?

Medicare, Medicaid, Commercial, and Employer Participants



Source: Center for Medicare & Medicaid Services, June 2014; M. Bailit and M. Houy, "Key Payer and Provider Operational Steps to Successfully Implement Bundled Payments," *Health Care Incentives,* May 28, 2014; Advisory Board, The Camden Group.

1. Think "Fusion Reimbursement" Models

A common misperception in the industry today is that fee-for-service is dead. Fee-for-service is alive, although due to the fact that it drives over-utilization, we will see decreased reliance on fee-for-service in acute and post-acute environments. We should expect traditional fee-for-service to continue in some sectors of the industry such as rural healthcare. For acute and post-acute care, fee-for-service will not be replaced with a single payment construct; rather, it will be a fusion of multiple reimbursement models on the risk continuum, including bundled payments, accountable

1 This idea is presented in his book *The Tipping Point: How Little Things Can Make a Big Difference*, 2000.

care organizations (ACOs), patient-centered medical homes, and others, all working synergistically based on the unique needs and economic risk associated with a population.

2. Not All Bundles Are Created Equal in Terms of Risk

Early tests of bundled payments have taught us that not all bundles are created equal from an economic standpoint. For example, orthopedic knee revisions are particularly challenging as patients present with knee hardware that may not be on formulary where an organization is getting preferred pricing. In this instance, an organization often pays retail rates for hardware. Any population with historically high readmission rates, such as with congestive heart failure, also pose more economic risk. Finally, any bundle in which patient behavior change is required represent heightened financial risk. Elective procedures have been well studied with bundled payments and work well. As patient complexity increases so does the economic risk, which must be accounted for.

3. Demand Destruction

Inherent in any risk-based construct is the reality of demand destruction. Areas most affected by demand destruction will be high-end post-acute care such as inpatient rehabilitation, diagnostic testing, lab, and inpatient length of stay. The ability to manage and offset demand destruction is the "middle game" of payment transformation and likely cannot be offset by some sort of "volume play." New business development, partnerships, and innovative approaches to revenue growth are needed to manage the middle game.

4. A Portfolio Approach

As payment transformation unfolds, smart leaders will take a portfolio approach to payer contracting. Market factors and population health status demand a portfolio approach to reimbursement. We will see some markets more dominated by one payer strategy over another. We are already seeing variability among payers and employers when it comes to tolerance for risk, which will influence adoption rates of new payment methodologies such as bundled payments.

5. The Confidence Quotient

Confidence is the single most important ingredient to being able to run to risk. Risk can be described as the gap between opportunity and success, and without it the greatest opportunities your organization holds may not have the possibility to develop and flourish. For many healthcare leaders and providers, the risk terrain is nerve-racking, but it does not have to be. Confident executives with an eye on the long view will enable their organizations to get smart about the nuances of payment reform and make strategic risk decisions that make sense for their market and patient population, both in the short-term and the long-term.

6. The World's Best Athletes Need Coaches and So Do You

The best athletes in the world have someone behind them observing their every move and telling them how they could be better. The ability to execute change is not inherent among all leaders, and with payment reform comes a new playbook. The difference between good leaders and great leaders is that great leaders know what they know and seek outside expertise to guide them through the "risk" terrain.

7. Your Worst Failure Is Your Greatest Success

Managing "fusion" reimbursement models requires an understanding that innovation is the hardest work to do, and failure is not failure at all; rather, it is just a data point on the journey to transformation. Failure cannot be personalized, and future leaders understand the need to "roll with it" and move quickly through tests of change. In order to effectively compete in a time of industry transformation, the really great leaders, those capable of transforming organizations, will demonstrate a high degree of failure tolerance.

8. Upending Orthodoxies and Traditions

Healthcare and the practice of medicine are steeped in tradition, which often slows us down. New payment models will drive demand destruction; therefore, we must be willing to ask better questions and find innovative solutions to eliminate waste and duplication. Put yourself in the shoes of your patients, their families, and your staff and begin to ask better questions. What are the irritants of a physician's day? What is it like for a patient to navigate your organization? Speaking truth to orthodoxy and tradition is the birthplace of care delivery transformation upon which payment transformation is predicated.

9. Now Is the Right Time to Lock In Your Post-Acute Care Strategy

In 2012, Medicare spending on post-acute care exceeded $62 billion, with post-acute care representing the use of home health services, skilled nursing facilities, rehabilitation facilities, long-term care hospitals, and hospices.[2] While research has demonstrated that Medicare beneficiary spending varies greatly among the 306 Dartmouth hospital referral regions (HRRs), the largest driver of overall variation can be attributed to spending on post-acute care, with skilled nursing facilities and home health as key drivers. Bundled payments have the

2 Larry H. Bernstein, "Post-Acute Care—Driver of Variation in Healthcare Cost," Leaders in Pharmaceutical Business Intelligence, February 21, 2014.

potential to improve care coordination and quality of services, rationalize service use, and lower potentially avoidable readmissions.[3] Through regional partnerships, opportunities for savings include lower total cost of care through the reduction of waste and clinical variation, service line efficiencies through enhanced care redesign and resource allocation, increased transparency through data and analytics, and improved operational performance through lower average length of stay and readmissions.

10. The Innovation Imperative

Healthcare transformation is heavy lift, and payment transformation will only get us so far. It is estimated that bundled payments may offer Medicare approximately 5.4 percent reduction in spending growth.[4] It is estimated that 25 to 35 percent of what we do today adds no value. To reduce even half of the waste in our system requires ubiquitous access to health information and significant process reengineering. Healthcare organizations must build an innovation engine if they are going to compete tomorrow. Innovations in care delivery, smart partnerships, and new products and services will enable healthcare leaders to remain strong leading into the unknown.

Closing Thoughts: Taking the Long View

Payment reform is still evolving. First generation transformation is not the end game; however, this does not give us a "pass" to do nothing. Healthcare in the United States is *still* the most expensive in the world with an estimated price tag of $3.5 trillion for 2014, representing nearly 20 percent of the U.S. economy. Of the 11 wealthiest nations in the world, the U.S., once again in 2014, comes in dead last on average life expectancy, infant mortality, and efficiency.[5]

So while we continue to pay more—more than double the highest-performing countries—we don't get more. If we know anything, it is that while fixing healthcare is complex and highly political, there is no nation and no group of leaders more capable. Humility, failure tolerance, innovation, and smart execution will guide leaders as they make the run to risk. The run to risk includes embracing accountability for the care that we provide. We can, and we must do better, and while payment reform is not the end game, it is a critical step toward world-class healthcare in the United States.

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3 Report to the Congress: Medicare and the Health Care Delivery System (MedPAC Report), June 2013.

4 Peter S. Hussey et al., "Episode-Based Performance Measurement and Payment: Making It a Reality," *Health Affairs*, Vol. 28, No. 5, September/October 2009, pp. 1406–1417.

5 K. Davis, K. Stremikis, C. Schoen, and D. Squires, *Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally*, The Commonwealth Fund, June 2014.