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Bundled Payments:
Opportunity, Threat, or Another Policy Fad?

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In the fits-and-starts movement toward population health management, bundled payments are one of the most immediately actionable – and immediately rewarding – efforts that hospitals, skilled nursing facilities, and home health and hospice providers can tackle as part of their clinical integration and physician alignment efforts.

As groups, these organizations are approaching and embracing bundled payments at different rates, but overall, the move toward bundled payment is being driven by cost savings, competition and capitation. And it is one that is here to stay: The capitation and other health reform efforts made 20 years ago were well intended, but they came at a time when health insurance costs were lower and employee cost-shifting was less prevalent, fewer clinical guidelines and technologies were available, and physician engagement in management and operations was limited. In short, the reforms were attempting to address issues that individuals, providers and payers could still afford to ignore, so they did.

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The Three Cs

The insurance, technology and cost environments have changed, and the trend toward full capitation and population health management has now been established. But a significant number of large insurers and self-insured companies have little faith that providers can handle global payment as they currently operate.

Bundled payments are a first step along the path toward capitation. They offer providers controlled opportunities to develop processes that provide more efficient and effective treatment at lower price points, without taking on the full risk of an insured life.

Whereas capitation or global payment involves an insurer giving a health system a set dollar amount per month or year for care of an insured life over that time, bundled payments offer a set dollar amount that covers all care for a single episode within a set time frame, usually 30, 60 or 90 days.

Most providers are familiar with bundled payment through Medicare's Bundled Payments for Care Improvement initiative (BPCI), the pilot program with four bundling methods whose 299 hospital and 166 post-acute-care participants were announced in 2013. But bundled payment initiatives are taking place at employers and commercial insurers, too. Even non-traditional payers are getting into bundles. The state of Arkansas, for example, recently announced they intend to move all medical reimbursement, including Medicaid, to bundled payments.

Preliminary information from Kurt Salmon has revealed that when bundled payments are implemented, significant savings opportunities are identified immediately, interest from potential partners spikes, and providers are quickly able to impact episode-specific market share and care costs.

Early adopters have seen more than just cost savings. They are being looked to as leaders and are cementing their roles in future care delivery systems. Hospitals who enact bundled payment pilot programs may find they draw interest from additional physician groups in the hospital, or from insurers curious to find out what is being done, and how — and asking how they can get involved.

> **"This is not a time to hold back or wait and see, especially for community providers in areas where large systems are already establishing bundled payments."**

This is not a time to hold back or wait and see, especially for community providers in areas where large systems are already establishing bundled payments. When Cleveland Clinic signed an orthopedic bundled payment agreement with Lowes and Target, it took ownership of that market, and flying a patient to Cleveland for knee surgery became a cheaper option than local treatment. But not a realistic one. Lowes and Walmart now have bundled payment agreements with systems across the country.

These types of agreements set the bars for local providers in terms of what they must do to stay competitive. Ultimately, late-adopting local providers will find they must provide a service at a price point that they did not set.

Great Opportunities

In selecting a specific service to bundle – say, knee replacement – providers must thoroughly evaluate every cost associated with individual episodes of care in a way that has not been done before. The great challenge here comes in aggregating the cost of every visit to every physician, every in-hospital test and every drug, appointment and procedure from initial visits through rehabilitation and follow-up.

This analysis, however, has also created new opportunities for the early adapters to identify and eliminate unnecessary costs and to create consistency in processes that can vary widely.

Physicians participating in bundled payment programs at three hospitals in Oregon and Ohio have used this data to actually change treatment processes. It is the physicians who are identifying the inefficiencies in the system, and the physicians who have been empowered through data to improve care value: Why is this expensive drug being used instead of a lower-cost alternative? Why were two CT scans performed, when one told us what we needed to know? When an elderly spouse couldn't care for a discharged patient at home, why was the patient kept in the hospital instead of being moved to a lower-cost skilled nursing facility or recommended to a home health organization?

Bundled payments have enabled physicians to design more cost-effective protocols and to contribute directly to the hospital's bottom line – a benefit not just to the patient and the hospital balance sheet, but to broader physician alignment efforts.

Acute Care Considerations

In the acute care setting, which is leading the bundled payment way on the care continuum, early bundled payment experimentation has been with high-cost orthopedic and cardiac procedures, which often have defined physician groups and enough similarity to determine why one episode was more expensive than another. Further, competition is often high in these areas, offering greater impetus to create a cost-efficient service where the value is clear to patients and payers alike, and increased market share helps offset revenue lost to reduced billing.

One Ohio hospital has started doing outpatient knee surgery and covering 60 days of rehabilitation in its bundle. The reduced length of stay in the hospital has created cost savings, and patients appreciate the ability to recuperate at home. Efficiencies identified in some orthopedic episodes have created cost savings of $2,500 just for the procedure. Other hospitals are considering the creation of bundles setting a new regional price point for a specific procedure with an overall strategy to gain greater market share and increase their margins.

Hospitals that wish to explore bundled payments should start with one practice group and episode to gain experience before considering replicating the process with additional episodes or physician groups.

The first step is to identify willing partners. If the orthopedic surgeons are losing market share, that group may be interested in experimenting with new options. Or maybe the hospital employs all of its cardiac surgeons and can create interest there.

In addition to care providers, organizations should identify willing payers. Identify an insurer that might be interested in a bundle, and make a list of the local self-insured companies – one might be the care provider itself. Work with these willing partners, both physicians and payers, to identify the most appropriate episodes and services to bundle.

Skilled Nursing Considerations

SNFs will eventually contract for bundled payments with four payers: Medicare, managed care, ACOs and employers. Medicare at the moment is the most prominent (with the BPCI initiative) but bundled payments in long-term care are in only an early stage of adoption.

Despite this, we are very bullish on the concept of bundles taking hold in skilled nursing facilities (SNFs), and we also project that they will be adopted fairly quickly, with more than half of facilities participating in some bundles within four years.

Significant savings are to be had in the post-acute arena, as evidenced by Medpac's June 2013 report to Congress, which reviewed data from ten conditions[1] with high rates of post-acute-care use:

1) The variability in spending on post-acute-care is very high, with the top quartile costing an average of 4.3 times as much as the bottom quartile.

2) Spending for patients discharged from hospitals to SNFs was 2.1 times the cost for those discharged to home health.

3) Spending on bundles that included hospital readmissions were on average twice as costly as bundles without readmissions.

National Medicare data also show that over the past decade, while acute care spending is gradually declining, post-acute spending is still increasing.

SNF providers also know, from their own experience, that average lengths of stay (ALOS) can vary considerably simply based on whether the payer is Medicare or Managed Care.

All of this suggests there is much room for improvement, and as we move from fee-for-service to a predominantly global-payment, capitated system, the payers will become highly motivated to squeeze all excess cost from the system. The two biggest levers within SNF that can suppress costs: reducing hospital readmissions and lowering ALOS. Bundling payments can help identify ways to do both.

[1] The 10 conditions, which represented 23 percent of all hospital episodes and 15 percent of all fee-for-service spending (90 day bundles), were: stroke, pneumonia, coronary bypass, heart failure, bowel procedures, major joint, hip and femur, hip and pelvis fractures, kidney and urinary tract infections, and septicemia.

ALOS reductions can be significant. We know of several providers that have trimmed their ALOS by half or more to serve new managed care contracts. As managed care begins to create closed provider networks (an increasing trend), these networks will concentrate their referrals to a few SNF providers who can deliver the same or better quality care for less cost. Health system and physician group ACOs are interested in the same thing – curtailing the number of post-acute partner providers, sometimes dramatically, to focus on those who can deliver quality and low cost. And high volume. Ultimately, those SNFs that want to succeed in bundles will be dealing with much higher patient churn than they have historically had.

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No one in long-term care has a real track record in bundled payments, and a few challenges are clear:

1) Outcomes data will be important. Managed care will want to see who can back up their claims to be worthy bundled payment partners. What is your hospital readmission rate, and how is it trending? What are your costs, by patient condition, and ALOS, and outcomes?

2) Managing risk will be important. Once a SNF accepts bundles, it accepts all patients. It is important to understand the analytics and the downside of the unusual patient who can cost six or seven figures, and take on reinsurance to mitigate this risk.

It behooves progressive-minded SNF providers to be bold about getting into bundles. While the Medicare BPCI project is closed to new entrants

as of November 1, 2013, they have periodically opened the gates for new providers. And consider approaching managed care with a bundling proposal. Be "leading edge" on this topic, not "trailing edge."

Home Health/Hospice Considerations

Generally speaking, bundling in home care is in the early stages of experimentation and preparation. There appears to be an understanding among progressive home care leaders that fee-for-service reimbursement as we currently know it will disappear, and there will be a gradual shift to value-based payment and bundling in alignment with hospitals, physician practice groups and long-term care providers.

As with acute care and skilled nursing, BPCI initiatives are the most well-known, with 14 different home care organizations participating, many with multiple locations participating. But other forms of bundling are being tested by ACOs for care transitions, advanced illness management and integrated/coordinated chronic care management.

"This is the 80/20 rule today – only about 20 percent of the providers in either home care or hospice have the sophistication, capital, risk tolerance and actuarial soundness to manage a bundle, or even prepare for the bundle. It is these 20 percent that are setting the example for the rest of the nation."

In the ideal situation, home care providers would have the sophistication, capital, risk tolerance and actuarial soundness (i.e., volume) to handle the role of the bundler. This is the 80/20 rule today – only about 20 percent of the providers in either home care or hospice have the sophistication, capital, risk tolerance and actuarial soundness to manage a bundle, or even prepare for the bundle. It is these 20 percent that are setting the example for the rest of the nation.

Sutter Care at Home is an example of an extreme pace-setter. With a decade-old Advanced Illness Management (AIM) program and an evolving Integrated Care Model, it has proven in previous internal studies, and now with a $13 million CMMI grant, that it reduced costs for payers by $5,000 per patient at 90 days post-enrollment, a 75% reduction in ICU days, and more than 50% reduction in hospitalization at 90 days post-enrollment. The impact of improved care, better outcomes and cost savings may be a telling story for the future of the delivery system and determine who should or could hold the bundled payment with the right infrastructure in place.

AIM and integrated care management models are being tested and driven by other home care providers, too, most notably Visiting Nurse Services of New York and Hospice of Michigan. These providers are already demonstrating significant cost savings, in some instances up to $2,000 per enrolled patient per month (Sutter, *Health Affairs*, March 8, 2011) and up to 36 percent overall costs savings (Hospice of Michigan, *Modern Healthcare*, April 27, 2013).

Although hospice providers have always been paid on a bundled payment basis and been at full risk for care related to the patients' terminal illness (hospitalizations, at home care, supplies, equipment and medications), hospices have generally gone unnoticed as an example of bundled payment success due to a dearth of data supporting outcomes for patients or survivors. With Sutter Care at Home's AIM program, VNSNY's SPARK program and Hospice of Michigan @HOMe Support, this is beginning to change as hospitals and health plans take more notice.

Bundles are clearly here to stay and various models will evolve with a focus on value-based outcomes. Health plans will be a big driver of accountability, and managed care organizations will be at the forefront holding the bundle and

designing payment methodologies. With the increased focus on the dually eligible (Medicare and Medicaid) population, providers will be driven quickly to work with managed care organizations who are assigned responsibility for these 10 million patients nationwide. The 15 state demonstrations are a catalyst for home care providers to seek contracts with managed care organizations and prepare to shift billing and payment expectations to these contractors.

While ACOs may take a different form, bundled payments will become synonymous with accountable care, and home care providers will become synonymous with pre- and post-acute care management. After all, patients are in their homes 97 percent of the time, and only 3 percent in the hospital or nursing facility. There will be no new money in the pot, so higher value will be placed on outcomes and efficiencies. Home care providers' value propositions must center on better care, better care management, improved outcomes along the continuum and cost reductions to the overall system. A day of care at home is a fraction of the cost of a day of care in an institutional setting.

Progressive home care providers are already preparing by re-thinking their business model and care delivery models. These providers are already situating themselves at the center of the health care delivery system – pre and post acute – and establishing a relevancy that will be undeniable to the future delivery system. The standard approach of accounting for revenues, costs and outcomes will shift from visits and days to encounters, units, links or a new creative term that will clearly demonstrate the relationship between a patient and caregiver in a larger health care delivery system.

Hospitals too are recognizing that "frequent fliers" to the ED are much cheaper to care for at home. One example of a COPD patient returning weekly to the hospital caused the hospital administration to recognize that round-the-clock home care was dramatically cheaper. The hospital ultimately provided care at home and improved its ED and hospitalization rates.

Home care is at the center of the universe for hospitals, health plans and physician groups, and bundled payments allow home care providers to shine – to demonstrate their ability to improve care, improve outcomes and reduce costs. The early demonstrations of AIM and care transitions underscore this capability and the interdisciplinary home care team who understands the patient's physical, social and psychological dynamics. A brief hospital stay of two to three days does not foretell a patient's home environment.

The key to bundling for home care providers is understanding where it starts and how you might be able to change behavior to create savings. In the case of AIM and palliative care programs, there is clearly a sweet spot to reduce hospitalizations readmissions and avoidable hospitalizations.

There are many obstacles for home care providers: naysayers, administrators too fragile to make changes in care delivery, inadequate infrastructure, inadequate risk tolerance and health care delivery system that has valued home care providers as an "after-thought" at the bottom of the food chain rather than as the integral component it needs.

It is and will continue to be difficult for providers to continue fee-for-service Medicare – with looming and dramatic reductions – and test out new payment methodologies. VNSNY is an example of a provider that has gambled on the provider and payer side. It has made bold and dramatic reductions in force in anticipation of additional Medicare payment reductions, and a shift to care coordination and managed care. Most providers do not have the capacity to make these dramatic shifts and survive.

Home care providers should plan with the understanding that bundling is here to stay, and that fee-for-service will go away over the next five

to 10 years. The shift will happen gradually in rural areas, and more rapidly in major metropolitan areas with ACOs or similar initiatives.

In the near term, progressive providers should prepare for the shift to Managed Care for the dually eligible. This is happening now. Get contracts with health plans serving your population, and meet with hospitals to establish partnerships and preferred provider arrangements, even if they have a home care provider internally. Consider partnering with other progressive home care providers to establish similar programs in your service area.

Cross-Continuum Challenges

Implementing bundled payment is a task providers can approach immediately, but it is not an easy one. The challenges are similar across the continuum:

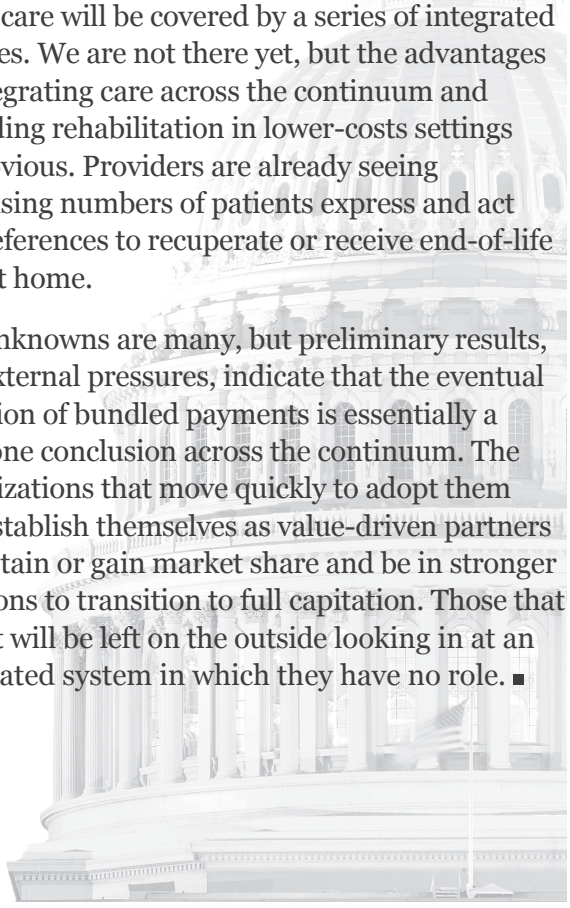
- *Who are the willing clinician partners in the organization? If there aren't any, then the organization must first address its physician alignment strategy. If physicians are on staff, they will need to be incentivized, and if they are not, they will have to be contracted.*
- *Do you have the data from every entity that would traditionally bill for an episode? What is the cost of every drug, appointment, test, procedure and analysis? Who is responsible for gathering and evaluating that information?*
- *What services will be included in the bundle?*
- *What care event triggers a bundle, and what length of time will it cover?*
- *How much will the bundle cost? How will the cost be risk-adjusted for patients with comorbid conditions or other factors? Will a payer or self-insured company be willing to come on board at that cost?*
- *The cost of a drug, a hospital stay and a rehabilitation visit are all now included in one fee – how will it be split among the multiple care providers involved in treating an episode?*
- *What contractual and legal issues will need to be addressed?*

Conclusion

It's not going to be an easy adjustment. And providers, who still make most of their money by doing, will be doing less as procedures are made more efficient. The reality is that there will be no replacement revenue to make up for those losses. Providers that move first, however, may be able to gain market share. Further, they will establish their reputations as value-driven providers that are able to handle shifts in the care delivery platform, thereby drawing partners to them in the move toward clinically integrated networks and population health management.

Today, bundled payments are essentially siloed. But as physicians and organizations gain experience in managing patients in a bundle, they will begin to manage sicker patients and more complex episodes, not just healthy electives. The time will come when bundles will reach across the care continuum so an emergency patient who requires skilled nursing rehabilitation and then home care will be covered by a series of integrated bundles. We are not there yet, but the advantages of integrating care across the continuum and providing rehabilitation in lower-costs settings are obvious. Providers are already seeing increasing numbers of patients express and act on preferences to recuperate or receive end-of-life care at home.

The unknowns are many, but preliminary results, and external pressures, indicate that the eventual adoption of bundled payments is essentially a foregone conclusion across the continuum. The organizations that move quickly to adopt them and establish themselves as value-driven partners will retain or gain market share and be in stronger positions to transition to full capitation. Those that do not will be left on the outside looking in at an integrated system in which they have no role. ■



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