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Navigating bundled payments:
Strategies to reduce costs and improve health care

Executive summary

As alternative payment models (APMs) in health care become more prevalent, the role of bundled payments, also known as episodes of care, is likely to increase. All payers—Medicare, Medicaid, and commercial health plans—are interested in strategies that use incentives to achieve better value; legislation including the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is encouraging more health care organizations to participate in APMs. Bundled payments can be an organization's first step into APMs; they are relatively focused, engage specialists, and do not upend a hospital's fee-for-service (FFS) business model. Furthermore, bundling can be compatible with a population health strategy where savings from reducing post-acute care count towards reducing total cost of care. Health care organizations interested in bundled payments can learn from the experience of early participants.

Medicare has been the major driver of bundled payment initiatives to date; health systems are not reporting a significant degree of bundling activity with commercial health plans or employers, although there is interest, as well as some Medicaid activity. The Centers for Medicare and Medicaid Services Innovation Center's (CMMI) Bundled Payments for Care Improvement (BPCI) initiative, a voluntary program encompassing a variety of conditions and risk-sharing arrangements, is the first bundling model CMMI has tested and, thus, the model with the most results. Other bundled payments programs, including oncology, cardiac care, and comprehensive care for joint replacement (CJR), have or are just beginning to launch through the US Centers for Medicare and Medicaid Services (CMS) or CMMI.

What is MACRA?

The Medicare Access and CHIP Reauthorization Act of 2015 is a transformative law from CMS that is intended to drive payment and delivery reforms for clinicians and health systems across Medicare, other government programs, and commercial payers. The law establishes a path towards a new payment system that will likely more closely align reimbursement with quality and outcomes. MACRA offers significant financial incentives for health care professionals to participate in risk-bearing, coordinated care models and to move away from the traditional FFS system. In addition to significant new performance measures, reporting requirements, and compliance exercises, MACRA will necessitate major strategic decisions for physicians and other clinicians in how they organize themselves and how quickly they move into coordinated care arrangements. Similar decisions await health systems and health plans that employ those health care professionals or rely on them for patient referrals and to build their networks.[1]

What have health care organizations learned from their early experiences with the BPCI program? Deloitte conducted 20 interviews with health systems, conveners (organizations that provide technical assistance), technology companies, skilled nursing facilities (SNFs), and health plans participating in bundled payments about their reasons for participating—including how bundling fits into their other APM activities, major challenges, and keys to success.

Although BPCI allows organizations to choose a variety of conditions for bundling, most of the focus has been on hip and knee replacement cases.[2] Most of the interviewed participating systems are:

- Including BPCI as part of an overall APM strategy. Some organizations are participating in a wide array of APMs—including accountable care organizations (ACOs) and patient-centered medical homes (PCMHs)—while others are starting with bundles.
- Investing in data and analytics to identify cost-saving opportunities and post-discharge providers who have good patient outcomes and can manage length of stay. Conveners have been particularly helpful to health systems and physician groups getting started with bundled payments.
- Reducing use of SNFs after orthopedic procedures by sending patients directly home or by decreasing the length of stay at SNFs.
- Working to improve communication and workflow among diverse care teams, including leveraging physician champions, pharmacists, and care coordinators, to track and set expectations with patients with the goal to prevent re-hospitalization, reduce or eliminate post-acute care stays and improve outcomes.

The most recent BPCI program evaluation confirmed what we heard in the interviews: the greatest savings have resulted from reducing use of post-acute care following joint replacement. The CMS demonstration identified savings of $864 per episode, while maintaining claims-based quality measures and patient experience, and improving on some survey-based quality measures.[3] While additional research is needed, these findings are promising.

Most interviewed participants are investing in data and analytics to identify cost-saving opportunities and post-discharge providers who have good patient outcomes and can manage length of stay.

Background

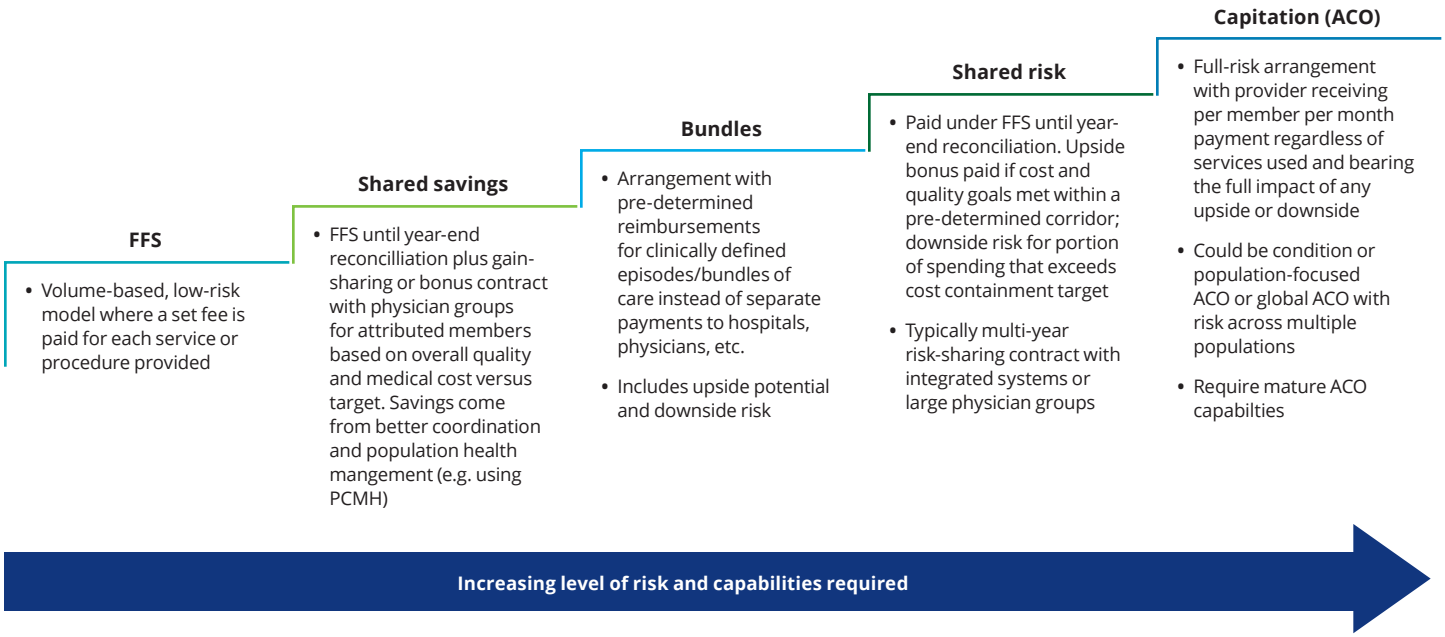
What are bundled payments?

Episodes of care are not new—they have been cited in health care research as early as the 1960s[4] and Medicare started moving towards bundled payments in the 1980s.[5] Bundling is one alternative payment model within a spectrum of strategies that focus on improving health care quality while reducing costs and driving clinical transformation (see Figure 1). Others include primary care initiatives such as PCMHs and ACOs, which aim to reduce the total cost of care. Bundling is an important initiative that has the potential to align incentives across health care stakeholders, reduce waste and medical services overuse, and coordinate care.

Bundled payments is a method of paying for health care in which one price is set for a package, or bundle, of services that previously would have been paid for separately. Bundling models in the BPCI program are triggered with an inpatient hospital stay. For example, in the past, if a patient required knee replacement surgery in a hospital setting, Medicare or a private health plan would pay the specialist, hospital, and post-acute care provider separately.

Under BPCI, Medicare initially might pay for these services separately but after the episode finishes, it will compare total spending for the combined services to a target.[6] Providers are at risk in this arrangement: If spending for that episode exceeds the target they have to return some of the original payment. However, if they save money, they keep some of the savings. This arrangement gives providers an incentive to find cost-saving and care-improvement opportunities such as reducing complications and readmissions.

Figure 1. Bundling in the APM strategy spectrum



Source: Deloitte Center for Health Solutions.

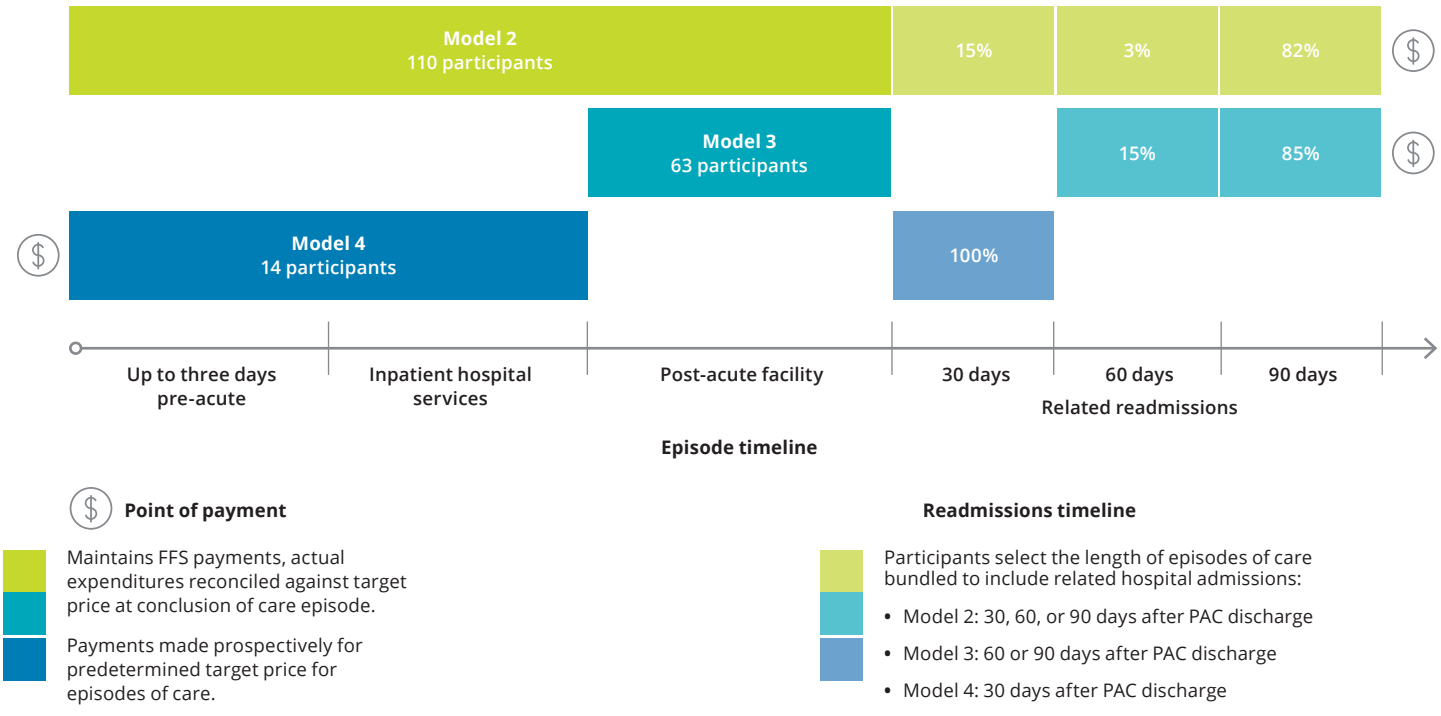
BPCI program design

The CMS BPCI initiative allows participants to choose bundled payments for as many as 48 clinically defined episodes of care. The program design includes four models; participants select from among them. The options have different episode lengths, service mixes, and risk-sharing rules. The start of a beneficiary's hospital stay typically triggers an episode (the "anchor" hospitalization).

- Model 1, which concluded earlier in 2016, defines an episode of care solely as a beneficiary's inpatient, acute care hospitalization.
- Model 2 is the most comprehensive bundle, as well as the most widely adopted. Episodes in this model include all services and treatments from the anchor hospitalization through related hospital readmissions delivered within the chosen episode length of 30, 60, or 90 days post-discharge from a post-acute care (PAC) facility.
- Model 3 episodes include all services in a participating PAC facility following the anchor hospital discharge, and related hospital readmissions for 60 or 90 days post-PAC discharge.
- Model 4 episodes extend from the anchor hospitalization to any related readmissions within 30 days of PAC discharge.

As shown in Figure 2, under both Model 2 and Model 3, participating providers are still paid on the Medicare FFS physician fee schedule, and total payment amounts are reconciled against the bundled payment target price at the conclusion of care. Participants in Model 4 receive their payment prospectively.

Figure 2. BPCI Models 2-4: Episode timeline and payment differences



Source: CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 2 Evaluation & Monitoring Annual Report, 2016.

The special role of conveners

BPCI participants include a wide array of health care stakeholders: hospitals, health systems, physician groups, PAC providers (e.g., inpatient rehabilitation or SNFs)—and national professional health care organizations. Organizations that apply for a BPCI contract agree to accept risk for Medicare episode payments, and can fill one of two distinct roles based on the model they choose: awardee or convener.

An awardee bears risk solely for its own BPCI beneficiaries. Awardees can be hospitals, health systems, or physician groups.

A convener provides technical assistance to awardees to reduce the administrative burden on BPCI providers. There are two kinds of conveners:

- **Awardee conveners** are BPCI awardees which agree to act as the organizing partner for two or more separate awardees. All organizations under an awardee convener bear collective risk. Awardee conveners can include parent companies, health systems, or other organizations that can assume financial risk for episodes initiated by their BPCI partners.
- **Facilitator conveners** are third-party administrators which do not bear risk or receive payment from CMS. Facilitator conveners can partner with single awardees or with awardee conveners to provide supplemental assistance. Facilitator conveners include state hospital associations, national PAC associations, or venture capital companies that engage with acute care or post-acute care providers but do not assume financial risk.

Bundled payment programs can be quite complex and providers are at various states of readiness. Conveners have been particularly helpful to health systems and physician groups in helping them understand program design, success strategies, care model redesign, and claims data. Premier, a facilitator convener, offers support across bundled payment programs by partnering with providers so they "don't go it alone." Premier suggests that health systems that are in bundled payments engage, either formally or informally, with organizations with experience in bundles. Learning, through mechanisms like a collaborative environment, from other organizations and discussing program details with peers, can make the transition easier and increase the likelihood of achieving quality and financial success.

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Interview findings

Deloitte interviewed 20 organizations including health systems, conveners, technology companies, SNFs, and health plans participating in bundled payments to examine why and how health systems are exploring or participating in bundling, what major challenges organizations are facing, and what the future of bundling may look like.

Why are organizations investing in bundled payment programs?

Some organizations we interviewed are experimenting solely with bundles while others are testing the full array of APMs. A number have been receiving bundled payments for at least a decade, while others—seeing that CMS was going to mandate bundles in the future—wanted to start setting up and refining their program.

Provider organizations newer to bundling said they saw different opportunities. Some wanted to dip their toes in the water in one area, such as joint replacement, and leverage lessons learned before expanding to other bundles. Others are working with conveners on data analytics. Many organizations stressed that pilot projects could provide an opportunity to develop new processes and learn from them. They also cautioned CMS not to progress too quickly with mandatory bundles and to let organizations with different levels of understanding and experience move forward over time.

All of our interviewees saw bundling as a way to increase alignment among the hospital, health system, and clinicians—especially specialists.

A few of the health systems we spoke with are participating in both ACOs and bundled payments, and have found these programs can be compatible. Under the ACO payment model, providers are accountable for the total cost of care for a patient population. In bundling models, they receive a fixed payment for a single episode of care. Both models rely on building care network relationships, reducing readmissions, and making care transitions as efficient and appropriate as possible. The key difference is that in Medicare, bundles are defined relative to a hospitalization so health systems do not have an incentive to invest in reducing initial hospitalizations, either via preventive care or shifting patients from inpatient to outpatient settings.

Several organizations interviewed which have a history of working with CMS on building competencies around APMs, including bundling, are striving to become leaders in these models. Trinity Health, for example, is working towards a long-term goal of gaining experience in risk-based payment models and identifying opportunities to improve patient care, and believes that bundling is a critical step in this journey. All of our interviewees saw bundling as a way to increase alignment among the hospital, health system, and clinicians—especially specialists.

The collective answer to our interview question "why bundling, why now?" was summed up by a Brookdale Senior Living executive, who expressed excitement about taking on the challenge of bundled payments: "Investing in bundled payment models demonstrates Brookdale's readiness to show CMS its ability to manage federal dollars wisely, and to be stewards of quality care in a time of escalating costs for the patients and families we serve."

Even as health systems are investing in changing care patterns, we heard that some are proceeding cautiously with bundled payments, as BPCI is a pilot and only affects a relatively small share of patients. With wider stakeholder commitment to permanent bundled payment arrangements, these investments would likely grow.

What strategies are integral to bundled services?

Invest in analytics and other technologies

Crucial to managing a successful bundled payments program is understanding which patients fall under the BPCI program, physicians' referral patterns, where patients go after discharge, and service use and outcomes over the post-discharge period. Before bundles, most health systems neither had the data nor the incentive to track patients after they left the hospital. Being able to analyze such data to identify variations in care and savings opportunities is an essential, albeit challenging, capability that BPCI participants need. Many interviewees also described this data as critical for engaging physicians in changing their referral patters.

While CMS provides data to BPCI participants, it is often delayed, limited in detail, and needs a fair amount of "slicing and dicing" for organizations to understand resultant opportunities. Organizations have found that having their own analytical capabilities or leveraging a technology company or convener is critical to identifying variation sources and savings opportunities. Large providers that plan to participate in more advanced payment models may want to build these capabilities in house. Smaller physician offices without ample resources to spend on technology may find that working with a third party is an easier, more cost-effective option. We learned that some conveners supporting physician practices tend to provide aggregated reports rather than customized and dynamic information. If these practices continue their involvement with bundled payments and other APMs, they may want to ask more of these third parties or develop some internal data analytics capabilities.

According to interviewees, one valuable application in bundling initiatives is predictive analytics to identify patients at highest risk. Being able to identify those most likely to need additional support because of their home situation or clinical comorbidities can be helpful in targeting care resources.

Other necessary technology investments per our interviewees include collaboration platforms to enable different care providers (both internal and external) to communicate with each other about patient care—including making sure everyone knows when a patient is discharged from the hospital. Patient engagement tools are also of interest, although most organizations have not yet focused their attention on this area.

Bundled payments in action:

DataGen markets its ability to provide accurate patient readmission data; confirm that patients are going to the most appropriate, cost-effective care setting; and determine care components and cost drivers within each episode of care.

"At DataGen, we have a history of partnering with health care organizations across the country, illustrating the financial implications of payment policy changes, and promoting a pragmatic view of how changes will affect revenue and profitability. Our goal is to simplify the complexities of health care payment change. Most of our provider clients were working on their population health strategy and saw bundling as a good fit within this strategy; some of our clients saw bundling as a way to gain experience in alternative payment models."—Kelly Price, Vice President and Chief of Healthcare Data Analytics

Reduce use of SNFs

Across all of our interviews, we heard a common theme: most of the savings for orthopedic bundles have come from reduced use of SNF care. Organizations reported that, as a first step, they used detailed analytics to review utilization and outcomes across all the SNFs in their market area. Not only did they find that SNF use after joint replacement was common, patients typically stayed for the length of the SNF benefit. The analysis uncovered two main opportunities for reducing costs:

- Avoiding SNF use altogether by preparing the patient and care team for the patient to go home rather than to the SNF;
- Shortening the SNF length of stay for those patients who do need SNF-level care by identifying—through data and, frequently, visits—the SNFs that were willing to work with the health system (or convener or consultant) to change the pattern of care. These SNFs would form a narrow network to which the system would refer patients. Health systems prefer SNFs that partner to restore patients to mobility quickly and send them home.

We also heard that the opportunities for savings via SNF utilization varied considerably by market and hospital. Each facility has a different patient mix and referral pattern, and each market has a different set of post-acute care providers and PAC care patterns, so the specific strategy—informed by analytics—should be tailored to the hospital and market.

Other savings for orthopedic and medical bundles have been found in reducing readmissions—already an area of focus for many health systems. Several interviewees reported that they have invested in care coordinators to track and periodically contact patients after hospital discharge to assist with medication reconciliation, educate them on symptoms to monitor, and encourage follow-up with their physicians. Prompt scheduling with community doctors and outpatient rehabilitation services is important to help patients have good outcomes. Pharmacists can also support medication reconciliation and underscore the necessity for adherence. Some health systems told us that it is important to invest in care coordinators prudently and target outreach to highest-risk patients. One system said that it started by using nurses as care coordinators, but realized that less-expensive staff could also do this work well. Analytics can help identify patients with the constellation of comorbidities and other health and support issues that put them at the greatest risk for readmissions.

Finally, we heard that some SNFs are offering other services—including hospice and short-term assisted living—to help reduce the cost of care following discharge. Health systems did not see an increase in home health care, as utilization is already common. A few health systems mentioned savings from reducing inpatient rehabilitation facility use; none reported savings from long-term-care hospitals.

Bundled payments in action:

Owned Outcomes' software is tailored specifically to BPCI participants to help them make data driven decisions, engage physicians, and support patients.

"We want to match the right patient to the right [discharge] setting. Different patients have different areas of vulnerability. We can help flag what variables are most important."—Anita Pramoda, Chief Executive Officer

Engage the care team and patients

One of the core principles of APMs is aligning and engaging care teams to move away from the siloed approach typical of the traditional health care system. Health systems participating in bundled payments must be able to coordinate and manage care over settings and time, which requires an engaged care team with capabilities to track patients, share care plans, and communicate with each other to achieve desired clinical and financial outcomes. Some interviewees told us that the patient and family can be part of this team.

One convening organization noted that some of its care team engagement began with the incremental, administrative approach of changing referral patterns in the discharge planning process. In other cases, care team engagement was part of a total care transformation—an approach that benefits from having a physician champion to help staff understand the long-term value of improved patient care.

Most health systems interviewed agreed that clinical teams which worked together to coordinate care often helped patients take an active role in their care—for example, to start rehabilitation (i.e., get out of bed) as early as possible and feel confident that they could manage at home. Both of these steps are critical success factors for joint replacements under bundling.

Patients usually trust the advice of their physicians and surgeons, such as whether to heal at home versus in a PAC setting or rehab facility. Thus, this advice may be more effective than if a patient hears it from a discharge planner they have just met. One example we heard that demonstrates the importance of clinician engagement is pain management: Under clinician guidance, patients who understand what pain levels they might experience after a procedure typically have reduced opioid use and may be more open to alternative methods to manage pain.

Interviewee Geisinger discussed the important role of community health assistants (CHAs), inspired by the health system's work caring for Medicaid patients. CHAs are often non-licensed professionals (their role does not necessarily require a medical or nursing degree so they may be more cost-effective) who assess patients' needs, link back to the primary/case management team, coordinate referrals, and connect patients to transportation sources for medical appointments and to pick up prescriptions. They also spend time listening to patients, and as social isolation is a critical factor in health and health care, they play a vital role. Thus, CHAs can help reduce readmissions and help patients manage their condition and challenges outside of the hospital.

Health systems interviewed also stressed the importance of educating patients and families early about their condition, the surgery or procedure they were going to have, and steps they could take to be as healthy as possible. Quitting smoking pre-surgery, actively helping patients manage comorbidities, and identifying and mitigating the social determinants of health (e.g., stable housing, food insecurity, and transportation) are some areas of upstream patient engagement that interviewees are working to continually improve. For example, some health systems are providing pre-surgical videos to patients and making them required viewing.

Another practice is to brief patients and their caretakers on how long a typical length of stay is, what to expect during the stay, and what should happen after discharge. A patient may have heard from friends who had knee replacement surgery that they were sent to a SNF for several weeks, and expect the same treatment regimen. Providers may need to explain that new research has shown that patients prefer to recover at home and the plan, assuming there are no medical indicators, is that the patient goes directly home.

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What are some barriers and challenges?

Despite early successes and the potential for bundling payment models to improve health care outcomes and reduce costs, all interviewees have faced and continued to experience financial, cultural, and structural challenges.

Financial: When health care organizations begin their bundling initiatives, one of the biggest unknowns is how the money will flow and whether or not their investment will pay off in the long term. It is challenging to track patients in real time in order to influence care. Also, the target used to determine whether organizations saved or lost money continues to move. Further, the upfront costs (staff, training, data analytics, and more) can be significant, and it is difficult to predict if the resulting savings will be enough to offset the upfront investment. One interviewee described the process as trying to hit an unknown, unpredictable target.

It can be difficult for health systems to make projections when there is no immediate feedback and the projection is based on an average benchmark. Inevitably, there will be both winners and losers in a given year, as bonus payments or disincentives come in months after the fact.

Cultural: Bundling, like many APMs, shifts both health care professionals and patients away from the traditional FFS payment system. Nurses and care managers often need training on how to transition patients to the next appropriate care setting rather than follow protocols they relied on in the past. Physicians, surgeons, nurses, discharge planners, and care managers also may need to consult more with each other and get used to a new workflows and protocols.

And while patients may never hear terms like "alternative payment model" or "bundled payment," they may have certain expectations as to where they will be discharged or how long their hospital stay will be, and may require education to help them adapt to a different care model.

Lastly, if health systems decide to take on more bundles, they may need to increase their investment in analytics and staff resources. Today, many care providers spend time determining which patients are in BPCI and which patients are not, focusing on separate workflows for each. Ideally, organizations will provide the best care to patients regardless of what program they are or are not in, because it is "the right thing to do."

Structural: Interviewees cited structural challenges concerning data, program administration, and coordination with other organizations, including CMS. Like the organizations implementing bundled payments, CMS is learning from health systems' implementation successes and failures and is making adjustments to the BPCI program as needed. Continued communication and collaboration between CMS and health systems is likely to reassure individual organizations that CMS understands and will consider their experiences "in the trenches" as the agency develops future guidance.

Interviewees understood that they should expect a lag time with CMS data, but some stated that having more data on a monthly basis rather than quarterly would help for planning purposes. Many also thought that as more data came in, there may be increased visibility into applicable trends or benchmarks. Finally, staff turnover at both CMS and hospitals/health systems was another structural challenge that interviewees anticipated having to deal with in coming years.

Bundled payments financial savings

Interviewees reported that the preponderance of bundling-related savings came from post-discharge care. This is primarily due to Medicare's payment through diagnosis related groups (DRGs)—reducing the hospital portion of the cost does not produce savings under the bundle. Moreover, many hospitals already have mined the savings from reducing implants and other medical technology costs through group purchasing and narrowing physicians' available product choices.

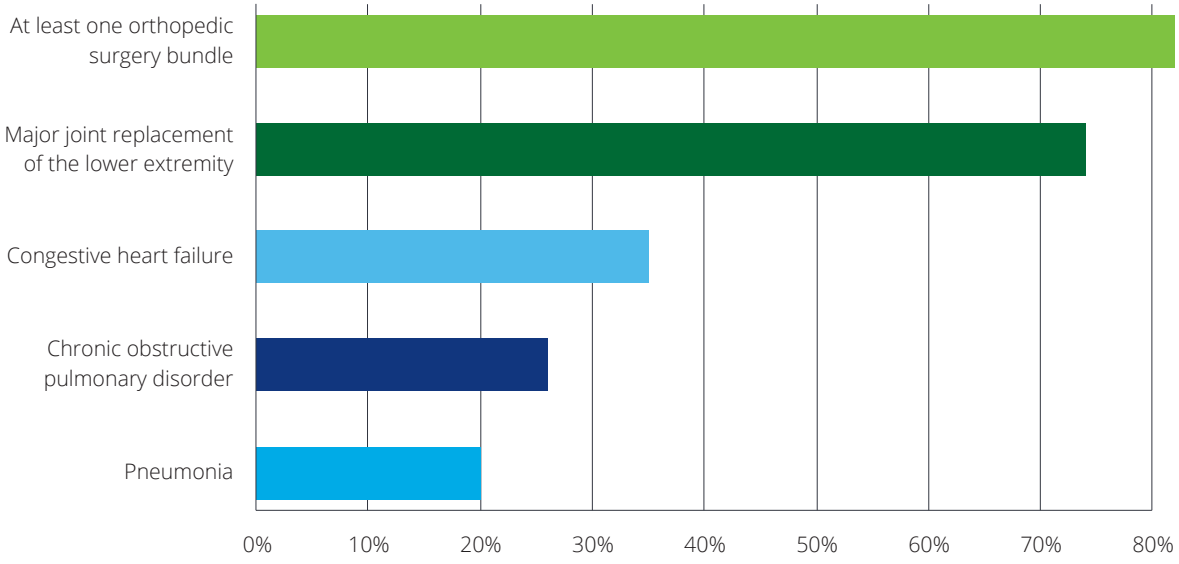
A few health systems did report finding some savings within the hospital stay that they were able to share with physicians through gainsharing arrangements. Such arrangements, they told us, were helpful to align incentives and could be explored to a greater extent with both physicians and post-acute care facilities.

BPCI evaluation results

The BPCI Models 2-4: Year 2 Evaluation Report, published September 2016, found that BPCI participants were producing encouraging results on reducing costs while maintaining or improving quality of care. According to the report, more than 1,400 providers are currently participating in the initiative, with orthopedic surgery bundles showing the most improvement in cost and quality measures.

Eleven of the 15 clinical episode groups evaluated in the report showed Medicare savings. The most significant savings were found in Model 2 orthopedic surgery bundles, which was the most widely adopted clinical episode group (see Figure 3).

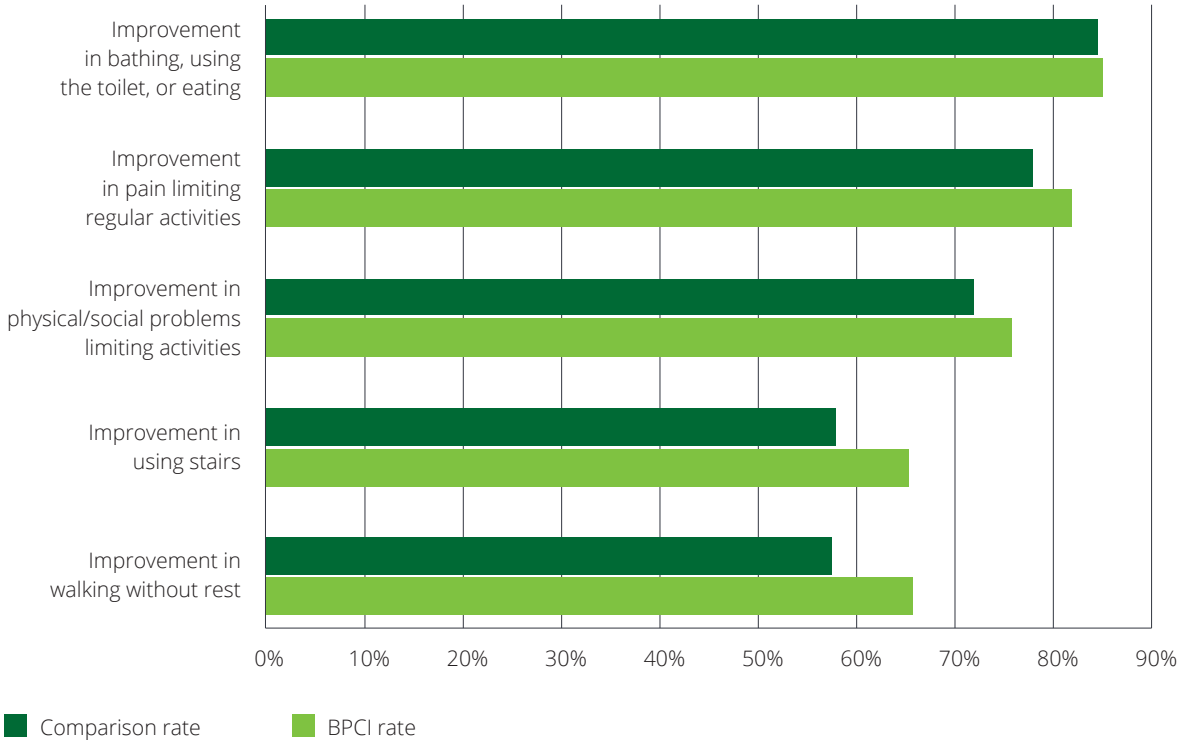
Figure 3. Top five clinical episode bundles selected by Model 2 BPCI participants



Source: CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 2 Evaluation & Monitoring Annual Report, 2016.

Orthopedic surgical bundles accounted for 45 percent of all episodes initiated for Model 2 participants, and showed average savings of $864 (or three percent of overall cost) per episode, while achieving improvements in beneficiary mobility measures (see Figure 4). According to CMS data, orthopedic surgery services accounted for seven percent of all 2012 Medicare spending.

Figure 4. Bundled services for major joint replacement of the lower extremity showed improvement in mobility measures for patients

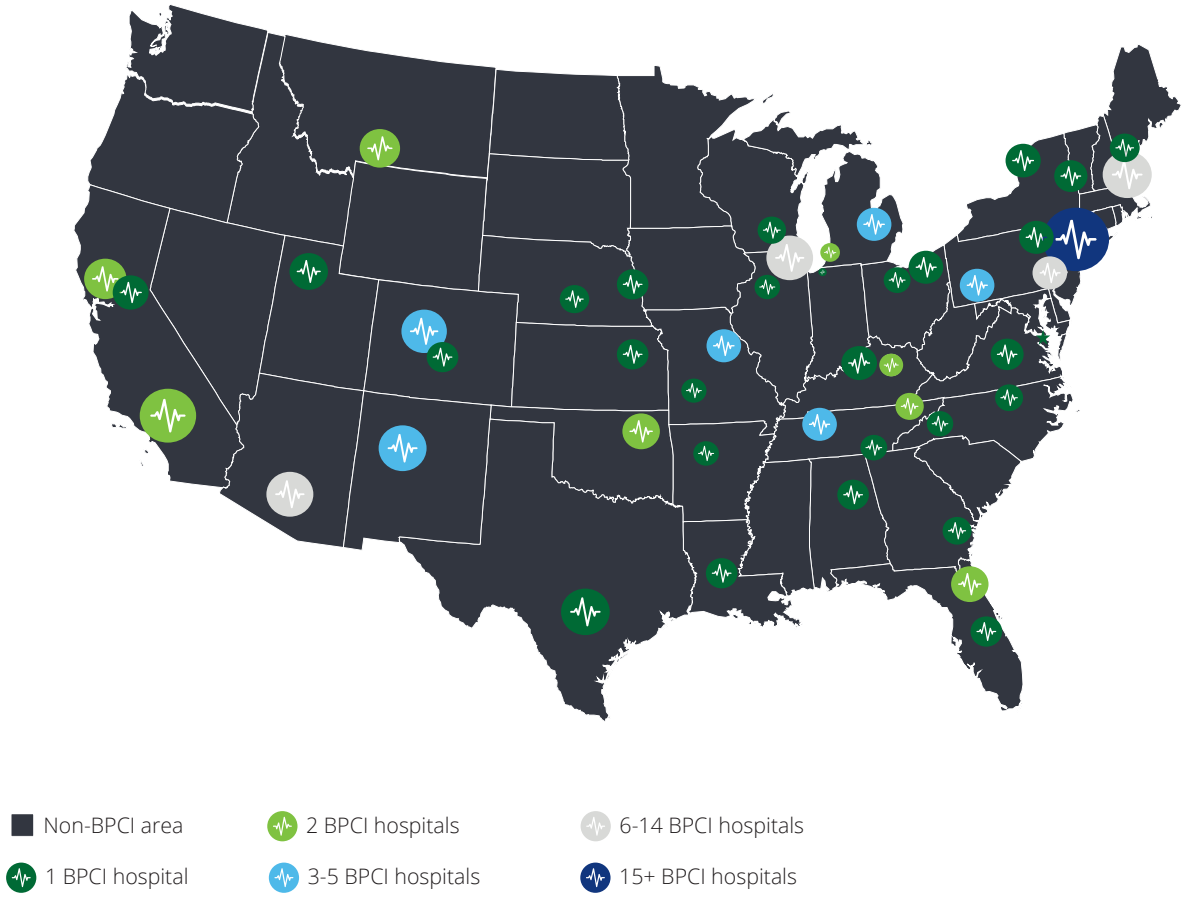


Source: CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 2 Evaluation & Monitoring Annual Report, 2016.

Lower total BPCI costs came from less use of institutional PAC facilities—Medicare Inpatient Rehabilitation Facility payments alone declined by a statistically significant $459 per episode—and a slight increase in use of home health care.

Lastly, according to the evaluation, hospitals in certain more densely populated, urban areas tended to be more likely to participate in BPCI (see Figure 5), and tended to be nonprofit facilities with more than 250 beds.

Figure 5. BPCI participating hospitals tend to be concentrated in major metropolitan areas



Source: CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 2 Evaluation & Monitoring Annual Report, 2016.

Oncology bundled payments: Challenges and opportunities

Oncology is one area where pioneering health plans and health systems are experimenting with alternative payment models, including bundling, to improve care and cost-effectiveness. Deloitte's recent paper, "The evolution of oncology payment models: What can we learn from early experiments? " finds that there is a high level of uncertainty around APMs as well as which models will achieve the dual goals of improving outcomes and controlling costs.

The health plans and providers interviewed used different terminology to describe a bundled payment, including case rates and episodes of care. While several organizations interviewed are piloting bundles, others strongly oppose the use of bundles in oncology care. These organizations expressed concern about the underlying complexities of standardizing a bundle for a disease where there could be variation based on patient and disease characteristics, particularly when patient volumes for any particular bundle are low. Among the specific concerns raised are the:

- Collection of additional detailed information that is not typically included in claims data to appropriately define and measure bundle performance
- Need to formally integrate service lines (e.g., medical oncology, surgery, and ER) to be able to appropriately allocate costs or savings within a bundle
- Unpredictability of drug costs, especially given the recent pace of innovative new drugs becoming available. Providers fear that if they were to take on risk and a new expensive treatment was made available, the financial burden would fall upon the practice.

Beyond these operational considerations, some critics of bundled payments in oncology believe that it will not help to reduce spending. While bundled payments may create short-term incentives to reduce cost, they may overlook potential long-term cost implications of choosing one type of treatment over another. In addition, bundled payments do not address other drivers of increasing oncology care spending, including the problem of inaccurate or misdiagnoses, in which patients may continue to receive inappropriate treatments despite provider participation in a bundled payment model.

So what might the future hold for bundled payments for oncology? Provider and health plan organizations are experimenting with approaches to make exceptions for the appropriate use of expensive new therapies as part of value-based payment models, including bundles. Strategies such as defining bundles based on cancer stage and biomarker status may be one direction. Using software like COTA (Cancer Outcomes Tracking and Analysis), which captures more granular information on patient characteristics, including genomic information, may help define more accurate bundle prices that align with the most recent evidence-based medicine for a specific patient sub-population. Another strategy may include frequently adjusting bundle prices by matching patients in a bundle with similar patients in a health plan's FFS membership to calculate the benchmark price. If a new treatment is being reimbursed under FFS then the cost could be considered part of the updated bundle's total cost.

Future of bundled payments

MACRA is a game-changing law that is likely to drive the future of health care payment and delivery system reform for clinicians, health systems, and health plans. MACRA offers significant financial incentives for health care professionals to participate in risk-bearing, coordinated care models and to move away from the traditional FFS system. Since MACRA enjoys bipartisan support, many in the health care industry have said that implementation is likely to continue, further accelerating the adoption of APMs including bundled payments. Several initiatives, including bundling for acute myocardial infarction, coronary artery bypass graft, surgical hip/femur fracture treatment, future episode payment models based on BPCI, and comprehensive joint replacement, could be included in alternative payment models moving forward. As APMs become more prevalent, though CMS requirements may change, our interviewees agreed that bundled payments are likely here to stay.

Health system considerations:

- Invest in analytics to identify opportunities to save money. Reduced use of SNF care, coupled with technology investments (either in-house or outsourced to a convener or vendor), were key lessons learned when interviewees were implementing a bundled payments program.
- Find the best partners. High-quality SNFs willing to work to decrease the length of stay and engaged physicians can help organizations succeed. Engagement across the care team, both internal and external, and with patients was also important to drive change.
- Bundles can be an important part of an APM strategy—and an especially good way to engage specialists. The focus here is not on reducing overall hospitalizations but on reducing readmissions, transitioning patients to the most appropriate site of care, and reducing length of stay, if appropriate. As APMs continue to increase, health care providers will likely continue to evaluate bundled payments and population health models. These two models are not mutually exclusive and, in fact, some health systems find that bundled payments are an easier step for providers than an ACO.
- Focus on improving quality. Many of the health systems that we interviewed stressed the care improvement part of BPCI. Bundled payments are not just about savings, though that is a large part of the model's appeal. Bundling, at its core, is a care transformation project.

Health plan considerations:

Health insurer interest in bundled payments is growing. A few health systems have contracted directly with employers on services, but these are not typically structured like bundled payments; the emphasis is on a more narrowly defined bundle offered to high-quality health systems that agree to take discounts. Plans can define their own bundles, though consistency across CMS and private plan bundles will likely make it easier for health systems to scale bundles. Some Medicaid agencies are committing to increasing APMs through their Medicaid Managed Care contracts; one APM especially relevant to the Medicaid population is labor and delivery bundles. Health plans are intently watching CMS' initiatives, and will likely follow those that are successful.

Authors

Bill Copeland
National Industry Leader
Life Sciences & Health Care
Deloitte Consulting LLP
+1 484 222 1117
bcopeland@deloitte.com

Christine D. Chang, MPH
Research Manager
Center for Health Solutions
Deloitte Services LP
+1 212 492 3994
chrchang@deloitte.com

Project Team

Casey Korba assisted in interview outreach and research analysis, and contributed to the writing of the paper. Laura DiAngelo also contributed to the writing and analysis and supported outreach to subject matter experts outside the firm. Mohinder Sutrave contributed to the secondary research and interview outreach.

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Sarah Thomas, MS
Managing Director
Deloitte Services LP
+1 202 220 2749
sarthomas@deloitte.com

Web: www.deloitte.com/centerforhealthsolutions
Twitter: @DeloitteHealth

Endnotes

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