The Case for Bundled Payments in Health Care

A HARVARD BUSINESS REVIEW WEBINAR FEATURING

Robert S. Kaplan and Michael E. Porter

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Medtronic
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OVERVIEW

Transforming health care delivery in the United States and around the world requires paying differently. The current fee-for-service payment model results in high volume, high cost, and inadequate outcome. There is a fundamental mismatch in that providers are incented to produce more volume while patients want greater value.

So aligning the interests of patients and providers requires changing the payment system. A better approach: paying providers a single bundled payment for all care delivered for a specific condition across the entire episode of care. Bundled payments will encourage providers to deliver better value and will change the nature of competition. Bundled payments will lead to transformational change, while capitated payments—which are an improvement versus fee-for-service—could produce incremental change. Capitation focuses on caring for entire populations—not patients with specific conditions. And this form of payment doesn’t hold providers accountable for condition-based outcomes.

Bundled payments are not merely a theory; adoption is gaining momentum around the world, producing improved outcomes and lower costs.

CONTEXT

Harvard Business School professors Michael Porter and Robert S. Kaplan reviewed the main points from their recent HBR article where they argue that bundled payment is a superior health care payment model.

KEY LEARNINGS

There is a misalignment in how clinicians are paid and what providers want.

In the United States and much of the world, the dominant health care payment model is fee-for-service. Under this model, providers are paid based on the volume of services they provide, rather than the quality. Health systems with fee-for-service payment models produce high volume, high costs, and inadequate quality. The dominance of this fee-for-service model is seen by many as possibly the single biggest obstacle to improving health care delivery.

The fundamental problem is a misalignment and a mismatch between how clinicians are paid (based on volume) and what patients want (which is value). Value in health care is defined as the outcomes that matter to patients divided by the cost to produce those outcomes.

Value = \frac{\text{Set of health results that matter for the condition}}{\text{Total cost of all necessary services over the care cycle}}
Value is created in caring for a patient’s specific medical condition, such as diabetes or breast cancer, over the full cycle of care for that condition. It is created when care is delivered by integrated teams (integrated practice units, or IPUs). Producing value requires measuring the outcomes that are delivered and the cost to deliver those outcomes.

**Bundled payments are a far better payment method than fee-for-service.**

A bundled payment is a single payment for all care associated with a specific condition. For example, a provider might receive a payment of $8,000 for a hip replacement. This single bundled payment covers all of the services to treat a particular condition over the full care cycle, or a defined time period for chronic conditions or primary care. The payment is risk adjusted, and receiving the payment is contingent on condition-specific outcomes. Providers receiving bundled payment for an episode of care will be accountable for delivering outcomes and managing costs condition by condition.

**Bundled payments will improve system value.**

Value will be improved through bundled payments for all stakeholders.

- **Patients** will be able to **choose** providers who **deliver the best outcomes** for their medical condition.

- **Providers** will **change how care is provided** by delivering care in integrated teams, will **concentrate patient volume** for medical conditions in fewer organizations enabling **better outcomes** at lower costs, and will focus attention on **measuring and reducing costs**.

- **Payers** will **pay less** for care, achieve substantially **better outcomes**, and will have simpler and **lower administrative costs**.

- **Suppliers** will **compete based on value** and those who deliver better value will **achieve higher market share**.

- **Employers** will **improve employee outcomes** at lower prices, will **negotiate directly** with clinical centers of excellence for specific conditions, and will **drive bundled care**.

**Bundled payments will drive competition.**

When payment is bundled, providers will compete to deliver the greatest value for particular conditions. Those who focus on particular conditions and deliver the best outcomes will attract more patients, raise efficiency, and earn good margins. Conversely, less effective or efficient providers will receive payment below their costs. Over time they must improve the outcomes and efficiency or exit the market for a medical condition.

As a result of competition based on the outcomes and costs for particular conditions, average outcomes will rise and average costs will fall. Providers will focus on service lines where they can excel.
Bundled payments are a better payment model than capitation.

Capitation is a payment model where a provider receives a single risk-adjusted payment for the overall care of a population of patients for a period of time, typically one year. From this single payment the provider is responsible for all of the needed care for the patient population. There are quality metrics, but they are for populations and tend to be generic as opposed to the more specific metrics of bundled payments for conditions.

Compared to fee-for-service, capitation is an incremental improvement. It incent providers to lower costs, pay attention to high-cost areas (such as expensive drugs, readmissions, and post-acute services), and keep patients healthier. Capitation also encourages lower-cost treatment options.

However, unlike the bundled payment model, with capitation there is no accountability at the patient level. There is a focus on keeping patients in the provider network to avoid leakage as opposed to encouraging patients to choose the care that will provide the most value. Capitation leads to competition, but at the wrong level on the wrong things.
Bundled payments are not theoretical; they are happening.

There are multiple objections levied against bundled payments. Some people argue that implementing this approach is too complicated and that it is too difficult to measure outcomes or costs. Others argue that some conditions can’t be covered by bundled payments or that providers won’t work together under this payment method. None of these objections hold water. The reality is that bundled payments are a better approach because they focus providers on delivering value, and bundled payments are being broadly adopted. CMS is paying based on bundles for many conditions, and both private insurers and employers are also increasingly shifting to bundled payments. This is causing providers to innovate to deliver care as efficient, integrated teams and, in doing so, to attract more volume. Outside of the United States, bundled payments are being used in countries such as Sweden and the Netherlands for a variety of medical conditions ranging from spine surgery to diabetes. This is not just some conceptual idea; it is rapidly becoming a widespread reality.

“This is not a theory; it is happening today by the thousands all over the world.”

– MICHAEL PORTER
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BIOGRAPHIES

Robert S. Kaplan
Senior Fellow, Marvin Bower Professor of Leadership Development, Emeritus, Harvard Business School

Bob Kaplan is Senior Fellow and the Marvin Bower Professor of Leadership Development, Emeritus, at the Harvard Business School where he has taught for more than 30 years. Kaplan received a B.S. and M.S. in Electrical Engineering from M.I.T., a Ph.D. in Operations Research from Cornell University, and several honorary degrees. Kaplan has authored or co-authored 14 books and more than 150 papers including 25 in Harvard Business Review. He has co-developed both activity-based costing and the Balanced Scorecard, measurement systems that link operations to strategy implementation. For the past six years, he has collaborated with Michael Porter on a major project to improve the value of health care—better outcomes at lower costs—delivered to patients.

Michael E. Porter
Bishop William Lawrence University Professor, Harvard Business School

Michael E. Porter is a leading authority on competitive strategy; the competitiveness and economic development of nations, states, and regions; and the application of competitive principles and strategic approaches to social needs, such as health care, innovation, and corporate responsibility. Porter is generally recognized as the father of the modern strategy field, and has been identified in rankings and surveys as the world’s most influential thinker on management and competitiveness. As the Bishop William Lawrence University Professor based at Harvard Business School, Porter has received the highest professional recognition that can be awarded to a Harvard faculty member.

Adi Ignatius (Moderator)
Editor in Chief, Harvard Business Review

Adi Ignatius joined HBR as Editor in Chief in January 2009. Previously, he was Deputy Managing Editor for TIME. He was the editor of two New York Times bestselling books: President Obama: The Path to the White House and Prisoner of the State: The Secret Diaries of Premier Zhao Ziyang. Prior to his 2007 appointment as Deputy Managing Editor, Ignatius served as Executive Editor of TIME starting in 2002, and from 2004 to 2007, he also held the additional title of Editor of TIME Canada. Ignatius joined TIME as Deputy Editor of TIME Asia in 1996 and was named Editor of that edition in 2000. He also wrote frequently for TIME, including cover stories on Google Inc. and the 2007 Person of the Year profile of Vladimir Putin. Prior to joining TIME, Ignatius worked for many years at the Wall Street Journal, where his work was nominated for a Pulitzer Prize.

Ignatius was awarded a Zuckerman Fellowship at Columbia University’s School of International and Public Affairs in 1990. He received his BA in History in 1981 from Haverford College. He is a member of the Council on Foreign Relations and the Asia Society.
Sponsor’s Perspective

GOING LONG ON VALUE

Value-Based Healthcare Starts With Measuring and Improving Long-Term Outcomes

The move toward value-based healthcare starts with standardizing how we think about outcomes and how we measure them. Currently, the healthcare industry has been focused on measuring short-term medical outcomes: Was the procedure a success? How quickly did the patient leave the hospital? Did he or she have to come back to the hospital for follow-up care?

What’s missing are some of the longer-term outcomes that matter most to patients — what is the patient’s long-term prognosis? Will the therapy improve the patient’s quality of life? How often will the patient need to use healthcare resources going forward? These are the long-term questions we need to be asking and answering collaboratively as our industry moves toward value-based care.

Standardization of outcomes measurement has to begin with collaboration amongst providers, suppliers, physicians, payers and patients on disease-specific outcomes. Collectively, we have to agree on how to systematically measure outcomes for specific disease states and medical conditions.

Once we have established the importance of long-term outcomes and standardized the measurements, then we have the ability to link them to cost of care. The last step — measuring outcomes and tying them to reimbursement — is important, not just for providers and payers, but for the entire healthcare system. We need to know more about how patients’ outcomes look across medical technology, pharmaceuticals, and other interventions.

At Medtronic, we define value-based healthcare as an effort to develop and deploy products, services and integrated solutions that improve patient outcomes per dollar spent in the healthcare system by improving the quality of care and/or reducing the associated expense. Most importantly, the value derived from the quality of care isn’t determined at a specific point in time that focuses on transactional value. Instead, value should be measured holistically over a longer time horizon and in ways that are meaningful to the patient.

We believe Medtronic has an important role to play in the move toward value-based healthcare. There’s an opportunity to build on what we are driven to do every day: leverage the full power of our technologies, services and people to work in collaboration with others to help improve healthcare outcomes around the world.

Learn more about Medtronic’s perspective on value-based healthcare and ways we can work together to improve outcomes at medtronic.com.

ABOUT MEDTRONIC

As a global leader in medical technology, services and solutions, Medtronic improves the health and lives of millions of people each year. We believe our deep clinical, therapeutic and economic expertise can help address the complex challenges — such as rising costs, aging populations and the burden of chronic disease — faced by families and healthcare systems today. But no one can do it alone. That’s why we’re committed to partnering in new ways and developing powerful solutions that deliver better patient outcomes.

We’re now among the world’s largest medical technology, services and solutions companies, employing more than 85,000 people worldwide, serving physicians, hospitals and patients in nearly 160 countries. Join us in our commitment to take healthcare Further, Together. Learn more at www.medtronic.com.