SPECIAL SECTION: HEALTHCARE REFORM

Jonathan W. Pearce
John M. Harris

healthcare financial management association www.hfma.org

the Medicare bundled payment pilot program **participation considerations**

The Medicare bundled payment program included in the recent healthcare reform legislation offers a unique chance to align relationships with key physician specialty groups.

AT A GLANCE

> The Medicare bundled payment pilot program is scheduled to begin in January 2013 and will run for five years.
> The program holds the promise of increased alignment between hospitals and physicians, presenting opportunities for hospital cost reduction and improvements in quality.
> Nonetheless, the program carries fixed costs and assumption of risks that hospitals need to evaluate as they deliberate over whether to seek to participate in the program.

With a sizable number of Medicare cases in the mix, a hospital participating in the Medicare bundled payment program, which is a significant component of the recently passed Patient Protection and Affordable Care Act of 2010, may be able to decrease costs, improve quality, and solidify its market position in vital service lines. In addition, the focus on providing a coordinated set of services may increase market share and profitability.

Nonetheless, there are significant costs involved in participating, so careful analysis is essential. Success will require detailed analysis and planning, selection of the right physician partners and other organizations who will participate with the hospital in the pilot, and development and implementation of an aggressive cost-reduction program.

The pilot program may also provide significant financial benefits to physicians who participate. This potential may lead large specialty groups to seek out hospitals that might want to partner with them in the program. Indeed, some hospitals may choose to participate to maintain or attract the loyalty of significant physician groups whose preference is to build relationships with hospitals participating in the pilot.

Hospitals first need to understand the requirements of this new program, use an appropriate framework to evaluate the opportunity, and be ready to perform the key analyses necessary to inform the decision of whether to participate.

What Is a "Bundled Payment"?

Policymakers have grown increasingly frustrated with fee-for-service payment methodologies. Fee-for-service payment rewards volume and encourages silos and fragmentation of care. Several provisions of 2010's healthcare reform legislation seek to shift provider payments to value-based approaches that encourage quality improvement and cost reduction. Payment bundling is one such approach.

Broadly defined, a *bundled payment* encompasses any payment methodology that includes multiple services paid in one single payment. Many current payment systems bundle some services together. DRGs bundle a range of inpatient services, APCs bundle particular outpatient services, and certain physician office services are included within office visits. The Medicare Acute Care Episodes (ACE) demonstration project currently under way combines hospital and physician payments into one bundled payment for certain acute care episodes.

The bundled payment pilot program described in the reform legislation is unique because it bundles the payment for a wider range of services across many provider types. This approach brings both opportunity and challenge.

The Bundled Payment Pilot Program

Although many necessary details are left to the forthcoming regulations, several important details were spelled out in the legislation, including the requirements for participation. These are as follows:

> Submit application to provide and direct services for applicable condition(s).
> Be accountable for quality, cost, and overall care.
> Have a structure to distribute payments to providers.
> Offer an adequate choice of providers of services and suppliers.
> Perform care coordination, medication reconciliation, discharge planning, transitional care services, and other patient-centered activities.
> Report quality measures for episodes of care including post-acute care.
> Submit data through electronic health records (EHRs).

The pilot program will begin in January 2013 and will run for five years. It will cover services for a number of medical conditions related to an acute care episode, within three days before admission and 30 days after discharge.

Payment for all providers of services will be bundled into a single payment that will be paid to a contracting organization. According to the legislation, that organization must include a hospital, physician group, skilled nursing facility, and home health agency. The contracting organization will be responsible for allocating the payment among all providers. CMS will select the medical conditions that will be part of the pilot, and it is expected that providers will have the option of contracting for one or more of these conditions.

Under the bundled payment pilot, the contracting organization is responsible for the cost of all post-acute care within 30 days of discharge.

The legislation also specifies that the payments to the contracting organization under the pilot may not exceed the amount that those providers would be paid for those same services outside of the pilot. The contracting organization therefore should not expect to see an increase in per episode revenue as a result of participating in this program. The financial benefits must be derived through reductions in internal expenses, lower payments to some providers, and/or reduced utilization or an increased volume of cases. In the ACE demonstration project, selection of the participating hospitals was based on the size of the discount (as a percentage of the historical payment level), as well as an evaluation of the quality of care expected under the proposal.

Opportunities for Sharing Cost Savings Among Providers

The benefits of increased alignment between hospitals and physicians have been well established, and include opportunities for hospital cost reduction and improvements in quality. Methodologies for financial alignment to achieve this level of integration have been stifled by laws and regulations that limit the opportunity to reward physicians for cooperating in reducing costs. The law allows the Centers for Medicare &

Medicaid Services (CMS) to "waive such provisions of this title and Title 19 as necessary to carry out the pilot program." However, until regulations are issued, the level of regulatory flexibility on this issue will not be known.

The ACE demonstration project may provide a model for understanding the pilot program's requirements for sharing savings with physicians, if CMS uses the same approach. The ACE project includes requirements specifying that payments must not be based on the volume or value of referrals; must not induce physicians to reduce or limit medically necessary services; must be based on net savings attributable to the program; and must be linked to actions that improve overall quality and efficiency.

Under the ACE demonstration, organizations implementing "gainsharing" programs have been required to prepare detailed explanations of the approaches physicians might use to create cost savings, the methods for measuring financial gains, the proportion of the gains to be distributed to the physicians, and the process for distributing these physician payments to individual physicians. If the bundled payment pilot follows a similar methodology, these programs would need to be robust, complete, and able to withstand public scrutiny.

Payment to Providers

Because the contracting organization will receive all of the payment for all providers who deliver services under the episode, it must develop a methodology to distribute the payments among these providers. For example, under the ACE demonstration project, the entire payment for hospital and physician services is made to the contracting organization, typically a hospital or health system. Payments by the contracting organization to the physicians have consisted of a fee-for-service payment based on the Medicare fee schedule and a gainsharing payment subject to the regulatory guidelines above. The bundled payment pilot may allow a larger number of payment options.

Potential Cost-Saving Opportunities

The bundled payment pilot offers a number of opportunities for hospitals to accrue cost savings through reductions in actual hospital costs, decreases in length of stay (LOS), avoidance of readmissions, and management of post-acute care. These can occur through physician participation in cost-saving efforts.

Savings in hospital supply costs. In previous Medicare demonstration projects, hospitals achieved numerous cost savings as a result of aligning physician and hospital incentives. Savings were realized through reducing the variety of medical prostheses used and drug substitutions, working carefully with groups of pharmacists and physicians. Many of the savings are likely to be incurred for all such patients, not just Medicare patients, allowing the hospital to leverage the pilot program to achieve savings for all payers' patients in the related service lines.

Reductions in LOS. Reductions in LOS achieved through physician participation are common. In the Heart Bypass Center demonstration, most hospitals reduced LOS in the intensive care unit by one full day, and routine stays by another two to three days, through careful attention to managing the stay.

In addition to saving hospital costs, LOS reductions can free hospital beds, allowing additional admissions under some circumstances.

Reductions in readmission rates. Under the new Medicare rules, hospitals will not be paid for many readmissions. Under the bundled payment pilot, no additional payment would be available to the contracting organization for a readmission within 30 days. Depending on the approach used to pay physicians, they might not be paid by the contracting organization for services related to the readmission. Therefore, the physicians may have a strong incentive to work with the hospital's discharge planning staff, to closely follow post-discharge care, and to take other steps to avoid readmissions.

Management of post-acute care. Under the bundled payment pilot, the contracting organization is responsible for the cost of all post-acute care within 30 days of discharge. There may be some options for reductions of these costs through careful contracting with post-acute providers, insistence on better care protocols from these providers, and steerage of patients to low-cost providers. However, the major opportunities in working with post-acute care providers may be in providing more comprehensive care to avoid readmissions. This approach may actually increase post-acute care costs, but it will help reduce acute care costs.

Costs and Risks of Participation

Participation in the pilot program by a hospital carries some fixed costs and assumption of risks that must be evaluated.

Discounts given to CMS. CMS may seek discounts from the contracting organization that result in a lower payment than the organization's providers would receive outside of the pilot. In the ACE demonstration, participants have agreed to accept a payment from 1 to 6 percent lower than the average expected payment for each DRG. In some instances, this discount is applied to only the hospital payments; in others, it is applied to both the hospital and physician component. When the physician component is discounted, the hospital has chosen to assume the cost of the physician discount as well as the hospital discount. If the pilot operates similarly, the hospital could start with somewhat lower revenue under the pilot program.

Administrative costs of maintaining the organization. The contracting organization may incur significant additional costs. Staff will be required to perform the claims payment functions for all providers, to record and report on the quality measures, to work with physicians on savings initiatives, and many other tasks. Office space,

Examples of Medicare Bundled Payment Demonstration Projects and Their Results

In attempting to understand how this demonstration program would operate, it is useful to review the results of previous similar demonstrations.

Acute Care Episode Demonstration (2009)

The Acute Care Episode (ACE) began in 2009 with five hospitals and involves nine orthopedic and 28 cardiovascular services. The contracted bundled payment has been about 5 percent lower than the equivalent fee-for-service payments for those services. This program provides a financial inducement to beneficiaries to utilize participating hospitals. Although results are not available, early reports indicate that some hospitals have begun gainsharing payments to the participating physicians.

Heart Bypass Demonstration (1991-94)

Of the demonstration projects, the heart bypass demonstration conducted during the early 1990s is the most instructive. In this program, seven hospitals (four originally, three added later) received a single global payment, including outlier payments, for each discharge in diagnosis-related groups (DRGs) 106 and 107. This payment included all hospital and physician services provided throughout the inpatient stay, but did not include services before and after the stay. The payments negotiated between the hospitals and Medicare averaged about 10 percent lower than the equivalent amounts that would be paid outside of the demonstration. This approach created an immediate cost savings to the Medicare program, but also required the hospitals to make up the revenue loss in cost savings to break even.

The financial results for the participants were inconsistent. The two academic hospitals experienced significant declines in variable margins, primarily because of the discounts given to Medicare for the demonstration. These hospitals were not able to create significant cost savings for the programs. By contrast, the nonacademic hospitals were able to significantly increase their variable margins for the services through reductions in LOS, pharmacy costs, laboratory costs, and other costs. Although measurement of quality was not a major part of this demonstration, many of the common quality metrics for heart surgery improved in the demonstration hospitals.

SAMPLE CALCULATION OF NET IMPACT PER CASE UNDER BUNDLED PAYMENT PILOT PROJECT

Provider	Cost
Hospital	$30,000
Physician	$6,000
Home Health, SNF, etc.	$4,000
Total	$40,000

Factor	Scenario 1	Scenario 2	Scenario 3
Total Medicare historical payment	$40,000	$40,000	$40,000
Percentage discount	2.5%	2.5%	2.5%
Amount of discount given	$1,000	$1,000	$1,000
Estimated hospital Medicare cost	$30,000	$30,000	$30,000
Percentage hospital cost savings achieved	2.0%	4.0%	9.0%
Medicare cost after savings	$29,400	$28,800	$27,300
Medicare savings	$600	$1,200	$2,700
Savings from other payers	$300	$600	$1,350
Total cost savings—all payers	$900	$1,800	$4,050
Gainsharing percentage of Medicare savings	25%	25%	25%
Gainsharing payment to physicians	$(150)	$(300)	$(675)
Net cost savings to the hospital	$750	$1,500	$3,375
Allocation of administrative cost	$(500)	$(500)	$(500)
Net overall savings (loss)	$(750)	$0	$1,875

computers, and other infrastructure will also be required.

Potential loss of coinsurance. Contracting organizations may bear the risk of copayment collections. Under the ACE demonstration, participating hospitals are required to make 100 percent of the appropriate fee-for-service payment to the physicians. Deductible and coinsurance payments are made to the hospital by the patient secondary insurance carrier if the patient has such coverage. If not, the hospital is required to bill the patient on behalf of the physician for these amounts, and to accept the risk of nonpayment. This cost and risk may also exist under the bundled payment pilot.

Risks of increases in costs and utilization. If costs and utilization decrease, members of the contracting organization can benefit from those savings. However, if costs or utilization increase, the hospital may be required to absorb those increased costs unless its arrangements with the other providers require them to share in some of the losses. Under the DRG payment system, hospitals are already at risk for hospital costs, but the pilot may extend these risks to payments to other providers who deliver preadmission or post-acute care. For example, if the number of physician consultations were to increase, or if a patient were to require an extended postdischarge stay in a rehabilitation hospital, the contracting organization may be required to pay those additional costs.

Analyzing the Opportunity

The exhibit above shows an example of the financial results of a hospital involved in a bundled payment contract for a particular condition. The total "cost" represents the historical payments

POTENTIAL IMPACT OF ADDITIONAL VOLUME

	Estimate A	Estimate B	Estimate C	Estimate D
Additional admissions	10	25	50	100
Average payment per admission	$30,000	$30,000	$30,000	$30,000
Total additional revenue	$300,000	$750,000	$1,500,000	$3,000,000
Contribution to surplus	$180,000	$450,000	$900,000	$1,800,000

for that condition, which will become the basis for the bid price to CMS.

The exhibit also involves three assumptions. First, the contract will specify the discount from the total Medicare payment (if any), including all providers. In all scenarios, the organization accepts a 2.5 percent discount from the Medicare baseline payments, with the hospital assuming this discount. Second, the payer mix of the episode is assumed to be 50 percent Medicare. Savings are assumed to accrue to 50 percent of the non-Medicare patients for whom the bundled payment discount would not apply. It is assumed that gainsharing payments to physicians would be made only for Medicare patients. And third, the percentage of cost savings shared with physicians is assumed to be 25 percent. In the demonstration, this amount is also likely to be limited to a specified percentage of the physicians' total payment.

Three scenarios are shown. Under Scenario 1, the hospital's cost savings after the gainsharing payments to the physicians do not exceed the discount given to CMS, resulting in a loss to the hospital. In Scenario 2, the hospital achieves a 4 percent reduction in expenses, creating a break-even situation in which the costs of participation are offset by the cost savings achieved. In Scenario 3, the hospital achieves a 9 percent reduction in cost, producing a $1,875 positive impact per case.

Benefits of Increased Volume

Participating hospitals may also experience increased market share for the service lines covered under the pilot program. These increases may occur as a result of patient selection of a hospital with perceived higher quality and a more coordinated set of services for their conditions.

CMS may also elect to provide rebates to beneficiaries who use participating hospitals, as in the ACE demonstration, where CMS has shared half of the contract discount with beneficiaries who have selected participating hospitals. The financial effects of these admissions on the hospitals will depend on the marginal profitability of the services provided to those additional patients.

The exhibit above shows the additional revenue and contribution to surplus of additional admissions in a service line having average payments per discharge of $30,000 and variable costs of 40 percent of the payment.

The Need to Compute an Accurate Price Proposal

Once cost-saving opportunities have been identified and quantified, the next step is to determine a pricing approach that will lead to an acceptable level of profitability. The price should include all of the hospital costs identified above, as well as the amounts paid to all other providers involved in the treatment of the patient, including gainsharing payments to physicians, if such payments are expected.

Determining the payments to nonhospital providers is a critical step and may present unfamiliar challenges to hospitals. In the ACE demonstration, CMS provided historical data to organizations preparing proposals, including the Part B payments made to physicians. Similar data may be made available for the bundled payment pilot.

The variation in cost among patients with specific conditions should also be considered, because it provides an estimate of the risk assumed by accepting a fixed payment to provide a service of

potentially widely varying cost. This level of variability differs significantly among the medical conditions that may be included in the pilot project. In a recent CMS study, the coefficient of variation (which is a standard deviation divided by the mean) of cost for patients with back pain was more than 200 percent, while the coefficient for patients that experienced an acute myocardial infarction (AMI) was less than half of that amount. Therefore, all other things being equal, it would be riskier to participate in a pilot involving back pain than one involving AMI.

However, a condition with high historical variability in costs may represent the greatest opportunity for savings. If the high-cost, lower-quality approaches are shifted to best practices, the results can be improved quality as well as savings. Therefore, it may be helpful to involve physicians early in analyzing data.

Nonfinancial Considerations

Although the financial implications and cost-reduction opportunities of the pilot program will be viewed as the primary drivers of the decision to participate, the program may present other, more significant benefits over the long term. These benefits include the abilities to:

> Create stronger relationships with key physicians to take advantage of other contracting opportunities
> Develop medical best practices programs
> Coordinate care
> Develop effective care teams

Participants in similar programs involving hospitals and physicians have also demonstrated significant increases in quality measures. Although recording quality indicators was not part of the Heart Bypass Demonstration, its participants showed improvements in many of the metrics that were recorded, such as mortality rate and appropriateness of care. These quality improvements have also been noted in other situations involving collaboration between physicians and hospitals to improve quality of care. Because the bundled payment requires comprehensive measurement and reporting of a number of quality measures, there will be greater transparency and quantification of quality under the pilot program, which may work in favor of its participants.

The Medicare bundled payment pilot program may offer significant opportunities to hospitals by extending their ability to work cooperatively with their medical staff to achieve cost savings.

An Opportunity?

The Medicare bundled payment pilot program may offer significant opportunities to hospitals by extending their ability to work cooperatively with their medical staff to achieve cost savings. Opportunities to increase market penetration in the service lines covered by the demonstration may also yield significant financial results. However, careful analysis, preparation, and implementation of aggressive cost-reduction strategies will be necessary to achieve success under these arrangements. ●

About the authors

Jonathan W. Pearce is director, DGA Partners, and a member of HFMA's Philadelphia Metropolitan Chapter (jpearce@dgapartners.com).

John M. Harris is principal, DGA Partners, Bala Cynwyd, Pa., and a member of HFMA's Philadelphia Metropolitan Chapter (JHarris@dgapartners.com).

DGAPARTNERS

MANAGEMENT CONSULTANTS TO THE HEALTHCARE INDUSTRY

PLANNING SERVICES

> Strategic Planning
> Business Planning
> Financial Planning & Modeling
> Mergers and Acquisitions
> Facility Master Planning

PHYSICIAN-HOSPITAL ALIGNMENT

> Medical Staff Planning & Community Needs
> Accountable Care Organizations
> Physician Compensation Design
> Joint Venture Development
> Academic Department Assessment

BUSINESS INTELLIGENCE & OPERATIONS

> Healthcare Business Intelligence
> Business & Functional Requirements for IT
> Payer Contracting
> Managed Care Operations
> PACE Services

VALUATION SERVICES

> Medical Practice Valuation
> Business Valuation
> Physician Compensation Fair Market Value
> Litigation Support

Philadelphia   New York   Washington, DC   www.dgapartners.com
800 241-5268

Reprinted from the September 2010 issue of *hfm*.
Copyright 2010 by Healthcare Financial Management Association, Two Westbrook Corporate Center, Suite 700, Westchester, IL 60154.
For more information, call 1-800-252-HFMA or visit www.hfma.org.