FEATURE STORY

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Medicare bundled payment what is it worth to you?

Bundled payment can represent a tremendous strategic opportunity for a hospital and can result in financial benefits if an organization understands where to best target its cost-reduction efforts.

AT A GLANCE

- Hospital leaders who are contemplating participation in a bundled payment initiative should first assess current circumstances to determine the extent of the opportunity for their organizations.
- Those who have decided conditions are favorable for such an initiative should next perform a financial assessment that includes modeling direct contract results, assessing the financial impact of reduced utilization and of improved clinical care and operations, and evaluating the net financial impact.
- Hospital executives also should understand the competitive and strategic benefits that bundled payment offers.

Bundled payment arrangements are gaining traction with some hospitals, partially due to Medicare's Bundled Payments for Care Improvement (BPCI) initiative. One piece of good news from BPCI is that hospitals can obtain savings from reducing someone else's utilization—specifically that of post-acute care facilities. The fact that savings also may be gleaned from reducing readmissions could be seen as a bonus, although this result must be achieved in any case to avoid Medicare penalties.

Hospitals contemplating participating in the BCPI program should perform an in-depth analysis to determine whether they can benefit from bundled payments and, if so, how to achieve maximum benefits. The analysis should examine the extent to which the participating providers can reduce costs for episodes of care, because success under bundled payment arrangements will depend on achieving such cost reductions.

Particular attention should be given to evaluating opportunities to reduce readmissions and/or skilled nursing facility (SNF) costs (BPCI Model 2). Research suggests that these two areas present the greatest opportunity to reduce episode costs because they not only account for a large percentage of the episode costs, but also exhibit the greatest variation in utilization across the country.[a]

To illustrate key steps for assessing a bundled payment opportunity, we have chosen to focus on Model 2 because it offers the best opportunity for reducing episode costs, and because it helps engage and reward physicians, offering strategic benefits to the sponsoring hospital.[b] It also involves the least amount of administrative effort and encourages hospitals to partner with

a. *Interim Report of the Committee on Geographic Variation in Health Care Spending and Promotion of High-Value Health Care*, Institute of Medicine, March 22, 2013, www.iom.edu/reports (search on key words *healthcare spending*).
b. For information about the CMS BPCI Initiative and its four models, go to innovation.cms.gov/initiatives/Bundled-Payments/index.html.

post-acute care providers to manage care transitions effectively.

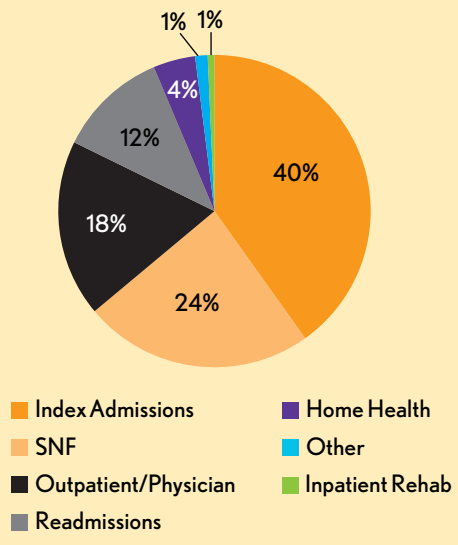
Assessment of the Extent of Opportunity

Identifying whether there is opportunity in bundled payment, and where it lies, requires identifying the types of initial admissions (termed *index admissions*) that offer the greatest potential to reduce SNF and/or readmission costs. Depending on how much cost cutting the hospital has already done, there could be additional benefit from reducing hospital operating costs.

Hospitals that are not actively coordinating care after hospitalization (that is, most hospitals today) are likely to find there is significant potential for improvement in this area. SNF and readmission costs account for 36 percent of the average episode costs. Although many providers have begun to address 30-day readmissions in conjunction with Medicare readmission penalties, SNF costs have been largely unaddressed.

The greatest BPCI opportunity lies with major common conditions—particularly congestive heart failure, major joint replacement, and pneumonia—that are likely to have post-acute episodes of different lengths. The first 30 days after discharge constitute the critical period for generating savings on episode costs. However,

ILLUSTRATIVE COSTS BY SETTING



hospitals choosing bundled payment that includes a 90-day post-acute period can benefit from a lower required discount from the Centers for Medicare & Medicaid Services (CMS)—i.e., 2 percent instead of 3 percent.

When seeking to identify specific conditions that offer savings opportunities, it's important to know the conditions for which SNF care adds substantially to cost and those for which readmissions are most likely. Although SNF care accounts for 24 percent of episode costs, on average, and readmissions account for 12 percent, these proportions vary tremendously by condition. For example, readmissions tend to constitute a higher percentage of costs for care around atherosclerosis, pacemaker device replacements, and medical peripheral vascular disease, whereas SNF costs tend to run higher with diabetes care, care related to hip or knee replacement, and treatment of medical noninfectious orthopedic conditions.

Financial Assessment

Performing a financial assessment is essential to getting a true picture of the financial and strategic impact of bundled payments or any new payment model.[c] A comprehensive assessment of financial results from a bundled payment initiative should consider direct contract results, the financial impact of reduced utilization and of improved clinical care and operations, and the net financial impact. To illustrate the requirements for such an assessment, we will present hypothetical case examples of an organization that is considering pursuing bundled payment for major joint replacement at 90-days.

Direct contract results. The organization should begin the financial assessment by modeling the direct contract results required to meet hospital goals. In this case, the direct contract results are the CMS episode savings.

Our sample BCPI participant will manage 200 episodes annually with a historical 90-day

c. Harris, J.M., and Hemnani, R., "The Transition to Emerging Revenue Models," *hfm*, April 2013.

episode cost of $40,000 each, representing about $8 million in episode costs annually (see the top exhibit below).

The organization wants to ensure that the 2 percent discount ($160,000) and care management and IT costs ($250,000) are covered, but also aims to have modest gain-sharing with physicians. To achieve these goals, it must target a 7 percent cost savings ($560,000).

The organization should then test the feasibility of achieving $560,000 in cost savings, and identify specific opportunities for improvement. In our example, care redesign focuses on shifting costs from higher-cost to lower-cost settings (for instance, from SNF to home health or from home health to home) and eliminating readmissions. Overall, a 20 percent cost reduction would be required in each of four targeted areas to achieve the desired level of savings, as shown in the bottom exhibit below.

To this end, the organization should compare its readmissions and SNF length of stay and costs with industry averages to assess whether a 20 percent reduction seems feasible. The organization could also look at internal variation in readmissions and SNF costs to see whether some physicians might be able to improve their care processes. Engaging physicians in the assessment can help to verify this analysis. Let's assume that, in our example, the

ESTIMATED DIRECT CONTRACT IMPACT

		Total for All Episodes
Number of Episodes	200	
Adjusted Readmissions	100	
Historical Episode Costs (90-Day)	$40,000	$8,000,000
CMMI Discount Rate	2.0%	2.0%
CMMI Discount	$800	$160,000
Target Price	$39,200	$7,840,000
Amount Required to Cover CMS Discount		$ (160,000)
Operating Expenses (Care Management/IT)		$ (250,000)
Targeted Funds Available for Gainsharing		$ (150,000)
Savings Required		$(560,000)
Percentage Savings Required		7%

SIMULATION TO GENERATE 7 PERCENT SAVINGS

	Total Episodes	Percentage Reduction	Number of Episodes	Savings
Reduced SNF Care	100	20%	20	$292,500
Substitution of Home Health for SNF Care			20	(68,250)
Reduced Home Health for Current Home Health Patients	200	20%	40	136,500
Readmissions: Avoided Readmissions	100	20%	20	199,250
Total Savings				**$560,000**
Percentage Savings				7%

organization finds its SNF usage and readmissions are higher than average. Given that 20 percent savings is aggressive, the participant should next consider what it would take to achieve breakeven results (see the exhibit below).

Chances are that most providers will find that the direct contract results of bundled payment are breakeven or slightly positive at best. Although there is a risk of experiencing downside losses if savings are not achieved, this risk can be managed through selection of episodes where the participant has a good expectation of being able to reduce costs. Assuming direct contracting results are near breakeven, the organization should consider the impact of other financial and strategic factors.

Financial impact of reduced utilization. The impact of utilization shifts on BPCI participants will differ depending on whether they own a skilled nursing unit or facility. Participants in model 2 will reduce SNF volume, so this model is likely to be most appealing to hospitals that do not own SNFs, because they can reduce episode costs without reducing the health system bottom line.

The impact of BPCI on hospital revenues also will vary depending on whether readmissions occur at the participating facility. Nationally, most readmissions do occur at the same facility as the index admission, so if readmissions are reduced, then the hospital participant will experience the full benefit. Better coordination of care can ensure that the remaining readmissions that are necessary now occur at its facility instead of another hospital.

Again, modeling is important to teasing out the most likely impact on revenues. In our example, we assume two impacts: readmissions decrease by 20 percent from historical levels during the performance period through increased care coordination efforts, and readmissions occuring at the same hospital increase from 70 percent to 80 percent.

In this example, the participant hospital would lose $42,000 based on six fewer readmissions and the fixed costs associated with those readmissions (see the exhibit on page 5).

Financial impact of improved clinical care and operations. It is possible that the bundled payment initiative will result in improvements in care and operations, such as reductions in hospital-acquired infections and complications, or in cost reductions from decreased duplication of services and/or supply standardization. In the past, hospitals with independent medical staffs may have had difficulty engaging physicians in developing pathways and standards of care; however, if physicians understand that they could share in the savings derived from improved quality of care and reduced costs, they are likely to be more amenable to participating in such endeavors.

Several factors will influence whether operational savings can be generated:

> The extent to which the hospital has already succeeded in making significant operational improvements (no more low-hanging fruit)

SIMULATION FOR BREAKEVEN RESULTS

	Total Episodes	Percentage Reduction	Number of Episodes	Savings
Reduced SNF Care	100	15%	15	$225,000
Substitution of Home Health for SNF Care			15	(52,500)
Reduced Home Health for Current Home Health Patients	200	15%	30	105,000
Readmissions: Avoided Readmissions	100	13%	13	132,500
Total Savings				**$ 410,000**
Percentage of Breakeven Achieved				100%

IMPACT OF READMISSIONS REDUCTION

	Total Readmissions	Sponsoring Hospital	Average Payment	Hospital Payments
Historical	100	70	$10,000	$700,000
Under Bundled Payments	80	64	$10,000	$640,000
Impact on Readmissions				$(60,000)
Variable Cost Percentage				30%
Total Readmission Impact				$(42,000)

> The hospital's performance compared with external benchmarks
> The amount of internal variation
> The scale of the initiative (with more episodes being more likely to impact overall hospital cost structure)
> The care redesign plan

For modeling purposes, we assume $500 can be saved on each of the 200 episodes through supply standardization and LOS reduction efforts. The amount of savings may be much higher or lower depending on what actual operational efficiency efforts have already been achieved with respect to relevant MS-DRGs.

Hospitals may also benefit from a bundled payment initiative by avoiding readmission penalties. However, the overall impact for a participant engaged in only one episode may be slight. In this model, we assume zero impact in reducing or affecting readmission penalties, although readmission penalties for major joint conditions are expected by 2015 and the performance period would occur from 2014 to 2016.

Net financial impact. At this point, after having addressed the three more quantitative aspects of the financial impact of a bundled payments initiative on a hospital participant, the hospital can consider the likely net financial impact. In our example, assuming a 7 percent savings can be achieved, a hospital participant is likely to reach breakeven and/or create a modest savings pool to be shared with the physicians (see the upper exhibit on page 6). Pooling positive effects related not only to the direct contract, but also to any operational savings may increase the liklihood of having funds to share with physicians.

Although the financial benefits to both parties are somewhat limited, the hospital may also be able to gain significant competitive and strategic benefits from pursuing bundled payment. The hospital therefore should consider these aspects of the opportunity before finalizing its decision about pursuing a bundled payment initiative.

Competitive Benefits

Some hospitals may be interested in bundled payment as a way to respond to increasing value-based payment in a market, using a model that does not require as much change as accountable care. A potential hospital participant may see bundled payment as a strategy to ensure competitors are not actively encroaching on its market share. A hospital that engages in bundled payment more extensively (e.g., more than 10 episodes) can improve its chances of holding its own against competitor initiatives.

More narrowly, a bundled payment initiative also can be an effective competitive response for key, profitable service lines, particularly where a hospital has an independent medical staff and wants to retain key or loyal physicians. Many such bundled payment initiatives focus on orthopedic and cardiac care and highly profitable procedures.

Will the potential savings from both internal and episode savings be enough to ensure physician participation? The answer depends on the extent

NET REVENUE IMPACT

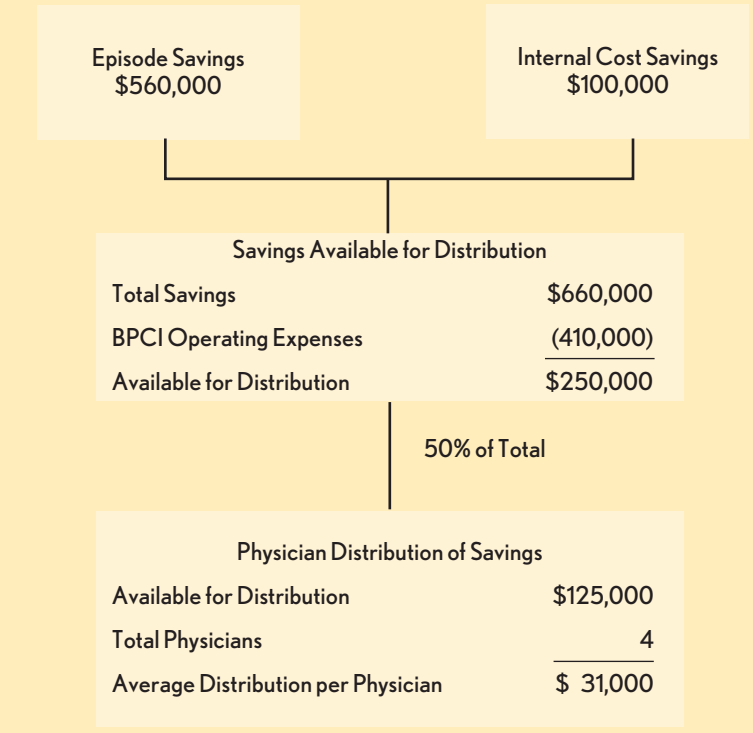
	Hospital	Physicians
Direct Contract	$ 75,000	$ 75,000
Volume/Market Share	(42,000)	
Clinical Care/Operational Improvement	50,000	50,000
Total Impact	$83,000	$125,000

to which physicians have taken a leadership role in redesigning care and have been willing to increase their focus on managing costs across episodes in bundled payment arrangements. Under such circumstances, the physicians will probably have had to yield some autonomy and rely more on protocols and pathways to help determine the next level of care. The hospital also will need to perform more measurements and comparisons and focus on quality of care, not only in the initial hospitalization, but also in post-acute settings.

Moreover, physicians may not regard gain-sharing distributions alone as sufficiently attractive to compel them to participate, so it is important that they also understand the other aspects of the opportunity.

With waivers for certain fraud and abuse laws available for those piloting this initiative, it is possible to share not only in the episode savings, but also in the hospital internal operating cost savings. With modest costs savings, physicians may realize only modest distributions, such as is shown under our scenario in the exhibit at left. Nonetheless, the arrangement is risk-free for most physicians, and if incremental operational savings and episode savings are achieved, it is a win. Although there are restrictions under BPCI to ensure that the distributions do not exceed 50 percent of the physicians' previous year's fee-for-service revenues, it is unlikely that this level of distributions can be achieved.

IMPACT OF BCPI AND INTERNAL COST SAVINGS ON DISTRIBUTIONS TO PHYSICIANS



Strategic Benefits

Overall, bundled payment requires a lot of work to get physicians on board, redesign care, enable data and information sharing solutions, and administer gain sharing. So why would a hospital choose to enroll? There are several compelling strategic benefits.

Carryover benefits. The hospital may be engaged only in Medicare bundled payment, but once physicians are on board, the physicians will be more inclined to implement operational and quality improvements for patients with other insurance as well. For example, orthopedic surgeons associated with this initiative may consider bringing patients now being admitted to other hospitals to the participating hospital, whether to simplify their practice or because they appreciate the coordinated system of care being extended to patients beyond the bundled payment initiative.

Positive patient reaction. Traditionally, the link between hospital care and post-acute care has tended to be weak, making it difficult for patients to navigate a complex healthcare environment. Patients may appreciate a more seamless care network, building the hospital's reputation as a center of excellence for care of a particular condition.

Good partners. Hospitals that are engaged in bundled payment initiatives are more likely to be good partners for accountable care organizations, narrow network arrangements, and self-insured entities. As low-cost providers focused on operational excellence in managing episodic care, such hospitals can position themselves to effectively manage the cost of care for these networks, where transitions of care and readmission reduction programs are emphasized.

Readiness for new payment models. Hospitals that participate in bundled payment will be developing a recipe for successful care coordination that includes managing costs while maintaining or improving quality. It takes time to master these processes, so hospitals that have participated in BPCI will have a head start on adopting the requisite best practices in their own institutions should bundled payment be rolled out globally. Having physicians and clinical leaders who have expertise with bundled payment will be useful in ensuring success on a broader scale.

An Opportunity Well Worth Considering

The direct financial benefits of a bundled payment initiative may be breakeven or a slight win for hospital participants, at best. However, the competitive and strategic benefits may make participation worthwhile. A focused bundled payment initiative is an opportunity to "dip one's toe in the water" of payment change without significant implications for the hospital's volume or market share while still aligning with physicians.

The opportunity for participating physicians is greater, especially if both post-acute costs (read: missions and skilled nursing) and internal clinical and operational costs can be addressed.

Bundled payment requires real culture change, even if it is focused within a fraction of the total care provided by hospitals. Hospitals and physicians will need to work together more closely not only to address clinical and operational costs in the hospital, but also to address the costs of care across an episode of 30 to 90 days. They will engage more closely with post-acute providers, such as skilled nursing, to focus on readmissions, skilled nursing LOS, and transitions of care to home and the community.

With everyone watching the care process, better quality and lower cost care just might be achieved. Because CMS already has the legislative authority to roll out bundled payment more broadly, it is wise to be prepared. Thus, whether or not hospitals choose to participate in bundled payment now, they should be watching bundled payment participants and considering what steps they would need to take in the event of a broad roll-out. ●

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