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Breaking Even Under Medicare Bundled Payments

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To emerge successful from CMS's bundled payment pilot, hospitals and physicians have to select the right bundles where cost savings and/or market share growth opportunities exist.

Bundled payments are the talk of the town. Numerous providers, from community hospitals to national systems, have submitted letters of intent to participate in the Medicare demonstration. However, few organizations are thinking strategically about improving margins as they prepare for these demonstration projects, nor are they adequately preparing to take on the increased risk.

In this article, we focus on the Centers for Medicare & Medicaid Services (CMS) **bundled payment models 2 and 4** because these pilots are specifically related to a targeted set of DRGs. As we will demonstrate, hospitals and physicians must understand the potential risks as well as the benefits of participating in these CMS demonstration projects. To succeed, you need to engage in a detailed analysis to determine which bundles hold the best possibility of breaking even financially—and you must buckle down for serious cost containment efforts to achieve afford .

Potential Benefits

Previous bundled payment pilots have been successful in reducing Medicare spending on episodes of care, including the frequently referenced five-year Medicare Heart Bypass Center Demonstration project that saved Medicare roughly 10 percent versus expected (Cromwell, et al., "Medicare Participating Heart Bypass Center Demonstration," Health Economics Research, July 1998). However, 86 percent of Medicare's savings were generated through negotiated discounts across Part A and Part B payments, while only 5 percent of savings were generated through lower than expected spending on post-acute care. In addition, 9 percent resulted from shifts in market shares to lower cost facilities.

The Bundled Payments for Care Improvement Demonstration project:

- Requires a minimum 2 percent to 3 percent discount on Part A and Part B services
- Permits providers to select the DRGs that best fit their unique circumstances
- Permits providers to develop a physician gain-sharing model with up to a 50 percent increase in professional fees to share in cost savings achieved

- Permits flexibility to providers in selecting and designing the bundles, including the option to include post-discharge services in the bundle and proposing a risk adjustment methodology

The high level of interest demonstrated by providers in Medicare's Bundled Payments for Care Improvement initiative is correlated with the increased pressure to align physician and hospital incentives. Participation in the demonstration gives providers a vehicle—gain-sharing—to align incentives with the goals of reducing cost, rewarding hospitals and physicians for reducing unnecessary readmissions, and improving care coordination through post-acute settings of care.

Breakeven Scenarios

It is important that providers define their strategic goals as they evaluate their participation in the pilot and have a solid understanding of what is required to break even on margin. To get an idea of the level of cost containment or volume growth required, we conducted a sample breakeven analysis (see the exhibit below).

				Scenario 1:	**Scenario 2:**
		Current State*	Gain Share Max±	Maintain Margin via Cost Reductions	Maintain Margin via New Volume
Facility Per Case Bundled Cases	Bundling Volume	328	328	328	381
	Bundling Allowed	$32,359	$31,388	$31,388	$31,388
	Bundling Cost	$40,102	$40,102	$37,562	$36,488
	Gain share to MDs		$1,569	$1,569	$1,569
	Bundling Margin	**($7,743)**	**($10,283)**	**($7,743)**	**($6,670)**
Physician Per Case	Bundling Allowed (assume10% of facility)	$3,236	$3,139	$3,139	$3,139
	Bundling Gain share		$1,569	$1,569	$1,569
	Bundling Total	**$3,236**	**$4,708**	**$4,708**	**$4,708**
Facility Total	Bundling Allowed	$10,613,752	$10,295,339	$10,295,339	$11,952,302
	Bundling Cost	$13,153,456	$13,153,456	$12,320,276	$13,894,391
	Bundling Gain share to MDs	$0	$514,767	$514,767	$597,615
	Bundling Margin	**($2,539,704)**	**($3,372,884)**	**($2,539,704)**	**($2,539,704)**

This analysis illustrates that providers would need to achieve significant cost reductions or volume growth to break even. Hospitals will need to reduce variable costs by about 15 percent (from $14,036 to $11,496 in the example shown in the exhibit). These substantial savings are needed to cover the 3 percent discount on Medicare fees and to fund payment to physicians within the gain-sharing opportunity at the maximum payout.

Alternatively, hospitals will have to grow volumes by approximately 20 percent, assuming 65 percent of current state costs are variable.

This sample financial model exercise underscores a few important facts.

- Providers should select services where they are comfortable that variable costs can be reduced by more than 10 percent
- Providers should focus on ensuring a clear "line of site" between cost savings and gain-sharing so that the gain-sharing pool can be funded by improved efficiencies
- It is highly unlikely that providers can grow their way to neutrality

The Right Bundles

While providers have given considerable attention to thinking through the technical details of designing a bundle payment (e.g., definitions, risk adjustment, episode time windows, etc.), the analysis above illustrates that selecting the right bundles for the Medicare initiative is the foundational step required to be successful. Selecting bundles where it is likely that providers can achieve 15 percent to 20 percent variable cost savings and/or 20 percent volume growth should be a prerequisite for including services in the pilot.

Providers must spend the time at the beginning of their bundled payment analytics to identify such services and to map out the path towards achieving such goals. We recommend six specific steps to identify the services that will be considered for inclusion in the Medicare bundling initiative.

1. Analyze three-year volume trends by episode versus competitors and the overall market
2. Benchmark current per unit costs to competitors
3. Benchmark current per unit cost variation on internal data
4. Identify cost drivers resulting in current cost position and variation
5. Quantify savings opportunity and compare estimated spend related to gain sharing
6. Work with physicians to understand current variation in performance and to create a plan to standardize care processes and pathways

This level of detailed analytics is essential for both selecting episodes to include in the pilot and to getting physician buy in that cost savings can be achieved through standardizing the care delivery model.

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