USING BUNDLED PRICES AND DEEP DISCOUNTS TO OBTAIN MANAGED CARE CONTRACTS: SELLER BEWARE

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In an effort to obtain managed care contracts for new patients, many hospitals with excess capacity discount their prices, sometimes by significant amounts. Unless its contract is carefully structured so as to include special provisions for both payers and patients, however, a hospital engaging in discounting could find itself in considerable financial difficulty.

To illustrate the dilemma, consider the case of Boston University Medical Center Hospital (BUMCH). Several years ago, to obtain a contract with a managed care payer in New Hampshire, BUMCH offered a "bundled price" (i.e., a price that includes both hospital and physician charges) for each of six cardiology DRGs. As Exhibit 1 shows, BUMCH discounted the combined total of its hospital and physician charges by approximately 50 percent.

Exhibit 1. Bundled Prices for Six Cardiology DRGs versus Historical Physician and Hospital Charges and Hospital Costs

	DRG 104	DRG 105	DRG 106	DRG 107	DRG 112	DRG 124	DRG 125
Bundled Price	$37,260	$24,100	$27,442	$17,707	$10,463	$4,500	$4,500
Physician Charges							
Cardiology	$ 300	$ 300	$ 1,700	$ 250	$ 2,500	$1,300	$1,000
Cardiothoracic	8,250	8,250	6,000	6,000	NA	NA	NA
Anesthesiology and Radiology	1,500	1,500	2,000	2,000	1,000	1,000	1,000
Total	$10,050	$10,050	$ 9,700	$ 8,250	$ 3,500	$2,300	$2,000
Plus Hospital Charges	64,689	43,820	41,631	30,474	14,123	6,697	4,867
Total Charges	$74,739	$53,870	$51,331	$38,724	$17,623	$8,997	$6,867
Bundled Price % of Total	49.9	44.7	53.5	45.7	59.4	50.0	65.5
Hospital Costs							
Direct	$21,545	$14,807	$15,133	$ 9,682	$ 5,194	$2,753	$1,524
Indirect	17,354	9,465	13,420	8,025	4,990	2,753	2,105
Total	$38,899	$24,272	$28,553	$17,707	$10,184	$5,506	$3,629

DRG 104 -- Valve Replacement with Catheterization*
DRG 105 -- Valve replacement without Catheterization*
DRG 106 -- CABG with Catheterization*
DRG 107 -- CABG without Catheterization*
DRG 112 -- PTCA#
DRG 124 -- Catheterization, Unilateral#
DRG 125 -- Catheterization, Bilateral#

* Include Cardiology, Cardiothoracic Surgery, Anesthesiology and Radiology
\# Include only Cardiology and do not require anesthesia

At that time, because physicians were collecting only about 50 percent of their charges, the bundled price for each DRG barely covered their *collected* fees and the hospital's direct costs, leaving little contribution to the hospital's indirect costs, as shown in Exhibit 2: Why would BUMCH agree to such an arrangement?

Exhibit 2. Contribution and Overall Profit (Loss) per DRG

	DRG 104	DRG 105	DRG 106	DRG 107	DRG 112	DRG 124	DRG 125
Bundled Price	$37,260	$24,100	$27,442	$17,707	$10,463	$4,500	$4,500
Less:							
50% physician charges	5,025	5,025	4,750	4,125	1,750	1,150	1,000
Hospital direct costs	21,545	14,807	15,133	9,682	5,194	2,753	1,524
Total	$26,570	$19,832	$19,883	$13,807	$6,944	$3,903	$2,524
Contribution	$10,690	$4,268	$7,559	$3,900	$3,519	$597	$1,976
Less:							
Hospital indirect costs	17,354	9,465	13,420	8,025	4,990	2,753	2,105
Full cost profit (loss)	($6,664)	($5,197)	($5,861)	($4,125)	($1,471)	($2,156)	($129)

BUMCH's rationale lay in part on its desire to obtain additional market share, but also on its recognition that, because it had excess capacity, it would incur only the variable portion of its direct (and indirect) costs, Variable direct costs included drugs, medical supplies, medical devices (such as a valve), and a few other miscellaneous items. Since the HMO was proposing to send only 20 patients each year, BUMCH knew that it could absorb the incremental volume without the need to hire additional nurses and technicians, or to incur other step-function or fixed costs. Its incremental indirect costs were negligible, including such relatively trivial items as meal ingredients, cleaning solvents, and laundry soap. When the contribution analysis was performed in accordance with variable costs, the results approximated those shown in Exhibit 3.

Exhibit 3. Contribution Using Variable Costs Only

	DRG 104	DRG 105	DRG 106	DRG 107	DRG 112	DRG 124	DRG 125
Bundled Price	$37,260	$24,100	$27,442	$17,707	$10,463	$4,500	$4,500
Less:							
50% physician charges	5,025	5,025	4,750	4,125	1,750	1,150	1,000
Variable costs*	8,000	7,000	7,000	6,000	2,000	1,000	1,000
Total	$13,025	$12,025	$11,750	$10,125	$3,750	$2,150	$2,000
Contribution	$24,235	$12,075	$15,692	$7,582	$6,713	$2,350	$2,500

* Author's estimate based on interviews with cardiologists and cardiothoracic surgeons.

Seen in this light, the apparent "losing" proposition seems like an extraordinarily good deal. And it quite likely would be if it could stand alone, restricted to only the 20 incremental patients. But what happens when other payers, many of which have considerable purchasing power, learn of this arrangement and want similar charges? What happens when this so-called incremental business morphs into the hospital's full book of business? Not only would all of the direct costs now be applicable but so too would the indirect costs. The short-term dream would become a medium-term nightmare.

A PARALLEL SCENARIO

This nightmarish scenario is not unlike a situation that TWA faced many years ago when it introduced its "Fly America" program—a scheme designed to attract vacation and leisure travelers with highly discounted fares. TWA's reasoning was similar to BUMCH's—to fill its unused capacity, and, in so doing, to incur only the variable costs of the incremental passengers.

Much to its chagrin, TWA discovered that many of its business travelers—who otherwise would have paid a full fare—began to use the Fly America program. What TWA thought was going to be incremental business turned into almost all of its business. This fiasco and similar ones in other airlines, led to the realization that a discounted fare needs to be accompanied by a set of conditions that cannot be met easily by existing full fare passengers. Airline discounts now are accompanied by a variety of "strings," such as required Saturday night stays, advance purchases, minimal refund potential, and so forth.

TRANSITION TO HEALTH CARE

Healthcare discounting poses a conceptually identical problem—a provider that offers a discount to a managed care plan, needs to create a set of conditions that cannot be met easily by other purchasers. What might these be?

Some are obvious, and parallel those in the airline industry. Advance scheduling for non-urgent procedures is an example. Requiring admissions to take place on a hospital's slow day (if there are slow days) is another. As is, say, conducting pre-procedure blood tests, and x-rays on an outpatient basis. Similarly, in the case of some orthopedic procedures, research has shown that the length of stay can be shortened if certain rehabilitation activities, such as stretching, begin well in advance of the inpatient admission. Some or all of these can be required by the hospital in exchange for a discounted price.

Every hospital needs to develop its own set of conditions based on factors such as its staffing patterns, slow days, capacity constraints, and others. Importantly, the conditions need to be cost reducing or cost avoiding; otherwise, they have little value. For example, by requiring, say, advance scheduling, a hospital must be able to eliminate or reduce its need to use agency nurses to supplement its full-time nursing staff.

Ironically, this is nothing new. Some 30 years ago, the Massachusetts Eye and Ear Infirmary (MEEI) developed a scheduling system based on a nursing acuity study that identified the level of nursing care needed on each day of stay for each of several dozen procedures. Physicians who called the hospital to schedule a non-urgent admission were given a date several weeks later. Overall, admissions were scheduled in such a way that the total acuity level of nursing care remained relatively constant for the hospital as a whole. from one month to the next, and

there was virtually no need to use agency nurses. For MEEI, this represented some significant cost savings, as well as greater consistency and continuity of patient care.

Advance scheduling and pre-admission rehabilitation activities are the low-hanging fruit. There no doubt are a variety of other cost-saving conditions that a hospital could create in exchange for incremental business at discounted prices.

In addition, there are several key issues that need to be included in contract negotiations. One of these concerns related services and readmissions. Does the contract include outpatient follow up? Home health services? Readmissions for complications? Similarly, what provisions does the contract include for patients with complications and comorbidities, and other matters that add to costs but are outside the control of the hospital and its physicians? Should the contract include a stop loss provision for patients whose severity exceeds some predetermined level? If so, the conditions that define an "outlier" must be specified.

NEW ROLE FOR THE MEDICAL STAFF

A hospital's medical staff is essential to the success of a bundled-price contract. Prior to undertaking its detailed negotiations with a managed care provider, a hospital's senior management first must assure itself that the medical staff is prepared to be part of the collaborative patient-management process. It then needs to identify the physicians who will be treating the new patients, and incorporate their thinking into the development of the contract's provisions. Physicians no doubt will have a variety of ideas and concerns that can help the negotiating team to assure itself that incremental business at discounted prices does not become the hospital's full book of business.

But including physicians in the contract *negotiations* is only a first step. If a bundled price contract is to be successful, a hospital's senior management team must find way to make sure the hospital's incentives are aligned with those of the physicians. There are several issues that it will encounter in undertaking this task.

Dividing the Pot

When there is no bundled price contract, physicians bill the managed care plan (and other payers) separately from the hospital. Under bundled pricing, only one bill will be sent, thereby creating a zero-sum game. How much of the total fee should go to the physicians and how much to the hospital? In effect, the hospital's physicians, instead of negotiating rates with the insurer, now must negotiate them with the hospital. These negotiations could become quite contentious.

Moreover, the hospital must recognize that, under bundled pricing, its physicians will be taking much greater risk than previously. Previously, physicians could bill a managed care plan for each unit service provided (e.g., a procedure or visit), with some considerable assurance that a payment, although discounted, would be forthcoming. With bundled pricing, no such assurance exists. As a result, the hospital and its medical staff may need to develop a separate pool of funds to be shared if the overall effort is successful.

Determining the size of this pool and the criteria used to divide it between the hospital and the medical staff, and then among the involved physicians, will be complicated. For example, if the average length of stay declines by, say, a half a day, should the associated savings accrue entirely to the medical staff? If so, which physicians should receive the credit?

Defining Eligible Physicians

Which physicians will be eligible for compensation from the physician pool. As Exhibit 1 indicates, the physician fees at BUMCH were those for cardiologists, cardiothoracic surgeons, anesthesiologists, and radiologists. What about pathologists? What if a consult is needed with, say, a pulmonologist or a endocrinologist? If these matters are not spelled out in advance, there no doubt will some serious difficulties in managing the contract. (Alternatively, the hospital could argue in its negotiations with the managed care plan that the bundled price contract should exclude the fees of certain specialists, which could be billed separately.)

Managing the Physician Pool

Should the medical staff be asked to manage the physician pool? If so, which physicians should do so, and what kind of latitude will they have. Will they, for example, be allowed to negotiate with, say, the radiologists in another hospital to do film reading if they can get a better price. Similarly, if they can get a better price at a freestanding laboratory from that charged by the hospital's pathologists, will they be allowed to send lab tests outside the hospital for processing, rather than use the hospital's pathology lab?

If those charged with managing the physician pool have this sort of latitude, there is the potential for some cost savings. However, these savings cannot be realized without staffing reductions. If, for example, radiology films are read in another facility, the workload of the hospital's radiology staff will decline, resulting in a potential reduction in the radiology staff. Will the hospital and its chief of radiology be willing to bite this bullet?

Performance Incentives

In addition to agreeing on a price structure with its physicians, a hospital's senior management team also must design a performance measurement system. The system must provide incentives to both control costs and maintain quality of care. As discussed above, one possible approach is to designate a portion of the bundled price as an incentive pool, to be shared between the hospital and the medical staff based on meeting predetermined financial and non-financial performance targets.

The development of such a system relies, in large measure, on the ability of the hospital's accounting staff to identify the costs associated with the patients treated under the bundled price contract. Unfortunately, many hospitals do not have accounting systems that can make the requisite computations. Yet without an ability to make these computations, the division of the incentive pool no doubt will pose another contentious issue.

GUIDELINES AND STRATEGIES

In principle, the use of a bundled price contract with a managed care plan has considerable potential to align the incentives of the medical staff and the hospital. Both parties can focus on the resources used to treat patients during their inpatient stay, their timely discharge, and appropriate post-discharge activities. However, to achieve the potential of bundled pricing, a hospital and its medical staff must keep four factors in mind.

Balancing Risk, Reward, and Control

To take on risk because there is potential for substantial rewards, without the ability to maintain some reasonable control over the elements that comprise the risk is a recipe for disaster. Similarly, to assume risk, and have the ability to control it, but not be rewarded appropriately for managing it, is absurd.

Aligning Responsibility with Control

Unless the hospital's senior management clearly divides patient care responsibilities, it will have difficulty performing successfully under the contract. For example, the medical staff is responsible for the length of stay, but the hospital's departmental directors are responsible for the cost of each day of stay (for housekeeping, dietary, laundry, and so forth). The costs associated with each must be clarified so that performance can be measured.

Linking Costs and Features

Senior management must make sure that the discounted rates are matched with a set of cost-saving conditions (such as scheduled admissions). Otherwise, it may find that successful performance with the incremental patients is insufficient for long-term financial viability. In effect, senior management must design a set of features so that it can assure itself that not all managed care plans can obtain the same pricing structure as that used for the incremental patients.

Developing Appropriate Information

Finally, the hospital's accounting staff must be able to provide its attending and other physicians with transparent accounting of the relevant costs. This means much more than a *willingness* to provide that information (which will be a change for some hospitals), but also an *ability* to provide it. Many hospital accounting systems are not up to the task, which will lead to considerable frustration among members of the medical staff charged with managing resource utilization. For example, most hospitals use ratios of costs to charges to determine the cost of a test or procedure, but this produces extremely misleading information for patient clusters below the DRG level.[1]

SUMMARY

Bundled pricing is intuitively appealing as an approach to simplify a hospital's pricing to managed care payers. Moreover, designed properly, it can help to align the incentives of the medical staff with the hospital overall. However, there can be many slips between the bundled-price cup and the performance lip. Unless a hospital and its medical staff pay attention to these potential slips, what seems like a panacea may turn out to be a disaster.

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[1] For additional discussion of this matter, see "On the Folly of Using RCCs and RVUs for Intermediate Product Costing," *Healthcare Financial Management*, April 2007