

BUNDLED PAYMENT: NATIONAL PILOT PROGRAM AND NEW INITIATIVE

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Since the Center for Medicare and Medicaid Innovation (CMMI) announced their Bundled Payments for Care Improvement Initiative on August 23, the Health Dimensions Group (HDG) team has witnessed a flurry of interest across acute and post-acute care providers. CMMI's Models 2 and 3 and the National Pilot Program on Payment Bundling offer post-acute providers a variety of options for entering risk-based contracts with CMS that promote the organization's "Triple Aim" of improved patient outcomes and experiences, effective population health management, and lower costs. A summary of these two programs is detailed below.

Overview of Medicare and CMMI Bundled Payment Programs

	National Pilot Program on Payment Bundling	CMMI's Bundled Payments for Care Improvement Initiative
Key Dates	January 1, 2013 launch; CMS has not yet released further details	<ul style="list-style-type: none"> • LOI due October 6 and November 4, 2011 for Model 1 and Models 2-4, respectively • Application due November 18, 2012 and March 15, 2012 for Model 1 and Models 2-4, respectively
Eligible Participants	Acute care hospitals and health systems, physician groups and post-acute care providers	<ul style="list-style-type: none"> • Model 1 and 4: Acute care hospitals and health systems, physician practices, physician-hospital organizations, conveners of health care providers • Model 2 and 3: Model 1 and 4 participants and Medicare-certified post-acute providers (IRFs, SNFs, LTACHs and HHAs)
Bundle Definition	Three days prior to acute admission, acute care stay and 30 days following discharge	<ul style="list-style-type: none"> • Model 1: Acute care admission through discharge • Model 2: Acute care admission through minimum of 30 days post-discharge • Model 3: Acute care discharge through period specified in application • Model 4: Acute care admission through discharge
Reimbursement Methodology	Acute care hospitals will "bid" for bundle by discounting IPPS rate	<ul style="list-style-type: none"> • Model 1: Discounted IPPS payment • Model 2 and 3: Retrospective comparison of target price (proposed in application) and FFS payments • Model 4: Prospective payment set by CMMI
Targeted Conditions	Eight conditions that will likely include a mix of medical and surgical MS-DRGs and acute and chronic illnesses; selected MS-DRGs will have high variation in readmissions and costs	<ul style="list-style-type: none"> • Model 1: All MS-DRGs • Models 2 through 4: Applicants to propose MS-DRGs
Quality Measures	Not yet specified	Initially proposed by applicants; CMS will ultimately establish a standardized set of measures aligned with metrics used in other CMS quality improvement initiatives

Although the bundled payment **pilot** begins January 1, 2013, the CMMI bundled payment **initiative** starts with letters of intent due November 4, 2011, for acute/post-acute or post-acute models (Models 2 and 3 respectively). Then the organization has until March 15, 2012, to develop its proposal for the model it wishes to pursue.

Is there a first mover's advantage?

The prospect of accepting risk through CMMI's bundled payment program is undoubtedly daunting for a number of providers. However, closer examination reveals that the financial downside is relatively manageable compared to other reforms, such as Medicare's Shared Savings Program. Further, the steps needed to succeed under the bundling initiative are almost fully aligned with those needed under other payment models gaining in dominance such as accountable care organizations (ACOs), global payment, and value-based purchasing. All require implementation of evidence-based clinical pathways for prevalent chronic illnesses; effective cost management; optimized care transitions with physicians and hospitals; efforts to increase patient self-management; use of information technology to promote care coordination across settings; and a methodology for ensuring the patient is consistently placed in the most cost-effective care setting.

Though many post-acute providers are considering pursuing these actions, uncertainty surrounding the pace of payment and delivery system reform has left many stalled in the planning stage. CMMI's initiative provides progressive stakeholders with the ammunition needed to jumpstart change as successful applicants must have the aforementioned actions implemented by March 15, 2012. After passing this hurdle, early reformers will have their choice of hospitals to develop preferred provider networks to secure future referral volume, enter value-based contracts with health plans that encompass financial rewards for

improved performance and lower costs, and pursue other opportunities to enhance financial return on their investment in reform.

Along with the potential strategic rewards of bundled payment comes financial risk. Fortunately, the degree of risk conferred to providers under CMMI's Models 2 and 3 is minimal and manageable for those who are adequately prepared. Providers must propose a discount from current fee-for-service payments that will ultimately be reconciled with the fee-for-service charges to determine the financial reward due to the provider or overage that must be paid to CMS. This approach penalizes those who fail to accurately assess historical costs for a service bundle, implement care delivery reforms, and estimate the cost savings these reforms will yield to ensure the discount proposed is a feasible target.

Imperatives for Success for Post-Acute Bundled Payment

Since CMMI's announcement of a November 4 deadline for letters of intent and information requests for Models 2 and 3, the HDG team has served as a thought partner for a myriad of clients assessing their readiness to accept risk. The conversations have been insightful not only for our provider partners but for our team as well. Despite idiosyncratic differences across markets, a number of common imperatives for success have emerged that should frame any providers' approach to bundled payment. While providers should give themselves as much leeway as possible in terms of partners, included Medicare severity diagnosis-related groups (MS-DRGs), episode length, and discount rate in the letter of intent (LOI), the actual application will require robust analysis to create a specific bundle that can be effectively managed to minimize variance in cost and quality outcomes.

As your organization prepares its application for CMMI's initiative, we invite you to review our findings below and share any comments or questions you may have by contacting Kathleen Griffin at KathleenG@hdgi1.com or Sarah Katz at SarahK@hdgi1.com.

IMPERATIVE #1 – Conduct a rigorous assessment of partners prior to LOI submittal and the application deadline

Post-acute providers – unlike acute care hospitals under Models 1 and 4 – must partner with hospitals, physicians, and complementary post-acute providers (e.g., a standalone skilled nursing facility [SNF] provider must secure Medicare certified home health, inpatient rehabilitation facility [IRF], and long-term care hospital [LTACH] services) to effectively manage costs within a service bundle. HDG has noted significant variation in how prepared providers are. While we recommend listing a wide variety of potential partners for the LOI, a rigorous assessment of partners should be conducted prior to submitting the actual application on March 15, 2012, to ensure each is as committed to managing costs through implementation of evidence-based care pathways, enhanced care coordination, and patient engagement. Failure of just one provider to effectively manage a care under a bundled payment scenario will have a negative financial impact on all providers included as awardees in the bundled payment application.

IMPERATIVE #2 – Select MS-DRGs with existing evidence-based protocols proven to minimize variations in cost and clinical outcomes

Given the short time frame between the LOI submission and application deadline, post-acute providers have limited time to independently develop clinical pathways. Providers should select conditions that already have evidence-based clinical protocols, such as the American Medical Directors Association

(AMDA) clinical practice guidelines. A recent article published in Health Affairs¹ suggested that hip fracture and joint replacement are good conditions to include in the initiative because they show strong potential for cost savings and pose less financial risk to providers than conditions associated with multiple chronic diseases. Moreover, it was found that longer episode lengths captured a higher percentage of costs and hospital readmissions while adding little financial risk. CMMI has indicated a strong interest in bundled initiatives that extend over periods of time that exceed 30 days. Thus, findings by the authors in the above referenced article are important to heed.

After narrowing down potential MS-DRGs by researching the existence of clinical guidelines, providers should customize their analysis by looking at volumes, clinical outcomes, and costs for each MS-DRG under consideration. Since the goal of CMMI's program is to reduce costs and improve quality, MS-DRGs that constitute a high proportion of a providers' volume and demonstrate wide variation in cost and quality across episodes are the best candidates for a successful application.

IMPERATIVE #3 – Engage clinicians in bundle development to maximize downstream clinical compliance

CMS's acute care episode demonstration project (commonly referred to as the "ACE demo") revealed that detailed clinical process standardization was essential to minimizing high cost outliers. In order to convince physicians and other clinical providers to abide by such protocols, HDG recommends engaging physicians and other key clinical leaders from the outset to solicit their feedback on how existing guidelines should be customized for their own organization.

¹Sood, N; Huckfeldt, P; Escarce, J; Grabowski, D; and Newhouse, J. Medicare's Bundled Payment Pilot for Acute and Postacute Care: Analysis and Recommendations on Where to Begin. Health Affairs, September, 2011, Vol. 30, No. 9, 1708-1717.

Otherwise, clinicians may perceive they are being forced to practice “cookbook medicine” at the cost of patient quality and refuse to abide by recommended guidelines. Achieving a high level of specificity throughout these discussions is critical. Failure to do so may lead to conflict surrounding care decision points after the guideline has been implemented and cause unwanted variation in cost and quality outcomes.

Clinician involvement is essential not only to ensure downstream compliance but also to accurately construct and price bundled services. Clinicians will provide key insight on which services and staffing levels are needed to deliver care for a specific MS-DRG.

Hospitals that participated in the ACE demonstration or have made independent efforts to standardize clinical processes, such as Intermountain Health Care or Geisinger Health System, offer best practice models for creating a protocol development committee. Post-acute providers need only slightly adapt these models to use them within their own organization.

IMPERATIVE #4 – Achieve real-time, line-item visibility into cost structure

After identifying the services and staffing needed for a given bundle of care, providers must be able to accurately identify the cost of each service to determine a feasible discount to propose to CMS. Between submitting the LOI and full application, providers should ensure that such line-item cost visibility can be updated and accessed by staff on a daily basis. Use of agency and overtime labor, non-generic pharmaceuticals, additional ancillary services (such as lab or imaging), or specialty consults drive costs and may result in exceeding the target price. Recognizing cost overruns in real-time allow providers to correct such issues before they have a significant financial impact.

IMPERATIVE #5 – Establish performance improvement infrastructure

The clinical protocol development committee established during the LOI and application process should evolve into a standing committee that identifies and addresses cost overruns throughout the duration of the bundled payment program (organizations that use a productivity-based compensation model should consider adding compensation for participating clinicians). While some issues may be easy to address, others are likely to be more contentious. The ACE demonstration project revealed conflict with physicians to be a frequent challenge and when mismanaged, a driver of cost overruns. While only higher acuity post-acute settings will encounter this problem, similar issues may arise with nursing staff opposition to staffing to a specified level or following a prescribed pathway for a given patient.

Establishing a committee to identify such problems and address them directly by meeting with relevant clinical personnel will ensure staff remains supportive of the initiative while maximizing the probability of financial success.

These imperatives provide a high-level overview of the issues that must be addressed in order to succeed under CMMI's bundled payment program. Full exploration of each imperative will likely reveal a host of sub-issues for each organization to address prior to deciding whether their organization is prepared to accept risk, especially given the limited financial upside to the model as defined by CMMI. Nonetheless, participation will confer a significant strategic advantage on post-acute providers interested in joining an acute care hospital's preferred provider network or serving as a contractor to an ACO. For those organizations that cannot prepare a LOI by November 4, 2011, we understand that there likely will be another opportunity to apply for a bundled payment initiative in early 2012.

Similar to many of the decisions faced by post-acute providers in the wake of health care reform, deciding whether to accept risk through bundled payment and applying for being part of developing models through the CMMI initiative is not subject to a strictly financial calculus.

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Sarah Katz provides project leadership and client relationship management for Health Dimensions Group. Sarah's areas of expertise include emerging health care payment and care delivery models, provider growth and revenue management strategy, and the impact of health reform and economic trends on provider relationships and industry structures.

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Kathleen Griffin is recognized as one of the foremost thought leaders on the acute-post acute care continuum. She has assisted numerous systems to integrate LTACHs, rehab hospitals, skilled nursing, home health, hospice and home- and community-based services to enhance patient outcomes and experience while reducing costs.