

Summary of Acute Hospital And Post Acute Care Bundling

By Kathleen M. Griffin, Ph.D.

Bundled payment initiatives are based on research and policy proposals from five sources:

- MedPAC discussions over the past several years
- CBO Budget Options Book, December 2008
- Commonwealth Fund's Recommendations, March 2009
- President's Proposed Budget for 2010
- Senate Finance Committee's Policy Options, April 2009

Although none of the initiatives provide details on specific procedures for bundling acute and post-acute payments, and there are variations in implementation timelines, all include certain key elements:

- Payment for acute hospitalizations, physician services, re-hospitalizations within 30 days, and post-acute care within 30 days should be bundled into a single payment.
- Bundling will save Medicare about \$18 billion over a 10-year time period
- Payment for acute hospitalizations and re-hospitalizations within 30 days would occur as Phase 1; and, bundling for post-acute care would occur in Phase 2.

Impetus for Bundling

Payment bundling is one of a number of Medicare payment reforms to stem federal spending increases, which are predicted to come more from growth in per capita spending rather than aging of the population. Studies by Dartmouth and the Commonwealth Fund found a high correlation between hospital readmissions and total Medicare spending per beneficiary. Moreover, the geographic areas of the United States with the highest acute care spending per beneficiary correlated with those with the highest post-acute care spending. As stated in the Commonwealth Fund Report, offering a bundled acute-care payment (a global fee covering hospitalization and a specified set of services for 30 days following discharge) would give hospitals and other providers an opportunity to share the

savings from their efforts to reduce complications of treatment and numbers of re-admissions; it would also allow more flexibility in allocating their resources. The size and scope of the bundle would increase over time to allow providers the chance to respond to the growing incentives to work together to offer their patients coordinated, effective, and efficient care.

The Banker

The *banker*, or recipient and manager of the bundled payment, differs among the proposed policy documents. Both the Commonwealth Fund and the President's proposed 2010 budget state that the **acute hospital** would be the recipient of the bundled payment. "Hospitals could provide the post-acute-care services directly or contract with post-acute providers for such services with the option of using Medicare payment rates for those services."ⁱ (Page 14)

The President's 2010 budget proposal states, "...hospitals will receive bundled payments that cover not just the hospitalization, but care from certain post-acute providers the 30 days after the hospitalization, and the hospitals with high rates of readmission will be paid less if patients are re-admitted to the hospital within the same 30-day period."ⁱⁱ (Pages 28-29)

The Senate Finance Committee expands the recipient options: "...payments would be made to one entity, such as the hospital, but CMS would have the authority to allow *other legal entities* (such as non-profits that include the hospital and/or post acute care providers) to receive bundled payments, as long as the hospital would be involved."ⁱⁱⁱ (Page 15)

MedPAC appears to be intrigued by Accountable Care Organizations (ACOs) as the potential recipients of the bundled payments. ACOs are defined as a combination of a hospital, primary care physicians, and possibly specialists. ACOs may be integrated delivery systems, physician hospital organizations (PHOs), a hospital plus multispecialty groups, or a hospital plus independent practices. Each ACO would be associated with a defined population of patients (5,000 as a minimum) and would be accountable for total Medicare spending and quality of care for that population.^{iv} To date, post-acute providers have not played a role of any significance in MedPAC discussions about ACOs. However, the Senate Finance Committee Report includes a discussion of ACOs, focusing on gain sharing for physicians, based on quality and cost metrics.

Implementation of Bundling

The \$18 billion savings estimated by the CBO from bundling extends from 2013 through 2019. Similarly, the President's 2010 budget proposal shows savings beginning in 2013 from bundling.

The Commonwealth Fund and the Senate Finance Committee each describe a phase-in for bundling, although the timelines differ. The Commonwealth Fund promotes the following schedule:

"The policy starts in FY2010 with the acute-care global case rate being applied to all hospitals currently under Medicare prospective payment (i.e., short stay hospitals but excluding critical-access hospitals...). The bundle is expanded to include post-acute care in FY2013 and inpatient physician care related to acute episodes in FY2016."^v (Page 15)

The Senate Finance Committee has Centers for Medicare and Medicaid Services (CMS) starting in FY2010 calculating national and hospital-specific data on the readmission rates of hospitals related to the eight conditions with the highest volume and highest rates of

readmission. In FY2011, CMS would provide readmission rate information to the hospitals and establish a national readmissions rate benchmark for each of the selected conditions.

In FY2013, hospitals with readmissions above the 75th percentile for selected conditions would be subject to a 20 percent payment withhold on a MS-DRG-by-MS-DRG basis, based on prior year's performance.

Beginning in FY2015, acute hospital services and post-acute services occurring or initiated within 30 days of discharge from a hospital would be paid through a bundled payment. Post-acute payments would include home health, skilled nursing facilities, rehabilitation hospitals/units, and long term acute care hospitals (LTACHs). Bundled payments would be implemented in three phases:

- FY2015, bundling would apply to admissions for conditions that account for the top 20 percent of post-acute spending.
- FY2017, bundling would apply to admissions for conditions that would account for the next 30 percent of post-acute spending.
- FY2018, bundling would apply to all other conditions and MS-DRGs that account for the remaining 50 percent of post-acute payment.

Implications for Providers

Healthcare payment reform will occur and Medicare payment methodologies indeed will change in the near future. A seven-year savings (FY2013–2019) of \$18 billion from bundling payments to hospitals, post-acute providers, and physicians is too significant to ignore.

Payment reform through bundling likely will include changes in certain Medicare rules, such as the transfer MS-DRG payment reduction for acute hospitals, the three-day prior hospital stay for skilled nursing, the 25-day average length of stay for LTACHs, and the “60% rule” for rehab hospitals/units. Payment reform, combined with new minimally invasive surgical procedures and more sophisticated home medical monitoring, indicate that post-acute care utilization for Medicare beneficiaries, now at 40 percent of all hospital discharges, will decline. However, the vast increase in volume of Medicare beneficiaries due to aging baby boomers may result in little if any reduction in post-acute provider occupancies and caseloads.

Under bundling, the value proposition will be best outcomes at least cost. Regardless of whether the banker is a hospital, an accountable care organization, or an entity that integrates acute and post-acute providers, as well as physicians, it is certain that the amount of per beneficiary payment for post-acute care will be reduced.

Acute and post-acute providers are responding to the expectation of Medicare payment reform. Many hospitals are “beefing up” their post-acute continuums, by adding venues through acquisition or preferred provider relationships. Post-acute providers have been expanding their own continuums, by adding other lower cost venues; for example, LTACHs adding transitional care units; and, rehabilitation hospitals and skilled nursing facilities adding home health agencies.

Post-acute providers that wish to take the lead in creating acute hospital preferred relationships should consider the “big picture”, that is, that bundling will begin with hospital readmissions within 30 days. Those post-acute providers that have the capability to manage patients effectively in their own setting instead of sending that patient to the acute hospital emergency room should be able to demonstrate a lower readmission rate than their competitors. That capability likely will require a greater on-site presence of physicians and nurse practitioners as well as highly qualified nursing staff.

While acute rehabilitation hospitals now measure a patient's functional status at admission *and* discharge, skilled nursing facilities are not required to measure change in function at the time of patient discharge. To be able to compare both cost and outcomes for patients

with similar conditions, post-acute providers must be able to furnish “the banker” with patient metrics at admission and discharge as well as after discharge.

Finally, the more seamless the post-acute care continuum, the easier it will be to assure that patients are discharged to the right place at the right time at the right cost. That means that those post-acute providers with multiple venues should have common referral/intake systems, common reporting systems, and simplified access to patient information across settings—ideally, an electronic health record.

Even though post-acute providers must operate efficiently and effectively in today’s environment of facility- or venue-based Medicare payment, they should be taking steps recommended above to position themselves to be the most desirable partner for a hospital or accountable care organization when bundled payment becomes a reality.

References

ⁱ Guterman, S, Davis, K, Schoen, C, and Stremikis, K. *Reforming Provider Payment: Essential Building Block for Health Reform*. The Commonwealth Fund Commission on a High Performance Health System, March 2009; available online at www.commonwealthfund.org

ⁱⁱ Office of Management and Budget, Executive Office of the President of the United States. *A New Era of Responsibility, Renewing America’s Promise*. February 26, 2009.

ⁱⁱⁱ Description of Policy Options. *Transforming the Health Care Delivery System: Proposal to Improve Patient Care and Reduce Health Care Costs*. Senate Finance Committee, April 29, 2009.

^{iv} Glass, D and Stensland, J. *Accountable Care Organizations*. MedPAC, April 9, 2009

^v Ibid

Kathleen M. Griffin, Ph.D. is the National Director, Post Acute and Senior Services for Health Dimensions Group, Minneapolis, Minnesota. She can be reached at 480.922.9366 or via e-mail: kathleeng@hdgi1.com



Health Dimensions Group
4400 Baker Road, Suite 100
Minneapolis, MN 55343
Tel 763.537.5700
Fax 763.537.920

