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BUNDLE OF RISK

POST-ACUTE PROVIDERS NEED TO PREPARE FOR UP-AND-COMING BUNDLED PAYMENT SYSTEMS

The healthcare payment landscape is shifting, and the government increasingly is realizing the value of bundling payments for episodic care.

As proof, the Centers for Medicare & Medicaid Services has already beat a goal that 30% of all fee-for-service payments be made through alternative payment methods this year; it expects half of FFS payments will be through alternative models by 2018.

"Bundling has been no small part of that strategy," noted Brian Ellsworth, MA, Director of Payment Transformation at Health Dimensions Group and a featured speaker at the May *McKnight's* webinar "Risky business: finding success in a bundled payment world."

Skilled nursing facilities and the rest of the post-acute care world — including home health agencies, inpatient rehabilitation facilities, long-term acute care hospitals and physican group practices — are critical players in this payment system. As hospitals are being thrust into the world of payment bundling, they are incentivized to develop close relationships with key downstream providers with the goals of reducing readmissions and containing costs.

The upshot is post-acute care providers need to become better at forging alliances with hospitals. These subjects were among topics discussed during the "Risky business" bundled payment webinar, which was sponsored by Medline with educational assistance from Health Dimensions Group.

Here to stay

While healthcare trends come and go, payment bundling is not a flash in the pan, says Ellsworth.

It's here, it's staying, and quality still has to be the number one focus for caring for patients, he and colleagues believe.

"I think bundling has a lot of possibilities," he adds, noting that as CMS evaluates the model and finds that it continues to show reduced costs and quality improvement, "I think we'll see continued expansion."

One reason bundling is likely to stay is because so much early evidence has pointed to its success. In 2011, CMS launched a major three-year, voluntary demonstration program, the Bundled Payments for Care Improvement (BPCI) Initiatives. It set up two bundling models: Model 2, which begins at hospitalization and carries through post-acute care, and Model 3, which begins at initiation of post-acute care services.

The first CMS evaluation of

A SUPPLEMENT TO McKnight's LONG-TERM CARE NEWS

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> *Bundling has a lot of possibilities. I think we'll see continued expansion.*

BPCI for a small number of orthopedic bundlers showed institutional post-acute care fell by 30% while home health use stayed about the same. In addition, a recent letter to the *Journal of the American Medical Association* about New York University's Model 2 BPCI program indicated a 34% reduction in discharges to institutional post-acute care for joint replacement and a 49% reduction for cardiac episodes.

A mature joint replacement bundling program for major joint lower extremity under Model 2 BPCI at the Cleveland Clinic also showed impressive results.

Readmissions fell to 1.6% in the first quarter of 2014, compared to 5% in the first quarter of 2013. Further, discharge disposition for home or home healthcare rose to 75% in the first quarter of 2014, compared to 39% in the first quarter of 2013. Discharge disposition for skilled nursing facilities fell to 25% in the first quarter of 2014, compared to 56% in the first quarter of 2013.

Knowing the basics

Bundling represents a move away from FFS and toward value-based care. A bundled payment is an aggregation of individual provider payments into an episode of care for a given condition.

"In a nutshell, bundling consists of what are termed 'clinical episodes,' which are selected by the voluntary bundler for one of 48 possible diagnostic families," Ellsworth explains. "All the episodes are triggered by anchor hospitalizations."

Unlike the FFS model, which calls for paying for each unit of care delivered, bundling demands that providers assume financial risk for the cost of services for a particular treatment and the costs associated with related services.

FFS payments are made based on expected costs for clinically defined episodes spanning 30, 60 or 90 days in length. These episodes may involve several types of practitioners, care settings and services.

"This isn't really prospective payment," Ellsworth notes. "This is a retrospective, virtual calculation."

Actual FFS expenditures for each quarterly performance period are compared to target prices about six months after the end of an episode. (Target prices contain exclusions for the following: conditions unrelated to the bundle diagnosis, Medicare Part D drugs and hospice claims.)

According to the BPCI initiative, the most frequently bundled diagnosis-related groups are: major joint replacement of the lower extremity; congestive heart failure; simple pneumonia and respiratory infections; chronic obstructive pulmonary disease, bronchitis and asthma; and hip and femur procedures (except those involving the major joints).

"By far and away, major joint replacement of the lower extremity has been the most commonly selected DRG for Models 2 and 3," Ellsworth explains.

Following BPCI, the Comprehensive Care for Joint Replacement (CJR) demonstration program, which went live on April 1, 2016, represents the second major development in bundling.

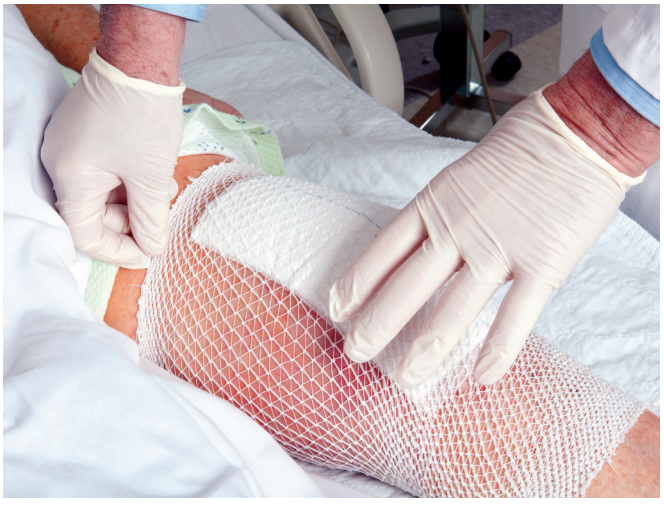
"This program is basically taking bundling and expanding it and making it a mandatory program," Ellsworth says.

More predictable costs

The program requires participation from all inpatient PPS hospitals in 67 metropolitan regions. The nature of it indicates how ripe joint replacement procedures, in particular, are candidates for a bundling.

Between 2000 and 2005, there was a 70% percent increase in hip and knee replacements. Experts estimate that almost 4 million replacement surgeries will be performed in the year 2030 alone. Since hip and knee replacements have easily identifiable start and end points, they are two conditions that work well with the bundling modality.

One objective in pursuing a bundled payment arrangement is for providers to have more predictable and lower costs.



For more information

The original webcast is available at www.mcknights.com/may17webinar

IMPRESSIVE RESULTS

Bundled pay initiatives involving joint replacements have shown success, participants say.

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Joint replacement bundler strategies include: increasing discharges to home and/or outpatient therapy; developing tight relationships with preferred downstream providers; improving pre-operative care for elective cases; reducing costs of supplies, such as implants; and for more complicated cases or patients lacking support at home, using SNFs with daily access to physicians, trained staff and customer-friendly facilities.

Bundling is expected to lead to the continued formation of preferred networks, shifts in referral patterns and expectations of shorter lengths of stay. Also, further evolution of care redesign, risk stratification strategies and quality metrics; increased alignment between accountable care organizations and bundlers; evaluation of BPCI by CMS, followed by further growth opportunities; and increased adoption of bundling and shared savings approaches by Medicare Advantage plans.

Since federal regulators have set a goal that at least 50% of Medicare post-acute provider payments should be bundled by 2022, there is abundant opportunity now for post-acute players, Ellsworth says.

Making it work

Successful players will catch the notice of hospitals, particularly because post-acute care is critical to hospitals' success in the programs. The BPCI initiative has revealed that as much as 65% of the target price identified for many bundles falls outside acute care into the post-acute care arena. The reasons include historically poor transitions across the continuum, lack of overall care coordination and inefficient practice patterns based on misaligned financial incentives.

STRATEGIC MOVES
Developing closer relationships with patients in their care journey is a major focus of bundling initiatives.

Historically, those poor transitions across the continuum have created a lot of the problem and now create a lot of the opportunity, Ellsworth and colleagues agree.

The incentive for post-acute care providers to become part of bundling partnerships? "It comes down to one simple fact: You get the patients," Ellsworth says.

To receive these patients, a post-acute provider must become a hospital's preferred partner. Time is of the essence since hospitals are already paring down their networks quickly.

A hospital's preferred provider selection process for post-acute providers typically takes into account the following criteria: Five-Star Quality Rating, readmission rate, the strength of the medical director, stability of the management team, depth and breadth of clinical capabilities and patient satisfaction.

To be successful, Health Dimensions Group suggests the following actions for post-acute care providers:

- Keep good data regarding the readmission rate and the type of patient you are taking. Remember the mantra: Data is king; you have to have it.
- Demonstrate quality
- Review processes regularly

It's important for post-acute providers to realize that as bundling grows, each level of post-acute care will intensify in acuity. This could lead to an increase in readmissions, which might overshadow post-acute provider performance improvements.

"Bundling will create incentives to shift the acuity levels of patients at the same time it is also creating performance expectations," Ellsworth points out.

A move in the right direction

Bundling is ultimately a good development for the patient, Ellsworth stresses. Traditionally, acute- and post-acute care delivery has been siloed. Once a patient left the hospital, there was little interaction between the hospital and post-acute provider. Poor transitions can result in heightened readmissions. Under bundling, all providers have a stake in the patient's successful recovery following a hospital visit.

Doing the right thing for the patient is becoming the overriding factor, numerous industry veterans point out.

Ellsworth says he is pleased that bundling shows no signs of going away.

"It's an excellent program in terms of improving care," he explains.

Since it is likely to grow, providers need to learn to live with it, he adds: "Maintaining the best quality care you can is part of your future survival."

Not every nursing home is going to be picked as a preferred provider at the outset, so those facilities that strive to become preferred providers need to improve care and staffing right away.

Ellsworth says there's still plenty of time to get into the game. But you have to act with purpose: "Don't let analysis paralysis stop you from starting a conversation in your market." ■

Editor's note

This McKnight's *Webinar Plus supplement is based on a themed webinar* McKnight's *presented on May 17. The event was sponsored by Medline. The full presentation is available at* www.mcknights.com/may17webinar.