



Post-Acute Care and Bundled Payments: Why Is This Important to You?

Part 2 in a Two-Part Webinar Series

Louise Bryde, RN, BSN, MHA
Carla Brock Wilber, DNP, RN, NE-BC
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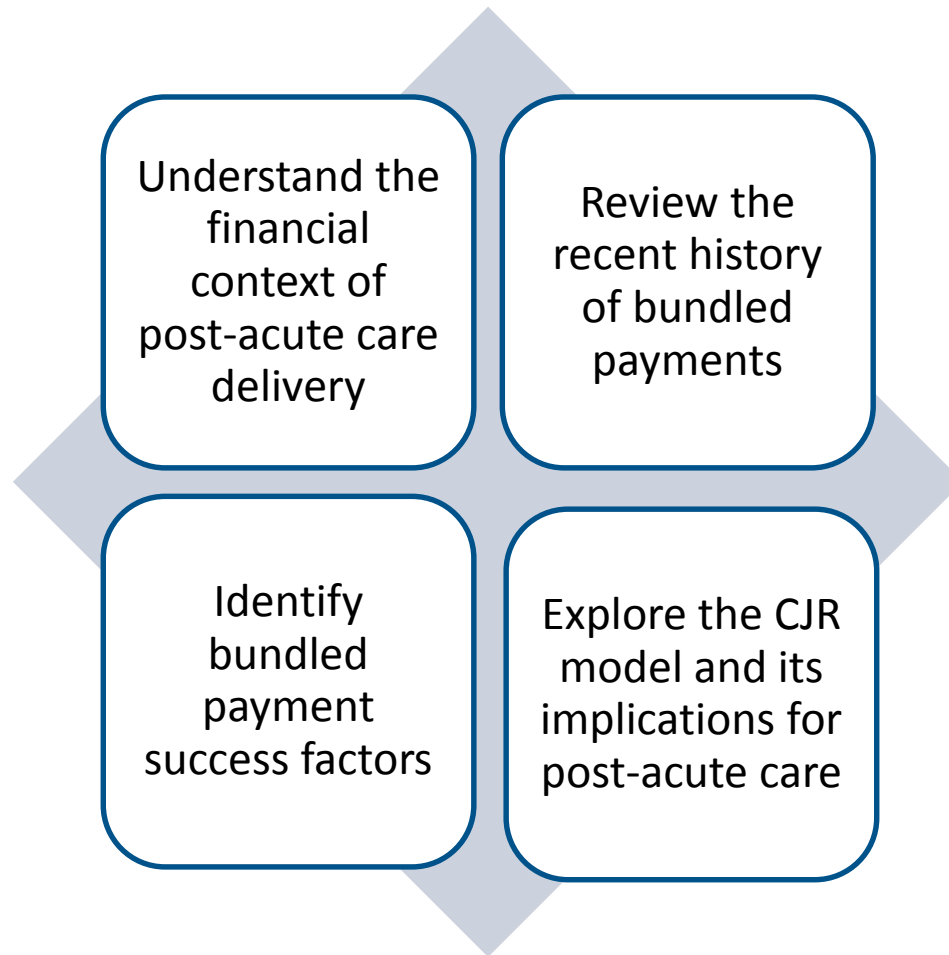


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Learning Objectives



Post-Acute Care Lexicon

Acronym	Term	Relative Cost
IRF	Inpatient Rehabilitation Facility	\$\$\$\$
SNF	Skilled Nursing Facility	\$\$\$
LTAC/LTACH	Long-Term Acute Care/Long-Term Acute Care Hospital	\$\$\$
HHA	Home Health Agency	\$\$

Costs of Post-Acute Care

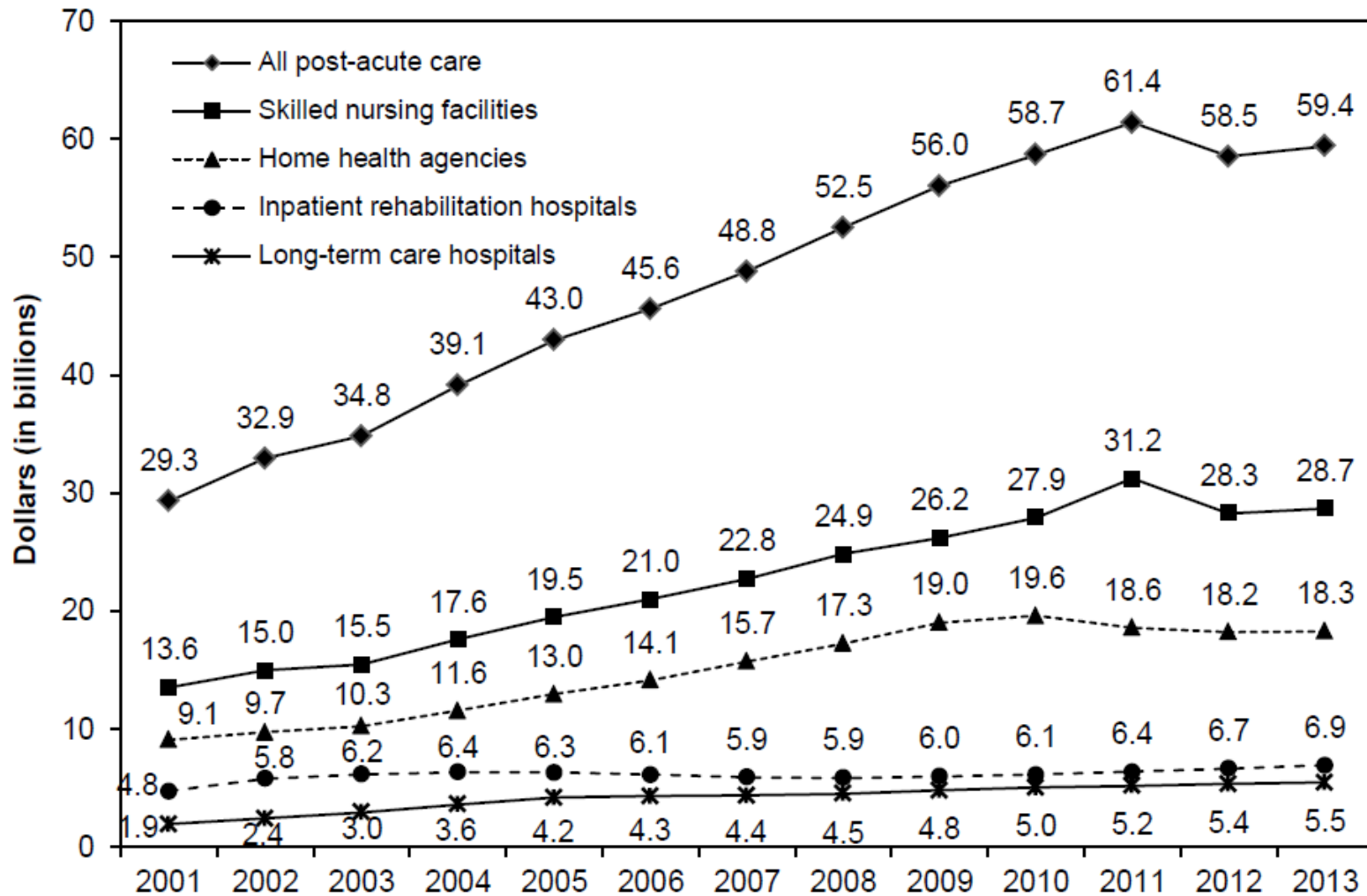
Passage of the ACA in 2010 heightened focus on the Triple Aim of improving patient experience of care, improving population health, and reducing per capita costs of health care

An Institute of Medicine report in 2013 identified PAC as the source of **73% of the variation** in health care spending, significantly increasing attention to the post-acute sector

Estimated that as many as 43% of Medicare FFS Beneficiaries are discharged to one of the Medicare-recognized post-acute settings: SNFS, LTACs, IRFs, Home Health*

Between 2001 and 2012, program payments to PAC providers doubled to \$59 billion

Medicare Spending on PAC by Sector

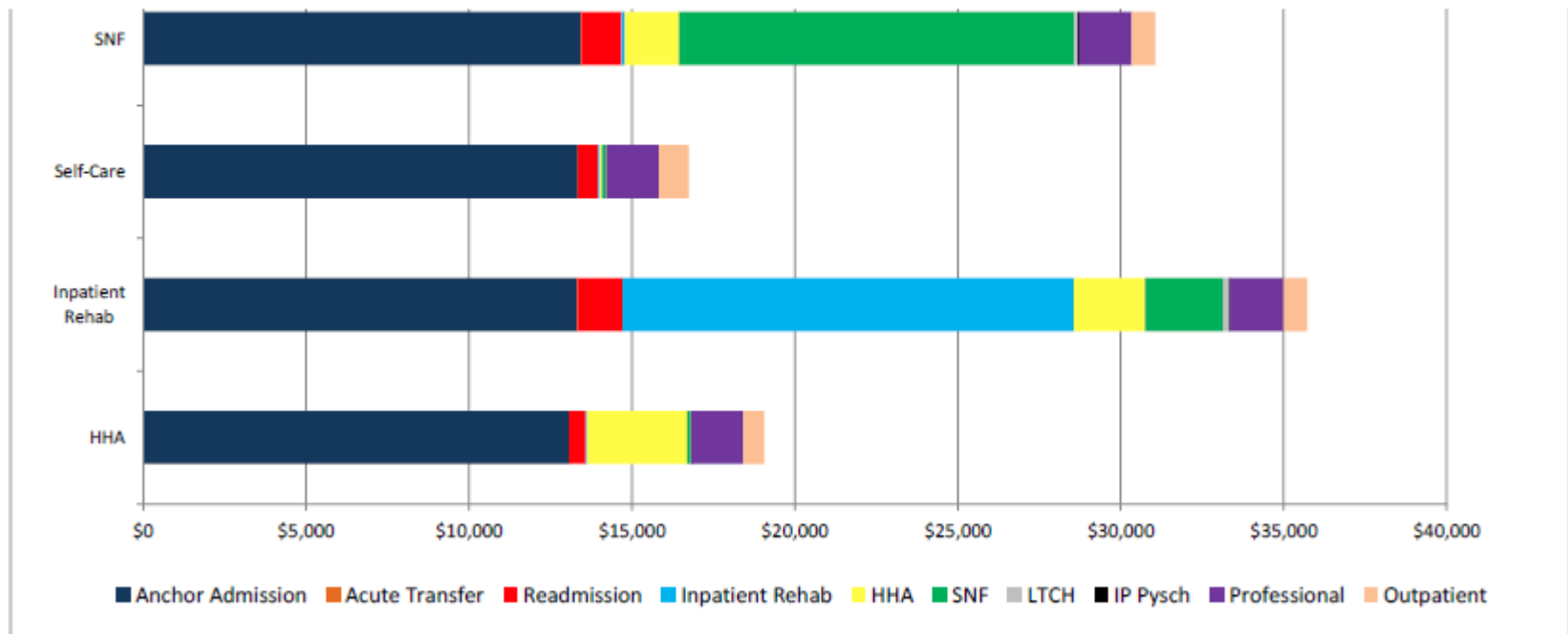


Average Episode Spending

Further analyses have demonstrated significant differences in cost related to the initial post-acute setting of care following hospitalization.

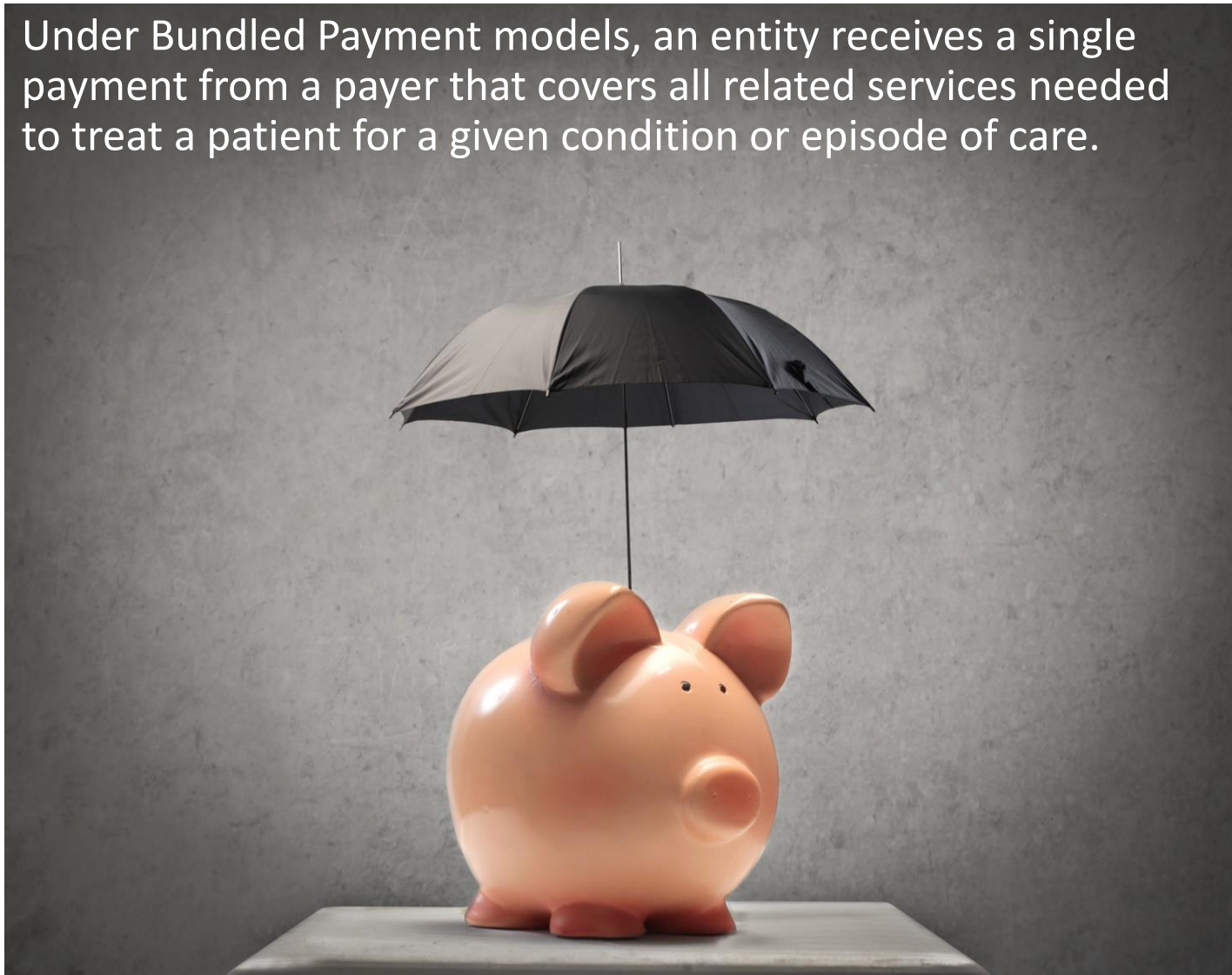
Exhibit 2—Average Episode Spending by First PAC Setting

DRG 470



What Is a Bundled Payment?

Under Bundled Payment models, an entity receives a single payment from a payer that covers all related services needed to treat a patient for a given condition or episode of care.



Bundled Payment History



Traditionally, Medicare has made separate payments to providers for each of the individual services they furnish to beneficiaries for a single illness or course of treatment.



This approach can result in fragmented care with minimal coordination across providers and health care settings. Payment has rewarded the quantity of services offered by providers rather than the quality of care furnished.



Research has shown that bundled payments can align incentives for providers – hospitals, post-acute care providers, physicians, and other practitioners – allowing them to work more closely together across the care continuum.

BPCI Initiative



The **Bundled Payments for Care Improvement (BPCI)** initiative was developed by the Center for Medicare and Medicaid Innovation (Innovation Center).

The Innovation Center was created by the Affordable Care Act to test innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid, or Children's Health Insurance Program (CHIP) expenditures, while preserving or enhancing the quality of care for beneficiaries.

Over the course of the initiative, CMS is actively working with participating organizations to assess whether the models being tested result in improved patient care and lower costs to Medicare.

Medicare Bundled Payments for Care Improvement

Four models were developed for the Medicare BPCI Program:

Types of Services Includes in Bundle	Model 1 Acute Hospital Stay Only	Model 2 Acute Hospital + Post-Acute	Model 3 Post-Acute Care Only	Model 4 Acute Hospital Stay + Readmissions
Inpatient hospital and physician services	✓	✓		✓
Related post-acute care services		✓		
Post-acute care services			✓	
Related readmissions		✓	✓	✓
Other services defined in the bundle (Part A & Part B)		✓	✓	

Medicare Bundled Payments for Care Improvement



Under the **Medicare Bundled Payments for Care Improvement (BPCI) Initiative**, two models included PAC services: Model 2 and Model 3.

Model 2 episodes start with the initial hospital stay for an included MS-DRG; the acute hospital is the episode initiator. Episode of care includes inpatient, PAC, and all related services and may be for 30, 60, or 90 days post hospital discharge.

Model 3 includes only the PAC period. Episodes start with a HHA, SNF, IRF or LTACH stay within 30 days following an inpatient discharge for one of the included MS-DRGs; the first post-acute site is the episode initiator. Episode of care may be for 30, 60, or 90 days post initiation.

In November 2015, CMS released Final Rules for a new mandatory Bundled Payment Initiative, the **Comprehensive Care for Joint Replacement (CJR) Model**.

Bundled Payment Critical Success Factors

- Choosing the right services to bundle
 - High cost
 - High volume
 - Right providers
- Performance of the participating system
- Integrated system (or already taking risk)
- Design of payment system
- Culture of organization
- Resources
- Benefit design:
 - Reference pricing
 - Center of excellence
 - Co-insurance differential
 - Ability to direct contract with providers



Bundled Payment Critical Success Factors

Care Redesign:

- Administrative and physician collaboration
- Reduction in unnecessary care (reduce resource utilization)
- Lower risk and complication rate for patients
- Improved patient function and outcomes
- Evidence-based care
- Functional transition of care
- Technology
- Ability to measure improvement



Comprehensive Care for Joint Replacement (CJR) Model:

A new five-year CMS retrospective Bundled Payment Initiative for lower extremity joint replacement/reattachment (LEJR) episodes of care

CJR: CMS Objectives

Improve care for Medicare beneficiaries who undergo LEJR – better coordinated, higher quality care from initial hospitalization through recovery

“Smarter spending” — LEJRs are common, expensive procedures with significant recovery periods

- Substantial regional variation in care patterns and episode spending for LEJRs
- Average Medicare expenditures for surgery, hospitalization, and recovery range from \$16,500 to \$33,000 across geographic areas*
- Hip and knee replacements- most common inpatient surgeries for Medicare beneficiaries

Healthier people and communities—improved coordination across the health care continuum

Who Is Impacted by the CJR Model?

- Most acute-care hospitals paid under the Inpatient Prospective Payment System (IPPS) are required to participate, if located in the 67 selected MSAs.
 - As of November 2015, approximately 800 hospitals are required to participate nationally.
- Participating hospitals have the opportunity to partner with surgeons, other physicians, and post-acute care providers to coordinate patient care more effectively across the care continuum.
- Medicare beneficiaries meeting certain criteria who have an inpatient hospitalization at participant hospitals for lower-extremity joint replacement (LEJR) and/or other major leg procedure (**MS-DRG 469 or 470**) are included in the model.
 - Primarily includes single-joint total hip and total knee replacement procedures


The CJR Model

- Bundled payment episode includes hospitalization and 90 days post-discharge
- Includes almost all Medicare Part A and Part B services
 - Excludes certain services clinically unrelated to the LEJR episode
- Retrospective, two-sided risk model; hospitals bear the financial risk
 - Providers paid via Medicare FFS
 - Reconciliation after each performance year—actual episode spending compared to CMS episode target prices for each participant hospital
- First performance period began April 1, 2016
- Beneficiaries must be discharged to SNFs rated 3 stars or above for at least 7 of previous 12 months, on CMS's Nursing Home Compare website

Quality Performance Measures: Pay-for-Performance

- Hospitals will be assigned an annual **composite quality score** reflecting Performance and Improvement on two quality measures:
 - THA/TKA (Total Hip Arthroplasty & Total Knee Arthroplasty) Complications measure – specific risk standardized complication rates
 - HCAHPS Survey – 11 measures
- Composite quality scores will determine:
 - Hospital eligibility for reconciliation payments

Comprehensive Care for Joint Replacement Model

 Share

The Comprehensive Care for Joint Replacement (CJR) model aims to support better and more efficient care for beneficiaries undergoing the most common inpatient surgeries for Medicare beneficiaries: hip and knee replacements (also called lower extremity joint replacements or LEJR). This model tests bundled payment and quality measurement for an episode of care associated with hip and knee replacements to encourage hospitals, physicians, and post-acute care providers to work together to improve the quality and coordination of care from the initial hospitalization through recovery.

Questions and Discussion

Thank you

