Bundling and Coordinating Post-Acute Care (BACPAC)

Toolkit for Preliminary Modeling and Implementation

PREPARED FOR and PRESENTED TO:
Alliance for Home Health Quality and Innovation

PRESENTED BY:
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Findings from the Clinically Appropriate and Cost-Effective Placement (CACEP) Project indicated that Medicare savings could be achieved via health care delivery and payment reform and care re-engineering

A post-acute care bundle triggered by hospital discharge and an HHA, SNF, or IRF admission could be designed that incentivizes clinically appropriate and cost-effective care and generates substantial savings

Focusing a bundle on post-acute care (excluding index hospitalization) would allow for the development and implementation of a bundle and coordinated care networks while mitigating provider risk
Study Highlights

- A convener (either third party or a provider) is essential to allocate patients to the most cost-effective and clinically appropriate setting.

- Convener catchment area size matters:
  - Regional-level convener catchment areas (which would likely be managed by third parties or post-acute care providers) would produce more financially stable bundles than those organized around hospital discharges (which would likely be managed by individual hospitals).
  - The larger and more homogenous the volume the convener is responsible for, the more stable the bundled payments would be, thereby reducing provider risk.

- A series of blends and transitions, as well as an outlier policy, will be required to mitigate provider risk and ensure quality care to patients.
Post-Acute Care Bundling Context

- Bundled payments for post-acute care services are a logical first step in considering care and payment redesign.
- Goal of bundling is to increase the efficiency of care across settings and encourage care coordination that is not currently provided under siloed prospective payment systems in fee-for-service medicine.
- Success of bundles in constraining cost growth relies on the delivery of care in the most clinically appropriate, cost-effective, and stable manner.
- CMS has developed the Bundled Payment for Care Improvement (BPCI) initiative that investigates and tests how post-acute care payment bundles could be structured, implemented, and paid.
- Due to financial risk to providers, bundled payments must be carefully crafted and implemented with safeguards for patients and providers.
PAC Reform Can Achieve Savings

- **CACEP-modeled reform could produce $34.7 billion in Medicare savings (2014-2023) without payment adjustment.** With a 5.3% payment adjustment, projected savings reach $70 billion. With a 7.5% adjustment, projected savings reach $100 billion.


Dobson | DaVanzo analysis of research-identifiable 5% SAF for all sites of service, 2008, wage index adjusted by setting and geographic region, and standardized to 2009 dollars.

* Percent of post-acute care spending after discharge from the Index hospital.
Parameters of PAC Bundles

• PAC payment bundles can be designed to either include or exclude the index acute care hospital stay

• A bundle that includes the index acute care hospital stay requires a MS-DRG + post-acute care management process that has not been developed and tested under the current fee-for-service system
  • Generally, hospitals lack the infrastructure or experience to manage PAC

• A PAC-specific bundle (excluding index hospitalization and managed by post-acute care providers or third party conveners) may allow bundling to function with reduced risk and impact on providers and patients

• The stability of the bundle for both providers and the convener is directly related to the catchment area of the convener, with larger catchment areas yielding more stable bundles with lower provider risk
## Proposed BACPAC Structure

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<tr>
<th>Parameter</th>
<th>Consideration</th>
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| **Episode Trigger**        | • Initiated the **day after discharge** from the acute care hospital  
• Convener is incentivized to coordinate with the hospitals to manage the transition to the post-acute care setting as soon as clinically appropriate to reduce the likelihood of adverse events                                                                                     |
| **Clinical Condition Categories** | • Bundles should include diagnostic conditions that are both **high in volume and represent a significant share of Medicare expenditures**  
• High volume conditions allow providers to better manage risk over a larger number of cases; High volume conditions could also result in significant savings for Medicare  
• Index hospital MS-DRG is used to clinically define the patient’s condition; MS-DRGs could then be divided further based on the patient’s functional ability or post-acute care needs                                                                 |
| **Bundle Length**          | • Long enough so the bundle captures the **majority of the care for the bundled condition** without being too long to capture the utilization of unrelated events  
• Different episode lengths could exist to capture the specific rehabilitative timelines of various conditions                                                                                                                                                                         |
| **Care Settings Included** | • Trigger an episode following a physician’s order: **HHA, SNF, and IRF**  
• Does not trigger a BACPAC bundle but is included in the bundled payment amount: **ER; readmissions to acute care hospital (planned and unplanned); outpatient therapy**  
• Excluded from the bundle and paid for either through fee-for-service or other arrangements: **LTCH, Physician visits, Outpatient visits, DME, Hospice**                                                                                           |
| **Role of Convener**       | • A risk-bearing entity that manages the bundle and helps direct patient care transitions  
• A convener – **either the first PAC setting provider or a third party administrator** – is needed to:  
• Take responsibility for risk and manage the bundle  
• Distribute payments to providers  
• Select first PAC setting
Proposed BACPAC Structure (cont’d)

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<tr>
<th>Parameter</th>
<th>Consideration</th>
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<tbody>
<tr>
<td>Risk-Adjustment of Bundled Payments</td>
<td>• All Medicare prospective payment systems risk-adjust payments to account for variation in costs of treating patients based on:</td>
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<tr>
<td></td>
<td>• Patient demographic characteristics – age, gender</td>
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<tr>
<td></td>
<td>• Clinical characteristics – clinical severity, such as comorbidities and functional ability, and</td>
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<tr>
<td></td>
<td>• Geography</td>
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<tr>
<td>Payment Blends and Transitions</td>
<td>• Three-part blend implemented at the MS-DRG condition category level over several years, ultimately transitioning to the national payment:</td>
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<td>• Convener’s 3-year historical average payment to reflect variation in local practice patterns</td>
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<tr>
<td></td>
<td>• Region’s historical average payment under FFS Medicare to capture variation in practice patterns</td>
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<tr>
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<td>• National historical average under FFS subjected to an overall discount</td>
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<tr>
<td>Payment Distribution</td>
<td>• Virtual Payments: Payments are made from CMS directly to each provider under the existing FFS prospective payment systems and reconciled at the end of the episode in the form of future withholds to the convener</td>
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<td>• Negotiated Payments: CMS gives the total payment bundle (not negotiated) to the convener; the convener then distributes payments to each provider. Those rates are negotiated between the convener and the providers prior to patient admission to the care setting</td>
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<td>• Under both arrangements, convener is responsible for managing care and transitions to ensure that total payments do not exceed the CMS-determined bundled payment rate</td>
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REVIEW OF ANALYTIC ASSUMPTIONS AND FINDINGS
Review of Analytic Assumptions

- **Episode Trigger**: Day after discharge from acute care hospital
- **Bundle Length**: 60 days
- **Care Settings**: HHAs, SNFs, and IRFs can trigger a bundle; planned and unplanned readmissions, ER visits, and outpatient therapy visits are included in the bundle
- **Conveners are modeled in two different ways:**
  - **Regional-level convener catchment area** in which we assume that one convener will be responsible for all patients in the HRR (n=306 conveners)
    - Regional-level convener catchment areas will likely be managed by third parties or post-acute care providers, while individual hospitals are more likely to (but not required to) manage hospital discharge-level convener catchment areas
  - **Hospital discharge-level convener catchment area** in which we assume that a single convener would be responsible for all patients that are discharged from a single acute care hospital (n=1,793 conveners; trimmed to remove low volume providers)
    - In actuality, the number of hospital conveners is likely to be greater, as few if any hospitals are expected to cede management of their MS-DRG revenue to another hospital convener
- **Payment blend for each MS-DRG clinical condition category in year 1:**
  - Convener: 80%; Region: 10%; National: 10%
Regional-Level Convener Catchment Area: Larger Catchment Areas Provide Stability and Mitigate Provider Risk

Larger HRRs have higher volume to mitigate risk and stabilize the impact of BACPAC payments.

The distribution of losses is consistent with the current IPPS system, even after 30 years of operation.

Source: Dobson | DaVanzo analysis of 5% sample of Medicare beneficiaries, 2007-2010.
Hospital Discharge-Level Convener Catchment Area: Low Volume Conveners could Experience Extreme Losses, Leading to Access Issues

Introducing lower volume into the system could result in less payment stability at the provider level.

Even with stop loss (e.g., 50%), provider risk remains significant in the small catchment area model.

Source: Dobson | DaVanzo analysis of 5% sample of Medicare beneficiaries, 2007-2010.
* Low volume providers were trimmed (<20 episodes represented in a 5% sample; n=1,793 hospitals of 4,236)
Implementation Considerations

• Quality measures must be implemented to ensure that providers are held accountable for outcomes and stinting of patient care is avoided
  • Quality measures are critical to the success of bundling; conveners can use quality measures to determine patient placement to maximize outcomes

• Freedom of choice must be assured for all beneficiaries
  • We assume patients, family members, discharge planners, conveners and physicians (though not in the bundle) are involved in discharge planning and transitions

• Evaluation of BACPAC
  • An impact analyses of “winners and losers” and payment compression (under-payment of high “cost” and over-payment of low “cost” episodes) is needed

• Determining CBO savings
  • Savings could be determined by the absolute payment reduction at the program level, such as a cap on total Medicare payments (per ESRD bundle), for example
Further Considerations

- **Inclusion of LTCH admissions:** would allow for an inclusive “post-acute care bundle” and the appropriate placement of patients into all possible post-acute care settings.

- **Exclusion of planned and unplanned readmissions:** The frequency of observation stays in lieu of hospital admissions has increased, which could underestimate the existing base bundled payment rate (to the extent that the “readmissions” are billed as observation stays and not captured in the BACPAC payments).
  - If readmissions are excluded, providers would need to be dis-incentivized from discharging patients to the hospital to avoid a loss on their bundled payment.

- **Role of the convener and its interaction with beneficiary choice:** Within a hospital there may be multiple conveners representing different post-acute care entities all interested in managing the care for a patient.
  - Extensive thought must be put into designing a policy that ensures both assignment of patients to conveners and how beneficiary choice will be ensured.
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