MEMORANDUM

TO: AHCA State Affiliates and Members

FROM: James Michel, Director of Medicare Research & Reimbursement

RE: An Update to Members on Bundled Payments

DATE: March 20, 2013

CC: Elise Smith, Senior Vice President, Finance Policy and Legal Affairs
Peter Gruhn, Senior Director of Research

Editor's Note: ***We are hereby announcing a new Transmittal series on bundled payments. As you know we have already inaugurated a separate transmittal series on ACOs.*** *The purpose of this second series is to keep members up-to-date on bundling developments and steps providers may wish to take to become involved in bundled payments. Bundled payments are often discussed in the context of other reform initiatives such as Accountable Care Organizations (ACOs) and are often confused with each other. Bundled payment is a payment system while an ACO is a service delivery system. ACOs may adopt bundled payments, and bundled payments may be adopted in non-ACO settings.*

Through both Transmittal series, we expect to report to members at least once a month or whenever developments call for an alert.

Introduction

Traditional fee-for-service, the predominant Medicare payment system, is widely thought to be a major factor contributing to the accelerating growth of health care costs in the United States according to researchers and organizations such as the Medicare Payment Advisory Commission (MedPAC). Under this system, critics indicate that providers are rewarded financially for *volume* of medical services rather than the *quality* of care or patient *outcomes*. As such, policymakers and industry experts want to move the system toward one that (1) rewards value over volume and (2) is population-based rather than focused on the individual. Bundled payments are one method for moving the system in that direction.

Bundled payment models have been tested on a small scale for decades with results that suggest they would significantly reduce the growth in health care spending if adopted more broadly. But such findings went unnoticed for some time, until a renewed focus from lawmakers on the national budget, debt and deficit thrust bundled payments back into the national spotlight. Recent reports from the Brookings Institution[1] and the National Commission of Physician Payment reform[2] have supported policy

[1] Michael Chernew and Dana Goldman, *Transitioning to Bundled Payments in Medicare*, February 26, 2013. The Brookings Institution. Available at: http://www.brookings.edu/research/papers/2013/02/transition-bundled-payments-medicare.

[2] Report of the National Commission on Physician Payment Reform, *Our nation cannot control runaway medical spending without fundamentally changing the way physicians are paid*, March 2013. Available at: http://physicianpaymentcommission.org/wp-content/uploads/2013/03/physician_payment_report.pdf.

recommendations that, over time, would replace fee-for-service with bundled payments, citing potential savings in the hundreds of billions. For this reason, and many others, AHCA believes post-acute providers need to be aware of what is happening in the marketplace with regard to bundled payments. This series of memoranda will address bundled payment issues pertinent to post-acute care and long term care providers as they relate to policy, research and operational viability.

Below, we first provide an overview and an explanation of the critical components of this type of payment system. Next, we describe the CMS Bundled Payments for Care Improve Initiative. Lastly, we discuss bundling challenges for post-acute providers in adopting bundled payments, AHCA activity, and next steps for providers.

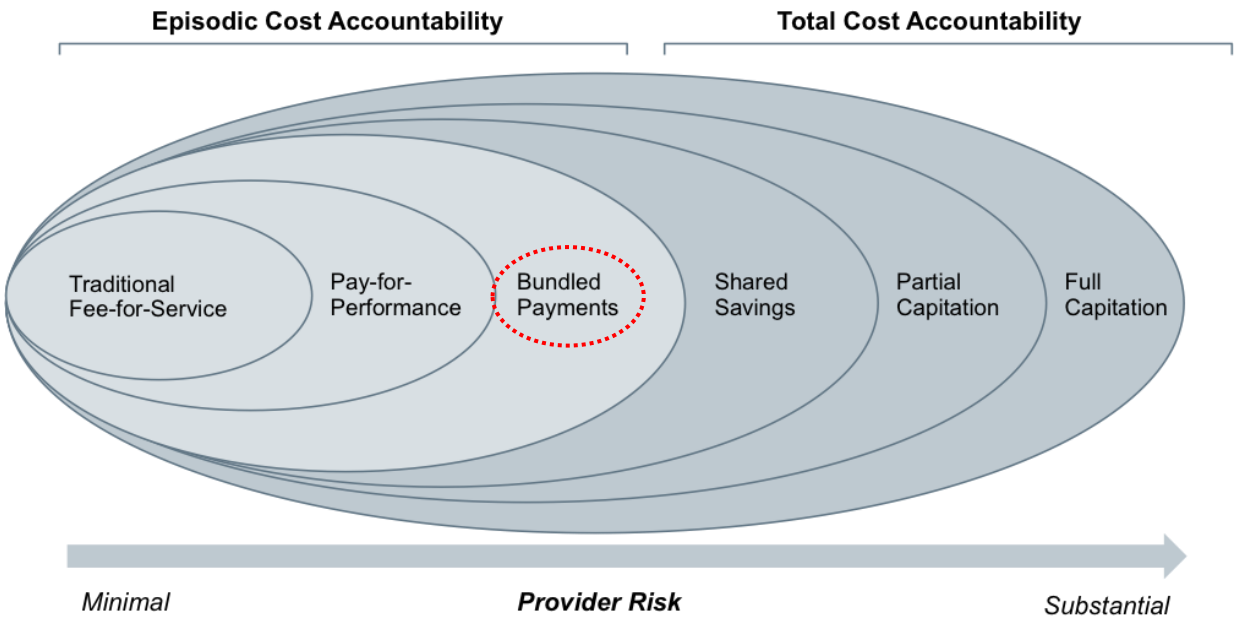
We understand the concerns shared by many of our members regarding hospital "control" of the bundle and potential pressure on SNFs to accept lower payments. Please note that SNF providers may participate in a bundled system in two very different ways. One may be as a participant in a bundled business model. In such a model, the hospital might be the organizer/initiator of the model. But, as we explain further on, a SNF could also be the organizer/initiator of the bundle.

Bundled Payments – An Overview

Definition

Bundled payments, also known as episodic payments, are reimbursements to providers based on the expected costs for clinically-defined episodes of care for a defined time period. Along the continuum of evolving payment models, as is shown in Figure 1 below, bundled payments lie somewhere between traditional fee-for-service and fully capitated or global payments. As providers move away from fee-for-service, their level of financial risk with a given patient, or patient population, increases.

Figure 1: Continuum of Payment Models



Source: The Advisory Board Company

Defining the Bundled Episode

Clearly defining the characteristics of a bundled episode is critical. Characteristics include the services and provider types that fall within the bundle, the initial site of care for an episode of care, and the length of the episode. Adjusting any of these characteristics can significantly impact the level of risk the provider in the bundle assumes, but also increase the overall episode savings. Each of these characteristics is discussed in more detail, below.

- ***Inclusion of Services and Provider Types:*** Services may include anything for which a provider is currently reimbursed under a fee-for-service model. Thus, in Medicare, bundled payments may include Part A hospital and SNF services, physician fee payments, and ancillary services (medications, laboratory tests, diagnostic imaging, etc.) The more services packed into a bundle, the greater financial risk to any of the providers because the total cost of the episode becomes more difficult to predict. Providers and services should be evaluated for inclusion in the episode based on *clinical criteria* and their likely *impact on variation* in episode payments[3].

- ***Originating Site of Care:*** The originating site of care is the site of care where the episode is initiated. The most common originating site of care is the hospital, but there are other models as well. In a post-acute-only episode, the episode may originate upon admission to the SNF. In other models, the episode may originate at the hospital, and it may retrospectively include a period of time prior to admission.

  Determining the originating site of care is important, because that provider must be able to "initiate" the bundle (i.e., having a method to identify the patient for downstream providers to be aware that the patient is part of a bundled episode). Additionally, at some point in time regarding some prospective payment models, the originating provider must be able to accept the bundled payment and pay downstream providers for furnishing services that fall within the episode parameters (see section below). And finally, determining the originating site of care may impact how many providers have the potential to treat the patient over the course of the episode; the more providers that are involved in patient care within an episode, the more complex the bundle becomes and the more risk the originating provider assumes.

- ***Length of the Episode:*** The length of the episode is a defined period of time beginning when the patient presents with the episode; all services by any provider furnished to the patient within this time frame is paid for from the original bundled payment. The length of the episode has direct correlation to the level of risk the provider assumes: the longer the episode length, the greater the risk and therefore the greater the potential for savings. To date, the literature has discussed episode lengths of usually 30, 60, or 90 days depending on the type of episode.

  For post-acute providers, two things are particularly important with regards to episode length. First, if the episode originates in a SNF, the provider must be willing to accept the risk of hospital readmissions if they occur within the episode. Second, if the episode originates upstream from the SNF (i.e., the hospital), then the provider must be aware of how far into the episode the patient is when they are admitted to the SNF, as the method and amount of payment may change during the patient stay. These details must be addressed in the negotiation and planning phase between the payer and other involved providers.

[3] See Risk Adjustment section below.

How Providers Are Paid

There are two ways in which bundled payments may be operationalized: *prospective payment* (an "actual" bundle) or *retrospective payment* (a "virtual" bundle).

- In a ***prospective*** (actual) payment model, the total bundled payment is paid up front to the provider. In this model, the provider manages the bundle and may be responsible for paying downstream providers who furnish services associated with the defined episode.
- In a ***retrospective*** payment (virtual) model, providers submit Medicare claims as they normally would in a traditional fee-for-service environment. At the end of the episode, there would be a reconciliation process: if the FFS charges were less than the bundle amount, the difference is paid to the providers. If the FFS charges were more than the bundle amount, the providers are responsible for paying that difference. The details of how the gains or losses are shared between the providers would be established in the contract ahead of time.

There are benefits and challenges to both approaches that must be considered. For example, while a prospective payment model would allow for a greater deal of flexibility in care delivery, it would require the bundle holding provider to have the infrastructure to be able to pay downstream providers who provide care during the episode. Most SNFs and post-acute providers do not have this type of infrastructure already in place, and many would find it difficult to do so. In a retrospective payment model, providers are able to bill fee-for-service as they always have done, but they would lack real-time information as to the amount of the bundle already spent, information that may be useful in managing the care delivery of that patient.

Risk Adjustment and Pricing the Bundle

One of the most challenging yet critical issues that will determine the success of a bundled payment model – and the success of the SNF provider – is how to price the bundle using appropriate risk-adjustment factors. Many post-acute providers and industry experts concur that a bundled payment model that uses hospital-based MS-DRGs alone to group patients into episodes does not accurately predict the level of care and costs of those patients in the post-acute setting.

AHCA research has shown that there can be tremendous variation in the post-acute costs of caring for patients within the same MS-DRG. This poses a significant challenge for post-acute providers, and so it will be critical to include *post-acute-specific risk adjusters*, in addition to general risk adjusters, for different bundled episodes. Examples of general and post-acute-specific risk adjusters are included in the table below:

General Risk Adjusters	***Post-Acute-Specific Risk Adjusters***
• Patient Demographics (age, sex) • Chronic conditions • Functional status • MS-DRG w/ comorbid conditions • Facility characteristics • Clinical pathway from hospital to home	• *Functional status specific to frail and elderly patients* • *Mental health status (dementia, depression)* • *Elective procedure vs. trauma* • *Need for certain extensive or specialty services*

In addition, post-acute providers should seek outlier policies and exclusion criteria in any bundled payment model. In an outlier policy, providers would receive an add-on payment for patients in a bundled episode who incur unpredictably high costs of care. Similarly, exclusion criteria would be used to identify situations or clinical conditions that are unrelated to the event that triggered the episode, and remove the costs of those conditions from the bundled payment model altogether (i.e., hip fracture patients who are receiving post-acute rehab who are also receiving chemotherapy cancer treatments that are completely unrelated to the hip fracture). Both of these tactics should be used accordingly to capture both predictably and unpredictably high cost patients.

To see a ***hypothetical*** example of how to apply this type of risk adjustment methodology for orthopedic episodes, please see the Appendix.

The Bundled Payments for Care Improvement Initiative

The Patient Protection and Affordable Care Act (ACA), signed into law in 2010, included a requirement that the Centers for Medicare and Medicaid Services (CMS) implement a national, voluntary bundled payment pilot by January 1, 2013. Last year, CMS announced the Bundled Payments for Care Improvement (BPCI) initiative. The BPCI initiative is comprised of four broadly defined models of care, which link payments for multiple services beneficiaries receive during an episode of care. Those models are[4]:

- **Model 1 – Acute Care Hospital Stay Only (Retrospective):** Under Model 1, the episode of care is defined as the inpatient stay in the acute care hospital. Medicare will pay the hospital a discounted amount based on the payment rates established under the Inpatient Prospective Payment System used in the original Medicare program. Medicare will continue to pay physicians separately for their services under the Medicare Physician Fee Schedule. Under certain circumstances, hospitals and physicians will be permitted to share gains arising from the providers' care redesign efforts. Participation will begin as early as April, 2013, and no later than January, 2014, and will include most Medicare fee-for-service discharges for the participating hospitals.

- **Model 2 – Acute Care Hospital Stay + Post-Acute Care (Retrospective):** In Model 2, the episode of care will include the inpatient stay in the acute care hospital and all related services during the episode. The episode will end either 30, 60, or 90 days after hospital discharge. Participants can select up to 48 different clinical condition episodes.

- **Model 3 – Post-Acute Care Only (Retrospective):** For Model 3, the episode of care will be triggered by an acute care hospital stay and will begin at initiation of post-acute care services with a participating skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency. The post-acute care services included in the episode must begin within 30 days of discharge from the inpatient stay and will end either a minimum of 30, 60, or 90 days after the initiation of the episode. Participants can select up to 48 different clinical condition episodes.

[4] Source: The Center for Medicare and Medicaid Innovation (CMMI), Bundled Payments for Care Improvement Home Page, available at: http://innovation.cms.gov/initiatives/Bundled-Payments.

- **Model 4 – Acute Care Hospital Stay Only (Prospective):** Under Model 4, CMS will make a single, prospectively determined bundled payment to the hospital that would encompass all services furnished during the inpatient stay by the hospital, physicians, and other practitioners. Physicians and other practitioners will submit "no-pay" claims[5] to Medicare and will be paid by the hospital out of the bundled payment. Related readmissions for 30 days after hospital discharge will be included in the bundled payment amount. Participants can select up to 48 different clinical condition episodes.

On January 31, 2013, CMS announced the over 500 organizations that were accepted to participate in the pilot. Over the course of the last year, CMS has been working closely with their group of applicants to identify challenges and work out the details of the pilot.

Post-acute providers, including SNFs, inpatient rehabilitation facility, long-term care hospitals and home health agencies will participate in models 2 and 3; hospice organizations have been excluded from participating in the BPCI initiative. Model 2 (Acute + Post-Acute) consists of 37 participants representing 75 facilities, and model 3 (Post-Acute only) consists of 14 participants representing 165 facilities. All applicants are currently in Phase 1 of the pilot (Planning Phase), with Phase 2 (Payment Phase) estimated to begin in June of 2013. All of the applicant organizations, with the details of the episodes and models they will be testing, can be found on CMS' Office of Innovation's (CMMI) website[6].

Challenges for Post-Acute Providers in Adopting Bundled Payments

Several provider members of AHCA applied to participate in the CMS initiative and were accepted. In communicating with these providers, AHCA has identified several key challenges posed to post-acute providers with the current structure of the BPCI initiative. These issues were raised in previous memos[7], and are as follows:

- ***The CMMI BPCI models are predicated on the MS-DRG classification system, which industry experts have found is not a good predictor of the cost and need of services in the post-acute setting.*** Perhaps the biggest challenge to post-acute providers is operating within a bundled payment model that is based on hospital MS-DRGs. AHCA, in coordination with research partners, has found that MS-DRGs do not accurately predict post-acute needs and costs and that there is wide variation of post-acute care within given MS-DRGs. Within the BPCI initiative, post-acute providers are forced to work within these constraints.

- ***CMS is currently moving forward with bundled payments at, and therefore has not yet developed a clinical classification system for bundled payments that is more appropriate for post-acute providers.*** AHCA is working on an alternative model of patient classification that more closely aligns to the costs of care in post-acute settings and intends to deliver it to CMS as a potential additional model.

[5] "No-pay" claims, or shadow claims, are claims to CMS which are specially coded to NOT receive payment. They are used to collect information and data only, with payment coming from another source (i.e., the hospital in a bundled payment model).
[6] CMS' Office of Innovation (CMMI) keeps a comprehensive database of all participant organizations and the models and episodes they will be testing, available at: http://innovation.cms.gov/initiatives/Bundled-Payments.
[7] See Appendix.

- ***The BPCI models require a sophisticated level of data sharing between providers in order to be successful.*** Acute and post-acute providers historically have not been good at sharing data across settings. In Model 2, it will be vital for hospitals and post-acute providers to share clinical and operational data in order to track patients within an episode. And in model 3, SNFs need to be able to share data with other post-acute providers (e.g., home health agencies). This is a significant challenge because, up until now, these settings have not had to share data, thus IT systems have been developed without that capability. IT systems will need to evolve quickly to accommodate this need.

- ***The BPCI uses limited risk-adjustment methodology.*** As described above, success of a bundled payment model largely depends on appropriate risk adjustment to account for the wide variation in post-acute costs for patients within a given MS-DRG.

AHCA and Bundled Payments

AHCA has remained engaged with its membership, providing guidance and instruction on how to get involved with the BPCI initiative. AHCA retained The Moran Company to provide insights and analytic resources. The AHCA-contracted Moran work was made available to facilities through the AHCA Bundled Payment Initiatives website[8]. The Moran Company is also conducting ongoing research intended to develop an alternative bundled payment approach that better suits the post-acute care industry. The findings of this research will be communicated to members once it has been completed, likely in the summer of 2013.

In addition, AHCA convened a Bundled Payments Workgroup comprised of interested and engaged members which meets regularly to review developments and discuss analytic findings from research.

And finally, AHCA remains engaged with its member organizations that have been accepted into phase 1 of the BPCI pilot as they move through the application and planning process. In the future, AHCA will use this memo series to communicate lessons learned to help educate and inform all members who may be exploring future BPCI initiative participation.

Next Steps for Providers

Issue #2 of this memo series *will focus, in more detail, on the specific action steps providers could be taking to prepare for participating in bundled payments.*

Those action steps include:

1. Visit the CMMI website[9] and identify any providers, specifically referral sources in the same health care market, who are participating in the BPCI initiative. Initiate a dialogue with those providers about their intentions and potentially collaborating in bundled payments.
2. Review the bundled payment episode list on the CMMI website and compare those with your facility to determine which episodes have a high enough volume to test. CMMI recommends

[8] All resources on bundled payments that have been developed by AHCA are available to members on the AHCA/NCAL website: http://www.ahcancal.org/facility_operations/finance/Pages/BundledPaymentInitiatives.aspx.
[9] http://innovation.cms.gov.

testing bundled payments with episodes for which the facility sees higher volumes to help account for variation in costs.

3. Watch out for communications from CMMI and from AHCA regarding the next phase of BPCI applications. AHCA will release regular communication with important announcements and milestones for the next application cycle.
4. Contact your AHCA Bundled Payments Team with any questions or comments. They are:

James Michel | jmichel@ahca.org | (202)898-2809
Elise Smith | esmith@ahca.org | (202)898-6305
Peter Gruhn | pgruhn@ahca.org | (202)898-2819

APPENDIX

Selected AHCA Memoranda – *available upon request.*

1. October 2011 – Memo to Members on CMS Bundling Initiative
2. November 10, 2011 – Differences Between ACOs and Bundled Payments
3. July 24, 2012 – AHCA Bundled Payment Update

Additional External Resources

4. Center for Medicare and Medicaid Innovation (CMMI): http://innovation.cms.gov
   Website contains a wealth of information on Medicare ACOs, including tools, maps, and informational documents.
5. *"Bundling" Payment for Episodes of Hospital Care*, Center for American Progress, July 18, 2011.
6. Cromwell J., Dayhoff DA., McCall NT., et al. Medicare Participating Heart Bypass Center Demonstration: Final Report. Prepared by Health Economics Research, Inc. 1998.
7. Abt Associates, Inc., Medicare Cataract Surgery Alternate Payment Demonstration: Final Evaluation Report, Cambridge, MA: Abt Associates, Inc; 1997.
8. Casale A.S. et al. ProvenCare: A Provider-Driven Pay-for-Performance Program for Acute Episodic Cardiac Surgical Care, Annals of Surgery. 2007;(246) 4:613-621.
9. Medicare Acute Care Episode Demonstration. http://www.cms.gov/DemoProjectsEvalRpts/downloads/ACESolicitation.pdf
10. Avalere Health. *Piloting Bundled Medicare Payments for Hospital and Post-Hospital Care: A Study of Two Conditions Raises Key Policy Design Considerations*. March, 2010.
11. Dobson | DaVanzo. *Medicare Payment Bundling: Insights from Claims Data and Policy Implications: Analyses of Episode-based Payment.* October 26, 2012.
12. Navigant Consulting, Robert Wood Johnson Foundation. *Global and Episodic Bundling: An Overview and Considerations for Medicaid*. April 2011.
13. AHA and AAMC. *Issue Brief: Medicare Payment Bundling*. October 2012.
14. Miller, Harold D., Center for Healthcare Quality & Payment Reform, Network for Regional Healthcare Improvement. *Implementing Episode and Bundled Payments*. 2011.
15. Peter S. Hussey, M. Susan Ridgely and Meredith B. Rosenthal. *The PROMETHEUS Bundled Payment Experiment: Slow Start Shows Problems in Implementing New Payment Models.* Health Affairs, 30, no. 11 (2011):2116-2124.
16. Steven F. Schutzer, MD, CT Joint Replacement Institute. *How to Develop a Bundled Payment Program: The Essentials.* Hartford, CT.
17. Government Accountability Office. *GAO-11-126R Private Sector Initiatives for Bundled Payments*. January 31, 2011.
18. Michael W. Painter, JD, MD. Robert Wood Johnson Foundation. *Bundled Payment Across the U.S. Today: Status of Implementation and Operational Findings.* Available at: www.hci3.org.
19. Bob Kelley, Center for Healthcare Analytics. *The Importance of Data & Analytics in a Bundled Payment Approach.* Prepared for Thomson Reuters, October 2011.

Hypothetical Risk Adjustment Model for Bundled Payments of Orthopedic Episodes

<table>
<tr><td colspan="12">All Bundled Orthopedic Conditions
Base Bundle Price: $10,000</td></tr>
<tr><td colspan="4">Hips
(most expensive)
Risk Adjustor: 1.25
Risk Adjusted Price: $12,500</td><td colspan="4">Knees
Risk Adjustor: 0.90
Risk Adjusted Price: $9,000</td><td colspan="4">Other Non-Hip/Knee
(least expensive)
Risk Adjustor: 0.70
Risk Adjusted Price: $7,000</td></tr>
<tr><td colspan="2">Traumatic
Risk Adjustor: 2.50
Risk Adj Price:
$31,250</td><td colspan="2">Elective
Risk Adjustor: 0.95
Risk Adj Price:
$11,875</td><td colspan="2">Traumatic
Risk Adjustor: 1.60
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