Post-Acute Care Bundling Plan –

Improving Patient Care and Reducing Health Care Costs??

by:

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Introduction

With our country enduring an economic recession and the national expenditure for health care exceeding sixteen percent of GDP, health care reform is no longer an academic argument but a fundamental part of the plan for economic recovery. Over the past several months, many policy ideas have surfaced for plans on revamping America's healthcare delivery system.

In December 2008, the Congressional Budget Office (CBO) released its much awaited report on budget options in Health Care. The CBO addressed many long standing policy and payment issues, which the new Obama Administration has at its disposal. One of the most controversial CBO budget options addresses Medicare's payment for post-acute services and President Obama's 2010 proposed budget lends further support in favor of this proposal. Also, on April 29, 2009 the Senate Finance Committee released its own version of this proposal in its description of policy options, "Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs."

Presently, as Medicare beneficiaries with complex health conditions and multiple co-morbidities move between hospital stays and a range of post-acute care providers, Medicare makes separate payments to each provider for covered services across the entire episode of care. The controversial solution proposed by the CBO and Senate Finance Committee and supported by President Obama is to bundle payments for acute care and post-acute care services provided within the first thirty days after being discharged from an acute care hospital.

Motivation Behind Proposal

The Medicare Payment Advisory Commission (MedPAC), among others, has expressed concern that providers do not have financial incentives to coordinate across episodes of care. MedPAC also believes that providers do not properly evaluate the full spectrum of care a patient may receive. Additionally, there is also a lack of accountability of providers for all care provided during the episode of care.

In its June 2008 report, MedPAC reported that 18 percent of Medicare hospital admissions result in readmissions within 30 days post-discharge and these readmissions accounted for $15 billion in spending in 2005. According to MedPAC, approximately $12 billion of this spending may represent potentially preventable readmissions. In light of these findings, MedPAC has recommended that Medicare payments to hospitals with relatively high readmission rates for certain conditions be reduced. In this report, MedPAC also recommended that a bundled

payment system be explored for an episode of care where separate payments for distinct types of providers would be eliminated.

Current Medicare Fee-for-Service Program

The Medicare fee-for-service program pays health care providers fixed amounts for each service provided to beneficiaries. Medicare pays for most acute care hospital stays and post-acute care services, including inpatient rehabilitation facility stays, long-term acute care hospital stays, skilled nursing facility stays, and home health care visits. Medicare has a different payment system for short term acute care hospitals and for the various post-acute care venues.

Short term acute care hospitals are paid under the inpatient prospective payment system (IPPS), while inpatient rehabilitation facilities (IRF) and long term acute care hospitals (LTACH) have separate payments systems, the IRF prospective payments system (PPS) and LTCH PPS, respectively. Under each PPS, a predetermined rate is paid for each unit of services, such as a hospital discharge or a payment classification group.

Thus, under the current Medicare fee-for-services program, short term acute care hospitals receive payment for Medicare patients discharged under the IPPS. Presently, Medicare payments cover Post Acute care in one of four settings: Long Term Acute Care Hospitals, Inpatient Rehabilitation Facilities, Skilled Nursing Facilities, and Home Health Agencies.

When patients are discharged from a short term acute care hospital to a post-acute venue, a new admission is triggered. Thus, the post-acute venue will receive payment for this patient upon discharge from the facility based upon the relevant payment system involved.

Post-Acute Care Bundling Proposal Details

Under the CBO and Senate Finance Committee proposals, short term acute hospitals would become the gatekeeper of all post-acute care. Under the post-acute care bundling plan, the unit of payment for acute care provided in hospitals would be redefined and expanded to include post-acute care provided both in acute care hospitals and non-hospital settings. Hospitals would receive a single bundled payment from Medicare for such services. Post-acute payments should include home health, skilled nursing, rehabilitation hospital, and long-term care hospital services.

The new bundled payment rates would initially be set equivalent to the current rate paid for each Medicare severity diagnosis-related group (MS-DRG) plus the average costs across all post-acute care settings for treating patients in that MS-DRG. Hospitals would receive the full bundled payment regardless of whether a specific patient received post-acute care.

Therefore, under the proposed post-acute care bundling plan, Medicare would no longer make separate payments for post-acute care services following an acute care inpatient hospital stay. In other words, for the first thirty days after discharge from a short term acute care hospital, payments for acute care and post-acute care services would be bundled into one single payment to the short term acute care hospital. Thus, post-acute services would be provided either directly by the hospital or by other providers under contractual arrangements with the discharging hospital.

The CBO plan proposes that bundled payments would be implemented in three phases. Starting in October 2014 (FY2015), phase one of the policy would be implemented and would apply to admissions for conditions that account for the top 20 percent of post-acute spending. In determining which conditions to include in the bundle for phases one, CMS would be required to include a mix of the following conditions: chronic and acute, surgical and medication, those with significant variation in readmission and post-acute spending, and those with high-volume and high post-acute spending.

Phase two would be implemented in FY 2017 and would apply to admissions for conditions that would account for the next 30% of post-acute care spending. Starting in FY 2019, the final phase of bundling would be implemented and would include all other conditions and MS-DRGs that account for the remaining 50% of post-acute care spending.

Proposed Timeline for Implementation of Post-Acute Bundling Policy

2014	April-August: CMS would release proposed and final rule FY 2015: 1st phase would start in October and apply to first 20% of post-acute spending
2015	1st phase continues
2016	April-August: CMS would release proposed and final rule FY 2017: 2nd phase would start in October and would apply to next 30% of post-acute spending
2017	1st and 2nd phases continue
2018	April-August: CMS would release proposed and final rule on final phase of bundling FY 2019: Final phase would start in October and would apply to remaining 50% of post-acute spending

Source: Senate Finance Committee

Industry Reaction

On May 15, 2009, the American Academy of Physical Medicine and Rehabilitation (AAPM&R) submitted comments to Senate Finance Committee Chair Max Baucus (D-Mont.) and committee ranking minority member Charles Grassley (R-Iowa), expressing their concerns relative to the committee's description of policy options – T*ransforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs*. The Academy specifically addressed the issue of bundled payments for acute and post-acute hospital care and said that "without any evidence-based medicine studies to prove that the concept is indeed cost effective, any bundling proposal should be examined closely, pilot-tested, and problems should be resolved prior to implementation". The Academy stated that the proposals "may negatively impact patients and the quality of care."

In addition, AAPM&R made the following recommendations to the committee that must be pursued prior to the implementation of post acute care bundling:

1. Conduct pilot demonstrations of any proposed bundling method (acute hospital and post acute hospital control of the bundled payment) and systematically analyze the results of any acute- Post Acute Care (PAC) bundling experiment prior to its wholesale adoption;
2. Complete the PAC Payment Reform Demonstration (PAC-PRD) project, analyze data from the Continuity Assessment Record & Evaluation (CARE) tool, and factor these findings into the design and assessment of bundling; and
3. Obtain detailed data on clinical conditions, costs, access and outcomes for potentially affected patients and post acute care providers.

Conclusion

While the economic crisis requires some changes in the healthcare industry, it is imperative to ensure proposed changes do not jeopardize the quality of patient care received in the United States. Some critics of the post-acute care bundling policy comment that providing a fixed payment based on a diagnosis to the short term acute care hospital creates an inherent financial incentive for these hospitals to under serve the most severely impaired patients. Also, bundled payment might not match the costs of treatment as well as payment currently does under Medicare's prospective payment system. These considerations must be fettered out in the coming years in order to assure that patient care does not suffer in order to save healthcare costs.

It is the opinion of this author that the present bundling proposal is fraught with ambiguity and may have a significant impact on the delivery of post acute care; in particular, physical medicine and rehabilitation. All in all, it appears we are headed down a rocky road as we struggle with the means to maintain a balance of quality of care, quality of life, accessibility and costs efficiency / containment. This issue will not be resolved without much dialogue and compromise. STAY TUNED!

About the Author:

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