Bundled Payments Aren't Mandatory for Everyone (Yet): Is Your Group Ready?

written by Dave Halpert | January 6, 2016

It's taken more than a half-century, but the Medicare Final Rule on Comprehensive Care for Joint Replacement (CCJR) has set in motion utilization reporting that will shift the focus from static data about diagnoses, services and days in hospital to meaningful information about care transitions and outcomes.

It's taken a long time. But now that we're here, the train is leaving the station. The big question facing providers: with Medicare's push to ensure that compensation from Alternative Payment Models (APMs) accounts for half of reimbursements by 2018, is a Bundled Payment the best APM for you and your group?

A Little Historical Background

Believe it or not, the idea that the medical profession is using overly simplistic metrics to define utilization, given the complexity of patient care, was introduced back in 1965—and embellished in a paper published two years later. The authors argued that utilization data "couched in such elementary terms as counts of visits and days" does not represent the "changing scope and character of medical care." Sound familiar?

Indeed, we're still struggling to understand why a patient was re-admitted when reviewing quality reports. Was this the result of natural disease progression, or was discharge premature? There have been payment models intended to address fragmented care and utilization, but they've been limited (e.g. the Inpatient Prospective Payment System, or IPPS).

Alternative Payment Methods are Here to Stay

With the arrival of APMs, Medicare is now forcing the conversation to change. Utilization measurement and reporting must reveal reasons for hospitalization and discharge as a step toward improving patient outcomes. This move is key to Value-Based Health Care.

Some providers will have no choice but to participate in Bundled Payments. Starting on April 1, 2016, and continuing over the next five years, 67 metropolitan areas are locked into the Comprehensive Care for Joint Replacement (CCJR) program, which will track costs associated with Hip and Knee replacements, from the procedure through 90 days post-discharge. While costs may not be the best substitute for inpatient days as a measure of utilization, an astonishing variance in those costs among different institutions reflects differences in quality.

Others have an option to participate and can do so by selecting a payment mechanism and any of 48 bundles. However, October 1, 2015, marked the end of the "free trial" period and the start of downside risk, and not surprisingly, some providers are starting drop out. Bundled Payments are not (yet) mandatory for most, and providers do not want to take unnecessary financial risks.

But that strategy is only good for so long. Bundled Payments are becoming more common methods of reimbursement within the Private Health Plan community, including Anthem, Aetna, UnitedHealth Group, and Blue Cross and Blue Shield. Coupled with Medicare's goal to transition half of reimbursements to APMs by 2018, programs similar to CCJR are likely to emerge.

How to Evaluate Your Readiness for Bundled Payments

For those who are not in the CCJR community, consider these questions before pursuing Bundled Payments:

1. Do you have the technical capability (or, are you using a CDR to effectively share data with your Bundled Payment partners)?

Private groups are neither clinically nor financially integrated with the hospital, meaning that each side is missing a piece of the puzzle. This leads to duplicative, inefficient care—or worse. It's no secret that complications aren't coded to the extent that they actually occur, or that patients may provide different information to different providers. Each of these scenarios can contribute to a poor outcome, and without a mechanism for identifying why it occurred, there is no opportunity to address the problem. Simply tallying inpatient days, tests performed and other services rendered will not illuminate whether the process broke down, or where. To succeed in an episode-based care initiative like Bundled Payments, you need a Clinical Data Registry (CDR).

We've previously written about how CDRs are instrumental in improving outcomes over time, and how they'll help you fulfill emerging CMS EHR reporting requirements, and even how a Registry can help you succeed in Bundled Payments.

The ability to understand why an adverse outcome occurred is the only way to determine how to avoid its repetition. CDRs will provide a distinct advantage to their clients by facilitating patient care and care transitions from an episode, from beginning to end. Those who are not using a CDR will find themselves struggling to answer the same 50-year-old questions.

2. Does it make sense from a clinical standpoint (or, are your episodes centered on conditions or procedures)?

Bundled Payments, regardless of the episode, are triggered by MS-DRG codes. For a patient to be eligible, he or she must have been discharged from the hospital. For many bundles that focus on procedures, that's a given. There will obviously be variations within the population (an active 65-year-old and an overweight 80-year-old may each find her way into the total knee replacement bundle), but the episode itself is more defined—specifically, as the procedure and inpatient care, plus the care received 90 days post-discharge.

On the other hand, those who opt for condition-based bundles are putting themselves in a riskier position. How? Their bundles will only apply to patients with chronic conditions who have been hospitalized. In particular, patients who are in the eligible denominator for bundles focused on congestive heart failure, COPD and diabetes only become eligible based on a hospitalization for these conditions—categorized as the dreaded Ambulatory Care Sensitive Condition (ACSC) admission. Medicare considers these types of admissions failures on the ambulatory care side; higher rates of ACSC admissions for attributed patients are detrimental to ACO and VBPM quality composites. In other words, you are starting with patients who are out of control—and counting against your quality tier.

For some, that may be an incentive to pursue this option—focusing on a group of patients with poor outcomes may prevent a downward spiral, preserving the patient's health and your group's quality profile. For others, this may be too significant a risk. Yes, there will be risk-adjustment, which should account for a condition's complications, but that may be too much of a gamble for those just starting to get a feel for Value-Based Health Care.

3. What will this mean for you professionally (or, have you considered personal and professional risk, reputation and relationships)?

In an endeavor specifically designed to align providers, have you considered your practice's

referrals, reputation and risk? Ask yourself the following questions:

> As a hospital administrator, what do you do if a private group has better outcomes than providers in the same specialty in your employed group? As a provider, if you choose to opt out, what will happen to your referrals?
> If you are a private group who is going in with a hospital on a Bundled Payment, do you know if there are others doing the same? A procedure-based episode may include surgery, anesthesia, infectious disease and more, any and all of which may be coming in from the private side. Do you know with whom you're aligned?
> Do you have enough information to determine whether your financial risk is in keeping with your share of the services in the bundle?

The Time is Now to Plan Ahead for APMs

The 2018 deadline, when reimbursements from APMs eclipse traditional Fee-for-Service payments, is just down the track. Bundled Payments are among the most popular, but you may decide that they're not for you—at least, not yet.

Whether you choose to participate in Bundled Payments or not, however, the concept is here to stay, and will soon be applied on a broader scale. Like the mandatory CCJR, specialty care models are either already in place (ESRD) or in development (the Oncology Care Model). Even ACOs are getting into the game, leveraging their care coordination efforts in an effort to succeed simultaneously in two programs.

Regardless of your choice, consider your technical, clinical and professional preparation as you make the leap from Fee-for-Service to Value-Based Health Care—and commit to greater depth than counting services, days or diagnoses. This isn't 1965, after all.

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