Deirdre Baggot and Andy Edeburn

mandated bundled payments compel hospitals to rethink post-acute care
FEATURE STORY

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Medicare’s Comprehensive Care for Joint Replacement program signals an evolution in payment that demands a strong strategic response from hospitals and health systems.

Over the past three years, we have observed a shift in the way hospital and health system executives view the post-acute care continuum. Many health systems walked away from the post-acute care business in the late 1990s and early 2000s, closing their inpatient rehabilitation and skilled nursing units and selling off home health and other post-acute care assets due to lagging payment.

With the passage of the Affordable Care Act (ACA) in 2010 came significant reforms in payment, inviting a new level of cross-continuum integration and presenting an opportunity for shared accountability for clinical outcomes that is virtually unprecedented in the U.S. healthcare system. On July 9, the Centers for Medicare & Medicaid Services (CMS) took another bold step, announcing its intent to mandate a 90-day bundled payment model in the form of a new program for Medicare beneficiaries undergoing lower-extremity joint replacement—given that the annual price for major joint replacements is estimated at $7 billion. The program, called the Comprehensive Care for Joint Replacement (CCJR) initiative, is based on the Bundled Payments for Care Improvement (BPCI) program launched in 2011 and on evidence gleaned from the Acute Care Episode (ACE) demonstration project from 2008 through 2010. The model’s aim, according to CMS, is to improve cost efficiencies, patient outcomes, and collaboration among various types of providers for an episode of care.

AT A GLANCE

Health care is on the brink of an industrywide shift to a bundled payment model in which payment covers episodes of care extending from prehospitalization into post-acute care. Hospitals and health systems should begin development of a post-acute care network strategy in preparation for bundled payments. The strategic effort will require four broad phases:

> Defining the value proposition
> Developing the post-acute care network
> Building the bundle
> Executing smartly from the start with new delivery models that reduce clinical variation and real-time performance monitoring
For acute care hospitals and health systems, bundled payment is no longer an option—it is an inescapable reality. The CCJR Model represents the first of what is likely to be a series of hospital-based bundles, given CMS’s stated intention earlier this year to accelerate deployment of value-based payment initiatives. CCJR places all risk for the 90-day episode with the hospital, which should compel hospital leaders across the country to start thinking outside their walls.

The initial impact of bundled payments in general will be to eliminate the demand for unnecessary testing and treatments. Acute and post-acute care providers alike should expect to see reductions in inpatient diagnostic testing, patient length of stay (LOS), avoidable readmissions, and inpatient rehabilitation facility (IRF) and skilled nursing facility (SNF) utilization. There also will be a need for closer scrutiny of physician preference items.

The net financial impact of such changes will be substantial for most providers. Bundled payments create incentives for a new set of behaviors for the entire industry, all aimed at giving patients specifically what they need in the most cost-effective setting. To successfully navigate this new risk paradigm, hospitals must understand cross-continuum economics and reconceive their engagement and contracting strategies to include post-acute care providers and the associated risk.

**A Call to Action**

Ready or not, Medicare’s mandated 90-day bundle will require immediate action. Astute hospital and health system leaders will quickly lock in network partners and make critical buy-versus-build decisions when it comes to developing post-acute care capability.

When developing a risk-based relationship extending into post-acute care, healthcare executives should address two major considerations: the need for workforce development and the pervasive lack of technology and health information in the post-acute care world. Much of the post-acute care workforce lacks the necessary clinical skill and ability to manage medically complex patients. Meanwhile, post-acute care lags seven to 10 years behind hospitals in terms of integrated health information system development.

These limitations are no cause for hesitation; quite the opposite, they illuminate precisely why it is so important for health system to get started now on locking in post-acute care network development strategy with the right partners, whether for CCJR or for other bundled payment initiatives. The process will require four broad action steps.

**Step 1: Defining the Value Proposition**

As an organization increases its commitment to post-acute care bundles, it should define the value proposition associated with such a shift. Beyond the looming imperatives posed by CMS around bundled payment adoption, a change in payment approach inevitably drives alternative or innovative approaches to how care is delivered. Fortunately, bundles will push providers along the path to better outcomes and better health.

Building a bundle means considering the broader episode of care and all the players involved in that time frame—the post-acute care provider, physicians, ancillary providers, and even patients. Any episode is rife with opportunities for process improvement and greater efficiency. The acute care hospital bundler should consider

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**KEY FEATURES OF THE COMPREHENSIVE CARE FOR JOINT REPLACEMENT (CCJR) MODEL**

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<th>Category</th>
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<td>Eligible to bear risk</td>
<td>Hospitals and health systems in only 75 preselected markets</td>
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<td>Participation</td>
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<tr>
<td>Episode length</td>
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<tr>
<td>Baseline period</td>
<td>Years 1 and 2: 2012 to 2014 Years 3 and 4: 2014 to 2016 Year 5: 2016 to 2018</td>
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<td>Target price</td>
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the following questions, among others, to define the new standard of delivery:
> How will care be delivered across network providers?
> Which providers are most appropriate to care for a particular patient population?
> When, where, and how will physicians and physician extenders render care?
> What are the most effective means for actively involving patients and families in the care process?
> What critical performance and outcome measures are truly most helpful for managing total cost of care?
> What tools and technology are required to enable the integration of care processes across settings?

Using an informed selection process, bundlers will likely choose to align with only a few post-acute care providers within their markets. As a result, market share will shift—perhaps from 20 historical providers to three to five preferred organizations. These select providers will experience more volume, which may pose challenges initially but will inevitably promote greater care efficiency and better outcomes. Because aligning with fewer facilities will help minimize the bundler’s span of control, the bundler can focus its resources to improve performance in that smaller pool. In truth, less means more, a growing body of literature has shown with respect to health care.

In combination, these considerations drive a value proposition around a care and service experience that is markedly different from fee for service. Patients, physicians, and providers have greater opportunity for engagement, and payers realize savings from a better product.

**Step 2: Developing the Post-Acute Network**
Hospital executives and providers all too often are not fully informed about what exactly happens when a patient leaves the hospital. Some may be surprised that as much as 50 percent of the spend in a given episode of care can be related to post-acute care. Therefore, as Medicare continues to introduce new approaches to payment transformation such as bundled payments, it is critical that hospital leaders embark on the process of selecting and developing a post-acute care network with their eyes wide open.

Post-acute care is much more than long-term care delivered via SNFs or in-home services. Over the past several years, post-acute care providers have developed expanded capabilities to address clinically and medically complex populations. Physician roles in post-acute care medicine have expanded greatly, and many value-based organizations view post-acute care as an essential part of their broad continuum. In the drive to value-based payment, early-adopter organizations have not let post-acute care be an afterthought.

Despite this evolution, all too many acute care provider organizations lack adequate knowledge and awareness of the post-acute care providers in their communities, including their capabilities, outcomes, and efficiency in delivering care. Gaining such understanding should be a key step for a hospital in ramping up for bundles, to inform efforts to identify the best partners for the organization’s bundled payment strategy.

More important, however, is clearly defining and understanding the risks and rewards associated with post-acute care. From a risk perspective, high post-acute care LOS and readmission rates drive up cost. Post-acute care use is highly variable (as is cost), with few controls in place. Hospitals can realize the rewards of decreased utilization, shortened LOS, and improved patient satisfaction from such partnerships by addressing post-acute care provider skill and redesigning care. Hospitals should take steps to engineer best-in-class approaches to standardize care transitions with post-acute care providers, and create opportunities for knowledge transfer to these providers. Integrating post-acute care providers into hospital care transition and readmission committee structures is just one

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a. This statement is based on findings of research performed by The Camden Group in 2014.
example of the cross-setting competency development that is necessary to manage total cost of care.

In short, knowledge of the providers and the risk-reward factors is essential before exploring a bundle involving post-acute care. Subsequent steps in the process serve to more effectively qualify the opportunity and establish specifics.

**Step 3: Building the Bundle**
An organization that is preparing for bundled payment for episodes extending into the post-acute care period faces four key considerations.

**Population.** Some populations, such as cardiology patients, have relatively low post-acute care utilization, while such utilization tends to be higher among other populations, such as orthopedics patients. Historical readmission rates for the population also are an important consideration to ensure that the pricing supports the risk.

**Pricing.** Payment often lags behind technology, so when determining pricing for the acute and post-acute care portions of the bundle (assuming the bundle is not part of a Medicare initiative, where CMS unilaterally sets the target price for the bundle), it is essential to go in with a clear picture of historical costs. Hospitals are not used to looking at total cost of care over a 90-day period, for example, and often find this information illuminating. Careful analysis and scenario building based on historical claims data will ensure that pricing is well on target.

**Volume.** Sufficiency of volume to address the associated risk is important to ensure that the economics of the bundle work. Because joint replacement often represents a high-volume procedure for hospitals, the CCJR initiative offers an ideal opportunity to accelerate the learning curve. But the typical distribution of these patients across multiple post-acute care venues potentially dilutes the ability to optimize ROI. Again, consolidation of the post-acute care provider base is essential. A post-acute care provider’s willingness to engage with a hospital and invest in its own infrastructure will hinge on how much volume it can expect to receive, so it will want to see that it is among the hospital’s select few preferred partners.

**Opportunities to increase savings.** Identifying opportunities for additional savings involves a more specific evaluation of post-acute care provider performance, often with respect to LOS and readmission behavior, and is examined more fully below.

For any of these four areas, historical provider practice patterns remain the most reliable predictor of future behavior, or at least the basis for guiding change. Thus, in-depth analysis of available claims data (e.g., Medicare or commercial) will inform historical volume and use patterns related to various episodic time frames (commonly 30, 60, or 90 days). The results of this analysis can help answer key questions, such as:

- What time frame for a bundle makes the most economic sense for the organization?
- What is the benchmark price of a given bundle?
- Does the particular clinical condition covered by the bundle have sufficient volume against which to spread the risk?

In considering opportunities to increase savings, historical-use data can provide an array of measures (often at the individual provider level). But such results should be compared with the desired targets or benchmarks, which usually are better than current or historical behavior. For instance, if a nursing home’s typical LOS after a major joint replacement is 24 days and a “well-managed” target is 15 days, the net difference between these two figures represents an opportunity both for improvement (via care redesign) and for net savings. Such circumstances also present opportunities for sharing the savings among the bundle participants.

**Step 4: Implementing Effective Care Processes and Performance Monitoring**
When the bundled payment inevitably goes live, executing effectively right out of the gate is
critical. If well-executed, a single bundle relationship with a post-acute care provider can be the prelude to a much deeper relationship over time. For the executives who closed the deal, there is nothing worse than getting the “Yes!” and then having it fall apart over poor execution.

For both acute and post-acute care organizations, care redesign and implementation of the changes often are the critical ingredients in determining program success. Real-time information on new patients entering the bundle enables leaders on both the acute and post-acute care sides to ensure that the deal is secure and moving forward.

To this end, hospitals should monitor the performance of their post-acute care partners using performance measures established with input from the partners. Measures such as complication rates, LOS, and readmission rates (i.e., major drivers of cost) should be monitored and reported in as close to real time as possible. Additional measures—such as patient experience of care, ancillary use, and physician utilization—also should be tracked, but with the understanding that they are secondary to the economics of the bundle.

Cross-continuum bundles succeed when there is concurrent information exchange through technology leveraged across settings and providers. A checklist can serve as an easy first-phase approach to ensure smart execution, especially when systems are not yet talking. Although systems to effectively track and monitor measures ideally will involve integration among health information platforms that capture actual utilization and cost data, most post-acute care measurement is likely to be manual or self-reported.

Effective performance monitoring depends on having clear processes for reporting and documenting essential data. In total, these data should inform an ongoing financial analysis of the bundle—specifically, performance with respect to the desired financial targets, given changes in post-acute care use.

Although Medicare bundled payment evaluations rely predominantly on retrospective comparisons that take place long after conclusion of the episode, future-thinking bundlers should seek to create systems that offer more timely and predictive results. Because ubiquitous access to health information is not yet the norm (particularly in the post-acute care environment), explicit contract terms that spell out performance monitoring will ensure all parties are winning with the bundle.

For hospital executives, CMS’s CCJR Model represents a clear signal of the agency’s intent to extend bundled payments across an array of both conditions and provider types—all with a goal of reducing unnecessary testing and treatment. Beyond the CCJR initiative, commercial payers are looking at similar opportunities to reduce costs. The significant role that post-acute care will play in this evolution makes it incumbent on hospitals to accelerate their efforts today to establish a strong post-acute care network.

About the authors

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