Caring Transitions

Bundled Payments, CBOs Drive Care Transitions

This column continues the discussion regarding programs within the Affordable Care Act (ACA) that impact care transitions in long-term care. The two programs reviewed here are the Bundled Payments for Care Improvement (BPCI) initiative and Community-Based Care Transitions Program (CCTP). A fair question as a nursing facility medical director is: "Why should I care?" The answer is that unless you and your facility carefully review the trends barreling down at the post-acute/long-term care (PA/LTC) sector, the facility will not thrive and perhaps not even survive.

Skilled nursing facilities (SNFs) across the country are being contacted about participating in one, or both, of these programs, and some are already participating. Some uninfomed SNFs are entering into contracts to participate in such programs for two reasons: first, to fill empty beds; and second, is with the mistaken belief that the only financial risk is related to simply not being paid. However, uninfomed entry into such agreements can result in poor payment or may make the SNF responsible to repay losses incurred in the program, regardless of the facility’s performance. As is often the case in PA/LTC, an informed medical director can determine success or even avert monetary ruin.

BPCI Initiative

The BPCI initiative is a voluntary program that began in 2013 and is administered through the Innovation Center of the Center for Medicare & Medicaid Innovation (CMMI). The Innovation Center was created by the ACA to test innovative payment and service delivery models that have the potential to lower costs while preserving and enhancing quality of care in the Medicare, Medicaid, or Children’s Health Insurance Program. CMMI has the authority to redesign all payments within the CMS-DRG payment system that applies a discount to historical based reimbursements with a possible share in any savings. This can be subdivided into three options with the prospective payment for one of three choices of care episodes: inpatient care only, inpatient stay plus postdischarge services, or postdischarge services only.

Model 1: A retrospective payment system that applies a discount to historically based reimbursements with a possible share in any savings. This can be subdivided into three options with the prospective payment for one of three choices of care episodes: inpatient care only, inpatient stay plus postdischarge services, or postdischarge services only.

Model 2: A bundled payment is provided for a medical event that begins at a hospital and subsequently involves post-acute care. The episode will end 30, 60, or 90 days after hospital discharge. Participants can select up to 48 different clinical episodes.

Model 3: A bundled payment for post-acute care that does not involve an inpatient hospital stay. CMS selected more than 165 operators to take part in Model 3. The post-acute care services included in the episode must begin within 30 days of discharge from the inpatient stay and will end either 30, 60, or 90 days after the initiation of the episode. Participants can select up to 48 different clinical episodes.

Model 4: Only inpatient stay and readmissions for selected Diagnosis-Related Groups (DRGs) with compensation via a prospective payment bundle. All practitioners, including physicians, submit claims to Medicare but are paid by the hospital from the bundled payment. All services furnished during related readmissions for 30 days after hospital discharge are also included in the bundled payment amount. Participants can select up to 48 different clinical episodes.

The second and third models are the most relevant to the LTC community, as they define episodes of care to include clinical services delivered in both the hospital and post-acute facilities (Model 2) or the post-acute environment alone (Model 3). LTC clinicians and medical directors can have an enormous impact on these models. Any savings accrued can be shared with physicians based on risk-sharing agreements negotiated between the risk-bearing entity and the LTC physician.

CCTP Project

The CCTP is a 5-year demonstration project created by Section 3026 of the ACA, and funded and administered through the CMMI. Started in 2011, the program provides funding to local community-based organizations (CBOs) as the payee and critical partner. The CBOs are contracted to provide services across the continuum of care and must have formal agreements with a suitable array of partners, including a hospital or hospital. CBOs then partner with acute care hospitals to test models of improved care transitions for high-risk Medicare patients moving from the acute hospital to other care settings. There also must be sufficient representation of multiple health care stakeholders, including consumers, on the CBO board.

The initial award is for 2 years, with annual renewal thereafter based on performance. With 102 sites participating across the country, the program will provide care transition services to nearly 700,000 Medicare beneficiaries in 40 states over the next 5 years.

Many CCTP sites are seeing positive results in lowering hospital readmission rates. However, other program sites are having difficulty meeting the CCTP requirement that each program reduce hospital readmissions. Challenges have included:

Low enrollment, with some sites unable to meet their enrollment benchmarks.
Meeting the required 20% reduction in readmissions within 2 years. This is due in part to administrative delays in data reporting from CMS and upfront costs to recruit and train program personnel.
Concerns regarding the performance measure metric. The 20% readmission reduction will include all high-risk fee-for-service beneficiaries across partner hospitals whether or not they are enrolled in the CCTP program being measured. Of particular note, the language in the enabling Section 3026 for the CCTP program denotes no specific readmission targets, the 20% readmission reduction standard having been set administratively.

Initially, $500 million was authorized to be distributed over 5 years to eligible CBOs. However, in March 2013, a Senate continuing resolution stripped $200 million from the $500 million that had been appropriated for the duration of the CCTP. Facility directors and practitioners have voiced concern about reducing support for a program that is an incubator for innovative ideas in care transitions that can drive cost-effective improvements, and whether current programs are sustainable over time to demonstrate their effectiveness.

Both the BCPI and CCTP programs will be successful only with knowledgeable, engaged post-acute care partners, particularly LTC facilities and their providers. The window of opportunity is now open. How widely, and for how long, remains to be seen.

(Editorial note: These programs are evolving rapidly. Numbers of participants and operational aspects were current when this column was written.)

A past AMDA president, Dr. Lett chaired the AMDA workgroup that created the clinical practice guideline “Care Transitions in the Long Term Care Continuum” and currently is chairman of the AMDA Transitions of Care Committee. You can comment on this and other columns at www.caringfortheages.com, under “Views.”

By James Lett II, MD, CMD

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