

## **Bundling Post-Acute Care Payment Conference Report June 24<sup>th</sup>, 2009**

On June 24<sup>th</sup>, 2009, I represented the AAPM&R at a one-day conference: “Bundling Post-Acute Care Payment,” at Georgetown University in Washington, DC. Speakers at the conference included Academy members Dr. Bruce Gans and Dr. Dexanne Clohan. About 150 people attended.

It was the consensus of the speakers that bundling is a very complex issue and that any bundling plan should begin as a demonstration or pilot project and be field-tested. Various configurations were presented. This is consistent with the Academy’s May 15<sup>th</sup>, 2009 letter to Senators Baucus and Grassley. *A key issue which was not addressed in the letter is whether or not physician payment should be included in the bundling.*

The complete conference is available at [www.postacuteconference.org](http://www.postacuteconference.org)

It is well to recall that in President Obama’s June 15<sup>th</sup> speech on Healthcare Reform to the AMA, he stated: “We need to bundle payments so you aren’t paid for every single treatment . . . but instead are paid for how you treat the overall disease.”

Here is a summary of the presentations and discussion:

### **Health Reform: Five Stories, Five Insights, and Five Truths**

Jon Glaudemans, Avelere Health

Mr. Glaudemans said that he was “not bullish on prospects for healthcare reform this year.” He discussed his “Law of Complex Systems: everything must go right, it fails if one thing goes wrong,” as a key to successful healthcare reform. He believes that “the public must be engaged.” He suggested that the “debate is driven by re-hospitalization and care site/transition concerns . . . bundling presumes relationships that do not exist in many markets. . . the role of physicians should not be underestimated or ignored. . . Likely to start in large-scale, semi-voluntary projects. . . absence of take-up in private market should give advocates pause.”

### **The Building Blocks of a Bundled Payment system for Post-Acute Care (PAC)**

Gerben DeJong, PhD, National Rehab Hospital

Dr. DeJong noted that the current system is “sub-optimal, inefficient,” but that “bundling has not been tested. . . we need to guard against unintended consequences. . . to make this happen, we need consensus. . .” He discussed various structures: post-acute care only, acute + post-acute, acute + physician, acute + physician + post-acute. and various time frames: 7 days, 30 days, 45 days. He questioned whether “services should be bundled differently for different types of patients based on the natural history of the condition, disease, or disability,” and “to what extent should payment be linked to outcome?” He discussed “who/what should be the accountable entity?” in detail. He advocated demonstration projects and pilot studies.

Respondent:

Melinda Beeuwkes-Buntin, PhD  
Rand Corporation

Dr. Buntin reported “what we hope to gain from bundling: to improve quality, to decrease the cost of health care delivery, and prevent downstream complications.” She felt that “fee-for-service is to blame for the current problems.” She concluded that “everyone is in favor of the concept of bundling.”

How Should Bundled Payments be Structured Bundling from the Prospective of an  
Administrative Price Setter

Allen Dobson, PhD, Dobson / DaVanzo

Dr. Dobson reviewed the diversity of the current payment systems to acute care hospitals (ACH), long-term care hospitals (LTCH), skilled nursing facilities (SNF), inpatient rehab facilities (IRF), and home health agencies (HHA). He identified readmission/ transfers and short and long stay outliers as key issues. He reviewed his “Study of Hospital and Post-acute Care Episodes (SHAPE),” which concluded that bundling should “start with the ACH admission and include the SNF, IRF, LTCH, and HHA PCA settings.” He questioned “can we incorporate existing PPS (prospective payment system) payment technologies?” and the role of pay-for performance.”

Respondent:

Alan Sauber, RehabCare

Mr. Sauber identified the following “common themes: acute care will not control the money, doctors will not be outside bundling,” and that “it will not be in the next two years.” He concluded that it will occur “incrementally.”

Accountable Organizations: What Can Current Episodes of Care Tell Us?

Barbara Gage, PhD, Research Triangle Institute

Dr. Gage noted that both President Obama's initiatives to improve access and limit costs and Congress' initiatives to increase inefficiencies propose "bundled payments." She noted that 20% of Medicare beneficiaries are hospitalized at least once per year and that 35% of those hospitalized will be discharged to post-acute care as follows: 41% SNF, 37% HHA, 10% IRF, 9% Outpatient, 2% LTCH. She also noted that most patients will use more than one post-acute care provider during a single episode of care, with IRF patients subsequently using HHA (45%), Outpatient Therapy (17%), SNF (13%), and 12% Readmits. She identified "Case Mix Complexity" as the most important factor predicting service use/cost. She listed four domains: medical severity, physical functional impairments, cognitive functional impairments, and social support environmental factors.

Respondent:

Bruce Gans, M.D., AMPRA

Dr. Gans identified bundling as a "tactic, not a goal," to address the issue of variation in care (underutilization and overutilization). He cautioned that this would be a "massive change with increased risk," and warned to "watch for unintended consequences." He identified AMPRA priorities: "quality care (top priority), full access, transparency, the disabled are vulnerable, doctors are important in the system." He concluded that people are intrinsically irrational and we need safeguards for accountability."

Respondent:

Judith Dahl, Visiting Nurse Service of New York

Ms. Dahl noted that their typical patient has four co-morbidities and eight daily medications. She recommended that Home Health Models be "nurse managed and nurse led."

Quality Metrics for Post Acute Care Bundling

Allan M. Jette, PT, PhD

Dr. Jette reviewed some limitations for traditional measurement methodology for creating post-acute care quality indicators and concluded that “in post acute care, it is vital to have quality measures that transcend sites of care.” He identified a “common set of quality indicators to evaluate outcomes as patients move across sites of care” as the “critical challenge,” and the “diversity within post-acute care” as a “huge challenge.” He reviewed current post-acute care “legacy tools,” and “computer adaptive testing” with the “activity measure for post-acute care (AM-PAC CAT).” He concluded by emphasizing “the need to focus on outcomes, not process.”

Respondent:

Toby Edelman, Center for Medicare Advocacy

Ms. Edelman emphasized the preservation of choice and recommended that screening criteria be relative, not absolute.

Respondent:

Dexanne Clohan, M.D., HealthSouth

Dr. Clohan discussed functional measurement tools and cost efficiency. She noted similarities with Pay-For-Performance.

Respondent:

Reg Warren, PhD  
Senior Matrix

Dr. Warren discussed functional measurement and transparency.

Post-Acute Care Bundling

Bill Altman, Kindred Healthcare

Mr. Altman noted that there is “little known about the real world implications of bundling . . . (it is) untested except for managed care and integrated health systems like Kaiser and Geisinger.” He remarked that “bundling could be capitation by another name.” He noted that “entities other than acute care hospitals could control the bundle.” He recommended that we “proceed incrementally, testing a variety of models.” He advocated pilot studies and demonstration projects.

Summary and Conclusions;

Dr. Gerben DeJong

Dr. DeJong identified “Key Themes:”

1. The current system is substandard and inefficient.
2. We should take an incremental approach to bundling.
3. What should be in the bundle? Where should it start? Where should it end?
4. Capacities vary across the country.
5. Do no harm.
6. Test multiple models – demonstration projects.
7. Health care reform is not certain, bundling may endure anyway.
8. Bundling will require an infrastructure, regulation, a metric, and information technology.
9. Where does patient choice come in?
10. Shared risk and shared benefits.
11. Who should be the bundler?
12. We will need quality indicators that can capture the diversity of settings and patients.

I appreciated the opportunity to represent the Academy at this conference.

Leon Reinstein, M.D.