

Rural Issues Related to Bundled Payments for Acute Care Episodes

Overview

Bundling is the practice of providing a fixed payment for a set of services. For example, the current DRG system is a form of bundling as it gives hospitals a single payment for all the services provided to the patient in the hospital. Recent bundling proposals would, in essence, expand the DRG payment for certain conditions and procedures to include post-acute care services. Hospitals would then either have to provide post-acute care themselves or establish arrangements with post-acute care providers. Bundling payments makes the most sense for those episodes of acute care that have the largest post-acute care expenditures and where coordination of care can significantly impact patient outcomes. Examples of the types of care episodes that fit these criteria and that also are prevalent in rural hospitals include pneumonia, stroke, hip fractures, congestive heart failure and acute myocardial infarction.

A Centers for Medicare and Medicaid Services (CMS) demonstration project is assessing the feasibility of bundled payments for acute and post-acute care episodes with a focus on urban-based integrated delivery systems (CMS, 2007). The effective implementation of a bundled payment system faces several challenges, including ensuring that hospitals can form the necessary agreements with other providers on how the single payment will be allocated, measuring quality and implementing quality improvement initiatives and the construction of risk-adjustment systems. Implementing bundled payments in rural settings raises several additional challenges if the policy is to achieve its desired results.

1. Bundled payments may improve the quality of care in rural areas but the impact is likely to be unevenly distributed across geography and care systems

Bundled payments are likely to work best in integrated health care systems where it is easier to align incentives across care modalities. While there are several large integrated health systems in rural areas, much of the rural health care infrastructure is not formally linked to other

providers. Current and past bundled demonstration projects have focused on integrated systems linking predominantly large urban-based providers. It is unclear if the findings of the demonstrations can be generalized to a rural context.

Challenges in making bundled payments work in non-integrated environments:

- Allocating a bundled payment across providers can be a complex and time consuming negotiation that can vary according to the bundle of services, availability of post-acute care providers, and the service capacity of the admitting hospital.
- Urban referral centers will have an incentive to provide post-acute services for discharged rural patients to improve efficiency and quality of service delivery.
- Contracts among rural providers will likely favor physicians and hospitals over other post-acute providers because of their greater bargaining power. Thus, post-acute care providers may see a decline in their net Medicare reimbursements.
- Appropriately aligning incentives across providers requires some form of monitoring. The rural environment poses particular challenges in monitoring including the lack of health information technology infrastructure and low levels of competition, with some providers having sufficient bargaining power to compromise the goal of bundling contracts.

Potential Strategies to Address this Issue:

- CMS should design optimal contractual arrangements to provide rural providers with templates to minimize the cost of negotiating contracts across providers and the potential imbalance of provider bargaining power.
- CMS should develop risk and volume-adjusted performance criteria to facilitate contract monitoring and selection of post-acute care providers for contracting.

- CMS should provide contract guidance and technical support for small rural providers negotiating contracts with larger urban and rural referral centers.

2. Bundled payments may lead to greater provider consolidation and fewer provider options in rural markets.

Since bundled payments work best in integrated systems, rural providers will have incentives to consolidate vertically and horizontally. This increased consolidation could impact the costs of health care and private payer premiums as well as the number of uninsured and under insured.

Rural patient referrals for the types of care likely to be covered in the initial phases of bundled payment implementation will largely go to urban and larger rural referral centers. These providers may be less likely to transition their patients to post-acute care settings in or near a discharged rural patient's community. Such changes in care patterns may lead to a decline in demand for post-acute care facilities in rural areas. The resulting loss of Medicare reimbursement for rural hospitals could undermine their ability to provide lower-margin safety net services. Lower-volume providers with a high dependence on Medicare revenue such as nursing homes and home health agencies will be particularly vulnerable to changes in care patterns.

Potential Strategies to Address this Issue:

- Congress should adjust the criteria for monitoring the anti-trust implications of provider mergers and acquisitions (such as the Hart-Scott-Rodino thresholds) to increase their sensitivity to scale differences found in rural health care markets.
- The Office of Rural Health Policy should assure that rural providers are fully aware of the Department of Justice/Federal Trade Commission anti-trust enforcement policies regarding service delivery integration.
- Where feasible, CMS should require larger hospitals to establish multiple post-acute contracts to accommodate consumer choice in health care providers and settings.

3. Incorporating Critical Access Hospitals into a bundled payment mechanism may be infeasible

Almost two-thirds of all rural community hospitals are Critical Access Hospitals (CAHs), which receive cost-based reimbursement for inpatient, outpatient and swing bed services. Cost-based reimbursement of CAHs could provide

a counter-incentive to the goal of bundled payments. The challenge for policy makers is to appropriately pay CAHs under a bundled payment mechanism without financially jeopardizing CAHs or discouraging referral facilities from contracting with CAHs for post-acute services.

Potential Strategies to Address this Issue:

- Policy makers should consider:
 - Exempting CAHs from the bundled payment methodology by continuing cost-based payments for acute and post-acute services. This option would allow CAHs to receive the same levels of reimbursement, but could provide a counter-incentive to the efficiency goals of bundled payments. It could affect the willingness of larger rural and urban referral centers to accept transferred CAH patients. It could also undermine the ability of CAHs to successfully bid on contracts with referral centers and provide an incentive for those facilities to keep sub-acute care patients instead of referring them to CAH swing beds.
 - Carving out post-acute services provided by CAHs to patients who are referred by larger rural and urban acute care providers. CAHs could be paid for these services under the same bundled payment methodology used for Prospective Payment System (PPS) providers. While this option would likely contribute to achieving bundled payment goals, it could create significant financial challenges for CAHs, especially if outpatient services are included. It could limit CAHs' abilities to continue offering lower-margin, safety net services, particularly if third party payers follow Medicare's lead.
 - Creating a "fixed-bonus" payment for CAH acute and post-acute services to support the continued operation of CAHs and avoid loss of access to needed services in rural communities without alternative sources of care. Performance incentives can be incorporated into the bonus payment methodology to encourage service delivery efficiencies and quality.

4. Under a bundled payment system, safeguards may need to be implemented to protect consumer choice and patient/provider relationships

There will be strong incentives to keep the provision of post-acute services within the admitting hospitals' organizational umbrella or under contract with neighboring providers. The potential loss in access to post-acute providers in a rural patient's own or nearby community threatens a consumer's right to choose their care setting.

Without sufficient safeguards, patient choice may be lost, support for patient self-management and treatment compliance may be compromised, and the well-being of rural residents could be jeopardized.

Potential Strategies to Address this Issue:

- CMS should implement contract requirements that encourage patient choice such as documenting that a specific percent of discharges of rural residents from referral hospitals are able to obtain post-acute services within a reasonable distance from their home community (e.g., within 30 miles).
- CMS should foster communication to assure care coordination during the transition between hospital discharge and transfer back to the patient's community (e.g., treatment plans for post-acute providers, medication reconciliation and care plans sent to the patient's primary care provider).

Reference

CMS, Acute Care Episode Demonstration: Implementation and Support Contract, U.S. Department of Health and Human Services, Baltimore, MD, 2007.

Additional Information

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