



Statement for the Record

Submitted by

The Premier healthcare alliance

House Energy and Commerce Subcommittee on Health

“Medicare Post Acute Care Delivery and Options to Improve It”

April 16, 2015

The Premier healthcare alliance appreciates the opportunity to provide a statement for the record of the House Energy and Commerce hearing, titled “*Medicare Post Acute Care Delivery and Options to Improve It.*” Premier, Inc. is a leading healthcare improvement company, uniting an alliance of approximately 3,400 U.S. hospitals and 110,000 other providers to transform healthcare.

Among the more than 110,000 alternative care sites in the Premier alliance are skilled nursing facilities, home health agencies, rehabilitation centers and long-term acute care facilities.

Together, Premier’s hospitals, post-acute care sites and other providers are seeking better ways to reduce the fragmentation of healthcare and increase coordination of care. Premier operates a number of large-scale collaboratives, including those focused on bundled payment and accountable care organizations (ACOs), in which Premier health systems push for improved quality at a reduced cost.

We applaud the leadership of Chairman Joe Pitts and Ranking Member Gene Green for holding this important hearing. While there are many initiatives our alliance members can undertake on their own to improve the quality, safety and affordability of healthcare, continued government

action is needed to fix perverse payment incentives and foster greater coordination of patient care.

Aligning incentives across the full continuum of care through bundled payments

The current fee-for-service (FFS) payment system impedes healthcare providers' attempts to achieve high-quality and cost-effective healthcare. Premier believes that one promising approach that breaks down the existing silos of care aligns providers' incentives and improves patient outcomes and satisfaction is bundled payment.

Because of the goal of coordinating care, bundled payments can include participation by multiple provider types across the continuum of care. We believe it is critical to include the full continuum of care across payment silos to improve patient outcomes and achieve better value. Bundling post-acute care payment systems alone will not achieve the transformations that patients, providers and the government are seeking.

A post-acute care bundled payment model based on hospital-related conditions that does not include the inpatient hospital stay in the bundle is similar to constructing a building without starting with the foundation. For episodes that start with a hospital stay, such as hip/knee joint replacement, the episode should include the hospital stay and a time prior to hospitalization. Including acute inpatient and post-acute care into a single payment bundle provides the most opportunity for market innovation in post-acute care coordination for Medicare beneficiaries. Unlike the existing silo-based fee-for-service arrangements, providers would have strong incentives to work together to provide quality, cost-effective services across the acute and post-acute spectrum of care and to actively manage transitions between sites of service. With a single payment bundle triggered by a hospital stay, preventable hospital readmissions and medically unnecessary use of post-acute services would be discouraged, and quality measures could be employed to ensure that beneficiaries receive the post-acute services needed to promote the best outcome.

By contrast, creating a bundle for post-acute payment that is separate from the acute inpatient stay that triggers the bundle continues the fragmentation of care that does not serve the best

interests of Medicare beneficiaries or the Medicare program. This fragmentation leads to poor care transitions and care coordination among providers, which hurts outcomes of care and patient satisfaction. While a separate bundle would offer post-acute providers new incentives to improve coordination within the bundle, innovation would be stifled by excluding the payment for the hospital stay that is integral to defining the episode of care. For example, a patient plan of care initiated for the post-acute bundle that is separate from the discharging hospital's planning and readmission reduction efforts could result in duplication of effort among providers, confusion for beneficiaries and their families, and might not achieve the most efficient use of Medicare's resources.

There are many examples of the fragmentation and divergence from patient-centeredness that could emerge based on segmenting a bundled payment. Some examples include the exclusion of the admitting physician and care team from the planning and implementation of the post-acute bundle, issues related to communication for the transition of care, and the need for the development of multiple care plans - one for the acute stay, and then one developed by the PAC entity responsible for the bundle for the post-acute timeframe. For an improvement in clinical outcomes to be achieved, there is a need for consistent planning across the continuum of care. Best practices for discharge planning, such as Project RED¹, suggest that a team-based approach with consistent care planning and communication leads to the best outcomes. By not officially including the care team from the hospital in the bundled payment, there is a large possibility for inconsistency between the two care plans.

The Medicare Payment Advisory Commission (MedPAC) identified a number of advantages to bundling payments for combined hospital-post-acute care, including encouraging care coordination between providers, encouraging more efficient resource use across an episode of care, narrowing the wide variation in post-acute care spending and improving quality of services. Specifically, in the June 2013 report to Congress, MedPAC noted that a post-acute care-only bundled payment model may not achieve the levels of care coordination of larger hospital plus post-acute care bundles because providers would have fewer incentives to coordinate care between the hospital and the PAC settings. In addition, the commission noted

¹ <https://www.bu.edu/fammed/projectred/newtoolkit/ProjectRED-tool2-how-to-begin.pdf>

that post-acute care providers could encourage physicians and discharge planners to refer beneficiaries to post-acute care, which could generate unnecessary care. Commissioners also discussed that improved care coordination could result in better and fewer care transitions between settings, lower risk of readmissions, and less time elapsed between hospital discharge and post-acute care admission.

A combined inpatient plus post-acute care payment bundle builds on incentives already in place in the Medicare hospital payment system. Medicare's inpatient Value-based Purchasing (VBP) program scoring system heavily weights hospital performance on a measure of Medicare spending per beneficiary that includes all expenditures for an episode of care beginning three days prior to a hospital stay and extending through 30 days post-discharge. Because post-acute providers are not affected by the inpatient VBP program, incentives are not aligned and hospitals currently have little or no ability to affect the post-acute expenditures that are a key component of their performance on this measure. Additionally, the substantial penalties in place under Medicare's Hospital Readmission Reduction Program have already led hospitals to develop innovative post-discharge care management programs for Medicare beneficiaries at risk of readmission. A combined payment bundle would encourage more fruitful results from these requirements by aligning post-discharge care coordination activities of hospitals with those of post-acute providers, and providing the tools needed to ensure that care is delivered efficiently throughout an episode of care.

Advancing bundled payments through a permanent, national program including acute and post-acute care

We believe it is time to move beyond pilot programs and implement a broad-scale, permanent, voluntary bundled payment program that includes both acute and post-acute care. Whereas a post-acute care bundle that excludes the acute care portion is wholly untested, this type of model has already been tested by the Centers for Medicare & Medicaid Services (CMS) through the Acute Care Episode Demonstration, among other programs, and such arrangements are successfully operating in the private sector. Premier members have participated in these

programs, as well as the Center for Medicare & Medicaid Innovation's Bundled Payments for Care Improvement (BPCI) initiative that is currently underway.

With the investment of time and resources needed to implement bundled payments, providers can be reluctant to engage in these transformative efforts because of uncertainty about whether such payment systems will ever be deployed widely. The enactment of a national, voluntary bundled payment program would provide certainty to providers by placing a stake in the ground, signaling that Congress and CMS are dedicated to improving quality and safely reducing costs for Medicare beneficiaries through such a mechanism. This will assure providers that bundled payment is not a passing fad, but one they can invest in for the long term. At the same time, making it a voluntary program will give providers time to redesign their care processes and take steps that will allow them to transition to accepting greater payment risk.

With sustained diligence and oversight by Congress to advance models such as bundled payments that create incentives for efficiency and better care coordination, we are confident that we will continue on the path toward higher quality care while bending the cost curve.