Bundle Up for Value-Based Heart Failure Care

Christopher M. O’Connor, MD, FACC, Editor-in-Chief, JACC: Heart Failure

A single twig breaks, but the bundle of twigs is strong.
—Tecumseh (1)

With the announcement in 2013 that Medicare will embrace the Bundled Payments for Care Improvement initiative, the government has signaled that it is serious about value over volume. Two additional signals have been made: the Centers for Medicare and Medicaid Services (CMS) stated that by 2018, 50% of payments will be for alternative models such as Bundled Payments for Care Improvement and accountable care organizations, and in July 2015, CMS announced a mandatory bundle for lower joints in select geographic regions. These actions make it clear that there will be no turning back from value-based care. The payment model going forward will include financial and performance accountability for episodes of care. Currently, health systems are encouraged to participate in demonstration projects to learn how to coordinate care when bundled payments become mandatory for many high-ticket conditions, especially heart failure.

To this end, heart failure is the subject of one of the most important bundled care initiatives, given the high rate of hospitalization and high readmission rates within 30 to 90 days after admission, as well as excessive costs. The objectives of these bundled care payments are to improve care coordination, provide collaboration, increase quality, and reduce costs. The program represents an initiative based on value-based reimbursement, not volume-based payments. In some proposals, hospitals assume all the financial risks in the program. This provides an incentive for physicians to participate in the program, which is exciting and affords the possibility of improving the care of our patients with heart failure. Commercial payers are expected to follow CMS’s lead, expanding their own bundled-payment programs.

Model II is believed to have an important opportunity for heart failure care compared with the other models, in that it has the lowest minimum discount for CMS.

What will be included in the bundle? CMS sets the target price for an episode on the basis of historical spending, minus 2% savings for Medicare. If spending is below the target, the savings is split between the health system and health care providers. In Model II, the only way to reduce overall cost within an episode of care is to reduce post-acute care utilization, which includes readmissions (2).

Strategies to improve the value of the care of patients with heart failure include redesigning care pathways, enhancing care delivery, patient engagement, risk management, and care coordination. Between 10% and 30% of patients with heart failure are admitted to skilled nursing facilities after their initial hospitalization. In this setting, length of stay in skilled nursing facilities range from 20 to 30 days. This represents a great opportunity for a reduction in cost by reducing the length of stay in skilled nursing facilities and reducing the number of patients who actually go to these facilities by using more aggressive home health care methods.

In an example of how this might work for the health system, the savings will be shared between the health system and the physicians. Assume, for example, that the benchmark of care for heart failure is $5 million for an institution. With the 2% CMS discount, the cost of care would be $4.9 million, and the actual costs would be $4.4 million. The savings would be $500,000, and with a 15% administrative cost, $475,000 would be divided between the hospital and the physicians, at $237,500 each. If 10 physicians
participated in this proposal, they would each receive $23,750 for their participation in the coordination of care. Not bad for doing the right thing!

It is likely that not only cardiologists but hospitalists, geriatricians, and midlevel providers who participate will also be part of the shared proposal. The distribution would be determined on the basis of professional fees for services provided by each of the providers who participated in the care. The gain-sharing for each physician will also be adjusted to reflect quality metrics and citizenship scores, with the quality metrics weighted at 75% and citizenship weighted at 25%.

In the end, it is believed that the opportunities for bundled care in heart failure are promising within the CMS innovation projects and subsequent mandated care initiatives. In the bundled care experiments that CMS is advocating, many hospitals have already moved to integrated delivery models and may not be able to show substantial savings in care. However, the heart failure bundle is still of particular interest because of the high rate of readmission and the high use of skilled nursing facilities in which coordinated care has been neglected. There is a great variation in hospital readmissions and cost on the basis of teaching versus nonteaching, large versus small, and safety-net versus non-safety-net hospitals (3). Because we have had a culture of team-based care, disease management, and strategies to reduce readmissions at 30 days, heart failure clinicians are uniquely poised to tackle this change in reimbursement with success.

In summary, the emphasis is on quality, reducing the fragmentation of care, and value for patients, the health care delivery system and health care providers. To this end, let's all bundle up for heart failure care.

ADDRESS CORRESPONDENCE TO: Dr. Christopher M. O'Connor, Editor-in-Chief, JACC: Heart Failure, American College of Cardiology, Heart House, 2400 N Street, NW, Washington, DC 20037. E-mail: jacchf@acc.org.

REFERENCES

