Why is the Commission looking at bundling again?

• Policy world has moved forward since Commission recommendations in 2008
  • PPACA bundling pilot
  • CMS innovation center initiatives
  • Private sector efforts
  • Post-acute care demo / CARE tool
• Bundling provides another FFS strategy apart from ACOs to manage spending while increasing value
Definition of a bundle

• Single payment for an array of services
• Bundles used in current Medicare fee-for-service
  • Home health episode
  • Inpatient admission
  • Day of SNF care
• Bundles can be defined more broadly by combining services across settings
  • Hospital and physician services during inpatient stay
  • Services provided for some time period after discharge from hospital
Bundling around a hospital stay and services provided post discharge

- Current policy
  - Hospital
  - Physician during hospital stay
  - Readmissions
  - PAC provider: SNF HH IRF LTCH
  - Physician post discharge
  - Other services: Outpatient DME Drugs

- Bundling option 1
  - Hospital bundle

- Bundling option 2
  - Hospital + post discharge service bundle
Why bundle?

- Discourages volume of services within bundle
- Encourages more efficient use of resources
- Encourages coordination across providers
- Potentially improves quality
- Could lower program spending
Why focus on PAC services in a bundle?

- PAC services account for a substantial portion of program spending
- Patterns of post-acute care spending may not reflect efficient care
  - Setting used for PAC greatly affects total episode spending
  - Patient placements for PAC are not necessarily most clinically appropriate
  - Observe substantial variation in PAC spending within condition and across geographic areas
Importance of PAC services differs by condition and patient severity

Source: MedPAC analysis of 2004-2006 5% Medicare claims files.
Including PAC services provides opportunity for program savings

- PAC spending varies substantially within condition for same severity level of patient

<table>
<thead>
<tr>
<th>Condition</th>
<th>25&lt;sup&gt;th&lt;/sup&gt;</th>
<th>75&lt;sup&gt;th&lt;/sup&gt;</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip &amp; femur SOI 1</td>
<td>$6,697</td>
<td>$12,829</td>
<td>1.9</td>
</tr>
<tr>
<td>Heart failure SOI 1</td>
<td>949</td>
<td>4,007</td>
<td>4.2</td>
</tr>
</tbody>
</table>

- Substantial geographic variation in PAC spending
  - 2-fold difference from 10<sup>th</sup> to 90<sup>th</sup> percentile
  - 8-fold difference from lowest to highest spending areas

### CMS bundling initiative

<table>
<thead>
<tr>
<th>Model features</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services covered</td>
<td>Hospital</td>
<td>Hospital + MD + post discharge + readmissions</td>
<td>Post-discharge + readmissions</td>
<td>Hospital + MD during stay + readmissions</td>
</tr>
<tr>
<td>MS-DRGs</td>
<td>All</td>
<td>Selected</td>
<td>Selected</td>
<td>Selected</td>
</tr>
<tr>
<td>Payment Rate</td>
<td>Discount on PPS rate—</td>
<td>Negotiated target price</td>
<td>Negotiated target price</td>
<td>Negotiated discounted prospective rate</td>
</tr>
<tr>
<td>Min discount</td>
<td>0.5% to 2.0%</td>
<td>2.0% to 3.0%</td>
<td>None</td>
<td>3.0%</td>
</tr>
<tr>
<td>Payment to provider</td>
<td>PPS rate minus discount</td>
<td>FFS with reconciliation to target</td>
<td>FFS with reconciliation to target</td>
<td>Prospective rate</td>
</tr>
<tr>
<td>Gain sharing with physicians</td>
<td>Allowed</td>
<td>Allowed</td>
<td>Allowed</td>
<td>Allowed</td>
</tr>
</tbody>
</table>
Bundling design issues

- Scope of services—separate or combined with hospital bundle
- Hospital readmissions
- Time period
- Paying for the bundle
Separate PAC and hospital bundles or a combined bundle?

- Payments are more likely to be accurate with separate bundles than a combined bundle
- Combined bundle
  - Predict who gets PAC AND
  - Predict cost of all services
- Separate bundles
  - Predict cost of each bundles’ services
Bundle design needs to consider uneven PAC use

Share using PAC

- Hip replacement
- Stroke
- CABG
- COPD

30-day spending for stroke, level 4 severity

No PAC users

PAC users

$ - $20,000 $40,000

Hospital Post-discharge

Source: MedPAC analysis of 2004-2006 5% Medicare claims files.
### Scope of service: separate PAC-hospital bundles or a combined one?

<table>
<thead>
<tr>
<th>Option</th>
<th>Advantages</th>
</tr>
</thead>
</table>
| Separate hospital and PAC bundle | • Payment likely to be more accurate  
• Minimizes patient selection  
• PAC use based on clinical, not financial considerations |
| Combined bundle             | • Strong incentive to coordinate care  
• Strong incentive to control PAC use |
Options to discourage hospital readmissions

• Include readmissions in the bundle
  • With separate PAC and hospital bundles, need to decide which providers will be at risk for readmission

• Pay for readmissions separately and apply readmission penalty to PAC providers
Time period of the bundle

- Short—e.g. 30 days after discharge
  - Parallels hospital readmission policy
  - Limits liability for PAC care
  - Excludes a large share of PAC use
- Long—e.g. 90 days after discharge
  - Includes most PAC use
  - More flexibility but also more risk
Setting the payment

• Setting a payment based on care needs not site of service
• How much of current practice patterns to include in setting the payment?
• Need to ensure payment level does not encourage stinting or inappropriate site selection
Matching the payment method to characteristics of the condition

Part cost/part prospective payment method

- Quality hard to measure
- Care needs not clear
- Best practice unknown

Medically complex

Fully prospective payment method

- Quality measures available
- Care needs clear
- Best practice known

Hip replacement
Risk adjustment

- Key to discouraging patient selection and stinting
- Allows fair comparisons of facilities
- No method is perfect
- Exploring addition of comorbidities and functional status to hospital stay information
Measuring performance under bundled payments

• Multiple dimensions need to be assessed
  • Spending
  • Outcomes and clinical quality
  • Patient experience
• Monitor increases in bundles
  • Counter with admission policies?
• Detect stinting on care
  • Counter with pay-for-performance or inlier policies or payment method design
Other issues to consider

• Protect against potentially large losses
• Balance beneficiary freedom of choice and networks of providers
Next steps

• Refine risk adjustment
• Develop a data set to examine different bundling options
• Examine variation in spending to consider payment amounts
• Model alternative payment amounts for a bundle (one price for all institutional PAC settings)
Questions for Commissioners

- What additional analyses would help you consider scope, time period, level of payment, and payment method?
- Are there bundling designs we should exclude from our analyses?