Using episode bundles to improve the efficiency of care

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Purpose of the value-based purchasing (VBP) program

- The basic FFS system lacks incentives to improve quality and limit unnecessary services
- Medicare moving towards tying its FFS payments to value
- Hospital value-based purchasing (VBP) ties a small share of hospital payments to quality metrics and Medicare spending per episode
- Should we increase the magnitude of the incentive in the VBP program?

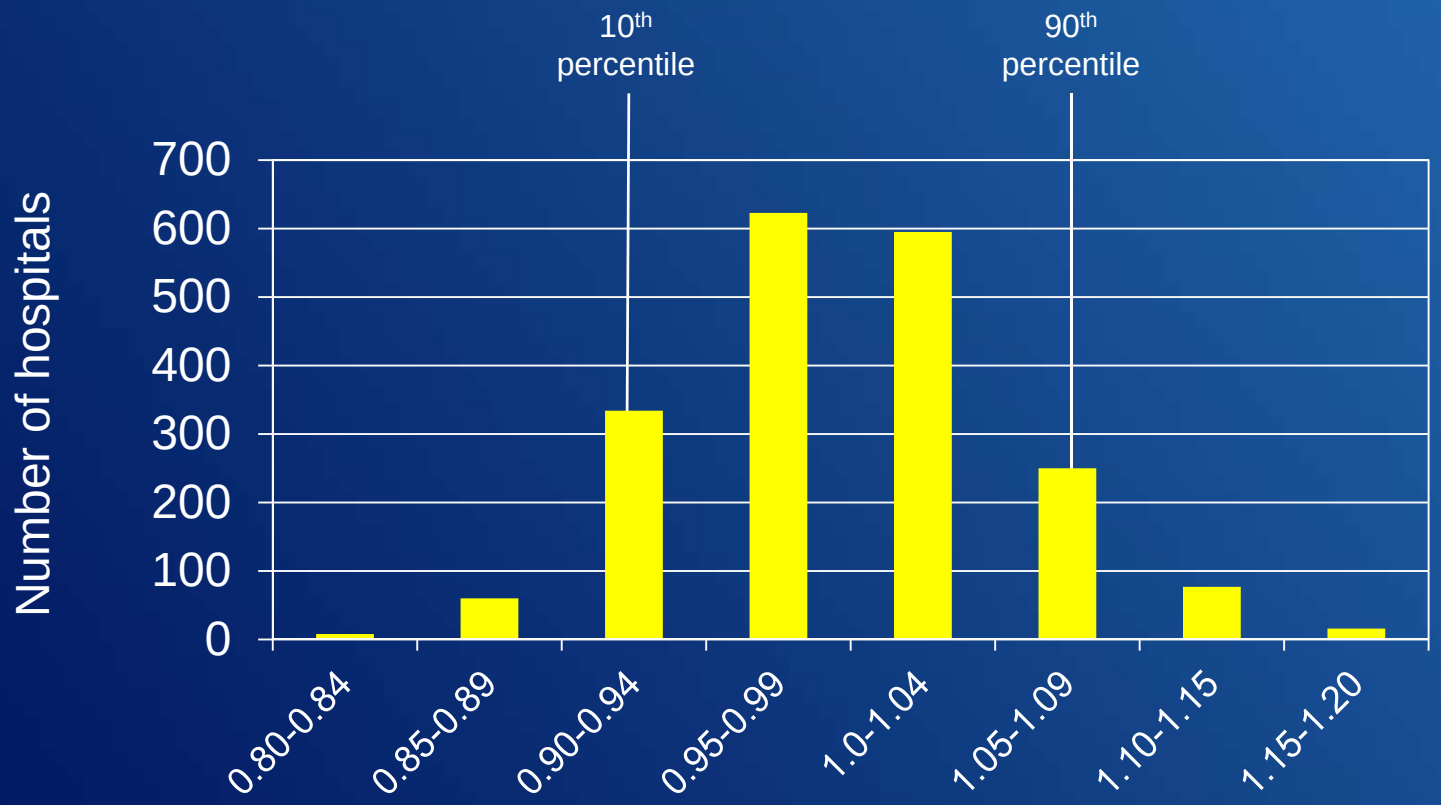
Value-based purchasing for hospitals

- The VBP program began in fiscal year 2013
- For 2017 and future years, 2% of payments are tied to value
- Value measures:
  - Medicare spending per beneficiary (25%)
  - Quality measures (75%)
    - Patient safety (20%)
    - Outcomes (25%)
    - Process measures (5%)
    - Patient experience (25%)

Magnitude of the Medicare spending per beneficiary (MSPB) incentive

- Computation of the MSPB measure
  - Episode starts 3 days prior to admission and ends 30 days after discharge
  - Includes all part A & B spending
  - Spending standardized to national rates
- Expected effect in 2017:
  - Low episode spending hospitals receive about 0.5% more than without the MSPB policy
  - High episode spending hospitals receive about 0.5% less than without the MSPB policy

Risk-adjusted episode spending (MSPB) varies by 16 percent from 10th to 90th percentile



Relative 30-day episode costs for hospitals with over 1,000 discharges. A score of 1.0 is average spending after standardizing prices

Source: MedPAC analysis of 2012 claims data and SSI data from for hospitals with over 1,000 discharges

Data are preliminary and subject to change.

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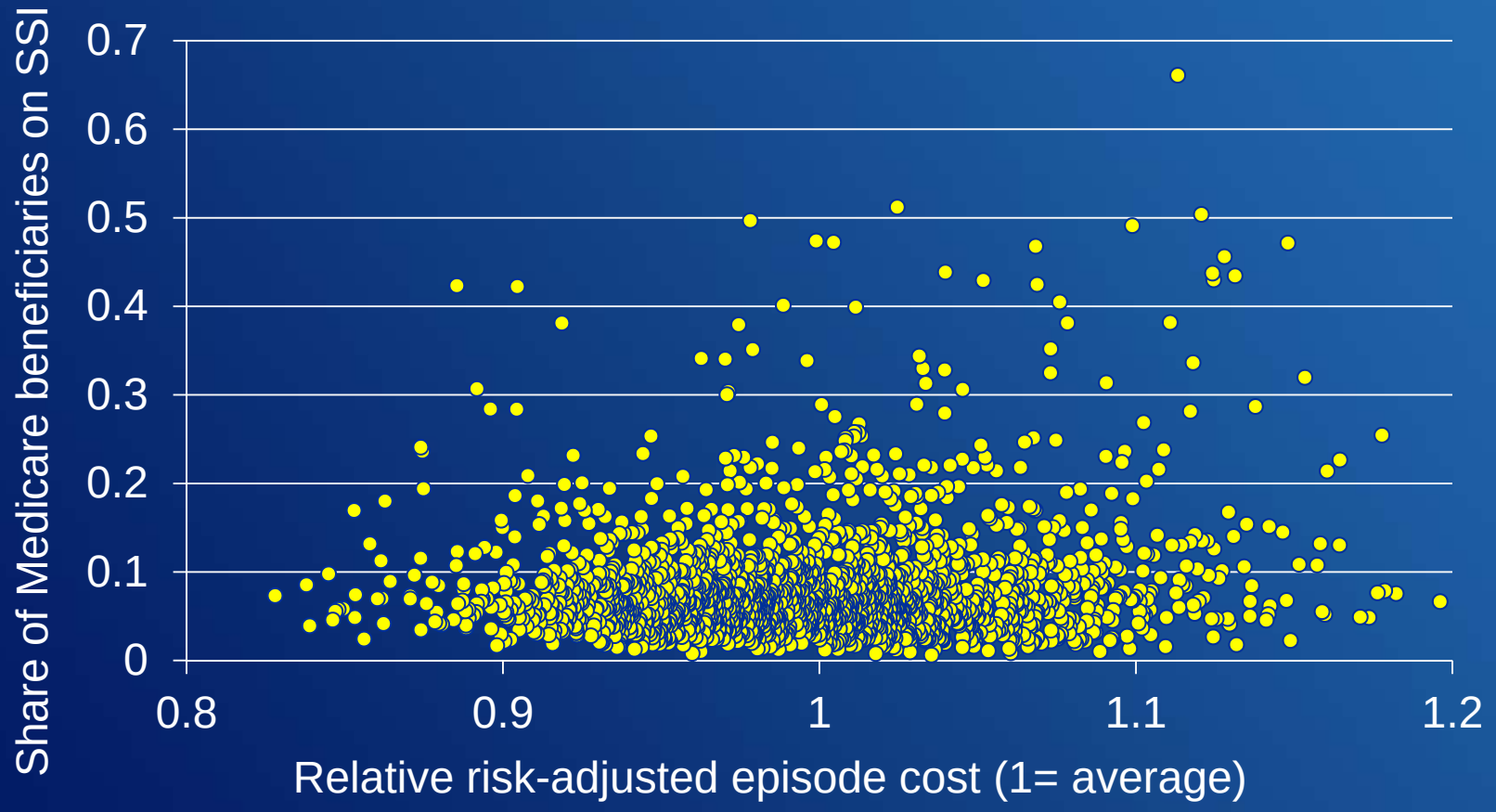
Patient income is not a material driver of episode costs



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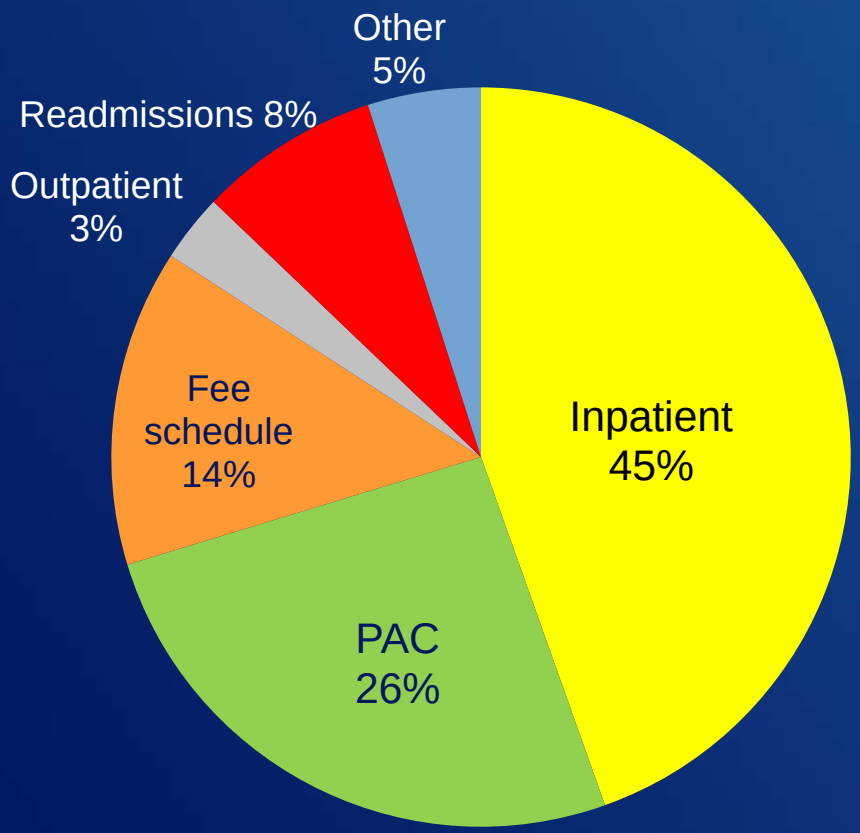
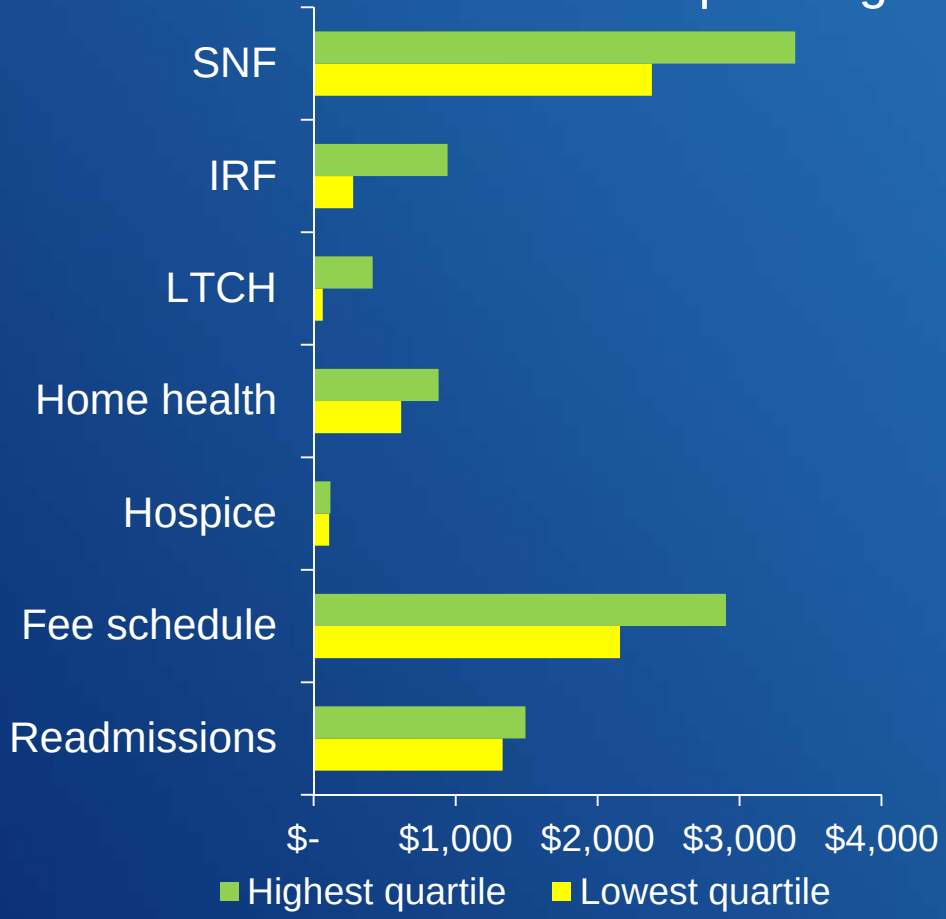
Post-acute care accounts for a minority of spending but the majority of variation

Share of episode spending



Sources of variation in spending



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Source: MedPAC analysis of 2012 Medicare claims. Data are preliminary and subject to change.

Strengthen incentives for episode spending efficiency

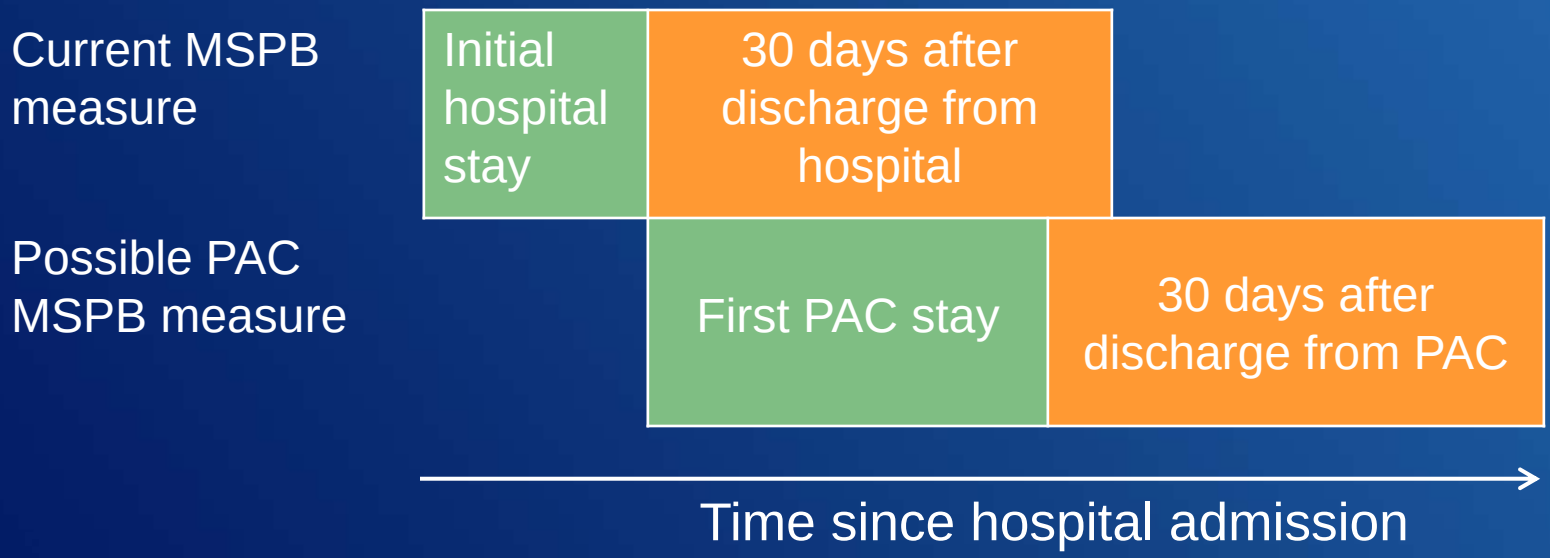
- Amplify current MSPB
- Develop a PAC-MSPB
- Increase clarity for hospitals to guide beneficiaries to high-value PAC providers

Amplify current hospital MSPB

- Raise the amount withheld
  - In 2017, withheld will be 2% of hospital base payments
  - Could increase withhold to 3-4%
- Increase the “weight” of MSBP within VBP score
  - In 2017, MSBP score will account for one quarter of the hospital VPB score
  - Could increase weight to up to 50% of the score

Develop a PAC MSPB measure

- PAC accounts for majority of variation in episode spending
- Implement VBP for PAC providers
- Align PAC and hospital provider incentives



Guide beneficiaries to high-value PAC providers

- Hospitals are at risk for PAC care but lack clarity on what they are allowed to do to guide beneficiary decisions
- Explore options to allow “soft steering”
- Need to ensure
  - Beneficiary choice
  - Physician input
  - PAC networks are adequate and include high-value providers

Are the incentives of the MSPB and ACOs aligned?

- Incentives to lower episode spending are aligned
  - Minimize unnecessary PAC use
  - Physician consults
  - Minimize readmissions
- ACOs have the additional incentive to control the volume of episodes

Ways to discourage unnecessary hospital admissions

- ACOs
- Develop potentially avoidable hospital admissions policies
  - Nursing homes
  - Hospitals
    - Questionable effectiveness of joint accountability across multiple providers
    - Which entities in a market to hold accountable?

Discussion topics

- Amplify the current MSPB
- Develop a PAC MSPB
- Guide beneficiaries to high-value PAC
- Ways to discourage unnecessary episodes