Issues related to risk adjusting payments for bundled services

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Bundling payments

- FFS system does not encourage efficient mix of services
- Bundle definitions vary
  - What starts and stops a bundle
  - Scope of services included
  - Length of the period
- For this work, bundle = hospital stay + all services during 30 days after discharge

What is risk adjustment and why does it matter?

- Risk adjustment raises or lowers payment to account for differences in patient care needs
- Protects beneficiary access to services
- Protects providers from undue financial risk
- Protects the program from excessive payments

The Commission's past work on bundling

- In 2008, Commission recommended testing bundled payment around hospitalization
  - Part of 3 step recommendation: disclosure, readmissions penalty, voluntary bundling pilot
  - A pilot balances recognition of operational challenges/unintended consequences with urgent need to change incentives

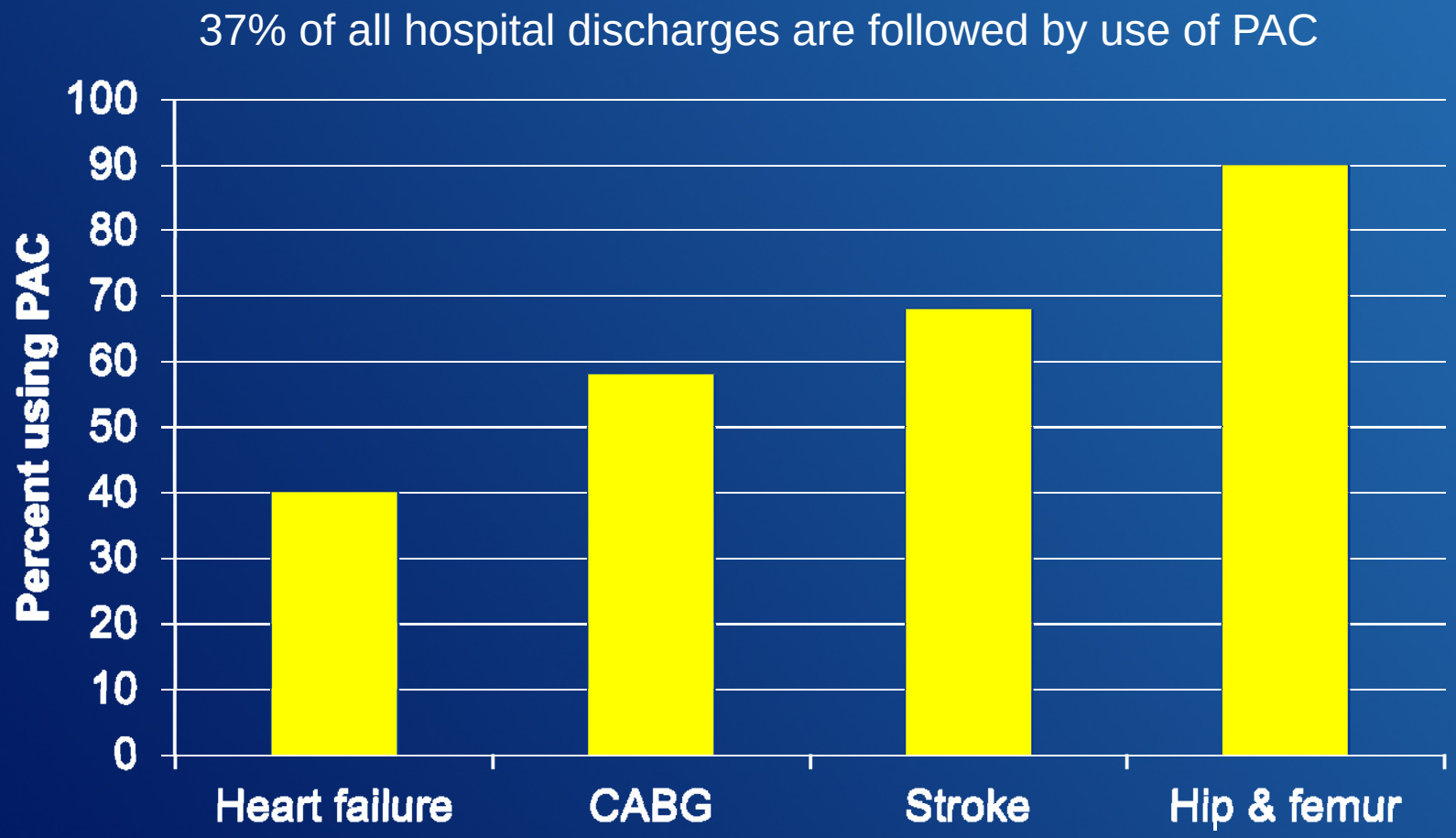
PPACA requires a Medicare bundled payment pilot

- To be launched in 2013
- Around a hospitalization, voluntary participation, tests multiple models, select conditions, allows for a range of providers to apply to receive bundle
- Specifically calls for
  - One model to involve payment for such services as care coordination
  - One model to be the continuing care hospital model

Implementation issues

- Recognize there are a variety of implementation issues (e.g., design of quality incentives, what entity receives the payment, beneficiary choice, tempering incentive to increase the number of bundles, compatibility with ACOs).
- Today, we explore variation in Medicare spending and important factors to consider in risk adjustment

Use of post-acute care varies by diagnosis



Note: Data are preliminary and subject to change. Rates reflect use within 30 days of discharge. Beneficiaries that die during the hospital stay or within 30 days of discharge are excluded.
Source: MedPAC analysis of 5% Medicare claims files 2004 to 2006.

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Medicare spending varies across 30-day payment bundles for beneficiaries who use post-acute care

Condition and severity level	Ratio of Medicare spending at 75th to 25th percentiles: All services including PAC	Ratio of Medicare spending at 75th to 25th percentiles: PAC spending
Stroke		
Severity level 1	2.7	6.7
Severity level 4	1.6	2.9
Hip and femur procedure for trauma		
Severity level 1	1.4	1.9
Severity level 4	1.3	1.7
Cardiac bypass with catheterization		
Severity level 1	1.1	1.6
Severity level 4	1.4	7.5
Heart failure		
Severity level 1	2.3	4.2
Severity level 4	1.5	5.3

Note: Data are preliminary and subject to change. Numbers reflect standardized payment rates and therefore do not reflect provider specific adjustments such as the area wage index or DSH payment adjustments.

Source: MedPAC analysis of 5% Medicare claims files 2004 to 2006.

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Average PAC spending differs by the setting first used after discharge

Hospital condition	PAC Average	Outpat. Rehab.	Home health	SNF	IRF	LTCH
Stroke						
	$10,680	$569	$2,478	$8,527	$18,923	$22,070
Hip and femur procedures for trauma						
	10,392	1,217	2,595	8,761	16,018	22,738
Cardiac bypass with catheterization						
	5,230	837	1,778	5,737	14,631	24,526
Heart failure						
	4,144	612	1,611	6,462	14,698	20,236

Note: Data are preliminary and subject to change. Numbers reflect standardized payment rates and therefore do not reflect provider specific adjustments such as the area wage index or DSH payment adjustments. Spending captures payments for all PAC services that occur within 30 days of discharge from the hospital.

Source: MedPAC analysis of 5% Medicare claims files 2004 to 2006.

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Risk adjusting bundled payments for the care needs of patients

- Adjust for the acuity of patient during the hospital stay
- Adjust for chronic conditions
- No risk adjustment is perfect

Patterns of post-acute care spending unlikely to reflect efficient care

- No incentive to consider downstream costs over period of time
- HHA and SNF PPSs encourage patient selection and service provision
- Patient placements in post acute care are not necessarily cost effective
- Lack of evidence about “best” settings for care

Factors in Medicare's case-mix adjusters for post-acute care

- Diagnoses: acute and chronic conditions
- Functional status
- Age
- Service use

Factors suggested by others that raise issues for risk adjustment

- Presence of a caregiver
- Socioeconomic status
- Regional variation in supply and practice patterns

Other policies will need to accompany bundled payments

- Policy to counter incentive to generate bundles
- Outlier policies for high-cost bundles
- Inlier policies for low-cost bundles
- Policies to protect beneficiaries from service under-provision
- Policies to smooth the transition from FFS to bundled payments

Next steps

- Examine additional measures of patients' comorbidities
- Design issues
  - Length of the bundle
  - Additional risk adjusters