Advising the Congress on Medicare issues

Bundling post-acute care services

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MEDPAC

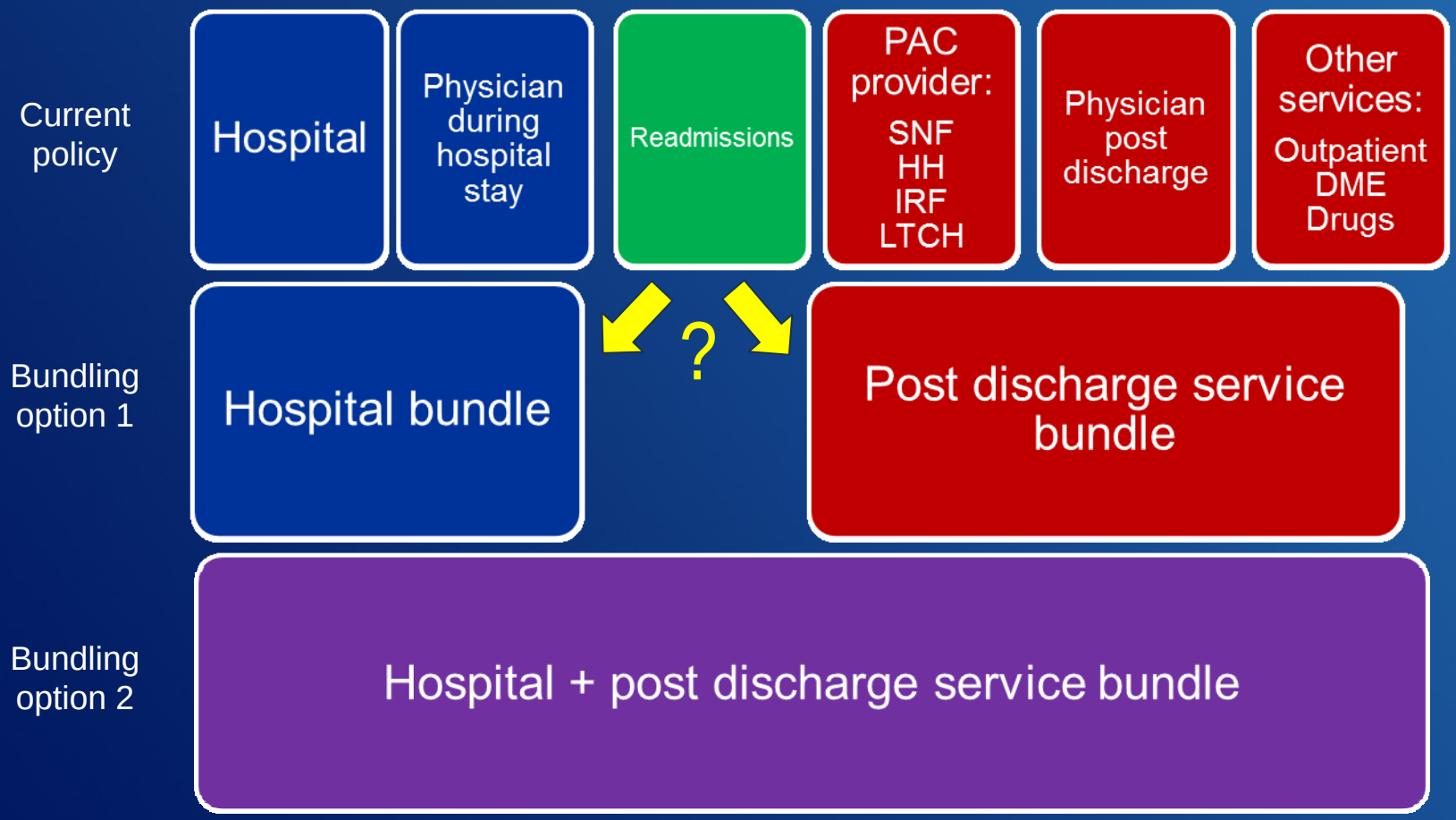
Why is the Commission looking at bundling again?

- 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



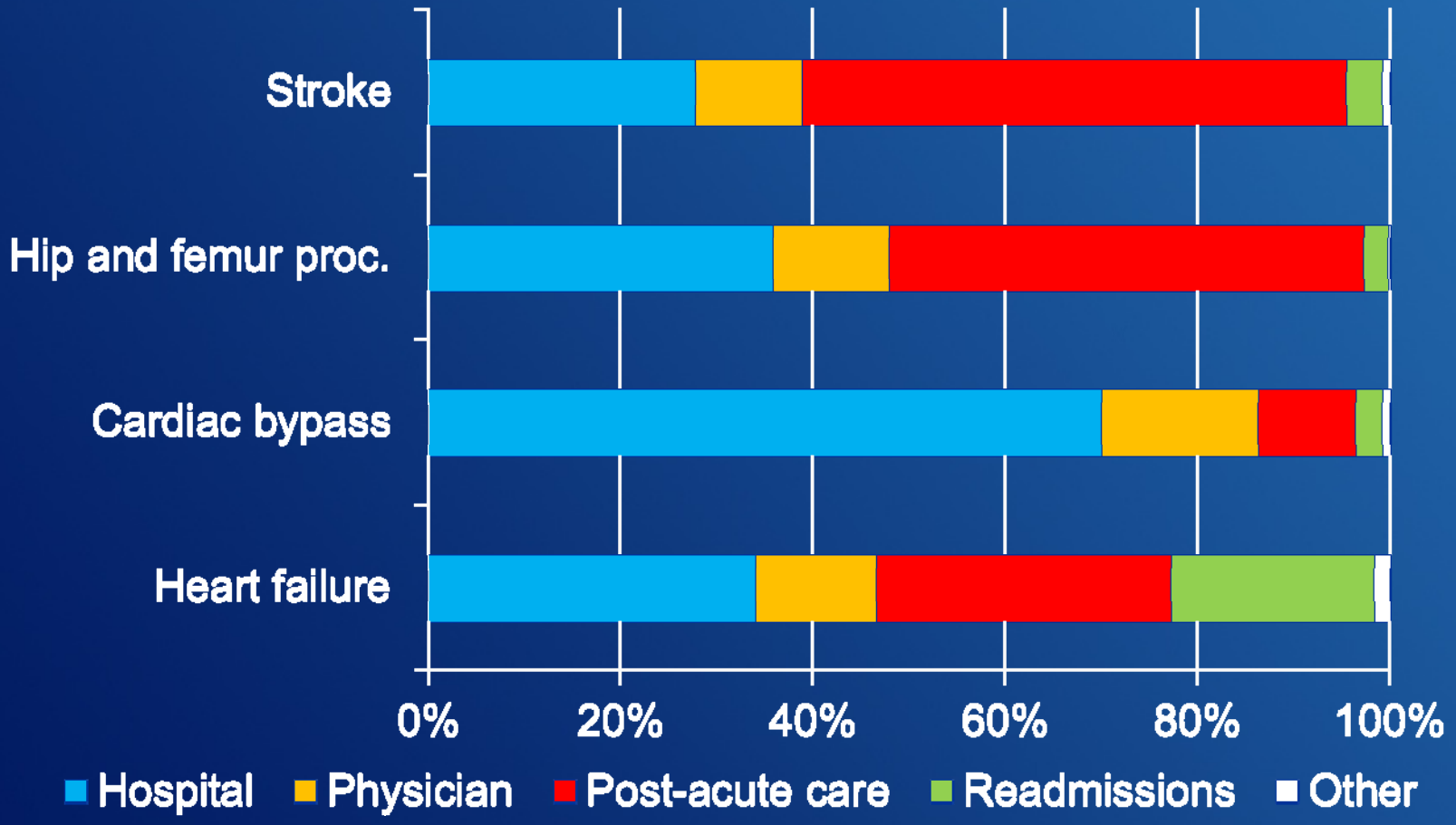
Why bundle?

- 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

Condition	25th	75th	Ratio
Hip & femur SOI 1	$6,697	$12,829	1.9
Heart failure SOI 1	949	4,007	4.2

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

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Source: MedPAC analysis of 2004-2006 5% Medicare claims files and 2006-2008 beneficiary annual summary file and Medicare inpatient claims.

CMS bundling initiative

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

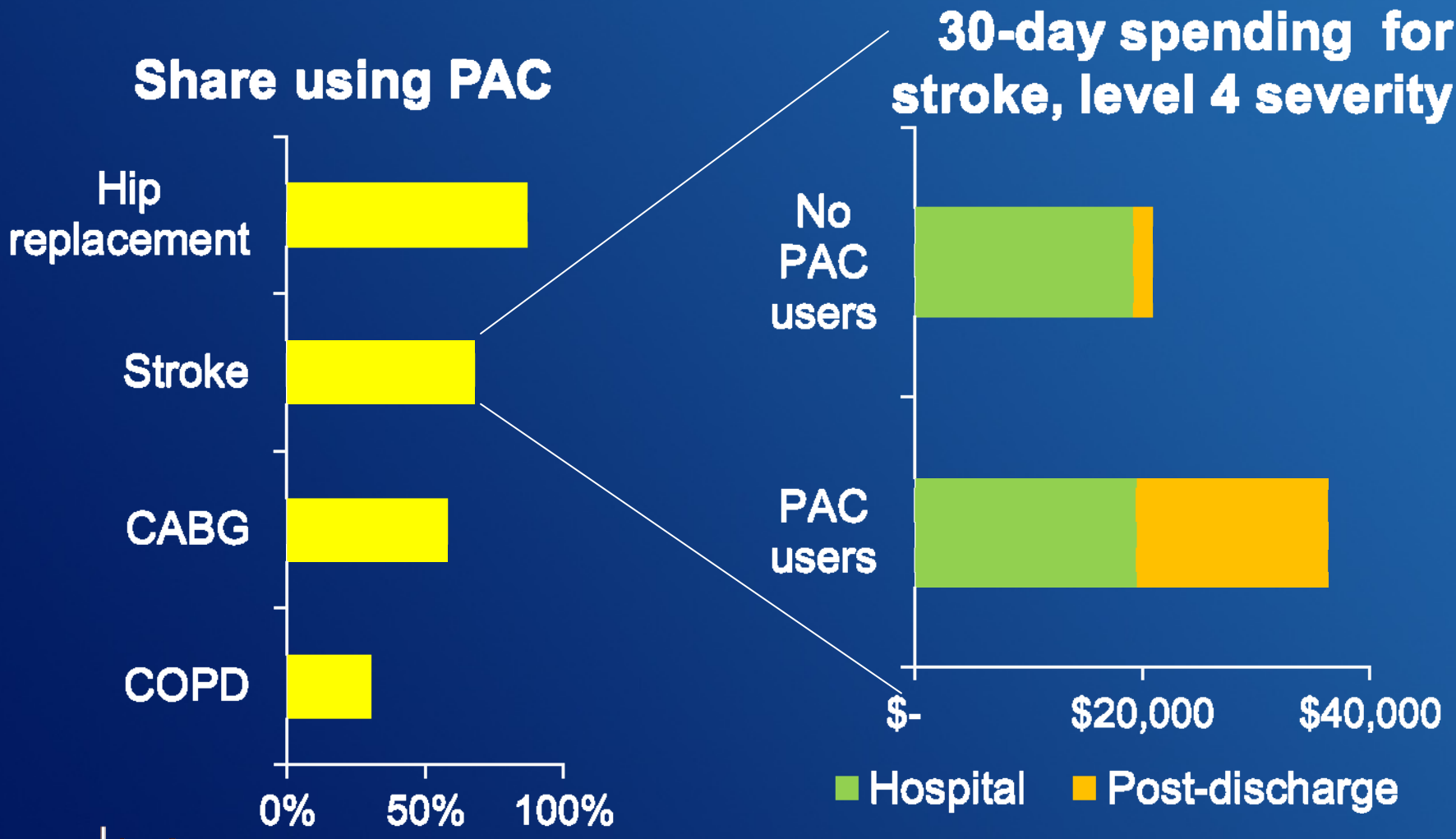
Bundling design issues

- 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



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

Scope of service: separate PAC-hospital bundles or a combined one?

Option	Advantages
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

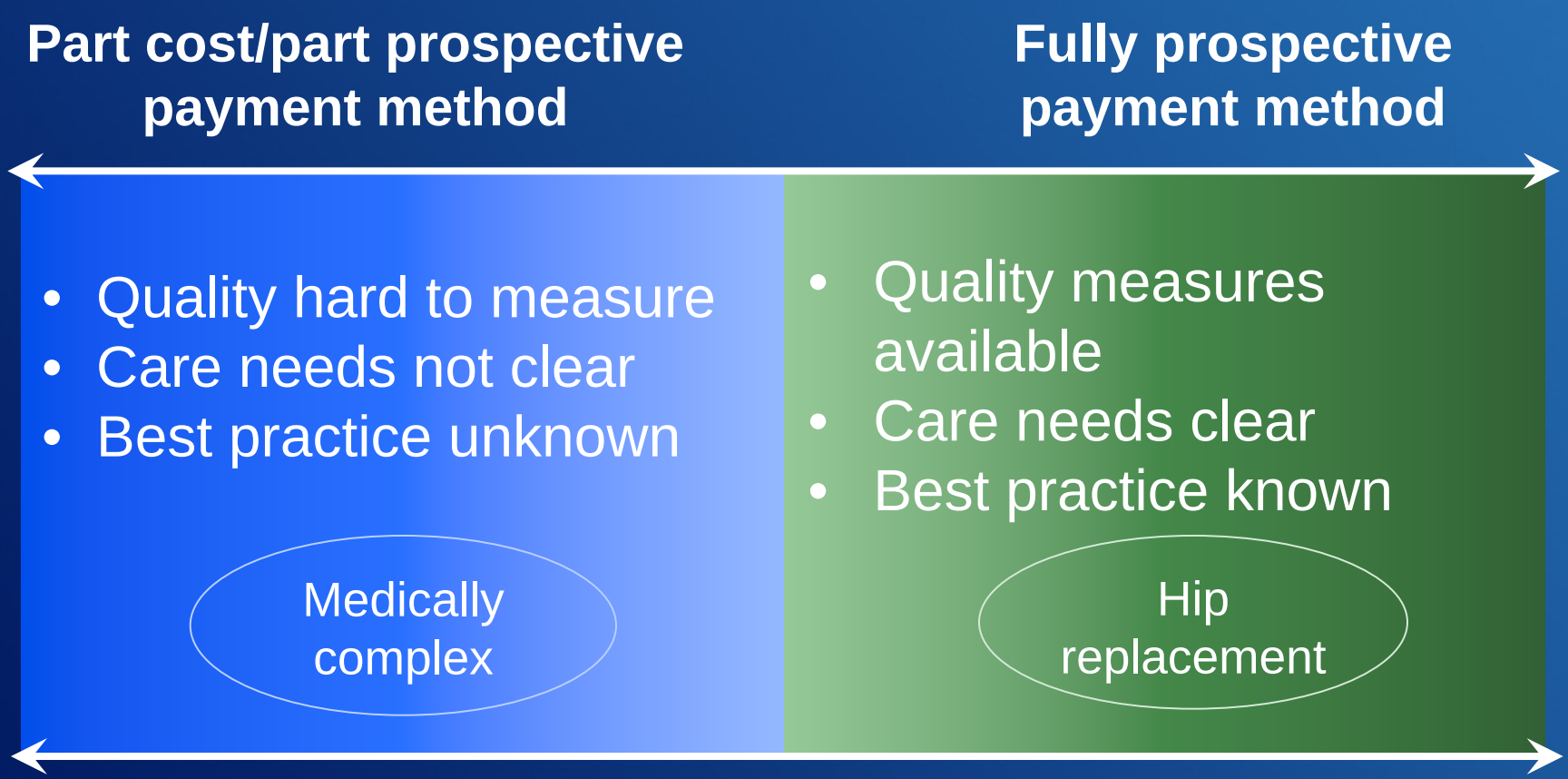
Time period of the bundle

- Short—e.g. 30 days after discharge
  - Parallels hospital readmission policy
  - Limits liability for PAC care
  - Excludes a large share of PAC use
- Long—eg. 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



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?