



Advising the Congress on Medicare issues

Bundling post-acute care services

Evan Christman and Carol Carter

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Overview

- Rationale for bundling
- Key decisions for scope of a bundle
- Setting episode payment
- Incentives for quality in a bundle
- Addressing beneficiary concerns

Why should Medicare bundle payments for post-acute care?

- Encourage care coordination between providers
- Encourage more efficient resource use across an episode of care
- Narrow the wide variation in PAC spending

Illustrative approach to bundling

- 90-day bundles that include both inpatient, physician, post-acute care, and readmissions
- Assume providers will continue to receive FFS payments minus a small withhold
- Risk-adjusted episode benchmark (spending target)
- Providers' actual spending compared to episode benchmark

Initial approach uses FFS-based bundles

- Minimizes incentives for stinting, providers must provide service to receive payment
- Lower administrative burden for providers
 - No need to establish a separate bundled entity to accept payment
 - Relies on existing administrative systems for collecting payment and quality data

Why have a withhold amount?

- Incentive for providers to achieve episode spending targets
- Some financial protection for the Medicare program
- Tie risk-adjusted outcome measures to return of payment withhold in addition to savings

Measures to ensure care coordination and appropriate utilization during and after a bundle

- Care under a bundle
 - Readmissions and ED use during bundle
 - Functional change at discharge
- Monitor post-bundle expenditures to detect cost-shifting services to outside bundle
- Monitor volume to detect increase in bundles provided

Risk-adjustment improves with the addition of patient comorbidities and functional status

Hospital MS-DRG	Comorbidities	Functional status	Ability to explain differences in resource use (r ²)
X			31%
X	X		34%
X	X	X	36%

Source: 3M Health Information Systems analysis of 2006-2008 Medicare claims data and functional status data for beneficiaries who used SNF, HHA, or IRF services.

Principles for setting the episode benchmarks

- Benchmarks should be based on patient characteristics, not setting
- Benchmarks should be set below current level of FFS spending given the wide variation in practice patterns
- Provider performance against the benchmarks should be measured across all episodes during a time period (e.g., annually)

Possible approaches to setting the episode benchmarks

- Base on lower spending on PAC and readmissions
- Base on spending in geographic areas with low resource use

Base on lower spending on PAC and readmissions

- PAC spending: wide range in whether beneficiaries use PAC, the mix of PAC services, and high HHA and SNF Medicare margins
- Variation in readmission rates suggest these could be lower
- Example: 10% lower spending on PAC and readmissions would set total episode benchmarks at 5% less than current FFS spending

Base benchmark on spending in geographic areas with low resource use

- Per capita spending on PAC varied two fold between the 10th and 90th percentiles and 8-fold between areas with the highest and lowest spending
- Base benchmark on some portion of the difference between high- and low-spending areas

Illustration of how the benchmarks and withholds would work

Episode benchmark = \$43,000

	Spending is below benchmark	Spending is over benchmark
Amount billed to Medicare	\$41,000	\$47,000
Amount withheld (4%)	\$1,640	\$1,880
Net Payment	$\$41,000 - \$1,640 = \$39,360$	$\$47,000 - \$1,880 = \$45,120$
Amount of withhold returned	\$1,640	\$0
Total program payment	\$41,000	\$45,120

Implications for beneficiaries: more coordinated, higher-quality care

- Improved coordination
 - Better care transitions between settings
 - Lower risk of readmission
 - Days between hospital discharge and PAC admission; days until 1st follow-up MD care
- Improved patient experience
 - Pain management
 - Provider communication
 - Shared decision-making

Providers may encourage beneficiaries to seek high-quality, low-cost care

- Give beneficiaries information about quality differences across providers
- Offer services to better manage care
 - Care manager oversees the beneficiary's care after discharge from hospital
 - Medications are carefully reviewed
 - Focused patient and family education about managing the condition at home

Longer-term program changes to encourage high-quality, low-cost bundles

- Restructure beneficiary cost-sharing
 - Raise cost-sharing when recommended providers are not used
- Revise conditions of participation
 - Set higher standards for participating providers. Exclude lowest-quality providers from the program.

Ways to ease the transition to bundled payments

- Implement for a select set of conditions; expand number over time
- Initial benchmarks based on small reduction to FFS spending and make larger reductions over time
- Initial withhold is small but increases over time

An alternative bundling strategy: Medicare spending per beneficiary

- Establishes target spending for groups of conditions
- 30-day bundles that include hospital, PAC, MD, and readmissions
- Used as a measure of hospital efficiency: implicitly holds hospital responsible for all care. Eventually will be used for value-based purchasing.

Commission discussion

- Preferred ways to establish the episode benchmark and withhold
- Ways to influence beneficiary selection of providers while preserving choice
- Need for a transition and possible approaches
- Impact analyses