Moving toward bundled payments around hospitalizations

Anne Mutti, Craig Lisk

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MEDPAC

Episode analysis

- Episodes examined
  - Hospital admission
  - Hospital admission plus 15 days
- Conditions examined
  - Chronic obstructive pulmonary disease
  - Congestive hear failure
  - Coronary bypass graft surgery
  - Hip and knee surgery
  - Large and small bowel procedures

Average risk adjusted spending during a hospital stay—CHF

Service	Bottom quartile	Average	Top quartile	Top quartile difference from average	
				Percent	Dollar
Total	$5,339	$5,624	$5,937	5.6%	$313
Hospital	4,788	4,808	4,820	0.2	12
Physician	549	813	1,112	36.8	299
# encounters	10	14	18	29.5	n/a

Note: Analysis limited to hospitals with 10 or more episodes on analysis file. The total includes a miscellaneous expenditure category with very small spending so columns may not sum.

Source: MedPAC analysis of 5 percent 2001-2003 Medicare claims files.

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Average risk adjusted spending during and 15 days after a hospital stay—CHF

Service	Bottom quartile	Average	Top quartile	Top quartile difference from average	
				Percent	Dollar
Total	$6,412	$7,409	$8,550	15.4%	$1,141
Hospital	4,813	4,812	4,817	0.1	5
Physician	633	731	798	9.2	67
Readmission	379	911	1,562	71.5	651
PAC	404	730	1,101	50.7	371
Other	182	225	272	20.8	47

Note: Analysis limited to hospitals with 10 or more episodes on analysis file. Payments are based on national rates. Physician includes only physician spending during the initial hospital stay. Readmission spending includes both hospital and physician spending during the readmission. Other includes outpatient spending, physician spending that occurs outside a hospital stay, and other miscellaneous spending.

Source: MedPAC analysis of 5 percent 2001-2003 Medicare claims files.

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How does physician service use vary for the top quartile of providers during the hospital stay?

- Hospital visits generally largest factor in explaining spending differences
- Consultant services second biggest factor for medical patients
- Procedures generally second biggest factor for surgical cases
- Imaging and tests small factor in explaining spending differences

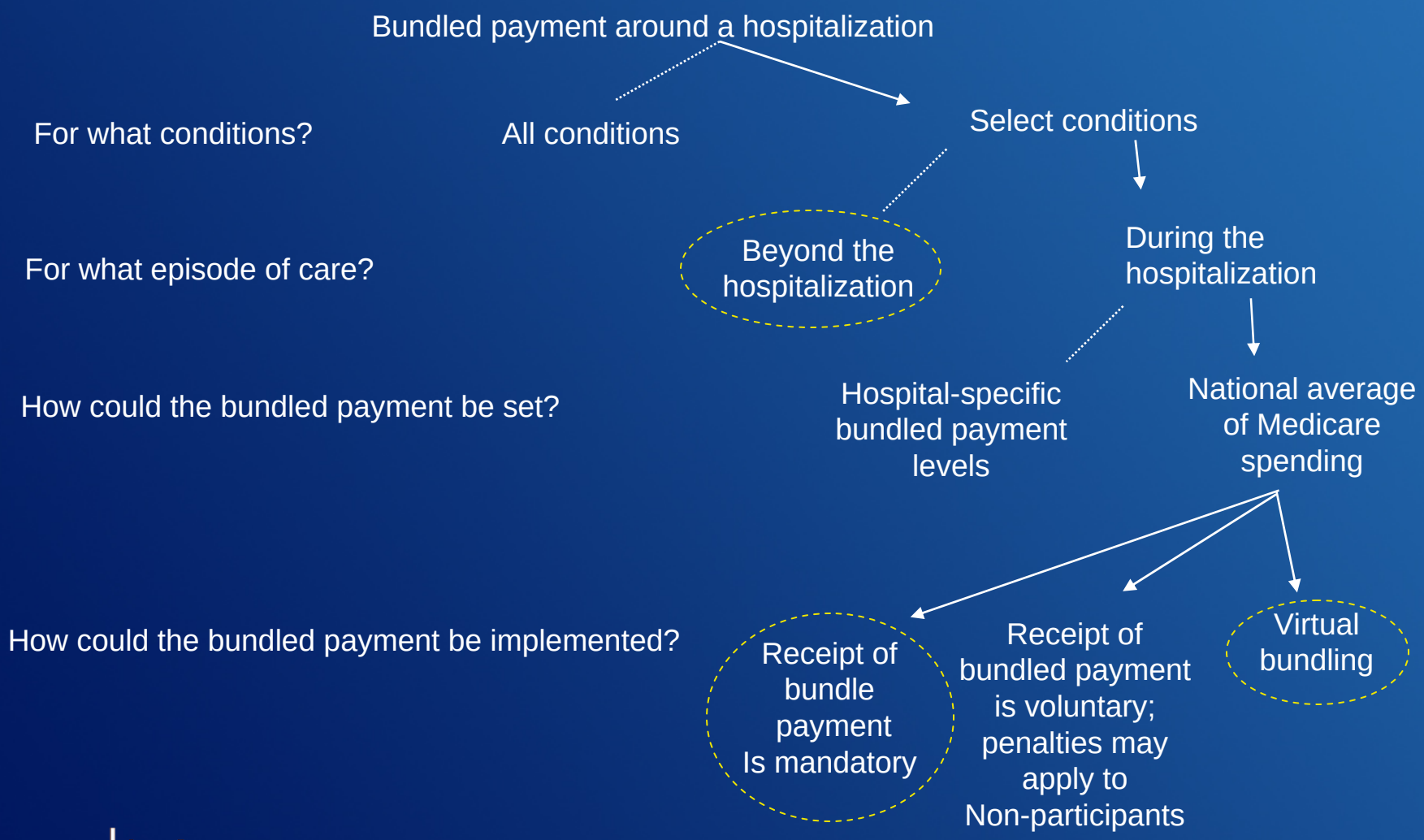
Characteristics of hospitals in top quartile of spending

- Hospital only episodes
  - More likely to be from Middle Atlantic region less likely to be from New England
  - More likely to be proprietary less likely rural or major teaching
- Hospital stay plus 15 days
  - More likely to be from Middle Atlantic, New England, and West South Central due to higher PAC spending
  - Less likely to be from West North Central region or be rural
  - Teaching and ownership—no consistent pattern across conditions

Do hospitals tend to be uniformly efficient or inefficient across different types of cases?

- High spending on one condition is not necessarily an indicator for high spending on another condition
  - 31 to 43 percent of hospitals in the top spending quartile for one condition (hospital stay plus 15 days) are in the top quartile for another condition

Exploring design issues



Implementation options

- Bundled payment
  - Single payment to joint entity for all A&B services provided during the episode
- Virtual bundling
  - Separate payments to providers, adjusted based on the volume of services provided across episode
- P4P must be implemented in tandem with either bundling option

Bundled payment: rationale

- Providers have incentive and flexibility to figure out most efficient mix of services
- Promotes collaboration; reduces fragmentation
- Shared accountability

Bundled payment: policy challenges

- Payment issues
  - Risk adjustment
  - IME/DSH subsidies
  - Interaction with other FFS payment systems
  - How Medicare shares in savings

Bundled payment: policy challenges (cont.)

- Risk of providers not participating
- Administrative complexity and costs
- Benefit flexibility and cost-sharing
- Potential increase in volume of admissions
- Unbundling

Virtual bundling: rationale

- Rewards providers for containing service use across an episode
- Provides incentive for providers to collaborate
- Incentives weaker than under bundled payment
  - Smaller potential reward
  - If prohibition on shared accountability continues, no additional incentive to contain unit costs

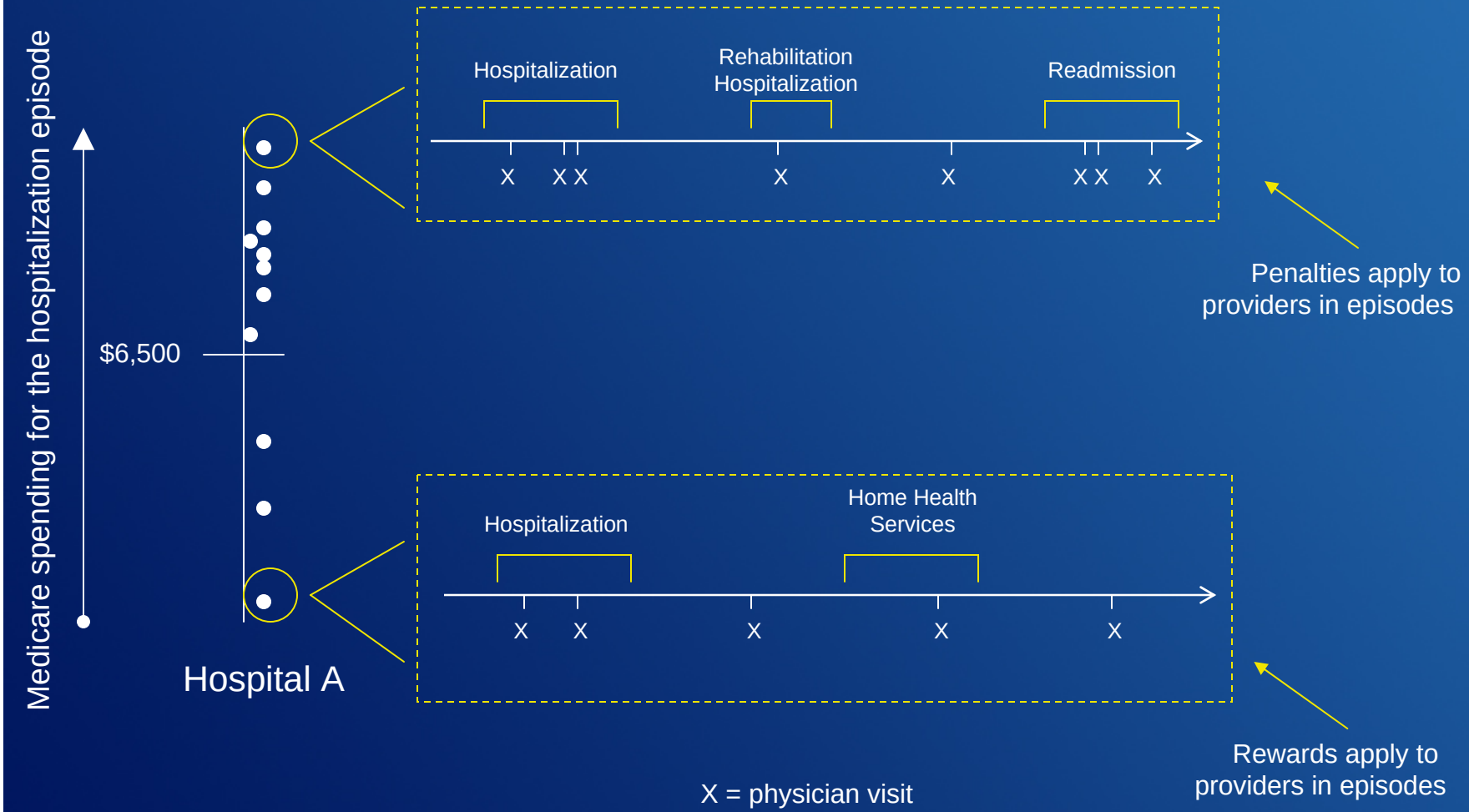
Virtual bundling: some issues remain

- Risk adjustment
- Volume of admissions
- Unbundling

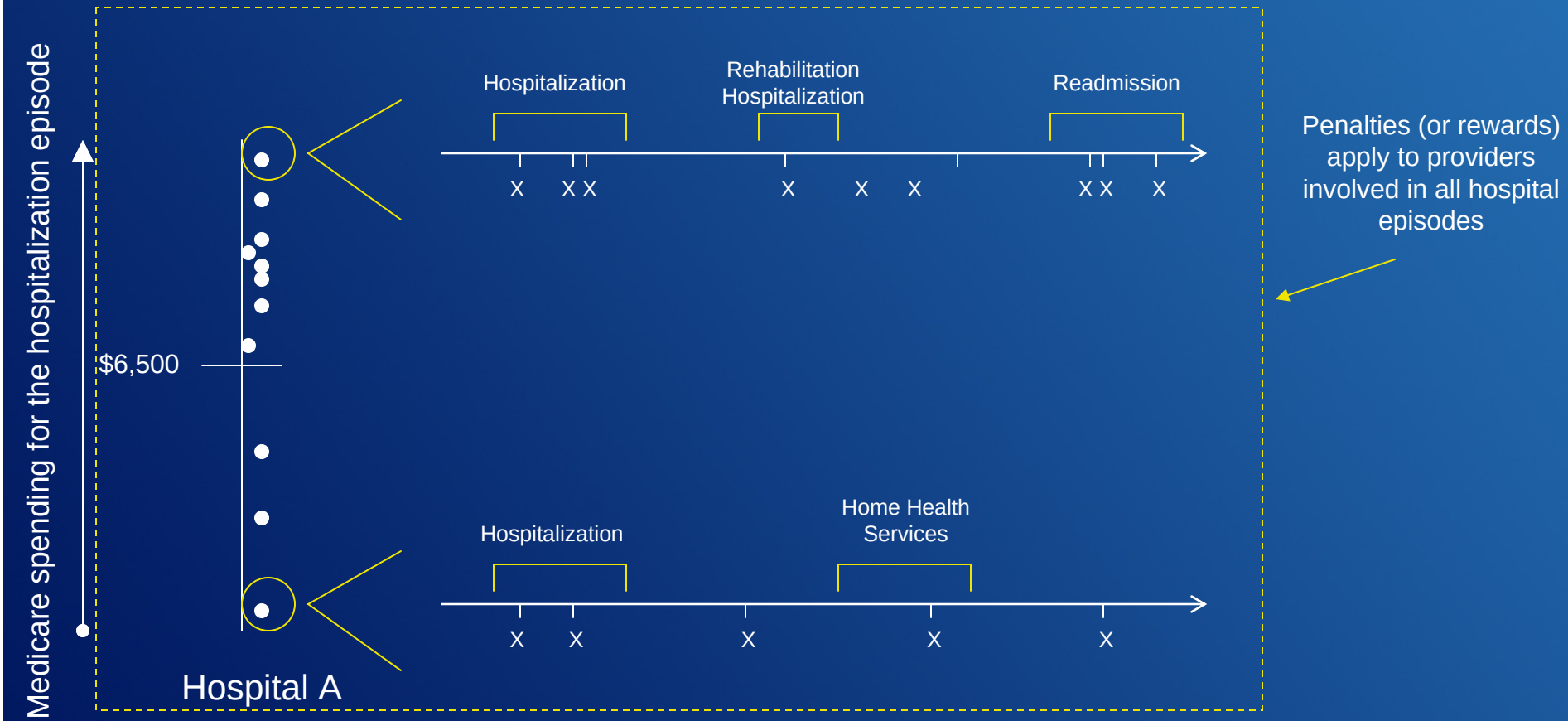
Incremental approaches

- May want to consider incremental options
- We illustrate
  - Virtual bundling: episode-specific approach
  - Virtual bundling: system-level approach
  - Bundled payment
  - Hybrid approach

Virtual bundling: episode specific approach



Virtual bundling: system-level approach



X = physician visit

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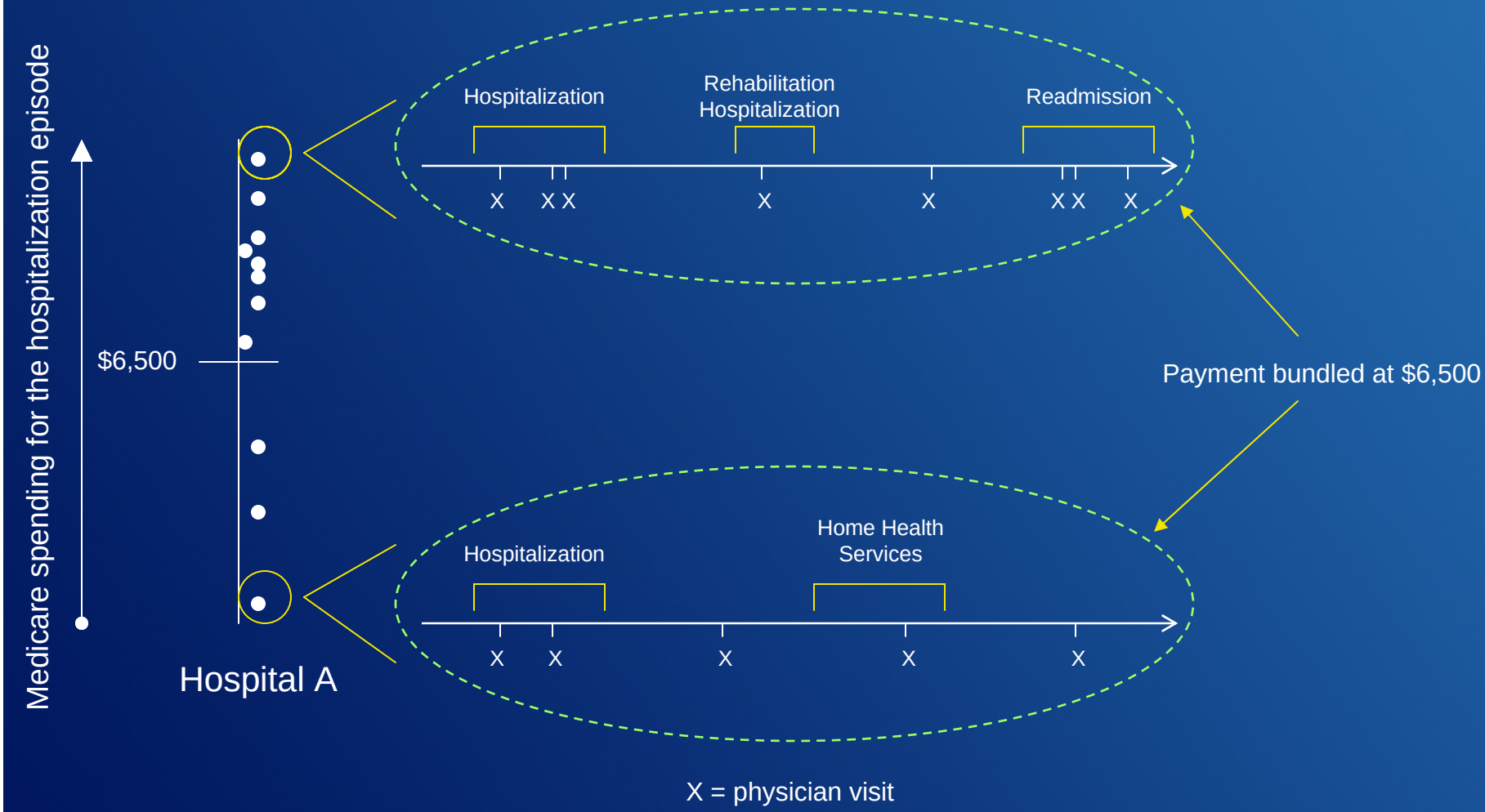
Bundled payment



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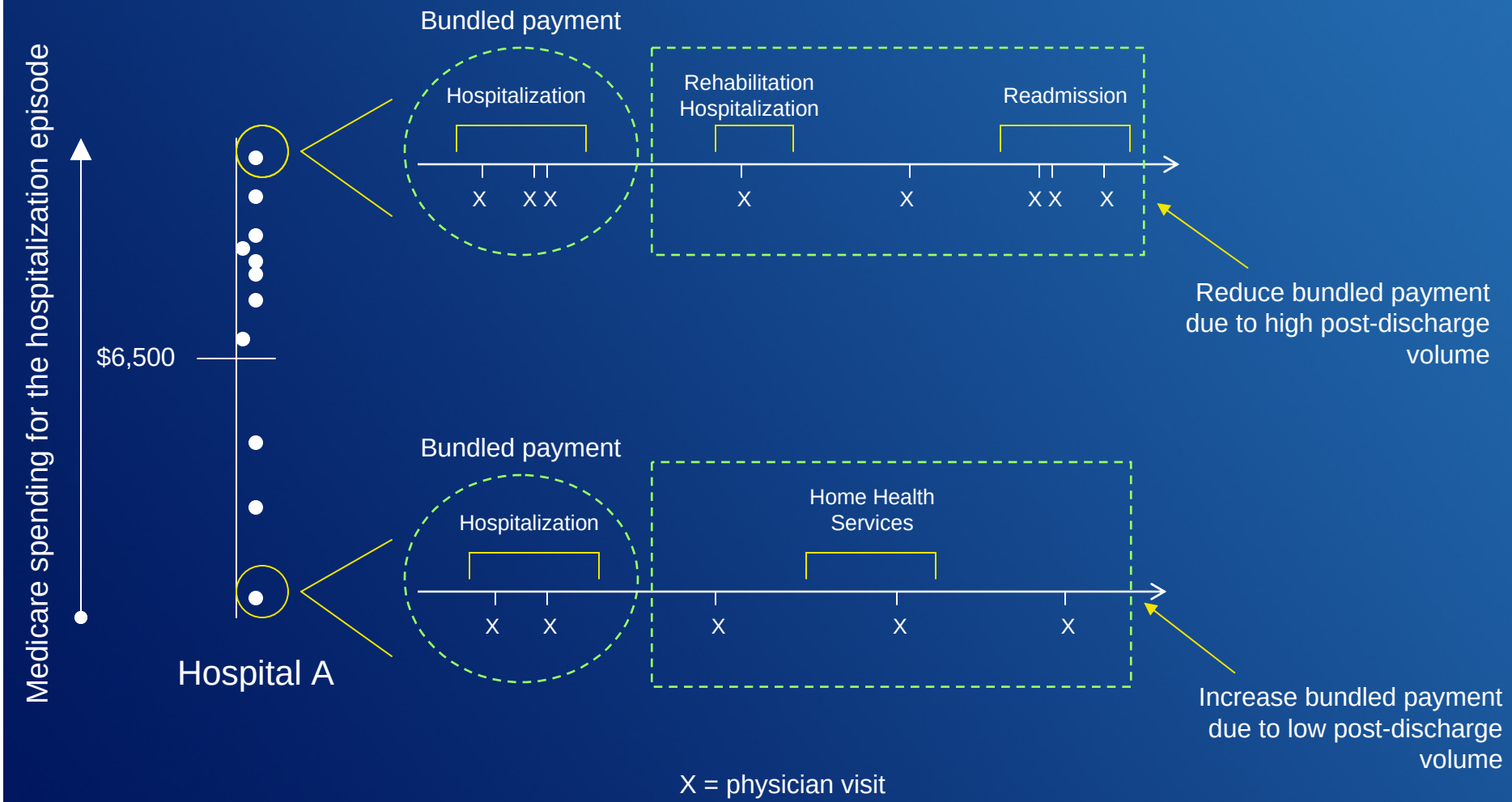
Hybrid approach



Staging approaches

- One path may be
  - Virtual bundling: episode-specific approach
  - Virtual bundling: system-level approach
  - Mandatory bundling
- Another may be
  - Virtual bundling: episode-specific approach
  - Hybrid approach
  - Mandatory bundling

For discussion

- How daunting are the implementation issues of bundled payment and virtual bundling?
- What sequence of incremental steps holds the most promise?