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Bundle with Care — Rethinking Medicare Incentives for Post–Acute Care Services

Judith Feder, Ph.D.

Although health policy experts disagree on many issues, they largely agree on the shortcomings of fee-for-service payment. The inefficiency of a payment method that rewards increases in service volume, regardless of health benefit, has become practically indefensible. But replacing discrete payments for each service with bundled payment for a set of services does not simply promote efficiency; it also potentially promotes skimping on care or avoidance of costly patients.

The Center for Medicare and Medicaid Innovation at the Centers for Medicare and Medicaid Services recently announced a large-scale demonstration of bundled payments for hospital and post–acute care services, and President Barack Obama's 2014 budget proposes to move forward with that approach. Lest we sacrifice quality and access in the pursuit of efficiency, it is worth considering whether a payment approach in which savings and risk are shared — a hybrid of a fee-for-service system and one providing rewards for spending reductions — will achieve a better balance of cost, quality, and access than a system of single bundled payments, at least until our capacity to measure patients' care needs and outcomes is sufficiently robust.

The Medicare program already has considerable experience not only with capitation payments to health plans for the full range of Medicare services but also with bundled payments for sets of services: inpatient hospital services are bundled into "stays," skilled-nursing-facility (SNF) services are bundled into "days," and home-health-agency (HHA) services are bundled into "episodes." That bundles' powerful rewards for reducing costs create an efficiency–selection trade-off — simultaneously rewarding desirable and undesirable behavior — is old news. But even new news (regarding Medicare Advantage plans) documenting that technical payment refinements can reduce the rewards provided for avoiding costly patients or costly care also shows that behavior favoring service to low-cost patients over high-cost patients persists.[1]

Experience with current prospective payments raises particular concerns about selection and skimping in post-acute care. The tip-off to the risk involved in offering powerful incentives for these providers to keep costs low is the presence of extremely high and varied profits, in a service area devoid of standards for high-quality care. In 2010, SNFs and HHAs earned profits of 19%, on average, and the top quarter earned in excess of 27%.

In theory, these high and widely varying profits might reflect variations in efficiency. But two factors other than relative efficiency probably explain these margins. First is that classification of patients into payment categories for rate-setting purposes is not sufficiently precise to eliminate variation in expected costs among the patients within a category — so providers serving patients whose care needs are lower than average for the category are overpaid, and those whose patients have above-average care needs are underpaid. Second is the long history of patient selection in nursing homes and recent evidence that the HHAs with the highest profit margins provide fewer visits, despite serving patients with greater measured care needs.[2]

Given the weakness of patient classification and quality norms, policymakers would do well to heed previous advice that, in these circumstances, a hybrid approach better balances efficiency and appropriate care.[3]

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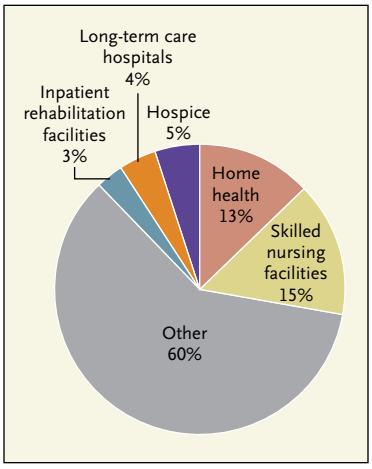

Variation in Total Per Capita Medicare Spending Explained by Categories of Post–Acute Care Spending and All Other Spending (2007–2009).

Data are from the Institute of Medicine.[5]

Rather than replace fee for service with a single-payment system, I believe we should rely on a hybrid approach in which both savings and risk are shared. Providers would receive a share, rather than the full amount, of any excess payments over the actual costs incurred. Similarly, Medicare would pay a share of any provider costs that exceeded the amount of prospective payments. To encourage efficiency, the system would ensure that providers could earn a sufficient share of profits but would also bear the larger share of losses.

By reducing profits, a shared-savings-and-risk approach would reduce the incentive for providers to maximize efficiency. And it would increase administrative burdens, since it would necessitate monitoring of costs and assurance of accurate reporting. But these additional costs might well be offset by reduced incentives for providing inappropriate service to people who don't need care. Increases in SNF admissions and HHA episodes are driving up Medicare SNF and HHA spending at twice the rate of spending growth on hospital and physician services.[4] Indeed, variation in spending on post-hospital services (which are overwhelmingly SNF and HHA services) explains a full 40% of the overall geographic variation in Medicare spending per beneficiary (see pie chart) — variation that has called the program's overall efficiency and quality into question.[5]

Sharing savings and risk would essentially produce for Medicare, which sets payment rates administratively, profit levels similar to those a competitive market would provide. When some providers are earning excessive profits in a market, others will offer services at lower prices (earning lower profits) to attract more business. Sharing savings and risk gives Medicare a means of keeping profits high enough to maintain access for beneficiaries, while narrowing the range of profit levels closer to those a competitive market would produce.

All in all, applying a shared-risk-and-savings approach to Medicare's existing SNF and HHA payment bundles — as well as adopting it for evolving bundles — may be the best strategy for promoting Medicare's efficiency without undermining quality and access to care. As long as cost reductions from efficiency gains cannot be distinguished from reductions due to stinting or selection, it behooves policymakers, as prudent purchasers and stewards of beneficiary interest, to be mindful of the risks as well as the benefits of policy choices.

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From the Health Policy Center, the Urban Institute; and Georgetown Public Policy Institute, Georgetown University — both in Washington, DC.

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Influenza A (H7N9) and the Importance of Digital Epidemiology

Marcel Salathé, Ph.D., Clark C. Freifeld, M.S., Sumiko R. Mekaru, D.V.M., Anna F. Tomasulo, M.P.H., and John S. Brownstein, Ph.D.

On March 31, 2013, Chinese health officials notified the World Health Organization of three cases of human infection with novel influenza A (H7N9). Since then, 132 people have been infected, 37 of them fatally (see figure, Panel A). To date, there is no evidence of ongoing

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