Policies to encourage collective accountability: readmissions and bundled payment

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Traditional Medicare rewards volume over quality

- No financial incentive to work cooperatively to manage patients' care over time
  - Providers paid in silos
  - No longitudinal accountability
- Does not penalize for poor quality or reward good quality
- Pays more generously for some high tech services than for low tech services

Improving value is imperative and possible

- Adverse implications of the status quo
  - Quality of care unacceptable
  - Medicare and beneficiaries spend more than is needed
  - Strain on trust fund, economy
- Potential for improvement evident
  - Geographic variation research
  - Examples of success stories

Policies to encourage joint accountability and efficiency

Medicare should

- Share information on service use around hospitalization episodes with providers
- Reduce payments for hospitals with high readmission rates
  - Permit shared accountability (i.e., gainsharing)
- Test bundled payment for hospitalization episodes of care

Focus on hospitalization episodes

- Cogent, clinically-related episode
- Vulnerable juncture in patient care
- Hospitalized beneficiaries are most costly for Medicare
- Hospitals have the managerial resources to restructure care

Recommendation #1

Medicare should:

- Confidentially report readmission rates and resource use around hospitalization episodes to hospitals and physicians.
- Beginning in the third year, providers' relative resource use should be publicly disclosed.

Recommendation #2

Medicare should

- Reduce payments to hospitals with relatively high readmission rates for select conditions
- Allow shared accountability (i.e., gainsharing) between physicians and hospitals.
- Study the feasibility of broader approaches, such as virtual bundling, for encouraging efficiency across hospitalization episodes.

Preventable readmissions

- Some readmissions occur that could have been prevented. May be due to
  - An inpatient adverse event
  - Medication errors
  - Patient confusion about self-care
  - Poor communication between providers at hand-offs
- Some hospitals have addressed these problems to reduce readmission rates

Readmission rates point to need for greater care coordination

	Readmissions		
	7-day	15-day	30 day
Percent readmitted 2005	6.2%	11.3%	17.6%
Percent potentially preventable (3-M logic)	5.2	8.8	13.3
Spending on potentially preventable (billions)	$5	$8	$12

Changing payment for readmissions should

- Encourage hospitals to improve quality of care
- Encourage patient-centered care
- Coordinate care across providers
  - Chips away at the silos; encourages collaboration

Design issues in a readmission policy

- Timeframe in defining readmissions
- All readmissions or just the potentially preventable? Same hospital or across hospitals?
- Benchmark performance level that triggers the penalty
- Holding other providers (e.g., SNFs, home health agencies) also accountable

Allow shared accountability arrangements (gainsharing)

- Hospitals and physicians agree to share savings from reengineering clinical care in the hospital
  - e.g., reducing use of unnecessary supplies, complying with clinical protocols, standardizing devices
- Has potential to encourage cooperation among providers in reducing costs and improving quality (including readmission rates)

Recommendation #3

Medicare should:

- Conduct a voluntary pilot program to test the feasibility of bundled payment for select conditions.

Bundling payment can improve incentives for efficiency

- Under bundled payment, Medicare pays a single entity an amount intended to cover the full range of costs of an episode
- Encourages restraint in the volume of service under the bundle. More services are not rewarded with increased payment
- Providers are motivated to collaborate with partners to improve collective performance

MedPAC's recommendation: specifics

- Voluntary participation
  - Recognize that not all providers would be prepared to accept bundled payment
- Pilot program (rather than a demonstration)
  - Can be expanded nationally
  - Providers may be more inclined to invest in change

More specifics

- Start with select conditions
  - Both chronic and acute conditions
- Budget-neutral or results in savings
  - Payment rate discounts could be negotiated
- Bundled payment should cover care for stay plus some time after discharge (e.g., 30 days)
  - spending on readmissions and post-acute care varies widely

Concurrent accountability for quality of care is essential

- Value is a function of both resource use and quality
- Quality accountability is particularly important when bundling payment – it is a check on the incentive to stint