Hospital Readmissions in Medicare

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MEDPAC

Medicare Payment Advisory Commission

- Independent, nonpartisan commission of 17 national experts
- Appointed by Comptroller General for 3-year terms; can be reappointed
- Make recommendations to the Congress and the Secretary of HHS
- Vote on recommendations in public
- Two standing reports to Congress; also various mandated reports

Principles of Medicare Payment

- Ensure beneficiary access to high quality care in an appropriate setting
- Give providers an incentive to supply care efficiently
- Control program spending

Seeking Better Value for Medicare

"Moderating projected spending trends requires fundamental reform in payment and delivery systems to improve quality, coordinate care, and reduce cost growth. (MedPAC, June 2008)"

- Problems in Traditional Medicare Program
- Directions for Delivery System Reform

Seeking Better Value for Medicare
- *Price accuracy and equity*

Problems

- High costs and rapid cost growth
- High utilization of services (esp. costly services) and rapid volume growth

Directions for Reform

- Fiscal pressure on providers to constrain costs
- Price accuracy for physician, hospital, and imaging services
- Measuring resource use

Seeking Better Value for Medicare

- *Information for patients and providers*

Problems

- No information on what works
- No transparency on financial relationships that influence practice patterns

Directions for Reform

- Public reporting of quality
- Comparative effectiveness research
- Disclosure of physician financial relationships

Seeking Better Value for Medicare - *Quality and coordination*

Problems

- No incentive for coordination
  - Providers paid in silos
  - No longitudinal accountability
- No penalties for poor quality or rewards for good quality
- High utilization of services

Directions for Reform

- Payments for primary care
- Medical home
- Pay for performance
- *Target readmissions*
- *Bundled payments*
- Accountable Care Organizations
- Gainsharing
- Quality standards for imaging services

Average Risk-Adjusted Spending for Hospital Stay + 30 Days Post-Discharge – Chronic Obstructive Pulmonary Disease

Type of service	Spending Low Resource Use Hospitals	Average Spending	Spending at High Resource Use Hospitals	Difference between Spending at Hospitals with High Resource Use and Average Spending	
	$	$	$	%	$
Total Episode	6,372	7,871	9,748	23.8	1,877
Hospital	4,408	4,414	4,406	-0.2	-8
Physician	547	569	576	1.2	7
Readmission	671	1,543	2,550	65.3	1,007
Post-acute care	466	998	1,780	78.4	782
Other	280	347	436	25.6	89

MEDPAC

Source: MedPAC analysis of 5% of Medicare claims files for 2001-2003

MedPAC recommendations related to changing payment policy for readmissions

- Inform providers of their risk-adjusted readmission rates; later, publicly share this information
- Reduce payments to hospitals with relatively high readmission rates for select conditions
- Allow shared accountability (gainsharing) between physicians and hospitals

Source: MedPAC, *Reforming the Delivery System,* June 2008.

Medicare's role in supporting quality improvement

- Payment incentives and public reporting may not be sufficient to spur needed quality improvement
- Possible approaches
  - Target low performers?
  - More, different actors?
  - Providers select?
  - Modify conditions of participation (COPs)

Readmissions in PPACA

- Reduced payments to hospitals with high readmission rates (Section 3025)
  - Begins in 2013, based on past readmission experience
  - Begins with 3 conditions, expands in 2015
  - Public reporting
    - Hospital specific all patient readmission rates
    - Hospital submission of all patient data

Readmissions in PPACA

- Quality Improvement program (Section 399KK)
  - Designed to improve readmission rates using patient safety organizations
  - Eligible hospitals would have high rates of risk adjusted readmissions and not taken steps to reduce readmissions and patient safety
  - Report on processes used to improve readmission rates and their impact

Readmissions in PPACA

- Community-based care transitions for high risk Medicare beneficiaries (Section 3026)
  - 5 year program supported with $500 million
  - Expandable if proven to save money
  - Eligibility—application process, requires at least one care transition intervention
    - High readmission rate hospitals
    - Community based organizations providing care transition services

Readmissions moving forward

- Other providers?
- Gainsharing
- Testing approaches to bundled payments
- Flexibility and innovation at CMS