Medicare Payment Advisory Commission
Targeting Hospital Readmissions

National Medicare Readmissions Summit

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MEDPAC

Medicare Payment Advisory Commission

- Independent, nonpartisan
- 17 national experts selected for expertise, not representation
- 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

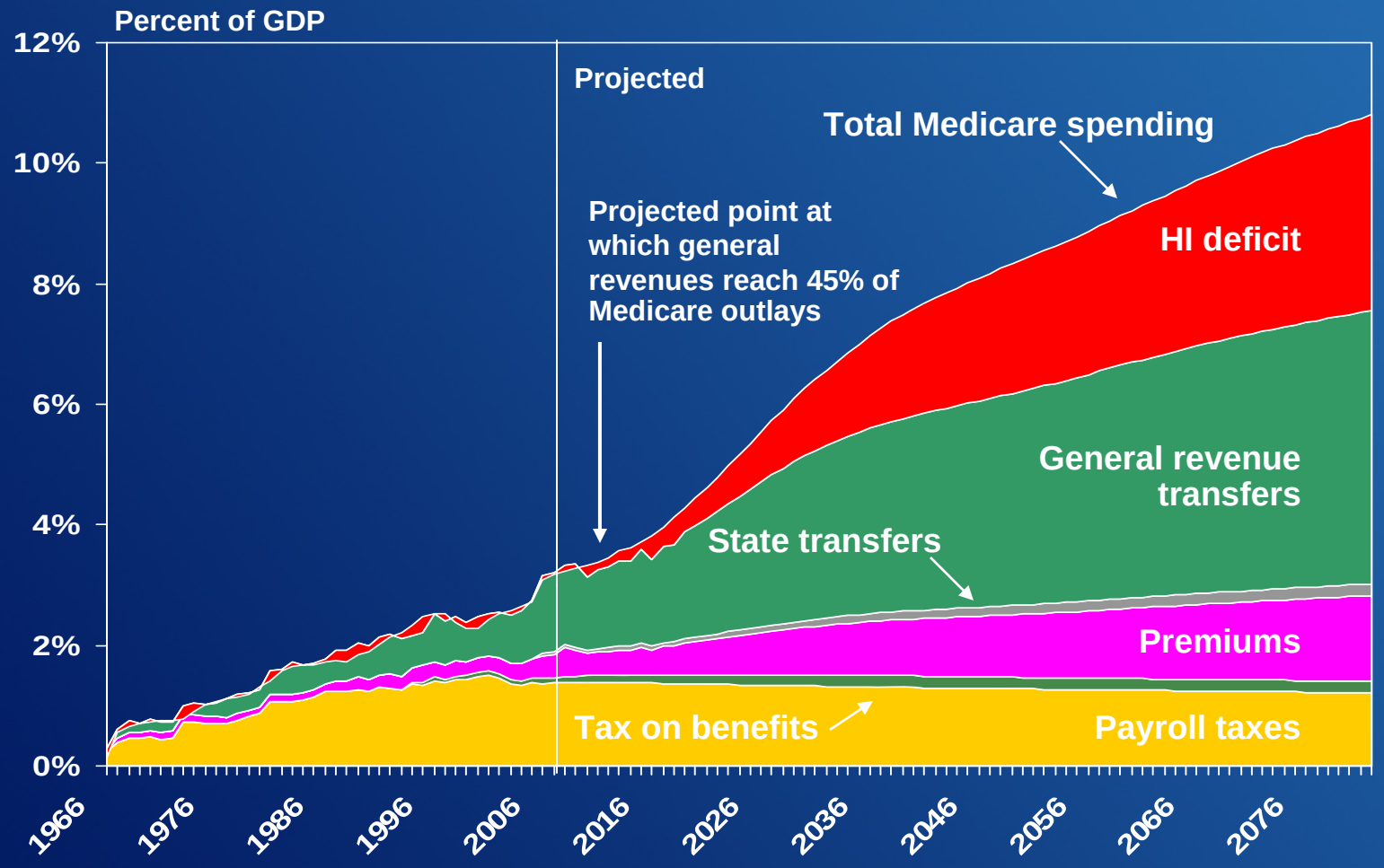
MedPAC Approach

- Commissioners supported by 25-30 analysts
- Work targeted to ensure access to high quality health care services in Medicare
- Focused on interests of beneficiaries, taxpayers, and providers
- Research includes:
  - Data, analysis
  - Site visits
  - Expert panels

Principles of Medicare Payment

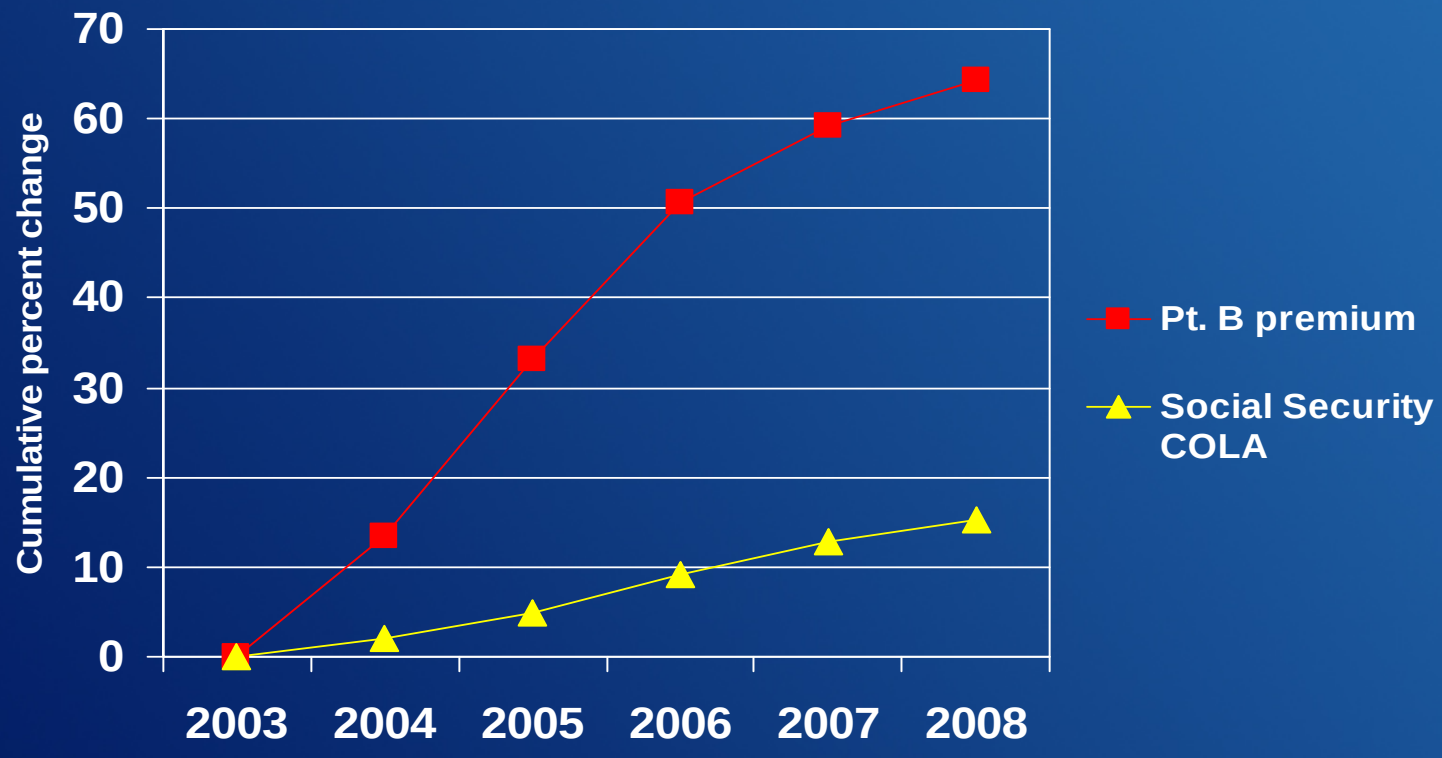
- Ensure beneficiary access to high quality care in an appropriate setting
- Give providers an incentive to supply care efficiently
- Control program spending

Medicare faces serious challenges with long-term financing



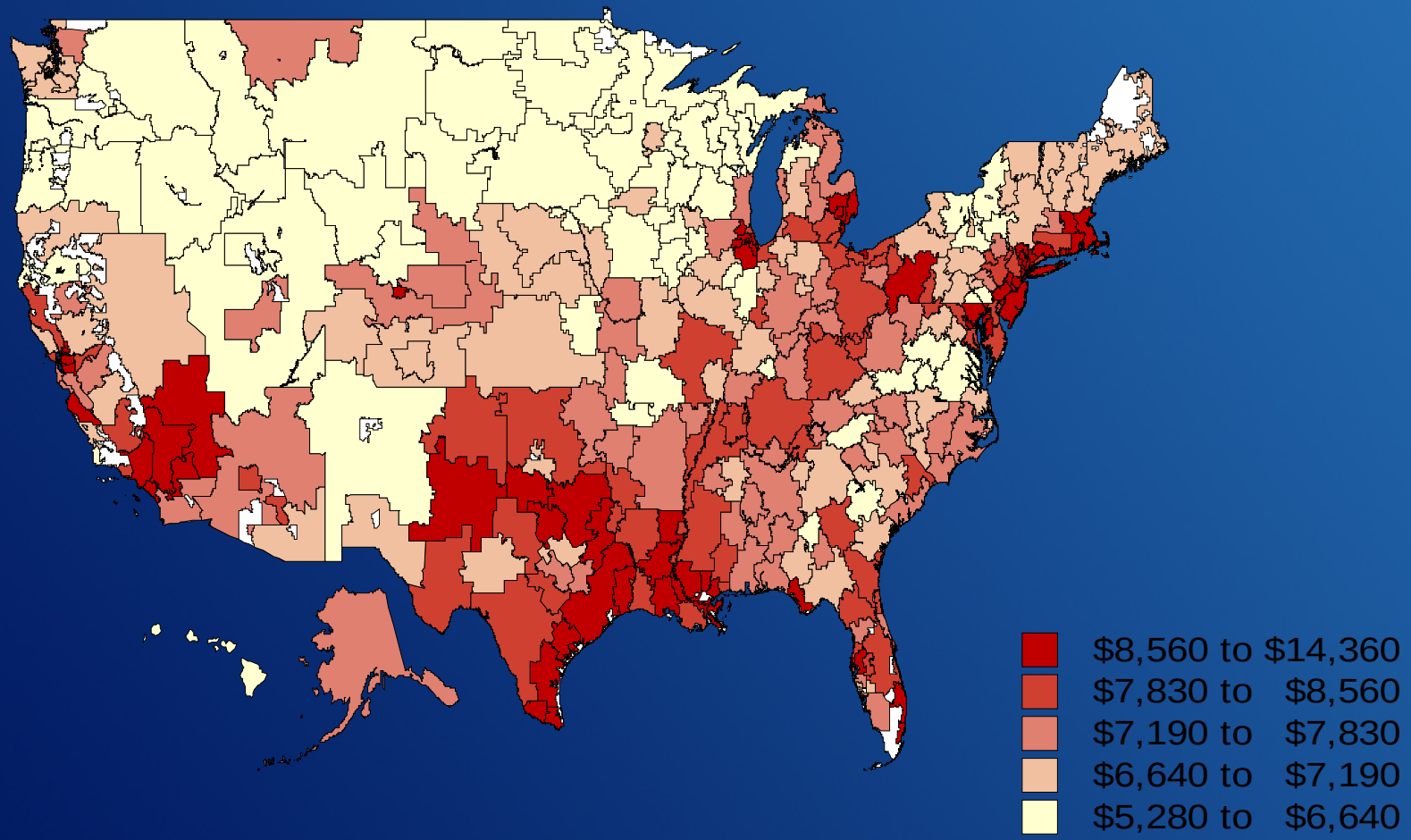
Source: 2008 annual report of the Boards of Trustees of the Medicare trust funds.

Medicare beneficiaries are already facing growing financial liability



Note: COLA (cost-of-living adjustment).
Source: Social Security Administration and Medicare trustees' report.

Significant geographic variation in spending



MEDPAC Source: Dartmouth Atlas of Health Care, 2005 Medicare claims data.

Traditional Medicare rewards volume over quality

- Providers paid in silos
- No financial incentive to work cooperatively to manage patients' care over time
- No financial incentive to provide quality care

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

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	$5 billion	$8 billion	$12 billion

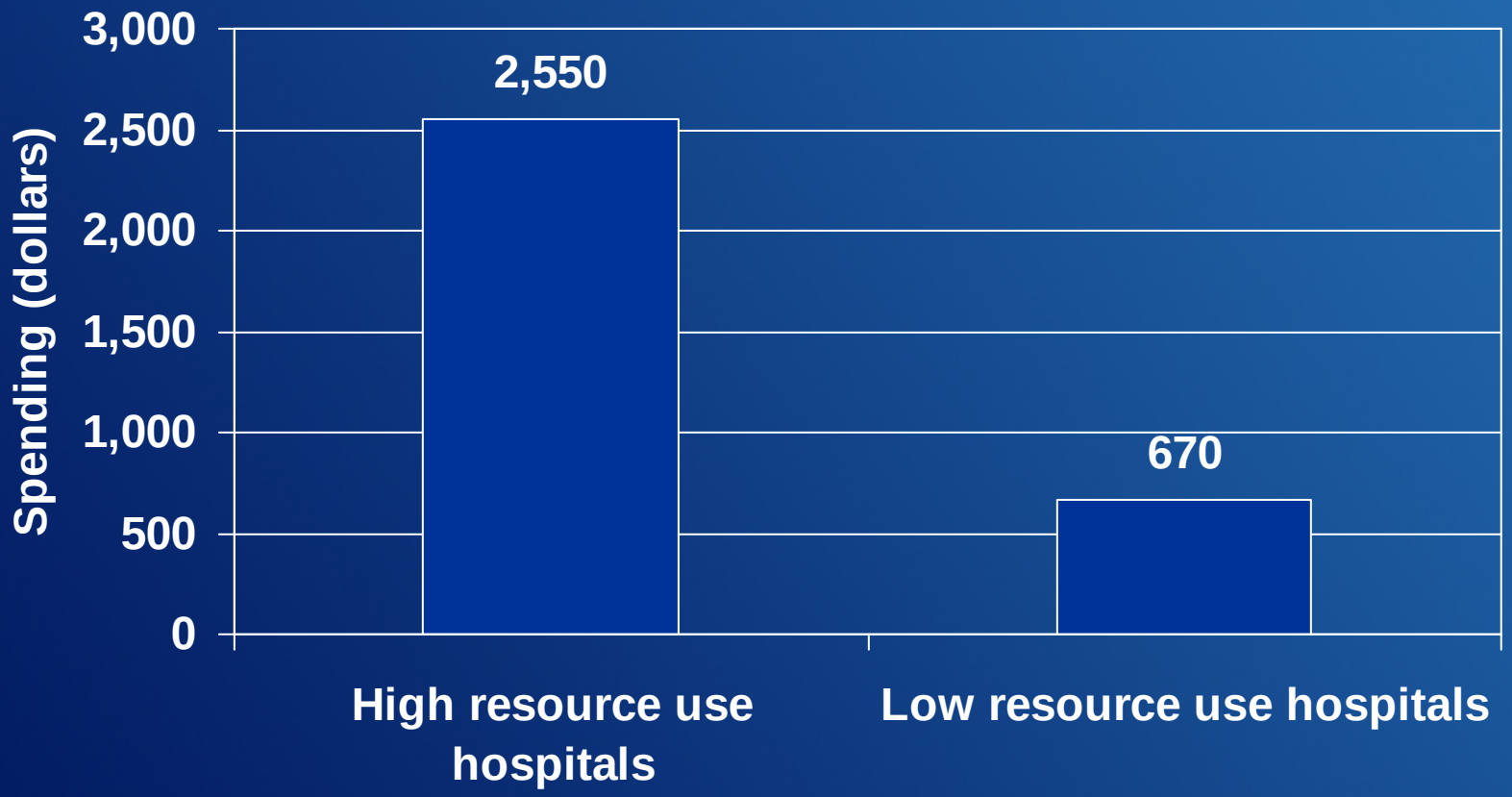
Source: MedPAC analysis of 2005 claims data

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

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

Average spending on readmissions in 30-day COPD hospitalization episodes



Source: MedPAC analysis of 2005 Medicare claims data.

Preventable readmissions

- Preventable readmissions occur – variety of strategies to reduce their likelihood
  - Reconcile medications
  - Use “teach back” technique to educate patients about self-care
  - Make appointment prior to discharge for follow-up care in the community
  - Call patient at home to check-in
  - Provide care partners timely and complete discharge notes
  - Provide safer care during the admission (e.g., reduce central line infections)

MedPAC 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.

MedPAC 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.

Design issues in a readmission policy

- Selected admissions
- Timeframe – e.g., 30 days
- Adjusting for risk
  - 3M logic identifies admissions that are likely related to original admission and are potentially preventable
  - Rate based policy with focus on hospitals with high readmission rates
- Benchmark performance – Average? Better than average?
- Hold other providers (e.g., SNFs, home health agencies, physicians) also accountable?

Goals of the payment change

- Changing payment for readmissions should encourage hospitals to
  - Improve quality of care
  - Provide more patient-centered care
  - Coordinate care across providers
    - Chips away at the silos
- Stepping stone for more broad-based coordination policies