MEDPAC Medicare Payment Advisory Commission

TESTIMONY

Reforming the Health Care Delivery System

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Statement of
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Before the
Committee on Ways and Means
U.S. House of Representatives

Chairman Rangel, Ranking Member Camp, distinguished Committee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss MedPAC's views on delivery system reform.

The health care delivery system we see today is not a true system: Care coordination is rare, specialist care is favored over primary care, quality of care is often poor, and costs are high and increasing at an unsustainable rate. Part of the problem is that Medicare's fee-for-service (FFS) payment systems reward more care, and more complex care, without regard to the value of that care. In addition, Medicare's payment systems create separate payment "silos" (e.g., inpatient hospitals, physicians, post-acute care providers) and do not encourage coordination among providers within a silo or across the silos. We must address those limitations—creating new payment methods that will reward efficient use of our limited resources and encourage the effective integration of care.

Medicare has not been the sole cause of the problem, nor should it be the only participant in the solution. Private payer rates and incentives perpetuate system inefficiencies, and the current disconnect among different payers creates mixed signals to providers. This contributes to the perception that one payer is cross-subsidizing other payers and further exacerbates the problem. Private and other public payers will need to change payment systems to bring about the conditions needed to change the broader health care delivery system. But Medicare should not wait for others to act first; it can lead the way to broader delivery system reform.

Why is fundamental change needed?

The Medicare program should provide its beneficiaries with access to appropriate, high quality care while spending the money entrusted to it by the taxpayers as carefully as possible. But too often that goal is not being realized, and we see evidence of poor-quality care and spending growth that threatens the program's fiscal sustainability.

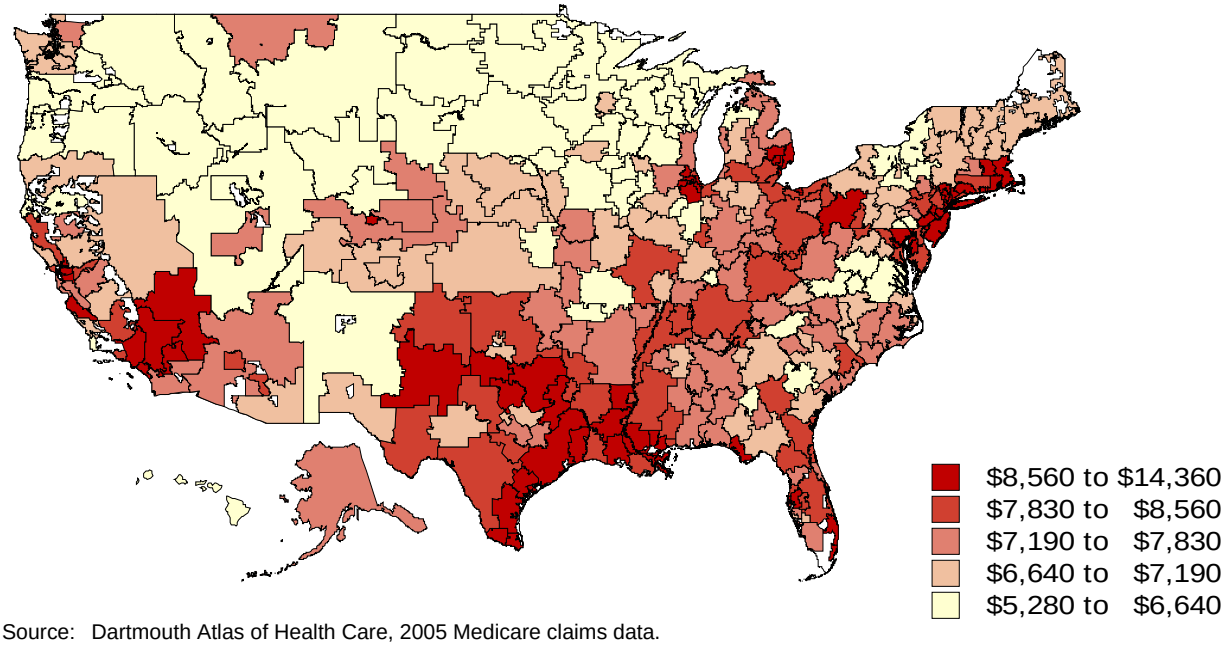
Poor quality

Many studies show serious quality problems in the American health care system. McGlynn found that participants received about half of the recommended care (McGlynn et al. 2003). Schoen found wide variation across states in hospital admissions for ambulatory-care-

sensitive conditions (i.e., admissions that are potentially preventable with improved ambulatory care) (Schoen et al 2006). In *Crossing the Quality Chasm*, the Institute of Medicine pointed out serious shortcomings in quality of care and the absence of real progress toward restructuring heath care systems to address both quality and cost concerns (IOM 2001).

At the same time that Americans are not receiving enough of the recommended care, the care they are receiving may not be appropriate. For 30 years, researchers at Dartmouth's Center for the Evaluative Clinical Sciences have documented the wide variation across the United States in Medicare spending and rates of service use (Figure 1). Most of this variation is not driven by differences in the payment rates across the country but instead by the use of services. Dartmouth finds most of the variation is caused by differing rates of use for supply-sensitive services—that is, services whose use is likely driven by a geographic area's supply of specialists and technology (Wennberg et al. 2002). Areas with higher ratios of specialty care to primary care physicians also show higher use of services.

Figure 1. Total Medicare spending by Hospital Referral Region



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

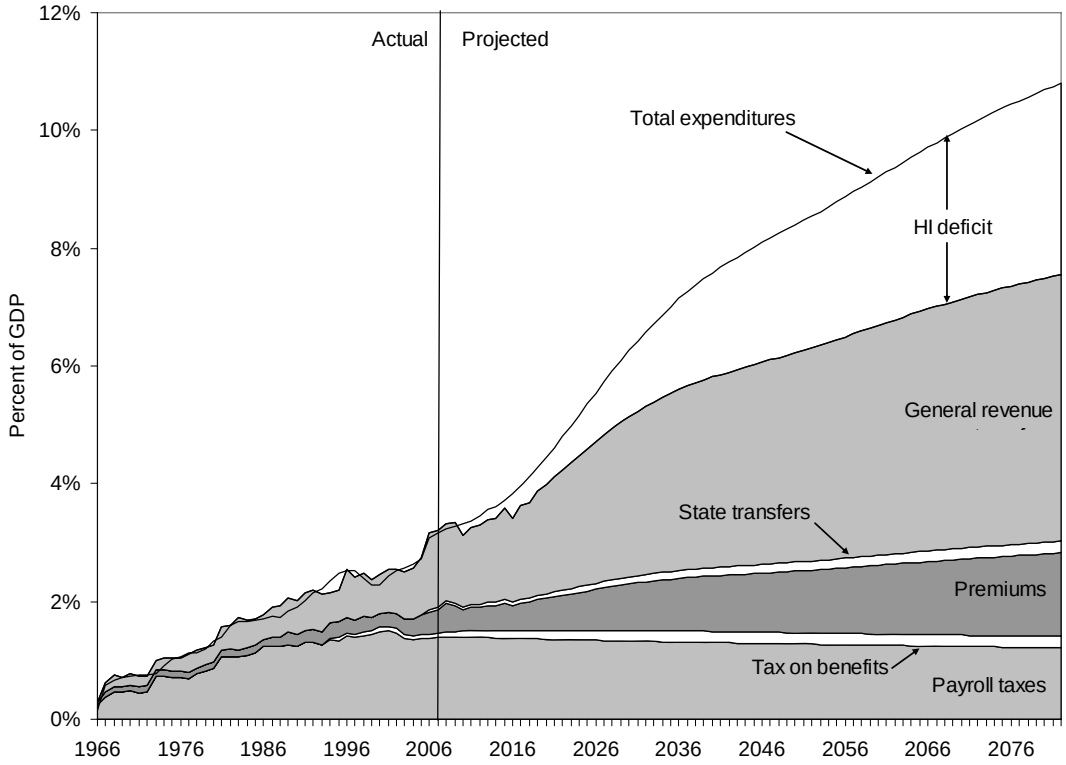
The higher rates of use are often not associated with better outcomes or quality and instead suggest inefficiencies. In fact, a recent analysis by Davis and Schoen shows at the state level that no relationship exists between health care spending per capita and mortality amenable to medical care, that an inverse relationship exists between spending and rankings on quality of care, and that high correlations exist between spending and both preventable hospitalizations and hospitalizations for ambulatory-care-sensitive conditions (Davis and Schoen 2007). These findings point to inefficient spending patterns and opportunities for improvement.

Sustainability concerns

This inefficiency costs the federal government many billions of dollars each year, expenditures we can ill afford. The share of the nation's GDP committed to Medicare is projected to grow to unprecedented levels, squeezing other priorities in the federal budget (Figure 2). For example, the Supplementary Medical Insurance Trust Fund (which covers outpatient and physician services, and prescription drugs) is financed automatically with general revenues and beneficiary premiums, but the trustees point out that financing from the federal government's general fund, which is funded primarily through income taxes, would have to increase sharply to match the expected growth in spending.

In addition, expenditures from the Hospital Insurance (HI) trust fund, which funds inpatient stays and other post-acute care, exceeded its annual income from taxes in 2008. In their most recent report, the Medicare trustees project that, under intermediate assumptions, the assets of the HI trust fund will be exhausted in 2019. Income from payroll taxes collected in that year would cover 78 percent of projected benefit expenditures. (The recent downturn in the economy is expected to move the HI exhaustion date closer by one to three years in the next Trustees' Report (BNA 2009).)

Figure 2. Medicare faces serious challenges with long-term financing



Note: GDP (gross domestic product), HI (Hospital Insurance). These projections are based on the trustees' intermediate set of assumptions. Tax on benefits refers to a portion of income taxes that higher income individuals pay on Social Security benefits that is designated for Medicare. State transfers (often called the Part D "clawback") refer to payments called for within the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 from the states to Medicare for assuming primary responsibility for prescription drug spending.
Source: 2008 Annual Report of the Boards of Trustees of the Medicare Trust Funds.

Rapid growth in Medicare spending has implications for beneficiaries and taxpayers. Between 2000 and 2007, Medicare beneficiaries faced average annual increases in the Part B premium of nearly 9.8 percent. Meanwhile, monthly Social Security benefits grew by about 4 percent annually over the same period. The average cost of SMI premiums and cost sharing for Part B and Part D absorbs about 26 percent of Social Security benefits. Growth in Medicare premiums and cost sharing will continue to absorb an increasing share of Social Security income. At the same time, Medicare's lack of a catastrophic cap on cost sharing will continue to represent a financial risk for beneficiaries. Almost 60 percent of beneficiaries (or their former employers) now buy supplemental coverage to help offset this risk and Medicare's cost sharing.

Barriers to achieving value in Medicare

Many of the barriers that prevent Medicare from improving quality and controlling costs—obtaining better value—stem from the incentives in Medicare's payment systems. Medicare's payment systems are primarily fee-for-service (FFS). That is, Medicare pays for each service delivered to a beneficiary by a provider meeting the conditions of participation for the program. FFS payment systems reward providers who increase the volume of services they provide regardless of the benefit of the service. As discussed earlier, the volume of services per beneficiary varies widely across the country, but areas with higher volume do not have better outcomes. FFS systems are not designed to reward higher quality; payments are not increased if quality improves and in some cases may increase in response to low-quality care. For example, some hospital readmissions may be a result of poor-quality care and currently those readmissions are fully paid for by Medicare.

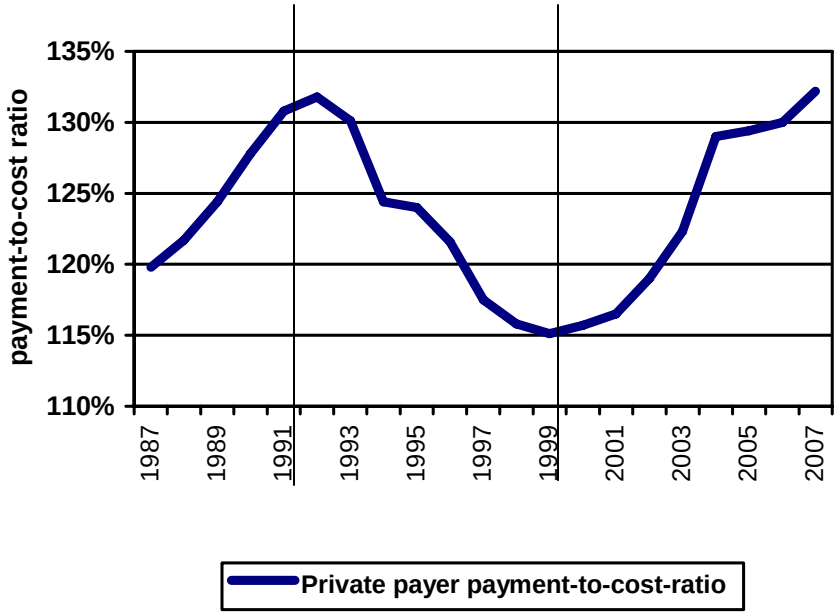
While this testimony focuses on changes to Medicare FFS payment systems that would encourage delivery system reform, the payment system for Medicare Advantage (MA) plans also needs reform, as we have previously reported. In aggregate, the MA program continues to be more costly than the traditional program. Plan bids for the traditional Medicare benefit package average 102 percent of FFS in 2009, compared with 101 percent of FFS in 2008. In 2009, MA payments per enrollee are projected to be 114 percent of comparable FFS spending for 2009, compared with 113 percent in 2008. Many MA plans have not changed the way care is delivered and often function much like the Medicare FFS program. High MA payments provide a signal to plans that the Medicare program is willing to pay more for the same services in MA than it does in FFS. Similarly, these higher payments signal to beneficiaries that they should join MA plans because they offer richer benefits, albeit financed by taxpayer dollars. This is inconsistent with MedPAC's position supporting financial neutrality between FFS and MA. To encourage efficiency across the Medicare program, Medicare needs to exert comparable and consistent financial pressure on both the FFS and MA programs, coupled with meaningful quality measurement and pay-for-performance (P4P) programs, to maximize the value it receives for the dollars it spends.

MedPAC has identified five specific problems that make it difficult for Medicare to achieve its goals: lack of fiscal pressure, price distortion, lack of accountability, lack of care coordination, and lack of information. These are discussed below.

Lack of fiscal pressure. Medicare payment policies ought to exert fiscal pressure on providers. In a fully competitive market, this happens automatically through the "invisible hand" of competition. Under Medicare's administered price systems, however, the Congress must exert this pressure by limiting updates to Medicare rates—or even reducing base rates in some instances (e.g., home health). MedPAC's research shows that provider costs are not immutable; they vary according to how much pressure is applied on rates. Providers under significant cost pressure have lower costs than those under less pressure. Moreover, MedPAC research demonstrates that providers can provide high-quality care even while maintaining much lower costs.

Our analysis shows that in 2007 hospitals under low financial pressure in the prior years had higher standardized costs per discharge ($6,400) than hospitals under high financial pressure ($5,800). Over time, aggregate hospital cost growth has moved in parallel with margins on private-payer patients (Figure 3). Due to managed care restraining private-payer payment rates in the 1990s, hospitals' rate of cost growth in that period was below input price inflation. However, from 2001 through 2007, after profits from private payers increased, hospitals' rate of cost growth was higher than the rate of increase in the market basket of input prices. All things being equal, increases in providers' costs will result in lower Medicare margins. We also found that hospitals with the highest private payments and most robust non-Medicare sources of revenues have lower Medicare margins (–11.7 percent) than hospitals under greater fiscal pressure (4.2 percent).

Figure 3. Three periods to the private-payer payment-to-cost ratio



Note: Private-payer margins do not include Medicare Advantage and Medicaid managed care patients.
Source: MedPAC analysis of data from the American Hospital Association.

Price distortion. Within Medicare's payment systems, the payment rates for individual products and services may not be accurate. Inaccurate payment rates in Medicare's payment systems can lead to unduly disadvantaging some providers and unintentionally rewarding others. For example, under the physician fee schedule, fees are relatively low for primary care and may be too high for specialty care and procedures. This payment system bias has signaled to physicians that they will be more generously paid for procedures and specialty care, and signals providers to generate more volume. In turn, these signals could influence the supply of providers, resulting in oversupply of specialized services and inadequate numbers of primary care providers. In fact, the share of U.S. medical school graduates entering primary care residency programs has declined in the last decade, and internal medicine residents are increasingly choosing to sub-specialize rather than practice as generalists.

Lack of accountability. Providers may provide quality care to uphold professional standards and to have satisfied patients, but Medicare does not hold them accountable for the quality of care they provide. Moreover, providers are not accountable for the full spectrum of care a

beneficiary may use, even when they make the referrals that dictate resource use. For example, physicians ordering tests or hospital discharge planners recommending post-acute care do not have to consider the quality outcomes or the financial implications of the care that other providers may furnish. This fragmentation of care puts quality of care and efficiency at risk.

Lack of care coordination. Growing out of the lack of accountability, there is no incentive for providers to coordinate care. Each provider may treat one aspect of a patient's care without regard to what other providers are doing. There is a focus on procedures and services rather than on the beneficiary's total needs. This becomes a particular problem for beneficiaries with several chronic conditions and for those transitioning between care providers, such as at hospital discharge. Poorly coordinated care may result in patient confusion, over-treatment, duplicative service use, higher spending, and lower quality of care.

Lack of information and the tools to use it. Medicare and its providers lack the information and tools needed to improve quality and use program resources efficiently. For example, Medicare lacks quality data from many settings of care, does not have timely cost or market data to set accurate prices, and does not generally provide feedback on resource use or quality scores to providers. Individually, providers may have clinical data, but they may not have that data in electronic form, leaving them without an efficient means to process it or an ability to act on it. Crucial information on clinical effectiveness and standards of care either may not exist or may not have wide acceptance. In this environment, it is difficult to determine what health care treatments and procedures are needed, and thus what resource use is appropriate, particularly for Medicare patients, many of whom have multiple comorbidities. In addition, beneficiaries are now being called on to make complex choices among delivery systems, drug plans, and providers. But information for beneficiaries that could help them choose higher quality providers and improve their satisfaction is just beginning to become available.

Commission recommendations to increase efficiency and improve quality

In previous reports, the Commission has recommended that Medicare adopt tools to surmount barriers to increasing efficiency and improving quality within the current Medicare

payment systems. These tools include:

- *Creating pressure for efficiency through payment updates.* Although the update is a somewhat blunt tool for constraining cost growth (updates are the same for all providers in a sector, both those with high costs and those with low costs), constrained updates will create more pressure on those with higher costs. In our March 2009 Report to the Congress, the Commission offers a set of payment update recommendations that exert fiscal pressure on providers to constrain costs. For example, the Commission recommends a zero update for home health agencies in 2010, coupled with an acceleration of payment adjustments due to coding practices, totaling a 5.5 percent cut in home health payments for 2010. Another example is the Commission's recommendation to reduce overpayments to MA plans by setting the MA benchmarks equal to 100 percent of Medicare FFS expenditures. This recommendation is consistent with the Commission's commitment to retaining high-quality, low-cost private plans in Medicare.

- *Improving payment accuracy within Medicare payment systems*. In our 2005 report on specialty hospitals, the Commission made recommendations to improve the accuracy of DRG payments to account for patient severity. Those recommendations corrected distortions in the payment system that—among other things—contributed to the formation of hospitals specializing in the treatment of a limited set of profitable DRGs. In another example, in our June 2008 and March 2009 Reports to the Congress, the Commission recommended increasing fee schedule payments for primary care services furnished by clinicians focused on delivering primary care. This budget-neutral adjustment would redistribute Medicare payments toward those primary care services provided by practitioners—physicians, advanced practice nurses, and physician assistants—whose practices focus on primary care. This recommendation recognizes that a well functioning primary care network is essential to help improve quality and control Medicare spending (MedPAC 2008, MedPAC 2009).

- *Linking payment to quality***.** In a series of reports, we have recommended that Medicare change payment system incentives by basing a portion of provider payment on the quality of care they provide and recommended that the Congress establish a quality incentive

payment policy for physicians, Medicare Advantage plans, dialysis facilities, hospitals, home health agencies, and skilled nursing facilities. In March 2005, the Commission recommended setting standards for providers of diagnostic imaging studies to enhance the quality of care and help control Medicare spending.

- *Measuring resource use and providing feedback.* In our March 2008 and 2005 Reports to the Congress, we recommended that CMS measure physicians' resource use per episode of care over time and share the results with physicians. Those who used comparatively more resources than their peers could assess their practice styles and modify them as appropriate.

- *Encouraging use of comparative-effectiveness information and public reporting of provider quality and financial relationships.* In our June 2007 Report to the Congress, we found that not enough credible, empirically based information is available for health care providers and patients to make informed decisions about alternative services for diagnosing and treating most common clinical conditions. The Commission recommended that the Congress charge an independent entity to sponsor credible research on comparative effectiveness of health care services and disseminate this information to patients, providers, and public and private payers. Second, the Commission recommended public reporting to provide beneficiaries with better information and encourage providers to improve their quality. Third, the Commission has recommended that manufacturers of drugs and medical devices be required to publicly report their financial relationships with physicians to better understand the types of financial associations that may influence patterns of patient care.

The need for more fundamental reform

The recommendations discussed above would make the current Medicare FFS payment systems function better, but they will not fix the problems inherent in those systems for two reasons. First, they cannot overcome the strong incentives inherent in any fee-for-service system to increase volume, thus it will be difficult to make the program sustainable. Second, they cannot switch the focus to the patient rather than the procedure because they cannot directly reward care coordination or joint accountability that cut across current

payment system "silos," such as the physician fee schedule or the inpatient prospective payment system.

There is evidence that more fundamental reforms could improve the quality of care and potentially lower costs. For example, patient access to high-quality primary care is essential for a well-functioning health care delivery system. Research suggests that reducing reliance on specialty care may improve the efficiency and quality of health care delivery. States with a greater proportion of primary care physicians have better health outcomes and higher scores on performance measures (Baicker and Chandra 2004). Moreover, areas with higher rates of specialty care per person are associated with higher spending but not improved access to care, higher quality, better outcomes, or greater patient satisfaction (Fisher et al. 2003, Kravet et al. 2008, Wennberg 2006). Countries with greater dependence on primary care have lower rates of premature deaths and deaths from treatable conditions, even after accounting for differences in demographics and GDP (Starfield and Shi 2002). Changing the balance in the delivery system between primary and specialist care may have high payoffs for Medicare.

Evidence points to other potential reforms:

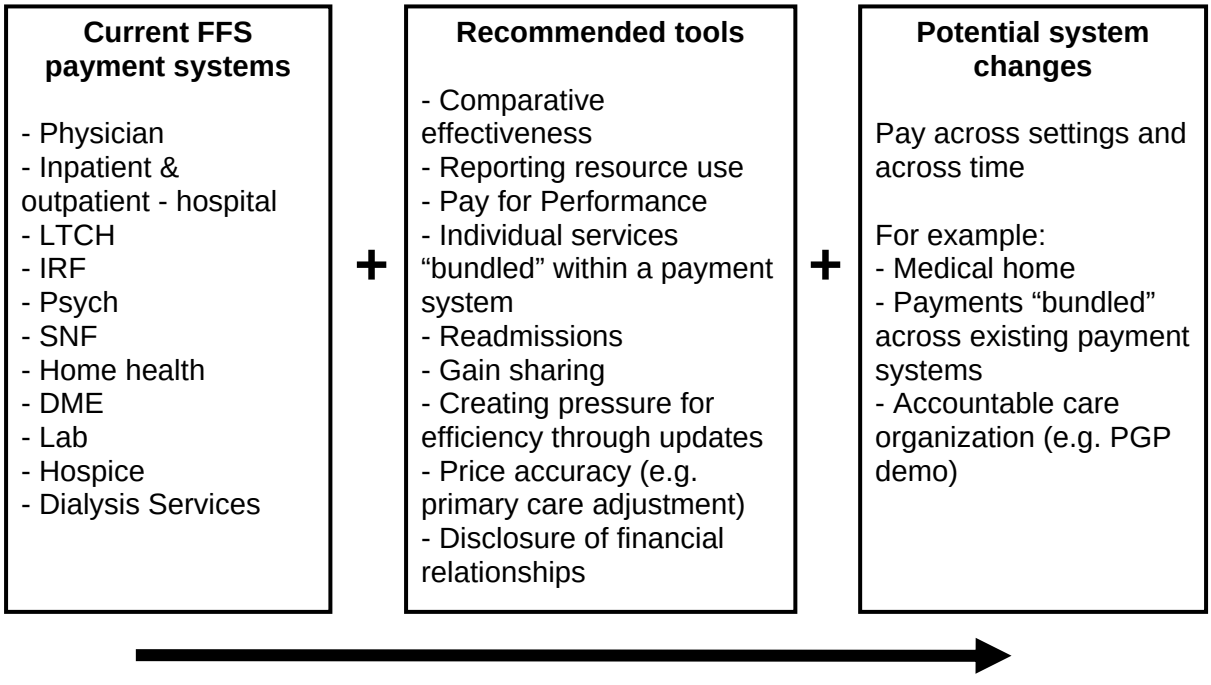
- *Greater care coordination.* Evidence shows that care coordination can improve quality. As we discussed in our June 2006 Report to the Congress, studies show self management programs, access to personal health records, and transition coaches have resulted in improved care or better outcomes, such as reduced readmission for patients with chronic conditions.
- *Reducing preventable readmissions.* Savings from preventing readmissions could be considerable. About 18 percent of Medicare hospital admissions result in readmissions within 30 days of discharge, accounting for $15 billion in spending. The Commission found that Medicare spends about $12 billion on potentially preventable readmissions.
- *Increasing the use of bundled payments.* The Medicare Participating Heart Bypass Center demonstration of the 1990s found that bundling hospital DRG payments and inpatient physician payments could increase providers' efficiency and reduce Medicare's costs. Most of the participating sites found that, under a bundled payment, hospitals and physicians reduced laboratory, pharmacy, and ICU spending. Spending on consulting physicians and post-discharge care decreased and quality remained high.

A direction for payment and delivery system reform

To increase value for the Medicare program, its beneficiaries, and the taxpayers, we are looking at payment policies that go beyond the current FFS payment system boundaries of scope and time. This new direction would pay for care that spans across provider types and time and would hold providers jointly accountable for the quality of that care and the resources used to provide it. It would create payment systems that reward value and encourage closer provider integration—delivery system reform. For example, if Medicare held physicians and hospitals jointly responsible for outcomes and resource use, new efficiencies—such as programs to avoid readmissions and standardization of operating room supplies—could be pursued. In the longer term, joint responsibility could lead to closer integration and development of a more coordinated health care delivery system.

This direction is illustrated in Figure 4. The potential payment system changes shown are not the end point for reform and further reforms could move the payment systems away from FFS and toward systems of providers who accept some level of risk, driving delivery system reform.

Figure 4. Direction for payment and delivery system reform



History provides numerous examples that providers will respond to financial incentives. The advent of the inpatient prospective payment system in 1983 led to shorter inpatient lengths of stay and increasing use of post acute care services. Physician services have increased as payments have been restrained by volume control mechanisms. Finally, a greater proportion of patients in skilled nursing facilities (SNFs) were given therapy, and more of it, in response to the SNF prospective payment system incentives. Financial incentives can also result in structural changes in the health care delivery system. In the 1990s, the rise of HMOs and the prospect of capitation led doctors and hospitals to form physician–hospital organizations whose primary purpose was to allocate capitated payments. Paying differently will motivate providers to interact differently with each other, and—if reforms are carefully designed for joint accountability—to pay more attention to outcomes and costs. To be sure, implementing these changes will not be easy. Changes of this magnitude will undoubtedly be met with opposition from providers and other stakeholders. In addition, the administrative component of the proposed payment system changes will require refinement over time.

Recommended system changes

We discuss three recommendations the Commission has made that might move Medicare in the direction of better coordination and more accountable care: a medical home pilot program, changing payments for hospital readmissions, and bundling payments for services around a hospital admission.

Medical home

A medical home is a clinical setting that serves as a central resource for a patient's ongoing care. The Commission considers medical homes to be a promising concept to explore. Accordingly, it recommends that Medicare establish a medical home pilot program for beneficiaries with chronic conditions to assess whether beneficiaries with medical homes receive higher quality, more coordinated care, without incurring higher Medicare spending. Qualifying medical homes could be primary care practices, multispeciality practices, or specialty practices that focus on care for certain chronic

conditions, such as endocrinology for people with diabetes. Geriatric practices would be ideal candidates for Medicare medical homes.

In addition to receiving payments for fee-schedule services, qualifying medical homes would receive monthly, per beneficiary payments that could be used to support infrastructure and activities that promote ongoing comprehensive care management. To be eligible for these monthly payments, medical homes would be required to meet stringent criteria. Medical homes must:

- furnish primary care (including coordinating appropriate preventive, maintenance, and acute health services);
- use of a team to conduct care management;
- use health information technology (IT) for active clinical decision support;
- have a formal quality improvement program;
- maintain 24-hour patient communication and rapid access;
- keep up-to-date records of beneficiaries' advance directives; and
- maintain a written understanding with each beneficiary designating the provider as a medical home.

These stringent criteria are necessary to ensure that the pilot evaluates outcomes of the kind of coordinated, timely, high-quality care that has the highest probability to improve cost, quality, and access. The pilot must assess a true intervention rather than care that is essentially business as usual.

In rural areas, the pilot could test the ability for medical homes to provide high-quality, efficient care with somewhat modified structural requirements.

Beneficiaries with multiple chronic conditions would be eligible to participate because they are most in need of improved care coordination. About 60 percent of FFS beneficiaries have two or more chronic conditions. Beneficiaries would not incur any additional cost sharing for the medical home fees. As a basic principle, medical home practitioners would discuss with beneficiaries the importance of seeking guidance from the medical home before obtaining specialty services. Participating beneficiaries would, however, retain their ability to see

specialists and other practitioners of their choice. Under the pilot, Medicare should also provide medical homes with timely data on patients' Medicare-covered utilization outside the medical home, including services under Part A and Part B and drugs under Part D.

A medical home pilot provides an excellent opportunity to implement and test physician pay-for-performance (P4P) with payment incentives based on quality and efficiency. Under the pilot project, the Commission envisions that the P4P incentives would allow for rewards and penalties based on performance. Efficiency measures should be calculated from spending on Part A, Part B, and Part D, and efficiency incentives could take the form of shared savings models similar to those under Medicare's ongoing physician group practice demonstration. Bonuses for efficiency should be available only to medical homes that have first met quality goals and that have a sufficient number of patients to permit reliable spending comparisons. Medical homes that are consistently unable to meet minimum quality requirements would become ineligible to continue participation.

It is imperative that the medical home pilot be on a large enough scale to provide statistically reliable results with a relatively short testing cycle. Additionally, the pilot must have clear and explicit results-based thresholds for determining whether it should be expanded into the full Medicare program or discontinued entirely. Focusing on beneficiaries with multiple chronic conditions and medical homes meeting stringent criteria should provide a good test of the medical home concept.

Readmissions and bundled payments around a hospitalization

Evidence suggests there is an enormous opportunity to improve care and address the lack of coordination at hospital discharge. Discharge from the hospital is a very vulnerable time for patients, and in particular for Medicare beneficiaries, who often cope with multiple chronic conditions. Often they are expected to assume a self-management role in recovery with little support or preparation. They may not understand their discharge instructions on what medications to take, know whom to call with questions, or know what signs indicate the need for immediate follow-up care. Often they do not receive timely follow-up care and communication between their hospital providers and post-acute care providers is uneven. These disjointed patterns of care can result in poorer health outcomes for beneficiaries, and

in many cases, the need for additional health care services and expenditures.

The variation in spending around hospitalization episodes suggests lower spending is possible. There is a 65 percent difference in spending on readmissions between hospitals in the top quartile and the average of all hospitals; the top quartile is almost four times higher than the bottom quartile. The spread between high- and low-use hospitals is even larger than spending for post-acute care. These high-spending hospitals often treat the beneficiaries with the costliest care. Greater coordination of care is needed for this population, and changing incentives around their hospital care could be the catalyst.

How can Medicare policy change the way care is provided? First, the Commission recommends that the Secretary confidentially report to hospitals and physicians information about readmission rates and resource use around hospitalization episodes (e.g., 30 days post-discharge) for select conditions. This information would allow a given hospital and the physicians who practice in it to compare their risk-adjusted performance relative to other hospitals, physicians, and post-acute care providers. Once equipped with this information, providers may consider ways to adjust their practice styles and coordinate care to reduce service use. After two years of confidential disclosure to providers, this information should be publicly available.

Information alone, however, will not likely inspire the degree of change needed. Payment incentives are needed. We have two recommendations—one to change payment for readmissions and one to bundle payments across a hospitalization episode. Either policy could be pursued independently, but the Commission views them as complementary. A change in readmissions payment policy could be a critical step in creating an environment of joint accountability among providers that would, in turn, enable more providers to be ready for bundled payment.

Readmissions

The Commission recommends changing payment to hold providers financially accountable for service use around a hospitalization episode. Specifically, it would reduce payment to hospitals with relatively high readmission rates for select conditions. Conditions with high volume and high readmissions rates may be good candidates for selection. Focusing on *rates*

rather than *numbers* of readmissions serves to penalize hospitals that consistently perform worse than other hospitals, rather than those that treat sicker patients. The Commission recommends that this payment change be made in tandem with a previously recommended change in law (often referred to as gainsharing or shared accountability) to allow hospitals and physicians to share in the savings that result from re-engineering inefficient care processes during the episode of care.

Currently, Medicare pays for all admissions based on the patient's diagnosis regardless of whether it is an initial stay or a readmission for the same or a related condition. This is a concern because we know that some readmissions are avoidable and in fact are a sign of poor care or a missed opportunity to better coordinate care.

Penalizing high rates of readmissions encourages providers to do the kinds of things that lead to good care, but are not reliably done now. For example, the kinds of strategies that appear to reduce avoidable readmissions include preventing adverse events during the admission, reviewing each patient's medications at discharge for appropriateness, and communicating more clearly with beneficiaries about their self-care at discharge. In addition, hospitals, working with physicians, can better communicate with providers caring for patients after discharge and help facilitate patients' follow-up care.

Spending on readmissions is considerable. We have found that Medicare spends $15 billion on all-cause readmissions and $12 billion if we exclude certain readmissions (for example, those that were planned or for situations such as unrelated traumatic events occurring after discharge). Of this $12 billion, some is spent on readmissions that were avoidable and some on readmissions that were not. To target policy to avoidable readmissions, Medicare could compare hospitals' rates of potentially preventable readmissions and penalize those with high rates. The savings from this policy would be determined by where the benchmark that defines a high rate is set, the size of the penalty, the number and type of conditions selected, and the responsiveness of providers.

The Commission recognizes that hospitals need physician cooperation in making practice changes that lead to a lower readmission rate. Therefore, hospitals should be permitted to financially reward physicians for helping to reduce readmission rates. Sharing in the financial

rewards or cost savings associated with re-engineering clinical care in the hospital is called gainsharing or shared accountability. Allowing hospitals this flexibility in aligning incentives could help them make the goal of reducing unnecessary readmissions a joint one between hospitals and physicians. As discussed in a 2005 MedPAC report to the Congress, shared accountability arrangements should be subject to safeguards to minimize the undesirable incentives potentially associated with these arrangements. For example, physicians who participate should not be rewarded for increasing referrals, stinting on care, or reducing quality.

Bundled payments for care over a hospitalization episode

Under bundled payment, Medicare would pay a single provider entity an amount intended to cover the costs of providing the full range of care needed over the hospitalization episode. Because we are concerned about care transitions and creating incentives for coordination at this juncture, the hospitalization episode should include time post-discharge (e.g., 30 days). With the bundle extending across providers, providers would not only be motivated to contain their own costs but also have a financial incentive to better collaborate with their partners to improve their collective performance. Providers involved in the episode could develop new ways to allocate this payment among themselves. Ideally, this flexibility gives providers a greater incentive to work together and to be mindful of the impact their service use has on the overall quality of care, the volume of services provided, and the cost of providing each service. In the early 1990s, Medicare conducted a successful demonstration of a combined physician–hospital payment for coronary artery bypass graft admissions, showing that costs per admission could be reduced without lowering quality.

The Commission recommends that CMS conduct a voluntary pilot program to test bundled payment for all services around a hospitalization for select conditions. Candidate conditions might be those with high costs and high volumes. This pilot program would be concurrent with information dissemination and a change in payment for high rates of readmissions.

Bundled payment raises a wide set of implementation issues. It requires not only that Medicare create a new payment rate for a bundle of services but also that providers decide how they will share the payment and what behavior they will reward. A pilot allows CMS to

resolve the attendant design and implementation issues, while giving providers who are ready the chance to start receiving a bundled payment.

The objective of the pilot should be to determine whether bundled payment for all covered services under Part A and Part B associated with a hospitalization episode (e.g., the stay plus 30 days) improves coordination of care, reduces the incentive for providers to furnish services of low value, improves providers' efficiency, and reduces Medicare spending while not otherwise adversely affecting the quality of care. The pilot should begin applying payment changes to only a selected set of medical conditions.

Conclusion

The process of reform should begin as soon as possible; reform will take many years and Medicare's financial sustainability is deteriorating. That deterioration can be traced in part to the dysfunctional delivery system that the current payment systems have helped to create. Those payment systems must be fundamentally reformed, and the recommendations we have made are a first step on that path. They are, however, only a first step; they fall far short of being a "solution" for Medicare's long-term challenges. MedPAC has begun to consider other options and will continue its evaluation of accountable care organizations (ACOs) at our April meeting. In addition, MedPAC will consider steps to alter the process by which payment reforms are developed and implemented, with the goals of accelerating that process. I thank the Committee for its attention, and look forward to working with you to reform Medicare's payment systems and help bring the health care delivery system into the 21st century.

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