CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

PATHS TO HEALTHCARE PAYMENT REFORM

Using Medical Homes To Reduce Readmissions

Reducing Healthcare Costs Without Rationing

Many people are convinced that the only way to significantly reduce healthcare costs is by some type of rationing, i.e., limiting the kinds of services that Medicare or health insurance will pay for. But there are ways to significantly reduce healthcare spending without taking away anything that consumers want.

A perfect example is hospital readmissions. Research studies and quality-reporting initiatives around the country show that 15-25% of people who are discharged from the hospital will be readmitted to the hospital within 30 days or less, and that many of these readmissions are preventable. The patients certainly wouldn't mind having fewer hospitalizations, and billions of dollars in spending on hospital stays could be saved if these hospitalizations could be avoided. In other words, reducing readmissions is a win-win for both cost and quality, without a hint of rationing.

Should Hospitals Be Penalized for Readmissions?

A number of proposals have surfaced for reducing preventable readmissions by reducing or eliminating payments to hospitals when these readmissions occur. The problem with this approach is that it assumes that if a readmission is preventable, it is preventable *by the hospital*, and that is not always the case. One can divide the causes of preventable readmissions into three broad categories:

- **Readmissions for complications or infections arising directly from the initial hospital stay**, e.g., if a surgery patient develops a surgical site infection or other complication and has to return after discharge.
- **Readmissions because of poorly managed transitions during discharge**, e.g., if a patient or a caregiver does not receive clear instructions from the hospital about the types of medications to take or what to do or not do during recuperation.
- **Readmissions because of a recurrence of a chronic condition that led to the initial hospitalization**, e.g., an exacerbation of asthma, congestive heart failure, or chronic obstructive pulmonary disease.

Readmissions in the first category and many readmissions in the second category can be viewed as primarily the responsibility of the hospital, and most of these readmissions occur quickly – within 15-30 days. Payment changes for hospitals to reflect this would be appropriate; ideally, hospitals should offer a "limited warranty" for these types of cases and readmissions.

But the largest numbers of readmissions are among patients with chronic disease. Many of these patients are being admitted and readmitted because they are not receiving good primary care support in the community, and that is not likely to change simply by penalizing hospitals for these readmissions. Moreover, a 30-day window of time is arbitrary; more than half of the readmissions among chronic disease patients occur after 30 days.

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Using Medical Homes to Reduce Readmissions

Many of the readmissions among chronic disease patients can be prevented, but the prevention comes from improvements in primary care, not (just) from changes in hospital care. Study after study has shown that very simple, low-cost interventions by primary care practices, such as in-person education of patients about how to manage their conditions and use medications properly, can dramatically reduce hospitalizations and readmissions among people with chronic

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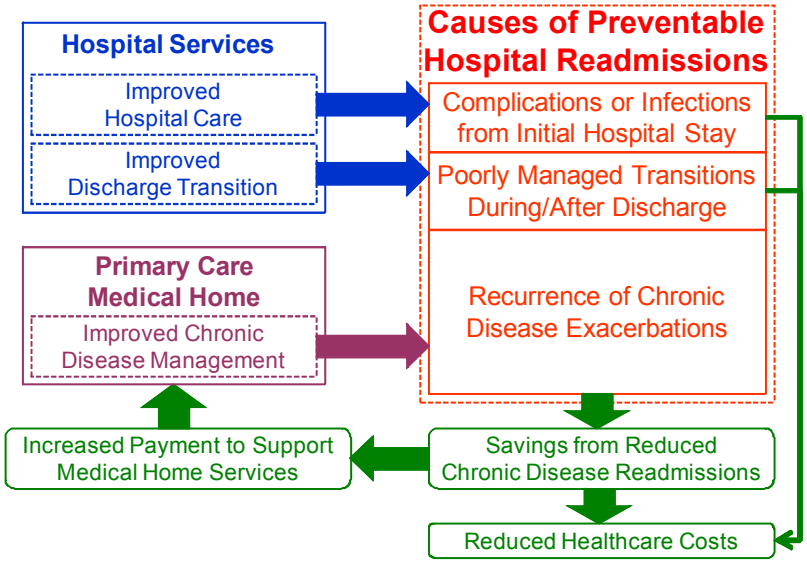
disease. Unfortunately, under current payment systems, Medicare and commercial health insurers won't pay for many of the services that would keep patients out of the hospital, even though they will pay every time the patient goes into the hospital. For example, primary care practices cannot be reimbursed for hiring a nurse care manager to educate patients about how to use their medications, visit them after a hospitalization, etc.

Addressing these problems is one of the key goals of proposals to create "Patient-Centered Medical Homes." Efforts are underway all across the country to encourage primary care practices to become medical homes, but payers, and the purchasers they represent, are reluctant to pay more for medical home services without assurances that patient outcomes will be better and that costs will be saved elsewhere. Most medical home demonstration programs are requiring that primary care practices meet medical home standards established by the National Committee for Quality Assurance (NCQA), but there is no guarantee that meeting the NCQA standards will result in either better outcomes or lower costs. As a result, payers want to hedge their bets by making the payments as low as possible. This creates a Catch-22: if the payments are too low to allow the primary care practices to make the changes in care needed to improve patient outcomes, then all that will happen is that costs will go up, the medical home projects will be labeled failures, and the healthcare system will return to its ineffective *status quo ante*.

So on the one hand, we have a primary care improvement initiative (the Medical Home) without a clear outcome to be achieved, and on the other hand, we have an outcome improvement goal (reducing readmissions among chronic disease patients) without a clear strategy for achieving it. The obvious solution is a marriage of the two: Primary care practices should receive special additional payments that are both adequate in magnitude and sufficiently flexible to enable the practices to provide the kinds of patient education and self-management support that have been shown to reduce hospitalizations among patients with chronic disease and other ambulatory care sensitive conditions. In return, each participating practice would agree to establish and work towards achieving goals for reducing hospital readmissions sufficient to at least offset the cost of the increased payments that are being provided. The special additional payment would not be continued if a practice did not achieve its readmission reduction goal (after accounting for changes in patient characteristics).



"Sharing Savings" Up Front

It's important to note that this approach is different from the concept of paying physicians or care delivery systems "shared savings" after the fact, as in Medicare's Physician Group Practice Demonstration. The primary care practices need resources up front to provide improved services – most primary care practices are small and can't afford to recruit and hire new staff, install clinical registries, and restructure their practice operations and then wait for a year or more to be reimbursed. Providing resources to them up front represents a degree of "shared risk" between the primary care practice and the payer, but it's a small risk – since most hospital readmissions occur within 30-60 days, primary care practices will get rapid feedback on how they're doing, and payers will be able to generate savings in the same year as the additional funding is provided.

Marrying the Patient-Centered Medical Home and Readmission Reduction provides a mechanism for simultaneously achieving three important goals – improving primary care, improving patient outcomes, and reducing the nation's healthcare expenditures.

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