vices for the American people. Preemption will undermine the confidence that doctors and patients have in the safety of drugs and devices. If injured patients are unable to seek legal redress from manufacturers of defective products, they may instead turn elsewhere.

In May, a Congressional hearing on preemption was held by Representative Henry Waxman (D-CA) and the House Committee on Oversight and Government Reform. As we stated in our testimony to the committee, to ensure the safety of medical devices, we urge Congress to act quickly to reverse the *Riegel* decision. Congressman Waxman and Congressman Frank Pallone, Jr. (D-NJ), are poised to introduce legislation that would unambiguously eliminate the possibility of preemption of common-law tort actions for medical devices. And if the Supreme Court rules for preemption in *Wyeth v. Levine*, which we hope it will not, Congress should consider similar legislation for drugs. Such legislation is in the best interest of the health and safety of the American public.

Dr. Curfman is the executive editor, Dr. Morrissey the managing editor, and Dr. Drazen the editor-in-chief of the *Journal*.

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Collective Accountability for Medical Care — Toward Bundled Medicare Payments

Glenn Hackbarth, J.D., Robert Reischauer, Ph.D., and Anne Mutti, M.P.A.

Medicare's projected spending growth is unsustainable. The program already strains the resources of beneficiaries and taxpayers alike and will someday crowd out other public- and private-sector priorities, given that Medicare spending as a percentage of the gross domestic product is expected to nearly double in the next 20 years. At the same time, neither beneficiaries nor taxpayers are getting good value from the program. Per-beneficiary spending in high-spending regions of the country exceeds that in low-spending regions by one third, and yet beneficiaries in high-spending regions receive no better quality of care.[1] The incentives inherent in the dominant fee-for-service payment system are the root cause of these problems. Fee-for-service payment spurs spending growth, supports a fragmented and compartmentalized delivery system, and does nothing to reward quality or value.

In our June 2008 report, the Medicare Payment Advisory Commission (MedPAC) makes three recommendations intended to create collective accountability across providers for selected hospital episodes, such as those for congestive heart failure, chronic obstructive pulmonary disease, and cardiac bypass surgery. Our hope is that this set of policies will create an environment that encourages and enables providers to accept bundled payments while also testing the feasibility of this payment design. Under a bundled payment approach, Medicare would pay a single provider entity (comprising a hospital and its affiliated physicians) a fixed amount intended to cover the costs of providing the full range of Medicare-covered services delivered during the episode, which might be defined as the hospital stay plus 30 days after discharge. Bundling payments in this way should provide incentives to increase efficiency, coordinate in-hospital and post-hospital care, and, if combined with pay-for-performance initiatives, improve the quality of care.

Standardized Medicare spending for an episode of care varies greatly among hospitals (see table). The greatest variation occurs in spending for readmission and post-acute care. Variation in spending for physicians' services after discharge (included in the "other" category) is also notable. Physicians influence the variation in the use of both their own services and all other services. They also influence hospitals' costs, since they exercise their judgment in determining the length of a patient's stay and the use of the intensive care unit and surgical supplies, for example. Accordingly, to encourage joint accountability for both the volume and the cost of services, payment for physician services as well as hospital and other post-acute care services must be included in the bundle.

Average Risk-Adjusted Standardized Spending for Selected Conditions between the Start of a Hospital Stay and 30 Days after Discharge.*

Type of Condition and Service	Spending at Hospitals with Low Resource Use	Average Spending	Spending at Hospitals with High Resource Use	Difference between Spending at Hospitals with High Resource Use and Average Spending	
	$	$	$	%	$
Chronic obstructive pulmonary disease					
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
Congestive heart failure					
Total episode	7,757	9,278	11,019	18.8	1,741
Hospital	4,837	4,826	4,824	0.0	–2
Physician	612	647	650	0.5	3
Readmission	1,102	1,986	2,965	49.3	979
Post-acute care	842	1,378	2,041	48.1	663
Other	363	441	539	22.2	98
Coronary-artery bypass grafting with cardiac catheterization					
Total episode	31,534	33,421	35,656	6.7	2,235
Hospital	25,591	25,474	25,390	0.3	–84
Physician	3,390	3,452	3,404	–1.4	–48
Readmission	947	1,887	2,911	54.3	1,024
Post-acute care	800	1,651	2,822	70.9	1,171
Other	806	957	1,129	18.0	172

* Spending for each service is risk-adjusted to reflect differences in the severity of illness and reflects national standardized payment rates, which exclude spending associated with specific missions (e.g., teaching) and payment adjustments according to geographic region. It does not reflect differences in the cost to the facility of providing services. Accordingly, hospital spending remains relatively constant across hospitals. Hospitals with low resource use are in the bottom quartile of risk-adjusted spending per episode, and hospitals with high resource use are in the top quartile. Physician spending reflects care provided by the physician during the hospital stay. Readmission spending represents average spending for in-hospital care by the physician and care during the readmission. Other spending includes spending for outpatient care and care by physicians outside the hospital. Data are from MedPAC's analysis of a sample of 5% of the Medicare claims files for 2001 through 2003.

Variations in Medicare payments per episode suggest that the fee-for-service payment system does not provide adequate incentives to ensure that care throughout an episode is coordinated, that a hospital's communication with community physicians and providers of post-acute care is thorough and timely, and that the mix of prescription drugs is appropriate and sufficiently reviewed at discharge. Too often, transitions do not go smoothly; patients, many of whom are vulnerable and are not well prepared to organize their own care, get lost in the handoff, and avoidable readmissions occur.

Bundling the payments for multiple providers would create incentives for providers not only to contain their own costs but also to work together to improve their collective efficiency. Providers accepting bundled payments would have the flexibility to develop entirely new approaches to organizing care and allocating payments among themselves in ways that could help them achieve efficient, high-quality care. They could then share in any savings gained by improving coordination, quality, and efficiency.

Before a payment-system change of this magnitude can be implemented, answers must be sought to a number of relevant questions. For instance, will providers (primarily hospitals and physicians) be able to come together to form entities that can accept bundled payments? Will they be able to agree on appropriate ways to share payments? Will providers be able to keep their costs lower than the payments for an episode? Can Medicare protect against possible adverse effects of this policy, such as stinting on necessary care during an episode or increases in low-complexity admissions? How would Medicare, beneficiaries, and providers share in any savings?

Medicare has some experience

MedPAC Recommendations for Bundling Payments for Episodes of Hospitalization.

The Congress should require the Secretary [of Health and Human Services] to 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.

To encourage providers to collaborate and better coordinate care, the Congress should direct the Secretary to reduce payments to hospitals with relatively high readmission rates for select conditions and also allow shared accountability between physicians and hospitals. The Congress should also direct the Secretary to report within 2 years on the feasibility of broader approaches, such as virtual bundling, for encouraging efficiency around hospitalization episodes.

The Congress should require the Secretary to create a voluntary pilot program to test the feasibility of actual bundled payment for services around hospitalization episodes for select conditions. The pilot must have clear and explicit thresholds for determining whether it can be expanded into the full Medicare program or should be discontinued.

with these issues. The Medicare Participating Heart Bypass Center Demonstration of the 1990s showed how bundled payments might be structured and that this approach could be successful. Many providers applied to participate, and most of the sites that did participate both lowered their costs and reduced Medicare spending. Under a bundled-payment system, hospitals and physicians reduced spending on laboratory and pharmacy services and intensive care, as well as spending on consulting physicians and postdischarge care. Quality remained high.[2]

To further test the desirability and feasibility of a broad system of bundled payments for episodes of care while also creating an environment encouraging acceptance of bundled payments, MedPAC has made three recommendations (see box). As a first step, the Centers for Medicare and Medicaid Services should share with hospitals, physicians, and other relevant providers information about how their payments per episode compare with those of their peers. These data should include payments for readmission and post-acute care.

Second, MedPAC recommends that payments be reduced for hospitals with high risk-adjusted readmission rates for selected high-volume, high-cost conditions. These payment penalties would apply to the hospital of initial admission if the readmission was to a different institution. Such a change should encourage hospitals to dedicate resources to processes that can reduce avoidable readmissions, which (as the table shows) are a major source of the variation in total resource use associated with episodes of care. Hospitals that have focused on the problem have successfully reduced readmission rates, particularly among patients with congestive heart failure, by avoiding complications during the stay,[3] reconciling medications,[4] improving communication among providers at handoffs, and educating patients about self-care.[5] Because hospitals will undoubtedly need physicians and other post-hospital care providers to collaborate to reduce avoidable readmissions, MedPAC also recommends that Congress ease existing restrictions so that hospitals are able to reward physicians financially if they help to address this problem (an arrangement sometimes referred to as "gainsharing").

Finally, MedPAC recommends that Congress initiate a voluntary pilot program that would test the use of bundled payments for episodes of hospitalization for a small number of conditions. Pilots, like demonstrations, provide the opportunity to test a policy's efficacy, uncover difficulties that could be encountered in its implementation, and make any needed adjustments. But, unlike demonstrations, pilots can be expanded nationally, without further legislative approval, if the policy achieves specific goals set by Congress. Providers may be more willing to invest in the difficult task of changing their culture, practice patterns, and infrastructure if they have greater assurance that a successful experiment will become national policy.

MedPAC is under no illusion that the path of policy change outlined here is easy. Unforeseen consequences are likely, and midcourse adjustments will be needed. But a continuation of the status quo is unacceptable. The current payment system is fueling many of the worst aspects of our heath care system, leaving beneficiaries' care uncoordinated, and increasing health care costs to an extent that strains many beneficiaries' ability to pay their health care bills, the nation's ability to finance Medicare, and the ability of a large segment of the non-Medicare population to afford health insurance.

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Mr. Hackbarth is chair, Dr. Reischauer vice-chair, and Ms. Mutti a senior analyst at MedPAC, and Dr. Reischauer is president of the Urban Institute — both in Washington, DC.

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