Better Care at Lower Cost

An Approach to Reduce Federal Health Spending by Paying for Outcomes

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Introduction

This paper outlines a payment reform proposal to promote improved care in Medicare and save over $52 billion in federal dollars over 10 years. The savings come from weeding out wasteful spending that subsidizes potentially preventable hospital readmissions and complications.

Our suggestions have multiple advantages over other less targeted proposals to curb Medicare spending: not only would they yield extensive savings, but they would improve the quality of care for everyone. They build on successful strategies piloted by state governments for better managing Medicaid spending, as well as key Medicare payment policies initiated under the George W. Bush administration. These policies can be implemented quickly, they are scalable to gain more or less savings, and they are compatible with a variety of payment and delivery models.

This approach is neither inherently liberal or conservative. It simply requires the federal government to be a good steward of public dollars. With the adoption of the two steps outlined below, we could set our health care system on a better course for curbing expenses in the short and long term, while improving the quality of the care delivered.

Background

Long term fiscal forecasts by the Congressional Budget Office (CBO) and others show an ever increasing debt-to-GDP ratio which cannot be sustained indefinitely.[1] Rising health care costs, are a substantial contributor to the projected increase in debt. Practical and credible solutions to slow health care spending are therefore necessary and should not be postponed.

Efforts to contain federal health care costs should focus on reducing Medicare's subsidization of unnecessary and harmful care. We can do that in part by making quality (paying for outcomes) a key principle of reimbursement in public health insurance programs. A number of states, including Texas, Maryland and New York have begun to implement these types of payment incentives in their Medicaid programs and initial results are promising.[2] Based on a review of the available literature we estimate that a moderate and partial adoption of these principles within Medicare, as described below, would reduce federal spending by more than $52 billion dollars over 10 years, with additional savings possible through broader application.

A policy agenda for savings billions while improving care

1. Reduce payments for potentially preventable complications

Approximately 9 percent of spending on inpatient hospital stays is driven by the cost of potentially preventable complications[3] such as infections in surgical sites, urinary tract infections from catheters, or patients experiencing a heart attack or contracting pneumonia after being admitted into the hospital. Hospitals can generally avoid these types of costly complications by following

[1] Congressional Budget Office, CBO's 2011 Long-Term Budget Outlook, June 2011. http://www.cbo.gov/ftpdocs/122xx/doc12212/06-21-Long-Term_Budget_Outlook.pdf

[2] See for example Calikoglu, Murray and Feeney, "Hospital Pay for Performance Programs in Maryland Produced Strong Results", *Health Affairs*, 31, no.12 (2012):2649-2658

[3] Richard L. Fuller et al.,"Estimating the costs of potentially preventable hospital acquired complications," Health Care Financing Review, Summer 2009.

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evidence-based guidelines for care. By fully reimbursing for the costs associated with these potentially avoidable events, our health care system rewards hospitals for failing to invest in systems that help to prevent them.

Under President George W. Bush, Medicare stopped reimbursing hospitals for the added costs of certain "never events" – hospital-acquired conditions that could almost certainly have been prevented through the application of evidence-based guidelines. While this is an important step weeding out spending on harmful care, these particularly egregious and extremely rare medical errors represent only a tiny sliver of the potentially preventable hospital-acquired complications that alter families' lives and drive up our nation's health care costs every day. The scope of hospital payment reform can and should be greatly expanded beyond this short list of complications by including one that are usually – but not always – preventable.

Because this broader list includes complications that are not always preventable, and no hospital could be expected to lower its rate to zero, CMS should not eliminate payment altogether for the costs associated with them. Instead, CMS should focus on hospitals with higher- rates of these types of complications than their peers. CMS could identify each hospital's number of complications above the average complication rate. The payment reduction would be based on the estimated cost of these "excess" complications, and would be applied to all payments that Medicare makes to the hospital. This avoids the problem of linking payment reductions to a determination that the complication for any specific individual patient was preventable.

Savings from reducing payments for potentially preventable complications: $23 billion over 10 years (estimate based on Fuller et al[4])

2. Reduce payment for potentially avoidable readmissions

Billions of dollars are spent on hospital readmissions that could have been prevented had the hospital provided appropriate discharge care planning and coordinated outpatient follow-up when the patient left the hospital after their initial admission. In 2007 the Medicare Payment Advisory Commission (MedPAC) estimated that readmissions result in $15 billion in additional annual Medicare expenditures.[5] As with complications, readmissions are not always preventable, but reducing payments to institutions with higher rates of potentially avoidable readmissions compared to average hospitals could yield substantial savings.

Adjusting Medicare payments to incorporate incentives to reduce avoidable readmissions would involve similar steps to reducing payments for potentially preventable complications outlined above:

- Identify readmissions that are potentially preventable
- Apply risk adjustment to potentially preventable hospital readmission rates
- Compare the risk-adjusted readmission rates of hospitals

[4] Richard Fuller et al, "A new approach to reducing payments make to hospitals with high complication rates," Inquiry, Spring 2011.

[5] The Medicare Payment Advisory Commission, Report to the Congress: Promoting Greater Efficiency in Medicare, June 2007. http://www.medpac.gov/chapters/Jun07_Ch05.pdf

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- Establish the magnitude of hospital specific rate-based payment reductions
- Incorporate the payment reductions into all payments that Medicare makes to that hospital

Savings from reduce payment for potentially avoidable readmissions: $29 billion over 10 years. Based on Averill et al[6], we estimate that applying a payment reduction to hospitals that had a 30 day risk-adjusted readmission rate in excess of the average would save $29 billion over 10 years.

Estimating Conservatively

The savings estimates presented above are very conservative for several reasons.

- First, they are a straight line extrapolation from current spending that doesn't take into account inflation or enrollment growth.
- Second, they reflect only a partial and moderate application of quality and efficiency principles. We do not include any savings from expanding the same principles more fully into Medicare (e.g. to potentially preventable initial admissions, emergency room visits or ancillary services) or to Medicaid. For a recent MedPAC analysis found that nearly 60% of all ambulatory emergency visits were potentially preventable[7]. Nor do we attempt to press savings to the extreme. For example, significantly more savings could be realized by setting more rigorous performance benchmarks than the average rate of complications or readmissions (i.e. by using the best performing providers as a benchmark instead of the average).
- Third, we assume no behavior change as a result of incentives for quality and efficiency. However, historical experience indicates that this type of payment reform will lead hospitals to take steps that reduce the number of potentially preventable complications and readmissions – thus lowering health care costs independent of the payment reductions. For example, Maryland recently began reimbursing hospitals based on their rates of 49 adverse events. But they implemented the reform on a budget-neutral basis – while hospitals with high rates of complications were paid less, hospitals with low rates were paid more. Nevertheless, Maryland saw over $60 million in savings in the first year alone, accrued entirely from reduced complication rates.[8] (It is important to note that, to the extent that providers responded to the financial incentives by improving performance, the impact of payment reductions on operating margins would be greatly reduced.)

[6] Averill et al, "Redesigning the Medicare Inpatient PPS to Reduce Payments to Hospitals with High Readmission Rates," Health Care Financing Review, Summer 2009.
[7] Sadownik and Ray, "Population-based Measures of Ambulatory Care Quality http://www.medpac.gov/transcripts/1012_presentation_ppv.pdf , MedPAC, October 2012
[8] The Maryland Health Services Cost Review Commission, Complications: Maryland Hospital Acquired Conditions (MHAC), http://www.hscrc.state.md.us/init_qi_MHAC.cfm (accessed July 17 2011.)

A flexible approach to improving system performance

There are numerous attractive features of the policy agenda outlined above. First, the ideas presented here can be implemented quickly and are compatible with a variety of payment and delivery models (e.g. ACOs, capitation, or fee for service). And unlike across-the-board cuts that hit every hospital by the same proportional amount, payment reform moves the health care system in a positive direction, and gives individual hospitals some control: by improving the quality of care, hospitals can minimize or even eliminate their exposure to reimbursement cuts.

Another positive feature of this approach is that the ideas presented here are scalable. That is, additional savings could be generated by selecting a more stringent benchmark (e.g. in the case of complications, tying financial incentives to complications in excess of the best performing hospitals rather than the average rate). Additional savings, not estimated here, could be generated by further expansion of these ideas into other areas (e.g. initial admissions, emergency room visits and ancillary services). Similar principles applied to the Medicaid program would yield additional savings to federal and state government while improving care and without undermining coverage for beneficiaries.

On the other hand, while we estimate the savings that *could* be generated with the policies we describe, there is no inherent reason why those *must* be the levels of savings achieved. Less stringent benchmarks, gradual phase of payment reforms over a period of years or a substantial sharing of savings with providers to support or reward performance improvement would cushion the impact of changes.

Protecting providers that serve high-risk patients

As payment reform is implemented, it is important to protect providers that serve high-risk patients. It may be harder for hospitals that treat sicker patients to lower their complication or readmission rates. And it is well known that low-income populations have higher rates of comorbidities and other risk factors that may make readmissions more likely. Therefore it is important to risk-adjust before applying any payment incentives.

Although the estimates provided above include a risk adjustment factor, no system of risk adjustment is perfect. To the extent that additional measures need to be taken to protect providers that serve higher-risk patients, several steps are possible. These include:

- Redirecting a portion of the savings to providers with high rates of readmissions or complications to help them improve. This is a particularly beneficial strategy since it would tend to improve quality over time.

- Creating a temporary separate performance standard or payment adjustment for providers serving a disproportionate share of low-income patients, so that they are more gradually phased in to the complete payment reform program.

- Limiting the amount of reimbursement that can be placed at risk for disproportionate share providers.

- Creating a different phase-in period for financial incentives for disproportionate share providers.

These steps can be taken alone or in combination. As with the core policies themselves, they are scalable and can be fine-tuned to strike a desired balance between financial incentives and limiting risk.

Beyond public sector cost containment

Although payment reforms along the lines of those outlined above can yield substantial, immediate savings, we must recognize that to be successful, a long-term commitment to reducing wasteful and harmful health care spending must go further. Beyond efforts aimed at reducing public health insurance spending, we must also include private sector cost reductions and investments in improving the underlying health of the American people.[9] While not a complete strategy, one good place to start with this broader effort would be to extend payment initiatives similar to the ones outlined above to the private sector, starting perhaps with Federal Employees Health Benefit Plan and with national plans offered through Health Insurance Exchanges.

Conclusion

Members of Congress continue to search for savings in federal health spending, to reduce the deficit and to pay for other congressional priorities. Additionally, CMS is charged with implementing a 2 percent reduction in Medicare provider payments starting in 2013.

By targeting wasteful spending, financial incentives to reduce readmissions and complications we could save at least $52 billion in federal Medicare expenditures over the next 10 years. In addition, these efforts would give hospitals incentives to reduce hospital-acquired conditions (such as painful infections) and readmissions, improving the quality of care for everyone. This is a much preferable policy to across-the-board provider rate cuts that do nothing to drive the system in a better direction and give hospitals little control over how they are impacted financially.

[9] Community Catalyst, A Better Path to Solving the Debt Problem: Capping Federal Health Expenditures Misses the Mark, May 2011. http://www.communitycatalyst.org/doc_store/publications/Caps_Miss_the_Mark.pdf

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