Three Steps to Save Billions of Health Care Dollars and Improve Care

An approach to reduce federal health spending by providing incentives for quality and efficiency

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Introduction

This paper outlines a three-part actionable plan to promote quality and efficiency in Medicare that could yield substantial savings; an estimated $120 billion over 10 years. The savings come from targeting wasteful spending and creating financial incentives to reduce readmissions and complications.

Our suggestions have multiple advantages over other 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 programs already included in the Affordable Care Act (ACA), they 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. Most importantly, unlike many of proposals on the table to reduce federal health care spending, these policies move the health care system in a positive direction and target real cost-drivers rather than simply shifting costs onto vulnerable Americans or struggling state governments.

Our savings estimates are intentionally conservative. Our goal is not to oversell or add to the rhetoric. Our goal is to find real savings that will sustain these critical programs, while focusing on the care they provide the most vulnerable people in our communities. With the adoption of the three 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, particularly in Medicare and Medicaid, 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.

A striking feature of the recent debt debates, at least as they have pertained to health care, has been the dearth of good ideas on the table related to reducing health care spending. In part this may be due to the scope of actions already included in the ACA, and it may reflect the long shadow cast by various parts of the health care industry over the political process, rendering many ideas "off the table." But for whatever reason, most recent proposals for reducing federal health spending would do nothing to address underlying health care costs. Instead, they would reduce federal spending by shifting costs onto those who least can afford to pay them: struggling state governments and vulnerable Americans. Proposals such as block granting Medicaid, reducing the percentage of Medicaid costs picked up by the federal government or increasing Medicare cost-sharing would jeopardize care for our most vulnerable citizens and place new burdens on financially strapped state governments. The likely consequences would also include undermining, perhaps fatally, implementation of the ACA.

But slowing the growth of health care spending need not entail retreat from our historic commitment to provide health security to elderly, low income and people with disabilities. Nor does

[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

it preclude honoring our recent and long overdue commitment to extend that same security to all Americans.

Efforts to contain health care costs and/or reduce provider payments should focus on reducing unnecessary, harmful and low-value spending by making quality (paying for outcomes) and efficiency a key principle of reimbursement in public health insurance programs. Based on a review of the available literature we estimate that a moderate and partial adoption of these principles, as described below, would reduce federal spending by more than $120 billion dollars over 10 years, with additional savings possible through broader application.

A three part, actionable agenda for promoting quality and efficiency

Step 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[2] 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 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.

Beginning in 2008, 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. But 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 post hospital-acquired conditions can and should be greatly expanded beyond these complications by including ones that are usually – but not always – preventable.

Because these complications 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 high risk-adjusted complication rates and identifying the excess number of complications in a hospital compared to the average complication rate. The payment reduction for complications would be based on the number of excess complications in a hospital 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.

Step 1 Savings: $21 billion over 10 years

Based on Fuller et al[3], we estimate that this would save $21 billion over 10 years. (Note that this savings estimate assumes the adoption of a payment efficiency standard along the lines outlined below. The savings estimate would be slightly higher without an efficiency standard.)

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

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

Step 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.[4] As with complications, readmissions are not always preventable, but reducing payments to institutions with excess rates of *potentially* avoidable readmissions could yield substantial savings.

Adjusting Medicare payments to incorporate incentives to reduce avoidable readmissions would involve the following steps:

- Identify readmissions that are potentially preventable
- Apply risk adjustment to potentially preventable hospital readmission rates
- Compare the risk-adjusted readmission rates of hospitals
- Establish the magnitude of hospital specific rate-based payment reductions
- Incorporate the payment reductions into all payments that Medicare makes to that hospital

Step 2 Savings: $26 billion over 10 years

Based on Averill et al[5], 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 $26 billion over 10 years. (Note that similar to the savings estimate for preventable complications, this savings estimate assumes the adoption of a Medicare payment efficiency standard along the lines outlined below.)

Step 3: Incorporate an efficiency standard into hospital reimbursement

Medicare currently reimburses hospitals through what's called an Inpatient Prospective Payment System (IPPS). Through this system, every patient is assigned to one or more distinct diagnostically related groups (DRG) – such as a hip replacement without complications or one with complications. Medicare then pays the hospital a flat fee to cover the costs of all the services the hospital provides that are related to that DRG. These fees have been updated annually and periodically recalibrated by the federal government, and are generally set close to the average cost of providing the services per case. Specific adjustments are made for teaching status and differences in wages.

Currently DRG payment amounts are based on the national average "cost" of providing care to patients in each DRG. As a result, efficient and inefficient hospitals are blended together to determine the "average" national treatment cost in each DRG. The 1982 HHS IPPS Report to Congress acknowledged that other alternatives should be considered.

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

[5] Averill et al, "Redesigning the Medicare Inpatient PPS to Reduce Payments to Hospitals with High Readmission Rates," Health Care Financing Review, Summer 2009.

> "National average, median or geometric mean cost per discharge levels (or proportions thereof) could be used."
>
> 1982 HHS Report to Congress

However, because the application of the median cost for determining the DRG payment amounts would result in a substantial payment decrease, an alternative approach to using the median cost would be to continue to use the average cost, but to exclude the least efficient hospitals when calculating the baseline DRG payment amounts. (Additional payments would still be made to take into account teaching and higher cost-of-living areas.)

Step 3 Savings: $73 billion over 10 years

Based on Averill et al[6], we estimate that basing DRG payments on the amount of the lowest case-mix adjusted cost in hospitals that in total comprised 75 percent of patient volume would save about $73 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 admissions, emergency room visits or ancillary services) or to Medicaid. For example, many emergency room visits by nursing home residents are preventable but the current payment system rewards hospitals, nursing homes and ambulance companies for preventable ER visits. 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

[6] Averill et al, "Achieving Cost Control, Care Coordination, and Quality Improvement Through Incremental Payment System Reform," Journal of Ambulatory Care Management, Jan-March 2010.

entirely from reduced complication rates.[7] (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.)

A flexible approach to improving system performance

There are numerous attractive features of the policy options 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). Even more importantly, unlike many of the savings ideas that have been recently debated, they actually move the health care system in a positive direction rather than relying on across the board cuts or cost-shifting. And unlike across-the-board cuts that hit every hospital by the same proportional amount, payment reform 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 all of 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 care 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.

Savings estimate goes beyond what is already in the ACA

The savings estimate presented here is over and above the estimated savings from payment reform in the ACA. There are a number of provisions in the ACA related to payment reform. CBO scored these extremely conservatively, in some cases assuming no savings.

The provisions most closely related to the above proposals are:

- Section 3008 related to hospital acquired conditions. The CBO projects no savings from this section for FY2010-2014, and $1.4 billion in savings for FY2010-2019.

- Section 3025 (modified by Sec 10309) relating to preventable readmissions. The CBO estimates $0.5 billion in savings from this section for FY2010-2014 and $7.1 billion in savings for FY2010-2019.

While we cannot speak with knowledge about the assumptions that CBO used, in both cases the proposals outlined above go beyond what is in the ACA.

[7] 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.)

Beyond the ACA: hospital acquired conditions

The policy we outline goes beyond section 3008 in three key ways:

- **The benchmark against which hospitals are measured:** Section 3008 reduces payments only for hospitals in the top 25th percentile of rates of hospital acquired conditions (HAC). Our proposal reduces payments for any hospital with a risk-adjusted HAC rate above the national average, so the payment reductions would apply to more hospitals.

- **The amount of hospital revenue at risk:** Section 3008 puts only 1 percent of hospital revenue at risk. Our proposal estimates the cost of the hospitals' excess HACs, and reduces their payments proportionately. This puts more revenue at risk, since HAC account for well over 1 percent of hospital inpatient costs. You could design the policy to use the cost of excess HACs as the basis for the payment reduction, while also placing a cap on a hospital's risk, but our estimates do not include such a cap.

- **Which metrics are included in hospital performance measurement:** Section 3008 specifically references the HACs that are already included in Medicare's non-payment policy. Our proposal would reduce hospital payments based on their rates of 64 HACs – going well beyond the list that Medicare currently uses. Since Section 3008 allows the Secretary of Health and Human Services to add more conditions, the law gives the authority – but does not require – the Secretary to add all 64 events that we include in our proposed policy.

These differences lead our policy to accrue significant additional savings beyond what's achievable through 3008 alone. The CBO scored Section 3008 as saving $1.4 billion over 10 years. Based on our very conservative estimates, our more aggressive HAC policy would yield $21 billion in savings over 10 years.

Beyond the ACA: readmissions

The policy we outline goes beyond Section 3025 in two key ways:

- **The set of readmissions included in the payment adjustment:** For the first two years, section 3025 adjusts payments to hospitals based on their 30-day readmissions rates for only three conditions: myocardial infarction, heart failure, and pneumonia. Beginning in FY2015, the ACA allows – but does not require – the Secretary to add conditions to that list.

  By contrast, we propose including a much more extensive set of potentially preventable readmissions in the payment adjustment. We do not limit the measure of potentially preventable readmissions to specific diagnoses. Instead, our proposal includes *all* readmissions within 30 days that are clinically related to the initial admission, and for which there was a reasonable expectation that it could have been prevented by one or more of the following: (1) the provision of quality care in the prior hospitalization, (2) adequate discharge planning, (3) adequate post-discharge follow-up, or (4) improved coordination between the inpatient and outpatient health care teams.

- **The amount of hospital revenue at risk:** Both our proposal and the ACA estimate the cost of the hospital's excess readmissions, and adjust hospital payments proportionately. But section 3025 caps the amount of a hospital's revenue that can be put at risk: no more than 1 percent in FY2013, 2 percent in FY2014, and 3 percent in FY2015 and beyond. Our

proposal does *not* cap hospital liability.

These differences lead our policy to accrue significant additional savings beyond what is achievable through 3025 alone. The CBO scored Section 3008 as saving $7.1 billion over 10 years. Based on our very conservative estimates, our more aggressive readmissions policy would yield $26 billion in savings over 10 years in Medicare alone (plus more when applied to Medicaid).

Although we did not subtract CBO's estimated savings from reducing readmissions and complications from our estimate, the bottom line is not significantly affected because the savings projected from the ACA are small and because of the conservative nature of our estimate (e.g. no adjustment for inflation or enrollment growth as noted above).

Protecting low-income patients and the providers that serve them

As payment reform is implemented, it is important to protect low-income patients and the providers that serve them. It is well known that low-income populations have higher rates of comorbidities and other risk factors that may make complications or 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 low-income patients and the providers that serve them, 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 separate performance standard or payment adjustment for providers serving a disproportionate share of low-income patients.

- 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 (as was done in the ACA).[8] 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 and improve efficiency, Congress and/or CMS could save at least $120 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, driving up 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. It's also a far better alternative to the ideas that have recently dominated the debate over reducing health care spending–Medicaid and Medicare cuts that would simply shift costs onto struggling states or vulnerable Americans.

[8] 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

