Payment Reform: Addressing Hospital Concerns

States can save millions of dollars and improve quality of care in Medicaid by reducing payments to hospitals with higher-than-average rates of potentially preventable complications and readmissions.[1] Opposition from the hospital industry may be a barrier to implementing this type of payment reform, and advocates must be equipped to respond to their concerns.

Talking to policymakers

Policymakers will have concerns about patient care and how payment reform will impact hospitals that often wield significant power in their communities. Advocates must be prepared to discuss these issues, and present payment reform as a positive path to both control spending and improve patient care.

Making the Case. Start by sharing the stories of individuals who have been personally affected by hospital complications or readmissions, and if possible have that person join you in your outreach. Advocates must define the problem as part of a systemic issue tied to the quality of care, not just dollars and cents. Then address the concerns about the impact of payment reform on hospitals:

- **Payment reform tackles an underlying driver of health care costs.** Hospital care accounts for a major portion – 31 percent – of health care costs nationally.[2]
- **Payment reform is a better alternative to across-the-board rate cuts – it gives hospitals more control and improves patient care.** Cutting provider payments is the most common budgetary action to reduce Medicaid costs.[3] 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.
- **Payment reform helps moves the health care system in a better direction** by creating incentives to improve patient care. Across-the-board cuts serve only to save funds without addressing systemic problems in our health care system.
- **Payment reform can be structured so it does not penalize hospitals that serve the most vulnerable patients**. There are many ways to protect low-income, high-risk patients and the providers that serve them (see policy options below).

Policy options to address hospital concerns

Hospital Concern: Low-income patients have higher rates of comorbidities and other risk factors that may make complications or readmissions more likely. If not designed properly, payment reform could penalize hospitals that serve a larger proportion of low-income and high-risk patients.

Policy options: Steps can be taken to avoid unfairly penalizing hospitals that serve low-income populations, including:

- **Risk adjustment:** It is important to adjust hospitals' complication and readmission rates to account for differences in the patients they serve – such as age, severity of illness, and socioeconomic factors – before modifying payments based on those rates.

- **Additional measures:** No system of risk-adjustment is perfect, so other options may be needed to protect low-income patients and the providers who serve them:
    - Redirect a portion of the savings from payment reform to providers with high rates of readmissions or complications to help them improve. This is a particularly beneficial strategy since it would improve quality over time.
    - Create a separate performance standard or payment adjustment for providers who serve a larger number of low-income patients.
    - Limit the amount of reimbursement cuts for a disproportionate share of low-income and high-risk patients.
    - Create a longer phase-in period for financial incentives for a higher percentage of low-income and high-risk patients.

Hospital Concern: Although many hospitals currently provide coordinated care and have lower rates of readmission and complications without adversely affecting their finances, some hospitals will have to invest in new systems to improve patient care or face financial penalties.

Policy Options: In order to mitigate the financial impact, payment reform can be dialed back to have a smaller financial impact on hospitals, or phased in gradually to allow hospitals time to adapt.

- **Adopt a narrower definition of complications and readmissions:** For example, a state could start by looking only at the 10 or 20 most common complications, and gradually broaden the number of complications it includes in payment reform. Similarly, a state could only look at readmissions that occur in a 7-day window, and gradually expand to a 30-day window.
- **Target financial penalties on a smaller number of hospitals:** A state could use a variety of "benchmarks" for measuring hospital rates of complications and readmissions. For example, a state could start by penalizing only hospitals in the bottom 20 percent or bottom third of performers, and gradually phase in penalties for hospitals with higher-than-average rates of complications and readmissions.
- **Introduce financial rewards for high-performing hospitals:** To win supporters in the hospital industry, a state could increase payments to the highest performers in addition to cutting payments to the lowest performers. This would give hospitals with the highest quality records a stake in passing payment reform policy**.**
- **Cap the amount of hospital revenue at risk:** States could initially cap the hospital revenue that is at risk in payment reform. For example, in the first year no more than 0.5 percent of hospitals revenue could be at risk, and that cap could increase annually until it is eventually lifted altogether.
- **Redirect a portion of the savings from payment reform to help hospitals invest in care improvements.**

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[1] See our paper, Smart Payment Reforms Can Reduce Costs and Improve Quality, for an overview of the advantages to this type of payment reform, and the policy considerations involved in designing smart payment reform. See also our payment reform toolkit for model legislation, state savings estimates, and other helpful resources.

[2] Kaiser Family Foundation, "U.S. Health Care Costs", http://www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx#What is driving health care costs?, accessed Oct. 4 2011.

[3] From the National Association of State Budget Officers, see tables 28 and 29 in http://nasbo.org/LinkClick.aspx?fileticket=yNV8Jv3X7Is%3d&tabid=38