Smart Payment Reforms Can Reduce Costs and Improve Quality: A Short Primer

A Critical Situation for Medicaid Beneficiaries

Although the economy has begun to recover from its worst downturn since the Great Depression, state budgets are still in dire condition. For state fiscal year 2012, states have to close an estimated $125 billion gap between projected spending and revenue, and they have already exhausted many of the easier savings and revenue options in order to balance budgets over the last few years.[i] Meanwhile, unemployment remains high, putting an extra strain on Medicaid budgets, and enhanced federal Medicaid matching funds are scheduled to expire at the end of this state fiscal year.

In response to these fiscal pressures, at least 25 states have proposed deep, identifiable cuts in health care in FY2012 – primarily Medicaid provider rate cuts, benefit cuts, and cost-sharing increases, and eligibility cuts. These cuts would jeopardize access to needed services for America's most vulnerable populations.[ii] And Governors of both parties have called for a repeal of the Maintenance of Effort (MoE) requirement in the Affordable Care Act (ACA) which requires most states to preserve current eligibility levels and enrollment procedures for most adults through 2014 and for children through 2019. This request is a precursor no doubt to significant Medicaid eligibility cuts.[iii] [iv]

In addition to the harm they do to beneficiaries, cuts in eligibility, benefits and provider rates do nothing to move the health care system in a better direction. Instead they increase the cost of uncompensated care and the burden of medical debt, reduce provider participation in the Medicaid program, and often lead patients to use more inpatient and institutional care over lower cost alternatives.

Taking the high road

Instead of taking the low road of eligibility, benefit and rate cuts, states can put Medicaid on a more sustainable path by tackling the waste in our fragmented health care delivery system that not only drives up costs, but too often harms the quality of care. Although many promising payment and delivery system reforms can take several years to begin generating substantial savings, one option can generate immediate savings: changing the way Medicaid reimburses hospitals and other providers to improve incentives for reducing costly, potentially avoidable events such as hospital-acquired infections.

What are potentially avoidable events?

Potentially avoidable events (PAEs) consist of care that is delivered because something else went wrong in the health care system. They are different from medically unnecessary care because at the time of a PAE the care delivered is often very necessary, but it could have been avoided.

Potentially avoidable events occur in all health care settings (hospitals, nursing homes, doctors' offices). The most frequently discussed PAEs in the context of payment reform occur in hospitals and fall into two categories:

- **Potentially avoidable complications**, such as infections in surgical sites, urinary tract infections from catheters, instruments or other foreign bodies left in patients after surgery, or patients experiencing a heart attack after being admitted into the hospital. These types of complications can most often be avoided by following evidence-based guidelines for care, add significant costs to a patient's hospital stay, and often lower the quality of life for patients.
- **Potentially avoidable readmissions**. These are hospital readmissions – occurring in a fixed period of time – that could have been prevented had the patient received discharge care planning and coordinated outpatient follow-up when leaving the hospital after their initial admission.

How much can states save through smart payment reform, and how will it impact quality of care?

The savings potential from reducing the frequency of these events is substantial. A study of potentially preventable hospital acquired conditions in Maryland and California found that they added more than nine percent to the cost of hospital care,[v] and even more hospital costs are attributable to potentially preventable readmissions.[vi] Not all of these costs are attributable to Medicaid, but reducing payment for these events represents a tremendous opportunity for Medicaid savings both now and in the future. While it may take time to capture the total possible savings, some savings should be achievable immediately for most states. Additionally, tying payment rates to potentially avoidable events provides incentives to improve quality of care while reducing cost.

For example, in its second year of payment reform Maryland experienced an 11.9 percent drop in the frequency of hospital-acquired complications, resulting in savings of approximately $62.5 million.[vii] And New York estimates that they will see $47 million in total savings in the first year of their payment reform through rate changes alone (not counting cost-savings associated with a potential drop in preventable readmissions.)[viii]

Federal Action to Reduce Preventable Events

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. Although they weren't required to, approximately 17 states followed suit by passing nonpayment laws for their Medicaid programs that mirrored or were close variations on the Medicare never events.[ix,1]

A new federal floor

The Affordable Care Act (ACA) charged the Secretary of Health and Human Services (HHS) with developing regulations to withhold federal Medicaid payment to states for the costs

[1] For more information on state nonpayment laws, see this NASHP report. Though slightly outdated, it provides a comprehensive look at 11 states' Medicaid non- (or reduced-) payment policies and lists the measures for which those states deny payment.

associated with certain health care acquired conditions beginning July 1, 2011. The proposed rule, released in February, would deny payment for the same list of potentially avoidable complications as Medicare uses in its nonpayment policy. However, this list of events is considered only a "floor" for state payment policies; the rule allows states to go further on their own if they want to deny payment to a larger set of preventable events.

The Need for States to Go Further

Relying entirely on the list of events that Medicare currently uses to deny payments to providers – as many states already do and the proposed Centers for Medicare and Medicaid Services (CMS) Medicaid nonpayment regulations will soon require all states to do – has significant limitations. This is a limited list of a handful of never-events, such as surgery on the wrong body part, that are virtually always preventable if providers follow evidence-based guidelines for care. Fortunately, this type of event occurs very infrequently. But as a result, reducing payment for these events is unlikely to incur major savings or improve quality of care significantly. For example, Medicare's nonpayment policy is estimated to reduce payments by only .001 percent.[x] In contrast, estimates suggest that up to nine percent of the costs of hospital care are attributable to potentially preventable hospital acquired conditions[xi], and more are attributable to potentially preventable hospital readmissions. Clearly, there is room for states to be more aggressive in their payment reform policies.

Specifically, states could go further than the proposed minimum federal requirements by exploring a broader list of adverse events that are frequently – but not always – preventable, such as surgical site infections. Because these types of events are not always preventable, and no hospital could be expected to lower its rate to zero, it is not appropriate to eliminate payment altogether for the costs associated with them. Instead, states could *adjust a portion of hospital payments* based on their relative risk-adjusted rates of complications.

By moving past nonpayment to reduced payment, states could also expand their measures to potentially preventable readmissions. Under the ACA, Medicare will begin doing just that: it will reduce reimbursement – by up to three percent of total inpatient payments – to hospitals with high readmissions rates for certain conditions such as heart attack and pneumonia.

Two leader states: Maryland and New York

States can follow the lead of Maryland and New York – two states that are going much farther than current CMS policy in tying hospital Medicaid payments to preventable events.

Maryland's Medicaid payment policy, implemented in 2009, looks at a much more comprehensive list of potentially preventable events than the list from CMS – 49 in total. After risk-adjustments to account for patient characteristics, hospitals with higher than average complication rates got an overall decrease in their payment rates, and hospitals with lower than average complication rates got an overall increase in their payment rates. And in 2010, New York began reducing Medicaid hospital inpatient rates for hospitals with higher risk-adjusted rates of potentially preventable *readmissions*.[xii]

Key considerations in designing smart payment reform

In the short-term the best place for states to focus is on preventing hospital acquired complications and readmissions because, as noted above, there are significant savings to be had and, even allowing for ramp-up, most states should be able to realize some savings in year one. To move forward, states will need to take a number of key steps including:

- Collecting the right data
- Deciding on a list of potentially preventable events
- Adjusting for risk
- Choosing an appropriate benchmark for measuring avoidable events

Collect the right data

In order to parse-out conditions that patients enter the hospital with from conditions that were acquired at the hospital and that could have been prevented, states will need to collect data on which conditions are present at the time of admission to the hospital. While some states already collect this data, many do not.[xiii]

Decide on a list of potentially preventable events

States must decide which potentially preventable events to consider when determining payment adjustments for hospitals. States can look at a narrower list of complications that hospitals have more control over, or consider a broader list of complications and potentially preventable readmissions that are still usually preventable but over which hospitals have slightly less control. Looking at a wider array of preventable events will produce greater savings and quality improvements.

Risk adjustment

To put in place a successful payment reform strategy, states will need the ability to risk-adjust hospitals' rates of preventable complications or readmissions to take into account the unique health status and social risk factors of the patients each hospital cares for. This is essential to prevent penalizing facilities that treat patients who are sicker and harder to care for, since patients with a greater burden of co-morbidities or social risk factors are more prone to hospital-acquired complications and are more likely to be readmitted. Risk adjusting hospitals' rates of complications or readmissions allows the state to see how their rates would compare if they all saw the same patient-mix.

Creating a risk adjustment system is likely to be the greatest technical challenge for states to overcome. Although some states already have a risk-adjustment method in use for payment rates, many states use simplistic or outdated payment methodologies that don't account for varied risk.[xiv]

Choose an appropriate benchmark against which to measure provider performance

The potential for savings from payment reform varies from state to state and depends in part on how aggressive a state is willing or able to be. States have a number of choices that will determine the size and speed at which they realize savings. These include:

- deciding whether to measure – and base payments on – hospitals' performance against the *average* for all facilities or against some stricter benchmark such as the rate of potentially avoidable events at the best performing hospitals
- deciding whether to base payment modifications only on those conditions or admissions where a facility does worse than the benchmark, or looking at their average rate across multiple conditions or readmissions (in other words, does a facility get "credit" for those areas where their rate of potentially avoidable events is better than the benchmark level)
- deciding on the appropriate time window in which to evaluate readmissions e.g. 7, 15 or 30 days
- deciding whether to apply a payment modification to all hospital admissions or just fee for service

Consider the political dynamics

All things being equal, considering a **wide array of potentially preventable complications and readmissions,** using **best performance** as a benchmark, **only calculating payment incentives based on those events where the benchmark is exceeded**, **having a longer window** for analysis of readmissions and **applying the adjustment to both fee for service and managed care** will yield more savings and produce them faster.[xv] However, caution is in order. While the current imperative to achieve savings is great, deliberate and gradual implementation is more likely to produce broad-based acceptance and long-term success and pave the way for applying similar principles to other services beyond hospital care. On the other hand, moving too aggressively is more likely to produce resistance, especially from hospital leaders.

A role for CMS

As noted above, one of the challenges in moving forward is technical. It is administratively easier to just cut rates than to redesign payment incentives. Given the limited administrative capacity in many states, one of the most helpful things CMS could do would be to make technical assistance and resources available to states seeking to move in this direction. In her recent letter to governors, Secretary Sebelius committed to stepping up its technical assistance to states to help them better manage their Medicaid costs, and this is one area where CMS assistance could be particularly valuable.

Final thoughts

The approach to payment reform sketched above goes well beyond current Medicare (and Medicaid) efforts to eliminate payment for never events, a policy which has only a minimal impact on spending[xvi] It is important to remember that in a less than perfect world only a small subset of potentially avoidable events can be classified as never-events — that is, preventable in all or almost all cases. Even where an admission or complication is potentially preventable, even the best performers will not be able to reach a level of zero in most cases. The goal is not to eliminate but rather to reduce potentially avoidable events, moving the entire health care system toward the rates achieved by the best performers. This will be better for Medicaid beneficiaries, better for state budgets and, given the alternatives, better for providers as well.

[i] Elizabeth McNichol, Phil Oliff and Nicholas Johnson, "States Continue to Feel Recession's Impact", March 9 2011. http://www.cbpp.org/cms/?fa=view&id=711

[ii] Michael Leachman, Erica Williams and Nicholas Johnson, "Governors are Proposing Further Deep Cuts in Services, Likely Harming Their Economies", March 21 2011. http://www.cbpp.org/cms/index.cfm?fa=view&id=3389

[iii] "GOP Governors Ask Feds to Ease Health Care Mandates", January 7 2011. http://www.rga.org/homepage/gop-governors-ask-feds-to-ease-healthcare-mandates/

[iv] NGA News Release, "States Call on Federal Government to Work Together to Reduce Deficits", January 24 2011. http://www.nga.org/portal/site/nga/menuitem.6c9a8a9ebc6ae07eee28aca9501010a0/?vgnextoid=fc63c07128cad210VgnVCM1000005e00100aRCRD&vgnextchannel=759b8f2005361010VgnVCM1000001a01010aRCRD

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

[vi] U.S. Agency for Healthcare Research and Quality, "Nationwide Frequency and Costs of Potentially Preventable Hospitalizations, 2006,"April 2009. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb72.jsp

[vii] "Maryland Hospital Acquired Conditions Trends and Data Analysis for FY2010 and FY2009", memo from Sule Calikoglu to Maryland's Health Services Cost Review Commissioners, January 2011.

[viii] "Medicaid Update 2010", New York State Department of Health PPT. http://www.hfmametrony.org/Portals/0/B1-NYSReformInitiatives.ppt.

[ix] "Medicaid Program: Payment Adjustment for Provider Preventable Conditions Including Health Care Acquired Conditions", Proposed Rule, Document ID: CMS-2011-0017-0001, Feb 17 2011. http://www.regulations.gov/#!documentDetail;D=CMS-2011-0017-0001

[x] Peter McNair, Harold Luft and Andrew Bindman. "Medicare's Policy Not To Pay For Treating Hospital-Acquired Conditions: The Impact." Health Affairs. September 2009, vol 28 no 5 1485-1493.

[xi] Richard L. Fuller, et al. "Estimating the costs of potentially preventable hospital acquired complications", Health Care Financing Review, Summer 2009. http://findarticles.com/p/articles/mi_m0795/is_4_30/ai_n39634914/pg_9/?tag=content;col1

[xii] "Medicaid Update 2010", New York State Department of Health PPT. http://www.hfmametrony.org/Portals/0/B1-NYSReformInitiatives.ppt.

[xiii] Kevin Quinn, Connie Courts, ACS "Sound Practices in Medicaid Payment for Hospital Care", November 2010. http://www.chcs.org/usr_doc/Sound_Medicaid_Purchasing_FINAL.pdf

[xiv] Kevin Quinn, Connie Courts, ACS "Sound Practices in Medicaid Payment for Hospital Care", November 2010. http://www.chcs.org/usr_doc/Sound_Medicaid_Purchasing_FINAL.pdf

[xv] In Medicare context, R Averill et all HCFR Summer 2009 find savings of 1.3-3.7% of inpatient payments depending on benchmarks and methodology http://findarticles.com/p/articles/mi_m0795/is_4_30/ai_n39634913/?tag=content;col1

[xvi] Peter D. McNair, Harold S. Luft and Andrew B. Bindman. "Medicare's Policy Not To Pay For Treating Hospital-Acquired Conditions: The Impact." Health Affairs, September 2009, vol. 28 no. 5, 1485-1493.