Pittsburgh Regional Healthcare Initiative

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***Your examples of a broken reimbursement system***

# Reimbursement's perverse incentives

PRHI partners have told us that the way we pay for health care is too often not in the patient's best interest. People in health care want to meet the needs of the people for whom they care. But we have created payment systems that pay for errors and rework, and tacitly encourage overuse or under-use.

The complex, inflexible reimbursement system does not reward higher quality or better outcomes, and does not invest in quality improvement. Intellectually, policy makers, payers and insurers embrace "pay for quality," but the concept has not yet been deployed at sufficient scale to shape behavior or outcomes in the healthcare delivery system.

The following examples, most provided by PRHI partners, illustrate particular problems with dominant reimbursement systems.

- **The entire health care delivery industry keeps two sets of books.** The practice of insurers securing discounts from providers' "list prices" has created a fictional reimbursement system. In FY '02, actual revenue to Pennsylvania hospitals was 30% of what they billed for care. [1] This adds to cynicism, obscures true prices, and further separates measures of resource consumption from quality. It also raises serious fairness concerns. Uninsured people are typically billed at "full price" by hospitals, while the hospitals accept massively discounted payment for insured customers.[2]

- **Errors (rework) are paid for. Reimbursement remains the same whether care is perfect or defective.** The backbone of the reimbursement system is the Medicare DRG, or Diagnostic Related Group. In more than 100 DRGs, a hospital-acquired urinary tract infection (UTI) causes the patients' care to be classified as "complicated." Although hospital-acquired infections are almost always preventable, reimbursement to the hospital almost doubles when they occur.[3]

  In Pennsylvania during FYI '02, patients with UTI's stayed 149,796 additional days in the hospital (vs. patients with the same conditions and risk factors that did not contract UTIs). This translates to $202,226,625 in additional payments to hospitals (average payment per hospital day in Pennsylvania is $1,350).[4]

  Although readmissions are usually preventable, they result in huge hospital charges. For FY '02, 73,527 people were readmitted to Pennsylvania hospitals for the 38 conditions studied by the Pennsylvania Health Care Cost Containment Council. If only those hospitals with HIGHER than average readmission rates, reduced them ONLY to the statewide average, 7331 fewer people would have had to be readmitted, resulting in $191,470,421 less in hospital charges (and an estimated $57,441,126 less in payments to hospitals).[5]

- **Providing better care for chronic disease can actually cost providers.** Hospitals that provide exemplary care for chronic disease, including care coordination and effective discharge counseling, see fewer readmissions than those that do not. Yet they are rarely reimbursed for the cost of their programs. Nor is their loss of revenue from reducing readmissions offset in any way.[6]

  One Pittsburgh-area hospital system developed a program to help patients manage congestive heart failure, the largest single cause of admission for this hospital, as it is for Medicare. The program focused on careful discharge planning for admitted patients and more effective outpatient management. The hospital system saw admissions for heart failure fall significantly during the operation of the program. Over several years of negotiation, it could not get any payer to reimburse for its activities or reward its reductions in hospital admissions. Last year, the inpatient components of its heart failure program became part of a pilot quality incentive program with a major insurer, but its outpatient program has no support from any payer.

- **By tying payment to patient acuity without corresponding quality checks, we risk over-treatment.** Commercial managed care companies often reimburse hospitals at differing rates, or deny additional days of care, based on the patient's diagnosis and intensity of service. Traditionally, a patient with an IV line is judged to have a higher acuity, creating a higher rate of payment. Hospital and medical staff leaders have pointed to the incentive this creates to leave IVs in for more days than patients require, opening the patient to additional risk of both infection and medication error.

- **By artificially restricting care to certain settings, we**

**can negatively affect patients and caregivers.** In July, 2003, Medicare instituted a prospective payment system for long term acute care facilities. The facilities can no longer be reimbursed for extra care for specific services, such as electro-convulsive therapy (ECT) for psychiatric patients. As a consequence, patients requiring ECT are now transferred to inpatient facilities, and transferred back to the long-term facility following treatment, inconveniencing both patient and provider, and increasing cost. Restrictions like these result in patients being moved between facilities across many different settings in the healthcare delivery system.

- **We pay for doing the wrong thing.** Americans with heart disease are undergoing revascularization procedures (such as cardiac bypass surgery and stents), intended to clear heart vessel blockages, in huge numbers. Yet as early as 1986 clinical science indicated that these procedures do not address the root cause of 75 to 80 percent of heart attacks—unstable plaque that can burst from any location, including less occluded vessels. Evidence shows that for most patients (those without severe angina) medical treatment may be more appropriate and less dangerous than surgery.[7] For example, stents can cause minor heart attacks in up to 4% of patients.
- **While we pay for defects and inappropriate care, we don't pay for quality. For example, effective chronic care is not fully reimbursed.**[8] A series of case studies analyzed in *Health Affairs* showed that neither Medicare nor most private payers cover most techniques that can improve chronic disease outcomes, such as group visits, physician-patient e-mail, and smoking cessation. Medicare is only incrementally expanding support for preventive procedures, such as screening and wellness exams. Providers who offer these activities are rarely reimbursed for them, nor are they rewarded for improved patient outcomes.[9]
- **Physicians and other providers are generally paid for activity rather than outcome.** This may lead to overuse. Under Medicare fee for service, physicians are reimbursed for each office visit by a patient, or physician visit to a sick patient in a hospital. Physicians and hospitals have few incentives for preventing hospitalization. Further, hospitals are generally paid a flat rate per admission, complicating quality improvement activity.

  Surgeons are paid to perform surgery, but are rarely rewarded for discouraging surgery when it may not be the best course for the patient.

  Until recent rule changes, many oncologists derived a significant portion of their income from inflated reimbursements for chemotherapy drugs. Even under current rules, Medicare now reimburses at 120% of market value for all chemotherapy agents. The potential incentive to over-treat has been lessened, but not eliminated.
- **Payment methods meant to address overuse (especially capitation) are not sufficiently safeguarded to prevent under-use or poor care.** Paying providers monthly or annual stipends per patient can result in sharp drops in access to care. Farsighted managed health plans have started to monitor consumers' access, and make a portion of reimbursement conditional upon it. However, these approaches are not yet in place in most managed health care plans in the United States.
- **The dominant model, administrative pricing, prevents customization to pay for the care that specific patients need, especially those with chronic disease.** "People and payers who might be quite willing to pay a premium for more fully integrated chronic disease care, for the option of a group visit, or for detailed management of their lipid medications do not have the option to do so because of fixed fee schedules and complex payment rules. This is particularly true under Medicare. In effect, people do not have the option to pay for what they want, even if what they want is better than what they have."[10]
- **Tying a significant portion of reimbursement or prospective payment to the actual outcomes of care (paying for quality) can protect patients from overuse, under-use and misuse.** Few "pay for quality" demonstrations use a large enough portion of providers' income to create incentive to achieve specified outcomes or processes of care. Hospital executives report that tying 5% of revenue to quality measures would significantly raise the prominence of quality performance in financial management.

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1 PHC4 hospital financial report

2 "How those with least are charged most," Pittsburgh Post-Gazette, March 25, 2004

3 Source: Pennsylvania Health Care Cost Containment Council, presentation to the Pittsburgh Business Group on Health, 4/28/04.

4 *IBID*

5 *IBID*

6 *The Business Case for Quality: Case Studies and An Analysis*, Leatherman, et. al, Health Affairs, March/April 2003

*7 New Heart Studies Question the Value Of Opening Arteries*, New York Times, March 21, 2004

8 *The Business Case for Quality: Case Studies and An Analysis*, Leatherman, et. al, Health Affairs, March/April 2003

9 *IBID*

10 *IBID*

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