

Four Ways that Federal Healthcare Reform Could Improve Local Healthcare Value

1. Encourage Reductions in Hospital Readmissions

Many people believe that healthcare costs can't be reduced without rationing of services, but in fact, there are ways to significantly reduce healthcare spending without taking away anything that consumers want. A perfect example is hospital readmissions. Research shows that 15-25% of people who are discharged from the hospital will be readmitted to the hospital within 30 days or less, adding billions of dollars to healthcare spending. Many of these readmissions are preventable through simple, low-cost interventions, both inside the hospital and after discharge. But hospitals and doctors lose revenue if they reduce readmissions, and in many cases, Medicare and other health insurers won't pay for the services that would keep patients out of the hospital, even though they will pay every time they go into the hospital.

Most hospitals and doctors have no idea how many of their patients are readmitted, so **the first step in reducing readmissions is producing reports on readmission rates, similar to what Florida and Pennsylvania now do. The second step is to change Medicare and other payment systems so they support programs that will reduce readmissions and stop rewarding hospitals and physicians that have high readmission rates.**

2. Create “Medical Homes” With a Focus on Improved Outcomes

A major reason for high rates of emergency room use, hospitalization, and readmission is the inadequacies in the current primary care system. A number of efforts are underway to improve the quality of primary care delivery through programs to create “patient-centered medical homes.” Most of the medical home programs that have been proposed or implemented to date make higher payments to primary care practices that meet certain standards, most commonly the medical home standards developed by the National Committee for Quality Assurance (NCQA). But there is no guarantee that merely meeting such standards will result in either better outcomes or lower costs, leading payers and providers to try and keep the payments for medical homes as low as possible. But this creates a Catch-22: if the payments are too low to allow the primary care practices to make the changes in care needed to improve patient outcomes, then all that will happen is that costs will go up, and the medical home projects will be labeled failures.

The solution is to have medical homes explicitly focus their efforts on improving outcomes and controlling costs, such as by reducing preventable hospital admissions and readmissions, emergency room visits, etc. For example, the largest number of hospital readmissions occurs among patients with chronic disease, and studies have shown that with better patient education, self-management support, and coordination of services —precisely the kinds of improvements medical homes are intended to make – hospital admission rates for these patients can be dramatically reduced, thereby creating a clear business case for the financial investment in medical home services. **Medicare and other payers should provide increased funding for medical homes based on improving outcomes, rather than merely meeting process standards, which would help to reduce spending as well as improve the quality of life for patients.**

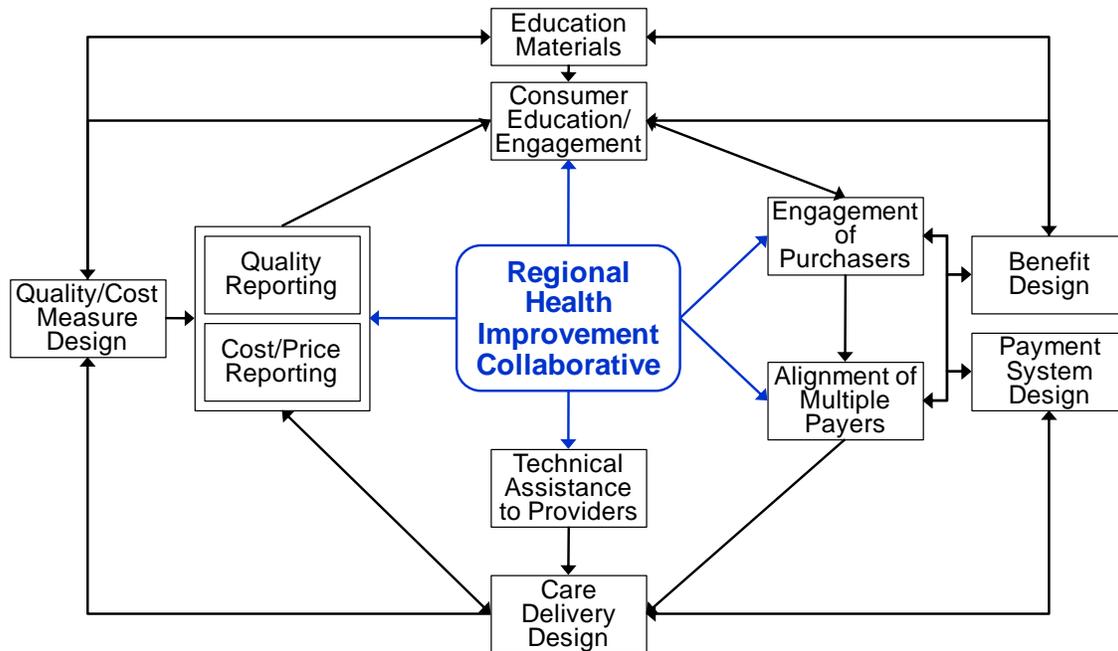
3. Support Regional Healthcare Collaboratives

Reducing hospital readmissions and creating outcome-driven medical homes would represent a major step in transforming today's volume-driven healthcare system into a value-driven system. But to be successful, any such step requires coordinated changes in multiple areas – reforming payment systems and benefit designs to reward quality and value, redesigning care delivery systems to be more efficient and better coordinated, creating effective performance measurement and reporting systems, and educating and assisting consumers to take an active role in maintaining their health and choosing high-value healthcare services. Moreover, these changes will need to be designed and

implemented differently in different parts of the country, in light of the tremendous diversity in payer and provider structures across the country. No single national solution is likely to be successful.

Fortunately, a growing number of communities have formed Regional Health Improvement Collaboratives to build consensus among healthcare providers, health plans, employers, consumers, and others on the changes needed in their local healthcare systems and to help support and coordinate the implementation of those changes. Over 50 Regional Health Improvement Collaboratives across the country provide critical services supporting transformation, ranging from public reporting on healthcare quality and costs to training and technical assistance to providers to help them improve the quality and value of their services.

Regional Collaborative Roles in Healthcare Transformation



Federal support is needed to help Regional Health Improvement Collaboratives continue and expand these important roles. In addition to the technical assistance currently being provided through the Agency for Healthcare Research and Quality (AHRQ), **the Federal government needs to (1) provide funding for Regional Health Improvement Collaboratives to help them maintain and expand their services, and (2) authorize Regional Health Improvement Collaboratives to analyze Medicare claims data and to publicly share standardized measures of the cost and quality performance of providers and practitioners based on those data.**

4. Authorize Medicare Participation in Local Payment Reform Pilots

A major cause of many other cost and quality problems in health care today is that payment systems reward providers for delivering more services and penalize them for providing better-quality services and improving health. As a result, many Regional Health Improvement Collaboratives are working to design a range of reforms to health care payment and delivery systems and to encourage the payers in their regions to implement those reforms. However, since Medicare is often one of the largest payers in a region, it is very difficult for health care providers in a particular community to improve the way they deliver care if private payers improve their payment systems but Medicare does not.

Although the current payment reform demonstrations developed by the Centers for Medicare and Medicaid Services (CMS) are laudable and should continue, **CMS also needs to have the authorization and resources to participate in regionally-defined payment and delivery system reform projects that can present a clear business case for controlling costs as well as improving quality.**