EDITORIAL

# Toward Evidence-Based Policy Making to Reduce Wasteful Health Care Spending

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**In this issue of *JAMA*,** Shrank and colleagues report a thorough review of studies published over the past decade to provide updated estimates on the proportion of US health care spending that is wasteful, defined in 6 broad categories: failure of care delivery, failure of care coordination, overtreatment or low-value care, pricing failure, fraud and abuse, and administrative complexity.[1] The authors estimate total annual waste to be $760 billion to $935 billion—smaller as a share of total spending than previous estimates, yet clearly showing that a gulf remains between the current efficiency in the US health care system and what may be possible. But the authors go further than previous studies to assess evidence on how much of this theoretical gulf could potentially be closed, and they conclude that approximately a quarter of that total ($190 billion to $282 billion) could be eliminated if evidence-based strategies to reduce waste were scaled nationally.

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The 3 "clinical" categories of waste identified by Shrank and colleagues (failure of care delivery, failure of care coordination, and overtreatment or low-value care) collectively account for as much as an estimated $345 billion in waste. Together, these categories represent the waste associated with suboptimal quality of care.

The remedies for poor-quality care, outlined by the authors, could be considered as being in 2 interdependent categories. The first is clinical care redesign, which includes approaches such as care pathways, care coordination, and delivering the right primary, secondary, and tertiary preventive care for those who qualify. The second is composed of the policy initiatives that are meant to incent and support those care redesign activities, which include approaches like the Hospital Readmissions Reduction Program, Center of Excellence designations, and bundled payment programs. These policy initiatives entail using financial or recognition incentives to nudge clinicians, hospitals, and health systems to improve care and reduce costs, as well as new payment structures to sustain them.

However, many of these policy initiatives have not led to major shifts in costs of care. Bundled payments, for example, have demonstrated approximately 4% savings in 90-day episode costs for joint replacement, but no significant savings for the broader group of medical conditions.[2,3] The Medicare Shared Savings Program showed modest savings for physician group–led accountable care organizations, but no savings on average for hospital-integrated participants.[4]

Why have major policy initiatives led to limited financial savings?

First, current value-based and alternative payment models are generally complex. For example, the Merit-based Incentive Payment System (MIPS), which focuses on physician practices, evaluates cardiologists against dermatologists against urologists, and it includes more than 250 quality measures from which practices can choose.[5] Such complexity renders performance "scores" difficult to interpret both for payers and consumers. Instead, focusing on a small number of specialty-specific meaningful measures with a solid evidence base for implementation could drive greater reductions in waste through clinical interventions, while at the same time improving information for patients and families.

Second, and related, current models are inadequately aligned across payers. A hospital may need to collect one type of data on urinary tract infections for its Medicare programs, another for Medicaid, and yet another for a private payer. Greater alignment on which performance and utilization measures have adequate face and statistical validity to be used for quality improvement and accountability would allow hospitals to redirect resources currently used for collecting unharmonized metrics toward improving patient outcomes. This could reduce both administrative waste and clinical waste.

Third, the current "mixed" payment system fails to create the sustainable business case for truly redesigning care. Most new payment models implemented to date represent only a limited or modest shift away from fee-for-service, and they are still dominated by financial incentives favoring admissions and more utilization.[6] Hospitals must pursue a strange calculus to determine the trade-offs between investing in readmission reduction to avoid penalties under the Hospital Readmissions Reduction Program and the lost revenue from those averted admissions. Most accountable care organizations similarly attempt to balance often incremental per-episode or per-person payments or shared savings against their base fee-for-service revenues. As long as these groups are operating in a primarily fee-for-service environment with only limited "value-based" payment, it is challenging to justify the investment in care redesign and structural change that is likely necessary to meaningfully reduce waste.

Fourth, there has been inadequate clinician buy-in to these programs. Congress required CMS (the Centers for Medicare & Medicaid Services) to conduct national programs with standard approaches for a wide range of health care organizations, and, consequently, CMS has implemented performance measures and alternative payment models that many

clinicians do not feel reflect their unique circumstances, capabilities, and patients' needs. Therefore, even if measures are reasonable, pushback from clinicians has likely impeded progress. Disagreements around the Hospital Readmissions Reduction Program have detracted from improving care transitions. Disagreements around patient safety measures like the Patient Safety Indicators composite (PSI-90) have detracted from reducing hospital-acquired infections and complications. While there will always be pushback, efforts that assess clinician readiness for participation in reforms, combined with more support and flexibility around how to improve care, may be better received. A number of emerging examples offer promising paths forward, including state-based multipayer initiatives that include support for care improvement. CMS also aims to do more to support such aligned efforts.[7]

Fifth, as some of these newer initiatives recognize, the cost of implementing interventions to reduce waste remains large. Due to a lack of data, Shrank et al were unable to include these costs in their calculations, but if they had, the total achievable savings would certainly have been lower. For example, the authors suggest that bundled payment models could save as much as $555 million in Medicare spending, but hospitals participating in bundled payment programs are paying consultants millions of dollars for strategic, technological, and clinical support to participate. One prior study suggested that each year, US practices spend 785 hours per physician and more than $15.4 billion to report quality measures for existing quality programs.[8] Thus, the savings of any program should be measured not only as the Medicare costs averted, but as those costs minus the investment made by each hospital in achieving them. Programs that "save" money for CMS are not cost-saving at the health system level if they require hospitals or practices to grow their administrative overhead to employ analysts, financial experts, and administrators to oversee these quality programs. In fact, these are likely significant drivers of exorbitant prices for medical care: payments must support not only clinical care delivery but also a large and growing administrative infrastructure. More efficient, data-rich systems to support clinical care improvement and accountability are needed.

Sixth, new payment models and related reforms must more explicitly address the elephant in the room: prices. Steps to address high prices can be complementary and reinforcing to the steps described above. While there has understandably been a great deal of analysis on pharmaceutical prices, less attention has been given to hospital prices, where the growth in prices and magnitude of excess pricing are perhaps even greater.[9,10] Some states have sought to tie private payer rates to Medicare rates to control prices, although these approaches may not support shifts to more value-based care that could address the other sources of waste; for example, across-the-board reductions in prices may encourage higher volumes of low-value care. Shrank et al suggest that all-payer global budgeting, as is currently being expanded in Maryland,[11] may hold potential for reducing hospital spending while providing revenue stability. Alternatively, making available consistent and reliable information on the price and quality of episodes of care at different hospitals may help clinicians and patients make better decisions, especially as they shift to alternative payment models.

Collectively, these takeaways suggest a path forward. The current piecemeal approach, which imposes complexity and additional implementation costs on clinicians, hospitals, and health systems, should evolve to a simpler and more holistic approach to value-based payment. Primary care should move toward a capitated payment system, with a streamlined set of quality measures and financial supports for keeping people healthy and out of the hospital. Specialty care will likely need a combination of a primary care–like chronic disease management track and add-on "bundles" for procedures, with quality measures relevant to specialized care comprising the core of quality measurement. Hospital care should be structured within such bundles where feasible, with clear quality measures around safety, and the move of accountable care organizations from fee-for-service–based models to organizations paid on a person level should continue.

Such an approach could address 5 of the 6 domains of wasteful health care spending outlined by Shrank et al,[1] improving care delivery and coordination, decreasing the use of low-value care, and reducing administrative complexity, and could provide new tools and motivation to reduce prices for care at the episode and person level. But it will require an approach that integrates strategies that have shown promise across payers and programs, with more engagement and leadership from the clinical community so that they can be implemented fully and improved along the way. If so, perhaps the next iteration of measuring waste in the US health care system will find that progress has been made.

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**Published Online:** October 7, 2019. doi:10.1001/jama.2019.13977

**Conflict of Interest Disclosures:** Dr Joynt Maddox receives research support from the National Heart, Lung, and Blood Institute (R01HL143421), National Institute on Aging (R01AG060935), and Commonwealth Fund, and previously did contract work for the US Department of Health and Human Services. Dr McClellan reports earning fees as an independent board member for Alignment Health Care, Cigna, Johnson & Johnson, and Seer Biosciences. He co-chairs the Accountable Care Learning Collaborative and the Guiding Committee for the Health Care Payment Learning & Action Network, and is an adviser for Cota and MITRE.

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