

# Charting a Path for Health Care Payment Reform

## Recommendations for the Field

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## Introduction

On April 8, 2010, the Robert Wood Johnson Foundation (RWJF) convened a payment reform advisory panel composed of health policy experts as well as representatives of health plans, purchasers, consumer groups, health professionals, government and philanthropy. Please see the attached participant list. The panel developed a set of general, high level recommendations to the field of relevant policymakers and health care stakeholders regarding pragmatic next steps necessary for payment reforms. Reforming payment is a critical piece of the ongoing, years-long effort to help American health care drive sustainable high quality, efficient, and high value care. Most understand that current payment strategies too often promote fragmentation and high volume rather than high value. The recent Patient Protection and Affordable Care Act (PPACA) incorporates this view about the critical nature of payment reform for the overall success of health care reform. The advisory panel made its recommendations against this reform backdrop of heightened attention to and concern about the success of payment reform.

This paper provides a brief summary of the key issues raised by the panel's discussion and some next step recommendations. It reviews the observations made by the panelists on the key issues stakeholders will face in a post-reform world. It then concludes with recommendations for achieving successful reforms.

### Summary of Key Points

The panel identified several issues that should remain top of mind for stakeholders:

**Goal.** It is very important to keep the goals in mind—payment reform is not an end in and of itself—rather we are urgently seeking payment reforms to support and drive sustainable high value care. Also, payment and incentives are critical and necessary for high value care—they are not, however, sufficient.

**Community.** While improving health care is a national priority, health care is organized and delivered at a community level. Health care, itself, is an intensely local matter. Further, health care payment is, at its core, a transactional activity between or among interested parties paying for and providing services. Nevertheless, successful payment reform depends on more than national impetus and local transactional activity. The ability of each community and its local health care stakeholders to design and implement payment reforms will be critical to the success of those reforms. Payment reform is both a national issue, because of national payers such as Medicare, and a local issue, because negotiations

at the local level reflect local market conditions. At a minimum, successful payment reform requires participation and collaboration of key stakeholders in local communities as well as conducive, supportive national leadership. Payment reform requires action at both the national and local levels.

**Information.** Payment reform cannot be successful without appropriate information to support it. For example, although a growing number of useful measures exist, payment reforms that will drive high value will require substantially more and better information about the quality and cost of care. Those developing and implementing payment experiments need better process and quality measures, better and more outcome measures, consumer and patient-centered results oriented measures, cost and efficiency measures, and value measures. National measurement entities should accelerate efforts to develop and implement this wide range of measurement. Making that information public and transparent should also be a high priority. Some panelists noted that a completely revised system of measurement is needed to guide fundamental payment reforms, not simply more measures. Nevertheless, the critical nature of payment reform dictates that the field cannot wait on the perfect metrics or measurement system before developing viable payment models. The ongoing development of measures and payment models will need to unfold concurrently. Measures that will support payment reforms also need accessible, available, accurate and timely data. All relevant parties should make concerted efforts to ensure that measurement efforts have the necessary accurate, timely data. Here too, though, payment reforms cannot wait for the perfect—most believe that there is sufficient data right now to proceed.

**Consumer.** Payment reform will not be successful if it does not support care changes that consumers see as improvements. High value care is care that is of value to the health care consumer—if consumers don't value it, it's not high value. The field cannot achieve high value care without orienting the underlying measures, outcomes and payment tools to the consumer perspective. Also, the task of incorporating the consumer perspective is not an after the fact messaging challenge, but rather, a concerted, explicit effort to bring the consumer concerns and desires into every stage of the payment reform process. However, messaging does matter. Not only do measures, outcomes and tools need to reflect the consumer perspective, but there is also a significant communications and messaging challenge when engaging the public about reducing costs.

**Coordination.** Reorienting payment away from incentives for fragmentation and high volume to alignment and high value is one of the most complex parts of an overall health care reform. It is fraught with risk for failure. It requires dramatically more coordination than any part of health care is currently accustomed to providing. For example, the multiple payers in each community need to develop coordinated payment reforms so that providers have consistent incentives and are not overburdened with the administrative tasks involved with multiple

payment systems. The various new and existing relevant federal agencies responsible for delivery and payment reform must prioritize, network and communicate with each other and align their various reform efforts and strategies all to ensure that learning is disseminated quickly, gaps are addressed systematically, progress is sustained, and needless redundancy is avoided. Local community leaders must work together to resolve political tensions in their local markets in order to facilitate local payment experimentation and reforms. The non-profit sector should communicate with other funders and prioritize their disparate efforts to promote payment experimentation maximally. And the field of interested policy makers and stakeholders needs to knit together the various pieces of reform into a cohesive plan that integrates other reforms, like health IT implementation and comparative effectiveness research, into the effort.

**Commercial Plans and Medicaid.** Payment experiments must engage both Medicare and commercial plans if they are to be successful. One of the biggest problems with current payment experimentation around the country is getting commercial plans, particularly national plans, to support locally-defined payment and delivery reforms. Attention to Medicaid is also critical. Medicaid is already a large purchaser of health care—and will likely have an even larger set of responsibilities as PPACA reforms unfold. Payment reform must explicitly incorporate state and federal Medicaid perspectives into the models and strategies.

## Setting the Initial Mile Posts: Key Issues In the Post-Reform World

While the health reform debate and enactment of PPACA have enhanced momentum for payment reform, many questions remain unanswered.

The Centers for Medicare and Medicaid Services (CMS) will be responsible for executing the demonstrations, pilots, and other programs called for in the law, but there is uncertainty about what tasks lie ahead for stakeholders who want to participate, as well as how these reforms will play out through private sector initiatives. The advisory panel highlighted several key issues or principles for moving forward:

**Community.** Successful reform will require participation and collaboration of key stakeholders in local communities – working together to implement innovative payment schemes that promote quality improvement and cost containment. Without the support of all relevant stakeholders in a given locale, reform initiatives may not achieve the desired goal of high value care.

**Measurement and Data.** Reforming payment so that it rewards high value health care means that the ability to measure the quality processes

and outcomes, as well as the cost, efficiency and value of care are critically important. Similarly, timely access to data needed to redesign payment systems and care delivery systems is critically important. Existing performance measures need to be updated and expanded to capture relevant information for a multitude of purposes and stakeholders; however, perfection must not be the enemy of good. Stakeholders should not wait for perfect measures to implement reforms – they’ll be waiting forever.

**Coordination.** In addition to payment reform, there are a number of other separate initiatives already underway or just beginning, including incentives for adoption of electronic health records, investment in comparative effectiveness research, and development of a national quality measurement strategy. These initiatives can vastly accelerate, and be enhanced by, payment reform. It is essential to recognize that these initiatives – along with payment reform – are all components of a larger reform movement—and to create a conceptual understanding of how all these pieces fit together to drive sustainable high value care.

**Consumers.** Reform efforts that are not informed by consumers’ perspectives are not likely to achieve the desired perspective of high value care for consumers. That point is particularly true if consumers feel they will lose flexibility or autonomy in where and from whom they seek care. In addition to payment changes, consumer benefit design must be adjusted to improve the alignment of consumer and payment incentives.

**Commercial plans.** Payment experiments must engage both Medicare and commercial plans if they are to be successful. One of the biggest problems with current payment experimentation around the country is getting commercial plans, particularly national plans, to support locally-defined payment and delivery reforms.

**Medicaid.** Similarly, state Medicaid programs should be at the table. In the near future, Medicaid will be the largest payer for health care services in the country. As such, state Medicaid programs’ participation and support will be necessary for reforms to be successful.

## Illuminating the Pathway: Recommendations for the Field

Based on these themes or principles, the payment reform advisory group identified key tasks for stakeholders and recommendations on roles and responsibilities as we move down the path to reform.

There are a number of stakeholders who need to be involved in executing these tasks – not only those who will be directly impacted by payment reform, such as providers, payers, patients, consumers and purchasers, but also those whose support will be essential to success, like local and regional coalitions, the HIT and measurement communities, academics and other thought leaders, and non-profits such as philanthropies.

Most of the tasks will require collective action, while others will fall on one or only a few stakeholders. Where appropriate, we have noted which stakeholders should be responsible for taking the lead roles.

**1. Identify opportunities for quality improvement and cost savings.**

Different types of payment reforms can and should be used to solve different problems – payment reform is not a “one size fits all” strategy. For example, a bundled payment approach can help to reduce variation in costs of episodes of care, while a global payment can be used to reduce the frequency and volume of certain episodes. Stakeholders, including purchasers, payers, providers, and coalitions need to examine the opportunities to improve quality and reduce costs in their communities to identify which payment reforms might be best suited to meet their needs. By identifying explicit objectives, the payment reform can be much more targeted and, presumably, more successful.

**2. Craft short and long-term strategies.**

Some payment reforms are more incremental in nature; others will require significant changes in claims processing, benefit design, delivery system organization and ultimately professional, patient and consumer behavior and will thus take longer to design and implement. Stakeholders should consider short-term strategies, such as making incremental reforms to the fee-for-service system, while working to refine longer-term approaches, like bundled payments for acute or chronic care episodes.

Extracting greater value from the fee-for-service system is critical, as more complex payment models often use those payment levels as a foundation for setting episode-based and global payment levels. Stakeholders in the research community (e.g., academics and non-profits such as foundations) should help to define the appropriate future uses of fee-for-service to take advantage of its inherent incentive to drive volume over value, such as payments for preventive care or immunizations.

Longer-term strategies should also include recommendations for aligning multiple reform efforts, such as comparative effectiveness research and health information technology adoption, to fully support

transformation of payment and delivery structures. Non-profits such as philanthropies seem well positioned to lead the charge in disseminating the learning about best practices for such alignment. They may also have a role in promoting the development and evaluation of those practices.

- 3. Identify potential unintended consequences and possible remedies.** Payment reform could render multiple benefits to the health care system, but it is equally important to recognize the potential unintended consequences of overhauling long-standing payment and delivery models. For instance, in anticipation of pending payment reforms, some stakeholders might perceive incentives to pay close attention to key baseline measures such as status quo cost—and then to increase those pre-reform baselines to maximize the opportunity to achieve “savings”. That maneuver could have the unintended effect of promoting health care inflationary pressures rather than efficiencies and value—at least in the near term.

Using the accountable care organization as another example, one of the primary hoped-for benefits of this model is that it will promote clinical integration and provider collaboration to make care more cost-effective. While integration is often deemed a positive result of reform, there is the potential for integration to lead to significant market consolidation – integration to the point of creating monopolies – which could actually lead to anticompetitive pricing behaviors that drive prices and costs up.

Another example of a potential unintended consequence pertains to global payments and capitation. In those payment methods, providers receive a set amount for treating a population of patients. If providers’ spending exceeds this set amount, they are not eligible to receive additional reimbursement. Providers, therefore, have a strong incentive to keep costs under the budgeted amount. Without proper protections, like risk-adjustment or quality metrics, providers may under-treat or refuse to treat patients likely to need costly services for fear that they will overspend.

Communities seeking to understand the impact of local payment reforms need to have a clear understanding of these and other potential unintended consequences, as well as actionable strategies they can put in place to avoid the possible pitfalls. A number of stakeholders should be involved in articulating the range of unintended consequences associated with various payment reforms – including health plans, academics and other thought leaders, and non-profits such as philanthropies. The federal government (and regional, state or local government entities) should leverage their power as conveners to bring relevant stakeholders such as – providers, patients, consumers and

payers – together to agree on how they will monitor and minimize the impact of unintended consequences.

#### **4. Create tools for success.**

Once stakeholders have identified their priorities and are oriented to the road that lies ahead, they will need tools and technical assistance to assist them with implementations. It is not enough simply to create financial incentives that would reward providers for high-quality, cost-effective care. Without tools to help build the skills and capacity necessary to achieve those objectives, payment reforms are not likely to improve quality and reduce costs.

The leading payment reform concepts assume a certain level of coordination, collaboration, and practice redesign to reduce inappropriate utilization of services across the spectrum of care. An example of this assumption is a payment model that financially rewards physicians for reducing avoidable hospitalizations for complications related to chronic conditions. Under the current payment schemes, it has not generally been necessary for physicians to develop the capacity for care management in order to maximize payment – and, in fact, in the fee for service status quo adding this capacity would likely perversely penalize physicians with higher cost and no compensating revenue. Consequently, physicians will likely need help to develop case management and other types of improvement capacity and capability.

The task of creating and disseminating these tools must be a shared responsibility. Stakeholders like academics and thought leaders, non-profits such as philanthropies, and local or regional alliances should take a leading role in assessing the improvement needs of providers and making recommendations for tactical steps to achieve higher-quality, cost effective care. Health plans should use their experience with utilization management to help providers identify opportunities for efficiency and quality gains, while the HIT community might work to build clinical decision support tools to deploy evidence-based guidelines to providers at the point of care.

#### **5. Measure and report on progress.**

Measurement is central to understanding the impact of payment reforms. There are two distinct categories of measurement necessary for payment reform. The first is measuring the quality, cost, efficiency and value of care. Payment reforms that reward high value require information about quality and cost in order to work. The second is measuring whether implemented payment reforms actually work in enabling and encouraging high value care.



For the first category – measuring quality and cost of care – obviously, many measures exist; however, these metrics largely examine structures and processes of care. Outcomes measures are particularly challenging to construct and validate. They are even more challenging to develop across episodes of care that span multiple providers and care settings. The field also needs significantly more and better measures for cost and efficiency of care. Stakeholders agree that existing measures need to be improved and expanded to encompass the range of stakeholders and uses of the information to truly understand the impact of payment reforms. Additionally, stakeholders agree that measures can and should be used to increase the level of accountability for providers. The need for measures of accountability is particularly true under models like global payments, which may create incentives for providers to under-treat patients who need higher (and often more expensive) amounts of care – further exacerbating disparities for minority and low-income populations. Some panelists strongly argued that the problem was not simply more measures—that more measures would never be sufficient to understand impacts of incentives and interventions on total costs. These panelists argued that a completely revised system of measurement is needed to guide fundamental payment reforms, not simply more measures. The difficult but necessary tasks of updating and expanding measures should fall primarily to those developing and endorsing measures, but again, all measures should be informed by the full complement of stakeholders, including consumers.

The second category, assessing and measuring the impact of reform, will be challenging. First, a broad range of stakeholders need to reach consensus on a consistent nomenclature for the types of reforms. For example, currently, bundled payments and episode-of-care payments are often used interchangeably, and stakeholders may have differing understandings of the scope of services included in each – if in fact they are distinct reforms. Second, stakeholders probably need to reach agreement on a “scorecard” that could be used to measure and compare different payment approaches. Again, these tasks might fall to academics and thought leaders and philanthropies as leaders and conveners of a broad range of stakeholders, including providers, payers, purchasers, and patients. Formal assessment and evaluation is probably critical to assessing the success and viability of various kinds of payment efforts.

## Conclusion

PPACA will shift the health care delivery and payment landscape dramatically; however, considerable challenges around implementation of payment reforms must be resolved to reach the desired outcomes of improved quality and reduced costs. The considerations and recommendations raised by the advisory panel should help guide public and private stakeholders as they begin to explore how to apply innovative health care payment concepts in their communities.

Leaders in both the public and private sectors need to tackle these issues now, not only to ensure that providers are able to meet the demand of transformation, but also to guarantee long-term success of the vision for a high-value health care system.

## Appendix

### Pinpointing the Destination: Payment Reform Elements in Health Reform

A primary goal of health care reform is to contain rising health care costs by realigning financial incentives for providers to supply high-quality care in a cost-effective manner. Over the past twenty years, Congress has continuously sought to find potential solutions by enacting demonstration programs in Medicare and Medicaid. Through PPACA, Congress took an important step toward supporting locally-defined innovations in care delivery and payment models.

PPACA includes a number of care delivery and payment reform provisions. The law directs the Secretary of Health and Human Services (HHS) to establish a Medicare Shared Savings (i.e., accountable care organizations, or ACO) program, in which groups of providers that form ACOs will be allowed to share in savings achieved through higher quality and more efficient care provided to Medicare patients. The program will test multiple payment approaches, including a risk sharing model. PPACA also includes a one-year Pediatric ACO demonstration for Medicaid based on a shared savings model. Both the Medicare and Medicaid programs are slated to begin in January 2012.

The new health reform law promotes the patient-centered medical home (PCMH) model. A medical home provides accessible, continuous, comprehensive, and coordinated care. The law permits the Secretary to award grants to states to implement multidisciplinary “health teams” to support the PCMH. Health team requirements include the use of certified electronic health records and implementation of interdisciplinary care plans that integrate clinical and community prevention and health promotion services for patients.

PPACA includes two bundled payment demonstrations. The first is a Medicaid bundled payment demonstration that would pay for hospital and physician services for an episode-of-care surrounding a hospitalization. The demonstration would begin in 2012 and be conducted in up to 8 states. The second is a Medicare pilot program for bundling payments for acute, post-acute care, and ambulatory services. The pilot will be for ten conditions selected by the Secretary and will begin by 2013. In addition to the bundled payment demonstration, PPACA also extends the current Medicare Hospital Gainsharing Demonstration until September 30, 2011. The Gainsharing Demonstration tests financial arrangements between hospitals and physicians under a shared savings model. The savings are a result of collaborative efforts between the hospital and the physician to improve overall care quality and efficiency.

Congress also established the Center for Medicare and Medicaid Innovation, within the Centers for Medicare & Medicaid Services (CMS), which starting in January 2011 will begin testing innovative care delivery and payment models

for Medicare and Medicaid beneficiaries. PPACA also creates an Independent Payment Advisory Board which starting in 2014 will submit proposals to Congress on how to reduce Medicare spending while preserving and enhancing care quality.

Lastly, PPACA established a hospital value-based purchasing (VBP) program and a hospital readmissions program which will begin in 2013 as well as a value based physician payment program which will start in 2011. These VBP efforts will allow for payment differentials to physicians or physicians groups based on quality and provide incentive payments to hospitals that meet certain quality benchmarks while the readmission program would reduce payment to hospitals for preventable readmissions.

While these reforms lead toward the possibility of greater value in health care, the law includes little detailed guidance on how to get there. The aim of the payment reform advisory panel and RWJF is to help fill in some of these gaps for stakeholders.

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