Aligning Forces for Quality | Improving Health & Health Care in Communities Across America

Robert Wood Johnson Foundation

PRIMER/BRIEF

Beyond Widgets: The Pursuit of Payment Reform

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I. Introduction

In a normal market-based economic model, rational actors respond to incentives. Competition raises quality and lowers costs. Innovations can be disruptive to market participants but usually act to improve the product or service for consumers. Prices fall, value rises, and the economy expands or contracts based on what the market demands. Most functioning industries follow this path.

Health care in the United States is a notable exception. Costs remain stubbornly high, and quality remains lower than it should be. Consumers generally do not or cannot choose value. Providers, not consumers, usually drive demand for health care services. Employers and other purchasers of care should be able to exercise buying power to obtain better value, but often that power is limited—to employers' great frustration. Competition does not reward the best providers, and weaker providers often remain in business.[i] In short, the normal rules of how a market-based economy should function seem not to apply to health care in the United States.

About Aligning Forces for Quality

Aligning Forces for Quality (AF4Q) is the Robert Wood Johnson Foundation's signature effort to lift the overall quality of health care in targeted communities, as well as reduce racial and ethnic disparities and provide real models for national reform. The Foundation's commitment to improve health care in 16 AF4Q communities is the largest effort of its kind ever undertaken by a U.S. philanthropy. AF4Q asks the people who get care, give care and pay for care to work together to improve the quality and value of care delivered locally. The Center for Health Care Quality in the Department of Health Policy at George Washington University School of Public Health and Health Services serves as the national program office. Learn more about AF4Q at www.forces4quality.org. Learn more about RWJF's efforts to improve quality and equality of care at www.rwjf.org/goto/quality-equality.

Today, health care providers are usually paid based on the number of procedures they perform. The quality or even the necessity or desirability of these procedures is of little importance from a financial perspective. Today, physicians, hospitals, and other health care providers usually reap higher revenues simply by delivering more services to more people, which in turn fuels health care inflation.

The health care system ultimately is volume-driven: more procedures equals more payment. This volume-based, "fee-for-service" approach is commonly derided within the field as "paying for widgets," because it treats health care as a collection of commodities bought and sold rather than as an endeavor focused on improving the health of individuals and populations.

"Paying for widgets" leads to two seemingly contradictory results. First, increased services and higher spending don't usually result in better health. In fact, the opposite often is true. It sounds counterintuitive, but there is significant evidence that unnecessary treatment harms patients. Health care in the United States is plagued by overspending and overtreatment, paradoxically resulting in poorer health outcomes.[ii, iii]

Second, the volume-based model means that millions of Americans have trouble getting access to any care at all. The "more procedures equals more payment" equation is true only when the patient receiving those procedures has health insurance or independent means of paying for care. For the approximately 17 percent of Americans who lack health insurance,[iv] the equation is different. These millions of Americans usually lack financial means to pay for even

minimally necessary care and thus face difficult challenges when trying to access care. If they do get access, it can be sporadic and insufficient. For some of them, the equation can be summed up as, "no coverage equals no care."

These problems—overtreatment and lack of access—are confounding, because they violate the fundamental purpose of health care. The overwhelming majority of physicians, nurses, allied health professionals, and administrators enter health care not to enrich themselves but to care for patients. Unfortunately, the best of their professional intentions run into systemic realities.

"If there is one thing that frustrates health care practitioners more than anything else, it's that system of perverse incentives," said Robert Graham, MD, program director of the *Aligning Forces for Quality* (AF4Q) National Program Office. "Not only are providers not rewarded financially for doing the right thing, but very often they are actually rewarded financially for doing the wrong thing. That's crazy. Nobody wants that."

Payment reform is high on the list of priorities of AF4Q, the Robert Wood Johnson Foundation's (RWJF) signature effort to lift the overall quality of health care in targeted communities. The Patient Protection and Affordable Care Act of 2010 opens the door to innovations in how the federal government pays for care. And, perhaps most importantly, communities across the United States are also exploring ways to reform the health care reimbursement system so clinicians and organizations are rewarded not for providing a lot of care but for providing the right care, and only the right care.

II. What We Mean When We Say Reform

What should a reformed payment system look like? There isn't agreement on the details, but many observers agree on the goals of such a system. These goals typically include the aims that health care payment should reward high-quality care and not reward low-quality or unnecessary care, that care should be efficient, and that providers reap equal rewards for providing care to patients regardless of factors such as race, gender, age, or financial condition.

Thus, it is helpful to think about payment reform in terms of underlying principles. A good starting set of principles could include:[v]

1. Payment reforms should reward the delivery of high-quality, cost-effective, and affordable care.
2. Health care payment should encourage and reward care that coordinates services across the spectrum of providers and settings of care.
3. Payment policies should promote quality improvement and innovation.
4. Decisions about payment should be made through independent processes involving local stakeholders and parties directly affected by these decisions, and not set solely by a government agency.
5. Payment should reduce spending on administrative processes.
6. Payment reforms should have realistic goals and timelines.

The details behind such principles can be difficult and very contentious. But the principles themselves should not be, says Michael Painter, MD, senior program officer at RWJF. "Current payment schemes generally are not worth defending, and therefore fewer and fewer people defend the payment status quo," Painter says. "We know, broadly speaking, the things payment should reward. What we need is the will and fortitude to try new approaches that move us toward those lofty goals."

Fortunately, outlines for how to reform payment in U.S. health care exist. In fact, some forward-thinking providers and communities have been trying innovative experiments for a decade or longer.

Models for Reform

Many initial payment reform experiments were built on capitation—the concept of paying a fixed amount to a provider organization on a "per member, per month" basis, as with health maintenance organizations (HMOs). However, this model lost favor in the 1990s, as HMOs were accused of routinely using capitation to limit spending on needed care services while ignoring quality concerns.

This was followed by experiments built around "pay for performance," or "P4P." P4P is a broad term describing payment mechanisms that reward providers who improve their performance or exceed goals, usually on quality and cost benchmarks. P4P initiatives have included significant regional and national programs, such as the CMS/Premier

Hospital Quality Incentive Demonstration[vi] and Bridges to Excellence.[vii] These have varied widely in scope and design, but tend to be based on a common set of elements, including performance measurement, incentives, and transparency and consumer engagement.[viii]

Yet P4P, while explicitly rewarding quality, leaves the fee-for-service intact, offering payment bonuses on top of a still-flawed payment scheme. Thus, a more ambitious approach was desired, one that would move away from fee-for-service altogether. A leading approach was PROMETHEUS Payment®, an ambitious initiative developed in 2007 and supported by RWJF as a means to improve quality, lower administrative costs, and pay providers fairly. A "bundled payment" (or, episode-based) experiment, PROMETHEUS rewards both quality and efficiency by offering a set price for a bundle of services, such as a knee replacement or coronary artery bypass graft. PROMETHEUS starts with commonly accepted clinical practice guidelines, or CPGs; then calculates what it would cost to use CPGs to treat a patient for the condition addressed, taking into account all of the providers that would treat that patient for that condition (e.g., a hospital, a physician, and a rehabilitation facility). That calculation forms the basis of the Evidence-informed Case Rate™ (ECR)—the total amount that is paid to all providers for a particular condition. ECRs are then adjusted to take into account the severity and complexity of the patient's clinical condition. Providers declare which portions of the case rate they agree to deliver and at what price.

Today: Accountable Care Organizations and Patient-Centered Medical Homes

The passage of the Affordable Care Act in 2010 paved the way for delivery system reforms that include a payment reform element. Chief among these was support for Accountable Care Organizations, or ACOs, a payment and delivery reform model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. The Centers for Medicare & Medicaid Services (CMS) defines ACOs as "groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients."[ix]

Under the Affordable Care Act, doctors and hospitals are encouraged to form ACOs as a network, sharing responsibility for providing care. An ACO would agree to manage all of the care needs of a minimum of 5,000 Medicare beneficiaries for at least three years. ACOs formed under the Affordable Care Act will continue to operate under the fee-for-service model but will create savings incentives by offering bonuses when providers meet quality and cost benchmarks. Thus, providers would be incentivized to focus on health rather than on the volume of procedures they perform.

"The advantage of ACOs is that the model gives doctors and hospitals an incentive to treat the whole patient, rather than as a vessel for a set of services," says Harold Miller, executive director of the Center for Healthcare Quality & Payment Reform. "But they'll have to compete in the marketplace. If they can't provide better care at a more attractive price, they'll fail."

CMS has published guidelines for providers forming ACOs, but so far providers report that meeting the guidelines is a great challenge. And the cost savings projections aren't overwhelming. CMS estimates that the Medicare program could save up to $960 million in its initial three years,[x] but that figure is a tiny fraction of $555 billion annually spent[xi] on the federal health program. Still, ACO supporters assert that the long-term cost savings and quality improvements will be real.

The Affordable Care Act also contains provisions advancing another movement that contains elements of payment reform: patient-centered medical homes, or PCMHs. The concept was introduced in 1967[xii] and grew in popularity in the 2000s. One common definition of a medical home has emerged as "a physician practice committed to organizing and coordinating care based on patients' needs and priorities, communicating directly with patients and their families, and integrating care across settings and practitioners."[xiii] Today, health care and industry coalitions such as the Patient-Centered Primary Care Collaborative (PCPCC)[xiv] and the Future of Family Medicine Project[xv] are advocating for the model's widespread adoption.

The PCMH is conceived as a coordination of care function and not as a means to achieve payment reform. Under the PCMH, a single provider assumes responsibility for all aspects of the patient's care. But the movement's advocates say that PCMHs will lead to payment reform and that reform is required to truly realize the benefits of the PCMH. "It's integral to the concept of a medical home that we need to reform how care is paid for," says Edwina Rogers, JD, executive director of the PCPCC. Thus, PCPCC has called for a national payment reform scheme that includes a monthly care coordination payment for physician work that falls outside a face-to-face visit; a visit-based, fee-for-service

component that reflects current realities of the existing payment scheme; and a performance-based component to encourage quality improvement.[xvi]

The Affordable Care Act commits $42 million over three years for up to 500 Federally Qualified Health Centers (FQHCs) to coordinate care under the PCMH model. To help participating FQHCs make these investments in patient care and infrastructure, they will be paid a monthly care management fee for each eligible Medicare beneficiary receiving primary care services. In return, FQHCs agree to adopt care coordination practices recognized by the National Committee for Quality Assurance (NCQA).[xvii]

New National Developments

The underlying problems that drive the need for payment reform are a source of frustration to all health care stakeholders, but especially purchasers of care. Thus, purchasers are driving or supporting many reform efforts. Three nascent national initiatives show promise in driving the conversation on payment reform.

One is Catalyst for Payment Reform (CPR), a purchaser-driven organization that is advocating for payment reforms in the private sector to support public-sector (e.g., Medicare) reforms such as those contained in the Affordable Care Act. CPR, formed in 2009 and led by former Leapfrog Group Executive Director Suzanne Delbanco, PhD, is at work on a national framework for payment reform along with tools that catalyze change in the marketplace and align public and private-sector strategies. So far, CPR has produced four key products: a payment reform toolkit, a national and local purchaser strategy, a national scorecard on payment, and an advocacy strategy.

A second is called Buying Value, an RWJF-funded initiative of private health care purchasers—employers, leading business health organizations, and union health funds. The initiative is made up of 19 organizations that either represent or are themselves large health care purchasers—including Fortune 500 corporations, union health funds, and business coalitions—and national consumer organizations. It builds on and mirrors the direction taken by CMS, applying the same principles that are being used for the Medicare population to the commercially insured population. Buying Value is designed to encourage and assist private purchasers changing from the traditional volume-based purchasing model of paying for care based on the number of individual tests or procedures performed to a model that emphasizes coordination, patient safety, and care that is proven to work.

A third is the National Commission on Physician Payment Reform, announced in March 2012. The commission, chaired by former RWJF President Steven Schroeder, MD, and funded in part by RWJF, will focus on reforming the physician payment system. It met over the course of a year, producing an analysis and recommendations in March 2013. Its recommendations include: 1) largely eliminating stand-alone fee-for-service payment to medical practices; 2) testing of new models of care over a five-year time period, incorporating them into increasing numbers of practices, with the goal of broad adoption by the end of the decade; 3) continuing to recalibrate fee-for-service payments to encourage behavior that improves quality and cost-effectiveness and penalize behavior that misuses or overuses care; and 4) increasing annual updates for evaluation and management codes, which are currently undervalued. Former Senate Majority Leader Bill Frist, MD (R-TN), served as honorary chairman.

III. How Communities Can Make a Difference

The federal government—chiefly Medicare—remains the largest purchaser of health care in the United States. As long as this is true, federal purchasing policy will continue to dictate the national picture of health care payment. Nevertheless, there is a significant role for local and regional payment reform initiatives, some of which already are up and running. Many of these initiatives are led by or feature significant involvement by employers.

Many communities are home to one or a few large health plans that dominate the local commercial payer market, or to one or a few large hospital systems that dominate the provider market. Health plans have the same motivation as the public interest in reforming the payment system, because a higher-quality, value-driven payment system would limit unnecessary expenditures and bring needed efficiencies to the market. The value equation for dominant hospital systems is less clear in strict dollar terms, but even these participants share a common interest in promoting care that is of high quality and given only when necessary.

Thus, some communities, including AF4Q Alliances, are gathering stakeholders to build local support to undertake a payment reform initiative.

Patricia Montoya, project director of the Albuquerque AF4Q initiative, led by the New Mexico Coalition for Healthcare Quality, is working with local health plans that have volunteered to work with the Alliance on a bundled payment pilot as part of their payment reform work. The work is very timely as the New Mexico Medicaid office is redesigning Medicaid in the state, and they also are looking to move toward bundled payment. The timing of these projects creates the potential of real alignment between the private- and public-sector payers.

In January 2012, the multi-stakeholder group initially began with a summit that focused the community on the need for payment reform, specifically bundled payment methodology. The coalition then convened community members—including health care providers, hospitals, health plans, employers, and patients—to educate them about the pilot. Through funds from the AF4Q grant, the New Mexico Alliance brought in national experts from Health Care Incentives Improvement Institute, Inc., who presented on the PROMETHEUS Payment® model. Dr. Jay Want, Harold Miller, Francois DeBrantes, and Doug Emery also provide technical assistance in this project. Later that year, the New Mexico Medicaid office began discussing bundled payments, and wrote it into its proposal for Medicaid redesign.

“The intent of the system is to improve or maintain the quality of care while decreasing health care spending,” said Montoya.

The New Mexico Medicaid office is looking to the pilot to inform the state’s efforts as it moves ahead with its bundled payment pilot in 2014. The New Mexico AF4Q Alliance is well positioned in the state to influence the direction of payment reform based on its strong partnerships with stakeholders and the excellent technical assistance providers it has been able to offer as part of the project. The Centennial Care (Medicaid Redesign for New Mexico) request for proposal directed the health plans to work with the coalition on these payment reform pilots, as it will inform Medicaid’s efforts before they move into their own implementation in 2014.

Three health plans have voluntarily signed agreements to participate in the New Mexico Alliance’s bundled payment pilot and are providing their claims data for data analysis. Based on the data analysis and feedback the health plans receive, they will decide what areas they will focus their bundles on (such as diabetes, asthma, coronary artery disease, or joint replacements), and which providers they will contract with to conduct the pilot.

Montoya said the data are crucial in making thoughtful and effective progress with the pilot. “For instance, imagine that one health plan is planning to focus bundles on asthma. After reviewing the data, they might see that they are already successful with asthma efforts and go in a different direction,” she said.

The pilot is separated into three phases. In 2013, the initiation phase, the pilot is focusing on data analysis, provider identification, contracting, and engine vendor identification. The coalition also is hosting a “boot camp” for the participating health plans. The camp allows each plan to have a conversation about the data results and best practices in moving forward.

In 2014, the pilot will enter the learning phase. In this phase, the coalition will focus on feedback and provider and plan communications. The plans will identify methods for engine testing, reporting, and modifications. Through careful observation in this phase, the coalition also will consider expansion options.

The money phase will start in 2015. The systems will be actively in place, and the coalition will focus on improving productivity, enhancing quality, and reducing costs. The coalition will prepare a final model for the state’s bundled payment efforts.

“It’s about partnership, dialogue, and engagement,” said Montoya. She said much of the pilot’s success has been achieved because of strong partnerships with state Medicaid and health plans. “We don’t bring people along with a hammer. Everyone wants to be here because they sense that something is really happening. AF4Q dollars are driving a public change and bringing people together.”

IV. Conclusion: Starting Small, but Starting!

Existing payment mechanisms that are so dominant in U.S. health care discourage the very improvements in quality and cost we so desperately need. Payment reform is not a detour, sideshow, or distraction from health care reform. Payment reform is health reform.

“A method of health care payment that rewards anything less than the highest-quality care possible is a system crying out for reform,” said CPR’s Suzanne Delbanco. “We need to refashion our system so that the right thing to do is both the easy thing to do and the most rewarding thing to do.”

Payment reform matters because today’s mechanisms use incentives to encourage poorer-quality care, a fact that galls both payment experts and quality experts. The “paying for widgets” model inevitably rewards unnecessary care, which often can be harmful to the very patients the system exists to serve.

The federal government, through its support of ACOs and PCMHs, is encouraging the development of models that could lead to national system delivery reforms that will include payment reform. This is important because the federal government is the nation’s single largest purchaser of health care, and thus sets many national payment policies either by force of law or with the power of its purse. Additionally, many national and regional demonstrations are proving that payment reform initiatives can work.

The best possibilities for lasting reform may come not from the federal government or national initiatives but from local communities in employer-driven initiatives. Employers are anxious to move toward value, not volume, in their payment mechanisms and have been seeking ways to enact payment reform locally. Communities, including AF4Q Alliances, are taking leadership roles by convening stakeholders and building consensus around reforms that, while not easy, are doable.

While most stakeholders support some sort of payment reform, AF4Q’s Graham cautioned that the arcane details will prove troublesome for some time. “In every system before reform, change can be threatening to entrenched interests,” Graham said. “Local initiatives, combined with national demonstration projects, should indicate to these participants that it is in their long-term interests to pursue payment reform—because what we have right now isn’t sustainable.”

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