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## THE WAY WE PAY FOR HEALTH CARE

### SUMMARY

Unsustainable health care cost trends have state and federal policymakers exploring ways to align provider payment to improve quality and ensure appropriateness of care without jeopardizing affordability. Some of the more popular options include pay-for-performance models, reimbursement for episodes of care, value-based purchasing and global payments. This article explores these options and their potential for increasing value while helping control costs.

The push to revamp the way we pay for health care has landed the traditional fee-for-service model with its head on the political chopping block. Kill it before it kills us and before out-of-control medical costs mean visiting your doctor is a luxury only the richest Americans can afford. Whether this method of payment will be axed for good or survive in a different form remains uncertain. But there is a growing consensus that significant reform requires an end to the fee-for-service system.

Critics of the fee-for-service model oppose it because it reimburses individually for each item of medical care rather than paying for it comprehensively. They say it can potentially reward doctors, hospitals and other medical providers for conducting tests and procedures that are medically unnecessary.<sup>1</sup>

Policymakers considering reforms may find it useful to look to Massachusetts, where lawmakers enacted health care reform in 2006 that requires most state residents to enroll in a health plan if it's available to them. In August 2009, the RAND Corporation released a report prepared for the Massachusetts Department of Health and Human Services detailing ways the state might curb the cost of health care. The RAND researchers concluded that the most promising opportunities for slowing spending were those that altered the way health care services were paid for. These approaches included both market-based strategies, such as bundled payment, and regulatory strategies, such as all payer rate setting.<sup>2</sup>

### PAY-FOR-PERFORMANCE

According to the Agency for Healthcare Research and Quality (AHRQ), a research arm of the U.S. Department of Health and Human Services, the pay-for-performance model offers incentives for meeting predetermined measures for quality and cost efficiency. This model rewards doctors and other medical providers with financial bonuses when they meet established quality-based targets for the delivery of health care services.<sup>3</sup> One way providers measure and encourage quality is through monitoring clinical outcomes such as glucose control in patients with diabetes.

Some advocate taking the concept further by employing disincentives for negative results. For example, if a mistake made during a hospital stay requires readmission to fix the error, some pay-for-performance models would not reimburse the hospital for the second stay.

Pay-for-performance turns traditional treatment philosophy inside out by focusing on doing what it takes to keep patients well instead of waiting until they are seriously ill. Proponents of the model contend that putting wellness at the heart of treatment will reduce health care costs because the longer an illness or disease is ignored the costlier it is to treat in the long run. Pay-for-performance encourages doctors and other health care workers to tackle a medical condition, disease or ailment while it's still manageable and before it has progressed into something more serious and costly to treat.

For example, high blood pressure treated early can prevent serious illness. Undiagnosed and untreated, it increases the risk of stroke, heart attack, heart failure, kidney disease and even blindness.

The need for early intervention is reinforced by recent estimates that “about one in three U.S. adults has high blood pressure” but “nearly one-third of them don’t know it,” according to the American Heart Association.<sup>4</sup>

One drawback, critics say, is that the cost to administer a pay-for-performance model eliminates much of the savings. Those who dislike the model point to added expenses for new technology as well as costly and time-consuming burdens on administrative staff to collect the information that measures performance. Additionally, health care policy expert Gail Wilensky argues that it’s difficult to implement because the data required to measure performance is not easily acquired given the fragmentation of our health care system.<sup>5</sup>

Nevertheless, just because it’s difficult doesn’t mean we should not attempt it, notes Wilensky, a senior fellow at Project Hope, a foundation for international health education, and a former Medicare administrator under the first Bush presidency.

Policy experts have launched pilot studies to test the viability of this payment method. The Integrated Healthcare Association, an alliance of California health care providers, scores doctors and other medical providers annually on the quality of their performance. The group uses agreed upon measurements to calculate incentive payments for physician groups. Each health plan develops its own formula to determine what they will pay doctors for meeting clinical quality goals.<sup>6</sup>

A pilot program that rewards doctors for performance saved Medicare roughly \$32 million over three years, according to data released in August 2009 by the Centers for Medicare and Medicaid Services (CMS). Physicians in the Physician Group Practice Demonstration earn incentive payments for providing high quality care preventive care and care for people with chronic illnesses. The physicians receive financial incentives when they meet quality targets and reduce Medicare expenditures.<sup>7</sup>

A pay-for-performance program introduced in the United Kingdom in 2004 met with mixed results, according to the *New England Journal of Medicine*.<sup>8</sup> A year after it began, the rate of improvement in the quality of care for asthma and diabetes had accelerated but there was no improvement in quality for coronary heart disease. For asthma and diabetes, the improvement in the quality of care for patients leveled off and continuity of care decreased following the introduction of the payment scheme. In addition, quality declined for some aspects of care not associated with the incentive-based plan.<sup>9</sup>

The American Medical Association asserts in a policy statement that achieving better value for health care spending is the ultimate public policy goal.<sup>10</sup> But would doctors want to sign on to a system that pays them depending on whether the patient gets better? As health care policy blogger Tim Foley said, “It scares the bejesus” out of most doctors he knows.

“...They’d be at the mercy of the patient following instructions. The nightmare looming in their mind is the patient who is overweight, with high blood pressure and warning-sign cholesterol levels, who irregularly takes his pills and makes no serious effort to change lifestyle. Their compensation would be very poor indeed – through no fault of their own.”<sup>11</sup>

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## EPISODE OF CARE

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A reimbursement for the episode of care model that pays a lump sum to doctors and hospitals for a bundle of services over a set duration or episode rather than paying each doctor for individual patient services has the support of key legislators, like Sen. Max Baucus, a key player in the national health care reform debate.

The idea is to give doctors and hospitals incentives to minimize complications and reduce the number of unnecessary procedures while improving care. Former senator Tom Daschle, still active in the health care debate, recommends testing it in a pilot program through Medicare saying it could lead to “better outcomes and lower cost, and far less hassle for providers.”<sup>12</sup>

“We need a good revision of our payment system. Today we pay for volume, and we really need to change that to pay for value,” Daschle said in a July interview with Newsweek Magazine.<sup>13</sup>

Wilensky, an economist who testifies frequently before Congress on health care and advised Sen. John McCain during his presidential campaign, also favors an expansion of the practice of bundling payments for services. “This would allow physicians to care for a patient with a particular medical problem without having to monitor each service provided and without encouraging more services than might be medically necessary” said Wilensky in a recent New York Times article. “It means making a single payment for all of the services provided in a joint replacement or for a cardiac bypass procedure.”<sup>14</sup>

United Healthcare is testing an “episode of care” program for oncologists while Medicare has used the approach with hospitals but not yet doctors. Minnesota is experimenting with lump sum “basket of care” payments to treat chronic conditions such as asthma and diabetes.<sup>15</sup>

The reimbursement for episode of care model, according to the American Association of Retired Persons (AARP), encourages cooperation among providers who care for a patient; however, it requires careful use of resources because the physicians involved get one payment for a package of services. This method also poses a challenge in implementing because exactly what constitutes an episode – for example, when did it begin and end – could vary to a degree that it is difficult to define and therefore complicated to implement.<sup>16</sup>

Drawbacks to the episode of care model are that it lacks incentives for providers to help patients avoid episodes of care and does not sufficiently curb incentives to increase volume of care, according to a special commission in Massachusetts that reviewed payment models for health care. The commission also expressed concern that there is limited operational experience with the model, which could make it difficult to swiftly implement.<sup>17</sup>

## VALUE-BASED PURCHASING

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Power in numbers is the idea behind value-based purchasing, which attempts to monitor quality and measure results (e.g., did a treatment work and was the patient satisfied?). Employers and other buyers of health care come together with the goal of obtaining the best value for their health care dollars. Competition, negotiation and accountability are the driving forces that encourage hospitals and doctors to prove that they offer the best care (quality) at the best price (value). Those who can prove it gain the reputation and clout to attract more enrollees and patients.<sup>18</sup>

The concept was spawned by the Deficit Reduction Act of 2006 that requires development of a quality-based plan for hospital inpatient care to reduce spending for Medicare by 2009. Pay-for-performance is one of the programs in this area.

“Value-based purchasing brings together information on the quality of health care, including patient outcomes and health status, with data on the dollar outlays going towards health,” according to an AHRQ-commissioned report that examines the concept and how employers use it. “It focuses on managing the use of the health care system to reduce inappropriate care and to identify and reward the best performing providers.”<sup>14</sup> In contrast, more standard approaches focus on reducing costs by negotiating discounts with little emphasis on improving quality, according to the report.

Harvard business professor, analyst and author Michael Porter, a frequent commentator on health care, says we must systematically change how care is delivered by organizing it around value rather than strictly cost. According to Porter, our delivery system currently rewards those who shift costs and bill for more services rather than those who deliver the most value. Minimized costs and limited service gets more attention than efforts to maximize value over the entire care cycle.

“The big question is whether we can move beyond a reactive and piecemeal approach to a true national health care strategy centered on value,” Porter wrote in the *New England Journal of Medicine*. “This undertaking is complex, but the only real solution is to align everyone in the system around a common goal: doing what’s right for patients.”<sup>19</sup>

The AHRQ-commissioned research project found that most employers focus exclusively on costs and expect insurance companies and providers to do the negotiating. The Agency for Health Care Policy and Research (the predecessor to AHRQ) began a series of research initiatives focused on employers. Researchers held in-depth discussions with several employers and reviewed written materials from others to get a picture of barriers and possibilities for value-based purchasing.

Some employers collect quality information but then fail to use it when making purchasing decisions. More innovative employers, however, do more than pay lip service to the concept of value-based-purchasing. They don’t stop at collecting data on cost and quality; they use the results to make informed decisions when selecting providers and plans. In turn, they offer financial incentives to their employees when they enroll in plans that receive high marks.<sup>20</sup>

While other groups such as Minnesota’s Department of Employee Relations report significant savings with value based purchasing, the AHRQ report does not specify whether employers saw a cost benefit by adopting the strategy. In 2006, the Minnesota group that had implemented many value driven strategies had a zero percent premium increase and an estimated \$20 million in savings.<sup>21</sup>

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## GLOBAL PAYMENTS

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Global payments are another major payment reform model drawing attention. Under this model, doctors and other medical professionals receive a regular fee payment (e.g., once a month or annually) based on how many patients they have, how sick their patients are and whether they meet quality standards.<sup>22</sup>

Global payments, usually estimated from past cost experience, prospectively compensate providers for all or most of the care their patients may require over a contract period. They are a form of capitation that may be combined with other payment related strategies, such as pay-for-performance, to encourage improvements in quality, care coordination and patient-centered care. One important advantage is that they offer strong incentives for the efficient delivery of the full range of services that most patients need, according to a draft report from the Massachusetts Special Commission on the Health Care Payment System, which endorsed the model.<sup>23</sup>

Some say global payments encourage doctors to provide more care up front to keep patients healthy but it also means health care on a budget, and many doctors likely do not have the budgeting experience necessary to successfully manage under this model. Critics also charge that the global payment system’s strong financial incentives to constrain health care expenditures could pit doctors’ and hospitals’ interests against what’s best for the patient.<sup>24</sup>

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## CONCLUSION

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Our health care system is flirting with failure. Many say that the core of the problem is how we pay for medical care with a fee-for-service model that’s costly and breeds waste. Policymakers are exploring a system overhaul that will allow us to better budget our health care dollars while improving the quality of care. Some advocate the adoption of new payment models that reward performance over volume of services. Pilot projects involving the payment models being considered demonstrate that the potential to save the system money while redirecting the focus of our reimbursement methodology from quantity to quality. Before adopting any one model on a systemic level, however, careful consideration must be given to the cost and challenges associated with administering them.

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