

# FROM VOLUME TO VALUE: IMPLEMENTING FUNDAMENTAL REFORMS IN HEALTH CARE PAYMENT SYSTEMS TO SUPPORT VALUE-DRIVEN HEALTH CARE

Recommendations from the  
2008 NRHI National Payment Reform Summit  
and  
Next Steps for Payment Reform



# 2008 NRHI Payment Reform Summit

**Over 100  
attendees  
from 21 states  
and DC**



**Key payment  
reform issues  
identified for  
resolution**



**Sponsor:** Robert Wood Johnson Foundation



**Support:**



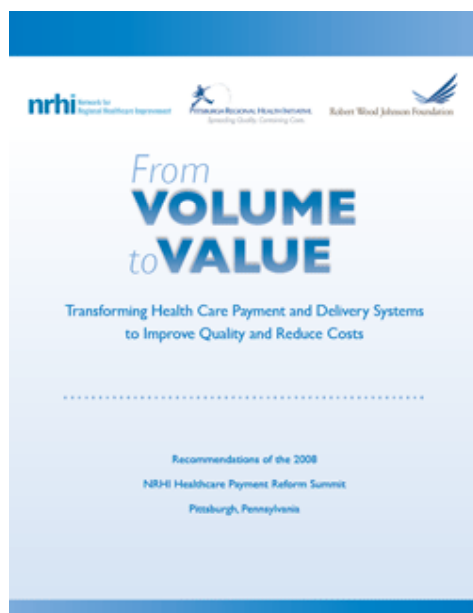
**Two Intensive  
2 hour  
work  
sessions**





# Reports from the 2008 Summit

## Full Recommendations from the Summit



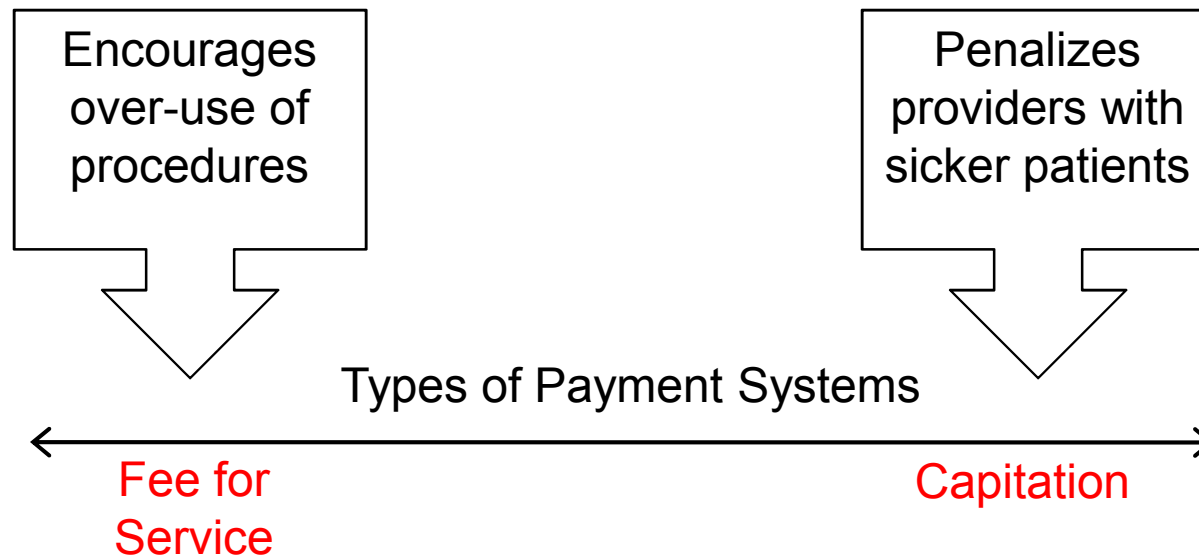
## "Payment Reform Series"



[www.nrhi.org/reports.html](http://www.nrhi.org/reports.html)

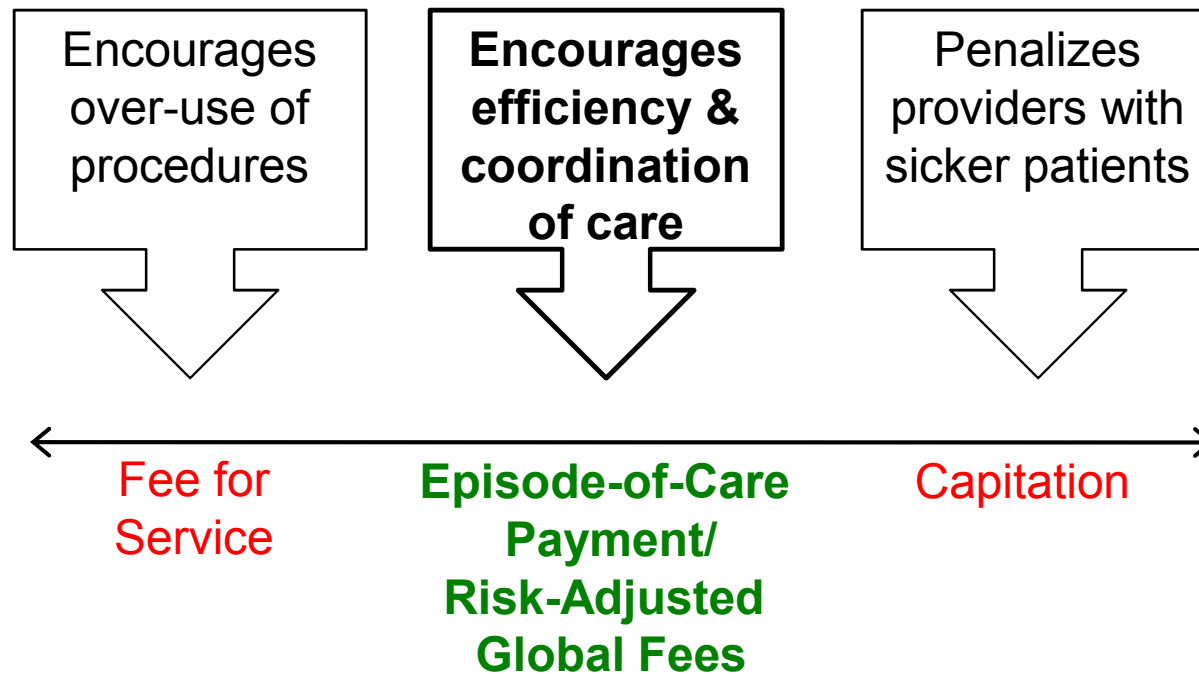
# The Problems with Existing Payment Systems

---



# 2007 Summit Recommendations: Better Payment Systems

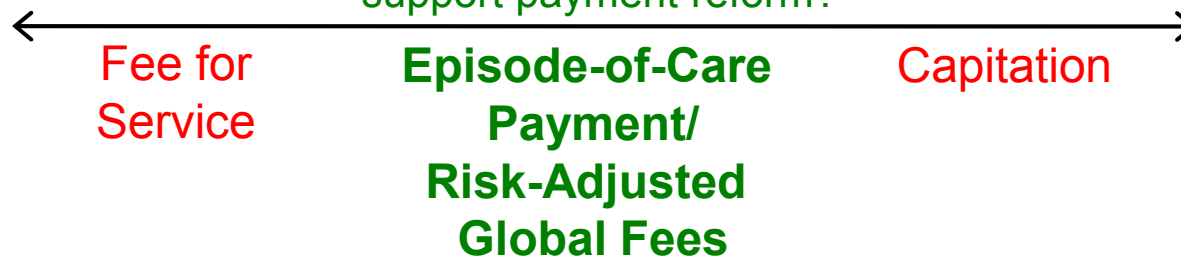
---



# 2008 Summit Agenda: Implementation Challenges

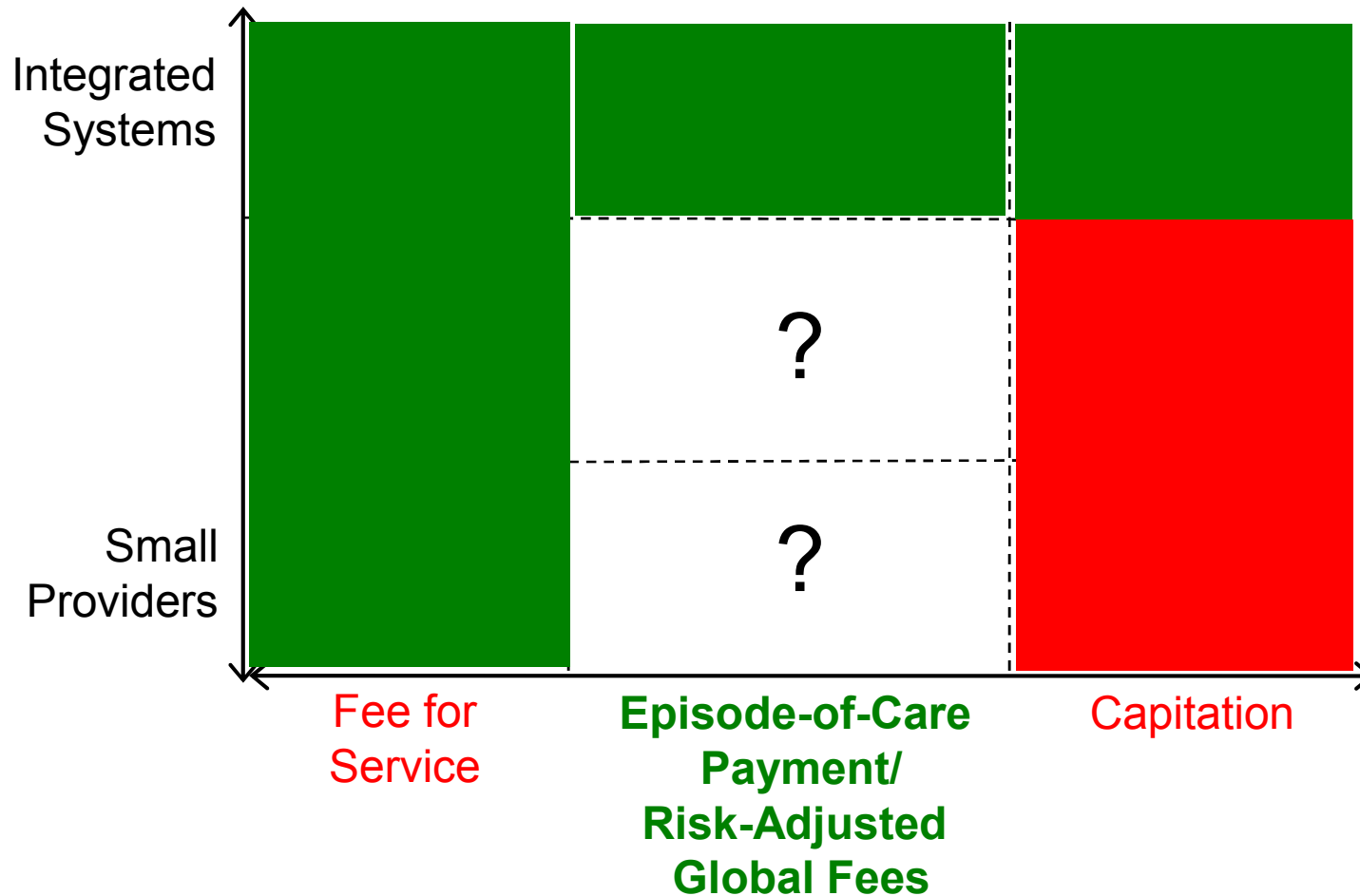
---

- Which providers are willing/able to accept new payment structures?
- How should use of high-value providers be encouraged?
- What protections are needed to ensure quality for patients?
- How can payers and providers be encouraged to participate?
- What kinds of pilot projects are needed?
- What community-wide structures are needed to support payment reform?

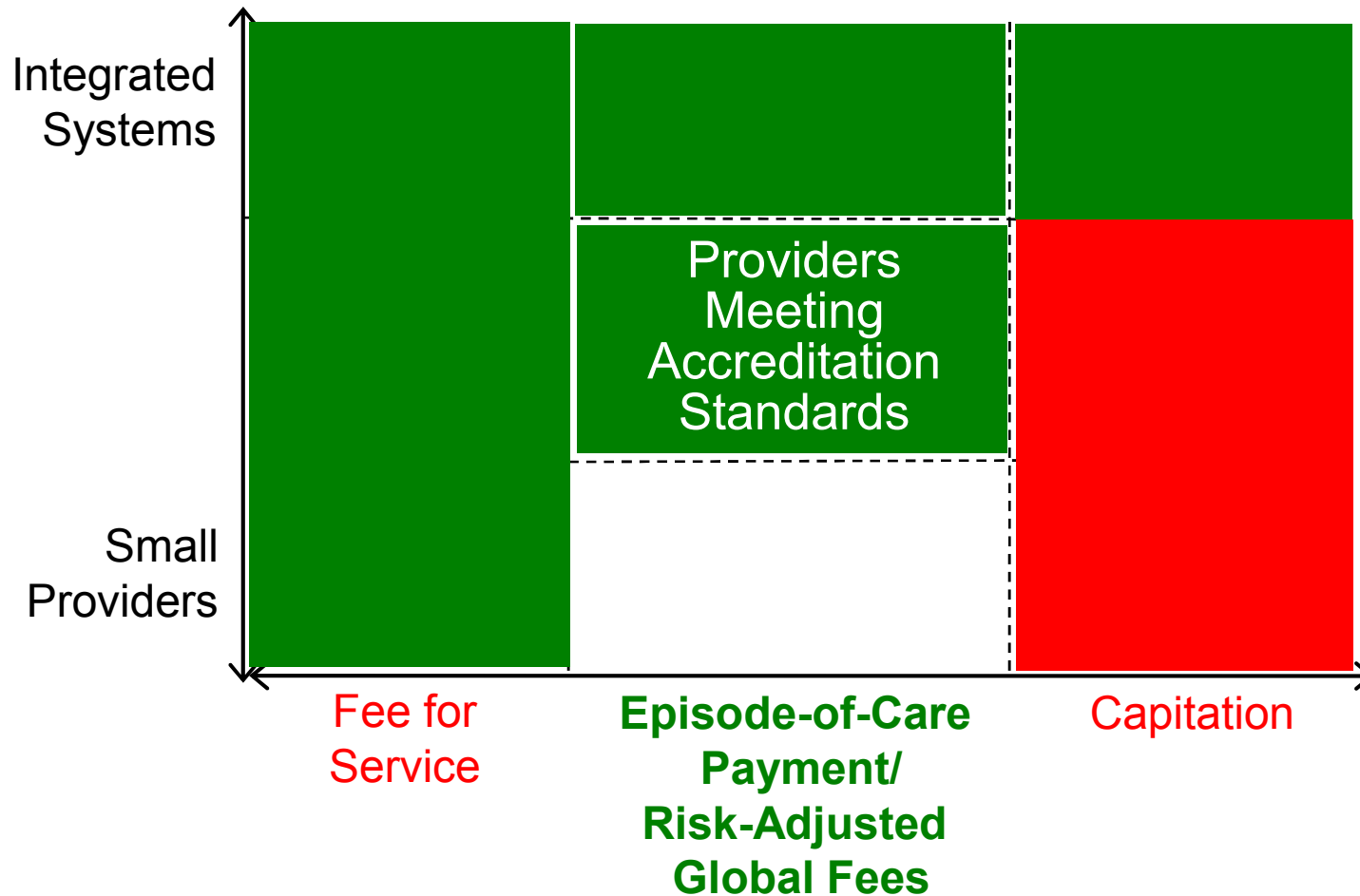




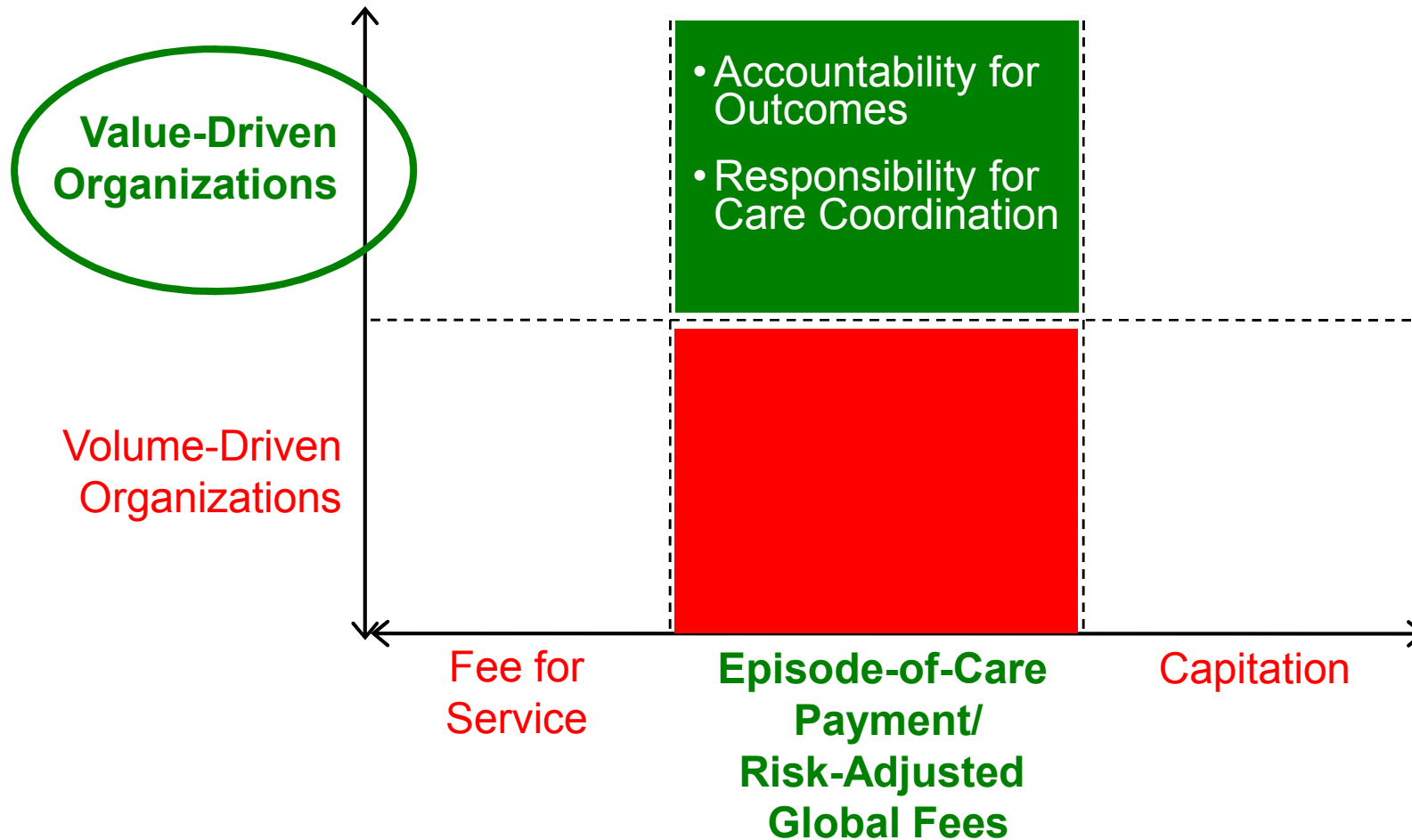
# Which Organizations Can Manage New Payment Systems?



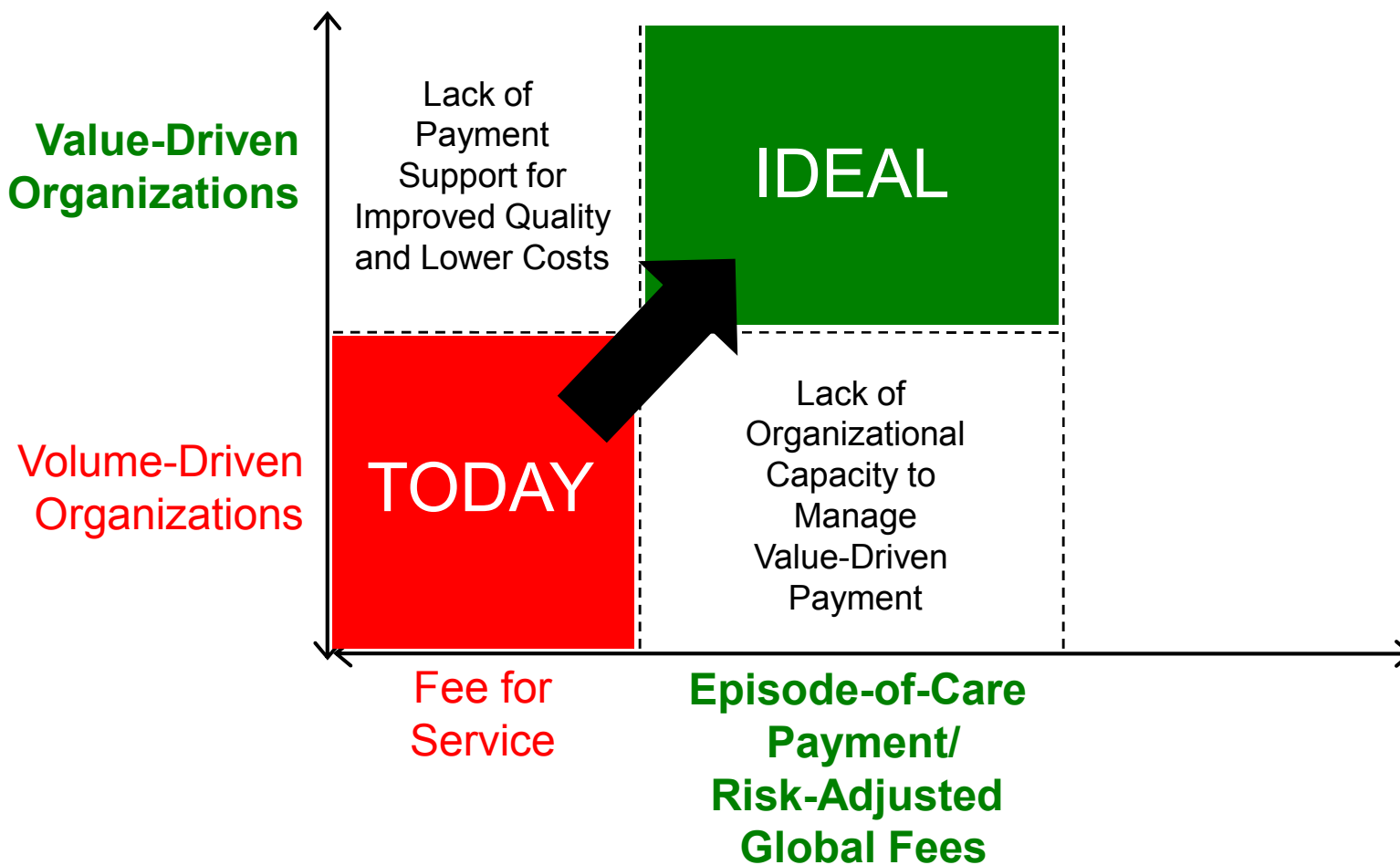
# Current Trend: Requiring Accreditation Standards



# Recommendation: Focus on Outcomes, Not Structure



# Co-Evolution of Payment and Organizational Capacity

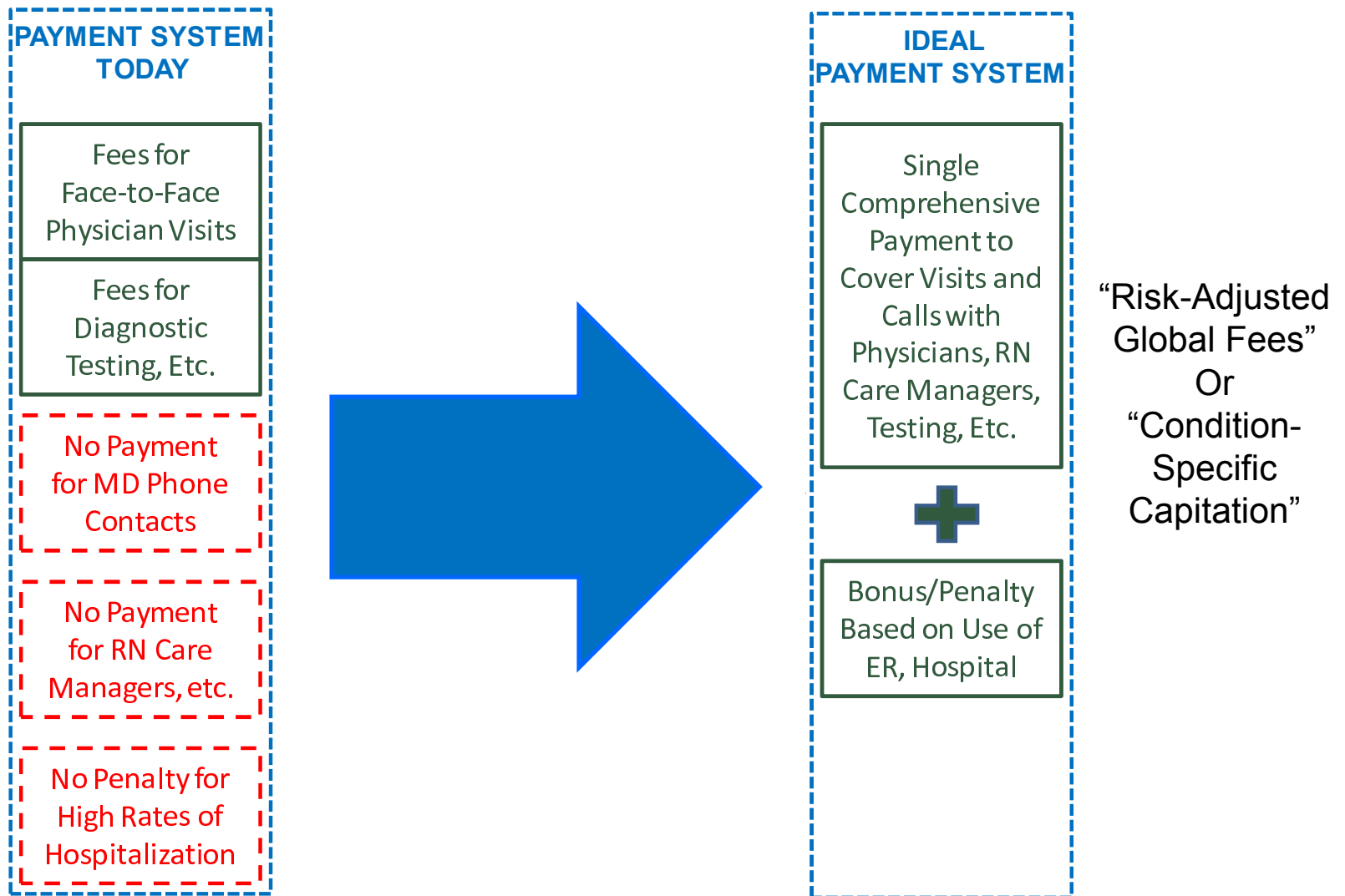




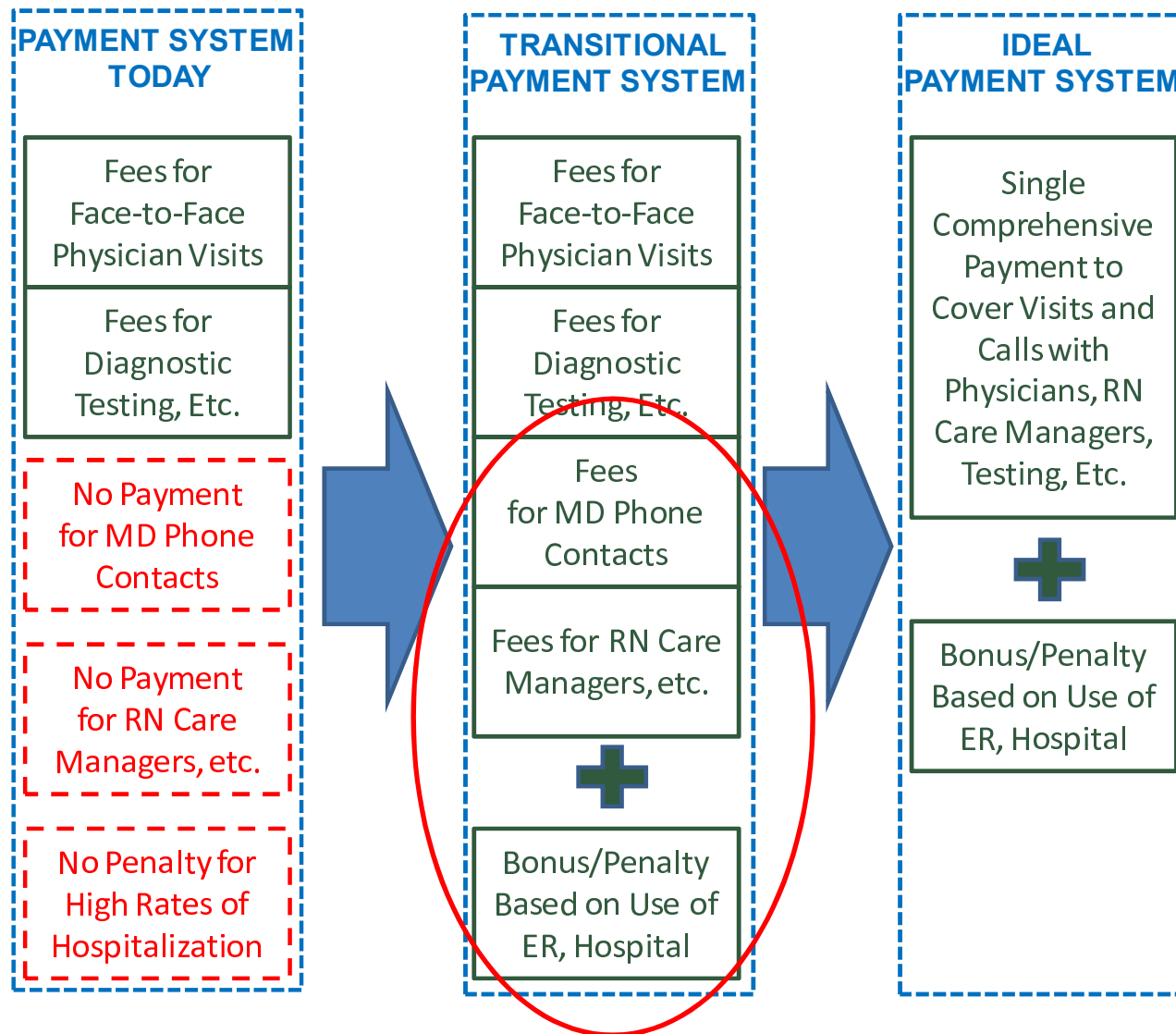
# Changing the Payment Structure for Medical Homes



# Changing The Payment Structure: Long-Run Goal



# Changing the Payment Structure: Transitional Steps



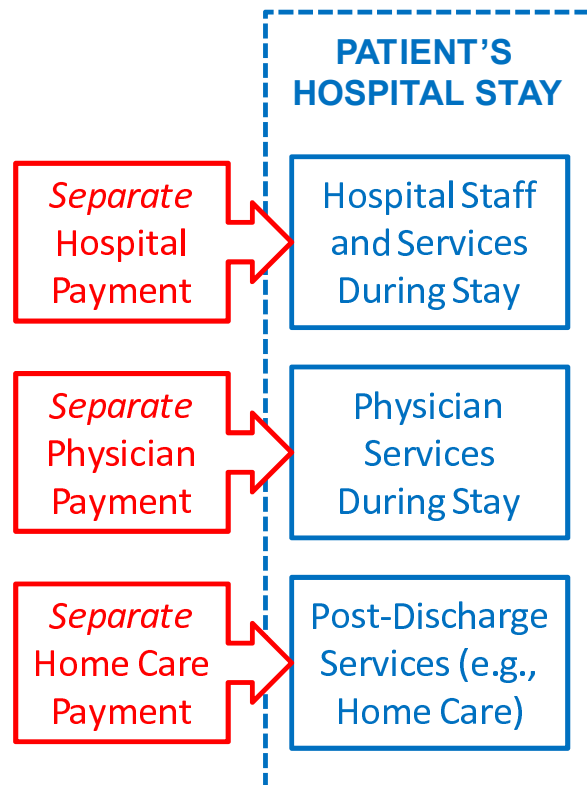
# Who Should Be Eligible for Medical Home Payments?

---

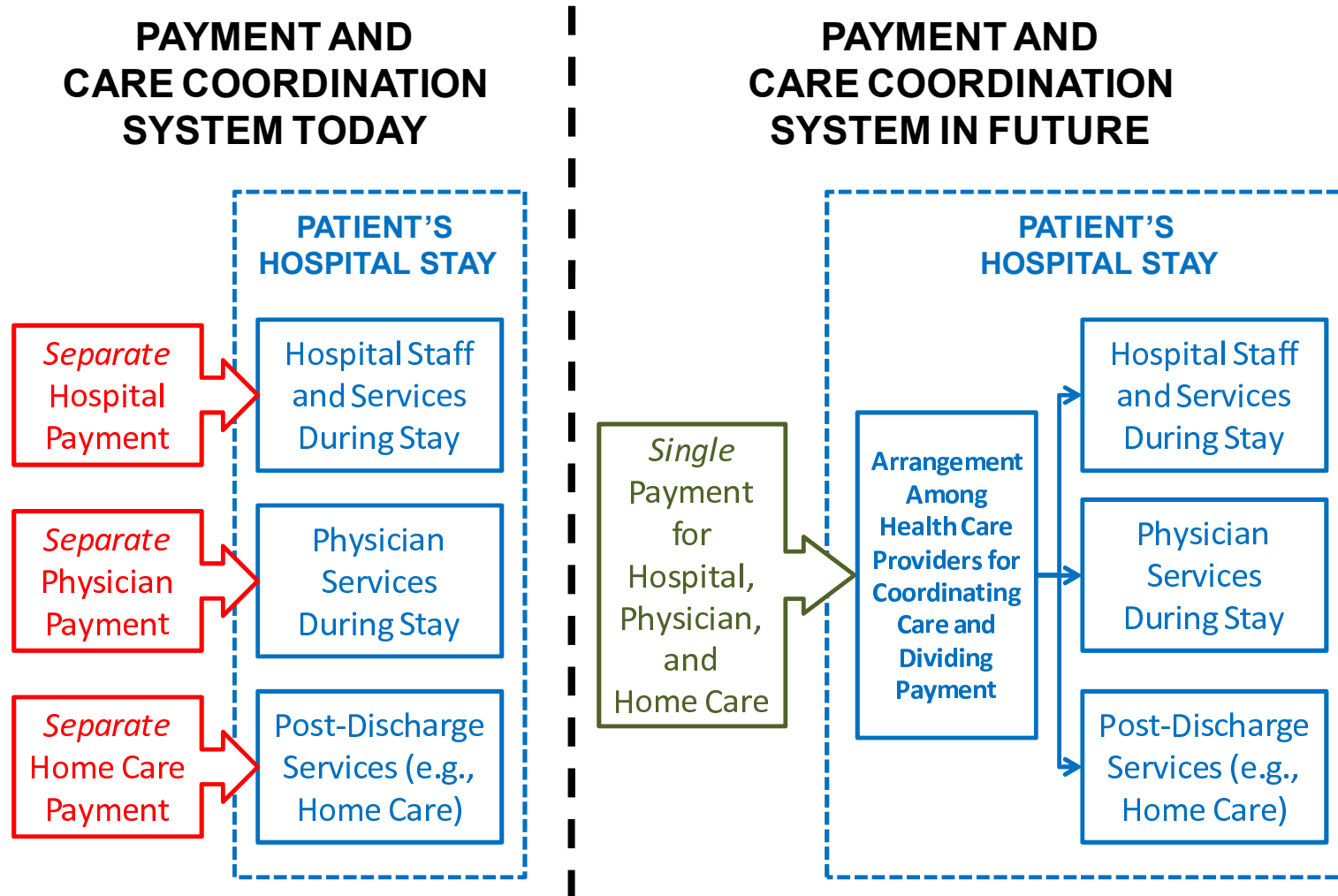
- **Current Approach: Require MD Practices to Meet NCQA Standards for Medical Homes**
  - Insufficient evidence to demonstrate that primary care practices meeting NCQA standards will deliver better value than those which do not
- **Recommended Approach: Focus Should Be on *Outcomes***
  - e.g., reducing preventable hospitalizations, improving patient satisfaction
  - Resist unnecessary barriers to entry, particular for smaller practices
  - Use NCQA standards as *guidance* to providers on how to organize
- **Research/Demonstrations Needed Before Standards Set**
  - Some pilot projects requiring NCQA standards would be desirable
  - But pilot projects with different standards and outcome-driven requirements are needed to determine what actually makes a difference

# Organization and Payment For Major Acute Care

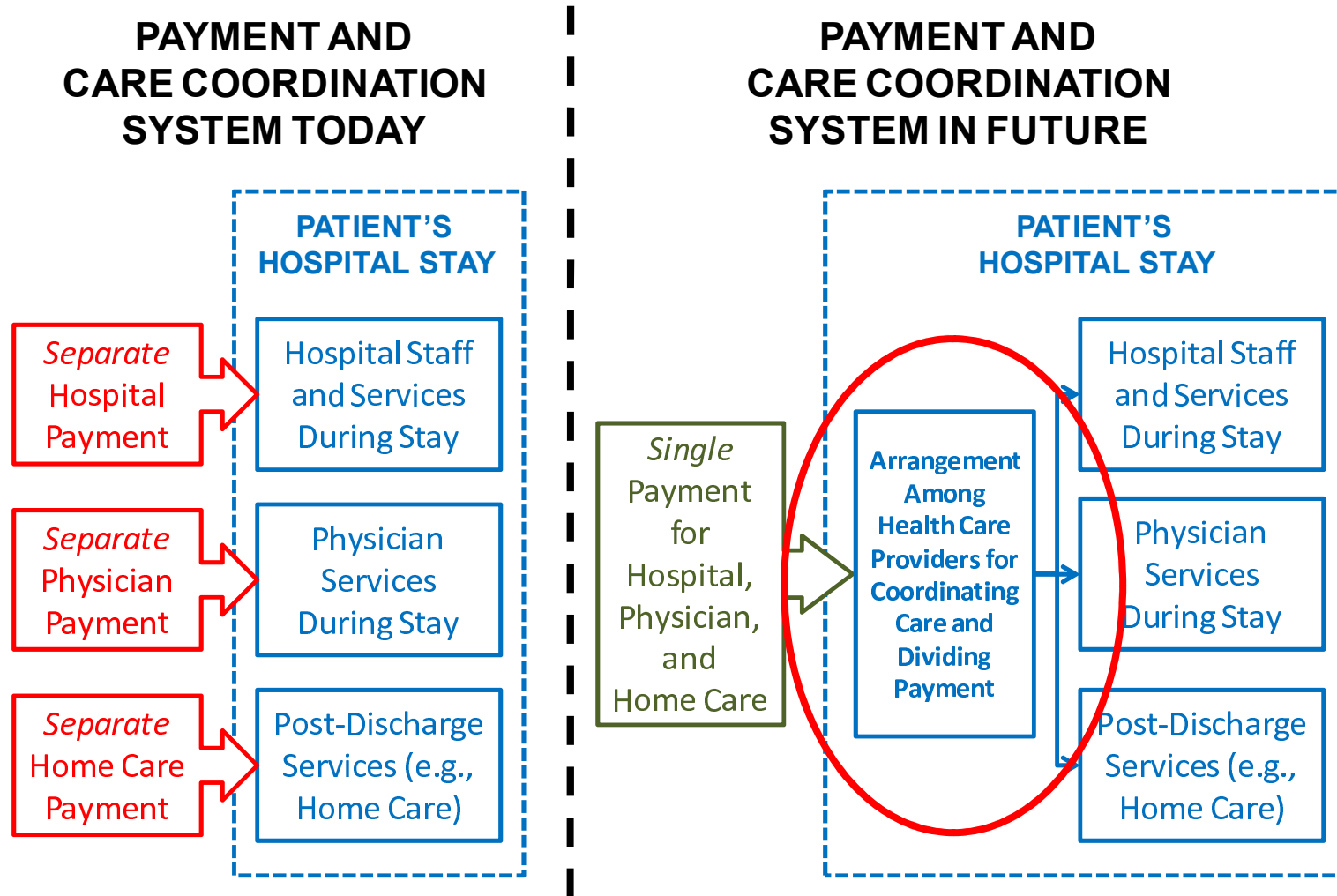
## PAYMENT AND CARE COORDINATION SYSTEM TODAY



# Recommended System: Bundled Payment to All Providers



# The Organizational Challenge: Creating Coordination Mechanisms

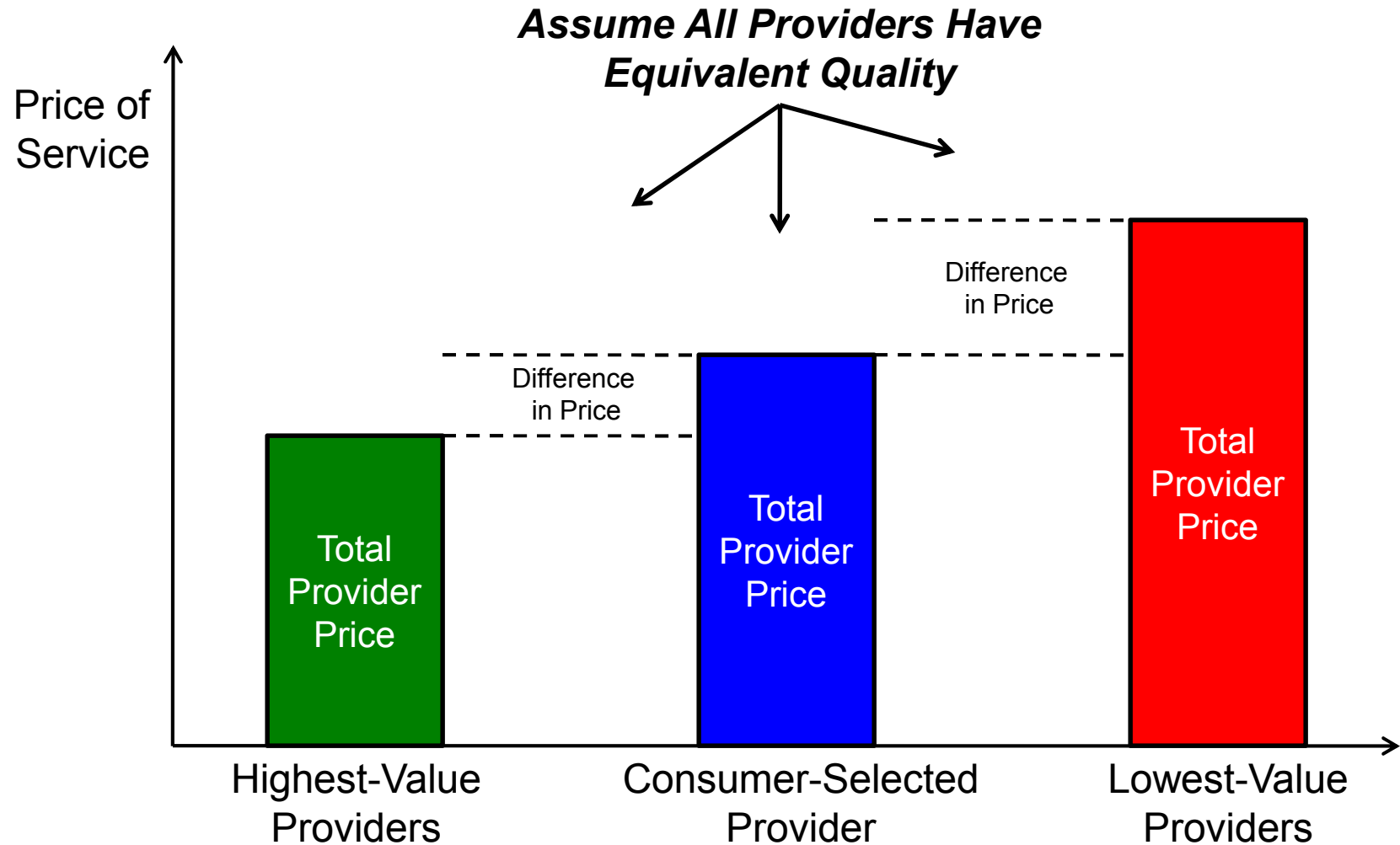


# Transitioning to Bundled Payment

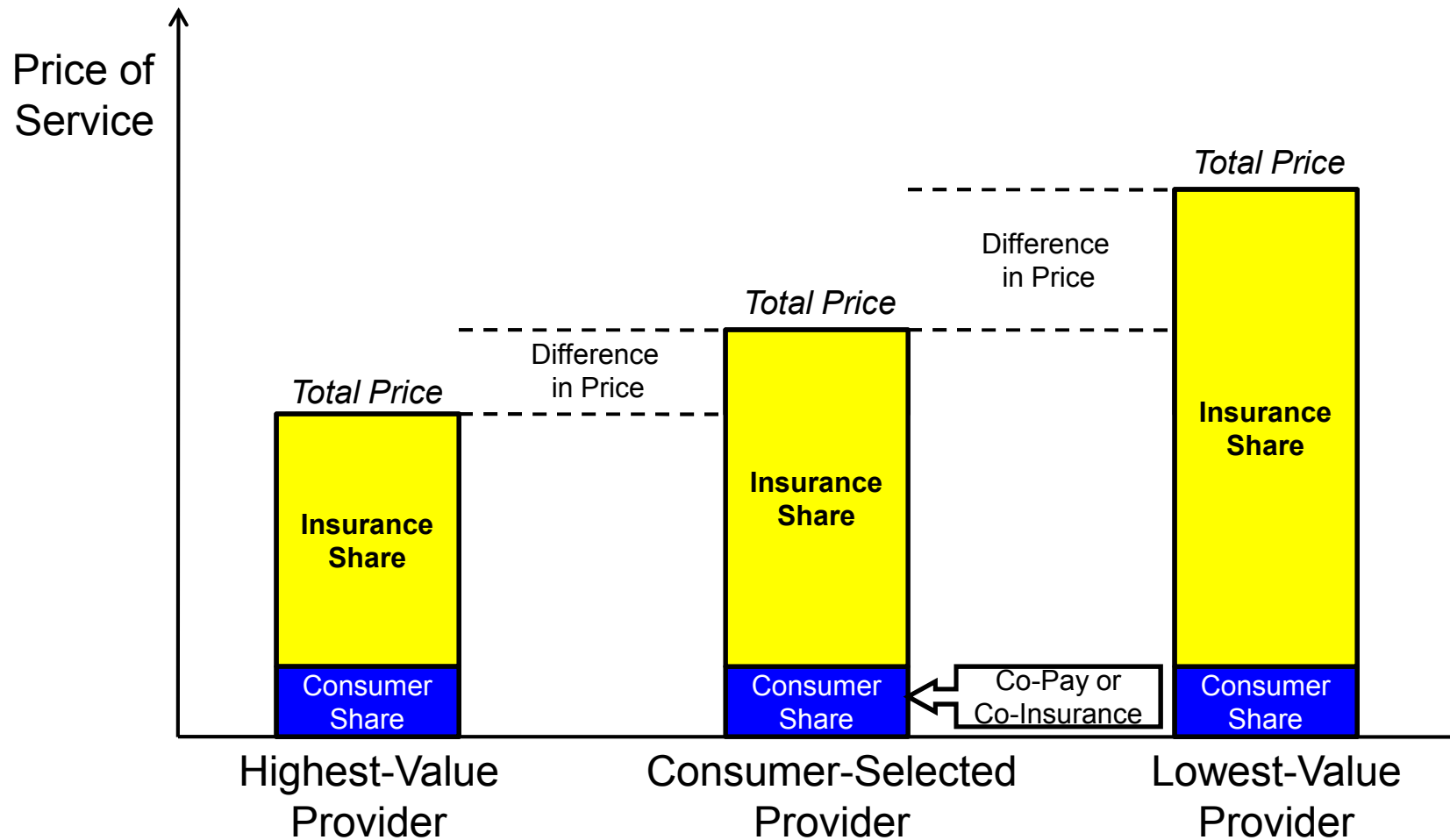
---

- **Create Case Rates for All Providers:** Pay non-surgeon physicians in hospitals on a case rate basis for patients in major DRGs.
- **Expect Warranties from Each Provider:** Establish financial rewards for hospitals and physicians that reduce hospital readmissions (or penalties for those that do not). Give preference to providers that provide warranties on their care.
- **Increase Use of Gain-Sharing Between Providers:** Remove restrictions on gain-sharing between hospitals and physicians for efforts to improve efficiencies in hospital care.
- **Create “Virtual” Bundling Among Providers:** Provide rewards and/or penalties to all providers involved in an episode of care, based on the total cost of the episode relative to regional or national averages.
- **Bundle Case Rates for Providers into True Episode Payments:**
  - Bundle hospital and surgeon payments for surgical procedures
  - Bundle hospital and post-acute care payments for major DRGs

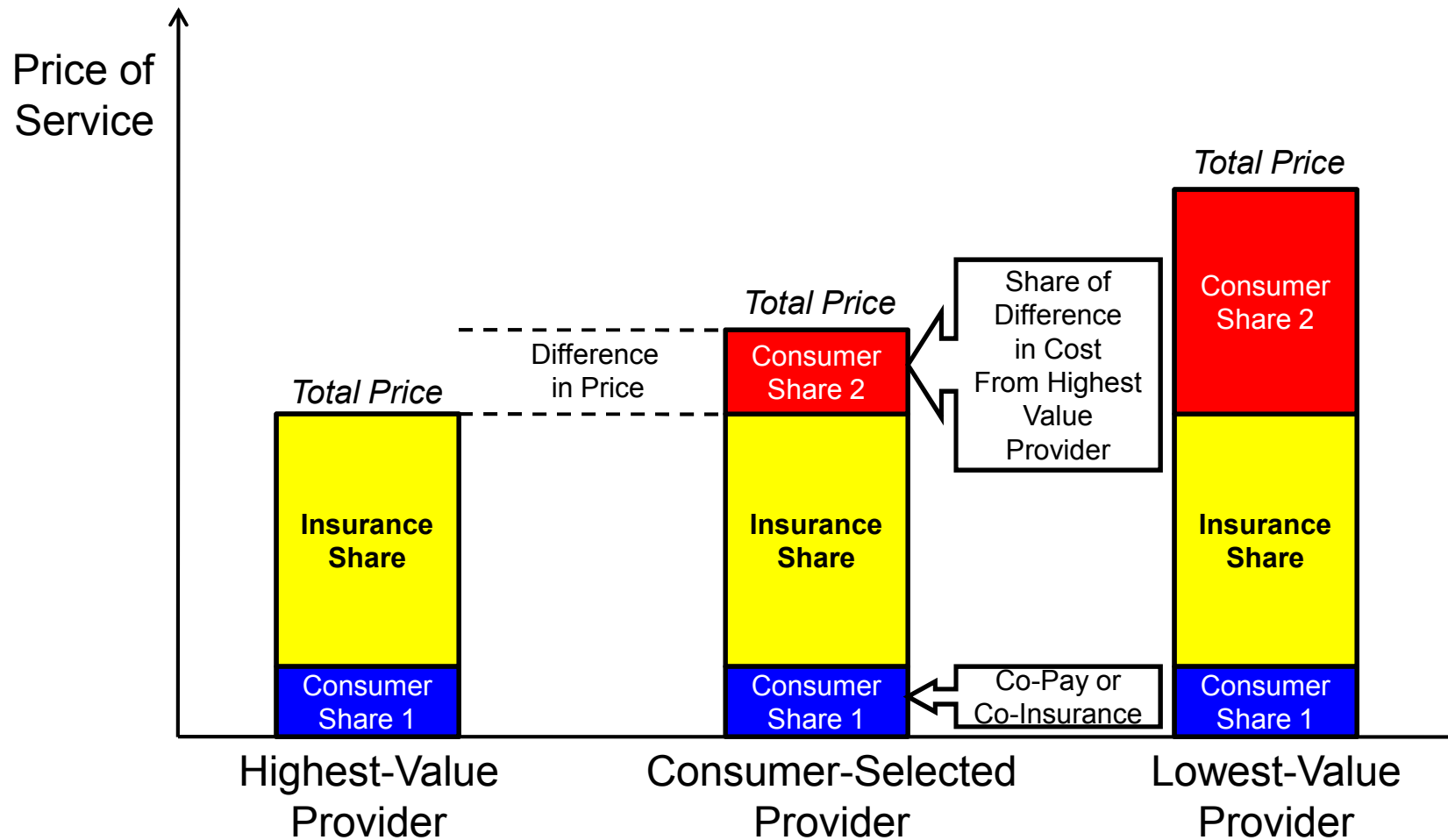
# Current Systems Don't Encourage Use of Lower Price Providers



# Current Systems Insulate Consumers from Price Differences

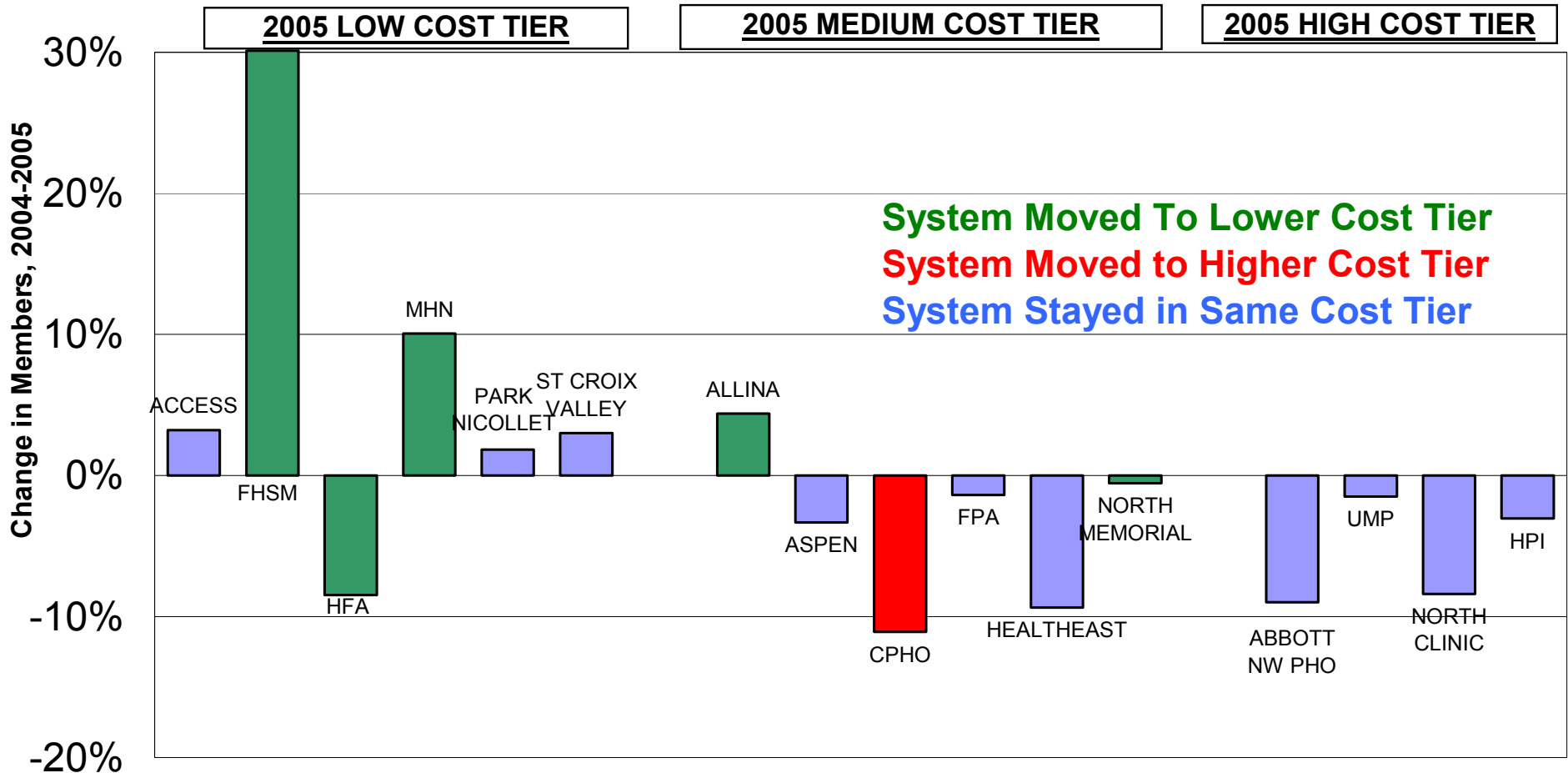


# Requiring Consumers to Pay All or Part of the “Last Dollar”





# Results of Patient Choice With Cost-Tiered Providers



Source: Ann Robinow, Patient Choice



# Encouraging Use of Higher-Value Providers and Services

---

- **Small Number of Tiers:** Tier providers into a small number of tiers based on cost and quality (for easier consumer choice)
- **Significant Consumer Share for Higher Cost:**  
Charge consumers a significant share of the difference in cost of providers in lower-value tiers;  
Charge consumers more for using lower-value services
- **Consumer Education:** Educate consumers how to use information

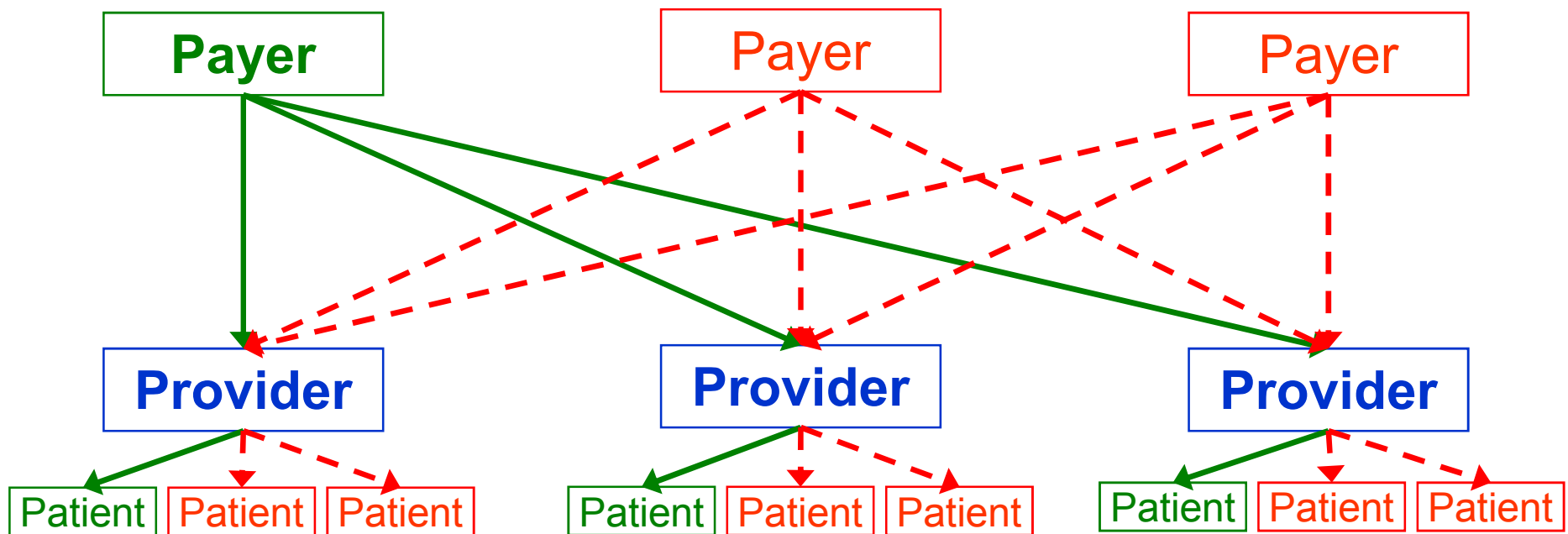


# Protecting Patients Against Under-Service by Providers

---

- **Require Essential Services:** Require providers to deliver minimal, evidence-based services (where strong evidence exists) in order to get paid
- **Public Reporting on Quality:** Collect/report data on underuse and care of disadvantaged populations
- **Adjust Payment to Patient Need:** Develop and use good severity/risk-adjustment systems with outlier payments/reinsurance so providers aren't penalized for accepting sick patients/keeping patients healthy
- **Incentives for Patient Adherence/Health:** Create patient incentives to adhere to recommended care

# A Key Challenge: Gaining Support from a Critical Mass of Payers



***Provider is only compensated for changed practices for the subset of patients covered by participating payers***



# Encouraging Participation by Payers

---

- **Lead Role for Purchasers:** Educate purchasers about the importance of new payment systems
- **Demand Use of New Payment Systems:** Purchasers should give preference to health plans that use new payment systems
- **Coordination of Multiple Purchasers:** A sufficient number of purchasers should participate to make it worthwhile for plans to change systems
- **Medicare Participation:** Authorization by Congress for Medicare to participate in regionally-defined payment reforms

# Encouraging Providers to Support Changes

---

- **Hospitals and Specialty Providers**
  - Provide technical assistance in eliminating waste and increasing efficiency, to reduce costs as well as revenues
  - Payers should reduce administrative burdens on providers (e.g., inconsistent reporting requirements)
  - Payers and providers should collaboratively plan for the transition (make changes *with* providers, not *to* them)
- **Small Physician Practices**
  - Provide technical assistance in managing care and finances under new payment models
  - Provide help in forming organizational structures to facilitate quality improvement, share resources, and accept accountability for outcomes/costs



# Regional Systems Needed to Support Payment Reform

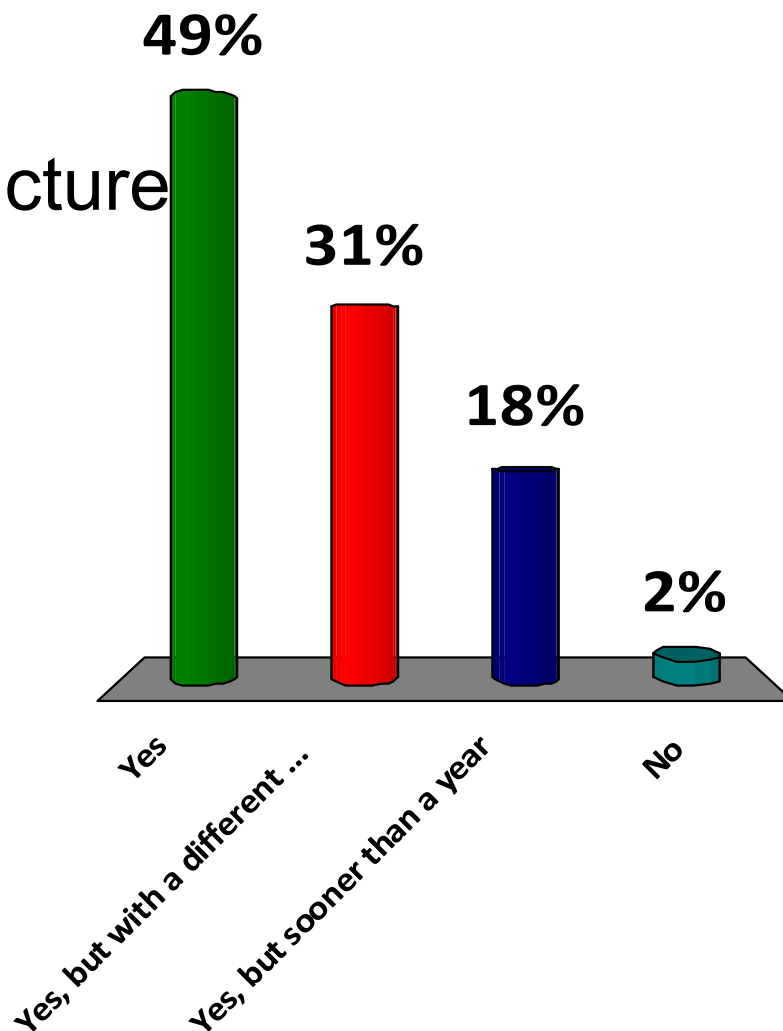
---

- **Alignment of Payment Structures**
  - Due to anti-trust restrictions, there is a need for a neutral body to provide a mechanism for developing a payment structure acceptable to multiple payers
- **Quality and Cost Reporting**
  - Methodologies should ideally be developed consistently across the country
- **Community/Patient Education**
  - Educate the community about the urgent need for change
  - Involve consumers in planning payment changes in meaningful ways

# Should NRHI Hold Another Payment Reform Summit Next Year?

1. Yes
2. Yes, but with a different structure
3. Yes, but sooner than a year
4. No

*The 2009 Summit should focus on the lessons and results from actual pilot projects*

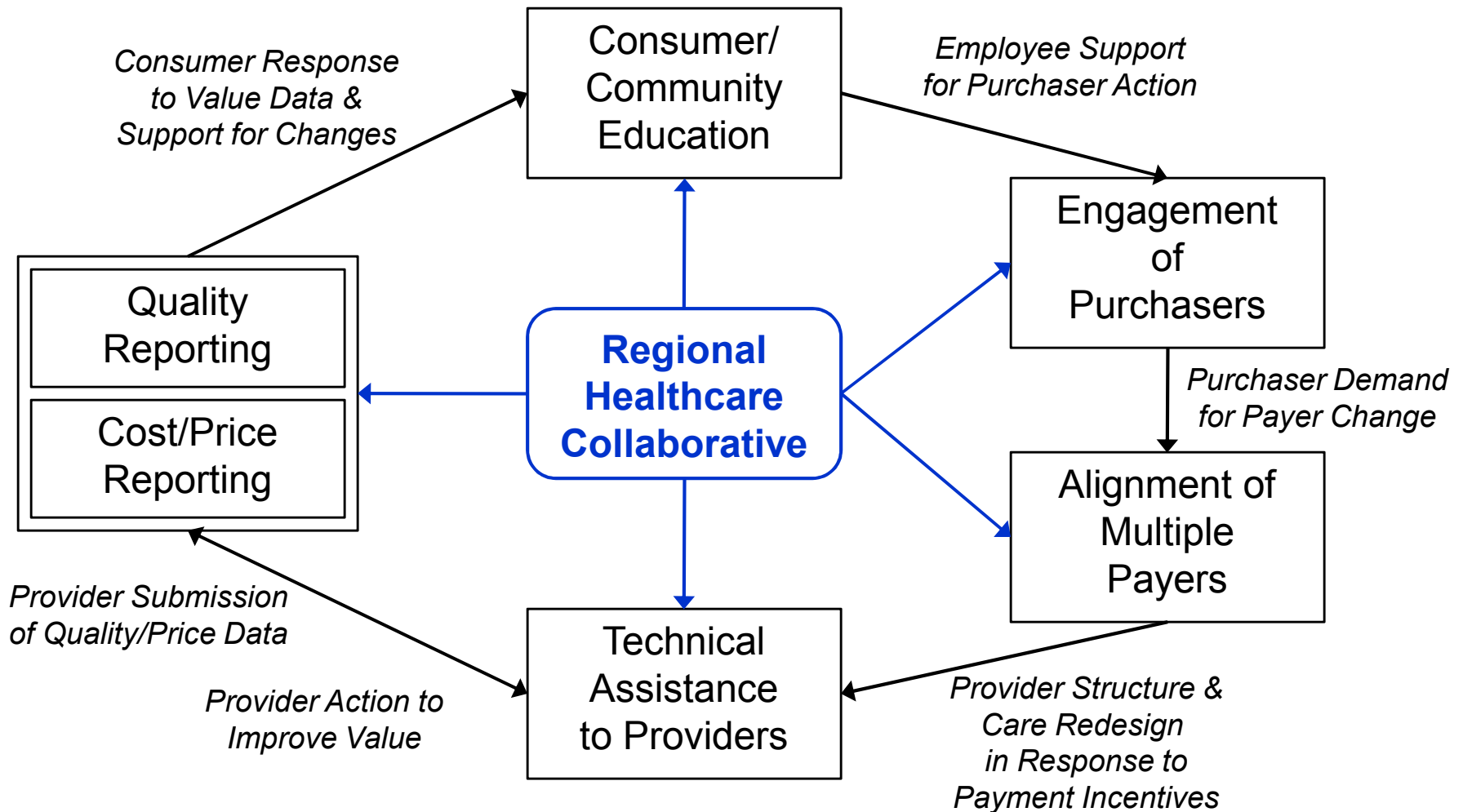


# Piloting New Payment Systems

---

- **Improve Cost & Quality:** Focus on projects with ability to reduce cost and increase quality, e.g., patients with overuse and underuse of care
- **Phase In Providers:** Start with willing providers, to gain experience with care improvements needed to achieve better value and to identify unintended consequences, then phase in more providers
- **Short-Term Impact:** Focus on projects expected to produce impacts in 2-3 years; Some increase in costs may be needed in first year both for one-time costs and until changes can be fully implemented

# Functions Needed for Healthcare Payment & Delivery Reform



# Types of Help Needed in Putting Key Functions In Place

---

- Summaries of experiences from regions that have implemented (or attempted) each function
- Peer speakers (e.g., purchasers, payers, consumers) from other regions
- Startup funding for staff/consultants to plan, build consensus on, and organize key regional functions
- Descriptions of options for payment reform projects
- “Working capital” to cover startup costs in payment changes, fill in for missing payers, etc.

# For More Information:

**Harold D. Miller**

President & CEO, Network for Regional Healthcare Improvement  
and  
Executive Director, Center for Healthcare Quality and Payment Reform

[Miller.Harold@GMail.com](mailto:Miller.Harold@GMail.com)

(412) 803-3650