



EXECUTIVE SUMMARY

CREATING PAYMENT SYSTEMS TO ACCELERATE VALUE-DRIVEN HEALTH CARE

Recommendations from the
Network for Regional Healthcare Improvement's
2007 Summit
March 29, 2007
Pittsburgh, Pennsylvania

The Need for Improved Payment Systems in Health Care

In many cases, current healthcare payment systems don't reward efforts by physicians, hospitals, and others to improve the quality and reduce the costs of health care. In fact, all too often, they actually financially *penalize* them. This has led to a variety of pay-for-performance ("P4P") programs which add a new layer of rewards and incentives on top of the existing payment systems. While well-intended, there is a growing recognition that most current pay-for-performance initiatives won't by themselves solve the fundamental problems and disincentives that are built into the underlying payment systems.

What Changes Should Be Made in Health Care Payment Systems?

The Network for Regional Healthcare Improvement (NRHI) convened a national Summit on *Creating Payment Systems to Accelerate Value-Driven Health Care* on March 29, 2007 to accelerate thinking about how healthcare payment systems can be redesigned to reward improved quality and lower costs.

The participants at the NRHI Summit – major healthcare payers, health plans, regional coalitions, researchers, and other thought leaders – agreed that fundamental changes to payment systems, rather than just pay-for-performance add-ons, were essential, and they developed specific recommendations regarding the changes needed:

- **For patients with chronic illnesses**, a single, periodic Comprehensive Care Payment should be paid to a group of health care providers to cover all of the care management, preventive care, and minor acute care services associated with the patient's chronic illness, instead of those providers being paid on a fee-for-service basis for each individual service. (Major acute care and long-term care would be paid separately.) The amount of the payment should vary based on the patient's characteristics. The provider group should receive payment bonuses or penalties based on patient outcomes, satisfaction, and utilization of major acute care services, and patients should receive incentives to use higher quality/lower-cost providers and to adhere to processes needed to insure good outcomes.*
- **For preventive care**, if health care providers continue to be paid on a fee-for-service basis, fees should set at levels sufficient to cover time spent counseling patients, encouraging compliance with health maintenance regimens, etc. Alternatively, a single health care provider could be paid an annual Preventive Care Management Payment to cover a full range of preventive care services for a patient, with the amount of the payment adjusted for the age and risk of the patient. Providers should receive payment bonuses for encouraging patients to

* This model is adapted from the concept described in "Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care," by Allan H. Goroll, Robert A. Berenson, Stephen C. Schoenbaum, and Laurence B. Gardner, *Journal of General Internal Medicine*, 2007.

use preventive services and for improving patient outcomes, and patients should receive incentives for using preventive care services.**

- For patients with a major acute episode**, a single Episode of Care payment should be paid to a group of health care providers – including all of the hospitals, physicians, home health care agencies, etc. involved in the patient’s care – to cover all of the services needed by the patient from initial diagnosis of their condition to completion of treatment for that condition, instead of those providers being paid separately and the physicians being paid on a fee-for-service basis. The amount of this “bundled” payment should vary based on the patient’s characteristics. The provider group should receive payment bonuses or penalties based on the outcomes of the patients they care for, and patients should receive incentives to use higher-quality/lower-cost providers and to adhere to processes needed to insure good outcomes.***

Key Elements Of Better Health Care Payment Systems	
Instead of:	Payment Systems Should:
Paying separate fees for each individual service provided	Make a single payment to cover the full range of services required for good quality care
Paying each health care provider separately, with no coordination	Make a single payment to all providers involved in a patient’s care
Paying inadequately for time spent counseling, educating, and monitoring patients	Pay providers adequately for time spent counseling, educating, and monitoring patients in order to improve patient outcomes
Paying the same for a specific service regardless of the complexity of the patient’s needs, while paying for multiple services that may not be needed	Vary payment levels depending on a patient’s age, risk level, and other characteristics affecting the cost of care
Paying for a service regardless of the quality of the service provided or the outcomes achieved	Pay for services with a demonstrated relationship to desired outcomes, and give providers payment bonuses and/or penalties based on the outcomes they achieve for their patients, the satisfaction levels of the patients, and the patients’ level of utilization of other health care services
Charging patients the same copayments for services regardless of their relative value, and paying for additional services required because patients don’t comply with preventive care	Give patients incentives for using higher-quality, lower-cost providers and for adhering to processes needed to insure good outcomes
Having health care providers make decisions about treatment options with little or no involvement of the patient	Give providers incentives for providing information to patients on the benefits, costs, and risks of treatment options and for involving patients in decision-making

** The alternative model is similar to the payment concept for an Advanced Medical Home proposed in *A System in Need of Change: Restructuring Payment Policies to Support Patient Care*, by Neil Kirschner and Robert Doherty, American College of Physicians, 2006.

*** The model described here is similar in many ways to the proposal in *PROMETHEUS: Provider Payment for High Quality Care; A White Paper*, by Prometheus Payment, Inc.

What is Needed to Implement Payment Changes?

Moving from the current payment systems to these proposed new payment systems will be complex and challenging endeavors. But participants at the NRHI Summit agreed that this transition was essential in order to achieve efficient, effective, and sustainable improvements in the quality and costs of the health care system, and they made several recommendations as to how the concepts outlined above should be advanced towards implementation:

- **Payment systems need to be improved without increasing overall healthcare costs.** In light of the deep national concern about the affordability of health care, payment changes need to be developed in ways which do not increase health care spending, and ideally decrease it. Many studies have shown high levels of waste and unnecessary services in healthcare systems, and establishing payment systems which encourage the reduction of waste and unnecessary services could reduce health care costs as well as improve quality. In several areas, increases are needed in the amounts paid for certain services, such as preventive services and care management for people with chronic diseases. Although it is believed that encouraging provision of these services in a quality way will reduce utilization of other, more expensive services, it will be important to have explicit measures of how utilization of other services is changing and to have rewards/penalties for cost reductions/increases elsewhere in order to avoid having payment reform result in even higher healthcare costs. However, it is also important to consider the time period in which costs are measured – some changes in practice, such as many prevention programs, might require increases in spending in the short run but result in reducing spending in the longer-run. Moreover, the transition to a new payment system and to the organizational structures needed to support it, even if it reduces costs and improves quality in the long run, will likely require significant transition costs for both payers and providers.
- **The goals of payment system changes need to be clearly defined.** Changes in payment systems are not ends in themselves, but means to achieving improved health care quality and lower costs. The success of a new payment system, therefore, is not determined by whether it is implemented as designed, but by whether it achieves the goals that were intended. Consequently, it is essential that clear goals – in terms of improved quality, reduced cost, or both – are established as part of any change in payment systems.
- **Pilot tests and demonstrations of new payment systems should be developed, implemented, and evaluated** in order to make progress on payment reform. Even where there is agreement on the general structure of improved payment systems, there are many details to be worked out; in other cases, there is insufficient knowledge or experience to identify the preferred option. There will likely be unintended consequences and unexpected difficulties that need to be identified and rectified before broad-based implementation is warranted, and there will likely be differences in the structure of payment systems needed from region to region in response to differences in the number and type of providers available. Consequently, a wide variety of payment demonstrations are needed.

- **Demonstrations should be developed and implemented at the regional level.** Health care is a fundamentally regional enterprise, since most payers and providers operate exclusively or primarily in metropolitan regions or states. However, this does not mean that payment reform should be a parochial enterprise – regional initiatives across the country should work to coordinate their efforts, and national organizations should support the development, evaluation, and replication of regional payment demonstrations.
- **Incentives should be aligned across multiple payers within the constraints of anti-trust laws.** It is difficult, if not impossible, for health care providers to redesign their processes of care to respond to improved payment system incentives if only a small subset of payers change their approach to payment. Moreover, if most payers change payment systems in ways that are similar but different in the details, it will be more difficult and expensive for providers to respond. Although having multiple payers and multiple providers agree to use the same payment structure would still allow competition on price, it will be important to insure that discussions and agreements on changes in payment systems are carried out in ways that are permissible under federal and state anti-trust laws.
- **Regional Collaboratives should take the lead in payment restructuring wherever possible.** Because both payers' payment systems and providers' processes of care need to change in order to achieve the goals of improved quality and reduced cost, a neutral convener can help to reach consensus on payment system changes that are workable for both payers and providers as well as patients. Regional health care collaboratives, where they exist, can play a key role in finding win-win solutions for payment reform.
- **Improvements should be made in provider capacity and coordination as well as in payment systems.** The ability to implement many improvements in payment systems will be dependent on having providers operating in a coordinated fashion with the capacity to do sophisticated patient care management. Conversely, the ability and willingness of providers to coordinate their efforts and improve patient care will depend on having supportive payment systems. Consequently, in addition to developing demonstrations of payment system changes, there will also need to be efforts to encourage and assist providers to make investments in improved care management infrastructure (e.g., staffing and information systems) and to enter into coordination agreements with other providers for both payment and quality improvement.
- **Improvements will be needed in outcome measurement and risk adjustment mechanisms.** Creating payment systems that focus more on outcomes will require improved systems of measuring outcomes and improved systems of categorizing different levels of patient risk and severity associated with different levels of healthcare services required to achieve those outcomes. Although research programs and consensus-building systems for this exist at both the regional and national levels, the scope and speed of these systems will likely need to be increased in order to support improved payment systems.