nrhi Network for Regional Healthcare Improvement

Robert Wood Johnson Foundation

From VOLUME to VALUE

Transforming Health Care Payment and Delivery Systems to Improve Quality and Reduce Costs

NRHI Healthcare Payment Reform Series

EXECUTIVE SUMMARY

Recommendations of the 2008 NRHI Healthcare Payment Reform Summit

A major cause of the quality and cost problems in health care today is that payment systems encourage *volume-driven* health care rather than *value-driven* health care. Under current payment systems, physicians, hospitals and other health care providers have strong financial incentives to deliver *more* services to *more* people but are often financially penalized for providing *better* services and *improving health*. Research has shown that more services and higher spending do not result in better outcomes; indeed, they often produce exactly the opposite result.

Fortunately, many people now believe that there are better ways to pay for health care—ways that give health care providers more responsibility for increasing quality and controlling costs of services without penalizing them financially for treating sicker patients. "Episode-of-care payment" systems involve paying a single price (a "case rate") for all of the services needed by a patient for major acute episodes, such as a heart attack or a hip replacement, regardless of which providers are involved instead of multiple fees for each specific service provided. "Risk-adjusted global fee" and "condition-specific capitation" systems go a step further, paying health care providers a single fee for all of the outpatient care needed by their patients, particularly those with chronic diseases, in ways that reward the providers for keeping their patients healthy and for reducing duplicative and unnecessary health care services. (For more detail about these new payment systems, see "Better Ways to Pay for Healthcare" by Harold D. Miller, a report prepared for the 2008 Summit on Healthcare Payment Reform convened by the Network for Regional Healthcare Improvement and a part of the NRHI Healthcare Payment Reform Series.)

Implementing these kinds of improvements in payment systems holds significant promise for improving the quality and reducing the cost of health care. But there are a number of important issues that need to be addressed and a variety of challenges that need to be overcome in order to move these improvements from concept to reality. In particular:

- Which health care providers, if any, are able and willing to accept new payment structures and deliver value-based care?
- How should the use of high-value providers and services be encouraged? What protections are needed to ensure appropriate quality for patients?
- How can payers and providers be encouraged to participate in new payment and delivery systems? How similar do different payers' systems need to be?
- What kinds of pilot projects are needed to test new payment systems?
- What community-wide structures are needed to support payment reform?

More than 100 health care leaders from across the country—physicians; hospital administrators; health plan executives; academics; foundation leaders; regional coalition directors; federal, state and local government officials; executives of health care quality improvement organizations; and others engaged in efforts to move towards a more value-driven health care system—participated in the 2008 Summit on Healthcare Payment Reform convened by the Network for Regional Healthcare Improvement. Participants in the summit discussed these issues and challenges, and they made a series of recommendations to help address them.

Payment Systems and Organizational Structures Needed to Improve Primary Care

There is growing agreement that there need to be significant improvements in the way America both delivers and pays for primary care services. For example, many states, regions, payers

and providers are trying to improve the quality of primary care delivery by implementing the principles of the "patient-centered medical home" that were developed by a number of physician organizations. The basic concept of a medical home is that each patient has an ongoing relationship with a personal physician and a team of other health care professionals who collectively take responsibility for providing or arranging for all of the patient's health care needs in a coordinated way. Other concepts, such as the chronic care model, are also being pursued. However, most primary care providers cannot make the changes in care delivery envisioned in these models without improved payment systems to support them. Additionally, payers want assurances that the providers will reduce costs and/or improve quality before changing payment systems. How should both payment systems and provider structures evolve to meet these goals?

Recommendation 1.1: Payers should not require primary care providers to meet rigid certification or accreditation standards in order to participate in improved payment systems, but should instead encourage innovations that improve outcomes and control or reduce costs.

Recommendation 1.2: Payers should phase in changes to payment systems to support the changes in primary care needed to improve quality and cost outcomes, beginning with enhanced fees and moving toward more comprehensive payments.

Provider Organizational Structures Needed to Manage Bundled Payments and Warranties in Major Acute Episodes

A true episode-of-care payment system for major acute care involves paying a single price for all services delivered by all providers involved in a patient's care. But combining the services of hospitals, physicians and post-acute care providers into a single payment—known as "bundling"—presumes the existence of an entity that can serve as the recipient of the single payment and divide it among the individual providers in a manner acceptable to those providers. Episode-of-care payment also envisions the provision of warranties—commitments by health care providers to address errors or complications without charging for additional services—but this increases the challenges associated with bundled payments because of the difficulties of apportioning responsibility for the errors or complications among the multiple providers involved. What kinds of organizational structures can support payment bundling, and how can both payment systems and health care organizations evolve to achieve these goals?

Recommendation 2.1: Payers should make bundled payments to provider organizations and partnerships that demonstrate the capacity and expertise to manage the full episode of care and the associated payments.

Recommendation 2.2: Payers, providers, regional collaboratives and other organizations should take steps to facilitate the transition to bundled payments, including public reporting about the total cost of care, providing technical assistance to providers, and making transitional changes to payment systems.

Recommendation 2.3: Restrictions on providers' ability to divide bundled payments among themselves should provide an appropriate balance between protecting patients and encouraging innovation and should ensure a level playing field for negotiations among providers.

Encouraging Use of Higher-Value Providers and Services

In order to have a more value-driven health care system, payment systems need to assist and encourage patients to use higher-value providers and services. A provider delivers "higher value" if it delivers the same quality of services

as another provider but at a lower cost or if it delivers higher-quality services at the same cost. When there are multiple providers that can deliver the care a patient needs or when there are different types of services available that vary in effectiveness or cost, how should payment systems encourage consumers to use the higher-value providers and services?

Recommendation 3.1: Consumers should have choices about which health care provider to use, but they should be required to pay significantly more if they choose lower-value providers when higher-value providers are available.

Recommendation 3.2: Consumers and providers should have valid and understandable information on the relative value of different options for diagnosing or treating a health condition, and consumers should be required to pay more if they choose lower-value options.

Protecting Patients in New Payment Systems

Episode-of-care and condition-specific capitation systems give health care providers greater responsibility for managing the overall cost of a patient's care. However, in doing so they also may provide a greater financial incentive for the provider to inappropriately limit services—particularly those services whose preventive value will manifest many years in the future—or refuse to care for patients who appear likely to have poor outcomes within a severity-adjusted category. How should patients be protected under such payment systems?

Recommendation 4.1: Health care providers should be required to deliver essential, evidence-based services to patients —unless the patients refuse—in order to receive payment and should be required to report publicly on the level and quality of services provided to patients, particularly to minority and disadvantaged populations.

Recommendation 4.2: A combination of effective severity/risk adjustment mechanisms and outlier payments must be included in new payment systems to protect both patients and providers.

Recommendation 4.3: Patients should receive financial incentives to use high-value preventive services and to adhere to effective care processes.

Piloting Payment Systems

Even where there is agreement on the general structure of improved payment systems, there are many details to be worked out and there is always the risk of unintended and unanticipated consequences. Pilot projects provide the opportunity to test new payment systems and their components so that refinements can be made before widespread implementation. However, there are also significant costs and challenges associated with organizing pilot projects. How should pilot projects be designed in order to most effectively advance the creation of value-driven payment systems?

Recommendation 5.1: Pilot projects for new payment systems should be designed to gain experience with care changes that will both improve quality and reduce or control costs.

Recommendation 5.2: Pilot projects should support care changes that can benefit large numbers of patients but should focus on specific patients and conditions with significant potential for improvements in value.

Recommendation 5.3: Pilot projects should phase in provider participation, beginning with the most interested and capable providers.

Recommendation 5.4: Pilot projects should be expected to provide aggregate cost

savings within two to three years, but higher expenditures may be needed initially.

Recommendation 5.5: Participation by a critical mass of payers is essential to the success of pilot payment reform projects.

Encouraging Payers and Providers to Support New Payment Systems

Although there is growing agreement that fundamental reforms in payment systems are needed to solve the problems that exist in health care today, payers, providers, purchasers, and patients will all likely worry about the cost, effort, and potential negative consequences to them in transitioning to new payment systems and care delivery models. How can or should these concerns be mitigated? How can the inertia of existing systems be overcome? And if new payment systems achieve savings, who will gain and who will lose?

Recommendation 6.1: Purchasers of health care and health insurance must demand changes in payment systems that support high-value health care.

Recommendation 6.2: Hospitals and specialty providers should begin planning now to adapt to the changes resulting from value-driven health care.

Recommendation 6.3: Assistance should be provided to small physician practices to help them adapt to the changes resulting from value-driven health care.

Community-Wide Structures Needed to Support Payment Reform

Markets other than health care have a variety of structures to facilitate and regulate transactions among market participants and to protect consumers, e.g., consumer protection bureaus, financial rating agencies, etc. These structures and systems are independent of individual buyers and sellers but are designed to support them in their dealings in the marketplace. Similarly, many of the structures and activities needed to facilitate the transition to new health care payment systems are not specific to any one payer or provider and could be supported by regional, state, and national organizations other than payers and providers. A particular challenge in health care is finding ways to enable payers to align their payment systems without fear of violating antitrust laws.

Recommendation 7.1: Neutral public-private organizations at the regional or state level should encourage and assist payers to align their payment structures.

Recommendation 7.2: Systems for reporting on the quality and cost of health care providers and services should be established at the regional or state level in order to help payers and consumers identify higher-value providers and services, but the methodologies used should be consistent across the nation to the maximum extent possible.

Recommendation 7.3: Aggressive efforts are needed to educate consumers about the critical need for new payment systems and more value-driven care and to actively involve consumers in the process of designing and monitoring implementation of changes in payment and care.

Supporting Regional and State Payment Reform Efforts

The systems for delivering and paying for health care differ dramatically from region to region, so initiating payment reforms at the regional or state level is appropriate. What kinds of national support should be provided to facilitate the development, evaluation, and replication of regional payment reforms?

Recommendation 8.1: The federal government should provide funding to support

regionally defined pilot projects and should authorize participation by Medicare.

Recommendation 8.2: The Network for Regional Healthcare Improvement should support regions in pursuing payment reform through information sharing and advocacy.

Moving From Concept to Reality

Major changes in health care payment systems are essential in order to achieve the kinds of improvements in health care quality and reductions in costs that the nation badly needs. These changes will require a significant investment of time and effort by all participants in the health care system, and these participants will face a number of significant challenges. However, as the recommendations above demonstrate, there are ways to overcome the challenges.

Ultimately, the ability to make the changes in both payment systems and health care delivery that are envisioned here will depend on the support and engagement of all of the stakeholders in the health care system—citizens, payers, providers, purchasers, regional coalitions, government officials, and others. The extensive and enthusiastic participation of so many stakeholders in the NRHI summits, and their ability to reach consensus on the types of bold recommendations described in this report, should be a cause for optimism that the kind of support and interest needed for true reform of health care payment systems may now be in place.

We thank the Robert Wood Johnson Foundation for its support in developing this series.

This report is an Executive Summary of the full set of recommendations made at the 2008 NRHI Healthcare Payment Reform Summit. Visit www.nrhi.org to access detailed versions of the recommendations in the full report.

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