



Payment and Delivery System Reform: Creating Conditions for More Efficient and Effective Health Services

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Conference Report

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The Health Industry Forum is based at Brandeis University, chaired by Professor Stuart Altman, and directed by Robert Mechanic. The Forum brings together public policy experts and senior executives from leading healthcare organizations to address challenging health policy issues. The Forum conducts independent, objective policy analysis and provides neutral venues where stakeholders work together to develop practical, actionable strategies to improve the quality and value of the US healthcare system.

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Health Care Payment Reform: What Went Wrong in the 1990s and What's Needed to Make it Work Today

Presenter: **Stuart Altman, PhD**, Dean, Heller School, Brandeis University

Overview

Slowing the long-term rate of growth in health care spending will require significant delivery system reforms and movement away from fee-for-service reimbursement towards new models such as pay-for-performance, case rates, and capitation. Although the US health care system has experimented with payment reforms in the past, no approach has proven sustainable. The challenge moving forward will be committing to a (perhaps imperfect) model before the system collapses under the weight of its cost burden.

Context

Dr. Altman presented an historical overview of the nation's health care cost crisis, and offered suggestions for restructuring the reimbursement system to improve health system efficiency and quality.

Key Takeaways

- **Relentless growth in US health care expenditures threatens the stability of the entire system.**

U.S. per capita health spending has been rising 2% faster than inflation for the past 40 years. Despite efforts to change this trend, politically powerful health system stakeholders have successfully maintained the status quo.

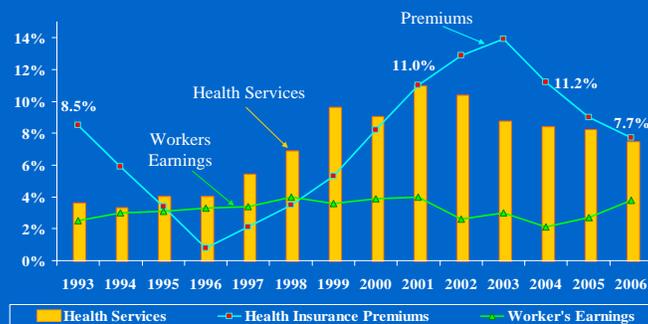
The extent of the health cost problem becomes apparent when viewed in the context of premium and wage growth. While premium growth was below the cost trend through the managed care era, premiums have since risen sharply. Today, premiums are growing at the same rate as health spending, and both are growing much faster than wages. It is unclear how much longer this large gap between premium and wage growth can continue before the system begins to melt down.

- **Unprecedented growth in health premiums is driving the nation's insurance coverage crisis.**

Not surprisingly, the growth in premiums has resulted in a decline in the percentage of workers covered by employer-based coverage and an increase in the percentage of uninsured Americans. In 2001, 65% of workers were covered by employer-based insurance; by 2007, that figure dropped to 59%.

For a family of four at the median income level, health insurance premiums currently represent 16% of their income (up from 4% in the 1970s); that figure increases to 59% for families living at the poverty level. Future projections are staggering: if premiums and wages continue to grow at their historical rates, by 2017,

Health Insurance Premium Growth Now Equals Underlying Health Expenses --- Both Are Significantly Higher Than Wage Growth?



premiums would represent almost 30% of median income for a family of four, while premiums would exceed total income for families at poverty level—clearly an unsustainable scenario.

Data from the Dartmouth Atlas of Health Care show significant variation in health spending across geographic areas and researchers have demonstrated that quality is actually lower, on average, in the higher spending regions. There are also significant variations in the cost of care for patients across health systems. Those with the highest spending have higher rates of hospital days, ICU days, and specialist visits. Similarly, higher use in systems is not correlated with higher quality; some systems with the lowest utilization (for instance, Cleveland Clinic) deliver superior clinical outcomes.

- **A historical perspective shows that multiple diverse approaches to cost control have been unsuccessful.**

The American health care system has gone through multiple cycles. Although the regulatory mechanisms imposed by government in the 1970's controlled expenditures in the short term, the gains disappeared in the 1980's when the Reagan administration brought about a more deregulated, market-driven system.

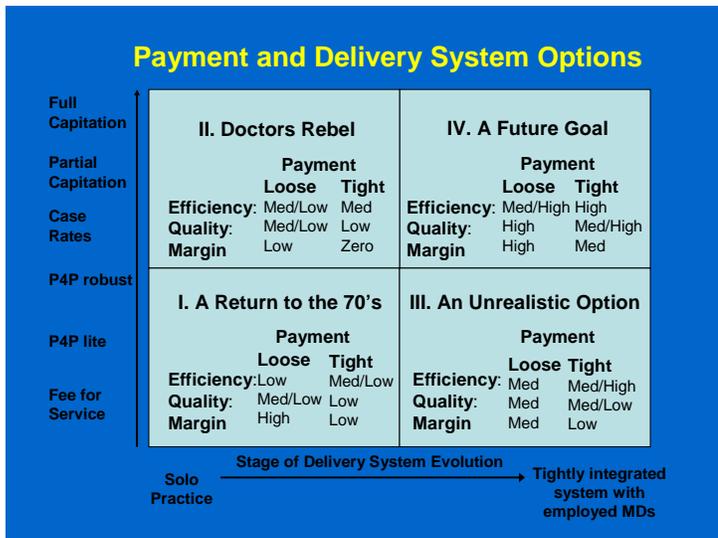
Growth in spending was once again moderated in the early 1990's with the widespread adoption of managed care, but this success was short-lived due to the unpopularity of managed care controls. Real spending growth today stands at unprecedented rates, even greater than during the 1980s. This historical view suggests that real change is extremely challenging. Progress will require the nation to make difficult choices, including a major restructuring of the payment system.

"There are a lot of things we can do to control costs. The question is whether we are willing to sustain them."

— Stuart Altman

▪ **Restructuring the payment system is necessary but not sufficient; also needed is delivery system reform.**

To shed light on where the health care system has been and what might transpire in the future, Dr. Altman presented the graph with four quadrants shown below.



Each quadrant reflects the market dynamics likely given the extent of delivery system integration (x-axis) and payment system integration (y-axis).

- **Quadrant I: Return to the '70s.** In this scenario, the payment system remains fee-for-service and there is no change in the current integration of the delivery system.
- **Quadrant II: Doctors Rebel.** In this scenario the payment system evolves toward capitation but the delivery system remains fragmented. Many providers have difficulty managing in a capitated environment leading to financial losses and rising dissatisfaction.
- **Quadrant III: An Unrealistic Option.** In this scenario the payment system remains fee-for-service, but the delivery system integrates. This is unrealistic because providers would have little incentive to integrate and even integrated providers would have little incentive to reduce unnecessary utilization.
- **Quadrant IV: A Future Goal.** This is the desired future state with payment evolving toward capitation and delivery systems becoming highly integrated.

Evolving from one quadrant to the next impacts three vectors: efficiency (in the delivery of care), quality (of the care provided),

and provider margins. Moving from Quadrant I to II, efficiency improves but some providers face sharp margin declines (which is what caused physicians to rebel in the mid-1990s). Moving from Quadrant I to III would yield efficiency gains and margin improvements, but substantially less than if payment was more integrated. Quadrant IV signifies health system "nirvana," characterized by high levels of efficiency, quality, and profitability. Unfortunately, today's health care system is nowhere near this state.

Over time, only Quadrants I and IV are sustainable; and Quadrant I may not be sustainable without substantial reductions in provider payment rates. Moving toward capitation without integrating the delivery system will only alienate physicians, while fully integrated systems operating under a fee-for-service model will not optimize care coordination or efficiency.

▪ **Health system reform must begin with payment reform.**

The current fee-for-service payment system must be substantially modified or abandoned in order to enable significant delivery system restructuring. Fee-for-service not only leads to inefficiency and waste, but encourages aggressive competition between hospitals and physicians, discourages collaboration, and leads to distorted pricing structures.

There are several options for changing the payment system:

- Bundled or case payments.
- Significant pay-for-performance add-ons or penalties.
- Value-based payments.
- "Gain sharing" between hospitals and doctors.
- Employing physicians.

Whatever the model, it is critical to align incentives between physicians and hospitals, and to integrate the delivery system.

"There's war out there . . . between the doctors and the hospitals. And it is a war that is not productive . . . We need to change that."

— Stuart Altman

Other Important Points

- **Employed physicians.** Compared to five years ago, a greater percentage of health systems employ physicians. While some employment models work extremely well (e.g., Mayo, Geisinger, Cleveland Clinic), others have failed. Dr. Altman does not believe that employing physicians is the long-term solution to the cost problem. He noted that models where physicians are employed are most effective when salaries are complemented with significant performance incentives.

Case Study #1: The Role of Payment Reform in a Multi-Year Health Care Transformation Initiative in Massachusetts

Presenter: **Andrew Dreyfus**, Executive Vice President, Blue Cross Blue Shield of Massachusetts
Jeffrey Levin-Scherz, MD, MBA, Assistant Professor, Harvard School of Public Health

Overview

Blue Cross Blue Shield of Massachusetts (BCBSMA) is attempting to implement a systematic strategy for transforming the health care system that will address the rapid growth in health spending and variable quality. BCBSMA's multi-year strategy will engage health care providers, legislative leaders, and the general public. An important component of the strategy is an alternative payment model based on a health status-adjusted, global payment with significant financial incentives for quality.

Context

Mr. Dreyfus described BCBSMA's approach to transforming health care in Massachusetts, and shared a new model for payment. Dr. Levin-Scherz offered a provider perspective on payment reform.

Key Takeaways

- **The two largest problems in today's health care system are variable quality and uncontrolled costs.**

Patient care suffers from wide variability in quality across markets, within markets, and even within highly regarded provider systems. Data suggest that the "right" care is delivered only about 50% of the time.

"Our health care system can work effectively, heroically, compassionately . . . but it also can be insensitive, ineffective, and harmful."

— Andrew Dreyfus

Unsustainable growth in medical costs has created an economic imperative for transforming the health system. For example, BCBSMA's medical cost trend is growing five times faster than workers' earnings and four times faster than the rate of inflation.

Mr. Dreyfus believes that both the quality and cost problems can be addressed with the same solution—better care. Consistently delivering clinically appropriate, evidence-based care can improve patient outcomes and slow health spending. This has been illustrated by the CMS/Premier Quality Demonstration Project, which shows that hospitals providing the highest quality of care (both process and outcomes measures) are also the least expensive.

- **Despite deep systemic health system problems, few significant systemic solutions have been pursued.**

Although all stakeholders in health care agree that the system is flawed, there has not been a "call to arms" demanding change. The system is stuck. There are several reasons for this:

- *Cognitive dissonance.* The public is divided and confused about the quality of health care. For example, most people in Massachusetts love their local health care provider but are distrusting of health care organizations in general.
- *Conflicts with physician training and beliefs.* The "quality movement" is in conflict with physicians' expectations of autonomy, independence, and significant financial reward.
- *Misaligned incentives.* The payment system still rewards *more* care, not *better* care. Most payers pay an equal amount of money for a service whether outcomes are good or poor.
- *Lack of leadership.* There is simply not sufficient will, coordination, and vision among the nation's health care leaders to tackle this enormous problem. As was the case with issues like tobacco use and HIV/AIDS, it may take years to change the national perspective on the need for improvements in health care quality and safety.

- **BCBSMA is optimistic that transformational change can occur in Massachusetts over the next decade.**

BCBSMA's Transformation Vision: 2016 envisions a health care system that provides safe, timely, effective, affordable, patient-centered care for everyone in Massachusetts. To achieve this goal, BCBSMA has identified seven levers where simultaneous, sustained pressure for change could result in system transformation. They are:

1. *Governance.* To improve health care quality, trustees of health care delivery organizations must view themselves as accountable for their organizations' clinical performance in the same way they are accountable for financial performance.
2. *Quality and safety.* The state needs a single set of evidence-based quality and safety measures to support quality-based payment systems.
3. *Technology.* Broad access to clinical information technology, including electronic medical records with decision support, is needed to connect providers and health plans.
4. *Public engagement.* Consumers and health care purchasers must demand improved performance from the health care system, and become more informed, active health care decision makers.

"Until patients are engaged, the system won't change."

— Andrew Dreyfus

5. *Organizational readiness.* Provider organizations and health plans must be prepared culturally and organizationally to put safety and reliability first.
6. *Legislative and regulatory change.* As Massachusetts has passed a revolutionary law expanding health coverage, similar legislative and regulatory actions must be taken to fundamentally improve quality and safety, and to reduce cost.
7. *Finance and payment.* Most importantly, health care purchasers must develop a payment system that promotes quality, safety, and appropriate care rather than quantity or intensity of services.

"The payment system is the single most important lever that health care purchasers have to change health care."

— Andrew Dreyfus

▪ **BCBSMA's new model offers a health status-adjusted, global payment with significant incentive payments.**

Recognizing the need to go beyond traditional P4P, BCBSMA has established an Alternative Quality Contract (AQC) with the following goals:

- *Quality and total cost.* BCBSMA wants to encourage hospitals and doctors to take responsibility for the quality and cost of care and to innovate around new care delivery models.
- *Integration.* With the goal of more patient-centered care, BCBSMA will reward integration across the care continuum.
- *Performance drivers.* BCBSMA plans to tie payment to quality, safety, efficiency, and patient-centeredness goals.
- *Plan designs.* BCBSMA will offer new plan designs to drive volume to high-quality providers and improve transparency.
- *Member incentives.* BCBSMA will create incentives for members that align with goals of improved quality and healthy behavior.

The AQC is structured as a five-year contract. In year one, payment is a global rate based on the regional network average adjusted for patient health status, plus a performance-based payment based upon a set of pre-defined measures (including outcomes, process, and patient experience measures).

Each year, the global payment is increased by an inflation factor and adjusted for changes in health status. Provider organizations can earn up to 10% in incentive payments by reaching the highest level of performance.

The AQC's goal is to generate value for all stakeholders. Providers who achieve high quality and efficiency will realize increased volumes and higher margins. Employers will benefit from more affordable premiums and predictable cost increases. BCBSMA will

fulfill its promise to focus on patients' health. This system will help members become more informed consumers and will offer incentives for wellness and compliance with evidence-based care plans.

▪ **Payment reform must take physicians' goals and perspectives into consideration.**

According to Dr. Levin-Scherz, physicians have their own set of goals for payment policy. They want: payment for the value they deliver (not the unit of service); accountability for what they—not patients—control; incentives that are aligned with patient needs; simple financial arrangements; and prompt payments. They also want full risk adjustment, in theory, although are less avid if it does not validate their belief that their patients are "sicker than average". Physicians also want to minimize non-value-added work, and health plans can gain some traction by avoiding imposing additional hassles. Physicians in organized groups want to limit health plan medical management, although many physicians are in groups without the scale to do medical management themselves.

Dr. Levin-Scherz's suggested that it would be optimal for payer contracts to include fee-for-service payments for services that are under-utilized and capitated payments for over-utilized services. He also believes that the payment system should focus on achieving reliable and consistently high quality care, rather than fixing problems after they occur. Ideal would be a system that promotes engaged, educated patients who participate actively in their care.

"We need to change the paradigm of how we improve health care . . . we can't continue dealing with defective care after the fact."

— Jeff Levin-Scherz

Other Important Points

- **Applicability outside Massachusetts.** The AQC model has not yet been adopted by other payer organizations, though other Blues plans are exploring similar approaches. Attendees noted that the model is difficult to replicate in markets where physicians work in predominantly solo and small group practices, because these groups do not have the resources necessary to carry out aspects of the model, such as disease management.
- **Capitation by another name?** When an attendee questioned whether the BCBSMA payment model is really just capitation, Mr. Dreyfus pointed out that the AQC model includes two key features designed to address flaws in the capitation model: health status adjustment to ensure that payments are sufficient to cover needed care, and incentive payments for quality performance, to guard against undertreatment.

Case Study #2: ProvenCareSM — Establishment of Evidence-Based Case Rates at Geisinger Health System

Presenter: **Bruce Hamory, MD**, Executive Vice President, Chief Medical Officer Emeritus, Geisinger Health System

Overview

Geisinger Health System, a large integrated delivery system in Central Pennsylvania, has begun experimenting with payment methodologies outside of traditional fee-for-service or capitation. Supported by a system-wide electronic health record (EHR) and a provider-owned health plan, GHS has implemented a provider-driven process for improving surgical outcomes that includes a global payment for 90-day episodes of care – in effect providing a “warranty” for the cost of complications and readmissions. Through this approach, combined with efforts to engage patients in their treatment and implement systematic post-discharge follow-up, GHS has achieved lower mortality, complication, and readmission rates. This approach has also provided financial benefits for the system, through reduced length of stay, increased net revenue and higher margins.

Context

Dr. Hamory presented Geisinger Health System's approach to redesigning care delivery through global case rate payments and evidence-based guidelines.

Key Takeaways

- **Geisinger's unique integrated health service model and market position allow experimentation with innovative financial arrangements.**

Geisinger Health System (GHS) is a fully integrated health service organization in rural Pennsylvania covering a population of 2.6 million. GHS is organized as a “hub and spoke” model, with tertiary/quaternary medical centers, specialty hospitals, ambulatory centers, multi-specialty group practices, and owned primary care practices. In addition to its health system, Geisinger Health Plan (GHP) covers 210,000 members under HMO, PPO, and Medicare Advantage products.

There is significant overlap between GHS and GHP; approximately 30% of GHS patients are GHP members (meaning that 70% of the patients GHS treats are covered by non-GHP payers), and 50% of GHP members are treated at GHS primary care clinics. Owning physician practices along with a health plan allows Geisinger to pursue a “hedging” strategy, where the risk of adopting innovative financing arrangements is shared among both entities.

- **Geisinger's electronic health record is a strategic tool for delivering excellent care and strong financial results.**

To support system integration, in 1995, Geisinger implemented an enterprise-wide electronic health record (EHR) linking its

hospitals and practice sites. Real time data from the EHR is an essential tool for managing resources and monitoring clinical quality. In addition to its employed physicians, Geisinger provides EHR access to affiliated community physicians. Patients also benefit; 90,000 are now active users of MyGeisinger, a Web portal that provides patient access to portions of their health records, including lab work, a problem list, current medications, and allergies. MyGeisinger also allows for appointment scheduling and prescription renewals.

- **Geisinger has embarked upon a transformation plan to address unjustified variation, fragmented care, and perverse payment incentives.**

Geisinger's vision for the next five years is to “strive for perfection.” This includes focusing on quality, innovation, market expansion, and training the next generation of clinicians. To achieve this vision, a transformation plan is in place with three main areas for improvement:

- *Unjustified variation.* Even though GHS delivers efficient care, there is still significant variation among physician groups.
- *Fragmentation.* Geisinger interfaces with many local providers and handoffs at care transitions can be complicated.
- *Perverse payment incentives.* The majority of GHS's revenues come from payment models that reward increases in units of work rather than outcomes.

- **Geisinger's provider-driven, pay-for-performance program is a key component of its transformation initiative.**

ProvenCareSM is a provider-driven, evidence-based, pay-for-performance (P4P) program predicated upon delivering consistent, patient-centered, outcome-focused care.

“Our goal is to routinely deliver exactly the same care to every patient with the same condition or . . . procedure, mitigated only by what that particular individual may require.”

— Bruce Hamory

The distinguishing element of this program is that GHS accepts financial responsibility for quality. Specifically, GHS receives a global payment for specific procedures such as CABG and all related services for a 90 day episode that includes any related complications, readmissions, or follow-up care. The global fee calculation reflects a 50% reduction in historical complication rates, creating strong incentives to reduce readmissions.

ProvenCareSM is different from traditional P4P programs. It is provider-imposed and inpatient specialty care focused, with significant financial incentives for quality. The program requires

that patients and families to participate actively as partners in the care process.

▪ **ProvenCareSM has been successful with CABG and is now being expanded.**

Geisinger chose CABG as the starting point for ProvenCareSM because: there were well established evidence-based guidelines; the procedure was performed by a small group of motivated clinicians with an effective leader; it had high CABG volume; the procedure was financially important; and Geisinger's baseline performance (readmission and complication rates) was already strong.

To establish best practices, Geisinger created a "guideline team" of cardiologists and cardiac surgeons to review the existing American College of Cardiology (ACC) and American Heart Association (AHA) guidelines and translate them into bundles of clear, actionable steps. Geisinger's Clinical Effectiveness team then worked with surgeons to assess existing care processes, which revealed significant variation among surgeons.

To engage patients, Geisinger created a "patient compact" to explain what the procedure entailed and what was expected of patients (e.g., smoking cessation, weight management). In addition, Geisinger standardized and simplified patient educational materials.

After ProvenCareSM was implemented for CABG, the percentage of patients' care that followed the entire bundle of evidence-based practices increased from 60% to 100% in just a few months. In addition, there were substantial reductions in complications, and readmissions rates. ProvenCareSM also improved financial performance because length of stay fell while revenue and contribution margin grew.

An important aspect of ProvenCare'sSM financial success is that GHS operates at capacity with significant excess demand. As it reduces length of stay and readmissions, the program frees up capacity for new patients, generating additional revenues.

"This is much better for the patient, better for doctors . . . better for the hospital, better for the insurer, and as the insurer passes on the savings, better for the customer."

— Bruce Hamory

Results were so impressive that surgeons have expanded ProvenCareSM into additional procedures such as angioplasty, cataract surgery, hip and knee replacements, bariatric surgery, and administration of biologics like erythropoietin. Suitability of ProvenCareSM to other areas depends on:

- Tight operational linkage of physicians with the hospital.
- Provider consensus on guidelines, particularly "off-the-shelf" national recommendations as a starting point.
- Real-time measurement and feedback of performance data.
- Alignment of financial incentives among patient, provider, purchaser, and payer.

Although the ProvenCareSM payment system is only used currently for Geisinger Health Plan members, ProvenCareSM best practices have become the standard of care for all patients.

Other Important Points

- **Potential limitations.** The extent to which ProvenCareSM is scalable, applicable to environments without an integrated delivery network or an EHR is uncertain.
- **Support from leaders.** Dr. Hamory suggested that the most important factor behind the success of ProvenCareSM is the GHS culture of innovation and the strength of commitment from Geisinger's leadership.

Quality			
Clinical Outcomes - (18 mos)			
	Before ProvenCare SM (n=132)	With ProvenCare SM (n=181)	% Improvement/ (Reduction)
In-hospital mortality	1.5 %	0 %	
Patients with any complication (STS)	38 %	30 %	21 %
Patients with > 1 complication	7.6 %	5.5 %	28 %
Atrial fibrillation	23 %	19 %	17 %
Neurologic complication	1.5 %	0.6 %	60 %
Acropulmonary complication	7 %	4 %	43 %
Blood products used	23 %	18 %	22 %
Re-operation for bleeding	3.8 %	1.7 %	55 %
Deep sternal wound infection	0.8 %	0.6 %	25 %
Readmission within 30 days	6.9 %	3.8 %	44 %

GEISINGER

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Bringing Innovative Payment and Delivery Reforms to New Markets

Presenter: **Lewis Sandy, MD, MBA**, Senior Vice President, Clinical Advancement, UnitedHealth Group

Discussants: **Robert Galvin, MD**, Director, Global Healthcare, General Electric
Robert Berenson, MD, Senior Fellow, Urban Institute

Overview

Panelists agreed that the current payment system is broken, but that no “one-size-fits-all” approach could be broadly successful. Payment reform must be attentive to local market conditions. Future progress will require significant collaboration between the public and private sectors.

Context

These presenters—representing a major payer, a major employer, and a former CMS official—shared their perspectives on payment and delivery reforms.

Key Takeaways – Dr. Sandy

Dr. Sandy discussed UnitedHealthcare’s (UHC’s) past efforts to control spending and improve quality, described current initiatives, and suggested elements for future payment reforms.

- **UHC’s Centers of Excellence for Uncommon Conditions is one example of delivery network innovation.**

In most medical specialties there is significant variation in the quality and cost of care. More than twenty years ago, UHC established its Centers of Excellence for Uncommon Conditions, a network of mainly academic medical centers for transplant services, congenital heart disease, complex cancer treatment, and end-stage renal disease (ESRD). It is the largest such network in the US, and also contracts with other health plans and self-insured employers. To join the network, centers must meet high performance standards and agree to contracting discounts.

UHC has extensive data confirming the relationship between volume and outcomes; more volume at a center results in improved survival and decreased length of stay. UHC has found it easy to steer patients to centers of excellence, as families are willing to travel for better outcomes. Improving outcomes also requires establishing clear performance measures and effective patient engagement programs. While important, payment policy is only one part of the equation.

- **UHC is engaged in multiple activities to scale payment reform.**

These efforts are based on the realizations that:

- *Most care delivery is not integrated.* While Kaiser, Geisinger, and others are held up as beacons of integrated delivery, these systems are not representative of health care in the US. The modal medical practice is small, fee-for-service, and “loosely coupled” to other providers, if at all.

- *There is significant heterogeneity of delivery “ecosystems.”* Local delivery systems have very different capacities for adapting to new payment methods.

- *Building blocks for improvement are evolving.* These include performance metrics and service bundles. However, most provider groups don’t devote much organizational capacity to improvement.

- *Reforms should anticipate dynamic responses.* Any changes in payment policy will trigger changes in provider behavior.

UHC is moving forward with the following strategies:

- *Performance transparency.* United concluded that the first step towards improved care was quality transparency. Therefore, it is working to gather, analyze, and disseminate performance data for individual providers. Physicians are measured first in terms of quality; those who meet the quality criteria are then measured based on efficiency.

UHC’s program is having positive results. Consumers are accessing the data, some employers are using it for benefit design (i.e. adjusting co-pays based on provider’s ratings), and overall performance is improving.

“Performance transparency drives change in the delivery system.”

— Lewis Sandy

- *Incentive alignment.* UnitedHealth Practice Rewards is a program that provides financial recognition through fee schedule enhancements for practitioners who have met quality and efficiency criteria.

- *Patient-centered medical home.* United has turned the medical home concept into a testable model. This model is based on standards from leading clinician organizations and entails reimbursement that combines fee-for-service with a monthly per member supplement.

- **Future payment strategies will build on lessons learned through previous experience.**

Dr. Sandy laid out a set of considerations for any future payment models. They include:

- *Alignment of incentives.* Payment strategies must align the incentives of all actors—plan sponsors, payers, delivery systems, and consumers.

- *Performance transparency.* Payment must reinforce other performance goals.

- *Administrative feasibility.* A payment strategy must be practical and feasible.

- *Long-term contracts.* Incentives for improved quality, efficiency, and patient experience need to be built into long-term contracts (which United is doing).
- *Episode-based payment.* Payment should ultimately focus on care episodes. Initially, payers might define episodes while still paying fee-for-service. They can then analyze financial and clinical outcomes and share results with providers along with strategies for improvement. Gain sharing programs could be established for providers willing to take risk for episodes. Such a model would create accountability and incentives for “systemness” for independent providers.

Key Takeaways – Dr. Galvin

Dr. Galvin gave his assessment of the payment problem and offered potential solutions.

▪ The current payment system isn't working.

There is broad agreement among employers and other stakeholders that the current payment system is broken. There is also agreement that payment is the main lever for driving better health care.

And, while there is much talk of performance-based payment, the reality is that the portion of health care spending tied to performance is negligible. GE found that less than 1% of its total health care spending is performance-based. Also, the inconsistency of programs among different payers has created a pay-for-performance Tower of Babel.

“For any given physician, performance-based payment is a small percentage of their income . . . and below the cost of change.”

— Robert Galvin

▪ One size payment reform does not fit all.

The appropriate model will depend on local market conditions: Recognizing that one size does not fit all, GE believes that employers can drive change by:

- *Standardizing contract language.* Lack of standards inhibits coordination. Employers need to work together and develop standard contract language.
- *Reshaping the relationship between employers and CMS.* Employers should follow CMS when appropriate, coordinate with CMS when possible, and provide leadership when necessary.

▪ Moving forward with payment reform requires an entity to coordinate public and private sector collaboration.

The public sector has sufficient scale to drive change, but moves slowly and faces challenging politics. The private sector is more flexible and innovative but lacks the volume to bring about payment reform. Thus, both sectors must work together. But there is currently no mechanism for a coordinated payment reform effort.

Dr. Galvin suggested formation of a non-profit Center for Payment Reform (CPR). CPR would:

- Develop a comprehensive strategic framework, laying out the direction for payment reform.
- Coordinate payment reform efforts across sectors and markets.
- Identify and spread best practices.
- Create a national scorecard on payment reform.
- Play a role in shaping public policy.

Without such an entity, it is hard to envision the collaboration needed to move payment reform forward.

Key Takeaways – Dr. Berenson

Dr. Berenson shared his observations based on his previous role at CMS and his current work at the Urban Institute.

▪ Delivery systems are undergoing massive changes even in the absence of payment reform.

In recent interviews with hospital chief medical officers (CMO), Dr. Berenson noted significant activity including new investment in health information technology; use of electronic ICUs, telemedicine; and 24/7 interventionist coverage. To his surprise, most CMOs said that these activities were driven by local clinical champions or an increased organizational focus on quality improvement rather than pressure from payers. The CMOs saw the current DRG system as *supporting* these activities, but not as the catalyst for them.

▪ Medicare can drive significant provider system changes within the context of the current payment system.

Fully 17 percent of Medicare admissions result in readmission within 30 days. Dr. Berenson noted that some hospitals are implementing programs to reduce readmissions because executives believe that “Medicare doesn't pay for readmissions within 30 days.” While a misunderstanding of Medicare policy, this urban legend illustrates the program's power to drive change. Other changes such as gainsharing for reduced readmissions, or physician payments for post-discharge coordination could be implemented under the current system.

Participant Discussion

- **National standards, local techniques.** While multiple speakers indicated that one size payment policy does not fit all, there was agreement that there should be a common set of national performance standards to support local payment policies.
- **Forcing delivery system change.** Dr. Altman's expressed his opinion that no industry wants to change, and that solo practitioners will resist changing in how they deliver care without significant financial incentives to do so.

Federal Policy Options for Accelerating Delivery System Reform

Presenter: **Mark McClellan, MD, PhD**, Director, Engelberg Center for Health Care Reform

Overview

Medicare has traditionally tried to control spending by reducing payment rates or limiting coverage. These approaches have not achieved long-term cost control and have precluded efforts to more fundamentally reform payment policy. More recently Medicare has increased its focus on programs for rewarding value and outcomes. Most policy makers support a Medicare payment system that fosters greater provider accountability for both quality and cost. Potential for progress on payment reform is greatest if Medicare collaborates with the private sector as it has in the area of quality measurement.

Context

Dr. McClellan discussed Medicare's past, present, and future efforts to control spending, including value-based purchasing, accountable care models, and changes in benefit design.

Key Takeaways

- **Medicare policies to control spending have not addressed fundamental payment or delivery system problems.**

Medicare's typical approach has been fee schedule cuts or limiting access to services (e.g., prescription drugs, preventative services, care coordination). These strategies have not controlled costs, and have precluded the more fundamental need for payment and delivery system reform. Until the payment system is changed to reward value and not volume, achieving better outcomes and lowering resource use will remain a challenge. Fortunately, there is increasing political support for shifting towards a more value-based approach.

- **To date, Medicare's value-based purchasing initiatives have had limited impact on overall costs.**

In recent years, Medicare has been more actively engaged in pilots focused on improved quality and value. These include pay-for-reporting, pay-for-performance, and new transparency initiatives. Medicare has collaborated with organizations such as the Hospital Quality Alliance (HQA) as well as private sector organizations. While good first steps, data suggests that the impact of these programs on costs has been limited.

- **The next step in payment reform is holding providers accountable for quality and cost.**

A key theme in recent Medicare demonstration projects is the notion of provider accountability—which means better overall care for patients and lower overall costs. For example, the Physician Group Practice (PGP) Demonstration, which includes ten large multi-specialty group practices, sets population-wide spending targets for each group, and shares savings below the

target with providers. The project closely tracks 32 different process, outcome, and patient satisfaction measures.

"These are all steps towards . . . what we really want in the Medicare program—better results at the patient level, better overall care and lower costs."

— Mark McClellan

- **Along with rethinking provider payment, reforms should focus on benefit design.**

Benefit design can be an effective tool for controlling costs as illustrated by the Medicare Part D program where prescription drug spending has been significantly lower than initially projected. Rather than selecting the standard defined benefit package (deductible plus 25% co-insurance combined with catastrophic coverage), the majority of beneficiaries have chosen tiered coverage plans. Under these plans, Medicare has seen generic use rise from 50% to 67%. Additionally, there has been a big shift from non-preferred to preferred brand name drugs. The savings from these shifts are far more significant than the savings from lowering drug prices.

"The lesson from this . . . is putting the benefit design as well as the provider payments on the table."

— Mark McClellan

Benefit design changes could be applied more broadly. For example, tiered payments could be established for elective surgery, assuming availability of high quality data that allow the program to tier physicians based on quality and efficiency.

- **Public-private collaboration is critical to the success of payment reform.**

Medicare must play an important role in the payment reform process, but Medicare cannot succeed alone. A key tool is Medicare's demonstration authority, which can be used to facilitate multi-payer projects. Medicare is currently working with some regional groups to develop private/public reforms. The recent joint effort to improve quality reporting is an example of the benefits of Medicare proceeding in conjunction with the private sector.

"Medicare doing something [on payment reform] by itself is very difficult. Medicare moving . . . in conjunction with the private sector . . . is the kind of model for what's going on . . . in Medicare today."

— Mark McClellan

Other Important Points

- **Role of QIOs.** Medicare's Quality Improvement Organization (QIO) Program provides a necessary complement to financial reforms. QIOs offer a valuable mechanism for working with providers to help them refine care delivery systems. CMS leaders should work together with QIOs to leverage their value in bringing about reforms.
- **Lack of CMS staffing.** A key factor limiting CMS's progress is internal staffing constraints. Despite the growing number of demonstration projects, CMS's staffing levels are similar to those in the 1980's. Since it is unlikely that CMS's staffing situation will improve in the near term, this reinforces the need for CMS to collaborate with outside organizations.
- **Further research addressing practice variation.** There is significant variation in the care provided to patients with severe chronic diseases. Currently there is little evidence about the "appropriate" frequency of office visits, ordering tests, and specialist referrals for common conditions. While there is general support for the concept of comparative effectiveness, there is a need to go beyond head-to-head trials of drugs or devices and evaluate practice patterns, which will require a different analytic framework.

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