Leaving Fee-for-Service Behind: Moving Toward Pay-for-Performance

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Problems with the Current Payment System

- Fragmented care
- Lack of coordination
- Variable quality
- High and rapidly-growing costs
Potential Waste and Inefficiency: More Than Half of Adults Experience Wasteful and Poorly Organized Care

Percent reporting in past two years:

- Doctors ordered a test that had already been done: 23%
- Time spent on paperwork related to medical bills and health insurance a problem: 26%
- Health care system poorly organized: 36%
- Any of the above: 54%

## Poor Coordination of Care Is Common, Especially if Multiple Doctors Are Involved

<table>
<thead>
<tr>
<th>Percent reporting in past two years:</th>
<th>Number of Doctors Seen</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Any</td>
</tr>
<tr>
<td>After medical test, no one called or wrote you about results, or you had to call repeatedly to get results</td>
<td>27</td>
</tr>
<tr>
<td>Doctors failed to provide important information about your medical history or test results to other doctors or nurses you think should have it</td>
<td>23</td>
</tr>
<tr>
<td>Test results or medical records were not available at the time of scheduled appointment</td>
<td>18</td>
</tr>
<tr>
<td>Your primary care physician did not receive a report back from a specialist you saw</td>
<td>15</td>
</tr>
<tr>
<td>Your specialist did not receive basic medical information from your primary care doctor</td>
<td>12</td>
</tr>
<tr>
<td>Any of the above</td>
<td>47</td>
</tr>
</tbody>
</table>

Quality and Costs of Care for Medicare Patients Hospitalized for Heart Attacks, Hip Fractures, or Colon Cancer, by Hospital Referral Regions, 2004

* Indexed to risk-adjusted 1-year survival rate (median=0.70).
** Risk-adjusted spending on hospital and physician services using standardized national prices.
Data: E. Fisher, J. Sutherland, and D. Radley, Dartmouth Medical School analysis of data from a 20% national sample of Medicare beneficiaries.
## What Drives Variation in Spending?

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Low</th>
<th>Average</th>
<th>High</th>
<th>%</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total episode</td>
<td>6372</td>
<td>7871</td>
<td>9748</td>
<td>23.8</td>
<td>1877</td>
</tr>
<tr>
<td>Initial hospital stay</td>
<td>4408</td>
<td>4414</td>
<td>4406</td>
<td>-0.2</td>
<td>-8</td>
</tr>
<tr>
<td>Physician</td>
<td>547</td>
<td>569</td>
<td>576</td>
<td>1.2</td>
<td>7</td>
</tr>
<tr>
<td>Readmissions</td>
<td>671</td>
<td>1543</td>
<td>2550</td>
<td>65.3</td>
<td>1007</td>
</tr>
<tr>
<td>Post-acute care</td>
<td>466</td>
<td>998</td>
<td>1780</td>
<td>78.4</td>
<td>782</td>
</tr>
<tr>
<td>Other</td>
<td>280</td>
<td>347</td>
<td>436</td>
<td>25.6</td>
<td>89</td>
</tr>
</tbody>
</table>

Federal Health and Total Spending as a Percentage of GDP, 2000-2087
(Under CBO’s Extended Alternative Fiscal Scenario)

NOTE: Figures for 2012-2087 are projections; CBO’s extended alternative fiscal scenario assumes that Medicare payment rates for physicians are maintained at the 2012 levels, the automatic spending reductions required by the Budget Control Act of 2011 do not take effect, and after 2022 several policies that would restrain spending growth do not take effect; most other federal spending is assumed to grow at the same rate as GDP after 2027.

Is Fee-for-Service Payment the Culprit? The Pros and Cons of ‘Pure’ Fee-for-Service

Pros:
- Corresponds to traditional notion of service-based health care
- Encourages productivity (at least in terms of volume of service)
- Applicable to a wide variety of services, providers, settings, patients, areas

Cons:
- No incentive for efficiency
- Limited to face-to-face interactions
- Encourages unnecessary care
- Doesn’t reflect quality, value, or outcomes (e.g., recent JAMA article indicating that hospitals profit from surgical errors)
- Doesn’t encourage coordination, management across providers, settings

Goals of Payment Reform

- Create incentives for providers to take broader accountability for patient care, outcomes, and resource use
- Provide rewards for improved care coordination among providers
- Slow growth in health spending
- Put in place an infrastructure to support providers in improving quality and efficiency
Some Alternative Payment Models

• Value-Based Purchasing—providers receive bonus payments based on quality/value measures; example: Medicare Premier Pay-for-Performance demonstration.

• Shared Savings—for providers who hold their costs below a target level, they receive a share of the savings; example: Medicare Shared Savings Program for Accountable Care Organizations.

• Bundled Payment—a single payment is made for a specified bundle of services provided to the patient for a given condition or time period involving a service; example: Medicare Bundled Payments for Care Improvement initiative.

• Global Payment—a single payment is made for all the services provided to a patient over a specified period of time, regardless of whether any services were provided to the patient; example: Medicare Advantage.
More Than Two-Thirds of Opinion Leaders Say the Current Payment System is Not Effective at Encouraging High Quality of Care

“Under the current payment approach, payment is given to each provider for individual services provided to each patient. How effective do you think this payment system is at encouraging high quality and efficient care?”

Not effective 69%

Somewhat effective 22%

Effective 5%

Very effective 2%

Not sure 2%

A Majority of Opinion Leaders Say Fundamental Provider Payment Reform is the Most Effective Strategy in Improving U.S. Health System Performance

“How effective do you think each of the following policy strategies would be in improving U.S. health system performance (improving quality and/or reducing costs)?”

- **Fundamental provider payment reform with broader incentives to provide high-quality and efficient care over time**
  - Very effective: 45
  - Effective: 40
  - Total: 85

- **Bonus payments for high-quality providers and/or efficient providers**
  - Very effective: 14
  - Effective: 41
  - Total: 55

- **Public reporting of information on provider quality and efficiency**
  - Very effective: 18
  - Effective: 35
  - Total: 53

- **Incentives for patients to choose high-quality, efficient providers**
  - Very effective: 15
  - Effective: 27
  - Total: 42

- **Increased competition among health care providers**
  - Very effective: 10
  - Effective: 18
  - Total: 28

- **Increased government regulation of providers**
  - Very effective: 9
  - Effective: 16
  - Total: 25

- **More consumer cost-sharing**
  - Very effective: 5
  - Effective: 14
  - Total: 19

Slightly More than Half of Opinion Leaders Prefer a Blend of Modified Fee-for-Service and Bundled Per-Patient Payment Systems

“Of these options, which do you prefer?”

- A blend of the modified fee-for-service and bundled per-patient payment systems: 53%
- Bundled per-patient payment with bonus payments for high quality: 23%
- A modified fee-for-service system, with bonus payments for high quality and efficiency: 9%
- None of these: 11%
- The current fee-for-service payment system: 1%
- Not sure: 3%

Nearly Three of Five Opinion Leaders Say Shared Accountability is Effective in Improving Efficiency

“Two approaches for encouraging improved efficiency are “paying for performance on efficiency” (providing bonus payments for high performance on measures of efficiency) and “shared accountability for resource use” (holding health care organizations including hospitals and physicians accountable for use of resources in care of patients over time and sharing a portion of any savings with the accountable care organizations). How effective do you believe each of these approaches would be in improving efficiency?”

Support for More Accessible, Coordinated, and Well-Informed Care

<table>
<thead>
<tr>
<th>Percent reporting it is very important/important that:</th>
<th>Total: Very important or important</th>
<th>Very important</th>
<th>Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>You have one place/doctor responsible for primary care and coordinating care</td>
<td>93</td>
<td>64</td>
<td>29</td>
</tr>
<tr>
<td>On nights and weekends, you have a place to go besides ER</td>
<td>85</td>
<td>54</td>
<td>31</td>
</tr>
<tr>
<td>All your doctors have easy access to your medical records</td>
<td>96</td>
<td>70</td>
<td>26</td>
</tr>
<tr>
<td>You have information about the quality of care provided by different doctors/hospitals</td>
<td>96</td>
<td>58</td>
<td>38</td>
</tr>
<tr>
<td>You have information about the costs of care to you before you actually get care</td>
<td>89</td>
<td>58</td>
<td>31</td>
</tr>
</tbody>
</table>

Note: Subgroups may not sum to total due to rounding.

Support for Doctors Working in Teams and Groups to Improve Patient Care

Percent reporting it is very important/important for improving patient care

Doctors and nurses working closely as teams, with expanded role for nurses

Doctors practicing with other doctors in groups, rather than on their own

Note: Subgroups may not sum to total because of rounding.

The Relationship Between Payment Methods and Organizational Models

Continuum of Payment Bundling

- Global Payment
- Bundled payment
- Shared savings
- Value-based purchasing
- Fee-for-Service

Continuum of Organization

- Small practices; unrelated hospitals
- Independent Practice Associations; Physician Hospital Organizations
- Fully integrated delivery system

More Feasible

- Continuum of Rewards for High Performance
  - Outcome measures; large % of total payment
  - Care coordination and intermediate outcome measures; moderate % of total payment
  - Simple process and structure measures; small % of total payment

Less Feasible

Relationship Between Payment Reform and Delivery System Reform

• More sophisticated payment methods are necessary to encourage and support delivery system reform.

• More sophisticated delivery systems are necessary to respond appropriately and effectively to payment reforms.

• “Payment reform can’t happen without delivery system reform…and vice versa.”

• So, what do we do?
Center for Medicare and Medicaid Innovation: Development, Evaluation, and Expansion of Pilots

- New Center in CMS to test innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid, and CHIP while preserving or enhancing the quality of care; previous demonstration authority expanded.
- Models to be selected based on evidence that they address a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures.
- Emphasis on care coordination, patient-centeredness.
- Could increase spending initially, but over time must improve quality without increasing spending, reduce spending without reducing quality, or both.
- Evaluation should include quality of care, including patient-level outcomes, and changes in spending; could consider cross-program impact.
- Secretary could expand duration and scope if model reduces spending without reducing quality.
Delivery System and Payment Reforms That Are Being Tested/Implemented

- Accountable Care Organizations
  - Shared savings
  - Shared savings and shared risk
  - Global payment -- partial or full capitation
- Patient-Centered Medical Homes
  - Blended fee for service, care management fee, bonuses for quality
- Bundled payment for acute hospital episodes
  - Inpatient hospital care and inpatient physician services
  - Inpatient hospital care, inpatient physician services, post-acute care services
- Value-Based Purchasing
- Tools, infrastructure support
  - Enhanced care coordination/chronic disease management
  - Health information technology
  - Beacon communities; health information exchanges
- Combination strategy in innovator communities
Key Considerations for Successful Pilots

- Multi-payer involvement
- ‘Ground-up’ as well as ‘top-down’ development
- Array of potential models
- Flexibility in design and implementation
- Try vs. test/trust but verify
- Establish infrastructure to support success
Payment Reform Must be Supported by System Reform: Accountability, Transparency, and Better Information for Better Decision-Making

• Accountability: Quality standards, reporting, and rewards
• Transparency: Medicare publishes quality, accountability, and provider profile information
• Information technology: Electronic medical records, health information exchange networks, personal health record accessible to beneficiaries
• Comparative effectiveness: Mechanism to coordinate evaluation of drugs, devices, and procedures with payment implications
“The country needs, and unless I mistake its temper, the country demands, bold, persistent experimentation. It is common sense to take a method and try it. If it fails, admit it frankly and try another. But above all, try something.”

Franklin D. Roosevelt, 1932
Take-Away Message

• The U.S. health care system needs to improve along all three dimensions of performance: access, quality, and cost.

• Addressing these dimensions together promises to be more effective than addressing them separately.

• The way we pay for and deliver health care needs to change.

• System reform is essential to support and encourage the changes that are needed.