# Paying for What Matters: Opportunities and Challenges

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# Broad Consensus of the Need to Pay for Value, Not Volume

There are plenty of examples of abuse of and poor results from volume-based payment approaches

We are finally talking not about how we pay (or deduct) an extra 1-2% on top of the 100% payment stream, but how to pay the 100%

But it is not so easy, conceptually or operationally, to “pay for value”

In the details will surely come stakeholder opposition

# DME Variation in South Florida

(MedPAC BASF file for 2006)

| Counties | Beneficiaries | DME $ per capita |
|---|---|---|
| Collier | 60,000 | $220 |
| Monroe | 11,000 | $260 |
| Broward | 141,000 | $430 |
| Miami-Dade | 184,000 | $2200 |

# Home Health Use, Spending, and Episodes Vary Widely

Price adjusted spending per capita in McAllen is more than 7 times national average

In some counties > 35% of beneficiaries use Home Health (before the recent court decision liberalizing who can get the services)

MedPAC Sept, 2010

A CMS contractor found that only 9% of claims were properly coded for Houston beneficiaries with the most severe clinical rating served by potentially fraudulent HHAs.

GAO, Feb, 2009

# Hospice Use Patterns Differ Widely

(MedPAC, Sept 2010)

| State | decedents in hospice | spending (relative natl. avg.) | Stays > 180 days | Live discharge rate |
|---|---|---|---|---|
| Miss | 35% | 1.9 | 39% | 55% |
| Iowa | 48 | 1.1 | 16 | 13 |
| Natl. avg. | 39 | 1.0 | 18 | 16 |

# Medicare Physician Fee Schedule

Berenson, et al. *What if All Physician Services Were Paid Under the Medicare Fee Schedule?* A Contractor Report for MedPAC, 2010

The study simulated MD compensation as if all of their services (in Relative Value Units) were paid at Medicare Fee Schedule Rates

# Simulation Results

For 2007, actual mean M.D. compensation was $272,000. Simulated at Medicare rates was $240,000

Some specialties had simulated compensation 2.5X's that of primary care and were in the mid-$400,000 range

So the assertions that Medicare pays only "80% of physician costs" ignores the generous income take-out that is part of practice costs

And some specialties have no plausible option to not take Medicare patients

Part of reason why MedPAC recommended cuts only to specialists' fees in its SGR proposal

# What Do We Mean By Value?

In health policy parlance, Value = Quality/Costs and is used to mean getting a “bigger bang for the buck”

But there is no quantitative precision to the value equation

Is value increased when quality increases at a higher cost?

# The Quality Numerator

Quality is measured differently for each measure, e.g., % compliance with a standard, mortality rate for a condition – there is no common metric, like quality-adjusted life years (QALYS), as used in cost-effectiveness research (but not US health policy)

We have very good quality metrics in some areas with more coming daily. In other important areas, we have few measures, e.g. diagnostic errors, appropriateness of interventions.

# The Cost Denominator

Costs are usually measured as dollars spent but can also represent the rate of increase in dollars spent

But even with something as seemingly straight forward as dollars spent, there are disagreements on how to measure  and report costs (which go beyond the usual error of mistaking charges or payments for costs).

# There Is Disagreement Over the Role of Measurement in Value-based Payment

For some, value-based payment means literally measuring quality and costs and directly rewarding higher measured value. Equivalent to “pay-for-performance.”

For others, it means adopting payment methods that have a higher demonstrated relationship to desired outcomes of care (quality, cost, and patient experience) and using measures more opportunistically -- while relying more on the design of basic payment approaches to affect value, which may not be measured except in special studies

# Some Concerns About Over-Reliance on Measurement

Value-based purchasing is a broader concept than pay-for-performance but often the two are equated

Measures and measurement are essential but have more limitations than often recognized (by policy-makers)

In some areas there are excellent measures. e.g., dialysis. In others, there are major gaps, which may not be filled for the foreseeable future, e.g., diagnosis errors, provision of unneeded, even harmful, services.

# The CMS Premier Hospital Quality Improvement Demonstration

- Largest P4P program for US hospitals
- Voluntary – 421 hospitals asked, 261 joined
- Ran from late 2003 through 2009
- Rewards performance for AMI, CHF, PN
- Primarily focused on processes, e.g., aspirin and beta blocker use in AMI, antibiotic timing in PN
- Bonus of 1-2% for top 2 deciles
- 2007, changed to reward improvement also

# Conclusions

- The Premier Hospitals P4P demonstration results do not demonstrate proof of effectiveness although performance on quality measures has been improving for all
- There is increasing doubt that process measures in general predict outcomes, esp. mortality, for hospital care
- Outcome measurement is more difficult but is where the action should be

# Conclusions (cont.)

- Mostly untested is whether P4P produces desirable cultural, organizational, and other change which “spillover” into other activities or alternatively “crowd out” other quality enhancing activities
- Regardless, the US seems embarked on a P4P course for hospitals and physicians (and other providers) because the approach sounds appealing to many policy makers (as in education policy) and because it challenges an unacceptable status quo

# When in Doubt, Quote Albert Einstein (If No Yogi Berra Quote)

"Not everything that can be counted counts, and not everything that counts can be counted"

– attributed to Einstein (turns out it was not Einstein but a fellow named William Bruce Cameron. Go figure)

We should move more decisively from measuring processes to measuring disease-specific outcomes, with the attendant operational challenges involved

Should evolve from measuring at the individual level to the organization as delivery changes

And adopt other strategies to increase value

# Affordable Care Act ProvisionsThat Emphasize Measures and Reporting

Sec 3001 Hospital Value-based Purchasing starts in 10/12

3007 Physician Fee Schedule Value-based Payment Modifier by 2015 (good luck with this one)

3022 Medicare Shared Savings Program – accountable care organizations (use of performance measures are central to the ACO concept – ACOs don't get to keep money unless they achieve quality targets)

# More ACA Sections Related to Reporting

3002 Physician Quality Reporting to provide feedback to physicians on performance – related to meaningful use

3003 Physician Feedback Reports – on resource use

10331 Public Reporting of Physician Performance Information – creates a Physician Compare website by 1/1/13

3015 Collection of Quality and Resource Use Measures

# Many ACA Provisions Do Focus on Incentives and Organization

Sec 3021 Center for Medicare and Medicaid Services ($10 billion dollars already appropriated to test new payment approaches and new organizational models of care, such as accountable care organizations and patient-centered medical homes

3022 Medicare Shared Savings Program

3023 Bundled Payment Pilot (CMMI moving on 4 models based around a hospitalization. A model for this is the ACES demo (acute care events in southwest hospitals for coronary stents, CABGs, hip and knee replacements.)

# ACA sections (cont.)

3024 Independence at Home (geriatric home care for frail elderly – to use “shared savings”)

3025 Hospital Readmissions Reduction in FY 2012 (is the payment penalty enough to change behavior in hospitals where most needed?)

3026 Community-based Care Transitions – already in place to assist hospitals in reducing readmissions

3027 Gainsharing Demonstration extension (doesn’t gainsharing accomplish the objectives of bundled payments, without the technical and physician-hospital relations difficulties?)

# ACA sections (cont.)

3502 Community Health Teams to support PCMH

3506 Shared Decision Making – sets up SHM Resource Centers

3126 Community Health Integrated Model Demo – for tests of rural integration models

3140 Medicare Hospice Concurrent Care Demo

2703 Medicaid Health Home targeted to individuals with chronic conditions

2704 Medicaid Bundled Payment demo in up to 8 states

2705 Medicaid Global Payment System demo for safety net hospitals to move from FFS to global payment in up to 5 states

2706 Medicaid Pediatric ACO demo

# Research and Evaluation of Outcomes of Different Payment Approaches is Very Difficult, If Very Important

Major confounders:

- Contextual influences on provider behavior – professionalism, demand-side incentives, regulations (public and private), organizational culture, etc.
- Specific design features – e.g., the generosity of the payment, the size and immediacy of any marginal incentive, attempt to address “loopholes” in any payment approach

**“There are many mechanisms for paying physicians, some are good and some are bad. The three worst are fee for service, capitation and salary.”**

-- Robinson, Milbank Q, 2001

# FFS Attributes

Advantages

- Rewards activity, industriousness
- ***Theoretically can target to encourage desired behavior***
- Implicitly does case-mix adjustment
- Commonly used by payers and physicians

Disadvantages

- Can produce too much activity, physician-induced demand
- ***Maintains fragmented care provided in silos***
- High administrative and transaction costs
- ***What is not defined as reimbursable is marginalized***
- Complexity makes it susceptible to gaming and to fraud
- ***Susceptible to pricing distortions as with the Medicare fee schedule***

# PPPM (Comprehensive or Global Payment)

Advantages

- ***Internalizes allocation of activity and costs to meet needs***
- Direct incentive to restrain spending
- Predictable and capped spending
- Administratively simple (until address some of the problems)
- Low transaction costs

Disadvantages

- ***May lead to stinting on care***
- Susceptible to cream-skimming
- ***Incentive to cost shift to services outside the PPPM***
- Can't specifically promote desired activity
- May resist innovation/ new services

# Episode/Condition/Bundle/Case

Advantages

- ***internalizes incentives for efficiency within the episode***
- ***potentially aligns incentives across siloed providers***
- arguably, is an intermediate step on the way to real integration

Disadvantages

- does not fundamentally alter incentive to generate units of service
- ***be careful about what you wish for, e.g. physician-hospital alignment without determination of appropriateness in a FFS environment***
- currently, political challenges in bundling among providers
- technically challenging (esp. for ambulatory care) – vagaries of diagnosis (more episodes in Miami than Minnesota), bias to performance of a procedure in a case rate, sorting out where particular claims are assigned to

# Public Reporting and Pay-for-Performance (P4P)

Advantages

- provides a hybrid payment to mitigate disadvantages of pure models; some natural blends – PPPM and under-service measures
- ***can start to actually reward desired performance, instead of rewarding volume of services produced***
- ***can include measures of patient experience, which have been generally ignored in considerations of reformed payment approaches***

Disadvantages

- underdeveloped measure set – especially for physicians
- what gets measured gets done?
- marginal incentives may be insufficient to counter basic incentives in whatever base model it is superimposed over
- contributes more administrative complexity

# Examples of Blended or Hybrid Payment Models

- PPPM with FFS carve outs or "bill aboves" and public reporting on underuse measures
- For PCMH, FFS for visits (possibly "discounted"), PPPM for medical home activities and P4P for patient experience
- Shared savings for ACOs
- Partial capitation – FFS/PPPM and/or risk corridors and/or particular sector (professional services, but not institutional)
- Any of the above with public reporting and/or pay-for-performance
  - quality measures where they exist, expenditure or utilization targets, patient experience measures

# Some Opportunities for Philanthropy

Research and evaluation on effects (including on untoward side effects on not measured outcomes)

Policy analysis – esp. on operational issues

Convening

Advocacy

# The Missing Topic In Payment Policy, Indeed, Health Policy

The inexorable growth in provider -- especially hospitals and affiliated physicians – market power to raise prices, with the concomitant rise in what Atul Gawande labeled Big Medicine