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Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform

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Overview

This paper is designed to assist health care payers and policymakers to restructure payment systems in ways that will improve the quality of health care and reduce (or slow the growth in) the costs of health care. Drawing on the research and proposals of many researchers and practitioners, it attempts to: summarize the key concepts involved in any discussion of ways to restructure payment systems; catalog the quality and cost problems that current payment systems create; list the key concerns that have been raised about pay-for-performance systems in health care; propose 12 goals that revised payment systems should seek to achieve in order to effectively address the problems; define the specific issues that need to be resolved in order to achieve these goals; describe the primary options for addressing each of these issues; and suggest a general strategy for making progress on payment restructuring.

Executive Summary

The Need for Improved Payment Systems

A growing number of health care professionals around the country are increasingly frustrated by health care payment systems that do not reward efforts to improve health care quality, and that often penalize them financially. There is fairly widespread agreement that one reason for high costs and quality gaps is that current health care payment systems impose significant financial penalties and offer disincentives to providers (hospitals, physicians, and others) who supply quality, efficient care (e.g., lower-cost services, higher-quality care, cognitive services, preventive care, etc.), while they offer significant incentives for providing expensive, inefficient care (e.g., invasive treatment, use of technology, etc.) irrespective of outcomes.

Current payment systems create penalties and disincentives across all elements of health care, including the prevention of illness, diagnosis, treatment of conditions, and the follow-up to care. For example:

- Current fee-for-service systems generally do not pay adequately (or at all) for many elements of preventive care. In addition, low payment levels are believed to

discourage physicians from entering primary care, as opposed to specialty care.

- Payers often do not have an incentive to invest in preventive care, since the payoff in terms of better health and lower costs occurs in the (distant) future and may accrue to other payers.
- Fee-for-service systems may not pay adequately for the time needed by a provider to make an accurate diagnosis and to develop an appropriate care plan and discuss it with their patient, particularly in complex or unusual cases. At the same time, providers are not financially penalized for ordering more tests, regardless of whether the tests are necessary to make an accurate diagnosis/prognosis.
- Fee-for-service payment systems reward providers for supplying more services, even if the services are unnecessary or of low value. Moreover, payment systems generally pay for services regardless of whether all of the processes recommended in clinical practice guidelines are performed by the provider, and research has shown that large proportions of patients do not receive important elements of care.
- Under most payment systems, providers are paid more for patients experiencing adverse events, particularly serious adverse events resulting in multiple complications, and the providers' "profits" on patients experiencing such events may actually be higher than on patients with no adverse events.
- Payment systems reinforce fragmentation of care by paying multiple providers for multiple services or tests for the same patient, regardless of whether the care is coordinated or duplicative.
- Current payment systems generally do not pay hospitals or physicians more to manage the needs of patients with complex conditions after discharge from the hospital or to work proactively to encourage and assist the patient in complying with post-discharge instructions in order to improve outcomes and prevent rehospitalization.
- Patients generally do not have a financial incentive to adhere to prevention and disease management recommendations that could improve outcomes and reduce health care costs. Copayments and deductibles may discourage or prevent individuals from obtaining desirable preventive care services.
- Many payers do not have mechanisms for encouraging or directing patients to providers who supply better value—i.e., care at lower cost for the same quality, or higher quality at the same cost.

The Weaknesses of Current Pay-for-Performance Systems

Although a wide range of pay-for-performance, or P4P, systems have been developed to try to counteract some of these kinds of problems, there is growing concern that these systems are inadequate and potentially counterproductive. For example:

- The amount of performance bonuses and penalties in most P4P systems is relatively small, reducing the likelihood that they will overcome the problems they are intended to address. In fact, the reductions in a provider's net revenues from implementing a quality improvement initiative may exceed the payment incentives provided through a P4P system for that initiative.
- Most P4P systems focus on rewarding processes, rather than outcomes, which may (a) reward providers with poorer outcomes, and (b) unintentionally deter innovation and experimentation with new processes that achieve better outcomes.
- Measures are only available for a subset of the processes that are important to good outcomes; P4P systems that reward a subset of processes may divert attention from other important processes.
- Providing incentives based on outcomes (or even some processes) can create incentives for providers to exclude or under-treat patients who are likely to have poor outcomes or to be non-compliant with treatment regimes, or to over-treat patients who are likely to have better outcomes or be more compliant.
- Because of the fragmentation of care, it is often difficult or impossible to clearly assign responsibility for performance or lack of performance to a particular

provider.

Potential Goals for Effective Value-Based Health Care Payment Systems

In order to address the problems with current payment systems and avoid the concerns about existing pay-for-performance systems, the following are 12 potential goals that revised payment systems should seek to achieve:

1. Payment systems should enable and encourage providers to deliver accepted procedures of care to patients in a high-quality, efficient, and patient-centered manner.
2. Payment systems should support and encourage providers to invest, innovate, and take other actions that lead to improvements in efficiency, quality, and patient outcomes and/or reduced costs.
3. Payment systems should not encourage or reward over-treatment, use of unnecessarily expensive services, unnecessary hospitalization or rehospitalization, provision of services with poor patient outcomes, inefficient service delivery, or choices about preference-sensitive services that are not compatible with patient desires.
4. Payment systems should not reward providers for under-treatment of patients or for the exclusion of patients with serious conditions or multiple risk factors.
5. Payment systems should not reward provider errors or adverse events.
6. Payment systems should make providers responsible for quality and costs within their control, but not for quality or costs outside of their control.
7. Payment systems should support and encourage coordination of care among multiple providers, and should discourage providers from shifting costs to other providers without explicit agreements to do so.
8. Payment systems should encourage patient choices that improve adherence to recommended care processes, improve outcomes, and reduce the costs of care.
9. Payment systems should not reward short-term cost reductions at the expense of long-term cost reductions, and should not increase indirect costs in order to reduce direct costs.
10. Payment systems should not encourage providers to reduce costs for one payer by increasing costs for other payers, unless the changes bring payments more in line with costs for both payers.
11. Payment systems should minimize the administrative costs for providers in complying with payment system requirements.
12. Different payers should align their standards and methods of payment in order to avoid unnecessary differences in incentives for providers.

Issues and Options for Improved Health Care Payment Systems

Five categories of issues need to be addressed in redesigning health care payment systems to meet these goals:

1. What basic method of payment should be used to compensate providers for care, i.e., fee-for-service, episode-of-care, capitation, or some other approach;
2. Whether payments for multiple providers should be "bundled" together;
3. How the actual level of payment should be determined;
4. What performance standards should be set and whether incentives for performance should be added to the basic payment method; and
5. Whether specific incentives should be provided to patients regarding choice of providers and participation in care.

There are multiple options available to address each of these issues, many of which are described in Section VI of the paper. In addition, different types of payment may be appropriate for different types of patients and conditions. Section VI provides examples of how the options can be combined into revised payment systems for several types of patients and conditions.

If incentives for performance are to be used, then nine additional issues should be addressed:

1. How should payments be changed based on provider compliance with non-mandatory processes?
2. How should payments be changed based on provider achievement of better patient outcomes?
3. How should payments be changed based on reduced utilization of services (or otherwise lower costs or slower growth in costs)?
4. How should payments be changed based on achievement of higher patient satisfaction levels?
5. Should payments be changed based on any other situations?
6. What threshold of performance should trigger payment changes?
7. How large should rewards or penalties be relative to base payment levels?
8. How should high-cost patients be protected against exclusion from care?
9. Should there be any adjustment in payment levels to reflect costs of information technology that providers need in order to comply with requirements for reporting on processes, outcomes, patient satisfaction, or reduced utilization/cost?

Again, there are multiple options available for addressing these issues, many of which are described in Section VII of the paper.

In addition, both basic payment systems and incentive systems presume the existence of:

- Categories of diagnosis and patient severity (with age and risk) for which payment levels can be consistently established;
- Guidelines for care (often called Clinical Practice Guidelines) for each category of diagnosis and patient severity;
- Estimates of the cost to providers of following guidelines for care in an efficient manner;
- Performance measures for each category of diagnosis and patient severity; and
- Methods of collecting and reporting on performance measures.

In many regions of the country, systems are in place for one or more of these activities, but in others, they are not. In addition, concerns have been raised about whether the processes that are in place at the national level are moving quickly enough. Options for addressing these issues are described in Section VIII of the paper.

Finally, several important issues need to be resolved in implementing a desired payment system, including:

- How should payment changes be phased in?
- Should payment changes be required to be "budget neutral?"
- How will the effects of payment changes be evaluated?

  Some options for addressing these issues are described in Section IX of the paper.

Next Steps in Improving Payment Systems

Unfortunately, there are no easy answers regarding which options offer the best resolution for these many issues. Uncertainty exists due to the fact that there have been relatively few cases where significantly different payment systems have been attempted, and even fewer where thorough evaluations have been conducted. This leads to several conclusions about next steps:

- Payment demonstration projects must be developed, implemented, and evaluated in order to make progress on payment reform.
- A wide variety of payment demonstrations are needed. Just as experimentation and evaluation is a hallmark of evidence-based medicine, experimentation and evaluation will also likely be needed in order to develop the most effective cure for the ills of the payment system.
- The leadership for payment reform demonstrations should come from the regional level, rather than the national level. Health care is a fundamentally regional enterprise, since most providers and even most payers operate exclusively or primarily in metropolitan regions, states, or multi-state areas.
- While payment demonstrations can and should be pursued at the regional level, this does not mean that payment reform should be a parochial enterprise. Indeed, just as medicine itself advances the state of the art through local innovations that are supported, replicated, and evaluated nationally, so too can payment reform be more successful if there is national support for the development, evaluation, and replication of regional payment demonstrations.

Citation

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