Payment System Reforms: What Consumer and Patient Advocates Need to Know

Introduction

Americans pay too much for a health care system that delivers too little. The Congressional Budget Office (CBO) predicts that nearly 18 percent of the Gross Domestic Product will be spent on health care in 2009, increasing to 20 percent by 2018.1 In the past year alone, health care costs for a typical American family of four have increased by 7.4 percent – from $15,609 to $16,771.2 Yet, on average, Americans only get the right care for their condition 55 percent of the time.3 To ensure that we get the most from our health care dollar, we need to address one of the root problems: a payment system that encourages quantity of care over quality of care.

Most health care in the United States is still paid for on a fee-for-service (FFS) basis where each service or procedure is paid separately and reimbursement is not tied to the quality of the care delivered. Oftentimes, multiple tests are ordered when one would be sufficient. Surgical procedures are performed when evidence shows less costly, less invasive options are just as effective. Hospitals are paid again if a patient is re-admitted because of poor quality care.

There are several new payment models that promise to reward quality, discourage waste, and encourage better health outcomes. If successful, these new models can help patients, particularly those with chronic health conditions, receive higher quality, better coordinated, comprehensive care. But, if implemented poorly, these new models could create inappropriate incentives for hospitals and physicians to reduce needed care for patients or disregard patient preferences.

The nationwide health insurance reform debate is the start of an extended process that presents a much needed opportunity to employ these models and transform our payment system to prioritize effective delivery of the right care at the right time at the right cost. Consumer and patient advocate participation in the development and implementation of these models is essential to ensure that appropriate safeguards are in place so that they are truly patient-centered.

This issue brief details the leading models and the safeguards necessary to their implementation.

New Payment Reform Models

Bundled Payments

An alternative to paying individual fees for each service provided is to “bundle” payment – so that all services provided over an episode of care are covered by a single flat fee. For example, if a patient needed to have surgery, the hospital would be paid a pre-determined single amount that would cover the expected physician and hospital fees and prescription drug and medical device costs associated with care provided before, during and after surgery, based on evidence for what constitutes good care. If additional care were required because the hospital made mistakes, such as if the patient acquired an infection while at the hospital, the hospital would absorb those costs. But, if unforeseen complications arise and the patient needed additional care, they would be able to get it. In this way, the hospital has a financial incentive to provide the best care and focus on ensuring patients get and stay well.

Some health insurance reform proposals call on the Secretary of the Department of Health & Human Services (HHS) to develop a plan for bundling Medicare payments for all inpatient hospital services and services provided in post-acute settings, such as nursing facilities, home health care and rehabilitation hospitals.
Accountable Care Organizations

To encourage effective coordination and management of care, physician group practices or physician/facility groups can form “Accountable Care Organizations” (ACOs). Under an ACO framework, participating providers agree to manage the full range of patient care – from hospital to home to physician’s office – while receiving a fixed payment per patient. Groups that meet spending benchmarks and satisfy quality standards share in any generated savings.

Some health insurance reform legislation establishes Medicare pilot programs to test different models of ACOs, including one based on partial capitation (payments are made in part on a fee-for-service basis and in part by a fixed amount per patient) and another based on incentive payments for achieving savings targets. If either model proves effective at improving quality or reducing costs, HHS may implement it on a permanent basis in Medicare and private health plans may be encouraged to implement ACO payment models for the under-65 population.

Medical Home

A medical home is a medical office, health center or clinic that assigns a point person and a team of health professionals to offer personalized, coordinated, comprehensive primary health care to each patient. It is paid a fee for each beneficiary who receives medical home services over a given period time. This fee encompasses the range of services essential to the provision of high quality primary care, such as care coordination and enhanced communication access, which are not reimbursed under the traditional FFS payment system. Separate FFS payments may continue to be paid for face-to-face visits.

Two different models of the medical home are under consideration and will likely be tested as pilot programs under Medicare and Medicaid. One would create independent patient-centered medical homes which would be led by either physicians or nurse practitioners and be specifically designed to focus on high need Medicare beneficiaries. The other model would create community-based medical homes – nonprofit community-based or state-based organizations would employ community health workers (including nurses or other non-physician practitioners) or lay health workers to assist the patient’s primary care provider in chronic care coordination activities.

Other Payment Strategies

In addition to payment reform models which move completely away from traditional FFS payments, some payment strategies can be used in conjunction with both the old and new models. While not completely re-shaping the payment system, they could move towards the goal of high quality, patient-centered care.

Value-Based Purchasing

Value-based purchasing rewards the provision of high quality care by offering providers higher payments for meeting certain quality standards. Correspondingly, providers may receive lower payments if they are shown to continually provide substandard care.

In a reformed health care system it is likely that a percentage of Medicare payments to hospitals, home health agencies and skilled nursing facilities will be based on performance on quality measures, either for meeting high benchmarks or for significantly improving from one period to the next. Demonstration projects may be created to test how similar value-based payments could be tailored towards critical access hospitals and small hospitals.

Value-Based Benefit Design

In addition to changing the way providers are paid, the level of cost-sharing patients face can be changed to encourage the use of clinical treatments and services that have proven effective. For example, blood pressure medication is proven to be effective in preventing long-term complications from diabetes so diabetic patients would be charged lower cost-sharing for drugs that control blood pressure. Value-based benefit design can
support consumers in their ability to take actions to prevent and manage disease, and achieve both better health outcomes and lower costs.

**Reduced Payment for Hospital Readmissions**

Publicly reporting hospitals’ Medicare readmission rates, and subsequently adjusting payments to hospitals based on their percentage of preventable readmissions, can improve patient outcomes as hospitals are incentivized to better manage transitions from hospitals to other settings, such as the patient’s home or a nursing home.

There are a number of ways payment reductions can be structured. Two options proposed in health insurance reform legislation include models in which hospitals with readmission rates above a certain threshold have payments for the original hospitalization reduced if a preventable readmission occurs within a given time period, or payments for hospitals are reduced based on the dollar value of each hospital’s percentage of potentially preventable readmissions for certain conditions.

**Consumer Safeguards**

The models described above hold great promise, but if poorly designed, they could create inappropriate incentives for providers to under-deliver services, cherry pick patients, or disregard patient preferences for types and sources of care. Therefore, it is important for consumer and patient advocates to engage lawmakers and administration officials – through both the legislative and regulatory process – to ensure any new payment reform proposals are truly patient-centered.

To do this, the following consumer safeguards must be included with every model and strategy:

First, **payments should be risk adjusted to reflect the severity and complexity of the patient’s needs.** When providers are paid appropriately for patients who have complex medical needs (known as risk adjustment), then incentives are aligned with patients’ needs for care.

Second, **payments should be linked to the provider’s performance on patient-centered measures of care,** such as improved health outcomes and functional status, appropriate coordination with other providers, high quality patient and caregiver experience and reduction of disparities. Unlike the FFS system, which incentivizes volume by focusing on services delivered, models that pay based on patient-centered strategies like these are better suited to ensuring providers focus on the things most important to patients – like whether they get better, having a point person to coordinate care, and having a positive experience in their encounters. Doing this requires the creation of “measures” that assess whether providers are delivering this kind of care. Payment is then based upon performance on these measures. Measures that matter most to patients – and can save money in the system – include composite measures that provide a total picture of care, measures that reflect the actual outcome of care, and measures of patient experience.

Quality data derived from these measures should be fed back to physicians so that they have useful feedback and, where appropriate, can improve their performance. Data should also be publicly reported so that patients and families can make informed choices.

Third, **payments should reflect the cost of delivering patient-centered services.** Real patient-centered care includes comprehensive patient and caregiver capacity assessments; regular communication with the patient’s care team; medication reconciliation at every encounter; regular communication of key information to patients and caregivers (care plans and summaries, test results, and discharge instructions); providing language services to limited English proficient patients; and connecting the patient and caregiver to community supports, as needed. Practitioners who provide these vital services should be compensated accordingly.
Conclusion

The process of transforming the health care system is an enormous opportunity, but it is also extraordinarily complex. Each change is fraught with consequences, intended and otherwise. Consumer and patient advocates must be ready at every step to guarantee that payment reform puts patients first.

Additional Resources on Payment Reform

- Center for Payment Reform (CPR): http://www.centerforpaymentreform.org/
- Consumer-Purchaser Disclosure Project: http://healthcaredisclosure.org/

For further information you can also contact us at (202) 986-2600 or cmonahan@nationalpartnership.org, or visit our website at www.nationalpartnership.org.

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