

# Thinking Clearly About Payment Reform

Robert S. Galvin, MD, MBA

**T**he health reform debate of 2009-2010 has highlighted the consensus that the payment system itself must be reformed. The importance of payment in shaping the healthcare system has long been recognized (eg, diagnosis-related groups [DRGs] in the 1980s and resource-based relative value scale methodology in the 1990s). What's different now is the recognition that payment must be tied to quality, outcomes, and overall cost growth. This new viewpoint is a triumph for the quality movement.

The critical role of value-based payment was articulated in the Institute of Medicine's *Crossing the Quality Chasm*<sup>1</sup> and led to the founding of 2 private-sector pay-for-performance programs, the Integrated Healthcare Association in 2001 and Bridges to Excellence in 2002, as well as to Medicare's value-based payment initiative. As of 2010, the majority of private and public payers are committed to having their provider payments incorporate both quality of care and efficiency. Although only a small percentage of actual payment is truly performance based at this point, an historic shift in how providers will be paid is under way.

However, neither a rigorously thought-out conceptual framework for performance-based payment nor a path to achieve this type of payment has accompanied this momentum. Different groups are driven by different factors: the Centers for Medicare & Medicaid Services (CMS) by prior legislation and political constraints on its authority to act; private health plans by weak signals from employers as well as their own reluctance to lead in payment change; and academics by a belief (bordering on faith) in integrated delivery systems. Our decentralized healthcare system has demonstrated that uncoordinated pursuit of multiple pathways results not in innovation guided by an "invisible hand" but in wasted resources, duplication, and confusion (eg, regarding the development of performance measures).

In this commentary, I use the current thinking about medical homes and accountable care organizations (ACOs) to argue for the importance of having a strategy for payment reform. Then I suggest 4 steps that, if followed, could maximize innovation and decrease confusion as our pluralistic system moves full speed ahead on this reform.

there is considerable enthusiasm among academics and policy makers regarding the promise of these models, both represent significant changes in how providers are organized. There is surprisingly little analysis weighing the potential benefits against either realistic expectations or possible negative consequences.

It is easy to see why the 2 models have such fervent boosters: both promise to fulfill several criteria elucidated in *Crossing the Quality Chasm*, including patient-centeredness, teamwork, and coordination of care. Several ACOs currently deliver high-value care (eg, the Geisinger Clinic, Kaiser, Gundersen Lutheran). In addition, the medical home attempts to address the critical primary care shortage; the reasoning is that the number of medical school graduates entering primary care will increase when practitioners are better compensated and more satisfied.

However, there is ample reason to mix caution with the enthusiasm. In a recent article, several health services researchers cautioned that the development of functioning medical homes will require far more time, information technology capacity, and resources than are currently envisioned.<sup>4</sup>

For a medical home to control costs, physicians will have to case-manage with enough intensity to avoid preventable hospitalizations and change their specialist referral patterns to preferentially selected practitioners who deliver high-quality care with minimum use of necessary resources. A primary care medical practice is a very busy place; although the concept of the medical home is attractive, it is very optimistic to assume that many practices can be transformed to manage patients in the way envisioned.<sup>5</sup> So although medical homes represent a promising innovation in care delivery, we should be modest in our short-term expectations and generous in the time given to allow these organizations to develop.

The organizations on which the ACO model is based are characterized by 2 critical elements in addition to their integration: culture and longevity. The well-known organizations that deliver the highest value, several of which were listed above, have been in existence for at least 30 years. In every case, physicians joined voluntarily because their values and philosophies of medical practice were compatible with the organization's mission. To assume that new organizations of physicians and hospitals, motivated to form in response to changes in payment policy and with physicians drawn from hospital-based medical staffs, will have the same capacity and degree of trust to manage care as aggressively as the best integrated delivery systems is optimistic at best and naïve at worst. Relationships between medical staffs and hospital administrations are always a delicate balance, and efforts to bundle pay-

## CASE IN POINT: MEDICAL HOMES AND ACCOUNTABLE CARE ORGANIZATIONS

The momentum around ACOs<sup>2</sup> and medical homes<sup>3</sup> shows why we need an approach that is more rigorously thought through. Although

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ments for physicians and hospitals have led to conflict about how to share revenues.<sup>6</sup>

In addition to provider-side issues, there are challenges on the patient side. The track record is not favorable for patients agreeing to seek care in a single delivery system or trusting a capitation-type payment system. In the end, we should not mistake the enthusiasm for models like medical homes and ACOs for a strategy that is supported by data and based on rigorous examination. Policy should be as evidence based as possible and selected exemplary examples do not qualify as evidence.

## FOUR STEPS TO PAYMENT REFORM

### Step 1: Agree on a Conceptual Framework and Glide Path

The Center for Payment Reform (CPR), a recently formed organization composed of labor, consumer groups, employers, and providers, and focused solely on payment reform, is in the process of developing a conceptual framework and a glide path to reform the payment system (see [www.centerforpaymentreform.org](http://www.centerforpaymentreform.org)). Although not yet complete, the CPR framework begins with 4 premises, described below.

**Premise 1.** Payment changes should be evidence based to the extent possible and there is limited evidence about what works at this point. Although there is some evidence on how changes in payment affect provider behavior, this evidence is insufficient to make widespread assertions about future policy. Accordingly, there needs to be rapid cycle assessment of payment changes (with methodologies that allow for real-time evidence generation), and payment systems should be part of studies of comparative effectiveness.

**Premise 2.** Substantive alternatives to the fee-for-service and DRG models will take a long time to develop. Therefore, it is imperative that simultaneous improvements be made so that the current payment system becomes performance sensitive.

**Premise 3.** One size does not fit all when it comes to a new payment system. In any given market, the path from the current payment system to a system based increasingly on value needs to be specific to that locale's payers, plans, and providers.

**Premise 4.** A model of "structured flexibility" needs to be developed to encourage innovation while reducing confusion. This model would include (but not be limited to) issues like the standardization of definitions, agreement on which quality and cost measures are acceptable as bases for payment, a common framework for evaluation, and so forth.

**The Glide Path.** The CPR is developing a tool that will enable each market to assess its best next move to make payment increasingly value based. The alternatives will include ACOs, medical homes, and bundled payments as well as changes that make fee-for-service and DRG payments models more perfor-

mance sensitive, such as value-based bonuses, gain sharing, and other changes not yet thought of.

### Step 2: Coordinate Public- and Private-Sector Efforts

There are 2 key reasons why the 2 sectors need to be coordinated in ways they haven't been before. First, performance-based payments must be large enough to make it worthwhile for providers to participate. The size of the rewards for better performance have to cover, at the very least, the costs of improvement. Realistically, these rewards should exceed the income that would be generated by simply providing more services. Even with CMS's size, it will take both privately insured and publicly insured enrollees to create this amount of revenue. Second, public-sector efforts must guard against increasing cost shifting to the private sector. If an organization succeeds in managing its Medicare business by raising prices to private-sector insurers, the system as a whole has not improved. Only by coordinating efforts can the sectors ensure that providers achieve true efficiency.<sup>7</sup>

It is possible that health reform legislation will include language enabling CMS to work with the private sector in ways it hasn't before. This language will be necessary but not sufficient. Both sectors will have to change old habits of working in their respective silos. The Center for Payment Reform will be working with employers to encourage the private insurers with whom they contract to coordinate with Medicare initiatives as they execute their own payment reforms.

### Step 3: Ensure Models That Promote Competitiveness

To the extent that health reform makes it financially advantageous and more legally permissible for physicians and hospitals to form consolidated organizations, there needs to be increased scrutiny of the impact that these larger organizations will have on the price of services for private-sector payers. Integrating physician outpatient and hospital inpatient services potentially could result in more patient-centered and coordinated care, but it simultaneously creates big organizations that assume the total care of larger and larger groups of patients.

Size matters in healthcare contracting, and the experience to date is that provider integration has been used mostly to negotiate higher prices, not to deliver higher value care. Employers want to avoid situations in which they either accept large price increases or face the consequences of a provider organization important to their employees refusing to stay in a contracted network. In 2009, private employers saw their costs increase several times faster than the consumer price index in an economic environment in which every other part of their supply chain costs either stayed flat or decreased. More than 60% of cost increases were due to increases in hospital prices.

In many markets, the same facilities that justified expansions or mergers based on clinical integration were the ones with the highest price increases. In one major market, a facility focused internally on becoming an ACO was involved in a protracted and public battle with a health insurer regarding year-over-year price increases of 18%.<sup>8</sup>

Unfortunately, antitrust action has been unsuccessful in preventing the growth of pricing power, whether this growth is associated with insurers or providers. Proven remedies to forestall anticompetitive market power while enabling more clinical integration do not yet exist. Two promising ideas are (1) to make sure that price and performance transparency are visible and meaningful to patients in a way that would allow them to be cost-conscious consumers and (2) for CMS and private payers to build into their contracts ceilings for price increases.

### Step 4: Develop a Learning System and a Plan to Implement New Payment Models

If managed intelligently, the pluralism of our healthcare system is a great source of innovation. Particularly because there is no “one size fits all” model of payment reform and because healthcare is provided locally, pilots and other forms of experimentation are necessary. However, without a systematic approach to evaluating results—which includes a common lexicon, standards for new payment models, and agreed-on outcome measures—our pluralistic system will work to the detriment of patients as providers struggle to understand and juggle multiple approaches.

A learning system for payment reform needs 2 critical components. First, there should be a national information resource that both provides a clearinghouse for the results of different reforms and is able to disseminate these results (which would include specific recommendations for ways in which communities could use them). Second, at the local level, a community-based entity should coordinate differing payment reform pilots so that providers could focus their efforts on clinical improvement rather than administrative adjustments, to the extent possible.

Transferring learning into action is a key step. In the current draft legislation (at the time of this writing no bill had been passed), new entities like the CMS Innovation Center and the Independent Payment Advisory Board have accelerated pathways for their recommendations to become CMS policy. Hopefully, the final language also will ensure that these changes do not lead to increased prices and diminished affordability for privately insured individuals. The extent to which these entities will integrate private-sector innovations into their framework remains to be seen.

On the private-sector side, the CPR is working with employers to coordinate their approaches to payment reform and make sure that a clear, strong message is sent to the health

insurers with whom they contract through requests for proposals, contract language, and financial incentives that continuously increase the percentage of performance-sensitive provider payments is a condition of doing business. The CPR also is developing a national scorecard that will measure the actual percentage of payment that is based on performance.

Payment reform is only one component of what’s needed to deliver higher value healthcare, but meaningful improvement will not occur without it. Paying differently is important not only to spur advances in quality but also to bring about significant improvements in affordability. The good news is that momentum is growing around reforming payment. Any observer of our system can attest that once an idea gets embraced by both sides of the political aisle as well as by both public-sector and private-sector payers (think managed care, safety, or quality measurement), significant change occurs. The troubling news is that managing a change of this size to minimize duplication, confusion, and wasted resources is no small task in our complicated and decentralized health system.

An agreed-on conceptual framework is key. It’s time to spend the time to define in more detail what we mean by “performance-based” payment and how we can achieve it in a rational, evidence-based way. In the words of Abraham Lincoln, “if I had eight hours to chop down a tree, I’d spend the first six sharpening the axe.”

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**Address correspondence to:** Robert S. Galvin, MD, MBA, Executive Director, Health Services, and Chief Medical Officer, General Electric, 3135 Easton Tpk, Fairfield, CT 06828. E-mail: robert.galvin@corporate.ge.com.

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