Paying for What Works:

A U.S. PIRG Policy Primer on Health Care Delivery and Payment Reform

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Introduction

Our health care system is in crisis. Interrelated problems with the affordability and quality of care are undermining patient care and threatening the economic future of American families and small businesses.

The total premium cost for employer-sponsored family health insurance has doubled in less than ten years, [i] and may double again by 2016.[ii] In the face of high-cost premiums, both large employers and small businesses face tough choices: shoulder greater costs and potentially harm their competitiveness, pass on large increases on to employees who aren't equipped to pay them, or reduce coverage. In many cases, employers are covering less of employees' premiums and requiring increased deductibles.[iii] Employee health care costs for small businesses, which lack the buying power of larger firms, are 18% higher than for bigger companies.[iv]

Americans might accept these rising costs if their health care dollars were purchasing quality care on which they could depend. Instead, today's health care system is undermining family physicians' and other primary care providers' ability to provide quality, personalized care to American families. These cost and quality challenges are both rooted in the way our system pays for and delivers health care. The same incentives which are driving up costs are undermining health professionals' ability to provide the best care.

Over the first few months of 2009, these twin crises of cost and quality have helped generate an unprecedented breadth of support for reform. Senators and Representatives from across the political spectrum have echoed President Obama's statement that "health care reform cannot wait, it must not wait, and it will not wait another year."[v] Very difficult political arguments remain to be resolved around the role of the public sector, employers and private insurance in comprehensive legislation. Yet a remarkable consensus is emerging on the broad policy strokes needed to fix the incentive structure in America's health care payment and delivery systems.[vi]

In the context of this emerging agreement, Congress still faces the challenge of transforming macro-level consensus into detailed, workable policy. This policy primer is intended to help meet that challenge. It examines seven factors which have led to the interrelated crises in cost and quality, and prescribes specific policy remedies to tame costs and restore health professionals' ability to provide the care on which American families rely.

Factors Driving Inferior Care and Higher Costs

1. Paying for Quantity not Quality

America's cost and quality problems start with the payment system that Medicare and many private health insurance companies use. Under this system, known as "fee-for-service," health care providers receive payment for each visit with a patient, each test ordered, and each procedure performed. Payment is based solely on the quantity and

complexity of care that the patient receives, regardless of how effective that care actually is or how well it is delivered. This payment structure penalizes those providers or hospitals who focus on disease prevention and treatment protocols which identify medical problems before they become acute. At the same time, it rewards hospitals and doctors who rely on a higher complexity and quantity of tests and treatments.

Perhaps the most striking evidence of this problem is the rate of avoidable hospital re-admissions. Recent studies have show that 19.6% of Medicare beneficiaries who receive hospital care are hospitalized again within thirty days.[vii] Hospitals can decrease readmissions by counseling patients about their treatment after leaving the hospital and focusing their efforts on conditions which frequently result in additional hospital visits.[viii] But the fee-for-service system, as currently structured, provides little incentive to implement these practices more broadly.

2. Payment Fails to Encourage Coordinated Care

Today's health system also fails to encourage coordination or teamwork amongst providers and health care institutions. Without coordination of care, patient care becomes more fragmented, with no single person in charge of the patient's overall well-being. For example, poor communication among providers may result in the patient having the same test performed twice. Different physicians may even prescribe drugs that should not be taken at the same time. Unaware of the overall picture, each physician attempts to give the patient only the care within that doctor's specialty. This results in less effective care, wasted resources, and, occasionally, actual harm to patients. The problem can become particularly acute for patients who have multiple chronic diseases, who often require care from a number primary and specialty care physicians and other providers. Coordinating care amongst teams of providers has been shown to deliver better care.[ix] Efforts to implement a new approach known as the "the medical home" also show promise.[x] Under these arrangements, providers receive additional payment to provide coordination of care for patients. Unfortunately, today's payment systems have failed to make these more effective approaches the norm.

3. Primary Care is not prioritized

Primary care is an essential element of effective medical care. Primary care providers include the family physicians, internists, pediatricians, gerontologists, nurse practitioners and physician assistants who provide the face-to-face personal diagnosis and treatment which Americans need. Where coordination of care exists, it is these professionals that usually provide it. The primary and preventive care they prescribe can prevent patients from getting sicker and often avoid the need for more expensive hospital and specialty care.

Quality primary care requires devoting substantial time to actual consultation with patients. Unfortunately, the reimbursement systems used by Medicare and many private insurers place a higher value on procedures than on consultation, even if consultation is more useful to patient health. This means that whenever a physician or other provider takes additional time to talk through a patient's treatment options, that provider is actually losing money. Primary care providers who deal with the poorer populations

most in need of care are in even more difficult situation. Medicaid, which insures many of these patients, only pays on 69% of the Medicare rates.[xi]

Already, most medical school graduates choose more lucrative specialty care over primary care. In 2007, only 7% of medical students were planning careers in general practice or primary care internal medicine.[xii] The payment imbalances noted above are making this problem worse.

4. Patients Are Left Out Of Their Own Medical Decisions

A lack of patient knowledge and involvement in their care decisions also contributes to our cost and quality crisis. Currently, physicians generally make care decisions, with patients playing a passive role. However, when patients are more involved in treatment decisions and better understand the benefit and risks of their options, they prefer less intensive care options. Not only does shared decision-making result in patients getting more of the care they actually want, but researchers estimate that shared decision-making could result in as much as 30% less utilization of many of the most expensive surgical procedures.[xiii]

5. Many Treatments Lack Adequate Scientific Basis

Our current system fails to give family physicians and other primary care professionals the information needed to determine the best course of treatment for each individual patient. Only half of medical interventions are supported by adequate evidence of clinical effectiveness.[xiv] For certain diseases which have an established, evidence-based treatment, studies show that patients receive the recommended care only 54% of the time.[xv] Even when evidence exists and an established course of treatment is available, clinical guidelines can fail to account for differing effects of the same treatment on different populations such as children or minorities. These gaps lead to the waste of precious health care dollars on care that is unnecessary and doesn't work, They also undermine a family doctor's or other caregiving professional's ability to give American families the care on which they depend.

6. Regional Variation in Price of Care Drives up Everyone's Costs

The prevalence of the above-mentioned factors and the cost of treating patients varies widely in different health care markets. In California alone, Medicare pays some hospitals four times more than others for treatment of chronically ill individuals in the last two years of life.[xvi] The amount of resources involved are vast. If Medicare reduces levels of spending in Los Angeles, for example, to the typical level of spending in Seattle, it would save enough money to buy each Los Angeles retiree a new BMW.[xvii]

These regional variations cannot be explained by differing costs of living or the age of the population.[xviii] Rather, some health care markets simply bill for a greater quantity and complexity of care, and receive more taxpayer and private insurance premium dollars for it. The market structure of these regions actually encourages unnecessarily intensive and costly care. By contrast, the lower-cost regions not only focus on less-expensive primary care but also provide better results for patients.[xix] So, while higher-cost regions might

offer more tests and procedures, the patients lose out when it comes to the primary care professionals and treatments they want and need.

7. The Current Health Care Marketplace Has Not Rewarded Innovation
In recent years, "accountable care organizations" or ACOs such as the Mayo Clinic and the Intermountain Health System, have tackled the delivery system problems described above. They have implemented reforms which reduce costs while providing world-class quality.[xx] They have given doctors and other providers the tools they need to provide the best, most efficient care: access to scientific research on the treatments that work best, payment policies which reward primary care and care coordination, and an emphasis on shared decision-making with patients.

According to the Dartmouth Institute for Health Policy and Clinical Practice, hospital spending would decrease by 43% if the entire nation matched Intermountain Health's per patient costs.[xxi] This amounts to a $299 billion in savings to taxpayers, insurance beneficiaries, and the economy as a whole in just one year[xxii]

Unfortunately, less efficient insurers and health systems, supported by the perverse incentives in the current payment system, continue their outdated practices and dominate most health care markets. Consequently, most doctors and patients must navigate an ever-more costly health care system, without the quality, affordable choices which accountable care organizations can provide.

Recommendations: Reducing Costs through Better Care

To fix these problems, the United States must address the root cause of the quality and cost crises. We must fix the skewed incentives in today's health care marketplace. If we can succeed, we can rein in skyrocketing costs while restoring quality, personalized medical care to American families.

Because public programs like Medicare are directly controlled by the American people and account for a 35.3% of health spending in the US,[xxiii] transforming these public programs offers the easiest first step toward system-wide delivery and payment reform. Therefore, change must start with how the public sector pays for care.

- **Reform Public Payment Systems To Provide Incentives For Quality Of Care, Not Quantity**.
  Doctors and hospitals should be rewarded for providing the type of care that improves patients' health—not simply for providing an ever-higher quantity and complexity of medical care. To prevent disruption of care, however, these changes must be gradually phased in.
    1. Step 1: Replace Medicare fee-for-service payment with a bundled payment system that pays hospitals a set amount for every admission for particular diagnoses. This reform would be optional for hospitals in low-access, rural areas who often struggle to remain financially healthy.

2. Step 2: Expand bundled payment to include follow-up care and emergency room care within thirty days of admission, as well as hospital care by 2013.
3. Step 3: Expand bundled payment to include hospital care, follow-up care, emergency room care, and related physician care within 30 days of admission by 2016.
4. Hospitals which have already developed the needed capacity may "skip ahead" and receive Step 2 or 3 bundled payments before their nationwide implementation dates in 2013 and 2016.

- **Reward High-Quality Primary Care And Build The Primary Care Workforce**:
    1. Adequately compensate physician's for patient consultation by implementing a 5% increase in Medicare's payment rate for evaluation/management services provided by geriatricians, family physicians, internists, pediatricians, nurse practitioners, and physician assistants, as recommended by the Medicare Payment Advisory Commission (MEDPAC).[xxiv] This increase could be paid for by a 0.5% decrease in payment rates for specialists.
    2. Reform the annual payment updates in Medicare to provide greater yearly increases for primary care providers.
    3. Invest federal resources to bring Medicaid provider payment rates up to Medicare levels.
    4. Strengthen federal workforce and education programs which support primary care.
        a. Lift the cap on medical residencies supported by federal Graduate Medical Education programs in specific primary care disciplines: family practice, internal medicine, pediatrics, and geriatrics
        b. Increase federal funding for federal programs to support the primary care workforce, known as Title VII.
        c. Double federal investment in the National Health Service Corps which forgives medical students' educational debt in return for providing primary care services to the communities that need it most

- **Implement Innovative Coordinated Care Models, Including The Medical Home**
    1. Implement the Commonwealth Fund's recommendations on the medical home[xxv]
        a) Medicare would offer smaller co-pays and other cost-sharing beneficiaries who use a medical home
        b) Participating providers would receive a share of Medicare savings as year-end bonuses, based on quality measures and patient satisfaction
    2. Prioritize medical home and care coordination implementation for Medicare beneficiaries with multiple chronic conditions, as provided for in

legislation like the Independence at Home Act and the Geriatric Assessment and Chronic Care Coordination Act.
3. Encourage other models of care coordination, by offering "shared savings" bonuses to provider groups that coordinate care, achieve quality benchmarks, and provide care at costs lower than the average.
4. Initiate a Medicare demonstration project which tests a bundled payment for all the hospital care (Part A) and physician care (part B) received by beneficiaries with selected chronic disease diagnoses.

- **Promote Patient Participation in Treatment Decisions**.
  Health reform legislation should promote "shared decision-making" in which patients are given detailed information about treatment options and empowered to make decisions about their medical care.
  1. Immediately allow nationwide, voluntary participation in a Medicare Pay for Performance program to reward hospitals for implementing shared decision-making processes for the ten most common inpatient surgeries.
  2. Gradually increase the number of diagnoses included within the shared decision-making Pay for Performance program.
  3. Within five years, Medicare should require that hospitals use shared decision-making processes to inform patients of their options before surgery for diagnoses covered by these programs.

- **Correct Regional Imbalances in Hospital Spending:**
  Fix regional spending should start with Medicare's annual updates, the yearly increases in the payment rates for hospitals.
  1. End the customary annual increases in Medicare payment rates for hospitals in regions with a per-beneficiary cost above 125% of the Medicare median.
  2. Institute a sliding scale of reduced Medicare annual increases for regions with a cost per beneficiary between 105% to 125% of the median
  3. Penalize the most costly hospitals by reducing Medicare payments to a very small group of "outlier" hospitals by 2% of normal Medicare payment rates.

  It is critical that these measures be applied judiciously. Procedures should be in place to exempt facilities which can demonstrate a more distressed patient population or higher costs due to provision of services to low-access regions such as rural areas.

Efforts to reform the delivery system will not be complete unless Medicare reforms are paired with vigorous federal action to empower the private-sector to reform itself.

- **Study What Works And What Doesn't**.
  Every consumer and provider deserves access to the best, unbiased information about their treatment options. Building on funding in the recent American Recovery and Reinvestment Act, the federal government must continue to invest in comparative research which studies the effectiveness of various treatment

alternatives. But to sustain political support, and maximize its impact, such comparative clinical effectiveness research must be guided by the following principles:

1. Results of the studies should be made available to all: providers, payers, and consumers.
2. Research priorities and study outcomes must be insulated from political pressure or undue influence from special interests.
3. Studies and recommendations must reflect the differing effects of treatments on disparate sub-populations.
4. Research must include both clinical interventions (such as drugs) and behavioral or community-based approaches (such as diet or exercise programs).

- **Encourage Accountable Care Organizations**.
  For years, innovative "accountable care organizations" (ACOs) like the Mayo Clinic and Intermountain Health System have provided better care at lower prices. In a better functioning market, cost-saving, quality improving innovations like theirs would have been quickly adopted throughout the country. Instead, our health system has continued to support inefficient care. The following policy steps will encourage the spread of accountable care organizations.
  1. In regions where an ACO exists and offers an adequate plan and network of providers, any federally-sponsored connector or exchange mechanism must allow participants to choose an ACO plan
  2. Health reform legislation must fund a comprehensive NIH grant program to help health systems and insurers form new ACOs.
  3. To encourage networks of doctors, hospitals and other sources of care to form accountable care organizations, Medicare should allow ACOs to share in the savings they generate for the Medicare program, provided they meet benchmarks for quality of care.

Conclusion

Once fully implemented, the recommendations in this report can pull America out of its health care crisis by making health care better for patients and doctors. Family health providers will be armed with the most up to date information so that they can provide the best care. Patients will be more involved in decisions about their care and will have more time to discuss their care with their providers. Payment systems will encourage more coordinated, team-based approach to care.

Fortunately, accomplishing these transformations won't break the bank. In fact, by fostering quality and effective care, these policies will make our system far more efficient and save money for taxpayers and consumers. America can tame rising health care costs while helping physicians and other providers be more effective at the job they signed up to do in the first place –providing the best personalized care to America's families.

Endnotes

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