

**April 10, 2008**

## Healthcare Payment Reform: Creating Conditions for More Efficient Health Delivery

**M**ost experts who examine America's persistent healthcare cost and quality problems identify fee-for-service (FFS) reimbursement as an key contributor to the system's chronic ills. Under FFS, doctors and hospitals are paid more for doing more, not for delivering better outcomes. The economic incentives under FFS actually discourage quality improvement because care that "gets it right the first time" frequently reduces revenues. Under FFS, providers also lack a business case for excelling at prevention, chronic care management, or efficient use of technology. Without other strong mechanisms for encouraging best practices, FFS has enabled significant geographic variation in health care spending across the U.S. with high cost regions often delivering lower quality care.

Payment reform is essential for moving the U.S. healthcare system onto a sustainable cost trajectory while improving quality. Despite agreement that new payment systems are needed, there is no consensus on the "right" payment system or the best way to start a systematic process of change. During the 1990s, managed care plans pushed hard to replace FFS with capitation - an all inclusive payment for each patient regardless of how much care they actually received. Although many providers signed capitation contracts, most of these efforts ultimately failed because doctors and hospitals were not organized to coordinate care efficiently. Providers did not change their style of practice despite capitation contracts because many large payers including Medicare continued to pay FFS. As physicians began losing money on capitation contracts, patients became fearful that clinical decisions were affected by financial considerations. By 1999, the public outcry against managed care reached a fever pitch. This backlash, combined with a strong economy that buffered concerns over health spending, led employers to pull the plug on managed care, letting capitation go with it down the drain.

Although the 1990s experience made payers, physicians, and patients cautious about payment reform, there is growing consensus that without significant payment policy changes, health care costs will continue growing regardless of what else is done. On April 10<sup>th</sup> 2008, The Health Industry Forum brought together health plans, delivery systems, and public officials to examine current initiatives to implement more effective payment policies, and discuss strategies for expanding these programs to a range of markets. Key themes from the meeting are summarized below.

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***The growth in U.S. healthcare spending is unsustainable and will lead to a system "meltdown" without reforms that moderate future rates of increase.***

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Health spending has grown 2.5% faster than GDP for the past 40 years and since 2000, spending grew faster than any time since 1970. The Congressional Budget Office projects that if this trend continues, Medicare and Medicaid spending will rise from 4.6% of GDP today to 20 percent of GDP by 2050. Private health insurance costs have grown even faster than national health spending, 9.5% annually since 1998. If premiums continue growing at this rate, family coverage will rise from \$12,106 in 2007 to \$30,000 by 2017 encompassing nearly one-third of the median income for a family of four.

If health spending does not slow, the system will face a "meltdown" comprised of the following events: rapid growth in the number of uninsured Americans; deteriorating health benefits for those that remain insured; significant financial stress on health care organizations leading to disinvestment in low-margin services; a growing number of "horror stories" where middle class

patients are denied access to potentially lifesaving treatments; and ultimately public pressure that leads to strong government regulation of health care spending. Signs of systemic stress are already showing; growth in the number of uninsured has accelerated despite a robust economy, accompanied by a rising rate of medical bankruptcy.

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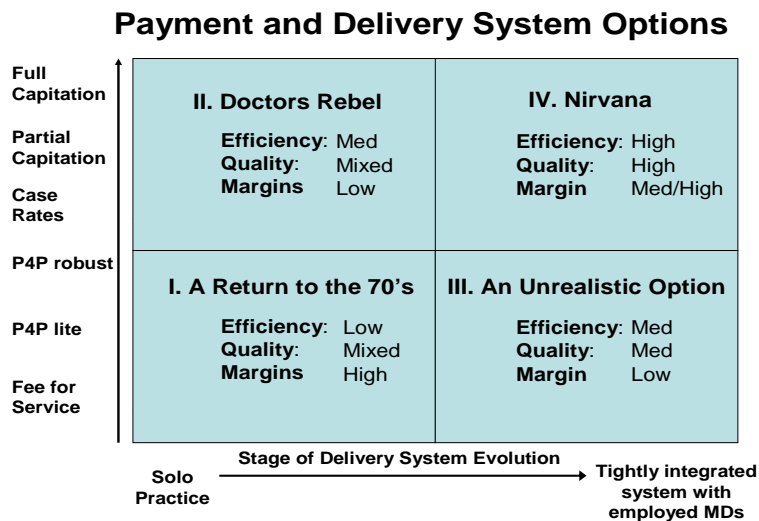
*Payment reform alone will not solve the emerging cost and quality crisis, but it is essential for driving delivery system changes that will lead to more effective care.*

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Many experts believe that integrated delivery systems offer the greatest promise for efficient, high quality health care. Expanding integrated delivery will require that physicians join groups capable of managing patients efficiently across a continuum of services or invest in infrastructure that enables virtual integration. These groups must be capable of implementing evidence-based best practices across their networks and coordinating patient care within a budget. Under FFS reimbursement, physicians have few financial incentives to establish integrated groups, and those in such groups lack incentives for curtailing marginally useful services. More integrated payment focused on episodes or populations would create stronger incentives for integration and for efficiency within integrated systems. Exhibit 1 illustrates different paths the health system might take along a continuum of payment and delivery system structures.

- **Quadrant 1** represents the current health system characterized by poor efficiency and mixed quality. Although provider margins are currently robust, cost containment will include significant fee reductions with a negative impact on quality.
- **Quadrant 2** recalls the mid-1990s and reflects the impact of imposing rapid payment reform on a fragmented delivery system. Providers may become more efficient, but if they cannot integrate quickly, many will experience fiscal distress, generating intense political resistance.
- **Quadrant 3** is an unrealistic scenario because without financial incentives for integrated delivery, the pace of network development will be slow. Integrated networks that manage care effectively will lose revenue under FFS, leading to declining margins, sub-optimal performance, or both.
- **Quadrant 4** is where the health care system will ideally move with promise of better efficiency, higher quality and better financial performance.

The challenge for policy makers is determining how to move the system towards the 4<sup>th</sup> quadrant at a reasonable pace and with support from the provider community.



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*There are many promising payment reform options but no one-size-fits-all solution. The most effective approach will depend on local market characteristics.*

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The nature and potential effectiveness of local payment reform initiatives depends on the size, organization, and political strength of payers and providers as well as the local culture, public policy environment, and effectiveness of individual leaders. Communities that develop multi-stakeholder collaborations may be able to reduce provider resistance and establish an acceptable transition to a new payment structure. Three examples illustrate potential methods, challenges, and opportunities.

- **Geisinger Health System’s evidence-based case rates.** Geisinger is an integrated health system that includes a hospital network, employed physician group, and health plan with 212,000 members. Geisinger has established global case rates under which the network accepts a single fee for all services provided 30 days before and 90 days following certain surgical procedures. The payment levels assume a 50% reduction in the historical complication rate for each procedure. Participating clinical departments have established strict criteria for proceeding with surgery and a uniform set of evidence-based clinical interventions that are tracked for each case. Initially launched for cardiac surgery, Geisinger now offers its “ProvenCare” approach for a range of procedures including angioplasty, cataract surgery, and hip replacement.
- **Blue Cross Blue Shield of Massachusetts’ (BCBSMA) alternative quality contract (AQC).** The AQC is a health status adjusted global payment that includes a base per-member per month payment and a performance payment of up to 10 percent for meeting quality and safety goals. BCBSMA envisions this as a multi-year arrangement where base payments grow by inflation. Contracted delivery systems can improve margins through efficiency improvements that keep baseline expenditure growth below inflation and by earning performance payments for meeting quality benchmarks.
- **United Healthcare’s multi-faceted approach.** United Healthcare (UHC) is the nation’s second largest health plan, though it has relatively limited share in most local markets. Through its large database UHC has identified significant variation in provider efficiency and quality. UHC encourages provider improvement, and steers patients towards high quality, efficient providers using centers of excellence networks for high cost, low volume services, provider performance transparency, a uniform physician recognition program with financial rewards, and patient engagement initiatives. Other initiatives include a medical home pilot program and development of new payment bundles.

As these examples illustrate, the approach and success of payment reform initiatives are affected by local delivery system structure and capacity. The Geisinger program was implemented in a context that is not common to most other markets - a physician-driven integrated delivery network with dominant market share, and an affiliated health plan to defray the financial risk of new payment structures. However, the program was developed by physicians, and based on national clinical guidelines which could make it attractive to a range of delivery systems including academic medical centers with affiliated practice plans. BCBSMA’s program is focused on a region with a high concentration of large multi-specialty group practices. Its emphasis on combining a global payment with large quality incentives counters the historical concern that global payment systems create incentives for physicians to withhold necessary care. UHC’s programs, while lacking local market clout, illustrates a strategy of leveraging large data bases to identify high quality efficient providers, and using a variety of levers, including payment to shift patient volume and encourage improvement.

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*Payment reform cannot succeed broadly unless Medicare plays an active role; Medicare must develop ways to collaborate with the private sector on innovative new models.*

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Medicare is the largest healthcare funder in the US, accounting for roughly one-third of total expenditures. Virtually all providers rely on Medicare for a significant share of their budget. Medicare payment policy can fundamentally influence provider behavior as evidenced by the changes that occurred following implementation of Medicare's hospital DRG system. At the same time, doctors and hospitals are unlikely to respond to private payment initiatives that run counter to Medicare incentives. Despite its market power, Medicare lacks the flexibility of private insurers to adopt innovative new payment policies, benefit designs, or competitive models. Major change frequently requires Congressional action; and the politics are difficult. Success with payment reform will require greater alignment between public and private payment policy. Private payers need to demonstrate the efficacy of new payment models in order to build Congressional support. But Medicare needs to support promising initiatives. One avenue is through local demonstration projects in which Medicare and local payers agree on uniform payment standards. Developing these programs will be challenging, but CMS has authority to do so through section 646 of the Medicare Modernization Act. Success will ultimately require a combination of local, national, and Congressional champions for a range of demonstrations that could have the potential for moving payment policy and the healthcare delivery system onto a more sustainable path.

*This policy brief was prepared by Robert Mechanic of Brandeis University  
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