

RECOMMENDATIONS
to the
United States Senate Committee on Finance
on the
Policy Options for Transforming the Health Care Delivery System

The Center for Healthcare Quality and Payment Reform commends the Committee for advancing many important and innovative ideas that can help to create a more value-driven healthcare system in the U.S., and offers the following comments and recommendations.

Summary of Recommendations:

Provide Resources to Primary Care to Reduce Readmissions

- Provide payments to primary care practices for transitional care activities as proposed by the Committee, but include all types of primary care practices, not just physicians. (See page 4 below for more detail.)
- Focus any readmission penalties for hospitals on readmissions that are not only preventable, but due to complications deriving from the care they received in the hospital. Prevention of readmissions for chronic disease patients should be accomplished through improved primary care resources. (See page 3 below for more detail.)

Establish Comprehensive Care Payment Options for Providers

- Establish three different levels of Comprehensive Care Payment as part of the Medicare program to give healthcare providers both the flexibility and the accountability to transform the way they deliver care. (See page 9 below for more detail.)
- “Shared savings” has serious weaknesses as a payment reform approach, and the Committee’s focus should be on moving to Comprehensive Care Payment systems. (See page 6 below for more detail.)

Enable and Encourage Medicare to Participate in Regionally-Defined Payment and Delivery System Reforms

- Provide the authority to CMS to participate in regionally-defined payment and delivery system reforms, as the Committee has proposed through an extension of Section 646 and creation of a Chronic Care Management Innovation Center. (See page 11 below for more detail.)
- Provide additional resources to CMS to enable it to evaluate and respond quickly to proposed demonstrations, and establish clear standards and deadlines for evaluating proposals. (See page 11 below for more detail.)

Build a Strong Regional Health Improvement Infrastructure

- Provide funding to Regional Health Improvement Collaboratives to enable them to build consensus among healthcare providers, health plans, employers, consumers, and others on the changes needed in their local healthcare systems and to help them support and coordinate the implementation of those changes. (See page 12 below for more detail.)

1. Providing Resources to Primary Care to Reduce Readmissions

In the Policy Options paper, the Committee has appropriately focused attention on the problem of hospital readmissions. Research studies and quality-reporting initiatives around the country show that 15-25% of people who are discharged from the hospital will be readmitted to the hospital within 30 days or less, and that many of these readmissions are preventable. Reducing readmissions is a win-win for both cost and quality, without a hint of rationing.

However, the options that the Committee has proposed for reducing readmissions in the section on “Hospital Readmissions and Bundling” (pp. 13-16) have two serious weaknesses:

- They do not distinguish whether the cause of a patient being readmitted to the hospital is due to something the *hospital* did or did not do, or due to a lack of appropriate care and support in the *community*; and
- They do not recognize that for many patients, particularly patients with chronic diseases, effective primary care is the most important “post-acute care” service of all.

Who Is Responsible for Preventable Readmissions?

Clearly, some readmissions are either not preventable or are actually desirable. When a patient leaves the hospital after successful surgery but returns for trauma care two weeks later following a car accident, the patient has been “readmitted,” but due to circumstances that are beyond the control of any healthcare provider. Also, some patients will return to the hospital within a short period of time because completion of their treatment during their initial admission was inappropriate or because their treatment is designed to be administered over a series of admissions (e.g., in cancer care). The Committee’s proposal appropriately recognizes this important distinction between preventable and non-preventable readmissions.

However, even if a readmission is preventable, it may not be preventable *by the hospital*. Indeed, one can divide the causes of preventable readmissions into three broad categories:

- **Readmissions for complications or infections arising directly from the initial hospital stay**, e.g., if a surgery patient develops a surgical site infection or other complication and has to return after discharge.
- **Readmissions because of poorly managed transitions during discharge**, e.g., if a patient or a caregiver does not receive clear instructions from the hospital about the types of medications to take or what to do or not do during recuperation, or if a post-acute care provider does not implement the discharge instructions properly.
- **Readmissions because of a recurrence of a chronic condition that led to the initial hospitalization**, e.g., an exacerbation of asthma, congestive heart failure, or chronic obstructive pulmonary disease.

Readmissions in the first category and many readmissions in the second category can be viewed as primarily the responsibility of the hospital, and most of these readmissions occur quickly – within 15-30 days. Payment changes for hospitals to reflect this would be appropriate; indeed, ideally, hospitals should offer a “limited warranty” for these types of cases and

readmissions.

But the largest numbers of readmissions are among patients with chronic disease. Many of these patients are being admitted and readmitted because they are not receiving good primary care support in the community, and that is not likely to change simply by penalizing hospitals for these readmissions. Moreover, a 30-day window of time is arbitrary; more than half of the readmissions among chronic disease patients occur after 30 days.

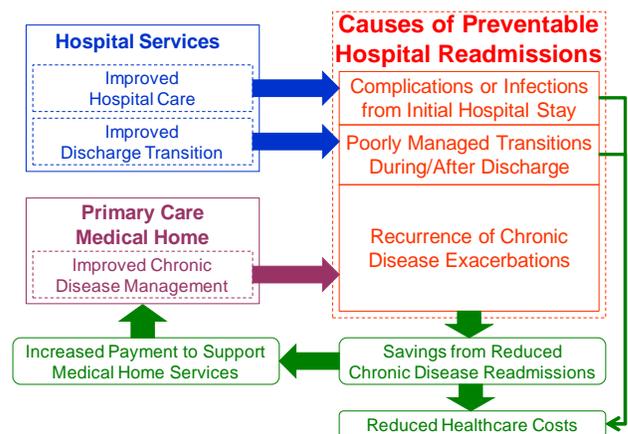
Many of the readmissions among chronic disease patients can be prevented, but the prevention must come from improvements in *primary care*, not (just) from changes in *hospital care*. Study after study has shown that very simple, low-cost interventions by primary care practices, such as in-person education of patients about how to manage their conditions and use medications properly, can dramatically reduce hospitalizations and readmissions among people with chronic disease.

There are at least two important disadvantages to penalizing hospitals for these readmissions:

- Hospitals may begin discouraging chronic disease patients who have been recently discharged from seeking hospital treatment even if they need it and even if there is not adequate community support to serve as an alternative;
- Hospitals may feel compelled to establish new 30-day-long disease management programs to try and keep chronic disease patients from coming back to the hospital during the penalty window, but then the patient will still be at risk of being readmitted after the end of the 30 days since no fundamental changes in primary care have been made. Moreover, a new temporary disease management program would likely create further fragmentation of care.

We would recommend that instead of creating a blanket policy to penalize hospitals for all preventable readmissions, that the Committee adopt the following approach:

- **Make hospitals responsible for all or part of the costs of those readmissions that are caused by factors that are not only preventable, but due to complications deriving from the care they received in the hospital; and**
- **Provide additional resources to primary care practices to reduce readmissions among patients with chronic disease. (See the following discussion for more details on this element.)**



Providing Resources to Primary Care to Reduce Readmissions

Although knowledge is still evolving about the precise nature of what types of primary care services work and don't work in reducing hospital admissions and readmissions, there are strong indications that the following elements provide a positive return-on-investment (ROI):

- At least one home visit or other face-to-face contact, rather than purely telephonic support;
- Providing education and coaching to the patient as to how to take their medications and how to manage their conditions;
- Targeting services to a moderate-risk population, e.g., those who have been recently discharged from the hospital; and
- Close coordination between the care manager and the patient's primary care physician.

Unfortunately, under current payment systems, Medicare and commercial health insurers won't pay for these services that can keep patients out of the hospital, even though they will pay every time the patient goes into the hospital.

The Committee's proposed option under "Payment for Transitional Care Activities" (pp. 10-11) is an excellent first step in addressing this problem. It will enable primary care practices to pay for the kinds of patient education and self-management support that have been shown to reduce hospitalizations among patients with chronic disease and other ambulatory care sensitive conditions. Moreover, it will help to ensure offsetting savings for Medicare by focusing this support on those patients who are at highest risk of hospitalization.

However, we would recommend that the option be modified to state that "Medicare would reimburse ~~physicians~~ primary care practices for certain care management activities..." It is important that the reimbursement mechanism ensure that these services are directly connected to the primary care practice, rather than disconnected as so many disease management programs are today. However, many primary care practices utilize nurse practitioners and other non-physician providers, and these should not be precluded from participating.

If the Committee would like to understand better how this approach would work, there are two programs that could be used as models:

- The Pittsburgh Regional Health Initiative designed and is implementing a program specifically designed to reduce hospital readmissions among chronic disease patients by helping both primary care practices and hospitals improve their care of these patients. A key element of the program is hiring nurse care managers who serve as an integral part of the primary care practice team, making home visits and phone calls as necessary to help patients manage their conditions appropriately. Moreover, the program has been structured in a way that enables multiple small physician practices to share care management resources so that they can be delivered efficiently.

- Blue Cross Blue Shield of Michigan is using T-Codes to reimburse for care management services by primary care practices to chronic disease patients as part of its Physician Group Incentive Program.

In preparing the enabling legislation for this option, it will be important to ensure that it remains focused on achieving the following goals:

- Enable primary care practices to pay for non-physician resources to provide care management;
- Enable small primary care practices to share care management resources among themselves or to contract with a community agency, home health agency, etc. to provide the staff;
- Ensure that care management services are integrated with primary care practices;
- Focus the care management resources, at least initially, on a large population known to be at high risk of hospitalization (i.e., through readmission);
- Increase payment to physicians to enable them to spend more time developing care plans, responding to patient calls regarding their chronic disease action plans, etc.;
- Reward physicians for monitoring and improving outcomes (i.e., reducing hospitalizations/readmissions); and
- Avoid cost deterrents to beneficiaries accepting the care management services.

The approach proposed by the Committee is more likely to achieve benefits to Medicare, particularly in the short run, than most current approaches to creating Medical Homes, which merely pay more to physician practices that meet NCQA Patient-Centered Medical Home Standards. Although “care management” is an element of the PCMH Standards, the standards do not encourage or ensure a focus on the above elements. Moreover, there is no emphasis in the PCMH Standards on measuring and reducing the rate of hospitalizations and readmissions, which would help ensure savings to Medicare.

Moreover, the Committee’s proposed payment change positions primary care practices to participate in a severity-adjusted comprehensive care payment system for chronic disease patients. Under such a system, the costs of both the care management services and the increased payments to primary care physicians would be incorporated into the comprehensive care payment amount, rather than being paid separately, and the primary care practice would have a built-in incentive to target the services on those patients where there is the biggest opportunity for savings from preventable hospitalizations, ER visits, etc. (See the next section for more detail on this approach.)

Providing more resources to primary care practices with a focus on reducing readmissions provides a mechanism for simultaneously achieving three important goals – improving primary care, improving patient outcomes, and reducing the nation’s healthcare expenditures.

2. Establish Comprehensive Care Payment Options for Providers

The Committee has also appropriately recognized the importance of moving away from fee-for-service payment and toward payment systems that encourage and support providers to take greater accountability for the costs and outcomes of the care they deliver.

There is growing consensus that the only way to truly rein in healthcare costs without harming quality is to use some form of population-based payment. There are a variety of different names for this — “Comprehensive Care Payment,” “Condition-Adjusted Capitation,” or “Risk-Adjusted Global Fee” — but the core element is paying a single price for all of the healthcare services needed by a specific group of people for a fixed period of time (e.g., all of the care needed during the course of a year by the people who live in a particular community or a group of beneficiaries who have chronic diseases).

The goal of a Comprehensive Care Payment is to encourage the healthcare provider receiving it to keep patients well and out of the hospital (i.e., to reduce the number of episodes of care they need) as well as to avoid providing unnecessary services within any particular episode of care. Moreover, Comprehensive Care Payment gives healthcare providers the flexibility to decide what services should be delivered and the upfront resources to deliver them, rather than being constrained by fee codes and amounts, or waiting for uncertain, after-the-fact shared savings payments to be made.

However, since Comprehensive Care Payment represents a dramatic change in the way most healthcare providers are paid, many people have expressed concerns about how many providers could manage under such a payment system. Also, since any type of population-based payment method sounds to many people like the capitation payment systems that caused so many problems during the 1990s, there are concerns about whether a Comprehensive Care Payment system can work successfully without causing financial difficulties for providers and resistance from patients. This has led to proposals for more incremental changes, most notably the concept of “shared savings” which the Committee has included as one of its options.

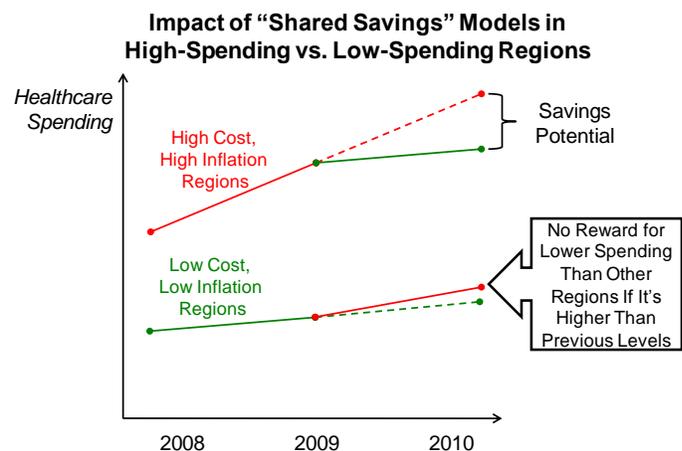
The Problem with “Shared Savings”

Unfortunately, there are some fundamental weaknesses in the shared savings approach that make it far less desirable as a payment reform than it might first appear:

1. **It’s P4P, Not Fundamental Payment Reform.** Shared savings is just another form of pay-for-performance (P4P). It doesn’t actually change the current payment system at all – key primary care services that aren’t paid for today (like nurse care managers for chronic disease patients, phone and email consultations with physicians, etc.) still wouldn’t be paid for, services where fees are too low to cover costs would still lose money, etc. Creating an incentive for providers to control total spending is a good idea, but only if it is coupled with significant changes in the underlying payment system.
2. **It Gives Providers Risk Without Resources.** At first glance, shared savings looks like the perfect deal for the healthcare provider – if the provider is successful in reducing total costs, it gets a bonus; if it’s not successful, it suffers no penalty. The flaw in the logic is assuming that there is no cost to the provider of doing what is needed to achieve success.

For example, although there are programs that have been demonstrated to reduce preventable hospitalizations, most of these programs require an increase in upfront spending by the primary care practice or the health system that implements them, or they take time away from other revenue-generating tasks. The shared savings payment might ultimately cover those costs or it might not, and so the provider has no assurance that its increased costs will be covered. Moreover, when multiple providers are involved, shared savings creates a variant of the “prisoner’s dilemma” – if one provider makes the investment to improve care but others don’t, the total savings may not be sufficiently large to insure the shared portion will cover an individual provider’s costs; conversely, if most providers make the investment, any individual provider can increase their profit by sharing in the savings without making any upfront investment themselves.

3. **It Rewards High Spenders Rather Than High Performers.** The communities and providers that have the most to gain from shared savings are the ones that are “wasting” the most resources today, through high rates of hospital admissions, use of unnecessary procedures, etc. In contrast, the communities that are the nation’s best performers — those with relatively low costs and high quality of care — are already “saving” Medicare and other payers significant amounts of money, but they receive no reward for doing so. The first group can improve relatively easily, since they have so much “low-hanging fruit” to pursue, and therefore would be eligible to get a large reward through a shared savings model. The latter group, even if it can still improve further, may need to invest significantly more resources to do so; this would require it to spend more in the short run, but with a lower probability of achieving enough savings to pay back those costs. In effect, shared savings exacerbates the current inequities in the payment system. The problem is even worse if the payer chooses to take a disproportionate share of the savings first, as Medicare has done in the Physician Group Practice Demonstration and as the Committee has specified in its proposal. Although this is intended to avoid rewarding providers for reductions in spending simply due to random variation, the practical effect is to increase the amount the provider has to spend or lose before receiving any reward through shared savings.



4. **A Smaller Reduction in Revenue is Still a Reduction.** In order for Medicare to have any savings at all, some provider has to get less revenue than it would have otherwise received. If that provider is participating in the effort to reduce spending, giving them back an arbitrary share of the savings reduces the amount they lose, but they may still get less revenue than their actual cost of delivering services, which will discourage them from participating in the effort to create the savings in the first place. Moreover, if only Medicare is sharing savings but the provider changes its approach with all of its patients, the shared savings program may offset only a small portion of the provider’s losses.

5. **It's Not a Sustainable Approach.** What happens after the initial savings have been achieved and shared? Even if costs remain lower than would otherwise have been expected, nothing has changed about the underlying payment system, and it will be hard for Medicare to continue making special "shared savings" payments indefinitely based on savings achieved in the past, particularly as the providers and their patients change over time. This will deter providers from making large investments in care improvements that would need to be paid off over a multi-year period.

Fixing What Was Wrong With Traditional Capitation

Since shared savings doesn't work well, what's needed is to design a true Comprehensive Care Payment system that avoids the problems that traditional capitation systems experienced. In particular:

- The amount of the payment must be adjusted based on the types of conditions, severity of conditions, and other characteristics of the patients being cared for. Traditional capitation systems paid a provider a fixed amount per patient, regardless of how sick or well the patients were, which penalized providers for treating sicker patients.
- Payments need to be set at adequate levels to provide good-quality care. In traditional capitation systems, payments were often arbitrarily set at levels far below the average cost of care experienced prior to institution of the capitation system, or were not increased adequately over time to reflect inflation.
- Special provisions are needed for unusually high-cost cases, such as outlier payments, reinsurance, etc., to avoid having a few expensive cases cause financial problems for providers who are doing a good job of managing typical cases.
- Providers should not be required to establish claims-payment systems. A provider contracting for a Comprehensive Care Payment should be expected to manage the total cost and quality of care, not necessarily to directly pay other providers delivering care. Medicare can still process claims from other providers using its existing claims-processing system, essentially treating the Comprehensive Care Payment as a debit account.
- Providers should be expected to collect and publicly report measures of quality of care, in order to assure both patients and payers that there is no inappropriate stinting on care.
- Patients must be given the flexibility to choose high quality providers, but patients must also be encouraged to use a consistent medical home to help them manage their health and healthcare services effectively.

There are payment systems in several regions that are making population-based payments in ways that meet many of these criteria. For example, in Minnesota, Medica's Patient Choice system pays providers the equivalent of a Comprehensive Care Payment by using the standard fee-for-service claims payment system and adjusting fee levels based on the severity-adjusted total cost of care. In Massachusetts, the Alternative Quality Contract offered by Blue Cross Blue Shield of Massachusetts is paying providers a severity-adjusted capitation payment combined with quality incentives.

Transitioning to Comprehensive Care Payment

Many large physician practices and healthcare systems could immediately participate in a Comprehensive Care Payment system. Smaller practices probably would be unable to participate immediately, but could evolve to do so over time. *Partial Comprehensive Care Payment* systems would help them to make this transition. Similar to partial capitation, a healthcare provider would receive the Partial Comprehensive Care Payment to cover the costs of a pre-defined set of services when they were needed by patients, but other services would continue to be paid by Medicare on a fee-for-service or other basis. For example, a small physician practice might be able to take responsibility for managing the costs of all outpatient services, but not the costs of hospitalization; a Partial Comprehensive Care Payment could replace fee-for-service payment for all outpatient services, but hospitalizations would continue to be paid directly under the DRG system.

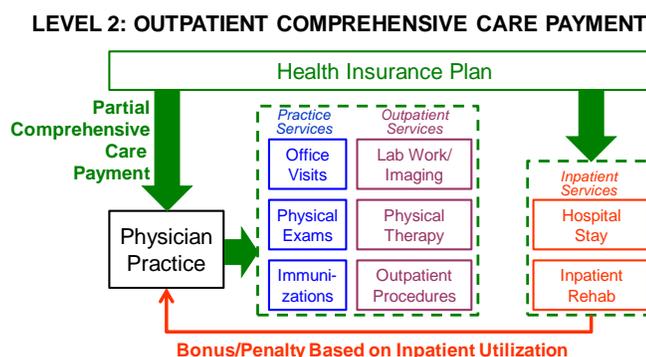
Since a Partial Comprehensive Care Payment would give the provider a financial incentive to substitute services that are not covered by the Payment for those which are covered, a pay-for-performance system could be used to maintain some level of financial risk for the provider for the costs of *all* services the patient receives.

We would recommend that the Committee establish three different levels of Comprehensive Care Payment as part of the Medicare program:

Level 1: Practice-Cost Comprehensive Care Payment, with P4P on Outpatient and Inpatient Costs. A physician practice (or health system) would receive a single (severity-adjusted) payment per patient to cover all of the services provided *within the practice* that would previously have been billed under individual fee codes, e.g., E&M codes, immunizations, etc. Other outpatient services (e.g., lab tests) and inpatient care (hospitalizations) would continue to be paid separately, but the physician practice would receive a pay-for-performance (P4P)-style bonus/penalty payment based on the level of utilization of those services (on a severity-adjusted basis). For example, the Massachusetts Coalition for Primary Care Reform is testing this type of approach in several small primary care practices.

Level 2: Outpatient Comprehensive Care Payment, with P4P on Inpatient Costs. The physician practice or health system would receive a single payment to cover all outpatient costs, but inpatient care would still be paid separately. The practice would receive a bonus/penalty payment based on the rate of utilization of inpatient services.

Level 3: (Total) Comprehensive Care Payment. All costs — practice-based, outpatient, and inpatient — would be included in a single payment. The payer



could still pay the actual claims, but the physician practice or health system would be responsible for keeping total costs within the Comprehensive Care Payment amount, except for outlier cases. Bonus/penalty payments based on outcomes and quality measures could be included as an incentive to ensure patients receive high-quality care.

At least in the short run, all of these would merely be options, i.e., providers could continue to be paid under the current Medicare fee-for-service structure if they wished. Having these types of parallel payment options is not fundamentally different than the way Medicare pays for services to some beneficiaries directly through the fee-for-service system and for others through Medicare Advantage (MA) plans. Indeed, the basic concept of a Level 3 Comprehensive Care Payment is very similar to the way Medicare pays MA plans now, but the payment would go directly to a provider, rather than to an insurance plan.

Small physician practices and those with no experience in any kind of capitation or risk-based payment could start at Level 1, then move to Level 2, and finally advance to Level 3 at some point in the future. But providers should be permitted to enter at any level they wished, and many providers would likely choose to enter directly at Level 2 or Level 3.

An additional transitional approach would be to initially provide Comprehensive Care Payments only for patients with chronic diseases, since (a) their costs of care are more predictable, and (b) there is a greater opportunity for both Medicare and the provider to benefit through improved care management.

As part of the transition process, small physician practices could also be encouraged and assisted to join together in virtual “accountable care organizations” that would enable them to better measure and improve their quality and cost performance and share costly care management resources (such as nurse care managers, electronic health records, patient registries, etc.). For example, Blue Cross Blue Shield of Michigan’s Physician Group Incentive Program (PGIP) encourages small physician practices to form multi-practice organizational structures that focus on quality improvement and enable sharing of quality improvement resources the practices could not individually afford to support.

3. Enable and Encourage Medicare to Participate in Regionally-Defined Payment and Delivery System Reforms

A number of regions and states are currently working to design reforms to health care payment and delivery systems and to encourage the payers in their region to implement those reforms. However, since Medicare is often one of the largest payers in a region, it is very difficult for health care providers to improve the way they deliver care if private payers improve their payment systems but Medicare does not. For example:

- In Minnesota, the Institute for Clinical Systems Improvement has developed the DIAMOND Initiative to improve the quality of care for people with depression. Under the program, primary care practices hire a care manager to provide education and self-management support to patients with depression, and psychiatrists are paid to provide consulting support to the care managers and physicians in managing the patient's condition. All commercial payers in the community are supporting this new model, and it is already proving effective, but the physicians cannot be reimbursed for the new way of delivering services to Medicare patients under current Medicare rules.
- In conjunction with the Pittsburgh Regional Health Initiative, the Governor's Office of Health Care Reform and the Governor's Chronic Care Commission have developed and are implementing a project to help physician practices implement the Wagner Chronic Care Model to improve the quality of care for patients with chronic disease. All commercial payers have agreed to participate and share the costs of additional services, but because Medicare is not participating, many physician practices may have financial difficulties implementing some of the most important additional services.

Based on experiences such as these, it is important that Medicare be able and willing to "follow as well as lead" on payment and delivery system reforms. Although CMS's current payment reform demonstrations are laudable and should continue, CMS also needs to participate in regionally-defined payment and delivery system reform projects that can present a clear business case for controlling costs as well as improving quality. Moreover, by increasing the probability of Medicare participation in locally-defined reforms, it would reduce the barrier that Medicare payment systems often present to such reforms.

The Committee's proposals to permanently authorize Section 646 of the Medicare Modernization Act and to create a Chronic Care Management Innovation Center would both provide improved mechanisms for CMS to participate in locally-defined payment and delivery system reforms. However, in addition to providing the *authority* for CMS to participate in locally-defined demonstration projects, Congress should provide CMS with the administrative *resources* needed to evaluate and respond quickly to proposed demonstrations. Moreover, CMS and OMB should be required to clearly define in advance the information that is needed and the standards to be met in terms of budget neutrality, etc. so that regions that wish to make proposals will clearly know what is expected, and there should be explicit and relatively short deadlines for both CMS and OMB to respond to such proposals.

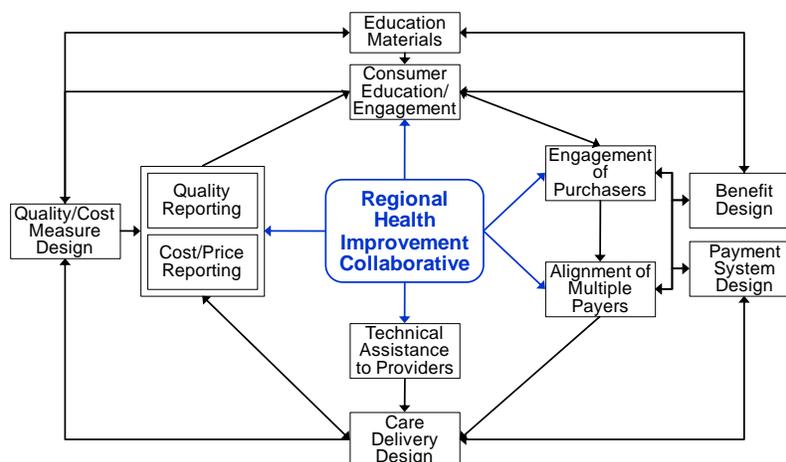
4. Building a Strong Regional Health Improvement Infrastructure

Reducing hospital readmissions and creating more accountable care organizations would represent a major step in transforming today’s volume-driven healthcare system into a value-driven system. But to be successful, any such step requires coordinated changes in multiple areas – reforming benefit designs to reward quality and value, redesigning care delivery systems to be more efficient and better coordinated, creating effective performance measurement and reporting systems, and educating and assisting consumers to take an active role in maintaining their health and choosing high-value healthcare services, as well as changing the payment system. Moreover, these changes will need to be designed and implemented differently in different parts of the country, in light of the tremendous diversity in payer and provider structures across the country. No single national solution is likely to be successful.

Fortunately, a growing number of communities have formed Regional Health Improvement Collaboratives to build consensus among healthcare providers, health plans, employers, consumers, and others on the changes needed in their local healthcare systems and to help support and coordinate the

implementation of those changes. Over 50 Regional Health Improvement Collaboratives across the country provide critical services supporting transformation, ranging from public reporting on healthcare quality and costs to training and technical assistance to providers to help them improve the quality and value of their services.

Regional Collaborative Roles in Healthcare Transformation



Federal support is needed to help Regional Health Improvement Collaboratives continue and expand these important roles in order to facilitate successful transformation of the healthcare delivery system at the local level. In addition to the technical assistance currently being provided through the Agency for Healthcare Research and Quality (AHRQ), Congress should provide funding for Regional Health Improvement Collaboratives to help them maintain and expand their services.