CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

nrhi Network for Regional Healthcare Improvement

Testimony of Harold D. Miller

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and
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to the
Committee on Energy and Commerce
U.S. House of Representatives
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Mr. Chairman and Members of the Committee:

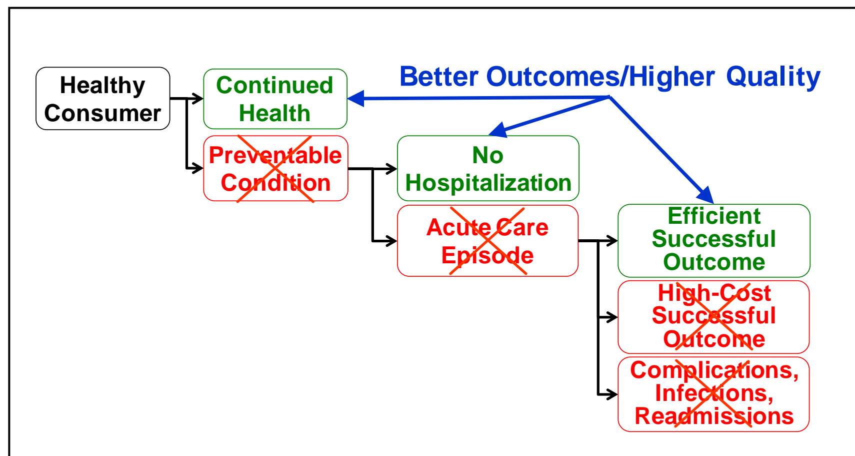
I commend you for working to address the important issues associated with physician payment reform and I appreciate the opportunity to provide input to your deliberations. The following are the major points that I would like to make to you today:

- Healthcare costs can be reduced without rationing, but a major barrier is current payment systems, which financially penalize physicians and hospitals for reducing costs.
- There are two principal ways healthcare payment should be reformed. The first is Episode-of-Care Payment, where physicians and hospitals are jointly paid a single price for all of the services associated with a hospitalization or procedure, including a warranty stating that they will treat any related infections and complications at no extra charge. The second is Comprehensive Care payment, where a physician practice receives a single payment to cover all of the care a patient needs for their chronic diseases or other conditions. These payment systems have been shown to improve quality and lower costs.
- Small, independent physician practices as well as large integrated systems can participate in these payment systems. However, small physician practices need a reasonable transition period and the following kinds of assistance to do so successfully:
    - Access to data and analysis on current utilization patterns and costs;
    - Training and coaching on restructuring of care processes;
    - Transitional payment reforms, such as accountable medical home payments, bundled payments, and condition-specific comprehensive care payments; and
    - Participation by all payers, including Medicare, Medicaid, and commercial plans.
- Because of the wide variation in the structure of healthcare delivery systems across the country, the best way to organize this help is through community-based, non-profit, multi-stakeholder organizations called Regional Health Improvement Collaboratives. Congress can help these Collaboratives support successful payment reforms for physicians by:
    - providing access to Medicare data so they can help physicians identify the best opportunities to improve quality and reduce costs.
    - giving them some modest federal funding so they can provide the hands-on help that physician practices need to reduce costs elsewhere in the system.
    - encouraging or requiring Medicare to participate in the multi-payer payment and delivery reforms their communities design.

Healthcare Costs Can Be Reduced Without Rationing

The challenge that the Committee and Congress have faced for many years has been how to control costs in the Medicare and Medicaid programs without denying care that patients need or limiting their access to high-quality physicians and hospitals. Although many people seem to believe that costs can't be reduced without rationing, there are three major ways to do so:

- **Preventing diseases from occurring in the first place.** Many illnesses can be prevented through interventions such as immunizations, weight management, and improved diet, and the severity of other illnesses can be reduced through regular screenings (e.g., for cancer or heart disease) that lead to early diagnosis and prompt treatment.
- **Helping patients manage chronic diseases and other conditions so they don't have to be hospitalized as often.** Studies have shown that rates of emergency room visits and hospitalizations for many patients with chronic disease and other ambulatory-sensitive conditions can be reduced by 20-40% or more through improved patient education, self-management support, and access to primary care.[1]
- **Reducing the high rate of infections, complications, and readmissions that occur today when patients do have to be hospitalized.** For example, work pioneered by the Pittsburgh Regional Health Initiative and replicated in other parts of the country proves that such events can be dramatically reduced or even eliminated through low-cost techniques.[2].



All of those things not only can save money for Medicare, Medicaid, and commercial health plans, but they improve outcomes for patients, too.

Current Payment Systems Are a Major Barrier to Higher Value Health Care

The problem today is that current payment systems drive the healthcare system in exactly the opposite direction. For example:

- Many valuable preventive care and care coordination services are not paid for adequately or at all (e.g., primary care practices are typically paid only when a physician sees a patient in person, not when the physician speaks to the patient on the phone). Similarly, specialists are only paid for seeing patients in person, not for advising primary care physicians on care management or for time spent coordinating services with the primary care physician. A primary care physician or specialist who hires a nurse to assist with patient education typically cannot be reimbursed for the time the nurse spends with the patient.[3] All of these things can limit the ability of physicians to flexibly design services to best meet a patient's needs, resulting in unnecessary illnesses and treatments.
- Physicians and hospitals can be financially penalized for providing better quality services. For example, reducing errors and complications during hospital stays can not only reduce both physicians' and hospitals' revenues, but also reduce hospital profits and their ability to remain financially viable.[4]

Perhaps most fundamentally, under current payment systems, health care providers don't get paid at all when their patients stay well.

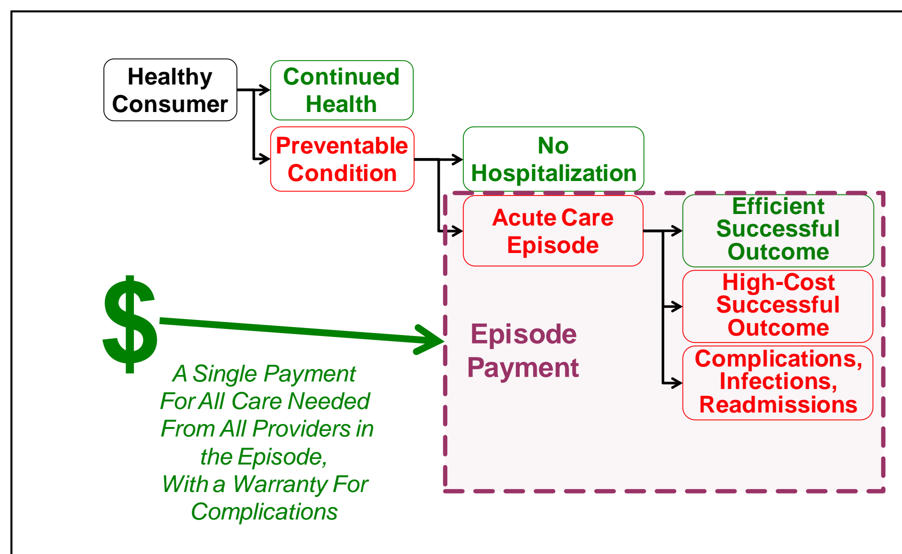
You can't fix those things by increasing or decreasing fee levels or by adding more and more regulations. The SGR obviously can't do it, either. The payment system itself is broken and has to be fundamentally changed.

There Are Better Ways to Pay For Health Care

There are two major kinds of payment reforms that would correct these problems and provide both the flexibility and accountability that physician practices, hospitals, and other providers need to both improve the quality and reduce the costs of healthcare.

Episode-of-Care Payments

One is to use Episode of Care Payments to pay for hospitalizations and major acute procedures. Instead of paying physicians and hospitals separately for each service associated with the hospitalization or procedure, they would jointly be paid a single amount. For example, once a patient has a heart attack, a single payment would be made to the hospital and physicians for all of the care needed by that patient for the heart attack. The amount of the payment would be severity-adjusted, e.g., the hospital and physicians would be paid more for caring for a heart attack patient with other health conditions such as diabetes or emphysema.



Moreover, the Episode-of-Care Payment would be designed to cover the costs of treating any related infections and complications that the patient experiences. In effect, the hospital and physicians would be providing a limited warranty on their care, i.e., if the patient experienced problems such as infections or preventable complications, the hospital and physicians would treat those problems at no extra charge.

The advantages of Episode-of-Care Payment include the flexibility it provides for hospitals and physicians to decide which services should be provided within the episode (rather than being restricted by the services specifically authorized under a fee-for-service system), the incentive it creates to eliminate any unnecessary services within the episode, the incentive for the hospital and physicians to better coordinate their services, and the incentive for everyone to prevent infections and complications.

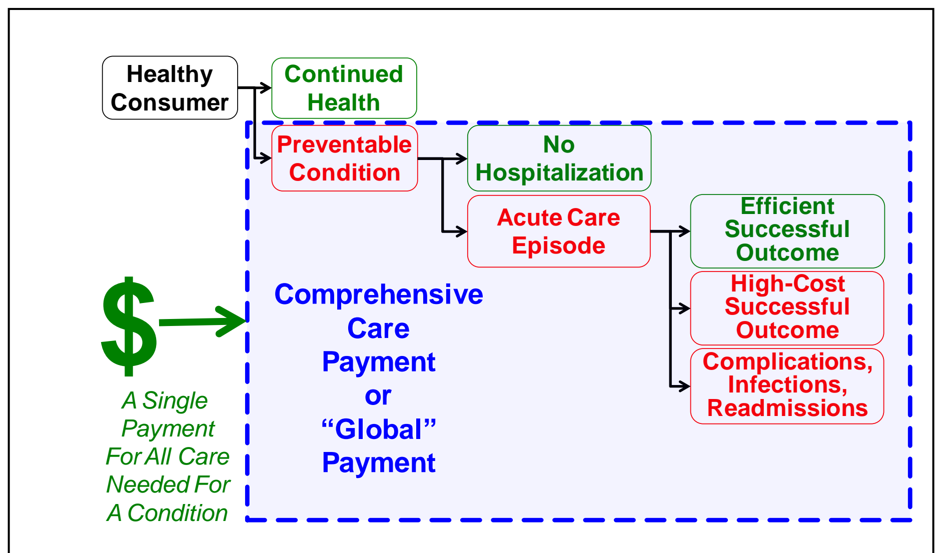
This approach – a single payment for a complete product or service, with a warranty to correct defects at no charge – is how most other industries are paid for their products and services, and it makes sense to use it in healthcare, too.

For example, the Geisinger Health System in Pennsylvania, through its ProvenCare[SM] system, provides a "warranty" that covers any follow-up care needed for avoidable complications within 90 days at no additional charge. The system was started for coronary artery bypass graft surgery, and has been expanded to hip replacement, cataract surgery, angioplasty, bariatrics, low back pain, perinatal care, and other areas.[5] Offering the warranty led to significant changes in the processes used to deliver care, and Geisinger has reported dramatic improvements on quality measures and outcomes.[6]

Comprehensive Care Payments

The major weakness of episode-of-care payment is that it does nothing to reduce the number of episodes of care. If a physician practice is managing the care for patients with chronic disease, we want the practice to find ways to reduce the frequency that those patients are hospitalized, not simply ensure higher quality and lower costs every time they *are* hospitalized. We also want to find ways to reduce the frequency of certain kinds of procedures where there is evidence of overuse that is harmful to patients.

A second payment reform that achieves these goals is Comprehensive Care Payment[7], or what is often referred to as "global payment." Under this model, a physician practice or health system would accept a single payment to cover all of the healthcare services their patients need for one or more health conditions during a specific period of time (e.g., a year). The amount of this payment would be adjusted based on the health of the patients (i.e., how many conditions they have) and other characteristics that affect the level of services needed. For example, a physician practice would receive a higher payment if it has more patients with severe heart disease rather than mild heart disease, but the payment would not depend on what kinds of treatment the patients receive. As a result, a



physician practice gets paid more for taking care of sicker patients, but not for providing more services to the same patients.

For example, the Alternative Quality Contract implemented by Blue Cross Blue Shield of Massachusetts in 2009 defines a single payment to a physician practice or health system for a group of patients to cover all care services delivered to those patients (including hospital care, physician services, pharmacy costs, etc.), with the payment amount adjusted by the health status of the patients. The physician practice or health system can earn up to a 10% bonus payment for achieving high performance on clinical process, outcome, and patient experience measures. The amount of the payment is based on historical costs for caring for a similar population of patients and is increased annually based on inflation. Outlier payments are made for patients with unusually high needs and expenses, and limits are placed on the total amount of financial risk the providers accept.[8] An evaluation of the first year results showed that healthcare providers participating achieved better quality, better patient outcomes, lower readmission rates, and lower utilization of emergency rooms.[9]

Separating Performance Risk from Insurance Risk

An important feature of both Episode-of-Care Payment and Comprehensive Care Payment is that they give physicians and health systems responsibility for *performance risk* – their ability to manage their patients' conditions in a high-quality and efficient manner –but not *insurance risk* – whether a patient has an illness or other condition requiring care. In contrast, traditional (non-condition-adjusted) capitation systems transferred *all* cost risk to the provider. Insurance risk is really what insurance is designed to address, and under both episode of care and comprehensive care payments, that risk remains with Medicare or a health insurance plan.[10]

Small Physician Practices Can Deliver High-Value Care

Because of the visibility of the outstanding work that the Geisinger Health System, Intermountain Healthcare, and other systems have done, a myth has developed that only large, integrated delivery systems can manage such payments and deliver higher-value care. The fact is that small, independent physician practices can also do so. For example, the earliest known example of someone offering a warranty in healthcare was not a large health system, but a single

physician. In 1987, an orthopedic surgeon in Lansing, Michigan collaborated with his hospital to offer a fixed total price for surgical services for shoulder and knee problems, including a warranty for any subsequent services needed for a 2-year period, including repeat visits, imaging, rehospitalization, and additional surgery. A study found that the payer paid less and the surgeon received more revenue by reducing unnecessary services such as radiography and physical therapy and reducing complications and readmissions.[11]

Moreover, just like in every other industry, small healthcare providers can often be more efficient and innovative than large systems can, if we give them the opportunity to do so without imposing unnecessary and expensive regulatory requirements.

The Help That Physician Practices Need

I've talked to physicians all over the country about these payment reform concepts, and what I've found is that once they understand them, they are willing to embrace them. But they need assistance to implement them successfully, and they need a reasonable transition period.

What kind of help do physicians need?

Data and Analysis on Cost and Quality

First, physicians need data,

Physicians today typically don't know how often their patients are being hospitalized, going to the ER, being readmitted, or getting duplicate tests. This will not be solved by Electronic Health Records, and this is very different than rating physicians on standardized measures of quality or efficiency.

and they need useful analysis of those data.

Training and Coaching in Process Improvement

Second, physicians need training and coaching in how to restructure their practices to deliver more efficient and higher quality care. Not only is this re-engineering not taught in

medical school, it is hard for physicians to do it and still keep up with the demands of ongoing patient care.

Transitional Payment Reforms

Third, physicians need *transitional* payment reforms that will enable them to restructure the way they deliver care without risking bankruptcy.

These transitional payment reforms can be designed in ways that save Medicare and other payers money and improve quality for patients.

Consistent Payment Reforms Across All Payers

Fourth, physicians need to have *all* payers – Medicare, Medicaid, and commercial health plans – make these payment changes and do so in similar ways.

The Role of Regional Health Improvement Collaboratives

The best way to organize this help is not through a one-size-fits-all federal program, but through community-level efforts. In a growing number of communities around the country, there are non-profit, multi-stakeholder organizations called Regional Health Improvement Collaboratives that are working to provide the data and technical assistance that physicians, hospitals, employers, health plans, and consumers need to design and implement better payment and delivery systems.

What Congress Can Do to Support Payment and Delivery Reform

You can help these communities help you reduce costs by giving them access to Medicare data so they can help physicians identify where the opportunities are to improve care, by giving them some modest federal funding to provide more hands-on help to physician practices, and by encouraging Medicare to participate in locally-designed payment and delivery reforms.

I would be pleased to answer questions and provide any additional detail about these recommendations.

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[1] See, for example, Bourbeau J, Julien M, Maltais F, Rouleau M, Beaupre A, Begin R, et al. Reduction of hospital utilization in patients with chronic obstructive pulmonary disease: a disease-specific self-management intervention. Arch Intern Med. 2003 Mar 10;163(5):585-91; Cordisco ME, Benjaminovitz A, Hammond K, Mancini D. Use of telemonitoring to decrease the rate of hospitalization in patients with severe congestive heart failure. Am J Cardiol. 1999 Oct 1;84(7):860-2, A8; and Gadoury MA, Schwartzman K, Rouleau M, Maltais F, Julien M, Beaupre A, et al. Self-management reduces both short- and long-term hospitalisation in COPD. Eur Respir J. 2005 Nov;26(5):853-7.

[2] See, for example, Shannon RP, Patel B, Cummins D, Shannon AH, Ganguli G, Lu Y. Economics of central line--associated bloodstream infections. Am J Med Qual. 2006 Nov-Dec;21(6 Suppl):7S-16S, and Pronovost P. Interventions to decrease catheter-related bloodstream infections in the ICU: the Keystone Intensive Care Unit Project. Am J Infect Control. 2008 Dec;36(10):S171 e1-5.

[3] For example, a number of projects have shown the value of having a nurse in primary care practices providing patient education and other care management services, but this is not a reimbursable service under Medicare or most health insurance plans. See, for example, Bourbeau J, Julien M, Maltais F, Rouleau M, Beaupre A, Begin R, et al. Reduction of hospital utilization in patients with chronic obstructive pulmonary disease: a disease-specific self-management intervention. Arch Intern Med. 2003 Mar 10;163(5):585-91; Gadoury MA, Schwartzman K, Rouleau M, Maltais F, Julien M, Beaupre A, et al. Self-management reduces both short- and long-term hospitalisation in COPD. Eur Respir J. 2005 Nov;26(5):853-7.

[4] Becker C. Profitable complications. Modern Healthcare, December 17, 2007.

[5] For more information, see http://www.geisinger.org/provencare/.

[6] Casale AS, Paulus RA, Selna MJ, Doll MC, Bothe AE, Jr., McKinley KE, et al. "ProvenCareSM": a provider-driven pay-for-performance program for acute episodic cardiac surgical care. Ann Surg. 2007 Oct;246(4):613-21; discussion 21-3.

[7] Miller, HD. From volume to value: Better ways to pay for health care. Health Aff (Millwood). 2009 Sept-Oct;28(5):1418-28.

[8] Blue Cross Blue Shield of Massachusetts, The alternative QUALITY contract. Boston (MA): BCBSM; 2008 Nov. Available from http://quality.bluecrossma.com/press/aqc_white_paper_11_19_08.pdf.

[9] Chernew ME, Mechanic RE, Landon BE, Safran DG. Private-payer innovation in Massachusetts: The ‘Alternative Quality Contract’ Health Aff (Millwood). 2011 January, 30(1): 51-61. The Alternative QUALITY Contract: Year One Results, Blue Cross Blue Shield of Massachusetts, 2011, available at http://www.bluecrossma.com/visitor/pdf/aqc-results-white-paper.pdf.

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[11] Johnson LL, Becker RL. An alternative health-care reimbursement system--application of arthroscopy and financial warranty: results of a 2-year pilot study. Arthroscopy. 1994 Aug;10(4):462-70; discussion 71-2.