



The Development of a Results-Based Payment System for Healthcare Steering Committee Progress Report 1 08/05/05

THE ISSUE

The current U.S. health payment system is not designed to support, promote, or reward high-quality care. In fact, the present system often is one of the primary barriers to the fundamental changes needed to provide patients with the care they want and need. For example, an effective chronic care program that prevents hospitalizations and acute care visits may lead to lower reimbursement revenues for providers. Additionally, because it bases reimbursement on incidents of care, the present payment system promotes overuse, does not correct under-use, and rewards for service volume regardless of the quality of care. Finally, there is no reward for the timeliness, appropriateness, or efficiency of the care delivered.

What is needed is a payment system that aligns payment with quality.

A SOLUTION

The American Medical Group Association (AMGA) has initiated a Results-Based Payment System (RPS) initiative. Led by a Steering Committee of thought leaders, the RPS initiative is a multi-year endeavor to consider (a) the current, flawed reimbursement model, (b) the premises and barriers to a new reimbursement system based upon the quality in care, and (c) strategies for the implementation of a results-based reimbursement system. The initiative's aim is to improve health care with new incentive systems that link provider compensation to quality measures and appropriate outcomes.

The value of this RPS initiative is multi-faceted. First, RPS is a timely and practical approach to addressing the perverse nature of traditional payment methods. Unlike traditional payment models, RPS incorporates modern techniques for evaluating the quality of care. The recent evolution of quality measures and outcomes-based care has produced benchmarks to gauge differences among care providers as well as objective means for distinguishing levels of quality among providers. Additionally, economical health information systems are now available for use in characterizing care and outcomes.

Second, a RPS will align care, quality, and payment in a more encompassing manner than current programs that are based on the notion of "pay for performance" (P4P), an initial and valuable attempt to link payment and quality. To date, P4P has focused on linking payment to attaining various HEDIS measures that are few in number and directed at the health plan level. At its basic level, P4P's protocols have a working assumption that, if all the items on the "check-

off list” are accomplished, the patient is expected to do well and the provider should be paid accordingly. However, P4P excludes two measurable factors that can optimally facilitate quality outcomes: (1) care coordination at both the administrative and clinical levels; and (2) a patient-centered emphasis. A RPS incorporates these factors to measure the efficiency and effectiveness of care as related to the attainment of quality outcomes.

Finally, RPS will contribute to a workable solution to reform Medicare’s problematic method of determining annual reimbursement updates for physicians’ office care. Many of the determinant factors for Medicare’s payment update formula are not under the physician’s control (gross domestic product, part B drug costs, CMS coverage determinations, etc.), and quality measures and outcomes-based criteria are not included in Medicare’s reimbursement formula.

INITIAL STEPS

The RPS Steering Committee held its inaugural meeting on April 26, 2005 in Washington, D.C. At this first meeting, the Steering Committee began the process of defining the elements and goals of a RPS along with the cultural characteristics of such a system. The Committee’s discussions also focused on the positive and negative elements of the present payment system and the barriers to creating a new payment system. Lastly, the Committee considered issues to be addressed at their second meeting, scheduled for Fall 2005.

The following discourse reflects the exchange of ideas during the first meeting.

1. Vision Statement for a Results-Based Payment System

A quality-based, results-directed payment system, driven by peer- and public-reviewed information that differentially rewards those providers (or teams of providers) who meet or exceed explicit performance standards, and offers incentives for improvement. This system recognizes and encourages efficiencies in care delivery derived from informational and medical technologies, care coordination, reduced redundancy, and transparency of standards.

2. Elements and Goals of a Results-Based Payment System

The RPS is a clinical systems approach at the administrative and clinical levels. Through the application of transparent metrics, a RPS would influence the structure of healthcare operations and payment, the processes of care delivery, and the outcomes of care. A RPS also would consider variables often ignored by present payment models, including case mix, risk adjustment, and patient satisfaction.

A RPS would establish an “accountable” health system, with appropriate linkages between quality outcomes and compensation. Accountability would promote patient-centric care and the active involvement of all stakeholders in the health care process.

Finally, a RPS would facilitate a culture of continuous improvement and best practice learning, while encouraging and rewarding innovation.

3. Clarifying the Character of a Results-Based Payment System

Multidimensional RPS provides a relationship among three domains that influence, and are influenced by, quality-based care: structure, process, and outcome. Measurement of structure and process is not new. Structure provides the setting, credentialing standards, and infrastructure to support good care. Process reflects appropriate evidence-based care as a key component in achieving good outcomes for patients. However, rewarding only care structure and process is still not satisfactory because structure and process do not ensure the accountability of a health system. While these two domains are necessary for delivering quality health care, measurement of either or both is unable to account wholly for the variation or value of any particular component in the delivery of health care.

The necessary third domain, outcomes, considers the appropriateness, efficiency, and variation of care and other elements that make possible a differential payment system for “value-added” and meaningful care. Without the inclusion of this domain, the relevance of quality measures in a health care system would be constrained by organizational form and rote delivery of care. By incorporating the domain of outcomes, a RPS would ensure that the value of care is an integral part of the payment equation.

For RPS to evolve, it may be necessary to change the cultural emphasis from “health care” to simply “health” or “wellness” in order to reorient our health system’s culture to focus on an end-target state of well-being rather than on the health care delivery process, itself. RPS would encourage a cultural change from a primary emphasis on treatment while the patient is sick to an emphasis on prevention and early detection, which would be reinforced through changed reimbursement patterns.

As a new payment system, RPS would encompass all types of care delivered by a health system (including acute care, chronic care, preventive care, etc.) and would extend across all care settings (including ambulatory solo, medical group practice, specialty and integrated systems, hospital care, nursing home care, public health, skilled nursing care, etc.). Because of this alignment across all health care settings, RPS would more closely integrate the best elements of organized health sectors (such as hospitals) along with the best elements of disaggregated sectors (such as disparate ambulatory settings).

Finally, case mix, risk adjustment, and time are three variables that also distinguish RPS as a “pay for results” rather than a “pay for service” model. RPS would incorporate measurements of appropriateness of care (case mix), size of health care systems and population-based aspects (risk adjustment), and efficiencies in chronic care (time).

4 Designing a Results-Based Payment System

a. The Current System

A brief comment on our current payment system would be helpful, as some aspects may be appropriate for incorporation into a RPS. The present system has generated the highest levels of appropriate care and promoted transparency and accountability through evidence-based practice guidelines, quality standards, and measurable outcomes.

b. Factors Initiating RPS

RPS would replace the current perverse incentives with incentives that encourage integration and coordination of care across all settings of care, additionally rewarding good outcomes and efficiency.

RPS emphasizes the primary role of the patient in the attainment and maintenance of good health through the patient's active involvement in treatment decisions. Empowering patients to make informed choices and including them in shared accountabilities with the practitioner and the health system are required.

The reward or reimbursement component in RPS should be linked to risk-adjusted outcomes, and that linkage should be clear as to the level of quality. Reimbursement should encourage and reward preventive services (rather than only treatment) and should emphasize outcomes and wellness. Efficiencies in care and cost must be factored in, as well. Further, a RPS must assure that adequate resources are available to provide quality care. Finally, there must be continued emphasis on innovation to advance new technologies, such as electronic health information, and to reduce long-term health costs.

c. Barriers to a RPS

As with any process that leads to major systemic change, barriers can be expected. There may be fears or distrust on the part of the provider community concerning the operational and fiscal impacts of a new payment system. Greater transparency could affect concerns regarding medical liability and whether evidence-based guidelines would form a new basis for lawsuits.

In addition, the measurement and comparison of outcomes will require further development and expansion across all disease states. A complete set of quality indicators must be developed and integrated with validated risk-adjustment methods (also still undeveloped). Moreover, for the provision of improved access to such data, a standard method must be developed for collecting and reporting data. In light of the Health Information Portability and Accountability Act privacy protections, waiver-protected access to such data is necessary for testing and implementing alternative and differential reimbursement models

Finally, there has been debate regarding how accountability will affect the cultural behavior of stakeholders. In the private sector, practitioners have not typically been selected by patients

according to quality measures. And as the largest purchasers of care, employers have focused upon cost factors rather than quality or outcomes. Changing these attitudes will be challenging and crucial to the creation of a RPS, and this cultural change will require strong public and political support from influential leaders, the Congress, and the community.

These barriers are not insurmountable obstacles to the establishment of a RPS.

NEXT STEPS

When the Steering Committee reconvenes, it will begin the process of drafting the design blueprints for a RPS.

Areas for continued discussion and examination include the following:

- **Current P4P Models:** The Steering Committee will examine past and current “pay for performance” initiatives in order to determine what works and does not work in the field.
- **Measuring Results:** The Committee will examine how to define and implement valid and accepted performance-based measures, and how to encourage data collection efforts that are necessary to show quality or improvement.
- **Transparency and Liability:** The Committee will examine issues related to transparency and public reporting, particularly their effect on the medical liability environment.
- **Changing Culture:** The Committee will review the changes in culture needed to shift the focus of the health care system from “health care” to “health,” with a focus on prevention and wellness.

Additionally, the Committee will begin to form advisory workgroups to study the various components of RPS. The workgroups will be supported by graduate students in public health and health policy, who will assist in the study of these components. Outside experts will also be asked to participate in these advisory workgroups to ensure that recommendations originating from them represent proposals and possible solutions that are considered “workable” by stakeholders.

The next meeting of the Steering Committee:

September 20-21, 2005

Sheraton Premiere, Tyson’s Corner, Virginia

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