NATIONAL COALITION ON HEALTH CARE

Working Together for an Affordable Future

POLICY BRIEF

Addressing America's Health Care Value Crisis

America's health costs are extraordinarily high and rising. Total national health expenditures represented 17 percent of the Gross National Product in 2010 and are projected to reach nearly 20 percent by 2020 and more than 40 percent by 2050. Yet according to the Institute of Medicine, approximately one third of this enormous investment is poised to be spent on goods and services that improve no one's health. Clearly America's health system faces a crisis of value. This National Coalition on Health Care Policy Brief is part of a series, designed to explore issues and priorities related to addressing this crisis.

This series examines a range of options including some policies on which the National Coalition on Health Care has yet to take a formal position. Discussion of any particular policy in this document implies neither support nor opposition by NCHC or its member organizations.

Curbing Health Costs, Improving Quality: Towards New Models of Provider Payment

By: Larry McNeely

Experts and advocates across the political spectrum have long argued for health systems that incentivize value and effectiveness in health services, rather than ever-greater volume and complexity. . Unfortunately, the fee-for-service approach to provider payment that is prevalent today represents a major barrier to achieving that transformation. In fact, the Medicare Payment Advisory Committee (MedPAC), an independent, nonpartisan panel of experts charged with advising Congress on Medicare policy, indicts the current fee for service approach as a hindrance to achieving a higher value health system:

> *First, [tools for increasing efficiency and improving quality] may not be able to overcome the strong incentives inherent in any FFS system to increase volume. Second, paying for each individual service and staying within current payment systems (e.g., the physician fee schedule*

or the inpatient PPS) inhibit changes in the delivery system that might result in better coordination across services and lead to efficiencies or better quality across these systems.[1]

The problems with today's fee-for-service, however, do not stop with those identified in MedPAC's critique. Those same incentives for volume and complexity of care naturally encourage providers and hospitals to invest in the facilities, equipment and staff capacity needed to deliver that greater volume and capacity. As researchers from the Dartmouth Institute for Health Policy and Clinical Practice have found, once that capacity is created, providers seek out patients who will utilize these new services, whether they are actually needed or not. The experts at the Dartmouth Institute term this phenomenon "supply-driven demand".[2]

This brief considers alternatives to today's provider payment system. It begins with an examination of the adequacy of the delivery reform provisions of the 2010 health care law and follows with two additional proposals to overhaul payment for physicians and other medical providers: a Center for American Progress plan developed by David Cutler, Ezekiel Emanuel and Topher Spiro; and the Medicare Physician Payment Innovation Act, introduced by Representative Allyson Schwartz (D-PA) and Representative Joe Heck (R-NV)

Today's Payment Reform Initiatives: Are they enough?

The Affordable Care Act established voluntary, limited tests of accountable care organizations (ACOs) and created a voluntary program for bundled, episodic payment for care. Perhaps most importantly, it gives the new Center for Medicare and Medicaid Innovation (CMMI) the power to develop and test other approaches to care, and gives the Secretary of HHS the power to extend those models across Medicare without going through the lengthy process of obtaining Congressional approval. . The theory behind these provisions is that the most successful payment models would gradually be extended across Medicare. Because Medicare is the biggest payer, the health care delivery system would become more efficient system-wide.

These innovative payment and delivery models are not entirely new. In fact, health care organizations across the country like Kaiser Permanente, Geisinger, and Intermountain have had remarkable success creating pockets of high value care for decades. Unfortunately, these reforms have often remained confined to those pockets.

As long as reforms like ACOs and bundled payments are voluntary and today's Medicare FFS approaches remain a lucrative option, even a substantial increase in the number of providers adopting these new models could prove inadequate to address today's cost and quality challenges.

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[1] Medicare Payment Advisory Commission. (2008, June). *Report to Congress*. Retrieved from http://www.medpac.go.v/documents/Jun08_EntireReport.pdf

[2] Dartmouth Center for the Evaluative Clinical Sciences. (2007, Jan). . *Supply-Sensitive Care: A Dartmouth Atlas Project Topic Brief.* Lebanon, NH: Kristen Bronner.

There would be more pockets of success, but the bulk of the delivery system would remain plagued by cost growth and uneven quality associated with fee-for-service reimbursement.

Policy Option: The Cutler/Emanuel/Spiro Proposal

Summary:
The proposal advanced by Cutler, Emanuel and Spiro envisions a transition from today's fee-for-service payment system towards an entirely new dual-track payment system.

By 2016, the plan would require Medicare providers to participate in two types of payment systems. For specialty care services, bundled payment approaches structured around episodes of care similar to the ACE program would be mandatory across a broader range of conditions. For primary care services, providers would be paid by a partial capitation approach. . Enrollees would choose a primary care provider, and those providers would receive a combination of fee-for-service reimbursement and a set payment for each enrollee. In both cases, the level of payments would be risk adjusted based on differing degrees of patient health and adjusted to reflect performance on quality metrics.

Analysis
Rather than waiting for further testing of innovative models as mandated by current law, Cutler, Emanuel and Spiro would move directly to implement the two of those models: bundled payment for episodes of care and capitated payments for primary care across the entire Medicare population. . They argue that Medicare is ready to proceed with these reforms now. Partial capitation in primary care is an established, well-tested approach to provider payment, and the Center for Medicare and Medicaid Services has used bundled payments for acute care hospital services since the advent of Diagnostic Related Group (DRG) payments in the 1980s.

The authors of this plan also highlight that it can generate scorable savings. In 2008, the Congressional Budget Office, known for its conservative budgetary, estimates $18.6 billion in ten-year budgetary savings from the implementation of a mandatory bundled payment program and $5.4 billion in savings for the national implementation of a partial capitation system.[3] Other reputable health experts estimate much greater savings from variants of this approach.[4]

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[3] Congressional Budget Office. (2008). *Budget Options Volume I: Health Car. .* Retrieved from http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf.

[4] Commonwealth Fund. (2007, December*). Bending the Curve: Options for Achieving Savings and Improving Value in America's Health System*. Washington, DC: Shoen S, Shih A, Guterman S, Davis K, Lau J, Ksaimow S, Gauthier A. . United Health Center for Health Reform and Modernization. (2009). *Federal Health Care Cost Containment: How in Practice Can it be Done*. Ken Thorpe. Blue Cross and Blue Shield Association'. (2011). *Building Tomorrow's Healthcare System The Pathway to High-Quality, Affordable Care in America. Retrieved* from http://www.bcbs.com/why-bcbs/health-reform/economic-analysis.pdf.

It should be noted, however, that the existing bundled payment programs that go beyond acute care are structured around well-understood conditions with well-defined courses of treatment. Episodic bundling has not been widely tested in the vast majority of conditions. .

For this reason, Paul Ginsburg recommends allowing the Bundled Payments Initiative, currently underway at CMS, to finish, and then proceed with expansion of bundled payments nationally. This approach would ensure that the expansion of bundled payments proceed with a broader knowledge base than currently available. .

Regardless, any wholesale implementation of an entirely new payment system across Medicare could be problematic. At a time when many providers, particularly those in primary care specialties are rapidly approaching retirement age, requiring adoption of an entirely new system could hasten the retirement of some providers.

Finally, the impact of a wholesale shift to bundled payments, either episodic or population-based, is liable to face objections from some non-physician providers. A range of independent providers, including physical and occupational therapists, are currently reimbursed through Medicare's fee-for-service provide payment schedule as physicians. Today, physicians can refer patients to these providers without cost to them. Under a wholesale shift to bundled payment, it is possible that the hospital or physician receiving the bundled payment would choose not to use those bundled dollars to support these providers' services. At the very least, such a shift would result in a shift of these providers from independent practice to employment by hospitals or physician groups.

Policy Option: The Medicare Physician Payment Innovation Act

Summary

The Medicare Physician Payment Innovation Act, sponsored by Rep. Allyson Schwartz (D-PA) and Rep. Joe Heck (R-NV), offers a more carefully constructed, alternative approach to provider reimbursement. The legislation would repeal the Sustainable Growth Rate (SGR) formula and provide five years of modest increases in fee-for-service payments for primary care providers, coupled with modest updates to specialist reimbursement. Throughout this period, CMS would be charged with aggressively testing alternative value-based approaches to provider payment. The legislation then would require CMS to identify at least four separate payment models that emphasize value. Providers would also have an option to receive payment through a value-based fee-for-service payment system if they participated in quality measurement, patient registry and health information technology initiatives. Beginning in 2018, traditional fee-for-service payment levels would gradually be reduced to create a strong economic incentive for providers to switch to those payment models.

Analysis

This approach offers both substantive and political advantages. . Substantively, the period of payment stability and the increase in primary care reimbursement could help retain and attract

practitioners to primary care at a time when a strong primary care workforce is badly needed. . As the Affordable Care Act brings thirty million more Americans onto the insurance rolls in 2014, provider groups and experts have expressed concern over the inadequacy of the current physician workforce, particularly in primary care specialties. Allowing providers to choose among alternative payment models could avoid some of the disruption that a one-size-fits-all payment system could create. Providers could choose the approach that works best for their practice and patient population from a menu of value-based options.

As a whole, this proposal, with its repeal of the SGR, five-year period of payment stability, and the provision for multiple new payment models, is aligned with the position of key physician groups. The American Medical Association outlined a very similar approach in testimony to the House Energy and Commerce Committee's Health Sub-Committee.[5] The American Academy of Cardiology, American Academy of Family Physicians and the American College of Physicians have explicitly praised the legislation.[6] This alignment could mitigate the potential for provider opposition, greatly increasing the prospects for actual enactment.

One of the principal objections to this legislation has been the manner in which it would pay for the "cost" of repealing the SGR. As introduced, the bill would use savings from the Overseas Contingency Operations (OCO) account, resulting drawdowns in military operations in Iraq and Afghanistan. Some members of Congress have expressed concern that these savings are actually a budgetary fiction-given that those military funds are unlikely to be spent anyway. . These concerns helped ensure that an earlier version of this proposal was not included in a May 2012 deal to extend the payroll tax cut.

However, the projection that repealing the SGR would increase the deficit is itself questionable. CBO's estimate is based on the assumption, consistent with current law, that the full force of SGR mandated 30% provider cuts will go into effect in 2013. It is impossible to foresee a circumstance in which Congress would allow such cuts to occur and remain in place. The cost of eliminating the SGR is at least as much of a budgetary fiction as the "savings" from the OCO.

Regardless of differences over the legislation's offsets, the Medicare Provider Payment Innovation Act is the most viable proposal to repeal the SGR and to move past fee-for-service which has been advanced to date. It deserves strong consideration by policymakers.

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[5] Wilson, CB. (2011, May 11). Statement of the American Medical Association before the House Energy and Commerce Sub-Committee on Health. Retrieved from http://www.ama-assn.org/resources/doc/washington/the-need-to-move-beyond-sgr-testimony.pdf.

[6] Office of U.S. Representative Joseph Heck. (2012, May 9). Press Release. Retrieved from http://heck.house.gov/press-release/heck-and-schwartz-introduce-legislation-repeal-sgr-and-reform-medicare-physician