HEALTH POLICY

Getting Value from Health Spending: Going Beyond Payment Reform

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It is widely held that fee-for-service (FFS) payment systems reward volume and intensity of services, contributing to overall cost inflation, while doing little to reward quality, efficiency, or care coordination. Recently, The National Commission on Physician Payment Reform (sponsored by SGIM) has recommended that payers “should largely eliminate stand-alone fee-for-service payment to medical practices because of its inherent inefficiencies and problematic financial incentives.” As the current and former Chief Medical Officers of a large national insurer, we agree that payment reform is a critical component of health care modernization. But calls to transform payment simultaneously go too far, and don’t go far enough. Based on our experience, we believe there are several critical ingredients that are either missing or under-emphasized in most payment reform proposals, including: health care is local so no one size fits all; upgrading performance measures; monitoring/overcoming unintended consequences; using a full toolbox to achieve transformation; and ensuring that the necessary components for successful delivery reform are in place. Thinking holistically and remembering that healthcare is a complex adaptive system are crucial to achieving better results for patients and the health system.

KEY WORDS: payment reform; health care reform; health policy.

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Get a group of health policy experts together, and ask them what single part of the US health care system is responsible for our overall suboptimal performance, and they would likely say “Fee-For-Service.” It is widely held that fee-for-service (FFS) payment systems reward volume and intensity of services, contributing to overall cost inflation, while doing little to reward quality, efficiency, or care coordination. The National Commission on Physician Payment Reform has recommended that payers “should largely eliminate stand-alone fee-for-service payment to medical practices because of its inherent inefficiencies and

problematic financial incentives,”¹ a position in line with many other reports and analyses emphasizing payment reform as central to health reform.^{2,3}

As the current and former Chief Medical Officers of a large national insurer, we agree that payment reform is a critical component of health care modernization. But we also believe that calls to transform payment (including the Commission’s) simultaneously go too far, and don’t go far enough. They go too far in the sense of putting too much weight on the power of provider financial incentives alone to drive transformation of a complex, dynamic system; and don’t go far enough in that they tend to avoid potentially controversial topics and put insufficient emphasis on other key aspects of health care modernization that are needed to meaningfully support the Triple Aim (better care, a better health care experience, and lower cost).

Starting with payment reforms, we largely agree with the Commission’s recommendations to move away from FFS towards a value-based payment approach, to carefully test new models, and to remediate a number of current distortions in FFS payment systems. A number of the Commission’s recommendations (e.g. virtual groups for small practices, concentrate on high-cost patients) focus on overcoming implementation challenges, and here is an area we see both over-reach and under-reach. We have participated in virtually all of the various payment reforms (from pay-for-performance to bundled payment to blended payments to global payments and capitation), in a variety of local markets across the US, and are currently implementing an ambitious plan to transform UnitedHealthcare’s payment program to a value-based approach—we currently have \$25 billion in annual spending tied to a performance-based Accountable Care Platform, with the goal of increasing that amount to \$50 billion by 2017. Based on this experience, we believe there are several critical ingredients that are either missing or under-emphasized in most payment reform proposals.

First, the most important concept is that “health care is local” so “one size does not fit all”. Different local markets have different capabilities to make progress on the Triple Aim, so payment reform strategies must account for and align with local conditions to achieve success. Having said that, a pure “bottom up” approach is also problematic, as it would lead to highly divergent and often idiosyncratic approaches that would be difficult to scale and administer

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efficiently. So we believe an optimal approach is to approach this task developmentally, beginning with relatively simple augmentation of FFS programs, followed by more complex gain-sharing and risk-sharing arrangements over time. We strongly agree with the Commission's view that these transitions take time.

Second, the existing state of performance measurement is not fit for this journey, but neither can we wait for a better set—we must move now. It is urgent that the performance measurement enterprise become both more aligned and more consistent, and rapidly fill high-priority gaps. Virtually every payment and delivery reform program has its own unique set of measures and metrics, even programs from the same agency centers for medicare & medicaid services (e.g. CMS). To address this, we have developed a menu of largely standardized measures that specific initiatives can draw upon, and are actively participating in national efforts to align measures. In addition to measure alignment, there are significant gaps in measures, especially cost of care and appropriateness measures, which simply must be addressed by measure developers, care providers, professional societies, and health plans with urgency and focus. These new sets of measures can better support both value-based payments and address the pervasive unwarranted variation in utilization and cost-effectiveness rampant throughout health care delivery.

Third, payment reform proponents need to monitor and overcome unintended consequences, such as hospital and health system consolidation and associated use of market power,⁴ and the aggregation of procedure-oriented physicians that could reduce competition and raise costs. Any serious payment reform discussion must include a frank assessment of hospital and proceduralist utilization and costs, since rationalizing these factors is essential to correcting the historical inequity in reimbursement to primary care physicians and other care providers.

Fourth, payment reform, while important, is only one tool in the full toolbox needed to support transformation. Payment reforms need to be combined with: delivery system transformation (which requires support); care management capabilities (which require data, analytics, and population health expertise); value-based benefit designs (which require easy to use transparency program and other tools for consumers); and patient activation and engagement support for patient-centered care.⁵

Fifth, we have found that there are key ingredients within health care delivery systems that are critical to successful implementation of payment and delivery reforms. These include: clinical leadership of delivery systems, comprehensive and effective prevention and care management programs, health information systems that can effectively analyze financial and clinical results, accountability for both clinical and financial results, and patient-consumer engagement. Of these, the most crucial (and in shortest supply) is clinical leadership. While many of the other capabilities can

be procured, leadership capacity to set a vision for the future and manage the process of change within the organization must be present, and highly skilled, to achieve success. Some health care organizations may need to augment (or replace) their existing leaders.

The current environment offers great promise in improving the performance of the US healthcare system and achieving higher value. We believe there is general, widespread agreement that payment reforms that reward value are an appropriate direction for change. We also see a strong willingness to collaborate on common goals that benefit patients, a willingness to try new ideas, and a “burning platform” for change, not only because of the Affordable Care Act, but also because of widespread recognition that the status quo is neither desirable nor sustainable. But we have also seen many promising ideas in the past that either oversold, or were attractive in theory, but not in execution. Given the imperative to rapidly drive improvement, we need to think and act holistically, and be mindful that healthcare is a complex, adaptive system. Only by going farther than payment reform can we achieve success for patients, and for the nation.

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