

Payment reform and quality-based purchasing

The problem

Health care costs in CT are soaring. CT family health insurance premiums grew over eight times faster than median family incomes from 2000 to 2007.ⁱ Connecticut's health care costs per person average 20% higher than the rest of the nation.ⁱⁱ

We aren't getting what we are paying for. Only half of CT adults over age 50 receive recommended screenings and preventive care. 17% of CT adults with asthma had an ER or urgent care visit in the past year.ⁱⁱⁱ From July 2004 to September 2009 there were 1,224 adverse events (medical errors) in CT hospitals; 116 of those patients died.^{iv} Eleven percent of CT hospitalizations are preventable, meaning that they could have been avoided with access to coordinated primary care. In 2008 these 47,345 preventable hospitalizations cost CT nearly \$1.2 billion in charges.^v Without containment costs are expected to continue to soar to unsustainable levels. Over 80% of Americans believe that the health care system needs fundamental change.^{vi}

Incentives in the current health care system encourage overtreatment and discourage prevention.

The vast majority of health care providers are reimbursed on a fee-for-service basis, meaning they get paid based on each face-to-face, individualized treatments. This system made sense when most health care could only be delivered in person but does not recognize the benefits of recent innovations such as secure email, care coordination and group visits. Providers are not paid to assist patients by phone when appropriate and have incentives to bring patients into the office for unnecessary follow up visits. Providers are also paid higher rates for more intensive interventions; reimbursement for watchful waiting and monitoring a condition are not as high as for preemptive treatment. Incentives favor duplication of services; 32% of Americans report that in the last two years a doctor ordered a test that had already been done and/or recommended unnecessary treatment or care with little health benefit.^{vii} The current system includes few incentives to prevent disease; every condition prevented means less business to a provider. In fact, providers who improve efficiency, coordinate care, reduce duplications, and invest in prevention can find that their revenues are reduced.^{viii}

Higher health care spending is not correlated with higher quality or better patient satisfaction. Areas of the US with higher per person health costs do not enjoy higher quality care, better access to care or better health outcomes. In fact, patients in higher spending regions are less likely to receive evidence-based care, are more likely to die following a heart attack, hip fracture or cancer diagnosis, wait longer for care and have worse inpatient experiences of care.^{ix} Current fee-for-service systems make no distinction between high and low quality care. Providers at the top and bottom of the quality scale are paid the same rate for each treatment and patients pay the same copays for each. In most cases, patients have little information to distinguish among providers. Often different providers have conflicting incentives; physicians and hospitals may compete for the most lucrative patients and procedures. Providers have greater incentives to provide more care to some patients, but refer others needing more time or attention to specialists or institutional providers. Providers who accept high-risk patients or specialize in complex medical conditions are at a disadvantage.

Quality-based purchasing is designed to address these problems. A consensus is emerging among payers, providers and consumers that our payment system needs reform that promotes and rewards value over volume. Quality-based purchasing refers to organized attempts by purchasers of health care services to improve and incentivize quality care. Quality-based purchasing aligns the incentives across the continuum of providers to improve quality and efficiency. 95% of Americans feel it is important to have information about the quality of care provided by different doctors and hospitals.^x As the largest purchaser of health care in the US, Medicare is conducting and testing over 20 quality-based purchasing programs and pilots.^{xi} One Medicare quality-based purchasing pilot, with the Premier consortium

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involving 225 hospitals, resulted in quality rating improvements averaging 17% over four years and redistributed over \$36 million in resulting savings back to hospitals.^{xii} One Medicare quality-based purchasing physician pilot program improved quality scores by 10% on average over three years and returned over \$25 million to high performing physicians.^{xiii} The national health reform bill, the Patient Protection and Affordable Care Act, devotes almost 100 pages to quality-based purchasing initiatives including a program to tie hospital payments to quality performance, tests new quality-adjusted payment systems and creates an Innovation Center at CMS to test new initiatives.^{xiv}

Connecticut's state government has an important and unique role in moving the health care system toward quality. The largest purchasing pool in CT is the HUSKY program providing care to 385,988 state residents as of 4/1/2010^{xv}. Medicaid consumes over 20% of the state budget.^{xvi} The state employee plan purchases care for over 200,000 state workers, retirees and their dependents.^{xvii} The state has a critical role in licensing providers, regulating insurers, protecting consumers and restraining costs for all payers. The state is the largest provider of public health programs including tobacco control, environmental health and healthy living. Most health care professionals are educated at public colleges and universities.^{xviii} The state is in a position to collect and analyze health care data across delivery and payment sources. The state can provide an important convening role, bringing competing interests to the table, leveraging relief from anti-trust concerns.^{xix}

There is a continuum of quality-based purchasing options available to state policymakers.

- Transparency – report cards, public reporting of quality and cost data, mandatory hospital quality reporting systems^{xx}
- Never events – most states, along with other payers, have limited or eliminated payment for serious adverse events that could reasonably be avoided using evidence-based guidelines, such as foreign objects left in the body after surgery and incompatible blood transfusions^{xxi}
- Pay for Performance (P4P) – provides bonuses for quality, more efficient care delivery, for example rates of well-child visits, cancer screening rates, and HbA1c testing for patients with diabetes, while P4P programs are widespread across state Medicaid programs and private plans, evidence of their impact on quality is mixed and provider resistance is significant^{xxii}
- Consumer financial incentives – reducing copays for appropriate care and exempting care accessed from high quality providers from deductibles, tiered networks of providers, health plans and providers are becoming more common^{xxiii}, a growing number of plans provide consumers with incentives to identify and reduce health risks such as smoking or overweight
- Shared savings or gain sharing – Allows physicians and provider networks to share in the savings they help generate by reducing ineffective care, enhancing high value care and coordinating care particularly for complex cases. A drawback is that incentives are delivered well after providers have incurred the costs of investing in quality and the level of incentive is unknown when providers are making the investment.^{xxiv} However this option places more control in the hands of the providers who are making most care decisions.
- Episode-based or bundled payments – Providers, or a network of providers, receive a set fee for each clinically defined episode of care, i.e. knee replacement, coronary artery bypass. The fee covers the full range of services associated with that episode including in-patient, and post-acute care following discharge. Obstetricians and general surgeons have traditionally been paid on an episode basis. A drawback to this option is that it still does not give the provider an incentive for preventive care to work with the patient to avoid the episode entirely.^{xxv}
- Global payments – Similar to bundled payments, global payments cover all the care needed by a patient for a given timeframe. Fees are risk adjusted to reflect higher resource needs for patients with complex conditions. Global payment systems give providers incentives to keep patients healthy, as well as reduce duplication and improve quality. This option gives providers

the most control as well as responsibility.^{xxvi} To counter any incentive to deny care, as was the problem with capitated systems in 1990s, global payments is linked to performance incentives such as P4P and quality monitoring.

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- ⁱⁱⁱ 2009 Commonwealth Fund State Scorecard
- ^{iv} 2009 October Adverse Event Report, DPH
- ^v Preventable Hospitalizations in CT, CT Office of Health Care Access, January 2010
- ^{vi} Public Views on US Health System Organization: A Call for New Directions, Commonwealth Fund, August 2008
- ^{vii} Ibid
- ^{viii} Pay for Value Policy Forum, June 18-19, 2007, Mayo Clinic; Now What?, Atul Gawande, The New Yorker, April 5, 2010, ER Woods, Filling the Gap: A Hospital's Response, Boston Children's Hospital Community Asthma Initiative, May 1, 2010.
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- ^{xiv} HR-3590, Patient Protection and Affordable Care Act, HR-4872, Reconciliation Act of 2010
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