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Providers: Reorganize and Refinance

By Jill Van Den Bos

"I told the doctor I broke my leg in two places. He told me to quit going to those places."—***Henny Youngman***

Note: This essay won second prize in the contest sponsored by the SOA Health Section.

The short and long term functionality of the U.S. health care system is heavily dependent on the quality, and perhaps happiness, of its providers. To the extent that physicians get beaten up in the course of reforming the payment system, the overall health care system may face a shortage in the supply of qualified providers in the long run, particularly primary care physicians. This is good for no one. The viability of the system as a whole is dependent on the industry's ability to address the incorrect financial incentives that have encouraged expensive and sometimes poor care delivery by physicians who are understandably responding to these incentives.

The common reaction on the part of payers is to control costs by simply cutting physician and hospital fee schedules. The recent 21 percent fee cuts for Medicare physicians are a particularly harsh example. This approach, while reducing costs in the short run, does nothing to incentivize improved care or ensure the long-term health of the delivery system by enticing new physician entrants.

High quality care delivered in the most efficient manner should be the expectation of every insured individual in the United States, and it is health care providers who are ultimately responsible for making sure that we receive it. Providers need to be enabled and financially incentivized to provide the best evidence-based care possible.

In order for meaningful provider payment reform to take place, there must be provider organizational rearrangement. We need to move away from fragmented and piecemeal delivery of care to more organized providers better capable of delivering contiguous, high quality, and efficient care. It is within the context of such an organized approach to care delivery that payment reform and all its intended consequences can occur in a meaningful way.

I therefore suggest a two-pronged approach to implementing provider payment reform:

- first, health plans should seek to contract with integrated provider organizations that make collaborative, evidence-based medical decisions; and
- second, payment to members of these organizations needs to be organized primarily around larger episodes of care within which providers are enabled, and indeed encouraged, to practice good evidence-based medical decision making.

Provider Organization

Last time I visited a sports medicine physician after a minor wipe-out on the ski slopes, I didn't remember to say anything about the incident to my primary care physician, so no record of all that was done to me ever made it back to her. This couldn't be a good thing; she had no idea that I was taking Celebrex, for example. Shouldn't she? Lack of direct and obvious avenues for communication among providers caring for a single patient seems like an obvious lapse in good medical care.

Not only the availability of easy provider communications, but a provider organization with a culture of coordinated decision making and collaborative peer review should be the ideal for achieving quality, efficient patient care. This has been demonstrated in provider organizations whose care is both low cost and high quality. The Mayo Clinic, for example, exercises its focus on quality of care in a collaborative fashion. This feature is mirrored in another group of physicians in Grand Junction, Colorado which operates with collaborative peer review committees to study patient cases together. Both achieve very good patient care at low cost.

Payment Alternatives

The predominant current provider payment paradigm is typically called fee-for-service, but it really should be called fee-for-procedure. There are many services that are done, or that should be done, that

are not readily compensated under the current system largely because they don't have a procedure code. Payment tied to a code is part of the problem—this encourages, even necessitates, a piecework approach to billing and therefore to providing services. A consequence of the system is that providers who perform a lot of procedures (like surgeries or MRIs) are at a financial advantage relative to providers who perform services that are harder to capture in a billing code yet may result in better overall health outcomes (such as care coordination with multiple providers, or phone calls to follow up with patients). This can't be best for patients.

Think of the "care" received for your car after an auto accident. You don't pay different providers for their services, you take your car to one shop where the needed technicians, facility, and tools are present. And your insurance company writes one check, the amount of which is determined in advance by an insurance adjuster. The repair shop will get this amount only, and can pocket any savings realized by being efficient. Of course, if the repair is not done properly, the car owner will be back to have the repair done again. With auto repair, it is usually quickly apparent if the repair was not done correctly; many repair shops will even guarantee their work for some period of time.

While treating people is naturally a more intricate issue, involving the very complex human body and human psyche, much of the analogy is applicable. Payment for discrete episodes of care can be calculated in advance based on what services are called for to deliver the best evidence-based medicine for the patient and the condition, and global episodic case rates can be developed for these. What makes use of this payment algorithm particularly appealing for inpatient care and outpatient surgeries is the readily definable start of the event and reasonably definable time period that the case rate should cover. What further makes this payment method appealing in these cases is the cost associated with care that has a facility component. If the providers in question are organized into a cohesive provider organization, use of a global episodic case rate seems all the more functional.

Not all care falls into a category that is easily billable. For those services that could be provided by a physician in a care coordination role, which I believe has clear value, a monthly fee per patient assigned has been proposed as compensation and I endorse this concept.

Generally, more health care procedures do not equate to better health care outcomes. Some excess is simple fee-for-procedure entrepreneurship—waste. Some excess is downright harmful. Back surgeries to relieve pain, for example, are in most cases no better than nonsurgical options. Yet 600,000 of these back surgeries are performed each year, as reported in a *New York Times* article highlighting medical practices that run contrary to evidence. Undoubtedly, some care is given due to pressure from family, even though the physician knows that it won't benefit the patient.

Just as CMS and other payers have put a stop to payment for "never events," I propose putting a stop, or at least a big slow down, on payments for expensive end-of-life treatments that are not recommended standard of care and are not shown to have much chance of being effective treatments. While quantifying the impact of this particular restriction is difficult, I know that overall end-of-life cost of care is enormous. In November 2009 CBS did a story reporting that, in the last year in the United States, $50 billion was spent on care in the last two months of life. Of this, it was estimated that 20 percent to 30 percent of these expenditures had no meaningful impact. It is in this cost that I hope to see providers, and society, empowered to make a dent.

Make no mistake, I do not advocate withholding care for critically ill patients, but I do advocate making it much easier for providers to say no to a request or to resist the inclination to try expensive new treatments with low proven probabilities of success. As uncomfortable as this topic this is for many people, I believe meaningful provider payment reform should address it.

My Vision

I can envision full payment reform having both revolutionary and evolutionary elements. I will discuss the former—those elements that I believe should be addressed first, and immediately. Other features

should develop over time.

1. Providers need to combine themselves into integrated care-giving, decision-making organizations. I believe the "lone physician with his shingle out" model, or even separate groups of physicians, is not conducive to efficient care but rather results in a patchwork of care that may or may not provide what is best for patients. Further, the patchwork arrangement is not conducive to the types of payment that promote the best care.

   For these provider organizations to be most effective, I believe they need to include both physicians and a hospital—the "extended hospital medical staff" described by Fisher and colleagues in *Health Affairs* in 2006—as the basis for an accountable care organization (ACO). Such an alliance of providers is best poised to deliver fully vertically integrated care to its patients. As it turns out, the health care reform legislation, both at a federal level and in some states (e.g., Colorado), is encouraging the development of ACOs for the treatment of Medicare and Medicaid insureds; providers are moving to assemble themselves into these organizations already. Commercial payers, too, can contract with such organizations to the betterment of the health care provided to their patients.

   Having all the players in one place, these groups can focus on quality and efficiency of care for their patients. The presence of a spectrum of expertise with aligned goals seems a far better opportunity for providing organized and rational patient care than does the current model. Having a collaborative decision-making element, perhaps functioning in a peer review capacity for difficult patient cases, would be all the better.

   Note that some legislative changes may be needed to facilitate the ability of providers to create ACOs, including antitrust and insurance law.

2. Properly organized providers will contract with health plans using global episodic case rate payments for hospital inpatient cases and outpatient surgeries where an index date and end of care are readily definable. Later, other types of care should also be covered by case rates as the industry gains experience with the method.

   Such case rates are good payment mechanisms for providers for two reasons. First, properly calculated case rates will be severity-adjusted, accounting for all the care needed to conform to best medical practices (with margin for complications); this will align incentives between the payer, provider, and patients. This alignment is largely missing in the current reimbursement environment. Second, properly calculated case rates leave the medical care decision making in the hands of medical providers, where it belongs. Providers who stay abreast of what constitutes best practices will benefit from this compensation method. Others should quickly learn to stay up to date in their patient care, to the benefit of us all.

3. Payment of a severity-adjusted monthly case management fee for the care-coordinating provider, whom the patient will choose and must remain with for a prescribed period of time. This physician will be the go-to provider for this patient, overseeing care by all providers of care for the patient, making phone calls, etc. This case rate will compensate the care coordinator for the effort that falls outside of the typically billed face-to-face patient visit, providing a financial incentive for the care coordinating physician to perform and really own this function. This person, in many cases, will be a patient's primary care physician, although for a chronically ill patient more likely to frequent a specialist that provider might be most appropriate.

4. Services not covered under items 2 or 3 above would be billed on a fee for procedure basis as is currently done. Over time, this bucket of "leftover" services should diminish as global case rate development becomes honed. At the end of the plan year, the total per patient rate of all compensation paid to providers in the ACO,

including all types of payment—case rates, case management fees, and fees for individually billed services, can be compared to a total age/gender/severity adjusted per member per year target and any savings experienced compared to the agreed upon target will be shared between the health plan and the ACO, much like what is recommended in the PPACA.

5. Treatments that are not standard of care for terminally ill patients should be subject to a risk-taking penalty. Any non-standard curative treatment that does not have evidence showing a mean extension of life of at least six months will be considered subject to a performance guarantee clawback. If such a treatment is used and the patient dies of the condition treated (or the treatment itself) within six months of the treatment start date, the treatment will be deemed ineffective and payment for that treatment will be reimbursed to the health plan. Health plans can review the clinical studies to determine what new treatments should be on this list. This stipulation should provide a disincentive for frivolous use of treatments that are experimental, and/or not demonstrated to be reasonably effective.

In summary, provider payment reform must simultaneously accomplish the goals of improving efficiency and quality for patients while allowing providers to focus on their core expertise of practicing medicine. At the same time, some element of accountability must be present. The changes outlined above steer providers in this direction without relying on previous methods of cost containment focused on simply cutting reimbursement rates or shifting risk. Instead, these changes steer providers toward approaches that stress professional collaboration, adherence to evidence-based care, and avoidance of costly and potentially ineffective care near the end of life when trying such options becomes tempting. ■

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