

Paying Wisely: Using Incentive Reforms to Reduce Costs and Improve Patient Outcomes

October 23, 2012

Center on Health Care Effectiveness (CHCE) Forum

**Robert Berenson • Christine Cassel • Stuart Guterman •
Timothy Lake • Eugene Rich**

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About the CHCE

- **CHCE is a resource for policymakers, the public, and other stakeholders who seek objective evidence for making today's most difficult health care decisions—answering questions about what interventions work best, and for whom**
- **Through more than 150 researchers at Mathematica Policy Research and the Center for Studying Health Systems Change, we offer broad-based expertise and objective evidence to inform today's health care policy and program decisions**

About the CHCE (cont'd.)

- **Our research addresses challenging, real-world issues facing policymakers, patients, providers, and payers, creating information they can use to improve health care effectiveness**
- **Today's meeting highlights an excellent example of that type of work**
- **For more information about CHCE, please visit <http://www.mathematica-mpr.com/chce/>**

CBO on Improving Value in U.S. Health Care

- **“...little rigorous evidence is available about which treatments work best for which patients”**
 - **Solution: Comparative Effectiveness Research/Patient-Centered Outcomes Research**

- **“...financial incentives...tend to encourage the adoption of more expensive treatments and procedures, even if evidence of their relative effectiveness is limited”**
 - **Solution: Provider payment reform**

Orszag and Ellis, *New England Journal of Medicine*, Nov. 2007

Considerations for Provider Payment Reform

- **Promoting evidence-based decision making at the point of care**
- **Addressing care fragmentation**
- **Enhancing the role of primary care clinicians**
- **Promoting new modes for addressing patient health concerns**
- **Reducing prices**

Considerations for Provider Payment Reform (con't)

- **Our focus is on strategies to promote evidence-based decision making at the point of care**
 - **Patients seek clinicians they can trust to recommend “what is best”**
 - **Professional societies and policymakers want clinicians to recommend evidence-based services**
 - **Payment reform that does not consistently reward evidence-based care will prove unacceptable to both patients and clinicians**

Today's Lineup

Speakers

- Eugene Rich (Mathematica)
- Timothy Lake (Mathematica)

Panelists

- Christine Cassel (American Board of Internal Medicine)
- Robert Berenson (the Urban Institute)
- Stuart Guterman (the Commonwealth Fund)

White Paper Presentation

Paying Wisely: Incentive Reforms to Promote Evidence-Based Decisions at the Point of Care

Eugene Rich • Timothy Lake

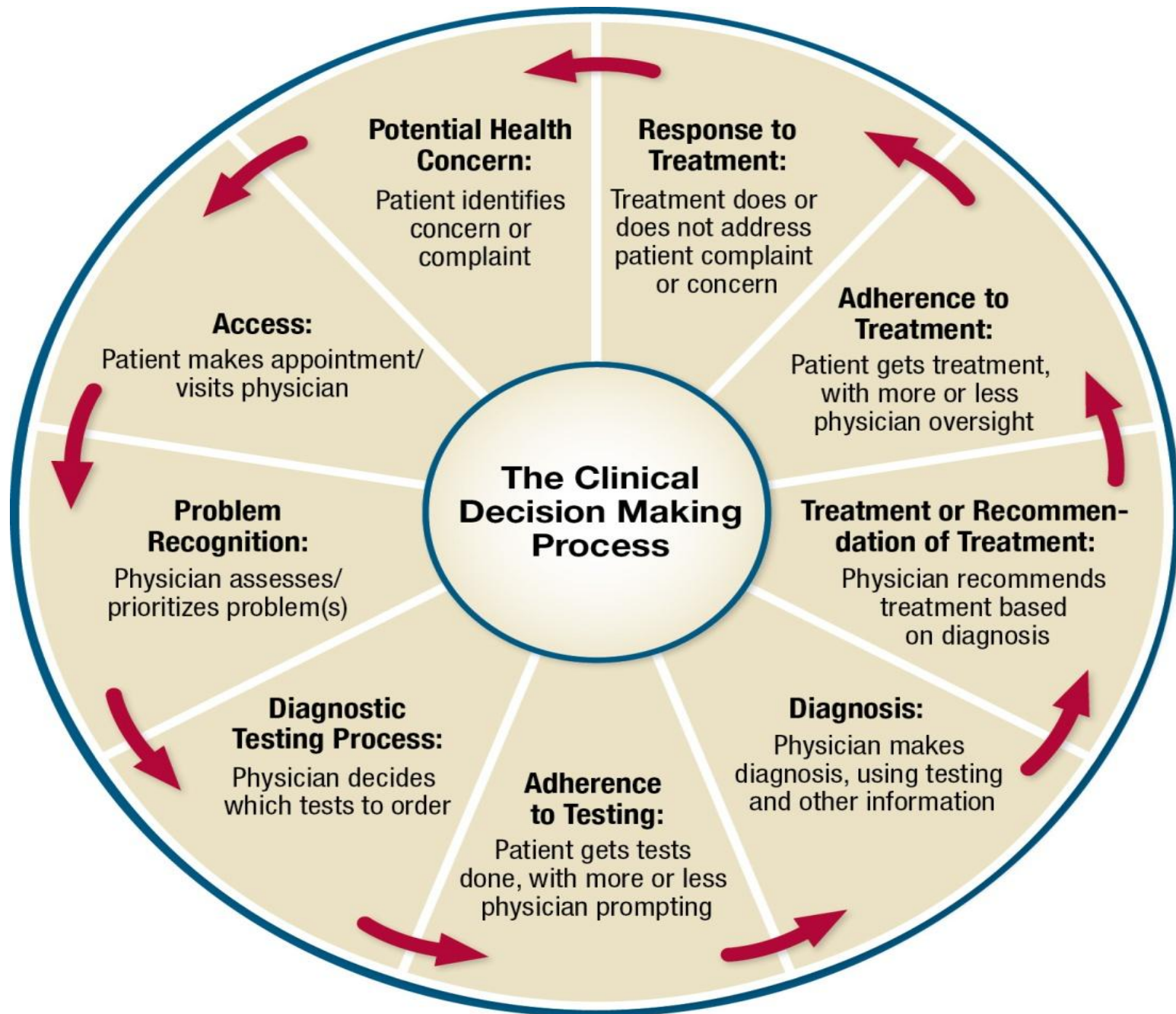
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Purpose of White Paper

- **Describe how current financial incentives for clinicians can distort point-of-care decisions**
- **Analyze how payment reform options reward evidence-based clinical decisions**
- **Recommend a strategy for payment reform to promote more evidence-based care**

Fee-for-Service (FFS) Payment

- **Long-standing approach to physician reimbursement**
- **Risks well-recognized**
 - Code of Hammurabi, Heraclitus, Ben Franklin, George Bernard Shaw
- **Physician as “seller of services”**
 - Buyer does not have physician’s specialized knowledge
 - Buyer further disadvantaged by pain, anxiety, cognitive impairment
- **Principal agent theory**
 - Physician contracts to act as patient’s agent
 - Patients interests are advanced when the physician (clinician) recommends services with evidence of benefit



Complexity of Decision Making at the Point of Care

- **Patients seek physicians to address health concerns**
 - And to act to relieve their symptoms/distress
- **Each patient encounter generates numerous decisions**
- **Physicians make these decisions in the face of extensive and conflicting relevant evidence**
 - 23,000 clinical trials every year, few answers
 - CER/PCOR intended to help with this
- **All diagnostic tests are imperfect**
 - Inherent risk of over- and underdiagnosis
 - Multiple sequential tests do not help

FFS and Point-of-Care Decision Making

- **FFS offers a straightforward method to encourage delivery of services at the point of care**
 - Patients have greater trust under FFS payment
- **FFS may not provide consistent incentives to promote evidence-based practice**
 - Poor calibration of fees (e.g., high margins for services of limited effectiveness)
- **Potential impact of FFS imbalance on point-of-care decisions**
 - Over- or undertesting
 - Over- or underdiagnosis
 - Over- or undertreatment

Imaging for Low Back Pain

- **Service identified by “Choosing Wisely” program**
- **High margin for imaging studies for back pain creates incentives for physician to:**
 - **Increase patient awareness of medical services available**
 - **Increase patient access for evaluation**
 - **Perceive higher likelihood of conditions that require testing**
 - **Provide services to help patients adhere to testing recommendation**

Imaging for Low Back Pain (cont'd.)

- **If imaging study is an efficient way to find candidates for a high-margin treatment, additional incentives for physician to:**
 - **Diagnose the condition that warrants the high-margin treatment**
 - **Provide services to help patients adhere to testing recommendation**

Antibiotic Prescribing in Sinus Infection*

- **No direct FFS incentive for antibiotic Rx**
- **FFS incentive to recommend an approach that satisfies patient expectations**
 - **Antibiotics plausibly effective in addressing the cause of symptoms**
 - **Patient's prior belief regarding antibiotic efficacy**
 - **Patient's desire to avoid missed work/school**
 - **Patient's preferences and shared decision making**

* Overused service identified by "Choosing Wisely" program

Antibiotic Prescribing in Sinus Infection* (cont'd.)

- **Current FFS provides inadequate incentive to educate patients regarding risks and benefits**
- **Clinician efforts to discourage antibiotic use may not enhance patient satisfaction**

* Overused service identified by “Choosing Wisely” program

Choosing Wisely Examples

- **Pulmonary function tests (PFTs) in asthma**
- **Drug management in gastro-esophageal reflux disease (GERD)**

Payment Reform Options: Potential Impact on Evidence-Based Care

- **Revised FFS**
- **FFS + P4Q**
- **Episode-based payment**
- **Global payment (capitation)**

Revised FFS: Description

- **Revisions to make margins for all services equal**
 - Increase payments for services with low margins
 - Decrease payments for services with high margins
- **More ambitious goal: Set payments to provide higher margins for highly effective services**

Revised FFS: Advantages

- **If margins for services are high, physicians will increase use**
- **Increased payments can address underuse of effective services**

Revised FFS: Disadvantages

- **Likely limited effects on overused services**
 - Inertia
 - Volume offsets
 - Unintended consequences
- **Challenges in adjusting FFS payments based on evidence of effectiveness**
 - Pricing relative effectiveness
 - Changing evidence base

FFS w/ P4Q: Description

- **Bonuses or penalties based on performance on quality measures**
- **Measures of process or outcomes**

FFS w/ P4Q: Advantages

- **Reward behavior not covered by FFS, e.g.**
 - **Monitor/reward better care management (eg GERD management, or antibiotic use)**
 - **Monitor/reward appropriate use of tests or referrals (e.g. back imaging)**

FFS w/ P4Q: Disadvantages/Challenges

- **Difficult to target numerous relevant point of care decisions**
- **Getting the strength and consistency of “signal” right**
- **Technical challenges to ensure fairness and a valid signal**
 - **Attribution to the correct clinician decision-maker**
 - **Patient risk adjustment,**
 - **Appropriate benchmarking**

Summary of FFS w/P4Q

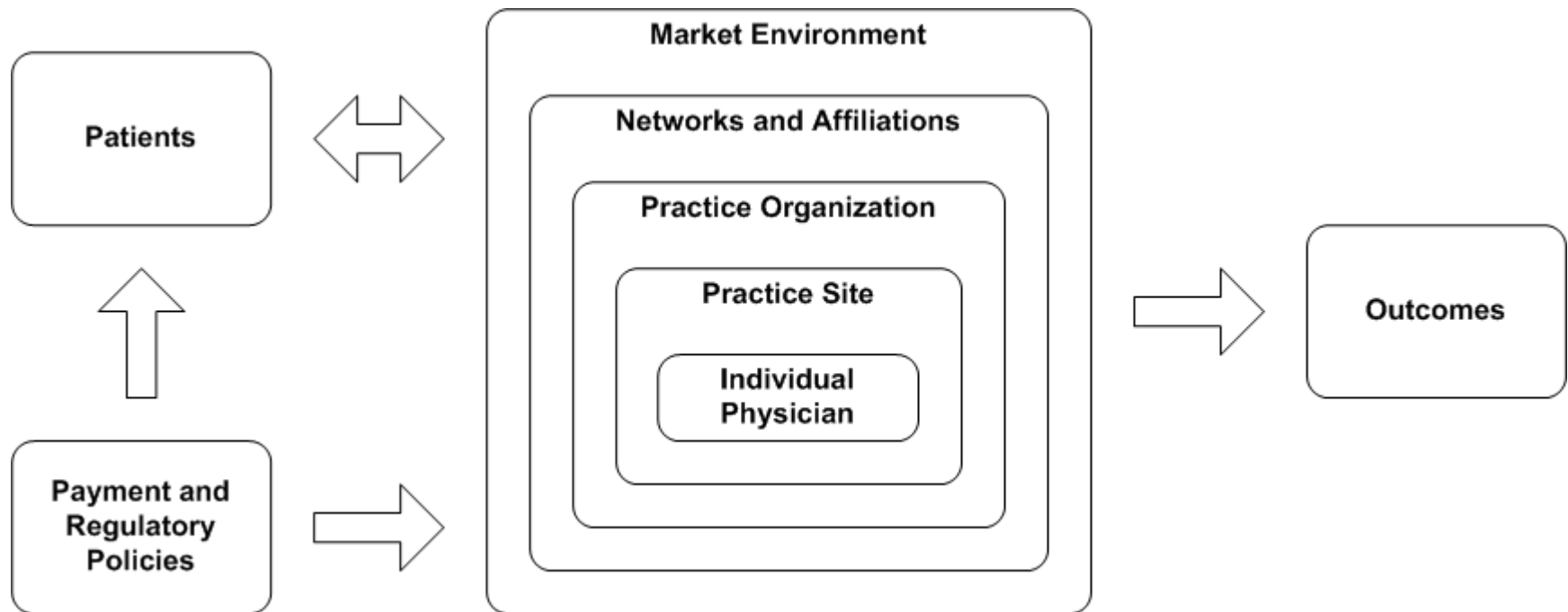
	FFS with P4Q
Overused test	+/-
Underused test	√
Over DX	+/-
Under DX	√
Overused Rx	+/-
Underused Rx	√
Undermanaged Rx	+/-

Episode-based Payment: Description

- **Single payment for all services needed during an episode of illness or care**
- **Removes “piecework” incentive of FFS within the episode**
- **Incentive for constraining volume of services during an episode**

Who to Give the Bundled Payment To?

Practice environment and clinical decision-making



Collecting Data on Physicians and their Practices, AHRQ Report, 2012

Changing the Employed Clinician's "Margin"

Compensation

- % income at risk
- Performance measures
 - Productivity measures
 - Quality metrics
 - Patient satisfaction
 - Organizational financial performance
- "Perks"
 - Education and travel funds

Work environment

- Workload
 - Work assignments
 - On-call responsibility
 - Admin "hassles"
- Support staff /space
- Ease/difficulty obtaining tests, services
- Recruitment /retention
- Professional culture
 - leadership

Episode-Based Payment: Advantages

- **Can reduce some overused services when designed correctly**
 - **Over testing example:**
 - Imaging for back pain during an episode represents higher cost, not additional revenue
 - Business case for lower cost alternatives
- **Can address under-diagnosis**
 - **Create episode payments initiated by diagnosis**

Episode-Based Payment: Disadvantages

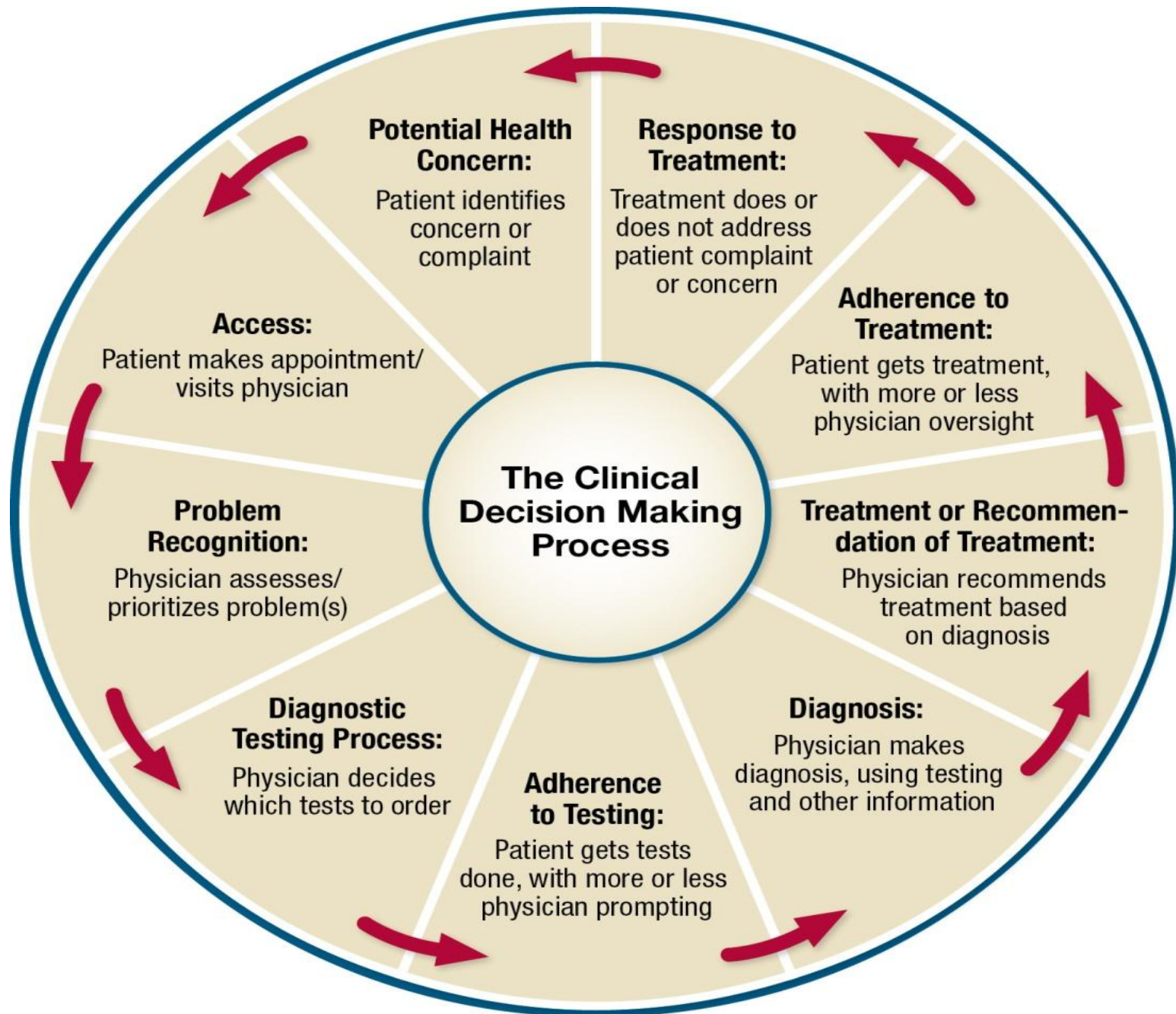
- **Discourages evidence-based testing and treatment during an episode of illness**
 - PFTs in asthma
 - Drug management in GERD
- **Potential incentive for over-testing and over-diagnosis**
- **Potential incentives for overtreatment, e.g. high-margin surgical episodes**
- **P4Q can help, but limitations**

Summary of Episode-Based Payment

	Episode-Based Payment
Overused test	+/-
Underused test	+/-
Over Dx	+/-
Under Dx	√
Overused Rx	+/-
Underused Rx	+/-
Undermanaged Rx	+/-

Global Payment (Capitation): Description

- **Fixed payment for all services needed by a patient during a year**
- **Removes “piecework” incentive of FFS**
- **Incentive for constraining volume of all services for patients**



Global Payment: Advantages

- **Provides incentive to reduce any overused services, especially those that are high cost**
- **Incentives for prevention of disease or exacerbation of disease**

Global Payment: Disadvantages

- **Can encourage reduced access and under-diagnosis**
- **Can discourage evidence-based testing and treatment**
 - PFTs in asthma
 - Drug management in GERD
- **P4Q can help, but limitations**

Summary of Global Payment

	Global payment
Overused test	√
Underused test	+/-
Over DX	√
Under DX	+/-
Overused Rx	√
Underused Rx	+/-
Under-managed Rx	+/-

Insights for Designing Payment Reform

- **No one payment reform addresses all problems with current FFS**
- **Some payment reforms are better than others for addressing certain problems**
- **Combinations of payment reforms may be beneficial, e.g. bundled payment and P4Q.**

Summary of Payment Reform Options

	Revised FFS	FFS with P4Q	Episode-Based Payment	Global Payment
Overused test	+/-	+/-	+/-	√
Underused test	√	√	+/-	+/-
Over Dx		+/-	+/-	√
Under Dx	√	√	√	+/-
Overused Rx	+/-	+/-	+/-	√
Underused Rx	√	√	+/-	+/-
Under-managed Rx		+/-	+/-	+/-

Considerations for Provider Payment Reform

- **Patients seek clinicians they can trust to recommend “what is best”**
- **Professional societies and policymakers want clinicians to recommend evidence-based services**
- **Payment reform that does not consistently reward evidence-based care will prove unacceptable to both patients and clinicians**

The Path Forward

- **Recalibrate FFS to recognize physician costs at the point of care**
- **Monitor patterns of care relative to highly effective services**
 - Overused and underused tests
 - Over- and underdiagnosis
 - Overused and underused treatments
 - Undermanagement of chronic conditions
- **Targeted approach to payment reform to reward more evidence-based decisions at the point of care**

Payer Options to Promote Evidence-Based Care

- **For underused, highly effective tests or treatments**
 - **Re-evaluate FFS for miscalibrated payments**
 - **If FFS looks appropriate, consider:**
 - Increased FFS payment (to jumpstart increased use for highly effective services)
 - P4Q incentives to increase awareness of appropriate use

Payer Options to Promote Evidence-Based Care (cont'd.)

- **For overused tests or treatments**
 - **Re-evaluate FFS for miscalibrated payments**
 - **If FFS looks appropriate, consider:**
 - P4Q incentives to increase awareness of appropriate use
 - Global utilization incentives within FFS
 - FFS payments to providers adjusted based on expected utilization for the local population
 - Episode-based bundled payments

Provider Options to Promote Evidence-based Care

- **Monitor for overuse, underuse, misdiagnosis**
- **Address clinical issues for identified problems**
 - Knowledge, diagnostic skills
 - Conflicting interpretations/professional standards
 - Easy access to knowledge resources and decision support
- **Re-evaluate for miscalibrated physician costs/assignments**
- **Incentive reform within provider organizations to address persistent problems**
 - Compensation plan
 - Work environment

Expert Reactor Panel: Payment Reform and Evidence-Based Care

Panelists

- **Christine Cassel (American Board of Internal Medicine)**
- **Robert Berenson (The Urban Institute)**
- **Stuart Guterman (The Commonwealth Fund)**

The Choosing Wisely® Campaign

www.choosingwisely.org

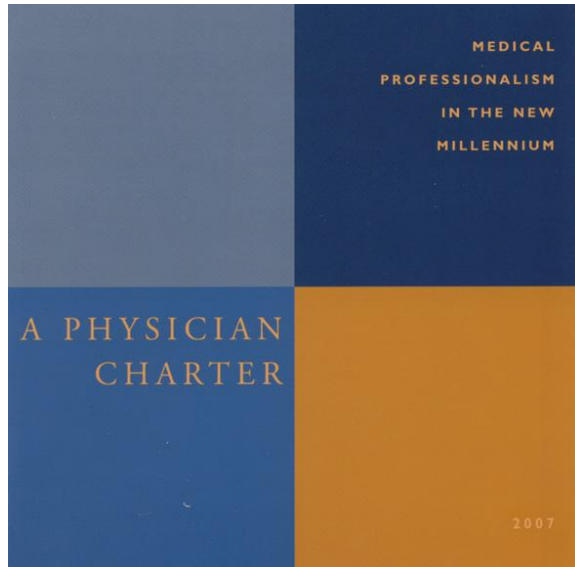


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Choosing Wisely is an initiative of the ABIM Foundation to help physicians and patients engage in conversations about the overuse of tests and procedures and support physician efforts to help patients make smart and effective care choices.

ACP Foundation/ABIM Foundation/EFIM Physician Charter



Fundamental Principles

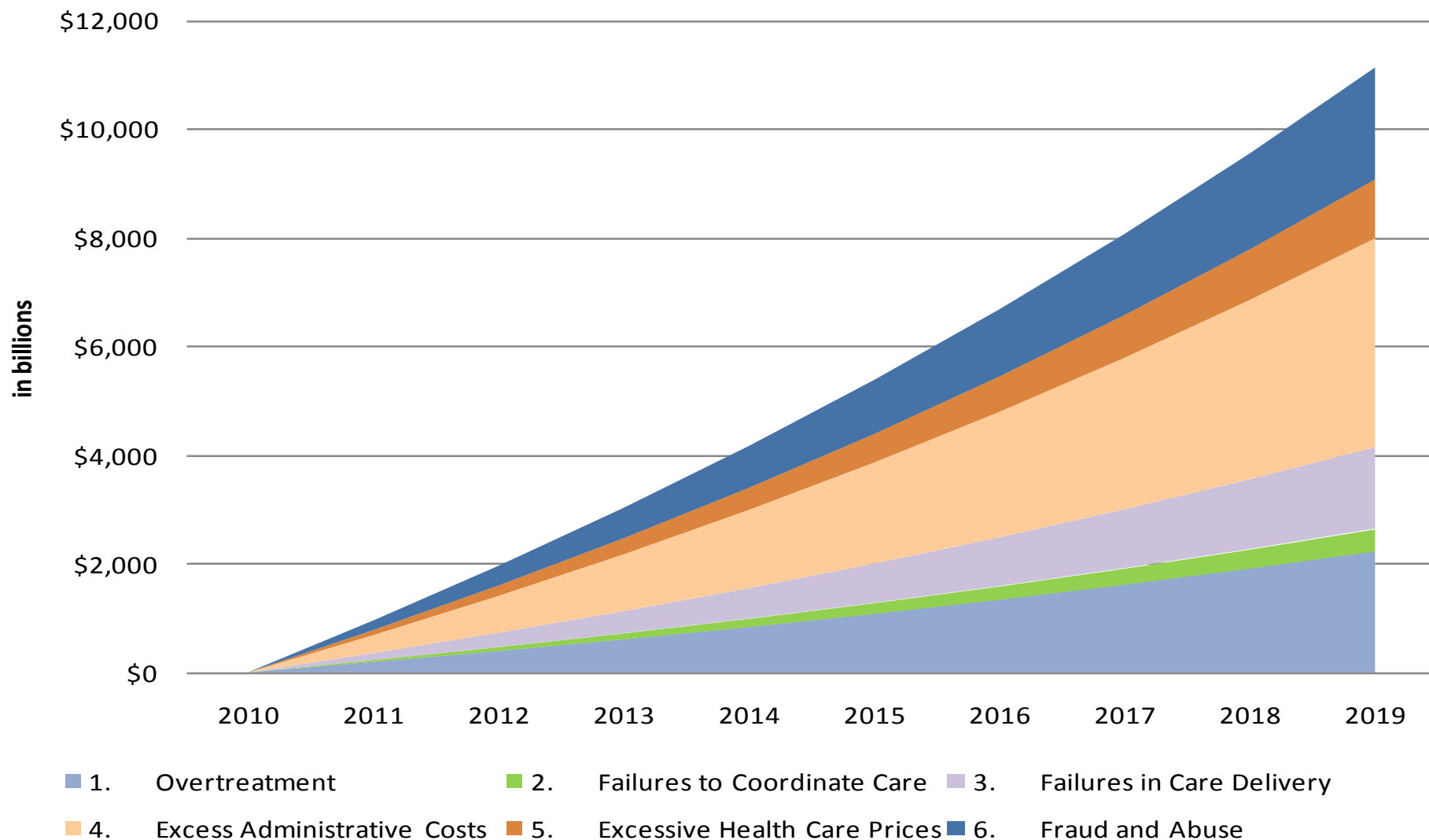
- Primacy of patient welfare
- Patient autonomy
- Social justice

A Commitment to

- Professional competence
- Honesty with patients
- Patient confidentiality
- Maintaining appropriate relations with patients
- Improving quality of care
- Improving access to care
- A just distribution of finite resources
- Scientific knowledge
- Maintaining trust by managing conflicts of interest
- Professional responsibilities

US Health Care System Theoretical Waste

(Aggregate Waste 2011 - 2019)



Berwick D, Hackbarth A. Eliminating Waste in US Healthcare *JAMA*. 2012;307(14):doi:10.1001/jama.2012.362

Components of the Campaign

- ***Messengers and Collaborators***
 - 30 specialty societies and Consumer Reports—and growing
- ***Communicate Messages***
 - Specialty societies, Consumer Reports, consumer organizations and ABIM Foundation
- ***Activate***
 - Concrete action around unnecessary tests and procedures

The “Top 5 Lists”

- Funded by an ABIM Foundation grant, the National Physicians Alliance conceived and piloted the concept through its Good Stewardship Working Group
- Developed lists of top five activities in family medicine, internal medicine, and pediatrics where the quality of care could be improved
- Published in *Archives of Internal Medicine*
- Subsequent research published in *Archives* found a cost savings of more than \$5 billion could be realized if the recommendations were put in to practice.



Choosing Wisely Partners

Societies Developed Lists

- American Academy of Allergy Asthma & Immunology
- American Academy of Family Physicians
- American College of Cardiology
- American College of Physicians
- American College of Radiology
- American Gastroenterological Association
- American Society of Nephrology
- American Society of Nuclear Cardiology
- American Society of Clinical Oncology
- National Physicians Alliance

Consumer Groups

Through Partnership with Consumer Reports

- AARP
- Alliance Health Networks
- Leapfrog Group
- Midwest Business Group on Health
- Minnesota Health Action Group
- National Business Coalition on Health
- National Business Group on Health
- National Center for Farmworker Health
- National Hospice and Palliative Care Organization
- National Partnership for Women & Families
- Pacific Business Group on Health
- SEIU
- Union Plus
- Wikipedia




Societies Developing Lists

- American Academy of Hospice and Palliative Medicine
- American Academy of Neurology
- American Academy of Ophthalmology
- American Academy of Otolaryngology-Head and Neck Surgery
- American Academy of Pediatrics
- American College of Chest Physicians
- American College of Obstetricians and Gynecologists
- American College of Rheumatology
- American College of Surgeons
- American Geriatrics Society
- American Headache Society
- American Society for Clinical Pathology
- American Society of Echocardiography
- American Society of Hematology
- American Society for Radiation Oncology
- American Urological Association
- Society of Cardiovascular Computed Tomography
- Society of Hospital Medicine
- Society of Nuclear Medicine and Molecular Imaging
- Society of Thoracic Surgeons
- Society of Vascular Medicine

How the Lists Were Created

- Societies were free to determine the process for creating their lists with the following requirements:
 - Each item was within the specialty's purview and control
 - Procedures should be used frequently and/or carry a significant cost
 - Should be generally-accepted evidence to support each recommendation
 - Process should be thoroughly documented and publicly available upon request


Consumer Reports

ConsumerReportsHealth
Choosing Wisely® 
An initiative of the ABIM Foundation

When to say 'Whoa!' to doctors

A guide to common tests and treatments you probably don't need

- EKGs and exercise stress tests
- Imaging tests for headaches
- Treating sinusitis
- Imaging tests for lower-back pain
- Bone-density tests
- Pap tests
- Treating heartburn and GERD



- Consumer Reports is a partner in Choosing Wisely and will support the effort by creating patient-friendly materials based on the society recommendations and engaging a coalition of consumer communication partners to disseminate content and messages about appropriate use to the communities they serve.
- Tools and resources can be found at: www.consumerhealthchoices.org.

What's Next?

- Scheduled announcements in early and mid-2013 of Five Things Physicians and Patients Should Question lists
- Continue the conversations among physicians and between physicians and patients
- Rollout of Consumer Reports patient-focused articles

What's Next?

- Roll out of communication skills modules to help physicians talk with their patients about appropriate care (Drexel University)
- Catalyze others to advance the campaign
 - Office practices
 - Health systems
 - Residency and medical training programs
 - State and local medical societies
 - Additional specialty societies

Thank you

Robert Berenson

The Urban Institute

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Aligning Incentives for Better Decision-Making: What Can Medicare Do?

**Stuart Guterman
Vice President and Executive Director,
Commission on a High Performance Health System
The Commonwealth Fund**

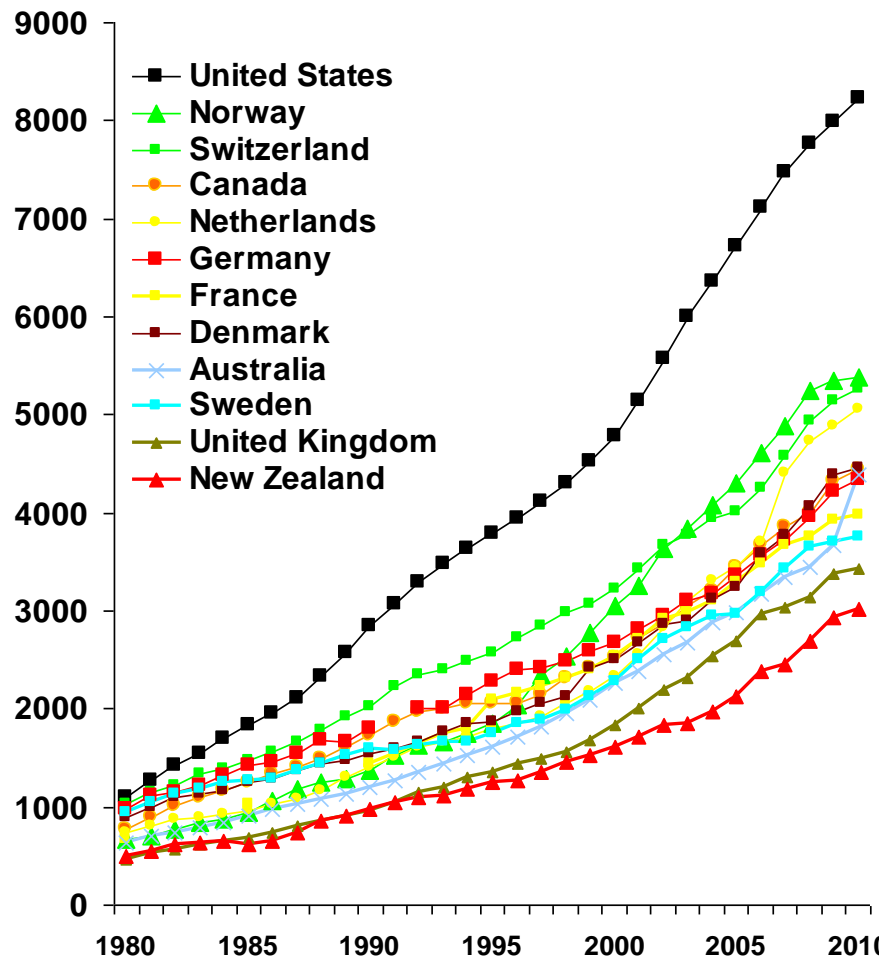
**Mathematica Center on Health Care Effectiveness
Forum on Paying Wisely
Washington, DC
October 23, 2012**

We have the most expensive health care system in the world—but do we get our money's worth?

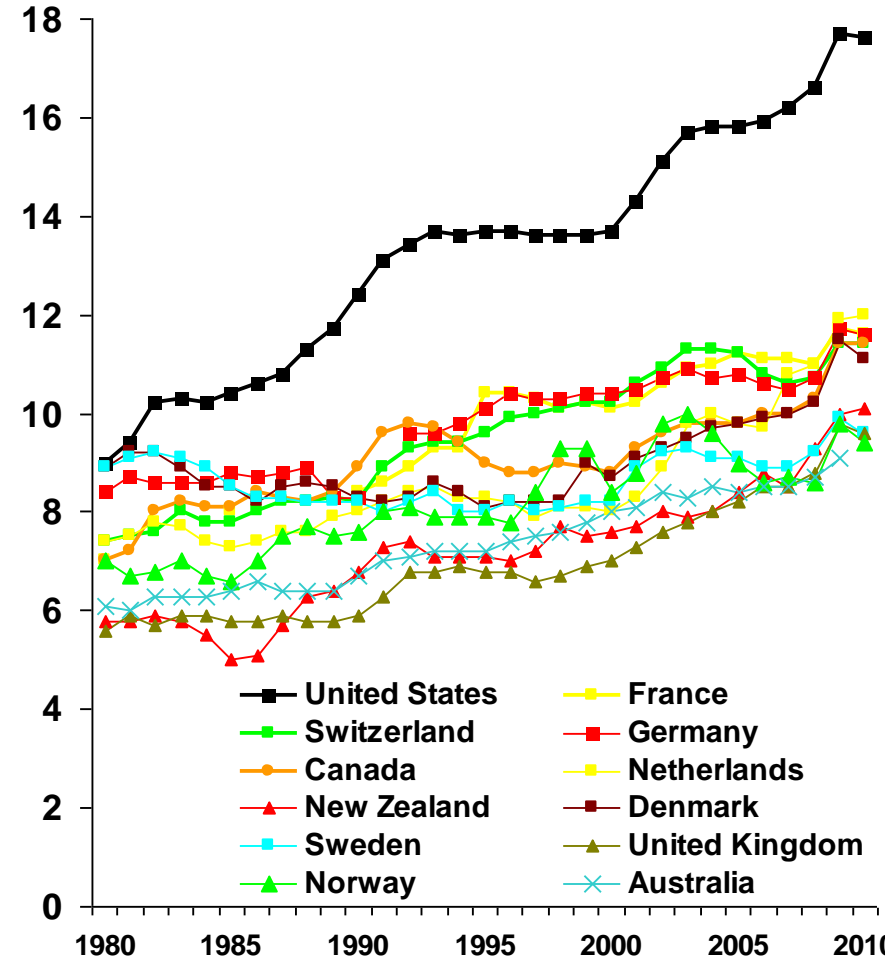


International Comparison of Spending on Health, 1980–2010

Average spending on health
per capita (\$US PPP)

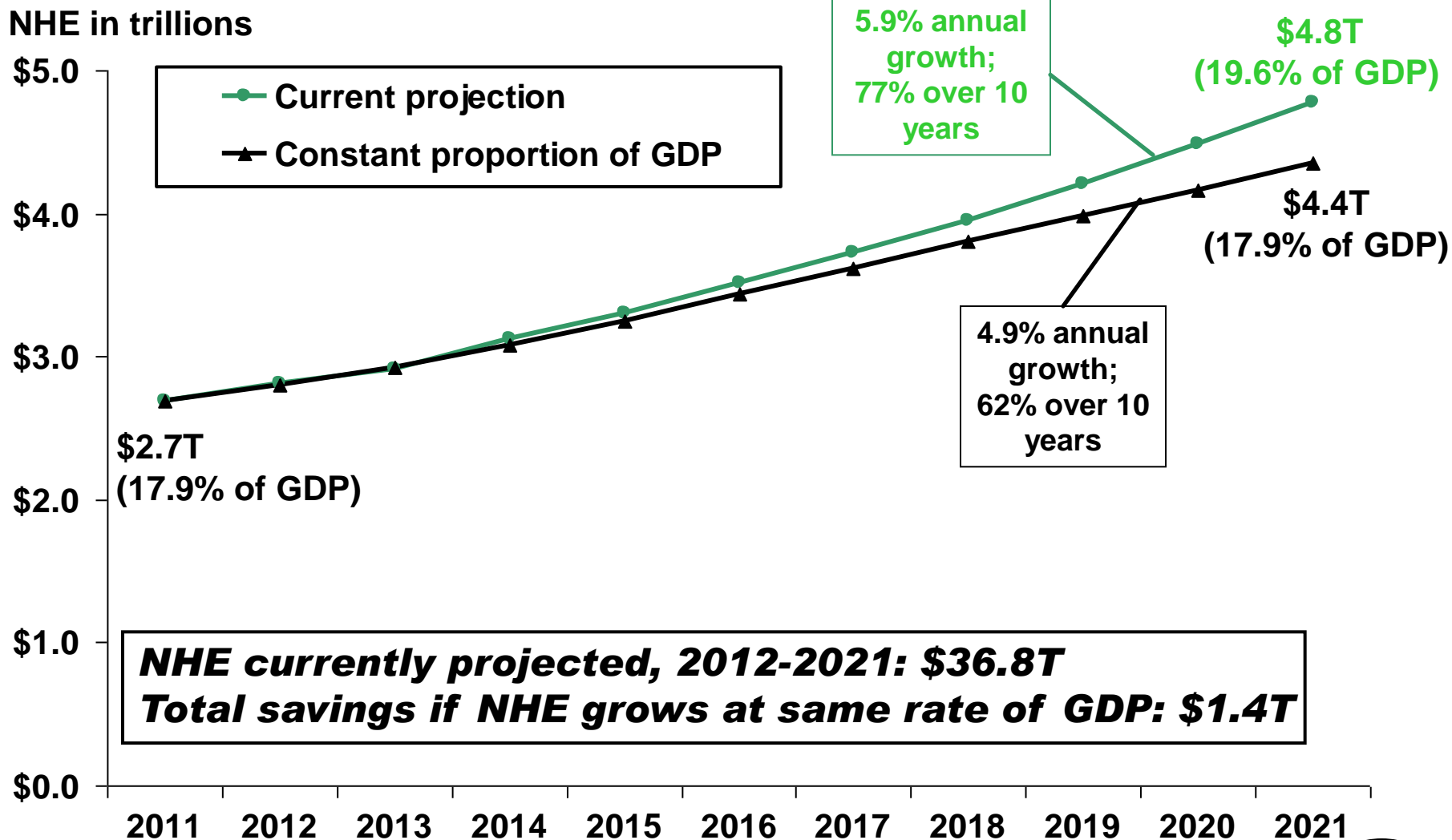


Total expenditures on health
as percent of GDP



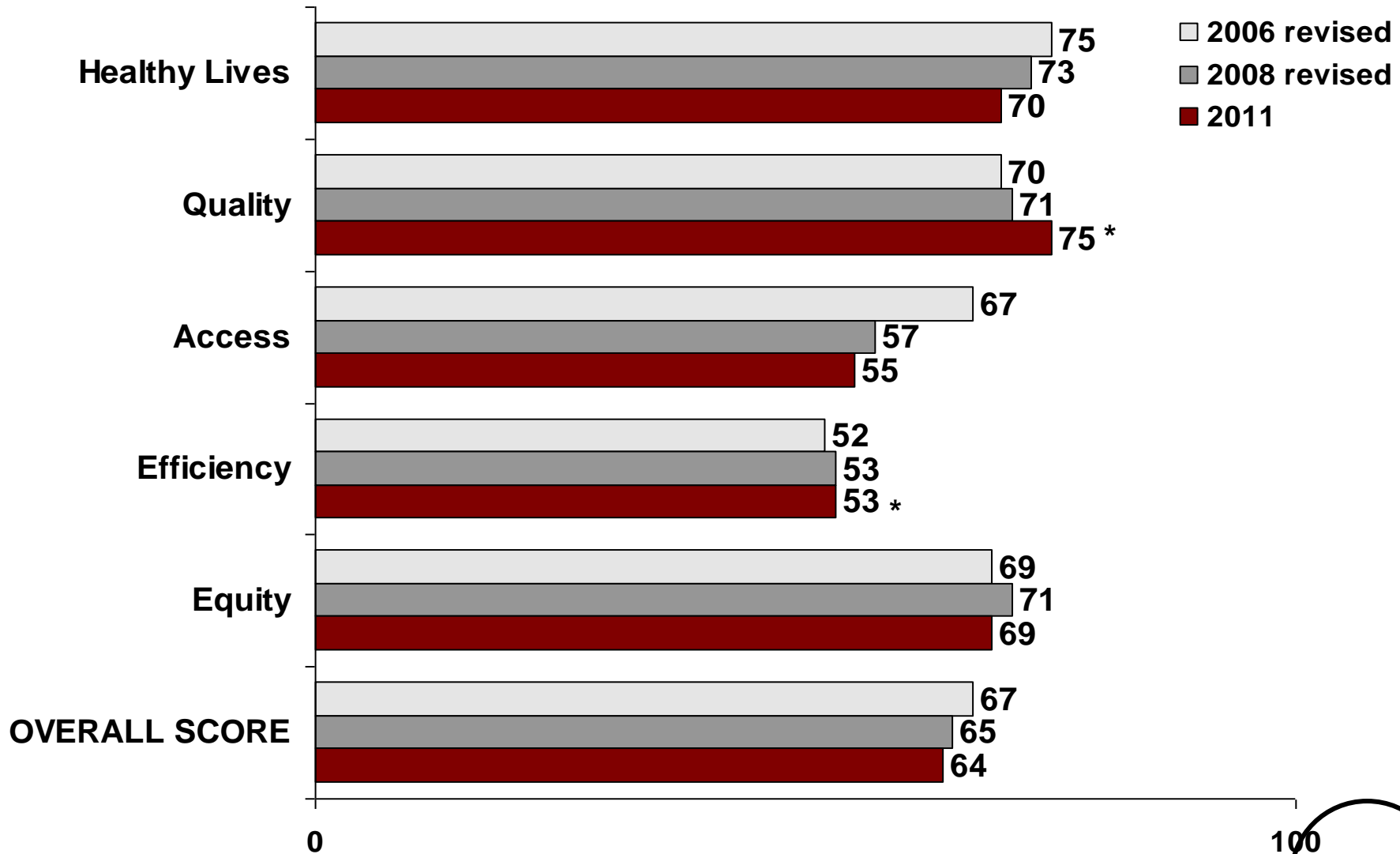
SOURCE: OECD Health Data 2012, available at <http://stats.oecd.org/Index.aspx?DataSetCode=SHA>.

Total National Health Expenditures (NHE) 2011–2021: Current Projection and Constant Proportion of GDP



Source: Commonwealth Fund CMS, Office of the Actuary, National Health Statistics Group, National Health Expenditure Projections 2011-2021, available at <http://www.cms.hhs.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf>.

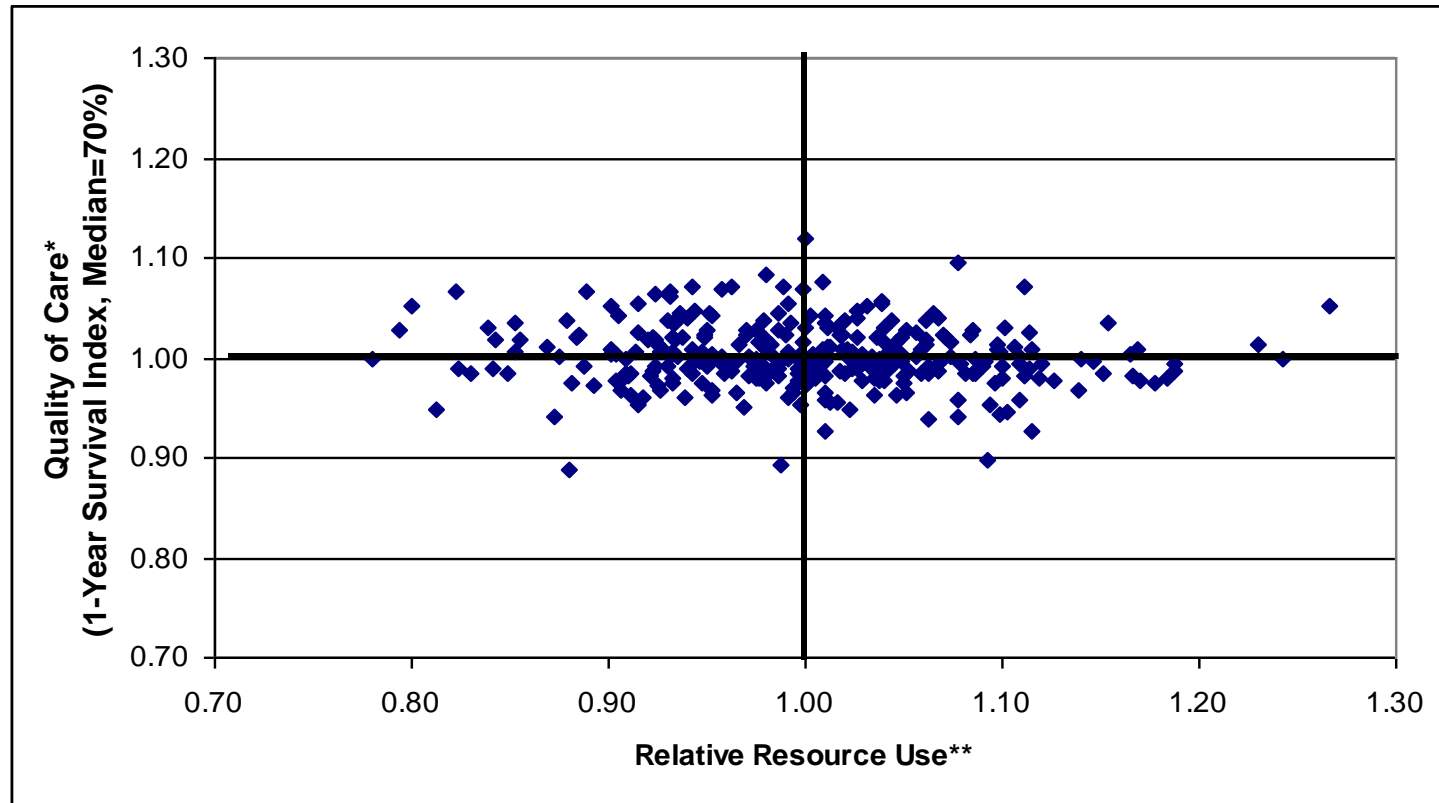
How the U.S. Health System Scores on Dimensions of a High Performance Health System



* Note: Includes indicator(s) not available in earlier years.

Source: Commonwealth Fund Commission on a High Performance Health System. *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2011* (New York: The Commonwealth Fund, October 2011)

Quality and Costs of Care for Medicare Patients Hospitalized for Heart Attacks, Hip Fractures, or Colon Cancer, by Hospital Referral Regions, 2004



* Indexed to risk-adjusted 1-year survival rate (median=0.70).

** Risk-adjusted spending on hospital and physician services using standardized national prices.

Data: E. Fisher, J. Sutherland, and D. Radley, Dartmouth Medical School analysis of data from a 20% national sample of Medicare beneficiaries.

Source: The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008*, (New York: The Commonwealth Fund, July 2008).



Payment and Delivery System Reforms Can Help Build a High Performance Health System



The Problem: Fragmented Health Care Delivery and Financing, Inconsistent Incentives That Often Punish Efforts to Provide Better Care

- **The Diagnosis: The U.S. health system has multiple co-morbidities, but one of the fundamental problems for patients is fragmentation of providers and fragmentation of care delivery**
 - **Poor care coordination and care transitions**
 - **Sub-optimal quality and efficiency**
- **The Treatment: Policies that change the way health care is organized, delivered, and paid for, to elicit and reward better results**
 - **Foundation of patient-centered primary care**
 - **Coordination of care among multiple providers and care settings**
 - **Accountability for the total care of a patient**
 - **Payment reform**
 - **Optimal use of health information technology**
 - **Continuous quality and efficiency improvement**

What Provider Delivery System and Payment Reforms are Being Tested/Implemented?

- **Accountable Care Organizations**
 - Shared savings
 - Shared savings and shared risk
 - Global payment -- partial or full capitation
- **Patient-Centered Medical Homes**
 - Blended fee for service, care management fee, bonuses for quality
- **Bundled payment for acute hospital episodes**
 - Inpatient hospital care and inpatient physician services
 - Inpatient hospital care, inpatient physician services, post-acute care services
- **Value-Based Purchasing**
- **Tools, infrastructure support**
 - Enhanced care coordination/chronic disease management
 - Health information technology
 - Beacon communities; health information exchanges
- **Combination strategy in innovator communities**

Payment Reform Must be Supported by System Reform: Accountability, Transparency, and Better Information for Better Decision-Making

- **Accountability:** Quality standards, reporting, and rewards
- **Transparency:** Medicare publishes quality, accountability, and provider profile information
- **Information technology:** Electronic medical records, health information exchange networks, personal health record accessible to beneficiaries
- **Comparative effectiveness:** Mechanism to coordinate evaluation of drugs, devices, and procedures with payment implications

We Need to Spend Smarter

- **Projected national health spending, 2011-2020: \$35.7 trillion (increase of 79%, from \$2.6 trillion to \$4.6 trillion, over 10 years)**
- **National health spending, 2011-2020, if held to same proportion of GDP as in 2010: \$33.8 trillion (increase of 60%, from \$2.6 trillion to 4.1 trillion, over 10 years)**
- **Overall score for U.S. health system: 64% (relative to achievable benchmarks, down from 67% in 2006 and 65% in 2008)**
- **Lack of information hinders decision-making**
- **Misaligned incentives—across payers, providers, and patients—send inaccurate signals about what services contribute most to better health and how those services can be most productively used**

Thank You!

For more information, please visit:

www.commonwealthfund.org



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Questions and Answers

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For More Information

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Save the Date!

**Join us for our next forum on
Thursday, November 29th**

Incentivizing EHR Use in Medicare: New Evidence