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Transforming Health Care Payment
and Delivery Systems to Improve Quality
and Reduce Costs

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NRHI Healthcare Payment Reform Series

**PAY FOR INNOVATION OR PAY
FOR STANDARDIZATION?**

How to Best Support the Patient-Centered Medical Home

Efforts are underway all across the country to improve the quality of primary care delivery by encouraging implementation of the “patient-centered medical home.” The basic concept of a medical home is that each patient has an ongoing relationship with a personal physician and a team of other health care professionals who collectively take responsibility for providing or arranging for all of the patient’s health care needs in a coordinated way. There are multiple goals for doing this, including improving patients’ health and reducing preventable hospital admissions.

There is general agreement that the current fee-for-service payment system in health care makes it difficult, if not impossible, for physicians and other primary care practitioners to implement the medical home concept. Some aspects of medical home services are not paid for at all, such as patient education by nurses and telephone contacts by doctors. Others are not paid for adequately, such as the time that primary care physicians spend diagnosing illnesses and working with patients to develop care plans.

However, health insurance plans and other health care payers are reluctant to pay more for medical home services without assurances that patient outcomes will be better and that costs will be saved elsewhere (e.g., through reductions in preventable hospitalizations). This has led to proposals to use the patient-centered medical home standards developed by the National Committee for Quality Assurance (NCQA) to determine which physician practices should receive increased or modified payments designed to support improvements in primary care. NCQA’s standards attempt to operationalize the general principles for the patient-centered medical home adopted by the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP) and American Osteopathic Association (AOA). NCQA’s medical home standards have nine

separate sections, with a total of 30 elements within those sections and 170 separate items on which a provider is to be scored to determine whether they meet the standards. There are three different levels of certification that a provider can achieve, depending on how many of the items they meet.

On July 31, 2008, the Network for Regional Healthcare Improvement (NRHI) held its second national Summit on Healthcare Payment Reform with support from the Robert Wood Johnson Foundation and the Pittsburgh Regional Health Initiative. More than 100 individuals from 21 states and Washington, D.C. participated in the summit, including physicians; hospital administrators; health plan executives; academics; foundation leaders; regional coalition directors; federal, state and local government officials; executives of health care quality improvement organizations; and others. The goals of the NRHI summit were to develop detailed recommendations on how to move from the current volume-driven health care system to a truly value-driven health care system.

One of the specific issues discussed at the NRHI summit was the best way to support the implementation of the patient-centered medical home. Summit participants developed recommendations regarding the type of payment changes needed and which primary care providers should be able to participate.

In summary, the attendees at the NRHI summit felt that both changes in payment systems and improvements in care delivery are needed to enable primary care providers to realize their full potential in improving the quality of health care and reducing health care expenditures. Because no one yet knows exactly which specific changes in care delivery will improve value, initiatives to implement the medical home and other models for primary care improvement should encourage innovative approaches focused on improving patient

outcomes. The specific recommendations from the summit follow.

Recommendation 1: Payers should not require primary care providers to meet rigid certification or accreditation standards in order to participate in improved payment systems, but should instead encourage innovations that improve outcomes and control or reduce costs.

- a. Any organization that is focused on primary care and accepts accountability for patient outcomes and costs should be able to participate in payment systems designed to support medical homes or other improvements in primary care delivery.
- b. Payers should wait for additional evaluations regarding which specific processes and structures produce better outcomes before establishing or utilizing strict standards for which organizations can serve as medical homes.
- c. Payers should encourage innovative approaches to cost-effective primary care delivery and minimize barriers to participation in new payment systems, particularly for small physician practices and nonphysician-led providers.

The participants at the NRHI summit felt it was both impossible and inappropriate, at least at this point in time, to establish strict standards as to which health care providers could serve as patient-centered medical homes. Too little is known about which specific processes are essential to quality care and which are cost effective to justify expecting primary care providers to meet detailed and potentially expensive requirements in order to participate in payment systems designed to support improved care.

The more narrowly that a payment system defines the types of providers that are eligible to

receive payment, the fewer providers there will be that can participate in the payment system (at least in the short run) and the less competitive pressure there will be for improvements in quality and efficiency. Since there is already a shortage of primary care providers nationally, unnecessary limitations are all the more undesirable. Moreover, the more restrictive the requirements are, the more likely they are to inhibit innovations by providers that could increase value.

For example, the NCQA standards and many payers have proposed rewarding practices that have electronic health record (EHR) systems. While EHR systems can be very helpful to physician practices in providing quality health care, merely having an EHR does not guarantee quality care. Additionally, many physician practices that do not have EHRs provide high-quality care. If a payment system requires that a physician practice have an EHR in order to participate, it will potentially exclude some practices that provide high-quality care but do not, at least yet, have an EHR. Moreover, it may force physician practices to devote disproportionate time and resources to installing EHRs rather than implementing other types of care improvements that could provide a bigger impact on quality and costs in the short run.

Another reason for proceeding cautiously in establishing standards is that the patient-centered medical home is not the only approach to improving primary care. Many communities are also pursuing efforts to implement the “chronic care model,” a concept developed by Dr. Edward Wagner of the MacColl Institute for Healthcare Innovation in Seattle to improve outcomes for patients with chronic diseases. Although the patient-centered medical home and the chronic care model have much in common, there are clear differences in emphasis and focus. For example, the chronic care model has a strong emphasis on self-management support and the creation and use of commu-

nity resources outside the physician practice. A provider could conceivably be viewed as meeting the criteria for a medical home but not be viewed as a successful implementer of the chronic care model, and vice versa.

Dr. Gordon Moore and Dr. John Wasson have developed yet another approach for improving primary care called “Ideal Medical Practices.” This approach addresses goals similar to those of the patient-centered medical home and the chronic care model, but stresses the critical importance of collaborative interaction between patients and their physicians and other care providers. Ideal Medical Practices use tools and techniques that are low cost and practical for small physician practices to implement. Moore and Wasson’s research has indicated that the quality of patient care and patient satisfaction are significantly higher in physician practices that follow this approach. (See “The Ideal Medical Practice Model: Maximizing Efficiency, Quality, and the Doctor-Patient Relationship,” *Family Practice Management*, September 2007, pp. 20-24.)

Consequently, summit participants felt that while standards such as those developed by NCQA could serve as helpful *guidelines* to providers in improving their care processes, it is impossible to say that a provider that meets the standards will deliver higher-value care than one that does not. Moreover, it was felt that while it was not inappropriate to have *some* pilot medical home projects requiring physician practices to meet these standards, it would be undesirable if *all* pilot projects had such a requirement, since it would preclude the ability to determine whether providers meeting lesser or different standards could deliver equal or better value.

Summit participants agreed that higher expectations should accompany higher payment levels for primary care, but they felt the expectations should be focused on achieving better outcomes, both in terms of quality and

cost, rather than on complying with process standards that may or may not improve outcomes. Participants agreed that health care providers should be permitted and encouraged to develop innovative processes for improving outcomes rather than be micromanaged through detailed process standards by external organizations. Similarly, summit participants felt that there should be as few barriers as possible for organizations of different sizes and types to participate in medical home payment systems. In particular, small physician practices should be encouraged to participate, as should non-physician providers (e.g., nurse practitioner-led providers). Because physicians in many parts of the country practice in solo or very small group practices, not allowing these physician practices to participate would result in relatively few patients being able to benefit from the improvements in care.

Recommendation 2: Payers should phase in changes to payment systems to support the changes in primary care needed to improve quality and cost outcomes, beginning with enhanced fees and moving toward more comprehensive payments.

- a. Ultimately, the current fee structure should be completely replaced, and primary care providers should receive a single, severity-adjusted comprehensive payment to cover all of the costs of a person’s outpatient care, with a portion of the payment based on outcomes and costs. In addition, consumers should receive incentives for utilizing a primary care provider as a medical home.
- b. In the near term, relatively few primary care providers will likely be able to effectively manage such comprehensive payments. To enable providers to make the transition, health care payers should modify current payment systems to support new or modified primary care

services such as improved care management, but only if providers accept greater responsibility for maintaining or reducing patients' total cost of care. Consumer incentives should be phased in when there is a sufficient number of primary care providers available to support them.

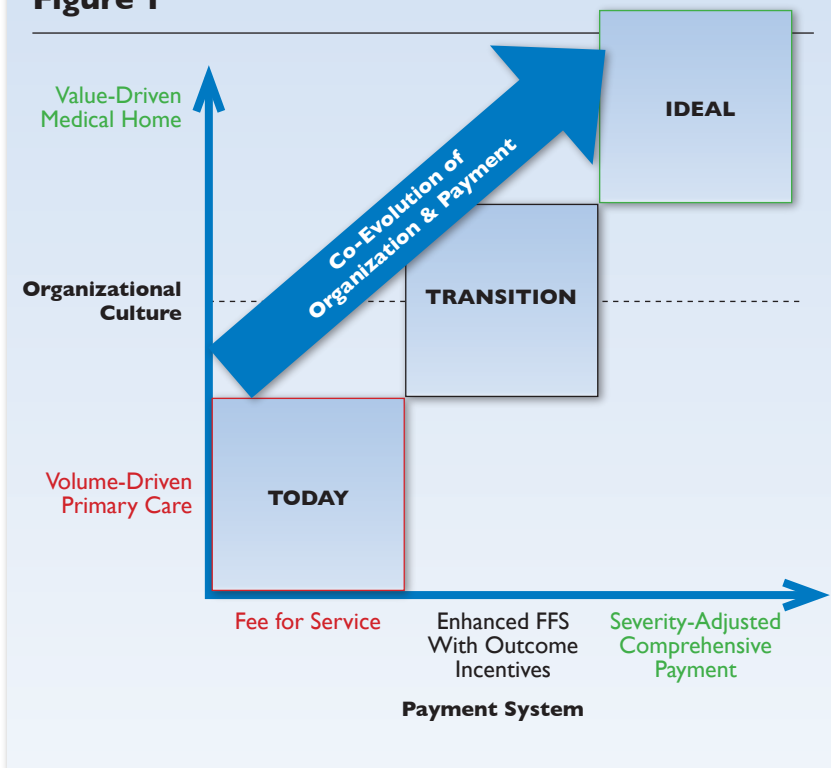
- c. At a minimum, all payers should change their payment systems to use similar measures and consistent expectations for primary care providers, so that providers can improve their care processes for all of their patients.

Consistent with the recommendations of the 2007 NRHI Summit on Healthcare Payment Reform regarding payment systems for chronic disease care (see *Incentives for Excellence: Rebuilding the Healthcare Payment System From the Ground Up*, Jewish Healthcare Foundation, September 2007), the participants in the 2008 NRHI Summit on Healthcare Payment Reform felt that in the long-run (i.e., within five to 10 years), primary care providers should receive a single payment for all of a person's outpatient care, completely replacing the current system of fees for individual services. The amount of the payment should be adjusted based on characteristics of the patient that affect the level of health care services needed, e.g., the number of chronic diseases they have and whether they have language barriers or disabilities. The payment amount should be adequate to compensate the provider for delivering high-quality care, and the provider should have the flexibility to use the payment for whatever combination of services will achieve

the best outcomes for the patient, rather than being limited to the specific types of services defined in fee-for-service billing codes.

Importantly, this comprehensive payment should also include rewards and/or penalties based on the cost and quality outcomes achieved for the patients under the provider's care. One of the goals of these rewards/penalties should be to ensure that *total expenditures* by health care payers do not increase beyond levels that would have been expected otherwise, even though the payments to the primary care providers might well be higher. For example, a key outcome of improved primary care should be reductions in preventable hospitalizations, so one approach would be to make higher payments to primary care providers whose patients have low rates of preventable hospitalizations and lower payments to providers with similar patient populations but higher rates of hospitalization.

Figure 1



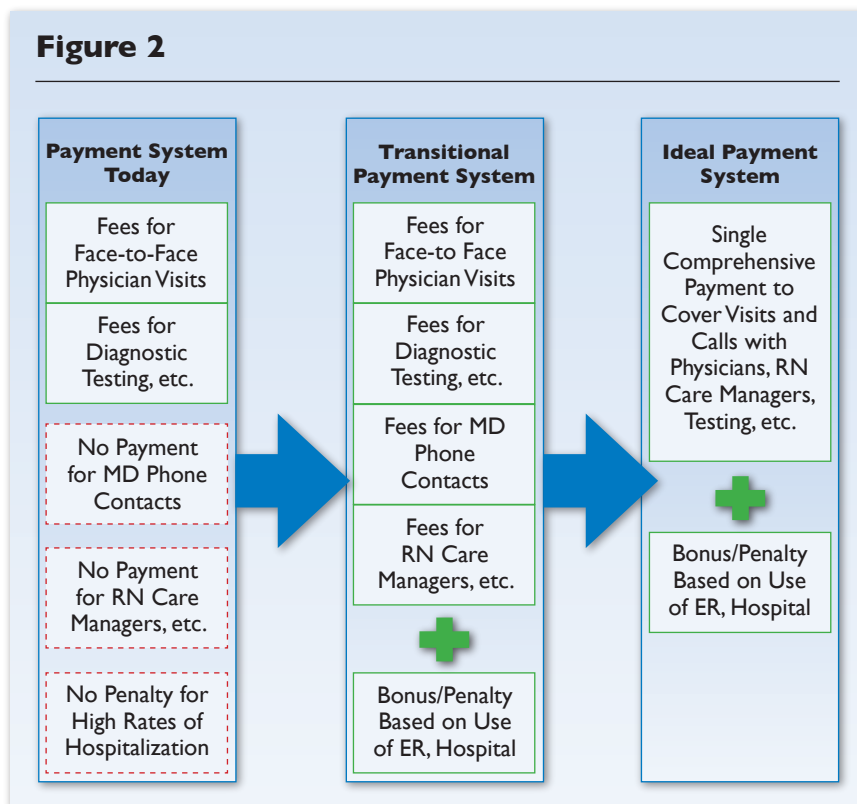
However, the summit participants agreed that while some primary care providers might be ready to accept such a new payment system today, others will not. For example, a significant amount of time and skill will be needed to re-tool the operations of many physician practices to meet the goals of the medical home; design or select and implement new billing, cash flow management and other systems; and recruit and integrate nonphysician staff such as nurse

There are several forms this transitional “enhanced fee-for-service system” might take. For example, as shown in Figure 2, new fees and billing codes could be created to pay for services and processes needed to deliver medical home capabilities, such as nurse care managers and phone contacts with patients, which are not reimbursed under the current fee-for-service system. Alternatively, providers could be paid a single additional fee on top of existing

fees to cover all of these additional new services and processes. In either case, providers should also receive bonuses or penalties based on things such as the number of hospitalizations, emergency room visits, and hospital readmissions in order to assure payers that total expenditures will remain budget-neutral.

Finally, it is very difficult for a health care provider to significantly change its processes of care for only a small subset of its patients. Similarly, it is highly problematic for a provider to manage some patients who are paid for under a fee-for-service system that rewards volume and other patients who are paid for under a value-driven payment system.

Figure 2



care managers into their care teams. Since current health care payment systems primarily reward volume not quality or efficiency, it is likely that skills in designing and managing care processes to improve quality and control costs will be in short supply until the incentives change. Consequently, transitional improvements to payment systems will be needed to support health care providers during their transition to a more value-driven structure—a “co-evolution” of payment and organizational capacity.

Consequently, it is highly desirable, if not essential, for a majority of health care payers to make changes in their payment systems to support and reward improved primary care. Although it would be ideal from the providers' perspective if all payers used identical methods of making payments, payers should, at a minimum, establish similar incentives and use consistent outcome measures, since the challenges of complying with multiple rules and systems can significantly increase administrative costs for providers.

However, because of antitrust concerns, even if payers are willing to agree on a common payment structure, it will be difficult or impossible for them to have direct discussions to achieve that agreement. To address this, the participants at the 2008 NRHI Summit on Healthcare Payment Reform recommended that neutral organizations should provide a forum for developing payment reform proposals with input from payers, purchasers, providers, consumers and others. Purchasers, consumers and community leaders can then encourage each payer to adopt and implement the consensus proposals, thereby achieving the desired alignment of payment systems.

The appropriate organization to provide such a forum will vary from region to region. One option is for a nonprofit regional health care

collaborative to play this role; another is for state government to do so. For example, in Minnesota the Institute for Clinical Systems Improvement worked with payers to develop multipayer support for the DIAMOND initiative to improve the quality of care for patients with depression. In Pennsylvania, the Governor's Office of Health Care Reform worked with payers to develop a multipayer demonstration of the chronic care model in the southeastern corner of the state. In Rhode Island, Quality Partners of Rhode Island worked with payers to develop a multipayer initiative to implement the advanced medical home and chronic care model.

More information about the recommendations of the NRHI Summit on Healthcare Payment Reform is available at www.nrhi.org/2008summit.html.

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