



Perspective

Payment Reform — The Need to Harmonize Approaches in Medicare and the Private Sector

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In the midst of heated debate over health care reform, there is an emerging consensus that the way we pay for health care — with our widespread reliance on fee-for-service payment models — is a

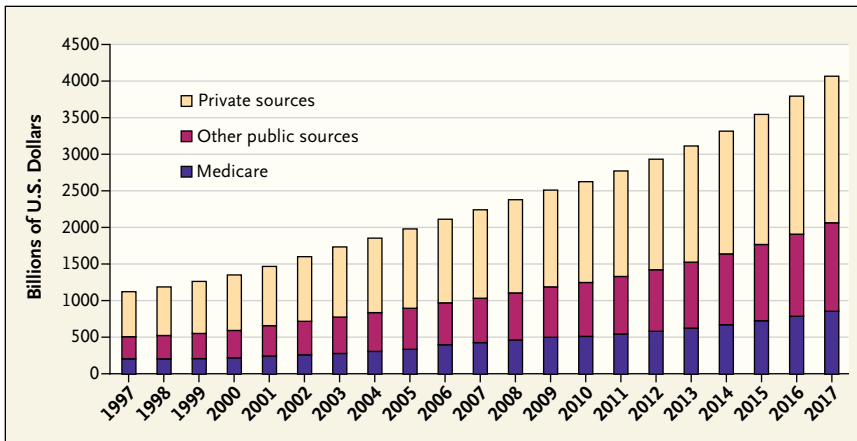
core problem that must be fixed. Unfortunately, too many of the policies proposed as part of reform seem to reflect the magical thinking that if we only “change Medicare” then all will be right in the world. Medicare is indeed the largest purchaser of health care in the United States, but at \$414 billion out of almost \$2.4 trillion, it represents only 19% of total health care spending (see graph).¹ Medicare must help lead the effort to change payment, but if we’re going to create a higher-value system overall, we need to change how all public and private payers reimburse for services.

The health care reform bill

passed by the House and the one being considered by the Senate contain multiple provisions designed to promote payment systems that move away from the traditional fee-for-service model. These provisions create opportunities for the Centers for Medicare and Medicaid Services (CMS) to explore, test, and implement new payment systems in Medicare that link payment to better health care outcomes, greater value, and improved patient experiences. Our cost problems, however, affect not only the federal budget deficit, but also individual American businesses and households. Only by aligning payment models across public and

private systems will we both address federal spending and make the health care system more affordable for all Americans. In addition, without aligned payment systems, doctors and hospitals are likely to continue to receive payments that are largely “value-blind” and to face a dizzying array of conflicting incentives, inconsistent reporting requirements, and disjointed administrative demands.

The Congressional reform proposals are based on a widespread consensus that the current model of fee-for-service payments undercompensate evaluation and management services as compared with procedures and technical services, do a poor job of providing incentives to clinicians for collaboration, do not improve efficiency, are not focused on quality and outcomes, and do little to encourage wellness and



Levels of National Health Expenditures, 1997–2007, and Projected Levels, 2008–2017, According to Type of Funding.

The data and projected data are from the Centers for Medicare and Medicaid Services, Office of the Actuary.

prevention. Yet these fee-for-service payments could serve as the building blocks for setting payments for some of the alternative payment approaches, if the fee-for-service payments are used to determine the elements of bundled payments or the component parts of payment for medical homes or accountable care organizations (ACOs). Medicare, Medicaid, and private-sector payers therefore have a common interest not only in creating new payment models, but also in correcting the pricing distortions that currently plague the fee schedules derived from the resource-based relative-value scale on which all payers rely.²

In an effort to go beyond “fixing” fee-for-service payments, the proposed legislation includes alternative models that would link Medicare payments more directly to quality and outcomes. These models include bundled payments to cover the range of services related to a defined medical condition; global fees to cover the entire cost of care (regardless of the setting) over an

extended period for a person with a condition such as cancer; extra payments for patient-centered primary care delivered through medical homes; and the rewarding of ACOs for achieving the desired performance in caring for a defined population over the course of a year.^{3,4} ACOs offer an illustration of the need for multipayer approaches: such organizations have the potential to improve the value of Medicare services, but because they might include most of the physicians and hospitals in a given community, they could easily use their “sanctioned” status in Medicare to negotiate higher prices from private payers.

The Congressional reform proposals describe these new payment models in broad strokes while acknowledging the critical need for rapid-cycle testing to ensure that, when fully implemented, they would have the intended consequences — promoting more-affordable, better-quality care. To address this need, both the bill adopted by the House and the bill before the Senate would estab-

lish a new “Innovation Center” within the CMS, charged with exploring and implementing new payment models.

These proposals have focused primarily on changing Medicare payments and, to a limited extent, Medicaid payments. Given lawmakers’ traditional responsibility for Medicare, the focus on innovation in Medicare payment is understandable. However, implementing new Medicare payment models without considering their effect on private-sector payment or aligning them with ongoing innovations by private purchasers will not promote needed changes in care delivery. Fortunately, Congress’s recognition of the need to improve Medicare payments can serve as the launching point for an integrated approach to payment reform, an approach that seeks to harmonize payment approaches among private and public purchasers of care. We believe that this harmonization would require a few simple steps that build on the revision of fee-for-service payments to reflect services’ value for patients.

First, the CMS should be charged with considering how Medicare’s adoption of new payment models, whether implemented through a new Innovation Center or otherwise, affects the cost or quality of care for patients outside Medicare and how the Medicare models can be aligned with payment approaches in the private sector and other parts of the public sector.

Second, in addition to supporting its own internally developed pilot programs involving the private sector and state payers, the CMS should foster participation by Medicare and Medicaid in lo-

cal pilot programs, designed by other payers and providers, that are responsive to state or regional community needs.

Third, the secretary of health and human services should work with the other payers to facilitate the collection, sharing, and public reporting of information on the quality, efficiency, and utilization of care. Rewarding higher-quality and more-affordable care requires far better information on quality and costs to permit comparisons among regions, types of services, providers, and payers; the results of such comparisons could then inform payment design and innovation.

Finally, the secretary of health and human services should establish formal advisory processes to determine which policies to pursue and how best to implement those policies to align incentives for patients and providers. This advisory process — whether it takes the form of an Institute of Medicine panel, as proposed by the House, or an independent Medicare advisory

board, as proposed by the Senate, or builds on the current Medicare Payment Advisory Commission — should include experts in delivery and payment reform, national payers and purchasers, patients, representatives of consumers and providers, and state and regional stakeholders, so that a wide range of perspectives can inform the CMS's implementation strategies.

By aligning incentives for improved outcomes, high value, and coordinated care, these steps would ensure that the important changes being proposed for Medicare payment would have positive systemwide effects. Without such harmonization, uncoordinated payment reforms run the risk of creating a confusing hodgepodge of requirements, incentives, penalties, and rewards for providers and patients alike. Conversely, if Congress, the CMS, and private payers work together, we may be able to achieve what has thus far eluded us — a health care system redesigned to provide patient-centered care fo-

cused on outcomes, value, and efficiency.

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