



Whole Health Campaign Policy Brief: *Payment Reform*

Situation statement: People with mental and substance use conditions, like people with other medical problems, receive fragmented and costly care that, too often, is not very effective. The way that the nation now pays for most health care services directly produces the disjointed and poor quality care delivered. Comprehensive payment reform is an essential part of national health reform.

Background: A phrase attributed to W.E. Deming aptly captures the problem with the nation's dominant health care payment system: "Every system is perfectly designed to achieve exactly the results it gets." To achieve different results, health care payments must be redesigned so that incentives and accountability line up with efficiency, effectiveness and lower costs.

Fee-for-service payment for medical services generates powerful pressures to increase the volume and intensity of health care services. Even when better, simpler and lower-cost ways exist to treat and prevent many illnesses, providers rationally respond to incentives. Those incentives are primarily set by the American Medical Association.¹ The specialty medical professional societies that are the members of the AMA's value-setting committee determine the relative worth of each medical procedure. Only physicians can vote on relative values. Nurses, psychologists, social workers, physician assistants, other non-physician health professionals, and consumers can observe the deliberations, but the secret ballot voting on relative values goes only to physician medical societies. The proprietary AMA value-setting process uses four criteria for deriving the relative value of procedures: the time it takes to perform the service; the technical skill and physical effort; the required mental effort and judgment; and the stress due to the potential risk to the patient. Only physician effort is considered in setting values. Effectiveness or cost-effectiveness of procedures or services are not criteria in setting values.

Not surprisingly, highly technical procedures requiring extensive medical training for very sick people are well paid. Prevention, counseling, recovery supports, care coordination, patient education in self-care management – all services with very strong evidence of effectiveness and cost-effectiveness – have low relative values. Often, these services that can be delivered effectively by non-physicians, are paid very little or not at all. The fee structure that Medicare, Medicaid and private health insurers use routinely pays physicians and hospitals 20 times more for intensive, heroic medical procedures than it pays for prevention, education of patients and their families to manage their

¹ The American Dental Association manages a parallel proprietary process for setting the relative value of dental procedures.

diseases, or coordination of care. Even when the health care system provides technically excellent care, payment methods almost insure that services are acute and episodic, and that essential communications fail between providers and between providers and patients. The elements of good, effective management of chronic medical and behavioral conditions are rarely reimbursed or are paid at such low rates that health care providers can not afford to provide them.

Good models exist of health systems that use incentives and accountability to consistently deliver higher quality care that produces better patient outcomes for lower costs than can be obtained elsewhere in the country. The Veterans Health Administration and integrated health care systems like Intermountain Health, Kaiser Permanente, Geisinger and HealthPartners have demonstrated the potential for better care by changing payment to encourage collaboration among providers, accountability for patient outcomes, and efficient use of resources over the course of an illness and over time.

Solutions:

1. Change the fee structure to include effectiveness and comparative effectiveness

CMS, the nation's largest health care payer, has the authority to use values in setting annual Medicare fee schedules that are different from the proprietary AMA values. Presently, CMS follows the AMA's relative value recommendations. Employment-based health insurers and State Medicaid agencies base their fee schedules on the annual Medicare schedule.

The Medicare Payment Advisory Commission (MedPAC) recommended in its June 2008 *Report to Congress* that an upward payment adjustment be made for primary care services billed under the Medicare physician fee schedule and furnished by primary care practitioners. CMS, through usual rule making processes, should be tasked with a thorough revaluation of relative values for health care procedures to include the cost-effectiveness and comparative effectiveness of procedures and services. Quality Adjusted Life Years (QALYs) and Disability Adjusted Life Years (DALYs) are well-established comparative effectiveness tools that are used internationally, and have been recently applied to rank the cost-effectiveness of US Preventive Services Task Force recommendations of prevention and screening services. CMS may be advised in this revaluation process by independent bodies that are authoritative and independent of the AMA and medical societies, institutions such as MedPAC, the Institute of Medicine, the US Preventive Services Task Force and AHRQ.

A re-valued payment system would likely reduce the rates paid for heroic, high intensity, high technology, high risk treatments that research indicates with high cost per QALY of DALY. It would likely increase reimbursement for prevention, screening and counseling to reduce risks, care management, self-care management education, care coordination and communication with patients, all of which have much lower costs per QALYs and DALY.

2. Create reimbursement mechanisms to support coordinated care that is responsible for and capable of providing a health care home for patients and their families' care across illnesses, episodes and the lifespan.

Over the past several years, a number of innovative models for integrated healthcare delivery have been developed, such as the medical home and collaborative care models. The goal of these models is to provide patient-centered and comprehensive medical, behavioral, and other health care and support services across a broad spectrum of services and providers in a culturally appropriate, evidence-based, accessible, and continuous manner. Integrated healthcare delivery is vitally important for people with mental illnesses and substance use disorders.

In addition to changing the way specific services are valued (as described in the previous section), the Federal government should use its health programs to create payment incentives for providers and patients to participate in person-centered health homes. Every person needs a regular provider who is accessible, knows the patient's medical history, maintains a complete medical record that is accessible to other providers and to the patient, and works with the patient to ensure that he or she receives all appropriate care in a timely and coordinated fashion that is focused on health need. For people with serious mental illnesses, addictions or complex behavioral health and health problems, their medical home may be within a community behavioral health program, a community health center or primary care practice. Wherever a medical home is based, the provider must have the responsibility, capability and incentives to provide integrated care for medical and behavioral conditions. Integrated care models should ensure that individuals with substance use disorders and/or mental illness have direct input into designing services and determining how their care is delivered. A new provider payment (in addition to payments for specific procedures and services) is needed to provide enhanced patient-centered care, with particular emphasis on accessible, appropriate and coordinated care for persons with chronic conditions and multiple co-morbidities.

To promote continuity of care through episodes which include acute and intensive care, the Federal government should create a bundled acute-care condition-based payment covering hospitalization and a specified set of services for some period following discharge. A bundled episode rate would give hospitals and other providers an opportunity to share the savings from their efforts to reduce complications of treatment and numbers of readmissions. It would also allow more flexibility in allocating their resources.

3. Promote accountability

The Dartmouth Atlas demonstrates that payment rates and quality are not closely linked. Risk adjusted, providers still vary dramatically in the outcomes they achieve with their patients. Payment reform must also reward excellence and promote quality improvement for providers who are less than excellent. In the last decade, innovative pay-for-performance and accountability systems have been piloted for diabetes and

cardiovascular disease management, patient safety in hospitals and emergency services, and computerized office practice. The Federal government, through its health programs, should follow the lead of the Veterans Health Administration to implement performance measurement and accountability systems that reward high performance and identify low performance for targeted quality improvement. Behavioral health must be part of every performance measurement and accountability system.

Specific Reform Recommendations on Mental Health and Substance Use Care and Prevention

Three documents have been prepared to define in detail the specific recommendations of the mental health and substance use fields around national health reform. These three documents are:

Benefit Design and Delivery of Care
Reforming the Healthcare Delivery System
Wellness Promotion and Chronic Disease Prevention Initiatives

We will be glad to provide either an e-version or paper copy of each of these documents.

Final 6-1-09