The Role of Comparative Effectiveness Research in Provider Payment Reform

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Objectives

- Review opportunities for CER on alternative approaches to provider payment
- Review alternative approaches to provider payment that could better reward use of CER findings
Are Studies of Provider Payment CER?

- **2008 IOM CER Priorities**
  - Compare the effectiveness of comprehensive care coordination programs, such as the medical home, and usual care in managing children and adults with severe chronic disease,
  - Compare the effectiveness of shared decision making and usual care on decision outcomes
  - Compare the effectiveness of accountable care systems and usual care …for …populations of patients with one or more chronic diseases.

- **2011 PCORI draft definition of PCOR**
Patient Centered Outcomes Research Draft Definition

- "Patient-Centered Outcomes Research (PCOR) helps people make informed health care decisions and allows their voice to be heard in assessing the value of health care options."

- PCOR answers patient-focused questions:
  - "How can the health care system improve my chances of achieving the outcomes I prefer?"
Patient Centered Outcomes Research
Institute Priorities

- The Institute shall identify national priorities for research taking into account
  - factors of disease incidence...
  - gaps in evidence...
  - the potential for new evidence to improve patient health...
  - patient needs, outcomes, and preferences,
  - relevance to patients and clinicians in making informed health decision...

- “The Institute shall establish and update a research project agenda for research to address the priorities identified”
The Evidence Base for Health Care Reform

AHRQ-ACA, NIH

Infra-structure for CER

• Stakeholder input
• Databases
• Training
• Methods
• Reviews

Comparative Effectiveness Research Studies

• Medications
• Medical devices and technologies
• Medical and surgical services, behavioral change strategies, delivery system interventions

NIH, AHRQ, PCORI

Research on using CER findings in practice

• Providers
• Patients
• Delivery Systems

NIH, AHRQ, CMMI, (PCORI)

Research on polices to promote using CER

• Payment and regulation
• Monitoring and feedback

AHRQ, CMMI

Evidence-based, Affordable Health Care

NIH, AHRQ, CMMI, (PCORI)
Rewarding use of CER thru payment reform

- It is difficult to get a man to understand something, when his salary depends upon his not understanding it
  - Upton Sinclair
Evidence-based medicine as a basis for clinical decision-making
- Empricism vs the “Scientific practice of medicine”
- “Scientific practice of medicine” vs EBM
- Societal and professional benefits of EBM

Current clinical practice not “evidence-based”
- overuse of services of unclear benefit
- underuse of effective services

Clinical decision-making in the real world
- where can clinician incentives bias decisions?
Real world clinical decision-making

- Where clinician incentives can bias decisions
  - Clinician beliefs about their professional role
  - Assessment of “prior probability” (availability heuristic)
  - Interpretation of clinical findings (eg over-diagnosis)
  - Recollection of clinical research evidence (availability)
  - Maslow’s Hammer
    - reputational bias
    - pseudo-consensus
  - Facilitating Adherence
    - Reminders
      - Physician
      - Patient
    - Active facilitation- system navigators, etc
Fee for Service incentives have been shown to affect which medical decisions?

1. Increased hospital admissions
2. Increased office visits
3. Increased tests/imagining
4. Increased invasive procedures
Physician Compensation Strategies and Intensity of Care

- highly capitated practice environments had the lowest risk adjusted spending per beneficiary,
  - Also lower intensity of care for episodes of care

- productivity payments had the highest spending

- True for practice owners

- and for employed physicians

Rewarding use of CER thru payment reform

- There are many mechanisms for paying physicians; some are good and some are bad.
- The three worst are fee for service, capitation, and salary.
  - James Robinson
Rewarding individual physicians for using CER

- Modifications in FFS
- Bundled payment
- Global per patient payment (capitation)
- Salary
Fee-for-Service  and Solo MD Income

Services= Charges= revenue
Services are a source of funds
More Services = higher profit

+ MD-related side business “physician entrepreneurism”
Modifying FFS to reward EBM

- Address “mis-priced” services in Medicare RBRVS
- Correct non-professional service income opportunities
- Value-based payment
Modifying FFS to Value-based payment

- Increase payments for highly effective services
- Add new “budget neutral RVU’s” that account for value as well as cost
- Reference pricing for unproven services
- Coverage with evidence development for new services
- Role for the Medicare “Value-based Modifier”? 
“...pay for performance.’ We already do that – providers perform, and we pay. It’s just that we pay the same whether the service is done on the right people at the right time -- or the wrong people at the wrong time!”
– Pete Stark- House Ways and Means Hearing

“The current P4P programs will ensure everyone gets at least one perfectly performed angioplasty “
– Anonymous- at a value based payment meeting for CMS
That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you,

should go on to give a surgeon a pecuniary interest in cutting off your leg,

is enough to make one despair of political humanity.

– G B Shaw
Moving Beyond FFS

- Bundled payment
- Capitation
- Salary
Bundling to reduce overuse

**Current**
- Bundled payments used for most of Medicare Part A (e.g. DRGs)
- Medicare bundles Part B payments for ESRD and Global Surgical Fees
- New Bundling Demos

**Potential Advantages**
- Bundled payments could facilitate more careful patient management, while reducing administrative burden for physicians.
- Medicare should realize cost savings because physicians would not have the same incentive to increase volume of services under a properly-bundled payment system.
Bundling to reduce overuse

- Options for a bundled payment system for physicians.
  - Major procedures - eg CABG Demo (combined A and B payment to hospital)
  - Episodes of Illness – eg use evidence/guidelines to bundle payments for imaging and other services typically part of managing an illness
  - Chronic illness and major conditions - year long bundled payments (e.g. diabetes, heart failure, colon cancer).

- Who to give the $ to??
Capitation and Solo MD Income

Patients generate revenue
Services are a source of expense
More services = higher loss
Rewarding individual physicians for using CER

- Modifications in FFS
- Bundled payment
- Global per patient payment (capitation)
- Salary
Rewarding physician employers for using CER

- AMA and the “corporate practice of medicine”
- Is salary a neutral incentive for CER?
- Practice organizations and physician incentives
Incentives faced by different physician employers

- single specialty group practices
- multi-specialty practices, hospitals
- fee for service oriented integrated delivery systems
- group and staff model HMOs
- how these might relate to “ACOs”.
“people of the same trade seldom meet together... but the conversation ends in a conspiracy against the public...”

– Adam Smith
Episode-based payment and ACO Income

Episodes = Charges = revenue
Episodes are a source of funds
More Episodes = higher profit
Bundling payments for practice organizations

- Procedure-based payment
- Episode based payment
- Chronic condition episodes
- Bundled payment with P4P
- Underuse vs overuse
Rewarding use of CER thru payment reform

The Path Forward

- There are many mechanisms for paying physicians…The three worst are fee for service, capitation, and salary.

- Aiming the right incentives at the right provider
  - Large entities- global payments with robust performance and appropriateness measures
  - Smaller entities- mixed incentives for doing the right thing within scope of practice
Example- rewarding better primary care

1. Enhanced FFS payment for office visits to a PCMH

2. FFS payment for Additional PCMH Activities

3. Standard FFS for Office Visits and PPPM for medical home activities

4. Reduced FFS for Office Visits and PPPM for medical home activities

5. Comprehensive payments: capitation for traditional primary care and new medical home services

Berenson and Rich JGIM April 2010
FFS payment for Additional PCMH Activities

- **Advantages**
  - Administratively straightforward (once new service codes approved)
  - Uses FFS power to incentivize performance of specific, targeted activities
  - May not require PCMH practice “certification”

- **Disadvantages**
  - Defining the desired PCMH activities for FFS payment
  - Limited applicability of FFS payments to some medical home services
  - Limits practice flexibility about how to design the medical home

Berenson and Rich JGIM April 2010
Paying for Email

Example of Problems with FFS fixes to Primary care

- “Moral hazard”- potential for extended email “conversations” between Docs and patients- each exchange billed to 3rd party

- Gaming and Fraud- how to assure “program integrity” in an era of electronic records, text writing software, automated billing
FFS for Visits and PPPM* for medical home activities

- **Advantages**
  - Hybrid approach
  - FFS rewards for access and “face to face time”
  - Management fee payment for providing infrastructure and special medical home services

- **Disadvantages**
  - Need to certify practices eligible to receive PPPM $
  - Case mix payment adjustment required to support varying range of medical home services for patients with different needs
  - P4P required to reward preventive services, enhanced access

* PPPM= Per Patient Per Month
Rewarding use of CER thru payment reform

The Path Forward-

To aim the right incentives at the right provider-

Need-

- Better evidence regarding what services are effective
- Better evidence regarding the optimal mix of incentives for different scopes of practice