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We Get What We Pay For

By David Merritt

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Today's acute-care system is based on the myth of the fifteen-minute cure: just go see your doctor, and he will make you better. And yet we wonder why health outcomes are not getting any better and costs continue to rise. This approach has to change. To build an intelligent, modernized health system that delivers more choices of greater quality at lower cost, we must enact real change—starting with the reimbursement structure.

Our current payment system is not based on the quality of care that is delivered. Instead it pays providers for simply delivering care, regardless of outcome. Hospitals and providers that deliver better care are for the most part reimbursed at the exact same rate as those who provide poorer care.

Additionally, the payment system encourages the over-utilization of resources. Like any contracted professional, be it a plumber or a builder, doctors are paid for performing their craft, which in this case is treating patients. They are not paid for keeping their patients healthy and out of their office or hospital—they are paid when they treat their sick patients in their office or hospital. This approach is so perverse that many argue that medical errors actually reward a hospital or physician because they can then bill for additional services.

We need a new model. Reimbursement drives adoption, be it a new test, device, or treatment, and we need a reimbursement model that takes into account the quality of the care that is delivered, not simply that it was delivered.

Current pay-for-performance and other incentive programs are a first step toward an outcomes-based payment structure. The Centers for Medicare and Medicaid Services (CMS) and many private insurers are partnering with their physician and hospital networks to pilot new financing and delivery models based on outcomes, from the Leapfrog Group and Integrated Healthcare Association to health insurance plans and Bridges to Excellence. All of them know that reimbursement drives adoption.

In Georgia the Center for Health Transformation is leading the nation's largest Bridges to Excellence diabetes program. Led by UPS, BellSouth and Southern Company, all members of the Center for Health Transformation, there are currently fourteen major employers, including the state of Georgia, participating in the program. The state medical society and hospital association are actively participating as well. Serving in the role of administrator are Blue Cross Blue Shield of Georgia, Humana, Aetna, CIGNA, Kaiser Permanente, and UnitedHealthcare. Physician recruitment efforts are ongoing, with WellStar Health System and the Morehouse Community Physician Network leading the way.

The program, like other pay-for-performance initiatives, pays incentives to physicians who practice best standards of diabetes care. The program encourages individuals with diabetes to see these physicians to improve their quality of life and avoid the long-term complications of the disease. In the process, physicians are rewarded for providing high-quality care, individuals with diabetes are healthier, and employers save money. A recent actuarial analysis of the program by Towers Perrin reports an estimated savings of $1,059 per individual if blood pressure, Hemoglobin A1C, and LDL control measures are met. By saving lives and saving money, this Bridges to Excellence module should be the minimum standard of diabetic care throughout the country.

CMS will soon roll out an innovative initiative called the Medicare Health Care Quality Demonstration Program, also known as the 646 demonstrations. A major focus of these five-year demonstrations will be to improve the delivery of care in ambulatory offices by testing significant changes to payment and reimbursement, as well as performance measures and the practice of evidence-based medicine. Health information technology, and reimbursing for its use, will be front and center.

Reimbursement drives adoption. One example is telemedicine. This is an innovative and cost-effective approach that allows hospitals, clinics, and physicians without technology to partner with those that do. Videoconferencing with experts, transmitting images and records for second opinions, remotely monitoring patients, and virtual emergency rooms and tele-pharmacy services are some of its uses. Particularly for rural facilities, telemedicine improves patient care by increasing access to specialists, and it also saves money by delivering better care and reducing expensive services.

Most insurers reimburse their network providers for telemedicine, which drives adoption, because they know it will save lives and save money. Colorado is poised to become the 39th state to reimburse its Medicaid providers for telemedicine services. Unfortunately this means that eleven states still do not reimburse providers for using this technology. This short-sighted perspective, most likely based on perceived budget savings, is blind to the financial savings that technology can bring, and, more importantly, the improved health outcomes.

One way to guarantee better health outcomes—which in the system of future should bring higher reimbursement rates—is to encourage the use of health information technology, such as electronic health records, decision support tools, barcoding, and computerized physician order entry.

If we truly want better health at lower costs, the number one priority of every stakeholder in healthcare should be to get technology into the hands of every provider in the country. And the surest way to accomplish this is to reimburse hospitals and physicians for using health information technology in the course of care. Reimbursement indeed drives adoption.

Insurers—especially Medicare and Medicaid—should incentivize the purchase of health information technology through higher reimbursement rates. From electronic prescribing tools to electronic health records, even nominally higher rates will drive the adoption of technology because providers want long-term, predictable revenue streams. Consider the Hospital Compare site, www.hospitalcompare.hhs.gov. CMS reimburses at a slightly higher rate those hospitals that electronically report their quality data. With an incentive of only .45%, nearly 99 percent of hospitals electronically submit their data. Organized properly, the broad adoption of technology would be no different.

Health insurance giants Aetna and CIGNA Healthcare recently announced that in select markets they will reimburse physicians for conducting electronic or web-based consultations with their patients. Studies have shown that utilizing technology this way decreases administrative time for providers and their staffs, increases patient satisfaction, and decreases office visits and utilization. Every other insurer, including Medicare and Medicaid, should follow their lead.

The real question boils down to this: if a provider endangers their patients' lives by delivering care through a paper record, should we pay them the same as a provider that delivers better care because they invested thousands of dollars in technology? A rational reimbursement system would pay more for the latter.

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