Better Ways to Pay for Healthcare in Nevada
A Payment Reform Summit
Consensus Documents

HealthInsight
a partnership for the future of health care

HealthInsight, a regional healthcare collaborative, convened a Payment Reform Summit in Las Vegas, NV on April 22, 2010. There were 140 attendees that included healthcare provider and health plan executives, outpatient practice managers, employers and members of purchasing coalitions, consumer groups, and other interested stakeholders. Featured speakers were:

- Marc Bennett, President & CEO, *HealthInsight*
- Harold Miller, President & CEO, Network for Regional Healthcare Improvement, and Executive Director, Center for Healthcare Quality and Payment Reform
- David Sayen, Administrator, Centers for Medicare & Medicaid Services, Region IX
- Randy Fuller, Director, Thought Leadership, Healthcare Financial Management Association

The speakers' presentation slides are available at www.healthinsight.org.

The attendees participated in one of two interactive breakout sessions:

- Medical Homes for Chronic Disease Patients (outpatient care)
- Efficient, Successful Care of Major Acute Episodes (inpatient care)

A list of issues and possible payment options, which had been distributed to the participants prior to the Summit, was used to guide discussion and to provide a format around which to build consensus. After the breakout sessions adjourned, the attendees reconvened as a single group to discuss and confirm the recommendations from each of the breakout groups. Attached are the discussion guides and the consensus documents from each group.

There was also consensus that *HealthInsight* would widely disseminate this document to both participants and non-participants to confirm the recommendations contained in the documents and to request feedback. It was also agreed that *HealthInsight* would convene interested stakeholders who will work collectively to develop pilot studies in both outpatient and inpatient settings.

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Work Session Topics for the Nevada Payment Reform Summit
A Discussion Guide

Supporting Medical Homes for Chronic Disease Patients

ISSUE 1: What Basic Method Should Be Used to Pay Medical Homes for Care of Patients with Chronic Conditions?

ISSUE 2: How Should The Fees/Payment Levels for Medical Homes Be Determined?

ISSUE 3: How Should Consumers Be Encouraged to Use a (Consistent) Medical Home?

What Basic Method Should Be Used to Pay Medical Homes for Care of Patients With Chronic Conditions?

OPTION 1: The patient's medical home should be paid on a fee-for-service basis. The fee levels should be revised and new service codes added in order to (1) enable time to be spent counseling patients and providing self-management education, (2) allow payment for services beyond those provided by a physician in a face-to-face visit, and (3) allow multiple services to be provided on the same day/in the same visit. Other providers should also be paid on a fee-for-service basis. A pay-for-performance system should be included to create incentives for the medical home to reduce the use of preventable ER visits, preventable hospitalizations, etc.

OPTION 2: The medical home should be paid a single, periodic, prospectively defined Care Management Payment (CMP) to cover all of the evaluation, management, and patient education services associated with the patient's chronic conditions, with the amount adjusted for the severity/risk of the patient. The medical home or other providers should be paid separately for preventive care and care of minor acute episodes provided beyond basic care management. Hospital care and long-term care associated with the chronic condition would be paid separately. A pay-for-performance system should be included to create incentives for the medical home to reduce the use of preventable ER visits, preventable hospitalizations, etc.

OPTION 3: The medical home should be paid a single, periodic, prospectively defined Care Management Payment (CMP) to cover all of the evaluation, management, patient education, preventive care, and minor acute care services (including diagnostic testing and outpatient procedures) associated with the patient's chronic conditions, with the amount adjusted for the severity/risk of the patient. Hospital care and long-term care associated with the chronic conditions would be paid separately, as would care for preventive care and minor acute care unrelated to the patient's chronic conditions. A pay-for-performance system should be included to create incentives for the medical home to reduce preventable ER visits, hospitalizations, etc.

OPTION 4: The medical home should be paid a single, periodic, prospectively defined Care Management Payment (CMP) to cover all of the care associated with the patient's chronic conditions, including any hospitalizations, with the amount adjusted for the severity/risk of the patient. Preventive care and minor acute care unrelated to the patient's chronic conditions would still be paid separately, as would long-term care associated with the chronic condition.

OPTION 5: The medical home should be paid a single, periodic, prospectively defined Care Management Payment (CMP) to cover all of the care needed by the patient, regardless of whether it is associated with the patient's chronic condition or a minor acute episode, including preventive care, minor acute care, and hospital care, with the amount adjusted for the severity/risk of the patient. Any long-term care services (e.g., nursing home or home health care) would be paid separately.

OPTION 6: The medical home should be paid a single, periodic, prospectively defined Care Management Payment (CMP) to cover all of the care needed by the patient, regardless of whether it is associated with the patient's chronic condition or a minor acute episode, including preventive care, minor acute care, hospital care, and long-term care services, with the amount adjusted for the severity/risk of the patient.

OPTION 7: Other: _____

How Should The Fees/Payment Levels for Medical Homes Be Determined?

OPTION 1 The Federal Government (e.g., through Medicare) should establish an appropriate payment level for each service or Care Management Payment, adjusted by the patient's diagnoses, severity, and geography. All other payers should use the same payment level.

OPTION 2: The State (e.g., through a state agency or Commission) should establish an appropriate payment level for each service or Care Management Payment, adjusted by the patient's diagnoses, severity, and geography, based on a study to estimate the cost of delivering good quality care for that category of diagnosis and severity, and all non-federal payers and providers should be required to accept that payment level.

OPTION 3: A multi-stakeholder collaborative (e.g., *HealthInsight*) should convene payers, providers, purchasers, consumers, and others to recommend an appropriate payment level for each service or Care Management Payment, adjusted by the patient's diagnoses, severity, and geography, based on a study to estimate the cost of delivering good quality care for that category of diagnosis and severity, and all payers and providers should agree to accept that payment level.

OPTION 4: Payers (e.g., health insurance plans) should negotiate with each provider to establish an appropriate payment level for each service or Care Management Payment, adjusted by the patient's diagnoses and severity.

OPTION .5: Individual providers should establish their own prices for each service or Care Management Payment, adjusted by the patient's diagnoses and severity. Payers should pay the lowest prices offered by quality providers in each geographic region (as determined by the payer or by a Regional Health Improvement Collaborative), and patients should be required to pay the difference between an individual provider's price and the lowest price (in addition to any copays or coinsurance required by their health plan).

OPTION 6: Other: _____

How Should Consumers Be Encouraged to Use a (Consistent) Medical Home?

OPTION 1: Provide education for consumers on the value of selecting and consistently utilizing a primary care provider (or appropriate specialist) as a medical home.

OPTION 2: Reduce copayments and co-insurance for patients utilizing a primary care provider (or appropriate specialist) as a medical home.

OPTION 3: Require consumers to pay a one-time fee for switching primary care providers unless there are appropriate justifications (e.g., a change in the consumer's residence or the provider's location, poor quality ratings of the provider, etc.)

OPTION 4: Require consumers to accept a greater share of the financial risk for their care (e.g., through higher cost-sharing for hospitalizations for ambulatory-care-sensitive conditions) if they do not select a medical home or otherwise use a consistent provider for their care.

OPTION 5: Other: _____

SUPPORTING MEDICAL HOMES FOR CHRONIC DISEASE PATIENTS

What Medical Home Payments Should Cover

A single, periodic, prospectively defined Care Management Payment should cover all of the evaluation, management, patient education, preventive care, and minor acute care services. This should include diagnostic testing and outpatient procedures associated with the patient's chronic condition. The payment should be adjusted for the severity/risk of the patient.

Hospital care and long term care associated with the chronic conditions should be paid for separately.

A pay for performance system should be included to create incentives for the medical home to reduce preventable ER visits and hospitalizations.

Determination of the Payment Amount

A multi-stakeholder collaborative, such as *HealthInsight*, should convene payers, providers, purchasers, consumers and others to recommend an appropriate payment level for each service or Care Management payment, that is:

- Adjusted by the patient's diagnoses, severity, and geography
- Based on a study to estimate the cost of delivering good quality care for that category of diagnosis and severity

All payers and providers should agree to accept that payment level.

Encouraging Consumers to Use a Medical Home

- Provide education on the value of selecting and consistently using a medical home and on the patient's chronic condition
- Require consumers to accept a greater share of the financial risk for their care if they do not select a medical home or do not follow the recommended treatment plan

Work Session Topics for the Nevada Payment Reform Summit *A Discussion Guide*

Supporting Efficient, Successful Care of Major Acute Episodes

ISSUE 1: How Should Hospitals and Physicians Be Paid for Inpatient Care?

ISSUE 2: How Should Hospitals and Physicians Be Paid When Preventable Adverse Events (e.g., Hospital-Acquired Infections, Medical Errors, etc.) Occur?

ISSUE 3: How Should The Payment Amounts for Hospital Care Be Determined?

ISSUE 4: How Should Unnecessary Acute Care Be Discouraged?

How Should Hospitals and Physicians Be Paid for Inpatient Care?

OPTION 1: Hospitals and physicians involved with hospital care should continue to be paid separately, as they are today.

OPTION 2: Hospitals and physicians involved with hospital care should continue to be paid separately, but each should receive incentive payments from health plans based on the total cost of their services for individual episodes compared to other providers.

OPTION 3: Hospitals and physicians should continue to be paid separately, but hospitals should have the ability to make additional payments to physicians if the physicians help the hospital reduce its costs or improve quality ("gain-sharing").

OPTION 4: A single prospectively-defined payment (a "bundled DRG payment") should be made to cover the cost of hospital care and the services of the physician managing the patient's care in the hospital, but other consulting physicians (e.g., anesthesiologists, consulting specialists) should continue to be paid fees separately. Additional outlier payments should be made for patients who require an unusually high number of hospital or physician services.

OPTION 5: A single, prospectively-defined payment should be made to cover the cost of hospital care and the services of all physicians involved in the patient's care in the hospital. Additional outlier payments should be made for patients who require an unusually high number of hospital or physician services.

OPTION 6: A single, prospectively-defined payment should be made to cover the cost of hospital care, all physicians involved in the patient's care in the hospital, and any short-term care following discharge (e.g., home health care, rehabilitation, etc.). Additional outlier payments should be made for patients who require an unusually high number of hospital, physician, or post-acute care services.

OPTION 7: Other: _____

How Should Hospitals and Physicians Be Paid When Preventable Adverse Events (e.g., Hospital-Acquired Infections, Medical Errors, etc.) Occur?

OPTION 1: A hospital and physicians should be paid more for the additional costs of treating a preventable adverse event which occurs during care of patient, but the rate at which such adverse events occur should be reported publicly to encourage patients to use higher-quality providers.

OPTION 2: A hospital and physicians should be paid more for the additional costs of treating a preventable adverse event which occurs during care of patient, but the hospital and physicians involved in the adverse event should receive financial bonuses or penalties based on the rate at which such adverse events occur.

OPTION 3: No additional payment should be made to hospitals or physicians for care needed to address a preventable adverse event (i.e., the payment to the hospital/physicians would include an "inpatient warranty"). (NOTE: If physicians are paid separately, physicians not involved in the care leading up to the adverse event who are needed to treat the result of the adverse event would still be paid.)

OPTION 4: Other: _____

How Should The Payment Amounts for Hospital Care Be Determined?

OPTION 1: The Federal Government (e.g., through Medicare) should establish an appropriate payment level for each type of acute care, adjusted by the patient's diagnoses, severity, and geography. All other payers should use the same payment level.

OPTION 2: The State (e.g., through a state agency or Commission) should establish an appropriate payment level for each type of acute care, adjusted by the patient's diagnoses, severity, and geography, based on a study to estimate the cost of delivering good quality care for that category of diagnosis and severity, and all non-federal payers and providers should be required to accept that payment level.

OPTION 3: A multi-stakeholder collaborative (e.g., *HealthInsight*) should convene payers, providers, purchasers, consumers, and others to recommend an appropriate payment level for each type of acute care, adjusted by the patient's diagnoses, severity, and geography, based on a study to estimate the cost of delivering good quality care for that category of diagnosis and severity, and all non-federal payers and providers should agree to accept that payment level.

OPTION 4: Payers (e.g., health insurance plans) should negotiate with each hospital or physician-hospital organization (and with physician practices and post-acute care providers, if they are paid separately) to establish an appropriate payment level for each type of hospital care, adjusted by the patient's diagnoses and severity.

OPTION 5: Each individual hospitals or physician-hospital organization should establish its own price for each type of acute care, adjusted by the patient's diagnoses and severity. Payers should pay the lowest prices offered by quality providers in each geographic region (as determined by the payer or by a hospital quality measurement program), and patients should be required to pay the difference between an individual hospital's price and that lowest price (in addition to any copays or coinsurance otherwise required).

OPTION 6: Other: _____

How Should Unnecessary Acute Care Be Discouraged?

NOTE: Options are not mutually exclusive.

OPTION 1: Provide better information to patients and providers on the relative value (quality, cost, and satisfaction) of alternatives to major acute care.

OPTION 2: Develop guidelines for when major acute care (e.g., surgery) is appropriate; require patients to pay a *portion* of the difference in cost between major acute care and alternative treatments/services when there is not clear evidence regarding the appropriateness of major acute care, and require patients to pay the *full* difference in cost when evidence-based guidelines indicate that major acute care is not appropriate.

OPTION 3: Reduce payments to hospitals and physicians that perform major acute care procedures at a significantly higher rate (adjusting for patient characteristics).

OPTION 4: Provide financial support or incentives to primary care physicians and specialists for involving patients in shared decision-making processes about the use of major acute care treatments and services.

OPTION 5: Provide financial incentives to patients to use shared decision-making tools (e.g., lower copayments/coinsurance for elective surgery if the patient has participated in shared decision-making).

OPTION 6: Other:_____

SUPPORTING EFFICIENT, SUCCESSFUL CARE OF MAJOR ACUTE EPISODES

What Acute Episode Payment Should Cover

A single, prospectively defined "bundled" payment should be made to cover the cost of all services associated with a patient's care for a major acute episode, including:

- All of the services provided by the hospital;
- The services provided by the physician managing the patient's care;
- The services provided by other hospital-based physicians (e.g., anesthesiologists, radiologists, etc.); and
- The services of any other consulting physicians.

Within 1-2 years after these inpatient bundles are being used, the bundles should be expanded to also include short-term post-acute care such as home health care and rehabilitation services.

The amount of the payment should vary based on the number, type, and severity of the patient's conditions.

Adjustments to the Payment Amount

An additional "outlier" payment should be made for a patient who requires an unusually high number of hospital, physician, or post-acute care services (unless the additional services are required to treat a preventable adverse event).

If an adverse event occurs during the patient's hospital stay (e.g., an infection or a medication error) that was clearly preventable, the hospital and physicians should not be paid extra for the services required to address the complications associated with that event. In cases where the adverse event was not clearly preventable, the hospital and physicians should be paid extra to address the complications, but t he rate of all adverse events (preventable or not) should be publicly reported, and hospitals and physicians should receive bonuses or penalties based on the rate at which such adverse events occur relative to state and national averages.

The quality of care delivered during acute care episodes and the readmission rates after discharge should be measured and publicly reported. Hospitals and physicians should be rewarded for good quality and low readmission rates (through bonus payments) and penalized for poor quality and high readmission rates (through payment reductions) based on the performance achieved for groups of patients over a period of time.

Recipient of the Bundled Payment

Bundled payments should not be made directly to either hospitals or physicians, but only to Physician-Hospital Organizations that are 50/50 owned by hospitals and physicians or to integrated delivery systems that employ physicians.

Determination of the Payment Amount

Each group of providers (i.e., hospitals, physicians, and post-acute care providers) should set the price for each episode that they feel is appropriate to cover the costs of necessary services. Payers should then define the highest-value providers as a High-Value Network, with "highest-value" defined as the lowest price providers (averaged across all episodes) among the providers which achieve high (i.e., well above average) performance on quality measures. Patients should pay lower premiums and cost-sharing if they limit their care to providers in the High Value Network.

For high-volume elective procedures, patients should be allowed to use any provider, even if it is not in the High Value Network. For these procedures, payers should agree to pay the lowest price offered for the procedure by high-quality providers in each geographic region (regardless of whether the providers are in the High Value Network), and patients should pay all or a significant portion of the difference between that amount and the price of the provider they choose.

Discouraging Unnecessary Acute Care

Patients and providers should be given information on the relative value (quality, cost, and patient satisfaction) of alternatives to major acute care.

Primary care physicians and specialists should receive financial support or incentives to involve patients in shared decision-making processes about the elective use of major acute care treatments and services. Patients should also receive financial incentives to participate in shared decision-making processes for elective procedures.

Patients should receive incentives to improve their health and to participate in preventive healthcare.