Guiding Principles on Health Care Delivery and Payment Reform

Innovators Committee
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Background

As both the public and private sectors desperately seek solutions to the unsustainable growth in health care spending, a once-in-a-generation opportunity has arisen to revitalize and transform our health care system. Key provisions set forth by the Affordable Care Act (ACA), enacted into law in 2010, focus on improving access to care, but in doing so, they beg the question of significant complementary changes in health care delivery, patient engagement/responsibility and payment to providers. Although some system and payment reforms are spelled out in the ACA (e.g., Accountable Care Organizations [ACO] and other shared savings models), much is left unspecified. In recognition of the fact that much new work needs to be done, the ACA authorized $1B per year for 10 years for developing and implementing system and payment reforms through the newly formed Center for Medicare & Medicaid Innovation (CMMI). If we as a nation are to realize in timely fashion the societal goals spelled out so clearly by Don Berwick’s Triple Aim of better care, better health, at lower cost, then much collaborative work is urgently needed engaging all stakeholders. Participation and leadership from the physician community will be essential.

In June 2011, the American Medical Association, the American College of Physicians and the American College of Surgeons convened a group of physicians with hands-on experience in the development, management, and operation of innovative health care payment and delivery models. This group, named the Innovators Committee (the committee), is charged with developing resources and guidance that will help local physicians from various specialties assume a leadership role in the development and diffusion of new delivery and payment models.
Process

As a first step towards this goal, the committee developed a set of consensus guiding principles to inform and evaluate specific proposals for both delivery and payment reform. In developing these principles, the committee determined that such principles should broadly:

1) Apply to the full spectrum of care
2) Apply to all stakeholders, including patients, health care professionals, other providers (i.e., hospitals, networks) and payers (both private and public)
3) Address and emphasize access to care
4) Address and emphasize patient autonomy and privacy and preserve the patient-physician relationship
5) Address fair compensation for health care professionals and other providers, with an emphasis on contribution to value (i.e., quality/cost)
6) Address models for incentives and attribution and include attention to risk adjustment
7) Address and incorporate best scientific evidence
8) Emphasize coordinated care and collaborative and team-based approaches; address authority and oversight issues
9) Address regulatory issues that impact on both delivery and payment
10) Address incentives and rewards for innovation
11) Address obstacles to implementation of delivery and payment reform in a durable but not inflexible manner

The committee developed two sets of guiding principles (below)—one for delivery of care and a second for payment. In order to achieve this goal, the committee first collected and collated statements of delivery and payment already developed by key stakeholder groups, including but not limited to national and state medical associations and societies and other professional groups that represent the full scope of primary care, specialties, delivery systems, patient advocacy groups, industry and government. Second, the committee identified areas of consensus and of major disagreement and contention among existing principles. Third, the committee developed a synthesized set of recommended principles, based on a reconciliation of the analysis of existing principles with the foregoing 11 criteria.

The Guiding Principles are designed to be evolutionary and, as such, represent the committee’s current thinking on delivery and payment reform. These principles may be refined periodically to reflect not only the committee’s learning curve but, more broadly, a rapidly evolving health care environment in which novel insights or models are discovered on an ongoing basis.
1. **Coordination of care must be clearly demonstrable in the delivery of health care.**

Care can and should be coordinated around defined conditions, episodes of care, or groups of episodes of care, regardless of the state/level of formal or financial integration of the providers involved, such that the health care team can identify clearly a single point of coordination, or alternatively well-defined care coordinators for patients with either acute and/or chronic conditions. Coordinated, team-based care must be demonstrated to occur across people, functions, activities, locations and time. While achieving this objective may be easier in more fully integrated delivery systems, less integrated systems may provide clearly demonstrable evidence that coordination of care occurs, and must be held to the same standards as more integrated systems. Patients and payers must also actively participate in coordination of care through demonstrable interactions with physicians and/or care coordinators and, where appropriate, relevant community resources, whether done face-to-face or via information and communications technology.

Thus:
- The coordinator(s) must be clearly identified
- All care should be coordinated, regardless of the level of integration of the delivery system
- Patients must participate in coordination of care and demonstrate understanding and satisfaction with said coordination
- Payers must participate in coordination of care and incentivize value

2. **Care must be centered on the patient.**

As systems of care delivery develop, there will be a risk that the system will become the end rather than a means to an end. The same holds true for payment reform mechanisms and the new institutions that may be formed to regulate them. These risks must be avoided. Any new delivery system that develops must, first and foremost, acknowledge that its mission is to serve the needs of the patients in its care. While clearly any delivery system must include patients, providers and payers, the central importance of the patient—and the patient’s needs—must always remain the principal focus. Moreover, appropriateness of care in a bundle of services often requires a combination of physician and/or other clinician guidance and patient choice. Many proposed bundles or care episodes, or components thereof, may represent clinical alternatives to medical management. Therefore, an informed consent mechanism, whereby a patient has access to all the treatment alternatives, and these alternatives are presented fairly with information on risks, outcomes and resulting changes in patient lifestyle, should be an essential and central component of any delivery model. However, a mechanism for resolution of dispute between patients and both providers and payers must exist that focuses on value: achieving the desired outcome(s) for the individual patient at the most reasonable cost.

Thus:
- Health care delivery systems, as well as new institutions and mechanisms designed to regulate them, must be a means to an end, rather than the end
- Patient centeredness must be manifested by understanding and free patient choice and demonstration of appropriateness regarding specific treatments, regardless of complexity
- Patient choice must be informed, at least in part, by physician guidance and recommendations that include a thorough discussion of alternatives accessible to the patient
- Evaluation of delivery systems should include a value proposition that weighs equally patient choice with desired treatment outcome, and health promotion with disease treatment

3. **Quality Assessment and Performance Improvement (QAPI) processes must become an integral component of both delivery and coordination of care.**

QAPI efforts around defined conditions, episodes of care, or groups of episodes of care must be centered on condition/episode/group-specific outcomes that include but are not limited to: a) appropriateness (doing the right thing for the right patient at the right time without underuse or overuse), b) measurable, risk-stratified medical/surgical processes and outcomes, c) patient service and satisfaction scores, d) patient safety and abrogation of medical errors and preventable complications, e) reduced length of stay (LOS), f) preventable admissions and/or re-admissions to inpatient facilities, g) preventable emergency department (ED) visits, h) process efficiencies and abrogation of waste, i) cost, including out of pocket expenses for patients, and...
j) benchmarking best practices. In order to maximize their impact, QAPI processes must receive appropriate buy-in from physicians and other health professionals before implementation.

Teams providing coordinated care must demonstrate evidence of ongoing QAPI strategies around specific episodes of care, especially but not exclusively around adverse events and/or “near-misses.” These efforts must be complementary and not substitute for other institutional QAPI efforts, and must be evident in all facets of care, including care provided by individuals and team-based coordinated care. QAPI processes must be protected (non-discoverable) and should be evaluated on an ongoing basis to determine whether they lead to unexpected adverse consequences such as increased racial, ethnic or socio-economic disparities, or that they adversely affect the patient-physician relationship.

Thus:

• All care should include QAPI processes that include an assessment of care coordination
• QAPI processes should include consideration of:
  • Outcomes compared to benchmarks and best practices (including but not limited to survival, functional status, complications, medical errors, cost, efficiency)
  • Patient perceptions of quality and patient satisfaction and a consideration of out-of-pocket expenses for patients, including potentially travel support benefits if essential for critical outcomes
• QAPI processes must be protected

4. Accountability for delivery of care for both acute and chronic conditions must be clearly defined, yet flexible enough to accommodate innovations and local differences in care delivery.

Accountability may be attributable to either the individual provider or to the team delivering said care. How attribution (how the care of each patient is attributed to different members of the health care team) is ascribed must be clearly defined and delineated for specific conditions, episodes of care, or groups of episodes of care, regardless of the state/level of integration of the providers involved, and must include consultations with not only the affected providers but also the patient and the payer. This is particularly important for team-based coordinated care, especially when adverse events might lead to litigation. Systems-based, self-regulated and blameless safe harbors must be created similar to those utilized for the evaluation of sentinel events in order to encourage disclosure without fear of repercussion, thus empowering participants to engage in patient safety improvement. These principles of accountability must exist for every facet of health care and for all settings, including patient-centered medical homes (PCHMs) and ACOs. To be meaningful, this will require collection and access to relevant and timely data related to individuals and populations.

Thus:

• Accountability for the quality of care must be demonstrable across providers (individuals/teams/institutions) and platforms (integrated versus non-integrated systems) using, for example, novel grouper technologies that allow episodes to run concurrently based on the treatment length or disease acuity
• Attribution lines must be similarly demonstrable and specified
• Blameless safe harbors must be present, particularly in the context of team-based care

5. The delivery system should measure, and strive to create, not only quality but also value.

Value is defined as quality divided by cost, or alternatively cost for a desired outcome. Quality is defined by a number of (not fully defined) process and outcomes measures, and includes measures of patient safety and satisfaction as well. Typical assessments of quality include a comparison of observed to expected outcomes in specified patient cohorts, for given conditions, episodes of care, or groups of episodes of care. Some of these measures are already defined, validated, and in use, for example by the Agency for Healthcare Research and Quality (AHRQ) and the Commonwealth Fund. Whereas qualitative process measures can be easily monitored, more quantitative outcome measures require validated risk-stratified adjustment and validation prior to being accepted as “expected” outcomes.

Accountability and attribution must not insert ambiguity and distract from assessments of quality and therefore value. Data/measures utilized for these assessments and risk-adjustment methodologies used to calculate outcomes must be validated across different patient populations (risk-stratified). Until these measures and methodologies are validated (this should be considered a priority), they should not be used as “bright line tests” of quality and value, but instead can serve as guidelines to improving delivery of care without punitive consequences (remediation), and with the opportunity for the provision of “mitigating circumstances” for consideration by payers and regulators.
Data collection and submission for the purposes of validating measures and methodologies should not become an unfunded mandate that financially burdens providers of care. While health care providers must contribute to the collection and submission of data, and to the analysis and science of the quality of health care delivery, medical industry leaders from all health care sectors, both public and private must consider payment methodologies to support these efforts. We also know that measurement and interventions on behalf of quality and safety are not identical. Safety as a system feature is a clear component of value as described here.

Thus:
- Value (cost per outcome) should be a required measure for all delivery systems
- The components of value, including cost and outcomes, must be risk-stratified across specific patient populations through validated and accepted methodologies
- The development and validation of risk-stratified methodologies (risk adjustment for co-morbidities and other risk factors that affect outcomes) must be considered priorities
- Data collection and submission necessary for risk-stratification must be viewed as a professional service and must not become an unfunded mandate to providers

6. Function must trump form/structure.

While many proposals have been/are being considered with regards to structure of health care delivery systems and these can take variable forms, it is essential that the functional principles of care delivery trump organizational structures. The objective is to deliver/provide patient centered health care services that consist of accessible and coordinated care with measurable processes and outcomes that can be monitored and risk-adjusted, so that all stakeholders (including patients and payers) are engaged and accountable with clear lines of attribution (see 1-5). However, this type of care does not necessarily need to be delivered by overly prescriptive organizational structures that some have proposed for ACOs, PCMHs, etc. There must be instead a fair degree of structural flexibility so that functionally integrated practices can deliver coordinated care, regardless of the state/level of integration of the delivery system. Thus, the principles outlined in 1-5 could be provided by a virtually integrated system, although they must still demonstrate strict adherence and performance with respect to these principles. The same type of flexibility must exist with respect to the specific roles providers might play in delivering coordinated team-based care. For instance, in highly specialized areas "primary care" may actually be provided by specialists, while in other settings, this care might be provided predominantly by primary care physicians. As an objective, care should be provided at the top of professional licenses, and neither below nor beyond. Therefore, these roles should be flexible, and individual team members should be incentivized to work collaboratively to provide needed care to specific patient populations, according to best practices, and subject to principles 1-5.

Thus:
- The focus should be on functionally integrated systems that deliver coordinated team-based care, and not on overly prescriptive descriptions of the structure of these delivery systems
- The principles delineated above (1-5) should be stringently demonstrable within any delivery system, while allowing for flexibility in system design, specifics related to type(s) of providers, etc.

7. Supporting infrastructure and technology must underpin all aspects of care delivery.

Principles 1-6 require a robust supporting infrastructure, including but not limited to shared data definitions, processes, procedures and information, including especially the medical record and other relevant data. Central to this aspect of health care delivery are interoperable health information technologies that lend themselves to meaningful use. Delivery of coordinated, team-based care requires data sharing within the bounds of patient confidentiality that allows for the provision of quality care by integrated practices. In addition, specific data elements must be made readily available to patients in a transparent manner, so that patient-centered decisions and choices can be fully informed by data. Interoperable health information technology (IT) must include data element specifications and data exchange interface standards. Validation processes, including reconciliation of disputes regarding data elements and reconciliation in recorded data must be standardized and required. In addition to clinical data, there should be an effort to amalgamate clinical data with administrative and claims data in order to fully leverage the impact of health information technologies. Given that much of the technology required to meet the above goals does not currently exist, the committee will attempt to propose possible solutions in future work.
Thus:

- Delivery systems must demonstrate access to infrastructure and technology, particularly interoperable health information systems necessary for reporting risk-stratified outcomes, resource utilization and other measures of value
- Data elements and data exchange interfaces must be standardized and mechanisms for reconciliation of disputes regarding both data elements and recorded data must be in place, especially as clinical, administrative and claims databases are amalgamated to improve meaningful use of databases over time
- Patient confidentiality and security protection surrounding these data must be explicitly defined and required, including approaches to be taken when and if breaches occur

8. Delivery systems should work to eliminate disparities and to address the needs of underserved populations.

One way to create good outcomes is for a delivery system to care selectively for low-risk patient populations. This type of “cherry picking” cannot be permitted. Delivery systems should be formed around the principle that their mission is to serve all populations, especially those currently underserved or in which disparate access and outcomes are known to exist, and to address these important and unmet patient needs. However, issues related to risk-stratification and accountability (see Principles 4 and 5) must be addressed in order to prevent worsening disparities.

Thus:
- All U.S. residents must have access to delivery systems
- Validated risk-stratification methodologies will help address disparities in access to care

Guiding Principles—Payment Reform:

1. Payment reform should promote fair physician and related clinician compensation for the provision and delivery of patient-centered coordinated care that demonstrates quality and value, underpinned by the requisite supportive infrastructure.

Guiding principles for payment reform should be consistent and reconciled with the principles for delivery outlined in guiding principles 1-8 (see above). Provision and delivery of patient-centered coordinated care must be recognized, encouraged, incentivized and fairly rewarded with compensation according to a) the level of effort needed (time), b) the intensity of effort, c) the potential consequences of not applying the appropriate level of effort (wastage, loss of efficiency and bad outcomes), d) customer satisfaction (patient and payer), e) complexity of care (measurable and standardized), and f) time-equivalent compensation for alternative activities by the care coordinator(s). To this last point, coordination of care should be provided by individuals/teams well versed in the specific condition, episode of care or groups of episodes of care and compensated according to training and effort required, responsibility undertaken and value created. That said, provider(s) must neither be under qualified, nor necessarily over qualified, for the level of skill/knowledge necessary to provide appropriate coordination of the specific condition, episode of care or groups of episodes of care.

QAPI efforts must be recognized, encouraged, incentivized and rewarded with compensation as improved efficiency and outcomes and patient satisfaction are demonstrated. In addition, innovation in this area should also be incentivized and fairly rewarded. Failing to incorporate payment for QAPI processes into contractual compensation schemes/agreements may result in financial disincentives for efficiency. For instance, decreasing LOS through innovative models of care may result in less payment to providers, in the context of streamlined processes, improved outcomes and improved patient satisfaction. In addition, decreased LOS will ultimately result in preventable ED visits and re-admissions to inpatient facilities resulting in financial disincentives in bundled payment agreements. Therefore, payment schemes should reflect payment for quality of services, and not for quantity of services, but there must be careful thought given to fair payment for efficiency (less waste, cost) and improved patient outcomes. The alternative to the adoption of QAPI
processes by providers as a result of incentives would be that of prescribed QAPI requirements, which is much less likely to be broadly accepted and incorporated by providers into models of care.

Accountability and attribution based on validated risk-adjusted measures and benchmarking with best practices should inform and guide contractual payment agreements. The mechanisms for ascribing attribution to the various providers, whether physicians or hospitals should be specified in contractual agreements in order for incentives (and disincentives) to be effective.

Payment for quality (value) should include a definition of quality based on process and outcomes measures, patient and system safety and patient satisfaction. Outcomes measures should be risk-stratified and adjusted for specific patient populations. However, the financial burden of collecting, submitting and analyzing the requisite data should not fall on providers alone. Instead, payment schemes that focus on quality (value) should include incentives and rewards for coordinated team-based care that utilizes evidence-based, risk-stratified process and outcomes measures to demonstrate value-based care delivery.

Payment must follow function and not form. In other words, contractual payment agreements should be informed by the quality of care delivered, regardless of the state/level of provider integration, as long as the care meets the criteria outlined in delivery principles 1-6. Payment should incentivize and reward the adoption of these principles, with a flexible consideration of organizational structure(s).

Contractual payment agreements should incentivize and fairly reward the meaningful use of interoperable health information systems as well as of other infrastructure and technologies that improve quality and efficiency, reduce costs and therefore provide value-added. In addition, proposals for payment reform must be executable at scale across many platforms and therefore will require wide adoption of grouper technology.

Thus:
- Payment reform should be indifferent to the actual structure of the delivery system focusing instead on the functional capabilities of the health care delivery system, allowing for flexibility and innovation across providers and care settings
- Payment reform must:
  - Incentivize and fairly reward team-based coordinated care, including recognition of provider “work” and licensure requirements and constraints on delegation to non-physician providers
  - Incentivize and fairly reward patient-centeredness and informed choice
  - Incentivize and fairly reward QAPI processes and review across providers and platforms and its costs, and not reward the performance of unnecessary procedures (appropriateness) and of preventable complications
  - Incentivize and fairly reward accountability along well-defined and ascribed lines of attribution
  - Incentivize and fairly reward risk-stratified outcomes with definable measures of quality, efficiency and value
  - Incentivize and fairly reward meaningful use of health information and other supporting infrastructure and technologies, including grouper technologies allowing for scalable implementation across episodes of care and groups of episodes of care, platforms and providers

2. Payment reform should preserve the tenets of physician compensation by recognizing parity of work and by preventing payment distortion, regardless of contractual context between providers, and the type of agreement between the provider(s) and the payer.

Comparative effectiveness requires fair assessment and allocation of cost. Contractual agreements between payers and providers, and resulting cost structures, may distort physician compensation beyond the level of skill, effort, intensity of work and various other elements of care. For example, some commercial payers may negotiate differential payments between primary care physicians and specialists or between medical specialists and surgical specialists for the same work as identified by billing codes. Therefore, it is essential that payment reform preserve the tenets of physician compensation by recognizing parity of effort and preventing distortion in the valuation of physician work.

Moreover, unlike hospital costs, physician costs are difficult to determine and allocate. This is especially true for variable costs. Therefore, it is equally essential that physician compensation not get distorted by payment for technology and facility costs, especially when these may be disproportionately high. Fairness and parity in payment for physician services
should be preserved whether a physician is (or physicians are) employed by hospitals, or instead are independent providers or contractors, especially as episode-of-care grouping and bundled payments may further confound potential distortions in physician work valuation, because of associated high technology and/or facility costs.

Thus:
- Payment reform should valuate physician work in a fair, transparent and justifiable manner
- Payment reform should preserve the tenets of physician compensation that include parity and lack of distortion by procedural costs
- Payment reform should recognize the difficulty in calculating and allocating physician variable costs
- Payment reform should be indifferent to contractual agreements among and between providers

3. **Payment reform should recognize, promote and incentivize innovation, and support education and training.**

As delivery reform rightly emphasizes the various elements of patient-centered, coordinated team-based care that provides quality and value, innovation (research) and education (training of future physicians) must not be devalued. Instead, payment reform should recognize, promote and incentivize innovation. As such, academic medical centers that provide infrastructure and support for innovative approaches to care must be incentivized to pursue such efforts. Also, medical centers that provide infrastructure and support for formally accredited education and training of future physicians must be incentivized to pursue such efforts. Failure of payment reform to recognize the need to promote and incentivize these activities will surely result in long-term losses in the quality and outcomes of management of both acute and chronic conditions.

Thus:
- Payment reform must recognize, promote and incentivize innovation
- Payment reform must recognize, promote and support training and education

4. **Payment reform must include differential assumption by different stakeholders of performance and actuarial risk.**

Regardless of the setting, complexity or the state/level of provider integration, the costs associated with delivery of services and provision of care will inevitably include costs associated with both preventable and non-preventable complications. Compensation/payment schemes, especially in the context of episodes groups and/or bundled payments, typically include rates that assume incremental payment for outlier costs. Implicit in these rates are certain assumptions of risk. As payers attempt to control health care costs, this can quickly translate into shifts of risk assumption towards providers. While it is fair for providers to assume some risk, namely risk attributable to care delivery and defined by preventable complications (performance risk), it is neither fair nor appropriate for providers to assume risk that is borne out of chance (actuarial risk). This latter risk corridor is mitigated by insurance premiums and should be in the domain of the payer, not that of the provider nor the patient. Therefore, contractual agreements and negotiated rates between payers and providers for conditions, episodes of care or groups of episodes of care, should include stratified outlier and stop-loss protection that separately addresses differential assumption of performance and actuarial risk. Appropriate and stratified assignment of risk corridors should be implicit in all types of contractual agreements, should be similar for all sectors of the health care industry (private and public alike) and should additionally be subject to market competition as well as other market forces, such as local and regional variances. Therefore, in applying these principles to all providers, including physicians, payment reform that simply cuts payment across the board without consideration of risk as quantified by the cost of care cannot be allowed. This same argument correlates well with concerns related to the flawed Medicare physician payment formula, the sustainable growth rate (SGR), which also inappropriately subjects physicians to across the board payment cuts.

Thus:
- Bundled payments for episodes of care and for groups of episodes of care must be based on validated grouper technologies and include fair outlier protection and risk mitigation
- Performance and actuarial risk corridors must be defined, and assumption of risk liability must be stratified
- Payment reform must consider alternative approaches to across the board payment adjustments, reflective of fundamental changes in delivery of care models
5. Medical Legal Liability and regulatory reform must be an integral part of payment reform.

Payment reform cannot occur in the absence of tort reform, given that process and cost efficiencies that lead to cost efficiencies and value are vulnerable to potential arguments about malpractice liability. For instance, the cost of providing care is related to medical legal liability expense both directly, through the costs of acquiring malpractice insurance and indirectly through the propensity to perform diagnostics and procedures simply to avoid the risk of claim of malpractice (defensive medicine). Antitrust and other regulatory reform will also be needed to allow delivery systems to provide integrated care and share data and processes. For example, the Federal Trade Commission in collaboration with Medicare has established new safety zones in federal anti-trust enforcement as a means to encourage participation in the Shared Savings Program and the Office of Inspector General has issued a series of waivers from certain fraud and abuse statutes, such as the anti-kickback and stark laws. These exceptions and waivers should be broadened where appropriate to cover the full range of innovations in health care delivery and payments that are designed to improve the quality and reduce the costs of care.

Thus:
- Tort reform is a necessary complement to payment reform
- Antitrust and other regulatory reform is also a complement to payment reform

6. Payment reform must proceed, independent of insurance reform, with a plan for staged reconciliation between the two.

Payment for care is often tied to socioeconomic factors in a way that actually reduces access to care among populations which are already underserved and which experience disparities in health outcomes. Payment reform should strive to reduce or eliminate disparities in access to care, increase coverage and thus address the needs of underserved populations. However, payment reform recommendations should, at least initially, occur separately from attempts to resolve disparities in access and care, particularly in underserved populations. Recommendations regarding payment reform must be made in the context of delivery reform principles 1-8 and payment reform principles 1-5. Once the path to payment reform is established, and as access and coverage disparities are addressed through insurance reform, every attempt should be made to reconcile the two.

Thus:
- Payment reform must address the needs of underserved populations with reduced access to care
- However, payment reform should proceed independent of insurance reform and issues of access to insurance for all Americans
- Payment reform should be instituted initially in the context of patients with access to care, staging a subsequent reconciliation between payment reform and insurance (access) reform