

Robert Wood Johnson Foundation Payment Reform Evaluation Project
Development and Implementation of Payment Reform to Pay Equally for What Works Equally Well
Institute for Clinical and Economic Review, Massachusetts General Hospital

Executive Summary: Autumn 2012 Site Report

Context

The Payment Reform to Pay Equally for What Works Equally Well project was facilitated by the Institute for Clinical and Economic Review (ICER) and sponsored by the Employers Action Coalition on Healthcare (EACH). EACH members include leading providers, three major regional health plans, and large regional employers and business leaders, and the coalition has convened employers, insurers, providers, consumers, and academics to address health care problems (e.g., fragmentation of care, medical errors). Another important partner of ICER is the New England Comparative Effectiveness Public Advisory Council (CEPAC), which aids patients, physicians and policymakers in the region in the application and use of comparative effectiveness information to improve the quality and value of healthcare in New England. The equal payment for equal outcome project in Massachusetts was facilitated by the combination of a highly educated populace with many academic institutions, a shared sense of responsibility and learning, universal health care coverage in the state, and an increasing need for cost control.

Since the time of the autumn 2011 report, there have been several contextual changes, among them the following:

- EACH had merged in 2012 with the Massachusetts Leaders (MHL) for Appropriate and Affordable Care, which uses a health policy perspective or ‘think tank’ approach. With the appointment of MHL’s two leaders to the Massachusetts Health Policy Commission, MHL has announced that it will be disbanding in spring or summer of 2013 – having served its initial purpose.
- State legislation in 2012 created a set of regulations and rules focused on health care cost reduction, including the formation of a new Health Policy Commission.
- The Alternative Quality Contract was implemented by Blue Cross Blue Shield of Massachusetts in 2009 and may have resulted in health care spending savings as well as improved quality indicators.
- There has been a shift in the Boston market from FFS payment-domination to a return to capitation payment, and a continuing and increasing emphasis on accountable care organizations and integrated care organizations.

Objectives

The two objectives were to shift the treatment mix for low-risk prostate cancer toward higher-value services, and to generate overall savings. To achieve these objectives, ICER intended to use comparative effectiveness research to inform and carry out payment changes for low-risk prostate cancer treatment.

Approach

The approach involved a coding algorithm and reimbursement change that rewarded physicians for using lower-cost treatments that are as equally effective as higher-cost treatments. The project consisted of the following steps:

- Identifying CPT category II F-codes to distinguish risk of recurrence (low risk, intermediate risk, high risk, and undetermined risk) for patients with localized prostate cancer.
- Notifying providers to use CPT category II F-codes on prostate cancer claims.
- Working with providers to disseminate information about the F-code requirement and impending payment change.
- Managing and maintaining engagement of EACH.
- Creating a “roadmap” of lessons learned and barriers throughout the project.

As of autumn 2011, stakeholders decided to end the prostate cancer payment reform project. Only one health plan was able to adjudicate claims with F-codes, a necessary component of the project. Other health plans determined that the costs of reprogramming their claims systems for a single condition outweighed the benefits. EACH and EMHI merged to form a larger coalition and decided to pursue another payment reform pilot project with the clinical condition of low back pain (LBP). The LBP project was predicated on the notion of supporting high value choices for the treatment of this condition. Since commercially insured patients have higher rates of LBP, it was expected to be a better business case than low-risk prostate cancer. ICER’s LBP comparative effectiveness work was completed during 2012 and the project was not implemented successfully. No further payment reform initiatives have emerged from the work of ICER and the Massachusetts Health Leaders group.

Logic Model

The project had expected to achieve its goals for the following reasons:

- Intensity-modulated radiation therapy (IMRT) and brachytherapy are two treatments for low-risk prostate cancer with equal effectiveness but different costs. By educating patients and providers about the equivalent outcomes of IMRT and brachytherapy, they will be better informed and choose a treatment that is driven by evidence, clinical judgment, and the patient’s values and preferences.
- By reducing IMRT payment to that of brachytherapy, there will be lower profit margins for IMRT.
- The combination of evidence-based information and lower profit margins will steer decisions toward less costly, equal outcome treatments.

Facilitators and Barriers

Facilitators:

- Favorable market social, legislative, and regulatory environments for payment reform.
- EACH’s board comprising the CEO of every major stakeholder and CEOs’ declared support
- Strong coalition governance.
- ICER’s role as neutral convener, a trusted source of comparative effectiveness evidence, and credibility with academia.
- CEPAC’s role as a facilitator and convener.
- Clarity of low-risk prostate cancer treatment effectiveness evidence.

- Stakeholder familiarity with alternative treatments for low-risk prostate cancer.

Barriers:

- Inability of health plans to adjudicate claims using the F-codes for risk of recurrence.
- Choice of low-risk prostate cancer as the clinical condition, a relatively infrequent condition in commercially insured populations.
- Senior executives' delegation of decision making to others within their organizations.
- Lost momentum due to lengthy implementation process.
- Divergence in priorities between providers and payers.
- Diversity of stakeholders and need to address multiple needs and priorities
- Differing payment methods across health plans and providers.

Evaluation and Sustainability

In January 2013 ICER produced a white paper that summarized the methods and conclusions of their local evaluation of the Payment Reform Project.¹ The authors interviewed a total of 10 persons involved in the implementation efforts of the project: three providers, five payers, one business consultant, and one employer representative. The local evaluation concluded that several factors ultimately led to the inability to implement the low-risk prostate cancer equal pay-for-equal outcomes reform: (1) misaligned goals of payers and providers; (2) competing priorities among quality improvement leaders of provider organizations; and (3) declining prevalence of fee-for-service payment arrangements. These conclusions from ICER's local evaluation square with those of our UW-based evaluation team.

Lessons Learned

Choice of clinical condition is important for an "equal payment for equal outcome" project. Operational challenges, such as the ability to adjudicate claims with F-codes, may be difficult to overcome, especially without a strong business case to invest in change. Additionally, strong and sustained support from senior executive leadership of employers and other purchasers is necessary to maintain momentum. It may be more effective to produce 'evidence statements' (rather than recommendations) that can be used by different stakeholders for their audiences. Finally, under current FFS reimbursement, payment reform creates winners and losers, which limits the appeal of reform.

¹ Emond SK, Reed SJ, Pearson SD. Using comparative effectiveness research to pay equally for equivalent outcomes: an evaluation of a multi-stakeholder effort focused on prostate cancer treatments. Institute for Clinical and Economic Review (ICER): January 16, 2013.