Bonnie: Welcome to a new episode of the Health Disparities podcast. I am Dr. Bonnie Simpson Mason and this week we are recording our conversations at the National Harbor in Maryland, where we are enjoying a packed program of speakers and workshops at the Annual Movement Is Life Caucus. Today, I have the pleasure of interviewing Harold Miller, who is the president and CEO of the Center for Healthcare Quality and Payment Reform, or CHQPR, a national policy center that facilitates improvements in healthcare payment and delivery systems. He's going to tell us all about what that means. Since its founding in 2008, CHQPR has become a nationally recognized source of unbiased information and assistance on payment and delivery reform. Mr. Miller, thank you so much for joining us today.

Harold: Thanks. Nice to be here.

Bonnie: Absolutely. Thank you very much. Well, we want to broaden our listeners understanding of your organization and why it is adamant about addressing the issues around payment reform. And we want our listeners to kind of get a better understanding, maybe of the fundamentals of your organization's mission.

Harold: Well, we got involved in this when we first started because of efforts to try to improve healthcare quality and what I found over and over again, was

that the efforts to try to improve healthcare quality were being impeded by the fact that the payment system actually either didn't allow it or penalized it. One of the very first things that I worked on was the issue of hospital acquired infections. And we had found that there had been techniques developed that could actually eliminate hospital acquired infections, even in, you know, intensive care units but hospitals weren't implementing these techniques. And when I looked into it, I found that the payment system hospitals would actually lose a huge amount of money by preventing infections because they got paid so much more. Now I don't believe any hospitals are actually giving people infections in order to make money. But on the other hand, if you're a hospital that's trying to keep positive margins and somebody says, here's this great quality improvement effort, but oh, by the way, you'll lose millions of dollars in the process, you're likely going to turn your attention somewhere else. So, that's where the idea of the Center for Healthcare Quality and Payment Reform came along.

Bonnie: And how do you all assert or affect change from your perspective and how do you position yourself in the healthcare community to emphasize quality in the face of payment reform?

Harold: Well, a couple of things, one is simply education because people don't understand these issues.

Bonnie: Exactly.

Harold: The payment system is actually remarkably complicated. I've talked to hospital CEOs who literally say, I just hope that it ends up okay because I really don't understand how it works. So, educating people about what's wrong with the current system, what some alternative approaches would be and then actually I spent a lot of time trying to facilitate discussions amongst stakeholders in individual communities. So, how to have the doctors and the hospitals and the employers and the patients in the community come together to be able to say, how should we actually make this work? Because you want to have what I like to refer to as a win, win, win solution. Something where the patient is better off, where you're not causing the providers of care to lose money, but you are saving money because we do need to find some ways to save the healthcare costs in this country. And there are what I would call win-win-win approaches. But the natural tendency everybody has is to try to find a win-lose approaches. You know, I can win more if you lose and that's not a very sustainable solution.

Bonnie: Right. It doesn't sound sustainable at all actually.

Bonnie: But it's what we keep doing is the problem.

Bonnie: Well, it is but I'm also encouraged that either you've seen examples of what you think that the win-win-win can actually occur. Is that what I'm hearing?

Harold: Yeah, they can. I mean, I tend to believe it's more likely at the local level because healthcare actually is local, but you have to have the physicians and the hospitals, and again, the employers who actually pay for a lot of healthcare in the community, figuring out what they really want to focus on because the opportunities are different. The things where there is overspending, different, different communities, some places have high hospital acquired infection rates, some lower rates, some places are doing unnecessary hip and knee surgeries, some places aren't doing that. So, you really have to target where those opportunities to reduce avoidable spending are. And obviously there are some communities where there's a lot more poor people, disadvantaged people and they have very different issues than the places where you got a much wealthier, highly educated community.

Bonnie: Right. Our safety net hospitals, I would imagine again, taking care of the most vulnerable patients but also the most vulnerable hospitals. Now, I'm curious because I don't hear you referencing working with any of the payers, meaning insurance companies, or even Medicare/Medicaid for

that matter. So, how does your organization or how do you foresee integrating the payers into the solution?

Harold: Oh, I spend a lot of time working with payers. I have to say to be completely truthful that the payers are the least co-operative generally in these things. So, for example, I serve on something called the Physician Focused Payment Model Technical Advisory Committee, which is a lot of words that people call PTAC for short. But it was actually created by Congress to make recommendations to CMS about what payment models they should implement. And the idea was, in fact, that physicians, that's why it's called the physician focused payment model technical advisory committee, the physician should be encouraged to develop payment models themselves and bring them forward and PTAC reviews them and then recommends whether they should be implemented or not. We've gotten really good proposals, we recommended over a dozen of these be implemented and basically HHS and CMS has said, no, thanks to all of them.

There are some private insurers around the country that have done some very innovative things. But I would say most, if not. So, for example, Horizon Blue Cross Blue Shield in New Jersey has done some, I think very innovative things. And particularly, their approach has been to work with the physicians and the hospitals and the community, and try to find

the win, win approach. In most other places, you see, it tends to be much more of a win-lose approach. So, let's take a second to delve in to maybe a layman's description of the payment models that we're referring to because then we can talk about payment reform and kind of what you see the future is and how to effectively move change.

Well, to understand a payment model, you have to understand what you're trying to fix. And so, there's a lot of concerns raised about the current fee for service system. And the fee for service system has several different problems. One is that it can actually encourage the delivery of unnecessary services because you get paid for a service, whether the patient needs it or not. It's undesirable in the sense that there is no real tie to quality or outcomes. So, you get paid the same amount for a service that delivers a good outcome as a service that delivers a bad outcome and fee for service. Also, one of the disadvantages of it is that while it's called fee for service, there actually isn't a fee for every service. So, a variety of things that would actually be helpful to patients, exercise programs, et cetera. There's generally no payment for a physician to answer the telephone when a patient calls. We'll pay to have an ambulance take him to the emergency room but we won't pay for a physician to answer the phone, you know, or to bring them into the office. And in many cases, the payment, if there is a payment, it isn't enough. So, rural hospitals for example, are closing because we simply don't pay enough because it

costs more to deliver care in a small rural community where there aren't that many patients. So, we simply don't pay enough. So, the idea is to try to fix that and to be able to say, so let's find a way where we can pay for the necessary and appropriate services. And if we stopped paying for the unnecessary services, we will save money. Let's start trying to tie payment to quality in some fashion. And you can even conceive of the idea of what I would refer to as an outcome-based payment, that says that you don't get paid at all if you don't achieve what it is you said you should be able to do. Now, that requires you to say what it is you thought you should be able to do, right?

So, if you know what you should be able to do, and you can say that. So, if you think about every other industry in America, you know, we have warranties on products, we have money back guarantees if it doesn't work. But in healthcare you basically come in and you say, we're going to charge you whether it works or not. And we'll charge you more whenever you get complications. So, there are systems, for example, that have put in place warranties where they actually will say, we will not be paid more for complications. And guess what the rate of complications goes down because of that. But the key thing is you have to pay more for the service whenever it has a warranty attached to it. So, for example, you wouldn't expect to pay the same price for a car without a warranty, as one with a warranty.

And it's the same thing. If you're doing joint surgery and you say, I'm going to have a warranty on that. So, I don't get paid more for complications. I'm going to have to charge you more for the joint surgery, with the warranty, because there's going to be some number of complications that occur. But if you do that, all of a sudden, the incentives all change because if I have a warranty, now all of a sudden, if I have a complication, it costs me money because I have to deliver the service and I'm not getting paid for it. So, I have an incentive to reduce the rate of complications. Whereas under the current fee for service system, you don't have that incentive because you actually get paid for the complications, same thing with a car, right? The manufacturer has an incentive to have a defect-free car.

They're not all defect-free, but to have an incentive to do that, because if they're paying for the repairs themselves, then they want to make sure that there are few repairs as possible. So, that's where you have to have the interaction between the payer and the provider of the services is to say, so what are the complications that are actually preventable? How much does it cost to prevent them? So, how much do we then need to pay you to be able to deliver defect-free care? And then you should be willing, if that's the case, to provide a warranty on that care. And in some cases, a defect will occur and you won't get paid for that. But the point is you'll then be making that up by being paid more on the services where you actually

do deliver good quality care. So, that's one example of a notion of a different payment model.

Another notion is a bundled payment that says rather than paying for every individual service separately, and then having an incentive to deliver more and more and more services and not getting paid for some services that might be innovative. Why don't we give you a bundled payment? I think for the condition that the patient has. So, if the patient has knee or hip pain, let's give you a condition-based payment for that. And then you can decide, does the patient need surgery? Does the patient need exercise and physical therapy? And in fact, if you think that that patient can be managed effectively with physical therapy, but you might actually be paying more for the physical therapy than the standard payment for physical therapy, because that patient need a much more intensive program of physical therapy followed by exercise therapy that nobody pays for. And so, it may be cheaper than surgery but it may be a whole lot more expensive than the thing that we pay for today.

No payer wants to suddenly create a new, higher payment for intensive physical therapy because they're afraid everybody will start suddenly getting intensive physical therapy because we pay more for that. So, you want to have it tied to the patient's condition. If this patient really has severe knee osteoarthritis but they are not a good surgical candidate, the

choices today are physical therapy that won't work because we don't pay enough for it or surgery that they can't get. So, why not create a middle ground that says for this patient, we'll pay for something in the middle based on the fact that that patient has the following characteristics, they have severe knee osteoarthritis, but they also have other comorbidities that make them a bad surgical candidate. So, rather than doing nothing for them, let's find a good intermediate option for them. And rather than giving them surgery that they shouldn't be getting, you know, which could create complications and be very expensive, let's give them something that is appropriate for their healthcare needs. So that's the idea of a different payment model, is being able to fix those problems in fee for service in a different way.

Bonnie: Oh, so I like those approaches, so at least we have options. But I'm concerned about the physicians, and as an orthopedic surgeon, concerned about the surgical candidates who come to the table with those comorbid conditions, because even with the quality reimbursements, those patients might likely get selected out and may not even be offered the surgery because they present a higher complication potential than the patients who are lean and may not have those comorbidities. It seems to me, and we actually know from this conference and from some of the work we've been doing, that in some of these ways, some of the quality payment reform systems have actually exacerbated healthcare disparities

and health equity. So, how do your approaches make sure that the most vulnerable are still taken care of given the second option that you gave of, you know, paying more or maybe even conservative therapies. I'm just summing that up. Is that enough where you're saying that's at least better than nothing?

Harold: Well, what I'm saying is the problem with the current crop of value-based payment models is that they don't actually adjust effectively for the patients, the differences in the patient needs. So, they will pay more for surgery if the patient has potential for surgical complications but they won't pay more for more intensive post-acute care for that patient. They won't necessarily pay more for the prehabilitation that the patient may need to be able to reduce their weight, to be able do that. And that's what you want. That's why I refer to it as a condition-based payment because it should be tied to the patient's condition, not just their knee osteoarthritis or hip osteoarthritis, the patient's total condition that's relevant to that particular thing. So, if you say they're obese and they have knee osteoarthritis, that's their condition. If they are obese and they have diabetes and they have asthma and they have new osteoarthritis and all those things interact to say, what's the right thing we can do for them, that's their condition.

And then you should say now, given that that's their condition, what's the most cost-effective way to be able to get the outcome for that patient that we need. So, you might say actually the best thing for them is surgery, but the surgery is going to require more time. It's going to require more recovery time. It's going to require more intensive rehabilitation, et cetera, but we think that's the right option. It's simply going to cost more. So, you'd say in that case, that patient needs to have a higher payment for surgery, et cetera, associated with that. On the other hand, you'd say the patient really it's bad risk to have that patient get surgery, but we don't want to say nothing for the patient. So, you'd say given this patient's condition surgery isn't appropriate, we should be able to do some kind of much more intensive outpatient therapy to be able to help them.

But the point is you should tie the payment to the patient's needs, not to the specific services that you deliver. And the problem today is that people get paid based on which service they deliver and the amount that they get paid for that service isn't even tied to that. So, the surgeon gets paid the exact same amount for the surgery, regardless of whether it's a high-risk patient or a low risk patient. The skilled nursing facility actually does get a higher payment in some cases for patient who have greater needs but a lot of the payment models, like the ones that CMS has put in place, don't adjust the budget for that. So, you end up, if you take one of those patients, you actually get penalized because it looks like somehow, you

know, you're not being efficient in your care when the truth is, you have higher risk patients who simply need higher costs.

Bonnie: And you haven't made any adjustment in your models to account for the fact that those patients exist?

Harold: Right. CMS hasn't, I think it's entirely possible to do that. But I do think what's important is that the physicians and physical therapists and nurses who are taking care of these patients need to identify what these characteristics are that really do make a difference in terms of the patient's needs and then start collecting that information. Because all Medicare and most health plans can risk adjust on now its diagnosis codes because that's the only thing that's collected. So, the only way to fix that is that we've actually got to start identifying what matters and start collecting that information so that we actually can adjust for that.

Bonnie: I think that's a novel idea to ask the healthcare providers to weigh in on what those metrics look like.

Harold: It is. I mean when I've talked to most physicians, most physicians say a lot of stuff that they're being required to collect today is useless. And so, what that has led to unfortunately is that CMS doesn't want to ask anybody to collect anything more, you know, there's this now patients over paperwork

initiative. The problem is that then that means that they also don't want to ask for the stuff they actually should be asking for because they think everybody's going to get mad at them and say ask for more stuff. But again, when I've talked to physicians, they say, I'd be happy to collect the stuff that matters, if it's actually going to be used. What I don't want to do is collect stuff that doesn't matter. And I don't want to collect stuff that's not going to be used for anything.

Bonnie: And actually, creates more administrative burden for me at two o'clock in the morning we're still doing charts.

Harold: Right. And it takes time away from you being able to spend time with the patients, which means that, you know, you're even less likely to be able to spend time on patients who need more time.

Bonnie: Exactly, Exactly. So, what's been the response either from a CMS perspective to being open to maybe a condition base payment model or reimbursement? Maybe CMS is not the right organization to query, but you know, what's been the overall response that your organization has gotten talking about these things?

Harold: The response from most physicians and healthcare providers is incredibly positive because they see that that's in fact, what makes the difference is

that, you know, the patients can, again, I'm using condition as a broad based, I don't mean a specific disease. CMS is actually interested in doing it, they just don't seem to know how to do it. And the concern is that if we start basing payment on all of these other characteristics of patients, that people will start saying the patients have those conditions, even when they don't or start what's often called upcoding the patient.

For example, CMS tends to have all of their payment models be based on hospitalizations because a hospitalization is a very objective thing. We know that the patient was in the hospital. And you would presume that patient wouldn't go to the hospital if they didn't have something wrong with them. But if you suddenly start saying, we're going to provide these other kinds of services to the patient because they need it, CMS is skeptical that everybody won't suddenly be living alone and have severe pain, you know, and have all these other kinds of complications. I think that fear is misplaced but I do think that it's going to be important for the people who do take care of these patients to find objective documentable ways of saying that the patient does have these comorbidities and factors like living alone and other things that really make a difference in terms of what their rehabilitation needs are. So, that if you would need to audit it, you can audit it. And you can say, yes, in fact, you know, this is not fraud and abuse, this physician actually did have 95% of their patients who were

high risk and high need patients. It didn't just that they somehow classified them all that way to get a higher payment.

Bonnie: Well, we've talked to many of our other guests about integrating the social determinants of health into the electronic health record system and how, even from that data collection perspective, these are the exact types of things, especially if we increase interoperability across different EMR systems. I mean, there are checks and balances right there. I mean, the information gathered from one's primary care physician transitions over to the surgeon, that information and data would be consistent.

Harold: But I think we have to be more specific. We can't just talk about social determinants of health because we're not going to say we're going to pay more simply because you're poor. We're not going to pay more simply because of the zip code you live in. We're not going to pay more simply because of your race. What we're going to pay more for is if in fact you have characteristics that genuinely affect your need for care. So, if you don't have a primary care physician, because you're on Medicaid, no one will take your Medicaid. That's what matters is that you don't have the primary care physician, not that you're poor, or if you can't afford to have help, or if you're living alone that’s what matters and it's different for different kinds of health problems. So, if you're sending somebody home after hip surgery, they have to have somebody at home who can help.

That's really what matters. And they're going to be less likely to afford to bring somebody in themselves if they're poor or they live in a rural area or something like that. So, we need to identify those specific objective factors that are driven by the social determinants, but we need to make sure that the payment model adjusts for the key differences in the patients that really affect their care and their care needs.

Bonnie: Yeah. I guess I don't see them as mutually exclusive.

Harold: No, no, no, they're not. I'm just saying though, I think most of what you see in social determinants tends to be based understanding because that's the only data that's available is based on income and race, et cetera, and that clearly shows the disparities, but we have to figure out then how to translate that into a payment model. What are the actual factors about the patient that you can base the payment on so that you eliminate the disparities? So, if poor people, you know, if people in rural areas are more likely to be living alone, if African Americans are more likely to be single, you know, or their spouses died or whatever, that's the thing that matters. And that's one of the things that's causing the disparity. So, if we say we're going to provide better payment for people who live alone, we're likely going to be helping the people who have those problems disproportionately. And therefore, we're going to reduce the disparities, but I think that's going to be critical for people to understand how you design

the payment model to fix the problem. Not just how do you show that the problem exists?

Bonnie: Well, I don't admire the undertaking because it's going to be quite complicated.

Harold: It's very complicated.

Bonnie: But we're going to look to you---

Harold: But it's important.

Bonnie: We're going to look to you as one of our drivers of bringing all of these stakeholders to the table because I think at the end of the day is the meaningful conversations, the important questions being asked of the people, especially those on the front line.

Harold: Yes. I think the Movement is Life group needs to be at the table more than they have been at the table on these kinds of issues.

Bonnie: Well, we'd be happy to be at that table. When we know when and where those meetings are taking place, we can be there, but I think also---

Harold: Call the meetings yourself and say something has to be done about it.

Bonnie: Okay, that sounds good. And we'll certainly use that license to do so. So, if I might, I'd like to maybe just summarize what I've taken away from today and I'm really appreciative of this time always to learn more. But we now know that quality of care has been impeded negatively by our current payment models. The efforts should be secondarily to look for the win-win-win as we move towards payment reform in a way that's meaningful so that all parties win and not in a win lose situation. So, I think that's a lofty but formidable goal. And then, you know, conceptually tying payments to the patient's needs and conditions as opposed to the services render which will help address the individual, where the patients as individuals.

We'd like to thank once again, Mr. Harold Miller, president and CEO of the Center for Healthcare Quality and Payment Reform. And thank you all for listening to our health disparities podcast, join us every two weeks at movementislifecaucus.com and all leading podcasts services for more conversations about health disparities with people who are working to eliminate them and who are passionate in their service. Thank you so much. This is Dr. Bonnie Simpson Mason.

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