A Business Case for Quality

TO THE EDITORS:

We were excited by the article by Dorr et al[1] and its bottom line: *It's the reimbursement, stupid.* In our ongoing work with Sheila Leatherman and colleagues at the University of North Carolina to assess whether there is a business case for quality in Medicaid managed care, we are finding, as have Dorr et al, that enhanced care management for high-risk chronically ill beneficiaries pays off—for the healthcare payers investing in stratifying risk and designing and implementing the interventions.

Yet even though we are pleased that health plans, state Medicaid agencies, and other payers now have more reason to invest in quality, we should worry about the hospitals and physician groups that may incur losses from these improvements. Can we find ways to realign healthcare financing so that "win-win-win-win" or "gainsharing" scenarios (for purchasers-plans-providers-patients) can occur?

Because Medicaid has so many high-risk patients with serious chronic illnesses and because many of them are in managed care or disease management programs with the infrastructure and incentives to support targeted interventions, we intend to design a "business case for quality" evaluation project involving all of these stakeholders. We hope to learn how financing can be realigned, so that winning and losing can be more evenly shared for the betterment of the entire healthcare system.

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Reference

1. Dorr DA, Wilcox A, McConnell KJ, Burns L, Brunker CP. Productivity enhancement for primary care providers using multicondition care management. *Am J Manag Care.* 2007;13:22-28.

IN REPLY:

We agree with the major points made by Bella and Somers (ie, that misaligned reimbursement stymies innovation in care management due to the lack of reward for high quality, patient-centered care); however, we believe that their summary mischaracterizes one of the novel findings of our article: that at least 1 type of care management can overcome reimbursement hurdles through efficiency gains in clinical practice. In fact, the bottom line might be better summarized to say that all parties have potential incentives (as well as disincentives) to change. It may be the reimbursement (per providers) or the prices (per

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purchasers and insurers) or the technology, or it may be (and likely is) all of the above, and more.

Our study did not look in depth at benefits to health plans; in fact, the higher productivity of the providers translated into revenue enhancement for them and potentially a net loss for insurers. However, the broader implications made by Bella and Somers do make sense. Other analyses we have completed do indicate that purchasers and insurers have $2 to $3 benefit from every dollar charged from primary care clinics (mainly through reductions in hospitalizations). In addition, the ability of primary care practices to bear the burden of the larger redesign efforts—electronic health records, changing payment methodologies, and the like—is extremely limited. Our more recent work has shown that vertical collaboratives—patients, purchasers, insurers, and providers—can work together to create success and minimize risk in the way that Bella and Somers describe.

The primary point of our article is to consider, from the perspective of the primary care clinics involved, what makes sense to do now while reimbursement is changing. The article concludes that reorganizing primary care practices with informatics-intensive programs like Care Management Plus can improve quality and efficiency within the current multipayer reimbursement system. The time to act is now.

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