UNDERSTANDING HIGHER EDUCATION FINANCE

INTERVIEW WITH HAROLD MILLER
PRESIDENT AND CEO, CENTER FOR HEALTHCARE QUALITY AND PAYMENT REFORM

As part of a project on higher education finance supported by the Bill and Melinda Gates Foundation, Nate Johnson interviewed a number of experts and leaders to gather different perspectives on how major budget choices are made. The interviews have been condensed for publication so that the key insights are available to anyone who is interested.

A renowned expert on healthcare payment and delivery reform based in Pennsylvania, Harold Miller discusses the similarities and differences between the healthcare industry and higher education, including payment system reform, prestige, and federal-state partnerships.

There are strong parallels between the healthcare sector and the higher education sector in terms of how the finance system works and some of the problems that people perceive with the conflicts between the payment systems and the outcomes that we want. You have the fee-for-service model itself where most of the payments either from the third party or from the recipient of the services are denominated in pretty discrete units and not in larger packages of procedures or treatments.

The way I would characterize the parallel is that what you're paying for may or may not be providing what you really want to get.

Right. And then there is the tension between competition and coordination. In some ways, they have the same goals to serve patients; in other ways, they're competing with each other, and sometimes that competition may be productive and other times, it may not be. Are there other parallels as well?

The most fundamental parallel is that both sectors are trying to figure out how to achieve greater value. Part of that is also even trying to define what "value" means. You hear that a lot in healthcare today as everybody's trying to move from volume to value. I was the inventor of the phrase "volume to value" to summarize the concept of going from a model that rewards providing more services to one that rewards outcomes, but how you actually define value has not been resolved. There is no agreement on how to define quality or outcomes, much less how much better quality or outcomes are worth.

The same issue comes up in higher education. How do you define quality of higher education and then what's it worth to pay for that? I think there's a general recognition that good healthcare and good education are both important to people. There's also growing recognition that it matters where you go. A hospital isn't always the best place to get care, and in some cases, treatment is more harmful than doing nothing. Similarly, for a long time, the assumption has been that simply having a college degree is a good thing. There's now growing recognition that just having a college degree may not necessarily be the best thing for every student and that not every college degree has the same benefits.

Another parallel is how do you measure value and is the measurement sufficiently good that it's actually not causing more problems than it solves? In healthcare, there's a lot of concern that if you measure quality in too simplistic a fashion, you may actually be harming patients who have greater needs.

That's because there are two ways a healthcare provider can look better on a quality measure. One is they can improve what they're doing. The other is that they can avoid dealing with the patients that make them look bad on the quality measure. Some of those patients may be the ones who actually need the services the most.

I think there's a parallel in higher education that says that once you start measuring things like who gets a job, and who makes money, without being able to control for all the factors that drive that besides higher education, you may create pressure on higher education institutions to be more selective and maybe inappropriately selective about who they admit, which then ends up harming some students. The institution may look better on the scores, but you haven't actually achieved the outcome that you want to achieve.

Another parallel to healthcare that goes the whole way through from basic education to higher education is that the outcome is not totally in the hands of the provider of the service, whether it's the teacher or the doctor. There's also a key role that the patient or the student plays in that.

In all cases, I think there's a lot of evidence that providers of services can have a significant impact on outcomes but it also depends on whether their patient or student complies with what the provider recommends. A fundamental issue is that we don't know how to measure which things the provider can be accountable for and which they can't. We can't easily point to either a physician or a teacher to say, "You didn't do what you could have done to be as effective as possible." There's a gray area where it's very difficult to assign accountability for outcomes, and because of that, there is the potential for unintended consequences, negative impacts on both the patients and the students, by trying to hold providers accountable for things they can't actually control.

There are a lot of studies showing certain things work for certain individuals but not others. So in order to properly assign accountability, you have to have a good risk adjustment system, i.e., how can you distinguish which individuals have bigger opportunities for improving outcomes?

Most efforts at risk adjustment are based on the ability of a formula to predict the outcomes providers are achieving today. But if you run a regression analysis where the dependent variable is what is currently being done, not what <u>can</u> be done, and you pick the variables and coefficients based on their ability to predict only what's being done, then it can reinforce doing the wrong things. Finding a good risk adjustment system is a big problem in healthcare—i.e., coming up with a fair system to figure out what would have happened in the absence of services in order to determine how much impact a provider actually had.

I'm less familiar with the education literature, but I think similar issues would exist there. We don't really fully understand how to assess what students can or can't do. What's their baseline ability? What is their home situation? What impact does all of that have on educational outcomes? You have to adjust for differences in student needs and abilities in order to fairly assess what the education provider accomplished.

In making the business case for payment delivery reform, you have a section that's called "Incentives Aren't Enough," which I would have written for higher ed. You haven't changed how tuition money flows and how financial aid flows, how indirect costs on federal research grants flow, all of that.

That's exactly the parallel. Everybody in healthcare keeps talking about incentives, and when you keep talking about incentives, it biases you toward thinking that providers aren't *willing* to improve rather than the fact that providers face *barriers* to improvement. What I prefer to talk about is what type of

accountability is possible if you're paying adequately for necessary services. The parallel question for higher education would be, "How should we pay you to be able to deliver education effectively, and then what are you going to take accountability for if we actually pay you the right way?"

Higher education has got to take ownership of the problem that it has. It has to say, "We've been getting paid really well for a long time, and we're not delivering the value that people want. We've got to come up with an answer to how to deal with that without threatening the things that we think are important to maintain."

It's the same thing for physician practices. They need to figure out how they can deliver better care at a more affordable cost, but do it in a way that keeps their practices financially viable.

One thing I was hoping you would be able to share with me are some examples of cases where payment systems have been reformed and what lessons may have been learned either positive or negative from that.

Sure. Most healthcare payment systems have tried to require physicians, hospitals, and other providers to meet a performance target without ever assessing what resources are needed to achieve that target and then ensuring adequate resources are available.

There has been a tendency to create a quality measure and then immediately penalize somebody for not achieving it, when in many cases, until you actually start collecting the data and look at it, you don't even understand whether a problem exists or know what to do about it. For example, physicians represent a fairly small percentage of overall spending in healthcare, and they often don't know what other services their patients are getting. They have no idea how often their patients are being hospitalized, going to the emergency room, going to see other doctors, etc. When you give them that data, it's a revelation and all of a sudden, they can start thinking, "Well, why is that happening?" They're generally willing to do better if the data shows there are opportunities to improve, but they often run into barriers in the current payment system that prevent them from doing better. So rather than immediately penalizing them for their performance, there needs to be a period in which the causes are identified and solutions implemented. The more successful payment models have involved a partnership between payers and providers to mutually work toward "win-win-win" approaches.

I would say the parallel in higher education is that if an institution represents itself as trying to prepare students for careers, then it's got to measure what's happening to the students it educates, and come back and say, "Guess what? Our students are having trouble getting jobs. What should we do about that?" Then there needs to be a reasonable period of time to develop and implement solutions, rather than immediately penalizing an institution because its students have a low employment rate.

In healthcare, the process we've been following is to start by asking, what's the opportunity for improvement? Then we ask, what's the barrier that's keeping us from making that improvement? Then we can try to structure an approach that fixes the barrier, but also requires accountability for actually achieving the result that healthcare providers said would be achievable if we removed the barrier.

I think that approach can apply equally well in terms of higher education. You'd start by asking what's happening today? Which students aren't doing well? What's the barrier to improvement? What don't we pay for? What don't we deliver? Examine all those barriers and then say, "Let's fix some of those things, but let's fix them in a way that works for both students and educators, and hold educators accountable for doing what they said was possible."

Instead of waiting for an external entity to impose accountability, the providers of services need to take responsibility for defining what they can and should be accountable for achieving. In many cases, nobody will know right away what will work, so you want to have a collaborative relationship of some kind between whoever it is that's paying you or regulating you or whatever so you can pursue improvement

jointly. If you assume it can all be figured out before anyone has done it, and try to set standards prematurely, what is generally going to happen is a win-lose, not a win-win-win.

I wanted to touch on a couple of the differences between healthcare and higher education. One thing that seems different is where the prestige lies in the two sectors. There is prestige for the physician in treating the hardest to serve patients. The payment structures might be messed up, but if you're a talented specialist doctor, then you get some professional value and prestige in treating hard to treat cases, writing them up in journal articles. I don't see, necessarily, the same thing or the same professional incentive for the universities.

The disconnect there is that university faculty are not paid, rewarded, or recognized for their teaching. They're paid, rewarded, and recognized for their research. You have a compensation model that's not tied to educational outcomes.

There are some similarities in healthcare, but in general, both the institution and the actual frontline providers are paid based on healthcare services or outcomes. Instead, the way the university is paid and how the faculty members are compensated are two different things, and anybody who's been an academic administrator, as I have, will lament the fact that in terms of revenue, you're running a teaching institution, yet your faculty are not rewarded for the thing that sustains the institution. They're rewarded based on research. The university is ending up subsidizing research based on teaching revenues.

The other difference, I think, is in the federal-state partnership and healthcare compared to higher education.

I think that there are more similarities than differences. Most universities depend on federal funding for research and student aid, and most healthcare providers depend on federal (Medicare) payment. Public universities are more dependent on state government funding than private colleges and universities. It's the same issue in terms of healthcare in that the safety net systems are heavily dependent on states' Medicaid programs and other kinds of support, whereas other hospitals are not as dependent on that.

In both healthcare and higher education, the solutions that might work in one community won't work in another. However, higher education is also a complex combination of national markets and local markets in terms of where students are going. Healthcare is inherently more of a local market except for rare diseases and a few employers that are trying to do medical tourism.

Harold Miller is President and CEO of the Center for Healthcare Quality and Payment Reform and an adjunct professor of public policy and management at Carnegie Mellon University. He a nationally recognized expert on healthcare payment and delivery reform. He has also testified before Congress on how to reform healthcare payment and has published multiple papers, journals, articles, and reports on the topic.