Provider Payment Reform: History and 2011 Big Picture

Paul B. Ginsburg, Ph.D.
National Pay for Performance Summit
March 23, 2011
Goals in Provider Payment

• Alignment of provider incentives with what patients and payers are seeking
  – Efficient and high-quality
    • Management of chronic disease
    • Treatment of episodes of disease
    • Prevention
  – Departure from fee-for-service and DRG payment
Ancient History (1)

• Prior to third party payment: pure FFS
  – Service use strongly constrained by patient financial resources
  – Few costly technologies
  – Less opportunity to address chronic disease
Ancient History (2)

• Third-party payment adopted existing payment methods—but with controls on price
  – Screen physician fees for “reasonableness”
  – Fee schedules with relative values based on charge patterns
  – Participating physicians in Blue Shield
  – Hospital cost reimbursement in Blue Cross
  – Medicare adopted Blues approaches
Two Major Medicare Reforms (1)

• Inpatient prospective payment (DRGs)
  – Uniform (specified adjustments) per case payment rates
  – Incentives to control costs per admission
  – Hospital opportunity for surplus
Two Major Medicare Reforms (2)

• Physician fee schedule
  – Uniform rates (specified adjustments)
  – Relative values based on relative costs (RBRVS)
  – Global budgeting (VPS/SGR) to address volume issues
  – Strict limits on permissible balance billing
Private Payer Reforms: Managed Care

• Creation of provider networks
• Use of capitation to varying degrees
  – Global, professional, primary care
  – Much abandoned in response to backlash
  – Delegated model maintained in California
• Administrative controls instead of DRGs
• Medicare RVS for physician payment
• Experimentation with P4P
Lessons from Earlier Reforms (1)

• Resource-based physician fee schedules difficult to update accurately

• SGR has failed to control volume
  – Lack of mechanism for physicians to respond
  – Penalties too large to follow through
    • Problem with direct link to short-term changes in economy
Lessons from Earlier Reforms (2)

• DRG payment leads to shift to post-acute setting

• Limits to applicability of capitation
  – Provider infrastructure to manage care and accept risk
  – Need for advances in risk adjustment to provider payment
  – Limited consumer acceptance of lock in
Strong Current Interest in Provider Payment Reform

• Driver--and supporter--of more effective delivery of care
  – FFS as barrier to effective delivery

• But absence of a consensus on strategy
  – Recognition of technical challenges
Payment Reform in ACA (1)

• Core is mandate/support for Medicare pilots
  – Forceful and well supported
  – Appropriate given lack of consensus on strategy
    • Contrast with earlier Medicare reforms

• Also concrete payment reforms
  – Mandate for CMS to revamp Medicare RVS
    • Additional payments for primary care
Payment Reform in ACA (2)

– Higher primary care payments in Medicaid
– Medicare value-based payment for hospitals and physicians
  • Limited incentives but valuable template for private payers
– Medicare ACO contracting with shared savings
– Medicare hospital readmissions incentives
Key Payment Reform Visions

• Encourage integration of delivery through multi-provider payments

• Broaden payment units
  – Partial capitation
  – Per episode payments
Payment Tools

• Accountable care organizations
  – Seeking benefits of capitation without the pain
• Multi-provider episode payments
• Patient-centered medical homes
Obstacles for Bringing Visions to Reality (1)

• Limited provider infrastructure to succeed under reformed payment
  – Provider investments in infrastructure undermined by
    • Lack of consistency across payers
    • Small incentives—often based on limited infrastructure
    • Problematic to invest in better delivery when most payment based on FFS and DRGs
Obstacles for Bringing Visions to Reality (2)

- Undesirable to push for consistency of payer methods at early stage
Narrow Approaches First?

• Example: New per episode payments
  – Bundled payment for all episodes that include hospitalization
  – Bundled payment for ten types of episodes
  – Warranty approach to readmissions
Period of Experimentation

• Large insurers contracting with capable and ambitious providers

• Medicare pilots with capable and ambitious providers

• What kind of success can be obtained with a contract with only Medicare or Medicaid or a large private insurer?
Setting Payment Rates: Historical Base?

• Bad idea for reforms
  – Cannot lock provider into historical base for long time
    • Not fair
    • Can be gamed

• But need historical base for pilots
  – Entice weak performers as well as strong ones
  – Avoid a budget disaster from self selection
  – Problem of limited upside for strong performers
Evolving from Pilots to Reforms

• Judgments about what is succeeding
  – Full evaluations
  – Administrative evaluations
  – “Seat of the pants” judgments

• Modifying methods in light of experience
Going Beyond Large Insurers and Ambitious Providers

- Smaller insurers follow larger insurers’ methods
- Insurers follow Medicare methods
- Market-wide agreements on methods (IHA)
- Government specification of methods for all payers

Massachusetts proposal
Unfinished Business: Engaging the Patient

• Incentives to choose higher value providers
  – Could magnify the impact of direct financial incentives
    • Example of Medicare value-based physician modifiers

• Political vulnerability when patients not engaged
Concluding Thoughts

• Process of reforming payment more challenging than in past

• Goals more ambitious
  – Providers working together
  – Focus on value rather than unit cost
  – Chicken/egg issue with infrastructure

• But consensus on importance of progressing