Provider Payment Reform: History and 2011 Big Picture

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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