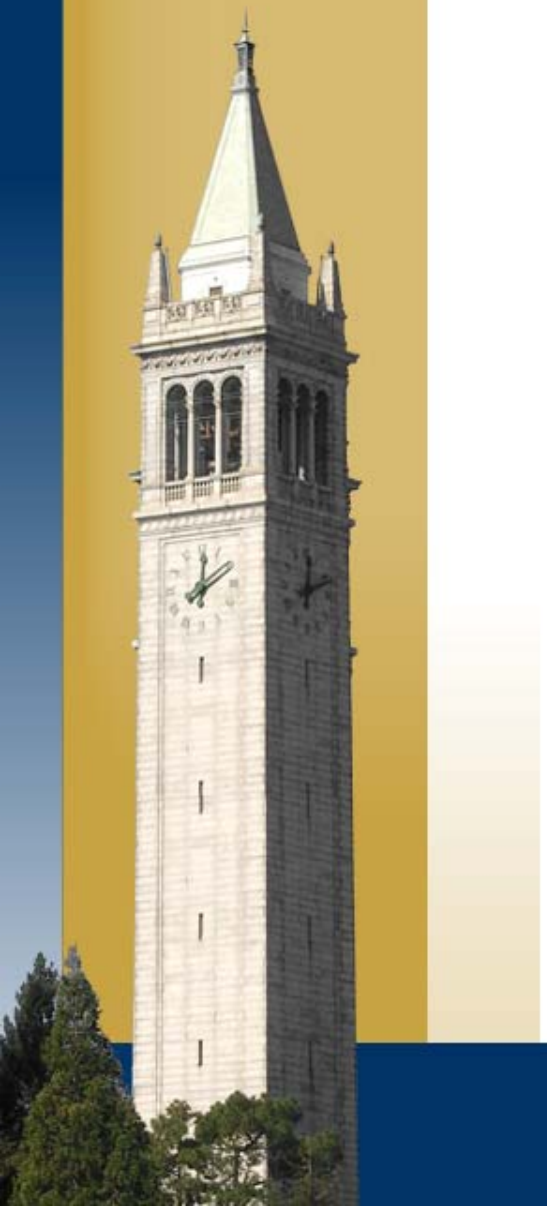

BERKELEY CENTER
FOR HEALTH TECHNOLOGY

Episode-of-Care Payment: From Concept to Implementation

James C. Robinson
Kaiser-Permanente Professor of Health Economics
Director, Berkeley Center for Health Technology

University of California, Berkeley

Episode of Care (EOC) Payment is a Good Idea

- Incentive alignment for physicians and facilities
  - Gain-sharing, shared savings
  - Support for a culture of cooperation
  - Support for unified data covering all participants/services
- Simplification and transparency for consumers
  - One price for one course of care
  - Ability to interpret and respond to cost sharing
  - Ability to compare prices in apples-to-apples manner
- Simplification and network expansion for insurers
  - EOC payment supports geographic expansion of markets and hence more competition among providers for elective services
  - Consistent with Center of Excellence strategy

If EOC payment is such a good idea, why are we still waiting for adoption, diffusion, a tipping point?

- Many initiatives have been tried, few has prospered
  - Medicare CABG demonstration
  - Oxford, HealthMarket, contact capitation, Adesso
- Implementation is hard
- We now have renewed interest and experimentation with EOC payment, yet again we are waiting for large numbers of procedures and patients
- What have been the experiences to date?

Which conditions and procedures?

- Which conditions/procedures are being targeted for EOC payment, and why?
  - Criteria used to pick conditions/procedures?
- How many patients will these conditions/procedures bring in? What is the minimum number for this to be worthwhile?
  - Getting MD attention in order to change behavior?
  - Getting patient attention in order to change behavior?
  - Offsetting administrative costs?

Which patient populations and insurance products?

- Which patient populations and insurance products most logically should be the subject of EOC payment for care?
  - Commercial insured PPO
  - Commercial insured HMO
  - Self-insured firms
  - Medicaid managed care
  - Medicare Advantage
  - Medicare fee for service
- Which ones are being targeted in practice?

Patient incentives and provider incentives?

- To what extent must financial incentives facing patients (consumer cost sharing) be revised for those services purchased using EOC payment?
  - Do current benefit designs impede EOC?
- Are any benefit design revisions underway?
  - Does EOC fit better with high deductible CDHP, with standard PPO, with HMO?
  - Reference pricing? Differential coinsurance?

Any role for shared decision making?

- What is the role of the patient in the context of EOC payment? Is there some mechanism for including or promoting better understanding, engagement by the patient?
  - Choice of treatment (appropriateness?): which services should be used?
  - Choice of provider (channeling?): which hospital or ASC or provider should be used? How to keep patients 'inside' the provider team that is paid on the EOC basis?
  - Choice of implant (formulary?) : how to convince the patient to cooperate with the economizing choices by the providers, once the providers are paid on an EOC basis?
    - Implantable joints, stents, defibrillators

EOC and ACO?

- Much current interest centers on Accountable Care Organization (ACO) experiments that include many or most conditions/procedures, rather than being selective as with EOC
- What is relationship between EOC and ACO?
  - Substitute? Complements?
- Are you promoting coordination between them?

Protecting providers against excessive risk?

- In principle, EOC shifts technical risk to providers while keeping epidemiological risk with insurers, but in practice…
- How to limit risk dumping onto providers?
  - Prospective risk adjustment?
  - Stop loss provisions?
- What actually is being done to correctly allocate risk?

How to ramp up?

- How can proponents of EOC payment ‘ramp up’ from a limited number of procedures/conditions and patients to a large number?