A Framework for Payment Reform

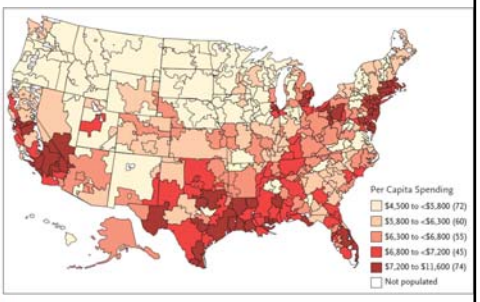
National Pay for Performance Summit
March 10, 2010

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

Overview

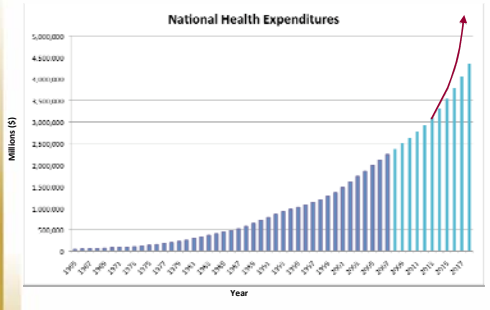
- A short, sober history of payment reform
- All eyes on bundled payment
- Integrated Healthcare Association initiatives
  - Value purchasing for medical devices
  - Bundled payment for device-intensive episodes
- Fears for bundled payment
- Conditions for sustainable payment reform
- A Hippocratic Oath for health policy

A short history of payment reform



Source: Dartmouth Atlas of Health Care

An even shorter history



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, 2009.

The menu of payment options

- Fee-for-service: rewards volume of services, not appropriateness or coordination of care
- Global capitation: shifts too much risk to providers, creates incentive for risk selection
- Pay-for-performance: framed as quality bonus and hence does not move enough money
- Episode payments: our best hope?
  - Case rates for major acute interventions
  - Episode payments for major chronic conditions

Goals for episode payment

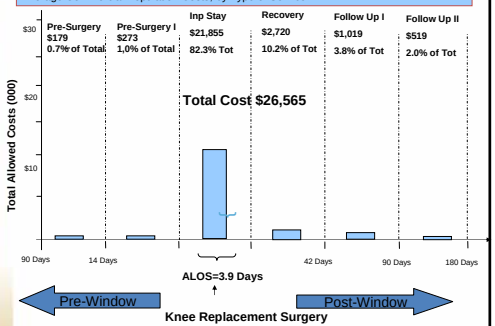
- Better than FFS: prospective defined payment for a range of related services
- Better than capitation: does not place provider at risk for epidemiology, adverse selection
- Quality measurement and improvement over the entire course of care, not just within silos
- Create joint financial destiny for hospitals, MD
- Promote transparency and consumer choice (price and quality comparisons)
- Improve supply chain management (devices)
- Encourage Toyota lean production, efficiency

Example: Osteoarthritis (episode of illness) and total knee replacement (episode of care)

- Annual cost for all patients with OA: **$5,900**
- United States: OA Patients with TKA:
  - Annual cost for all services: **$34,700**
  - 90 day surgical episode cost: $25,600
  - 4 day hospital inpatient cost: $18,000
- California: Patients with TKA
  - Hospital cost: **$13,200**
  - Device (artificial joint) cost: **$5,700**
  - Surgical complication (3%) cost: $1,500
  - Commercial reimbursement: **$24,200**
  - Commercial margin: **$11,000**
- India (Apollo Hospitals): Patients with TKA
  - TKA case rate: (hospital, surgeon, device): **$9,900**

Knee Replacement Procedure Episode Group

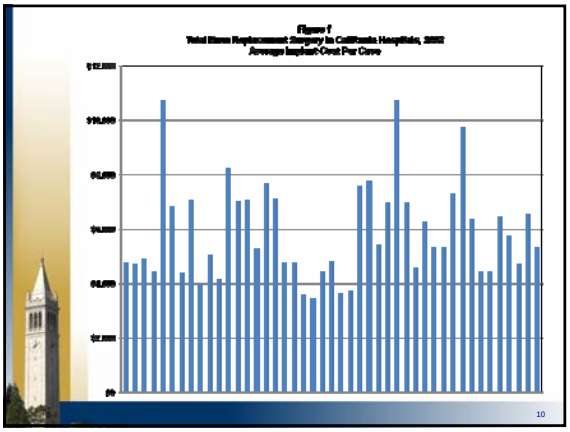
Average Commercial Population Costs, by Type of Service[1]

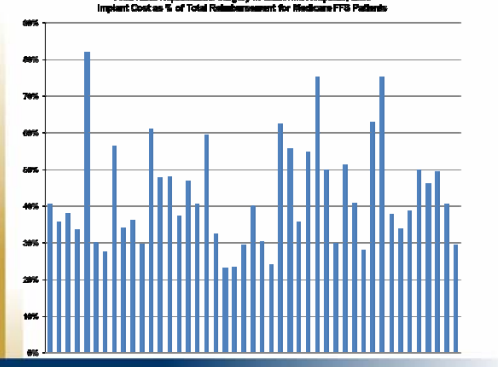


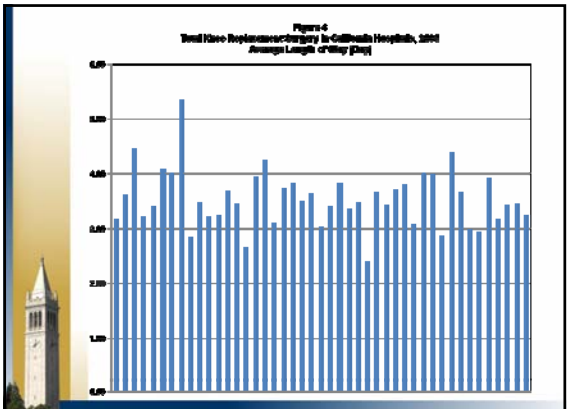
1) Source: Ingenix Claims Data- 602 complete episodes

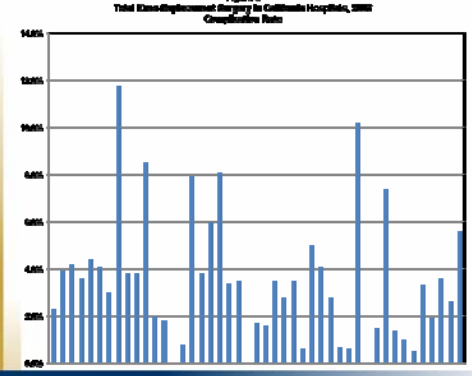
Example: Integrated Healthcare Association

1. **Medical device value purchasing project**
   - Goals: Improve physician-hospital alignment for device-intensive services (ortho, cardiac)
   - Collect comparable data from 52 hospitals on device costs, total costs, complications, LOS, payment rates, margins
   - Highlight best practices, strategies
2. **Bundled payment pilot project**
   - Builds on medical device project (begin with orthopedic surgery, to expand to cardiology, cardiac surgery, other)
   - See below ☺









IHA Orthosurgery Episode Payment Project

- Initial focus: Los Angeles and Orange County
  - Cedars Sinai, UCLA, Memorial, Tenet, Hoag
  - WellPoint, Aetna, CIGNA, BSC, HealthNet, United
  - PPO, to expand to HMO (prepaid group practice)
- Single payment to provider organization
  - Hospital, all physicians, some post-discharge care
- All health plans use same episode definition
  - Reduce administrative cost, confusion
- Payment rates differ (negotiated) for each health plan and hospital/physician entity
- Results: TBA ☺

Fears for Episode Payment

- All payment reforms have brought unintended, undesired adverse side effects
  - The cycle of illusion and disillusion
- Episode payment evokes three concerns
  1. Provider consolidation
  2. Consumer choice
  3. Performance data

1. Fears: Provider consolidation

- Hospital pricing leverage increases as it hires physicians, takes responsibility for pre-admission and post-discharge care
- Hospitals will continue to merge and squeeze out physician-owned ambulatory competitors
- With less competition, there is less pressure on hospitals to seek (always difficult) cost reductions
- Hospitals will be better able to pass costs of medical devices, Medicare and Medicaid shortfalls to commercial insurers

Scope of the market

- Episode payment must be conceptualized as means to expand, not restrict, the organizational and geographic scope of the market
- Health plans can contract on episode basis with wide geographic range of providers and facilitate consumer comparison and travel
  - Medical tourism from Sacramento to Los Angeles?
- Multi-hospital systems should quote different episode prices for different facilities to the extent they have different costs, performance

Limits on bundling

- More bundling is not always better bundling
- Separate a 'post-acute service bundle' from the acute care bundle to permit patient travel, choice
  - SNF, inpatient/outpatient rehab, home health and physical therapy, readmission to other hospital
- Separate a 'diagnosis & evaluation services bundle' from the acute care bundle?
  - Foster specialization and scale economies in evaluation
  - Reduce potential for self-referral and unnecessary care
- There remains a valid and important role for FFS 'around the edges' of episodes and case rates

2. Fears: consumer choice

- Too little choice?
  - Payers will create incentives (cost sharing) for consumers to stay inside the provider team that has been paid the case or episode rate
  - Will this limit ability of consumers to travel for care?
  - Will it limit their ability to manage their own care?
- Too much choice?
  - If consumers don't pay more to use services from provider teams/systems that charge higher episode rates, these providers will have incentive to increase, rather than decrease, rates
  - Without valid performance data, consumers will assume (high cost, high price) tertiary centers offer high quality

Last dollar cost sharing

- Episode payment for providers requires 'last dollar' rather than 'first dollar' cost sharing for patients
  - From deductible to reference pricing
  - From dollar copayment to percentage coinsurance
  - Reference pricing as replacement for deductible: the insurer negotiates episode rates with all provider teams and pays a rate equal to the lowest negotiated rate in the market. The consumer pays the difference between the lowest rate and the rate charged by the provider team chosen by the consumer. (Analogy: tiered formularies)
  - Coinsurance as replacement for copayments: The patient pays a share (percentage) of the cost difference across provider teams offering episode rates up to annual out-of-pocket maximum.

Value-based benefit design

- Cost sharing should target inappropriate services rather than high-cost services
  - VBID has been applied successfully to some primary care services, reducing cost sharing for preventive tests and chronic care medications. It has not been used to raise cost sharing for inappropriate services nor has it yet been applied to costly acute cases or chronic episodes.
- Value principles can be applied to major acute and chronic services once they are paid as episodes
  - Consumer cost sharing should be lower when choosing provider teams with better outcomes and/or lower cost
  - Center of Excellence model but with price as well as quality taken into consideration

3. Fears for episode payment: performance data

- Contemporary efforts at quality and satisfaction measurement are not aligned with episodes of care, inhibiting comparisons across competing provider teams/systems
  - The unit of measurement is not the unit of payment
- Provider organizations resist performance comparisons across internal services lines
  - The internal black box
- Everyone agrees: price transparency is for others

Better data collection

- There is extensive variation in price and quality performance across provider teams/systems
- Insurer claims capture some variation but miss other cost components (e.g., capture drug costs but not device prices)
  - Episode payment must be accompanied by detailed data on services and prices within the case or episode
- Comparative effectiveness research should measure outcomes at the case or episode level, not just for components (e.g., drugs, devices)

Uses for data

- Health plans must reward (higher payments, lower cost sharing) providers that collect quality data:
  - At the level of the case or episode
  - At the level of the service line (not just entire hospital)
- Quality data at the appropriate level of analysis (episode, service line) is 'actionable' for:
  - Providers adopting 'lean' production methods
  - Consumers making informed choices
- Price transparency is a consumer right
  - Coinsurance without transparency increases consumer anxiety, not efficiency and empowerment
  - Litigation and proposed legislation on price confidentiality (transparency) for medical devices (key to case rates)

Policy implications

- Much of public policy and regulation impedes a transition to episode payment
  - Ban on gain-sharing between hospitals, physicians
  - Bans on 'corporate practice of medicine' (physician employment by hospitals)
  - Rigid limits on consumer cost sharing
  - Limits on 'risk transfer' to providers (case rates)
  - Impediments to patient travel for care and coverage
  - Tax exemption for health insurance premiums
- We need a Hippocratic Oath for health policy
  - First, do not ban, tax, fold, or spindle efficiency initiatives

Summary and conclusions

- Payment reform is essential to health reform
- Episode payment is an important initiative that can encourage care coordination, physician-hospital cooperation, and service line efficiency
- Like other initiatives, it risks unintended consequences, especially provider consolidation
- To achieve its goals, episode payment requires supportive network contracting, consumer cost sharing, and performance measurement
- Public policy needs to support, not impede, change