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U.S. EXPERIENCE WITH PHYSICIAN PAYMENT REFORM:

Implications for U.K. Commissioning

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OVERVIEW

- Payment reform: coalition of the willing
- The range of payment alternatives
- Liabilities of population-based payment
- Reform options for payment reform
- Matching scope of payment to organizational capabilities
- Moving forward with enthusiasm and humility



The Importance of Payment Reform

- Health and health care demand coordination in order to improve quality and efficiency.
- But most payment methods reimburse each component of care separately.
- Provider organizations tend to focus only on selected elements of the patient's care.
- Narrow scope of provider organization matches narrow scope of payment incentives.
- This must change.



The U.S. Experience

- The U.S. has extensive experience with population-based payment methods (capitation, episode payment, hybrids).
- Each offers value in aligning incentives for cooperation, but each requires that providers develop sophisticated organizations capable of managing the financial risks and coordinating the clinical care.
- Population-based payment for unsophisticated organizations leads to failure and backlash.
- The U.S. has extensive experience with failure and backlash against payment reform.



Machiavelli

“It must be remembered that there is nothing more difficult to plan, more doubtful of success, nor more dangerous to manage than a new system, for the initiator has the enmity of all who would profit by the preservation of the old institution and merely lukewarm defenders in those who would gain by the new ones.”

- The Prince



The Range of Payment Alternatives

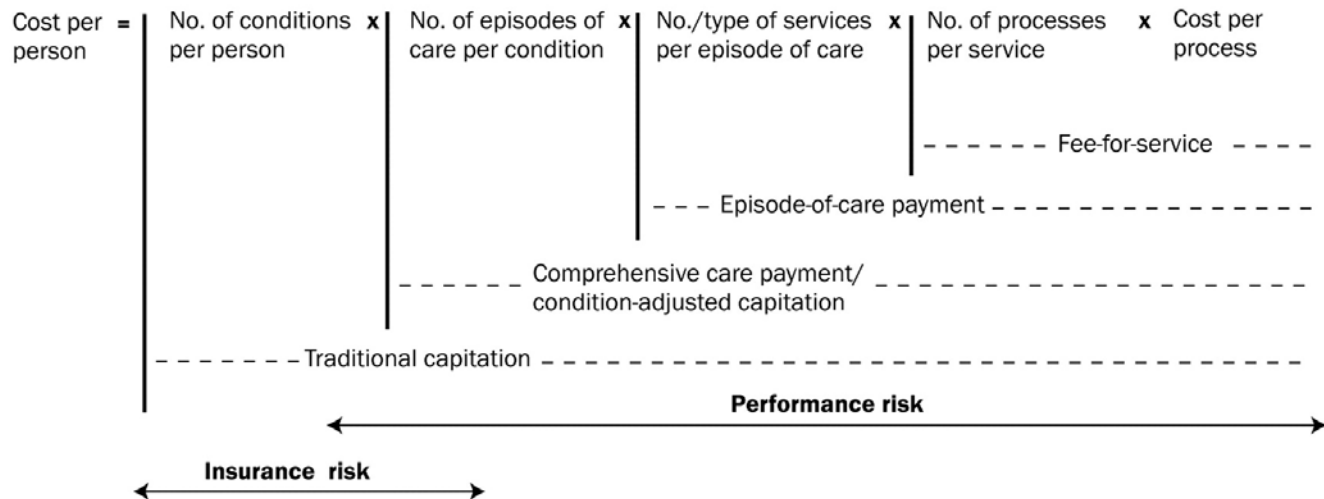
- Global capitation for all services (GP, specialist, drugs, hospital care, home care)
- Professional services capitation (GP and specialists)
- Condition-specific capitation (all services needed by patients with a chronic conditions such as diabetes)
- Acute episode of care (EOC) payment, e.g., for knee replacement surgery
- All forms of population-based payment can be moderated by excluding particular services or limiting potential losses/gains



The Range of Payment Alternatives

EXHIBIT 1

Variables For Which The Provider Is At Risk Under Alternative Payment Systems



SOURCE: Author's analysis.

Harold D. Miller,
From Volume To Value: Better Ways To Pay For Health Care,
Health Affairs, Vol 28, Issue 5, 1418-1428

Putting My Conclusions First

- Population-based payment has many virtues and should be pursued in the U.K. and the U.S.
- But it needs to be **supported & supplemented**:
 1. Large, sophisticated physician organizations
 2. Incentives for consumers & patients
 3. Incentives for specialty providers and hospitals, tests and procedures, new drugs and devices



Let's Start with the Liabilities of Population-based Payment

1. Pressures on providers to create organizations with managerial and clinical capabilities
2. Potential conflict with patients' views on entitlement
3. Difficulties in managing specialty care and the pipeline of new technologies



Liabilities of Population-based Payment

- It places great pressures on provider entities
 - Insurance risk: needs 'risk adjustment'
 - Business risk: needs strong financial management
 - Cultural risk: requires cooperation among traditionally autonomous individuals and organizations
 - Complexity of operations: needs sophisticated data systems
- Sophistication of payment methods must be matched with sophistication of provider organization
- Scale and scope are necessary but not sufficient for organizational sophistication



More Liabilities: Patient Entitlement

- Global payment creates strong incentives for physicians but no incentives for patients to appreciate and cooperate with provider-initiated changes in organization and care
 - Patients increasingly are exposed to advertising and/or media accounts of high-cost interventions and want access, despite lack of understand of clinical efficacy and risks
 - Consumer cost-sharing reduces demand for care, but patients have difficulty in distinguishing between appropriate and inappropriate interventions
- The backlash against 'managed care' in the U.S. was driven by a culture of entitlement and hostility to population-based payment incentives



More Liabilities: Technology

- Global payment for GP-based organizations places incentives for them to manage specialty care (procedures, drugs, devices, tests, hospital admissions) without providing the tools to do so.
 - Specialists will not allow GPs to dictate care for patients with complex conditions
 - GPs are not in the hospital frequently enough to understand and manage the flow of inpatient care
 - Medical technology (drugs, devices, tests) is very dynamic and undermines prospectively determined payment rates
- The retrenchment from capitation in the U.S. was driven by the inability of GP organizations to manage the high-cost and specialty elements of care



Reform Options for Payment Reform

- Capitation has its liabilities, but it can be improved
 1. Limit the scope of services covered by capitation
 2. Create hybrids of capitation and FFS
 3. Most important: increase the scale, scope, and capabilities of the provider organizations receiving capitation



(1) Limit the Scope of Capitation

- Restrict capitation to physician or only GP services
 - This undermines incentive to coordinate the full course of a patient's care
- Implement risk corridors: providers cannot earn bonus or incur loss greater than defined percentage of base capitation rate
 - This limits risk but also reward
- Replace two-sided capitation with one-sided shared savings
 - This limits the amount of risk but also the amount that can be offered in positive incentives
- Carve out specialty services, drugs



(2) Create Hybrid Payment Methods

- Capitation with FFS supplements
 - FFS for preventive services, high-cost tests and drugs
- Hospital DRG with FFS supplements
 - Supplement budgets with payment for cancer drugs
- Capitation with pay-for-performance bonus
 - PMPM bonus based on quality, satisfaction, IT adoption



(3) Create Sophisticated Provider Organizations

- Sophisticated payment methods require sophisticated provider organizations
- Physicians are highly trained and talented individuals who do not understand, appreciate, or invest in organizational infrastructure or management
- They are not natural candidates for sophisticated payment methods
- Every form of population-based payment requires a 'matching' form of physician organization, with the requisite capabilities to manage costs and care



Capabilities Required of Provider Organizations: Financial

- Financial accounting
 - GAAP (accrual), not cookie jar (cash) accounting methods
- Financial discipline
 - Financial reserves, strong balance sheets
 - Saying no to Doctor Jones, who needs cash for his vacation
- Internal payment methods
 - The global capitation payment needs to be allocated across individual physicians and facilities in a manner that creates incentives for productivity as well as cooperation, and does not create the war of all against all



Capabilities Required of Provider Organizations: Clinical

- Data systems that create real-time reports on which physicians are ordering and which patients are using which services
 - Hospitalization, expensive drugs, procedures, tests
- Registries and predictive risk software that gives insights into which patients are likely to need expensive care if not given early interventions
- Culture among physicians of sharing data, acknowledging errors, providing informal consultations, dividing responsibility for patients that have multiple or borderline conditions



Capabilities Required of Provider Organizations: Simplicity of Incentives

- FFS requires thousands of individual prices, but is simplified by fee schedules and value scales
- Capitation requires DOFR to indicate and price the various services that are covered
- Hybrid payment methods are better than pure FFS or capitation in principle, but are difficult to administer and for physicians to understand
 - People don't respond well to incentives they don't understand
- Patients can mistrust physician payment methods that seem to create incentives to deny care



The Alternatives to Payment Reform

- Payment incentives are a blunt and sometimes ineffective method to change behavior. What are the alternatives?
 - Medical education and socialization
 - This is slow and also often ineffective
 - Professional and organizational sanctions
 - These tend to be 'captured' by the providers
 - Tort liability, medical malpractice, and loss of licensure
 - This is costly and unpleasant
 - Slow torment and torture
 - This is very costly and very unpleasant



Enthusiasm for Payment Reform, with Appropriate Humility

- It often is difficult to influence physician behavior through payment incentives
- Payment incentives need to be supplemented by professional standards, education, and other non-financial methods
- But it's a bad idea to pay doctors to do A when you want them to do B

