A Framework for Payment Reform

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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

Year
Millions ($)


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: 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

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

3. Fears for episode payment: performance data

- 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)
- 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