Emerging Models of U.S. Payment Reform

Meredith B. Rosenthal, Ph.D.
Harvard School of Public Health
April 9, 2010

Outline

- Impetus for payment reform activity
- An overview of pilots and proposals
- Intersection of organization and financing
- Likely path for the U.S.
- Implications for Alberta

Payment Reform Has Moved to the Fore

- Flaws with fee-for-service, volume-based reimbursement in silos have long been understood
- Advantages for providers have preserved the status quo but:
  - Growing disparities among specialties have undercut uniform provider resistance to change
  - Crisis of affordability (lack thereof) has energized payers and policy makers
  - Evidence of poor quality cohabitating with high cost has become hard to ignore

Landscape of Payment Reform in the U.S.

- Pay for performance
- Non-payment for unacceptable performance (CMS, others)
- “Patient-centered” medical homes funded with partial or full primary care capitation
- Episode-based payment concepts
  - PROMETHEUS™ Payment
  - Geisinger’s ProvenCare™
- Shared savings
  - Upside-only models with shared savings relative to actuarial target
- Capitation, but better this time
  - True global payment (all in) with risk adjustment, pay for performance

How Are U.S. Pay-for-Performance Programs Structured?

- Physicians (medical groups) about twice as likely as hospitals to be target
- 5-10 performance measures, largely process measures of quality
- Maximum bonus 5-10% of pay for physicians, 1-2% for hospitals
- Rewards for reaching fixed threshold dominate; only 23% reward improvement

Overview of U.S. Experience with Pay for Performance

- Rigorous studies of pay-for-performance in health care are few
- Overall findings are mixed: many null results even for large dollar amounts
- But in many cases negative findings may be due to short-term nature, small incentives
- Fragmentation of payers in the U.S. is also an enormous challenge

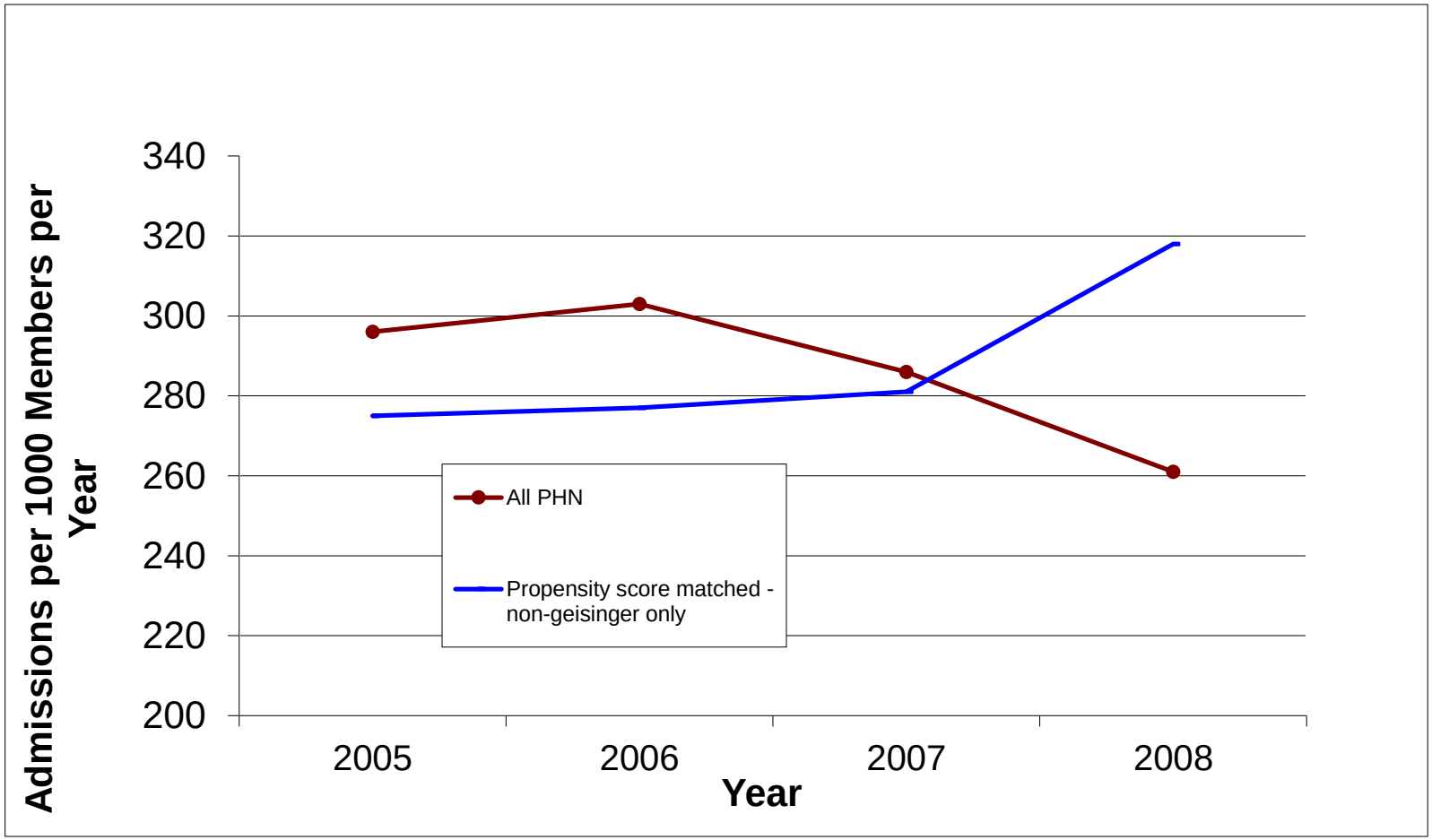
Medicare Rule on Complications That Will Not Be Factored into Payment

- Never events
  - Wrong-site surgery
  - Instrument left in patient
- Other complications that:
  - Were not present on admission
  - Are identifiable by unique codes in hospital billing data (including new present-on-admission codes);
  - Have been shown to be largely preventable in scientific studies;
  - Are prevalent and expensive enough to matter

Rhode Island Multi-payer Patient-centered Medical Home Pilot

- All payer pilot project with state backing
- Payers account for two-thirds of provider panels
- 26,000 patients, 28 providers, 5 sites
- Practices receive:
  - usual FFS,
  - care management resources (1 FTE in each practice),
  - PMPM fee (about $3) to implement PCMH services
- Training/support for practice improvements, redesign

Some Medical Home Results: Inpatient Admissions 2005-2008 Geisinger PHN



PROMETHEUS Payment

- Global (all covered services), episode-based payment model
- Condition-specific evidence-informed case rates (ECRs), for example:
  - AMI
  - Knee replacement
  - Diabetes
- “Warranty” for complications
- Pilots are active in several markets in the U.S.

Payment Reform and Shared Accountability

- Nearly all discussions of payment reform in the U.S. touch on the lack of entities that can manage/accept risk for a whole population
- Current proposals seek to either incentivize the creation of new accountable units (integrated organizations and other models), favor existing integrated organizations or create them by fiat
- Critical questions for implementing payment reform remain: To whom should a payer delegate accountability and how can accountability be shared across unrelated providers (i.e., outside Mayo, Geisinger, Kaiser)?

Which Way Will Payment Reform Go in the U.S.?

- One size does not fit all – there is likely a role for all of these models across settings, patient populations
- Health reform legislation has a number of provisions to promote experimentation and adoption of successful models
- There is already substantial evidence that episode-based and capitation payment reduce costs and little evidence of negative health effects
- Past experience suggests that implementation issues are critical – preventing physician and patient/public backlash

A Short List of Barriers to Success of Payment Reform in the U.S.

- Procedure-based specialists are still happy with the status quo
- Change is hard for payers with ossified systems
- Benefit designs that do not link patients to responsible providers (i.e., gatekeepers)
- Cultural, structural, legal barriers to shared accountability across the seams of the fragmented delivery system (e.g., gainsharing prohibitions)
- Continued lack of informational integration around care of a patient
- Fragmenting financing means any one payer has little leverage

Implications for Alberta

- Single payer advantages can address many of the implementation barriers – legitimacy, fragmentation are two big issues in the U.S. that would appear to be non-issues here
- Evidence on impact of global payment, episode-based payment, pay for performance likely relevant given similarity of delivery systems (as opposed to financing)
- Evidence suggests fee for service alone is not the solution: what mix of fee for service, case rates (DRGs, global episode payments) and capitation is optimal?
- For high-risk patients, opportunity to bundle medical and social care may be a significant advantage