

Health Care Payment Reform 101: What Is It? Why Pursue It?

Part One of a Three-Part Series

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Presentation Overview

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 - Richard Slusky, State of Vermont
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Robert Wood Johnson Foundation's State Health and Value Strategies Program

- Committed to providing technical assistance to support state efforts to enhance the quality and value of health care by improving population health and reforming the delivery of care services
- Connects states with their peers and experts to develop tools to undertake new quality improvement and cost management initiatives
- Places an emphasis on building systems capacity, engaging stakeholders, and promoting payment and other purchasing reforms

www.rwjf.org/en/grants/grantees/state-health-and-value-strategies--shvs.html

Webinar Logistics

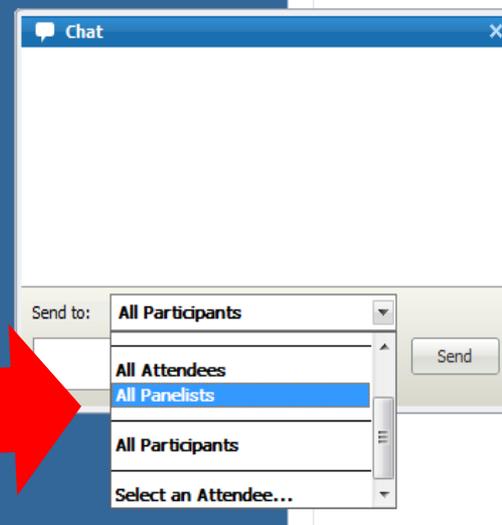
- The recording and slides will be available following the webinar.
 - www.rwjf.org/en/grants/grantees/state-health-and-value-strategies--shvs.html
 - An email with this information will also be sent to all webinar participants
- Due to the number of participants, we will not open the telephone lines for questions. Please use the webinar Q&A feature instead to ask questions.

Webinar Logistics

- Roll over the green bar at the top of the page and left click on Q&A.



- Type your question in the box.
Click on “All Panelists” in the “Ask” box.



Payment Reform Webinar Series

Three-part series on Tuesdays from 1:30-2:30 p.m. EDT:

- **Today**: Payment Reform 101: Why Payment Reform? What is it?
- **June 10**: State-based Payment Reform Models
- **June 24**: Special Topics in Payment Reform: State Levers, Multi-payer Approaches, and Measurement

- To register for future SHVS events go to:
<https://rwjfevents.webex.com/mw0401l/mywebex/default.do?siteurl=rwjfevents>

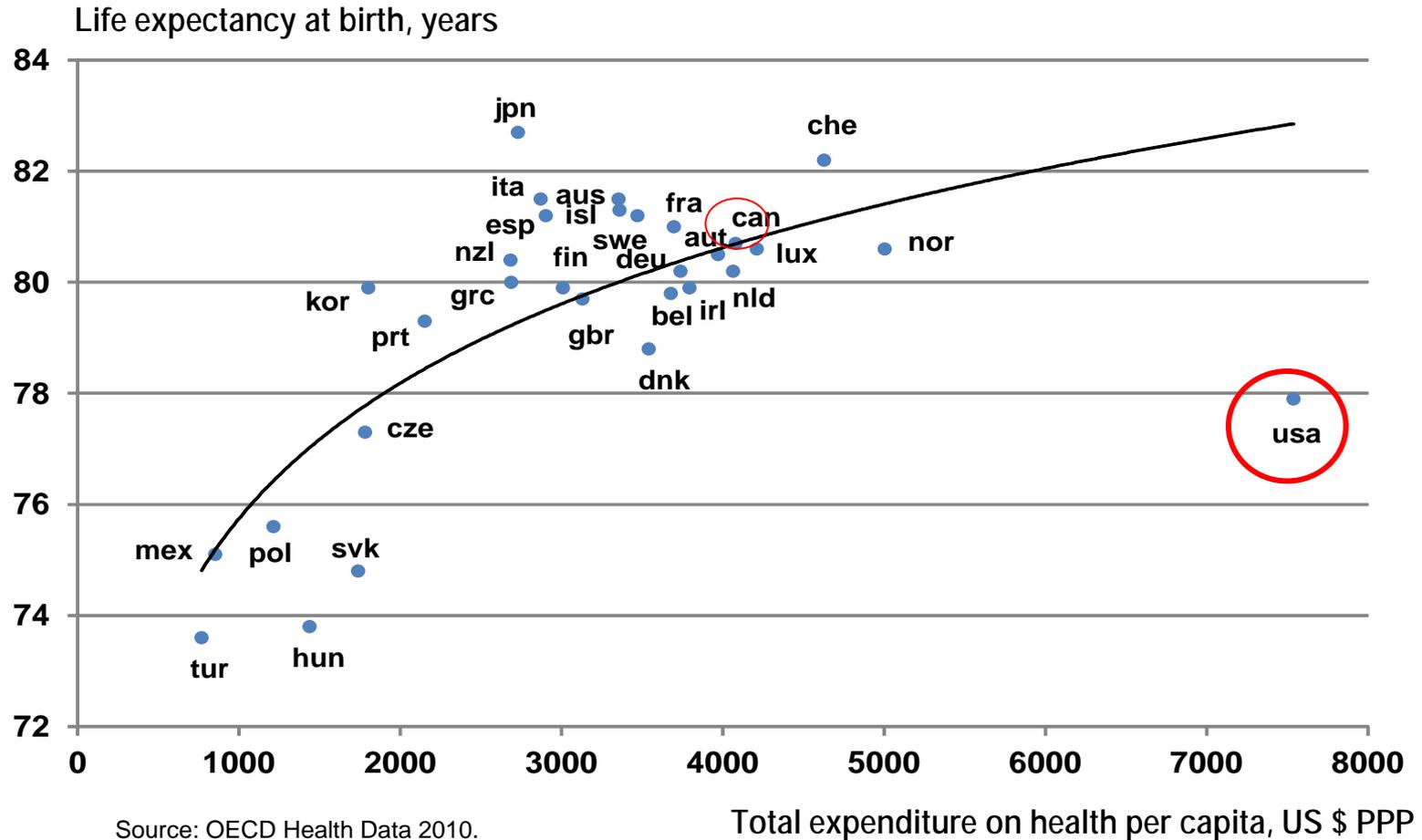
The Business Case for Payment Reform: Three Compelling Reasons for Change

1. The current system was not designed to promote value.
 - All health care payment systems create incentives and disincentives for providers.
 - Systems can reward doing more, doing less, delivering better care and delivering worse care.
 - All payment systems have undesired consequences and are subject to gaming behavior.
2. U.S. health expenditures are high, going up, and many would argue, unsustainable.
 - 2014 commercial premiums are projected to grow at 3-4 times the general inflation rate.

The Business Case for Payment Reform

3. More health spending has not produced better care or better health status.
 - It has been estimated that a third of expenditures produce no benefit to patients – and to varying degrees produce harm.
 - Tens of thousands of Americans die each year from medical errors and hundreds of thousands suffer nonfatal injuries that a high-quality health care system would largely prevent.

More Spending Does Not Equal Better Care



What is Fee-for-Service Payment?

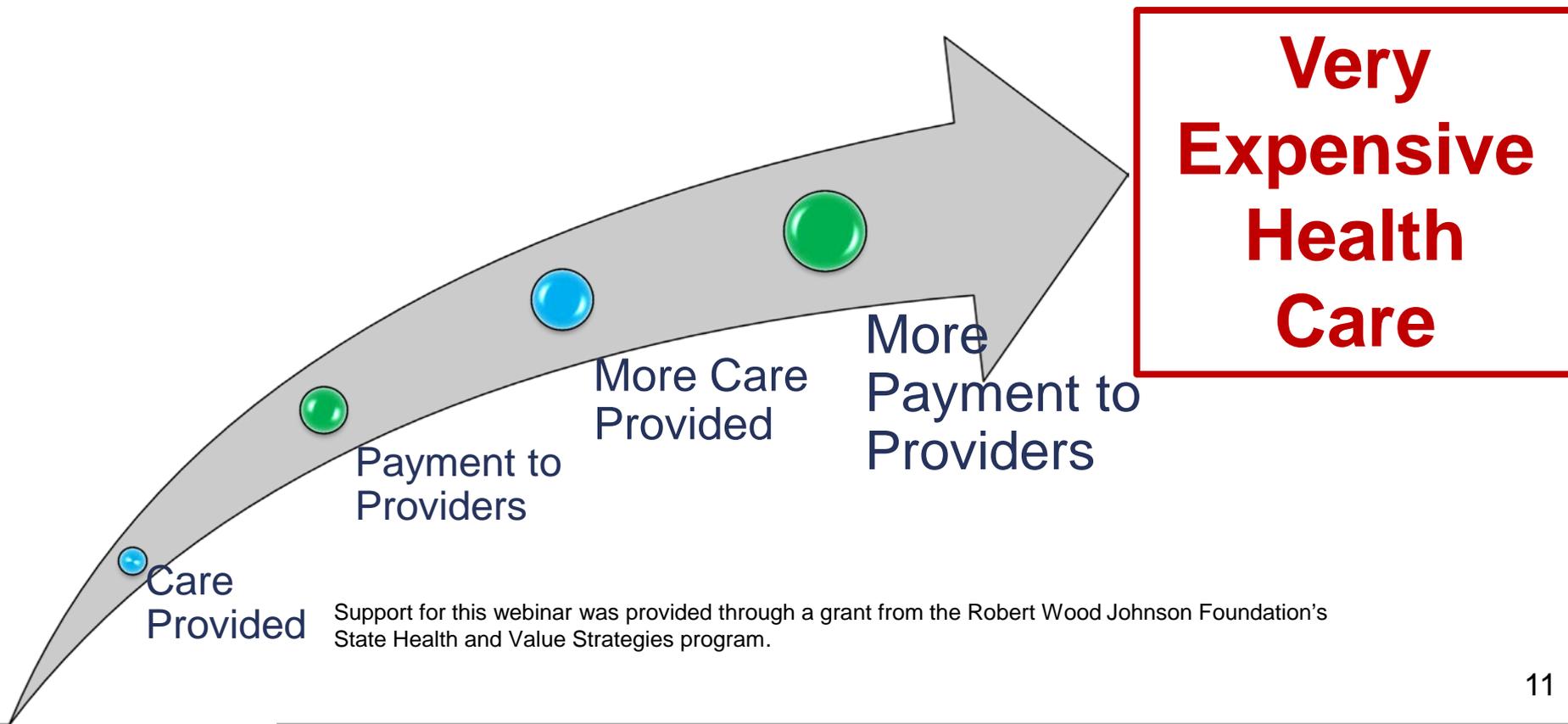
- It is the dominant payment model in the U.S. health care system – and has been for decades.
- Fee-for-service (FFS) payment offers providers a specific amount of compensation in exchange for providing a patient with a specific service.
- **FFS payment is inherently inflationary.**
- FFS creates incentives for “doing things” rather than for quality care and improved patient health.

FFS: Getting What You Pay For

“Fee-For-Service” pays for volume, so that is exactly what we get:

LOTS OF VOLUME

(visits, tests, procedures, duplication of services)



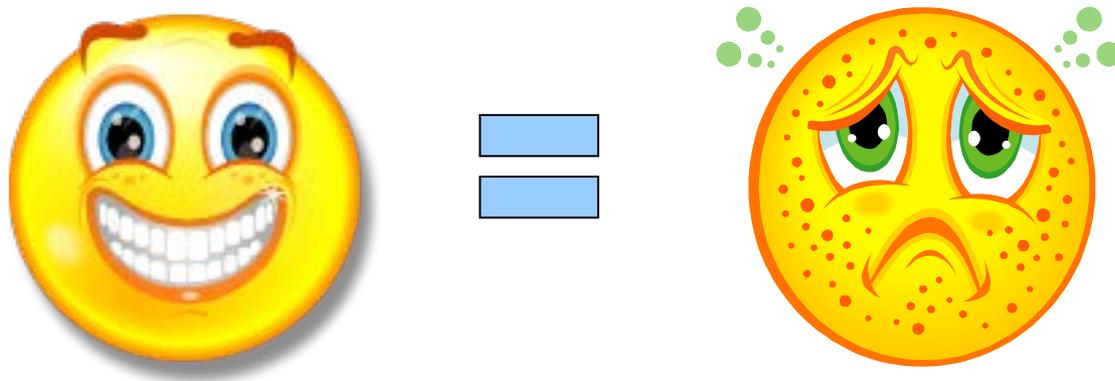
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FFS: not only rewarding volume, but rewarding volume of *highly priced* services

- FFS payment provides a financial incentive to:
 - Provide more of those services which are paid most handsomely – e.g., cardiology, orthopedics
 - Provide care in settings that yield higher fees
 - Introduce new services that generate higher fees than longer-standing services
- FFS payment provides a financial *disincentive* to:
 - Deliver services that generate comparatively lower remuneration – e.g., primary care, psychiatry
 - Provide services for which there is no FFS compensation – e.g., patient outreach, care coordination, treatment plan development, e-visits, web visits

FFS: No Financial Incentive for Quality

- Physicians get paid the same amount for one patient regardless of whether they provide excellent care or terrible care



Providers may actually be paid more for poor quality due to the need for “rework.”

Are there benefits to FFS payment? Yes.

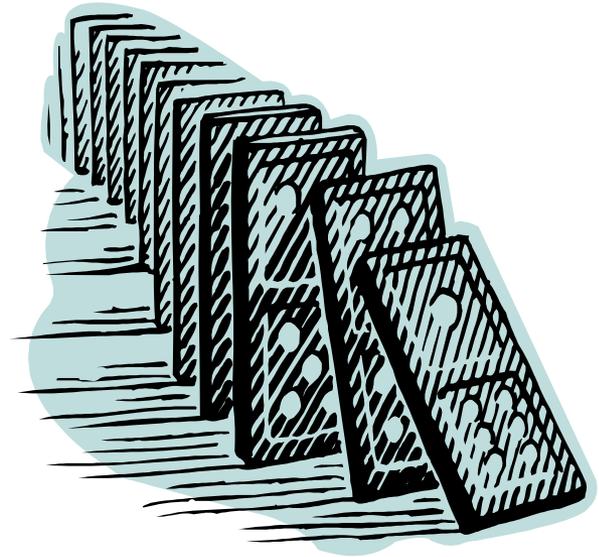
- FFS payment does motivate providers to provide patients with access to services.
- FFS payment does motivate technology firms and others to develop new services that might alleviate pain and suffering, and delay death.

Do we have empirical evidence of the effects of FFS payment on service utilization?

- Plenty.
 - Physician Reimbursement by Salary or Fee-for-Service: Effect on Physician Practice Behavior in a Randomized Prospective Study (Hickson et al., 1987)
 - How do financial incentives affect physicians' clinical decisions and the financial performance of health maintenance organizations? (Hillman et al., 1989)
 - The Effect of Capitated and Fee-for-Service Remuneration on Physician Decision Making in Gynecology. (Ransom et al., 1996)
 - Physician-Ownership Of Ambulatory Surgery Centers Linked To Higher Volume Of Surgeries (Hollingsworth et al., 2010)

Payment is the First Domino

- Payment influences provider behavior.
- It's not the only influence – but it is a significant one.
- If we want to improve care delivery, we have to improve payment.



Payment Reform is Essential for Delivery System Reform

- “Payment reform” means moving away from FFS and towards other ways of paying that financially incentivize provision of high quality, efficient care.
- Payment reform is not an end.
 - It is a means to spark fundamental changes in health care system function and enable meaningful delivery system reforms.
 - It removes barriers that prevent or inhibit providers from “doing the right thing.”
- The options for payment reform are neither mutually exclusive nor sequential.

So why should states care?

- The business case described earlier applies to states, but states are in a unique situation to respond.
 - States represent the largest purchasers of health care services in each state with the possible exception of the federal government
 - Medicaid alone covers 1/3 of the population of New Mexico
 - States have the ability to convene insurers, providers, employers and the stakeholders to collaborate on system-level change
 - Vermont facilitated a multi-payer, multi-provider pilot to implement population-based payment, and is testing other models too
 - States can utilize regulatory authority to foster payment reform
 - Rhode Island is directing insurers to expand use of non-FFS payment arrangements

Alternative Payment Models: An Introduction

- Having discussed FFS payment and its effects, we'll now introduce alternative payment models to FFS.
- This will serve as an *introductory presentation*. We'll examine each model, how it works, strengths and weaknesses, and examples of implementations, in Webinar #2.
- First, however, we'll share some precautions...

Payment Reform Models: Nine Precautions

1. There is mixed evidence, and varying amounts of evidence, regarding the efficacy of different FFS alternative payment models.
2. Each FFS alternative carries with it strengths and weaknesses.
3. Some FFS alternatives are more administratively demanding to implement for providers and payers than others.
4. How a model is implemented is as important as how it is designed.
5. Riding two horses at once is very difficult for providers.

Payment Reform Models: Nine Precautions

6. Providers must have the capacity to respond to new payment models for the payment model to succeed. Payment reform without delivery system reform accomplishes nothing.
7. Providers are averse to risk of financial loss, and risk of financial loss motivates behavior change.
8. Nobody can say definitively which payment model works best, or which payment model works best with what types of providers or services in what type of market.
9. FFS alternatives can motivate improved efficiency, but market power trumps any payment model.

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Still...

- Despite all of the aforementioned complexities, challenges and uncertainties, fee-for-service payment still directly contributes to:
 - to overuse of services
 - lack of care coordination
 - failure to deliver valuable but unreimbursed services, and
 - health care cost inflation
- For these reasons, we'll now consider the principal alternative payment models to FFS payment.

Alternative Payment Models Used by States

- We'll review five alternative models.
- These models can be used separately or in combination with one another.
- Payers will often use different models with different types of providers and in different types of contracts.
 1. Supplemental Payment, e.g., PCMH
 2. Pay-for-Performance
 3. Episode-based Payment
 4. Population-based Payment
 5. Global Budget

1. Supplemental Payment

- Generally a per member per month (PMPM) payment, supplementing another form of payment - often FFS.
- Purchasers or insurers pay qualifying providers a pre-determined sum for each qualifying patient every month to support specified activity (e.g., in a PCMH, enhanced outreach, communication, coordination and care management).
- Payments sometimes vary based on patient characteristics and are based on enrollment or attribution.

2. Pay-for-Performance (P4P)

- CMS has defined P4P as: “the use of payment methods and other incentives to encourage quality improvement and patient-focused high value care”
- There are different types of P4P, but generally it:
 - offers providers a financial bonus for excellence and/or improvement on specific performance measures (e.g., access, quality, efficiency)
 - continues to use FFS as the underlying mechanism of payment

3. Episode-based Payment

- Episode-based payment sets a budget for an “episode of care.” Episodes typically involve all care delivered specific to the treatment of a well-defined condition or for a procedure, spanning multiple providers. Episode examples:
 - Coronary artery bypass graph (CABG)
 - Upper respiratory infection
 - Colonoscopy
- Because episode-based payment sets a budget for each episode, it rewards efficiency. Providers are motivated to save money by reducing cost variation, including through prevention of avoidable complications.

4. Population-based Payment

- Population-based payment also defines a spending budget, but on a per capita basis for a broad population of patients for whom the provider assumes clinical and financial responsibility.
- Retrospective reconciliation to the target defines a population based on enrollment or attribution, and frequently includes risk adjustment.
- Providers can assume just “upside risk” (reward for savings), or also “downside risk” (responsibility for loss).
- Financial reconciliations typically adjust for performance on assessments of quality.

5. Global Budget

- Under global budget a provider entity agrees to accept clinical and financial responsibility for the health care for individuals living in a specified geographic region.
- Global budgets are often adjusted to reflect changes in the health status of the population, as well as changes in population size.
- Global budgets have been used with hospitals, but can be applied more broadly.

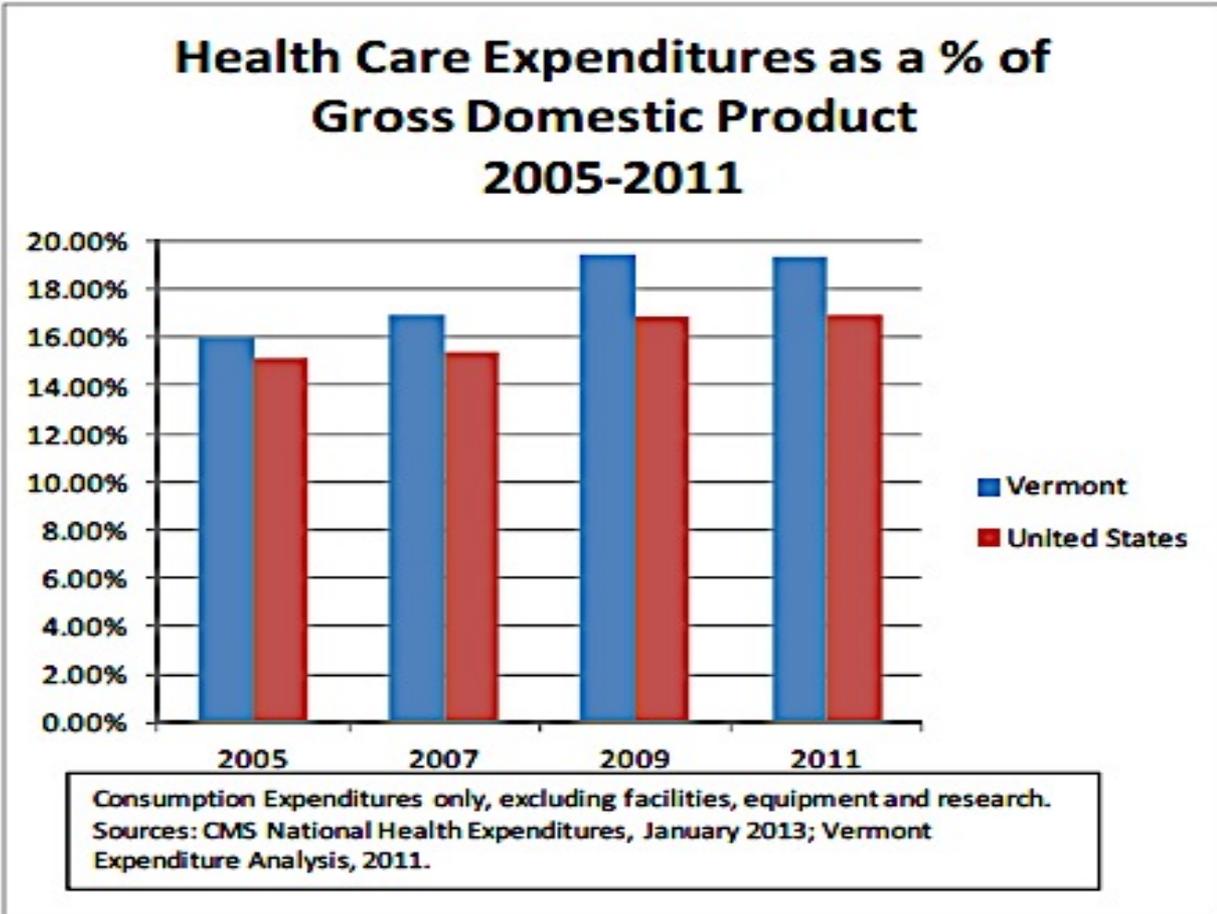
Five Models in Summation

- States are employing all five of these models, some with more frequency than others.
- Vermont is one state that has made a major commitment to payment reform.

Vermont Payment Reform Initiatives

Richard Slusky, Director of Payment Reform,
Vermont Green Mountain Care Board (GMCB)

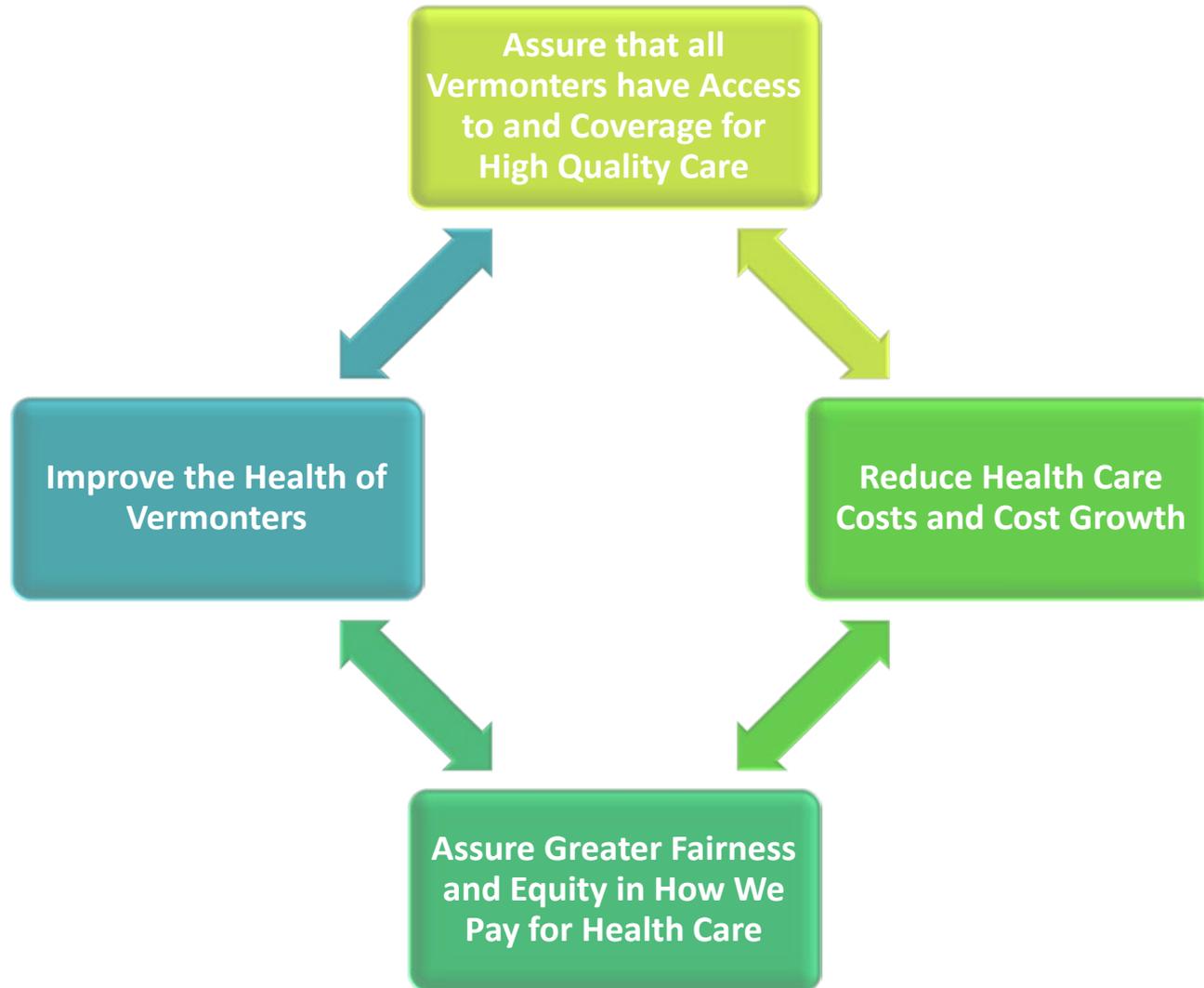
Vermont Has a Very High Proportion of Health Cost as % of Gross State Product (GSP)



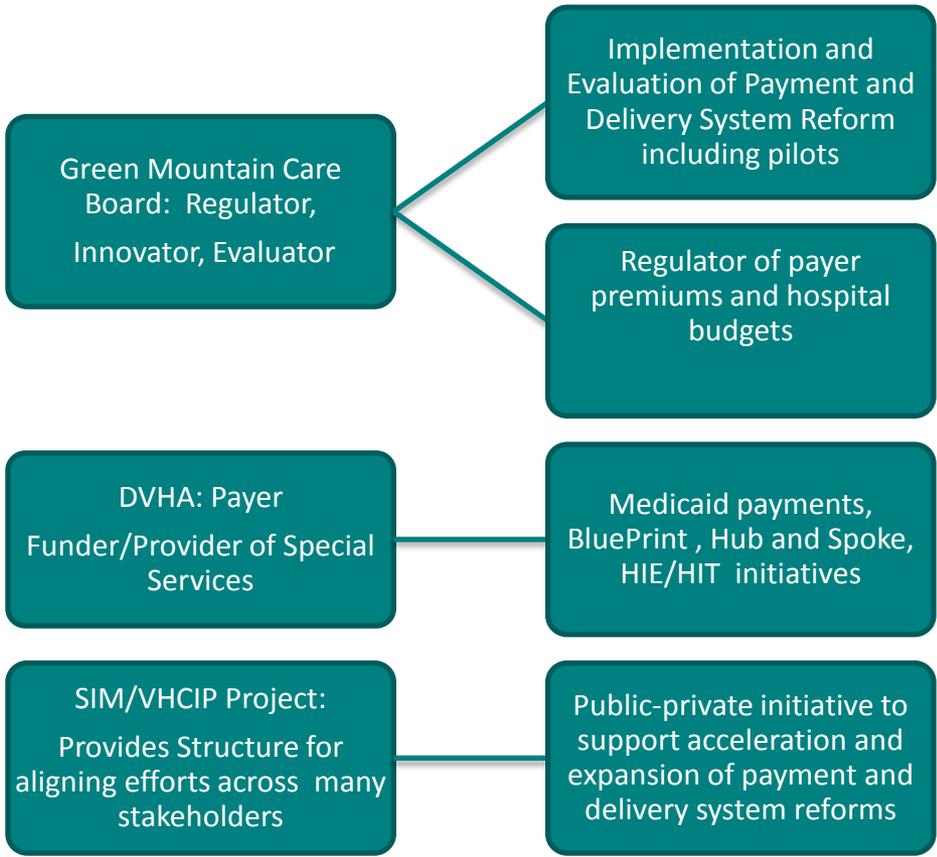
Source: study on payment variability conducted by the Vermont Association of Hospitals and Health Systems



Vermont's Health Reform Goals – “Universal and Unified Health Care System”



Green Mountain Care Board Role in Payment and Delivery System Reform



CMMI/SIM and RWJ Grant Funding and Payment Models

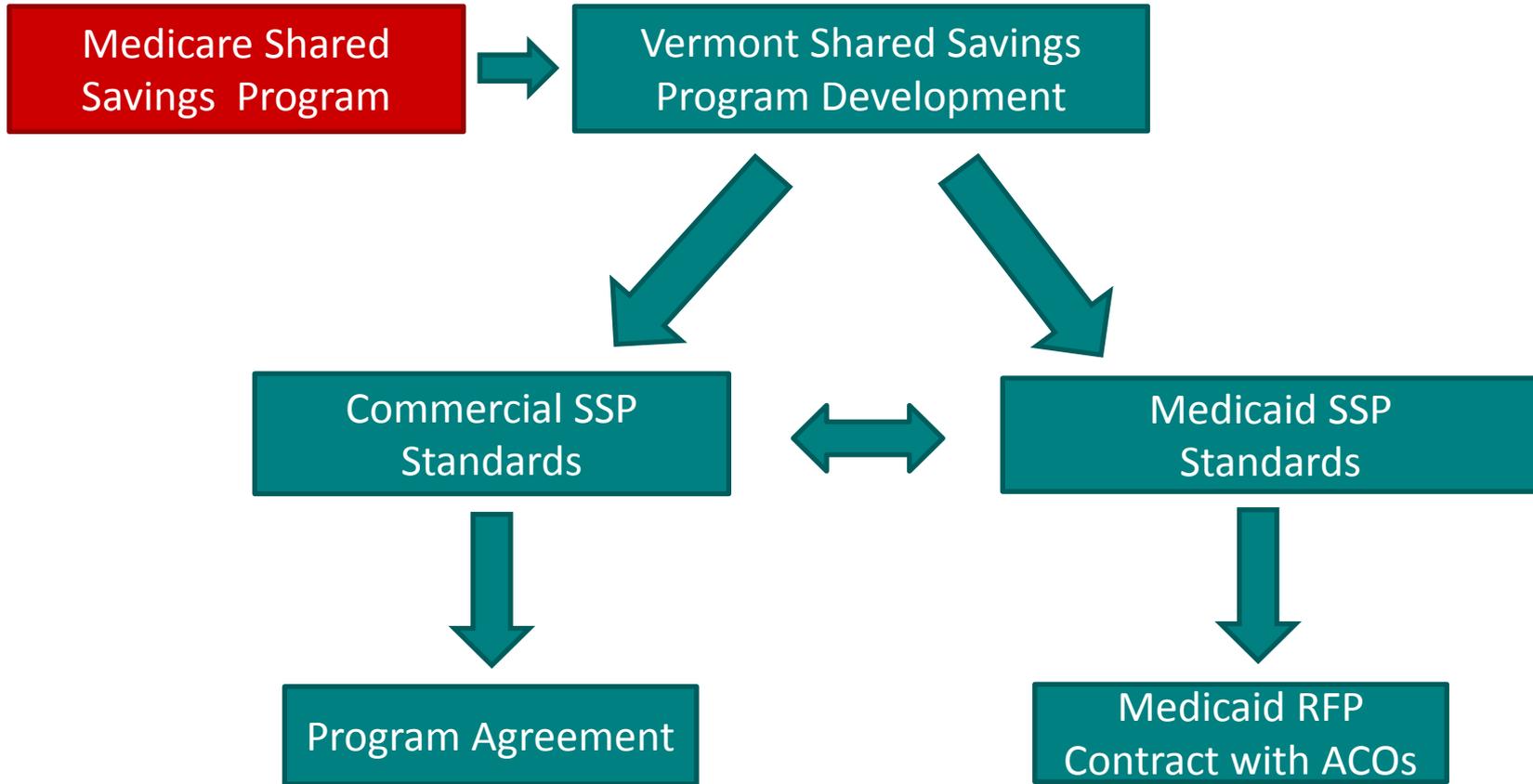
- CMMI/SIM Provides approximately \$45 million in funding and other resources over three years to support health care payment and delivery system reforms aimed at improving care, improving the health of the population, and reducing per capita health care costs, by 2017.
 - Provides resources to support the implementation and evaluation of the impact of value-based payment models;
 - Shared Savings/Accountable Care Organizations
 - Bundled Payments/Episodes of Care
 - Pay-for-Performance (P4P)
 - RWJ Funding Supports ACO and ECO development plus Global Budgets

Payment Models to be Tested Under the CMMI/ SIM and RWJ Grants



Grant Funding from Robert Wood Johnson Foundation and CMMI (SIM) support all four models

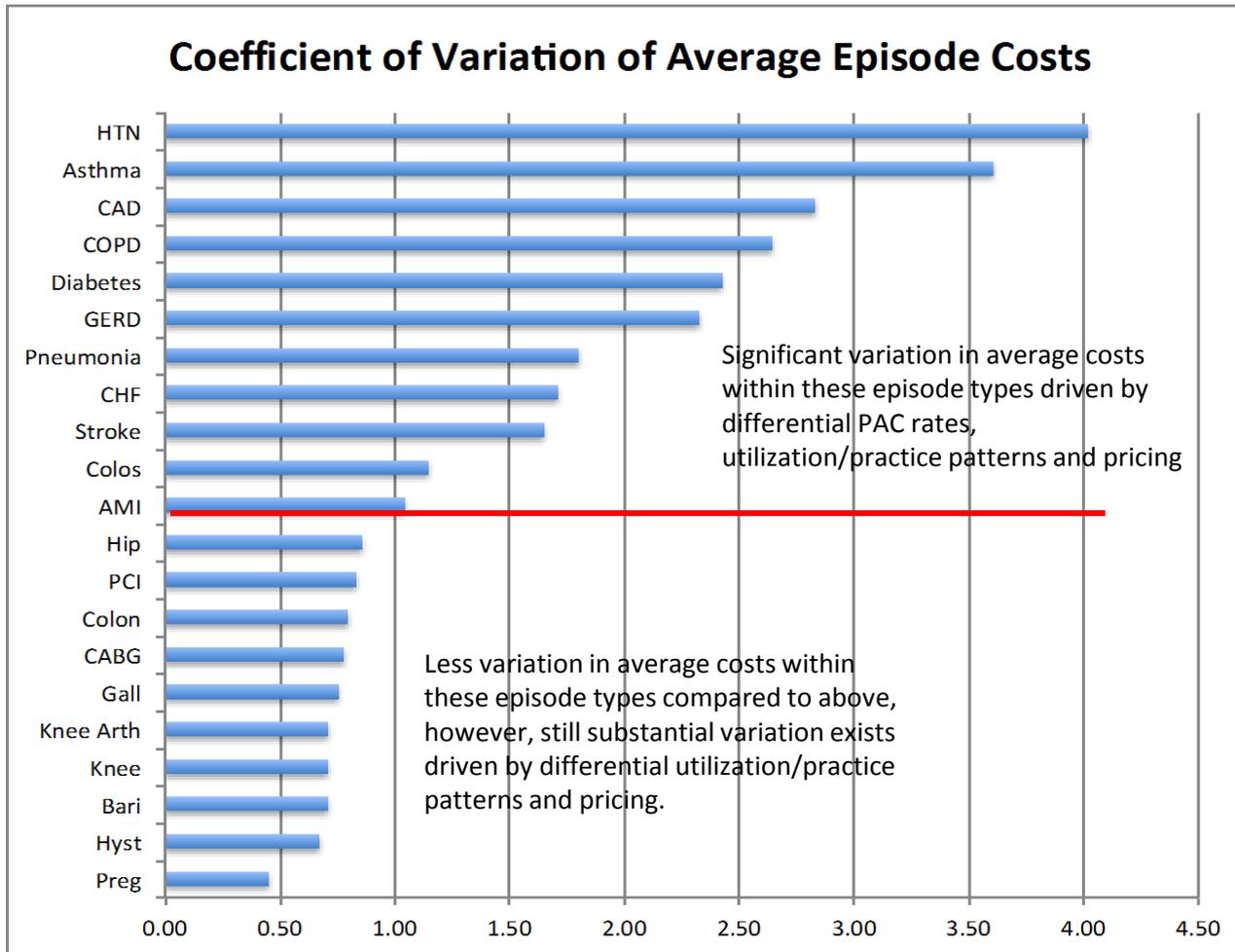
Development of VT Shared Savings Program



Episodes of Care (Definition)

- Patient-centered episodes of care for the treatment of an illness or condition
- They include all covered services related to the care of the condition as determined by tested, medically accepted clinical practice guidelines or expert opinion
- Time-delimited
 - Pregnancy and delivery episodes look back 9 months from delivery and one month post delivery
 - Joint replacements often include inpatient admissions and between 90-120 days post surgery

There is Substantial Variation in All Episode Costs



Why Episodes of Care Make Sense

- Provides clinical standards of care for specific conditions or procedures
- Promotes changes in care delivery through the sharing of data related to outcomes
- Proven to reduce potentially avoidable complications (PACs)
- Can be used as an internal management tool for ACOs in their attempt to reduce costs and improve quality
- Could be transformed into a payment model(s)
 - Bundled Payments
 - Pay for Performance

Hospital Global Budgets

- Provides predictable revenue stream for hospitals in the face of declining utilization
- Provides predictable payment stream for payers since there is essentially a cap on the hospital's expenditures in the event utilization increases
- Provides predictable growth in revenue and payments for the hospitals and payers over time
- Provides the State with health care expenditure growth that tracks with changes in inflation and demographics of the area

Hospital Global Budgets

- Moves away from FFS to a payment model that incentivizes value based care
- Provides incentives for hospitals to be more flexible in designing care models that better serve the health and health care needs of the population
- Promotes more integration between the hospital and community based providers

Hospital Global Budgets

- Issues to be resolved
 - Not clear how the global budget fits into the ACO/SSP model
 - How will savings be accounted for if the payers have guaranteed the hospital budget
 - Does this guarantee the status quo for all hospitals in the state---does that limit the ACO's ability to redesign the care system
 - Are the performance measures for global budgets the same as the ACO performance measures
 - Are hospital global budgets too narrowly focused—do they inhibit integration of care in a community/region

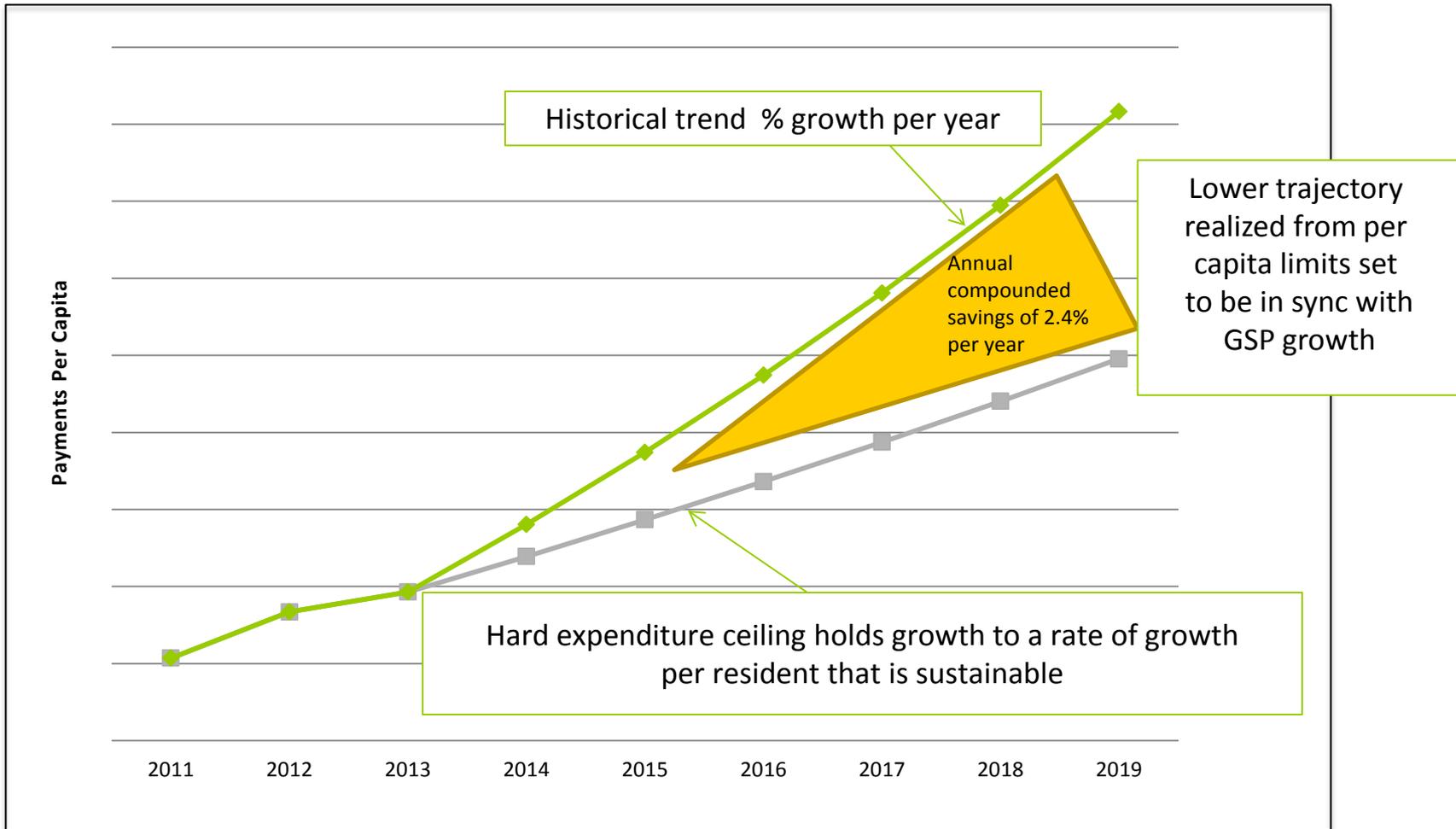
Regional Capitation

- Provides opportunity for a variety of providers in a region to better integrate care (Hospitals, PCPs/FQHCs, Specialists, Home Health, DA's, etc.)
- Promotes population based health and health care services in a defined region
- Moves away from FFS to a risk based payment model for defined services
- Provides predictable cost and revenue source for the payers and the regional providers

Regional Capitation

- Issues to be resolved
 - How regional populations will be defined and enrolled
 - Need to define the services and providers to be included under the capitation payment
 - Need to determine to whom the capitation payment be made and how payments for services will be made to other providers not in the risk model
 - How is the financial risk distributed among participating providers
 - Will the organization(s) assuming risk need to meet insurance regulations
 - How will quality be measured

Controlling Total Expenditure Growth Through Global Budgets or Capitation Payments



What are the Implications of Simultaneously Pursuing Multiple Payment Models

- Opportunity to test different approaches – many lessons to be learned
- Do the models conflict with each other?
 - How many times can savings be shared?
 - Should EOCs be viewed as a payment model or delivery system change, or both?
 - Are Capitation or Global Budgets an evolution of Shared Savings Programs or can they be incorporated into SSPs?
- Can the impact of each model be independently measured?
- How much change can the payers and providers manage?

Questions and Discussion

Contact Information for Presenters



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