NATIONAL INSTITUTE FOR HEALTH CARE REFORM

ADVANCING HEALTH POLICY RESEARCH

Provider Payment Reform

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Presentation to 2010 HealthCare Leaders Forum, Detroit, MI, April 27, 2010

CENTER *for* STUDYING HEALTH SYSTEM CHANGE

We Get What We Pay For

- Payers sending inadvertent signals to providers about types of care that are valued the most
  - Emphasis on volume
  - Procedures over management
  - Coordination has no value
- Providers responding to these incentives
- Response often involves increasing capacity
  - Capacity further increases use of those services
    - Especially physician-owned capacity

Two Distinct Aspects to Reforming Payment

- Getting relative payments for different services to better reflect relative costs
- Paying on the basis of units of service that are more reflective of what consumers seeking from delivery system
  - Solutions rather than services
    - Episodes of care
    - Management of chronic disease
    - Meeting medical needs

Pattern of Payment Structure Deviating from Cost Structure

- Surgical DRGs more profitable than medical DRGs
  - Magnitude reduced by CMS revamp of DRG methods
  - Distortions remain for per diem and discounted charges approaches

Pattern of Payment Structure Deviating from Cost Structure cont.

- Physician procedures involving new technology more profitable than evaluation and management services
  - Physician work component
  - Technical (facility) component
- Distortions not intended by payers

Vigorous Provider Response to Inadvertent Payment Incentives

- Hospitals pursue service line strategies
- Physicians invest in facilities
- Single specialty group mergers to reach scale needed for equipment-intensive services
- McAllen, Texas
- Physicians shifting to more lucrative specialties
  - Leading to primary care shortages

Capacity Leads to Higher Rates of Service Use

- Greater patient convenience
  - Third party payment changes calculus of patient convenience
- Self-referral incentives apply to more services
  - Not just physician professional time
  - Incentives likely more powerful when services highly profitable
  - Extra incentives when average costs much higher than marginal cost (major equipment)

Policies to Reduce Pricing Distortions

- Medicare best positioned to lead in this area
  - Credibility with providers
    - Engagement of provider leadership in its work
      - Value of RUC
  - Sufficient clout with many providers

Policies to Reduce Pricing Distortions cont.

- Private payers increasingly following Medicare payment structures
  - Extensive use of Medicare RVS
    - But need to deviate to accommodate provider market power
  - Trend toward adoption of Medicare outpatient methods

Policy Change in Relative Payment Structure Well Underway

- Phase-in of revamp of Medicare inpatient prospective payment mostly complete
  - Second generation DRG system
  - More accurate calculation of relative payment rates
- Long overdue update of practice expense relative values in Medicare RVS implemented 1/1/10
  - Impact already visible

Policy Change in Relative Payment Structure Well Underway cont.

- Policies in health reform legislation (PPACA)
  - 10 percent increase in payment rates for primary care services
  - Mandate to thoroughly update physician work values
    - Identify and adjust mis-valued codes
  - Revised assumptions on capacity utilization rates and larger reductions for multiple procedures

Governance Risks

- Increasing tendency for Congressional intervention in Medicare details
- Cardiology campaign to block 2010 revisions to physician fee schedule
  - Industry support leads to unlevel playing field among physician specialties

Broader Units of Payment

- Wide range of approaches possible
  - Some compatible with others
- Some ready for broad implementation
  - Penalties for avoidable hospital readmissions in PPACA
    - Reduced inpatient infections
    - Better transitions to community care
  - Bundling post-acute care
- Others need further development and testing
  - How to pursue this more deliberatively and rapidly

Promising Approaches under Development

- Patient centered medical homes
  - Pay for coordination and patient education
  - Numerous initiatives by private insurers
    - BCBS of Michigan pays higher rates for qualifying practices
    - Massachusetts General Hospital experiment
  - Medicare demonstration supplements FFS with partial capitation

Promising Approaches under Development cont.

- Bundled payment per episode
  - Innovation is inclusion of multiple providers
  - Episode grouper to assign services to episodes
    - Transparency of public grouper important for physician acceptance
  - Private plan contracting with hospitals and physician in select specialties for select episodes
  - Medicare ACE demonstration for selected orthopedic and cardiovascular episodes

Promising Approaches under Development cont.

- Can this work for management of chronic disease?
  - How effectively can groupers adjust for severity and multiple conditions?
- Debate on appropriateness for discretionary procedures
  - Does episode-based payment increase incentive to recommend procedures?

Promising Approaches under Development cont.

- High Performance Networks as early stage episode payment
  - Apply grouper across a specialty
  - Evaluate *all* claims costs
  - Rewards limited to lower patient copayment

Promising Approaches under Development cont.

- Numerous problems with implementation to date
  - Lack of transparency to physicians
  - Inadequate claims data to make assignments
  - Inconsistent results across payers
- Collaboration among payers can increase success
  - Like Integrated Healthcare Association approach to P4P

Promising Approaches under Development cont.

- Accountable Care Organizations
  - Incentives based on spending per enrollee
  - Shared savings models--Capitation “lite”
  - Focus on real organizations with contracts rather than creations from analysis of claims data
  - But enrollee attribution to ACO based on analysis of past or current claims data

Payment Methods for Bundled Approaches

- True bundled payment versus shared savings
  - Clear preference for bundled payment due to stronger incentives
  - But not always feasible
    - Accuracy of risk adjustment
    - Provider agreements to share risk
    - Provider capacity to take risk
    - Consumer willingness to accept physician referral

Payment Methods for Bundled Approaches cont.

- Importance of reforms to relative payments under FFS
  - FFS basis of bundled payment rates
  - Shared savings cannot succeed without reformed relative payments in FFS
    - Existing distortions in FFS may be stronger than shared savings incentives

Approach to Development and Piloting

- PPACA gives extensive authority to HHS Secretary
  - Contract with ACOs
  - Pilots for bundled payments for episodes
    - Authority to expand successful pilots and implement
  - Center for Medicare and Medicaid Innovation
    - Opportunity to bring new talent/resources into CMS

Approach to Development and Piloting cont.

- Extensive experimentation by private payers and providers
  - Large hospital systems with captive health plans well positioned, e.g. Geisinger
  - Dominant Blue plans also well positioned

Role of Insurance Benefit Structure

- Limits of purely supply side approach
  - Provider rewards limited to higher payment rates
    - No opportunity for more patients
  - Risk of lack of political support for strong incentives
    - “My favorite hospital is endangered”
  - Does not address issue of provider leverage against private plans

Role of Insurance Benefit Structure cont.

- Current benefit structures have few rewards for choosing more efficient providers
  - Even large deductibles provide little incentive when they are exceeded

Role of Insurance Benefit Structure cont.

- More meaningful payment units expand potential for using price incentives
  - More confidence in ability to choose efficient prices
  - Broader units can simplify incentives for consumers
    - Higher copayment per day/stay for less efficient hospitals
      - Consumer needs to focus on only one number

Role of Insurance Benefit Structure cont.

- Ultimate provider choice incentive is reference pricing
  - Reference price is the low-cost adequate quality provider
- "Cadillac" tax will eventually motivate such benefit structures

Coordination of Payers

- Payer fragmentation a large barrier to payment reform
  - Provider investments unlikely when only a minority of patients affected by reformed system
  - Facing distinct incentives for different patients dilutes provider incentives from reformed payment structure

Coordination of Payers cont.

- Approaches to coordination
  - Medicaid programs and private payers follow Medicare lead
  - States specify payment systems and seek waivers to include Medicare

Coordination of Payers contd

- Challenges to approaches
  - Medicare as lead
    - Potential slow pace
    - Limited potential to differentiate approach by market
    - Could make wrong decision
  - State specification
    - Could make wrong decision

Coordination of Payers cont.

- Reducing risks to success
  - Medicare invites private insurers to work with it on pilots
  - Allow more experimentation before settling on a reformed payment system

Market Issues

- Will Medicare payment reforms increase provider leverage with private insurers?
  - Payment reform increases incentive for vertical integration
    - Evidence of hospitals negotiating higher rates for physicians

Private Payers

- Potential for Medicare to work with private payers
- Distinct problem of private payer market power
  - Especially in hospital care
- Two basic strategies
  - Patient incentives to choose less expensive providers
  - All-payer rate regulation
  - Neither a part of health care reform

Concluding Thoughts

- Payment reform may have greatest potential to "bend the trend" of medical spending
- Medicare well positioned to lead
- But Medicare's potential to lead needs shoring up
  - Insulation from Congressional and White House intervention in payment decisions
  - Reliable resources to perform technical functions
- Limitations in private payer market power will need to be addressed