Payment Reform

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Payment Reform

- The consequences of the Fee-for-Service Payment Model
- The Goals of Payment Reform
- The New BCBSM Payment Model

The Current System
Fee for Service (FFS)

- Only billable services are delivered.
- Pressure to lower unit costs (widen the gap between input costs and payment).
- High margin services become high volume services.
- For high fixed cost services, capacity drives demand.
  - "A built bed is a filled bed is a billed bed."

Fee for Service

- Non-billable services are reduced to a minimum: coordination of care, decision support, process re-design (except to increase throughput).
- Preventing “Potentially Avoidable Complications” lowers payment to treat complications of care.
- ‘Systems of Care’ consists of efficiently organizing the care process to deliver more billable services more efficiently, not better manage a population.

Goals of Payment Reform[1]

- Flexibility to Deliver Highest Value Services
- Ability to Remain Profitable by Keeping People Healthy
- Lower Payment and Loss of Patients for Lower Quality Care
- Adequate Payment without Need to Cross-Subsidize
- Providers Paid More to Care for Sicker Patients

[1] How to Create Accountable Care Organizations by Harold D. Miller. www.CHQPR.org

And I would add…

- Explicitly reward population focus.
  - Identifying the population served
  - Setting population-based goals
  - Process management and improvement
  - Tracking performance to goal
- Introduce performance risk, not insurance risk.
- Transition the payment model in tandem with the practice model so that incremental improvement is rewarded.
- Avoid requiring large investments and burdensome process changes in reforming reimbursement.

New Payment Model: Reward Population level performance

- **Tiered fees**
- **Steerage** to high performing providers
- **Privileging**: Allowing only high performing providers to be paid for certain services, such as imaging.
- **Shared Savings**: reward improvements in resource management by sharing savings with providers.
- **Payments to Provider Organizations** for investments in performance-improvement (PGIP reward pool)
- **Bundled Payments** expand the DRG-based hospital payment system to other services, such as chronic conditions and certain surgery packages.

Tiered Fees

- High performing primary care practices are designated as “Patient Centered Medical Homes” and paid 10 percent more for selected services.
- PCMH designated practices in high-performing physician organizations are paid an additional 10 percent more. (120 percent of standard fees for evaluation and management services).

Steerage

- Patient volume is steered to PCMH-designated practices first by communicating such practices to members and later through product designs that enhance benefits.
- Provide PCMH-designated physicians with performance information of specialists and facilities to utilize and reward high-performance providers.

Privileging

- Limits payment for selected services to designated providers.
- Limits over-utilizing physicians without excluding them from the network.
- Incentivizes judicious management of resources.
- Allows limited approval of new technologies to providers with known track record for responsible use.

Shared Savings Programs

- Formula that compares population-level performance of physician organizations and defines how the savings are identified.
- A percentage of savings are distributed to physician organizations or physicians based on formula.

Payment to Provider Organizations

- Reward physician organizations based on population-based performance metrics (absolute and improvement)
- Reward investments in performance improvement such as Lean transformation events, building information infrastructure to track performance (MPAC)
- Defray costs of participation in provider-based utilization management programs (Oncology COPI and Chemotherapy Prior-Authorization program).
- Defray costs of vendor support for provider-based utilization management programs.

Bundled Payments

- Very complex analytics and payment processes. (Stimulus package for administration?)
- Major practical issues: payment delays, bundling covered and non-covered services, handling recoveries, etc.
- Commercial Health Plans will need to evaluate Medicare payment programs that employ bundled payment arrangements.
- Not population-based: incentive to treat less difficult patients and increase number of episodes billed.

BCBSM: Current Status

- ~ $100M of 2.7B paid to professional providers is performance based.
- ~ $180 of 4B paid to facilities is performance-based.

Summary

- Transformation of healthcare delivery is a long-term, stepwise process that must occur in tandem with payment changes that link higher payments to better performance.
- Payments must reward performance improvement and promote the delivery of high-value services that are not payable today.
- The payment model must provide a clear link between short-term savings and investment in performance improvement infrastructure.