Provider Payment Reform

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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