Payment Reform
Most healthcare services are reimbursed with a fee-for-service model.

- Pay regardless of quality, outcomes
- Pay for every test and procedure regardless of necessity
- Doesn’t pay for some important aspects of care – like coordination
The Objectives of Payment Reform

- To pay for the care we want, including better prevention, care coordination and disease management
- To not pay for care we don’t want (wasteful/harmful care)
- To incentivize and reward providers for delivering high-quality, efficient care
- To remove financial barriers to improving the deliver of healthcare
The Elements of Value-based Payment Reforms

- Payment that reflects provider performance, especially the quality and safety of care that providers deliver;

- Payment methods that are designed to spur efficiency and reduce unnecessary spending;

- If a payment method only addresses efficiency, it is not considered value-oriented; it must include a quality component.
Payment Framework

BASE PAYMENT MODELS

Fee For Service | Bundled Payment | Global Payment

Charges | Fee Schedule | Per Diem | DRG | Episode Case Rate | Partial Capitation | Full Capitation

Increasing Accountability, Risk, Provider Collaboration, Resistance, and Complexity

PERFORMANCE-BASED PAYMENT OR PAYMENT DESIGNED TO CUT WASTE
(financial upside & downside depends on quality, efficiency, cost, etc.)
### The Payment Reform Continuum

<table>
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<th>Type</th>
<th>Examples</th>
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| **Upside only for providers**       | Physicians  
  • Primary Care Medical Home/payment for care coordination  
  • Payment for shared decision making  
  • Payment for nontraditional visits (e.g. e-visits)  
  • Hospital-physician gainsharing  
  • Pay for Performance  
  • Shared savings  
  Hospitals  
  • Pay for Performance  
  • Shared savings |
| **Downside only for providers**      | • Hospital penalties (e.g. readmissions, Hospital Acquired Conditions, never events, warranties, Length of Stay) |
| **Two-sided risk**                   | • Bundled payment  
  • Global payment/capitation  
  • Shared-risk in Accountable Care Organizations |
Pay-for-Performance/Bonus Payments

- A pay-for-performance model provides performance incentives to providers for increasing quality of care and/or reducing costs
- Incentives paid on top of fee-for-service payments
Pay-for-Performance/Bonus Payments for Quality/Efficiency

Example:

- Bridges to Excellence (BTE) recognizes physician practices that meet performance benchmarks
- Participating physicians earn both peer recognition and bonuses from participating health plans.
Payments Not Tied to Individual Services or Visits

- Providers get incentives not tied to fee-for-service payments, such as a payment for care coordination given to patient-centered medical homes.
Payments Not Tied to Individual Services or Visits

Example:

- Payment and shared savings for care coordination and case management in a patient-centered medical home (PCMH).

- CareFirst Blue Cross Blue Shield annual medical cost increase dropped to 2 percent for 1 million members in its medical home program.
Bundled Payment

- A single payment to providers or healthcare facilities (or jointly to both) for all services to treat a given condition or to provide a given treatment
- Also known as “episode-based payment”
- Providers assume financial risk for the cost of services for a particular treatment or condition
Bundled Payment

Example: Surgery Center of Oklahoma

- Flat-fee, all-inclusive pricing for dozens of procedures
- Quotes prices on its web site
Shared-Savings/Shared Risk Models

- Shared savings
  - Providers paid to provide care for a defined population
  - Providers are incentivized to reduce unnecessary spending because they share savings with payers

- Shared risk
  - Contracts go one step farther: Providers not only share savings, but accept financial liability if they do not meet targets
Shared Risk

Example:

- Blue Shield of California, Hill Physicians and Dignity Health formed ACO to serve CalPERS

- ACO reduced Blue Shield premiums for CalPERS beneficiaries by $59 million, or $480 per member per year, over 3 years

Source: The Commonwealth Fund's Case Studies of Accountable Care Systems
Non-Payment Policies

- Providers do not get paid for performing services that are deemed harmful or do not contribute positively to the care process
Payment Reform Strategies

- **Non-Payment Policies**

  **Example:**
  - South Carolina Medicaid and Blue Cross Blue Shield of South Carolina teamed up to stop paying for early elective deliveries
  - Policy realized substantial savings
Full Capitation/Global Payment

- Health plan pays a fixed dollar payment to providers for the care that members receive in a given time period, such as a month.
- Payment adjusted for performance and severity of illness of the patient population.
Pairing Benefit Design & Payment Reform
Why Discuss Pairings of Benefit Designs and Payment Reform?

- Benefit design and payment reform are equally important
- Benefit design is taking on broader meaning
- Some promising payment reforms are slow to be adopted – benefit design could make a difference
- If doctors and patients work together, in the same direction, outcomes and value are more likely to improve
 Benefit Designs in Play Today

- Benefit design features fall into the following five domains:

  1. Cost sharing
     - Co-insurance, co-pays, deductibles
  2. Financial incentives around lifestyle choices and use of services
     - Consumer-directed healthcare
     - Value-based insurance design
  3. Financial incentives around choice of provider
     - Reference pricing
     - Centers of excellence
     - Narrow networks
  4. Policies
     - Prior authorization
     - Required referrals to specialists
  5. Transparency
     - Price and quality
Reference Pricing establishes a standard price for a drug, procedure, service or bundle of services, and generally requires that health plan members pay any allowed charges beyond this amount.

Consumers seeking care from providers above the reference price may be subject to additional out-of-pocket financial liability.

Consumers seeking care from providers at or below the reference price are typically responsible for normal or no cost-sharing.

What is Reference Pricing?

Catalyst for Payment Reform
CalPERs sets a reference price of $30,000 for hip/knee replacement surgery.

Members who seek care at a higher price provider pay the difference above the reference price.

- In the first nine months:
  - Number of enrollees who chose a designated high-value hospital increased from 50% to 64%
  - Average price fell from $42,000 to $27,000

- 40 hospitals cut prices
What is a Narrow Network?

- Plans with **narrow networks** of providers limit the doctors and hospitals their enrollees can use.
  - Go to doctor A or hospital A, and the plan will pay all or most of the bill
  - Go to doctor B or hospital B, and the enrollee may have to pay all or most of the bill herself
Effective Pairing: Narrow Network & Shared Savings (and Risk)

- Intel has a direct contract with Presbyterian Health System (PHS)

- Employees who select the PHS option must use a narrow network of PHS providers
  - Intel pays PHS directly to manage quality and cost
  - PHS shares in both savings and risk
What is Case Management for High-Cost Employees?

- Specially trained, multidisciplinary teams coordinate closely with primary care teams to meet the needs of patients with multiple chronic conditions or advanced illness.
Effective Pairing: Case Management & Shared Risk

- Blue Cross Blue Shield of North Carolina created program to identify patients who frequently use emergency rooms
  - Identifying and educating identify high ER users eliminated 1,300 inappropriate ER visits in a year

- Case management pairs well with shared risk.
  - Incents providers to work in cross-disciplinary teams to ensure the needs of complex patients are being met outside the hospital.