Provider Payment Reform Options: Aspiration Meets Reality

Presentation for Connecticut Health Policy Project

Robert A. Berenson, M.D.
(rberenson@urban.org)
Institute Fellow
The Urban Institute

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Policy Priorities in Medicare (Congressionally directed)

- Value-based purchasing (a euphemism for pay-for-performance) for most provider systems, including physicians
- New payment models in demonstrations: shared savings, bundled episodes, some attention to correcting distortions in the resource-relative value scale-based Medicare Fee Schedule
- New organizational delivery models, esp. accountable care organizations and medical homes

From Volume-based to Value-based Payment

- About the only area in health policy that Republicans and Democrats agree on
- For all of the Republican objections to Obamacare, there generally have not been major Republican objections to the payment/delivery system reform parts of the ACA
- See, for example, the deal in the SGR Repeal Bill (not enacted because they could not agree on a "pay-for") – close to a 20% swing on physician payment based on what is now being called Merit Based Incentive Payment -- the merger of the PQRS, the value-based payment modifier & meaningful use incentives

But What Do We Really Mean by "Value" in Health Care?

- In current health care policy parlance, Value = Quality/Costs and is used in a loose sense to mean a "bigger bang for the buck,"
  - relying on studies showing that the extra 60% the US spends on health services does not buy better health or health care
- But there is no quantitative precision to this equation -- is value increased when quality increases at higher cost?

The Quality Numerator

- Quality is measured differently for different quality items, e.g., % compliance with a process of care standard, 30-day mortality rate for a condition, patient experience from surveys, etc.
- There is no common metric like quality-adjusted life years (QALYS) as used in cost-effectiveness analysis
- We have good measures in some areas, but few or none in other important clinical domains, e.g., diagnosis errors, appropriateness of services, complex care management
- Identifying a measure gap doesn't mean it can readily be filled (which Congress doesn't seem to understand)

The Cost Denominator

- Costs are usually measured as dollars spent but for some purposes can also be measured as the rate of increase in dollars spent, as in “bending the curve”
- Even with something as seemingly straight-forward as dollars spent, there are disagreements on how to measure and report costs, beyond mistaking charges for costs
- Highly unreliable attribution of costs to a clinician or organization, unless you have a population-based metric, such as per person per month spending, for individuals somehow assigned to an organization for care

Dueling Aphorisms

- "You can't manage what you can't measure."
  - Apparently not W. Edwards Deming, to whom this is usually attributed

- "Not everything that can be counted counts, and not everything that counts can be counted."
  - guess who?

No, Not Albert Einstein but rather a sociologist named William Bruce Cameron

With the ACA, Value Payment Has Rightly Moved From P4P to Basic Payment Approaches

- The presentation will generalize about pros and cons of a range of payment methods, mostly for clinicians but some for hospitals
- But it is very hard to generalize because context/ culture and design features strongly effect behavioral response by providers
  - Capitation response depends on generosity of the PMPM and whether penalties for referring out
  - Salary for physicians at a multispecialty group practice performs differently from salary when hospitals buy independent docs and use it

Fee-For-Service

Pros –

- Rewards activity, industriousness
- Theoretically can reward desired, less provided activities
- Implicitly does case-mix adjustment
- In common use – do we want a disruptive payment technology?

Cons –

- Produce too much activity, clinician-induced demand
- Maintains fragmented care provided in silos
- High administrative and transaction costs
- What is not defined as reimbursable may be marginalized – and not everything can be defined
- Complexity makes it susceptible to gaming and fraud

Key Challenges

- Many non-face-to-face activities do not lend themselves to coding and payment in a fee schedule – especially for patients with disabilities and chronic conditions
- Despite growing evidence that payments to marginal cost are distorted in most fee schedules, politically difficult to correct the problem – tilting the system to tests and procedures rather than time spent; spawning inappropriate overuse of services; and self-serving, self-referral abuse
- Despite volume to value aspiration, FFS cannot be wished away, newer forms of payment will still heavily rely on FFS

PPPM – Per Person Per Month (Population-based payment/ Capitation)

Pros –

- Internalizes allocation of activity and costs to meet needs
- Direct incentive to restrain spending
- Predictable and capped spending
- Administratively simple (until address some of the problems)
- Low transaction costs

Cons –

- May lead to stinting on care
- Susceptible to cream-skimming and code creep – even more so than now because providers, now directly bear financial risk
- Incentive to cost shift to services outside the PPPM
- Can't specifically promote desired activity

Key Challenges

- Risk adjustment to protect against cream-skimming improving but still behind ability of the at-risk entity to select based on health status
- There are good quality measures in some areas, e.g., prevention services, so stinting can be detected here, but not in other important areas, especially referrals for specialized expertise
- Because consumers are not committed to a particular plan or provider group beyond a year, the “business case” for reducing long-term illness burden is reduced

Shared Savings (as generally but not universally implemented)

Pros –

- Provider's own experience fundamental to setting the spending target – so potentially achievable
- Payer doesn't spend more if savings are not generated
- Targets the most inefficient, so greater prospect for early savings
- No change in base payment methods required – a new layer
- An "on-ramp," "training wheels" – pick your metaphor

Cons –

- No change in base payment methods – so concern that this diverts attention from more fundamental change
- The incentives on the recipient, e.g., an ACO, may be different from those on its constituent members
- Lack of normative or community spending standards leaves best performers out in the cold -- better performers view as unfair
- Only a transitional model at best?

Key Challenges

- How and when to introduce financial risk – to remove the training wheels
- Finding the right balance between targets based on a provider's historic performance and a normative or community-standard such as % of premium
- Can a provider organization like an ACO manage risk when patients have freedom of choice of provider? Can we implement a kind of "soft" lock-in approach?

Bundled Episodes

Pros –

- Internalizes incentives for efficiency within the episode
- Potentially aligns incentives across a few siloed providers
- Arguably, is an intermediate step on the way to real integration
- Supports “focused factory” innovation for some services

Cons –

- Does not fundamentally alter incentive for more units of service
- Be careful about what you wish for, i.e., physician-hospital alignment without determination of appropriateness in a volume-based payment environment
- Chronic care episodes contradict holistic approach to care
- Operationally challenging (esp. for ambulatory care) – vagaries of diagnosis (more episodes in Miami than Minnesota), bias to performance of a procedure in a case rate, sorting out where particular claims are assigned to, etc.

Key Challenges

- Ongoing “political” challenges of getting different provider organizations to agree to be team – and divide the pie
- Assuming some but only some care is amenable to the approach, where does it get us? Lots of effort for marginal benefit?
- Successful implementation in a “Center of Excellence” does not necessarily translate into success if broadly adopted in payment policy – especially on the issue of appropriateness (see NY Times Sunday on knee replacements)

Public Reporting and Pay-for-Performance (P4P)

Pros –

- The theoretical case for rewarding desired behavior in particular areas of care is viewed by some as “compelling”
- can start to actually reward desired performance --“value,” instead of rewarding volume of services
- can include measures of patient experience so that it is not all about technical clinical issues

Cons –

- underdeveloped measure set – especially for physicians
- what gets measured gets done? At the cost of other quality
- marginal incentives may be insufficient to counter basic incentives in whatever base model it is superimposed over
- contributes much more administrative complexity
- may be conceptually flawed by “crowding out intrinsic motivation” of professionals

Public Reporting and Pay-for-Performance (P4P) – cont.

- Process measures commonly used don't predict outcomes – see Premier Hospital Demonstration findings
- Major gaps in current measure sets that may not be filled any time soon -- diagnosis errors (5-15% of care across medical care settings), inappropriate interventions, care for multi-morbidity patients are not measured
- Current state of the art of performance measurement suggests that ratings can provide misleading and unfair snapshot of performance – the worst will be the Physician Value-based Modifier in Medicare if it goes into effect by 2017 as current law requires
- Yet, what else do we have to get on with the movement of volume to value – the more fundamental, reformed payment approaches are all challenging