

Applying Alternative Payment Models to Manage Costs and Promote High-Quality Care

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PURCHASING

Our Search for a Solution

- We have long been seeking “the solution” for managing health care cost and quality (and especially cost).
 - Regulation
 - Competition
 - Regulation and competition
 - Managed care (HMOs)
 - Preventive care
 - Wellness programs
 - Consumer engagement
 - Disease management
 - Super-utilizers
 - Medical homes
 - Etc...

The Answer

- There isn't one answer (surprise).
- Addressing payment design is *part* of the answer, however, because our traditional payment model is certainly part of the problem.
- Today service providers (clinicians, facilities, etc.) are generally paid per unit of service.
- This payment model is inherently inflationary...and doesn't reward desired behaviors.

The Effects of Fee-for-Service Payment

- What economic incentives do FFS payment create?
 - Deliver more services
 - Deliver more services with high profit margins.
- What economic incentives do FFS payment *not* create?
 - Coordinate service planning and delivery with other health and non-health care providers and supports
 - Deliver care that is patient-centered and maintains or improves patient health status and well-being
 - Eliminate overuse and misuse (30-40% of health care spending)

Oregon Initiatives Involving Payment Change

- Two major state initiatives seek to advance alternatives to FFS:
 - Oregon's 1115 Waiver
 - Patient Centered Primary Care Homes (PCPCH)

Oregon's 1115 Waiver Requirement

- Through Oregon's 1115 Waiver, CMS requires the following of the state and its contracted CCOs:
 - *“Incentives must be correlatively reflected in the CCO/provider agreements to ensure that the incentives are passed through to providers to reflect the arrangement with the State CCO contract.”*

So what models might CCOs utilize?

- Note that the waiver language speaks to “incentives”
 - not all incentives relate to payment!
- Payment incentive models
 - Pay-for-performance
 - Supplemental payment
 - Episode-of-care payment
 - Population-based payment
- Non-payment incentive models
 - Volume incentives
 - Recognition incentives

Pay-for-Performance and its Pros

- Synonym: Quality bonus *and* service bonus
- How it works: (2 ways)
 - Based on quality score: benchmarks set, data collected either from claims or clinical audit, providers rewarded for meeting or exceeding benchmarks, or
 - Bonus payment for each desired service delivered (e.g., adolescent well-care visit).
- Pros:
 - Relatively simple to understand and administer: can be overlaid on existing FFS claims systems with little reconfiguration
 - Can be applied in instances in which other payment models may not be feasible.

Pay-for-Performance: Cons

- Does not explicitly lower costs in most cases, and can raise costs through additional payments without hoped-for changes in utilization
- Still linked to inherently volume-based FFS system – near-impossible to create a large enough bonus to overcome the volume incentive

Supplemental Payment and its Pros

- Synonym: infrastructure payments
- How it works:
 - Upfront payments provide support to build out functions that potentially improve quality and reduce avoidable utilization
- Pros:
 - Addresses upfront access to capital issues for providers, e.g., cost of hiring care managers in a primary care office
 - Can be administered in parallel to existing claims payment systems

Supplemental Payment: Cons

- Assumes supplemental payments will be well-invested by the provider and that the infrastructure investment will produce value
- Heavily dependent on provider buy-in and good faith

Episode-of-Care Payment and its Pros

- Synonym: bundled payment (but not really)
- How it works:
 - Shared payment across providers for a single episode of care
 - Fixed time period payment to hospital, physicians and rehab therapists together for a hip replacement
 - Combined payment over time for a chronic condition
 - Annual physician payment for congestive heart failure patient
- Pros:
 - Aligns incentives to reduce errors/waste in process between independent actors by payment in FFS
 - Rewards providers for finding more effective and efficient care protocols (clinical pathways)

Episode-of-Care Payment: Cons

- Does nothing to decrease the *incidence* of episodes (the FFS volume problem)
- Most payers are configured to pay FFS; it is complex and expensive to administer episode-of-care payments
- Requires risk adjustment to deter cherry-picking

Population-Based Payment: Shared Savings

- Synonym: up-side risk
- How it works:
 - Payer and provider define an “expected” spending amount for a defined population of payments – if spending falls below, provider and payer share in savings
 - Savings distribution usually informed by performance on a set of quality measures.
- Pros:
 - Creates a significant financial incentive for providers to strive to reduce costs and/or cost growth
 - Can incorporate a quality incentive and thereby balance cost reduction and quality improvement incentives
 - Protects providers from downside risk

Population-Based Payment with Shared Savings: Cons

- Some believe that the model does not provide a strong enough financial incentive because providers need the fear of downside loss to make transformative change
- Difficult to implement at the population level for small patient populations (e.g., less than 5K to 20K depending on the population risk profile)
- Methodologically complex
- Requires patient attribution
- For providers, limits potential financial gain

Population-Based Payment: Shared Risk

- Synonym: global payment, total cost of care payment, capitation
- How it works:
 - Identical to population-based payment with shared savings, except that providers can experience some form of financial loss if they exceed the budget for the population
- Examples:
 - Creates the strongest incentive of available models for management of the costs of care for a defined patient population
 - Other strengths comparable to those for population-based payment with shared savings

Population-Based Payment with Shared Risk: Cons

- Providers need substantial infrastructure to be able to manage care of a population within a budget, e.g., management knowledge and skill, data and refined data analysis, financial management, clinical care management
- If providers lack the necessary infrastructure, they can be at risk of significant financial losses, destabilizing their organization and patient care

Do alternative models support improved quality and lowered cost?

- The evidence is mixed. For each of the aforementioned models, there are examples of failure and of success, so generalization is difficult.
- Design is important, but so is execution.
- Many variables come into play, and some can certainly contribute. A few examples...
 - Organizational leadership
 - Mastery of management methods such as CQI and Lean
 - Clinical data and analysis infrastructure

What is alternative payment supposed to accomplish?

- Alternative payment should remove impediments to providers doing the right thing.
- Alternative payment is a *means* to an end – the end is improved (better quality, more efficient) care delivery.
- Changing incentives doesn't work if the provider entity doesn't know how, or is unable, to respond to the incentive.

General Advice

1. Learn from others

- The research literature is rich with studies of alternative payment models.
- Make the time investment to catalog what we know so far about what works and what does not in terms of detailed design and implementation considerations.

2. Align your efforts

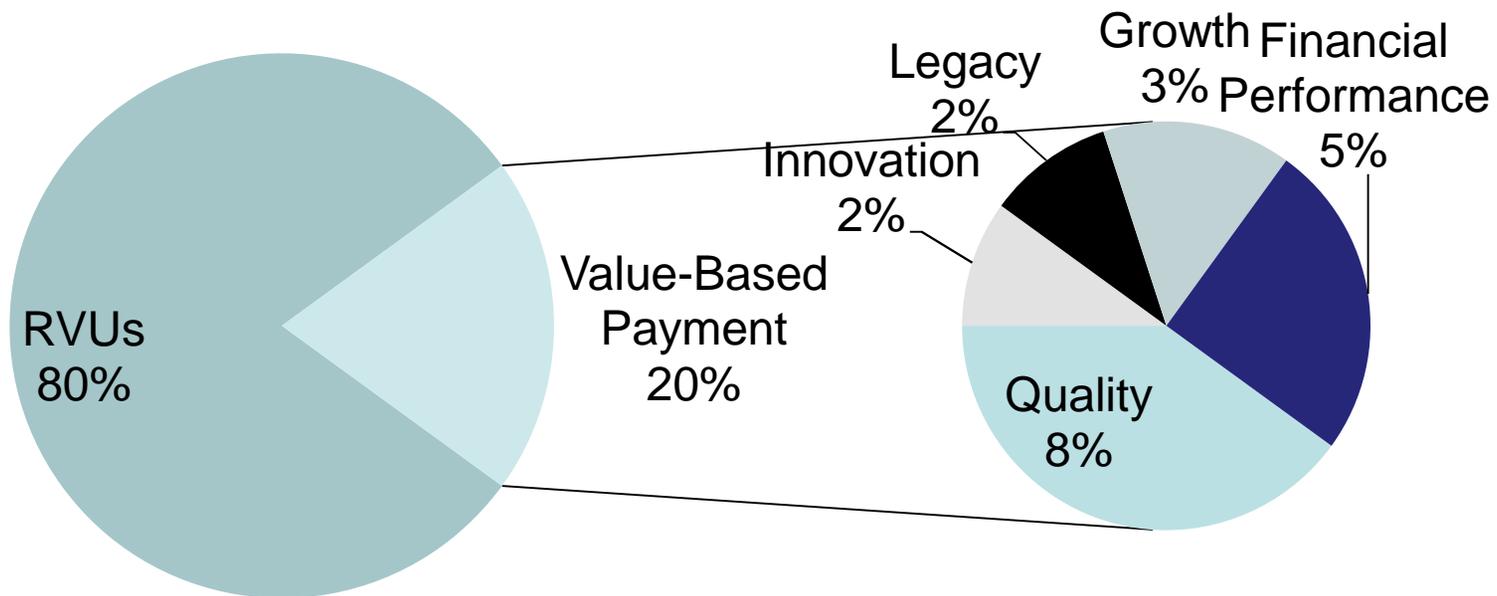
- Should CCO providers receive payments other than through the CCO, they will be receiving different competing and sometimes conflicting incentives.
- Attempt to work with others to align incentives and thereby increase the likelihood that CCO incentives will generate the desired response.

One Last Consideration: “The Payment Within The Payment”

- If a CCO uses an alternative payment methodology with a physician group, does that group’s payment incentive translate to individual physician compensation?
- In most cases across the U.S., the answer is “no.”
- This lack of alignment threatens the impact of the alternative payment methodology.
- Provider organizations in this context need to consider value-based compensation. An example follows from Geisinger Health System.

An Example from Geisinger: Specialty Physician Compensation

% of Specialist Compensation



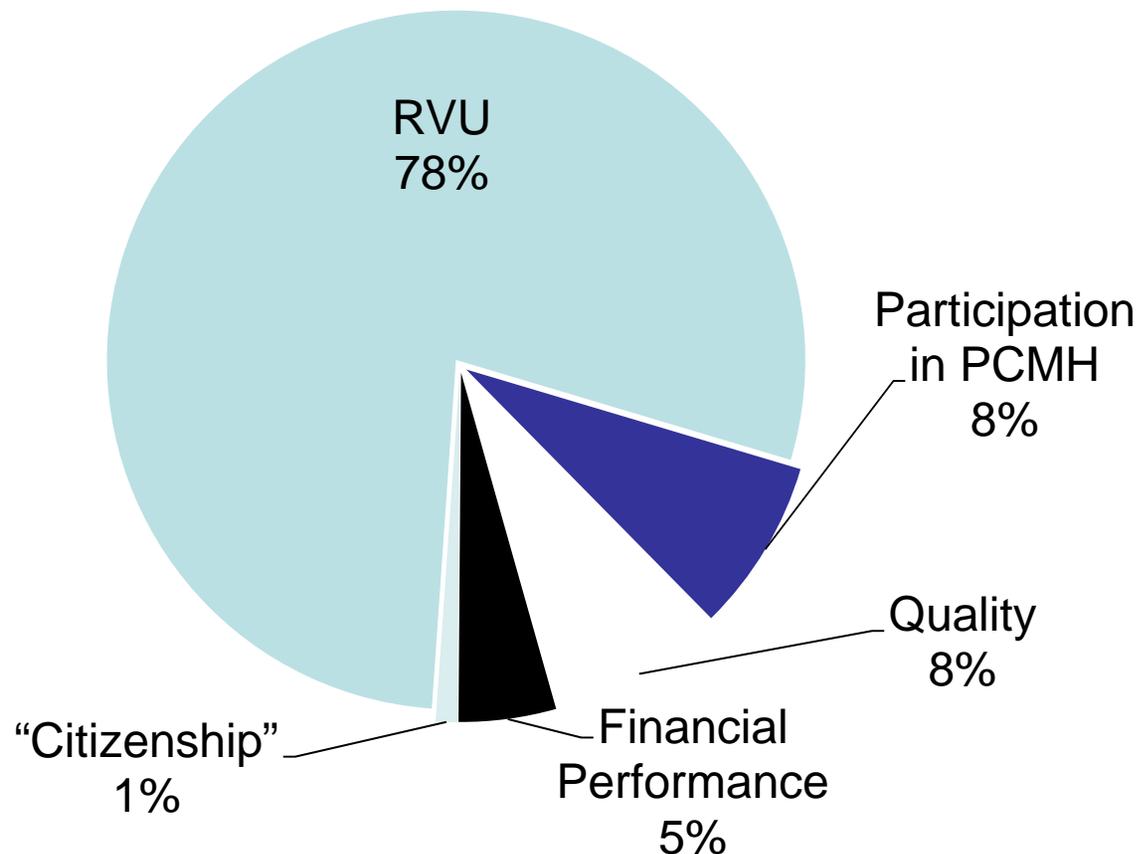
Physicians are generally expected to reach the 60th percentile of RVUs compared to a national database of productivity.

Geisinger Specialty Physician Compensation (Cont'd)

- The portion of physician compensation based on quality is defined for each specialty and typically includes 4 or 5 measures of performance.
- To achieve the desired performance, providers frequently need to collaborate with other providers across the system.
 - For example, endocrinologists are held accountable for the HbA1c levels of Geisinger patients with diabetes. The endocrinologists need to collaborate with other care providers and envision and incorporate programs to achieve this goal.

Geisinger Primary Care Physician Compensation

% of PCP Compensation



Physicians are generally expected to reach the 60th percentile of RVUs compared to a national database of productivity.

Source: <http://content.healthaffairs.org/content/31/9/2068.full>

Geisinger Primary Care Physician Compensation (Cont'd)

- The quality portion of PCP compensation is based on goals that align with Geisinger's strategic vision.
- Some goals include:
 - Implementing bundles of key processes for care of patients with chronic conditions (e.g., ProvenCare)
 - Increasing the proportion of patients who use Geisinger's patient portal
 - Improving performance in patient satisfaction and publicly-reported measures of quality

Results of the Geisinger Model

- While quality is a clear emphasis, the business realities of fee-for-service are still a driving force – today.
- The percentage of physicians who achieved the 60th percentile of RVUs increased from 37% in 2008 to 45% in 2012.
- Because of other system initiatives, it is too difficult to tell what the overall impact of the compensation model has been on quality.

So what alternative payment models are CCOs contemplating?

- CCO Transformation Plan Amendments have shed some light on the course of action payers are pursuing.

Implementation of Alternative Payment Methodologies

- Alternative payment methodologies identified in the CCO Transformation Plan Amendments ranged from unspecified methodologies to population-based payment.
- The majority of alternative payment methodologies focused one on type of service (e.g., emergency department visits) or specialty (e.g., behavioral or oral health).
- Milestones to be achieved in 2014 and 2015 varied from piloting a payment method with one provider to targeting a percentage of total payments being made to providers using an alternative method.

Details of Alternative Payment Arrangements

- Of those CCOs that have identified an alternative payment methodology, the following broad categories of payment arrangements are being considered:
 - 5 pay-for-performance
 - 2 population-based payment: shared risk
 - 2 population-based payment: shared savings
 - 1 bundled payment

Questions

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