Oregon Health Authority

Payment reform matters

Better health, better care and lower costs

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Why payment reform is an important piece of the puzzle

Employers are the largest purchasers of health care in Oregon. Health care is expensive and it is of variable quality. Both nationally and in Oregon, there is a concerted focus on improving health care quality and outcomes while reducing cost growth. Payment reform is an important piece of the puzzle. Increasingly, in Oregon and elsewhere, Medicaid, Medicare and the commercial market are changing the way health care is paid for and moving toward alternative payment models that reward high value.

As self-insured employers look to rein in their health care costs, they too should look to implementing alternative payment models that move payment away from fee-for-service and toward models that create financial incentives for high-quality, efficient care. There is no one-size-fits-all approach to implementing alternative payment models. They may be implemented across an entire population, or can be focused on specific portions of the population. An employer can implement a number of alternative payment models within its population.

Payment reform ROI:

- CALPERS saved over $30 million iwhen it implemented a population-based payment model. These savings were due in part to large reductions (15 percent) in inpatient readmissions and inpatient days, as well as reduction in surgeries.
- Walmart participates in payment reform activities in Arkansas, including episode-based payments and PCMHs
- IBM participates in Vermont's PCMH program
- Intel developed an employer-sponsored accountable care organization based on a patient-centered medical home model that is based on shared risk and rewards

Paying for Outcomes and Health

Payment for care should be based on quality and health outcomes rather than on volume of services provided. The alternative payment methodologies described below represent a continuum of payment options that increasingly hold providers accountable for health outcomes — offering incentives for performance and quality outcomes, episode-based payment, and population-based contracting — and support better care and lowered costs. The intent is to increase the use of payment models that improve health outcomes.

See Page 2 for details on these payment models.

Pay for performance (P4P)

In P4P arrangements, providers are eligible to receive bonus payments based on meeting or exceeding performance targets on an agreed-upon set of performance measures. P4P continues fee-for-service payments, but gives providers some incentive to focus on quality outcomes and not just volume.

Patient-entered medical home payments

As described in the Patient-Centered Primary Care Homes fact sheet, a patient-centered medical home (PCMH) is a primary care practice that gives patients individualized care and support through a multi-disciplinary care team to help them stay healthy. In Oregon, PCMHs are referred to as patient-centered primary care homes (PCPCH). Typically, providers receive a per member per month (PMPM) payment on top of their existing fee-for-service payment to provide enhanced outreach, communication and coordination.

Through advanced practice models, providers develop patient-centered, multi-disciplinary team-based care for patients with multiple chronic conditions. PMPM payments for these types of practices are often significantly higher than for regular PCMHs. PCMHs are foundational elements to more advanced population-based contracting models.

Episode-based payments (also known as bundled payments)

Under this arrangement, a provider entity agrees to accept responsibility for the health of a patient relative to a particular condition or treatment in exchange for a set dollar amount that is expected to cover the total cost of all condition-specific services the patient needs.

Population-based contracting

Under this arrangement, a provider entity agrees to accept responsibility for the health of a group of patients in exchange for a set dollar amount that is expected to cover the total cost of care. If the provider is able to effectively manage costs and perform well on quality-of-care targets, then the provider keeps a portion of the savings generated. However, if the provider is not successful and delivers inefficient, high-cost care, then the provider may be responsible for the additional costs incurred over the expected total cost of care. The purpose of population-based contracting is to align the financial interests of providers with the interests of the patients, allowing for innovative approaches to patient-centered care, so that everyone wins if the patients are healthy and costs are contained.

An employer can implement population-based contracting by requiring its third party administrator (TPA) to enter into such contracts with providers in an effort to increase the number of insured lives covered by this type of contract.