Payment Policies to Promote Integration and Value

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September 9-10, 2009

Washington, D.C.

What is it that Patients Want?

- Generally, a cure or a slowing in the decline of function, and often just simple reassurance
  - Not necessarily the provision of specific services
  - Technical choices need to be left to experts
- This implies that what we should be paying for is an episode of care or ongoing management
- And it suggests new ways of structuring payment
- Along with better measures of those services

The Capitation Alternative

- Capitation has a long, sometimes successful, history in prepaid group practice HMOs
- It is a fixed amount per year to provide all the services needed by a population of enrollees
- But, this reflects how organizations are paid, not how the clinicians within the organizations are paid. Physicians are typically paid either:
  - salaries (which raises issues about how to encourage higher productivity), or
  - based on RVUs, (which raises issues about how to reduce overall resource use)

Risk, Incentives, and Information—Finding the Middle Ground

- FFS eliminates not only risk to the provider
  - But also the incentives for efficiency, and information
- Capitation places all the risk on the organization
  - But relies on top-down management for efficiency
- Episode-based payment offers a middle ground
  - But the episodes need to be well-defined
  - With risk and incentives targeted to those who have the information and can manage the risks

Integration—At What Level?

- Full integration with capitation is unlikely to be viable everywhere and for everyone
- Consider partial integration and incentives:
  - Inpatient and similar care—single vs. repeated
  - Ongoing chronic illness management
  - Providing a medical home

Targeting Incentives

- Inpatient (and similar) high intensity, carefully coordinated, time-limited care
- Responsibility for readmissions
- Ongoing management of chronic illness
- Overall coordination and guidance, e.g., providing a medical home

Inpatient Care Episodes

- Don’t distinguish formal admissions from invasive “outpatient” procedures
  - a laparoscopy with a 23-hour stay isn’t an “office visit”
- Include condition-specific pre-admission and post-discharge care as part of the episode
- Bundled payment to include facility, physician, supply, imaging, and other costs
- Allocation of the payment among providers (e.g., within a Care Delivery Team, CDT) is up to them
- Capture information on the outcomes (clinical and experience) for the episode

Responsibility for Readmissions

- Readmissions may reflect sub-optimal quality during the initial admission or post-discharge care
- CDTs may be well-positioned to accept responsibility for reducing readmissions
- Many readmissions, however, may not be clearly the "fault" of the CDT, yet can be very expensive
- Hence, an approach is needed that eliminates fault determination and makes risk manageable
- Consider a "super DRG" with private reinsurance
- This doesn't necessarily need a "full ACO" model

Managing Chronic Illness

- Chronic illness is managed by an implicit team of the patient, outpatient physicians, and others
- Such teams may vary from patient to patient
- Once admissions are excluded, costs are much more stable (lower coefficient of variation)
- Use a monthly chronic illness management (CIM) payment to offset this, allow the “team” to find the best approaches
- Incentive payments (reinsurance) to reward those with lower than average admission rates
- The clinicians need not be in a fully integrated group, but may be a “virtually” linked by payment and data

Providing a Medical Home

- Patients should “enroll” with a primary care provider or setting, e.g., a community health clinic
- Who provides counseling, coordinating, facilitating, tracking, but not gatekeeping
- Data systems are needed to keep track of services and provide information to all clinicians involved
- Patient preferences are not predicable or even stable, but should be elicited and honored
- Patients should be protected from risk (that is why we have insurance—private and social)
- But, patients can (and should) be exposed in reasonable ways to the economic implications of their choices

Incentives and Information

- Bundle payments around what patients want, i.e., an episode of care or ongoing management
- Include information on clinical outcomes and patient experience with the care
- Allow provider flexibility in internally allocating funds
- Set “base” payments at the average of teams/groups achieving above-average outcomes—don’t focus on “price” but necessity
- Pool and share information on results—highlight the “stars”
- “Wanting to be a star” leads to self-identification
- Providers will demand (and pay for) better information on what works well—applying evidence based results

Implementation: Medicare

- Offer bundled payments to teams (CDTs) of physicians and hospitals taking responsibility for an inpatient episode
- Offer "super-DRGs" that include the actuarial value of all readmissions within 30-90 days and outlier costs
- Private reinsurers offer policies to hospitals (or CDTs) to reduce their risk from random events
- Reinsurers collect and share data on "best practices" that help reduce complications and readmissions
- For demonstrations, Medicare should offer "average" payments even though volunteers may be less than average cost to Medicare—transformation is expensive

Implementation: The Newly Insured Under Health Reform

- Exchanges are the “weak link” in all the proposals
  - Risk adjustment is very difficult and likely to fail
  - So, create a major risk pool (MRP) to reinsure plans on a demographic basis; participation by plans is voluntary
  - Pay directly for inpatient episodes via CDTs (see Medicare)
  - Pay health plans for monthly chronic illness management
  - MRP pools data from Medicare and the plans it reinsures and makes available anonymized data on MD practice patterns
- Plans seek out efficient PCPs and selectively contract with them using new payment structures

I am grateful for support by a Transitions Grant from the Robert Wood Johnson Foundation

Current Fee-For-Service FFS Payment

- FFS gives providers incentives to offer more
  - But this is similar to many parts of our economy
- With insurance, patients have little reason to decline additional services
  - Often with little information on the value of care
  - The absence of cost feedback on demand is unusual
- Legal restrictions on coordination and contracting
  - E.g., fee splitting, gainsharing, corporate practice
  - Perhaps uniquely, these restrictions affect efficiency