

Payment Reform: Defining the Ends and the Means

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Will Discuss:

- Some challenges and goals for payment policy
- A review of payment options with strengths and weaknesses
- MedPAC and Obama Administration recommendations and proposals



“The Tyranny of the Urgent”

“Amidst the press of acutely ill patients, it is difficult for even the most motivated and elegantly trained providers to assure that patients receive the systematic assessments, preventive interventions, education, psychosocial support, and follow-up that they need.” (Wagner et al. *Milbank Quarterly* 1996:74:511.)



The Pressure of the 15 Minute Visit

“Across the globe doctors are miserable because they feel like hamsters on a treadmill. They must run faster just to stand still...The result of the wheel going faster is not only a reduction in the quality of care but also a reduction in professional satisfaction and an increase in burnout among physicians.” (Morrison and Smith, BMJ 2000; 321:1541)

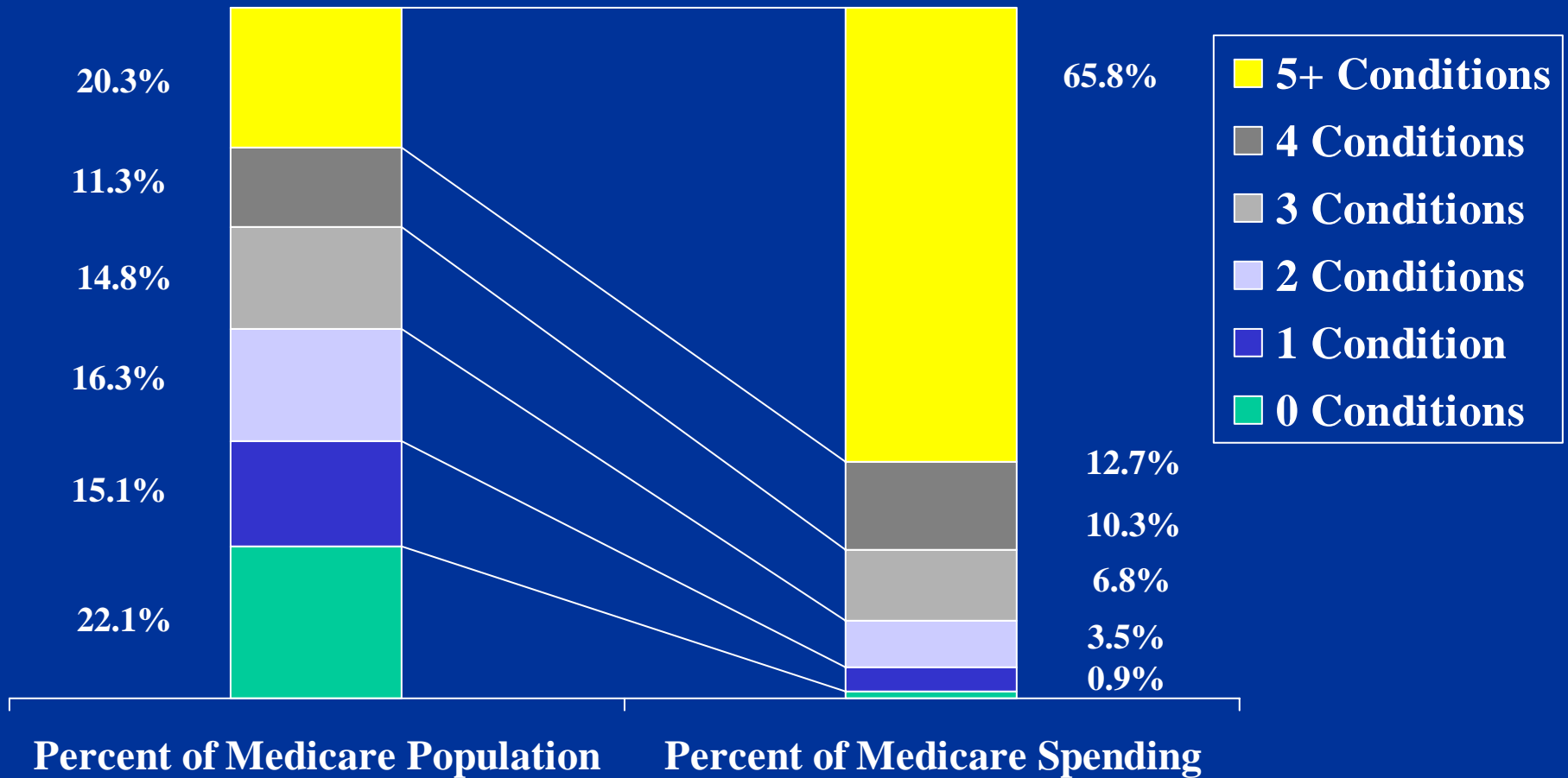


How Patients are Affected

- Asking patients to repeat back what the physician told them, half get it wrong. (Schillinger et al. Arch Intern Med 2003;163:83)
- Patients making an initial statement of their problem were interrupted by the PCP after an average of 23 seconds. In 23% of visits the physician did not ask the patient for her/his concerns at all. (Marvel et al. JAMA 1999; 281:283)



Medicare Spending Related to Chronic Conditions



Source: Partnership for Solutions, "Medicare: Cost and Prevalence of Chronic Conditions," July 2002; Medicare Standard Analytic File, 1999.

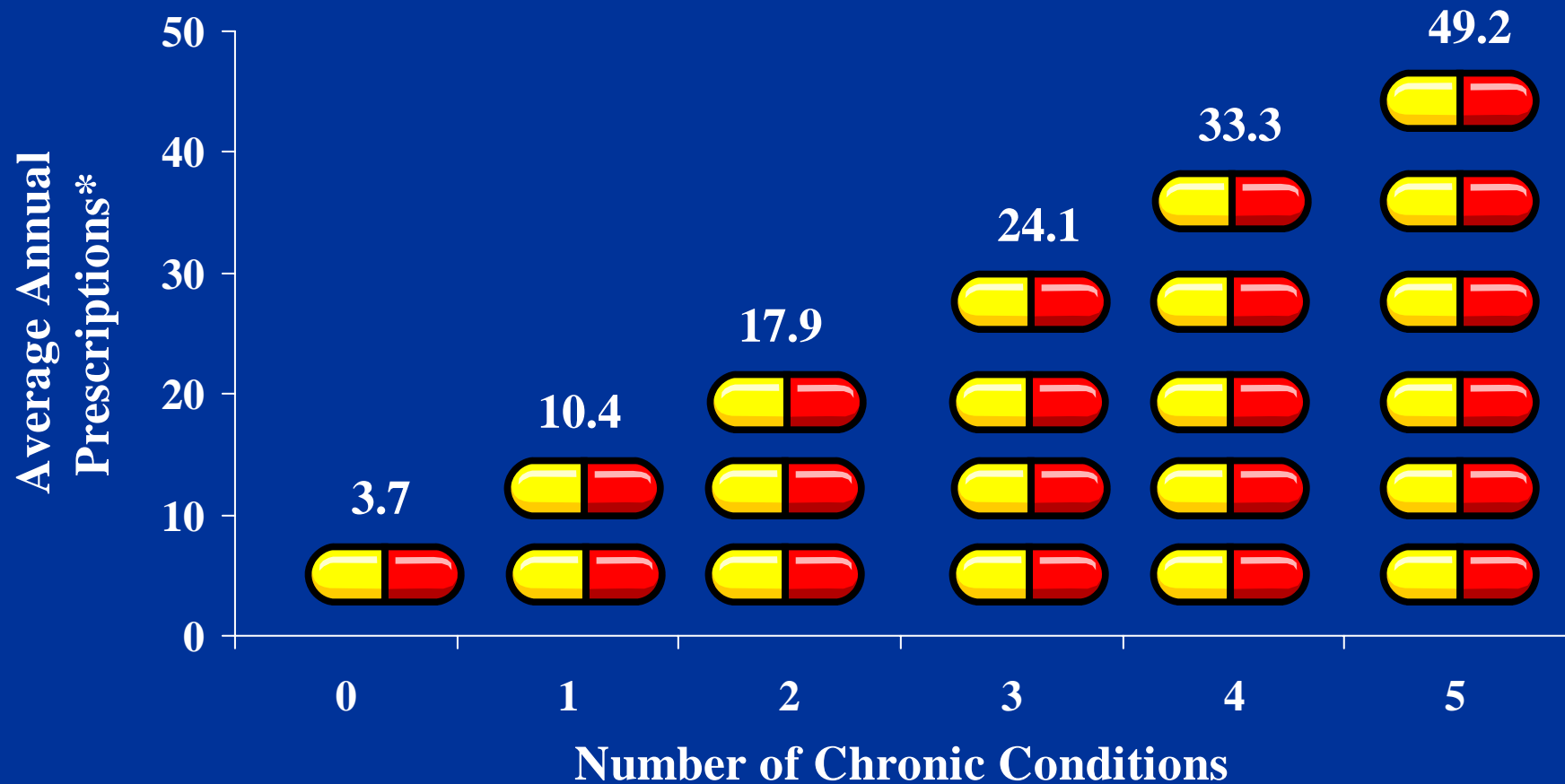


Recent Data on High Cost Patients

- 75% of high cost beneficiaries had one or more of 7 chronic conditions: asthma, COPD, CRF, CHF, CAD, diabetes or senility; 70% of inpatient spending was for beneficiaries with one of these – CBO, 2005
- 5% of beneficiaries accounted for 43% of total Medicare spending; the costliest 25% for 85% of spending – CBO, 2005



Annual Prescriptions by Number of Chronic Conditions



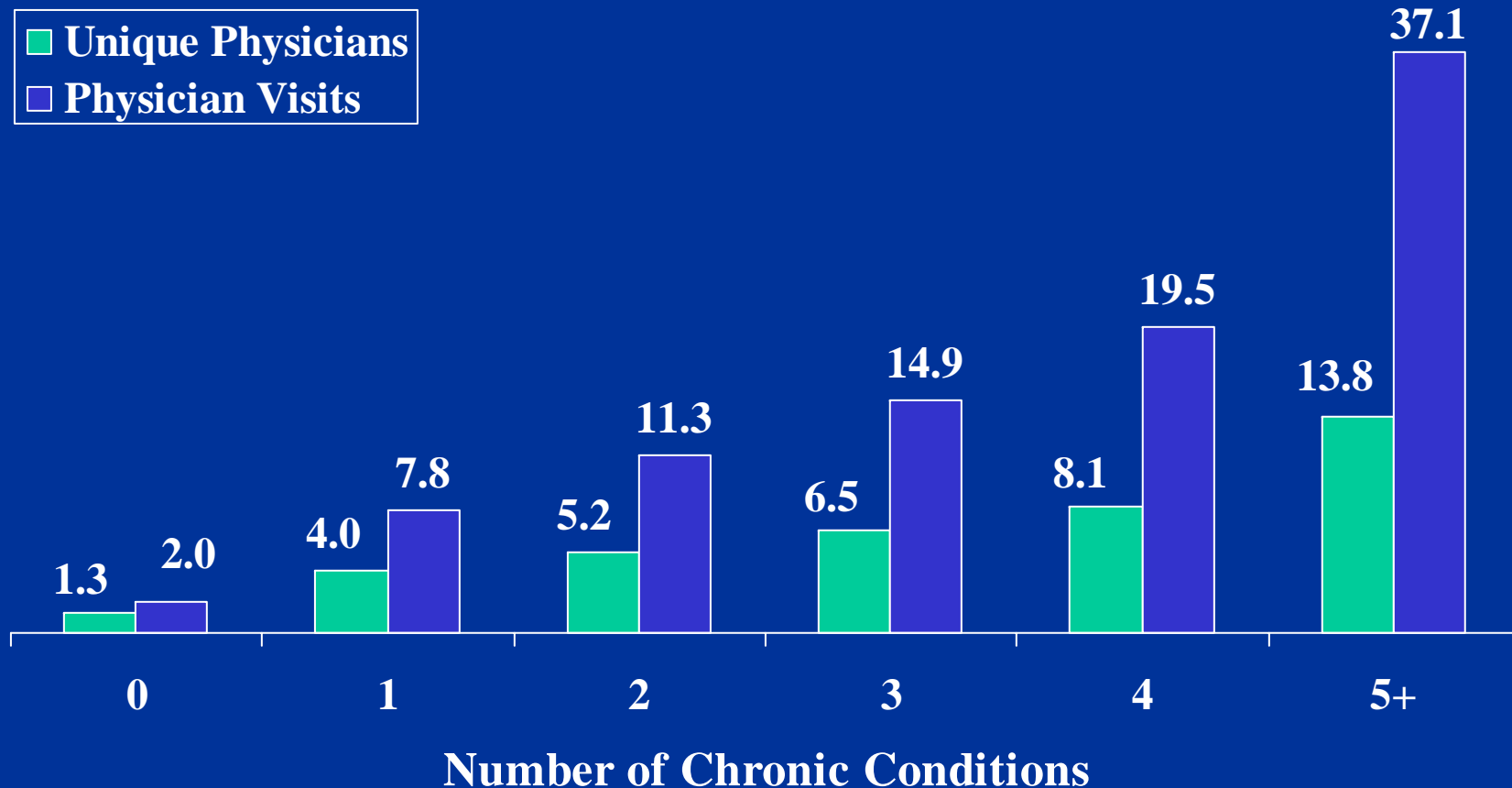
*Includes Refills

Sources: Partnership for Solutions, "Multiple Chronic Conditions: Complications in Care and Treatment," May 2002; MEPS, 1996.



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Utilization of Physician Services by Number of Chronic Conditions



Sources: R. Berenson and J. Horvath, "The Clinical Characteristics of Medicare Beneficiaries and Implications for Medicare Reform," prepared for the Partnership for Solutions, March, 2002; Medicare SAF 1999.



Incidents in the Past 12 Months

Among persons with serious chronic conditions, how often has the following happened in the past 12 months? (Harris Survey, 2000)

	<u>Sometimes or often</u>
1. Been told about a possibly harmful drug interaction	54%
2. Sent for duplicate tests or procedures	54%
3. Received different diagnoses from different clinicians	52%
4. Received contradictory medical information	45%



Readmissions

- In Medicare, about 11% of patients are readmitted within 15 days and almost 20% within 30 days
- 50% of patients hospitalized with CHF are readmitted within 90 days
- The majority of readmissions are avoidable – declining with time from the index admission
- Half of patients discharged to community and readmitted within 30 days after medical DRG had no bill for physician services in the interval



The Hospitals' Negative Business Case for Doing the Right Thing

- Reducing hospitalizations helps third-party insurers – and patients – but costs the hospital
- The hospital faces the direct costs of supporting programs that decrease admissions of ambulatory-care sensitive conditions and also loses inpatient admissions



Instead A Renewal of a Medical Arms Race

“Specialty Service Lines: Salvos in the New Medical Arms Race” -- Berenson, Bodenheimer, and Pham, *Health Affairs*, Sept/Oct, 2006

- Increased provider competition increases market costs
- Entry of physician-owned specialty hospitals is resisted by health plans because hospitals raise prices on other services and physician self-referral increases volume for the particular services provided in the specialty facilities



What Kind of Reform Is Needed?

- Commonwealth Fund Survey of 214 health care leaders:
 - 95% thought “fundamental payment reform”
 - Most thought “delivery system reform” needed as well, with 75% supporting need for integrated delivery systems and 73% supporting Medical Homes



“There are many mechanisms for paying physicians, some are good and some are bad. The three worst are fee for service, capitation and salary.”

-- Robinson, Milbank Q, 2001



Empirical Evidence

“It is remarkable how few robust studies are available in this important policy area.” Cites reviews that find fewer than half a dozen studies that met scientific standards. -- Alan Maynard, Incentives in Health Care, the Shift in Emphasis from Implicit to Explicit, in *Human Resources for Health in Europe*, European Observatory, 2005

“Analyses have been plagued by incomplete data, thorny methodological challenges, and inadequately developed conceptual frameworks.” – Jamie Robinson, Theory and Practice in the Design of Physician Payment Incentives, *Milbank Q.*, 2001

Both conclude that the peer-reviewed literature generally supports the presumption that payment incentives do affect physician behavior and in the predicted direction.



Distinguishing Between Payment to Groups and Payment to Physicians Within Groups

Within physician organizations, 1/4 paid FFS, 1/4 paid by either capitation or pure salary, 1/2 on blends of retrospective and prospective methods

– Robinson, Shortell, et al. HSR, Oct, 2004

Note that “salary with productivity incentives” usually means measures of productivity as defined by FFS payment parameters, either actual billings or RVUs generated



FFS

- Advantages

- Rewards activity, industriousness
- Can target to encourage desired behavior
- Implicitly does case-mix adjustment
- Commonly used by payers and physicians

- Disadvantages

- Can produce too much activity, physician-induced demand
- High administrative and high transaction costs
- What is not defined as reimbursable is marginalized
- Complexity makes it susceptible to gaming and to fraud



PPPM (Comprehensive Payment)

Advantages

- 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

Disadvantages

- May lead to stinting on care
- Susceptible to cream-skimming
- Incentive to cost shift to services outside the PPPM
- Can't specifically promote desired activity (why “bill aboves”)
- May resist innovation/ new services



Episode/Condition/Bundle/Case

Models include DRGs for hospitals, 60 day episodes for home health agencies, “episode groupers”

- Advantages
 - internalizes incentives for efficiency within the episode
 - potentially aligns incentives across siloed providers
 - arguably, is an intermediate step on the way to real integration
- Disadvantages
 - does not fundamentally alter incentive to generate units of service
 - be careful about what you wish for, physician-hospital alignment without any risk-taking
 - currently, political challenges in bundling among providers



Public Reporting and Pay-for-Performance (P4P)

- Advantages
 - provides a hybrid payment to mitigate disadvantages of pure models; some natural blends – P4P and under-service measures
 - can start to actually reward desired performance, instead of rewarding volume of services produced
 - can include measures of patient experience, which generally ignored in considerations of payment approaches
- Disadvantages
 - underdeveloped measure set – at least for physicians
 - what gets measured gets done?
 - marginal incentives may be insufficient to counter basic incentives in pure model
 - contributes more administrative complexity



Examples of Blended or Hybrid Payment Models

- PMPM with FFS carve outs or “bill aboves”
- “Contact capitation” for specialists
- Either FFS or capitation with P4P
 - Health plans commonly paid PCPs directly by capitation with withholds (or reduced capitation with bonuses) – the US HealthCare approach -- more than two decades ago.



The Medicare Payment Advisory Commission -- MedPAC

- Comprised of 17 Commissioners, this Congressional Advisory Commission has traditionally recommended payment updates for the various classes of providers and suppliers in Medicare – the March Report
- Increasingly, also addressing the need for major health delivery reform – the June Report



June 2008, Report to the Congress: Reforming the Delivery System

- “Promoting the use of primary care”
- “Examining hospital-physician collaborative relationships”
- “A path to bundled payment around a hospitalization”
- “Producing comparative-effectiveness information



MedPAC June Report (cont.)

- “Public reporting of physicians’ financial relationships”
- “A revised prospective payment system for skilled nursing facilities
- “Evaluating Medicare’s hospice benefits”



MedPAC Proposes Three Concepts To Promote Delivery System Change

1. Medical Home

2. Bundled physician-hospital payments

3. Accountable care organizations



Accountable Care Organizations

- To promote accountability for quality and resource use over an extended period for a patient population
- Seen as a complement to medical homes, which may often be too small to support full accountability and hospital-physician bundling, which creates no incentive to control the volume of admissions



ACOs (cont.)

- First pilots would be existing multispecialty groups and integrated delivery systems paid as under the physician group practice demonstration which is robust P4P – must achieve quality targets and if successful get to share savings with Medicare. Could have some financial risk based on spending against a control group.



ACOs (cont.)

- A form of direct contracting without relying on Medicare Advantage plans so that traditional Medicare continues to set payment rates.
- (An alternative approach could be mandatory, “virtual” ACOs, relying on setting spending targets for hospital-extended medical staff.)



Obama Administration Budget Proposals for the Health Care Reserve Fund

- Encourage hospitals serving Medicare beneficiaries to reduce readmissions rates
- Enable physicians to form voluntary groups that coordinate care to receive additional performance-based payments
- Bundle Medicare payments to hospitals to cover hospital and post-acute settings for 30days

