Payment Reform and the Transformation of American Medicine

John F. McCracken, PhD
March 7, 2014
What’s driving the transformation of American medicine?
The Usual Suspects

Obamacare

Government Regulation
The Real Culprits

Healthcare Cost  Healthcare Quality

Physicians
Cost

Annual Increase in National Health Expenditures per Capita vs. Increase in Consumer Price Index

SOURCE: Kaiser Family Foundation calculations using NHE data from Centers for Medicare and Medicaid Services
Cost
Projected Average Family Premium as a Percentage of Median Family Income, 2013–2021

Sources: Kaiser Family Foundation/Health Research and Educational Trust
A significant health system challenge

- 50% of adults live with chronic illness
- 80% of adults over age 65 have a chronic disease
- 60% of hospitalizations are due to chronic disease
- 66% of medical admissions via emergency are due to exacerbation of a chronic disease
- 80% of family doctor visits are chronic disease-related
- 60 to 80% medical costs are related to chronic disease

... and the quality of care varies substantially

Quality
Relationship between Medicare Spending and Quality of Care

Overall quality ranking

1

11

21

31

41

51

Annual Medicare spending per beneficiary (dollars)

Baicker and Chandra, “Medicare Spending, The Physician Workforce, And Beneficiaries’ Quality of Care,” 2004
Provider Payment Reform: The True Driver of Healthcare Transformation

Rising Costs

Uneven Quality

Provider Payment Reform

New Medical Delivery Model
The Provider Payment Archipelago

- Fee for Service
- Pay for Performance
- Bundled Payments
- Partial Capitation
- Shared Savings
- Shared Risk
- Global Capitation
- Episode Based Payments
- Salaried Employment
- Fee for Service
The Compensation Continuum

- Fee for Service
- P4P
- Bundled Payments
- Shared Savings
- Shared Risk
- Capitation

- Limited Integration
- Moderate Integration
- Full Integration

Payer Financial Risk
Provider Financial Risk
Fee-For Service
Fee-for-Service

Fee-for-Service is the dominant U.S. payment model in the U.S. healthcare system. It offers providers a specific amount of compensation in exchange for providing a patient with a specific service.

FFS incentivizes providing more of those services which are most highly compensated, e.g., cardiology, orthopedics. It disincentivizes services:

- that generate comparatively lower remuneration, e.g., primary care, psychiatry
- for which there is no FFS compensation – e.g., patient outreach, care coordination, treatment plan development, e-visits, web visits

The biggest problems with FFS is that it:

- promotes fragmented and uncoordinated delivery of care
- accommodate wide variations in treatment patterns
- provides no incentive for quality improvement.
Pay For Performance
Pay for Performance

P4P arrangements vary widely, but commonly provide enhanced fees or bonus payments based on achievement of defined performance goals typically encompassing:

- clinical quality (more process than outcomes measures)
- patient satisfaction
- appropriateness of services

They generally follow a “blended” payment approach with claims continuing to be paid on a fee-for-service basis along with a PMPM “care management fee” plus performance-based bonus payments.

Measured results to date have been modest, in part because:

- it’s often the initiative of a single payer only
- fee enhancements constitute a small share of total practice revenue
- administrative costs of collecting the data often exceed the bonus payments
- it hasn’t resulted in measured improvement in the cost or quality of care
Pay for Performance “Heavy”
The Patient Centered Medical Home

An example of “P4P heavy” is the Patient Centered Medical Home. Under this model, all patients are supposed to receive coordinated, patient-centered primary care. Key objectives are to:

- increase patient access to the practice and care team.
- establish accountability by having PCPs serve as the central provider for their patients and assume responsibility for coordinating all of the care they receive.
- manage transitions across different settings of care.
- address both prevention and wellness.
- improve coordination between primary care, other specialists and hospital care.
Patient Centered Medical Home: The Way it’s Supposed to Work

Access to Care
- Patients can select the day and time of their appointment.
- Email and telephone consultations are offered.
- Off-hour service is available.

Patient Engagement
- Patients have the option of being informed and engaged partners in their care.
- Practices provide information on treatment plans, preventative and follow-up care reminders, access to medical records, assistance with self-care, and counseling.

Clinical Information Systems
- Systems support high-quality care, practice-based learning, and quality improvement.
- Practices maintain patient registries; monitor adherence to treatment; have easy access to lab and test results; and receive reminders, decision support, and information on recommended treatments.

Care Coordination
- Specialist care is coordinated, and systems are in place to prevent errors involving care transitions.
- Follow-up and support is provided.

Team Care
- Integrated and coordinated team care depends on a free flow of communication among physicians, nurses, case managers and other health professionals.
- Duplication of tests and procedures is avoided.

Patient Feedback
- Patients routinely provide feedback to doctors; practices take advantage of low-cost, internet-based patient surveys to learn from patients and inform treatment plans.

Publically available info
- Patients have accurate, standardized information on physicians to help them choose a practice that will meet their needs.

Source: Health2 Resources 9.30.08

Paul Grundy, 2012
Patient Centered Medical Home: Early Results

A three year Rand study of 32 PCMH pilot programs covering 65,000 patients found only limited improvement in quality and no decrease in hospital, ED or ambulatory care utilization and no reduction in total cost of care delivered.
Bundled Payments
Bundled Payments

Aggregates the unit of payment from an individual service to a collection of related services for a given patient. A single, lump-sum risk-adjusted payment is does not depend upon the number of services actually provided.

Scope of services included in a defined bundle can be very narrow or quite extensive, depending upon what’s negotiated between the provider and the payer, e.g.,
- hospital only payment for an admission and related pre-admission services
- hospital only payment for admission and readmission
- services provided post-discharge only
- both hospital and physician services provided during an in-patient stay, as well as related post-acute services, physician visits, and hospital readmissions
# Current Hospital Practice

<table>
<thead>
<tr>
<th></th>
<th>Pre-Admission</th>
<th>Hospitalization</th>
<th>Post-Acute Care</th>
<th>Readmission</th>
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<tr>
<td><strong>PHYSICIANS</strong></td>
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<td><strong>DRUGS</strong></td>
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<td><strong>NON-MD STAFF</strong></td>
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<tr>
<td>Hospital Staff</td>
<td>Home Care PCP Care Mgr</td>
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<tr>
<td>DRG</td>
<td>Rehab Facility Long-Term Care</td>
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<td>Hospital DRG</td>
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<td><strong>FACILITY</strong></td>
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## Hospital “Warranty”

### Pre-Admission

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<td>Non-MD Staff</td>
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### Readmission

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# Full Bundled Payment

## Table of Components

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*DRG: Diagnosis-Related Group*
Bundled Payments

Incentivizes the provider to both coordinate care provided in a defined episode and to control its costs.

- If costs differ from the payment, providers keep the savings or bear overruns. Financial risk is limited to a subset of patient’s costs rather than their total medical spending.
- The cost of providing the bundle will vary, which means that profit margins on different patients for the same bundled service will vary.
- Incentivizes providers to control costs, but not to limit the number of episodes.

To make this work, providers need the information infrastructure to:

- determine which specific services that a patient receives belong in the bundle
- establish and enforce provider adherence to agreed-upon clinical protocols
- measure and report patient care costs and outcomes
- apply episode groupers to patients who have multiple chronic and related health problems.
- identify and bill for “outlier” risk payments
- receive and distribute the bundled payment among all the participating providers.
Shared Savings
Shared Risk
Shared Savings – Shared Risk

SS-SR focuses more on *population* health as opposed to acute individual care. It requires a significant degree of clinical integration and involves greater provider risk:

- allows providers to keep a meaningful share of the savings if they are able to limit gross expenditures for a defined patient population.
- payouts conditioned upon meeting quality targets, but amounts are determined by cost savings
- can either be “one-sided” (shared savings only) or two-sided (shared risk). Custom is to start as SS only, then evolve to SR as capabilities improve.
- creates incentives for providers to avoid inappropriate episodes of care, and to prevent episodes from occurring in the first place.
SS-SR Model Envisions Integrated Care

Patients

Hospital

Payers

Other Healthcare Providers

Specialists

Primary Care Providers
ACOs are the common means of implementing SS-SR. A group of care providers takes responsibility for the quality and cost performance for a defined population during a defined period of time. Key issues include:

- how patients are assigned to ACOs
- how spending targets are established for purposes of determining shared-savings payouts
- how care quality is measured and costs controlled
- how shared savings will be distributed among the providers and between the providers and the payer

The accountable care organization shifts away from the provider-centric worldview, where care is organized around physician specialization, to one where the care delivery process is built around the needs of the patient.

ACOs can be either be carve-outs or cover the full range of care. In carve-outs (e.g., cardiology), everybody who is a driver of cost has to be included in the ACO. Virtually all ACOs begin as carve-outs.
Capitation
Providers elect to take on full financial risk and accountability for a defined population.

- will work only for a provider organization that is well integrated clinically
- will not work under an open-network PPO plan, which has become the most popular form of insurance
- can impede the measurement of care quality because it doesn’t generate the claims data commonly used in analyses of quality
- provides incentives to keep patients healthy (prevent onset of disease as opposed to treating disease progression or acute episodes of care)

Capitation exposes providers to insurance risk.

- average cost of treating patients depends in part on the severity of the health problems their patient population develops, over which providers have only limited control
- professional services (partial) capitation—as opposed to global capitation—can reduce insurance risk, but also encourages shifts in the site of care
Medicine is Changing

From a craft-based practice

Individual physicians, working alone (housestaff = apprentices) handcraft a customized solution for each patient based on:
- a core ethical commitment to the patient and
- extensive personal knowledge gained from training and experience

To a profession-based practice

Groups of peers, treating similar patients in a shared setting, plan coordinated care delivery processes (e.g., standing order sets) which individual clinicians adapt to specific patient needs. The expectation is that it will:
- be less expensive—a facility can staff, train, supply and organize to a single core process
- be less complex, which means fewer mistakes and dropped handoffs, less conflict
- have better patient outcomes
## Evolution of the Medical Delivery Model

<table>
<thead>
<tr>
<th>The Old Paradigm</th>
<th>The Future Paradigm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evolved around medical and hospital practices</td>
<td>Designed around patient, community, and population needs</td>
</tr>
<tr>
<td>Disease focus, one patient at a time</td>
<td>Health and prevention focus</td>
</tr>
<tr>
<td>Hierarchical, physician controlled</td>
<td>Team-based systems substitute for hierarchy</td>
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<tr>
<td>Performance problems assumed as people-caused</td>
<td>Recognition that performance problems are systems-based</td>
</tr>
<tr>
<td>Lack of accountability</td>
<td>Accountable culture</td>
</tr>
<tr>
<td>Fragmentation of care givers and healthcare functions;</td>
<td>Integration of all system elements results in seamless care for patients</td>
</tr>
<tr>
<td>hand-off gaps common</td>
<td></td>
</tr>
<tr>
<td>Medical records paper, fragmented, “owned” by caregiver</td>
<td>Patient medical information owned by patient and accessible to all relevant caregivers</td>
</tr>
<tr>
<td>Complexity results in frequent errors, harm to patient</td>
<td>Systems of quality control minimize error, harm</td>
</tr>
<tr>
<td>Care quality opaque; improvement reactive and compliance-oriented</td>
<td>Care quality transparent and value oriented.</td>
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</table>
Why Are We Surprised at the Chaos?

*The interval between the decay of the old and the formation and establishment of the new constitutes a period of transition which must always necessarily be one of uncertainty, confusion, error, and wild and fierce fanaticism.*

John C. Calhoun, American Senator and Vice President
1782-1850