

Payment 101

Michael Bailit

Bailit Health Purchasing, LLC

October 5, 2009

Why Reform Payment?

- Perhaps nothing more heavily influences how the provider system is organized and how care is delivered than the fee-for-service (FFS) payment system. FFS...
 - provides a financial incentive for overuse
 - leads to underuse of low-priced services, including prevention
 - leads to underuse of high value services for which there is no fee, e.g., PCP phone consult with specialist
 - results in poor coordination of care across providers, including transition management

Principles of Payment

- Health care payment models pay providers for different levels of service aggregation
 - from individual services (FFS) to large aggregations of services (capitation)
- As payments are made for increasingly larger aggregations of services, the amount of financial risk borne by the provider increases and decreases for the payer

A Limited Range of Primary Models

1. Fee-for-Service

- “Piece work” payment system financially rewards providers for doing more, and for doing more of whatever yields the highest margin – inherently inflationary
- Supports patient access to and use of services
- The provider bears little financial risk; the payer bears a great deal of financial risk
- The predominant payment system in the U.S.

A Limited Range of Primary Models

2. Bundled or Episode-Based Payment

- Two applications:
 - payment for services by all involved providers around a procedure – may include services that precede and/or follow the procedure (e.g., OB)
 - payment for all services delivered over a period of time (e.g., a year) for patients with a specific condition (e.g., diabetes)
- Limited use to date, e.g., earlier CMS demo, three Prometheus Payment pilots started in 2009

A Limited Range of Primary Models

2. Bundled or Episode-Based Payment

- Payments for procedures will, in theory, create more efficient and effective procedures, but not necessarily fewer procedures, specifically for “gray area” procedures
- Payments for conditions should address the “volume incentive”, but need to deal with comorbidities and there are *many* conditions
- Needs to be balanced with access and quality incentives to address risk of undertreatment
- Provider bears more risk and payer less than with FFS

A Limited Range of Primary Models

3. Shared Savings

- Payer and provider agreed upon a budget of risk-adjusted expected expenditures for a population
- Should actual spending fall below expected spending, savings are distributed between payer, provider, and sometimes, purchaser
- Needs to be balanced with access and quality incentives to address risk of undertreatment
- Provider has no more risk than with FFS, but has a financial incentive to achieve upside gain

A Limited Range of Primary Models

3. Shared Savings

- In limited use in the U.S.
 - recommended by Fisher for ACOs
 - recommended by Mass Payment Commission as a transition strategy
- Some health plans report that it does not result in transformative change by providers

A Limited Range of Primary Models

4. Capitation

- Payer and provider agree upon a budget of risk-adjusted expected expenditures for a population
- Provider has the strongest financial budget management incentive of the four models
- Needs to be balanced with access and quality incentives to address risk of undertreatment
- Provider bears significant financial risk, and the payer much less than with FFS
- Requires provider risk mitigation for “insurance risk”
- Discarded in many regions of the country, persists in select markets (e.g., CA) where larger providers have organized to manage in response

Secondary Models

- Secondary models are those that can be used in conjunction with any of the primary models, but are not themselves payment models:
 - Pay-for-Performance
 - Medical Home

Secondary Models

- Pay-for-performance:
 - Traditionally used with FFS, but can be integrated into any of the four primary models
- Medical home:
 - Typically comprised of supplemental payments to cover the costs of historically uncompensated primary care services
 - Currently used with multiple primary payment models and with P4P

Implications of Varied Models

- Provider risk
- Provider organization
- Market competition and anti-trust risk
- Self-insurance