

Payment Reform – Can it Shift the Tides?

HRSA Conference : A Summit on the
Future of Primary Care: The Healthcare
Workforce Crisis

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Fee-For-Service

- Promotes volume growth, self-referral opportunities, fragmented care
- Prices are distorted in relation to underlying costs, which in turn distorts physician behavior;
- But FFS can promote desired behavior – if you can define services crisply, e.g., doing surgery, administering vaccines

Reasons to Spend Effort Improving Physician Fee Schedules

- The preferred payment alternatives are not easy -- either operationally or politically
- Correct prices will help set the conditions needed for other reforms – such as formation of multispecialty groups
- FFS prices often the building blocks for other payments
- Distortions not inevitable –
 - The DRA limit on imaging payments was a success – decreased prices and volume growth

Opportunities to Improve Medicare Physician Fee Schedule

- Which would improve other payers' fee schedules
- Do a better job of estimating resources costs (and revise role of the RUC in the process)
 - Rely less on estimates and more on real data
 - Payment adjustment for rapid volume growth to account for spreading of fixed costs
 - Market surveillance to identify “winners” and “losers” among services
- Value-based purchasing would ask whether the desired kind and mix of services and whether geographic variations deserve targeted payment bonuses and penalties

Bundles/Episodes/Conditions/Cases

- DRGs for hospitals are case rates; home health is paid for 60-day episodes
- Important to distinguish between bundling payments of different providers from payments to a provider for services over time
- The former attempts to align incentives – defragment care
- The latter attempts to internalize to the provider the benefits of greater efficiency/reduced resource use

Bundles Have Some of the Same Problems as Pure FFS

- Need to distinguish between aligning incentives and identical incentives
- Providers still have incentive to generate reimbursable units
 - Hospitals still have a negative business case for reducing hospitalizations
 - Thus, question whether aligning incentives of MDs and hospitals for inpatient stays might in fact be counter-productive in the absence of good appropriateness criteria

Political and Technical Challenges to Episodes

- Who gets to distribute the money?
- Technical challenges:
 - -- cases coming out of the “woodwork”
 - -- bias to performing procedures
 - -- risk adjustment
 - -- multiple chronic conditions
- What is an episode of a chronic condition like CHF? An oxymoron.
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Population-based Payment – PMPM or PPPM

- The only approach that truly alters incentives (and so is of concern to some)
- Depending on what level the payment is made, addresses provider fragmentation
- Conceptually amenable to direct provider contracting without health plan intermediary
- Technical challenges are even greater
- CMS PGP demo promising – shared savings
- Out of that arose the idea of “accountable care organizations”

Hybrids and Public Reporting/P4P

- Payment for medical home could be FFS for medical services and PPPM for medical home activities
- Robust public reporting and P4P might mitigate over-responsiveness to incentives
 - FFS with a resource risk pool
 - PPPM with quality and patient experience measures

The Patient Centered Medical Home

- Broad agreement on desirability (if not the name) but less so on specific design elements. For example, is it about all patients and enhanced primary care or about a target population and chronic care management
- Recent recognition that there may need to be various PCMH models – for “transformed” practices doing it directly and for less transformed practices working with community-based supports, e.g., North Carolina Community Care Networks
- -- House Bill would test both models

The Problem of Readmissions

- 20% of 30 day readmissions in Medicare and in 50% of cases no physician claim in interval
- So, some ideas to decrease readmissions --
- -- Alter payment levels to the hospital for a readmission within x days (all or outliers?)
- -- Provide a payment code for physicians for non- face-to-face, post-hospital collaboration
- -- Support for community-based transitions “coaches” or similar professionals