Better implementation of pay for value: Perspective from the front lines

Executive summary: The current “shared savings” payment approach penalizes high value providers, while rewarding historical inefficiency. In a true pay-for-value system, a national payment rate should be established and rooted in reality (e.g., based on the costs of the top performing healthcare delivery organizations, those with the best patient outcomes at lowest costs) and adjusted for three factors: a) risk of the patient population, b) geographic variation in the cost of doing business, c) patient outcomes.

Introduction: This paper outlines the challenges associated with delivering high value healthcare under the current provider reimbursement system and provides a set of recommendations to establish true pay for value incentives to move the country toward high value healthcare for all. The information contained within grew out of a forum, “The times they a’ changing – How are you leading,” held in Breckenridge, CO on February 23-24, 2016. Organized by Dr. Denis A. Cortese and Robert K. Smoldt of the Healthcare Delivery and Policy Program at Arizona State University, the meeting featured presentations by and discussions with operational and medical leaders of organizations with demonstrated success in delivering high value healthcare to the populations they serve (see list of participants and their affiliations below).

List of participants:
Julie Beecher, Director of Strategy & Operations, MedStar Health; Dr. Denis Cortese, Director, Healthcare Delivery & Policy Program, Foundation Professor, Arizona State University (ASU); Dr. Steve Jacobson, Associate Medical Director, Care Coordination, Family Medicine, The Everett Clinic; Dr. Dave Krueger, Executive Director & Medical Director, ThedaCare; Grant Lasson, Associate Vice President for Strategy, University of Utah Health Sciences; Marty Michael, Management Consultant and Strategic Advisor, MFM Consulting; Dr. Robert Pryor, Former President & CEO, Scott & White Healthcare, Senior Vice President Kaufman Hall; Rachel Regan, Program Manager, Payment Initiatives, ThedaCare Center for Healthcare Value; Robert Smoldt, Associate Director, Healthcare Delivery & Policy Program, ASU; Dr. Grace Terrell, President and CEO, Cornerstone Health Care; Dr. David Swieskowski, Senior Vice President and Chief Accountable Care Officer, Mercy Medical Center, Des Moines; Dr. John Toussaint, CEO, ThedaCare Center for Healthcare Value.

Global-based payment systems more conducive to higher value healthcare

While the participants agreed that all of the current payment approaches have some merit and potential use, an anonymous survey and the “payment approaches” discussion that followed, suggest that global-based payment systems (e.g., bundled payments, full capitation) are perceived as best positioned to move the U.S. healthcare system toward high value healthcare for all. Under current reimbursement structure most services are paid for separately and thus there are limited/no financial incentives for various parts of the system to work together to create value for the patient. Moreover, acute episode prevention and care coordination are not rewarded in the current fee-for-service (FFS) environment. Although in theory FFS removes any incentives to deny potentially beneficial care, “providers gain from delivering more care, but are not rewarded and will often lose revenue from evidence-based parsimony.” While shared savings, reference pricing, and varied provider payment updates were viewed as steps in the right direction, participants expressed concern that if these payment approaches continue to be based on the FFS model, they will not result in significant movement toward high value care. In turn, the primary concerns raised around more global payment approaches centered around ensuring that healthcare professionals and delivery organizations would not skimp on patient care. Which brought us to the next major discussion point – implementation.

Implementation is critical

The group felt strongly that the implementation of a given payment approach, and specifically how reimbursement is set for a given service, is a major issue that can either facilitate or significantly hamper an organization’s ability to deliver

high value care. In fact, the biggest frustrations expressed by the group centered around how Medicare currently implements various payment models, with many effectively rewarding the most inefficient providers while penalizing those that already provide high value care. As stated by Ginsburg and Rivlin, “Part of the difficulty involves provider benchmarks that reward improvement rather than level of performance.” This is further complicated by the constant downward pressure on payment benchmarks, which not only reduces or erases any prior gains, but also threatens to put the already high-value providers out of business. Additional concerns raised by the group around the topic of implementation included, inaccuracies with patient attribution, inconsistently set cost and quality targets, and the near-complete lack of patient involvement (except under reference pricing). Finally, given the high concentration of spending on a small group of highly complex patients (20% of patients account for 80% of the cost), it seemed most appropriate that novel payment approaches should be designed to address the care and needs of those high-need, high-cost populations, rather than a payment approach “for all”.

**Key components of a successful global-based payment model**

The group identified the following elements as key to establishing a payment model that is likely to promote high value care:

1. **Reality-based pricing:** Payments should be based on reality, i.e., not defined by complex formulas that are often incorrect and tend to reward delivery organizations that get the worst outcomes. Instead, we feel the approach should be one suggested by Dr. Harold Luft in 2008. This approach would determine what delivering care actually costs in delivery organizations that get the best outcomes (i.e., actual provider cost, not what Medicare currently pays). Moreover, the cost we are referring to here is total cost of care over time (e.g., episode, one year), rather than cost per line-item of services provided. In our example (see Figure 1) the base payment amount could be set at the 75th percentile of the high value quadrant delivery organizations, i.e., hospitals that get better than average quality at lower than average total cost per case. Therefore, all delivery organizations that had costs to the right of the dotted line would now have incentives to become more efficient. Recognizing that organizations with higher than average present costs will have a hard time adjusting to such a large upfront reduction, we recommend that this payment update be done in a phased-in approach over 3 years. A phased-in approach will also benefit payers, Medicare in particular, given that its current payment rates are often below the cost of delivering care. Thus, Medicare could start by setting its rates at the Medicare national average and gradually evolve toward actual costs of the high value quadrant providers.

2. **Bundled payment and Per Member Per Year (PMPY) reimbursement:** Payments should be further adjusted for population characteristics (risk), the cost of doing business (regional differences in wages and non-labor costs), and patient outcomes (quality). A risk-adjusted quality component/withhold is warranted to ensure that we do not sacrifice care effectiveness in the name of efficiency, i.e., patients are not denied appropriate care. For example, instead of receiving 100% of the base payment amount, delivery organizations would initially receive 95% of the base payment amount. Providers with above average outcomes would receive the full amount (95% + the 5% quality withhold). In turn, payment to providers with below average outcomes would remain at 95% of the base payment amount (they lose the 5% quality withhold). The quality withhold could be set at a higher percentage and could also be scaled.

3. **Margin:** Once you have established the baseline PMPY for a given provider, add 2-4% margin, as without a small margin even a not-for-profit organization cannot stay in business.

4. **Secondary re-insurance:** There should be an option to purchase secondary re-insurance to account for catastrophic events. This is particularly important for small and critical-access care delivery organizations.

5. **Patient involvement:** Patient benefits must be aligned with payment approaches in a way that allows for both patient choice and patient responsibility. Consumer choice has long been a key component of American society and consumer involvement is key to ensuring appropriate levels of healthcare utilization. Since the advent of the 3rd

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party payers in the 1940s and further coverage expansion in the 1960s through Medicare and Medicaid, patients have been increasingly insulated from the true costs of care. Not surprisingly, those with healthcare coverage have little incentive to limit their utilization of healthcare services. Consumer Driven Health Plans (CDHP) with Health Savings Accounts (HSA) and preventative care covered at 100% (i.e., no co-pays or co-insurance for visits to coordinating primary provider) present a potential option to accomplish both objectives. Such plans can accommodate low-income individuals by placing a government contribution directly into the individual’s HSA.

**Figure 1: Setting the baseline payment amount**

Each symbol represents a single delivery organization

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Appendix

Figure A1: Payment approaches survey results

Table A1: Summary of payment approaches considered

<table>
<thead>
<tr>
<th>Payment approach</th>
<th>Description</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee for service</td>
<td>Services are unbundled and paid for separately</td>
<td>• Simple to understand and administer</td>
<td>• Rewards process and volume, instead of quality and value</td>
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<td></td>
<td></td>
<td>• No patient concerns about denial of care</td>
<td>• Promotes (over) utilization</td>
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<tr>
<td></td>
<td></td>
<td>• Good for initial evaluation of complex patients</td>
<td>• Not conducive to integration and care coordination, a must for successful management of complex (and high cost) patients</td>
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<tr>
<td>Reference pricing</td>
<td>Insurers provide a defined contribution toward the full price for a procedure. A patient may seek service from a provider with a higher price, but is responsible for the difference between the defined contribution and the actual cost of the procedure.</td>
<td>• Allows for patient choice</td>
<td>• Does not account for quality of care</td>
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<tr>
<td></td>
<td></td>
<td>• Promotes price transparency</td>
<td>• Places significant burden on the patient in determining care quality</td>
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<td></td>
<td></td>
<td>• Encourages patient and provider responsibility around cost of care</td>
<td>• Does not encourage provider integration, unless the reference is on a global payment (e.g., bundle)</td>
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<td>• Puts providers at risk for full payment collection</td>
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<tr>
<td>Variable provider payment updates</td>
<td>Providers delivering higher value receive a larger payment update than those delivering lower value care.</td>
<td>• Creates incentives to provide high value care</td>
<td>• May be difficult to administer without a consistent definition of value across all payers</td>
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<td></td>
<td></td>
<td>• Marginalizes poorly performing providers</td>
<td>• Not conducive to provider integration and care coordination if based on FFS</td>
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<td>Shared savings</td>
<td>After establishing a baseline of annual per patient costs, provider</td>
<td>• Provides incentive to reduce costs while improving outcomes</td>
<td>• Tends to penalize historically efficient providers</td>
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<tr>
<td>Systems and Payers Share in Savings Generated if Per Patient Costs Come in Below This Baseline While Maintaining or Improving Outcomes</td>
<td>Less Risky Than a Fully Capitated Arrangement</td>
<td>Unsustainable Long-Term if Baseline is Continuously and Arbitrarily Lowered by Payers</td>
<td>Current Implementation Complex and Possibly Flawed (e.g., Attribution Methodology)</td>
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<tr>
<td><strong>Patient Centered Medical Home</strong></td>
<td>Promotes Use of Primary Care and Prevention</td>
<td>Low to Zero Payment Rates</td>
<td>Promotes Care Coordination</td>
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<tr>
<td>Patients, Particularly Those with Chronic Conditions, Choose a “Medical Home” for Their Primary Care and Care Management. The Medical Home Operates in a Mixed FFS and Bundled Payment Environment, a Monthly Bundled &quot;Care Coordination&quot; Payment Coupled with FFS Payments for Office Visits. Acute Care is Paid Separately.</td>
<td>Promotes Care Coordination</td>
<td>May Encourage Cherry Picking of Lower Risk Patients</td>
<td>May Promote Overutilization of Bundled Services Unless Appropriateness Criteria Are Included</td>
</tr>
<tr>
<td><strong>Bundled Payments</strong></td>
<td>Aligns Incentives Across the Care Continuum</td>
<td>May Encourage Cherry Picking of Lower Risk Patients</td>
<td>Links Cost to Performance</td>
</tr>
<tr>
<td>A Single Payment to Providers or Health Care Facilities (or Jointly to Both) for All Services to Treat a Given Condition or Provide a Given Treatment. Bundled Payment Asks Providers to Assume Financial Risk for the Cost of Services for a Particular Treatment or Condition, as Well as Costs Associated with Preventable Complications.</td>
<td>Discourages Overutilization</td>
<td>Potentially Rewards Lower Costs More than Care Quality</td>
<td>Creates Incentives to Innovate the Delivery of Care and Focus on Keeping the Patient Healthy</td>
</tr>
<tr>
<td>The Payment Covers the Entire Package of Services Negotiated Between a Purchaser and a Provider for an Enrolled Population.</td>
<td>Potentially Rewards Lower Costs More Than Care Quality</td>
<td>Complex to Set Up: Requires Sophisticated Infrastructure to Track System Performance</td>
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Bundled payments

A single payment to providers or health care facilities (or jointly to both) for all services to treat a given condition or provide a given treatment. Bundled payment asks providers to assume financial risk for the cost of services for a particular treatment or condition, as well as costs associated with preventable complications.

- Aligns incentives across the care continuum
- Links cost to performance
- May encourage cherry picking of lower risk patients
- May promote overutilization of bundled services unless appropriateness criteria are included
- May result in withholding of care unless outcomes are carefully monitored and tied to payment

Full capitation

The payment covers the entire package of services negotiated between a purchaser and a provider for an enrolled population.

- Discourages overutilization
- Creates incentives to innovate the delivery of care and focus on keeping the patient healthy
- Potentially rewards lower costs more than care quality
- Needed care may not be provided unless outcomes are carefully monitored and tied to payment
- Carries risk of adverse selection
- Complex to set up: requires sophisticated infrastructure to track system performance