Payment Reform 201: Can We Build Models that Work for Clinicians and Communities?

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Overview

- Where are we now?
- The Missing Link
- The Race Against Time, Nature, and Politics
- OR
- What We Need Communities and HHS to Do
Where are we now?

- Magnitude of budget pressures cannot be overstated
- ACA “models” emerging in private sector, too
Innovation Center Portfolio

ACO Suite:
• Shared Savings Program
• Pioneer ACO Model
• Advance Payment ACO Model
• Accelerated and Learning Development Sessions

Primary Care Suite
• Comprehensive Primary Care Initiative (CPCI)
• Federally Qualified Health Center Advanced Primary Care Practice Demonstration
• Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
• Independence at Home
• Medicaid Health Home State Plan Option

Bundled Payment Suite
• Bundled Payment for Care Improvement

Dual Eligible Suite:
• State Demonstration to Integrate care for Dual Eligible Individuals
• Financial Alignment to Support State Efforts to Integrate Care
• Demonstration to Reduce Avoidable Hospitalizations of Nursing Facility Residents
• Medicaid Health Home State Plan Option

Diffusion and Scale Suite:
• Partnership for Patients
• Million Hearts Campaign
• Innovation Advisors Program
• Care Innovations Summit

Healthcare Innovation Challenge

Rapid Cycle Evaluation and Research
Learning and Diffusion
Alternative Delivery and Payment Models—Private Sector Initiatives

*The map is current as of November 2011. As new programs are identified the map will be updated accordingly.*
Let’s be clear

• Fiscal balance requires lower total health spending
• Lower health spending can only come from:
  ➢ Lower use w/ less inefficiency or less inappropriate care
  ➢ Lower prices w/ countervailing power
  ➢ Higher quality w/ coordination + information
  ➢ Better health w/ VBID, wellness, pathways
• Reform mostly focuses on quantity and quality
• Someone is gonna lose here, but overall economy?
# Targets of Spending Reductions

- **Poor care delivery**
  - Unnecessary services: $210B (8% of NHE)
  - Inefficient delivery: $130B (5%)
  - Missed prevention: $55B (2%)

- **Excessive Admin Costs**: $190B (8%)

- **Prices**: $105B (4%)

- **Fraud**: $73B (3%)

- **TOTAL**: $765B (31%)

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D. Cutler, Senate Budget Testimony, citing IOM

Where Innovation Is Tradition
“Theory” of payment reform

• Changing the way we pay will so change behavior that total costs will fall AND SOME MDs (plus SOME hospitals) will gain*
  *(Compared to what? Which baseline?)
• AND this outcome will be sustained from new incentive structure
• When is this possible, and when not?
Sustainable Payment Reform

Intervention

Better Performance

Savings cover cost of infrastructure

Where Innovation Is Tradition
Pre-conditions for shared savings-based payment reform to work

• Savings must more than cover intervention

• Payers must share more than cost of intervention
  ➢ Cost could be foregone revenue
  ➢ Cost could be new services that must be added

• Current Baseline must be reference point, at least for a while
Simplest Possible Example

• Cardiologists doing x% inappropriate care in their offices

• Under simple but “reasonable” assumptions:

• Two parameters really matter:
  ➢ SHARE (S) of savings returned to MD
  ➢ MARKUP (M) earned on inappropriate use
    – M = Revenue/Cost of inappropriate use
    – Is GROSS margin (ex 120%, same as 20% net margin)
Simplest possible example

• (where $S = \text{share going to MD}$), then

• Cardiologist gains from reform IF

• $(1-S)M < 1$
  
  ➢ $= \text{share kept by payer} \ast \text{markup on inapp use} < 1$

• Note, for all $M \leq 100\%$, any $S > 0 \Rightarrow \text{gain}$
Simplest possible example

• But $M$ usually > 100%, need higher $S$

• Some $S$, $M$ combos that ‘work’:
  ➢ $M = 120\%, \ S > 20\% \Rightarrow \text{gain}$
  ➢ $M = 200\%, \ S > 50\% \Rightarrow \text{gain}$
  ➢ $M = 400\%, \ S > 75\% \Rightarrow \text{gain}$

• IF MDs accept lower baseline, then min $S$ required is lower
Opportunity cost key concept

- Freed up physician time/hospital beds could have alternative uses
  - New patients?
- More generally, reducing low markup services may enable higher markup services or market share growth
  - NOTE: market share is zero sum, BUT 10-15% more Americans will gain coverage*
Many ways to re-structure payments

• Combine FFS, PMPM, and SHARE(Q)
  - could transition to bundle/global cap over time

• Medical “neighborhood” vs. home

• Communities must define who is in, and who is out, of the neighborhood
  - Safety net, patients, employers, etc.,
What Can/Must Communities Do?

Grand Junction, Rochester

Partnership With CMS/State

Employers > Plans

Where Innovation Is Tradition
What Do We Need HHS To Do?

• Create Office of Local Collaboration = CMS

• Acknowledge the problem is bigger than CMS; requires data, analysis, technical assistance/collaboration, and local drivers

• Explain to Congress why flexibility is so key

• Hire some good “viceroys”