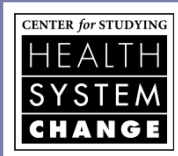


Provider Payment Reform

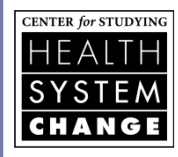
Paul B. Ginsburg, Ph.D.

■ NIHCM Policy Forum, June 26, 2009



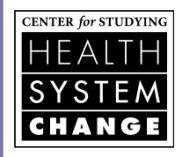
Introduction

- Payers sending inadvertent signals to providers about types of care that are valued the most
- Providers are responding to these incentives
- For many services response involves increasing capacity
- Ownership of capacity further increases use of those services



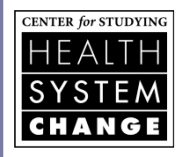
Payer Objectives in Setting Provider Payment Rates

- Structure of payment rates should not influence decisions on care delivery
- (Public payers) fairness to different providers
- Both achieved when relative payment rates align with relative costs



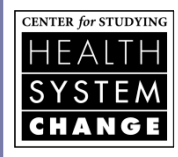
Pattern of Payment Structure Deviating from Cost Structure

- Surgical DRGs more profitable than medical DRGs
 - Magnitude reduced by CMS revamp of DRG methods
 - Distortions remain for per diem and discounted charges approaches
- Physician procedures involving new technology more profitable than evaluation and management services
 - Physician work component
 - Technical (facility) component
- Patterns not intended by payers



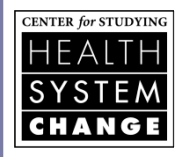
Vigorous Provider Response to Inadvertent Payment Incentives (1)

- Hospital service line strategies
- Physician investment in freestanding outpatient facilities
- Physician investment in facilities in offices
- Single specialty group mergers to reach scale needed for equipment-intensive services
- McAllen, Texas now a famous example of responses to payment incentives



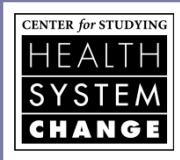
Vigorous Provider Response to Inadvertent Payment Incentives (2)

- Physicians shifting to more lucrative specialties
 - Primary care shortages seen increasingly
 - Research that specialty mix influences spending



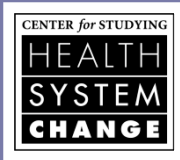
Capacity Leads to Higher Rates of Service Use

- Greater patient convenience
 - Third party payment changes calculus of patient convenience
- Self-referral incentives apply to more services
 - Not just physician professional time
 - Incentives likely more powerful when services highly profitable
 - Extra incentives when average costs much higher than marginal cost (major equipment)



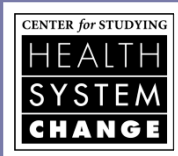
Policies to Reduce Pricing Distortions

- Medicare best positioned to lead in this area
 - Credibility with providers
 - Engagement of provider leadership in its work
 - Sufficient clout with many providers
 - Introduction of physician fee schedule did not lead to access problems
- Private payers increasingly following Medicare payment structures
 - Extensive use of Medicare RVS
 - But need to deviate to accommodate provider market power



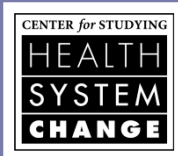
Medicare Policy Options

- “Easier” part of the payment reform agenda
 - Revision of current methods
- Updating physician work values
 - Identification of services with increasing productivity for reductions
- More accurate estimates of facility costs
 - Frequent updating to reflect declining costs associated with technology
 - Consider projections of unit cost trends
 - Higher assumptions on capacity utilization
 - Absence of entitlement by providers to offer services profitably
- Use of volume trends as indicator of pricing errors
 - Routine use in Japan for imaging



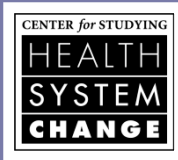
Broader Units of Payment

- Once payment structure is fixed, focus on broader units
- Potential initial steps
 - Incentives to reduce hospital readmissions
 - Bundling post-acute care into inpatient DRG
 - Capitation payment for medical home services
- Greater challenges—but greater rewards
 - Per episode bundles
 - Accountable care organizations



Per Episode Bundles

- Include all providers involved in an episode
 - Incentives for efficient episode
 - Choosing efficient provider partners
 - Attribution can be challenging
- Initially a modification to fee for service
 - Bonuses/penalties for per episode efficiency
 - Some private insurer experience
 - CMS laying groundwork with Resource Use Reports
- Recent criticism by advocates of ACOs
 - Incentive to generate more episodes?
 - Limited policy resources?



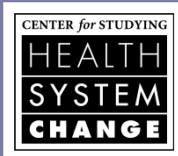
Accountable Care Organizations

- Per enrollee incentives
- Organizations formed to take per enrollee risk
- FFS payment with bonuses/penalties for quality and efficiency
- Key challenges
 - Can effective organizations be created?
 - Can enrollees be attributed accurately?



Private Payers

- Potential for Medicare to work with private payers
- Distinct problem of private payer market power
 - Especially in hospital care
- Two basic strategies
 - Patient incentives to choose less expensive providers
 - All-payer rate regulation
 - Neither being discussed in conjunction with health care reform



Concluding Thoughts

- Payment reform may have greatest potential to “bend the trend” of medical spending
- Medicare well positioned to lead
- But Medicare’s potential to lead needs shoring up
 - Reform of governance
 - Provide insulation from Congressional and White House intervention in payment decisions
 - Provider reliable resources to perform technical functions
- Limitations in private payer market power will need to be addressed