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Emphasizing Value: The Future of Payment Reform

Payment reform has taken center stage in national discussions about transforming the health care system, owing in part to the passage of the Affordable Care Act (ACA). The ACA contains numerous provisions for testing and implementing new forms of payment to providers that are intended to encourage and support delivery system reform. These provisions are designed to tackle the fundamental flaws of traditional methods of payment in health care: namely, that they do little to control costs and do not provide incentives for the provision of high quality care.

The United States has a poor track record with regard to both the cost and quality of health care. Health care costs continue to grow rapidly: in 2009, US health care spending grew 4.0% to \$8,086 per capita, or a total of \$2.5 trillion—17.6% of GDP,¹ higher than in any other industrialized country.² At the same time, outcomes are not commensurate with spending, and health care resources could be used much more efficiently. Consistent with prior research,³ a recent study found that only 51% of adults received recommended screening and preventive care.⁴ In addition, quality performance across care settings is extremely variable.⁵

California has historically fared better-than-average in terms of health care costs: the state's average personal health care expenditure per enrollee was \$4,638 versus a national average of \$5,283 in 2004, and its percentage growth per enrollee averaged 4.4% per year between 1991 and 2004, versus the national average of 5.5%.⁶ However, recent trends and quality concerns give immediacy to the goal of payment reform in the state. Between 2000 and 2008, employer-sponsored health insurance premiums grew five times faster than earnings in California;⁷ and the quality of care delivered varies, with the state lagging behind the national average on key quality indicators, including vaccinations for seniors and mortality rates for many inpatient heart conditions and cases of pneumonia.⁸

A Unique Context for Payment Reform

California presents a unique context for payment reform because capitation is still a predominant form of payment. California has higher managed care enrollment than any other state,⁹ the majority of which is serviced by large physician organizations that accept capitation payments for their patients who are enrolled in health maintenance organization (HMO) plans.¹⁰ This is in contrast to much of the rest of the country,

where capitation fell out of favor during the managed care backlash of the 1990s.

Capitation is a single lump sum payment that covers various services that an enrollee accesses. The scope of services covered under a capitation payment differs from contract to contract; global capitation refers to payments that cover the full scope of care, from primary care to hospital and post-acute care, whereas professional services capitation covers primary and specialty care services. Although capitation is more prevalent in California than in other states, physician organizations in California differ in the scope of capitation that they accept.¹¹

“Today we get what we pay for... If we change the incentives by changing the health care reimbursement system so that we pay for value, not volume, then we have enormous potential to slow the growth in health care costs.”¹⁶

—Center for American Progress, 2009

Capitation gives incentives to providers to consider the total costs of services rendered, as they can incur losses if a patient receives care that costs more than the monthly capitation rate. It also may encourage coordination across care settings that are covered by a single capitation payment. A common criticism of capitation is that it gives providers incentives to stint on care.¹² Another criticism is that, while a capitation payment gives providers incentives to ensure that the costs of the care delivered stay within that payment, there is no assurance that the amount of that payment will grow at sustainable levels.¹³

At the other end of the spectrum is fee-for-service (FFS) payment, which is a predominant form of payment in much of the US and is used in many non-HMO insurance products in California. FFS reimbursement means a separate payment is made for each service rendered—i.e., each office visit, surgery, and diagnostic test is paid for separately. Historically, payment has been tied to the cost, rather than the value, of the service. Under FFS payment, providers have incentives to deliver more

Bundled Episode Payment and Gainsharing Demonstration

The Integrated Healthcare Association (IHA) is working with California hospitals and physicians to implement a demonstration project to test the feasibility of bundling payments to hospitals, physicians, and ancillary providers for inpatient surgical procedures. Funded by the federal Agency for Healthcare Quality and Research, the project expects to:

1. Encourage financial alignment that will support delivery system and process re-engineering to improve patient care quality and efficiency,
2. Allow for shared savings among health plans, providers, employers, and patients to the extent bundled reimbursement improves quality and efficiency, and
3. Develop and test solutions to bundled payment implementation issues.

This 3-year project will cover ten inpatient surgical procedures including total knee replacement, diagnostic cardiac catheterization, and hip replacement. It will test the feasibility of bundling within the constraints of the California regulatory environment and the existing delivery system, and will include HMO, PPO, Medicare Advantage, and Medi-Cal managed care populations.

At the end of the pilot, there will be a rigorous evaluation of the impact of bundled episode payment on both clinical quality and health care costs in comparison to current payment mechanisms. The evaluation will be conducted by the RAND Corporation and UC San Francisco and UC Berkeley researchers.²³

care, as well as more expensive care, as this brings in more revenue. They also have no incentive to coordinate care with their counterparts in other care settings to reduce duplication or waste, because each treatment, test, or visit is paid for on a discrete basis.¹⁴ In most FFS systems, many activities that improve care between office visits—e.g., follow-ups via phone call or email—are not reimbursed, and innovations that reduce the costs of care disadvantage the provider because they can lead to lower reimbursement.¹⁵

California Examples of Payment Reform Initiatives

There have been several California initiatives to moderate the negative incentives created by current payment methods. Many of these initiatives are aligned with national efforts at payment reform, but modified for the state's health care environment.

Pay for Performance

Pay for performance (P4P) is an early example of payment reform that emphasizes rewarding providers for delivering higher quality care. P4P programs vary in design but provide incentives for the provision of higher quality care, which can be defined in any number of ways, including delivering care according to evidence-based guidelines, or enhancing patient experience. P4P can help to address FFS incentives to provide care regardless of its impact on quality and capitation incentives to underprovide potentially beneficial care in order to keep costs down.

California is home to the largest non-government physician P4P program in the US. The program is managed by the Integrated Healthcare Association (IHA) on behalf of eight health plans and covers over 200 capitated medical groups and independent practice associations (IPAs) that provide care for about 10 million commercial HMO enrollees. The goal of the program is to create a compelling set of incentives that drive breakthrough improvements in clinical quality, efficiency, and the patient experience through: 1) a common set of measures, 2) a public report card, and 3) health plan incentive payments. Results are publicly reported to consumers by the state Office of the Patient Advocate (www.opa.ca.gov).

Since measurement began in 2003, the IHA P4P Program has focused primarily on quality measures. However, over the life of the program, the cost of commercial HMO products has risen over 140% in the state, and stakeholders have grown concerned about the continued financial viability of these products. In response, the program has begun a strategic transition towards Value Based P4P, which will hold participating physician organizations accountable for both the quality and the cost of care provided to their HMO enrollees. The primary objectives of Value Based P4P are to emphasize cost control and affordability, continue to promote quality, standardize health plan efficiency measures and payment methodologies, and increase the amount

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- 2 David A. Squires. *The U.S. Health System in Perspective: A Comparison of Twelve Industrialized Nations*. The Commonwealth Fund, July 2011.
- 3 Elizabeth A. McGlynn et al. "The Quality of Healthcare Delivered to Adults in the United States." *NEJM*, 2003; 348:2635-45.
- 4 *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2011*. The Commonwealth Fund Commission on A High Performance Health System, October 2011.
- 5 This statement is borne out in a wide variety of research; see, for example, the work of the Dartmouth Atlas project: <http://www.dartmouthatlas.org/>.
- 6 CMS Office of the Actuary, *National Health Expenditure Data—U.S. State Estimates by State of Residence*, September 2007.
- 7 "California healthcare costs surge five times faster than earnings." *Los Angeles Times Booster Shot Blog*, October 16, 2008.
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- 11 Ibid.
- 12 John K. Iglehart. "Assessing an ACO Prototype—Medicare's Physician Group Practice Demonstration." *NEJM*, 2011; 364:198-200.
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of incentives available to physician organizations using a shared savings model.¹⁷

Bundled Episode of Care Payments

Under bundled payment, there is a single payment for all providers and services involved in the course of a treatment or “episode” (e.g., a total knee replacement). Unlike multiple FFS payments for all providers involved in a single episode, bundled payment encourages alignment among providers, who have an incentive to work together to reduce unnecessary services provided during the episode, use resources more efficiently,

“Cost and quality must be integrated to address the affordability issue in these harsh economic times. True value is a measure of both quality and cost-effectiveness.”¹⁸

— Steve McDermott, Hill Physicians Medical Group

and coordinate care across multiple settings (e.g., pre-surgery, inpatient stay, and post-discharge).¹⁹ Any reduction in costs below the price of the bundle results in savings for the providers; however, if the care costs more, the providers are financially liable for the difference.²⁰ In addition to this direct incentive to reduce costs, bundling also may provide an incentive to improve quality because avoiding complications or readmissions results in lower total costs. A new project in California that involves bundled episode of care payments is described on page 2.

Accountable Care Organizations

Both a payment reform and a delivery system reform, the Accountable Care Organization (ACO) model is rapidly taking hold across the country due in part to ACA provisions that encourage providers to form ACOs and participate in the Medicare Shared Savings Program. In this program, ACOs can receive a share of the cost savings they achieve on care covered under Medicare Parts A and B relative to a historical

CalPERS Accountable Care Organization (ACO) Pilot

Several ACO partnerships have developed between private payers and providers in California, including one between the California Public Employees’ Retirement System (CalPERS), Blue Shield of California, Catholic Healthcare West, and Hill Physicians Medical Group. This pilot covers 41,000 CalPERS members enrolled in a Blue Shield HMO in Sacramento, El Dorado, and Placer counties.²⁴

The initiative was started in 2010 when the health plan and providers entered into an agreement with CalPERS to be financially at risk for any variance from agreed-upon cost reduction goals for care provided to CalPERS members. The objective was to reduce costs of the local delivery system while improving quality.

To date, results of this initiative have been positive. By October 2010, hospital readmissions had been reduced by 17%; there was a 50% reduction in the number of patients hospitalized for 20 or more days; total inpatient days were reduced by 14%; and there had been a half-day reduction in the average length of inpatient stays. CalPERS estimated that by early 2011, the pilot had saved about \$15.5 million. A full evaluation will be completed in 2012.

Those involved in this partnership identified a willingness of all parties to align toward a common goal as being a key to the pilot’s success. This partnership illustrates that cost savings and quality improvement can both be achieved at the same time, and that these goals are not necessarily at odds. As noted by Ann Boynton, Deputy Executive Officer for Benefit Programs Policy and Planning at CalPERS, “So far, this pilot is clear evidence that better communication between the health plans, medical facilities, and doctors can and does lead to positive health outcomes and cost savings.”²⁵

benchmark—as long as they meet pre-defined quality goals. The ACO concept is flexible, but a common theme is that groups of providers, which could include medical groups, physician-hospital organizations, and other types of provider partnerships, are rewarded for increasing the quality and lowering the cost of care delivered to a population of patients. Although this concept is being met with enthusiasm by the Centers for Medicare & Medicaid Services (CMS) and many private payers, there are

14 Medicare Payment Advisory Commission (MedPAC). *Reforming the Delivery System*, Report to the Congress, Washington, D.C.: MedPAC, June 2008.

15 Ibid.

16 Ellen-Marie Whelan and Judy Feder. *Payment Reform to Improve Health Care: Ways to move forward*, Center for American Progress, June 24, 2009.

17 Emma Dolan and Dolores Yanagihara. *Value Based Pay for Performance in California*, Integrated Healthcare Association, September 2011.

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19 RAND. *Analysis of Bundled Payment*, 2011. http://www.rand.org/pubs/technical_reports/TR562z20/analysis-of-bundled-payment.html

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21 Robert A. Berenson, Paul B. Ginsburg, and Nicole Kemper. “Unchecked Provider Clout In California Foreshadows Challenges To Health Reform,” *Health Affairs*, April 2010, 29(4):699-705.

22 Catalyst for Payment Reform, Inc., 2011. <http://www.catalyzepaymentreform.org/Principles.html>

23 Integrated Healthcare Association. *IHA Bundled Episode Payment and Gainsharing Demonstration Project Description*, March 14, 2011.

24 California Public Employees’ Retirement System (CalPERS). “Integrated Care Pilot Exceeds Expectations,” CalPERS press release, April 12, 2011.

25 Ibid.

concerns that provider consolidation to form ACOs could lead to higher prices for commercial payers.²¹ Details about one ACO pilot program underway in California are provided on page 3.

The Future of Payment Reform in California

The above examples highlight a few of the many evolving reforms that are attempting to reduce costs in the health care system while simultaneously improving quality. There are a number of themes emerging from these efforts, including the importance of bringing multiple stakeholders—hospitals, physicians, purchasers, and health plans—together to solve cost and quality problems, and the ability to encourage greater integration across providers through novel payment mechanisms. Future initiatives likely will build on current efforts as rising health care costs increase the pressure on stakeholders to seek ways to save money while increasing quality.

Policy Recommendations

In an environment of shrinking state budgets, California state policymakers have the opportunity to take a pivotal role in health care payment reform, due to the state's function as a payer for Medi-Cal enrollees and state employees. The following recommendations focus on ways to improve the health care delivery system through payment reform initiatives that emphasize value by simultaneously pursuing both cost and quality goals. These recommendations build on payment reform principles that emphasize rewards for high-quality, cost-effective, patient-centered, affordable care; care coordination across providers and care settings; and alignment between public and private sector efforts.²²

1. Embrace payment reform as a strategic imperative in state programs. Health care is a large and growing share of state budgets, and to ensure the long-term sustainability of not only state health programs but also other state-run services upon which residents depend, reforms that reduce costs

are necessary. Delivery system re-design should be coupled with compelling incentives for desired behaviors that help to reduce costs and improve quality. An improved health care delivery system is essential to ensure the success of state and federal health reform initiatives.

2. Establish priorities for state programs that emphasize value rather than either cost or quality alone. Health care costs may be reduced at the expense of quality, but low quality is neither a desirable nor necessary outcome of cost reduction. There is a growing body of evidence showing that quality can be increased at the same time that costs are decreased, but an overall goal of value that encompasses both quality and cost must be explicit in program design.

3. Partner with and build on existing payment reform efforts. To avoid “reinventing the wheel” and increasing the administrative burden of payment reforms on providers, state health programs should partner with, or mirror, payment reform programs that already exist. This could include becoming involved in current pilot projects, or using overlapping metrics for programs. Doing so will help to prevent “measure fatigue,” which can result when providers are subject to multiple and competing performance measurement frameworks. Partnering with other payers in payment reform can also multiply the power of incentives to increase quality and lower costs.

4. Collect and analyze data to understand the impacts of payment reform. It is likely that there will be both intended and unintended results from payment reform efforts. At the outset of payment reform initiatives, evaluation plans should be developed so that an accurate assessment of the effects of incentives can be made. Evaluations can, for example, provide insights into whether incentives are adequate in size and appropriate in structure to have the desired outcomes (e.g., changes in provider behavior that lower costs and increase quality).



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