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Value-based Payment Systems to Incentivize Health Care Delivery

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Why link healthcare delivery and payment systems?

- Integrated care is the 21st Century effort to meet the needs of infectious, non-communicable and chronic illness – the trifecta of health challenges in LMICs
- To achieve that shift and to bolster the quality of primary care

→ financing must align with those objectives and,

→ the payment systems must provide the incentives to drive new behaviors and processes

What are payment systems?

Payment systems are simply the way health providers are paid

-- and they have profound impacts on how providers behave

- The major rationale for separating payment and provision is to allow payers – governments, social insurers, private insurers – to reward good performance and penalize poor performance → it can raise overall performance and quality in health care
- However, payment systems are necessary but not sufficient for raising provider performance

What are payment systems in healthcare?

- Payment systems are provider payment mechanisms (PPM) that transfer funds from the purchasers of healthcare services – Ministries of Health, social insurance funds, other public or private sources of funds -- to the providers, hospitals, clinics, physicians, nurses, other medical staff
- They are fundamental to the operation of healthcare services

PPMs are more than a way to transfer funds

- They are key to achieving government objectives in healthcare
- PPM are the most important leverage purchasers have in shaping health care delivery → because they have a profound impact on the behavior of managers, physicians and other staff
- Thus PPMs are important in affecting volume, quality and efficiency of services

Financing is not just about transfer of funds

- Financing changes behavior of providers and patients
- Ample evidence shows that explicit and implicit incentives in payment arrangements affect provider and patient behaviors
- Proper payment incentives influences efficiency and quality in healthcare delivery
- Integrating financing and delivery offers an opportunity to influence processes and outcomes – and ensure harnessing of incentives for healthcare objectives

Value based payment and integrated care

Driving change in healthcare

Payment system – value-based payment

a strategy to promote quality and value of health care services by shifting from volume based payments to payments tied to outcomes

(Michael Porter 2009)

Value-based health care delivery -- key concepts

- Value = patient health outcomes per dollar spent
- Goal is:
  - Value for patients, not just access
  - Cost containment,
  - Convenience
  - Customer service
- Choice and competition to encourage continuous improvement across providers

Porter's choice and competition to encourage continuous improvement in value and restructuring of care

- Integrate systems of care – integrated care
- Create integrated practice units – coordinate care
- Measure outcomes – generate data
- Measure costs – know relative costs
- Bundled prices rather than FFS -- targeted payment system
- Build an enabling information technology platform – data systems to track progress and manage the system

Michael Porter, 2009

Driving value based care → designs incentives and uses data to achieve results

- Payment systems designed to change behaviors to enhance quality and efficiency
- Different payment arrangements are appropriate for different purposes
- Effective use of payment systems requires:
  - Data
  - Policy and program engagement to design incentives and monitor impacts

Traditional payment systems have limited leverage to improve outcomes

- Common payment arrangements in public systems do not design incentives for productivity or quality:
  - Salary
  - Capitation
  - Fee for service
  - Line item budget
- They drive up volume rather than value

Traditional payment systems limit ability to manage healthcare

- No data on allocation of spending, so hard to know how funds are used and the impact of the payments
- No connection between level of payment and performance
- Limits ability to hold individuals or institutions to account for performance

→ no data and no accountability, that is, consequences for performance

Value –based care needs alternative payment systems

- New payment models geared to producing quality and value
- Entail more oversight from payers
- Require clear incentives for providers
- Need to equip providers to respond to incentives in payment systems
- Payers must be reliable

New payment systems and value-based care

New payment systems align with value-based care

- Global budgets with autonomy and accountability
- Capitation with autonomy and accountability
- Diagnostic related groups (DRGs)
- Bundled payments
- Pay for performance (P4P)
- Shared savings
- Accountable Care Organizations (ACOs)

Each payment system has different approach and confronts different issues

- Some are more complicated
- Others are effective but hard to use
- Autonomy of providers central to new payment models
- Role of data is key in all of them
- Accountability – that is, holding providers to account for their performance, is integral to the design

Global capitation with autonomy and accountability

Definition	Issues	Objective
• Fixed prospective payment to an integrated care entity to cover all patient services for a defined population over a specified time period. Payment adjusted for gender, age, income and location • Provider has autonomy in structuring and delivering services • Provider is held to account for performance	• Requires data to track activity, performance and outcomes • Requires management to assess data, compare performances, administer rewards and penalties • Performance and outcome goals defined in advance • Payer must be consistent over time and providers	Encourage use of primary care, promote wellness, reduce costs, improve quality. Autonomy provides incentive to innovate and provides tools to meet goals

Global budgets with autonomy and accountability

Definition	Issues	Objective
• Defined annual or bi-annual payment for full service provision by health provider, often for hospitals • Provider has autonomy in structuring and delivering services • Performance and outcome goals defined • Data tracks volume, value and outcomes • Provider is held to account for performance	• Requires data to track activity, performance and outcomes • Requires management to assess data, compare performances, administer rewards and penalties • Payer must be consistent over time and providers	Encourage use of primary care, promote wellness, reduce costs, improve quality. Autonomy provides incentive to innovate and provides tools to meet goals

Diagnostic related groups (DRGs)

Definition	Issues	Objectives
• A "case rate" payment (i.e. care associated with a particular condition or procedure) to hospitals based on expected cost of inpatient treatment • Predetermined amount for hospitalization for specific diagnosis based on primary and secondary diagnoses	• Complicated system for defining payment by diagnoses based on ICD-10 codes • Detailed data systems for tracking activity – also useful for monitoring provider activities • Provider data systems parallel payer systems	• Incentives for hospital efficiency • Provides a tool for monitoring hospital activity and tracking allocation of costs

Bundled payments

Definition	Issues	Objective
• Predetermined, risk adjusted payment for full cost of treatment over the entire care cycle of a clinical episode, encompassing hospital and outpatient services • Following of clinical protocols embedded in process • Provider is held to account for performance	• Need to define the full set of inpatient and outpatient needs and determine the associated costs to set prices for each bundled service • Need to monitor the process to ensure compliance	• Encourages integrated, higher quality care with better patient support • Greater efficiency in treatment lead to savings

Pay for performance (P4P)

Definition	Issues	Objective
• Bonus or supplemental payments for hospitals, physician groups or health care team that reward meeting of defined performance standards	• Requires data to track activity, performance and outcomes • Requires management to assess data, compare performances, administer rewards and penalties	• Encourages achieving specific goals for medical team or group of providers. • Goals can be processes, outputs or outcomes

“Shared savings” – sharing of cost savings

Definition	Issues	Objective
• Payment in which provider or provider organizations share cost savings with the payer; savings are generated when actual spending for a defined population is below a target amount • Payers often provide assistance and funding to initiate efficiency change	• Requires data to track costs, and efficiency or savings • Requires management to assess data, and manage the allocation of savings • Often achieved by physician groups or health care teams with new delivery arrangements	• Encourages improved care for patients including managing high risk conditions • Offers physicians and healthcare teams tools to improve efficiency and care

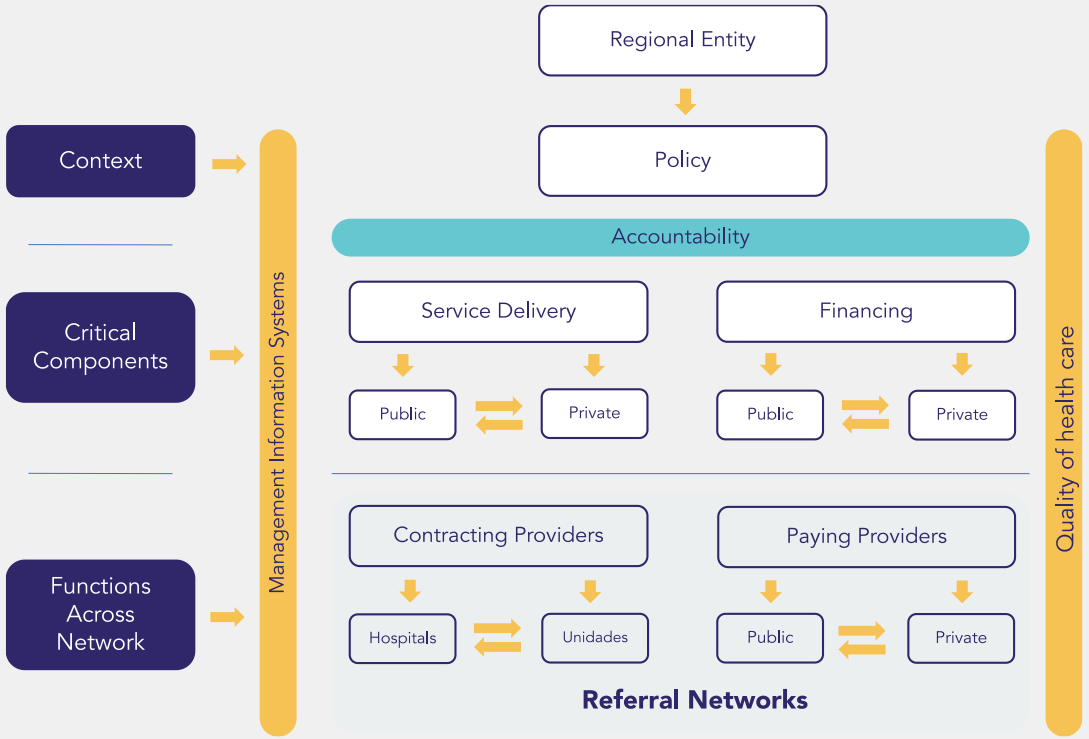
Accountable Care Organizations (ACOs)

Definition	Issues	Objective
• An organizational and financing arrangement that relies on different payment systems (capitation, bundled payments, shared savings) • Payments based on the results health care organizations and health care professionals achieve for patients in their care network • Provider has autonomy in structuring and delivering services. Performance and outcome goals defined in advance	• Requires data to track activity, performance and outcomes • Requires management to assess data, compare performances, administer rewards and penalties	• Encourages use of primary care, promotes wellness, reduces costs, improves quality • Autonomy provides incentives to innovate and provides tools to meet goals

Policy objective and ability to manage providers determine best payment system

- Value-based care more challenging than traditional payment as it entails:
  - More management by providers
  - More management and oversight by payers
  - More data across the system
- In effect it means a different culture –moving from "command and control" to one of greater autonomy and accountability with ability to manage and measure

Example of an integrated care model



Using payment systems as incentives for improved performance

Only payers can shift healthcare services for quality and value

- Financial and other incentives for providers and beneficiaries are key
- Payer support for providers important in clinical services, data and analysis

Financial incentives raise provider performance and quality

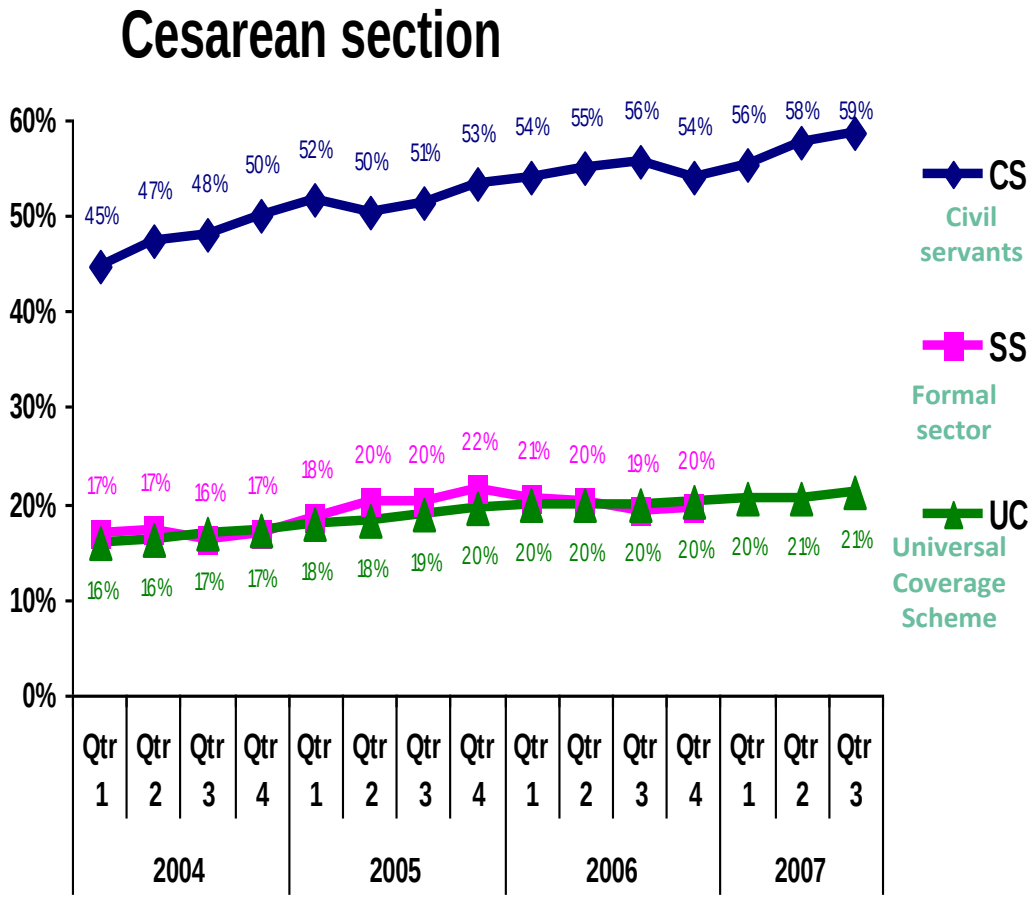
Through hospital alternatives:

- Improved outpatient services and outreach
- Day hospitals
- Rehabilitation hospitals
- Home care
- Palliative care

By targeting high cost, low value behavior:

- Systematically applying clinical protocols
- Reducing readmissions
- Reducing unnecessary hospital lengths of stay
- Discouraging use of emergency rooms for routine health problems
- Engaging patients in managing their health

Thailand - different payment schemes affect Cesarean-section incidence

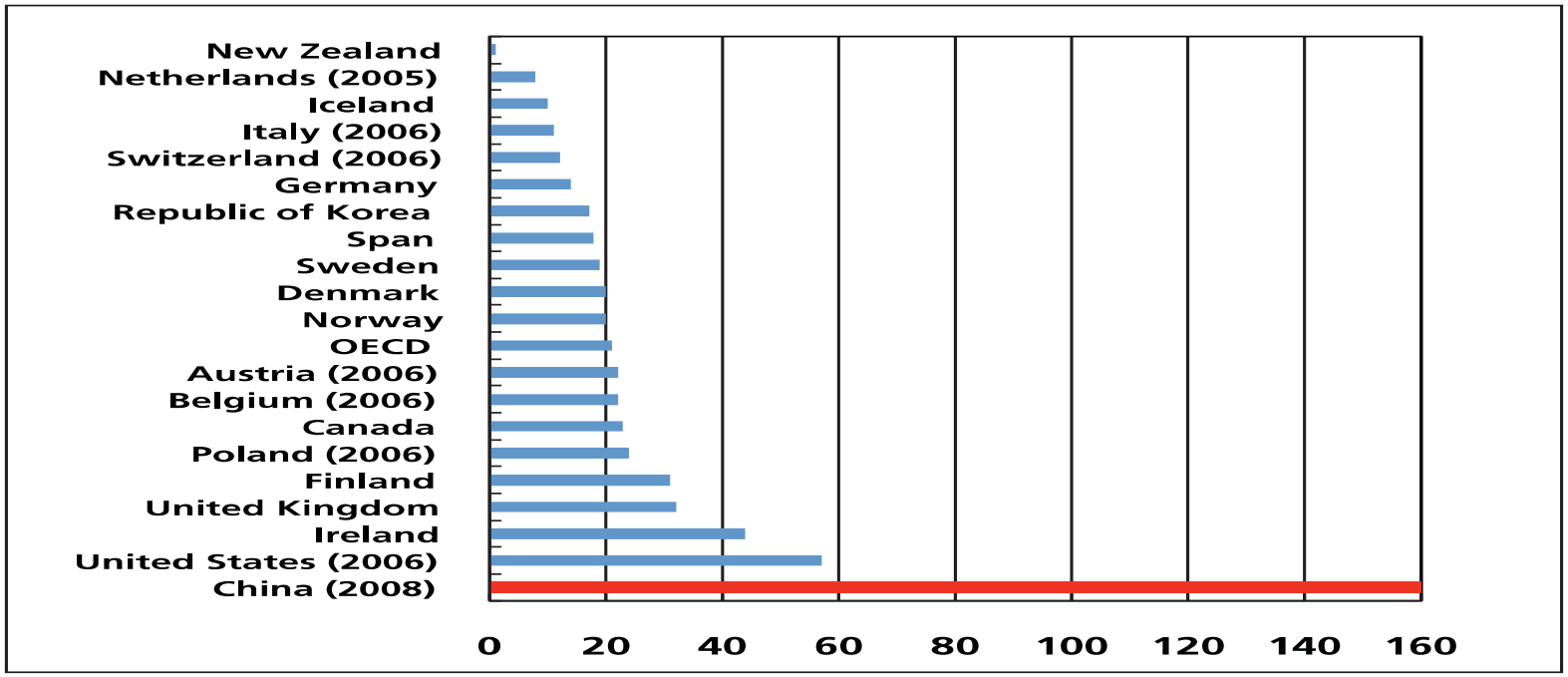


- Changes in how providers were paid resulted in significant variation in services provided to mothers at birth…natural delivery or C-section
- The 3 lines show payment models for 3 insurance schemes. The top line shows doctors paid under fee-for-service while the bottom two are under capitation

Source: Limwattananon, J., S. Limwattanon, et al. (2009). Analysis of practice variation due to payment methods across health insurance schemes. CDP Health report.

China: hospitalization for diabetes over 8 times the levels of European countries → no incentives to manage diabetes as chronic condition

Age-sex Standardized Rates per 100,000
Aged 15 and Over

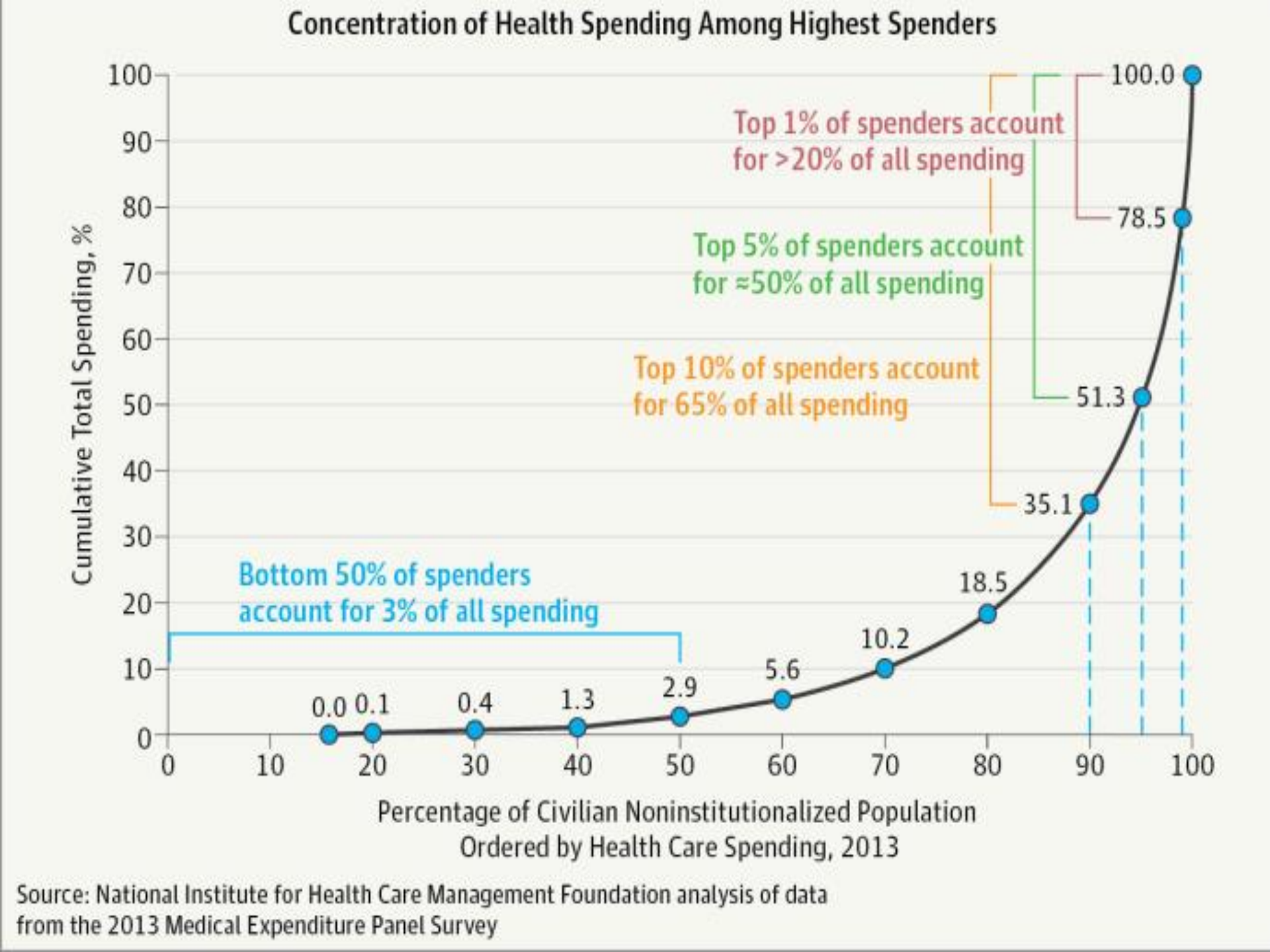


China's data point is an estimate based on the 2008 national household health surveys.

Source: Health at a Glance

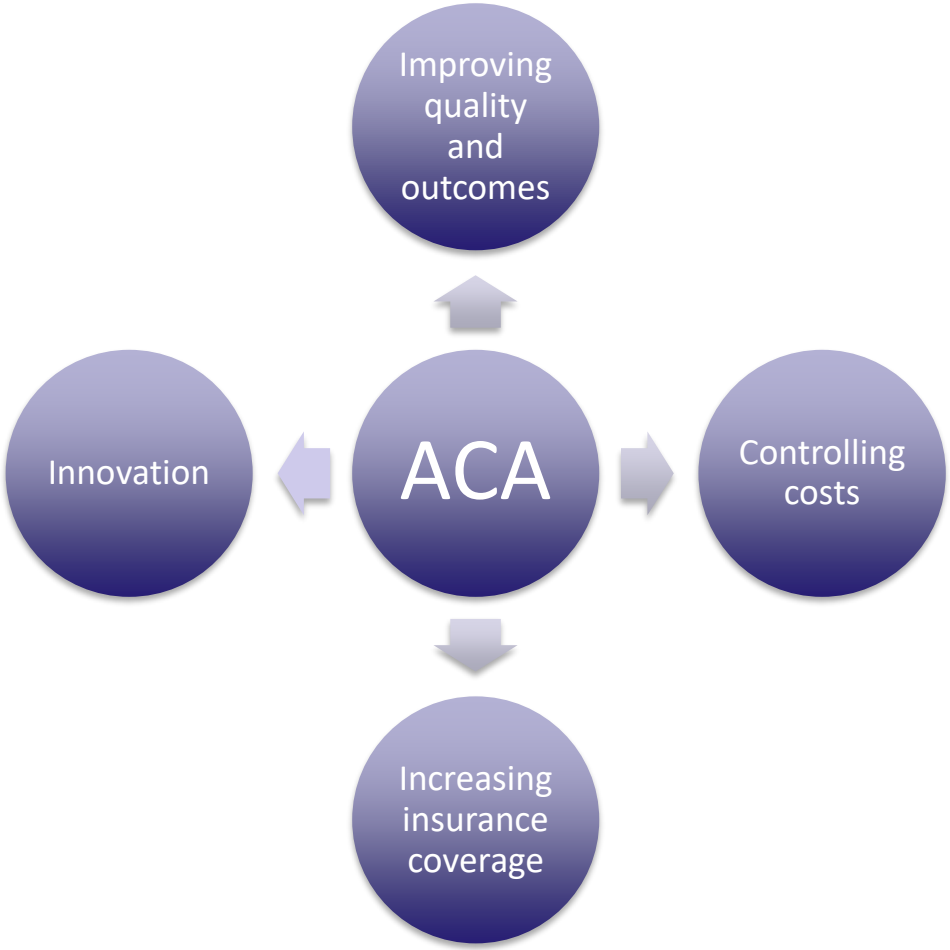
Obamacare has restructured the US healthcare system

- Big emphasis on quality
- Strong focus on integrated, coordinated primary care
- Built and expanded a national data system using electronic health records
- Different payment systems designed and deployed to reach objectives → value based purchasing
- Disease burden big driver for change



Source: National Institute for Health Care Management Foundation analysis of data from the 2013 Medical Expenditure Panel Survey

Obamacare was intended to:



Change initially driven by public sector,

but:

private sector adopted similar innovations to drive quality and better outcomes

US private and public payment systems shifting away from fee for service (FFS)

- "Pay for quality" and "pay for value"
- Promoting new models of care
- Reliance on big data to track performance, determine compliance and define rewards

Public insurer (CMS) revised payment arrangements under Obamacare

Alternative Payment Models

- Accountable Care Organizations – global capitation/shared savings
- Bundled Payments to include physicians and post-hospital care
- Comprehensive Primary Care through integrated care models

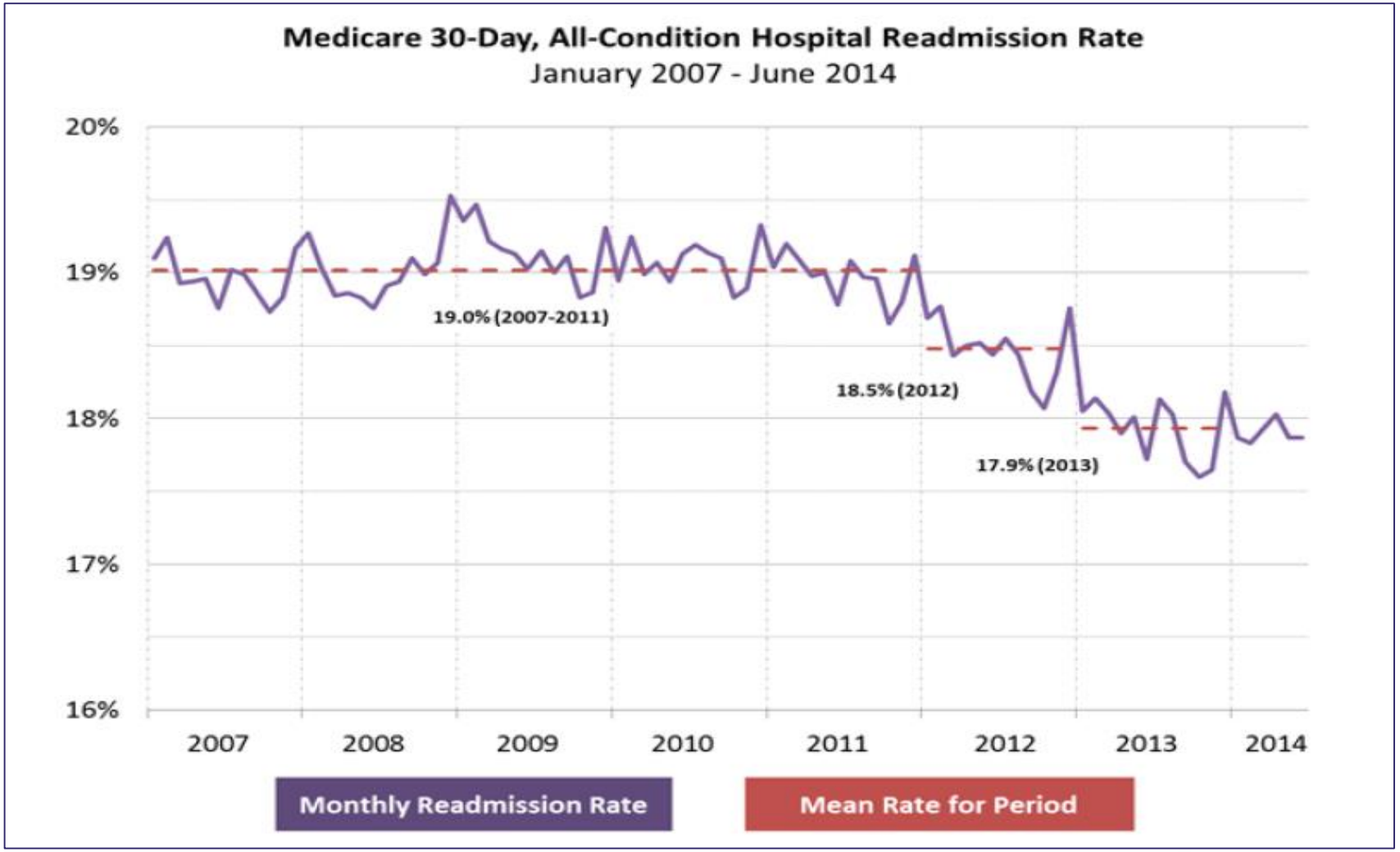
Payment for Quality and Value

- Hospital Value Based Purchasing for quality and value - bonuses
- Physician Value Based Modifier for quality and value
- Readmissions/Hospital Acquired Infections penalties
- Shared savings/Blended payments for PHC

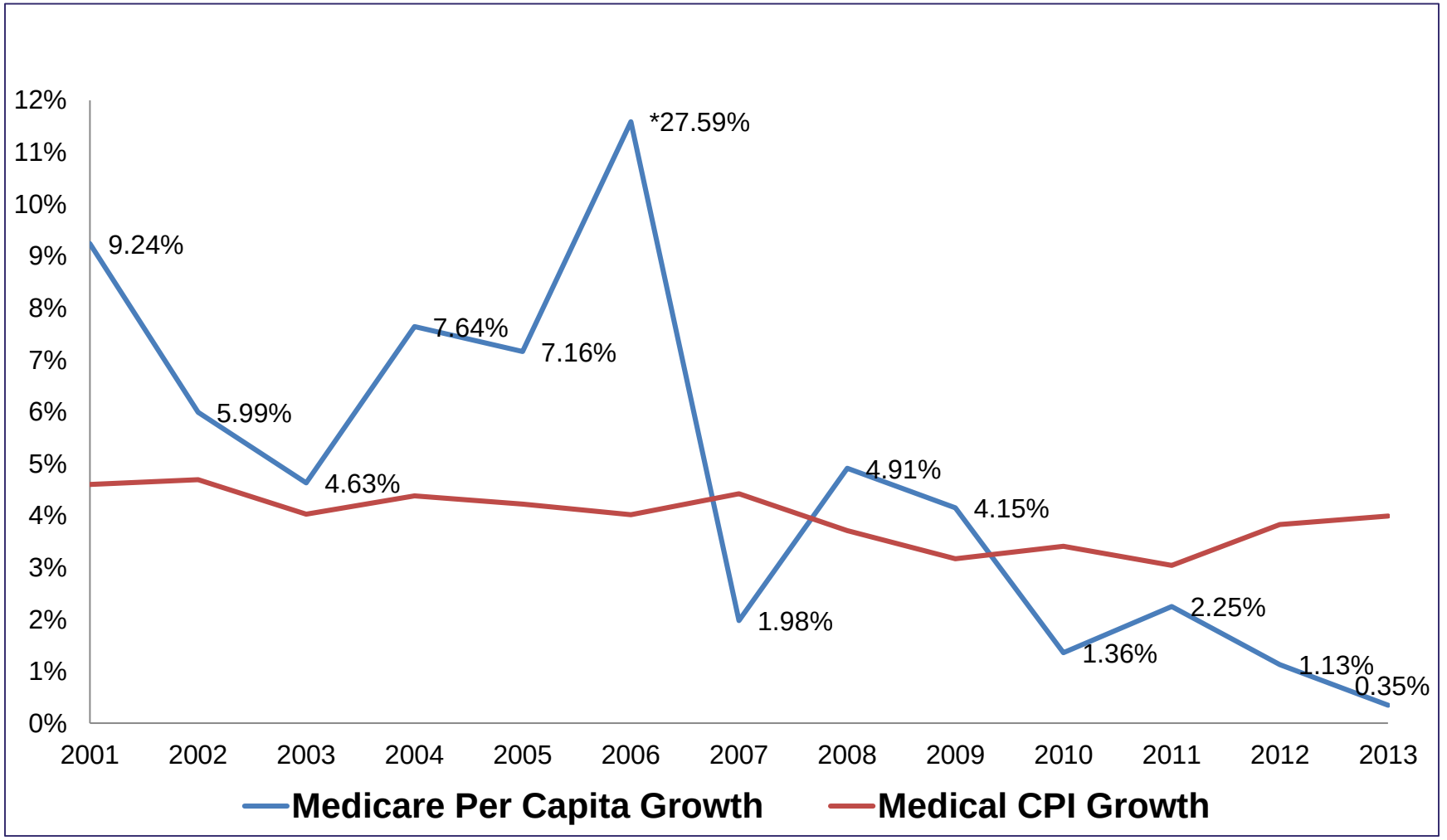
1. Hospitals paid for value and quality – not volume (FFS)

- Receive bonuses for improving trends in:
  - Reduced readmissions
  - Improved quality based on indicator targets
  - Controlling costs
- Face penalties for no improvement in:
  - Quality indicators
  - Patient outcomes
  - Efficiency

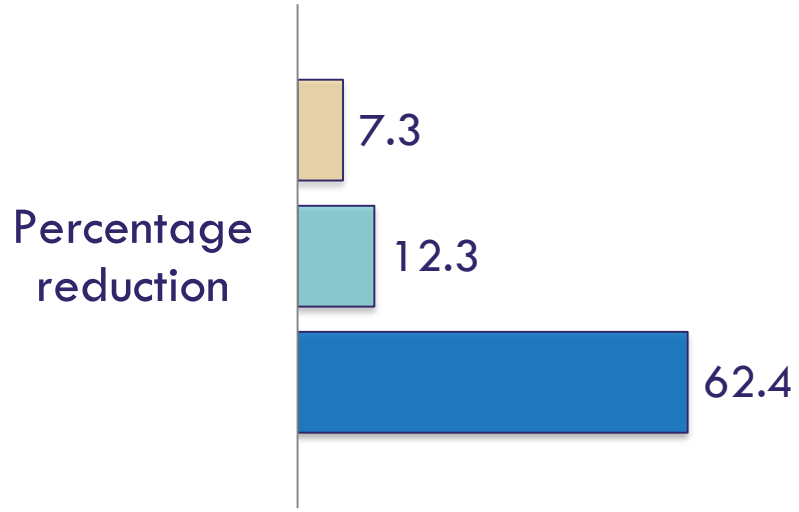
Positive Medicare Readmission Trends



Declining Per Capita Spending Growth



Quality and outcomes improved: hospital acquired infection reduction 2010-2013



17% fall in hospital acquired infections

50,000 lives saved

US$ 12 billion in savings

Source: CMS

2. Bundled Payments

Payment to provider(s) is "bundle" for:

- Hospital and physician payment: to encourage use of teams – physicians, nurses, community
- An episode of care, hospitalization and follow up outpatient care for discharged patients
  - to promote recovery and discourage reliance on emergency room care or readmission
  - To coordinate care and manage chronic conditions
- Used extensively for orthopedic surgery, cancer treatments, maternity

Successful application of bundled payments in US and Netherlands

Baptist Health System, Texas

Summary: Clinically integrated network of 5 hospitals with orthopedic surgery episode

Results:

- 21% decline in average overall episode spending
- 29% drop in joint implant device costs
- 54% drop in average inpatient rehabilitation spending
- Length of stay dropped 22% to 7%

Source: Cost of Joint Replacement Using Bundled Payment Models (Navathe et al., 2017)

Zorg In Ontwikkeling

Summary: Integrated primary care network for diabetes patients

Results:

- 15% drop in patients with poor glycemic control
- 54% decrease in hospitalization admission costs with assigned nurse specialist

Source: Case Study: Zio Integrated Care Network (Hubertus et al., 2017)

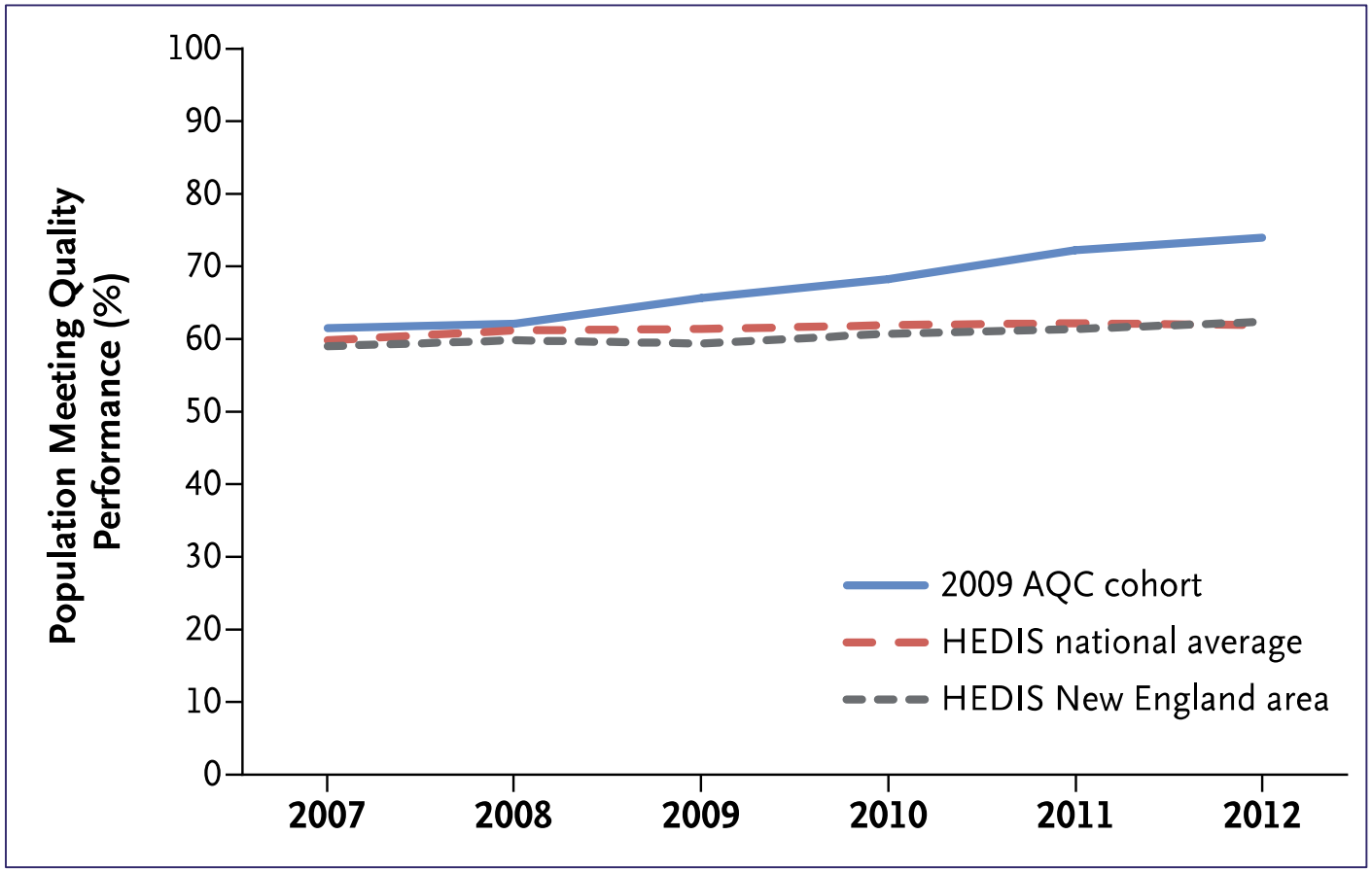
3. ACO integrated care networks provide value – though evidence mixed

- ✓ Rewards keeping chronic care patients healthy
- ✓ Payers & providers share risk -- and savings
- ✓ Avoid emergency rooms & hospitalizations

Massachusetts ACO: global capitated budget and shared savings

- Blue Cross, non profit quality and cost control finances large physician groups
- Physician group leads the process
- Spending and clinical performance data shared with providers – payer supported provider planning and testing
- Budgets based on historical provider spending
- Payer participated in redesign with ACO

AQC Improves Outcomes, 2007-2012



AQC enrollees had better outcomes on 5 measures of the Healthcare effectiveness data information (HEDIS)

Song Z, Rose S et al. Changes in Health Care Spending and Quality 4 Years into Global Payment, N Engl J Med 2014; 371:1704-1714 October 30, 2014

Massachusetts Alternative Quality Contract Components

Global Capitated Budget	Defined annual budget for all physician groups. All medical expenses covered for enrollees
Performance Indicators	Incentives based on quality measures; performance determines share of profits or losses
Clinical Support for data analysis and best practice	Physician groups have dedicated team from Blue Cross to generate performance data share, best practices across groups and drive innovation
Shared savings	Blue Cross shared savings from increased efficiency with Massachusetts ACO physicians after the integrated care network was operating and successful

Many payment systems, but they can fail for many reasons:

- Distorted incentives that are confusing and make responding difficult
- Providers that don't have sufficient autonomy or financial resources to respond adequately
- Targets too ambitious too soon
- Managers, medical staff or administrators not adequately trained to respond

Some ACOs have failed due to

- Confused incentives
  - Putting hospitals as leaders of the ACO –confused incentives as ACOs are meant to reduce hospitalizations, hospitals earnings are tied to hospital stays
- Raising the bar too high too fast

New payment systems create other demands

Payment systems require data to design incentives and hold providers to account for outcomes

Data extracted from EMRs and other data sources allow:

- Providers to manage performance
- Payers to encourage better outcomes

- Big data can be harnessed to compensate providers for quality and value, not volume
- Big data facilitates effective use of alternative payment mechanisms

How payers can move the agenda forward

- ✓Place quality of care at the center of the agenda
- ✓Create incentives for providers to integrate care and raise quality
- ✓Collaborate with providers in designing approaches that can work to ensure quality of care

Key Messages and Considerations

- Providers and payers have an interest in improving quality
- Quality and efficiency help to control costs
- Payers can collaborate with providers to support changes
- Many options for encouraging better care at lower cost
  - Different payment arrangements
  - "Nudges" for behavior shifts of providers and patients

Sources and References

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