Shifting accountability -
An international comparison of payment reforms

Jeroen N. Struijs

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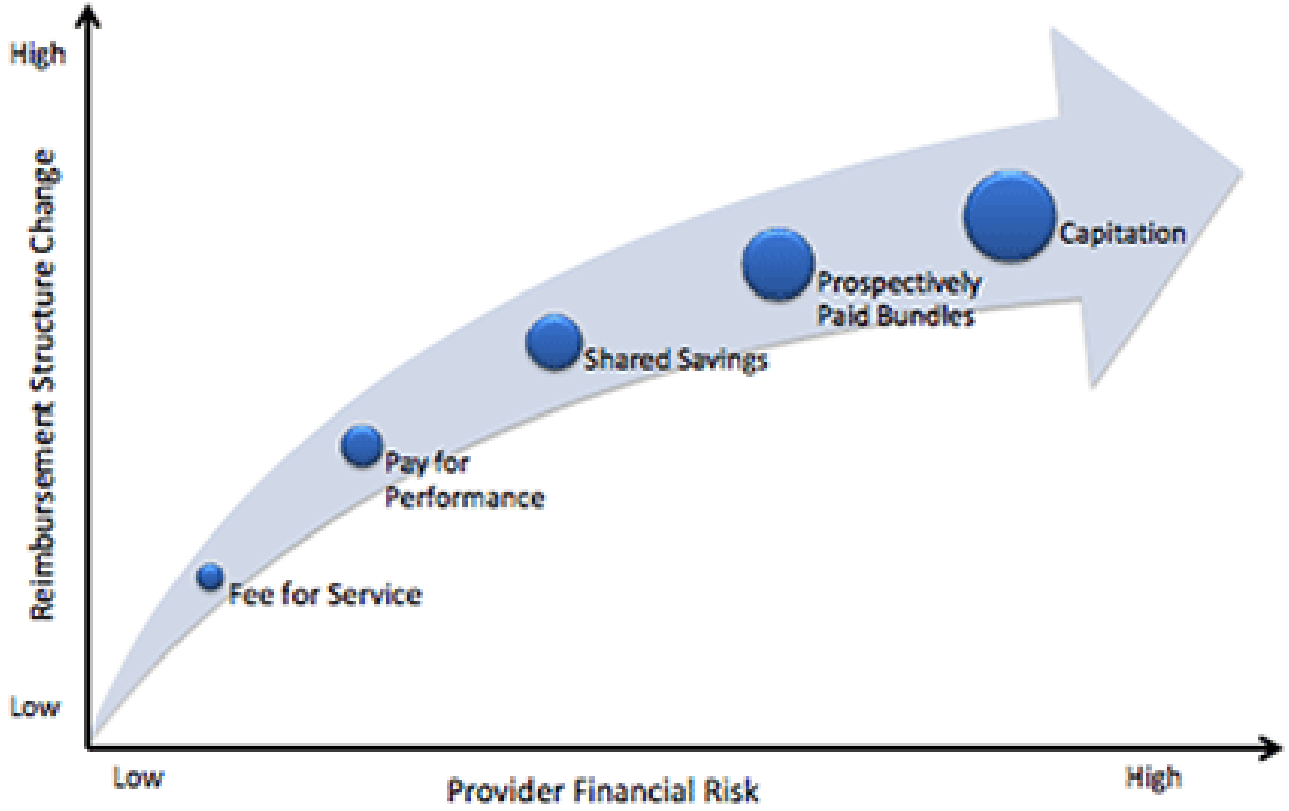
From volume based towards more value-based payment models



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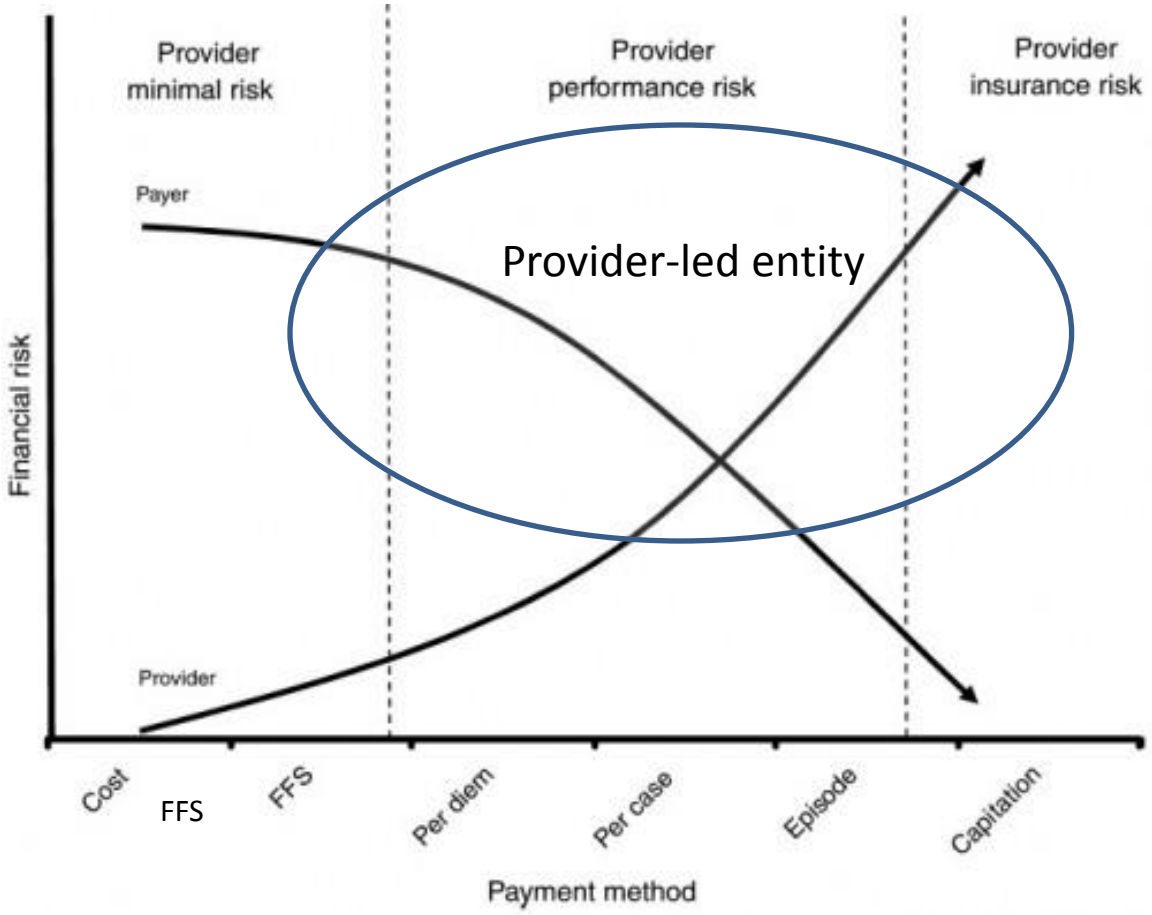
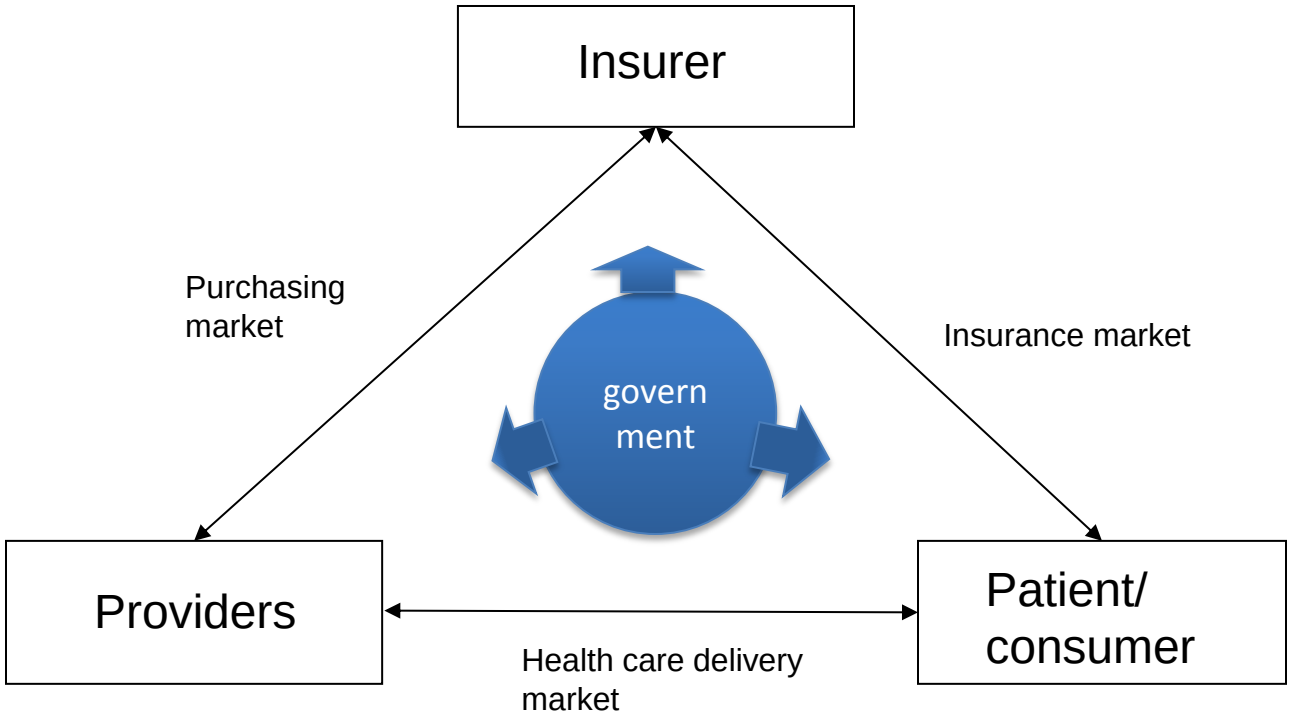


Bron: Averill et al., 2010


Insurer
Purchasing market
Insurance market
govern ment
Providers
Patient/ consumer
Health care delivery market

THE MILBANK QUARTERLY
A JOURNAL OF PUBLIC HEALTH AND HEALTH CARE POLICY

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Theory and Practice in the Design of Physician Payment Incentives

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University of California, Berkeley

There are many mechanisms for paying physicians; some are good and some are bad. The three worst are fee-for-service, capitation, and salary. Fee-for-service rewards the provision of inappropriate services, the fraudulent upcoding of visits and procedures, and the churning of "ping-pong" referrals among specialists. Capitation rewards the denial of appropriate services, the dumping of the chronically ill, and a narrow scope of practice that refers out every time-consuming patient. Salary undermines productivity, condones on-the-job leisure, and fosters a bureaucratic mentality in which every procedure is someone else's problem. But American medicine exhibits numerous interesting compensation systems that blend elements of retrospective and prospective payment, of fee-for-service, salary, and capitation. These innovations seek a middle ground between high- and low-intensity incentives, between piece rates and straight salary. Payment

Background

- FFS:
  - flexible and easy
  - maximizing patient visits (volume?)
  - No incentive to deliver efficient care or prevent unnecessary care
  - No accountability across setting and multiple providers
  - Financial risk for payer

Background

- Capitation:
  - flexible and easy
  - Minimizing patient visits (incentive to deliver efficient care or prevent unnecessary care
  - Stinting on care?
  - Financial partly for provider and provider (salary)

Background

- Alternative models:
  - Pay for coordination
  - Pay for reporting
  - Pay for Performance
  - Bundled payment
  - Shared savings
  - Global payment
  - Combination of above

Key questions

1. To explore the key design elements of the introduced payment reforms and related provider-led entities
2. How provider-payer contracts contribute to quality improvements and cost reductions? (Lesson from the AQC)

Casus:

- Bundled payment (NL)
- MSSP ACOs (US)
- Alternative Quality Contract (AQC) (US)
- Clinical Commissioning Groups (England)

Method: semi-structured interviews and literature

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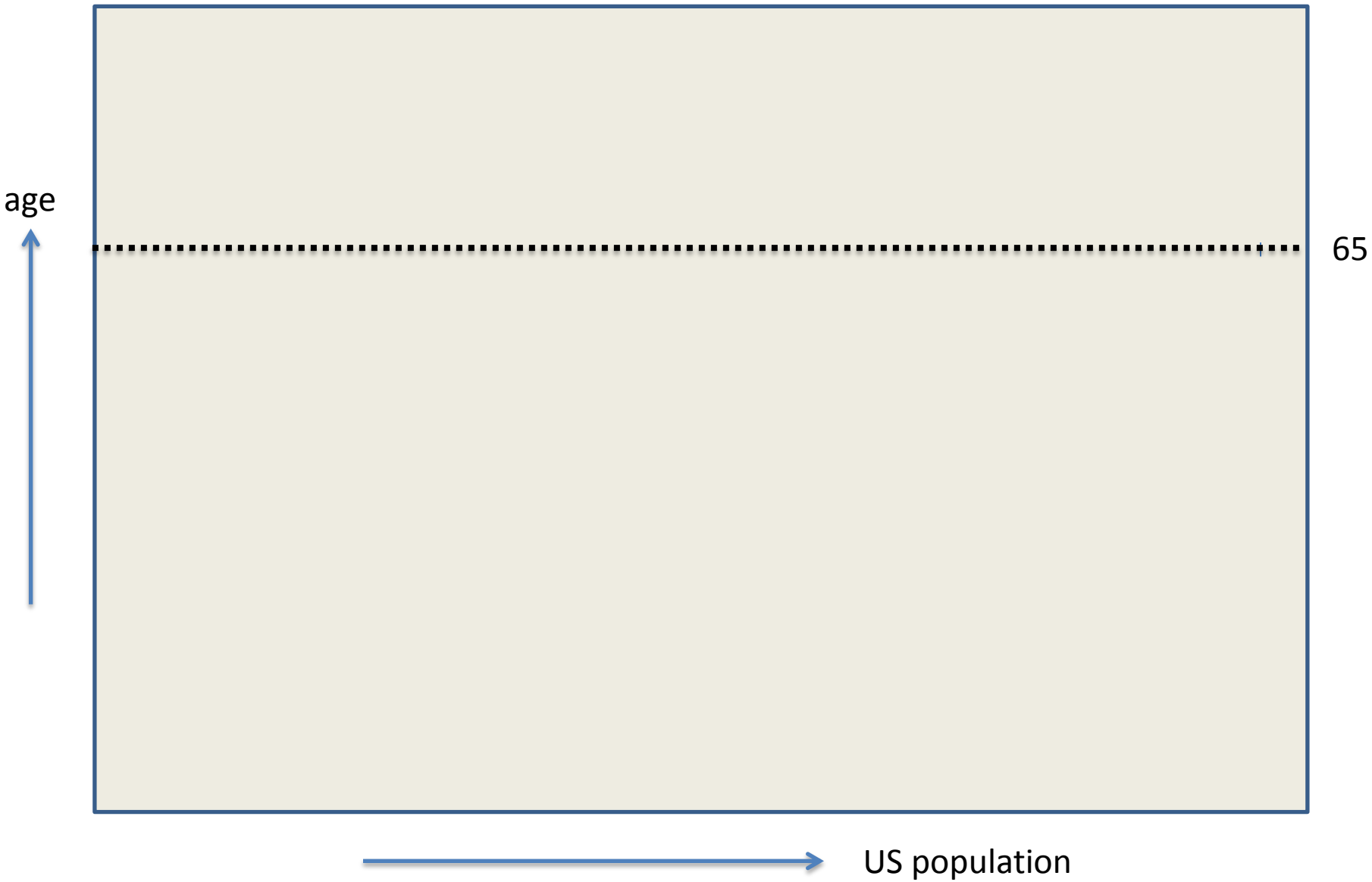
Background US health care system

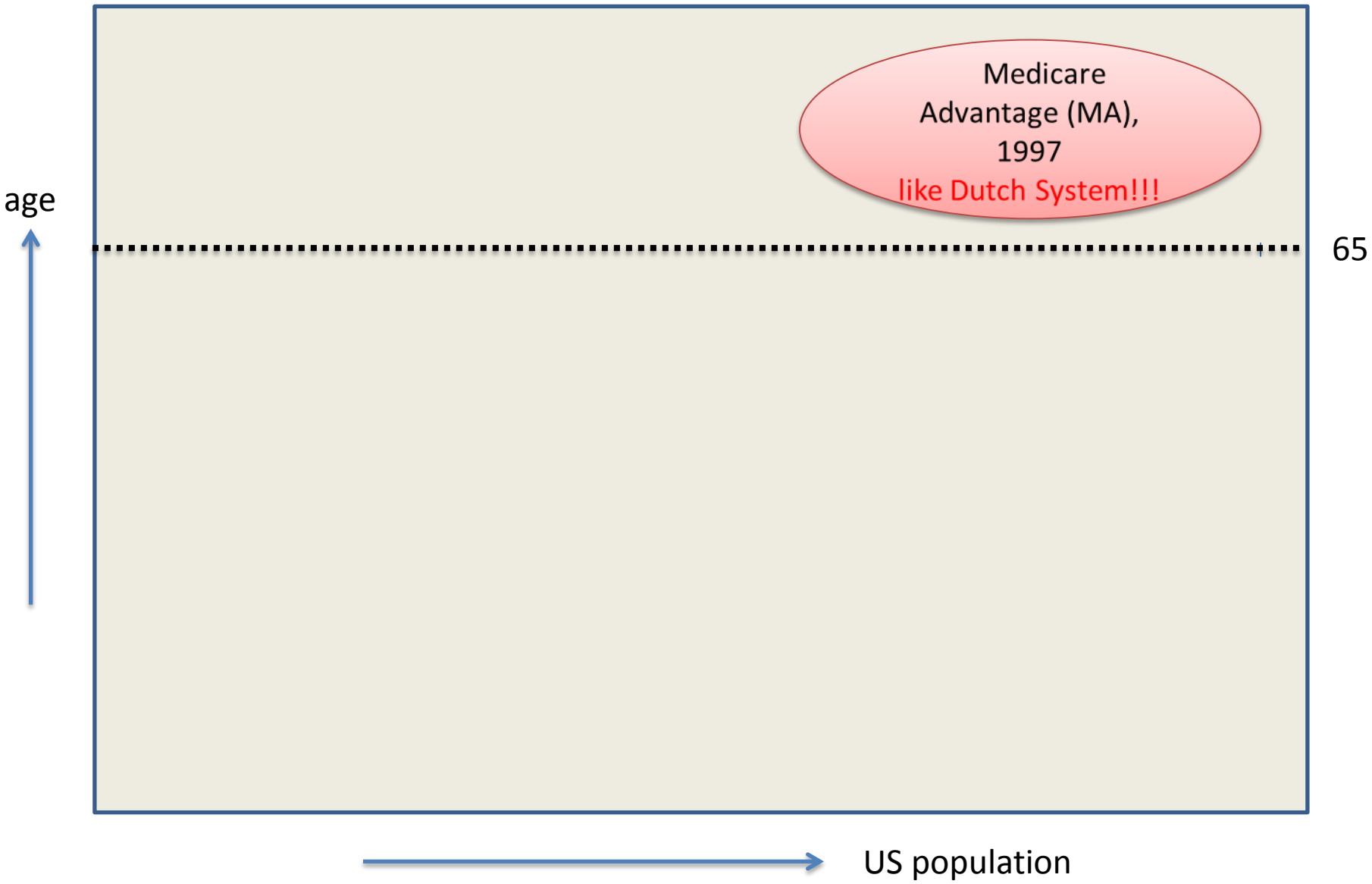
Affordable Care Act / ‘Obamacare’

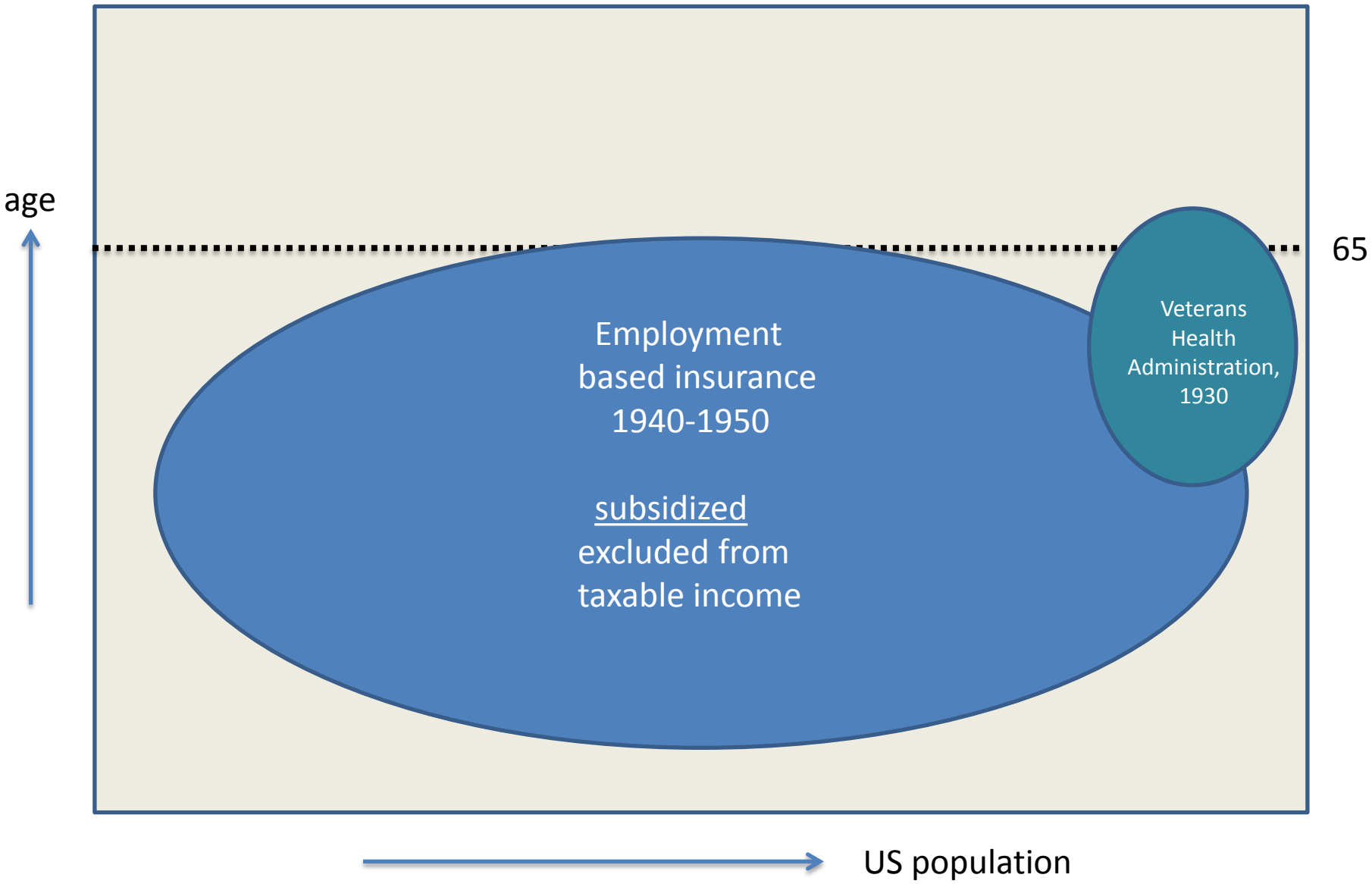
- Why the ACA?
- What is in it?

US Health Care System

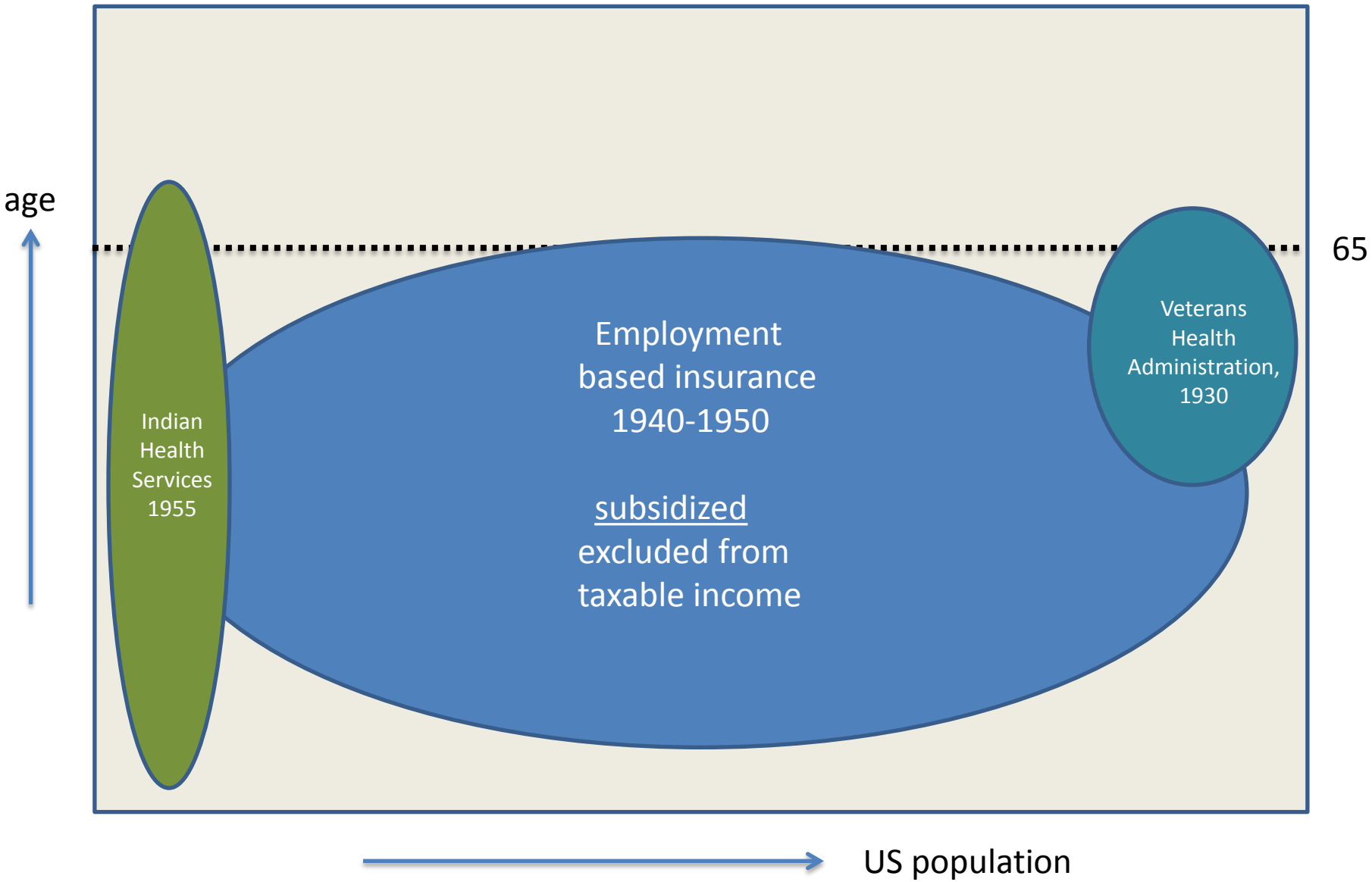


US Health Care System

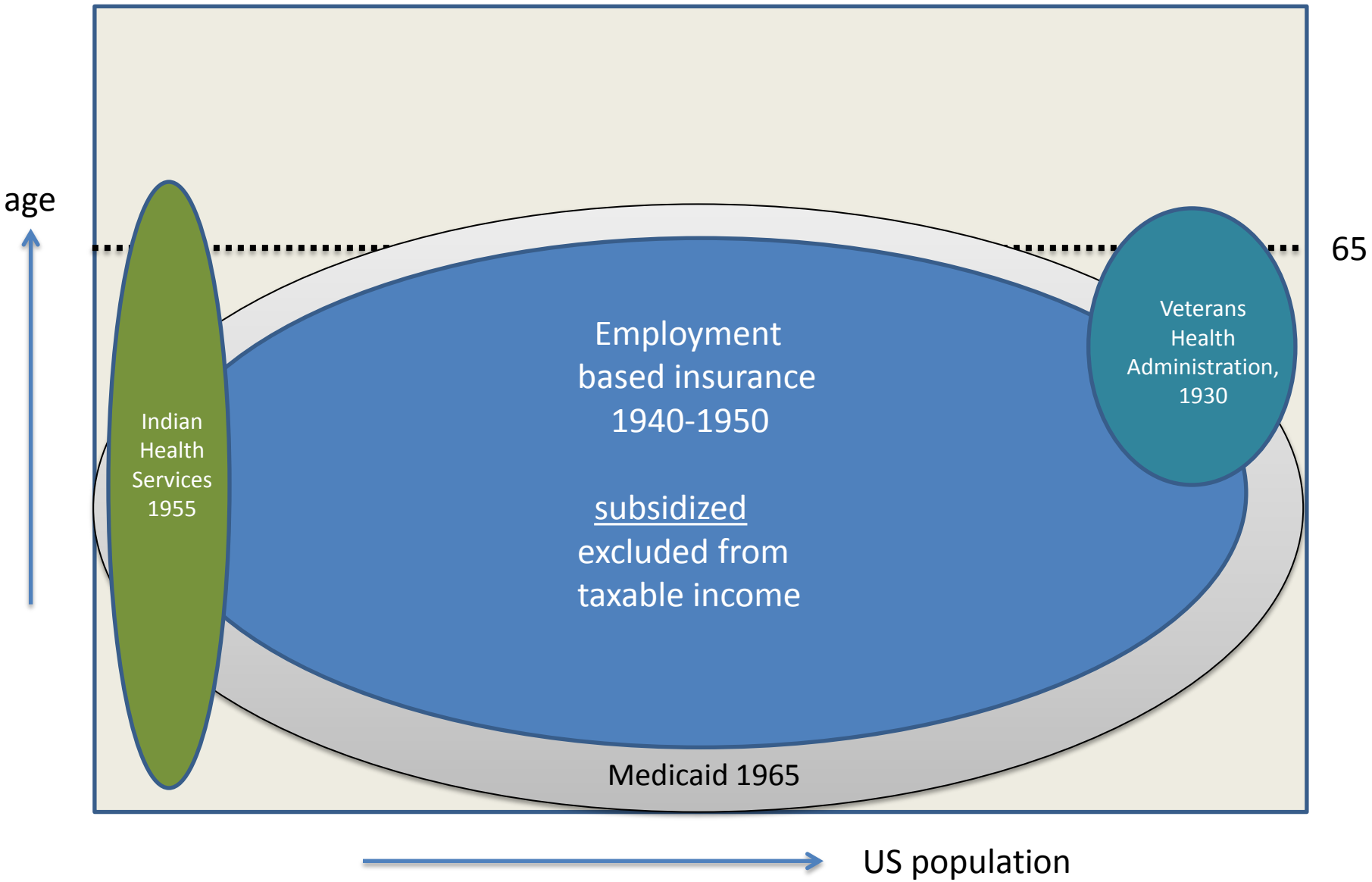



age
65
Employment
based insurance
1940-1950
subsidized
excluded from
taxable income
Veterans
Health
Administration,
1930
US population

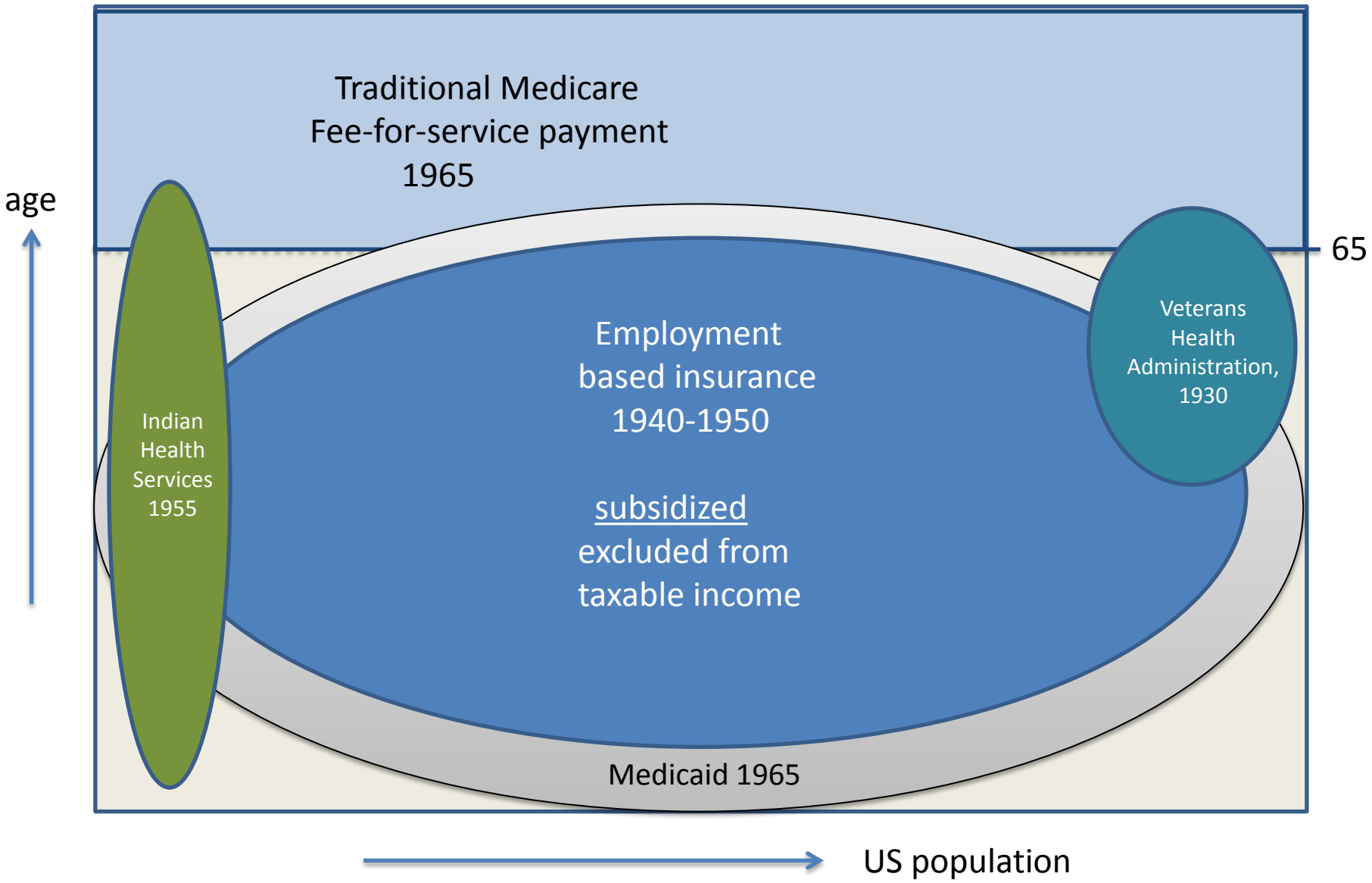
US Health Care System



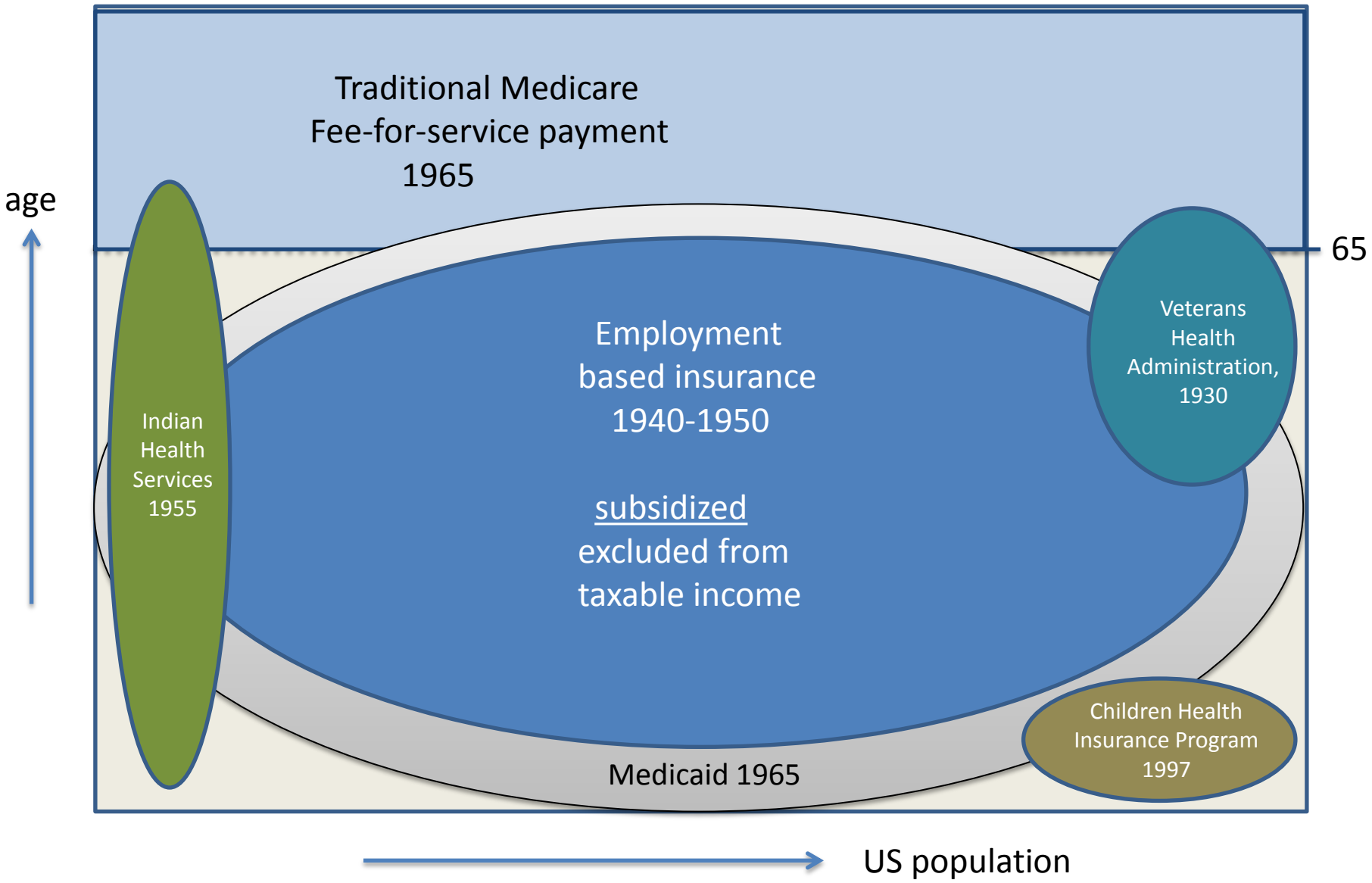
US Health Care System



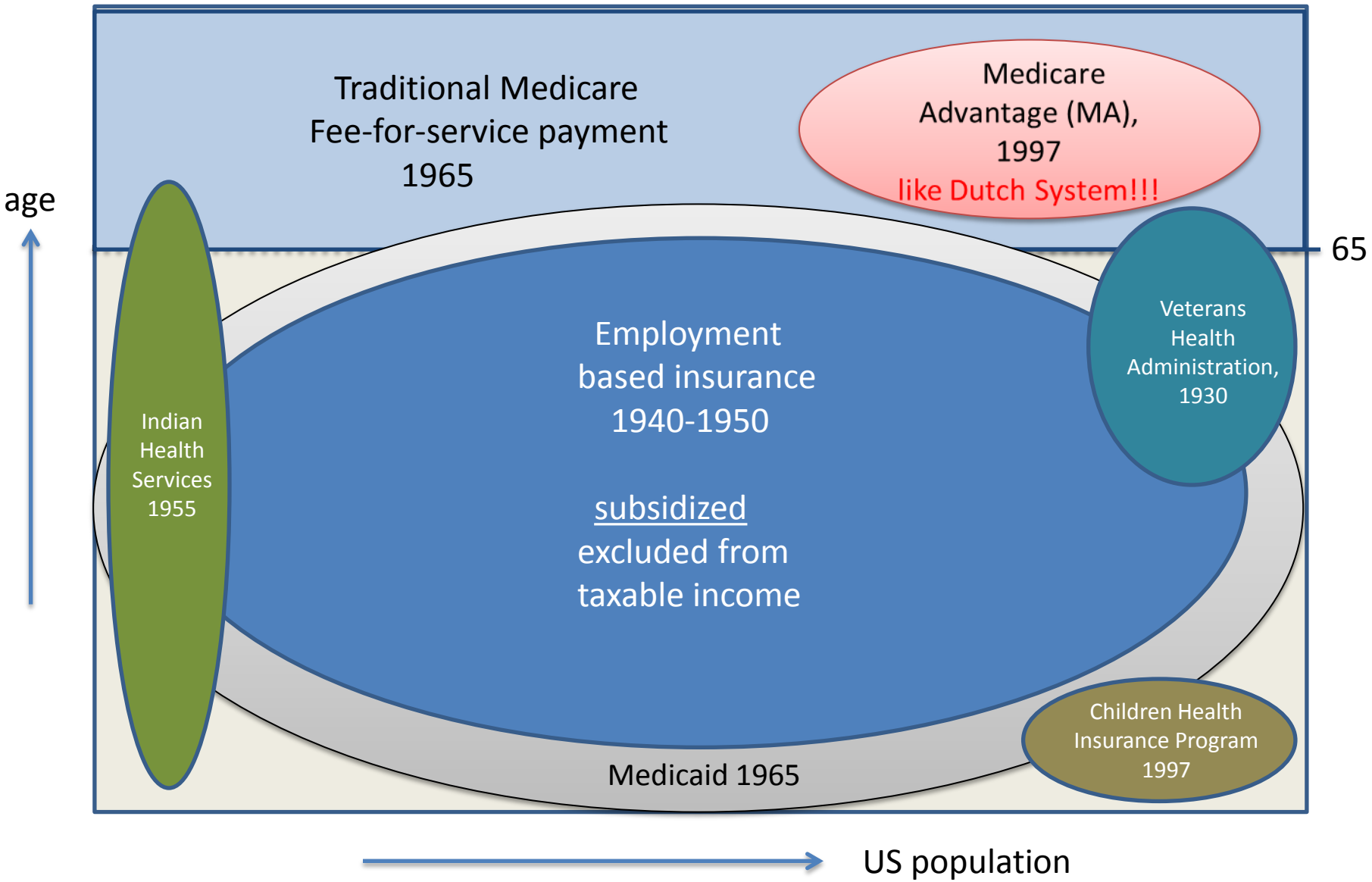
US Health Care System



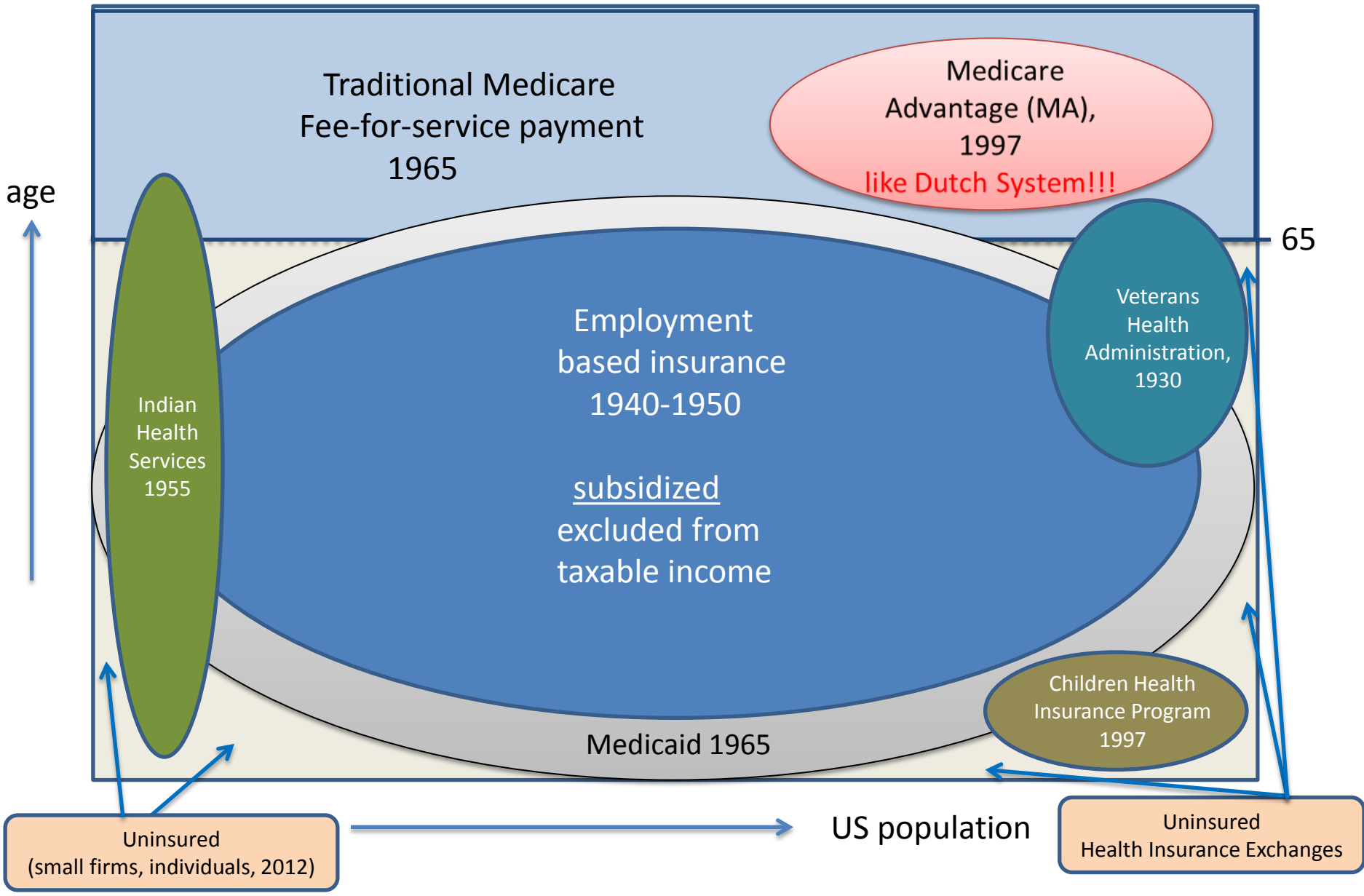
US Health Care System



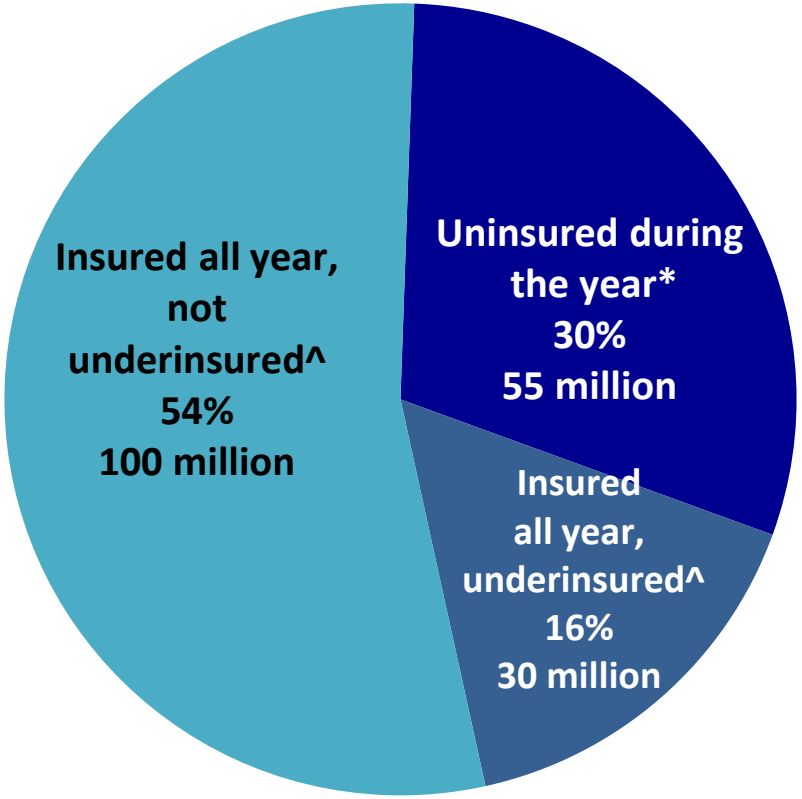
US Health Care System



US Health Care System



In 2012, Nearly Half of Adults Were Uninsured During the Year or Were Underinsured



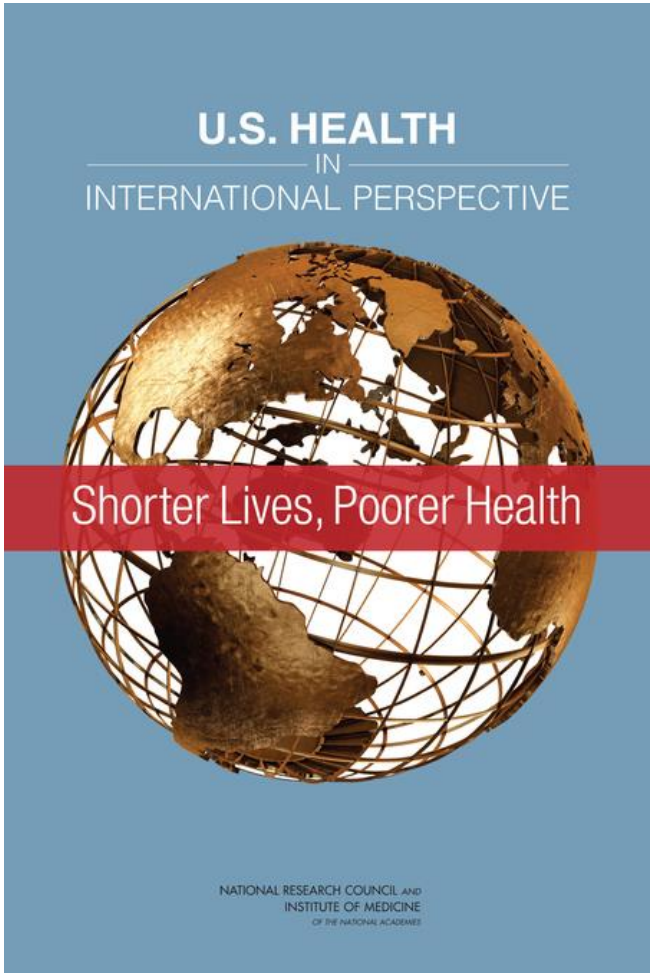
184 million adults ages 19–64

Note: Numbers may not sum to indicated total because of rounding.
* Combines "Uninsured now" and "Insured now, time uninsured in past year."
^ Underinsured defined as insured all year but experienced one of the following: out-of-pocket expenses equaled 10% or more of income; out-of-pocket expenses equaled 5% or more of income if low income (<200% of poverty); or deductibles equaled 5% or more of income.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2012).

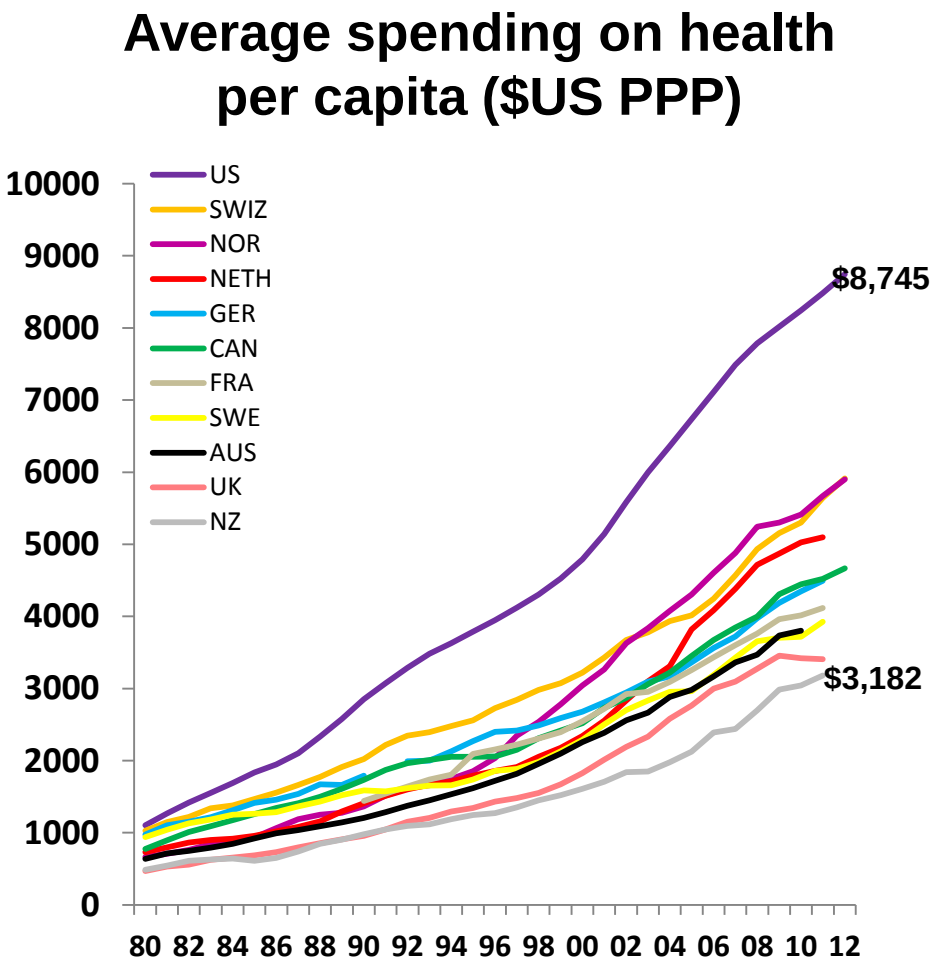
Why the ACA?

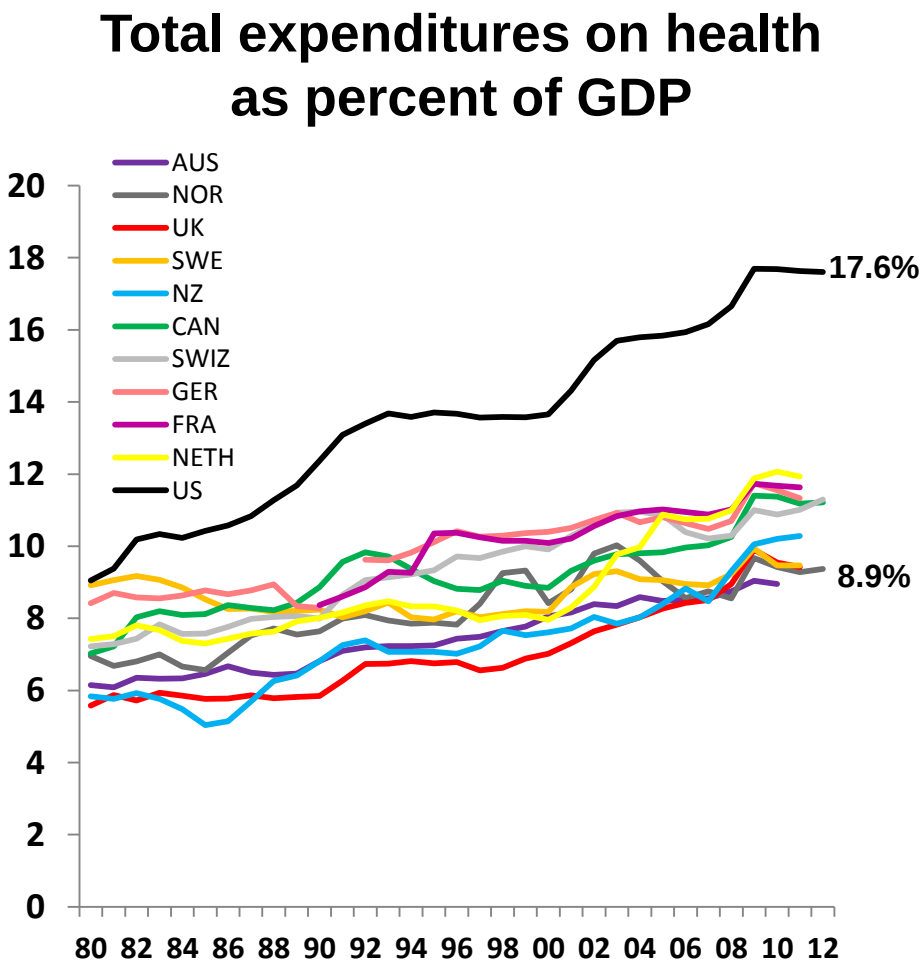
U.S. Health in International Perspective: Shorter Lives, Poorer Health

- Americans live shorter lives and are in poorer health at any age
- Poor outcomes cannot be fully explained by poverty or lack of insurance
- White, insured, college-educated, and upper income Americans are in poorer health than their counterparts in other countries



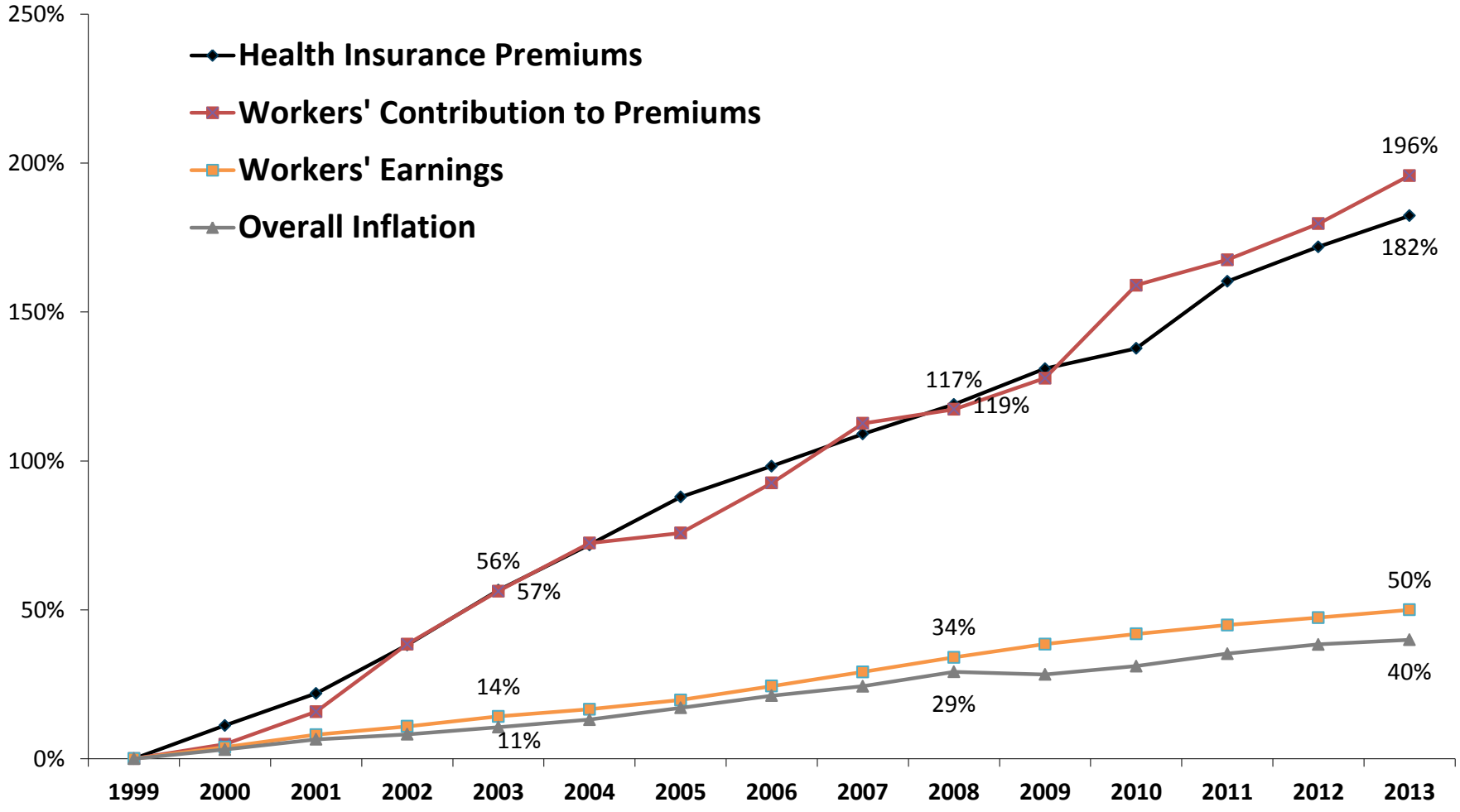
International Comparison of Spending on Health, 1980–2012





Note: $US PPP = purchasing power parity.
Source: Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, November 2013). US data from National Health Expenditure Accounts, adjusted to match OECD definitions.

Cumulative Increases in Health Insurance Premiums, Workers' Contributions to Premiums, Inflation, and Workers' Earnings, 1999-2013



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2013. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2013; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2013 (April to April).

The ACA: What's in it?

ACA Made Simple…

Hundreds of provisions in two big buckets:

Coverage expansion

Delivery system reform

Coverage Expansion

Cover the uninsured (26 million*):

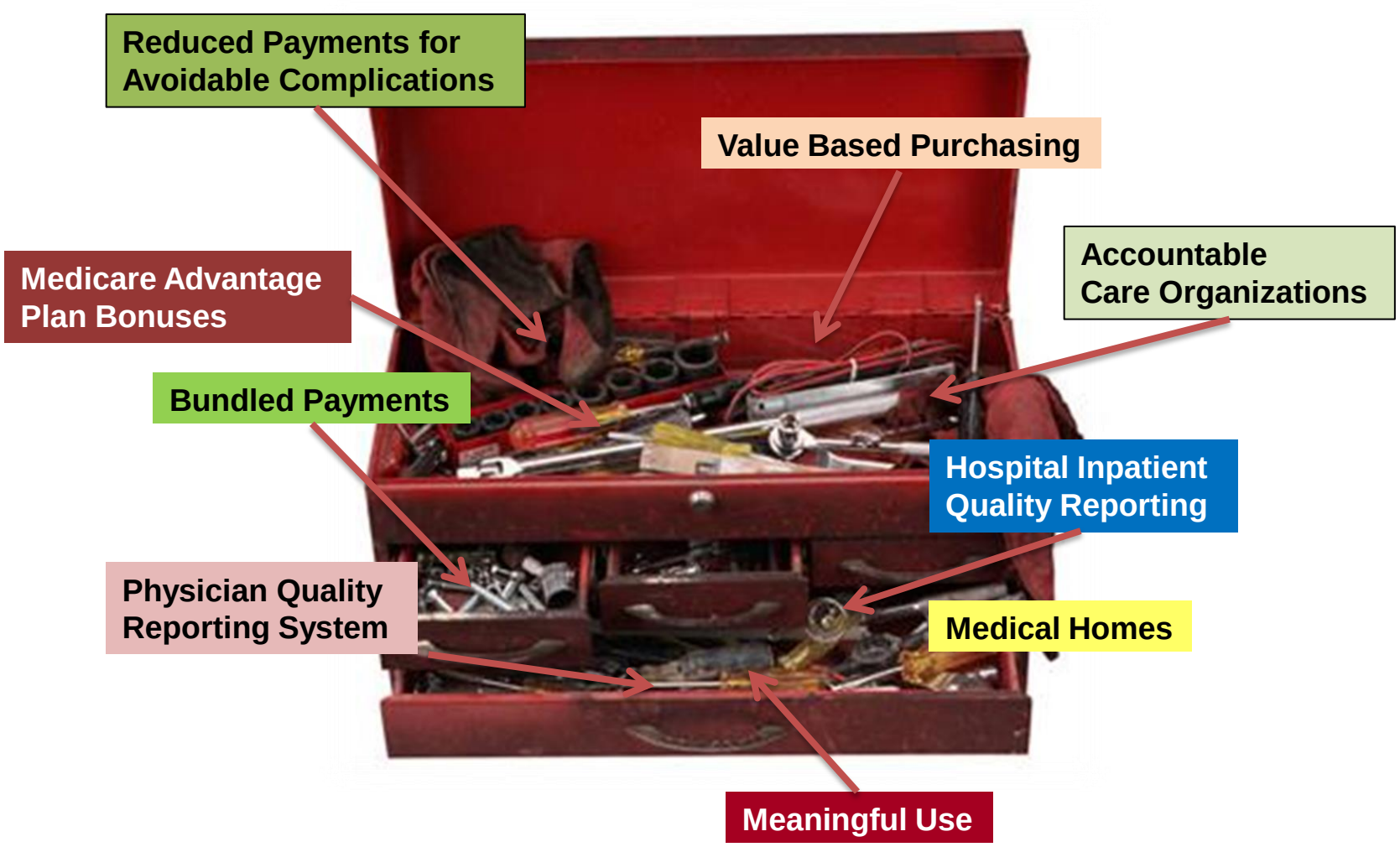
- Medicaid expansions (about half)
- Subsidies to buy private insurance (about half)

Regulate private markets:

- Insurance mandate
- Children to 26
- No discrimination against sick
- Health insurance marketplaces

* Latest CBO estimate (April 2014).

Delivery System Reform



Delivery System Reform: Three Buckets

Payment reforms: pay for performance

- Hospital and physician quality
- Medicare readmissions
- Hospital acquired conditions

Organizational reforms

- Accountable care organizations
- Patient centered medical homes
- Increased training and payment for primary care

Information availability

- Comparative effectiveness research ($500 million/year)
- Health information technology

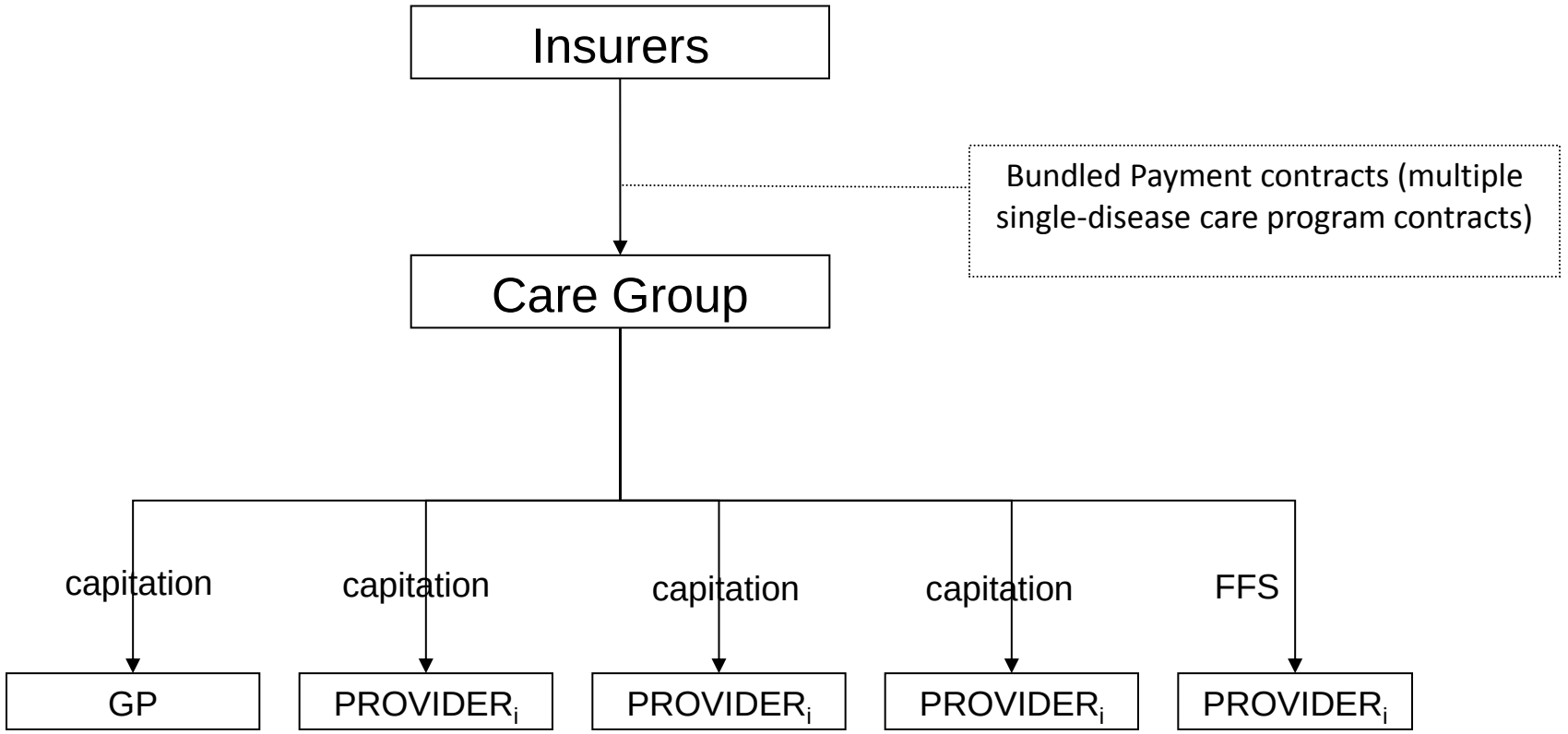
Delivery System Reform (con't)

Center for Medicare and Medicaid Innovation (CMMI)

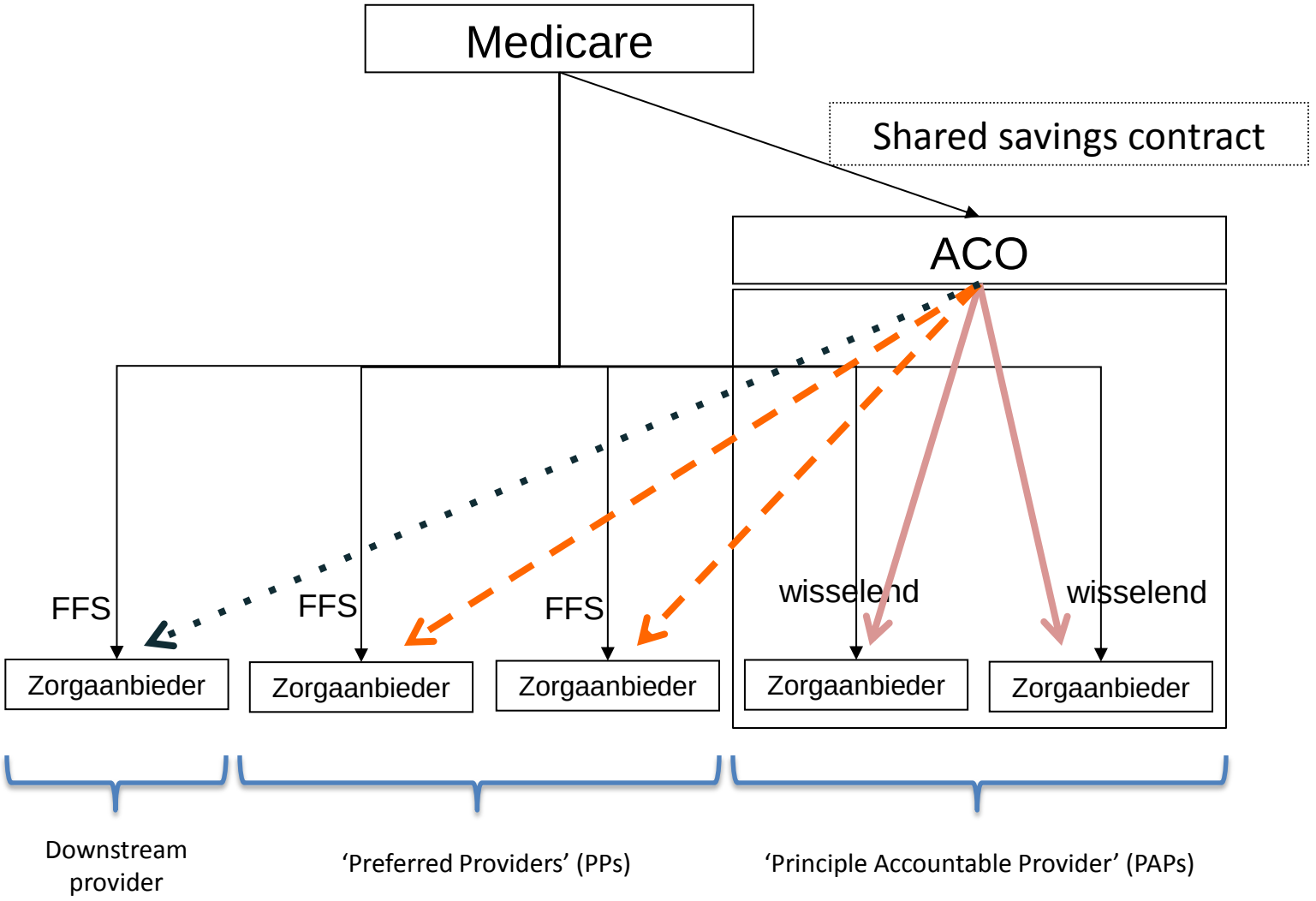
- $10 billion over ten years to undertake virtually unrestricted reform experiments and incorporate into routine Medicare and Medicaid practice

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Dutch payment reform

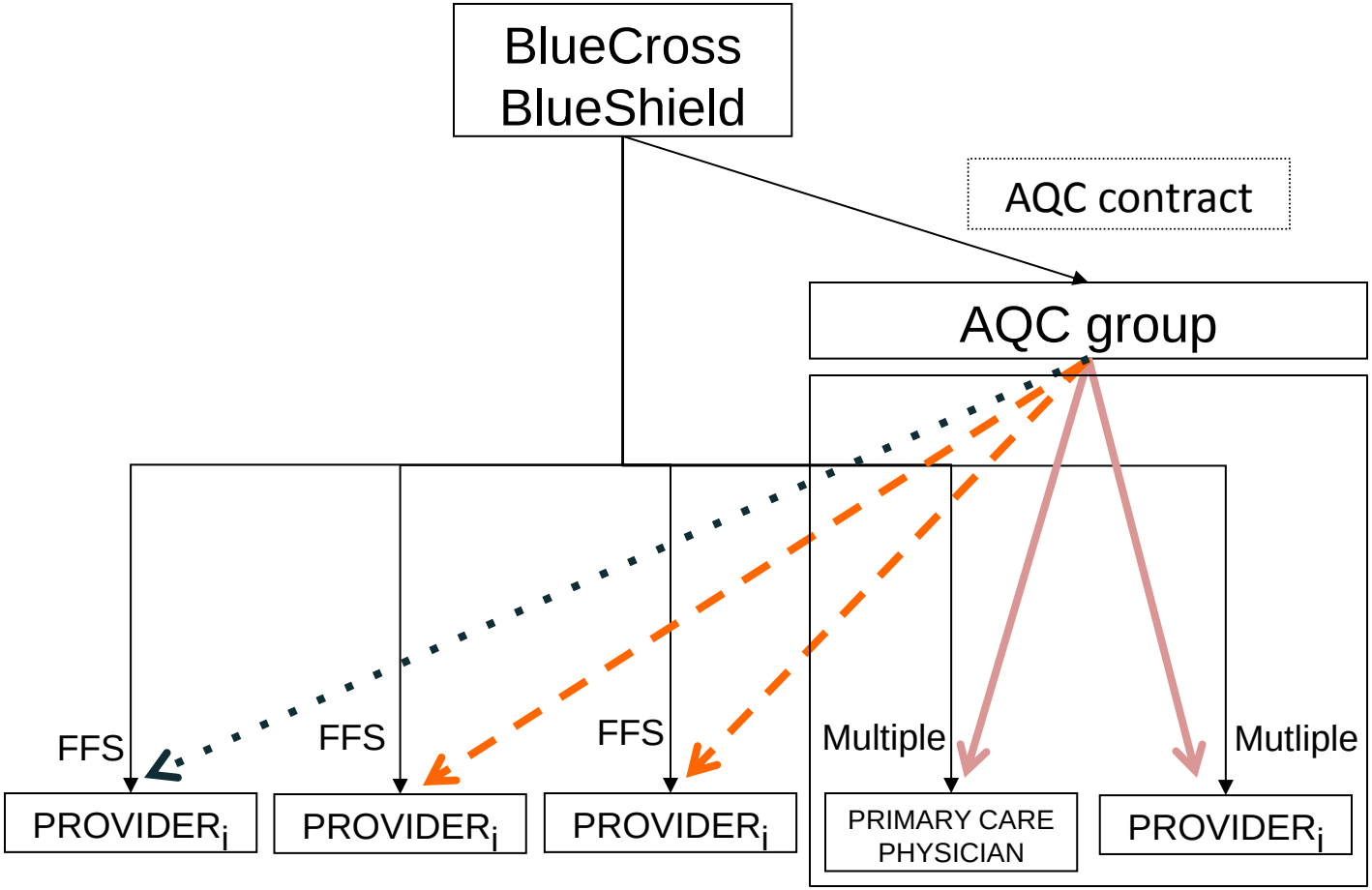


Medicare Shared Savings Program ACOs



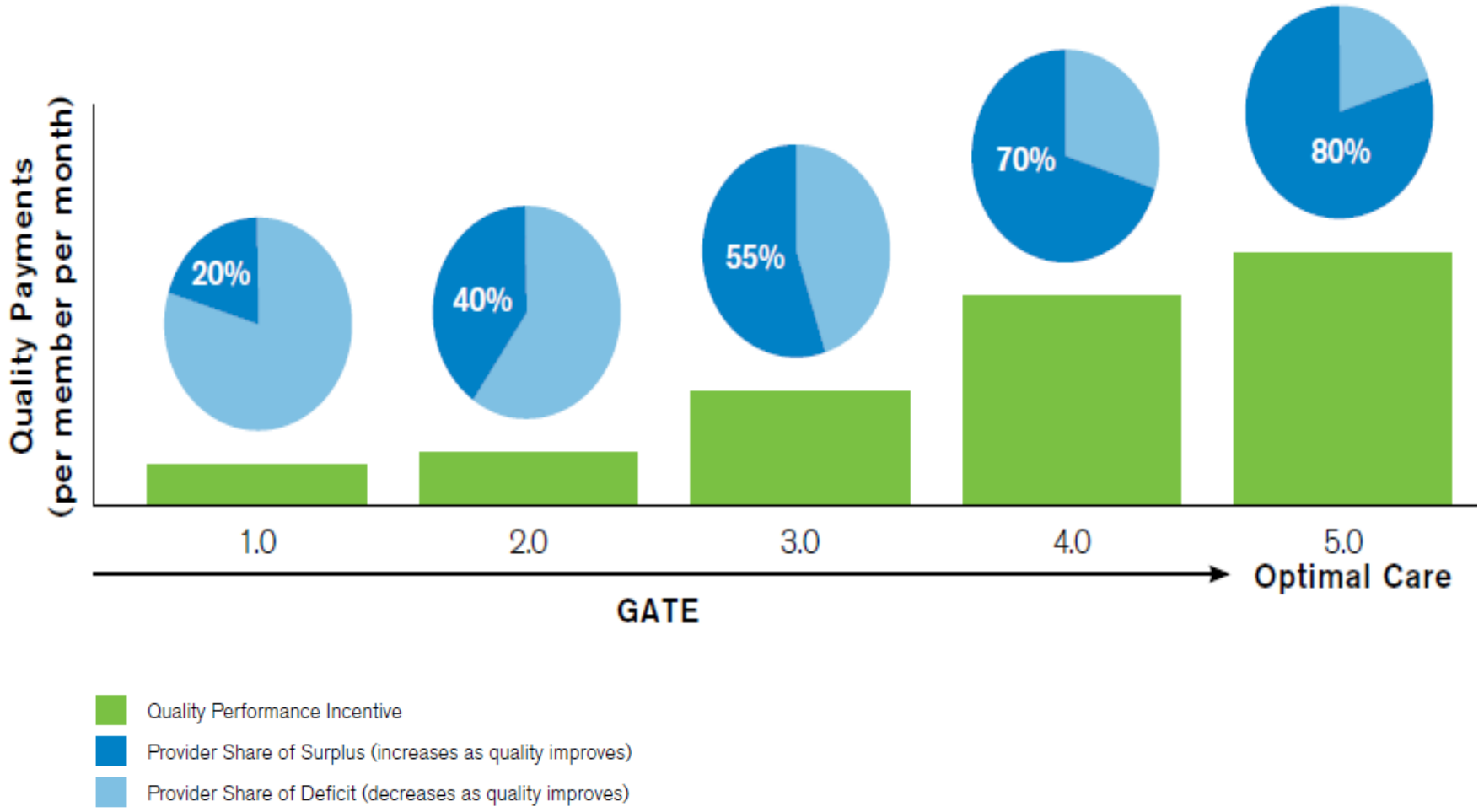
FFS = Fee For Service

Alternative Quality Contract (AQC)



FFS = Fee For Service

The AQC explained



Source: Blue Cross Blue Shields

AQC: Quality improvements…

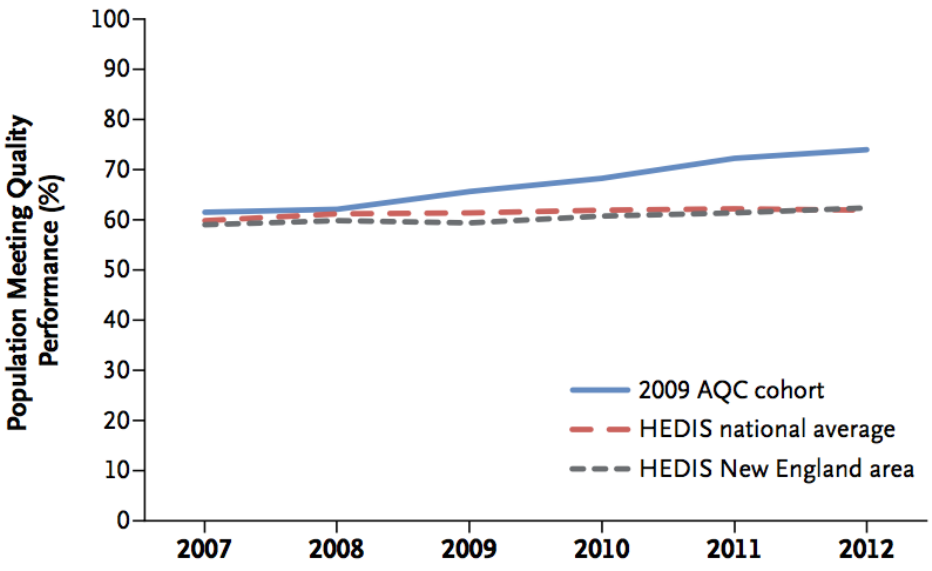


Figure 2. Outcome Quality in the 2009 AQC Cohort versus the Healthcare Effectiveness Data and Information Set (HEDIS), 2007–2012.

Outcome quality consisted of the following five measures: control of the glycated hemoglobin level (≤9%), control of the low-density lipoprotein (LDL) cholesterol level (<100 mg per deciliter [2.6 mmol per liter]), and blood-pressure control (<140/80 mm Hg) in patients with diabetes; the same level of control of LDL cholesterol in patients with coronary artery disease; and a blood-pressure control level of 140/90 mm Hg in patients with hypertension.

Reference: Song et al. NEJM, 2014

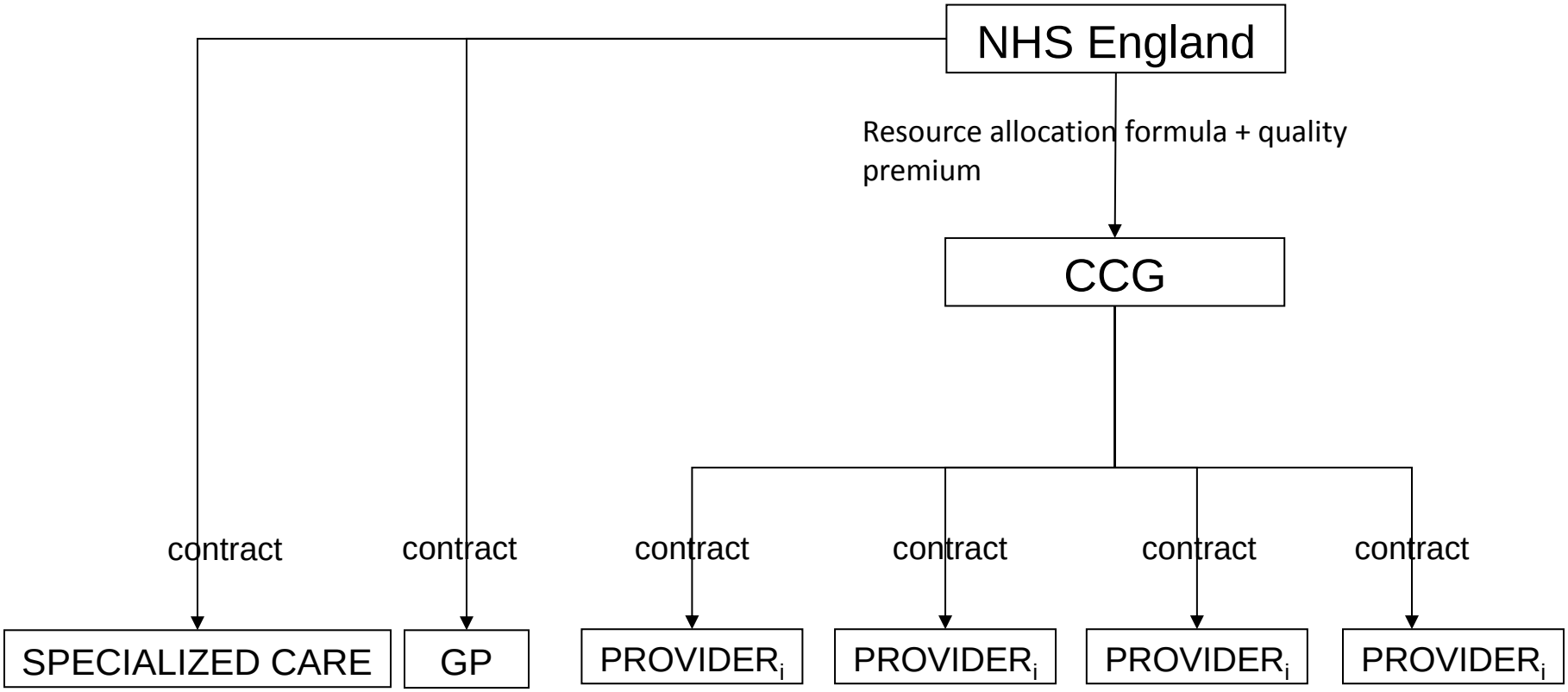
… while reducing the cost growth

Table 2. Changes in Medical Spending and Total Payments Associated with the AQC, According to Cohort and Year.*

Variable	2009		2010		2011		2012		Cohort Average		
	Change	P Value	Change	P Value	Change	P Value	Change	P Value	Change	P Value	Change as Share of Postintervention Cohort Spending
											%
Change in medical spending ($)†											
2009 cohort	−20.95	0.02	−30.06	0.02	−77.07	<0.001	−120.78	<0.001	−62.21	<0.001	−6.8
2010 cohort	—	—	−29.06	0.03	−85.49	<0.001	−131.21	<0.001	−81.92	<0.001	−8.8
2011 cohort	—	—	—	—	−76.96	0.001	−117.24	0.001	−97.10	<0.001	−9.1
2012 cohort	—	—	—	—	—	—	−59.39	0.04	−59.39	0.04	−5.8
Weighted average savings on claims (% of current-yr FFS claims)‡	2.4		3.1		8.4		10.0			N	
Incentive payments to providers (% of current-yr FFS claims)§	6–9		9–12		10–13		6–9			NA	
Implication	BCBS payments to providers, including shared savings and bonuses for quality and infrastructure, exceeded savings on claims		Payments to providers exceeded savings on claims		Payments exceeded savings on claims, but by a smaller amount than in earlier years		Savings on claims exceeded payments, rendering net savings			NA	
Scope of adoption in Massachusetts (% of BCBS providers in AQC)	Approximately 20		Approximately 25		Approximately 33		Approximately 75			NA	

Reference: Song et al. NEJM, 2014

England's payment reform



CCG: Clinical Commissioning Group

Results (I)

- Primary care providers' role is strengthened in all models:
  - 'Rostering' patients within primary care practice seems to be a key element (AQC, CG, CCG)
  - Up-scaling the organizational structures of primary care

- But applied to different markets:
  - ACO + AQC: price-sensitive referral system → delivery market
  - England + The Netherlands: use of clinical knowledge → purchasing market

- Under ACOs, AQCs and CCG no real 'transformation' of the way providers are paid, while CGs made some steps towards capitated fees

- Quality improvement tied to payment incentive in most models (CCG, ACOs, AQC)

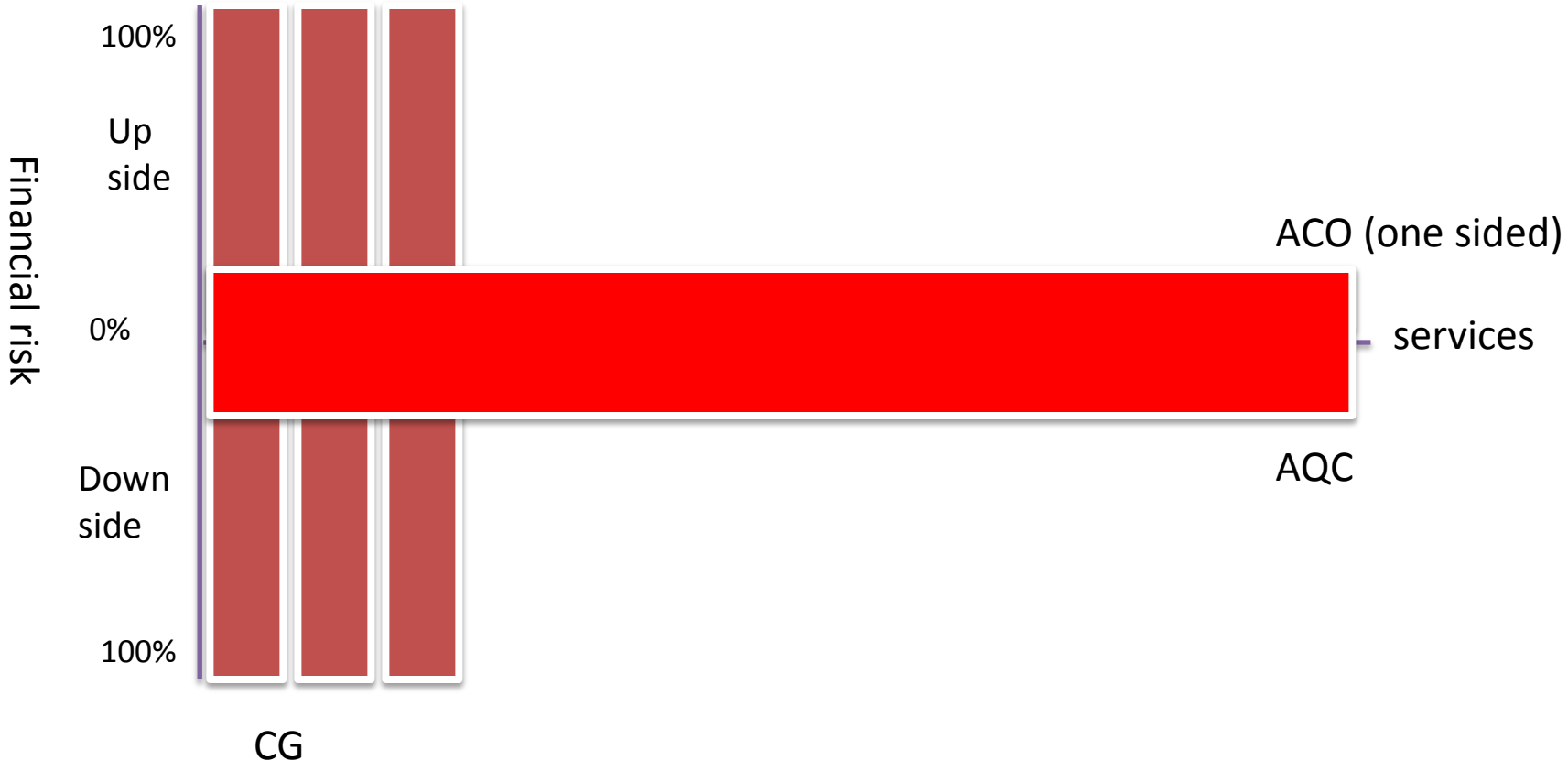
Results (II)

- Different approach to shift providers' financial risks across services:
  - The Netherlands: narrow services package but full financial risks
  - Other models: Broad services package but no / moderate financial risks

- Huge impact of contextual factors:
  - Data information for providers
  - Local market structure: diversity in AQC contracts
  - Voluntary (CGs, ACOs and AQC) vs. mandatory (England)

    → 'health care is local'

Financial risk across services



Policy Implications

General

- 'Joy of the workforce' is neglected within payment reforms
- How to evaluate payment reforms?

United States

- How ACOs incentivize their providers which still are paid on Fee For Service is unclear

The Netherlands

- How to tie quality improvement to payment model?

Concluding remarks

- Provider-led entities which assume financial risks are still in their early stages
- Moderate financial provider risks in all models, while incentives for providers entities to deliver less-costly and higher-quality care
- Methodological issues regarding evaluations of payment reforms
- Outcome-based payment models (e.g. pay-for-value) still in its infancy

Key drivers of payment reforms: Transferable lessons from the Alternative Quality Contract

Source

Ruwaard, et al. Transferring key drivers in provider-payer contracts: Lessons from the AQC (under review)