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Payment Matters: The ROI for Payment Reform

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Payment Reform: Good Return on Investment for Employers

As the largest purchaser of health care in America, employers are paying a high price for care of variable quality. To check soaring costs, some employers are switching from the inefficient fee-for-service model of paying for care, which encourages high volume and low quality, to payment models that reward high value.

There is growing evidence that payment reform strategies can yield a good return on investment for employer purchasers. In this brief, we discuss four promising approaches to payment reform (population-based payment, patient-centered medical homes, high-intensity primary care, and bundled payment) and provide some examples of employers that have adopted each approach.

Population-based Payment

In a population-based payment arrangement, a provider entity agrees to accept responsibility for the health of a group of patients in exchange for a set amount of money. If the provider effectively manages cost and performs well on quality-of-care targets, then the provider may keep a portion of the generated savings. However, if the provider delivers inefficient, high-cost care, then depending on the structure of the arrangement, it may be held responsible for some of the additional costs incurred. The goal of this type of payment arrangement is to align the financial incentives of the providers with the interests of the patients and the payers so that everyone wins if patients are healthy and costs are held down. This model is also sometimes called "global payment" or "total cost of care payment." Population-based payment is the underlying payment model used in Accountable Care Organizations.

There is emerging evidence that population-based payment programs are yielding a good return on investment for employers. We highlight below the early successes of the California Public Employees' Retirement System and describe the plans of Intel Corporation and the Maine State Employee Health Commission, all of which are convinced of the benefits of adopting a population-based payment model. In addition to these examples, many other organizations have been impressed with the promise of population-based payment programs and have begun to pursue the model, including the Centers for Medicare and Medicaid Services (CMS).[1]

What is Payment Reform?

The dominant model of payment in the United States is called "fee-for-service" (FFS). Fee-for-service payment offers providers a specific amount of compensation in exchange for providing a patient with a specific service.

FFS is an inefficient way of paying for care that incentivizes delivering high volumes of high margin services. Payment reform entails moving away from FFS and toward other ways of paying that create financial incentives for high quality, efficient care.

Payment reform is not an end in itself, but rather a means to incentivize improvement in the way that providers deliver health care.

Employers are beginning to experiment with implementing different types of payment reform programs that seek to simultaneously reduce costs and improve the quality of health care. Some promising models for reforming payment and care delivery include: population-based payment, patient-centered medical homes, high-intensity primary care, and bundled payment.

RWJF supports several grants testing health care payment reforms, which are managed by AcademyHealth.

AcademyHealth

Case Study #1: The California Public Employees' Retirement System Saved More Than $20 Million in Costs

In January 2010, the California Public Employees' Retirement System (CalPERS) launched a two-year population-based payment pilot program in collaboration with Blue Shield of California, and providers Catholic Healthcare West and Hill Physicians (CHW and Hill) in Sacramento. Blue Shield agreed to pay CHW and Hill a pre-determined amount to provide care to 41,500 CalPERS employees and dependents. By the end of the first year, the pilot had exceeded all expectations—saving more than $20 million in costs. More than $15.5 million of these savings went towards preventing a health insurance rate hike for CalPERS employees and the remaining savings was divided among the three partners. Over the first three years of the project, CalPERS has seen $32 million in aggregate savings. In addition, the partners saw a meaningful reduction in utilization including a 15 percent reduction in inpatient readmissions, a 15 percent reduction in inpatient days, and a 13 percent reduction in surgeries. As a result of giving CHW and Hill the opportunity to share in the savings for keeping patients healthy, rather than just paying them to provide services to the sick, CHW and Hill successfully shifted the focus to population health management—targeting patients with chronic illnesses and medically complex conditions, and reducing unnecessary care. Due to the project's success, $5 million in savings was built into CalPERS's 2011 health plan rates and an additional $12 million in savings was built into the 2012 rates. Blue Shield has also committed to working with CalPERS to expand the program across the state starting with two programs in Orange and San Joaquin Counties. An independent evaluation of the pilot will be conducted by the University of Southern California.[2]

By the end of the first year, the population-based payment pilot had exceeded all expectations—saving more than $20 million in costs and preventing a health insurance rate hike for employees.

Learn More About Population-based Payment

1. Read Catalyze Payment Reform's brief on implementing population-based payments. http://www.catalyzepaymentreform.org/uploads/CPR_Action_Brief_Global_Payment.pdf
2. Read about the success of Blue Cross Blue Shield of Massachusetts Alternative Quality Contract through this Aligning Forces for Quality (AF4Q) Bright Spot article. www.forces4quality.org/af4q/download-document/4370/1667
3. Gather resources from the Aligning Forces for Quality (AF4Q) initiative to help build coalitions and implement payment reform. http://forces4quality.org/a/6/paymentreform#featured-resource

Case Study #2: Intel Corporation Takes the Initiative

According to senior health program manager James Dickey, Intel felt that it was "time for the employer market to step up" and help move the health care system towards better performance at a lower cost. As a result, in 2010, Intel began a "two-year journey to reshape what health care should be for Intel families." Instead of just paying for services, Intel wanted to pay based on outcomes and quality of care. Intel worked directly with the Presbyterian Health System in Albuquerque to create the "Connected Care" program, a narrow network benefit that offers care through a patient-centered medical home model. Starting in January 2013, in exchange for caring for 10,000 of Intel's employees and their families, Presbyterian agreed to put a certain percentage of its revenue at risk using a risk-reward style program: if Presbyterian performs well, it gets the at-risk amount back. If Presbyterian does *really* well, it will receive additional performance payments. Intel is hopeful that this approach will reduce costs and improve care.[3]

"[It is] time for the employer market to step up."

– James Dickey, senior health program manager at Intel

Case Study #3: Maine State Employee Health Commission Puts a Health System at Risk for Performance

Concerned about the high cost of care at MaineGeneral Health (MGH)—a system of hospitals and physician practices—the Maine State Employee Health Commission (SEHC) was considering dropping the system from the preferred tier of its tiered network benefit design. As a result, MGH offered to move in a step-wise fashion toward significant payment reform that would guarantee the SEHC improved quality of care and cost savings. For Fiscal Year 2013, the partners signed an agreement that will guarantee savings for SEHC. This contract requires MGH to meet certain quality benchmarks and per member per month cost targets that if met will yield $1 million in savings for SEHC. The partners have committed to moving to a full global payment model in FY2014; MGH will take on greater risk for SEHC.[4]

Learn More about Patient-Centered Medical Homes (PCMH)

1. Learn more about PCMH programs from the Patient Centered Primary Care Collaborative's website. http://www.pcpcc.net/guide/purchaser-guide

2. Read other PCMH success stories, including the work of this Aligning Forces for Quality (AF4Q) community in Maine. http://qid.mainequalitycounts.org/project/maine-patient-centered-medical-home-pilot

3. Gather resources from the Aligning Forces for Quality (AF4Q) initiative to help build coalitions and implement payment reform. http://forces4quality.org/a/6/payment-reform#featured-resource

Patient-Centered Medical Home Payment

A patient-centered medical home (PCMH) is a primary care practice that gives patients the individualized care and support they need to stay healthy. In a medical home, the patient, the primary care physician and a medical team work together to develop and implement a plan of care for the patient that details the patient's optimal medication use, diet, exercise, behavioral health treatments, etc. to get and keep the patient healthy. Insurance companies and other payers typically pay the primary care practices a certain amount of money per patient per month to provide this enhanced outreach, communication and coordination. In exchange, the practices are required to meet certain performance measures.

Patient-centered medical home payment programs are starting to show a good return on investment for some employers. We highlight below the early successes of the Tri-Service PCMH project and describe the plans of Cleveland area employers who are working together to develop and implement a PCMH project. In addition, many other organizations have been impressed with the results of patient-centered medical home programs and have begun to pursue the model, including the Centers for Medicare and Medicaid Services (CMS)[5] and Walmart.[6]

Case Study #4: Success and Savings at Hill Air Force Base

Beginning in 2009, the U.S. Air Force, Army and Navy began working together to implement the Tri-Service Patient-Centered Medical Home (PCMH) Project to transform care at all primary care practices throughout the Department of Defense (DOD). Among the DOD project sites that demonstrated positive results is Hill Air Force Base in Utah. Since the implementation of PCMH at Hill, the Air Force has saved money and improved the quality of care. By offering team-based care with individualized care plans for patients, encouraging continuity of care, and providing care management and rapid access to care, the project has improved blood sugar control for 77 percent of the diabetic population and stayed at or above 98 percent symptom control for patients with asthma. The Air Force estimates that the project has saved $300,000 per year just by improving their diabetes care.[7] According to Col. Donald Hickman, "Health care costs go up 8 to 15 percent per year nationwide and we have managed to drive down our network care costs about 4.5 percent over the last two fiscal years."[8] Additionally, patients were extremely satisfied with the program, reporting 95 percent satisfaction.

> "Health care costs go up 8-15 percent per year nationwide and we have managed to drive down our network care costs about 4.5 percent over the last two fiscal years."
>
> *– Col. Donald Hickman, 75th Medical Group at Hill Air Force Base*

Case Study #5: Cleveland Area Employers Collaborate

Tim Kowalski, M.D., is the Chief Medical Officer of Progressive Insurance and is passionate about the need to change incentives for health care providers. Convinced by data for the Progressive Insurance employee population that those employees who receive care through medical homes have lower overall costs than those without them, Progressive, Lubrizol Corporation and the Lake County School District, working through the Health Action Council of Ohio and Better Health *Greater* Cleveland, are pursuing a medical home arrangement with Lake Health System, a health system in Northeast Ohio. Lake Health System has agreed to achieve NCQA PCMH recognition for all of its primary care sites. The three employers have agreed that they, in turn, will fund nurse care coordinators to support care of their employees and dependents within Lake Health System beginning in 2013. In addition, the parties have agreed that in the future they will implement a shared savings arrangement whereby Lake Health will be able to share some of the savings that its PCMH practices, augmented with employer-funded nurse care coordinators, are expected to generate. [9]

> The three employers have agreed that they, in turn, will fund nurse care coordinators to support care of their employees and dependents.

High-Intensity Primary Care Payment

High-intensity primary care provides patient-centered, team-based care to those patients with the most significant health care needs (e.g., multiple chronic conditions). The patient's team of medical professionals (which may include a primary care physician, specialists, a behavioral health clinician, a nurse care manager, a health educator, and a community health worker) work together with the patient to support him or her in developing and following his or her individualized care plan. This model of care often includes a significant level of patient-provider interaction (potentially daily) using in-person visits, telephone calls, and email.

Employers implementing high-intensity primary care payment programs have reported a good return on investment. Below, we highlight the early successes of three organizations—the Boeing Company, a union in Atlantic City, and the California Public Employees' Retirement System—with implementing high-intensity primary care payment programs. In addition, many other organizations have been impressed with the results of high-intensity primary care programs and have begun to invest in the model, including the Centers for Medicare and Medicaid Services.[10]

Case Study #6: Boeing's Project Improved Health while Per Capita Spending Dropped

In 2008, Boeing launched a pilot initiative called the Intensive Outpatient Care Program (IOCP) to use high-intensity primary care to support 740 Boeing employees, pre-Medicare retirees and adult spouses with severe chronic illnesses. Boeing engaged three Seattle-area physician groups that were willing to offer high-intensity primary care services in exchange for receiving set monthly payments for each patient enrolled. Each patient was assigned to a care team that included a registered nurse care manager and at least one IOCP-dedicated physician. The care team worked with each patient to develop an individualized plan of care and supported the patient through rapid access to care and frequent communication with the patient (in-person visits, telephone calls and email). The pilot's results were impressive. Not only did per capita spending drop 20 percent relative to a control group, patients' functional status scores, depression scores, experience-of-care scores and employees' absenteeism scores *all* improved after enrollment in the program. The drop in spending was primarily due to a reduction in emergency department visits and inpatient hospital stays. These reductions more than offset the additional fees paid to the physicians and any increases in office visits, pharmacy, and lab services.[11] Since the pilot ended in 2009, Boeing has expanded the program to include additional sites.

Not only did per capita spending drop 20 percent relative to a control group, functional status scores, depression scores, patients' experience of care scores and employees' absenteeism scores all improved after enrollment.

Case Study #7: Union Slows Spending and Improves Health of Hotel Workers

In 2007, Local 54 of the Hotel Employees and Restaurant Employees International Union Welfare Fund identified a primary care practice known as the "Special Care Center" to provide individualized, team-based care to its most costly and medically complex members. Since implementation, the total costs of the program have fluctuated, but preliminary data suggest that after the first year in existence, the center generated net savings for enrolled patients. A 2009 case-control study of 447 patients showed that total net spending was 12.3 percent lower ($208 per enrollee per month less) than the control group. Additionally, the program helped enrollees manage their blood sugar levels and blood pressure, lower their cholesterol (an average decline of 30 points) and increase healthy behaviors related to smoking cessation and medication compliance.[12]

Learn More about High-Intensity Primary Care

1. Read more about high-intensity primary care programs at the Robert Wood Johnson Foundation's website. http://www.rwjf.org/en/about-rwjf/newsroom/features-and-articles/Brenner11.html
2. Get suggestions for implementing high-intensity primary care programs by reading this Robert Wood Johnson Foundation brief on "Hot Spotting." http://www.rwjf.org/en/research-publications/find-rwjf-research/2012/01/expanding--hot-spotting--to-new-communities.html
3. Gather resources from the Aligning Forces for Quality (AF4Q) initiative to help build coalitions and implement payment reform. http://forces4quality.org/a/6/payment-reform#-featured-resource

Case Study #8: California Public Employees' Retirement System's (CalPERS) Program Shows Early Results

In June 2011, CalPERS implemented the "Priority Care" program to deliver high-intensity primary care services to members with chronic health care needs receiving care from the Humboldt–Del Norte IPA. After identifying those members most likely to benefit from this additional health support, CalPERS engaged 125 members in the program. The project will be formally evaluated for ROI in 2013, but the state reports encouraging preliminary findings. One patient case example is compelling: a program participant went from spending an average of $2,947 per month prior to enrollment to an average of $640 per month during the first four months after enrollment.[13]

Bundled Payment

Also known as "episode-based payments," bundled payments offer reimbursement for all of the services needed by a specific patient for a particular condition or treatment. Depending on the negotiated terms, the "bundle" may include payments for all of the providers and the care settings that may be required for the treatment related to that specific procedure or illness, but generally do not include services that are unrelated. For example, if a payer were to agree to a bundled payment for a hip replacement surgery, then the bundle would include the surgery as well as all of the pre- and post-operative appointments, rehabilitation and the treatment of any complications associated with the procedure. However, if the patient was in a car accident and needed stitches during the same time period, that would not be included in the bundle.

While there have not been any published evaluations of employer-initiated bundled payment arrangements, there is evidence that bundled payments have been effective at reducing costs for Medicare, particularly where there are high costs or significant variation in the costs associated with managing a particular condition or treatment. Employers are now beginning to experiment with bundled payment arrangements and evidence of their effectiveness should be forthcoming.

Learn More about Bundled Payment

1. Read more about Bundled Payments in this Health Care Incentives Improvement Institute brief. http://www.hci3.org/sites/default/files/files/HCI-IssueBrief-4-2012.pdf

2. Hear about how employers are working with payers and providers to implement a bundled payment program in this Aligning Forces for Quality (AF4Q) community in South Central Pennsylvania. http://forces4quality.org/af4q/download-document/5262/2325

3. Gather resources from the Aligning Forces for Quality (AF4Q) initiative to help build coalitions. http://forces4quality.org/a/6/payment-reform#featured-resource

Case Study #9: Acute Care Episode (ACE) Project at Baptist Health

The Baptist Health System in Texas was an early participant in Medicare's Acute Care Episode (ACE) project, which required that hospitals propose prices for bundles of physician and hospital services related to 28 cardiac and nine orthopedic services. In addition to the use of bundled payments, Medicare also offered the hospitals the ability to share in any cost savings with their physician partners (up to 25 percent of their regular fees), provided that they met certain quality benchmarks. As of May 2011, the implementation of bundled payments in the Baptist Health System saved more than $2,000 per case for a total of $4.3 million since the program began in 2009. Additionally, physicians were receiving approximately $280 in bonus payments per episode. Due to its impressive results, Baptist is hoping to expand its use of bundled payments at the conclusion of the ACE program.[14]

Bundled payments in the Baptist Health System saved more than $2,000 per case, for a total of $4.3 million since 2009.

Case Study #10: Medicare Heart Bypass Center Project Saved Millions

In the early 1990's the Centers for Medicare and Medicaid Services (then known as the Health Care Financing Administration), implemented a bundled payment pilot project called the Medicare Participating Heart Bypass Center Demonstration project. As part of the project, Medicare offered participating hospitals a single price for all inpatient services related to heart bypass surgery. From 1990-1993, the total cost per case fell in three out of the four hospitals as physicians changed their practices to reduce length of stay and overall costs. Over the first 27 months of the demonstration program, the project saved more than $17 million at four participating hospitals.[15]

In the first 27 months of the program, the bundled payments saved more than $17million at four hospitals.

Case Study #11: Employers' Coalition on Health (ECOH) in Rockford, Illinois is experimenting with Bundled Payments

The Employers' Coalition on Health (ECOH) is an employer coalition that performs group purchasing for its members. Concerned that it needed to do something to address health costs in order to stay competitive in the market, ECOH began searching for options. One member "stumbled across" the PROMETHEUS bundled payment model and, using the positive experiences of non-employer-led initiatives, convinced the coalition to pursue it. In 2011, ECOH began a three-stage "glide path" toward the implementation of their bundled payment program, anticipating significant savings over time for their employer members.[16]

How You Can Get Started on a Payment Reform Project for your Business today

1. Speak with your plan administrator about his or her experience with different types of payment reform. Many are experimenting with payment reform, or are making plans to do so.

2. If you have a large concentration of employees in one or more geographies, approach the largest medical group and/or health system that serves your population and ask about their experience with various types of payment reform projects, and their willingness to apply their program or develop a new one to serve your employees.

Endnotes

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