Payment Reform Options: Episode Payment Is A Good Place To Start

Before provider payments are reduced, our payment system must be reformed to encourage the more efficient delivery of care.

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ABSTRACT: New strategies to control U.S. health spending growth are urgently needed. Although provider payment cuts are likely, cutting fee-for-service (FFS) payments will hurt quality and access. A more sensible approach would be to restructure the delivery system into organized networks of providers delivering reliable, evidence-based care. But restructuring will not occur without payment policy reform. Four policy options are commonly cited: recalibrating FFS, instituting pay-for-performance, creating episode-based payments, and adopting global payments. We argue that episode payments are the most immediately viable approach, and we recommend that payment reforms precede any payment reductions so that new delivery models can gain traction. [Health Affairs 28, no. 2 (2009): w262–w271 (published online 27 January 2009; 10.1377/hlthaff.28.2.w262)]

There is strong consensus that the U.S. health care system fails to provide either the quality or the value that it should, and that substantial restructuring is urgently needed. Despite deep dysfunction and numerous public and private reform efforts, the system has been astoundingly resistant to change. But health spending has reached a level where continued annual increases two to three percentage points faster than the nation’s economic growth will increasingly limit the ability of employers and public programs to offer health coverage. Unless the forty-year historical spending trend miraculously abates, vigorous expansion of public and private cost control initiatives is inevitable.

Of the strategies capable of immediately slowing growth in health spending, reducing benefits and limiting services run counter to the urgent need to improve health care access. This leaves provider payment cuts as the “least bad” option for achieving short-term savings. However, in the fragmented U.S. delivery system, cutting fee-for-service (FFS) payments over any sustained time period will hurt
both quality and access. A more sensible approach would be to develop a long-
term agenda to restructure the delivery system into organized networks of provid-
ers capable of delivering reliable, evidence-based care within realistic budgets.

Expanding organized networks will not, by itself, reverse the health care spending trend. But in a future of constrained spending growth, organized net-
works will be better able to optimize the mix of patient services and preserve quality compared with the current system of unconnected providers, particularly if payers realign financial incentives. Physicians and hospitals now have few in-
centives to establish or join organized networks. We believe that payment reform is a necessary precondition for the types of delivery system changes needed to bring about a more efficient and effective health care system.

Four payment reform options have been widely discussed: recalibrating FFS; instituting pay-for-performance (P4P); creating episode payments that combine hospital and physician reimbursement; and adopting global payment approaches such as capitation. We briefly summarize each below, according to four criteria: (1) their potential for reducing unnecessary utilization; (2) their potential for en-
couraging high-quality care; (3) the support they provide for provider integration; and (4) operational feasibility. We also discuss blended approaches, and we con-
clude by discussing implementation issues.

Option 1: Recalibrate FFS Payments

FFS reimbursement pays for care regardless of whether services are appropriate or of high quality, and it supports wide geographic variations in health care use and spending. It penalizes organizations that try to reduce unnecessary services or shift patients into low-cost settings with reduced revenues and profits, creating a sizable barrier to delivery reform.

FFS also encourages overuse of many costly specialty services while short-
changing important but less lucrative areas such as primary care. Well-documented inaccuracies in Medicare hospital and physician payment have made certain services highly profitable and others money-losers. The most profitable have been those with rapidly advancing technology, where new equipment has increased physician productivity and reduced costs. Because prices have remained at their initial levels while costs have declined, use of cardiovascular procedures, orthopedics, and advanced imaging have increased rapidly.

Service-line profitability influences health care investment decisions. Recalib-
rating Medicare FFS rates to establish more-neutral financial incentives would encourage investments that are better aligned with communities’ medical needs. However, in a recalibrated FFS system, providers will still be paid more for doing more rather than for achieving better outcomes. The political challenges of recalibi-
ration are also great, as powerful interests will react negatively to potential income reductions.
Option 2: Pay-For-Performance

The concept of P4P has strong intuitive appeal. By 2006, 258 P4P programs were being operated by 140 public and private payers. however, few programs have been formally evaluated, and those that have show mixed results. One early analysis concluded that physician P4P may produce little gain in quality for the money spent, and it may largely reward physicians with higher baseline performance. Many design issues remain unresolved, including whether programs should target individual physicians or groups; the proportion of physician remuneration needed to change behavior; and whether incentives should reward the level of performance or the rate of improvement.

The most important factor limiting P4P’s potential, however, is the current lack of meaningful, actionable performance measures. Most programs rely on widely available process measures such as the Healthcare Effectiveness Data and Information Set (HEDIS). Clinical outcome measures such as death and complication rates associated with surgery are more meaningful but are technically problematic. Furthermore, most outcome measures focus on very small subsets of clinical practice. The deficit in performance measurement is a fundamental concern for all payment models discussed in this paper. Broader measures that target multiple dimensions of care and foster shared accountability among caregivers are needed.

In contrast to the modest impact of most P4P programs, Medicare’s new policy of withholding hospital payments for services caused by eight secondary conditions it defines as “preventable complications” has important implications for quality improvement. Although financial savings from this effort will be small, it could have a large impact on hospital behavior if seen as an initial phase of future Medicare policy changes that penalize poor performance.

P4P is an important development, but it must evolve beyond its current form to be effective. P4P addresses a major conceptual flaw in FFS by rewarding quality of care. However, P4P programs are unlikely to affect spending trends as long as their primary emphasis is rewarding providers for delivering “underused” services rather than for judicious use of potentially “overused” treatments. Nor is P4P likely to drive substantial provider integration, although programs that reward the adoption of information technology (IT) and care management processes may be beneficial on the margin. In spite of these issues, P4P can be a valuable component of either a modified FFS system or a more global model. However, P4P combined with FFS is not our preferred alternative.

Option 3: Bundled Payment For Episodes Of Care

Options 1 and 2 contain few incentives for cooperation among hospitals, physicians, and other care providers. As a result, there is growing interest in bundled payments that include all services associated with an episode of care, such as a hospital admission. This would go beyond hospital diagnosis-related groups
“Payers will encounter less resistance if they develop episode payments within a quality improvement framework.”

(DRGs) by bundling hospital, physician, and other clinical services into a single rate. It would also increase accountability for outcomes by extending the episode to a period of perhaps thirty days beyond the hospital discharge. Payers would develop rates based on the resources needed to provide care that is consistent with established clinical guidelines.

Desirable outcomes from episode-based payments include reducing unnecessary physician and ancillary services, compensating physicians for efficient resource use, and reducing complications and readmissions. Policymakers are concerned, however, about the potential for hospitals to increase admissions, seek to profit by limiting beneficial services, or avoid patients with complicated conditions.

Interest in episode payments has been heightened by a recent Geisinger Health System (GHS) initiative, which the New York Times has characterized as “surgery with a warranty.” Geisinger’s ProvenCare coronary artery bypass surgery (CABG) program promises to follow forty specific clinical processes for all patients undergoing elective procedures. For each case, surgeons must explicitly ensure that surgery is appropriate, document a shared decision-making process with the patient, and initiate postdischarge follow-up to ensure compliance with medication and rehabilitation recommendations.

The key aspect of ProvenCare is a flat payment for surgery and all related care for ninety days after discharge. The flat rate assumes that GHS will reduce its historical complication rate by half. An evaluation during the first year found reductions in most adverse events in the ProvenCare patient group, including a 10 percent drop in readmissions, shorter average length-of-stay, and reduced hospital charges. More recent data presented by Geisinger executives suggest a 44 percent readmission reduction over eighteen months. Based on these results, GHS has expanded ProvenCare to other areas including angioioplasty, cataract surgery, and hip replacement.

ProvenCare’s success is due in large part to Geisinger’s unique structure as a physician-driven, integrated delivery network with a systemwide electronic health record (EHR) and dominant market share. This structure addresses a key challenge for health care organizations: how to equitably distribute episode payments across physicians, hospitals, and other providers. Some of the nation’s 125 integrated academic medical centers and 1,000 physician-hospital organizations (PHOs) will be able to adapt quickly to episode payments, while others will struggle. Payers will encounter less resistance if they develop episode payments within a quality improvement framework and with substantial physician input. Groups like Prometheus are now developing “evidence-informed” case rates and defining services that should and should not be included in episode payments.
Option 4: Global Payment

The most common form of global payment is capitation: an all-inclusive payment per enrollee for a defined scope of services, regardless of how much care is actually provided. Studies comparing physicians paid under FFS and capitation show that capitation results in lower rates of elective surgery, patient consultations, diagnostic services, and specialist and hospital referrals. A principal concern is that capitation creates financial incentives for physicians to withhold care. This criticism helped fuel the managed care backlash in the 1990s, and it must be addressed if payers are to successfully resurrect capitation.

One model that tries to address these concerns is the Blue Cross Blue Shield of Massachusetts (BCBSMA) alternative quality contract (AQC), which combines a health status–adjusted global payment with performance incentives for meeting quality and safety benchmarks. BCBSMA envisions the AQC as a five-year arrangement in which base payments start at current spending levels and grow by inflation. Contracted delivery systems can improve margins through quality bonuses of up to 10 percent and by reducing spending growth below the level of inflation. As of this writing, BCBSMA has signed preliminary agreements with several multispecialty group practices.

Relative to other options, global payment has the greatest potential for encouraging shifts in health care resource use from low-value to high-value services. To counter the possibility of undertreatment, global payment should be implemented in a context of ongoing performance measurement and reporting. Expanding global payment will also encourage providers to become more organized. As FFS rates are restricted, physicians’ income prospects may well look better under global payment arrangements. There are obviously important challenges for global payment, including developing credible risk-adjustment mechanisms and finding provider systems willing to accept global risk.

Blended Payment Models

Although the foregoing payment reform options are usually discussed as if they were distinct models, future payment innovations will likely incorporate multiple approaches. Blended models are widely used by physician groups in California that reimburse specialists and primary care physicians using blends of capitation and FFS. Payers can design blended systems to achieve specific policy objectives—for example, combining capitation incentives for spending within budget targets with FFS for promoting preventive services such as mammography, and bonus payments for encouraging providers to meet quality and patient satisfaction targets. Importantly, blended models can be designed to limit physicians’ financial risk for aspects of care beyond their control.

The principal goals of payment reform articulated in this paper are (1) controlling unnecessary utilization, (2) encouraging high quality, and (3) supporting
provider integration (Exhibit 1). FFS reimbursement performs poorly on all of these goals, although a recalibrated FFS system improves on the current model. P4P encourages higher quality for aspects of performance that can be measured but falls short on the other two goals. Episode payments have potential for positively influencing utilization, quality, and provider integration, although the utilization impact is primarily within the episode itself. Global payment has the greatest potential for controlling utilization and encouraging provider integration, but like episode payments, it requires a strong performance monitoring framework and possibly financial incentives to ensure quality. Unfortunately, global payment is also the most challenging to implement on a large scale.

**Implementing Payment Reform**

Payment reform cannot succeed without Medicare as a major player, because Medicare is the only payer with sufficient market power to drive meaningful delivery system reforms. The Centers for Medicare and Medicaid Services (CMS) strategic plan calls for “achieving a transformed and modernized health care system.” However, one cannot underestimate the difficulty of this undertaking—administratively, technically, and politically. Unlike private payers, traditional Medicare has not yet been permitted to establish limited provider networks based on quality and efficiency, or to vary benefit designs to drive patients to efficient providers. Medicare’s “big stick” is payment policy. Here we focus on Medicare’s role in payment reform, in the belief that private payers will quickly implement successful Medicare payment policy changes.

There is much variability in the readiness of U.S. physicians and hospitals to adapt to major payment system reforms. Although multispecialty groups such as Kaiser Permanente already operate under global payment, most U.S. physicians are in solo practice or small groups, and are ill prepared to manage care under greatly modified financial arrangements. Reforms must be phased in so that pro-

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**EXHIBIT 1**

**Evaluation Of Payment Reform Options Based On Key Objectives**

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<tr>
<th>Reform option</th>
<th>Controlling unnecessary utilization</th>
<th>Encouraging high quality</th>
<th>Promoting provider integration</th>
<th>Operational feasibility</th>
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<tbody>
<tr>
<td>Recalibrated FFS</td>
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<td>Pay-for-performance</td>
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<td>Episode payment</td>
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<td>Global payment</td>
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**SOURCE:** Authors’ analysis.

**NOTES:** FFS is fee-for-service. Three stars denote high potential; two stars, medium potential; one star, low potential; and no stars, zero or negative potential.
“In the immediate future, global payment models will remain primarily in the private sector.”

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In the immediate future, global payment models will remain primarily in the private sector. The CMS should encourage these private models and, where appropriate, develop partnerships with health insurers to support and evaluate them. For example, the CMS could establish a voluntary, local Medicare payment option that reinforces BCBSMA’s alternative quality contract. The CMS should also expand its use of programs such as the Physician Group Practice demonstration, where participating groups share in savings below a projected budget.30

In addition to payment policy changes, policymakers need to consider fundamentally restructuring Medicare to be a more effective purchaser. One option would be establishing an independent Medicare board that is separate from both the CMS and Congress. This would be analogous to proposals for a Federal Health Board (FHB) that would make decisions about benefits, coverage, and payment policy based on sound empirical research in the context of national health reform.31 Among its potential benefits would be insulating Medicare from congressional micromanagement.

Finally, the federal government should develop a detailed payment reform agenda that sends clear signals to the market. Although provider reluctance is inevitable, the most effective inducement will come from restricting growth in FFS rates, while offering alternative models with greater potential for provider income. Limits on spending growth will require reductions in payment rates, but we recommend that new payment models be implemented first, to allow payment reforms time to gain traction. If payment reform is viewed simply as a way to cut spending, providers will resist as they did during the 1990s. Instead, if the new payment structure allows providers to earn more as part of organized delivery systems than as independent practitioners, the interaction between payment policy and delivery reform could become a virtuous cycle.

**Concluding Thoughts**

Although payers with market power can reduce spending by cutting FFS payments, doing so in a fragmented system will create serious quality problems. We believe that organized systems are more capable of adapting to the inevitable moderation in U.S. health spending growth while maintaining quality, but that delivery system restructuring will not happen without payment reform. We strongly recommend that payment reforms precede any significant reduction in payment levels. Payment reform must also be accompanied by new investments in quality measurement, comparative and cost-effectiveness research, IT, and techniques for managing complex chronic illnesses. Without such investments, we are not optimistic that the U.S. health system will be able to moderate spending growth while moving toward a delivery system that generates superior value.
NOTES


13. E.S. Fisher et al., “Creating Accountable Care Organizations: The Extended Hospital Medical Staff,” Health Affairs 26, no. 1 (2007): w44–w57 (published online 5 December 2006; 10.1377/hlthaff.w2.44).


