

# Payment Reform

Coverage Institute Summary

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Overarching goals of the payment reform proposal include:

- Provider accountability for the total cost of care for a given population
- Empower individuals with information and make them responsible for choice
- Improved coordination of care (medical home concept)
- Increased transparency and provider competition on price and quality
- Achieving and sustaining “critical mass” to make the reform successful

## 1. Provider accountability and individual choice

- Providers and care systems would submit bids on the total cost to care for a given population.
- Consumers would receive information on the bids, and their premiums would vary depending on whether they chose a high-cost or low-cost system.
- Payments to providers would be risk-adjusted based on the health of the population they enroll, to avoid penalizing providers for enrolling a less healthy population.
- Providers would be accountable for the total cost of care of the population they enroll.

Because this model holds providers accountable for the total cost of care, providers will have incentives to innovate and find ways to provide care more efficiently. Consumers will also have incentives to consider cost because their premiums would vary depending on the care system they chose.

- Remaining issues and questions:
  - Incorporating quality into the tiering system
  - Should there be bonus payments for high quality and/or improving population health outcomes?

## 2. Improved Coordination of Care

Although the mechanism described above to create accountability for the total cost of care would provide incentives for improved coordination of care, it may be necessary or desirable to provide some type of care coordination payments for high-cost populations (especially people with multiple chronic conditions). In order to receive payments for care coordination, a provider would have to meet standards for a “patient-centered medical home.”

### **3. Price and Quality Transparency**

- Price/quality transparency for episodes of care (“baskets” of services – e.g. maternity care)
  - Provides additional points of provider competition beyond just health plan/care system choice to make markets function better
- Community process for defining comparable “baskets” so that consumers can make “apples to apples” comparisons
  - Providers innovate on care design and efficiency within baskets
- Make it relevant to consumers: internet-based tool for consumers to make comparisons and to understand differences in out of pocket cost based on their *own specific* health plan benefits

### **4. Achieving and Sustaining Critical Mass**

In order to make it worthwhile for providers and care systems to participate in this new payment system, it needs to involve a significant percentage of their patients. In order to be successful, this effort must include as many providers and payers as possible. Potential mechanisms for achieving and sustaining “critical mass” include:

- Making participation a condition of receiving payment for any patient paid for with state funds (state employees and public program enrollees) – this requirement would apply to both health plans and health care providers
- Extending the participation requirement to the small group and individual markets
- Extending the participation requirement to the entire fully-insured market