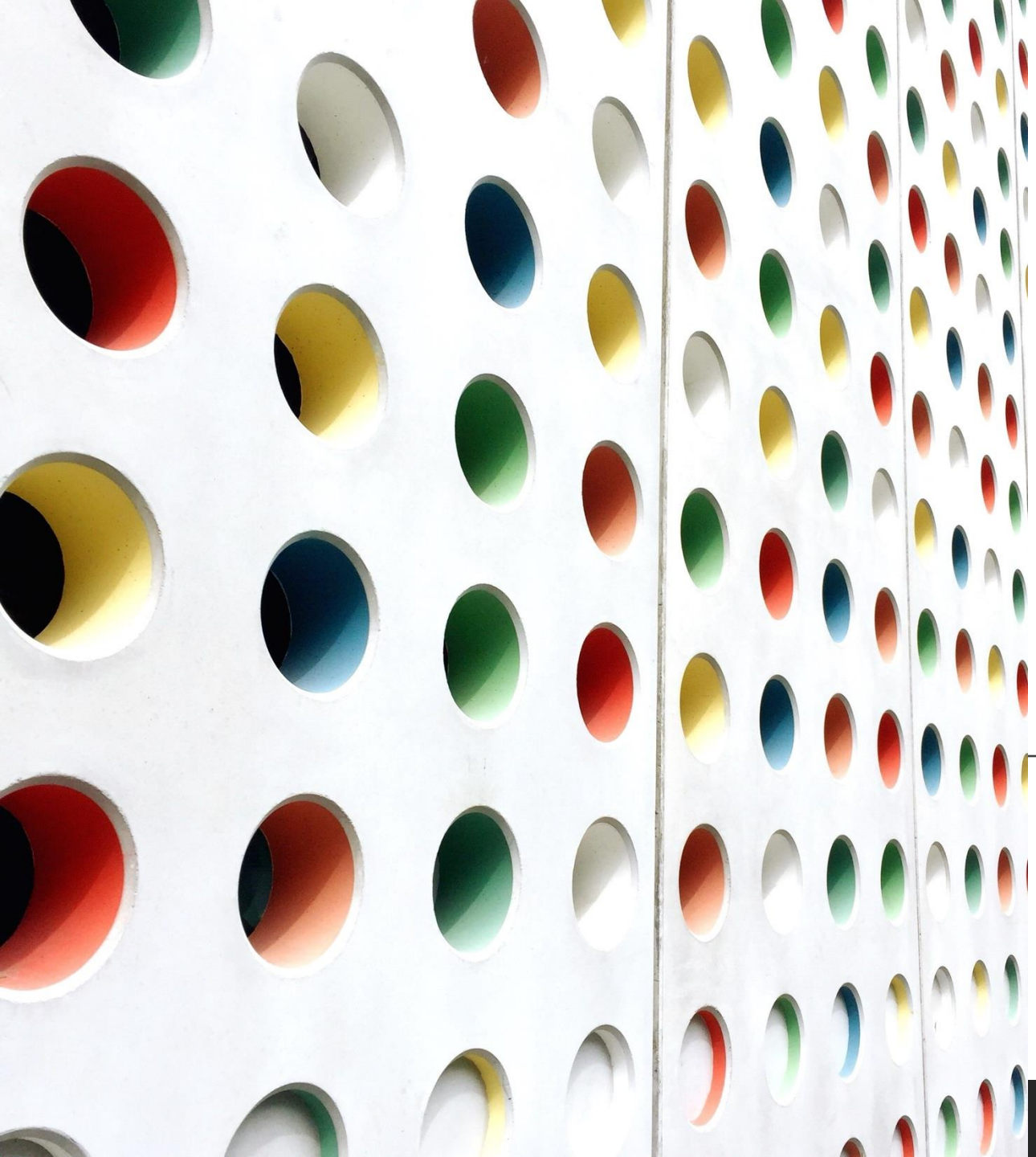

Health Care Reimbursement: The Promise of Reference-Based Pricing - Strategies to Control Spending, Promote Access and Competition

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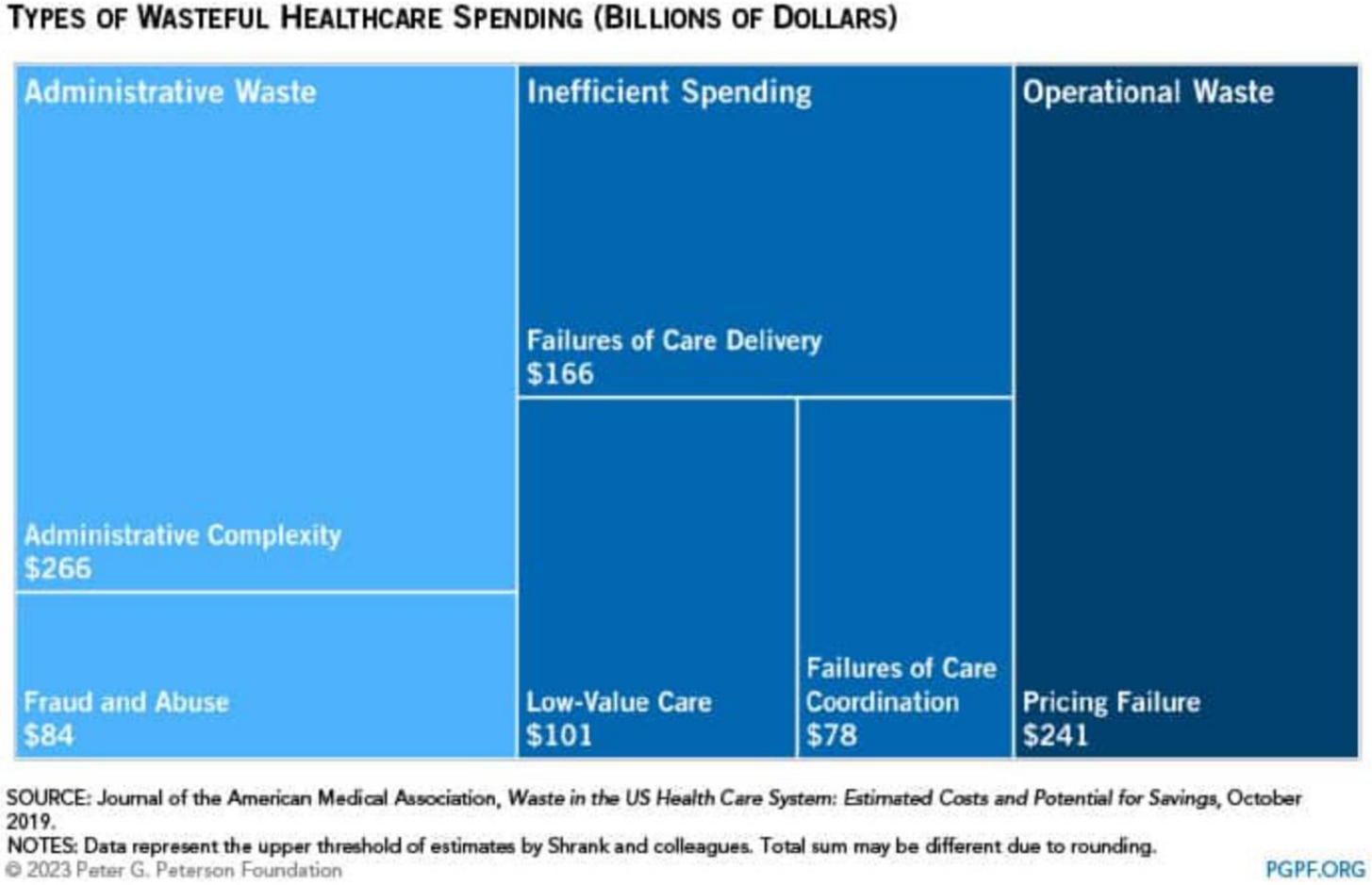
Wasteful healthcare spending can reach up to $935 billion a year



SOURCE: Journal of the American Medical Association, *Waste in the US Health Care System: Estimated Costs and Potential for Savings*, October 2019.
NOTES: Data represent the upper threshold of estimates by Shrank and colleagues. Total sum may be different due to rounding.

PGPF.ORG

The US spends more on health care, for worse outcomes, compared to peer countries.

Vermont is among the states with the highest spending per capita… and yet has significant challenges in access to care.

How does payment matter?

First, a quick reminder: Health Care Providers are also Financially Driven Organizations…

Payment models in Health care: three concepts

CAPACITY BASED

PAYMENT TO A PROVIDER ORGANIZATION TO ENSURE FUTURE CAPACITY FOR A RANGE OF SERVICES.

ACTIVITY BASED

REIMBURSEMENT CONDITIONAL ON THE DELIVERY OF UNIT OF SERVICE, SUCH AS DISCHARGE, ADMIT, BUNDLE OF TREATMENTS (E.G. FEE-FOR-SERVICE).

POPULATION BASED

MODELS THAT PAY AN ORGANIZATION (E.G. ACO) TO MANAGE CARE FOR A POPULATION, REGARDLESS OF THE NUMBER OF SERVICES.

Implications of different Payment Models

Payment Type	Impact on Volume of Services	Paid Entity
Capacity-based	Useful to ensure availability of services (e.g. floor for facility-based payment); or limit excess growth (e.g. global cap on spending).	Provider facility (e.g. VA).
Activity-based	Encourages greater use of unit services, and higher margin/revenue services.	Provider facility (Most US Providers).
Population-based	Encourages greater use of more preventative (vs acute) care and lower cost settings.	ACO, Managed Care Organization.
	Encourages lower use of services.	Provider facility (Rare).

Fee-For-Service

Medicare sets fees based on the "cost of production"

Medicaid varies by state; generally aligns with Medicare but pays less

Commercial payers negotiate prices, often per service/bundle, but contract structures and generosity vary.

Revenue = Price x Volume*

**Volume can come from patient care services, provider administered drugs, outpatient pharmacy, affiliated medical supplies, investments.*

Fee-For-Service: volume responses to price change

Table 1 - Analysis of an orthopedic surgery practice

Type of Service	Allowed Charges		Allowed Services		Price change	Volume change
	1994	1996	1994	1996		
Procedures	$38,430	$27,890	29	34	-27%	17%
Visits	$4,555	$9,773	45	83	14%	84%
Tests	$465	$228	5	5	-55%	0%
TOTAL	$43,451	$37,891	79	122	-23%	54%

From CMS actuarial report

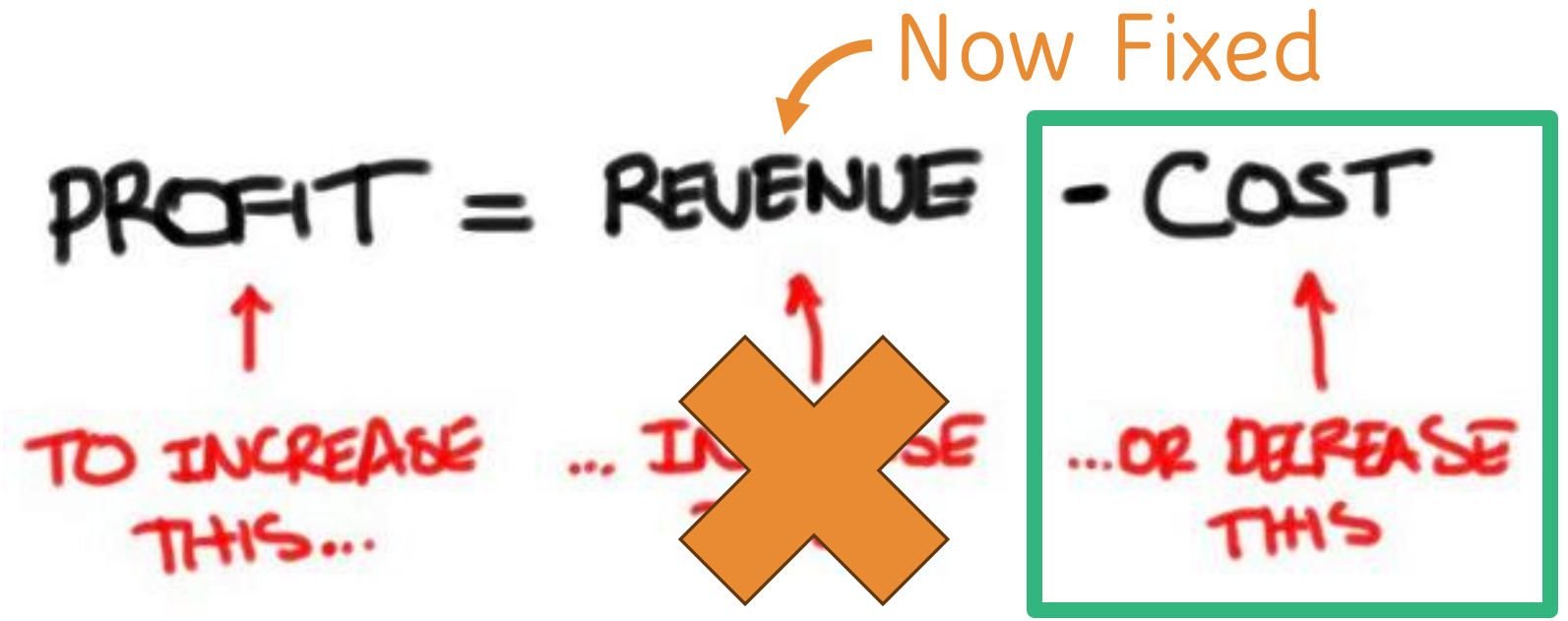
Capitation

Medicare Advantage: Medicare pays private companies a fixed price to manage care for the population; manages budget using plan design and provider contract negotiation (likely still on FFS basis).

Kaiser Permanente: Vertically integrated insurer and provider that manages care for a population, providers work together to manage the overall budget (including costs).

Revenue = (Monthly) Capitated Payment x Number Beneficiaries

Back to our equation (under capitation)…



Managing Costs: Rationing vs. Redesign

NEWS 'Deny, deny, deny': By rejeoting olaims, Medioare Advantage plans threaten rural hospitals and patients SHARE & SAVE

NEWS

'Deny, deny, deny': By rejecting claims, Medicare Advantage plans threaten rural hospitals and patients, say CEOs

Medicare Advantage plans "are taking over Medicare and they are taking advantage of elderly patients," said the CEO of one Mississippi facility.

"They don't want to reimburse for anything," Dr. Kenneth Williams, the CEO of Alliance HealthCare, said of Medicare Advantage plans.
Andrea Morales for NBC News

Facts at a Glance

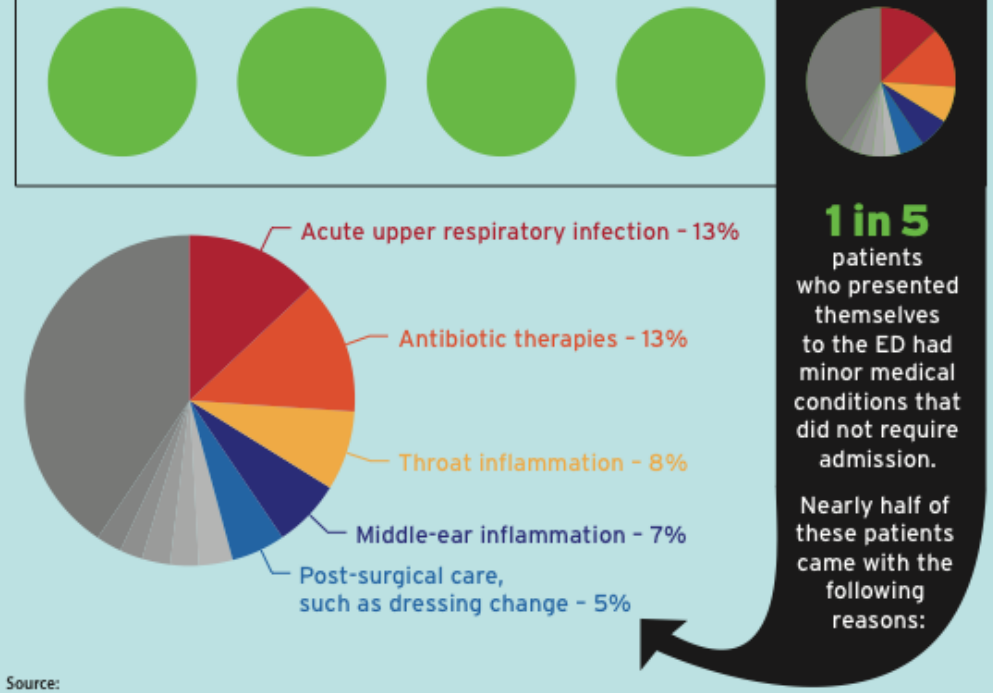
Sources of Potentially Avoidable Emergency Department Visits

Emergency departments (EDs) give priority to those patients with critical or emergency needs who require timely and highly skilled care. Despite this, many Canadians visit the ED for conditions that might be better dealt with in a different care setting.

This study looks at **two groups** of patients whose visits to the ED could potentially be avoided or addressed in other settings:

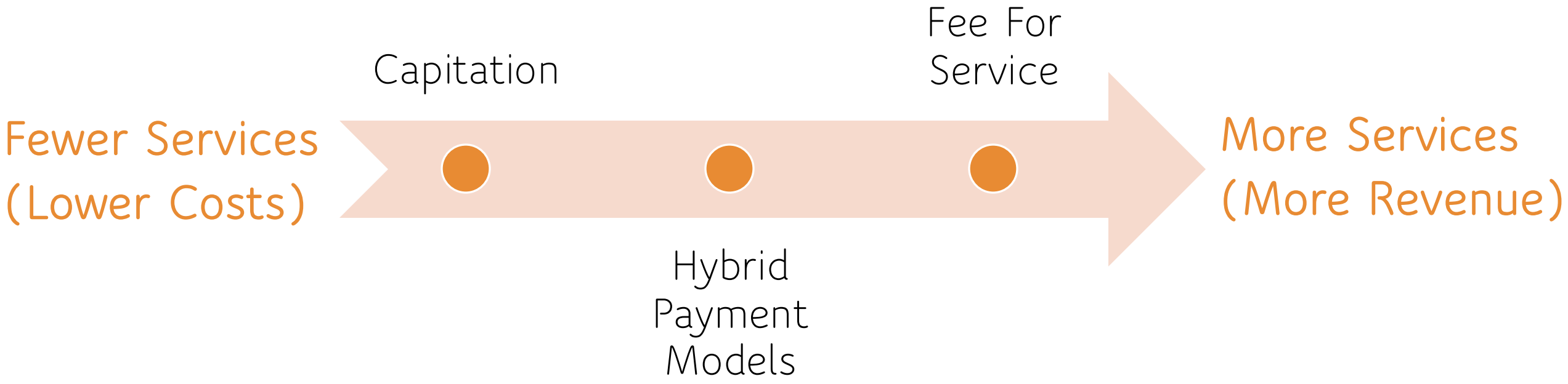
1. Those who visited the ED for minor medical complaints and were not admitted to hospital
2. Seniors in long-term care residences who visited the ED for conditions that were identified as potentially preventable or for less urgent reasons where they were not admitted to a hospital bed.

More than **1.4 million** visits to Canadian EDs were potentially avoidable.



Source:
Sources of Potentially Avoidable Emergency Department Visits,
Canadian Institute for Health Information (CIHI)

Payment Design → Financial Incentives



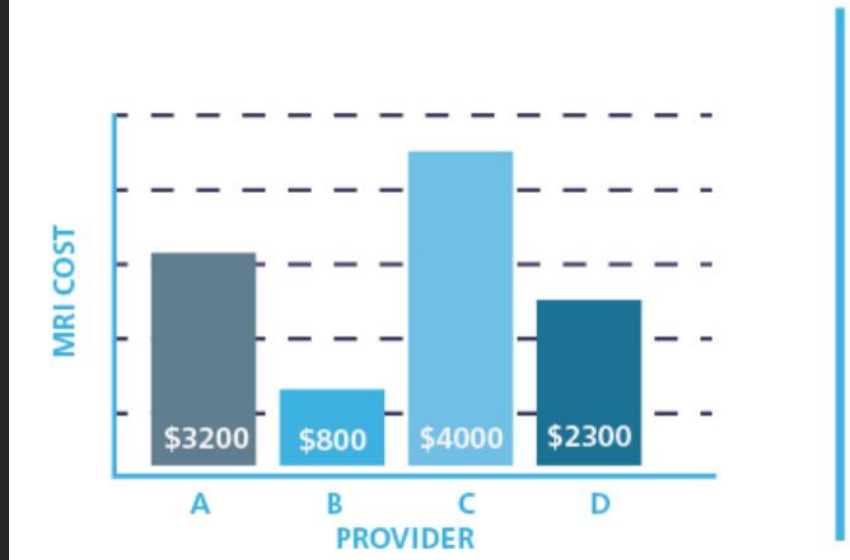
So what is referenced based pricing (RBP) and where does it fit in?

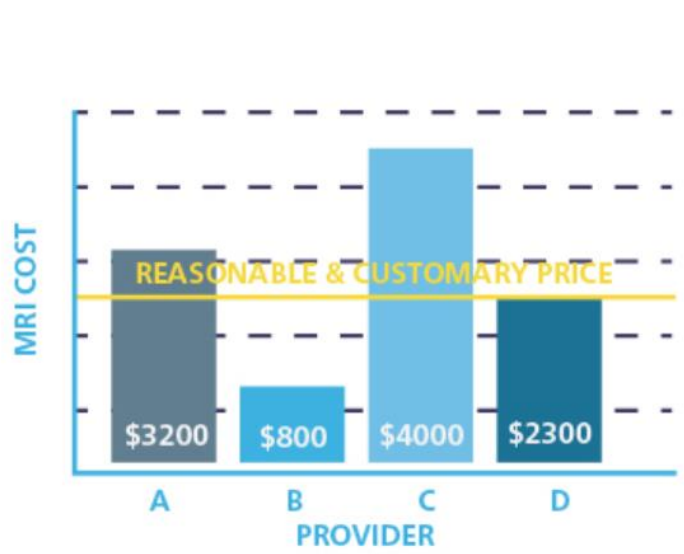
Reference-Based Pricing (RBP) is a health care payment strategy where:

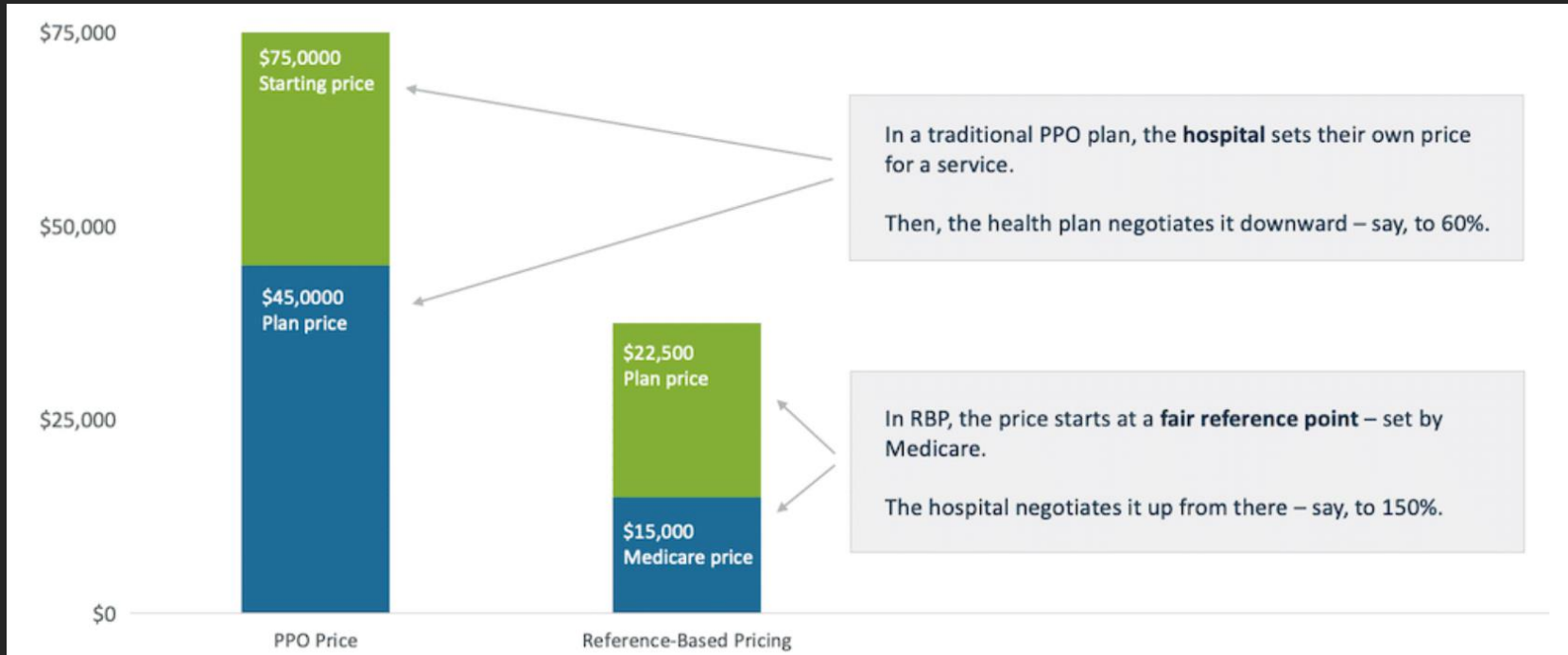
- a payer **(like an insurer or employer)** sets a **maximum amount they are willing to pay** for a particular health care service; OR
- a regulator establishes a **maximum and/or minimum** a payer can pay (insurance regulation), or a provider can charge (provider rate setting) for a particular service.

RBP: Two Examples…

THE "REFERENCE" CAN BE RELATIVE TO (1) THE MARKET OR (2) A PUBLIC PAYER (E.G. MEDICARE)







Figures adapted from: https://www.onedigital.com/blog/maximize-health-care-savings/ and https://varipro.com/what-is-reference-based-pricing/

Benefits & Challenges of RBP

BENEFITS

Cost containment

Increased transparency

Supports competition

Encourages Access

Rational pricing

CHALLENGES

Balance billing

Potential for over-utilization

So, when might RBP vs. Global or Capitated payments make sense as a payment strategy?

	RBP	Global/Capitated
Competition	More competitive provider markets.	A regionally dominant integrated provider system.
Supply vs. Demand	Supply exceed demand for services.	Limited capacity for particular services; can also guarantee capacity in low-volume areas.
Incentives for over/under-utilization	Encourages access, but less able to influence care coordination/non-duplicative care.	Strong incentive for provider to monitor and control utilization.
Price Efficiency	Payments are established based on the efficient delivery of a particular service.	Payments are established based on the efficiency of a facility to deliver a set of services.

“Every system is perfectly designed to get the results it gets”

Not just about selecting an approach (FFS vs. Capitation), but understanding *how the whole system works together*…

1. Which services should be paid in which way and how much?

2. How to make sure payment (encourages/discourages) utilization that we (want/don’t want)?

3. How do we know if access is improving or not (where and for which services)?

4. Are people getting primary and preventative care when they need it to avoid more costly care down the line?

Conclusion

There is no Silver bullet.

To take advantage of the opportunities and address the risks associated with any of these payment models, states may best serve the public interest by establishing a strong state agency tasked with:

1. **Health System Evaluation:** measure health care spending, access, and quality; how are funds flowing and what are we getting for what we are paying; and what are the drivers of underperformance?
2. **Planning**: Assess what patients need, leveraging broad community engagement to develop a plan that efficiently and effectively delivers what is needed.
3. **Payment Reform:** using incentives to improve affordability and access using targeted payment designs.