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The Future of Provider Payment

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Over the last several decades, public and private payors have experimented with a variety of payment mechanisms to manage rising premiums and underlying medical costs. Although there were early successes, such as Medicare's introduction of diagnosis-related group (DRG) payments for inpatient stays, costs have continued to climb at unsustainable rates. The number of uninsured and underinsured individuals, meanwhile, has also continued to rise, turning healthcare into a major political issue. We believe that the right set of payment reforms could address many of the systemic problems—including misuse, underuse, and overuse of medical care—and lead to net cost reductions of 15 to 25 percent.

To manage costs, the healthcare industry is focusing primarily on demand-side levers, such as consumer-driven health plans and cost shifting within traditional plans. But demand-side levers are not enough. The industry requires dramatic restructuring on the supply side to promote innovation and competition. Consumers will not change their behavior until they can choose from a range of differentiated provider value propositions that balance cost, quality, and service. History has shown that provider payment is

a key lever for prompting supply-side change in the U.S. healthcare system—practice follows payment (see Exhibit 1, page 2).

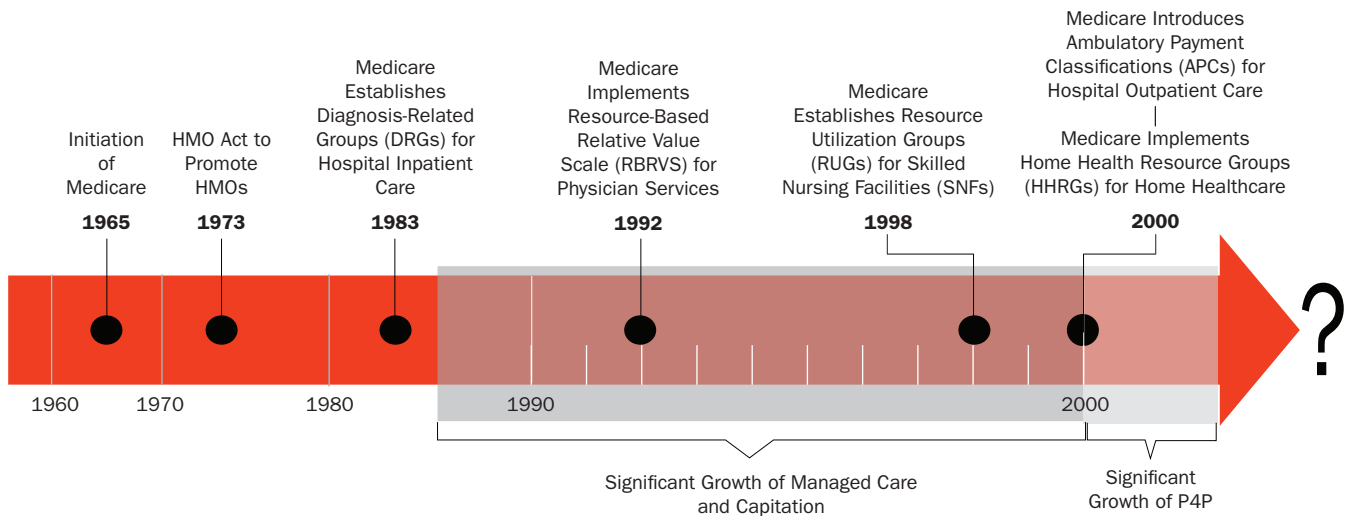
As momentum builds for change, there's broad agreement that the current fee-for-service system has failed because it often rewards providers for activity and complexity but not necessarily for the most appropriate care. Industry players—health insurance plans, employers, the government, and other stakeholders—accept that reform is warranted but are deeply divided on what shape that reform should take and how we should get there. There are two major schools of thought: The “incremental reformers” want to leverage the fee-for-service model that has evolved over decades into the mainstay of our current system, while the “fundamental reformers” want to revolutionize the underlying system to become more outcome focused and market oriented.

Four Viable Models and One Preferred Path

We've identified four promising models for reforming the payment system but believe that one solution in particular—evidence-based, bundled case rates—offers the most promise. An increasingly retail-oriented market may embrace each of these models or combinations of them to encourage payment innovation. Although the path forward is not entirely

Exhibit 1

Time Line of Major Payment Changes in the U.S. Healthcare System



Sources: Centers for Medicare & Medicaid Services, Institute of Medicine, Booz Allen Hamilton

clear, it is obvious that a collaborative effort across players is necessary if we are to remodel the nation's healthcare payment system.

1. Pay-for-Performance. Much of the emphasis in payment reform is currently focused on pay-for-performance (P4P) programs, which offer incentives for improvements in the process of providing care. Because there are already more than 150 employer- and payor-sponsored P4P programs in place and nearly 20 percent of doctors in group practice have pay linked to quality performance measures (according to a January 2007 study released by the Center for Studying Health System Change), this approach appeals most to incremental reformers. It promotes a gradual shift in provider behavior, relying on financial incentives to drive changes in provider performance. Even fundamental reformers tend to see P4P as an important early step toward a total system transformation because it opens a dialogue between providers and purchasers of healthcare, and it begins to reward providers for the quality rather than the quantity of services.

Although P4P is certainly a move toward delivering higher-quality healthcare, its incremental nature cannot deliver the kind of transformational improvements in quality and efficiency needed for fundamental healthcare reform. The limitations stem in part from the structure of P4P programs themselves, which are built on the inherently flawed fee-for-service reimbursement system. They also carry a number of risks, particularly for providers. Under P4P, providers take on a greater administrative burden and put a greater portion of their income at risk, which could affect both their take-home pay and their access to capital. P4P can also create incentives for providers to focus on improving their scores for a subset of patients, which could lead them to spend disproportionate energy "teaching to the test" rather than improving outcomes for all patients.

The impact of P4P on quality is another unknown. Well-developed evidence-based guidelines with associated metrics are currently lacking, as are mature systems of data collection, analysis, and dissemination. That being the case, few programs have been evaluated

scientifically, and the results from those that have been are mixed. Only six of 17 programs examined by the National Academy of Sciences' Institute of Medicine in 2006 exhibited "methodological strength," and a recent RAND report found "no studies demonstrating a relationship between P4P and improved performance in the hospital setting." Until we have comprehensive scientific measures combined with a robust data collection and monitoring process, we cannot know the true impact of P4P on quality.

Furthermore, according to a 2006 Congressional Research Service report, "There is little evidence that pay-for-performance programs save money in the long run, and they could actually increase healthcare expenditures." Once again, the problem is inadequate metrics. Most evidence-based metrics currently available target underused resources; very few target overused or misused resources. For a P4P program to lower costs, it needs to include measures of efficiency and also tackle the regional variations in care practices and outcomes. Such metrics will likely need to cross silos of care and to evaluate outcomes from a patient's perspective.

Although P4P has its limitations, we believe that the first generation of programs has proved worthwhile, because it underscores the urgent need to define and measure value. Having taken the initial steps in developing P4P programs, we now need to drive payment from fee-for-service through pay-for-performance to more transformational models.

2. An eBay for Healthcare. A more transformational approach to realigning incentives for providers would be the creation of a system resembling the market-making function of eBay, where consumers find trustworthy information comparing the cost and quality of different providers and then use that system to schedule an appointment with the preferred provider for a specified service.

At first the concept would probably apply only to commodity services, such as laboratory tests or X-rays. Eventually the eBay idea could be used to pay for more sophisticated services, such as colonoscopies. The eBay model is best suited for elective or discretionary procedures. We're already seeing how market dynamics are affecting the price, quality, and availability of services typically not covered by medical insurance, such as plastic surgery. In that area, providers now compete in what is essentially a free market.

There are drawbacks to this model. It promises transparency, but carries the risk that high-quality providers would be able to charge exorbitant rates that only a subset of the population could afford, thereby increasing disparities. The model also reduces the role of health plans in negotiating the price of services with providers and could thus lead to higher rates for individual consumers. Some employers facing extreme pressure to reduce healthcare costs might find this free-market approach appealing, but others might see it as difficult to implement, at least in the near term. Providers are likely to fear carve-outs of profitable treatments at specialized centers, which would create winners and losers among them. Finally, providers could be concerned about the transparency of quality and price information, particularly if they perceive the information to be inaccurate.

To overcome provider resistance, health plans and employers supporting this system would need to identify services that are compatible with the eBay model. They would also need to design benefits to support the eBay concept (for example, reference pricing for X-rays) and address concerns about carve-outs that could create shortages of treatment for certain types of patients.

3. Results-Based Payment. In a pure results-based system, providers could be paid to maintain and improve the health of patients, without regard to

whether those patients are chronically ill, in need of acute care, or perfectly healthy. This is an attractive notion. This model is likely to be controversial, however, because it hinges on the development of widely agreed-upon healthcare outcome metrics—no simple task. It would also require complex new risk adjustment mechanisms, new attribution models, and methods to track patient adherence to treatment plans.

The Centers for Medicare & Medicaid Services (CMS) is taking preliminary steps in this direction by disallowing payment for the treatment of a subset of hospital-acquired infections and complications beginning with October 2008 discharges. In the future, CMS may consider the option of paying providers on the basis of their ability to maintain or improve the health status of a patient population, divided into appropriate patient risk segments. Such a program design would help alleviate the negative consequences of establishing a reputation for treating the very ill.

This model promises to meet with significant resistance from providers. The problem isn't just the lack of accepted metrics. It's that providers know that their control over outcomes is limited; treatment success, especially with chronic conditions, often relies heavily on the behavior of patients themselves. In addition, desired outcomes are difficult to define for different patient populations. But some providers and suppliers are moving forward on their own. In Danville, Pa., for example, Geisinger Health System is now offering a 30-day warranty on cardiac surgery; in the United Kingdom, Johnson & Johnson offers a money-back guarantee to the National Health System on its cancer drug Velcade.

A system based solely on results could also raise politically sensitive questions about fairness and access to healthcare. If a results-driven system identifies the providers that get the best results, those providers might become so valued they could charge fees

that would effectively shut out all but the wealthiest consumers. Moreover, it is unlikely that the providers that get the best results would have the capacity to treat a significantly higher number of patients.

To successfully implement this model, health plans would have to partner with other players to develop outcome metrics and sophisticated risk adjustment formulas that would account for such factors as comorbid conditions (the effect of all ailments afflicting the patient other than the primary disease) and statistical errors in measurement. Plans would need to monitor the system constantly for unintended consequences, including the danger that providers could be penalized for treating sicker populations. They would also need to conduct wholesale redesigns of their benefit plans, tailoring them to results-oriented treatment.

4. Evidence-Based Bundled Case Rates. The model that we believe carries the greatest power to transform the system relies on evidence-based bundled case rates. Under this system, a team of medical providers would be paid for providing care to a certain patient risk segment—people afflicted with heart disease or diabetes, for example—based on guidelines with documented success in a clinical setting. The guidelines would spell out the appropriate mix of health services over a particular period of time or an episode of care tailored to the patient's needs. The services would then be valued at fair local market rates, and quality measurement would ensure compliance with the guidelines, providing added incentives for high performance.

The power of this model is that it could theoretically be applied to a wide range of healthcare services, particularly those involving the management of chronic conditions, which account for the majority of all healthcare spending. This model could also be used for acute episodes like hip replacements, where diagnosis, treatment, and follow-up care could all be

covered under one bundled case rate. This approach has captured the imagination of some of the leading thinkers in healthcare, among them Michael Porter of Harvard Business School, who notes that this bundling approach provides the critical prerequisite to improved transparency and smarter consumer choices—the fundamentals of a true retail marketplace.

The model's reach, however, will depend on the evolution of evidence-based medicine (EBM), the movement to apply uniform standards of scientific measurement to medical practice. Given that EBM cannot cover the entire universe of healthcare conditions in the future, the model cannot cover all healthcare services. However, by 2016, experts predict EBM could cover 50 to 75 percent of all healthcare delivery. If the healthcare system started moving in a serious way toward evidence-based bundled case rates today, in 2007, we estimate cost savings on a net basis of 10 to 15 percent by 2016.

This approach is still taking shape, as the industry tests ways to demonstrate quality. But it's already clear that certain factors will determine success. We see promise in evidence-based bundled case rates that cover patients' treatment through an acute phase of illness and an entire continuum of care, including pre- and post-hospitalization, an approach that Medicare has been testing with large physician groups since 2005. For example, bundled rates could cover not only a stroke patient's physician and hospital fees, but also the costs of physical therapy or nursing home care. One other critical success factor is neutrality in treatment sites—balancing the need for provider accountability in managing each patient's care with consumers' clear preference for flexibility in choosing their providers. Forcing care toward rigid delivery networks that are static for all diseases and all patients ties providers' hands and limits patients' choice. Patients balked at their lack of choice in the era of managed care. In today's more consumer-driven healthcare market, it would be all the more untenable.

Another critical success factor is establishing a single provider to take responsibility for coordinating medical care with the authority to make treatment decisions in consultation with the provider care team. This lead provider could also be responsible administratively for the allocation of payments to the provider care team. Prometheus Payment Inc., an independent nonprofit group aimed at reforming the healthcare payment system, is in the process of developing evidence-based case rates. A coalition of healthcare stakeholders, including the American Hospital Association, Bridges to Excellence, and the BlueCross BlueShield Association, is involved in the Prometheus effort.

Providers in this model would be free to take a more flexible, holistic approach to patient care. In the past we have seen physicians come up with simple and effective innovations driven by payment models with similar case-based characteristics. In many cases, these providers were capitated—that is, they were paid a fixed amount for each patient—so they had incentives to ensure that their patients remained healthy. For example, in low-income neighborhoods where stores typically stocked only white bread, some doctors used flexible spending authority to supply whole-grain bread to diabetic patients. For asthma patients, some doctors provided air conditioners to prevent expensive emergency room visits or hospitalizations. With a more holistic approach to patient care, evidence-based bundled case rates carry the promise of cutting back on overuse of the healthcare system and correcting underuse that can lead to higher costs in the long run.

The limitations to this model are the lack of evidence-based medicine; providers' inexperience in setting risk-adjusted case rates; and the scarcity of “episodes of care” methodologies that are based on expected, rather than delivered, care. Currently, EBM covers only about 25 percent of total medical costs, according to one industry estimate. Some providers may fear that bundled case rates will shift an increasing amount

of insurance risk onto their practices. To win provider buy-in for this type of reform plan, it is essential that payors and regulators address this issue and virtually eliminate that risk when setting case rates.

Specialists are likely to balk at the bundled case rates model because it resembles the capitation approach of managed care and will thus threaten their revenues. But there are three major differences between bundled case rates as we envision it and capitation: (1) the rates will be evidence-based, rather than arbitrarily determined or driven by negotiation, and thus will cover all necessary services and diminish access and underuse problems (though such problems may not be eliminated); (2) the rates will typically span all providers responsible for a patient's care; and (3) there will be an "out clause" that gives consumers flexibility in choosing providers. Whether specialists grow to like the model or not, it will appeal to integrated health systems, multi-specialty groups, and primary care physicians and other types of providers who are oriented toward holistic treatment.

Finally, the system will require a complex payment formula that will necessitate new systems and infra-

structure. To enact this model, health plans will have to actively partner with other organizations to develop targeted EBM and appropriate bundled case rates.

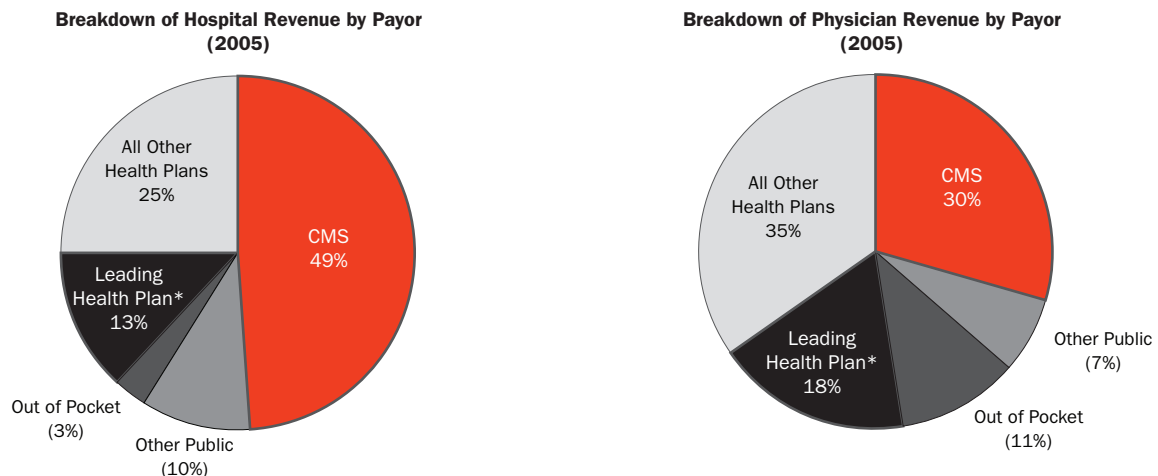
Collaboration Is a Must

Implementing any of these payment models will be complicated and politically difficult. Health plans, employers, consumers, providers, and government will all be sensitive to different aspects of each payment system but will nonetheless need to work together at some level to achieve meaningful progress. The key is to use payment reform to reduce or eliminate the misuse, underuse, and overuse of medical services that are driving up the cost of healthcare.

Although it is unlikely that any single health plan can drive national payment reform, there is one agency that must take part if payment reform is to succeed: CMS, the nation's largest single payor (see Exhibit 2). CMS provides about 30 percent of physician revenue and about 50 percent of hospital revenue. Even leading local commercial insurers, those that claim up to a 35 percent share of their markets, typically account for only 13 percent of total hospital revenue and 18

Exhibit 2

No Single Health Plan Can Drive Change

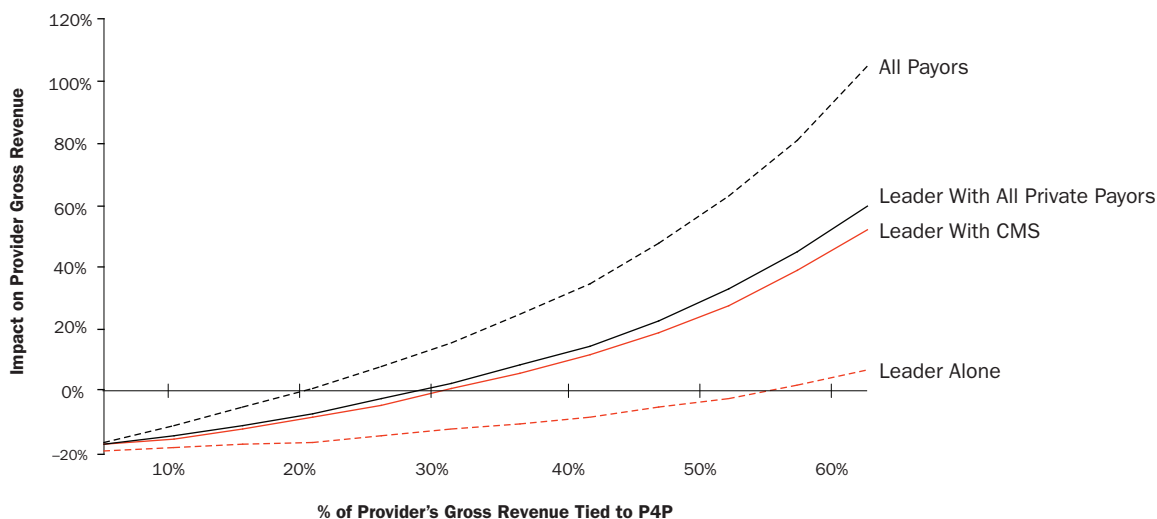


*Assumed that the leading health plan is a Blue plan with 35% of the commercial market share

Sources: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, Booz Allen Hamilton

Exhibit 3

Impact of Mature P4P Scenarios on Provider Gross Revenue—Physician Example



Sources: American Medical Association, Medical Group Management Association, Booz Allen Hamilton

percent of total physician revenue. If a payor decided to push through a pay-for-performance model that would be transformational, rather than incremental in its impact, on its own, it would have to pay about 50 to 60 percent of provider revenue through bonuses or incentive programs—far more than these programs currently pay—to make up for providers' likely loss in revenue (see Exhibit 3).

Put more starkly, a payor that decides to go it alone by attempting a P4P program with transformative intent without collaborating with other payors could be setting itself up for disaster. That payor would have to pay for the incentives on its own, and those incentives would have to offset the revenue that providers lose by changing their care practices to reduce overuse and misuse, or the providers would likely refuse to treat patients insured by that payor to avoid a negative balance sheet. Meanwhile, the provider's improved care practices would benefit all payors in terms of reduced healthcare costs, thereby creating a free-rider problem. On the other hand, if all payors collaborate on a P4P program with transformative intent, they would each put less into a bonus program to make up for the likely

loss in provider income. This would allow cost growth to be slowed without an immediate and drastic drop in provider income. Also, because all payors would contribute to the provider bonus program, no one payor would be disproportionately disadvantaged on costs.

At the urging of Congress, CMS has already taken steps to explore future payment models and appears to be open to collaborating with the private sector, as long as providers volunteer to participate. Pilot programs will speed learning, test reforms, and move the public and private sectors toward healthcare reform. A coordinated policy approach in Washington could hasten the work necessary to build the analytic underpinnings supporting new payment models. CMS could work with leading health plans and their local providers to design pilots and support them through demonstrations and waivers. MedPAC, the independent Medicare Payment Advisory Commission, could work to identify and recommend changes to Medicare payment legislation with strategies emerging from the pilots. Congress would enable the process with legislation and funds.

Individual health plans could have an important impact, too, but they should first determine how payment reform fits their corporate strategy, their near-term demands, and local market conditions that dictate the level of difficulty in introducing new payment schemes. For more than a generation, steep increases in healthcare costs have spurred cyclical attempts to remake the system. A sense of urgency is mounting again as employers face unsustainable increases in their healthcare premiums and government health plans slip closer to insolvency.

At the same time, we're seeing a growing emphasis on the consumer side of the healthcare equation. The provider-payment side of that equation needs to keep pace in order to trigger transformational change in care delivery. Tweaks won't be enough. We need major change to the current payment scheme. Only with real reform, including new payment models, will our healthcare system be able to provide care that is safe, effective, efficient, and patient-centered at affordable prices.

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