



RESEARCH REPORT

Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care

# Focused Factories—Specialty Service Expertise

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# Contents

<b>Contents</b>	<b>iii</b>
<b>Focused Factories—Specialty Service Expertise</b>	<b>1</b>
Introduction	2
The Basic Payment Approach	2
Complementary Payment Approaches	3
Complementary Benefits Designs	4
Environmental Factors	5
Conclusion	5
<b>Notes</b>	<b>7</b>
<b>Acknowledgments</b>	<b>8</b>
<b>Statement of Independence</b>	<b>9</b>



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Payment reform promises to substitute value for volume. Yet, value- and volume-based approaches typically are implemented together. All payment methods have strengths and weaknesses, and how they affect the behavior of health care providers depends on their operational design features and, crucially, on how they interact with benefit design. Those seeking greater value for their health care dollar are also turning to innovation in benefit design, which also typically involves the implementation of more than one approach at a time—each with its own strengths, weaknesses, and effect on consumer health care behavior. Although payment and benefit design each has received significant attention independently, the intersection between the two has received little if any. The Urban Institute partnered with Catalyst for Payment Reform to explore how established and proposed payment methods and benefit design options work on their own and together. We also examined how payment and benefit design can be blended to improve health care delivery. This chapter is one of the three pairs of interactions between payment methods and benefit designs discussed in the report *Matching Payment Methods with Benefit Designs to Support Delivery Reforms*. All reports and chapters can be found on our project page: [Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care](#).

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## Focused Factories—Specialty Service Expertise

The focused factory is characterized by a uniform approach to efficiently delivering a limited set of high-quality services. This typically means that a qualified set of specialists provides care for a procedure or a condition and for related services for which they have great expertise. It is possible to pay these organizations using legacy payments such as fee schedules and diagnosis related groups. Yet, the payment approach best able to support the objectives of a focused factory may be bundled episodes, a coordinated payment to all providers related to a procedure, condition, or treatment across an episode of care. Bundled episodes can be procedure specific, condition specific, or somewhere in between—a group of treatments for a given condition.

We can change supply-side incentives by paying a coordinated risk-based payment to all providers in an episode of care. But we also need to change incentives for consumers to seek care from providers with the greatest expertise, to ensure that they are receiving excellent, cost-effective care. Procedure-based episode payments are narrow and therefore easier to define. Reference pricing can pair well with

procedure-based episodes that have well-defined payments. This benefit design can also steer patients to more cost-effective providers. Other benefit designs that create richer coverage for use of centers of excellence give patients incentives to seek care from them. Additionally, value-based insurance design can encourage patients to seek particular services, such as diabetes care, by lowering cost-sharing for the services they need to manage their conditions. All of these components can better support the delivery of specialty services by these providers.

## Introduction

The “focused factory” is a concept developed by Wickham Skinner in 1974<sup>2</sup> based on the observation that “simplicity and repetition breeds competence.” It refers to provider organizations or their subsets that deliver highly specialized care for a defined and limited group of patients. The idea of providers taking a standardized approach to delivering a limited set of high-quality services efficiently contrasts with delivery-reform approaches like ACOs and PCMHs, which attempt to improve the continuum of care for a general population of patients.

Proponents believe focused factories offer clinical, operational, and financial alignment without the complexity inherent in managing a population’s health care needs. The focused factory provides a way for specialists, who so far are not central to ACO and medical home initiatives, to enhance the value of the care they provide while avoiding the data requirements, organizational challenges, and potential for monopolistic behavior that can come with ACOs.

## The Basic Payment Approach

Although it is operationally possible to pay a focused factory with legacy payment methods—fee schedules for physicians, per diems or diagnosis related groups (DRGs) for hospitals, and the various approaches used to pay postacute care facilities—these methods provide no incentive for health professionals and provider facilities to decrease fragmentation of patient care, or to mount initiatives that reduce costs and eliminate unneeded services.

The best approach to payment for focused factories may be bundled episode payment. Bundling first links payments that otherwise would be made separately to all of the providers performing services, then extends the period of care covered by payment beyond an individual encounter to the entire episode. More ambitious episodes based around a hospitalization extend beyond the hospital

discharge (the end point for a DRG episode) to 30, 60, or more post-hospitalization. The Centers for Medicare & Medicaid Services is testing bundled episodes that are mostly triggered by a hospitalization. But they are also testing bundled episode payments for chronic conditions, regardless of whether a hospitalization occurs. In contrast to “procedure-based episodes,” which are typically triggered by performance of a procedure, usually hospital based, such as joint replacement surgery, “condition-specific episodes” cover the care delivered by all involved providers for a patient with a particular diagnosis, such as diabetes or ischemic heart disease. A “treatment episode,” perhaps for a course of chemotherapy, is an intermediate episode designation. The bundled episode payment method has strengths and weaknesses, with some weaknesses related to implementation challenges.

Each approach poses specific operational issues. Within the prevailing system in which providers generate a claim for services rendered, a major operational challenge is determining which claims are part of a bundle and which should be paid separately; longer episodes generate greater chance of error in the allocation of claims to the bundle. For condition-specific episodes in particular, payers need a clear-cut and reliable approach to determining when an episode is triggered.

Payment for bundled episodes can be retrospective or prospective with financial bonuses or penalties. In a retrospective approach, actual expenditures are reconciled using standard payment amounts from the payer against a target payment amount. If the submitted claims for services are less than the target, a bonus payment is made, with the formula for distribution determined in various ways. If spending exceeds the target, the payer is owed a recoupment. Withholds on the routine payments made to providers participating in the bundle facilitate recoupment. In a prospective payment, a single bundled payment is made to one of the providers, often the hospital in a procedure-specific episode. Physicians and other practitioners and providers submit “no-pay claims” to the payer but are paid by the “convener” provider a previously agreed-upon amount.

## Complementary Payment Approaches

Procedure- or treatment-episode-based payments can be combined with condition-specific episode payments, such as when coronary stents are the appropriate treatment for a patient with ischemic heart disease. The procedure-based payment might go to different providers than those taking responsibility for the condition.

Procedure- and condition-specific bundled payments also are compatible with other payment methods that reward prudent health spending, including population health payment approaches. In this

case, the ACO-like organization receiving shared risk payments or capitation payments would administer the episode-based payments to constituents of the organization, or possibly to other providers, effectively substituting for the payer. Bundled episodes represent a variation in subcapitation approaches that globally capitated organizations have long used.

## Complementary Benefits Designs

For partners receiving a bundled episode payment, a fixed financial target is a strong supply-side approach to constraining spending. Yet, an appealing theoretical advantage of bundled episode payment is that it helps insurers manage financial risk. The narrow nature of a procedure-based payment, such as for a knee replacement, permits consumers to calculate their portion of the bundled price up front and select a provider accordingly. So, benefit designs that, for example, establish a reference price for the procedure-based bundled episode have theoretical appeal. Additionally, reference pricing would channel consumers to lower-cost providers. Condition-based bundled episodes are complex, with varying services, providers, and episode lengths, which may make reference pricing too difficult to establish.

The practical challenge to this concept, however, is that for virtually all bundled episodes, the patient's annual out-of-pocket maximum protection will kick in during the course of care. Medicare benefits do not include annual out-of-pocket maximums, but more than 90 percent of beneficiaries have supplemental coverage, which does provide such protection. As a result, cost-sharing—whether in the form of reference pricing or high deductibles that are designed partly to make consumers price and cost conscious—likely has greater impact on consumers' choices for discrete, often one-time services, such as colonoscopies or MRI scans, than for care provided over time in an episode. To maintain consumers' incentives for consumers to make high-value choices throughout an episode, continuous, thin cost-sharing—on the order of 5 to 10 percent—might better remind patients that costs are associated with each additional service they receive.<sup>3</sup>

Centers of excellence (COEs) can complement bundled episodes. In this combination, consumers or Medicare beneficiaries would have financial incentives to seek care from designated centers, which are typically selected because of demonstrated expertise and cost effectiveness in a discrete service line, akin to a focused factory. Quality is always a consideration in the designation of COEs. Purchasers and payers can put COEs under contract to follow evidence-based appropriateness guidelines and can monitor compliance to guard against inappropriate bundles.

Outside of COEs, payers can rely on regular utilization management tools, especially precertification, to protect against paying for unneeded episodes. The problem is that there is often a grey zone around appropriateness. Even external payer-based reviewers may only be able to detect and prevent clear-cut, inappropriate interventions, as they do under legacy payment approaches. The advantage of condition-specific episodes is that their inherent incentives discourage inappropriate procedural interventions. The concern under condition episodes, instead, is that providers would stint on services, especially high-cost procedural interventions. V-BID is meant to lower cost-sharing for high-value services. But so far, its application is mostly to primary and secondary prevention services related to specific conditions, not to procedures, the indications for which depend on clinical detail. For example, cost-sharing would be lowered for a patient with diabetes who wants an eye exam.

A tiered network could incentivize consumers to seek care from focused factories. This design would place the focused factory in the highest tier where consumers have the lowest out-of-pocket costs. Other specialist groups that are not highly specialized would be placed in lower tiers where consumers have high out-of-pocket costs. A COE for the particular procedure or condition could also be placed in tier 1.

## Environmental Factors

Focused factories will work best in markets where there is competition for patients and where acceptable quality can be assured and reasonable prices prevail. The markets also have to be large enough that the provider will have enough experience to achieve excellence and that ancillary services to improve patient outcomes are justified.

## Conclusion

For the focused factory, a bundled episode payment approach has potential as the preferred payment method, but operational challenges may limit their application. Current tests of the approach will help determine its future role in payment reform. On the demand side, benefit designs such as differential benefits for selecting COEs and narrow networks encourage consumers to seek care from providers with particular expertise. Reference pricing can both establish well-defined prices for procedure-based bundles and steer consumers to more cost-effective specialty providers. Value-based insurance design can encourage patients to seek particular services, such as primary preventive services or services

beneficial for their specific condition, from the providers in the bundle. All these components can better support the delivery of specialty services by providers with the most expertise in a given procedure or condition.

# Notes

1. Skinner, W. The Focused Factory. Harvard Business Review, May 1974. Available online: <https://hbr.org/1974/05/the-focused-factory>.
2. Payment Reform: Bundled Episodes vs. Global Payments- A debate between Francois de Brantes and Robert Berenson. Urban Institute, Washington D.C., September, 2012

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A [technical expert panel](#) advised the project team and reviewed the reports at different stages.

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