



RESEARCH REPORT

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

# Centers of Excellence

*Suzanne F. Delbanco*  
CATALYST FOR  
PAYMENT REFORM

*Roslyn Murray*  
CATALYST FOR  
PAYMENT REFORM

*Robert A. Berenson*  
URBAN INSTITUTE

*Divvy K. Upadhyay*  
URBAN INSTITUTE

April 2016





## ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is dedicated to elevating the debate on social and economic policy. For nearly five decades, Urban scholars have conducted research and offered evidence-based solutions that improve lives and strengthen communities across a rapidly urbanizing world. Their objective research helps expand opportunities for all, reduce hardship among the most vulnerable, and strengthen the effectiveness of the public sector.

# Contents

<b>Centers of Excellence</b>	<b>1</b>
Key Objectives of Centers of Excellence	2
Strengths	3
Weaknesses	3
Design Choices to Mitigate Weaknesses	4
Selecting the Services or Procedures	4
Selecting the Providers	4
Voluntary or Mandatory	5
Cost-Sharing or Consumer Benefits	5
Communication	5
Availability of Price and Quality Information	5
Compatibility with Other Benefit Designs and Payment Approaches	6
Focus of Performance Measurement	6
Potential Impact on Provider Prices and Price Increases	7
<b>Acknowledgments</b>	<b>8</b>
<b>Statement of Independence</b>	<b>9</b>



---

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 seven benefit designs discussed in the report *Benefit Designs: How They Work*. 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](#).

---

## Centers of Excellence

Centers of excellence (COEs) are designated groups of providers that meet high standards for both the quality and the cost of care for a particular service or set of services. Unlike network strategies that sort by provider organization, health care payers designate COEs for specific procedures or other services where both quality and cost vary significantly. Common examples are non-emergent and complex specialty services, such as total joint replacement, heart surgeries, spine surgeries, bariatric surgeries, cancer and transplants. In return for COE designation, which provider groups hope will draw more patients to them, they may be willing to accept a lower negotiated price or alternative payment arrangement, such as a bundled episode payment. In addition, the purchaser or health plan typically designs the health benefits to make selection of the COE financially favorable for the patient. Therefore, the purchaser or health plan benefits by creating a source of high-value care for their members. The patient benefits because the COE program points them to a preferable source of care, an improvement and an alternative to the uneven quality and payment amounts they were subject to previously.

COEs are established through contracts between either a payer or an employer and a provider group. Consumers' use of a COE is largely voluntary. To encourage consumers to obtain the service they

would like to receive from these high-value providers, payers or employers lower or waive out-of-pocket costs for their members or offer them a reward or cash bonus for seeking care. And because COEs can sometimes be situated in geographies that are inconvenient for the consumer, payers or employers often cover the travel costs for both the patient and a companion. If the patient has to travel for the service and needs coordination and follow-up post procedures, most COEs have agreements with providers in the patient's local market to follow up with the patient.

The Wal-Mart Associate Health Plan currently has COE contracts with five leading hospitals that perform heart, spine, cancer, and transplant surgeries—Cleveland Clinic, Mayo Clinic, and Geisinger Medical Center to name a few. Wal-Mart employees bear no out-of-pocket costs if they receive care from one of the five centers. Associates on Wal-Mart's HSA plan must meet their annual deductibles before the plan will make any payments, due to federal tax laws.

## Key Objectives of Centers of Excellence

Employers and payers typically create COE programs to address variations in quality and costs for particular high-cost services, thus enabling patient members to select care from a site offering high-quality, more affordable care.

Another objective of COEs is to ensure that the care patient-members receive is appropriate. For example, some COE programs compensate providers for thorough evaluations of patients, to ensure that the care the patient seeks is appropriate and necessary. If it turns out the patient needs the care, then another larger payment is made to cover the costs of those services.

Lastly, COE programs aim to offer a high-value alternative while preserving patient choice. Generally, centers of excellence programs are voluntary; it is up to the consumer to choose to use them. Consumers are not penalized if they seek the service from another provider, but they may have higher out-of-pocket costs as opposed to low or no out-of-pocket costs. Therefore, another objective is to preserve consumer choice, allowing them flexibility to choose where they would like to receive the service.

## Strengths

- COE programs give patients incentives to seek care from higher-value providers. This can lead to better, more appropriate, and less-expensive care for both the patient and the employer or payer.
- If COE providers are compensated for thorough evaluations of patients before performing the procedure or service, the procedure or service should be appropriate and necessary, starting with the right diagnosis and ending with an effective treatment plan.
- The development of COEs can create national markets for elective procedures and other care episodes, which may stimulate consistency and efficiency and create competition for local providers that otherwise may be able to command high prices. This could lead non-designated providers to offer price reductions and improve the quality of the care they provide.
- A national contract may be attractive to provider organizations because it would include many lives, which may translate into larger price concessions by the COE.
- COEs may offer better discharge planning and better continuity of care for the patient after an operation or service. Most COEs have agreements with providers in local markets to follow up with patients after a procedure or service.
- Generally, COE programs are voluntary, giving consumers the ability to make decisions about their care, rather than restricting them to a particular provider or group of providers. A COE can maintain consumer choice while improving patient care.

## Weaknesses

- There may be high administrative costs in creating a COE program—search costs, determining criteria and who meets them, negotiations, and claims administration, among others. If the COE requires high setup costs but represents a small amount of savings, it may not be worth the effort.
- The highest-value provider group, contracted as a COE for a specific service or procedure, may be located in a completely different geographic region than the consumer population. This may be inconvenient for consumers and families, as they face travel costs—in direct expenditures

and time—to seek care. Therefore, consumers may opt to seek care from a more conveniently located provider.

- COEs move the health care system toward setting up national markets for elective procedures. Local provider groups that perform these procedures face the possibility of shutting down if they no longer receive revenue for high-paying services, reducing local access to the services that are the focus of the COE program.
- The providers in the COE may be paid to ensure that the care the patient seeks is necessary. Even if they decide the care is unnecessary, the patient may return home and seek that service from another provider.
- Poor communication between the COE and patients' other providers, such as their primary care physicians, or other local specialists, could hurt the continuity of care.

## Design Choices to Mitigate Weaknesses

### Selecting the Services or Procedures

COE programs are most commonly implemented for non-emergent complex services where expertise may be concentrated among particular providers, for which there are established guidelines, or where there is high variation in cost and quality across providers. The first COEs were created for organ transplants due to the high cost and specialized nature of the procedures. Others have been designated for hip and knee replacements, cancer, and complex spine, heart, and bariatric procedures, among others.

### Selecting the Providers

Most COE programs select one or more provider groups that have expertise in the service or procedure of interest and that offer high-quality care for that procedure. Cost is also a consideration, and price negotiations will generally involve a discussion about offering a lower price or accepting an alternative payment arrangement in return for a higher patient volume. It is also important for the provider group to have medical travel destination experience.

## **Voluntary or Mandatory**

The use of COEs by consumers can be voluntary or mandatory. Most COEs are voluntary, giving consumers the ability to weigh trade-offs and decide which providers they wish to see. But in a voluntary program, consumers may not use the COE if the incentives are not strong enough or they lack information on the COE option. On the other hand, if the COE is mandatory, consumers may push back due to inconvenience (e.g., geographic) or disruption of the patient-provider relationship.

## **Cost-Sharing or Consumer Benefits**

The incentives (out-of-pocket costs) to encourage consumers to use the COE should be significant. Strong incentives can be created through either lowering or waiving out-of-pocket costs. The plan or purchaser may also offer consumers a cash bonus to seek care from the designated COE, helping cover consumers' travel costs.

## **Communication**

Systems to facilitate communication and care coordination between the COE and patients' regular providers are essential. After patients undergo their care at the COE, resources should be available to help them manage their health after the procedure. Most COE programs have agreements with patients' local or regular providers to follow up with the patient after an operation.

## **Availability of Price and Quality Information**

Price and quality transparency can show consumers the value of the care a COE offers versus that of the same service delivered by other providers. Such transparency, combined with the incentives to use the COE, may encourage consumers to choose the COE.

# Compatibility with Other Benefit Designs and Payment Approaches

COEs could be paired with narrow network products. Narrow networks restrict consumers' choice to a limited set of providers in a market. These providers may not be the best providers for given services and procedures. Therefore, a COE would give consumers a high-value option for the service they seek.

Incentives to use alternative, less expensive sites of care, specifically telehealth services, would be compatible with COEs. Telehealth would allow patients who live a significant distance from the COE to follow up with the COE after an operation without the costs of additional travel. The COE would be able to learn firsthand about the patients' progress and coordinate as needed with the patients' regular or local providers.

Most COEs, like all other health care professionals, are commonly paid fee schedules. However, COE programs are increasingly compensating providers with bundled payments for a procedure or other episode of care. Because the providers in the COE are designated for a particular set of services or procedures, a package price that includes all the services the patient will receive may be most effective and allows the purchaser to budget more accurately. If the payment arrangement centers on bundled episode payment, the payer must offer alternative compensation for the COE when it determines after evaluation that a patient is not an appropriate candidate for care.

COE contracts are more likely to allow for innovation in payment and delivery because the health plan can promise the COE higher patient volumes in exchange for lower negotiated fees or alternative payment arrangements.

## Focus of Performance Measurement

COEs are designated using quality and cost criteria. The quality measures used in selecting providers to serve as COEs could be flawed, meaning greater use of these providers will not lead to higher-value care for their consumers. Further, health care providers with leverage could demand to be designated COEs, even if their performance does not meet the criteria. To validate the criteria used for provider selection, payers would ideally to assess the quality of patient care the COEs deliver, particularly with outcomes measures. It may also be important to look at the effect of the COE program on the incidence of the procedure or service the COE addresses. With attractive cost-sharing arrangements, consumers

might be more likely to seek care than before, particularly for elective procedures. While the care may be appropriate for most, it may not be appropriate for all, and the COE program could lead to overuse.

## Potential Impact on Provider Prices and Price Increases

If there is significant, meaningful enrollment, the development of COEs can establish a national market for services and procedures, inserting competition for local providers where there may have been none. In these contracts, the COE typically grants pricing concessions for a large regional or national book of business, which is significantly lower than competitors' prices. The threat of losing patient volume to providers either within or outside of the market may encourage local providers to renegotiate their prices.

# Acknowledgments

This report was funded by the Robert Wood Johnson Foundation. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at [www.urban.org/support](http://www.urban.org/support).

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

## STATEMENT OF INDEPENDENCE

The Urban Institute strives to meet the highest standards of integrity and quality in its research and analyses and in the evidence-based policy recommendations offered by its researchers and experts. We believe that operating consistent with the values of independence, rigor, and transparency is essential to maintaining those standards. As an organization, the Urban Institute does not take positions on issues, but it does empower and support its experts in sharing their own evidence-based views and policy recommendations that have been shaped by scholarship. Funders do not determine our research findings or the insights and recommendations of our experts. Urban scholars and experts are expected to be objective and follow the evidence wherever it may lead.



2100 M Street NW  
Washington, DC 20037

[www.urban.org](http://www.urban.org)