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Research Insights

New Models to Pay for Health Care

Summary

Concerns about rising health care costs and low quality have prompted some public and private payers to adopt new ways of paying for health care services. These initiatives aim to reward doctors and hospitals that provide high-quality, high-value care, thereby better aligning providers' financial incentives with patients' health outcomes. The new payment models described in this brief include shared savings, payments to patient-centered medical homes, bundled payments, and global payments.

While these new models have the potential to encourage care coordination, improve quality and control costs, there are many challenges in implementing them. These include obtaining provider buy-in, implementing new performance measurement and reporting systems, and establishing effective risk adjustment. More broadly, because many of the new models are being implemented by adjusting fee-for-service payment rather than replacing it, their potential to be truly transformative may be limited. The success of new payment models will depend in part on identifying and incorporating lessons learned by early adopters.

Introduction

The way health care providers are paid is widely regarded as a key driver of U.S. health care costs. Fee-for-service payment, the predominant form of provider reimbursement, is blamed for incentivizing hospitals and physicians to increase the volume and intensity of their services, whether or not those services are appropriate, and penalizing those who improve patients' health and avoid unnecessary services. In addition, the decentralized nature of the U.S. health care system means that all of the providers involved in a patient's care are typically paid separately, creating few incentives for coordination of services. All too often, the result is low quality, poor patient experience, and skyrocketing costs.

In this environment, insurers and purchasers in the private and public sectors are experimenting with new payment and service delivery models that aim to contain costs while improving or maintaining quality of care. Drawing on previous demonstrations by the Center for Medicare and Medicaid Services (CMS), the Patient Protection and Affordable Care Act (ACA) established a range of new delivery system models to test within the Medicare program, including accountable care organizations and patient-centered medical homes. The newly-created Center for Medicare and Medicaid Innovation (CMMI) is charged with evaluating these and other models that have the potential to reduce expenditures within Medicare, Medicaid or the Children's Health Insurance Program (CHIP) while preserving or enhancing quality of care.

Accountable Care Organizations: Opportunities and Challenges

One of the more high-profile new payment models is the shared savings model. While there are many variations of this model, the most visible approach is being used in the context of accountable care organizations (ACOs). An ACO is commonly defined as a

Genesis of this Brief:

This brief is drawn, in part, from a panel titled "New Models to Pay for Health Care" held Feb. 4, 2013, at AcademyHealth's National Health Policy Conference in Washington, D.C. The panel was moderated by Harold Miller, executive director of the Center for Healthcare Quality and Payment Reform. Panelists were Susie Dade, M.P.A., deputy director, Puget Sound Health Alliance; Robert Mechanic, M.B.A., senior fellow, Heller School of Social Policy and Management, Brandeis University; and Karen Van Wagner, Ph.D., executive director, North Texas Specialty Physicians.

group of providers that assumes responsibility for the cost and quality of care it provides to a defined population of patients. Under the shared savings model of payment, ACOs that meet or exceed certain quality and cost performance benchmarks are eligible to share in any resulting cost-savings. The idea is that by linking provider payment to cost and quality outcomes, ACOs can discourage the provision of unnecessary treatments and services while emphasizing prevention, care coordination, quality, and value. Other payment models, such as capitation and risk-adjusted global payment, are being used to support some ACOs, too.

CMS is currently testing a handful of ACO models that aim to control costs and improve quality of care in the Medicare program. The health care organizations participating in the Medicare Shared Savings Program (MSSP) may receive bonuses for meeting annual performance standards on per capita expenditures and quality of care. The quality component includes 33 measures in areas such as patient safety, appropriate use of preventive services, and improved care for at-risk populations. A subset of MSSP participants are physician-based or rural providers that receive additional start-up support through the Advance Payment ACO Model. Another initiative, the Pioneer ACO program, involves large provider groups that have experience coordinating care across multiple settings and the ability to take on greater financial responsibility; the Pioneer ACOs will move from shared savings to a more global payment model in their third year. Taken together, the Medicare ACOs serve more than four million beneficiaries and are projected to save the federal government as much as $940 million over four years.[1] In all, there were more than 400 Medicare, Medicaid and private ACOs nationwide as of early 2013.[2]

Like other payment models, the success of the shared savings approach requires several key components to be in place:[3]

- **Focused provider accountability.** Providers must accept responsibility for the conditions that they can manage, but not for conditions or circumstances they cannot reasonably expect to influence. For primary care physicians, this means using prevention, early diagnosis, chronic disease management, and other tools that help reduce emergency department visits and avoidable hospitalizations. For their part, specialists must be accountable for reducing unnecessary testing and expensive low-value procedures.
- **Flexible provider payment.** In order to redesign care for higher quality and lower cost, both primary care physicians and specialists need flexible payment that allows them to decide what care is best for their patients without the restrictions imposed by payer-defined fee schedules or automatic revenue losses from performing fewer tests or procedures.
- **Protection from insurance risk.** While providers should be held accountable for reducing costs (performance risk), they should not be penalized for the initial severity of their patients' health conditions (insurance risk). If such protections are not in place, providers may avoid treating patients with multiple or serious conditions.

In addition, implementing shared savings through ACOs will require significant changes in physician and patient behavior – changes that some critics say may be unrealistic. As these skeptics observe, if ACOs are to meet their cost and quality objectives, most doctors will need to change some of their approaches to treating patients, for example, by more frequently incorporating evidence-based protocols into decision-making.[4] This change is unlikely to occur automatically considering the complex systems and relationships that have long shaped physician behavior. ACOs also require patients to play a more active role in their own care, else providers will be held responsible for patients who don't comply with their recommended treatments.[5]

Putting Patients at the Center of Care: A Medical Home Pilot in Washington

The growing interest in payment and delivery reform has been accompanied by the emergence of the patient-centered medical home (PCMH). First conceived in the 1960s, the medical home model reinforces the role of primary care practitioners in coordinating a patient's care across all elements of the broader health care system.[6] Primary care physicians work with nurses, pharmacists, nutritionists, social workers and others to provide care that is oriented to the whole person and responsive to the preferences of the patient.[7] The medical home model also emphasizes accessible services by way of shorter waiting times, enhanced in-person hours, and alternative forms of communication such as email and telephone. Guidelines developed by the four primary care physician societies inform the recognition and accreditation of these new models.[8]

In contrast to ACOs, most payment reforms to date for primary care practices in medical homes have focused on providing additional resources to practices, but have not required them to accept accountability for the cost of their patients' care.[9] However, because of concerns that more up-front resources are needed to enable primary care practices to successfully transform into true medical homes, some pilot projects are adding additional accountability to medical home models, making them look more similar to payment models for ACOs.

One such project is an ongoing multi-payer accountable medical home pilot co-sponsored by Washington State and the Puget Sound Health Alliance, a nonprofit organization dedicated to improving

health care in the five counties surrounding Puget Sound.[10] The pilot, launched in 2011 with seven Medicaid and commercial payers, seeks to reduce avoidable emergency department visits and potentially avoidable hospitalizations among approximately 27,000 patients served by 12 practice sites. Providers receive traditional fee-for-service payment for services, as well as a per member per month (PMPM) payment for activities such as care coordination. Each site's performance is measured against its own utilization reduction target determined at the start of the pilot. Sites also receive a "quality composite score" that measures performance on seven quality process of care indicators such as diabetes and cholesterol testing. Practices that do not meet their utilization reduction targets must repay up to 50 percent of their PMPM payments, while those that reduce utilization beyond their targets receive a portion of payers' corresponding savings.

Early results from the pilot are mixed. Some clinics did not generate any savings, while most generated some savings but not enough to exceed their upfront payments. However, interest in the pilot remains strong: All plans and practices remained involved in the pilot after nearly two years, with many practices adopting new strategies that may be cost-saving in the long term – i.e. designating a care coordinator within the practice, using registries to identify and reach out to high-risk patients, and offering same-day and after-hours appointments.

The Puget Sound experience highlights some of the challenges associated with coordinating multiple payers and providers in an accountable medical home model. While the pilot has overcome significant barriers to data sharing and reporting, this work remains challenging. The seven participating health plans use similar methods for data measurement and reporting, but the differences among each plan's processes are enough to create many opportunities for inconsistencies, errors and delays. In addition, mixed support from emergency departments has made it difficult for primary care providers to get the timely, actionable data they need to implement effective interventions at the practice level. These challenges underscore the importance of determining a single, agreed upon process for contracting, data calculations and data sharing early on.

The Medicare Bundled Payments for Care Improvement Initiative

There is growing recognition of the need for payment reform for specialists as well as primary care physicians. In this context, CMS has launched a new Medicare demonstration that will base provider payment on the collection or "bundle" of services delivered during a particular episode of care. As part of the Bundled Payments for Care Improvement Initiative,[11] hospitals across the country will test four new payment models for up to 48 defined clinical episodes.

The four models in the Bundled Payments for Care Improvement Initiative define an episode of care as follows:

- Model 1: The episode of care is defined as an inpatient stay in an acute care hospital.
- Model 2: The episode of care includes the inpatient hospital stay, as well as all related services within 30, 60 or 90 days after discharge.
- Model 3: The episode of care is triggered by an acute care hospital stay, but includes only post-acute care services that begin within 30 days of discharge. The performance period ends within 30, 60 or 90 days after the initiation of the episode.
- Model 4: The episode includes services delivered during the inpatient stay, as well as related readmissions within 30 days of hospital discharge.

While each hospital may choose which payment model to test and for which episodes, all participants in the demonstration face financial incentives to improve the efficiency, quality and coordination of patient care.

In the first three models, CMS will set a target price per episode based on each hospital's historical costs, minus a discount. CMS will continue to pay medical claims as they occur at Medicare's fee-for-service rates and periodically compare the hospital's actual spending on the selected episode with the predetermined target. Hospitals whose actual spending comes in below budget will receive additional payments, while hospitals that exceed their targets must return the excess amount to CMS. Under Model 4, CMS will make a prospective payment that covers all services delivered during a hospitalization, as well as any readmissions within 30 days of discharge. More than 500 health care organizations have applied to participate in the demonstration, with the performance or risk-bearing period scheduled to begin Oct. 1, 2013.

Researchers from Brandeis University analyzed a large Medicare claims database as they assisted more than 100 hospitals applying for the demonstration program, primarily under Model 2. Their work helps illuminate the opportunities and challenges facing participants in the demonstration, as well as potential steps that CMS could take to help hospitals succeed.[12] For example, the researchers observed significant Medicare spending in the 30 to 90 days after hospital discharge – spending that often equaled or exceeded the cost of the hospitalization itself.[13] In addition, the researchers found significant variation in post-acute care spending across hospitals,

due in part to differences in readmissions and utilization of post-acute facilities.

In another key finding, the researchers found that hospitals participating in the bundled payment demonstration face significant financial risk due to random variation in the severity of patients who are treated within a given year.[14] The researchers' simulations showed that a hospital could lose thousands of dollars per episode if it happens to treat a larger number of high-cost cases during the performance year than in the historical period used to set the target price. Conversely, random variation could result in large financial gains for hospitals that treat fewer than average high-cost patients during the performance period. As the researchers observed, this phenomenon could mask true trends in performance improvement and discourage payment and service delivery transformation among hospitals experiencing large short-term financial losses. They recommend that CMS consider multiple strategies for mitigating the risk created by random variation, such as stop-loss protection, risk adjustment, and excluding services not clinically related to the index admission from the episode definition. CMS is offering program participants several options for reducing risk through risk corridors that would limit gains and losses for individual cases.

Flexibility and Accountability Through Global Payment: A Texas Case Study

While a number of payment reform initiatives are being led by government payers, health care organizations in the private sector are also developing innovative ways to better align provider payment with quality of care. North Texas Specialty Physicians (NTSP) is a Fort Worth-based independent practice association whose nearly 600 family and specialty physicians see more than 15,000 patients a day. NTSP has its own health plan, as well as a regional health information exchange that offers e-prescribing and electronic medical record keeping for NTSP's 40,000 ACO and 35,000 Medicare Advantage covered lives.

Unlike most ACOs where individual physicians and other providers continue to be paid under traditional fee-for-service and receive a bonus or penalty later based on their performance, NTSP accepts global payment contracts and then changes the way physicians are paid to give them the flexibility to provide comprehensive, high-quality care.[15] Instead of using fee-for-service payment, NTSP provides its primary care physicians with a monthly capitated payment; on average, these physicians receive payment well over 250 percent of Medicare rates. In return, NTSP expects primary care physicians to spend more time with patients, serve as gatekeepers for their care, and conduct a range of activities that are not reimbursed under Medicare. For example, instead of addressing only the issue for which a patient explicitly comes for a visit, physicians are expected to review medications, assess any preventive health issues, and be attuned to any other issues affecting the patient's health and well-being. Meanwhile, most of the specialist divisions at NTSP receive a monthly capitated budget, with a cap and a floor placed on the total percent of Medicare rates paid. Specialists are guaranteed payment that at least equals Medicare rates every month.

In addition to these payments, NTSP's Board of Directors makes two end-of-year distributions based on the practice's operational performance throughout the year. The larger distribution is a "cap surplus" that is used to reward specialists for the number of unique patients seen, use of the health information exchange, leadership in the organization's boards, councils and divisions, and total revenue earned by the physician. Both specialists and primary care physicians are eligible for pay-for-performance bonuses awarded to divisions with high scores on a handful of quality indicators selected at the beginning of the year. Other eligibility requirements include attendance at practice meetings and number of unique or capitated patients served.

The NTSP approach offers a promising model for other health care organizations looking to move away from fee-for-service payment. While NTSP's primary care physician costs are two to three times higher than traditional fee-for-service, its Medicare Part A and remainder Part B costs are lower. The net result is 20 to 25 percent savings compared to traditional fee-for-service payment. NTSP uses the flexibility and accountability under global payment to make the necessary changes in payment and delivery to support this approach.

Challenges for Payment Reform

Many observers hope that new initiatives such as shared savings, medical home payments, bundled payments, and global payments will contribute toward a fundamental shift in the way U.S. health care services are paid for and delivered. While the design of these models varies, a shared objective is the movement away from fee-for-service payment toward financial incentives that reward high-quality, high-value care. The health care organizations that choose to implement new payment models will continue to face many challenges, including:

- **Changing physician behavior.** To improve quality and reduce costs under new payment models, physicians and other providers will need to deliver services in ways that are different from the past. This significant shift in behavior will take time and technical assistance, so changes in payment are necessary but not sufficient.
- **Encouraging greater consumer engagement.** New payment models not only require more of providers, but also expect more from consumers. Patients must play a more active role in

their own health by way of improved treatment adherence and attention to preventive care so that providers are not unfairly penalized for factors out of their control. Many payment reforms are not being accompanied by the necessary changes in benefit design.

- **Coordinating changes across payers.** True system transformation will require all of a provider's payers to change payment systems and to change payment in the same way so that the provider can focus on improving care for all patients, rather than the administrative work associated with slightly different payment systems, such as different measures of quality or cost.
- **Moving away from fee-for-service payment.** Many new payment models create new forms of pay-for-performance bonuses and penalties, but do not change the underlying fee-for-service payment system. In some instances, providers who deliver better care may still lose revenue if their efforts result in empty hospital beds or fewer office visits.

Challenges aside, the new payment models discussed in this brief represent an important first step in addressing longstanding concerns about costs and quality within the U.S. health care system. The insights gained by early adopters will provide a useful foundation for the efforts that follow.

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Endnotes

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