

Ten Barriers to Healthcare Payment Reform



And How to Overcome Them

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TEN BARRIERS TO HEALTHCARE PAYMENT REFORM AND HOW TO OVERCOME THEM

First Edition, December 2012

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TEN BARRIERS TO IMPLEMENTING HEALTHCARE PAYMENT REFORMS AND HOW TO OVERCOME THEM



BARRIERS	SOLUTIONS
#1: Continued use of fee-for-service payment in payment reforms	<ul style="list-style-type: none"> ◆ Use episode-of-care payment for acute conditions and global payments for all patients to eliminate undesirable incentives under fee-for-service and to give providers the flexibility and accountability to reduce costs and improve quality
#2: Expecting providers to be accountable for costs they cannot control	<ul style="list-style-type: none"> ◆ Use risk adjustment and risk limits to keep insurance risk with payers but transfer performance risk to providers ◆ Use risk exclusions to give providers accountability only for the types of costs they are able to control ◆ Make provisions for contract adjustments to deal with unforeseen events
#3: Physician compensation based on volume, not value	<ul style="list-style-type: none"> ◆ Change physician compensation systems to match incentives under payment reform ◆ Modify federal and state fraud and abuse laws to permit gain-sharing between hospitals and physicians
#4: Lack of data for setting payment amounts	<ul style="list-style-type: none"> ◆ Give providers access to timely analyses of both utilization and costs through community multi-payer claims databases
#5: Lack of patient engagement	<ul style="list-style-type: none"> ◆ Ask patients to designate their primary care physicians rather than using statistical attribution rules based on fee-for-service claims to assign them retrospectively ◆ Use value-based benefit designs to enable and encourage patients to improve health, adhere to treatment plans, and choose high-value providers and services
#6: Inadequate measures of the quality of care	<ul style="list-style-type: none"> ◆ Develop quality measures for all of the conditions and procedures that drive significant amounts of cost ◆ Use outcome measures instead of process measures to give providers flexibility to redesign care and support effective patient choice ◆ Use Regional Health Improvement Collaboratives to collect patient-reported information on outcomes
#7: Lack of alignment among payers	<ul style="list-style-type: none"> ◆ Ask physicians and other providers to define lower-cost, higher-quality ways to deliver care and the payment changes needed to support them ◆ Encourage employers to support regional payment reforms and to choose health plans which will implement them in a coordinated way ◆ Offer Medicare payment reforms to a broad range of providers on an ongoing basis ◆ Use state government and/or Regional Health Improvement Collaboratives to facilitate agreement among payers
#8: Negative impacts on hospitals	<ul style="list-style-type: none"> ◆ Reduce fixed costs and improve efficiencies in hospitals ◆ Change payment levels to hospitals to reflect higher costs per admission that may accompany lower admission rates ◆ Increase transparency about hospital costs to ensure that prices for hospital care are adequate, but not excessive
#9: Policies favoring large provider organizations	<ul style="list-style-type: none"> ◆ Remove anti-trust barriers to small physician practices joining together to manage new payment models ◆ Combat anti-competitive practices by large providers ◆ Avoid unnecessary standards for structure and processes in payment systems and accreditation systems that increase costs and favor large organizations
#10: Lack of neutral convening and coordination mechanisms	<ul style="list-style-type: none"> ◆ Support the creation and operation of multi-stakeholder Regional Health Improvement Collaboratives in all regions

INTRODUCTION



A major cause of the high cost of health care in America and of many of the serious quality problems in health care is the way healthcare providers are paid. Under the current fee-for-service payment system:

- Physicians, hospitals, and other healthcare providers are paid primarily based on how many services they deliver, not on the quality of those services or their effectiveness in improving a patient's health, i.e., they are paid for *volume*, not *value*.¹ Research has shown that more services and higher spending may not result in better outcomes; indeed, it is often exactly the opposite.
- Healthcare providers may actually be financially penalized for providing better quality services. For example, reducing errors and complications can reduce healthcare spending, but it can also reduce providers' operating margins and their ability to remain financially viable.² Moreover, under most payment systems, health care providers make less money if a patient stays healthy.
- Each physician, laboratory, hospital, and other healthcare provider involved in a patient's care gets paid separately; this can result in paying for duplicative tests and services for the same patient,³ and it provides no incentive for separate providers to coordinate their services.
- Many valuable preventive care and care coordination services are not paid for adequately (or at all),⁴ which can result in unnecessary illnesses and treatments. In addition, low payment levels are believed to be discouraging physicians from entering primary care, contributing to shortages of primary care physicians in many areas.

Because of these problems, there is now widespread agreement that significant changes in the way providers are paid for health care are necessary to reduce costs and improve quality. Indeed, in the National Quality Strategy, there are ten principles to guide implementation, and the first is to reform payment systems.⁵ However, despite agreement about the need for change, only a small proportion of the payments being made to providers today are based on the quality or value of care rather than the volume of services delivered.

Progress has been slow because there are many significant barriers to changing payment systems that have been in place for decades. Although these barriers seem daunting, they can be overcome. In the chapters that follow, ten of the biggest barriers that providers, payers, purchasers, and patients face in implementing payment reforms are described below, along with strategies for solving them.

BARRIER #1

CONTINUED USE OF FEE-FOR-SERVICE PAYMENT IN PAYMENT “REFORMS”



Even though the serious problems with fee-for-service payment have been widely acknowledged, many “payment reforms” do not change fee-for-service payment at all, but merely add new forms of pay-for-performance bonuses or penalties on top of it. Trying to fix a broken system merely by adding a new layer of incentives can be problematic for physicians, hospitals, and other healthcare providers, so it is not surprising that to date, acceptance of these types of payment changes has been slow, and where they have been implemented, the impacts on cost and quality have often been relatively small.

THE MANY PROBLEMS WITH “SHARED SAVINGS”

The most common payment change being implemented by Medicare and many commercial health plans today is “shared savings.” Under the shared savings approach, Medicare or the health plan pays providers using exactly the same fees as they receive today for their services, and then pays a bonus (or imposes a financial penalty) on the providers if the total cost of services for their patients is less than (or greater than) the amount that would otherwise have been expected.⁶

The fact that shared savings programs do not actually change the underlying fee-for-service system creates significant challenges for providers. For example:

- Today, Medicare and most health plans pay physicians only for office visits, not for phone calls. If a physician can respond to a patient’s health problem over the phone, thereby avoiding the need for the patient to make a visit to the office, the physician will lose revenue. Reimbursing the physician for a portion of the lost revenue through a shared savings program still penalizes the physician’s practice (recouping only a portion of the loss still results in a loss) and also creates a cash flow problem, since shared savings payments typically aren’t made until a year or more after the losses occur.
- If better coordination of a patient’s care can avoid an emergency room visit or hospital admission, the hospital will lose all of the revenue for that visit or admission, but it will still have to cover the costs of having the emergency room or hospital bed available. Giving the hospital a bonus or shared savings payment for lower admission rates can still penalize the hospital, since the portion of the lost revenues offset through the shared savings payment may be less than the fixed costs the hospital must continue to cover.

Having two or more providers participating in a shared savings arrangement creates a version of the prisoner’s dilemma: if provider #1 makes a good faith effort to reduce unnecessary services but provider #2 does not, provider #2 would “win” by maintaining its own fee revenues while also potentially receiving part of the savings generated by provider #1. If provider #2 increases its volume of services, it would receive more revenue and also thwart the opportunity for provider #1 to receive any shared savings to offset the revenue it lost.

The shared savings model is biased against hospitals which do not employ physicians, since under the most common shared savings approach, all savings are credited to the organizations where the patients’ primary care physicians work, even if the savings are generated through improved care or reduced utilization in the hospital. Forcing hospitals to solve that problem by acquiring physician practices may simply lead to higher prices, not lower costs.

Another serious problem with the shared savings model is that once the shared savings contract between the payer and provider ends, any shared savings bonuses will also typically end; providers will still be in the same fee-for-service system they had before, but they will now have lower revenues if they have reduced the volume of fee-based services in order to obtain shared savings payments, and they may also be receiving lower fee levels for individual services if payment cuts are being made through other policies, such as the federal Sustainable Growth Rate formula. In order to obtain continued shared savings payments in the future, a physician or hospital would have to find new sources of savings.

Providers may be unwilling to significantly change the way they deliver care or invest in better ways of delivering care if they can only reap the benefits of savings for a few years.

Some payers have made modifications to the payment system to try and address some of these problems, but in general, the modifications have not changed the underlying fee-for-service payment system in any fundamental way. For example:

- Many medical home payment programs provide a small, flexible, non-visit-based payment to primary care physicians to help them cover the costs of services that are not reimbursed directly through fees. Although these additional payments are highly desirable and address some of the problems of fee-for-service payment, in most cases, the vast majority of the physicians' revenue continues to come from visit-based fees. Moreover, as explained in more detail under Barrier #5, the amount of non-visit-based payment the practice receives in these programs may depend on how many fee-generating visits its patients make to the practice, which means that fee-for-service still represents the dominant incentive.
- The CMS Innovation Center created an Advance Payment Program that makes upfront payments to small provider organizations that want to participate as Accountable Care Organizations in the Medicare Shared Savings Program. These payments are very helpful, but they are only temporary, and they can only be used to help pay for the costs of new infrastructure or personnel, not to cover revenue losses the provider incurs due to changes in the way they deliver services that reduce fee-for-service payments.⁷

IMPLEMENTING TRUE PAYMENT REFORM

True payment *reform* cannot be achieved by adding new layers of bonuses and penalties on top of what is still fundamentally a fee-for-service payment system. Moreover, to be successful, a new payment system needs to be more attractive for providers than fee-for-service payment, not less, while still reducing costs for payers and improving quality for patients.

For most types of patients and health conditions, **fee-for-service payment must be replaced entirely with a new payment system that gives providers (a) greater flexibility to deliver the best combination of services for the patient, and (b) the accountability to ensure the combined cost of those services is less than the payment amount (along with the ability to retain any additional savings generated indefinitely).**

Examples of such better payment systems include:

- **“Episode-of-care” payments** for acute conditions or procedures⁸ that give a healthcare provider a payment or budget to cover the costs associated with all of the care a patient needs for that condition or procedure. Under this type of payment system, the provider has the flexibility to decide which services should be provided. If the patient's condition can be managed with fewer individual services or by substituting different services than are delivered today, the payment would remain the same, even if fee-based revenues would have declined, but costs will be lower. As a result, payers will save money, while providers can actually improve their operating margins.
- **“Global” payments or condition-specific comprehensive care payments** for overall management of patients' healthcare⁹ that give a healthcare provider a payment or budget for the costs associated with all of the care a group of patients need for all or some of their health conditions. The provider has the flexibility to choose the combination of services which will best help the patients address their healthcare needs, but the provider also has the accountability to ensure that the costs of all of those services remain within the global payment or budget amount.

Where these approaches have been used, both providers and payers have benefited. For example, in the Medicare Acute Care Episode (ACE) Demonstration, which “bundles” physician and hospital payments (i.e., it makes a single payment to both providers, rather than separate payments to each), Medicare has saved money, physicians have received

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AND GLOBAL PAYMENTS*

higher payments, hospitals have been able to reduce their costs and improve their operating margins, and patients have received better care.¹⁰ The positive results from this program led the CMS Innovation Center to create its Bundled Payments Initiative, which will both allow additional providers to participate in the bundling approach used in the ACE Demonstration and allow providers to accept full episode payments for a variety of conditions.¹¹ **This win-win-win approach – lower spending for payers, better care for patients, and better margins for providers – is only feasible with the types of significant payment reforms described above, not with minor tweaks to the fee-for-service payment system.**

Some payers have begun implementing these kinds of true payment reforms. For example, in addition to the CMS Bundled Payments Initiative, the Integrated Healthcare Association in California has created episode payment definitions for a number of different procedures that are being implemented by several different health plans and providers,¹² and the Health Care Incentives Improvement Institute is implementing episode payments with providers and payers in several different markets.¹³ Blue Cross Blue Shield of Massachusetts has implemented the Alternative Quality Contract, which gives a group of providers a risk-adjusted global budget to cover all of the costs of care for a population of patients.¹⁴ In Medicare's Pioneer ACO program, providers will move from shared savings to partial or full global payments in the third year.¹⁵

However, much faster progress is needed in more parts of the country. **All payers need to make episode and global payments available to providers for as many types of patients and conditions as possible, as soon as possible.**¹⁶ To be successful, though, these payment systems need to be structured appropriately to give providers accountability only for the costs they can control, as discussed under Barrier #2, and they need to be accompanied by appropriate benefit designs, as discussed under Barrier #5. If payment reforms are designed properly, there will be no need to mandate them; many providers will voluntarily accept a payment system that gives them the flexibility to deliver the best care to their patients and rewards them for high-quality care at an affordable cost without putting them at risk for costs they cannot control.

BARRIER #2

EXPECTING PROVIDERS TO BE ACCOUNTABLE FOR COSTS THEY CANNOT CONTROL



Many providers have been reluctant to accept episode-of-care payments and global payments because of concerns about their ability to manage significant financial risk. Patient advocates may also oppose payment reforms that create financial risk for providers because of a fear that if providers take on responsibility for controlling costs, they will stint on services that patients need or avoid patients with significant health problems.

Although this barrier has typically been framed in terms of *how much* risk providers can take, the real issue is *what type* of risk providers can and should take. If episode payments and global payments are structured in ways that give providers accountability for costs they can successfully manage, then providers will be more willing to accept them; conversely, if a payment system demands that providers take accountability for costs they cannot control, then the providers will either be unwilling to accept the payment system or, if they do, they could risk financial problems, which is what happened to many providers under capitation contracts during the 1990s.

There are two key ways to structure payments so that they give providers only the types of financial risk they can manage:

- **Separating Insurance Risk and Performance Risk.** First, a payment system should be structured so the payer retains the “insurance risk” (i.e., the risk of whether a patient will develop an expensive health condition) and the provider accepts the “performance risk” (i.e., the risk of higher costs from delivering unnecessary services, delivering services inefficiently, or committing errors in diagnosis or treatment of a particular condition).¹⁷ Many of the problems with managed care in the 1990s arose because traditional capitation payment systems transferred both insurance risk and performance risk to providers, causing bankruptcies when providers took on care of many sick patients without any increase in payment.

- **Focusing on Costs That a Provider Can**

Control. Second, a payment system should give a healthcare provider accountability for the types of services and costs that the provider can control or significantly influence, but not for services and costs over which the provider has little or no influence. For example, primary care physicians are in a much better position to determine the appropriateness of services they prescribe than health plans are, so building accountability for utilization of prescribed services into physician payment is better than trying to control utilization through prior authorization and utilization review programs operated by health plans. On the other hand, a payment reform system that only gives primary care physicians a bonus if there are reductions in the *total* cost of *all* services their patients receive from *all* providers goes too far in shifting accountability, since primary care physicians do not control all of the factors that drive the total cost of care for their patients. (For example, assume that a primary care physician is able to significantly reduce the rate at which his or her chronic disease patients are admitted to the hospital for exacerbations of their chronic condition; if the subset of patients who are still admitted to the hospital develop serious infections or complications, total costs might increase, even though the primary care physician had been successful in controlling the aspect of utilization that he or she could influence.)

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There are several ways to structure payment systems to give providers accountability for the costs they can control, without putting them at risk for costs they cannot control:¹⁸

RISK ADJUSTMENT

A common way to protect providers from insurance risk is to make higher payments for those patients who have more health conditions or more serious health problems, i.e., to “risk-adjust” payments. For example, in the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract, provider organizations receive a budget based on the number of patients they care for, but the budget is increased if the patients have more health problems, so the providers are accepting only performance risk, not insurance risk.¹⁹

Some payers have raised concerns about using risk adjustment as part of a payment system because a patient’s risk score tends to increase as soon as they become part of a risk-adjusted payment system, and this can cause overall spending to increase rather than decrease.²⁰ This happens because, under fee-for-service payment, the diagnosis codes used for risk adjustment are only recorded when a related claim for treatment is filed; as a result, many health conditions are not recorded in health plans’ claims data systems (particularly if patients have recently changed health plans). However, under a risk-adjusted payment system, the provider has an incentive to do complete coding of diagnoses, not just to ensure accurate payment, but to ensure that all of the patient’s health conditions are being managed in a comprehensive and coordinated way. Rather than eliminating risk adjustment entirely to avoid this artificial increase in risk scores (which could thereby discourage providers from taking on sicker patients), risk adjustment systems should be modified so that both the baseline risk score and current risk score are changed when a patient’s pre-existing condition is identified and documented. Broader use of electronic health records will help to address this problem by enabling risk adjustment to be based on complete clinical data on the patient’s past and current patient health conditions, not just on data recorded to support recent claims for payment to a particular health plan.

Current risk adjustment systems also need to be improved so they do not penalize providers for keeping their patients well. A patient’s risk score is typically based on the health problems that a patient has today, not on how those problems have changed as a result of the health provider’s care. So, for example, if a physician helps a patient lose weight or stop smoking, the patient’s risk score would decrease, and as a result, under a risk-adjusted payment system, the physician would receive a lower payment than if the patient had remained unhealthy, thereby penalizing the physician for a successful health improvement effort. Improved risk adjustment systems that capture such changes over time will be needed, particularly if more providers and payers sign multi-year contracts to manage healthcare cost and quality.

RISK LIMITS

At best, risk adjustment is only a partial solution; no formula could ever be 100% accurate in predicting legitimate variations in costs, simply because of the myriad factors that can affect patient costs and outcomes.²¹ To adequately protect both providers and patients, risk *adjustment* should be supplemented with risk *limits*, such as:

- Outlier payments to cover unusually high costs for specific patients.
- “Risk corridors” that require payers to provide additional payments to providers when the total cost of treating a group of patients significantly exceeds the agreed-to payment level. The sizes and cost-sharing parameters for these risk corridors could vary from provider to provider, since larger providers will be better able to manage variation in costs, and the parameters could also be changed over time as providers become more experienced in managing costs.²²

RISK EXCLUSIONS

In some cases, it is clear that certain kinds of costs cannot reasonably be controlled by a provider, and rather than using risk adjustment formulas or other complex calculations to adjust for this, these costs (or the situations that lead to them) should simply be excluded from accountability altogether. For example, the costs associated with patients who are seriously injured in accidents could simply be excluded entirely from a global payment model for a small group of physicians, and be paid for separately on an episode-of-care basis or under traditional fee-for-service.

In other cases, as noted earlier, a provider may be able to control certain aspects of a patient’s healthcare costs but

not others. Healthcare providers are far more likely to be willing to accept responsibility for the utilization and cost of services they deliver or prescribe themselves than services chosen by other providers. (For example, primary care providers can influence the rate at which their patients go to an emergency room, but not the number of tests that are ordered once the patient arrives; emergency room physicians can influence the number of tests ordered in the emergency room, but not how many patients come to the emergency room for conditions that could have been treated by their primary care provider.) To address this, payment to physicians in a particular specialty can be designed to only include the costs of the services that these physicians can control or significantly influence, while *excluding* the costs of other services. (The payer would continue to pay for the excluded services on either a fee-for-service basis or through separate payment reforms designed for the other specialties).²³ In some cases, one provider may be willing to take accountability for whether a patient *uses* a particular service delivered by another provider, but not for the *price* of that service, particularly if the provider of the service is in a position to negotiate high prices or increases in prices; this can be addressed by making the accountable provider responsible for the *utilization* of the services, but excluding accountability for increases in the *price* of the services.²⁴

Providers will also be better able to accept accountability for controlling costs if their patients are supporting their efforts. As described in more detail under Barrier #5, if a provider does not know until after the fact who their patients are, or if the patients' insurance benefits do not give them the ability and incentive to help the provider change their care in ways that will improve quality and lower cost, then the provider may be unable to control some of the key factors that are driving increases in costs. If the patients' benefit structure cannot be changed to support a provider's ability to control certain aspects of cost, then all or part of those costs could be excluded from accountability under the payment model. (For example, if some patients spend part of the year living in another part of the country, but their health insurance will pay for them to receive elective procedures while they are away, the designated provider in their home community might only be expected to control costs of care during the time the patient is actually resident in the local community, rather than all of the costs incurred by those patients during the entire year.)

ARBITRATED CONTRACT ADJUSTMENTS

It is impossible for anyone to predict exactly what will happen when payers and providers move to completely different payment models. New drugs, new medical devices, and new ways of delivering care are being developed at a rapid pace, and these can either help or hurt providers' ability to control costs and improve quality. It is not surprising that there are typically long delays in negotiating payment reform contracts, since both payers and providers will try to anticipate all possible contingencies and incorporate provisions covering them in the contracts.

This problem will be exacerbated with multi-year contracts. Multi-year contracts between payers and providers provide a better opportunity for providers to make changes in care delivery that take time to implement and to reap returns on investments in preventive care and infrastructure, and they give payers greater ability to control the trend in healthcare costs (for example, the Alternative Quality Contract developed by Massachusetts Blue Cross Blue Shield is a five-year contract that was designed to slow the growth in spending rather than achieve immediate savings). However, the longer the contract, the greater the potential for unexpected events to occur, the greater the difficulty of building appropriate protections into a contract to deal with those unexpected events, and the greater the reluctance providers and payers will have to sign.

A solution to this is simply to acknowledge that unexpected events may occur and to provide for opportunities to make adjustments in the contract to deal with them. Of course, the party which is disadvantaged by the unexpected event will be more interested in making an adjustment than the party which benefits from it, so the contract could provide for having a neutral arbitrator resolve any disagreements.

BARRIER #3

PHYSICIAN COMPENSATION BASED ON VOLUME, NOT VALUE



Changing the way Medicare and health plans pay provider *organizations* is necessary but not sufficient to support higher-value healthcare delivery. The *compensation system* for the individual physicians and other healthcare professionals who work in those organizations also has to change. Most physician compensation systems today, even for physicians who are “on salary,” are based on fee-for-service, i.e., the physician gets paid in part or in whole based on the number of visits they have or the number of procedures they perform. If this compensation structure continues when the provider organization begins being paid under a new payment model, the physician will be penalized for reducing unnecessary visits and procedures even though the provider organization would be rewarded, and the physician will be rewarded for higher volume even if it hurts the provider organization’s bottom line. It is difficult to imagine that Accountable Care Organizations can be successful if all of their member providers are still being based using fee-for-service.

Clearly, **if payment systems are changed to reward value rather than volume, the compensation of individual physicians and other providers will also need to be changed to align with the structure of the new payment system, rather than with fee-for-service payment.** Rather than primarily basing compensation on “productivity,” physicians will need to be compensated based on factors such as quality, teamwork, and overall cost-effectiveness that will determine the provider organization’s success under the new payment system.²⁵

However, it is difficult for a provider organization to change its physician compensation system if only a subset of its payers have implemented payment reforms. (See Barrier #7 for more discussion about lack of alignment among payers.) The factors that determine financial success under fee-for-service are, by definition, different from the factors that will determine success under new payment models, but if physicians are going to change the way they practice, they will do that for *all* of their patients, not just those covered by a particular payer. If the majority of patients are not covered by reformed payment systems, the provider organization will be penalized for changing its compensation system, but if it doesn’t change its compensation system, its ability to succeed financially in caring for patients covered under the new payment system will be limited. In short, trying to manage patient care under multiple payment systems can create a serious Catch-22 for physicians and their practices. (See the discussion under Barrier#7 regarding alignment of payment reforms.)

THE COMPENSATION
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Aligning physician compensation with new payment systems can also be challenging because of federal and state laws designed to prevent fraudulent or abusive conduct under current payment systems. For example, the federal Civil Monetary Penalty statute²⁶ imposes financial penalties on hospitals that make payments to physicians as an inducement to reduce or limit services to Medicare or Medicaid beneficiaries. The law has been interpreted by the Office of Inspector General at the U.S. Department of Health and Human Services as prohibiting such payments even if the services being reduced are not medically necessary or appropriate.²⁷ Consequently, gain-sharing programs designed to share savings with physicians when unnecessary services are eliminated could make a hospital liable for civil money penalties, as well as putting it in violation of the federal Anti-Kickback statute²⁸ and the Stark law.²⁹

Congress has recognized that changes in fraud and abuse statutes will be needed in conjunction with new payment models. The federal Affordable Care Act authorizes the Secretary of Health and Human Services to waive these statutes in conjunction with the Medicare Shared Savings Program and projects undertaken by the Center for Medicare and Medicaid Innovation.³⁰ However, providers may be reluctant to revamp their compensation systems based on these kinds of temporary waivers. **Permanent changes to the fraud and abuse statutes are needed if payment reforms are to be successful. In states that have enacted statutes similar to the federal laws, state legislatures will also need to make comparable changes.**³¹

BARRIER #4

LACK OF DATA FOR SETTING PAYMENT AMOUNTS



Most of the literature on payment reform has focused on how to change the *method* of payment, but there has been relatively little attention to how to set an appropriate payment *amount* (i.e., the price).³² Regardless of how good the payment method is, if the payment amount is too low, providers will be unable to deliver quality care, and if the payment amount is too high, there will be no savings for purchasers/payers and little incentive for providers to reduce costs.³³

A major barrier to setting good prices in new payment systems is the difficulty providers have in getting data on the utilization and costs of services that they do not deliver themselves. For example, in order for a physician to accept an episode of care payment for the type of treatment he or she delivers, the physician needs to know about *all* of the services that those types of patients have been receiving from the hospital, other physicians, and post-acute care providers, how much all of those providers are being paid, the frequency with which adverse events occur, and the extent to which any of those elements can be changed. Different prices will be needed for patients with different types of health conditions, and the impacts of risk adjustment and risk limits will need to be determined. The payer will need to have matching data so it can be sure the total episode price is lower than the average amount being paid today. (Similar data are also needed

under shared savings programs so that the provider can determine whether bonuses will cover its costs and whether it will be at risk for paying a share of cost increases.)

Electronic Health Records (EHRs), even if they are linked to Health Information Exchanges (HIEs), do not have enough information to fill this need. The only truly comprehensive information about all of the healthcare costs associated with an episode of care or with a group of patients, particularly the prices being paid for the services delivered, comes from claims data maintained by payers. Consequently, providers would be better able to participate in new payment models if they could get access to claims data from health plans, Medicare, and other payers.³⁴

A MAJOR BARRIER TO SETTING GOOD PRICES IN NEW PAYMENT SYSTEMS IS THE DIFFICULTY PROVIDERS HAVE IN GETTING DATA ON THE UTILIZATION AND COSTS OF SERVICES THAT THEY DO NOT DELIVER THEMSELVES.

Even if providers have access to claims data, however, most would not have the analytic capacity to assemble and analyze large claims databases, particularly if the data come from multiple payers. Also, there could be privacy concerns about giving providers patient-identifiable data about all services from other providers in order to find and combine multiple claims records for their own patients.

The best solution is for all payers to contribute their data to a multi-payer database managed by a multi-stakeholder Regional Health Improvement Collaborative that can help providers analyze the data while protecting patient privacy. For example, the Maine Health Management Coalition³⁵ and the Oregon Health Care Quality Corporation³⁶ are combining and analyzing claims data from multiple employers and health plans to help healthcare providers in their states successfully participate in new payment models.

Some health plans are providing Regional Health Improvement Collaboratives with data on the *services that patients received*, but not the *amount that was paid for those services*. Although these limited data sets are helpful for analyzing opportunities for reducing unnecessary utilization of services, they are inadequate for designing new payment systems and for helping providers redesign care under those new payment systems. In order to determine whether a different way of delivering care is affordable under a new payment model, both the provider and the payer need to know whether the cost of the new care delivery approach will be lower than the existing approach, and this can only be deter-

mined accurately if information is available on the payment levels for all of the involved services. **Health plans need to release claims data files to Regional Health Improvement Collaboratives that include “allowed amounts” (i.e., the prices paid for services) in order to accelerate the implementation of new payment systems.**³⁷ **Employers and other purchasers need to demand the release of this data from their health plans, and if necessary, switch to health plans that will agree to release the data.**³⁸

To date, one of the biggest gaps in the ability to create all-payer databases and help providers use them to redesign care and payment has been the inability to obtain Medicare claims data. Fortunately, this is finally changing: in November, 2012, the Centers for Medicare and Medicaid Services began giving access to Medicare claims data to organizations that meet legislative and regulatory standards as “Qualified Entities;” the first three such Qualified Entities are all multi-stakeholder Regional Health Improvement Collaboratives – the Oregon Health Care Quality Corporation, the Kansas City Quality Improvement Consortium, and The Health Collaborative in Cincinnati.³⁹ However, **changes in the authorizing legislation for this program are needed so that the Medicare claims data can be used for analyzing opportunities to reduce costs, not just to produce publicly-reported quality measures.**

PAYERS SHOULD CONTRIBUTE THEIR CLAIMS DATA TO A MULTI-PAYER DATABASE MANAGED BY A MULTI-STAKEHOLDER REGIONAL HEALTH IMPROVEMENT COLLABORATIVE THAT CAN HELP PROVIDERS ANALYZE THE DATA WHILE PROTECTING PATIENT PRIVACY.

BARRIER #5

LACK OF PATIENT ENGAGEMENT



No payment reform will be successful if it is perceived as harming patient care, and it is unlikely that significant reductions in cost can be achieved unless providers and patients are working together to improve the way care is delivered. Providers have faced two key barriers in effectively engaging patients under new payment models – knowing who their patients are, and giving their patients the ability and incentive to improve their health and use high-value services.

THE PROBLEMS OF RETROSPECTIVE ATTRIBUTION

In order for healthcare providers to take accountability for the cost and quality of care for patients, they need to know which patients they are accountable for. However, most patients today have a health insurance plan that does not require them to use any particular physician or provider for their care. Global payment models and capitation are already being widely used by payers in their HMO insurance products that require patients to have a primary care provider (PCP) and that limit patients' choice of providers, but in most parts of the country, HMOs represent a very small proportion of the patients that most providers see and therefore a very small proportion of the payment that the providers receive. The biggest changes in payment systems are needed for patients in commercial "PPO" insurance products and traditional Medicare, where there is no requirement that patients choose in advance the PCPs and other providers that they will use.

To address this, many current payment reform models, such as the shared savings model used by Medicare and many other payers, "assign" patients to physicians *retrospectively*, i.e., the payer looks back over the claims it paid for the patient over the past year or two to identify which providers the patient actually saw, uses statistical analyses to determine which, if any, physician delivered the majority or plurality of the patient's care, and if there is such a physician, assigns the patient to that physician for the purposes of the payment system.⁴⁰

Using these retrospective statistical attribution rules to assign patients to providers means that neither the provider nor the patient knows they are part of the new payment system until after the care is delivered, potentially a year or more later. If providers and payers only find out *retrospectively* that they are in a new payment system, it will be difficult for them to work together *prospectively* to change care and prevent unnecessary costs from occurring.

MANY PAYMENT REFORMS ARE USING STATISTICAL ATTRIBUTION RULES TO "ASSIGN" PATIENTS TO PROVIDERS RETROSPECTIVELY, WHICH MEANS THAT NEITHER THE PROVIDER NOR THE PATIENT KNOW THEY ARE PART OF THE NEW PAYMENT SYSTEM UNTIL AFTER THE CARE IS DELIVERED

However, the problems caused by retrospective attribution go far beyond mere uncertainty by providers and patients regarding whether they are in a payment model or not. In many payment models, attribution rules are used to determine how much the provider is paid and what costs the provider is accountable for, and these rules can penalize providers inappropriately.

For example, in various medical home programs, the primary care provider receives an additional, non-visit-based payment for each patient who is attributed to the PCP using these retrospective statistical attribution rules. However, if a patient does not make a

billable visit to their PCP during the specified time period, the patient will not be attributed to that PCP (or any other physician), which means there will be no change in payment to support better care for that patient. This is not a small problem. In one study of Medicare patients using these types of attribution rules, 15% of the patients could not be attributed to a primary care provider, and 6% could not be attributed to any physician.⁴¹ The unattributed percentage will likely be much greater for patients on commercial insurance, because when a patient switches insurance, even if they have a consistent PCP, it may take months or years for the new payer’s claims data to justify attributing the patient to that PCP. If there are multiple insurance companies in a particular market, and if they are competing aggressively for business, it is likely that a large percentage of a PCP’s patients will not be attributed to them by the payers, because the payers will not have a sufficiently long claims history on those patients to determine who their “real” PCP is.

This is only part of the problem, however. The types of care changes the non-visit payment is designed to encourage can actually cause the physician to stop receiving the new payment. This is because attribution rules are typically based on the number of visits a patient had to primary care providers. Physicians who redesign their practices to reduce the emphasis on office visits for healthy patients in favor of phone calls and emails, while providing longer office visits for more complex patients, will be harmed financially under this system, since they will not only lose fee revenue by having fewer office visits, but they may also not receive any additional payment for the patients who do not have the recent office visits that are required to trigger the attribution calculation.

In programs with a shared savings component, a provider is expected to reduce the costs of care for the patients who are attributed to that provider. However, if the attribution rules assign patients to the provider whose care the provider cannot influence, the provider can be inappropriately penalized if costs for those patients increase (or inappropriately rewarded if costs decrease). If the attribution rules fail to assign a patient even though the provider was responsible for improving the efficiency of care for that patient, the provider would fail to receive the bonus payment that they deserved.⁴²

ASKING PATIENTS TO CHOOSE A PCP

The only way to solve all of these problems effectively is for a physician or other provider to know in advance the patients for which he or she will be accountable and to have payments based on those prospectively assigned patients. In turn, this requires that patients proactively designate a PCP (or a specialty physician to serve as their PCP), rather than have a health plan “assign” them after the fact based on statistical rules.⁴³

PATIENTS NEED TO PROACTIVELY DESIGNATE A PCP (OR A SPECIALTY PHYSICIAN TO SERVE AS THEIR PCP), RATHER THAN HAVE A HEALTH PLAN “ASSIGN” THEM AFTER THE FACT BASED ON STATISTICAL RULES

tients to choose between two extreme versions of health plans – an HMO product that locks them into a narrow set of providers or a PPO product which assumes the patient will manage all of their own care – payers (including Medicare) could easily define a modified PPO product which requires a patient to designate a PCP so that PCP can encourage the

Asking patients to designate a primary care provider does *not* mean that the patient has to be “locked in” to this PCP (i.e., that the patient cannot change to another PCP) or that the PCP must serve as a “gatekeeper” for the patient’s care (i.e., that the health plan will not pay for the patient to receive care from any specialist or other provider that is not approved in advance by the PCP). It merely means that the patient needs to choose a primary care provider and notify both the provider and the payer about that; if the patient wished to change PCPs at any point, they would be free to do so, as long as they notified the providers and the payer of the change.

There is widespread agreement today that good primary care is essential not just to control costs but to help patients improve their health, so payers, providers, purchasers, and patient advocates should all be proactively encouraging patients to choose and use a primary care provider. Rather than expecting pa-

patient to allow the PCP to help coordinate their care. This would then eliminate the need for statistical attribution rules and the problems they create.

Patients could be given financial incentives to designate a PCP (assuming that there are PCPs available in the community for them to select); for example, they could be required to pay lower cost-sharing for their healthcare services to reflect the fact that their care would be better coordinated and likely less expensive. However, if payers implement payment changes that support better primary care, and if primary care providers change their practices to become more patient-centered, there is every reason to believe that most patients will *want* to select and use a PCP, avoiding the need for explicit financial incentives to encourage or force them to do so.

One of the arguments made in favor of the retrospective statistical attribution system is that it may reduce the possibility that physicians will “cherry-pick” their patients, i.e., avoid patients who are sick or likely to require expensive services. However, if the payment system includes appropriate types of risk adjustment, risk limits, risk exclusions, and provisions for adjustments as described under Barrier #2, physicians would actually have an incentive to care for sicker patients, because the opportunities to generate savings would be greater.⁴⁴

THE NEED FOR VALUE-BASED BENEFIT DESIGN

Even if the physician and patient both know they are part of the new payment model, it will be difficult for the physician to control costs if the patient is not collaborating in that effort. Unfortunately, most health insurance plans fail to give patients the ability and incentives to improve their health, take their medications, allow the physician to coordinate their care, and choose the highest-value providers and services when they need additional care.

To address this, “value-based *payment*” for *providers* must be accompanied by “value-based *benefit designs*” for *patients*. **There are three key components needed for a truly value-based benefit design structure that will support successful payment reform:**

- **Low or zero cost-sharing for those medications and preventive care services that are essential to avoiding more expensive services.** For example, for most chronic disease patients, a key factor affecting their ability to successfully manage their condition(s) and stay out of the hospital is the affordability of their medications, yet many patients face high copayments or high deductibles that force them to skip their medications.⁴⁵
- **“Last-dollar” cost-sharing for expensive services** offered by multiple providers. A growing number of studies have found that some providers are paid five to ten times as much as others to deliver procedures such as cardiac and orthopedic surgeries and labor and delivery.⁴⁶ Yet even with high copayments, co-insurance, or deductibles, most patients will pay the same amount regardless of whether they choose the most expensive or least expensive provider of a high-cost service, which in turn gives little incentive to the providers to lower their prices.⁴⁷ Instead of requiring consumers to pay a portion of the “first dollar” that the provider charges for each individual service (through a copayment, co-insurance, or deductible), consumers could be charged all or part of the “last dollar,” i.e., the difference in total prices between higher-cost and lower-cost providers.⁴⁸ Some employers and health plans are beginning to implement this through “reference pricing” of services, i.e., defining the maximum amount the health plan will pay for a service based on the existence of one or more quality providers who will deliver the service for that price, and then requiring the patient to pay the difference in price if they choose a higher-priced provider.⁴⁹ Episode-of-care payment and global payment systems will facilitate this approach by defining a true “total price” for services, avoiding the possibility that a provider might offer an unusually low price for the basic procedure to win the business but then make up the loss in revenue by delivering additional services.
- **Incentives for improved health.** Finally, the ideal way to reduce healthcare costs is by avoiding the need for health care services in the first place. A growing number of employers are changing their health insurance plans to create strong incentives for their employees to lose weight, stop smoking, and take other actions to improve their health, as well as providing insurance coverage for health improvement programs and establishing on-site health improvement programs in the workplace.⁵⁰

VALUE-BASED PAYMENT
FOR PROVIDERS
MUST BE ACCOMPANIED
BY VALUE-BASED BENEFITS
FOR PATIENTS

BARRIER #6

INADEQUATE MEASURES OF THE QUALITY OF CARE



The more responsibility a payment system gives a provider for managing the costs of care, the more ability and incentive the provider will have to reduce unnecessary services, avoid errors and complications, and utilize new and better approaches to care. However, patients may fear that cost pressures will also lead the provider to inappropriately stint on services the patients need. Consequently, there has been a strong desire to accompany new payment systems with quality measures to assure that patients are getting good care from their providers.⁵¹

However, just as more spending in healthcare doesn't necessarily result in better quality care, merely tying payment to a large number of quality measures doesn't necessarily result in better quality care, either. Requiring healthcare providers to measure, report, and improve on a large number of quality measures can actually be a deterrent to provider participation in new payment models, particularly if the quality measures demand changes that go far beyond the resources and flexibility provided in the payment system. For example, the regulations that were initially proposed for the Medicare Shared Savings Program were widely criticized for including 65 different measures of quality, despite providing no change in the underlying fee for service structure to support better care; in response, CMS reduced the list to 33 measures in the final regulations.

MERELY TYING PAYMENT TO A LARGE NUMBER OF QUALITY MEASURES DOESN'T NECESSARILY RESULT IN BETTER QUALITY CARE

Similar to the discussion under Barrier #2 regarding costs that providers can and cannot control, physicians and hospitals will likely resist participating in a payment model which holds them accountable for aspects of quality they cannot control. For example, many hospitals have objected to having Medicare and other payers impose financial penalties on them for high rates of readmissions for chronic disease patients when there is considerable evidence that such readmissions result from poor primary care in the

community as much or more than poor care in the hospital. Physicians will be reluctant to take accountability for quality measures that require patient adherence to care plans if the patients' health benefit structures make it difficult for them to adhere, as discussed in more detail under Barrier #5.

Using long lists of quality measures in payment systems can also hide the fact that the quality of many aspects of care is not being measured at all. In fact, most measures of physician quality that are in wide use today are focused on primary care, not specialty care, even though specialty care is where cost reduction efforts will increasingly need to focus. Measures of hospital quality also have an overly narrow focus; for example, despite the fact that maternity and infant care represents the single largest hospital expenditure for commercial insurers and Medicaid,⁵² the Joint Commission's "Accountability Measures"⁵³ do not contain a single measure related to maternity care. This creates the risk that those aspects of care which are *not* being measured could worsen because of an over-emphasis on improving the aspects of care which *are* being measured. **More aggressive efforts are needed to develop quality measures for all of the conditions and procedures that drive significant amounts of cost, but also to ensure those measures focus on the specific aspects of quality that physicians and hospitals can reasonably influence.**⁵⁴

A more fundamental problem is that most of the measures that are being used by payers today are process measures, not outcome measures, e.g., they measure whether a patient received a specific set of medications, not whether they avoided another heart attack, and they measure whether appropriate surgical procedures were used in the hospital, not whether the patient experienced an infection or was able to walk again. Not only is there evidence that good performance on many types of process measures does not guarantee good performance on outcomes,⁵⁵ process measures could actually impede efforts to reduce costs and improve quality by locking in less-than-optimal approaches to care.

(Although process-based quality measures are developed based on evidence that there are benefits from delivering care using those processes, there is almost never any evidence that all other possible processes of care would deliver worse outcomes.) **More flexible payment systems give physicians and hospitals the opportunity to completely redesign care for lower costs and higher quality, and so the quality measures that accompany payment reforms need to provide the same flexibility by focusing on outcomes, not processes.**

A key challenge in obtaining more outcome measures is not just defining them, but finding cost-effective ways to collect the data. Outcomes often cannot be measured using either claims data or EHRs; they must be collected directly from patients.⁵⁶ **In order for patient-reported information to be objective, reliable, and comparable, it will need to be collected by neutral community organizations, such as Regional Health Improvement Collaboratives, rather than either providers or payers.**⁵⁷ This will require a significant investment of resources, but there should be a return on the investment if better outcome measures encourage improvements in care and more informed choices by patients.

The need to develop more appropriate quality measures should *not* be seen as a barrier to moving ahead in implementing new payment models, however. Even fee-for-service payment, with its inherent incentives to deliver more services to patients, has not guaranteed the delivery of higher quality care, as evidenced by the proliferation of quality-based pay-for-performance components in commercial fee-for-service payment systems. In fact, better payment systems and better quality measures will likely need to evolve together. For example, one of the barriers to developing and implementing better measures of quality has been the difficulty providers have in improving quality under fee-for-service payment, so better payment systems that provide flexible resources will likely increase providers' willingness to support new quality measures. Similarly, quality measures for individual physicians tend to be unreliable because of the small numbers of patients involved, but as individual physicians join together to manage new payment models, measures can be calculated and reported for all of the participating physicians.⁵⁸

*THE QUALITY MEASURES THAT
ACCOMPANY PAYMENT REFORMS
NEED TO FOCUS ON OUTCOMES,
NOT PROCESSES, SO THAT
PROVIDERS HAVE THE FLEXIBILITY
TO REDESIGN CARE*

BARRIER #7

LACK OF ALIGNMENT AMONG PAYERS



Most physicians, hospitals, and other providers are paid by many different payers, including Medicare, Medicaid, multiple commercial insurance companies, and self-pay patients. Each of these payers typically pays for health care in somewhat different ways. Even a single insurance company may pay in different ways under different insurance products or for different sets of patients (e.g., an insurance company may pay a provider differently for care of patients in an HMO plan than for patients in a PPO plan).

The goal of payment reform is not just to *change payment*, but to enable and encourage *changes in the way care is delivered* in order to improve quality and lower costs. However, when physicians and hospitals change the way they care for patients, they do it for *all* of their patients, not just those covered by a particular health insurance plan. If only a subset of payers move away from fee-for-service payment, providers will either be penalized financially for those patients still being paid for under fee-for-service (if the providers change care in a way that will be supported under improved payment systems) or they will fail financially for patients covered by the newer payment systems (if the providers continue to deliver care consistent with traditional fee-for-service incentives).

DISINCENTIVES FOR HEALTH PLANS TO REFORM PAYMENT SYSTEMS

Many communities report having difficulties convincing commercial health insurance companies to commit to significant payment reforms even when providers are willing to accept them. It is not surprising that the most common “payment reform” implemented by payers is shared savings, because it requires the least possible investment by a payer of any payment change – the payer continues to pay under fee-for-service exactly the way it does today, then calculates

IF ONLY A SUBSET OF PAYERS MOVE AWAY FROM FEE-FOR-SERVICE PAYMENT, PROVIDERS WILL EITHER BE PENALIZED FINANCIALLY FOR THOSE PATIENTS STILL BEING PAID FOR UNDER FEE-FOR-SERVICE OR THEY WILL FAIL FINANCIALLY FOR PATIENTS COVERED BY THE NEWER PAYMENT SYSTEMS

whether its total spending during the year was lower than projected, and if it determines there is a sufficient amount of savings to share, it makes a lump sum payment to the provider. Yet as explained in more detail under Barrier #1, a payment change this small is also unlikely to achieve significant results.

True payment reforms will require more significant effort by payers. However, in markets with multiple payers, there is an incentive for each individual health insurer to be a “free rider,” i.e., to avoid the costs of implementing payment reforms while retaining all of the savings generated by providers in response to payment reforms implemented by other health plans. (Since physicians who improve the way they deliver care will do so for all of their patients, care improvements stimulated by one health plan will benefit the members of other plans, too.)

There is also a general disincentive for health insurance companies to participate in payment reforms, because if the reforms succeed in reducing healthcare spending, the insurance company may have to reduce its administrative costs and profits in order to comply with the minimum medical loss ratio requirements under the Affordable Care Act.⁵⁹

Even if a health insurance company is willing to change the way it pays, it may be unable to unilaterally use a new

payment model for all of its enrollees. On average, about 39% of health plans' business today is "administrative services only (ASO)" for self-insured employers, and for many national health plans, the percentage is 50% or more.⁶⁰ (Under an ASO contract, the health plan merely processes claims for the self-insured employer for a fee; the health plan is not directly at risk for whether the costs associated with those claims increase or decrease.) In order for a health plan to move all of its patients to a new payment model, it would have to get agreement from each of its self-insured accounts, which can be a significant administrative challenge. Here again, there are significant financial disincentives for health plans to participate; if the health plan's administrative fee from an ASO account is based on the number or amount of claims the health plan pays on behalf of the self-insured employer, then the health plan's revenue will decrease if a new payment model is successful in reducing healthcare spending.

BARRIERS TO ALIGNING PAYMENT REFORMS

However, even if all payers move away from fee-for-service, the most likely outcome is that they will do so in different ways. If each payer designs payment reforms on its own, each payer may choose to include different services in an episode or global payment, use different measures of quality, use different systems for risk adjustment, etc. At best, these differences will cause providers to face significantly higher administrative costs; at worst, they will create conflicting incentives that could impede improvements in care or deter providers from participating at all.

There are several reasons why it is challenging for commercial health plans to implement common payment reforms:

- Concerns about antitrust law violations make it difficult for health plans to discuss or reach agreement on a common approach to payment.
- Many health plans pay for patients located in multiple geographic markets, and they find it more efficient to use the same payment system in all of their markets, even if that results in lack of alignment with other payers in any particular market.
- Since employers, state Medicaid agencies, and other healthcare purchasers typically demand that health plans compete for their insurance business, health plans may fear that employers will penalize them for not being "innovative" if they simply use the same payment models as other payers.

Self-insured employers may also have concerns about moving to payment models that give greater accountability to providers, since the employers' exemptions from insurance regulation under ERISA depend on the fact that they are at risk for the healthcare costs of their employees. Using payment models that incorporate the kinds of risk adjustments, risk limits, and risk exclusions described under Barrier #2 will help ensure that the employers are retaining insurance risk and only transferring performance risk to providers, thereby preserving their ERISA exemption.⁶¹

The biggest payer for most healthcare providers is Medicare. Even if all commercial payers in a community implemented aligned payment reforms, continued fee-for-service payment to providers by the traditional Medicare program would make it difficult for the providers to truly transform the way they deliver care. As noted under Barrier #1, "shared savings" is still fundamentally a fee for service payment system, so even if a provider agrees to participate as an Accountable Care Organizations in the Medicare Shared Savings Program, it will have only limited ability to change care.

ACHIEVING ALIGNMENT OF PAYMENT REFORMS

It is clearly in the interest of patients, purchasers, and providers to see all payers adopt similar payment reforms in a community, since this would enable healthcare providers to change their care processes for all of their patients to reduce costs and improve quality without being financially penalized for any subset of patients. It would also be in the interest of payers themselves to align, since it would avoid creating a competitive disadvantage for those who implement payment changes.

Four things are key to achieving payment alignment among all payers:

- **Healthcare providers, particularly physicians, should take the lead in defining how care should change and the payment changes needed to support it.** Consensus on the need for payment reform originally developed because of the barriers created by the fee-for-service payment system to delivery of higher-quality, lower-cost care. However, all too often, payment reforms such as shared savings are being designed and implemented with no clear sense of whether they would provide sufficient support for desirable changes in care. Physicians, hospitals, and other providers are in the best position to define the changes in care that will reduce costs and

improve quality and how payment should change to support that. If feasible and appropriate changes in care are used as the basis for designing needed payment changes, providers can immediately proceed to implement those care changes when the payment changes are actually made, rather than waiting until Medicare or a health plan announces a new payment system it has developed and then having the provider try to figure out whether and how care can be changed in response.

- **Employers and other purchasers should commit to having payment reforms *aligned within regions*, and support reasonable *variations across regions*.** The savings from better healthcare will (or at least should) go back to the ultimate purchasers of care – employers, state Medicaid agencies, and individual patients – and so they must take a lead role in demanding that their health plans implement appropriately designed payment systems in an aligned way. Once providers show purchasers the opportunities for savings from improved care and the need for payment changes to support that, employers will have a strong incentive to demand rapid action to implement payment reforms. If health plans refuse to implement new payment systems or if they do so in an unaligned way, purchasers should switch to health plans which are willing to align. Since the biggest employers in most communities are hospitals and health systems, these providers can lead the way by using new payment models for their own employees; indeed, this would give health systems greater ability to ensure that payment structures are designed in a way that avoids the overly negative impacts on hospitals described in Barrier #8. National employers need to recognize that different payment changes may be needed in different regions, given the differences in delivery structures and the differences in the factors driving healthcare costs across regions; while a uniform national approach might be desirable for such employers, resisting participation in desirable payment reforms simply because they are not being implemented in all regions will deny employers savings in the regions that are willing to make changes and thereby also slow the pace of reform nationally.
- **Medicare should make a wider range of payment reforms more broadly available and do so in a way that aligns with regional efforts.** The CMS Innovation Center is currently implementing a number of important payment reforms, including Bundled (Episode) Payments, Comprehensive Primary Care Payments, and Pioneer Accountable Care Organizations (with a global payment component).⁶² The CMS Bundled Payments Initiative is a model for how a large national payer can support regional alignment of payment, since it does not require a single one-size-fits-all model for every provider in every region, but rather it allows providers to choose from four different models of payment and also to choose the specific types of patients and conditions to which the payments would apply. However, these payment reforms have only been available on a competitive basis to providers which applied during narrow windows of time. Medicare needs to make these types of programs available to a broader range of providers with more frequent application periods.
- **State governments and Regional Health Improvement Collaboratives should be used to help facilitate agreement on a common payment methodology in each region.** Although antitrust prohibitions are primarily designed to prohibit payers from agreeing on a common *price* for services, not to prohibit agreement on a common *method* of payment, the fear of running afoul of antitrust laws deters payers from discussing and agreeing on payment methodology changes without help from a neutral outside entity. One approach is for states to supervise the development of a common payment methodology, using the state action exemption under federal antitrust law. Another approach is for a neutral entity, such as a non-profit multi-stakeholder Regional Health Improvement Collaborative, to develop a common payment methodology and convince multiple payers to use it. For example, in a number of communities, non-profit Regional Health Improvement Collaboratives have developed agreement among multiple payers on a common payment methodology to support innovative care delivery programs.⁶³

HEALTHCARE PROVIDERS, PARTICULARLY PHYSICIANS, SHOULD TAKE THE LEAD IN DEFINING HOW CARE SHOULD CHANGE AND THE PAYMENT CHANGES NEEDED TO SUPPORT IT

BARRIER #8

NEGATIVE IMPACTS ON HOSPITALS



Hospital care represents the largest share of total healthcare costs and the largest contributor to the growth in costs in recent years.⁶⁴ Consequently, it will be difficult to make a significant impact on healthcare costs without significantly reducing the rate of hospital admissions and the cost of hospital stays.

However, hospitals will likely resist implementation of new payment systems unless their unique needs and challenges are recognized and addressed. Although hospitals are service businesses, they look more like manufacturing firms because of their large investments in specialized facilities and equipment. For both manufacturing firms and hospitals, an increase in volume will generally increase profits, because the marginal cost of producing an extra product or treating an additional patient is well below the average cost. Not surprisingly, this has led both manufacturing firms and hospitals to focus on building market share. However, if every hospital tries to increase its market share, the likely result will simply be an increase in total healthcare spending in the community, not less. As a practical matter, if healthcare spending is to be reduced, some or even all hospitals in each region will have to experience a decrease in volume, and this can have a negative impact on those hospitals' operating margins, because with fewer admissions, a hospital's costs will decrease far less than will its revenues, particularly in the short run.⁶⁵

The magnitude of the impacts will depend on the individual hospital and the characteristics of the market it is located in. In a community with a rapidly growing population, or with a stable, but aging population, the aggregate need for hospital services may continue to increase even if the per capita rates of hospitalization decrease. If a hospital is experiencing bed shortages today, a reduction in demand may simply avoid the need to add new capacity. The biggest negative impact will likely be on small community hospitals, since a large proportion of their admissions are patients with chronic diseases, and many of those admissions can be prevented if payment systems begin to support better primary care.

A new payment system will fail if it bankrupts hospitals or forces them to find ways to increase utilization simply to stay afloat. **Both payers and hospitals will need to make changes in order to ensure that payment reforms can successfully support high quality, affordable hospital care:**

- **Hospitals must reduce their costs.** Hospitals will need to aggressively look for ways to reduce their fixed costs and to improve efficiencies using the kinds of techniques that systems like Theadacare,⁶⁶ Virginia Mason,⁶⁷ and Intermountain Healthcare⁶⁸ have pioneered. Hospitals can benefit from technical assistance in redesigning the way they deliver care, such as through the types of programs operated by the Pittsburgh Regional Health Initiative⁶⁹ and the Iowa Healthcare Collaborative.⁷⁰ **Bundled payments which align incentives for both physicians and hospitals can help hospitals reduce their costs,** as described in more detail under Barrier #1, particularly if the legal issues described under Barrier #3 are addressed. In contrast, **consolidating hospitals in order to reduce costs should be a last resort.** Although in theory, consolidating hospitals can reduce duplication and increase efficiencies, in practice it has resulted in higher prices, particularly when neighboring hospitals are consolidated.⁷¹ If payment reforms are to be successful, they should encourage greater competition among hospitals, not less.
- **Medicare and health plans may need to pay more for some hospital services.** Payers may need to increase the amount they pay per admission or procedure to reflect the fact that a hospital's unit costs will be higher with lower volumes. For example, the cost of an individual surgery will depend on the number of surgeries done, since some of the cost of surgery is variable (e.g., the cost of a joint implant) and some is fixed (e.g., the cost of the surgery suite), so if the number of surgeries decreases, the cost per surgery will likely increase, at least in the short run. It is important to recognize that total spending can still be reduced, even with higher payments per admission, if admissions are being reduced. **However, hospitals will need to be more transparent about their cost structures.** If a hospital seeks to increase prices following a reduction in utilization, purchasers and payers will need to know if that is a legitimate recalculation of the average cost of care in response to a lower level of utilization after all possible efficiencies have been implemented, or merely a monopolistic effort to replace lost revenue.⁷²

BARRIER #9

POLICIES FAVORING LARGE PROVIDER ORGANIZATIONS



Managing episode-of-care and global payments successfully requires much greater coordination of care among primary care physicians, specialists, hospitals, and other healthcare providers than typically occurs today. This greater clinical integration is clearly highly desirable, and encouraging it is one of the major benefits of new payment methods.

However, clinical *integration* of providers does not require *consolidation* of those providers. Indeed, many healthcare systems that have achieved *corporate* integration have made little progress in achieving meaningful *clinical* integration. In some cases, their size and integration have been used more as a way of controlling market share and increasing prices rather than reducing costs and improving quality. There is a serious risk that encouraging and supporting the development of more large, vertically-integrated systems will simply result in higher prices for care.

Fortunately, there are a number of examples across the country of small independent physician practices and hospitals working together to manage global payments while remaining organizationally independent.⁷³ These providers may represent better models of clinical integration for many physicians and hospitals than large integrated delivery systems.

However, many laws and policies make it difficult for small providers to work together without consolidating. For example, under current antitrust law, if two physicians try to contract jointly with a payer using a single price, they are viewed as having committed a *per se* violation of prohibitions on price fixing. Yet if those two physicians abandon their independent practices and join the payroll of a hospital which has a single price for the services delivered by all of its physicians, there would be no antitrust violation at all.

THERE IS A SERIOUS RISK THAT ENCOURAGING AND SUPPORTING THE DEVELOPMENT OF MORE LARGE, VERTICALLY-INTEGRATED HEALTH SYSTEMS WILL SIMPLY RESULT IN HIGHER PRICES FOR CARE.

Rather than promoting competition, current antitrust policies may unintentionally encourage the creation of large providers at a time when there is growing evidence that large health systems are a major reason why healthcare costs are increasing. One study found that in more concentrated hospital markets, prices were 13%-25% higher for a range of cardiac and orthopedic procedures.⁷⁴

The best way to promote competition on prices and to control the market power of large providers is to remove the barriers to entry for smaller providers and the barriers to successful competition with larger providers. **Two types of actions by the Federal Trade Commission (FTC), the Department of Justice (DOJ), the Internal Revenue Service (IRS), and state Attorneys General would be desirable:**

- **Providing a safe harbor from antitrust enforcement for small providers participating in both public and private payment reforms.** Although the FTC and DOJ have issued a number of antitrust policy statements which define circumstances in which they will not challenge multi-provider networks and joint ventures,⁷⁵ these policies still create burdens for small physician practices that do not exist for large health systems. The agencies established a “safe harbor” for small Accountable Care Organizations (ACOs) in conjunction with regulations implementing the Medicare Shared Savings Program,⁷⁶ but this safe harbor should be expanded to providers participating in other kinds of payment reforms, including those implemented by private health plans, rather than limiting it only to providers which become Medicare ACOs. State Attorneys General could establish similar safe harbors in their own states.

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- **Challenging anti-competitive behaviors by large providers.** Clearer federal and state policies and more aggressive enforcement are needed to counteract anti-competitive behaviors by large providers, such as refusal by large providers to contract with payers who implement tiered benefit designs that explicitly encourage use of lower-cost providers and services. The FTC and DOJ issued a list of such behaviors that it cautioned providers against engaging in as part of its Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations that accompanied the Medicare Shared Savings Program,⁷⁷ but this list needs to be issued as a more comprehensive policy and it needs to be more proactively enforced. State Attorneys General could also pursue similar issues using state anti-trust enforcement powers. In addition, the IRS could revoke the tax-exempt status of providers that engage in these types of anticompetitive behaviors, since they are clearly not acting in the public interest.

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In addition, the standards established by many payers and/or by private accrediting bodies as to the qualifications needed by providers to participate in new payment models also tend to favor large provider organizations that can more easily afford to comply with many structural and process requirements, and so these standards can serve as a barrier to entry for small providers.⁷⁸ If costs are to be reduced and competition is to be supported, **payors, regulators, and accrediting agencies should only impose requirements for the structure or internal systems of providers if there is clear evidence that high-quality, affordable care cannot be provided without those structures or systems.**

BARRIER #10

LACK OF NEUTRAL CONVENING AND COORDINATION MECHANISMS



The discussion of the previous barriers makes it clear that a number of actions will be needed in each community to encourage and support successful payment reforms and in turn to reduce the costs and improve the quality of healthcare services. An overarching barrier that communities face is the difficulty of implementing all of these actions in a coordinated way. No one-size-fits-all national solution will work, since the actions need to be designed and implemented in ways that are feasible for the unique provider and payer structures in each community and in ways that complement, rather than conflict with, the quality improvement activities that are already underway in each community.

In addition, overcoming many of the barriers described earlier will require very different kinds of relationships between payers and providers, between physicians and hospitals, between purchasers and providers, and between providers and patients than exist today. Today, the only interactions many of these stakeholders routinely have with each other are win-lose negotiations over prices or compensation which often result in hard feelings on one or both sides. As a result, in many communities, there is considerable mistrust that will have to be overcome in order for the stakeholders to collaboratively redesign payment and care delivery and find win-win-win approaches.

Since there is no individual or organization “in charge” of all aspects of healthcare delivery and finance in any region, a growing number of communities have created non-profit Regional Health Improvement Collaboratives to bring together all of the key stakeholders – providers, payers, purchasers, and patients – to develop a common vision of how healthcare quality and value should be improved, to design win-win strategies for achieving those improvements, and to help resolve implementation problems in ways that are fair to all stakeholders.⁷⁹ Because Regional Health Improvement Collaboratives do not deliver care, pay for care, or regulate care, they can also serve as trusted, neutral facilitators of discussion among the various stakeholders, and they can provide objective information and analysis to help overcome the lack of trust that can prevent stakeholders from reaching agreement on significant reforms on their own.

Regional Health Improvement Collaboratives (RHICs) can play several key roles in encouraging and supporting the transition to better payment systems:

- **Identifying opportunities for savings.** Using the kinds of multi-payer data described in more detail under Barrier #4, an RHIC can identify variations in quality and utilization among the providers in its region and differences from best practices in other regions, which can help providers identify opportunities to achieve savings from redesigning the way care is delivered.
- **Building consensus on payment reforms and benefit changes.** A number of RHICs have organized Payment Reform Summits in their communities to forge consensus among all stakeholders on the kinds of payment reforms they want and the changes needed to implement them.⁸⁰
- **Providing training and technical assistance.** As noted under Barrier #8, some RHICs are providing technical assistance to hospitals in designing and implementing strategies for reducing costs; many others are helping primary care physicians create and successfully implement patient-centered medical homes, and some RHICs are working with specialists to reduce the cost and improve the quality of specialty care.⁸¹
- **Patient education and engagement.** Many RHICs have extensive programs designed to educate and assist consumers in improving their health and choosing high-value providers and services. These kinds of programs will become increasingly important in the future as physicians, hospitals, and other providers work to change the way care is delivered under new payment models and to change long-ingrained behavior patterns by consumers.⁸²
- **Neutral facilitation to achieve win-win solutions.** RHICs can bring employers, health plans, physicians, hospitals, patients, and government leaders together to design feasible ways of implementing changes in healthcare payment and delivery and then help resolve the many implementation problems which will inevitably arise in any such complex undertaking.

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- **Measuring progress on both quality and cost.** RHICs can help their communities to measure progress in implementing all of the many changes in payment, benefits, and care delivery and to assure that they are actually reducing the cost and improving the quality of care for all patients.⁸³

Although state governments will be playing an increasingly more central role in healthcare reform in the future, partly as a result of the programs in the Affordable Care Act, they cannot be effective substitutes for the roles that multi-stakeholder Regional Health Improvement Collaboratives play. The regulatory powers and financial resources of state governments give them some unique strengths, such as the ability to mandate the submission of quality and cost data by providers and payers and the ability to provide anti-trust safe harbors to help establish multi-payer payment reforms and help independent providers coordinate their services. However, it is difficult for state governments to support multi-year healthcare transformation efforts when changes in state administrations and changes in fiscal priorities occur, and it is difficult for states to balance regulatory enforcement powers with programs to facilitate provider improvement. In contrast, the independence and stakeholder governance of Regional Health Improvement Collaboratives provide them with greater ability to support multi-year transformation efforts and to do so in a way that can be adapted to the unique needs of individual geographic regions. Consequently, **the greatest success in healthcare transformation will likely come from strong partnerships between state governments and Regional Health Improvement Collaboratives.**⁸⁴

Although many aspects of the work done by Regional Health Improvement Collaboratives are challenging, one of the most challenging tasks Collaboratives face is obtaining adequate funding to support their work. **Payers, providers, and patients will all benefit from the kinds of work that Regional Health Improvement Collaboratives do, and so they need to contribute sufficient resources to Collaboratives to enable them to be successful.** Although program-specific funding is desirable, unrestricted funding is essential to support the core operations of Regional Health Improvement Collaboratives and to provide RHICs with the flexibility needed to pursue new opportunities in innovative ways. **The federal government also needs to provide financial support for Regional Health Improvement Collaboratives;** despite the key role that such Collaboratives can play in ensuring the success of federal healthcare reforms in local communities, there is currently no federal funding program that provides support for the administrative operations of Regional Health Improvement Collaboratives.⁸⁵

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ENDNOTES



1. Miller, HD. From volume to value: Better ways to pay for health care. *Health Aff (Millwood)*. 2009 Sept-Oct;28(5):1418-28.
2. Becker C. Profitable complications. *Modern Healthcare*, December 17, 2007.
3. In one survey, 20% of patients reported having received the same test that had been performed previously, much higher than in most other countries. The Commonwealth Fund Commission on a High Performance Health System. *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance*. July 2008. Available at <http://www.commonwealthfund.org>.
4. For example, a number of projects have shown the value of having a nurse in primary care practices providing patient education and other care management services, but this is not a reimbursable service under Medicare or most health insurance plans.
5. U.S. Department of Health and Human Services. Report to Congress: National Strategy for Quality Improvement in Health Care. Washington (DC); 2011 March. 17-18.
6. See, for example, Medicare Shared Savings Program: Accountable Care Organizations. *Federal Register* 76 (212): 67802-67990.
7. Information on the CMS Advance Payment Model is available at <http://www.innovations.cms.gov/initiatives/ACO/Advance-Payment/index.html>.
8. Mechanic RE, Altman SH. Payment reform options: Episode payment is a good place to start. *Health Aff (Millwood)*. 2009 March; 28:2w262-w2721.
9. See Miller HD. Transitioning to Accountable Care [Internet]. Pittsburgh (PA): Center for Healthcare Quality and Payment Reform; 2011. Available from: <http://www.chqpr.org/reports.html>. Also, Robinow A. The potential of global payment: insights from the field [Internet]. New York: Commonwealth Fund, 2010 February. Available from: http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Feb/1373_Robinow_potential_global_payment.pdf.
10. For more information on the ACE Demonstration, see <http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Medicare-Demonstrations-Items/CMS1204388.html>. Although no formal evaluation has been released yet, presentations by participating hospitals and physicians at various conferences have documented the benefits that Medicare, physicians, hospitals, and patients have received.
11. For more information on the CMS Bundled Payments Initiative, see <http://www.innovations.cms.gov/initiatives/Bundled-Payments/index.html>.
12. For more information on the IHA Bundled Episode Payment Program, see <http://www.iha.org/episodepayment.html>.
13. For more information on the Health Care Incentives Improvement Institute's projects, see <http://www.hci3.org/implementations>.
14. Chernew ME, Mechanic RE, Landon BE, Safran DG. Private-payer innovation in Massachusetts: the "alternative quality contract." *Health Aff (Millwood)*. 2011;30(1):51-61.
15. Center for Medicare and Medicaid Innovation. Alternative payment arrangements for the Pioneer ACO Model [Internet]. Washington (DC); 2012. Available from: <http://www.innovations.cms.gov/Files/x/Pioneer-ACO-Model-Alternative-Payment-Arrangements-document.pdf>.
16. In some cases, episode payments and global payments are being implemented as "virtual" payment reforms. The providers continue to be paid under the existing fee-for-service system, but their accountability is now based on a pre-defined budget for the episode of care or the overall costs of care for the patient population. Under these systems, the continued use of the fee-for-service system is simply a convenience for both the provider and the payer, so

that new claims payment systems do not have to be created immediately. Even though the providers managing the budget continue to be paid immediately by claims, they know that any losses of revenue due to reducing fee-based services will be repaid when the budget is reconciled. This is very different from the shared savings model in which there is no predetermined budget, merely a methodology for determining whether savings have occurred based on comparisons to costs for patients served by other providers, and in which only a portion of savings is shared.

17. Miller HD. From volume to value: Better ways to pay for health care. op cit.
18. For a more detailed discussion of methods of controlling provider risk, see Miller HD. Transitioning to Accountable Care. op cit.
19. Chernew ME, Mechanic RE, Landon BE, Safran DG. Private-payer innovation in Massachusetts: the “alternative quality contract.” op cit.
20. The preamble to the final Medicare Shared Savings Program regulations states “When applying a risk adjustment model, it is necessary to guard against changes that result from more specific or comprehensive coding ...” Federal Register 76 (212): 67916.
21. In addition, the “accuracy” of a risk adjustment system is typically assessed by measuring its ability to predict differences in the amount of current spending on different patients. However, since current variations in spending across patients are known to be due to both legitimate and preventable factors, any risk adjustment system designed to mimic current spending patterns will simply lock in the types of unnecessary variation that payment reforms are designed to discourage.
22. For example, Medicare uses risk corridors in paying health plans for pharmaceutical costs incurred under the Medicare Part D prescription drug benefit. If a Part D plan incurs costs between 95% and 105% of a defined target amount, the plan is responsible for covering those costs with no additional payment from Medicare. However, if a plan incurs costs between 105% and 110% of the target, it is only responsible for 50% of those costs, and Medicare pays the remaining 50%; if costs exceed 110% of the target, the plan is responsible for only 20% of the costs, and Medicare pays an additional amount sufficient to cover the remaining 80%. If the plan incurs costs between 90% and 95% of the target, the plan refunds 50% of the savings in that range to Medicare, and if the plan’s costs are below 90% of the target, it refunds 80% of the costs below 90% of the target to Medicare. The risk corridors were originally narrower in order to encourage private health plans to participate at a point where there was limited information about exactly how drug usage by Medicare beneficiaries might change in respond to the new program. A similar approach could be used by many payers to enable providers to transition into new payment systems.
23. For episode payments, the Integrated Healthcare Association and the Health Care Incentives Improvement Institute have each developed detailed specifications as to which services will be included and which will not, as well as risk adjustments, risk exclusions, etc. For more information, see <http://www.iha.org/episodpayment.html> and http://www.hci3.org/what_is_prometheus . For global payments, the Integrated Healthcare Association has developed a standardized Division of Financial Responsibility that can be used by providers and payers to clearly define those costs for which the provider will be accountable and those for which the payer will retain accountability. For more information, see <http://www.iha.org/dofr.html>.
24. For example, the Puget Sound Health Alliance and the Washington State Health Authority implemented a pilot program in 2011 that gives primary care practices an additional, flexible payment to support better care in return for a commitment to reduce preventable emergency room visits and/or ambulatory care-sensitive hospitalizations among the practices’ patients. See <http://www.pugetsoundhealthalliance.org/services/MedicalHome.html>. The medical home program created by Horizon Blue Cross Blue Shield in New Jersey pays practices based on their performance on four specific utilization metrics that can be directly affected by primary care physicians – hospital admissions/readmissions, emergency room visits, generic drug prescribing, and use of out-of-network providers – as well as quality metrics. See Patel UB, Rathjen C, and Rubin E. Horizon’s patient-centered medical home program shows practices need much more than payment changes to transform. Health Aff (Millwood). 2012;31(9):2018-2027.
25. Jacobs LP, Mertz M. Rethinking physician compensation in an accountable care world. Group Practice Journal. 2011 September; 30-33.
26. §1128A(b)(1) of the Social Security Act.
27. July 1999 DHHS-OIG Special Advisory Bulletin, Gainsharing Arrangements and CMPs for Hospital Payments to Physicians to Reduce or Limit Services to Beneficiaries. Available from: <http://oig.hhs.gov/fraud/docs/alertsandbulletins/gainsh.htm>.
28. §1128B(b) of the Social Security Act.
29. §1877 of the Social Security Act.

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30. §1899(f) and §1115A(d) of the Social Security Act.
 31. See, for example, American College of Radiology, State-by-State Comparison of Physician Self-Referral Laws, 2004.
 32. Miller HD. From volume to value: Better ways to pay for health care. op. cit.
 33. Ginsburg PB, Grossman JM. When the price isn't right: how inadvertent payment incentives drive medical care. *Health Aff (Millwood)*. 2005 Jul-Dec; Suppl Web Exclusives: W5-376-84.
 34. Large integrated delivery systems will also have access to information about most of the care that their patients are receiving, simply because they will likely be delivering that care themselves. However, if the only physicians and hospitals that have access to comprehensive data about care are those in large integrated systems, independent physicians and hospitals will have greater difficulties participating in new payment models, and this could lead to greater consolidation of providers and higher prices, rather than lower spending. See Barrier #9 for a more detailed discussion of the importance of supporting small, independent provider organizations.
 35. More information on the Maine Health Management Coalition is available from: <http://www.mehmc.org>.
 36. More information on the Oregon Health Care Quality Corporation is available from: <http://www.q-corp.org>.
 37. Some of the resistance to releasing price data is based on legitimate concerns that making price data publicly available could lead to increases in prices by providers or encourage consumers to use higher-priced providers. Data use agreements can be developed that ensure that price data are only used in ways that support programs that will reduce costs until payment systems and benefit designs are in place that encourage use of lower-priced providers, as discussed under Barrier #5.
 38. Some states have enacted legislation requiring all payers to contribute data on utilization and price to an all-payer claims database. For example, in Colorado, the Center for Improving Value in Health Care (CIVHC) is a non-profit multi-stakeholder Regional Health Improvement Collaborative that is using state-mandated claims data submissions to generate analyses designed to help reduce cost and improve quality. For more information, see <http://www.civhc.org> and <http://www.cohealthdata.org>.
 39. More information on the Medicare Qualified Entity program is available at <https://www.qemedicaredata.org/SitePages/home.aspx>.
 40. For example, under the Medicare Shared Savings Program, a patient is assigned to an Accountable Care Organization (ACO) if the patient had more charges for primary care services in the previous 12 months from physicians associated with the ACO than from physicians not associated with the ACO. *Federal Register* 76 (212): 67802-67990. Even if attribution calculations are done frequently, a patient who changes physicians may not be *assigned* to the new physician by Medicare until they have enough visits with the new physician to represent a majority of the charges over a 12 month period.
 41. Pham HH, Schrag D, O'Malley AS, Wu B, Bach PB. Care patterns in Medicare and their implications for pay for performance. *N Engl J Med*. 2007 March 15; 356(11): 1130-1139.
 42. For example, if a patient is admitted frequently to the hospital during the year for various problems, but makes his first visit to the PCP near the end of the year, the patient could be attributed to the PCP for the entire year, thereby making the PCP accountable for all of the hospital visits that occurred before the patient first saw the PCP. If an Academic Medical Center helps resolve an unusual and expensive condition for a patient in a way that saved money, but it does not provide routine primary care for the patient, the patient's PCP may receive credit for the savings that was created by the work of the Academic Medical Center.
 43. Having a patient prospectively designate their primary care provider is different from the "prospective assignment" methodology that CMS evaluated and rejected for use in the Medicare Shared Savings Program. *Federal Register* 76 (212): 67861 et seq. The "prospective assignment" methodology still used retrospective attribution to assign patients, it simply looked at the patients' utilization *prior* to the beginning of the new payment program and assigned them to the provider they had been using in the past. Although under this model, the Accountable Care Organization would know in advance a list of patients they would be accountable for, some of these patients might already have changed physicians. As a result, the prospective assignment process would not be more accurate than the retrospective assignment process, it would simply be inaccurate in a different way.
 44. In its evaluation of prospective vs. retrospective assignment, CMS argued that the retrospective assignment methodology would force providers to improve care to *all* of their patients, not just the subset who were *assigned* to them. However, this advantage arises from the flawed nature of the statistical attribution process CMS considered using for "prospective assignment," it is not inherent in a system where patients select providers in advance; if patients and

providers voluntarily choose each other, then the providers will have accountability for all of the patients they are seeing, rather than just a subset that happened to satisfy an arbitrary statistical rule.

45. See, for example, Kleinke JD. Access versus excess: Value-based cost sharing for prescription drugs. *Health Aff (Millwood)*. 2004 Jan-Feb;23(1):34-47.
46. Massachusetts Division of Health Care Finance and Policy. Massachusetts health care cost trends: price variation in health care services [Internet]. Boston (MA); June 2011. Available from: <http://www.mass.gov/eohhs/docs/dhcfp/cost-trend-docs/cost-trends-docs-2011/price-variation-report.pdf>.
47. For example, suppose two hospitals do knee replacements; one is paid \$25,000 for the procedure by the health plan and the other is paid \$30,000. If a patient has a \$1,000 copayment for a hospitalization or a \$5,000 deductible, the cost to the patient for the knee replacement will be the same regardless of which hospital they choose, even though going to the second hospital would cost the patient's health plan \$5,000 more.
48. Miller HD. From volume to value: Better ways to pay for health care. *op. cit.*
49. Robinson JC. Applying value-based insurance design to high-cost health services. *Health Aff (Millwood)*. 2010 November; 29(11): 2009-2016.
50. Fendrick AM, Chernew M, Levi GW. Value-based insurance design: Embracing value over cost alone. *Am J Manag Care*. 2009; 15:S277-S283.
51. In some cases, the incentive for quality can be built directly into the payment system more effectively than trying to reward or penalize it separately. For example, if a provider accepts an episode-of-care payment that includes a warranty for errors, infections, or complications occurring during treatment, there is no need to have a separate quality bonus/penalty for such errors, infections, and complications, because there is a built-in penalty for the provider if such events occur, namely, it has to correct the problems with no additional compensation. See, for example, Berenson RA, Paulus RA, Kalman NS. Medicare's readmissions-reduction program – a positive alternative. *N Engl J Med*. March 28, 2012.
52. Wier LM, Andrews RM. The national hospital bill: The most expensive conditions by payer, 2008. Agency for Healthcare Research and Quality, March 2011.
53. More information on the Joint Commission's Accountability Measures is available at http://www.jointcommission.org/accountability_measures.aspx.
54. For example, Quality Quest for Health of Illinois developed a composite measure of the appropriateness and quality of colonoscopies. The measure is easy for both physicians and consumers to understand, and Quality Quest publishes individual physician scores on the measure to encourage physicians to improve their performance and to encourage patients to choose the highest-performing physicians. See <http://www.qualityquest.org/quality-reports/colonoscopies/index.php>.
55. See, for example, Nicholas LH, Osborne NH, Birkmeyer JD, Dimick JB. Hospital process compliance and surgical outcomes in Medicare beneficiaries. *Arch Surg* 2010 October; 145(10): 999-1004.
56. Wu AW, Snyder C, Clancy CM, Steinwachs DM. Adding the patient perspective to comparative effectiveness research. *Health Aff (Millwood)*. 2010 October; 29(10): 1863-1871.
57. For example, Massachusetts Health Quality Partners has been surveying patients about their health care experiences since 2005; it was the first organization in the nation to publicly report statewide information about patient experiences with different healthcare providers. See <http://www.mhqp.org>.
58. Scholle, SH et al. Benchmarking physician performance: Reliability of individual and composite measures. *Am J Manag Care* 2008; 14(12): 829-838.
59. Under minimum medical loss ratio requirements, a health plan must spend a minimum percentage of its total premium revenues on medical services, which in turn limits the amount that it can use for administration and profits. Consequently, if the health plan is operating at the minimum medical loss ratio and medical spending declines, it would have to reduce its administrative costs or profits. U.S. Department of Health and Human Services. Medical Loss Ratio: Getting Your Money's Worth on Health Insurance [Internet]. Available from: <http://www.healthcare.gov/news/factsheets/2010/11/medical-loss-ratio.html>.
60. Namovicz-Peat S, Trompeter E, Sheppard J. AIS's Directory of Health Plans: 2010. Atlantic Information Services. Washington (DC); 2010.

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61. These same adjustments to payment systems will also reduce the likelihood that the provider organization will be required by a state insurance department to be licensed as a health plan in order to participate in the payment system.
 62. More information on the CMS Innovation Center's programs is available at <http://innovations.cms.gov>.
 63. For example, the Institute for Clinical Systems Improvement in Minnesota developed a new payment model to support better care for patients with depression that all commercial health plans agreed to support. More information on the "DIAMOND Initiative" is available from: http://www.icsi.org/health_care_redesign_/diamond_35953/
 64. Author's calculations from the National Health Expenditure Accounts. Available from: http://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage.
 65. Miller HD. Methodology on adverse events. *Health Aff (Millwood)*. 2007 January/February. 26(1):293.
 66. Toussaint J. Writing the new playbook for U.S. health care: lessons from Wisconsin. *Health Aff (Millwood)*. 2009 Sept-Oct; 28(5):1343-50.
 67. Blackmore CC, Mecklenburg RS, Kaplan GS. At Virginia Mason, collaboration among providers, employers, and health plans to transform care cut costs and improved quality. *Health Aff (Millwood)*. 2011 September; 30(9): 1680-1687.
 68. James BC, Savitz, LA. How Intermountain trimmed health care costs through robust quality improvement. *Health Aff (Millwood)*. 2011 June; 30(6): 1185-1191.
 69. More information on the Pittsburgh Regional Health Initiative is available at <http://www.prhi.org>.
 70. More information on the Iowa Healthcare Collaborative is available at <http://www.ihconline.org>.
 71. Williams CH, Vogt WB, Town R. How has hospital consolidation affected the price and quality of hospital care? Robert Wood Johnson Foundation. Policy Brief No. 9, February 2006.
 72. For a more detailed discussion, see Miller H. Making reform a reality: Ways to facilitate better healthcare payment and delivery systems and lower healthcare costs. Robert Wood Johnson Foundation. June 2010.
 73. For example, an Independent Practice Association with 72 primary care physicians and no specialists is successfully participating in the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract. Mechanic RE, Santos P, Landon BE, Chernew ME. Medical group responses to global payment: early lessons from the "alternative quality contract" in Massachusetts. *Health Aff (Millwood)*. 2011 September; 30 (9): 1734-1742. More than one-third of the providers participating in the Medicare Pioneer ACO program are physician-led organizations without a hospital.
 74. Robinson JC. Hospital market concentration, pricing, and profitability in orthopedic surgery and interventional cardiology. *Am J Manag Care*. 2011; 17(6):e241-e248.
 75. Department of Justice and Federal Trade Commission. Statements of Antitrust Enforcement Policy in Health Care. Available from <http://www.ftc.gov/bc/healthcare/industryguide/policy/index.htm>.
 76. U.S. Federal Trade Commission and Antitrust Division of the U.S. Department of Justice. Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program. *Federal Register* 76(209): 67026-67032. October 20, 2011.
 77. The October 20, 2011 FTC/DOJ Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program lists four types of conduct that large providers should avoid if they wish to become ACOs: (1) Preventing or discouraging private payers from directing or incentivizing patients to choose certain providers, including providers that do not participate in the ACO, through "anti-steering," "anti-tiering," "guaranteed inclusion," "most-favored-nation," or similar contractual clauses or provisions; (2) Tying sales (either explicitly or implicitly through pricing policies) of the ACO's services to the private payer's purchase of other services from providers outside the ACO (and vice versa), including providers affiliated with an ACO participant; (3) Contracting on an exclusive basis with ACO physicians, hospitals, ASCs, or other providers, thereby preventing or discouraging those providers from contracting with private payers outside the ACO, either individually or through other ACOs or analogous collaborations; and (4) Restricting a private payer's ability to make available to its health plan enrollees cost, quality, efficiency, and performance information to aid enrollees in evaluating and selecting providers in the health plan, if that information is similar to the cost, quality, efficiency, and performance measures used in the Shared Savings Program.
 78. For example, many of the standards that the National Committee for Quality Assurance has recommended that primary care practices meet in order to be designated as a patient-centered medical home have been difficult and expensive for small primary care practices to meet with no clear evidence that they would improve outcomes. Nutting

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79. Regional health improvement collaboratives: essential elements for successful healthcare reform [Internet]. Pittsburgh (PA): Jewish Healthcare Foundation. February 2012. Available from: <http://www.nrhi.org/downloads/RegionalHealthImprovementCollaboratives.pdf>.
80. See <http://www.nrhi.org/paymentdeliveryreform.html> for more information about the work of Regional Health Improvement Collaboratives to build consensus on payment reforms and benefit designs and encourage implementation.
81. See <http://www.nrhi.org/performanceimprovement.html> for more information about the ways Regional Health Improvement Collaboratives help providers improve quality and reduce costs.
82. See <http://www.nrhi.org/patientengagement.html> for more information about Regional Health Improvement Collaboratives’ programs to educate and engage patients in health and healthcare improvement.
83. See <http://www.nrhi.org/performancemeasurement.html> for more information about the work of Regional Health Improvement Collaboratives to measure and report on progress in improving quality and reducing cost.
84. For example, the Puget Sound Health Alliance and the Washington State Health Authority worked together to design and implement a multi-payer medical home pilot in the State of Washington. The state passed legislation to authorize health plans to collaborate on a common payment methodology and payment amounts, and the Alliance provided the analytical and convening support to reach agreement among the plans and providers on the way payment should be structured.
85. Although the Department of Health and Human Services (HHS) and the Agency for Healthcare Research and Quality (AHRQ) promoted the creation of multi-stakeholder collaboratives through the Chartered Value Exchange (CVE) program, they do not provide any funding for general operating support of CVEs or other Regional Health Improvement Collaboratives. The Beacon Communities Program, which was established through the Office of the National Coordinator for Health Information Technology at HHS, has provided significant funding to a number of communities for multi-stakeholder healthcare improvement activities, but since the funding was authorized by the 2009 American Recovery and Reinvestment Act, it is explicitly a time-limited program that will end in 2013.



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