

EXECUTIVE SUMMARY

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The Opportunity and Challenge of Payment Reform

There is growing recognition that the structure of current healthcare payment systems frequently impedes efforts to improve the quality of health care and control healthcare costs. Fee-for-service payment systems can financially penalize physicians for keeping people healthy, for reducing errors and complications, and for avoiding unnecessary care, and they can restrict physicians' flexibility to design and deliver care for their patients in the most efficient and effective manner.

This has led to a variety of different proposals for changes to payment systems. Each of these proposals has advantages and disadvantages, and each could have very different impacts on physicians and other healthcare providers.

The Building Blocks of Payment Reform

Most payment reform proposals differ from current payment systems in one or more of five basic ways:

1. Paying More for Certain Services

New payment systems may pay for certain services (or ways of delivering services) that are not currently paid for today, or they may pay more for services than are paid for today. Examples include:

- Payments for currently unreimbursed services
- Higher payments for currently reimbursed services

2. Paying Based on the Quality of Services

New payment systems may make the payment amount for a service dependent on the quality of the service delivered. Examples include:

- Pay for performance
- Non-payment for services required to treat complications, infections, etc.
- Limited warranties
- Non-payment for services that fail to meet minimum quality standards
- Quality-based tiering

3. *Combining Separate Services into a Single Payment*

New payment systems may make a single combined payment for two or more services for which a physician is currently paid separately (or for services not currently paid for).

Examples include:

- Care management payments
- Case rates/payments for episodes of care
- Practice capitation

4. *Making Payment Dependent on the Amount and Cost of Services Delivered by Other Physicians or Providers*

New payment systems may make a physician's payment dependent on the number of services or the cost of services delivered by other providers. Examples include:

- Resource use-based pay-for-performance
- Shared savings/Gain-sharing
- Bundling multiple providers into a single episode payment
- Comprehensive Care Payment/Global Payment/Capitation
- Virtual bundling
- Resource use-based tiering

5. *Paying to Support Specific Provider Structures, Systems, and Locations*

Finally, new payment systems may pay more for certain kinds of infrastructure or practice structures, or for physician practices located in particular geographic areas or serving specific kinds of patients. Examples include:

- Paying physicians more for locating in geographic areas with shortages of physicians;
- Paying physicians more if they use health information technology; and
- Paying to help physicians create care coordination systems.

Complementary Elements of Payment Systems

Each of the above categories defines a fundamental change in the *method* by which a physician is paid compared to traditional fee-for-service payment. However, in order to implement these changes in payment methods, decisions must be made about one or more other complementary elements of payment systems. These are:

- Condition/Severity-Adjustment
- Outlier Adjustments/Risk Corridors
- Price-Setting
- Quality and Resource Use Measures and Performance Targets
- Patient Attribution Rules
- Insurance Benefit Design (Including Value-Based Benefits and Wellness Incentives)

Different Payment Models for Different Types of Patients

It is not necessary and it may not be desirable to use the same payment system for every patient. Any of the payment changes listed above can be used for a specific subgroup of patients, while other approaches (including traditional fee-for-service payment) can be used for other subgroups of patients. The choice of payment system depends on the specific problems one is trying to solve.

Three Leading Models for Payment Reform

Most discussions about payment reform have focused on three basic models of payment: (1) payment changes to support patient-centered medical homes; (2) episode-of-care payments to improve the quality and reduce the cost of major acute care; and (3) comprehensive care or “global” payments to improve the quality and reduce the cost of the full range of healthcare services for a population of patients. However, there is no one best approach to any of these models; each of the building blocks that comprise them can be modified in order to address specific problems or achieve specific goals. The new federal Patient Protection and Affordable Care Act includes provisions designed to test each of these approaches in the Medicare program.

Opportunities and Challenges for Physicians in New Payment Systems

Any payment system presents both opportunities and challenges for physicians. The current fee-for-service system also poses significant opportunities and challenges, but physicians are used to dealing with them. Any new payment system will reduce some or all of the opportunities and challenges in the current system and add new ones, but since it is new, it will also inherently create uncertainty for a physician about his or her ability to capitalize on the opportunities and overcome the challenges.

Opportunities for physicians in the types of payment changes described above include:

- Being paid for desirable services that are not paid for today, or being paid more for services that are undercompensated today;
- Being paid more for delivering high-quality care;
- Gaining greater flexibility to determine which combination of services is most appropriate for an individual patient;
- Receiving more predictable revenues (e.g., based on the number of patients they are caring for, rather than the number of times the patients come for an office visit); and
- Being rewarded for reducing total healthcare costs and utilization.

Challenges for physicians in new payment systems include:

- Receiving inadequate payment amounts for new services or bundled payments;
- Receiving reduced payments for some services in order to shift money to new payment systems or components;
- Having performance standards set at unreasonably high levels, having payment based on problematic measures of quality or cost, or being penalized for focusing efforts on aspects of quality which are not measured or rewarded;

- Incurring higher administrative costs to implement and comply with new payment systems;
- Being unable to access the data needed to establish prices accurately or to monitor and improve performance in a timely fashion;
- Having insufficient capital to install new infrastructure or successfully manage financial risk;
- Experiencing a reduction in revenues through fewer referrals or lower utilization of services; and
- Being penalized for having improved quality or reduced utilization prior to the establishment of baselines for rewards.

Capabilities Needed to Implement New Payment Models

Depending on the nature of the payment changes which are made, physicians may need to enhance their capabilities in some or all of the following sixteen areas:

1. Achieving sufficient patient volume to support a new or improved service.
2. Having sufficient upfront capital to design and implement a new or improved service.
3. Having the skills/experience to efficiently/effectively implement a new/improved service.
4. Having the ability to obtain and analyze data on the quality of services.
5. Having the skills/experience to improve the quality of services.
6. Having adequate resources to support high-quality service delivery.
7. Gaining access to external resources to support patient adherence and health improvement.
8. Obtaining and analyzing data on the variation in services per episode or per patient.
9. Having skills/experience in improving the efficiency of service delivery.
10. Having the ability to obtain and analyze data on the quantity and cost of services delivered by other providers.
11. Having skills/experience in reducing utilization and costs.
12. Having the ability to manage the amount, quality, and cost of services delivered by other providers.
13. Accessing sufficient capital to invest in services that will produce savings.
14. Accessing sufficient capital to provide reserves for random fluctuations in costs.
15. Having the ability to pay claims from other providers or to divide revenues among multiple providers.
16. Having the ability to control or influence patient choice of providers and services.

Organizational Structures to Support Key Capabilities

None of the 16 capabilities identified in the previous section are uniquely or even automatically associated with any particular organizational structure. A solo physician practice could have all of these capabilities, and a large integrated delivery system could be missing many of them. Some organizational structures can make it easier to create and maintain certain

capabilities, but it is not necessarily the case that a specific organization with one of those structures will, in fact, adequately provide those capabilities. Consequently, it would be undesirable to either categorically exclude any organizational structures from new payment models or to automatically include a particular organization simply because it has a particular structure.

Accountable Care Organizations

There has been growing interest in creating “Accountable Care Organizations” which can take greater accountability for the overall cost as well as the quality of healthcare delivered to patients. Although there have been some efforts to establish a definition or standards for an Accountable Care Organization, there is very little evidence to prove that any particular type of provider or organizational structure cannot serve as an Accountable Care Organization. Indeed, the heart of the concept of an Accountable Care Organization is not a structure, or even a process, but an *outcome* – reducing or controlling the costs of health care for a population of individuals while maintaining, or preferably improving, the quality of that care.

It is clear that core elements of a successful ACO will be strong primary care and good communication and coordination between specialists and primary care physicians. Although the majority of healthcare expenditures and increases in expenditures are associated with specialty and hospital care, some of the most important mechanisms for reducing and slowing the growth in those expenditures are prevention, early diagnosis, chronic disease management, and other tools – tools which the majority of patients will access through primary care. However, nothing will change the fact that many patients will require specialists to provide all or part of the care they need. In order to manage costs and quality for the full range of services that patients need, there will need to be active involvement of the specialists involved with those services, and there will need to be more effective coordination between the specialists and primary care physicians, and between multiple specialists treating different conditions affecting the same patient, than typically exists today. Having good working relationships between the primary care physicians in an ACO and specialists does not necessarily mean that the primary care physicians and specialists must be part of the same organization. The goal of the Accountable Care Organization is to take responsibility for *managing* the costs and quality of healthcare for a population of patients, not necessarily to *deliver* every healthcare service itself.

Similarly, although some of an Accountable Care Organization’s patients will need hospital care at some point, this does not necessarily mean that a hospital must be part of the ACO itself. Although there are many potential advantages to having one or more hospitals as an integral part of an ACO, the ability for both a hospital and physicians to be successful as an ACO will depend on the hospital’s willingness and ability to adapt to lower utilization levels, particularly in the short run.

Compensation of Individual Physicians Under New Payment Systems

In any organizational structure other than a solo physician practice, a separate decision has to be made about the methodology the organization will use to compensate each individual physician using the revenues derived from the payments the organization receives. Any compensation system will be some combination of the following four models:

1. Compensation based solely or primarily on the *physician's own performance* on the factors used by the payer to determine the organization's payment;
2. Compensation based solely or primarily on *how the organization as a whole performs* on the factors which determine the organization's payment;
3. Compensation based on *factors that do not directly affect the organization's payment*; or
4. Salary compensation.

Even if a physician performs well on the factors that determine compensation in the organization, the physician's total compensation will depend on how much of the organization's revenue is devoted to physician compensation and how much is used for other purposes. Several key factors that affect the proportion of an organization's payment revenues that are used for physician compensation include:

- Whether the organization includes a hospital.
- Legal barriers to using non-physician revenues for physician payment.
- The need to invest in new services or infrastructure.
- The need to create or maintain financial reserves.

The Effects of Market Structure

The ability of a physician to succeed under new payment systems depends not only on the structure of the payment system, the capabilities that the physician practice has, the organizational arrangement it participates in, and the compensation structure for the physician, but also the structure of the local healthcare market. For example:

- Multiple, small payers may result in physicians being paid under many different payment systems, making it difficult for physicians to develop a single financially-viable approach to caring for all of their patients.
- A large or dominant payer may refuse to implement desired payment changes that could be beneficial for physicians and their patients.
- A large or dominant hospital, specialty group, or other provider may refuse to contract to provide necessary services under a new payment model, or may increase prices to offset any reductions in utilization.

Legal Issues Associated With Payment and Delivery Reforms

A number of laws and regulations have been enacted at both the federal and state levels that are intended to safeguard healthcare payment and delivery systems from fraudulent and abusive conduct. While these laws can discourage *undesirable* practices under *current* payment system, they can also serve to prevent or discourage *desirable* practices under *reformed* payment systems. The following are some major laws where changes will likely be needed to support payment and delivery system changes:

- Federal and state laws prohibiting physician referrals of patients to entities with which they have a financial relationship;
- Federal and state laws prohibiting payments in return for referrals of patients;
- Federal law prohibiting payments to physicians to reduce or limit services;

- Federal law prohibiting payments by tax-exempt hospitals to physicians;
- Federal and state laws prohibiting joint actions by payers and by providers;
- State laws prohibiting non-physician corporations delivering medical care;
- State laws limiting the construction of new healthcare facilities and the delivery of new services;
- State laws restricting the ability of providers to accept financial risk;
- State malpractice laws; and
- Federal and state laws restricting insurance benefit designs.

Regional Coordination of Payment and Delivery Reforms

Regional Health Improvement Collaboratives – non-profit organizations which bring together all of the key healthcare stakeholders in a metropolitan region or state to work collaboratively on healthcare improvement initiatives – can play a critical role in ensuring that payment changes, delivery system changes, benefit design changes, quality measurement and reporting, etc. are 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 individual community. Since all of the healthcare stakeholders in the community – consumers, physicians, hospitals, health plans, businesses, government, etc. – will be affected in significant ways, they all need to be involved in planning and implementing changes, and Regional Health Improvement Collaboratives can serve as a neutral facilitator to help design “win-win” solutions.

Examples of How Independent Physicians Can Successfully Participate in New Payment Models

Payment systems can and should be designed in ways that enable independent physician practices, including small physician practices, to not only survive but thrive. Payment reforms should be judged in part on their ability to support patient-centered, physician-led health care delivery. In order to succeed, physician practices will need to develop or enhance their skills and capabilities in managing costs and quality, and small physician practices will likely need to join together through IPAs or other structures to achieve the necessary economies of scale for effective support services. However, physicians do not need to be employed by hospitals or join large group practices in order to successfully achieve the goals of managing costs and quality that payment reforms are designed to support.

Examples of how physician practices, including very small practices, are successfully managing new payment models include:

- Physician Health Partners LLC (PHP), a management services organization, provides the necessary support services to enable four separate Independent Practice Associations (IPAs) in the Denver area to accept professional services capitation contracts for both Medicare and commercially insured patients. The median size of the individual practices in PHP’s IPAs is 3 physicians.

- Northwest Physicians Network (NPN) in Tacoma, Washington is an Independent Practice Association which contracts with health plans and self-insured employers, including full risk payment arrangements with Medicaid HMO and Medicare Advantage plans. NPN's 454 physicians – 109 primary care physicians and 345 physicians in 35 specialties –are in 165 separate small practices.
- Independent specialty physicians at both Baptist Health System in San Antonio, Texas, and at Hillcrest Medical Center in Tulsa, Oklahoma are participating in newly-formed Physician-Hospital Organizations and accepting “bundled” payments for 28 cardiovascular procedures and 9 orthopedic procedures under the Medicare Acute Care Episode Demonstration.
- The Mount Auburn Cambridge Independent Practice Association (MACIPA) and Mount Auburn Hospital in Massachusetts jointly accept full risk capitation and global payment contracts with three Boston-Area health plans covering 40,000 lives. MACIPA and Mount Auburn Hospital are independent organizations and there is no legal structure, such as a Physician-Hospital Organization, joining them; they develop agreements with each other as to how risk-sharing will be done. MACIPA has 513 physician members, nearly half (48%) of whom are in independent private practices.