

PAYMENT REFORM AND ALTERNATIVE PAYMENT MODELS: A PRIMER

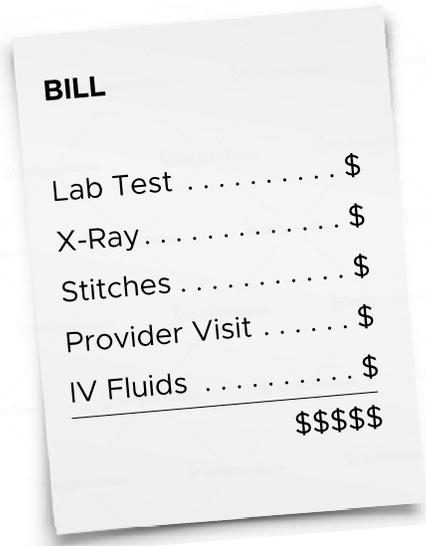
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INTRODUCTION

The way we pay for health care in the US is complicated. Sometimes the patient pays the provider directly, sometimes the patient pays an insurance company, and they pay the provider, and other times the government is involved in paying.



This primer explains how the way we pay for health care is changing in Colorado and around the country. These changes can impact the patient experience or reduce cost, by changing what we pay for.



Right now, we generally determine the amount that is owed based on the number and types of services a patient received. Services include things like lab tests, visits with providers, x-rays, as well as procedures such as surgeries and blood transfusions. This system of billing for services is known as a fee-for-service (FFS) payment model, and it dominates health care in our country.

In a fee-for-service model, providers are paid for each service they administer, which means that they have the incentive to increase the number of services provided.

If providers administer fewer services, they are paid less, so there is little incentive for them to deliver care more efficiently. Furthermore, the emphasis on providing individual services under FFS frequently causes providers to focus on acute concerns and individual components of care without adequately appreciating their relationship to a person's health and wellbeing as a whole. Some have described FFS as the single biggest contributor to both the excessive use of services and the fragmentation, or the lack of coordination between a patient's multiple providers, of the US health care system. Although FFS may have aligned with the priorities of the health care system in the past, it is increasingly agreed that this system falls short of meeting today's health needs.

“Payment reform” is the movement to change what we pay for in health care. Instead of paying for services, we should pay for good value: health care that improves our health and costs less. However, payment reform can be confusing, technical, and intimidating. It typically occurs at the intersection between health insurance (either private health insurance, like UnitedHealthcare or Aetna, or public health insurance, like Medicaid or Medicare) and health care providers. This is where incentives can be created for higher value care.



Because FFS can contribute to inefficiency in our health care system, recent reforms have aimed to replace the FFS model with **“alternative payment models.”** These models attempt to change financial incentives for providers so that they deliver better quality care for patients and cut costs. There are four common alternative payment models, and each has a different impact on patient experience. However, given that there is a lot of variation in how each model is implemented, it's difficult to say that one is better than another.

1. <https://www.brookings.edu/blog/health360/2014/07/23/the-beginners-guide-to-new-health-care-payment-models>
2. <http://jamanetwork.com/journals/jama/fullarticle/2533698>
3. <http://www.hci3.org/thought-leadership/why-incentives-matter/fee-for-service>
4. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2653966>
5. <http://www.hci3.org/thought-leadership/why-incentives-matter/fee-for-service>
6. <http://www.nejm.org/doi/full/10.1056/NEJMp1011024?viewType=Print>
7. <http://healthaffairs.org/blog/2014/02/06/the-payment-reform-landscape-overview>
8. <http://www.hci3.org/thought-leadership/why-incentives-matter/pay-performance>
9. <http://healthaffairs.org/blog/2015/04/15/the-payment-reform-landscape-impact-on-consumers>
10. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2787940>
11. Examples of P4P models in Colorado: http://www.ncsl.org/portals/1/documents/health/CO_PERFORMANCE_PAY.pdf

ALTERNATIVE PAYMENT MODELS

PAY-FOR-PERFORMANCE (P4P)

In a P4P model, providers are still paid based on the services they provide (FFS), but they are also subject to receive **financial rewards or penalties, depending on their performance on certain measures**. Findings on patient experience have been mixed. Some research has found that patients may not experience many changes to their care and may not even know they are participating in a P4P model while other findings suggest that patients receive better communication from physicians, improved care coordination, and better interactions with office staff.

SHARED SAVINGS

Shared savings models often take the form of accountable care organizations (ACOs), and they encourage doctors, hospitals, and other health care providers to form networks to coordinate patient care. These **networks share financial and medical responsibility for providing coordinated care to patients**, and if providers deliver care more efficiently, they become eligible for financial bonuses or for a percentage of the net savings. The hope is that better coordinated care will reduce the number of unnecessary services patients receive. Some research has found that overall ratings of care and physicians do not vary significantly for patients in ACOs compared to patients not in ACOs, but patients in ACOs reported more timely access to care.

BUNDLED PAYMENT

Providers participating in a bundled payment model would receive **one payment for an entire episode of care**. For example, a bundled payment for knee surgery might cover pre-operative evaluation, the surgery itself, the anesthesia for the surgery, and post-operative care, including in the hospital, in the office, and at home. Providers assume financial risk for the cost of treatments provided, over the bundled amount. Therefore, providers are incentivized to provide efficient care, reduce unnecessary treatments, and reduce complications. Some research has suggested that patient experience has improved under some types of bundled payments while other research has found no change in patient satisfaction with recovery.

CAPITATION/MANAGED CARE

Providers who are participating in a capitated payment model may receive a **fixed amount of payment to cover all of their patients' health needs for a period of time** (for example, a month or a year). In theory, patients may experience a greater emphasis on preventive health care, as there is a greater financial reward for providers to prevent illness than to use expensive treatment options. This system rewards providers for lowering the overall cost of treating a population, such as by better coordinating care.

12. <http://khn.org/news/aco-accountable-care-organization-faq>

13. Ibid.

14. http://www.civhc.org/getmedia/2e9d3aa9-15c7-48c2-9ba7-5cb64263db5e/New-Approaches-to-Paying-for-Health-Care_CIVHC_CHI-Issue-Brief_7.12.pdf.aspx

15. <http://www.nejm.org/doi/full/10.1056/NEJMsa1406552#t=article>

16. An example of a shared savings model in Colorado: <http://www.coaccess.com>

17. https://www.rand.org/pubs/technical_reports/TR562z20/analysis-of-bundled-payment.html

18. http://www.hfma.org/Leadership/Archives/2016/Summer/Collaborating_Around_Bundled_Payments

19. <https://innovation.cms.gov/Files/reports/bpci-models2-4-yr2evalrpt.pdf>

20. <https://hbr.org/2016/07/the-case-for-capitation>

21. Ibid.

22. An example of a capitation/managed care model in Colorado: <http://www.denverhealthmedicaid.org>

PAYMENT MODEL	FEE-FOR-SERVICE	PAY-FOR-PERFORMANCE	SHARED SAVINGS	BUNDLED PAYMENT	CAPITATION/MANAGED CARE
Description	Providers paid for the services they administer ²³	Providers earn financial rewards or penalties based on performance ²⁴	Providers form networks and coordinate patient care ²⁵	Providers receive one payment for an entire episode of care ²⁶	Providers receive fixed payments to cover patients' health needs over a period of time ²⁷
Provider Incentives	Provide large volume of services ²⁸	Provide large volume of services, and meet specific quality and cost metrics ²⁹	Reduce total cost of care and coordinate care with other providers ³⁰	Reduce the cost of a specific episode of care ³¹	Reduce total cost of care ³²
Potential Benefits³³	Emphasis on productivity and maximizing patient visits	Emphasis on health outcomes, collaboration, and efficiency	Emphasis on coordinated and timely access to care	Emphasis on reducing unnecessary treatments and simpler billing	Emphasis on population health and innovation in care delivery
Potential Risks³⁴	Little incentive to prevent unnecessary care	Administrative burden, providers could avoid high-risk patients	Care could be withheld from patients	Difficult to define episode of care, providers could avoid high-risk patients	Care could be withheld from patients, could have fewer choices in primary care
Potential Cost Savings to System	None ³⁵	Low ³⁶	Moderate ³⁷	Strong ³⁸	Strong ³⁹

CONCLUSION

The information presented in this report is based on our current understanding of payment reform literature, but it is crucial to continue to implement and evaluate alternative payment models. Since some payment reform models have the ability to change the patient experience and reduce cost, it is important to de-mystify some of the technical details in order to make the conversation accessible to people and organizations that have been historically left out of payment reform efforts.

23. <https://www.brookings.edu/blog/health360/2014/07/23/the-beginners-guide-to-new-health-care-payment-models>
24. <http://www.hci3.org/thought-leadership/why-incentives-matter/pay-performance>
25. <http://khn.org/news/aco-accountable-care-organization-faq>
26. https://www.rand.org/pubs/technical_reports/TR562z20/analysis-of-bundled-payment.html
27. <https://hbr.org/2016/07/the-case-for-capitation>
28. <http://www.hci3.org/thought-leadership/why-incentives-matter/fee-for-service>
29. <http://www.hci3.org/thought-leadership/why-incentives-matter/pay-performance>
30. http://www.civhc.org/getmedia/2e9d3aa9-15c7-48c2-9ba7-5cb64263db5e/New-Approaches-to-Paying-for-Health-Care_CIVHC_CHI-Issue-Brief_7.12.pdf.aspx
31. https://www.rand.org/pubs/technical_reports/TR562z20/analysis-of-bundled-payment.html
32. <http://www.hci3.org/thought-leadership/why-incentives-matter/capitation/capitation-models>
33. <http://www.house.leg.state.mn.us/comm/docs/clinical-silversmith-paymentmodels.indd.pdf>
34. Ibid.
35. <http://www.hci3.org/thought-leadership/why-incentives-matter/fee-for-service>
36. <https://hbr.org/2013/10/doubts-about-pay-for-performance-in-health-care>
37. <http://www.hci3.org/thought-leadership/why-incentives-matter/shared-savings/shared-savings-outcomes>
38. http://www.rand.org/content/dam/rand/pubs/research_briefs/2009/RAND_RB9464-1.pdf
39. <http://www.hci3.org/thought-leadership/why-incentives-matter/capitation/capitation-outcomes>