CENTER FOR HEALTHCARE QUALITY & PAYMENT REFORM

HOW TO MAKE HEALTH INSURANCE AFFORDABLE

Affordable Health *Insurance* Requires Lower Cost Health *Care*. The goal of the Affordable Care Act was not just to make health insurance *available*, but to make it *affordable*. The ability to buy health insurance means little if the combination of premiums, deductibles, and cost-sharing makes the insurance unaffordable. But health *insurance* will not be affordable unless health *care* can be delivered at a much lower cost than it is today.

The Cost of Health Care Can be Significantly Reduced Without Rationing. The good news is that the cost of healthcare can be reduced significantly without denying patients the care they need. Many patients develop health problems that could have been prevented, receive tests and procedures that are not needed, are hospitalized because their health problems were not effectively managed, or experience complications and infections that could have been avoided. Other patients could receive different types of treatment than they do today that would be equally effective but cost less. The Institute of Medicine's 2011 study *The Healthcare Imperative: Lowering Costs and Improving Outcomes*[1] found that 30% of healthcare spending could be eliminated without harming patients. If these unnecessary and avoidable health problems, services, and costs were eliminated, hundreds of billions of dollars would be saved, health insurance premiums could be reduced, and the quality of life for the patients would improve.

Current Payment Systems Prevent Healthcare Providers From Delivering Lower Cost Care. Most of these unnecessary costs persist because of problems with the way health insurance plans pay physicians, hospitals, and other healthcare providers. The two most important barriers are:

- **Lack of payment or inadequate payment for high-value services.** Medicare and most health plans do not pay physicians for many services that would benefit patients and help reduce avoidable spending. For example, there is generally *no payment* or *inadequate* payment for:
  - responding to a patient's phone call about a symptom or problem, even though it could help the patient avoid the need for far more expensive services, such as an emergency department visit;
  - communications between primary care physicians and specialists to coordinate care, or the time spent by a physician serving as the leader of a multi-physician care team, which can avoid ordering of duplicate tests and prescribing conflicting medications;
  - communications between community physicians and emergency physicians, and short-term treatment and discharge planning in emergency departments, which could enable patients to be safely discharged without admission;
  - providing proactive telephone outreach to high-risk patients to ensure they get preventive care, which could prevent serious health problems or identify them at earlier stages when they can be treated more successfully;

- spending time in a shared decision-making process with patients and family members when there are multiple treatment options, which has been shown to reduce the frequency of invasive procedures and the use of low-value treatments;
- hiring nurses and other staff to provide education and self-management support to patients and family members, which could help them manage their health problems more effectively and avoid hospitalizations for exacerbations of their condition;
- providing palliative care for patients in conjunction with treatment, which can improve quality of life for patients and reduce the use of expensive treatments; and
- providing non-health care services (such as transportation to help patients visit the physician's office) which could avoid the need for more expensive medical services (such as the patient being taken by ambulance to an emergency department).

- **Financial penalties for delivering a lower-cost mix of services.** Under fee for service (FFS) payment, physician practices and hospitals lose revenue if they perform fewer procedures or lower-cost procedures, but the costs of running the practices and the hospitals generally do not decrease by as much as revenues decrease. Under FFS, physician practices and hospitals do not get paid at all when their patients stay healthy and do not need health care services. If physician practices and hospitals do not receive sufficient revenues to cover their fixed costs, they will not be able to continue delivering care to the patients who need it.

Alternative Payment Models (APMs) Are Needed to Solve These Problems. Most of the so-called "value-based payment" programs used by CMS and commercial payers make small changes in current FFS payment rates based on measures of quality or total spending, but they do not remove the barriers in the payment system described above. The problem to be solved is not a lack of "incentives" for physicians or hospitals to deliver care in a different way, but the failure of the current payment system to provide the flexibility providers need to deliver care in a more efficient but financially sustainable way. A good Alternative Payment Model (APM) has two key elements:

- **Adequate, Flexible Resources to Deliver Effective Care to Patients.** The APM must give physicians and other providers the types and amounts of resources they need to deliver the services patients need in the most efficient and effective way possible. If the current payment system does not pay for the specific services physicians need to deliver in order to improve outcomes or reduce spending on other types of services, the APM must authorize payment for those services, broaden the definition of the services that can be provided using existing payments, or both. In many cases, physicians don't need *more* money, but they need to use the *current* money differently – for example, using payments to provide services to patients over the phone or by using a nurse rather than only through a face-to-face visit between the physician and patient. Payments must also be appropriately risk-adjusted based on characteristics of patients that increase their need for services. Paying physicians, hospitals, and other providers the same amount regardless of a patient's needs will mean that many higher-need patients won't get adequate services.
- **Accountability for Costs and Quality That Physicians Can Control.** In return for more flexible payments, physicians must assure patients and payers that spending will be controlled or reduced and that quality will be maintained or improved. However, individual physicians can only be expected to take accountability for the aspects of

spending and quality they can control or influence. For example, physicians can't control the price of drugs, but they can control which drugs are used; they can't control how much a hospital charges when a patient needs to be hospitalized, but they can reduce the rate of hospitalizations, and they can use lower-cost hospitals where they still exist. The goal of APMs should not be to simply shift financial risk from payers to physician practices, but rather to ask physicians to take accountability for the aspects of costs and quality they can control or influence.

In some cases, a small change in the current payment system, such as payment for a specific type of service in addition to existing FFS payments, may be all that is needed to support better outcomes and lower overall costs. In other cases, a more significant change may be needed, such as restructuring payments for many different services delivered by multiple providers.

(For more details on how to design alternative payment models and physician-focused payment models that actually remove the barriers to higher-value care, see *A Guide to Physician-Focused Payment Models* and *The Building Blocks of Successful Payment Reform*, which are available at www.CHQPR.org .)

Physicians That Have Participated in Well-Designed APMs Have Shown They Can Significantly Reduce Costs. For example:

- Stephen Zabinski, an orthopedic surgeon in New Jersey, was able to completely redesign the way services were delivered to patients receiving hip and knee surgery. He gave them "pre-hab" services to make them healthier for surgeries, which improved their recovery times, and he organized lower-cost post-surgery rehab services that enabled the patients to go home rather than going to a nursing facility for rehab. Instead of 33% of patients going home, now 80% go home after discharge, and the total cost of the procedure – not just the surgery, but the total cost with rehab – went down by 20%. This was only possible because Horizon Blue Cross Blue Shield was willing to pay him differently to enable him to deliver better care at lower cost.
- Barbara McAneny, an oncologist in New Mexico, has led a multi-site project that has reduced the frequency with which cancer patients have to go to the emergency room or be hospitalized to treat complications of their chemotherapy. She re-designed care so patients can call her office as soon as they start having a fever, nausea, or diarrhea, rather than them waiting until they're so sick they have to go to the ER. She brings them into the office and treats them immediately so they don't have to go to the ER or be hospitalized. She was able to reduce ED visits by 36%, hospital admissions by 43%, and reduce total spending on the patients by 22%. She had to use federal grant funds to support these changes in care; it wasn't possible under the standard way that Medicare and health plans pay for oncology services.
- Steve Calvin, a maternal/fetal medicine physician in Minneapolis, offers a "birth bundle" to parents so they know in advance the full cost of delivering a baby. The birth bundle provides the flexibility for the mother to deliver the baby in a birth center rather than a hospital, while enabling her to have immediate access to hospital care if there are complications of pregnancy. Together with nurse midwife colleagues, he opened a birth center across the street from Abbott Northwestern hospital. The midwives have hospital privileges and they can transfer and care for mothers at the hospital if they need a higher

level of care or physician involvement. The result is the ability to offer maternity and newborn care for significantly (15%) less than traditional hospital deliveries. In addition, the rate of C-Sections has been much lower than the national average (9% vs. 33%).

- Jennifer Wiler, an emergency physician in Denver, developed a program to create a "medical home" in the emergency room for low-income patients who were coming repeatedly to the emergency room because they had no primary care physician or other source of care. The program was implemented in 5 communities (Allentown PA, Aurora CO, Kansas City MO, Camden NJ, and San Diego CA). The result was a 41% reduction in emergency department visits and a 50% reduction in total cost (i.e., costs decreased by 50% even including the cost of the additional services). Federal grant funds had to be used to support the costs, because Medicaid does not pay for these services.
- Andrew Haig, a physiatrist (a physician specializing in rehabilitation) in Michigan, organized a program to help patients with back pain understand and access non-surgical treatment options, such as physical therapy. The result was a 29% reduction in spine surgery and a 12% reduction in total cost of treating back pain. This was only possible thanks to support by Priority Health, a local health plan in West Michigan.

Medicare and Most Health Plans Do Not Use Physician-Focused Alternative Payment Models to Pay Physicians. Although the Affordable Care Act created the Center for Medicare and Medicaid Innovation in 2010 in order to accelerate the development and implementation of innovative payment and delivery models, relatively little progress has been made in implementing the kinds of payment models that would enable every physician to do what Drs. Calvin, Haig, McAneny, Wiler, and Zabinski have done. As the American Medical Association has stated, "Years after CMS was authorized to implement 'new patient care models'…Medicare still does not enable the majority of physicians to pursue …opportunities to improve care in ways that could also reduce costs. Today, despite all of the demonstration projects and other initiatives that Medicare has implemented, most physicians – in primary care and other specialties – still do not have access to Medicare payment models that provide the resources and flexibility they need to improve care for their Medicare patients. Consequently, most Medicare patients still are not benefiting from regular access to a full range of care coordination services, coordinated treatment planning by primary care and specialist physicians, support for patient self-management of their chronic conditions, proactive outreach to ensure that high-risk patients get preventive care, or patient decision-support tools. As a result, the Medicare program is paying for hospitalizations and duplicative services that could have been avoided had physicians been able to deliver these high-value services."

The same is true of most Medicaid programs and commercial health plans. Premiums for health insurance policies will continue to increase if the insurance companies who offer them continue to pay for treating problems but not for preventing them.

Accountable Care Organizations Don't Solve the Problems with Current Payment Systems. Despite three years of effort, the CMS ACO program has increased Medicare spending rather than reducing it, and the losses increased in 2015. The reason the program isn't working is very simple – there is no change in the way the individual physicians or hospitals in an ACO are paid. They continue to receive the same payments in the same way they would if they were not in the ACO, but they get a bonus a year later if they have spent less than other physicians and hospitals

do. This program, and similar programs used by commercial health plans, provides no upfront resources to enable physician practices to improve the way they deliver care, and it encourages providers to deny or delay care to patients in order to get short-term financial bonuses.

Bundled Payment Initiatives Focus on the Wrong Thing. Although CMS and some commercial health plans have implemented bundled payment programs in addition to ACOs, almost all of them require the patient to be hospitalized in order to "trigger" the bundled payment. But the biggest savings opportunities come from helping patients *avoid* hospitalizations, not from reducing costs after the patient is *already in the hospital*. Neither CMS nor commercial health plans have implemented "condition-based payments" that enable physicians to better manage patients' health conditions so they can avoid unnecessary hospitalizations and surgeries.

Alternative Payment Models are Needed for Hospitals as Well as Physicians. The largest component of total healthcare spending is hospital care, and most of the opportunities to reduce spending without rationing are based on reducing avoidable hospitalizations, reducing unnecessary hospital procedures, and delivering procedures outside of hospitals. However, significant losses of revenues could jeopardize the ability of hospitals, particularly small hospitals in rural areas, to maintain essential services in their communities, such as the emergency room, the cardiac catheterization lab, trauma care, etc. Rather than simply paying hospitals higher prices for every service they offer, alternative payment models are needed that provide adequate funding to hospitals to cover the costs of these essential services without tying their payments and operating margins to the volume of services they deliver. Value-based healthcare payment and delivery initiatives will not succeed if they do not provide better ways of sustaining community hospitals.

Alternative Payment Models Are Needed for All Patients, Not Just "High-Cost" Patients. In any given year, a relatively small proportion of patients accounts for a large proportion of healthcare spending. This has led many payers to focus alternative payment models only on these "high cost" patients. However, the savings they claim to achieve is illusory, because regardless of what is done, the majority of those patients won't have high costs the following year, and a new set of high-cost patients will take their place. In many cases, spending on the patients is higher than other patients in a given year simply because they had a temporary health problem or need that year, e.g., the patient needed a hip replacement, developed cancer, or was delivering a baby. In other cases, spending was high because the patient wasn't treated effectively in the past, e.g., their cancer wasn't identified early, or their diabetes wasn't treated properly. Although high cost services like joint replacement and cancer care can be delivered at lower cost than today, the biggest opportunity to reduce spending occurs *before* the patient becomes sick enough to require expensive treatment. This requires paying physicians in ways that enable them to more effectively manage chronic conditions and deliver preventive care than current payment systems allow.

CMS and Private Health Plans Need to Move More Rapidly to Create True Alternative Payment Models for All Types of Physicians, Hospitals, and Patients. Although Congress created a mechanism for developing alternative payment models – the Center for Medicare and Medicaid Innovation (CMMI) – CMMI has used a far more complex and resource-intensive process to implement alternative payment models than is required or necessary. Under most of the payment demonstrations that it has implemented to date, 18 months or more have elapsed

from the time an initiative is first announced to the time when providers actually begin to receive different payments. This process is expensive for CMMI to administer, it dramatically reduces the number of alternative payment models that can be implemented, and it is also extremely burdensome for providers who are interested in participating in the initiatives that CMMI does attempt to implement. Many physicians and hospitals have decided not to apply to participate in otherwise desirable payment reforms, and others have dropped out of the programs in the early phases, because of the cost and time burden of participating and/or the problematic requirements that are imposed.

As slow as this process has been, CMS has made far more progress in implementing alternative payment models than the private sector. The "value-based payments" most commercial health plans are using are small pay-for-performance programs and shared savings models that have not and will not result in any significant changes in the cost or quality of healthcare services. Only a few commercial health plans, such as Horizon Blue Cross Blue Shield, Priority Health, and the Health Care Services Corporation, have implemented truly innovative payment models in areas such as gastroenterology, maternity care, oncology, and orthopedics.

This is clearly not what Congress intended either in the Affordable Care Act or in MACRA. A more aggressive timetable and a complete re-engineering of the processes CMS and commercial health plans use to implement alternative payment models is needed. This re-engineering process should start with the goal that is implicit in MACRA: every physician should have the opportunity to receive at least 25% of their Medicare revenues from physician-focused alternative payment models (not ACOs) in 2019, 50% of their total revenues from APMs in 2021, and 75% in 2023. CMS and commercial health plans should work collaboratively with physician groups and hospitals to design and rapidly implement the full range of true alternative payment models needed to reach those goals. Only then will the country achieve the kinds of savings needed to make health insurance not just available, but truly *affordable*.

[1] http://www.nationalacademies.org/hmd/Reports/2011/The-Healthcare-Imperative-Lowering-Costs-and-Improving-Outcomes.aspx