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Pathways for Physician Success Under Healthcare Payment and Delivery Reforms

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Miller organized the Network for Regional Healthcare Improvement's national Summits on Healthcare Payment Reform in 2007 and 2008. His report *Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform* which was prepared for the 2007 Summit was published by the Commonwealth Fund in September, 2007, and his summary of the recommendations from the 2008 Payment Reform Summit, *From Volume to Value: Transforming Healthcare Payment and Delivery Systems to Improve Quality and Reduce Costs*, was published in November 2008 by NRHI and the Robert Wood Johnson Foundation. His paper "From Volume to Value: Better Ways to Pay for Healthcare" appeared in the September 2009 issue of *Health Affairs*. He also authored the Center for Healthcare Quality and Payment Reform's report *How to Create Accountable Care Organizations* and the CHQPR publication series *Paths to Payment Reform*.

Miller has also worked with physician practices and hospitals to improve the quality and reduce the cost of care for patients. He designed and is currently leading a multi-year initiative with the Pittsburgh Regional Health Initiative (PRHI) that has successfully reduced preventable hospital admissions and readmissions through improved care for chronic disease patients. His work with PRHI demonstrating the significant financial penalties that hospitals can face if they reduce hospital-acquired infections was featured in *Modern Healthcare* magazine in December, 2007.

In 2007 and early 2008, he served as the Facilitator for the Minnesota Health Care Transformation Task Force, which prepared the recommendations that led to passage of Minnesota's path-breaking healthcare reform legislation in May, 2008. He is currently working with Regional Health Improvement Collaboratives in a number of states to design and implement payment and delivery system reforms.

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EXECUTIVE SUMMARY

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.

I. INTRODUCTION

A. The Problems with Current Payment Systems

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. Under most current healthcare payment systems:

- Physicians are paid primarily based on how many and which services they deliver, not on the effectiveness of those services in improving a patient's health, i.e., they are paid for *volume*, not *value*.¹ Physicians who deliver high-quality services are generally paid the same as those who do not.
- Many valuable preventive care and care coordination services are not paid for adequately or at all (e.g., primary care practices are typically paid only when a physician sees a patient in person, not when the physician speaks to the patient on the phone). Similarly, specialists are only paid for seeing patients in person, not for advising primary care physicians on care management or for time spent coordinating services with the primary care physician. A physician who hires a nurse to assist with patient education typically cannot be reimbursed for the time the nurse spends with the patient.² All of these things can limit the ability of physicians to flexibly design services to best meet a patient's needs, resulting in unnecessary illnesses and treatments.
- Payments for some services may be below the reasonably achievable cost of delivering the services, leading to shortages of those services (e.g., one factor contributing to the shortage of primary care physicians is low payment levels for primary care services) or requiring the delivery of higher-margin services to cross-subsidize underpaid services. In other cases, payments for service may be far above reasonably achievable costs, leading to higher-than necessary expenditures and incentives to deliver more of these services than needed.
- Physicians and hospitals can be financially penalized for providing better quality services. For example, reducing errors and complications during hospital stays can not only reduce both physicians' and hospitals' revenues, but also reduce hospital profits and their ability to remain financially viable.³ Moreover, under most payment systems, physicians make less money if their patients stay healthy and need fewer services.
- Each physician involved in a patient's care gets paid separately; this can result in duplication of services (e.g., a patient may receive two x-rays from two different physicians rather than having the results of the same x-ray used by both),⁴ lack of coordination of services (e.g., two different physicians may prescribe different medications for a patient's condition without knowing what the other has done, or without checking to ensure both medications can be taken together safely), or shifting of costs (e.g., a primary care practice may not have time to adequately educate patients on how to manage their chronic disease, resulting in preventable hospitalizations, or it may refer patients to multiple specialists for assessment instead of taking more time to narrow the potential diagnoses).

B. The Opportunity and Challenge of Payment Reform

Concerns about problems caused by current payment systems has led to growing interest in ways to reform payment systems. There are several goals which proposals to change payment systems generally seek to achieve:

- Giving a physician greater *accountability* for the *quality* of services used to treat a patient's conditions.
- Giving a physician greater *accountability* for the *cost* of services used to treat a patient's conditions.
- Giving a physician greater *flexibility* to provide the right services to patients in the right way at the right time.
- Paying a physician *adequately* (but not excessively) for delivering necessary, high-value services, including services that are not currently reimbursed, and enabling physicians to remain profitable if their patients stay healthy and avoid unnecessary services.
- Paying physicians *more to care for sicker patients* who need more services, unless the patient's condition was actually caused by the physician (e.g., through an error or poor-quality treatment), and enabling a physician to remain profitable if he or she cares for patients who have more health problems or more serious problems.
- Enabling and encouraging multiple physicians to *coordinate* their care for an individual patient.

A number of different payment reform models have been proposed, such as shared savings, episode-of-care payment, bundled payment, global payment, etc. Each of these models has advantages and disadvantages, and each will have different impacts on physicians and other healthcare providers.

Moreover, while payment reforms may be necessary to improve healthcare quality and reduce costs, they are not sufficient to achieve those goals; the goals are actually achieved by physicians and other healthcare providers transforming the way they deliver care. Different organizational structures will be helpful, if not essential, to enable physicians and other providers utilize new payment structures in ways that result in higher-quality and more cost-effective delivery of care.

Payment and delivery system reforms can present both opportunities and challenges for physicians, particularly the majority of physicians who practice independently of hospitals and large integrated systems. For example, episode and global payments can provide much greater flexibility for physicians to determine how to structure patient care, since they would no longer be constrained by payer-determined limits on which services are reimbursable, and they also provide the opportunity for physicians to increase their earnings by reducing inefficiencies in care, overuse of ancillary services, etc. On the other hand, unless they are properly structured, these payment systems can put physician practices at greater financial risk of caring for high-cost patients without adequate reimbursement, and they can also put small physician

practices at risk of receiving unfairly low allocations of payment relative to hospitals and other large providers.

In order to help physicians take advantage of the opportunities presented by payment reforms and overcome the challenges they can pose, this report will analyze several interrelated issues:

- How different payment models affect the ability of physicians to provide high-quality, cost-effective care to their patients, and how payment models can be adjusted to maximize the benefits for patients and physicians and reduce negative impacts;
- What capabilities physicians will need to successfully manage under different payment models, what organizational structures will best enable them to do so, and how transitional payment models can support successful transitions in care delivery;
- What impact the structure of local healthcare markets will have on the way payment systems and organizational structures affect physicians;
- How the compensation of individual physicians will be structured when payment changes are made; and
- What legal barriers could impede the changes in healthcare delivery needed to implement payment reforms most effectively.

II. The Building Blocks of Payment Reform

Several specific payment reform proposals, such as “shared savings,” “acute care episode bundling,” etc. have been extensively discussed in national policy debates, particularly in conjunction with reforms to the Medicare program. Many people have formed opinions about the overall desirability and feasibility of payment reform based on the details of these specific proposals. However, it is important to recognize that these proposals are just a small subset of a much broader array of choices that exist for reforming payment systems. In many cases, what appears to be a disadvantage of a particular proposal could be corrected through modifications to the details of that proposal. Conversely, what might appear to be an advantage of a particular proposal could be significantly compromised depending on how specific aspects of the proposal are actually defined in the implementation process.

Consequently, in order to determine whether to support payment reform and what kind of payment reform to support, it is critically important to understand all of the fundamental building blocks of payment systems and the ways that they can be adjusted and combined to create a new and more desirable approach to payment. Ideally, payment reforms will correct the problems of current payment systems rather than merely replacing those problems with new and potentially worse problems. This section will describe these building blocks; Section III will then describe in more detail how they have been combined to date into actual payment systems that have been implemented or are being tested, Section IV will describe the impact that individual elements can have on physicians, and Section V will describe the capabilities physicians will need to succeed depending on how these elements are structured.

(NOTE: Some readers may prefer to skim over this Section initially and come back to it later as a reference for understanding the discussion in Sections III, IV, and V.)

A. Five Fundamental Ways Payment Systems Can Be Improved

In order to address the concerns about current payment systems, new payment systems can be changed from current payment systems in five basic ways:

1. They can pay for certain services (or ways of delivering services) that are not currently paid for today, or pay more for services than the amounts paid today;
2. They can make the payment amount for a service dependent on the quality of the service delivered;
3. They can 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 at all);
4. They can make a physician’s payment dependent on the number of services or the cost of services delivered by other providers; and/or

5. They can 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.

1. Paying More for Certain Services

The first type of payment change is intended to remove barriers that prevent physicians from delivering specific types of services that could improve patients' health and reduce the need for other, more expensive care. The principal approaches include:

Payments for Currently Unreimbursed Services

Some important services that have the potential to help patients stay healthy and avoid the need for more expensive services are not paid for at all by Medicare and most health insurance plans. For example, physicians are typically paid only for face-to-face visits with patients, not for phone calls or emails with patients, and health plans do not typically reimburse for patient education and assistance delivered by nurses or other non-physician care managers. Specialists are only paid to see patients in person, not to consult with primary care physicians about how to manage a patient's overall care in an effective way. Consequently, one type of payment reform is to pay for these types of services.⁵

Higher Payments for Currently Reimbursed Services

In some cases, a service may currently be paid for, but at an amount too low to support delivery of the service in a profitable and high-quality fashion. For example, payments to physicians for office visits could be increased to allow for additional time to do diagnosis (particularly where a patient has multiple conditions), to ensure that all preventive measures have been taken, or to consult and coordinate with other physicians involved in the patient's care. Adequacy and accuracy of payment levels is important to ensure that patients can access high-quality care.

2. Paying Based on the Quality or Outcomes of Services

The second type of payment change is designed to reward physicians who do a more effective job of delivering high quality services to their patients. There are five basic approaches here:

Pay-for-Performance

The approach most commonly used in recent years to vary physician payment based on quality is "pay for performance (P4P)," i.e., paying a physician more or less based on measures of the quality or outcomes of care he or she delivers.⁶

Key issues in structuring P4P systems include:

- Which measures will be used to assess the quality of services and determine the P4P amount the physician practice will receive.

- How large the P4P payments will be. The larger the payment, the greater the financial incentive to improve performance (or maintain good performance).
- Whether the P4P payments will increase net payments to physicians over and above what they are receiving today (i.e., the P4P payments will represent a bonus), or whether payment levels for services will be reduced to offset the money allocated to P4P (i.e., physicians who fail to meet the P4P quality standards will receive less than in the past).
- What threshold of performance a provider must meet in order to receive a bonus (or what threshold of performance must be met to avoid a penalty). Alternative approaches include absolute standards of performance (e.g., 90% compliance with a process measure), relative standards of performance (e.g., a compliance rate at the 90th percentile relative to peers), and minimum levels of *improvement* in performance (e.g., 20% better performance than the prior year).

A weakness with P4P systems is that they can only reward what can be measured, and therefore they can implicitly create an incentive for providers to focus only on areas that are measured and let performance slip in other areas.

Non-Payment for Services Related to Complications, Infections, Etc.

Under most current payment systems, physicians are paid extra to deal with errors or complications they themselves cause. For example, if a patient hospitalized for a medical condition develops an infection which leads to a longer stay in the hospital, the physician managing the case will likely be paid more than if the infection had not occurred.

One approach to solving this is to reduce or prohibit additional payment for services associated with treating preventable errors or infections.⁷ However, this approach only denies payment for treatment of the error or infection itself, not for any additional complications which may be caused by the error or infection and result in far greater costs. Moreover, there is debate about which infections, complications, etc. are fully preventable. (An alternative approach is to reduce payment if the physician has an unusually high *rate* of such adverse events, but not to deny payment for treating the problems for any individual *patient*; this is, in effect, a pay-for-performance system.)

Limited Warranties

Rather than having a payer determine whether or not to pay for a service related to errors or complications, physicians can offer a “limited warranty” as part of their care, i.e., they commit that they will not charge more for addressing certain complications or readmissions that are related to the patient’s initial care.⁸ The advantage of this approach is that it enables providers to compete on the breadth of their warranties, rather than forcing payers to define a uniform set of circumstances when payment will not be made. A disadvantage is that differences in the definitions of warranties make comparisons among providers more difficult (although this is no different than for products and services in other industries). A warranty can also be viewed as combining multiple services into a single payment, i.e., the combining the treatment of the initial condition

and the treatment of any conditions caused by adverse events; more general examples of combining payments for multiple services are described in Section II-A-3 below.

Non-Payment for Poor Quality Care

Rather than merely providing pay-for-performance bonuses (or penalties) based on the proportion of patients for which a physician's services met quality standards, an alternative is simply to deny payment for any service that failed to meet minimum quality standards (e.g., there would be no payment at all for an office visit with a diabetic patient unless essential preventive screenings were completed).

Tiering

An alternative to paying physicians differently based on the quality of their services is to give patients incentives to use physician practices that deliver better quality care. This is generally accomplished by assigning a physician or physician group to one of two or more performance "tiers" and requiring lower cost-sharing for patients who use physicians in higher-performance tiers, or even refusing to pay for care from physicians in the lowest-performance tiers.⁹ (This approach can be very controversial, because it requires assigning a physician to a specific tier even though the measure used is imprecise and subject to error, particularly for small physician practices; see Section II-B for additional discussion of issues associated with quality measurement.)

3. Combining Separate Services into a Single Payment

Each of the changes in the previous two categories can be made while preserving the basic concept of making a separate payment for each separate service. A third category of payment change creates a single payment for all services that a patient needs from one or more physicians or other providers during a particular episode of care or period of time, in place of separate fees for each of those services.

It is important to distinguish this from simply paying jointly for two or more specific pre-identified services rather than paying for them separately. The concept described in this section is to create a single payment to cover *all* services that are needed *during an episode of care or during a specific period of time, regardless of how many* (or few) services are needed by the patient. This introduces an element of uncertainty about the relationship between the amount of payment and the number of services that does not exist under a pure fee-for-service model, where the physician knows in advance that he or she will get paid more for each additional service offered.

There are two basic rationales for doing this:

- From a payer's perspective, it reduces the ability of an individual physician or other provider to deliver unnecessary services, since the payment remains the same regardless of how many individual services are delivered during the episode of care or period of time for which the combined payment is being made.

- From both a payer's and a patient's perspective, it is easier to understand and predict the total cost of services and patient cost-sharing for the episode or period of time.

There are also potential advantages from a physician's perspective. A combined payment gives the physician more flexibility to customize services to what a patient needs without regard to the impact of delivering more or fewer services on the physician's revenue and the patient's cost-sharing; it may reduce or eliminate the need to bill for each individual service provided; and it can provide greater predictability of revenues for the physician (since payment will not vary based on the exact number of services a patient happens to need). For this reason, when a physician is seeking payment for several related services that are not currently reimbursed, a single combined payment designed to cover all of those services may be preferable to receiving separate payments for each individual service.

A disadvantage of this approach from the physician's perspective is that he or she is no longer paid more for a patient who needs an above-average number of services. Although this would be offset by the fact that the physician would no longer be paid less for a patient who needs a below-average number of services, the net impact would depend on whether the physician has an unusually high number of patients who need many services. This can be addressed through condition/severity adjustment systems and outlier payments, as discussed in Section II-B.

The principal approaches in this group of reforms include:

Care Management Payments

An alternative to creating more individual CPT codes or increasing payment amounts for existing codes as described in Section II-A-1 is to pay a physician a monthly "Care Management Payment," in addition to the existing payments he or she is receiving for individual services, to cover all of these additional services for his or her patients. Although such Care Management Payments are typically paid on a per-patient basis (e.g., a fixed amount "per member per month"), it is generally not intended that *each* patient should receive an amount of services equivalent to the per-patient payment amount, or even that *every* patient would receive *some* additional services, but rather that the physician would use the aggregate amount of payment received for *all* of the patients in his or her practice (or whatever subset of them the payment is based on) in order to add new services (e.g., to hire a nurse care manager) and target those new services to the subset of patients in the practice who need them the most. (Ideally, the amount of the Care Management Payment would be based not only on the number of patients the practice has, but also on how sick the patients are; this issue is addressed in Section II-B.)

A weakness of this approach compared to creating new payments for individual services is that since there is no explicit connection between the Care Management Payment and any specific service, a physician practice could conceivably accept the Care Management Payment and do nothing different at all for *any* of its patients.

Case Rates/ Episode-of-Care Payments

Today, most physicians are paid separately for each separate service they provide. However, physicians performing surgical procedures are paid differently – they receive a single “case rate” for each procedure; this case rate is intended to cover the procedure itself and follow-up hospital and office visits during a specific period of time. A similar approach is used for maternity care and end stage renal disease. The same concept can be extended to other physicians, but doing so requires defining the nature of the “case” or “episode” for which payments are being combined.¹⁰ For example, if a patient with chronic obstructive pulmonary disease is admitted to the hospital for treatment of an exacerbation, rather than paying the family physician, internist, hospitalist, or pulmonologist who manages the patient’s care separately for each time the patient is seen in the hospital, one could define a single case rate that physician would receive for the patient’s entire stay and immediate post-discharge follow-up care.

Practice Capitation

An extension of this concept is to pay a physician practice a single amount to manage a patient’s care over a fixed period of time, e.g., a year, replacing most or all individual payments for services. The traditional name for this used by health insurance plans is “practice capitation” or “contact capitation” to reflect the fact that the practice receives a single per-patient (“per capita”) payment to cover all of the services the practice provides to the patient (services delivered outside of the practice would still be paid separately). A growing number of primary care practices, particularly those describing themselves as “concierge” practices, have instituted a similar approach in the form of prepaid annual fees for self-pay consumers. Other versions of this approach use some form of severity/condition-adjustment to modify the payment based on how sick or well the patients are.¹¹ This type of payment gives the practice complete flexibility about what services to offer and how to target services to the patients who need them the most. However, this approach can also diminish the practice’s incentive to deliver services at all, since the practice is paid regardless of how many services it provides to the patients, as long as the patients remain associated with that practice. (This can be addressed through quality and cost incentives, as described in the previous section and the next section.)

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

All of the changes in the previous three categories continue to tie payment to the services delivered by the individual physician who is being paid (or to services which are delivered by other employees in his or her practice). A final category of payment change makes a physician’s payment depend on how many related services a patient receives from *other* physicians or *other* healthcare providers, such as hospitals and laboratories. Two principal rationales for doing this are:

- Creating an incentive for the physician to reduce referrals to the other physicians or healthcare providers when they can be avoided, to make referrals to lower-

cost/higher-value providers, and to provide appropriate preventive care to reduce the need for such referrals.

- Creating an incentive for all of the providers to coordinate their services for an individual patient, particularly where efficiencies in care delivery or avoidance of errors and complications can be achieved through coordinated action.

There are a number of different approaches to doing this:

Resource Use-Based Pay-for-Performance

Although typical pay for performance (P4P) systems started with an exclusive focus on the quality of care delivered, an increasing number of P4P systems are basing performance bonuses or penalties for physicians at least partially on measures of “efficiency” or resource use that are based on the number and/or cost of services delivered by other providers. The basis for rewards or penalties can be calculated in the same ways as described in Section II-A-2, i.e., there could be an absolute standard of performance (i.e., the utilization rate or cost per patient must be below a predetermined level), a relative standard of performance (i.e., the utilization/cost must be lower than other physicians), or a standard of improvement (i.e., the utilization/cost must be lower than the level for that physician in the past).

Shared Savings/Gain-Sharing

“Shared Savings” programs are a form of P4P based on resource use. Under a shared savings model, if the actual total cost of all care received by the patients associated with a physician or physician practice is lower than what would have been expected based on projected utilization rates and trends, the physician or practice receives a portion of the difference between the actual and expected costs (i.e., a “share of the savings”). This is intended to give the physician practice an incentive to focus on ways to reduce unnecessary and preventable hospitalizations, invasive procedures, diagnostic testing, etc. that involve large costs.¹²

A key difference between shared savings programs and most P4P-style programs, however, is that the benchmark against which performance is measured is a prediction of the future, i.e., “savings” are said to be created not if costs are lower this year than *last* year, but if costs this year are lower than they were *expected* to be *this* year. This means that the potential reward depends not only on how well the physician (and any other providers delivering care included in the cost calculations) performs, but how well someone determines the physician would have been *expected* to perform. The better the performance that is expected, regardless of how realistic the expectation is, the lower the potential reward for achieving high performance.

“Gain-Sharing” programs are similar, but they are typically focused on a narrower scope of services or costs, and are typically defined based on actual past costs, rather than predicted future costs.¹³ For example, if a surgeon works with the hospital to reduce length of stay or the use of expensive drugs or devices that the hospital pays for, the hospital would share a portion of its cost savings with the surgeon, so that both the

hospital and the surgeon benefit from the greater efficiency. (The hospital and physician could also potentially share a portion of the savings with the payer in exchange for having the payer direct a larger number of patients to the hospital and physician.)

The terms “shared savings” and “gain-sharing” imply that there are only upside rewards and no downside penalties. However, it is also possible to require physicians to pay a portion of any *increase* in costs above expected levels. (See the discussion of risk corridors in Section II-B-2 for more details on sharing both downside and upside risk.)

Bundling Multiple Providers into a Single Episode Payment

Pay-for-performance and shared savings programs can provide incentives to reduce over-utilization and use of higher-cost services, but if they are simply added on top of the current payment structure, they don’t eliminate the existing incentives in the fee-for-service payment system to deliver more services.¹⁴ Moreover, paying providers (such as hospitals and physicians) separately for each service they provide during an episode of care makes it hard for consumers and payers to determine the true cost of care, and it provides little incentive for those providers to work together to find the most efficient and effective way to deliver services.

Consequently, there has been considerable interest among policy-makers in creating single, “bundled” payments to cover the services delivered by two or more providers during a single episode of care. Most “bundling” proposals have focused on combining the services provided by both hospitals and doctors during a patient’s inpatient stay into a single payment. For example, if a patient has cardiac bypass surgery, rather than having one payment to the hospital, a second payment to the surgeon, a third payment to the anesthesiologist, and potentially additional payments to other consulting physicians, Medicare, Medicaid, or a health insurance plan would make a single “bundled” payment for all of these services, and it would be up to the hospital, surgeon, anesthesiologist, etc. to determine how to divide that payment among themselves. Under bundled payment, the surgeon has an incentive to help the hospital lower its costs, because the surgeon has the ability to share in the savings, which he or she does not today.

“Bundles” can be defined more broadly than just combining hospital and physician payments for inpatient stays. There is growing interest in also combining post-acute care services (e.g., home health care, rehabilitation services, etc.) with inpatient care, in order to discourage overuse of such services. However, since not all patients need post-acute care, it is more challenging to define a single price than with inpatient bundles, where every patient receives services from both the hospital and a principal physician.

Comprehensive Care Payment/Global Payment/Capitation

Rather than limiting bundling to individual episodes of care (e.g., making a separate bundled payment every time a patient goes to the hospital), a provider or group of providers could be paid a single amount to cover *all* of the services a patient needs

during a specific period of time (e.g., a year), regardless of how many episodes of care the patient has during that period of time or which providers deliver services during a particular episode. This “comprehensive bundle” gives the providers a financial incentive to reduce unnecessary use of services and to use lower-cost services instead of higher-cost services (similar to the incentives in a resource use-based P4P or shared savings program), but it also provides the flexibility to use the payments to deliver whatever combination of services will best help the patients, including services which may not be covered by separate payments today.

If all services are included in the comprehensive bundle, it is generally referred to as “global payment,” “comprehensive care payment,” “global capitation,” or “condition-adjusted capitation.”¹⁵ However, because hospital costs can be so large and unpredictable, this approach can cause significant cash flow problems and financial risk for small providers, even if the payment is managed as a budget and is adjusted based on how many conditions the patient has. Consequently, a common approach is to bundle payments for all physician services, laboratory and diagnostic services charges, and other outpatient services, but to pay for hospital services separately. This is generally referred to as “partial global payment” or “professional services capitation.”

Virtual Bundling

When services of multiple providers are bundled into a single payment, the question arises as to which provider will actually receive the combined payment. Many physicians will be reluctant to have their payments controlled by other physicians or by a hospital (and hospitals will likely be reluctant to have their payments controlled by physicians), because of concerns that the entity receiving the joint payment will fail to transmit the other providers’ share or that the recipient entity will not allocate the other providers’ shares in a way they view as fair.

One solution to the problem of “who gets the check” when combining payments for services delivered by multiple providers is called “virtual bundling.” In a virtual bundling system, the payer (e.g., a health plan) continues to pay each of the physicians, hospitals, and other providers independently for specific services they deliver to a patient or group of patients, but the payer adjusts each provider’s payment according to a pre-defined rule in order to ensure that the total payments to all of the providers for all of the defined services do not exceed the total bundled payment amount. In a virtual bundling system, the payment amount is, in effect, a budget, rather than an actual cash payment made to any one provider, and no provider ever receives the money owed to another provider.

The downside of the virtual bundling approach is that it requires pre-defined rules as to the way that payments will be allocated among the involved providers, which reduces the ability of the providers involved to dynamically change the allocation rules as new ways to deliver care and new opportunities for efficiencies are identified. Moreover, if there is not true coordination among the providers, virtual bundling could result in some participating providers attempting to “game” the system by boosting the number of

services they provide in order to capture a greater share of the fixed revenue in the bundled payment budget.

Resource Use-Based Tiering

Finally, as with efforts to encourage greater quality of care, an alternative approach to creating greater accountability for total costs of healthcare is not to change payment directly, but to place physicians and other providers into tiers based on relative use of resources by their patients, and then give incentives to patients to use those physicians and providers who are ranked as lower cost or higher-value (i.e., higher quality as well as lower cost). Under this approach, each physician would receive the same payment as they do today for each service they deliver, but some physicians would receive more *total* revenues as a result of caring for a larger number of patients, while others would receive less.

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

A final type of payment change is paying a physician practice or other health provider specifically to support the use of specific types of equipment, staff, programs, facilities, organizational structures, etc. which may be needed to support higher-quality, lower-cost care, to encourage practices to locate in certain geographic areas, or to serve specific kinds of patients. Although these payments may help to improve the quality of care delivered to patients, the payments are based on whether a particular structure or system is used, not whether actual improvements in care result. Typical uses of these kinds of payment changes include:

- Paying physicians more if they are located in geographic areas where there are shortages of physicians.
- Paying physicians more or differently if they are located in inner-city or high-poverty areas.
- Paying physicians more if they use health information technology, such as electronic health records.
- Paying physician practices more if they meet accreditation standards based on the use of desirable systems and structures.

Although it has not been widely done to date, special payments could also be made to enable physician practices to help them reorganize in ways that will foster greater care coordination and improved services to patients.

B. Six Other Essential Elements of Payment Systems

Each of the five categories in the previous section 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 other elements modify the payment methods in important ways that determine how successful a physician or other provider can be in delivering high-value care under the payment system.

1. Condition/Severity-Adjustment

Despite the criticisms of fee-for-service payment, one key strength it has that is important to preserve is the fact that physicians are paid more to deliver additional services needed by sicker, more complex patients. In moving to new payment models, the challenge is to preserve that strength while reducing or eliminating the incentive for physicians to provide more services than are necessary or appropriate.

Physicians generally cannot control whether a patient will have serious or major health conditions such as cancer, head trauma, pregnancy, etc., at least in the near term. The fact that some patients need more services, and therefore incur higher healthcare costs, because they have more health conditions or more severe conditions is known as “insurance risk.” Conversely, once a patient has a particular set of health conditions, physicians generally control how many and what types of services the patient will receive to treat those conditions, and therefore physicians (not payers) have the most direct influence on the quality and cost of care for any given combination of conditions. Consequently, a good payment system will keep as much insurance risk (the risk of whether a patient has an illness or other condition requiring care) as possible with the payer (Medicare, Medicaid, or an insurance company), and transfer as much “performance risk” (the risk of whether a condition can be treated successfully for a specific amount of money) as possible to physicians and other providers.¹⁶

The principal method for separating insurance risk and performance risk (or what may be more easily understood as necessary vs. unwarranted variation in services) is the use of a condition-adjustment or severity-adjustment system.¹⁷ If one patient has more health conditions or more severe conditions than another, the amount the physician is paid for delivering any particular combination or bundle of services to the first patient is “condition-adjusted” to be higher than the amount paid for the same combination or bundle of services to the healthier patient. Similarly, if the payment system includes a pay-for-performance, shared savings, or tiering component, then it is important that a physician’s bonus/penalty or tier assignment be determined using measures of quality and cost that have been adjusted based on the types and severity of conditions that the physician’s patients have. In addition, adjustments may be needed for factors other than health conditions; for example, patients with language barriers, low income, or other socio-economic challenges can require more intensive and expensive assistance in managing their health conditions.

Condition/severity-adjustment systems can evolve over time as a better understanding is developed of the factors affecting the need for services. For example, beginning in October, 2007, the federal Medicare program changed the condition/severity-adjustment system used in its hospital DRG payment system to ensure that hospital payments more appropriately reflected differences in patients’ needs for

services.¹⁸ Similarly, Medicare added a condition/severity adjustment system to the way it paid Medicare Advantage plans in 2000, and then introduced a new and improved system beginning in 2004.

2. Outlier Adjustments/Risk Corridors

There is no hard line distinguishing where insurance risk ends and performance risk begins. Consequently, no condition/severity-adjustment system will be perfect and there will be circumstances in which a physician could be underpaid or overpaid for the actual services he or she delivers even with use of such a system.¹⁹ To mitigate this, payment systems can incorporate provisions designed to protect physicians or other providers (and also payers) against such situations.

Outlier Adjustments

One commonly used approach is to make an additional payment or some other form of payment adjustment (e.g., an adjustment to the calculation of a P4P bonus) to a physician for a patient who has rare or unexpected problems that require an unusually large number of services or unusually expensive services, or who poses unusual challenges to the physician's ability to meet quality performance standards. Since these patients are "outliers" in the typical distribution of services and costs, the adjustment is known as an "outlier payment" or (in the case of P4P or shared savings calculations) "outlier adjustment." Typically, an outlier payment is made when the total costs of services exceed some threshold or multiple of the payment level. Outlier adjustments typically involve excluding the unusual patient from calculations of total cost or quality performance when determining P4P or shared savings awards.

Risk Corridors

A more elaborate approach is to measure the extent to which actual costs exceed payment levels for a *group* of patients. Instead of making an outlier payment for an individual patient if the cost of services for that one patient exceeds a certain threshold, a payer could make the additional payment only if the average costs of all similar cases exceed a predetermined threshold. For example, if the average cost of treating all patients who have pneumonia exceeded 110% of the payment amount for treatment of pneumonia patients, the physician might be paid for the costs that exceed 110% of the total payment for all of the patients treated. This is known as a "risk corridor:" when costs are between 100% and 110% of the payment amount (i.e., they are in "risk corridor #1"), the physician takes full responsibility (i.e., accepts full risk) for paying those costs even if the cost is greater than the payment amount, but when actual costs are above 110% of the payment amount (i.e., in risk corridor #2), the payer accepts that portion of the risk and pays an additional amount to cover the portion of the costs that exceed 110% of the base payment. The advantage for a payer of basing risk-sharing on groups of patients is that it avoids having to pay more for one unusually expensive case if the physician has managed to keep its costs for other patients well below the payment level and could offset the extra costs himself or herself.

Risk corridors can be defined in the other direction as well, i.e., if it turns out that a physician can treat a group of patients at significantly *lower* cost than the payment amount, the payer may want to share in those savings. So, for example, if costs are between 90% and 100% of the payment amount (i.e., in risk corridor #3), the physician might keep the full savings (i.e., bear the full “risk” of achieving savings), but if the costs are below 90% of the payment amount (in risk corridor #4), the payer could receive a rebate of a portion of the difference between the actual costs and 90% of the payment.

3. Price-Setting

The previous sections discuss how to adjust payment amounts to reflect differences in patient conditions and to deal with patients with unusual needs. However, this begs a more fundamental question: what is the right payment amount for any patient or group of patients? Indeed, many of the problems with healthcare payment systems are not caused by the payment *method*, but by inappropriate payment amounts. Whether one is using a fee-for-service system, bundled episode payments, or global payments, if the payment amount is set too low, physicians and other providers may be unable to deliver quality care, and if the amount is set too high, there will be no pressure to improve efficiency and there could be a financial incentive to over-provide that service.²⁰

Even if the current payment levels for current services were appropriate (and the many complaints about Medicare, Medicaid, and commercial payment rates not covering physicians’ costs suggest that few would agree with this), one cannot directly determine the appropriate levels for the many types of new payment from the current payment levels. For example, if a single payment is to be provided to cover two types of services for a group of patients where some patients may need one or the other service but not both, one cannot simply add the two current payment amounts together to determine the appropriate payment amount for all patients who receive either service, because then the payer is overpaying for those patients who only need one of the services.

A logical approach is to base the payment level for the combined set of services on some weighted average of the payments made for the individual services, with the weights being the rates at which patients with the defined condition(s) would be expected to receive each service in the future. However, since different providers use different mixes of services to care for their patients, should the weighting for the combined payment level be based (a) on *each* provider’s own historical mix of services, or (b) on the average historical rates of *all* providers, or (c) the combination of services that is viewed to be “best” in some way? In the first case, each provider would be paid an amount that is equivalent to what they are being paid now for the services they are delivering, but different providers would be paid different amounts for what ostensibly should be the same package of services. In the second case, about half of the providers would now be paid less than they had previously (namely those who had above average total spending per case), while the other half would receive an increase. And in the third case, some providers would also receive more and some might receive less; depending on how the “best” combination of services compares to current practice, it is possible that a majority of the providers would receive very different revenues than in the past.²¹ In the

case of a brand-new service or collection of services, a price would have to be defined from scratch based on the estimated cost of evidence-based services and other factors.

The way the decision is made about the actual payment level and who makes that decision will depend on the overall mechanism used for price-setting for specific payers in a particular healthcare market. There are four different approaches to price-setting used in healthcare today:²²

- **Regulation**, i.e., the government defines the price that a provider can charge or be paid. For example, the Maryland Health Services Cost Review Commission sets all-payer prices for hospital services in Maryland.
- **Price-Setting by Large Payers**, i.e., large payers define the amounts they will pay specific types of providers in a particular market. For example, Congress and CMS establish detailed rules defining the rates that Medicare will pay providers.
- **Negotiation**, i.e., individual payers negotiate with individual providers to determine prices. This is the most common way of setting the prices paid to providers by commercial health insurance plans in most markets, and the outcome depends on the relative bargaining power of the payers and providers.
- **Competition by Providers**, i.e., providers set prices themselves and consumers choose providers based on price as well as quality. The ability to do this depends on what proportion of the costs of care consumers are responsible for paying under the benefit design in their health plan.

At one extreme, where prices are set by regulation or by a payer that has little or no competition (such as Medicare), it is likely that the same price will be used for all providers, or that differences will be based on objective factors for differences in costs that are unrelated to practice variations (for example, Medicare pays physicians more for a specific service only if they are located in higher cost-of-living regions, health care professional shortage areas, etc.) Where prices are negotiated, it is common for different prices to be paid to different providers for the same services based on the relative market power of the providers as well as objective reasons for differences in cost. In cases where patients are made sensitive to price differences, providers can set different prices themselves and let patients determine whether there is sufficient difference in quality to justify the difference in price.

4. Quality and Resource Use Measures and Performance Targets

In order to use pay-for-performance, tiering, and other systems that make payments dependent on the quality of services that physicians deliver, there must be reliable and cost-effective ways of measuring quality. Similarly, if payments to physicians are to be affected by the overall cost of care which patients receive, reliable measures of the cost of care are needed. Moreover, payment systems which bundle payments for multiple services or which make physicians responsible for the total cost of all services delivered also need to have good ways of measuring quality, in order to reassure consumers that cost control is not being achieved at the expense of service quality.

The *quality* of physician care can be measured in three ways: (1) whether appropriate processes were used (e.g., were the right medications given in a timely fashion), (2) whether good outcomes were achieved (e.g., did the patient die, get an infection, etc.), and (3) whether patients were satisfied with the care they received. Measurement of outcomes is more challenging than measuring processes, since many outcomes occur well after the actual care is delivered (e.g., poor quality care for diabetes patients can result in cardiovascular disease, renal failure, retinal damage, and other conditions, but these complications may occur years after the initial poor primary care occurs). Consequently, most quality measures currently used are “process” measures, i.e., they measure whether a physician used a process deemed desirable, such as checking blood sugar levels for a diabetic. Since there is no guarantee that performing processes appropriately will result in better outcomes, a middle ground is to use “intermediate outcome” measures, e.g., whether a diabetic’s blood sugar levels are being maintained at an appropriate level; however, these measures require use of more difficult-to-access clinical information and depend on patient adherence as well as what the physician does.

Measuring and basing payment on the total *cost* of care is also challenging. In many cases, the amount that physicians charge for their own services is less relevant than the rate at which their patients use other expensive services, ranging from diagnostic testing to hospitalization. This has led to efforts to measure and compare physicians and physician groups on the total costs of services associated with their patients through what are known as “resource use” or “efficiency” measures. However, such measures can be controversial, particularly for patients with insurance plans that enable them to see any provider they wish, because no individual physician may have had the opportunity to influence all of the services that the patient received. In addition, the costs associated with lack of preventive services will occur in the future, and higher spending in the short run may be needed to reduce costs in the long run; measuring costs on an annual basis could actually discourage the use of preventive services.

5. Patient Attribution Rules

When a payment amount is designed to cover services provided by two (or more) providers, or when quality or resource use measures are based on the services delivered by two (or more) providers, an issue arises as to whether the cost and quality of services delivered by the second provider should appropriately be attributed to the first provider as well. For example, if a primary care physician sees a patient with emphysema, and that patient subsequently is admitted to the hospital for an exacerbation of the emphysema, should the hospitalization and its cost be attributed to the primary care physician for purposes of determining bonuses or penalties for that physician? One can easily imagine scenarios where the hospitalization should be attributed to the primary care physician (the PCP was the only physician the patient was seeing and he or she failed to prescribe appropriate medications to help the patient control the emphysema), and scenarios where it probably should not (the PCP saw the patient for a problem unrelated to emphysema, the patient independently chose a pulmonologist for treatment of the emphysema, and the pulmonologist admitted the patient to the hospital).

A variety of statistical rules have been developed to retrospectively determine, using claims data, whether a patient should be attributed to a particular physician. These rules are inherently imperfect, and they can potentially have a significant impact on the amount of payment that a physician receives. For example, if the attribution rule inappropriately assigns an expensive patient or a patient who has poor outcomes to a physician who had little or no role in selecting or providing most of the patient's care, then the physician could be unfairly penalized financially. Conversely, an attribution rule could fail to assign a patient with low resource utilization or good outcomes to a physician who played a critical role in determining the patient's overall care, but where the physician provided relatively few of the total services the patient received. Most patient attribution systems also fail to distinguish the *order* in which services occurred, so a physician could be penalized for a hospitalization that occurred before or just after the patient began to see the physician.

6. Insurance Benefit Design

“Payment systems” define the rules by which payers pay providers. But these rules, and more broadly, the ability of physicians to improve care delivery, are also affected by “benefit design,” i.e., the rules defining which services the payer will pay for, what restrictions patients face in using services, what portion of costs the patient is responsible for paying, etc.

For example, the need for statistical attribution rules in payment systems, and the likelihood of misclassifications from those rules, is greater in health plan designs such as PPOs which do not require patients to have a regular primary care physician or where patients can seek care from specialists who have no relationships with the patient's primary care physician. Consequently, comprehensive care/global payment systems are often used only for patients in HMO plans which require patients to have a primary care physician and/or limit the patients' choice of providers. However, traditional “gatekeeper” models are not the only way of structuring benefits to encourage patients to use a consistent primary care physician and to seek advice from that physician before seeking treatment; a patient could also be charged lower copays for using a consistent primary care practice or for using a specialist that coordinates care with the primary care practice.

If payment is going to be based on patient *outcomes*, rather than whether or how the physician delivers *services*, then the patient's ability and willingness to adhere to treatment regimes and avoid unhealthy behaviors will have a significant impact on payment. For example, for most chronic disease patients, a key factor affecting their ability to successfully manage their disease and stay out of the hospital is their ability to afford their medications; yet many pharmacy benefit plans do not ensure that the copayments for these medications are low enough to enable patients to afford and use them.²³ Consequently, there is growing interest in using value-based benefit designs which help patients access medications, preventive care, and other high-value services at an affordable cost, and which give patients incentives to lose weight, stop smoking, obtain preventive screenings, and take other actions to improve their health and adhere to recommended treatment plans.²⁴

C. Putting the Pieces Together

Each of the types of changes described in Section II-A, if supported appropriately by the elements described Section II-B, can address one or more of the problems with payment systems described in Section I. However, none of the changes alone can address all of the problems, and in some cases, changes which are implemented individually may result in undesirable or unintended consequences.

For example, creating pay for performance programs, shared savings programs, etc. as described in Sections II-A-2 and II-A-4 can provide incentives to improve quality or reduce costs, but they do not change the underlying incentives in the fee-for-service payment system nor do they provide any upfront financial resources to help physician practices achieve better results.

Conversely, paying for currently unreimbursed services or increasing payments for services which are reimbursed, as described in Section II-A-1, can increase total spending with no assurance that there will be improvements in quality or reductions in spending on other services. As a result, many payers are unwilling to implement these reforms, or are only willing to make small adjustments in payments.

Combining services into single payments as described in Sections II-A-3 and II-A-4 can provide greater flexibility for physicians in the way they deliver care and remove incentives to provide unnecessary services, but they can also create undesirable incentives to stint on services to patients.

Consequently, an increasing number of payment reform proposals combine elements of two or more of the five categories in Section II-A in order to provide an appropriate balance of resources, flexibility, cost control, and quality assurance. Moreover, more and more payment proposals are attempting to address the elements described in Section II-B. Section II describes how these elements have been combined in the three most commonly discussed payment reforms.

D. Using 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 reform models described in the previous sections can be used for a specific subgroup of patients, while other models (including traditional fee-for-service payment) can be used for other subgroups of patients.²⁵

The choice of payment systems depends on which of the following problems one is trying to solve:

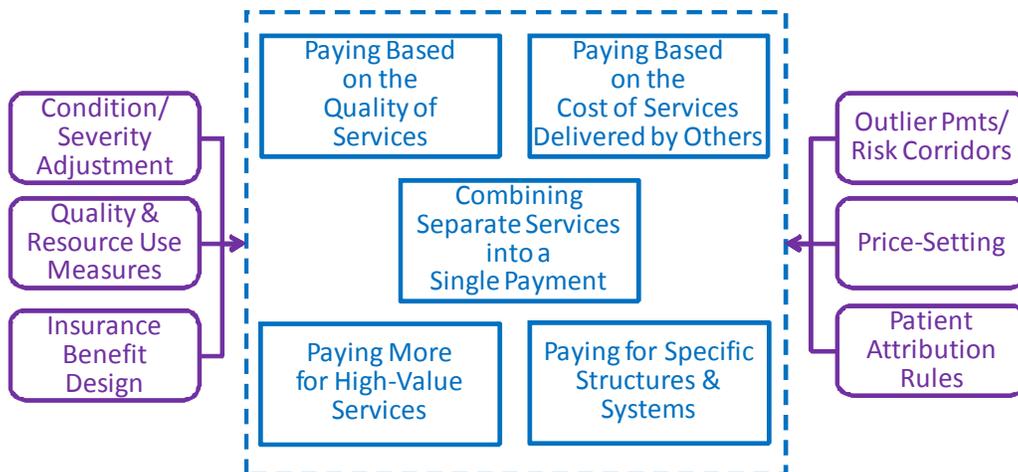
- **Underutilization of desirable services.** In this case, paying more for the service (category II-A-1) or providing rewards for increasing the use of the service (category II-A-2) most directly target the problem.

- **Poor quality of services being delivered.** In this case, paying based on the quality of the service (category II-A-2) most directly targets the problem.
- **Overutilization of services.** If the concern relates to the total number of services delivered by an individual provider, then combining those services into a single payment (category II-A-3) most directly targets the problem. If the concern relates to actions taken or not taken by one provider that leads to the overutilization of services by other providers, then making payment dependent on the amount and cost of services delivered by other providers (category II-A-4) most directly targets the problem.

Two payment systems can also exist simultaneously for the same patients. For example, a physician practice might accept a global payment to manage the care of patients with chronic obstructive pulmonary disease (COPD), which would give the practice the ability and incentive to help those patients avoid hospitalizations, but when a hospitalization occurs due to an exacerbation of the patient’s COPD, the practice could make a single, bundled payment to a hospital and its physicians to cover the costs of the hospitalization, thereby encouraging them to deliver the most efficient, effective care for the patient during the hospitalization.

Changing payment systems for some patients and not others can be particularly helpful during the early stages of implementing payment reforms, to enable physicians and other healthcare providers to transition slowly. For example, a comprehensive care payment could be made for patients with a specific chronic disease of mild to moderate severity, in order to support efforts to reduce preventable hospitalizations for those patients, while fee-for-service payments continue to be made for care of other patients. Later, the comprehensive care payment could be extended to patients with additional chronic diseases, while continuing to use fees and pay-for-performance for preventive care of relatively healthy patients.

THE BUILDING BLOCKS OF PAYMENT REFORM



III. Three Leading Models for Payment Reform

Clearly, an almost infinite number of different approaches to payment could be constructed using different combinations of the payment elements in Section II. Most discussions to date 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, as described below, 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.

A. Medical Home Payment for Primary Care

Medical home payment models are designed to better support primary care practices in their efforts to keep patients well, to avoid unnecessary hospitalizations, etc. A number of states, regions, businesses, and insurance plans have been pursuing such payment changes as part of initiatives intended to help primary care practices become “patient-centered medical homes.” Although these initiatives have ostensibly similar goals, they are using a wide range of payment models to do so which differ significantly on the components described in Sections II-A and II-B, as explained below:

- **Paying More for Certain Services.** Some medical home programs have created additional and/or higher fees for specific services. For example, for physician practices participating in its medical home program, Michigan Blue Cross Blue Shield has increased reimbursement levels for evaluation and management (E&M) services, and it reimburses medical home practices for patient education services provided by nurses using CPT codes that were not previously reimbursed.
- **Paying Based on the Quality of Services.** In many cases, payers already have pay-for-performance programs that reward primary care practices for their performance on quality measures, but the payers may also create new or modified quality incentive programs focused exclusively on the medical home practices.
- **Combining Separate Services into a Single Payment.** Instead of, or in addition to, paying for previously unreimbursed services or increasing payment for existing CPT codes, many medical home programs are paying primary care practices a monthly “care management” payment for each patient.²⁶ The payment does not require the delivery of any specific service (indeed, there is no requirement that an individual patient receive any additional services at all), but the revenues from the payment are presumed to be used by the practice to deliver services that are not currently covered by individual service payments (e.g., phone calls with patients), or to devote more time to services than the current payment structure supports (e.g., longer visits with some patients, or extended hours). Although the typical approach is for the monthly care management payment to be relatively small compared to the total revenues from existing payments for individual services, some programs have eliminated the fee-for-

service approach entirely and are paying practices a monthly per-patient payment to cover all services.²⁷

- **Making Payment Dependent on the Amount and Cost of Services Delivered by Other Physicians or Providers.** Some medical home programs have included a shared savings component which rewards the physician practice if the total cost of care for its patients is lower than expected, or if rates of utilization for specific types of services (e.g., emergency room visits and hospitalizations) decrease.²⁸ However, programs which solely use shared savings to pay practices, without any upfront increases in payment for currently unreimbursed or under-reimbursed services, or without any flexibility in the way reimbursed services can be delivered, may make it difficult or impossible for a physician practice to succeed.
- **Paying to Support Specific Provider Structures, Systems, and Locations.** Some medical home programs have made payments specifically for physician practices to install electronic health records or other infrastructure or systems. Another common approach is to make higher payments to practices or provide a higher care management payment if they meet medical home accreditation standards established by the National Committee on Quality Assurance (NCQA) or some other entity. A weakness of this approach is that it presumes that improved infrastructure or processes alone will enable a practice to improve its performance, and this may not be true.
- **Condition/Severity Adjustment.** Some medical home programs, such as the Health Care Home initiative in Minnesota²⁹ and the medical home demonstration program that was going to be implemented by Medicare³⁰ before the passage of the Patient Protection and Affordable Care Act, have defined different levels of payment based on the number or severity of the health conditions of the patients in the medical home practice. In the absence of such adjustments, medical home practices could be penalized for caring for sicker patients.
- **Payment Levels.** Even among programs with similar payment *structures*, the payment *amounts* may differ significantly, and most payment levels have been based on little or no information about the costs that physician practices will actually need to incur to implement the desired changes in care. If medical home payment systems are going to be successful, they need to ensure that payment levels are adequate to enable primary care practices to deliver high-quality care.

Although there are a wide range of medical home pilot programs underway or being planned around the country through the efforts of commercial payers and state agencies, most of them have been limited by the fact that the fee-for-service payment system cannot be changed for Medicare patients. To address this, Sections 3021 and 10306 of the Patient Protection and Affordable Care Act (PPACA) establish the Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid Services and charge it with testing innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid, and CHIP while preserving or enhancing the quality of care furnished. In selecting these models, CMS is required to give preference to models that improve the coordination, quality, and efficiency of health care services, including medical homes.

In addition, Section 3024 of the new federal Patient Protection and Affordable Care Act (P.L. 111-148) establishes an “Independence at Home Demonstration Program” to use physician- and nurse practitioner-directed home-based primary care teams to reduce expenditures and improve health outcomes for chronically ill Medicare beneficiaries. HHS is required to establish a method for sharing savings with independence at home medical practices that have expenditures below an annual target spending level.

B. Episode-of-Care Payment for Major Acute Episodes

There has been considerable interest among policymakers in paying for major acute care on a “bundled” or “episode” basis in order to encourage greater efficiency and coordination in the delivery of such care. There are many different ways in which payments for services and providers involved with an episode of care can be combined or modified, depending on the exact goals to be achieved. The most commonly proposed and tested models are:

- **Bundling hospital and physician payment**, i.e., making a single payment for both the services provided by the hospital and the services provided by physicians during an inpatient stay for a particular diagnosis or treatment. To date, this approach has been used primarily for surgeries, because surgeons are already paid on a case rate basis, making it easier to combine their payment with a hospital’s DRG payment. For example, in the 1990s, Medicare’s Participating Heart Bypass Center Demonstration selected four hospitals in Ann Arbor, Atlanta, Boston, and Columbus to receive a single payment covering both Part A (hospital) and Part B (physician) services for coronary artery bypass graft surgery. No outlier payments were permitted, and the amount of the combined payment was negotiated to be below current payment levels (depending on the city). The hospital and physicians were free to split the combined payment however they chose. An evaluation of the demonstration showed that the providers, patients, and Medicare all benefited: physicians identified ways to reduce length of stay and unnecessary hospital costs; costs decreased in nominal terms in 3 of 4 hospitals; and patients preferred the single copay.³¹ Medicare is testing bundled payment on a broader range of conditions in its Acute Care Episode Demonstration that got underway in 2009;³² examples of how it is being implemented are described in Section VI.
- **Paying for care on a “warrantied” basis**, i.e., making the same payment for hospital and/or physician services regardless of whether the patient experiences complications due to an infection, surgical error, etc. For example, the Geisinger Health System in Pennsylvania, through its ProvenCareSM system, provides a “warranty” that covers any follow-up care needed for avoidable complications within 90 days at no additional charge. The system was started for coronary artery bypass graft surgery, and has been expanded to hip replacement, cataract surgery, angioplasty, bariatrics, low back pain, perinatal care, and other areas.³³ Offering the warranty led to significant changes in the processes used to deliver care, and Geisinger has reported dramatic improvements on quality measures and outcomes.³⁴

- **Bundling payments for inpatient and post-acute care services and providers**, e.g., hospitals, physicians, home health agencies, rehabilitation facilities, etc. For example, PROMETHEUS Payment, Inc. is currently pilot testing an episode-of-care payment system called Evidence-Informed Case Rates (ECRs) that will cover all services from all providers during the full episode of care for a variety of conditions. The amount of the payment is based on a combination of historical actual costs and the estimated cost of delivering evidence-based care, and the actual payment amount to a provider is adjusted based on quality performance. If there is no single organization that can accept the single payment, PROMETHEUS has a default methodology that the health plan can use to divide the payment among the participating providers based on the proportion of services that each provider delivered during the episode.³⁵

Because of a concern that bundled payments, particularly without a warranty component, could create an incentive for providers to withhold desirable services from patients in order to increase their profit margins, many of these initiatives have included provisions for modifying payment levels or distribution rules based on the quality of care delivered. For example, in the Medicare Acute Care Episode (ACE) Demonstration, providers are required to ensure that quality is being preserved or improved in order for any savings in hospital costs to be shared with physicians.

As described in Section II-B-1, episode payment amounts can and should be adjusted based on the number and severity of the conditions the patient has; for example, Medicare does this today for the more narrowly defined “episode payments” it makes to hospitals under the Inpatient Prospective Payment System (more commonly known as DRGs). In addition, limits can be placed on how much responsibility a provider accepts to cover the costs of services that unusually expensive patients require using outlier adjustments or risk corridors, as described in Section II-B-2; again, Medicare does this today as part of its DRG payment system.

The leadership for creating episode payments can come from individual physicians as well as hospitals and health plans. For example, in 1987, an orthopedic surgeon in Lansing, Michigan collaborated with his hospital to offer a fixed total price for surgical services for shoulder and knee problems, including a warranty for any subsequent services needed for a 2-year period, including repeat visits, imaging, rehospitalization, and additional surgery. A study found that the payer paid less and the surgeon received more revenue by reducing unnecessary services such as radiography and physical therapy and reducing complications and readmissions.³⁶

Sections 3023 and 10308 of the new federal Patient Protection and Affordable Care Act (PPACA) require the creation of a “pilot program for integrated care during an episode of care provided to [Medicare beneficiaries] around a hospitalization in order to improve the coordination, quality, and efficiency of health care services.” The pilots are to be focused on ten specific patient conditions (including a mix of surgical and medical conditions) and the bundles are to include inpatient hospital services, physicians’ services both inside and outside of the hospital, outpatient services, and post-acute care services. Section 2704 of PPACA establishes a similar demonstration program under Medicaid.

C. Comprehensive Care Payment

Although there are many potential advantages to using bundled episode payments to improve the quality and reduce the cost of inpatient episodes, a major weakness of episode payments is that they do nothing to reduce the number of episodes. For many patients, such as individuals with chronic disease, the primary goal should not be to make their hospital stays better, but to prevent hospital stays from being necessary in the first place.

Comprehensive Care Payment or “Global” Payment addresses this weakness by making a single payment to a physician practice or other healthcare provider to cover the costs of all of the care needed to care for a patient’s health condition during a specific period of time (e.g., a year), regardless of how many inpatient episodes they experience. (The provider receiving the comprehensive care/global payment might, in turn, pay for any inpatient episodes using the episode payments described in the previous section.)

There are two major advantages of Comprehensive Care/Global Payment from a physician’s perspective:

- It is the only payment method that actually rewards a physician for keeping his or her patients well, since healthier patients would reduce the cost of care but the physician’s revenue would stay the same.
- It provides broad flexibility for a physician to customize services to meet a patient’s needs, rather than being constrained by which services a payer will reimburse or having to seek prior authorization to deliver certain services.

These advantages led to widespread use in the 1990s of the form of global payment called capitation. Although a number of primary care practices and multi-specialty groups across the U.S. are still paid today under capitation contracts, particularly in California, capitation payment fell into disfavor in many parts of the country because (1) physicians were paid the same amount even if they had patients with more health problems, which created a disincentive to take on sicker patients, and (2) because there were not good ways of measuring the quality of care to ensure that physician practices were not withholding needed care in order to save money.

However, there is no reason why comprehensive care payment systems cannot be designed to retain the best aspects of traditional capitation systems while correcting their weaknesses, using the building blocks described in Section II. In particular,

- By adjusting payment levels for the types and severity of patient conditions (as described in Section II-B-1), comprehensive care payment systems can avoid penalizing physicians for accepting sick patients into their practices.
- By setting limits on the total costs (or total number of services) for an individual patient that a physician is responsible for covering using the comprehensive care payment (as described in Section II-B-2), a comprehensive care payment system can avoid penalizing physicians for having an unusually sick or expensive “outlier” patient.

- By adjusting payment levels based on the quality of care, comprehensive care payment systems can avoid rewarding physicians for inappropriately withholding services from patients.

There are several examples of comprehensive care payment systems that have these features, including:

- Under the Patient Choice payment system in Minnesota, which was developed in the 1990s under the auspices of the Buyers Healthcare Action Group (BHCAG) and is now operated by the Medica health insurance company, “care systems” (groups of providers, but not necessarily integrated delivery systems) bid on the risk-adjusted total cost of caring for a population of patients; the care systems are divided into cost tiers based on their relative bids; consumers select a care system based on both cost tiers and quality information, and they pay the difference in the bid price if they select a care system in a higher cost tier. Providers continue to bill based on CPT codes (with payments also authorized for some previously unreimbursed codes), but the payment rates for individual services are adjusted up or down to keep total payments within a budget; the budget is based on the provider’s bid, but it is adjusted upward or downward based on the relative illness and other characteristics of the patients that the provider actually cares for (this is intended to ensure that providers are liable only for performance risk, not insurance risk associated with having sicker patients). Evaluations have shown that the system encourages patients to select more cost-effective providers and encourages providers to reduce their costs while maintaining or improving quality.³⁷
- The Alternative Quality Contract implemented by Blue Cross Blue Shield of Massachusetts in 2009 makes a fixed payment to a healthcare provider for each patient to cover all care services delivered to the patient (including hospital care, physician services, pharmacy costs, etc.), with the payment amount adjusted by the health status of the patients. The provider can earn up to a 10% bonus payment for achieving high performance on clinical process, outcome, and patient experience measures. The amount of the payment is based on historical costs for caring for a similar population of patients and is increased annually based on inflation. Outlier payments are made for patients with unusually high needs and expenses, and limits are placed on the total amount of financial risk the providers accept.³⁸
- A more limited version of global payment has been developed as part of the PROMETHEUS Payment System. PROMETHEUS has defined a risk-adjusted payment amount to cover all of the care needed during the course of a year by a patient with a specific chronic disease. The payment is intended to give primary care practices adequate resources to manage the care of the patient in a high-quality way, as well as a financial incentive to reduce preventable hospitalizations and other avoidable complications. This payment model is being tested in several pilot sites.³⁹

Sections 3022 and 10307 of the new federal Patient Protection and Affordable Care Act (PPACA) create an opportunity to move toward a comprehensive care payment system in Medicare by establishing a Medicare Shared Savings Program. Under this provision of the law, groups of providers that qualify as an “Accountable Care Organization” (see Section V-C below for a discussion of this concept) can be paid either

(a) a share in cost savings they achieve for the Medicare program in addition to current fee-for-service reimbursements, (b) through a partial capitation model or (c) through “other payment models.” As stated in the law, under the partial capitation model, the providers would be at financial risk for some, but not all, of the Part A and B items and services.

In addition, Section 2706 of PPACA establishes a Pediatric Accountable Care Organization Demonstration Project under Medicaid through which pediatric medical providers can be designated as accountable care organizations and receive incentive payments similar to those provided through Medicare under Section 3022, and Section 2705 of PPACA establishes a Medicaid Global Payment System Demonstration Project under which safety net hospital systems or networks can be paid using a global payment system.

IV. Implications of Payment Reform for Physicians

A. 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 has opportunities and challenges, but physicians are used to dealing with them. Any new payment system will modify 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.

Since each of the models described in Section III, as well as virtually any payment reform that is likely to be considered, is a combination of the various elements described in Section II-A, the opportunities and challenges associated with each individual element will be explored below. It is important to emphasize that in most cases, the challenges can be mitigated or exacerbated depending on way the payment system is designed, particularly in terms of the elements described in Section II-B.

1. Paying More for Certain Services

Opportunities

Paying for desirable services that are not paid for today, or paying more for services that are felt to be undercompensated today, clearly represents an opportunity for physicians to improve care for patients or to increase their income for what they are already doing.

Challenges

However, depending on how this type of payment change is actually structured and implemented, there are several potential challenges associated with it:

- Paying for a service, or paying more for a service, does not necessarily mean paying *enough* for the service. If the new or revised payment is too low (based on how the amount of payment is determined, as described in Section II-B-3), then payers and patients may expect the physician to deliver the service even though it makes the practice less profitable. Even if the payment amount is right “on average,” it may still be too low if the physician has a higher-than average number of patients who require extra time to deliver this service. Addressing this requires some form of condition/severity-adjustment as described in Section II-B-1.
- New or higher payments for one service may come at the expense of payments for other services if the payer is attempting to keep total payments “budget-neutral.” Reduced payments (or slower growth in payments) may affect a different set of physicians than those receiving the new/higher payments. For example, requirements for budget neutrality within the Medicare Part B program have meant that increasing

payment for one type of service generally requires an across-the-board reduction in payments for all other services. With this type of constraint, paying more for one high-value service could mean paying less for others.

2. Paying Based on the Quality of Services

Opportunities

This type of payment change provides the opportunity for physicians who deliver high-quality care to be rewarded financially for doing so, either through higher payment or higher patient volume or both compared to physicians who do not meet the same quality goals. In addition to financial benefits for physicians, the payment structure reinforces the importance of delivering quality care to patients.

Challenges

Despite the conceptual advantages of paying based on quality, the difficulties in implementation create several potential types of challenges for physicians:

- Although many pay-for-performance systems ostensibly represented net new spending above current payment levels, concerns about overall healthcare spending levels are increasingly leading to a reduction (or reduced growth) in the base payment levels for services in order to shift funding to the reward component of payment. Depending on what is being rewarded and how the changes in payment levels are made, it may not be possible for some physicians, even if they provide good quality care, to “earn back” all of the reductions they may have experienced in payments for individual services.
- A typical approach to creating performance-based payment without increasing total spending is to introduce “withholds,” i.e., reducing the upfront payment for a service and then paying the balance once it is determined that quality standards were met. Even if a physician practice receives the full withhold at the end of the year (or at the end of some other defined performance measurement period), the practice may experience cash flow problems due to the smaller upfront payment.
- If the standard of performance required to receive payment bonuses or withholds is unrealistic, then a physician practice may be unable to benefit from the bonuses or recoup the withholds, and may even experience a net reduction in payments if the bonus program is funded with savings generated by reducing payment levels. The aggregate impact depends on the extent to which a payer is obligated to distribute all of the money in a reward pool, or whether the payer can retain all or part of the reward pool if physicians do not meet the standards established to earn bonuses.
- If there are problems with the appropriateness, accuracy, or reliability of the quality measures used for determining payments, then physicians may be unfairly rewarded or penalized, or may be unfairly denied rewards or penalties. (Some of the issues associated with types of measures and patient attribution are discussed in Sections II-B-4 and II-B-5.)

- The physician practice may need to incur higher administrative costs to collect the data needed for quality measures or to verify the accuracy of quality measures generated by payers or other entities. These costs can reduce the net benefit of any revenue enhancements resulting from good performance or exacerbate net costs associated with lower performance. For example, many physicians have complained that the incentive payments under the Medicare Physician Quality Reporting Initiative (PQRI) do not cover the costs of actually collecting and submitting the data.
- In order to offer a “warranty” for services, the physician practice needs an understanding of how often the warranted problems occur today and how much variation there is in the rates of the problems in order to determine if the amount paid for warranted care is adequate, and the physician also needs to take appropriate steps to prevent the warranted problems from occurring, otherwise the physician will lose money on the service. The data needed to do this are often difficult to obtain from the physician practice’s data systems or from payers.
- A weakness with P4P systems is that they can only reward what can be measured, and therefore they can implicitly penalize physicians for focusing on areas that are not measured, even if those areas have a bigger impact on patient outcomes than the areas which are measured.

3. Combining Separate Services into a Single Payment

Opportunities

Although it isn’t always obvious at first, creating a single payment for a group of services in place of separate payments for each individual service that a physician provides can provide several significant advantages for a physician:

- The combined payment gives the physician the flexibility to determine which combination of services is most appropriate for an individual patient, including delivering services that may currently be unreimbursed, without being concerned that the most appropriate combination of services will generate less revenue or profit than another.
- The combined payment can make revenues more predictable for the practice, particularly where the payment is based primarily on whether the patient is under the physician’s care (e.g., the practice capitation model described in Section II-A-3). Many physicians prefer capitation payments (if they are appropriately structured in other respects), because they provide more predictable cash flow than making the physician’s income dependent on how many patients come in for visits in a particular month.

Challenges

Combining services into a single payment represents a more significant move away from current payment models than most of the changes under the previous two categories, and therefore it also brings with it greater potential challenges. In particular:

- If a physician currently delivers a relatively high number of services per patient compared to other physicians, then a new, combined payment which is the same for all physicians may result in lower revenues for the high-utilization physician than he or she currently receives. Although one of the goals from the payer's perspective is to reduce the number of services delivered, there may be good reasons why a particular physician's patients need more services. The more services that are combined, particularly where there is significant variation among physicians and patients, the more important it will be to have a good condition/severity adjustment system (as described in Section II-B-1) and a provision for outlier payments (Section II-B-2) accompany the combined payment. Even with appropriate severity adjustment, a fair mechanism of setting the payment level (as described in Section II-B-3) will be needed.
- If a particular physician typically only provides a portion of the services that are being combined, and other physicians (or other providers) deliver the remaining services, then the first physician will no longer be able to independently generate revenues strictly for delivering his or her current services, and may lose the opportunity to deliver the services independently at all if patients switch to the "full-service" providers. (There is also the opportunity for the physician to take over the delivery or management of all of the services, in which case the payment model is similar to the models in Section II-A-4, and these are assessed in more detail in the next section.)
- Patients may fear that when their physician advises that a service isn't necessary, the physician's judgment is being influenced by the fact that the physician will not be paid extra for that service.

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

Opportunities

The fourth category of payment change differs the most dramatically from the payment structures the majority of physicians operate under today. It can provide opportunities for many physicians to control or influence services that they do not deliver directly, and to benefit financially from that control. The precise opportunities depend on which services are connected together and who has the opportunity to determine how overall costs and savings are allocated.

- Today, if a physician provides a service or advice to a patient which avoids the need or desire for the patient to use another service, the physician may be compensated for the service or advice he or she provides, but he or she receives no financial benefit for saving the patient or the patient's health plan the money that would otherwise have been spent on the avoided service. In many cases, the savings from the avoided service (e.g., a hospitalization) vastly exceed the amount the physician is paid for what enabled the service to be avoided. Consequently, if the physician is rewarded through a resource use-based P4P system, if the savings are shared with the physician, or if the physician has the opportunity to directly save the money as part of

a bundled or comprehensive care payment, then the physician has the potential for a significant increase in revenue or profits.

- A number of demonstrations have shown that physicians have the ability to significantly reduce the costs of drugs and medical devices used by hospitals, and so bundled payments or gain-sharing arrangements for inpatient care can provide the opportunity for significant financial gains for physicians.
- As with the more narrowly defined combined payments discussed in the previous section, bundled and global payments provide the ability and flexibility for physicians to determine which combination of services is most appropriate for an individual patient, including delivering services that may currently be unreimbursed or delivering services in different ways that reduce costs while maintaining or improving outcomes.

Challenges

On the other hand, the fact that this payment change is so different from most payment structures today means that it can also pose significant potential challenges to physicians.

- As with the other payment changes described earlier, to the extent that the current payment levels for services are reduced in order to create a pool of money for resource use-based P4P awards, then depending on the amount of that shift and the standards for receiving the P4P awards, there is the risk that some physicians may receive less payment than today, even though their performance is not “bad.” (In theory, this problem should be less likely for resource use-based rewards than for quality-based rewards, since lowering resource use frees up money for bonuses but not all quality improvements will reduce costs.)
- A weakness with either P4P based on improvement or the shared savings approach is that physicians whose patients have high levels of resource use today have greater opportunities to reduce their resource use and achieve savings than physicians who are already helping their patients stay well and avoid expensive care.⁴⁰ Any system that only rewards physicians for changes they make in the future will implicitly penalize those who have made improvements in the past.
- As noted in Section II-A-4, shared savings is somewhat unique in that it is based in substantial part on a prediction of what the future would have been, rather than what is known to be happening now or in the past. The lower these predictions, the harder it will be to show “savings,” and therefore it will be even less likely that a physician will be able to actually achieve a share of savings. Moreover, even if savings are achieved in one year, there is no guarantee that the same level of spending the following year will still be determined to represent “savings” that can be shared. If the payer makes the projection of what the expected level of spending is in a given year (from which “savings” are computed), the payer may view the lower level of spending in the first year as the expectation for the second year, which means that the size of the shared savings payment will also decrease. (The same problems can occur in a P4P program that uses an absolute standard of resource use performance; if the

standard is very stringent, the chances of the physician receiving a bonus are very small, and if the standard is continuously tightened in order to exceed what any physician has actually achieved, then the payer may be able to retain all of the savings that are created and make no P4P awards.)

- If there is not an effective system of condition/severity adjustment and a provision for addressing outliers (as described in Sections II-B-1 and II-B-2), and if a physician has sicker patients during the year than in the past, then under a P4P or shared savings arrangement, the physician may be inappropriately denied a bonus or shared savings payment (or be penalized inappropriately), and under a bundled or global payment arrangement, they may receive a smaller payment than necessary to cover their costs.
- A shared savings payment to one physician may well come from a reduction in another physician's income. Although there are significant opportunities for all physicians, both primary care physicians and specialists, to share in savings from reducing spending on hospital services, drugs, and medical devices, if PCPs reduce their referrals to specialists or reduce hospitalizations, and if specialists reduce their referrals to other specialists, then specialists may well lose revenues under these payment arrangements, particularly specialists who deliver services that are used at a high rate in the community.
- Under a shared savings, bundled payment, or global payment system involving multiple providers, if one provider (e.g., a hospital) is significantly larger than another (e.g., a small physician practice), the larger provider may demand a disproportionately high share of the savings or payment, potentially reducing revenues for the small provider.
- Patients may fear that when their physician advises against receiving a particular service or treatment, the physician's judgment is being influenced by the fact that the cost of that service will reduce the physician's income.

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

Opportunities

To the extent that payments for specific structures, systems, and locations are designed in ways that support what physicians want to do, they can obviously be helpful, particularly if the payment is adequate to cover whatever gap exists between the costs of those items or actions and what can be supported under other aspects of payment systems.

Challenges

However, there are also potential downsides to such payments, including:

- to the extent that the basis for qualifying for the payments is defined narrowly, they may leave out physicians who have different structures or systems, or they may force physicians to implement structures or systems that are not ideal in order to qualify for

the payments. For example, if a payment is made specifically based on whether a physician practice installs a particular type of electronic health record and/or uses it in a particular way, it may force the physician to make a choice between buying a system that is less desirable from the physician's perspective but qualifies for the funds, or to get a better system (or no system at all) and pay the full price with no financial assistance.

- if the revenues to support the payments come from revenues that would otherwise be allocated to other types of payment, then the physician could end up with the same amount of money overall, but with less flexibility as to how to use it.

B. Implications for Different Types of Physicians

It is impossible to predict exactly how a particular payment structure will affect individual physicians. The balance of opportunities and challenges will vary from market to market, depending on current payment structures, the level of utilization of various services, and overall market structures. However, some general implications can be suggested.

1. Implications for Primary Care Physicians

Many of the most important opportunities for controlling costs can and should be addressed through effective primary care. Although the majority of healthcare expenditures and recent 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 – which the majority of patients will access through primary care.⁴¹

Although some patients with chronic diseases or complex conditions will receive their “primary care” through a specialist, the majority of individuals who are well or have mild to moderate chronic diseases will receive most or all of their care through a primary care practice. Moreover, in many parts of the country, particularly rural areas, primary care physicians manage not only ambulatory care, but also hospital care for a number of patients, such as patients admitted to the hospital for exacerbations of a chronic disease, women delivering babies, etc. In these areas, some of the cost reduction opportunities associated with hospitals may also be driven by primary care physicians.

Consequently, payment changes that are designed to improve quality and control costs will present significant opportunities for primary care physicians to increase their incomes and their influence over healthcare delivery. However, to take advantage of these opportunities, primary care physicians will need to develop or strengthen the kinds of capabilities described in Section V, such as better management of patients with chronic disease, analysis of utilization and outcome data to identify opportunities for improvement, etc. For primary care physicians in very small practices, this will likely require forming or joining some type of new organizational structure, such as an IPA, which can provide some of these capabilities in the most cost-effective manner.

There will also likely be a significant mismatch between the supply of and demand for primary care physicians for many years. There are already significant shortages of primary care physicians in many areas of the country, and expansions of health insurance coverage will create even more demand for primary care. Since the shortages of primary care physicians have been caused by factors such as low pay, long hours, and heavy on-call demands and an assembly-line approach to care delivery, new payment models that increase pay, allow more time with patients who need it, and give primary care physicians a more central role in planning and coordinating overall healthcare services should encourage more new physicians to go into primary care, and may even encourage some specialists to convert to primary care. However, it will take many years to reverse the effects of decades of under-investment in primary care, and so short-term solutions to expanding availability of primary care may also be needed.

2. Implications for Specialists

No payment system will change the fact that for many kinds of conditions, ranging from chronic disease to major acute conditions, patients will require specialists⁴² to provide all or part of the care they need. Payment systems such as episode-of-care payment can provide mechanisms that do not exist today for specialists to develop more cost-effective ways to deliver care and to benefit financially from doing so. For example, as noted in Section II-A-4, under a bundled acute care episode payment, physicians could share in savings achieved by reducing hospital length of stay, reducing the use of expensive drugs and medical devices, etc. in ways that they typically cannot today.

In addition, bundled and comprehensive care payments can support and encourage greater coordination between primary care physicians and specialists, and between multiple specialists treating different conditions affecting the same patient. Problems such as duplication of testing and conflicts between medications ordered by different physicians that lead to higher costs and poorer outcomes are created and aggravated by current payment systems which pay physicians only to see patients, not to consult with each other or to coordinate multiple aspects of a patient's care.

Moreover, better payment systems can create opportunities for specialists to provide care in new ways. For example, for patients with chronic disease, better quality, lower cost care could be provided by having specialists consult with the primary care physician about how the primary care practice can comprehensively manage the patient's care, rather than having a specialist separately manage a portion of the care. For example, if primary care physicians work with cardiologists to implement information systems and standards of care which facilitate successful management of coronary artery disease and heart failure, they may be able to achieve better outcomes for their patients than if the primary care physicians attempt to manage the patients on their own, with referrals made to the cardiologists only when serious problems arise. The current fee-for-service system is a barrier to this, since the specialists are paid for face-to-face visits with patients, but typically are not paid when they provide advice directly to the primary care physician. For example, under the DIAMOND Initiative organized by the Institute for Clinical Systems Improvement in Minnesota, psychiatrists are being paid for consulting

with primary care practices on the best way to manage patients with depression, which has resulted in dramatic improvements in patient outcomes.⁴³

In communities where a particular specialty is being heavily used for services that could be provided more efficiently or effectively through primary care providers, or where the need for the service could be prevented altogether, it is likely that utilization of that specialty will decrease. In the short run, this could mean that the existing specialists in the community will receive significantly lower revenues than in the past. In the longer run, it may mean that the community can support fewer specialists, but the remaining specialists could continue to succeed financially with the lower overall volume. (In communities which have had high rates of uninsurance and underinsurance, the expanded coverage under the federal Patient Protection and Affordable Care Act may lead to significant numbers of newly insured patients which could offset some or all of any reduction in volume from existing patients.)

V. Organizing for Success Under New Payment Models

A. Capabilities Needed to Implement New Payment Models

Each of the payment changes described in Section II-A has the potential to address some problematic aspect of current payment systems that serves as a barrier to higher quality and lower-cost healthcare. As described in Section IV, each presents opportunities, but also significant challenges to physicians' ability to deliver high-quality care in a financially viable way. A key question that physicians as well as payers and policy-makers need to address is: what capabilities and organizational structures will help physicians take maximum advantage of the opportunities presented by new payment models and overcome the challenges they pose?

Although criteria and standards have already been established by some payers and policy-makers to define which physicians and other healthcare providers should be eligible to participate in new payment models, there is not always a sound basis for the requirements. For example, in many states and regions, primary care payment reform initiatives have been limited to practices that are accredited as a "Patient-Centered Medical Home" based on standards established by the National Committee for Quality Assurance (NCQA) or standards established by the state. However, for many of these standards, there is relatively little evidence indicating that meeting the standard is essential to quality care,⁴⁴ and experience has shown that some of the standards are very difficult or expensive for primary care providers to achieve.⁴⁵ As an example, although electronic health records can have significant benefits for physicians and patients, they are very expensive and challenging to implement, and may not have as great a benefit in the short run as other changes, such as hiring of nurse care managers or use of computerized patient registries.

Creating unnecessarily stringent standards for participating in payment reforms will limit the number of physicians who can participate, which in turn will reduce the ability to impact cost and quality for the majority of patients. Overly stringent standards will also unnecessarily increase the costs of participation for those physicians who *do* participate, reducing the impact that payment reforms and improved care processes can have on total health care spending.

Consequently, it is important to be conservative in defining *requirements* for participation of physicians and other healthcare providers in new payment models, and to facilitate *innovation* by physicians by identifying a broad range of options under which they can successfully participate.

Capabilities Needed if Payers Pay More for Certain Services

The fact that a payer agrees to pay something for a desirable service that is not paid for today, or to pay more for a service that is felt to be undercompensated today,

does not automatically mean that a physician can successfully deliver that service for the amount that is being paid. Three key capabilities that can affect performance are:

1. **Sufficient patient volume to support a new or improved service.** The cost of delivering any service is a function of the fixed costs and the variable costs associated with a service. The greater proportion of the costs which are fixed costs, the more the profitability of the service will depend on the number of patients or units of services that a physician can deliver. For example, if a payer agrees to reimburse a physician practice for services provided by a nurse care manager, hiring a nurse care manager (on a full-time, salaried basis) is only feasible if there are enough patients with enough need for contacts from a nurse care manager to generate the revenue necessary to cover the salary and benefits for the position. This can require that a small physician practice find ways to collaborate with other small practices in order to deliver these services cost-effectively.
2. **Upfront capital to design and implement a new or improved service.** Even if a service is financially viable once it is up and running, there may be initial costs that a physician practice has to incur to get the service up and running which will not be reimbursed. To continue the preceding example, even if a nurse care manager's salary and benefits will be covered, a physician practice will need to incur unreimbursed costs for recruiting and training someone to fill the position and during the initial months when productivity is likely to be low. Using an electronic health record or other health information technology generally requires an upfront expenditure for computer equipment and software, staff training, and temporary reductions in productivity. If a physician practice does not have capital in reserve or access to a line of credit, it may not be financially possible for the practice to incur these upfront costs.
3. **Skills/experience to efficiently/effectively implement a new or improved service.** A physician practice may not have the skills or experience to design and implement a new service in the most efficient and effective way. Although these skills could be developed or purchased, the time and cost needed to do so may not be feasible for the practice.

Capabilities Needed if Payers Pay Based on the Quality or Outcomes of Services

Since health care providers have traditionally been paid based on what services they deliver, not the quality or outcomes of those services, basing payment on quality or outcomes requires a whole new set of capabilities.

4. **Ability to obtain and analyze data on the quality and outcomes of services.** In order for payment systems to base payments on quality or outcomes, they will need data supplied by physicians regarding whether patients received certain services, the results of those services, and the overall outcomes achieved for the patients. Physicians can incur significant administrative costs to collect these

data, to ensure they are accurate, and to submit them to payers. Even if the payer develops quality measures using claims data that the physician practice is already submitting or using other sources, the physician practice will need to have its own mechanisms of (a) validating and correcting the data the payer is using, and (b) analyzing the data to determine where quality problems (or opportunities for improvement) exist. Physicians may also need to obtain assistance in understanding and evaluating the statistical methodologies used to produce quality and outcome measures.

5. **Skills/experience in improving the quality of services.** The fact that a physician knows that a quality problem (or opportunity for improvement) exists or even what the causes of the problem are does not mean that he or she knows how to efficiently or effectively correct it. Analyzing the causes of problems, developing solutions, and changing care practices to improve performance benefit from involving individuals who have skill and experience in these activities. Consistent use of clinical practice guidelines is often suggested as a mechanism for improving quality, but this still requires an understanding of how to achieve that consistent use. Many physician practices will need training and technical assistance to develop these skills, such as through the Perfecting Patient CareSM program developed by the Pittsburgh Regional Health Initiative.⁴⁶
6. **Adequate resources to deliver services that achieve desired quality and outcome levels.** As noted in the discussion of payment methods, a solution to a quality problem may require providing new services or changing the way services are delivered, but if these new or modified services are not paid for, the physician practice may not be able to improve performance. In addition, changing care practices to improve performance may result in temporary losses of productivity and revenue. Finally, if payment systems utilize withholds that are only paid after measures of quality have been reported and shown to exceed thresholds, a physician practice will also need financial reserves to cover the practice's cash flow requirements between the time that services are delivered and the time the withholds are paid.
7. **Access to external resources to support patient adherence and health improvement.** In many cases, outcome and intermediate outcome measures are a function of what patients do or do not do as well as what physicians do. A physician may not be able to perform required preventive screenings if a patient cannot or will not come for screenings, and a physician may not be able to control a patient's blood pressure if the patient cannot afford their medications. The availability of community support programs, value-based benefit structures in health plans, etc. may affect some of the quality measures used to judge physicians' performance.

Capabilities Needed if Payers Combine Separate Services into a Single Payment

When physicians are paid based on episodes or periods of time rather than individual services, they can no longer assume that one more patient visit or one more service will result in additional revenue. Managing under this type of arrangement requires two additional capabilities:

8. **Ability to obtain and analyze data on the variation in services per episode or per patient.** Since a single payment will cover a group of related services, and different patients will need different numbers and combinations of those services, a physician will need the data and analytical tools to understand why some patients are receiving above-average numbers of services and whether any of those services are unnecessary or could be delivered in more cost-effective ways.
9. **Skills/experience in improving the efficiency of service delivery.** As with quality improvement, the fact that a physician knows that there are situations where patients are receiving more services than necessary does not mean that he or she knows how to efficiently or effectively correct it. Similarly, analyzing the causes of overuse and inefficient delivery, developing solutions, and changing processes to improve performance can result in temporary losses of productivity and revenue, particularly if a physician practice does not have skill or experience in efficiency-improvement methodologies. Many physicians will need training in tools that can improve efficiency and technical assistance in implementing those tools.

Capabilities Needed if Payers Make Payment Dependent on the Amount and Cost of Services Delivered by Other Physicians or Providers

As noted earlier, the fourth category of payment change differs the most dramatically from the payment structures the majority of physicians operate under today. Once a physician's payment depends on what other providers do, success will depend on having a number of important capabilities:

10. **Ability to obtain and analyze data on the quantity and cost of services delivered by other providers.** At the most fundamental level, most healthcare providers typically have very little information about what other providers have done or are doing for their patients. Although this problem has been widely reported in the context of efforts to create electronic health information exchange for real-time decisions about patient care, it is typically the case that even well after services are delivered, a physician has no way of knowing how many of his or her patients visited a specialist, went to an ER, were hospitalized, etc.⁴⁷ Access to such data is critical if a physician is going to be held accountable for what other providers do.

11. **Skills/experience in reducing utilization and costs.** As with quality and internal efficiency improvement, data can show where opportunities exist to reduce utilization and costs, but physicians also need the skill and experience to change care processes in ways that can take advantage of these opportunities. Consistent use of clinical practice guidelines may provide a mechanism for reducing unnecessary utilization and unwarranted variation in utilization, but physicians must develop mechanisms for identifying which guidelines are appropriate for individual cases and then implementing them. Many physician practices will need training in tools that can help manage utilization and costs and technical assistance in implementing those tools.
12. **Ability to control or influence the amount, quality, and cost of services delivered by other providers.** A critical factor in ensuring high-value care for patients is being able to coordinate and control the services of all providers involved. Even if there are ways that utilization and costs could be reduced, a physician may not be able to implement them or to control factors that could counteract them. For example, a physician might be able to reduce the frequency with which patients go to the emergency room or to a hospital, but if the emergency room or hospital increases its prices in proportion to the reduction in utilization, the net impact on costs may be zero. This may require physician practices to have contracts with these other providers defining the ways that they will control costs, or to piggy-back on contracts that health plans have with those providers.
13. **Sufficient capital to invest in services that will produce savings.** The need for upfront capital to design and implement new services was described earlier, but under shared savings and similar payment arrangements, the need for working capital will likely be even greater, since the revenue derived from savings may be paid to the physician practice well after the services are actually delivered, perhaps as much as 2 years later, because of the delays health plans experience in receiving and processing claims and then calculating shared savings.
14. **Sufficient capital to provide reserves for random fluctuations in costs.** There will also be a need for capital reserves that a physician practice can use to cover cash flow needs as actual revenues fluctuate up and down. Even if the payment system does a good job of protecting physicians from insurance risk, they will still be responsible for performance risk (i.e., controlling the costs of care for individuals with a particular set of health conditions, while maintaining or improving outcomes), and this will create new financial challenges that most practices are not accustomed to dealing with. Even if high revenue years more than offset low revenue years, if the practice does not have sufficient capital reserves to start the process or if it does not retain sufficient earnings along the way to maintain capital reserves, it could go bankrupt.
15. **Ability to pay claims from other providers or to divide revenues among multiple providers.** The need for this capability in a bundled or global payment

system depends on whether the payer has created a “virtual” bundling arrangement, or whether the payer is paying a single check to cover all costs and expecting the recipient of that check to pay all other providers who were involved in the care. Some physician practices and Independent Practice Associations have established claims payment and other capabilities so that they contract directly with self-insured employers to not only deliver care but also to manage payments to other providers.

16. **Ability to control or influence patient choice of providers and services.** As with quality outcomes, utilization and cost are a function of what patients do or do not do as well as what physicians do. If a patient’s health plan allows the patient to choose which hospitals and other providers they will use and if it provides little incentive for patients to use higher-value providers, then costs for a physicians’ patients could increase through no fault of the physician. Although physicians could attempt to influence patients’ choice, putting physicians in the position of encouraging patients to use lower-cost facilities when the patient’s health plan does not do so could cause patients to distrust the motivations of their physician.

Capabilities Needed if Payers Pay to Support Specific Provider Structures, Systems, and Locations

The fifth and final category of payment change described in Section II-A – payments designed to support specific structures, systems, or locations – could be helpful in building some of the capabilities described above, particularly for physician practices which may have particular difficulties assembling the resources or expertise needed to create those capabilities. However, physician practices may need technical assistance in determining which structures and systems will work best for them.

B. 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 for payers or regulators 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.

Nonetheless, since some organizational structures can facilitate the creation and implementation of a number of the capabilities defined in the previous section, it is

important to understand the relative strengths and weaknesses of different structures in doing so. Although several common organizational structures are discussed below, it is likely that unique organizational structures will likely evolve specifically to support the capabilities needed for physicians and other healthcare providers to succeed under new payment models. Indeed, during the 1990s, so many unique organizational structures were created to support managed care payment systems that some came to be referred to collectively as “OWA” (other weird arrangements).

There is relatively limited guidance available in the research literature as to the relative strengths and weaknesses of different organizational structures. Most studies are correlational, so at best they can report that certain organizational structures are more likely to be associated with certain capabilities than others, not that the structure has a causal relationship with the capability, nor that certain organizational structures *cannot* provide a certain capability. Moreover, the guidance of these studies is less relevant to assessing the capabilities of different organizational structures under *new* payment models, because there is little experience with the kinds of payment models being proposed and tested today. The fact that organizations of a particular type outperformed organizations of a different type under the current fee-for-service payment structure does not automatically imply that those organizations would also perform better under different payment structures. In fact, many analyses have indicated that a principal purpose or function of certain organizational structures has been to respond to current payment structures, so changing the payment structure could significantly change the organizations as well. Consequently, in most cases, only broad, qualitative assessments can be provided as to the advantages and disadvantages of various organizational structures under new payment models.

1. Large Single Specialty Group Practices

Advantages

The principal inherent advantage of large group practices compared to small or solo practices is achieving economies of scale. It is more difficult and expensive for an individual physician or small group practice to design and implement the kinds of care management services, quality measurement and reporting systems, financial management systems, bulk purchasing, etc. that are needed to manage quality and costs of services than it is for a larger practice, simply because a larger practice can spread the fixed costs of such services across a larger number of physicians and patients.⁴⁸ This does not *guarantee* that a group practice can deliver any of those services efficiently or effectively, it merely means that, all else being equal, a group practice may have more opportunities to install certain systems or provide certain kinds of services less expensively on a per-physician basis than a solo or small group practice.

A related advantage of having more physicians in a group is to reduce random variation in measures of quality and costs that could affect the practice’s payment under quality-based or resource use-based payment systems. It is very difficult, and in some cases impossible, to generate reliable measures of how the quality or total cost of care has changed or how it compares to benchmark levels if the measures are based on the small

number of patients managed by most individual physicians and small practices. The larger the number of physicians and patients involved, the less likely it is that a single unusually expensive or complex patient can significantly affect a cost or quality measure or cause significant fluctuations in cash flow for the practice.

In addition, a larger practice is more likely to have sufficient financial reserves or borrowing capacity to cover swings in cash flow and delays in receiving payment withholds, and to make the upfront investments needed to improve care management systems.

A traditional advantage of large groups is greater leverage in negotiations with payers and other providers (e.g., hospitals) regarding payment levels, coordination of services, etc. This can be particularly important in ensuring adequate payment levels for the services the practice itself provides, and also for ensuring affordable prices for the services it relies on other providers to deliver.

Another traditional advantage of group practices has been to provide a mechanism for physicians to compare their performance on quality and cost and discuss different approaches to care with other physicians so they can more easily identify opportunities for improvement. However, as quality measurement and reporting becomes a more integral part of payment systems, and as more communities establish multi-payer community-wide measurement and reporting systems and quality improvement collaboratives,⁴⁹ physicians will increasingly be able to get comparative information on their performance and have opportunities to work with other physicians on quality improvement initiatives regardless of the size or structure of the organization in which they work.

Disadvantages

There are limits to economies of scale, so a larger group practice could well be less efficient than a smaller one; one study estimated that after a group reaches about 10-15 physicians, economies of scale begin to decline again.⁵⁰

A related problem is that in some cases, it may be more difficult for a large practice to innovate in the way care is delivered. In a small group, all physicians could more easily agree to completely restructure the care processes they use, whereas in a larger group, a subset of the physicians could be precluded from implementing an innovation if the majority of physicians are unwilling to make the change.

Although a larger group enables more robust measurement from a statistical perspective, it also means that the highest performing physicians could be rewarded less than they would have been had they been practicing separately, and there could also be a smaller incentive for the lowest performing physicians to improve. The nature of the incentives for performance improvement by individual physicians depends on the compensation structure in the group; this is dealt with in more detail in Section V-E.

2. Independent Practice Associations

Advantages

An Independent Practice Association (in which small physician practices remain legally independent businesses, but join together with other independent practices to perform selected functions jointly) can provide many of the same advantages as a large group practice, but in a more selective fashion. For example, if the practices in the IPA wanted to use nurse care managers, but each individual practice was too small to support such a position itself, the IPA could hire the care managers and assign them on a part-time basis to individual practices. However, other functions could still be provided individually by each practice, rather than centrally as in a group practice.

Disadvantages

A disadvantage of the IPA is that there may be less cohesion and commonality of approach among the participating physicians than in a group practice where all physicians are employed by the same organization. If the IPA is pooling financial risk across multiple practices, the financial rewards for higher-performing practices could be negatively affected by some IPA members with very low performance, although this is not different from the problem described above with respect to a large group practice.

3. Multi-Specialty Group Practices and IPAs

Advantages

In contrast to a single specialty group practice or IPA, a multi-specialty group practice, or in some cases, a multi-specialty IPA, may have health information systems, physician compensation systems, and management and financial systems already in place which can be used to coordinate the work of primary care and specialty care, and to coordinate efforts between one sub-specialty and another, in order to achieve maximum overall performance on the cost and quality of care delivered.

A multi-specialty group also provides a mechanism for accepting a bundled payment encompassing services involving physicians from multiple specialties. Since the group practice already has mechanisms for dividing fee-for-service and other revenues among the physicians, it could perform a similar function for dividing revenues under a payment system that bundles physician services together (e.g., the professional services capitation/partial global payment models described in Section II-A-4).

Disadvantages

Potential disadvantages of a multi-specialty group or IPA include:

- the physicians within the group or IPA may not be the highest performing physicians in their specialty in the community. If higher-performing independent physicians in the community enter into a coordinated relationship with each other, they may be able to manage costs and quality more effectively than the multi-specialty group or IPA.

- if the multi-specialty group or IPA does not have all key specialties, it will still have to develop mechanisms for coordination with other specialists and management of utilization of their services. The ability to contract with external specialists could be constrained if it would require more favorable payment/compensation arrangements with the external specialists than the compensation arrangements that are in place for the specialists that are part of the group/IPA.

3. Group or Staff Model Health Maintenance Organizations

Advantages

A group model or staff model HMO is typically thought of as a health plan that contracts with a physician group or employs physicians to deliver care. However, a physician group which operates its own health plan can also have this structure and achieve several benefits.

- For those patients who receive their health coverage through the HMO, the physician group can decide how it wants to be paid, rather than having to negotiate a payment structure with an independent health plan. For example, for patients in the HMO, the HMO receives the benefits of any savings from reduced utilization of hospitals and other services external to the group, and the physician group can directly determine the most appropriate way to “share” those savings with the physicians in the group.
- If the health plan is healthy and well-funded, it can provide access to capital reserves that can be used to restructure the way care is delivered and take on additional risk.

Disadvantages

It is difficult for a physician group to only see patients using its own insurance plan unless it can attract a high volume of patients to that plan, which in turn generally requires that the group be large enough to compete effectively with health plans (either HMOs or PPOs) that offer broad networks of physicians. In addition, depending on the structure of the local market, it may be difficult for the plan to negotiate competitive contracts with hospitals or non-group specialists unless it is large enough to exercise sufficient market power. Consequently, in order to be successful, the physician group may have to become larger than it might otherwise wish to, or the insurance plan may need to become a network model and contract with additional physician groups.

4. Physician-Hospital Organizations

Advantages

A Physician-Hospital Organization (i.e., an organization that is jointly owned or controlled by independent physicians and one or more hospitals) can provide a number of advantages for physicians seeking to participate in new payment models:

- it provides a formal mechanism for multiple physicians and a hospital (or multiple hospitals) to coordinate their activities, without requiring the physicians to separately organize themselves into an IPA or larger group.

- it can provide an organizational mechanism for accepting a bundled payment involving both hospitals and physicians (but only within the limits of federal and state restrictions on gain-sharing between hospitals and physicians, as described in more detail in Section V-G).
- it can provide a mechanism whereby physicians can benefit from services and systems at the hospital, such as information systems and quality improvement staff to support process improvement in physician practices.
- the hospital's larger financial reserves and greater access to sources of capital can enable the PHO to more easily help physicians make capital investments in information technology, new facilities, etc. than the physician practices could do on their own.

Disadvantages

Disadvantages of a PHO can include:

- The physicians may be implicitly or explicitly limited to using the hospital(s) participating in the PHO for the delivery of services, even if other hospitals in the community may provide some services at lower cost or higher quality. In contrast, depending on the local market structure, annual contracts between a physician group or IPA with hospitals could provide more flexibility in terms of where hospital services would be delivered and greater ability for the physicians to negotiate favorable terms for splitting revenues under bundled payments and other payment arrangements.
- To the extent that the hospital is providing a disproportionate share of the capital and management for the PHO, it may also expect a disproportionate share of any savings or net revenues generated through the actions of the physicians in the PHO. This means that under a payment system based on total resource use, physicians who are part of a PHO will be less likely to benefit from initiatives to reduce hospital admissions and readmissions than those who are independent.

5. Integrated Delivery Systems

Advantages

Many people view Integrated Delivery Systems (IDSs), i.e., organizations that combine hospitals, specialists, primary care physicians, and (in some cases) health plans in a single corporation, as the ideal organizational structure for delivering high-quality, cost-effective care and for accepting bundled and comprehensive care payments. Several large IDSs, such as Denver Health, the Geisinger Health System, Intermountain Health Care, Kaiser Permanente, the Mayo Clinic, and ThedaCare are frequently cited as national models of quality and efficiency.

Integrated Delivery Systems have the potential to combine many of the advantages cited earlier for group practices, multi-specialty groups, and physician-hospital organizations. If the IDS also includes a health plan, the types of advantages

described earlier for group and staff model HMOs would apply even more strongly, since a broader array of savings for services would be internal to the system, rather than being dependent on external contracts. An integrated delivery system is also more likely to have the kind of comprehensive data on services and costs for patients that are needed to succeed under global payment arrangements, since the system provides a greater share of those services itself.

Disadvantages

However, there are many large Integrated Delivery Systems in the country that are not cited as models for either quality or efficiency or both. 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. Merely having a group of primary care physicians, specialists, hospitals and other providers combined in a single corporation does not guarantee that there will be *clinical* integration. Moreover, corporate integration may achieve some economies of scale in administrative functions, but there is no evidence that either horizontally- or vertically-integrated systems are always lower cost than non-integrated systems or that corporate integration automatically leads to more clinical integration.⁵¹ Leaders of some of the model Integrated Delivery Systems say that while their clinical integration helps them in fulfilling the vision of Accountable Care Organizations, the most important cause of their success is setting clear goals for the management of population-level costs and quality and developing the skills in operational execution needed to achieve those goals. (It should be noted that the leaders of the model systems note that current healthcare payment systems tend to penalize them financially for their successes, so it is not surprising that under current payment systems, a desirable organizational structure may generate undesirable results.⁵²)

Even if there is clinical integration and good leadership, there are some inherent disadvantages of an IDS, similar to those cited earlier for multi-specialty groups and PHOs. For example, the physicians in an IDS will likely be expected to use the integrated delivery system's hospital(s) for the delivery of services, even if other hospitals in the community provide some services at lower cost or higher quality.

C. Accountable Care Organizations

In light of the high and rapidly growing cost of healthcare in the U.S., there has been growing interest both in the federal government and in states and regions across the country in creating "Accountable Care Organizations (ACOs)," i.e., health care provider organizations that take accountability for the overall cost as well as the quality of healthcare delivered to patients. Despite the widespread interest in the concept of Accountable Care Organizations, there has been little agreement on which types of providers could play this role or the organizational structure under which they should operate. For example:

- MedPAC proposed that an ACO "would consist of primary care physicians, specialists, and at least one hospital," and suggested that it could be formed from

- an integrated delivery system, a physician-hospital organization, or an academic medical center.⁵³
- Stephen Shortell and Lawrence Casalino suggested five different models of an Accountable Care System: a Multispecialty Group Practice; a Hospital Medical Staff Organization; a Physician-Hospital Organization; an Interdependent Practice Organization; and a Health Plan-Provider Organization or Network.⁵⁴
 - Elliott Fisher and colleagues proposed designating all of the physicians in a geographic area whose patients are admitted to a particular hospital (the “extended hospital medical staff”) as an Accountable Care Organization.⁵⁵

None of these proposals is based on much, if any, analysis or evidence indicating that a particular option or options is better than others; this is not surprising, since there is very little evidence to prove that any particular type of provider or organizational structure *cannot* successfully manage total costs and quality for a defined population. 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.

In the long run, it should be possible to designate Accountable Care Organizations based solely or primarily on whether the organization actually achieves better cost and quality outcomes, not on the structure of the organization or the processes it uses to improve outcomes. However, because outcomes can only be known after the fact, and because there are risks to patients, payers, and providers if organizations are designated as ACOs and paid differently without having the ability to succeed, many payers and policy-makers feel a need to define which organizational structures and care processes offer the greatest probability of success in the near term.

The Role of Primary Care in an Accountable Care Organization

As noted in Section IV-B, many of the most important opportunities for controlling costs can and should be addressed through effective primary care. Consequently, it seems clear that, in order to be accountable for the health and healthcare of a broad population of patients, an Accountable Care Organization must have a sufficient number of primary care physicians playing a central role.⁵⁶ However, these primary care practices will have to function very differently from the way most primary care practices function today, including developing or strengthening many of the capabilities defined in Section V-A, such as collecting and analyzing data on quality and utilization of services, and redesigning care processes to improve quality and efficiency.⁵⁷

The Role of Specialists in an Accountable Care Organization

Although primary care must be the core of an Accountable Care Organization, specialists will still be needed to provide a significant part of the care that many patients need. In order to create a truly *accountable* organization, however, there will need to be much better coordination between primary care physicians and specialists, and between

multiple specialists treating different conditions affecting the same patient, than typically exists today, even in many multi-specialty group practices and integrated delivery systems. Since in most cases, each specialist will only be providing a portion of the care that patients need, the primary care practice (or a specialist playing that role for a patient with a dominant health condition) must serve as a coordinator if coordination is to occur. Moreover, primary care practices will likely benefit from advice from specialists in order to effectively manage the care of patients with chronic diseases, particularly those with advanced stage chronic diseases or multiple chronic diseases.

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 corporate organization, however. In some cases, they may be; for example, an integrated delivery system or a large multi-specialty group might become an Accountable Care Organization and use its own specialists to provide specialty care when such care is needed. But a primary care practice or an IPA could also function as an ACO by developing contractual arrangements or merely solid professional relationships with independent specialists in the community in order to ensure efficient, effective, coordinated care for the ACO's patients. Since many multi-specialty groups and integrated delivery systems do not directly employ physicians from all specialties, they will still be required to develop relationships with other specialists in order to manage the care of all of their patients.

The Role of Hospitals in an Accountable Care Organization

Similarly, some of an Accountable Care Organization's patients will need hospital care at some point. Hospitals provide critical services for the sickest patients who require the most costly services. As with specialists, however, this does not necessarily mean that a hospital must be part of the same corporate structure as the primary care physicians or specialists.

There are many potential advantages to having one or more hospitals as an integral part of an ACO. The hospitals in a community are generally larger organizations than physician practices, they have more extensive administrative resources and skills, ranging from information technology to finance to quality improvement tools, and they are more likely to have financial reserves or access to financing than will physician practices. These kinds of capabilities could potentially be used to develop and implement the key functions of an ACO.

Moreover, in many communities, hospitals have acquired primary care practices and now employ many primary care physicians⁵⁸; in other communities, hospitals and primary care physicians work together through Physician-Hospital Organizations (PHOs). In these situations, the hospital may be in a natural position to facilitate the steps needed to help primary care physicians make the transition to functioning as an ACO.

However, a key issue will be whether the hospital embraces the goal of cost reduction and control underlying the formation of Accountable Care Organizations and

whether the hospital is prepared to take the steps needed to transform itself in order to achieve that goal. Several of the most important ways to reduce healthcare costs would be to prevent the need for hospitalizations through more effective prevention programs, early detection, improved chronic disease management, etc. These initiatives would be achieved primarily or exclusively through the actions of physician practices, not by hospitals themselves. Moreover, to the extent that these initiatives are successful, they will not only reduce the hospitals' revenues, but they may well have a negative impact on the hospitals' margins, particularly in the short run, if revenues decline more than costs can be reduced. As a result, at least in the short run, the interests of primary care physicians and hospitals in many communities will not only be unaligned, but could be in *opposition* to each other.

The Desirability of Encouraging Multiple Models of Accountable Care Organizations

Consequently, some Accountable Care Organizations may decide to have specialists or hospitals as part of the same corporation as the primary care physicians, and other ACOs may not. 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. Some ACOs may have a subset of specialists or hospitals included in the organization, and have contractual or other relationships with the remaining specialists and hospitals in the community. The important factor will be the ACO's ability to successfully work with a comprehensive set of high-quality specialists and a sufficient number of high-quality, efficient hospitals to achieve the most coordinated, efficient care of the patients for whom the ACO is accountable.

Conversely, it would be inappropriate or infeasible to *require* that specialists or a hospital be part of an Accountable Care Organization along with primary care physicians.⁵⁹ Indeed, in a community where there is only one hospital (or where one hospital is the exclusive provider of certain services), or where there is only one physician group in a particular specialty, it would be undesirable to have that hospital or specialty group exclusively join with a subset of physicians in the community to form an ACO, since that may preclude the ability of other physicians to develop an ACO, particularly if the hospital or specialty group in the first ACO refuses to accept the patients of the second ACO.

Moreover, particularly in the short run, it may be desirable in many states or regions to allow a provider organization to serve as an Accountable Care Organization if it can make a significant impact on *some* costs, even if it cannot impact *all* costs for a given population of patients. For example, initially, an Accountable Care Organization might consist solely of primary care practices, and it could be held accountable for the types of costs and quality measures within the control of primary care physicians (e.g., physician office visits, diagnostic testing, and emergency room visits and hospitalizations for ambulatory-care sensitive conditions). A number of Independent Practice Associations around the country could likely become ACOs under this model very quickly with the appropriate changes in payment systems. Multi-specialty group practices or multi-specialty IPAs could take accountability for an even broader range of

costs, including a subset of acute care procedures. This would not preclude also having other Accountable Care Organizations, such as integrated delivery systems that included primary care physicians, specialists, one or more hospitals, home health agencies, etc., taking accountability for all or almost all costs and quality associated with a patient population.⁶⁰

The Desirability of Having Multiple Accountable Care Organizations in a Community

The less rigid the standards for creating an Accountable Care Organization, the more likely it is that multiple ACOs can be created in a particular community. This is desirable from the perspectives of all stakeholders. It gives physicians the choice of which ACO to participate in, since participating physicians have to *want* the Accountable Care Organization to work in order for it to be successful. It gives consumers a choice and creates an environment in which the ACOs can compete for patients based on their cost and quality. Although some forms of “competition” in healthcare in the past have contributed to higher costs (e.g., overbuilding of facilities and duplication of equipment), this is partly a function of current healthcare payment systems which pay providers more for delivering more services and benefit designs which make consumers indifferent to the costs of the services they receive.

Conversely, standards that require large numbers of physicians to be part of an ACO, require hospitals to be part of ACOs, etc. risk creating a monopoly and the potential for price-fixing, and even if the providers are participating willingly, there will inherently be less pressure or incentive for them to improve their performance since there would be no other local providers to which the Accountable Care Organization could compare its performance, and no alternative provider for a payer or patient to choose if the performance of the Accountable Care Organization is unsatisfactory. Even where there may be significant opportunities for efficiencies or greater clinical integration resulting from consolidation of providers, this will need to be balanced against the possible creation of a monopoly provider.

Although there are clearly advantages to having multiple ACOs in a region, there are also complexities that will need to be addressed:

- The more ACOs there are in a region, the greater the need will be for an appropriate risk/severity adjustment mechanism in the payment system in order to avoid having some ACOs selecting healthy patients or excluding sick patients in order to improve their quality or cost performance, and to avoid having a smaller ACO financially hurt by random variations in patient needs.
- In addition, the more ACOs there are in a region, particularly if hospitals or specialists are part of one or more of the ACOs, the more likely it will be that the patients of one ACO will need or want to use specific providers or services that are part of a different ACO. Although such patient choice is desirable, it will require more complex payment arrangements.

The resolution to these tradeoffs will likely differ from region to region. They will depend on the existing structure of the healthcare delivery system, the extent of the

collaborative relationships among the independent providers, and the existence of effective mechanisms to counteract anti-competitive behaviors.

Federal Requirements for Accountable Care Organizations

As noted in Section III-C earlier, Sections 3022 and 10307 of the new federal Patient Protection and Affordable Care Act (PPACA) establish a Medicare Shared Savings Program and authorize a group of providers that qualify as an “Accountable Care Organization” to be paid either (a) a share in cost savings they achieve for the Medicare program in addition to current fee-for-service reimbursements, (b) through a partial capitation model or (c) through “other payment models.” The legislation first defines an “ACO Professional” as a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist; then it lists the following groups of providers which can be considered as an Accountable Care Organization (ACO):

- ACO professionals in group practice arrangements;
- Networks of individual practices of ACO professionals;
- Partnerships or joint venture arrangements between hospitals and ACO professionals;
- Hospitals employing ACO professionals;
- Other groups of providers of services and suppliers as the Secretary of HHS determines appropriate.

Under the law, in order to qualify as an ACO, any of the above groups must:

- have established a mechanism for shared governance;
- be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it;
- participate in the program for not less than a 3-year period;
- have a formal legal structure that would allow the organization to receive and distribute payments for shared savings to participating providers of services and suppliers;
- include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO;
- have at least 5,000 Medicare beneficiaries assigned to it;
- have in place a leadership and management structure that includes clinical and administrative systems;
- define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies; and
- demonstrate that it meets patient-centeredness criteria specified by HHS, such as the use of patient and caregiver assessments or the use of individualized care plans.

Finally, the law states that HHS can choose to limit the use of the partial capitation payment model to ACOs that are “highly integrated systems of care” or “capable of bearing risk.”

In general, the provisions of the law are sufficiently flexible to allow the full range of organizational structures described in Section V-B to participate as Accountable Care Organizations.

D. Transitional Payment Reforms

It will be very difficult for physicians and other healthcare providers who have been operating under the fee-for-service payment system for many years to suddenly switch to operating under systems such as comprehensive care payment that require greater accountability for cost and quality. As described above, physicians will need to develop or hone a variety of skills and capabilities in order to manage successfully under dramatically different payment models, and it will take time for them to do so. Moreover, since there is relatively limited experience with how to implement the new payment models, there are many design details which will have to be worked out and there will likely be a variety of unintended consequences which will need to be identified and addressed.

On the other hand, one cannot wait for physicians to make these changes before implementing payment reforms because current payment systems are a major impediment to making the changes in processes needed to deliver higher-quality, more efficient care. The solution to this “chicken and egg” problem – better payment systems require better delivery systems, but better delivery systems require better payment systems – is to develop and implement *transitional* payment reforms, i.e., payment changes which will give physicians more flexibility and accountability for costs and quality than they have today under fee-for-service, but less than they would have under the ultimate payment system that would be used, so that the physicians have time to transition their processes and organizational structures to enable them to develop the capabilities to move to even higher levels of flexibility and accountability.

For example, in order to help a primary care practice transition from the current fee-for-service structure to a comprehensive care payment system, payers could make the following series of transitional changes in payment:

1. Provide a flexible “care management payment” on top of existing fees (or reduce the levels of current fees and use the savings to support a care management payment) for patients with chronic disease in return for a commitment by physicians to reduce the number of preventable ER visits and hospitalizations for those patients.
2. After the change in #1 is in place and operating successfully, replace all fees with (a) a single condition-adjusted payment to cover all services delivered by the physician practice for its patients and (b) a pay-for-performance bonus/penalty for utilization of services delivered outside of the practice, including hospital services.

3. After the change in #2 is in place and operating successfully, pay practices a condition-adjusted payment for all non-hospital services delivered by the physician practice and other providers, with limits on the practice's responsibility to cover the costs of services for unusually expensive patients.
4. Over a period of time, increase the size of the pay-for-performance bonus/penalty and reduce the limits on the practice's total financial risk.
5. At this point, the physician practice has most of the flexibility and accountability it would have under a full condition-adjusted comprehensive care payment system, so it would be relatively easy to take the final step and fully implement such a system.

This is just one example of how a transition could be made for this particular payment system and this particular type of physician practice; different transitional paths may be appropriate in different communities, and different transitional paths will be needed for other types of payment changes, such as episode-of-care payments for major acute care.

E. Compensation of Individual Physicians Under New Payment Systems

All of the preceding discussions relate to how a healthcare payer makes payments to a healthcare provider *organization*, not how an individual *physician* is paid. In the case of a solo physician practice, there is essentially no difference between the way the physician practice is paid and the way the physician is paid, but as soon as the organization receiving payment includes multiple physicians (whether it be a two-physician group practice or a large integrated healthcare system), or even a single physician and another provider (such as a hospital), a separate decision has to be made about the methodology the organization will use to compensate an individual physician using the revenues derived from the payments the entire organization receives.

1. The Mismatch Between Current Compensation Systems and New Payment Models

Although a wide range of different structures are used today to compensate physicians, the most typical structures used in larger groups and integrated delivery systems appear to be some combination of (1) a salary and (2) a bonus based on "productivity," i.e., the number of services that the physician delivers.⁶¹ The emphasis on productivity is not surprising, since fee-for-service payment systems pay physician practices and other healthcare organizations based on the number of services they deliver.

However, if a new payment system rewards the organization based on the quality of services it delivers, or if the payment system penalizes the organization for inappropriate utilization of services, then it will be difficult for the organization to succeed if its physicians are being compensated in ways that do not reinforce the new incentives. Consequently, it seems likely that current physician compensation systems will need to be significantly changed if payment systems are significantly reformed.

Alternative Structures for Compensation

The most basic decision is which combination of the following four different models of compensation will be used:

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.*** Under this approach, the physician's compensation most closely mimics what it would be if the physician were a solo practitioner. However, this model also gives the physician relatively little direct incentive to help others in the organization perform well, which could mean that a physician might be paid well (at least in the short run), but the organization would run into financial difficulties because its overall performance was poor, which in turn would ultimately affect the physician's compensation.
2. **Compensation based solely or primarily on *how the organization as a whole performs on the factors which determine the organization's payment.*** This approach can lead to a "free rider" problem, i.e., an individual physician can underperform but still be compensated at levels similar to others in the organization.
3. **Compensation based on *factors that do not directly affect the organization's payment.*** For example, a physician could be compensated based on the number of services he or she delivers (i.e., "productivity") even if the organization's payment no longer depends on the volume of services delivered, or the physician could be compensated based on internally developed measures of patient satisfaction, even if that is not an explicit factor determining the organization's payment level (or in determining its tiering level, if the payer uses a tiered system to encourage patients to use certain providers), or the physician's compensation could be based on quality measures other than those used in the pay-for-performance structure for the organization.
4. **Salary-based compensation.** Finally, a physician can be compensated in a way in which the compensation amount doesn't change based on any type of performance factors, e.g., the physician could receive a defined salary and receive salary increments that are not based on individual or organizational performance on the factors affecting the organization's payment.

The actual compensation system could be based on some combination of the above four factors. For example, 40% of a physician's compensation for the year might come from a straight salary, 20% could be based on how the organization as a whole performs on payment revenues (or perhaps on a narrower definition of the organizational team with which the physician most closely works), 20% could be based on the physician's own performance on the factors determining the organization's payment, and 20% could be based on factors such as the physician's patient satisfaction scores that do not directly affect payment levels, but may have longer term benefits to the organization in attracting and retaining patients.

2. Factors and Methods Used in Determining Performance-Based Compensation

To the extent that compensation is based, at least in part, on the method by which the organization is paid, the physician will need to be able to monitor and change factors such as:

- The extent to which specific processes are performed in conjunction with the services the physician delivers;
- The outcomes the physician's services achieve, both individually and collectively;
- The frequency with which patients use unnecessary or preventable services;
- The relative cost of the services that the physician and his or her patients use;
- The way the physician is coordinating with other members of the care team and with other physicians in the organization;
- How satisfied the physician's patients are with the quality of care they have received.

Most of the adjustment factors described in Section II-B apply to physician compensation *within* organizations as well as to payments from payers *to* those organizations. For example, if a physician's compensation depends on his or her performance on quality measures, there should be some method of condition/severity-adjustment to ensure that the physician is not unfairly penalized for treating unusually sick patients nor unfairly rewarded because of having unusually healthy patients.

3. Non-Compensation Incentives and Controls

Under any of these models, the incentives for the individual physician will not exactly match the incentives for the organization under the payment system, and so the organization receiving the payment will need to play an intermediary role, using methods other than compensation to ensure that the collective performance of all physicians and other providers in the organization remains high. This is conceptually similar to functions such as utilization review that health plans currently perform in order to ensure that the per-patient premiums they receive will be adequate to cover their fee-for-service payments to healthcare providers. For example, even if a provider organization pays its physicians on a salary basis rather than a fee-for-service basis, it may need to have an internal utilization review function to ensure that physicians are not ordering unnecessary tests or making unnecessary referrals that could harm the organization under resource use-P4P or a comprehensive care payment structure.

Although it might seem unwise for the organization to have a compensation system that has significantly different incentives for individual physicians (and other staff) from the way the organization's own revenues are generated, it may be desirable or necessary for it to do so in order to compete with other organizations in attracting physicians who desire a particular compensation arrangement, particularly during transitional stages. For example, if the organization wants to attract physicians who prefer a salaried arrangement, and if competing organizations offer such an arrangement,

then the organization may need to use a compensation system that is heavily weighted toward salaries. Conversely, if the organization wants to attract physicians who would be willing and able to provide services independently and to maximize their income based on the incentives in the payment system, then the organization may need to use a compensation system that enables those physicians to generate earnings in ways that parallel what they could do independently.

Even if the factors determining a physician's compensation parallel those driving the organization's payment revenues, the organization's compensation structure can be designed to serve as a buffer against random variations in quality or resource utilization for individual physicians. For example, if the physician were being paid as an individual under a resource-use based payment structure, an unusually expensive patient in one year would dramatically lower the physician's compensation (assuming the patient is not expensive enough to be treated as an outlier in the payment system), but in a larger group, the cost of such an outlier patient could be shared by all of the physicians, since in any given year, any physician might be randomly expected to have such a patient.

4. Proportion of Revenues Devoted to 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 revenues used for physician compensation include:

- **Whether the organization includes a hospital.** As noted earlier, because a hospital typically has larger financial reserves and greater access to sources of capital than a physician practice, the fact that a hospital is part of the same organization as a physician can help to address swings in revenues and costs that a small, physician-only organization might only be able to address through cuts in compensation. On the other hand, many of the costs associated with hospitals are "fixed," at least in the short run⁶², which means that if hospital payment levels are reduced or certain hospital services are no longer paid for (e.g., readmissions or hospital-acquired infections), the organization may need to disproportionately reduce physician compensation (or give smaller increases in compensation) in order to cover hospital costs. This also means that under a payment system based on total resource use, physicians who are part of a hospital system will be less likely to benefit from initiatives to reduce hospital admissions and readmissions than those who are independent. (If the independent physicians reduce hospital admissions, all of the payer's savings in hospital payments could be shared with those physicians, whereas in the integrated system, the hospital's costs will decrease less than its revenues, and it may need to use most or all of any shared savings payment to cover the deficit rather than to reward physicians.)
- **Legal barriers to using non-physician revenues for physician payment.** As will be described in more detail in Section V-G, there are a variety of laws and regulations which limit the ability of hospitals and integrated delivery systems to use revenues or

savings from hospital services to increase compensation for physicians (but no similar restrictions exist to prevent reductions in physician payments to cover hospital costs).

- **The need to invest in new services or infrastructure.** As explained in Section V-A, a physician practice may need to incur additional, upfront costs, such as recruiting, hiring, and training new staff, purchase and installation of health information systems, etc. in order to succeed under new payment systems. Although these costs will ideally be recouped over time through the incentives built into the payment systems, they may reduce the amount of revenues available for physician compensation in the short run.
- **The need to create financial reserves.** As noted in Section V-A, when physician organizations take on more performance risk, they will also experience greater variations in costs and payment levels from month to month and year to year. These variations are only problematic if the organization does not have adequate financial reserves to cover expenses when short-term decreases in revenue occur. Building and maintaining financial reserves requires that the organization have an explicit program for retaining some earnings, rather than paying all available funds in compensation.

F. 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.

1. Issues Caused by Multiple, Small Payers

Most healthcare providers receive payment for their patients' care from multiple payers. In most communities, there will typically be a wide range of different payers, including:

- The federal Medicare program;
- The state Medicaid program;
- National or multi-state commercial insurance companies (including Medicare Advantage plans);
- Local commercial insurance companies (including Medicare Advantage plans);
- Self-insured companies and organizations (including governments, for-profit businesses, and non-profit organizations); and
- Self-pay patients (including patients with high-deductible health plans)

Although the payment changes described earlier can support and encourage significant changes in the way that healthcare providers deliver care, it is difficult and may even be inappropriate for a provider to change the way it delivers care for only a small subset of its patients. Consequently, if one payer modifies its payment system to

support the better approach to care, but other payers do not, and the provider improves the way it delivers care for *all* patients, the provider may be financially penalized for those patients still paid for under the payment systems that have not been changed.

Payers may also be deterred from implementing a new payment system if they believe that providers will change their care processes for all patients but that other payers will not implement the same payment approach. If a physician practice improves care in a way that reduces the rate of hospitalizations for *all* of its chronic disease patients, regardless of which payer they have, then the payers which are not using the new payment system will not incur any additional costs for changes in care processes, nor will they need to share savings from reduced hospitalizations with the physician practice. This means that their medical cost expenses will be lower than the payers which are using the new payment system, yet their patients will not perceive any disadvantage to using that payer (since they receive the same improved services regardless). This gives the payers using the old payment system a competitive advantage over the payers using the new payment system.

Clearly, the ideal arrangement would be for all payers to adopt a new payment arrangement, since this would enable a healthcare provider to change its care processes for all of its patients without being financially penalized for any of them, while also avoiding creating a competitive advantage for any individual payer. However, achieving alignment of all payers in a market is very challenging, for several reasons:

1. As noted above, competition among payers may lead an individual payer to hold back on making payment changes in order to benefit relative to those payers who do implement the changes.
2. Antitrust laws make it difficult for payers to discuss or reach agreement on a common approach to payment (see Section V-G for additional discussion about antitrust laws).
3. Many payers pay for patients located in multiple geographic markets, and in some cases nationally, and they typically find it more efficient to use the same payment system in all of their markets, rather than having different payment systems in each market. This is certainly true of Medicare itself, national and multi-state health insurance firms, and even large self-insured employers.
4. Payers which are not headquartered in the market, or which only have a small portion of their patients in the market, may be particularly reluctant to participate in a payment reform structure that is uniquely tailored to the interests of that particular market.

In some states and regions, state agencies or non-profit Regional Health Improvement Collaboratives have worked with payers to facilitate agreement on a common payment methodology (see Section V-H for more detail on Regional Health Improvement Collaboratives). Antitrust prohibitions apply primarily to payers agreeing on a common price for services, not to payers agreeing on a common *method* of payment. States can supervise the development of a common payment methodology using the state action exemption under federal antitrust law. Non-profit collaboratives can propose a

common payment methodology and convince multiple payers to use it; this approach was used by the Institute for Clinical Systems Improvement to implement the DIAMOND initiative.⁶³

2. Issues Caused by Large or Dominant Payers

Although having multiple small payers makes achieving alignment more difficult than if there is a smaller number of payers, the opposite situation can also be problematic, i.e., if a very large payer in the market refuses to implement the desired payment reforms, or implements conflicting changes, then its size becomes an impediment, rather than an advantage, in implementing locally-designed payment reforms.

Medicare is one of the most notable examples of this, since several states have multi-payer payment reform initiatives that involve all payers with the sole exception of Medicare because of the difficulties in obtaining Medicare waivers for locally-defined payment reforms. Fortunately, HHS/CMS is making efforts to facilitate the inclusion of Medicare in state multi-payer payment reforms, and the new federal Patient Protection and Affordable Care Act authorizes the Center for Medicare and Medicaid Innovation to participate in locally-defined payment reforms.

3. Issues Caused by Large or Dominant Providers

Although there are efficiencies and other advantages to having multiple physicians working together as part of a physician group, IPA, or Physician-Hospital Organization, over-consolidation of providers can also cause problems, since a provider with monopoly or near-monopoly status with respect to a particular service can also take actions which thwart the goals of payment reform. For example:

- If a large provider feels that the new payment system would be less profitable for it, it could refuse to sign contracts with any payer seeking to pay the provider using the new payment system. If the provider delivers healthcare services to a large proportion of the patients in the community, then a large proportion of the payer's members will likely be receiving their care from the provider, and the payer will find it undesirable not to have the provider in its network. If the provider has a monopoly or near-monopoly in the community for one or more important services, the payer may be unable to offer a complete package of benefits to its members without that provider. As a practical matter, therefore, the provider's refusal to participate would significantly thwart the ability of the payer to implement the new payment system.

Depending on how the payment changes are implemented, the "payer" could also be a provider, rather than a health plan or self-insured purchaser. For example, a primary care physician practice that accepts a condition-adjusted comprehensive care payment for a population of patients might want to contract directly with specialty providers and hospitals to better coordinate on care. But if a particular specialty group or hospital holds a monopoly on a particular service and refuses to contract, it could impede the ability of the primary care practice to properly manage the overall quality and costs of care for its patients.

- If the payment reform is designed to enable or encourage other providers to reduce their utilization of services offered by the large/monopoly provider, the large/monopoly provider could respond by increasing its prices proportionally to offset the loss of revenue due to reduced utilization. For example, if the physicians in the community reduce hospital admissions by 20%, but the hospital increases its prices by 25%, then the net effect on hospital spending is zero.

This suggests that healthcare markets where there are multiple providers of essential healthcare services or multiple Accountable Care Organizations will, in general, be more conducive to implementing payment reforms that control costs than markets which are dominated by large providers or where major services are controlled by a single provider.

G. 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 health care payment and delivery systems from fraudulent or abusive conduct. While these laws and regulations are often designed to discourage *undesirable* conduct under *current* payment systems, they can also serve to prevent or discourage *desirable* practices under *reformed* payment systems.

Consequently, it is likely that significant changes to a variety of both federal and state laws and regulations will be needed in order to facilitate the implementation of new payment systems and the organizational structures providers will need to form in order to participate in those new payment systems. This will likely be a very challenging process, since the transition to new payment systems will occur over time and at different speeds in different parts of the country, and as described in Section II-D, it may well be the case that fee-for-service payment will remain in place for many types of patients and conditions.

Although a detailed legal analysis cannot be provided here, the following is a brief overview of some major laws and the barriers they may pose to the payment and delivery system changes described in previous sections.

1. Prohibitions on Physician Referrals of Patients to Entities With Which They Have a Financial Relationship

The federal Ethics in Patient Referrals Act, commonly known as the “Stark Law,”⁶⁴ prohibits physicians from referring Medicare and Medicaid patients to entities such as hospitals with which the physicians have a financial relationship (i.e., an ownership interest or a compensation arrangement) for the provision of “designated health services”⁶⁵ except in a number of specifically exempt circumstances, e.g. where the physician is an employee of the entity. In addition to the federal law, a number of states have enacted laws or regulations which also prohibit some types of self-referrals, including services reimbursable by private health plans.⁶⁶

The Stark law and similar state self-referral statutes or regulations are intended to avoid having financial considerations influence physicians' referral decisions. However, under a system that bundles payments to physicians and hospitals (or to physicians and other types of entities) to enable and encourage the delivery of coordinated services, physicians will inherently need to refer their patients to the hospital with which they have the bundled payment arrangement, and this may violate state and/or federal self-referral laws or regulations. Moreover, because the laws or regulations typically have exemptions for employment arrangements, they can create a disadvantage for organizational structures in which physicians are independent compared to health systems that employ physicians.

In July, 2008, the Centers for Medicare and Medicaid Services (CMS), which enforces the federal Stark Law and the associated regulations, proposed a specific exception designed to enable implementation of appropriately structured gainsharing programs,⁶⁷ but CMS has not yet finalized this exception. Even if appropriate changes are made to the Stark law or regulations, state laws could continue to pose a barrier unless they are also changed.

2. Prohibitions Against Payments in Return for Referrals of Patients

The federal Anti-Kickback statute⁶⁸ makes it a felony for any person to knowingly and willingly offer, solicit, or receive any remuneration for either referring a patient for an item or service, or for arranging or recommending an item or service, paid in whole or in part under a federal health care program. Many states have also enacted anti-kickback statutes or regulations.⁶⁹ The federal Anti-Kickback statute and state anti-kickback laws can make it illegal to create a program to reward physicians for following specific guidelines or to share the savings from the use of particular drugs or devices that have lower costs and higher quality.

The Office of Inspector General at the U.S. Department of Health and Human Services (OIG), which is responsible for interpreting the federal Anti-Kickback law and is one of the agencies responsible for enforcing it, can issue advisory opinions upon request concerning the applicability of the federal Anti-Kickback statute to specific arrangements. The OIG has created some "safe harbors" that protect certain types of arrangements from liability under the federal Anti-Kickback statute⁷⁰ However, without clear statutory authorization for the kinds of payment structures described in earlier sections, the federal Anti-Kickback statute, and in some cases state anti-kickback statutes or regulations, will likely discourage arrangements that could improve quality and reduce costs in addition to discouraging arrangements that would have the opposite effect.

3. Prohibitions Against Payments to Physicians to Reduce or Limit Services

Yet another federal law, the Civil Monetary Penalty statute⁷¹, 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

OIG as prohibiting such payments even if the services being reduced are not medically necessary or appropriate.⁷² Consequently, gain-sharing programs designed to reward physicians for reducing unnecessary services or unnecessary elements of services could make a hospital liable for civil money penalties. As noted earlier, gainsharing arrangements may also be in violation of the federal Anti-Kickback statute and the Stark law.⁷³

Although the law applies only to Medicare or Medicaid beneficiaries, the OIG has viewed it as prohibiting such payments even for commercially insured patients, since the assumption is that incenting changes in practice for commercial patients would likely also result in changes in practice for Medicare or Medicaid patients, or that the amounts of payment incentives for changing practices, even though applied only to commercial payments, are set at levels designed to incent the changes for all patients.⁷⁴

4. Prohibitions on Payments by Tax-Exempt Hospitals to Physicians

Many hospitals are tax exempt under section 501(c)(3) of the Internal Revenue Code (IRC).⁷⁵ To obtain and maintain 501(c)(3) status, an organization's operation cannot confer more than a nonincidental benefit on a private party, i.e., its operation cannot result in a "private benefit."⁷⁶ Since independent physicians are "private parties," this provision limits what hospitals can do to reward physicians. A prohibited private benefit can be conferred without any money flowing from the exempt organization to the private recipient,⁷⁷ or even if the payments to private recipients are at or below fair market value.⁷⁸ The Internal Revenue Service (IRS) may revoke an organization's tax exemption for violations of the private benefit prohibition.

In addition to the private benefit prohibition, section 501(c)(3) states that the tax exempt organization must ensure that no part of its net earnings inures to the benefit of any private shareholder or individual. The phrase "private shareholder or individual" refers to persons "having a personal and private interest in the activities of the organization."⁷⁹ Such persons are frequently referred to as "insiders." Whether or not a particular person qualifies as an "insider" depends on the level of control the person can exercise with respect to the tax-exempt organization. Unlike the private benefit prohibition, which permits incidental benefits to private persons, no amount of private inurement is allowed. The most common type of private inurement occurs when a tax-exempt organization pays excessive compensation to an insider. If the organization violates the prohibition on private inurement, the IRS may, in addition to revoking the organization's tax-exempt status, impose intermediate sanctions in the form of excise taxes on individuals participating in an "excess benefit transaction," i.e., a transaction in which the value of the economic benefit provided by the tax-exempt organization exceeds the value of the consideration (including the performance of services) received for providing such benefit.⁸⁰

However, under some circumstances, the IRC allows tax-exempt hospitals to enter into incentive compensation arrangements with physicians. Incentive compensation arrangements must meet a number of highly specific requirements in order to be permissible under the IRC.⁸¹ In many cases it will be unclear if, or to what extent, new

payment models will fit within these current incentive compensation guidelines or otherwise be permissible under existing IRS guidance. There will also likely be concerns about how the concept of “fair market value” will be applied and interpreted by the IRS under new payment models involving tax-exempt organizations.

5. Prohibitions on Joint Action by Payers and by Providers

Federal and state antitrust laws are designed to prohibit payers and providers from jointly acting in anti-competitive ways, such as payers colluding to keep provider payments below competitive levels or providers colluding to raise prices above competitive levels. However, these laws can also create barriers to the kinds of cooperation or coordination among payers and providers that have the potential to improve quality of care or reduce the cost of care. For example, efforts to reach agreement among multiple health insurance plans to use a new approach to payment can raise concerns about antitrust violations, even if there is no discussion or agreement on the actual payment levels.⁸² Independent Practice Associations and Physician-Hospital Organizations may be prohibited from negotiating a single contract with payers on behalf of their members, even if the goal is to create a more efficient and effective method of delivering care.

The Federal Trade Commission (FTC) and the U.S. Department of Justice (DOJ) have issued a number of joint statements on their antitrust enforcement policy.⁸³ Statement 8 describes the FTC and DOJ antitrust enforcement policy with respect to physician network joint ventures, and Statement 9 concerns enforcement policy with respect to multi-provider networks, i.e., networks in which providers such as physicians and hospitals offer complementary or unrelated services within a provider network. Statements 8 and 9 outline circumstances when the FTC and DOJ are not likely to challenge joint conduct by competing physicians acting as part of a physician network joint venture or joint conduct undertaken by provider participants in a multi-provider network. Under Statements 8 and 9, the FTC and DOJ are not likely to challenge joint conduct of physicians in a physician network joint venture or participants in a multi-provider network if those physicians or participants share substantial financial risk, e.g., through a global payment arrangement such as capitation, or if they are clinically integrated.

The challenge in many cases is that as multiple independent physicians or physicians and hospitals attempt to transition from non-integration to clinical integration, even if the endpoint would satisfy antitrust scrutiny, the intermediate steps taken in order to become clinically integrated may not. For example, at the commencement of efforts to form a clinically integrated network, participating physicians will likely want to begin working to develop systems for coordinating the way they deliver care however, the federal enforcement agencies may not view these initial steps as generating efficiencies sufficient to offset antitrust concerns.⁸⁴ The Federal Trade Commission has in a few cases preliminarily approved joint conduct by physicians and/or health care providers participating in networks that are in the process of becoming fully integrated.⁸⁵ However, there remains considerable uncertainty regarding when a network has achieved a level of

clinical integration such that the joint conduct undertaken by its participants is not seen as an antitrust violation.

As noted in Section V-F-1, states can protect healthcare payers and providers from antitrust liability under the “state action” doctrine of antitrust law. To do this, the state must (1) have a clearly articulated state policy supporting the need for common approaches, and (2) engage in active supervision of the activities that might otherwise cause antitrust concerns.⁸⁶ For example, the State of Washington passed legislation in 2009 that specifically authorized discussions among payers and providers about new payment approaches to support primary care medical homes.⁸⁷

6. Prohibitions on Corporations Delivering Medical Care

In contrast to some of the laws cited above that implicitly favor health systems that employ physicians, some states have “corporate practice of medicine” statutes which prohibit lay entities (i.e., non-physician-controlled corporations) from employing physicians.⁸⁸ Some of these statutes explicitly permit hospitals or non-profit hospitals to employ physicians, but others, such as California, do not. Depending on the circumstances, these laws may facilitate or impede specific types of payment and organizational structures.

A variant is that some state laws explicitly require that fees for physician services be itemized separately, which could serve as an impediment to bundled payments and episode pricing.

7. Limitations on the Construction of New Healthcare Facilities and the Delivery of New Services

The federal Health Planning Resources Development Act of 1974 required that every state have a “Certificate of Need” program requiring that a healthcare provider seek approval from the state before beginning any major capital project such as a building expansion or ordering new high-technology devices. Although the federal law was repealed in 1987, 36 states still have some form of Certificate of Need (CON) program, and some of those which repealed their program retain mechanisms intended to prevent duplication of services.⁸⁹

CON programs were designed to serve as a restraint against the incentives in fee-for-service payment systems for healthcare providers to add new and expensive services that would increase the costs of existing services (by reducing volumes relative to fixed costs). However, under a payment system that genuinely rewards and encourages the use of higher-value services, these programs could potentially impede the ability of a provider to introduce value-based competition into a market by creating a significantly higher-value service model.

8. Restrictions on the Ability of Providers to Accept Financial Risk

State insurance laws and regulations are designed to protect consumers from purchasing health insurance from companies which do not have sufficient financial reserves to cover all of the claims that they receive. Under a system where all risk is held by insurance plans and physicians and hospitals are paid for all services they deliver, the risk of insolvency is exclusively with the insurance plan and therefore the regulation of financial reserves is also exclusively focused on the insurance company. However, under payment models that split financial risk between insurance risk (which remains with the insurance plan) and performance risk (which is now held by a provider organization), there is also a risk of insolvency with the provider organization. This could subject physician organizations and other providers to overly burdensome regulations and reserve requirements,⁹⁰ thereby discouraging them from participating in payment models that require them to accept financial risk for their performance.⁹¹

9. Changing Malpractice Laws

Concerns about liability affect physician and hospital decisions about the way care is delivered, and those concerns could impede the ability for physicians to institute significantly new approaches to care even if payment methods are changed. Some states have modified their malpractice laws in an effort to address these concerns.⁹² The new federal Patient Protection and Affordable Care Act authorizes a program of demonstration grants to states for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers.

10. Restrictions on Insurance Benefit Designs

In the interest of consumer protection, many state insurance regulations limit the amount of cost-sharing that commercial health insurance plans can impose on consumers, or require that coverage be provided for certain kinds of services. In some cases, these regulations can serve as barriers to efforts by payers and providers to encourage consumers to utilize higher-value providers and services (e.g., by providing financial incentives to use services of equivalent value but lower cost) or to use providers that have lower prices for the same service.

H. Regional Coordination of Payment and Delivery Reform

As noted in Section II-B, although payment reforms are likely *necessary* in order to significantly improve healthcare quality and reduce costs, they are not *sufficient* to achieve those goals; the goals are actually achieved by physicians and other healthcare providers transforming the way they deliver care. It is difficult for payers to change the way they pay for care if physicians do not have the kinds of capabilities and organizational structures described earlier; however, at the same time, it is very difficult, if not impossible, for physicians to develop those capabilities without a payment system

that supports them. This “chicken and egg” problem means that payment and delivery reforms will need to co-evolve in a coordinated way.

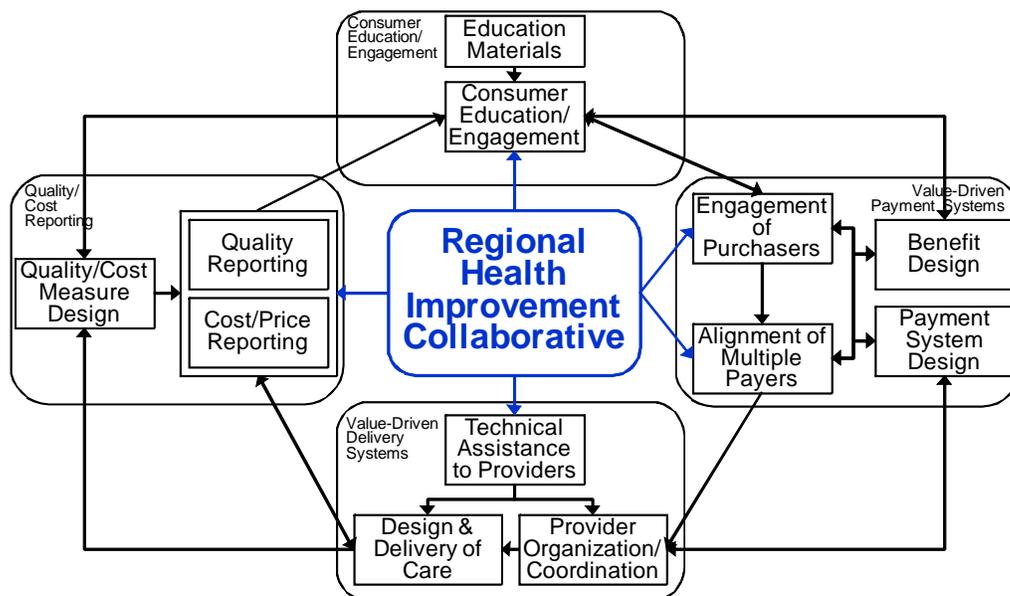
Other changes that need to be made to support payment and delivery system changes include:

- Changes in health plan benefit designs that enable and encourage consumers to improve their health, adhere to treatment plans, choose high-value providers and services, etc.
- Accurate and timely methods of measuring and reporting on healthcare quality to help the community be sure that payment changes are not harming the quality of care, to help consumers choose high quality providers, and to help physicians and other providers know where improvement is needed.
- Consumer education about how changes in benefits, payment systems, and delivery systems can help them get better healthcare at an affordable cost.
- Technical and financial assistance to physicians and other healthcare providers to enable them to build the capacity to succeed under new payment and delivery models.

Since all of these changes and actions are interrelated, a mechanism is needed to ensure that the changes are made in a coordinated manner. No one-size-fits-all national solution will work, since the changes 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 individual community. Moreover, 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; however, since in many communities there is considerable distrust between different stakeholder groups, a neutral facilitator is needed to help design “win-win” solutions.

Since there is no individual or organization “in charge” of healthcare in any region, much less the nation as a whole, a growing number of communities (typically either metropolitan regions or statewide efforts) have implemented Regional Health Improvement Collaboratives to provide leadership, planning, and coordination for the many different activities required for successful payment and delivery system reform. Regional Health Improvement Collaboratives are non-profit organizations which bring together all of the key stakeholders in the region – providers, payers, purchasers, and consumers – to develop a common vision of how healthcare quality and value should be improved, to design plans for achieving those outcomes in a way which equitably “shares the pain,” and to provide the necessary support to successfully achieve the goals and implement the plans in a coordinated fashion.

There are currently over 50 Regional Health Improvement Collaboratives in the country. Most were formed within the past 5 years, but some have been in existence for 10-15 years or longer. There has been a dramatic growth in the number of Regional Health Improvement Collaboratives in the past 5 years, partly due to the rapidly growing concern about healthcare costs and quality across the country, and partly due to proactive efforts by the Robert Wood Johnson Foundation (through the Aligning Forces for Quality program) and the U.S. Department of Health and Human Services (through the Chartered



Value Exchange program) to foster the creation of such entities. The leading collaboratives are members of the Network for Regional Healthcare Improvement, the national coalition of Regional Health Improvement Collaboratives.⁹³

Examples of the kinds of initiatives undertaken by Regional Health Improvement Collaboratives to advance healthcare quality improvement, payment reform, and delivery system reform include:

- Most Regional Health Improvement Collaboratives have established a mechanism for collecting and publicly reporting data on the quality of care delivered by physicians. Unlike many quality reporting initiatives developed by health plans and government agencies, these quality measurement and reporting initiatives are developed and operated with the active involvement and supervision of the physicians for whom quality scores are being reported, so the physicians can ensure that the measures are meaningful and the data are accurate. Although many of these measurement systems rely on health plan claims data, a growing number of Regional Health Improvement Collaboratives, such as Minnesota Community Measurement and the Wisconsin Collaborative for Healthcare Quality, are using clinical data from physicians for quality measurement. Some Regional Health Improvement Collaboratives, such as Massachusetts Health Quality Partners, also collect and report information on consumers' experience with healthcare providers.⁹⁴

- Many Regional Health Improvement Collaboratives are working with providers, either individually or in groups, to help them better organize and deliver healthcare in order to improve quality and efficiency. For example, the Pittsburgh Regional Health Initiative developed a Preventable Readmission Reduction Initiative that worked with primary care practices to improve care for people with chronic diseases and successfully reduced hospital readmissions for patients with chronic obstructive pulmonary disease.⁹⁵
- Several Regional Health Improvement Collaboratives are already working to build consensus among the multiple health plans and other payers in their communities on the types of payment reforms which should be implemented, so that physicians and other healthcare providers are not forced to deal with multiple, disparate new payment structures. A few Collaboratives have successfully implemented multi-payer payment reforms in their communities. For example, the Institute for Clinical Systems Improvement reached agreement among all of the major health plans in Minnesota on changes in payment to support better primary care for patients with depression.⁹⁶

As more communities begin efforts to develop and implement payment changes, the need for Regional Health Improvement Collaboratives will grow. For example, in order to define outcome targets and strategies for reaching them, physicians will need information about the *current* costs and outcomes associated with their patients. Because only payers generally have this type of information, and because the information about any particular provider's patients is fragmented across multiple payers, it is difficult for a physician or other healthcare provider to know how they are doing today and where improvements may be possible. Regional Health Improvement Collaboratives can help to bridge this gap, since many already have assembled multi-payer claims databases. Also, no matter how much effort is put into designing new payment systems and delivery system reforms, implementation problems will inevitably arise. A Regional Health Improvement Collaborative that is supported by all stakeholders and perceived by them as neutral can provide a critical mediation mechanism for resolving such problems quickly and effectively.

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

It should be clear from the previous sections that payment systems can and should be designed in ways that enable independent physician practices, including small physician practices, to not only survive but thrive. Indeed, payment reforms should be judged in part on their ability to support patient-centered, physician-led health care delivery.

This does not mean that physician practices will not have to change. 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.

The following are several examples of how physician practices in several communities around the country, including very small practices, are successfully managing the kinds of payment reforms described earlier.

A. Small Primary Care Practices Managing Global Payments

As an example of how small primary care physician practices can work together to manage comprehensive care/global payments without forming large group practices or being employed by health systems, Physician Health Partners LLC (PHP)⁹⁷, 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.

PHP was founded in 1996 to serve the largest primary care IPA in Denver, Primary Physician Partners, which has approximately 150 family practice, internal medicine, and geriatric physicians in northwest Denver. PHP now also supports Colorado Pediatric Partners, a multi-specialty pediatric IPA that serves patients throughout Denver; South Metro Primary Care, a primary care IPA with over 40 family practice and internal medicine physicians located in southwest Denver; and KEY Primary Care Physicians, a new IPA formed in 2008 with internists and family practitioners in east and south Denver. The individual practices in the IPAs are all small; the largest has 12 physicians and the median practice size is 3 physicians.

PHP negotiates capitated risk-based contracts on behalf of these IPAs with both Medicare and commercial HMOs, and it manages health services for several state agencies, in total involving 60,000 patients in the Denver region. The risk-based contracts do not include the costs of inpatient hospital services, but do include all

professional services (including physician fees for inpatient care) and some hospital outpatient services. (PHP has not had hospitals willing to enter into shared risk arrangements since 1999.) Since the three primary care IPAs do not include specialists, PHP contracts with several specialty groups, such as Rocky Mountain Cardiovascular Associates and Rocky Mountain Cancer Centers, to manage specialty care for the IPA patients under PHP's capitated contracts; some of these contracts with specialty groups are capitated and some are based on budget targets.

Through PHP, the IPAs can accept capitation contracts, and then the individual physician practices in the IPA are paid from the capitation revenues on a fee-for-service basis with a bonus based on utilization and quality targets. PHP provides the infrastructure and services, such as care management services, utilization management and analysis, etc., needed to successfully manage global payments and other payment arrangements.

Each of the physician practices in the IPAs contracts separately with health plans to deliver services to patients enrolled in PPO health plan products. Currently, less than half of the physicians' revenues come from the capitation contracts, a smaller share than in previous years due to the shrinking number of patients in HMO plans. The physicians prefer the capitation payment arrangements because they receive better pay due to the ability to manage overall costs. PHP would like to have more capitation contracts and to take responsibility for managing care of patients in PPO plans under capitated arrangements, but it has not been able to obtain additional capitation arrangements from any health plans.

One important factor affecting success is setting the price of the capitation contract at a level that benefits both the health plans and the physicians. Price-setting has been particularly challenging in PHP's commercial capitation contracts, since the payment levels are not adjusted based on conditions of the patients. (This means that the contracts shift insurance risk as well as performance risk to physicians). PHP's Medicare Advantage contracts appropriately shift primarily performance risk to PHP by adjusting payment levels using the same condition/severity-adjustment system that the Centers for Medicare and Medicaid Services uses to adjust payments to the Medicare Advantage health plan.

The most critical factor for the success of PHP and its IPAs has been helping physicians learn how to manage quality and costs effectively under global payment schemes, which is a very different set of skills than physicians need to succeed under fee-for-service payment. Making this transition generally takes physicians two years or more. PHP has been able to help its newest IPA clients transition more smoothly than they would likely have been able to do on their own thanks to more than a decade of experience in managing such payment arrangements and having built the necessary infrastructure and services to support physicians.

B. Independent Primary Care Physicians and Specialists Managing Global Payments

As an example of how independent physicians from a wide range of specialties can form a virtual “accountable care organization” and manage costs and quality for a population of patients, Northwest Physicians Network (NPN)⁹⁸ in Tacoma, Washington is an Independent Practice Association of 454 physicians – 109 primary care physicians and 345 physicians in 35 specialties – which contracts with health plans and self-insured employers, including full risk payment arrangements with Medicaid HMO and Medicare Advantage plans. The physicians are in 165 separate practices with an average of 2.4 physicians per practice.

NPN was organized in 1995 as a physician-owned managed care company that could accept full risk for providing high quality care for patients at adequate reimbursement rates for its member providers. It has evolved over time to include a number of affiliated organizations and programs, including:

- BenefitMD, a third-party administrator (TPA) to deliver and administer care for self-funded employers;
- Puget Sound Health Partners, a Medicare Advantage plan;
- MyOfficePartner, a full service practice management company; and
- South Sound Health Communication Network, a web-based chronic care improvement system that allows multiple physicians and patients to communicate and share information electronically.

NPN is also partnering with Clarity Health Services to build the first web-based, documented patient care coordination system that is accessible to all physicians, regardless of whether they have electronic health record systems or paper charts.

NPN has full or partial risk capitation contracts with two health plans covering approximately 16,000 patients, including its own Medicare Advantage plan. NPN pays its member practices using a five-tier bonus program based on reaching specific chronic care performance levels. NPN also provides services such as case and disease management, performance reporting, contracting with hospitals, etc. to help the practices successfully manage utilization, costs, and quality under such contracts. One of the biggest challenges has been negotiating adequate levels of payment with health plans. Although the Medicare Advantage plan payments are condition/severity-adjusted, the Medicaid HMO contract is challenging because of hospital price increases that are higher than state payment increases. The primary care physicians participating in NPN prefer the capitation contracts, but only 10-15% of their revenues on average come through NPN’s capitation contracts because most patients in the communities NPN serves have PPO health plans.

A key value that NPN brings to its member physician practices has been to help them access the types of technology and care coordination services that are generally

only available in large integrated delivery systems without having to give up their independence. This was a deliberate strategy to enable the physician practices to remain independent. These services help the physician practices become more successful on traditional fee-for-service contracts as well as enable them to participate in global payment arrangements that can increase their revenues above typical fee-for-service payment levels. NPN's physicians significantly outperform other physicians in Washington State on both quality and utilization measures (e.g., 30% lower rates of emergency room visits, 20% lower rates of inpatient days, 6-12% better diabetic management scores, etc.).

However, getting to its current level of success was not easy; NPN incurred significant losses in its early years before breaking even and becoming profitable. This required committed leadership, collaboration from its member physicians, and a strong, stable staff. It has taken about ten years for NPN to assist its primary care physicians to build the skills needed to manage utilization (e.g., reviewing data on utilization and implementing guidelines) using the support services provided by NPN, and for NPN to develop a sufficient volume of patients to cover the costs of those support services.

C. Physician-Hospital Organizations Managing Episode-of-Care Payments

As an example of how independent specialty physicians can benefit through a collaborative effort with hospitals under episode-of-care payment, in 2009, the Medicare Acute Care Episode Demonstration began paying five Physician-Hospital Organizations a single, "bundled" payment for 28 cardiovascular procedures and 9 orthopedic procedures (cardiac valve procedures, cardiac defibrillator implant procedures, coronary bypass procedures, cardiac pacemaker procedures, percutaneous cardiovascular procedures, hip replacement surgery, and knee replacement surgery).

The first two PHOs to begin the project were at Baptist Health System in San Antonio, Texas⁹⁹, and at Hillcrest Medical Center in Tulsa, Oklahoma.¹⁰⁰ In each case, new PHOs were established:

- At Hillcrest, two separate PHOs were established, one involving cardiac specialists and the other involving orthopedic specialists. The orthopedic surgeons at Hillcrest are independent physicians, while most of the cardiologists and cardiac surgeons are employed by the hospital. The hospital covered all of the costs of forming the new PHOs.
- At Baptist Health System, all of the orthopedic and cardiac specialists participating are independent physicians. Although a large PHO had already been in place for ten years, the hospital established a new PHO just for the Medicare project, which all of the participating specialists joined.

These PHOs were able to achieve significant savings in the costs of the cardiac and orthopedic procedures, particularly through negotiating discounts with medical device manufacturers (e.g., suppliers of coronary artery stents and orthopedic implants).

For example, during the first five months of the program, Hillcrest Medical Center reported reducing costs of orthopedic procedures by 7%.

Key to success was the fact that incentives were aligned for the hospital and the surgeons, i.e., both shared in the savings achieved from lower device costs and improved hospital efficiency, rather than having all of those savings accrue to the hospital budget. Medicare achieved upfront savings by having the amount of the bundled payment be slightly lower than the previous combined amount of the hospital DRG payment and the physician's fees (the exact discount was based on the proposal that the PHO submitted in order to be selected by Medicare to participate in the program). However, the hospitals agreed to absorb this upfront discount and committed that the physicians would receive at least the same amount from the bundled payment as they would have under standard Medicare physician payment levels. The physicians were then eligible for an up to 25% bonus above the standard payment levels based on the level of savings achieved in hospital costs, assuming quality targets were met.

Under the demonstration, patients also have an incentive to use the participating hospitals/physicians, since they receive 50 percent of the savings Medicare achieves up to a maximum of the annual Part B premium, currently \$1,157. For example at Baptist Health System, patients receive a \$1,157 rebate for most bypass and valve surgeries. Both hospitals have advertised their participation in the program and the financial incentives available for patients in an effort to attract a greater share of such procedures in their local markets.

Both sites indicate that it was critical to involve physicians in the planning and implementation of the program and to focus on quality improvement, not just cost reduction. Challenges included obtaining the necessary data to define and tackle opportunities for cost reduction and quality improvement.

D. Joint Contracting by Physicians and Hospitals for Comprehensive Care (Global) Payment

As an example of how physicians and hospitals can jointly manage outcomes and financial risk as an Accountable Care Organization without physicians being employed by hospitals or even forming a Physician-Hospital Organization, the Mount Auburn Cambridge Independent Practice Association (MACIPA)¹⁰¹ and Mount Auburn Hospital in Massachusetts were the first providers to jointly contract with Blue Cross Blue Shield of Massachusetts to manage the global payment arrangement under BCBSMA's Alternative Quality Contract.

MACIPA and Mount Auburn Hospital are independent organizations. MACIPA has 513 physician members, nearly half (48%) of whom are in independent private practices. One-third (31%) are owned by Mount Auburn Hospital, and one-fifth (20%) are owned by the Cambridge Health Alliance (a three-hospital system in Boston). 94 of MACIPA's members are primary care physicians, 402 are specialists, and 17 serve as both PCPs and specialists. MACIPA is paid on a full risk capitation basis by the three major Boston-area health plans for 40,000 lives.

MACIPA and Mount Auburn Hospital have worked collaboratively since 1985 to manage capitation and global payment arrangements for their patients. There is no legal structure, such as a Physician-Hospital Organization, joining them. In order to participate in capitation and global payment contracts, such as the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract, they sign a three-way contract, i.e., MACIPA and Mount Auburn Hospital are independent signatories to the contracts. MACIPA and Mount Auburn Hospital then develop agreements with each other as to how risk-sharing will be done, which entity will provide what services, and what the compensation will be for each service. About 50% of the services delivered under the capitation/global payment contracts are provided by MACIPA and Mount Auburn Hospital (services delivered by other physicians/hospitals are paid at the rates negotiated by the health plans). The two organizations work to reduce “leakage” of services to costlier providers as much as possible.

MACIPA’s skills and capabilities to manage these kinds of payment arrangements have been developed over many years. It has 46 employees and provides many of the types of services and functions that health plans provide under fee-for-service payment systems, i.e., case management, utilization management, credentialing, pharmacy management, quality measurement, etc. The resources and skills to provide these functions have been built up over time.

MACIPA attributes its success to a number of factors: having a primary care-centric culture, involving physicians in planning and decision-making, having physicians who are collaborative, being data-driven, focusing on quality as the way to drive efficiency, ensuring the IPA brings value to individual physicians, having stable leadership, having a good relationship with Mount Auburn Hospital, and having a sufficiently large number of patients participating in global payment arrangements to support the infrastructure needed to manage care delivery and finances.

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 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. See, for example, Bourbeau J, Julien M, Maltais F, Rouleau M, Beaupre A, Begin R, et al. Reduction of hospital utilization in patients with chronic obstructive pulmonary disease: a disease-specific self-management intervention. *Arch Intern Med*. 2003 Mar 10;163(5):585-91; Gadoury MA, Schwartzman K, Rouleau M, Maltais F, Julien M, Beaupre A, et al. Self-management reduces both short- and long-term hospitalisation in COPD. *Eur Respir J*. 2005 Nov;26(5):853-7.

³ Becker C. Profitable complications. *Modern Healthcare*, December 17, 2007.

⁴ 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>.

⁵ For example, as part of the DIAMOND Initiative developed by the Institute for Clinical Systems Improvement in Minnesota, health insurance companies in Minnesota pay psychiatrists to assist primary care physicians in managing the care of patients with depression. See the “DIAMOND Initiative,” http://www.icsi.org/health_care_redesign_/diamond_35953/.

⁶ See, for example, Rosenthal MB, Frank RG, Li Z, Epstein AM, Early experience with pay-for-performance: From concept to practice," *JAMA* 2005; 294(14):1788-1793.

⁷ Medicare, some Medicaid programs, and some commercial insurers have implemented these types of policies for hospitals. Rosenthal J, Hanlon C. *Nonpayment for Preventable Events and Conditions: Aligning State and Federal Policies to Drive Health Systems Improvement*. National Academy for State Health Policy, December 2009.

⁸ Some examples of this are given in Section III.

⁹ For example, the State Employees Health Commission in Maine assigns hospitals and physician groups to “preferred” and “non-preferred” tiers based on the quality rankings assigned by the Maine Health Management Coalition. Information on the State Employees Health Commission program is available on the State of Maine website http://www.maine.gov/tools/whatsnew/index.php?topic=oit_msenc&id=59425&v=ViewArticle. Information on the quality rankings from the Maine Health Management Coalition is available at <http://www.mhmc.info>.

¹⁰ The State of Minnesota refers to this as a “basket of care.” See <http://www.health.state.mn.us/healthreform/baskets/index.html>.

¹¹ The Massachusetts Coalition for Primary Care Reform is testing a comprehensive primary care payment model under which primary care practices receive a risk-adjusted comprehensive payment plus a risk-adjusted bonus for implementing medical home services and achieving desired outcomes. The concept is described more fully in Goroll AH, Berenson RA, Schoenbaum SC, Gardner LB. Fundamental reform of payment for adult primary care: comprehensive payment for comprehensive care. *J Gen Intern Med*. 2007 Mar;22(3):410-5.

¹² A demonstration and evaluation of the shared savings concept was undertaken by Medicare as part of the Physician Group Practice Demonstration. The program was implemented in ten large physician group practices across the country beginning in 2005 and was extended to run for a total of 5 years. As of the third year of the program, all ten of the physician groups achieved high-quality performance on the majority of quality measures, and five generated sufficient savings to qualify for shared savings payments.

Information on the Medicare Physician Group Practice Demonstration is available on the Centers for Medicare and Medicaid Services website, <http://www.cms.hhs.gov/DemoProjectsEvalRpts/>.

¹³ Wilensky G, Wolter N, Fischer, M. Gain sharing: a good concept getting a bad name? *Health Aff (Millwood)*. 2007; 26(1):w58-w67.

¹⁴ An analysis by MedPAC illustrated the fact that even under a shared savings program, a surgeon still makes more money by performing more surgeries. See Medicare Payment Advisory Commission. Chapter 2: Accountable Care Organizations. In: Report to the Congress: Improving Incentives in the Medicare Program. Washington (DC): MedPAC; 2009 Jun.

¹⁵ Miller HD. From volume to value: Better ways to pay for health care. *op. cit.*

¹⁶ *Ibid.*

¹⁷ “Condition-adjustment” is the same basic concept as “risk adjustment,” but since the payment is being adjusted based on the patient’s current status, not just on their risk of future needs, and since most risk-adjustment systems are based primarily on the conditions the patient has, it seems clearer to refer to this as condition-adjustment.

¹⁸ CMS replaced the previous 538 Diagnosis Related Groups (DRGs) with 745 “Medicare-Severity DRGs” (MSDRGs).

¹⁹ However, it is worth noting that this problem exists even in the fee-for-service system, because fee levels are fixed for specific services. For example, if a physician’s patients routinely require much more than the assumed amount of time for an office visit, the physician will lose money because he or she will be able to see fewer patients during the day than needed to cover their costs. Alternatively, compressing the visits to fit within the assumed time can result in failure to address all of the patient’s needs appropriately, resulting in poorer quality of care and poorer outcomes.

²⁰ Miller HD. From volume to value: Better ways to pay for health care. *op. cit.*

²¹ Basing payment rates on best practices rather than current practices is an approach that has been pioneered by PROMETHEUS Payment, Inc. PROMETHEUS has been working to develop “evidence-informed case rates” that define a combined payment amount for all services in an episode of care based both on (1) what evidence-based medicine indicates should be provided in order to achieve the best outcomes and (2) the current rates at which services are provided. (Since there is not clear evidence for all aspects of most types of care, the PROMETHEUS evidence-informed case rates are a mix of the second and third approaches defined earlier.) PROMETHEUS has currently developed evidence-informed case rates for both acute conditions (e.g., heart attack, hip replacement, and knee replacement) and chronic diseases (e.g., asthma, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, diabetes, and hypertension).

²² *Ibid.*

²³ 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.

²⁴ Chernew M, Rosen A, Fendrick AM. Value-based insurance design. *Health Aff (Millwood)*. 2007 Jan;26(2):w195-w203. Fendrick AM, Chernew M, Levi GW. Value-based insurance design: Embracing value over cost alone. *Am J Manag Care*. 2009; 15:S277-S283.

²⁵ Miller HD. From volume to value: Better ways to pay for health care. *op. cit.*

²⁶ The majority of state Medicaid programs pay at least some of their primary care practices a Primary Care Case Management payment, in addition to fees for service, to enable and encourage the primary care practice to improve the quality and reduce the cost of care to Medicaid beneficiaries.

²⁷ See, for example, the Massachusetts Coalition for Primary Care Reform. *Op. cit.*

²⁸ For example, the Alabama Medicaid Program implemented a shared savings program in 2007 as part of its Patient 1st primary care case management program. The program gives primary care practices in the

state 50% of the savings the state receives when patients use generic medications more frequently and use emergency rooms less often. \$4.7 million in shared savings was distributed to physicians in 2009 based on 2008 results. See http://www.medicaid.state.al.us/programs/patient1st/patient_1st_shared_savings.aspx.

²⁹ Minnesota Department of Health. Health Care Home Payment Methodology: Structure and Design. January 2010. Available at: http://www.health.state.mn.us/healthreform/homes/payment/PaymentMethodology_March2010.pdf.

³⁰ Centers for Medicare and Medicaid Services. Medical Home Demonstration Fact Sheet. January 9, 2009. Available at: http://www.cms.gov/DemoProjectsEvalRpts/downloads/MedHome_FactSheet.pdf.

³¹ Cromwell J, Dayhoff DA, Thoumaian AH. Cost savings and physician responses to global bundled payments for Medicare heart bypass surgery. Health Care Financ Rev. 1997 Fall;19(1):41-57.

³² Centers for Medicare and Medicaid Services, "Frequently Asked Questions About the Acute Care Episode (ACE) Demonstration, July 25, 2008 (<http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/ACEMoreInfo.pdf>).

³³ For more information, see <http://www.geisinger.org/provencare/>.

³⁴ Casale AS, Paulus RA, Selna MJ, Doll MC, Bothe AE, Jr., McKinley KE, et al. "ProvenCareSM": a provider-driven pay-for-performance program for acute episodic cardiac surgical care. Ann Surg. 2007 Oct;246(4):613-21; discussion 21-3.

³⁵ More information on PROMETHEUS is available at <http://www.prometheuspayment.org/>.

³⁶ Johnson LL, Becker RL. An alternative health-care reimbursement system--application of arthroscopy and financial warranty: results of a 2-year pilot study. Arthroscopy. 1994 Aug;10(4):462-70; discussion 71-2.

³⁷ Lyles A, Weiner JP, Shore AD, Christianson J, Solberg LI, Drury P. Cost and quality trends in direct contracting arrangements. Health Aff (Millwood). 2002 Jan-Feb;21(1):89-102. Robinow A. Patient Choice Health Care Payment Model Case Study [PowerPoint Presentation on the Internet]: Available from: <http://www.nrhi.org/2008summit.html>.

³⁸ Blue Cross Blue Shield of Massachusetts, The alternative QUALITY contract. Boston (MA): BCBSM; 2008 Nov. Available from http://quality.bluecrossma.com/press/aqc_white_paper_11_19_08.pdf.

³⁹ PROMETHEUS, op. cit.

⁴⁰ Center for Healthcare Quality and Payment Reform. Is Shared Savings the Way to Reform Payment? Available at <http://www.chqpr.org/downloads/SharedSavings.pdf>.

⁴¹ Sepulveda MJ, Bodenheimer T, Grundy P. Primary care: can it solve employers' health care dilemma? Health Aff (Millwood). 2008 Jan-Feb;27(1):151-8.

⁴² Although many primary care physicians are also "specialists," specializing in family practice, internal medicine, or pediatrics, for simplicity the term "specialist" will be used here to refer to physicians and other practitioners who focus on particular conditions or body systems.

⁴³ DIAMOND Initiative, op. cit.

⁴⁴ Network for Regional Healthcare Improvement. Pay for Innovation or Pay for Standardization? How to Best Support the Patient-Centered Medical Home. February 2009. Available at <http://www.nrhi.org/downloads/NRHI-HowtoSupporttheMedicalHome.pdf>.

⁴⁵ Nutting PA, Miller WL, Crabtree BF, Jaen CR, Stewart EE, Stange KC. Initial lessons from the first national demonstration project on practice transformation to a patient-centered medical home. Ann Fam Med. 2009;7(3):254-260.

⁴⁶ More information on the Perfecting Patient Care program is available at <http://www.prhi.org>.

⁴⁷ For example, the providers participating in the Medicare Physician Group Practice Demonstration (which gives them incentives to function like ACOs) had to wait 18-24 months to receive data on the costs of

services for the patients they were responsible for, which was much too slow to allow continuous improvement. Kautter, J, Pope G, et al. Physician Group Practice Demonstration Bonus Methodology Specifications. Waltham (MA): RTI International. 2004 December 20. Available at: http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/PGP_Payment.pdf.

⁴⁸ Crosson FJ. The delivery system matters. *Health Aff (Millwood)*. 2005 Nov-Dec;24(6):1543-8, and Nutting, Miller, et al., op. cit.

⁴⁹ See Section V-H for a more detailed discussion of Regional Health Improvement Collaboratives and their quality reporting initiatives.

⁵⁰ The study found that overhead costs as a percentage of group revenue declined until a group practice size of 10 to 15 physicians was reached, then the percentage increased until a group size of about 100 was reached. Havlicek, PL, Eiler MA, Neblett OT. *Medical groups in the US: A survey of practice characteristics — 1993 edition*. Chicago: American Medical Association.

⁵¹ See, for example, Bazzoli GJ, Dynan L, Burns LR, Yap C. Two decades of organizational change in health care: what have we learned? *Med Care Res Rev*. 2004 Sep;61(3):247-331.

⁵² See, for example, Toussaint J. Writing the new playbook for U.S. health care: lessons from Wisconsin. *Health Aff (Millwood)*. 2009 Sept-Oct;28(5):1343-50.

⁵³ Medicare Payment Advisory Commission, op. cit.

⁵⁴ Shortell and Casalino, op. cit.

⁵⁵ Fisher ES, Staiger DO, Bynum JP, Gottlieb DJ. Creating accountable care organizations: the extended hospital medical staff. *Health Aff (Millwood)*. 2007 Jan-Feb;26(1):w44-57.

⁵⁶ Although a specialized provider organization could take accountability for the cost and quality of care for a narrowly defined population (e.g., people with a specific chronic disease), it seems desirable to reserve the term Accountable Care Organization for organizations that intend to manage the care of as broad a population as possible.

⁵⁷ See, for example, Bohmer RM, Lee TH. The shifting mission of health care delivery organizations. *N Engl J Med*. 2009 Aug 6;361(6):551-3.

⁵⁸ Casalino LP, November EA, Berenson RA, Pham HH. Hospital-physician relations: two tracks and the decline of the voluntary medical staff model. *Health Aff (Millwood)*. 2008 Sep-Oct;27(5):1305-14.

⁵⁹ Miller, HD. How to Create Accountable Care Organizations. Center for Healthcare Quality and Payment Reform. September 2009. p. 28. Available at: <http://www.chqpr.org>.

⁶⁰ See Miller, HD. How to Create Accountable Care Organizations, op. cit., for a more detailed version of this concept, with four levels of ACOs.

⁶¹ Vaudrey BSJ, Loos SJ. Physician compensation update: Trends in 2008 and how RVUs played a role. *Group Practice Journal*. American Medical Group Association. September 2008.

⁶² Propp DA et al. Distribution of variable vs fixed costs of hospital care. *JAMA*. 1999; 281(7): 673.

⁶³ DIAMOND Initiative, op. cit.

⁶⁴ §1877 of the Social Security Act. The law is named after its author, Congressman Pete Stark of California.

⁶⁵ Designated health services are: clinical laboratory services; physical therapy, occupational therapy, and outpatient speech-language pathology services; radiology and certain other imaging services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.

⁶⁶ American College of Radiology, State-by-State Comparison of Physician Self-Referral Laws, 2004.

⁶⁷ 73 Federal Register 130, pp. 38,548 -38,558 and 38,604 – 38606.

⁶⁸ §1128B(b) of the Social Security Act.

⁶⁹ See e.g., Ark. Code Ann. § 20-77-902; Mich. Comp. Laws § 752.1004

⁷⁰ See the Office of Inspector General website at <http://oig.hhs.gov/fraud/safeharborregulations.asp>.

⁷¹ §1128A(b)(1) of the Social Security Act.

⁷² July 1999 DHHS-OIG Special Advisory Bulletin, Gainsharing Arrangements and CMPs for Hospital Payments to Physicians to Reduce or Limit Services to Beneficiaries; <http://oig.hhs.gov/fraud/docs/alertsandbulletins/gainsh.htm>.

⁷³ Ibid.

⁷⁴ OIG Advisory Opinion No. 08-16, October 7, 2008.

⁷⁵ 26 C.F.R. § 1.501(c)(3)-1(c)(1)

⁷⁶ Megosh, Scollick, Salins, and Chasin, “Private Benefit Under IRC 501(c)(3)” IRS Exempt Organizations Continuing Professional Education Technical Instruction Program for FY 2001, Topic H, accessible at <http://www.irs.gov/pub/irs-tege/eotopich01.pdf>.

⁷⁷ Ibid.

⁷⁸ Ibid.

⁷⁹ 26 C.F.R. § 1.501(a)-1(c)

⁸⁰ 26 U.S.C.A. § 4958

⁸¹ See Marvin Friedlander, IRS, Information Letter 2002-021 (Jan. 9, 2002), accessible at <http://www.irs.gov/pub/irs-wd/02-0021.pdf>; Brauer and Kaiser, “Physician Incentive Compensation,” IRS Continuing Professional Education Technical Instruction Program for FY 2000, Topic C, accessible at <http://www.irs.gov/pub/irs-tege/eotopicc00.pdf>.

⁸² Burke T, Cartwright-Smith L, Pereira E, Rosenbaum S. Health System Reform and Antitrust Law: The Antitrust Aspects of Health Information Sharing by Public and Private Health Insurers. Robert Wood Johnson Foundation Aligning Force for Quality Program, July 2009.

⁸³ See “Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care” at <http://www.ftc.gov/bc/healthcare/industryguide/policy/index.htm>. See also “Antitrust Guidelines for Collaborations Among Competitors,” issued by the Federal Trade Commission and the Department of Justice (2000) at <http://www.ftc.gov/os/2000/04/ftcdojguidelines.pdf>.

⁸⁴ Casalino, LP. The Federal Trade Commission, clinical integration, and the organization of the physician practice. *Journal of Health Politics, Policy, and Law*, 31(3), June 2006.

⁸⁵ TriState Health Partners, Inc. Advisory Opinion (April 2009), accessible at <http://www.ftc.gov/os/closings/staff/090413tristatealetter.pdf>; Greater Rochester Independent Practice Association, Inc. Advisory Opinion (September 17, 2007), available at <http://www.ftc.gov/bc/adops/gripa.pdf>; MedSouth, Inc. Advisory Opinion (June 18, 2007), accessible at <http://www.ftc.gov/bc/adops/070618medsouth.pdf>; MedSouth, Inc. Advisory Opinion (February 19, 2002), accessible at <http://www.ftc.gov/bc/adops/medsouth.shtm>; *but see* Suburban Health Organization, Inc. Advisory Opinion (March 28, 2006), available at <http://www.ftc.gov/os/2006/03/SuburbanHealthOrganizationStaffAdvisoryOpinion03282006.pdf> (concluding that a network of hospitals and physicians did not satisfy the requirements of clinical integration sufficient to justify rule of reason antitrust analysis to network joint contracting).

⁸⁶ Burke T, Cartwright-Smith L, Pereira E, Rosenbaum S. *op. cit.*

⁸⁷ Washington’s law states: “The legislature declares that collaboration among public payors, private health carriers, third-party purchasers, and providers to identify appropriate reimbursement methods to align

incentives in support of primary care medical homes is in the best interest of the public. The legislature therefore intends to exempt from state antitrust laws, and to provide immunity from federal antitrust laws through the state action doctrine, for activities undertaken pursuant to pilots designed and implemented under section 2 of this act that might otherwise be constrained by such laws.”

⁸⁸ Michal MH, Pekarske MSL, McManus MK. Corporate Practice of Medicine Doctrine: 50 State Survey Summary. Center to Advance Palliative Care and National Hospice and Palliative Care Organization, September 2006.

⁸⁹ National Conference of State Legislatures, “Certificate of Need: State Health Laws and Programs,” <http://www.ncsl.org/IssuesResearch/Health/CONCertificateofNeedStateLaws/tabid/14373/Default.aspx>.

⁹⁰ Hirshfeld E. Assuring the solvency of provider-sponsored organizations. *Health Aff (Millwood)*. 1996. 15(3):28.

⁹¹ There is a difference between an insurance company holding performance risk and a physician organization doing so, since the insurance company cannot deliver physician services directly and so it has to purchase them from physicians, whereas the physician organization can deliver services without compensation if necessary. Consequently, it can be argued that an insurance company needs to have greater reserves than a physician practice does to cover the same level of performance risk.

⁹² National Conference of State Legislatures, “Medical Liability/Malpractice Laws.” <http://www.ncsl.org/default.aspx?tabid=18516>.

⁹³ See the Network for Regional Healthcare Improvement website (<http://www.nrhi.org>) for a complete list of Regional Health Improvement Collaboratives.

⁹⁴ Multi-stakeholder Regional Health Improvement Collaboratives that report on the quality of physician care and involve physicians in the process of developing the measures include the California Cooperative Healthcare Reporting Initiative (www.cchri.org), the Greater Detroit Area Health Council (www.gdahc.org), the Maine Health Management Coalition (www.mehmc.org), , Massachusetts Health Quality Partners is available at <http://www.mhqp.org>, Minnesota Community Measurement (www.mncm.org), the Oregon Health Care Quality Corporation (www.q-corp.org), the Puget Sound Health Alliance (www.pugetsoundhealthalliance.org), Quality Quest for Health of Illinois (www.qualityquest.org), and the Wisconsin Collaborative for Healthcare Quality (www.wchq.org).

⁹⁵ More information on the Pittsburgh Regional Health Initiative is available at <http://www.prhi.org>. Other Regional Health Improvement Collaboratives that work with physicians to improve their performance on quality and cost include the California Quality Collaborative (www.calquality.org), the Iowa Healthcare Collaborative (www.ihconline.org), the Institute for Clinical Systems Improvement in Minnesota (www.icsi.org), the Louisiana Healthcare Quality Forum (www.lhcqf.org), and Quality Counts in Maine (www.mainequalitycounts.org).

⁹⁶ DIAMOND Initiative, op. cit.

⁹⁷ More information on Physician Health Partners is available at <http://www.phpmcs.com>.

⁹⁸ More information on Northwest Physicians Network is available at <http://www.npnwa.net/>.

⁹⁹ More information on the ACE Program at Baptist Health System is available at: http://www.baptisthealthsystem.com/services_ACE_AboutAce.aspx.

¹⁰⁰ More information on the ACE Program at Hillcrest Medical Center is available at: http://www.hillcrest.com/patients/incentive_program/.

¹⁰¹ More information on the Mount Auburn Cambridge IPA is available at <http://www.macipa.com>.