

Reforming Provider Payment

Moving Toward Accountability for Quality and Value

Statement of
Mark B. McClellan, MD, PhD
Director, Engelberg Center for Health Care Reform
Leonard D. Schaeffer Chair in Health Policy Studies
The Brookings Institution

Senate Finance Committee
Roundtable on Health Care Reform
April 21, 2009

About the Engelberg Center for Health Care Reform

The mission of the Engelberg Center for Health Care Reform, launched at the Brookings Institution in July 2007, is to develop data-driven, practical policy solutions that promote broad access to high-quality, affordable, and innovative care in the United States. Efforts currently underway at the Engelberg Center include making available better measures of quality and cost to drive higher-value health care and creating a policy framework for generating better evidence on what works, including medical treatments, provider practices, and care delivery models.

In addition, in collaboration with the Dartmouth Institute for Health Policy & Clinical Practice, the Engelberg Center is working toward implementation of reforms in health care financing that promote better care through feasible ways of linking provider payments to improved outcomes and lower costs. The Engelberg Center has also sponsored a series of public meetings on practical solutions to these and other issues. More information on these activities is available at www.brookings.edu/healthreform.

The following statement draws on the materials for one of these recent conferences, on accountability for quality and cost in health care payments, which were prepared jointly with the Dartmouth Institute for Health Policy & Clinical Practice.

Introduction

The debate about health care reform is increasingly about how to support needed changes in how health care is delivered. Concerns have expanded from targeted discussions about the millions of Americans without health insurance to broader consideration of gaps in quality, rising health care costs, and the structure of a system that is failing to address either problem. Dramatic variations in health care spending that bear little relation to health outcomes highlight the fact that simply trying to subsidize more affordable coverage in our existing health care system is not sustainable. Further, payments in Medicare and other health insurance programs are largely tied to the volume and intensity of medical services. As a result, many efforts by health care providers to prevent complications and implement innovative, lower-cost ways of delivering care – such as spending more time with patients to promote understanding of health risks and needed lifestyle changes or using allied health professionals to help with adherence to medications – actually reduce the

payments they receive. Similarly, patients with chronic diseases often get little support for taking steps to improve the quality and reduce the costs of their own care.

Feasible Principles for Reforming Health Care Payments

Increasing awareness of these problems has resulted in a growing array of public- and private-sector initiatives to promote efforts by providers to improve care and to foster greater accountability for both quality and cost. While there is ongoing debate over the specific form that such approaches should take and how to implement them around the country, these efforts are marked by growing consensus on several guiding principles for reform.

First, there is increasing agreement on the need for local accountability for quality and cost across the continuum of care. The consistent provision of high-quality care – particularly for those with serious and chronic conditions – will require the coordination and engagement of multiple health care professionals across different institutional settings and specialties. The health care system must not only facilitate, but also encourage such coordination.

Second, a successful approach to achieving greater accountability must be viable across the diverse practice types and organizational settings that characterize the U.S. health care system and should be sufficiently flexible to allow for variation in the strategies that local health systems use to improve care.

Third, successful reform will require a shift in the payment system from one that rewards volume and intensity to one that promotes value (improved care at lower cost), encourages collaboration and shared responsibility among providers, and ensures that payers – both public and private – offer a consistent set of incentives to providers.

Finally, with increased accountability on the part of providers must come greater transparency for consumers. Measures of overall quality, cost, and other aspects of performance relevant to consumers will facilitate informed choices of both providers and services and increase consumers' confidence in the care they are receiving as their providers face different incentives.

Many of the payment reforms that have been proposed or are already in use – for example, bundled payments, disease management, and pay for performance – represent meaningful steps toward greater accountability. The next step is accountability for care that leads to better outcomes and lower costs at the person level, with support for the infrastructure required to provide high-quality, coordinated care.

The Accountable Care Organization Model

The Accountable Care Organization (ACO) enables providers to receive more support for any steps they take to improve care, without big changes in their existing payments or big new financial risks. This model establishes benchmarks based on improvements in quality and spending. In addition to their usual payments, if providers in an ACO improve quality while slowing spending growth, they receive shared savings from the payers. ACO payment reforms can also be supported by other short-term steps to promote better quality care. For example, they are well-aligned with many existing reforms, such as the medical-home model and bundled payments, and also offer additional support (and accountability) to the provider organization to enable them to deliver more efficient, coordinated care. This approach has been implemented in programs like Medicare's Physician Group Practice (PGP) Demonstration, which has shown significant improvements in quality as well as savings for large group practices.

Because the groups receive a share of the savings beyond a threshold level, steps like care coordination services, wellness programs, and other approaches that achieve better outcomes with less overall resource use result in greater reimbursement to the providers. These steps thus “pay off” and are sustainable in a way that they are not under current reimbursement systems. In addition, the shared savings approach provides an incentive for ACOs to avoid expansions of health care capacity that are an important driver of both regional differences in spending and variations in spending growth, and that do not improve health.

The ACO approach also builds on current reform efforts that focus on one key group of providers, as in the medical-home model, or on a discrete episode of care, as in bundled payments. On their own, these initiatives may help strengthen primary care and improve care coordination, but they do not address the problem of supply-driven cost growth highlighted by the Dartmouth group. If adopted within a framework of overall accountability for cost and quality as is envisioned in the ACO model, both the medical home and bundled payment reforms would have added incentives to support not only better quality, but also lower overall spending growth (see Appendix).

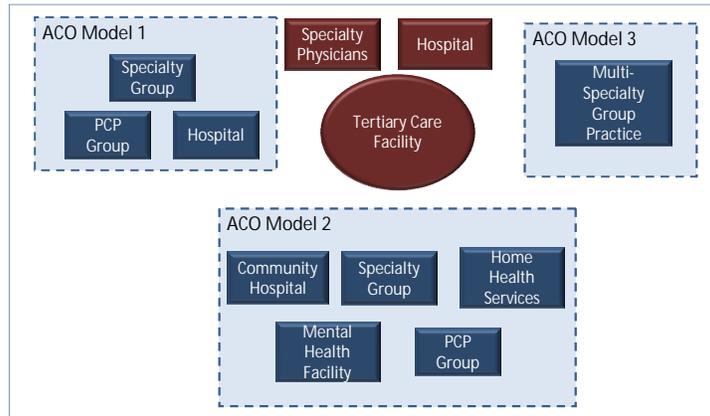
By shifting the emphasis from volume and intensity of services to incentives for efficiency and quality, ACOs provide new support for higher-value care without radically disrupting existing payments and practices. The ACO model builds on current provider referral patterns and offers shared savings payments, or bonuses, to providers on the basis of quality and cost. A wide variety of provider collaborations can become ACOs assuming that they are willing to be held accountable for overall patient care and operate within a particular payment and performance measurement framework. Examples include existing integrated delivery systems, physician networks such as independent practice associations, physician-hospital organizations, hospitals that have their own primary-care physician networks, and multispecialty group practices. Alternatively, primary-care groups or other organizations that provide basic care could contract with specialized groups that provide high-quality referral services with fewer costly complications.

Regardless of specific organizational form, the ACO model has three key features:

- 1. Local Accountability.** ACO entities will be comprised of local delivery collaborations that can effectively manage the full continuum of patients’ care, from preventive services to hospital-based and nursing-home care. Their patient populations are comprised of those who receive most of their primary care from the primary-care physicians associated with the ACO (see Figure 1). (As noted above, ACOs may include a range of specialists, hospitals, and other providers, or may contract or collaborate with them in other ways.)

Figure 1

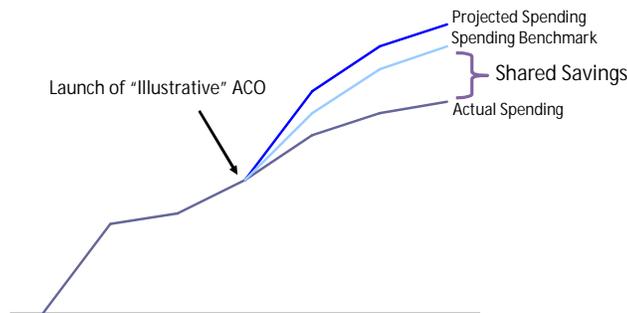
ACOs Can Be Configured in Different Ways (Some care will likely be delivered outside of the ACO)



- 2. Shared Savings.** ACO-specific expenditure benchmarks will be based on historical trends and adjusted for patient mix. Contingent on meeting designated quality thresholds, ACOs with expenditures below their particular benchmark will be eligible for shared savings payments, which can be distributed among the providers within the ACO. These shared savings allow for investments – in health IT or medical homes, for example – that can in turn improve care and slow cost growth (see Figure 2).

Figure 2

Shared Savings Derived from Spending Below Benchmarks That Are Based on Historical Spending Patterns



- 3. Performance Measurement.** Valid measurement of the quality of care provided through ACOs will be essential to both ensuring that cost savings are not the result of limiting necessary care and promoting higher-quality care. Such measurement should include meaningful outcome and patient-experience data.

Laying the Foundation for Successful Implementation

While the ACO framework holds promise for improving quality, cost, and overall efficiency, it does create some important implementation issues. It is worth highlighting some factors that can improve the likelihood of success.

Engagement of a broad range of key local stakeholders, such as payers, purchasers, providers, and patients alike, can provide momentum for ACOs. A demonstrated history of successful

innovation and reform with respect to health IT adoption and clinical innovations, for example, may also be a good foundation for further ACO reforms.

Having a structural foundation in place at the outset will also facilitate the transition to an ACO. Key factors include patient populations that are sufficient in size to permit reliable assessment of expenditures and quality performance relative to benchmarks, in order to calculate shared savings. Additional key elements include some degree of integration – either formal or virtual (i.e., for the purposes of the ACO) – within the delivery system and the capacity for collecting and reporting on the performance of participating providers.

Finally, having an agreement and process in place for distributing shared savings will be critical in terms of presenting an attractive proposition to providers – that is, a real opportunity to generate additional payments in return for improved care – and rewards genuine improvements in efficiency.

Key Design Components

While consideration of the more technical aspects of implementation are beyond the scope of this overview, a brief description of several key design questions highlights the decisions that will need to be made at the ACO level through negotiations with participating payers:

- **Organization of the ACO.** The form and management of the ACO need to be well-defined. ACO “leaders” who will drive improvements in care and efficiency must be identified from the start.
- **Scope of the ACO.** The specific providers involved in ACOs are likely to include primary-care physicians and may also include selected specialists as well as hospitals and other providers. Such decisions about the scope of providers to be included will clearly shape many of the technical aspects of the ACO, referral patterns, and other behavioral changes induced by the ACO itself.
- **Spending and quality benchmarks.** Spending benchmarks must be projected with sufficient accuracy based on historical data (or other comparison groups) and savings thresholds to provide confidence that overall savings will be achieved. Sufficient measures of quality to provide evidence of improvement are also essential.
- **Distribution of shared savings.** Elements of the distribution of savings that will be subject to negotiation include the percentage split between providers and payers, for example 80/20 or 50/50, and the specific agreement governing how the savings will be distributed among the ACO providers.

Looking Ahead: The Promise of ACOs

The ACO model is receiving significant attention among policymakers and leaders in the health care community, not only because of the unsustainable path on which the country now finds itself, but also because it directly focuses on what must be a key goal of the health care system: higher value. The model offers a promising approach for achieving this goal without requiring radical change in either the payment system or current referral patterns. Rather, fee-for-service remains in place, and most physicians already practice within natural referral networks around one or a few hospitals.

In addition, as provider organizations become more comfortable with payments that are based on value, further reforms can increase the “weight” on shared savings while reducing the “weight” on

traditional fee-for-service payments. By promoting more strategic and effective integration and care coordination, and by doing so without requiring disruptive short-term changes in payment, accountable care can provide a feasible path to meaningful improvements in health care.

For a more technical discussion of health care reform and the ACO model, see:

- “Real Health Care Reform in 2009: Getting to Better Quality, Higher Value, and Sustainable Coverage.” The Engelberg Center for Health Care Reform, November 2008.
- CBO, *Budget Options, Volume I: Health Care* (December 2008), pp. 72-74 (Option 37, “Bonus Eligible Organizations”).
- Fisher, Elliott, Mark McClellan, John Bertko, Steven Lieberman, Julie Lee, Julie Lewis, and Jonathan Skinner. “Fostering Accountable Health Care: Moving Forward in Medicare.” *Health Affairs Web Exclusive*, January 27, 2009: w219-w231.

Comparison of Payment Reform Models

	Accountable Care Organization (Shared Savings)	Primary Care Medical Home	Bundled Payments	Partial Capitation	Full Capitation
General strengths and weaknesses	Makes providers accountable for total per-capita costs and does not require patient “lock-in.” Reinforced by other reforms that promote coordinated, lower-cost care	Supports new efforts by primary-care physicians to coordinate care, but does not provide accountability for total per-capita costs	Promotes efficiency and care coordination within an episode, but does not provide accountability for total per-capita costs	Provides “upfront” payments that can be used to improve infrastructure and process, but provides accountability only for services/providers that fall under partial capitation, and may be viewed as too risky by many providers/patients	Provides “upfront” payments for infrastructure and process improvement and makes providers accountable for per-capita costs, but requires patient “lock-in” and may be viewed as too risky by many providers/patients
Strengthens primary care directly or indirectly	Yes – Provides incentive to focus on disease management within primary care. Can be strengthened by medical home or partial capitation to primary-care physicians	Yes – Changes care delivery model for primary-care physicians allowing for better care coordination and disease management	Yes/No – Only for bundled payments that result in greater support for primary-care physicians	Yes – Assuming that primary care services are included in the partial capitation model allows for infrastructure, process improvement, and a new model for care delivery	Yes – Gives providers “upfront” payments and changes the care delivery model for primary-care physicians
Fosters coordination among all participating providers	Yes – Significant incentive to coordinate among participating providers	No – Specialists, hospitals and other providers are not incentivized to participate in care coordination	Yes (for those within the bundle) – Depending on how the payment is structured, can improve care coordination	Yes– Strong incentive to coordinate and take other steps to reduce overall costs	Yes– Strong incentive to coordinate and take other steps to reduce overall costs
Removes payment incentives to increase volume	Yes – Adds an incentive based on value, not volume	No – There is no incentive in the medical home to decrease volume	No, outside the bundle – There are strong incentives to increase the number of bundles and to shift costs outside	Yes/No – Strong efficiency incentive for services that fall within the partial capitation model	Yes – Very strong efficiency incentive
Fosters accountability for total per-capita costs	Yes – In the form of shared savings based on total per-capita costs	No – Incentives are not aligned across provider, no global accountability	No, outside the bundle, no accountability for total per-capita cost	Yes/No – Strong efficiency incentive for services that fall within partial capitation	Yes – Very strong accountability for per-capita cost
Requires providers to bear risk for excess costs	No – While there might be risk-sharing in some models, the model does not have to include provider risk	No – No risk for providers continuing to increase volume and intensity	Yes, within episode – Providers are given a fixed payment per episode and bear the risk of costs within the episode being higher than the payment	Yes – Only for services inside the partial capitation model	Yes – Providers are responsible for costs that are greater than the payment
Requires “lock-in” of patients to specific providers	No – Patients can be assigned based on previous care patterns, but includes incentives to provide services within participating providers	Yes – To give providers a PMPM payment, patients must be assigned	No – Bundled payments are for a specific duration or procedure and do not require patient “lock-in” outside of the episode	Yes (for some) – Depending on the model, patients might need to be assigned to a primary-care physician	Yes – To calculate appropriate payments, patients must be assigned