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## **Pathways for Physician Success Under Healthcare Payment and Delivery Reforms**

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The AMA held a session on new payment models that could provide an alternative to the flawed sustainable growth rate. The session examined payment models included in the recent health care reform law as well as models that are currently part of Center for Medicare and Medicaid Services demonstrations. If implemented, these models will change how primary care and specialty physicians practice and are paid. Hepatologists will have to examine their practice arrangements with hospitals, primary care physicians and other specialists to ensure that these models are sustainable and provide high quality care to their patients.

### ***How to Restructure the Payment System***

***Harold Miller, Center for Healthcare Quality and Payment Reform***

There are three ways to reduce healthcare costs without rationing: keep people healthy, keep those who are sick out of the hospital and successfully treat those who end up in the hospital. But how should physicians be held accountable? Prevention is clearly a primary care issue; keeping those who are sick out of the hospital, falls to both primary and specialty care providers. Providing better acute care is the responsibility of hospitalists and specialists. Physicians are at the core of reducing costs without rationing; however, the payment system currently in place effectively promotes higher spending.

The alternative payment system- contained in the new health reform law calls for episode payments, i.e one payment to cover an acute care episode regardless of the outcome. In some models, it would include a warranty. Geisinger Health System uses an episode payment with warranty model; this includes a single payment for the initial hospital stay and any readmissions related to the initial diagnosis. However, this can apply to individual physician practices as well as to health systems. The main weakness of this model is that it does nothing to reduce the number of acute episodes experienced by a patient.

Another approach is to utilize comprehensive care payments that are designed to avoid acute episodes. Here, a comprehensive care payment or “global payment” is made to cover all care for a condition. This is distinctly different from capitation. The worst version of capitation provides no additional revenue for sicker patients. However, a comprehensive care payment would be adjusted based on patient conditions, limiting the total risk accepted by providers for unpredictable events. This payment would be further differentiated from a capitated payment through a system of bonuses and penalties based on a provider’s performance on specified quality measures. This system would allow providers to make more money if patients remain healthy. BCBS of Massachusetts currently has a version of this system in place with its Alternative Quality Contract, under which a single payment amount is established to cover all costs of care for population of patients. There is a five-year payment with limited inflation, risk adjustment and a quality bonus.

A comprehensive care payment and episodic payment can be complementary. An annual payment can be made to cover the costs of chronic disease management with a separate episode payment to cover acute incidents.

Can a new payment system provide better solutions to long-standing payment issues? Under the current fee-for-service system, Medicare treats costs as a series of fees. Spending is reduced either by denying care, restricting eligibility or reducing fees. If one thinks of healthcare as a collection of episodes of care, like primary care, chronic disease inpatient care, and surgery, all physicians might be able to make more money by saving money in certain places, like hospital stays, drugs and devices. To find this cost savings, inpatient and outpatient physicians would have to work together closely and develop an expanded skill set to reduce testing and hospitalizations. The simplest approach to the episode payment would be to provide a single “bundled” payment for hospitals and physicians to cover all the costs of an inpatient episode; portions of the savings would go to the hospital, to a physician bonus and to the payer.

Moving beyond the hospital, a “bundled” payment for an acute episode would include treatment for conditions present upon admission, for hospital-acquired conditions, post-hospital care and readmissions.

To move from fee-for-service to a global payment system, it is necessary to have a transitional system in place since there is such a large divide between payment models. The following are potential transitional models:

- Medical Home Payment: This includes a monthly care management payment per member per month. However, there is no commitment to reduce utilization elsewhere while paying more for primary care. Medical homes expand physician capacity, but not enough.
- Shared Savings: A portion of the shared saving from a reduction in total costs will be given to the provider. But that can be problematic because there is no upfront payment for better care. This system would also reward poor performers. Furthermore, the system is not sustainable since there will be a limited number of ways to reduce total costs.
- Preliminary “Accountable Care” Payment: This would provide upfront money to cover the cost of practice changes. Targets to be met would be defined upfront. This approach would also include a system of bonuses and penalties based on performance.
- Partial Global Payment: This would include flexibility and accountability for a condition-adjusted budget covering all professional services with a performance based bonus and penalty structure based on performance.
- Full Global Payment with a performance based penalty and bonus.

To achieve this type of payment reform, two payment silos, the medical home/chronic care model and reductions in hospital readmissions, would have to be merged. It would require payment to primary care physicians for care management and to specialists for consultations with primary care physicians. This would integrate specialty care, while improving care for patients. Physicians will need certain resources if the system were to be changed in this manner:

- Physicians must be paid in a way that provides them the time to do the required treatment planning. A care management fee should provide physicians reimbursement for the time they must spend outside of an office visit, which is not reimbursed under the fee for service model.
- More resources must be provided for patient education and self-management.
- There must be increased capability for tracking patient care and ensuring the appropriate follow up.
- A method must be established to target high-risk patients.
- Relationships between hospitals and specialists must be better coordinated.
- Data and analytics must be used to measure and monitor utilization and quality.

Small physician practices may not be equipped to manage global payments, but independent practice associations (IPAs) can be created to reach a critical mass of patients to manage capitation contracts. The organizational structure will ultimately determine how and how much physicians are paid. A major concern remains that under these payment models patients will not receive enough care, as providers are more accountable for costs. The solution is ensuring that incentives are provided to those who maintain and/or improve quality while reducing the cost of care.

The Patient Protection and Affordable Care Act (PPACA) provides broad waiver capability for those participating in models authorized by the law. The newly-established Center for Medicare [and Medicaid Innovation?] gives CMS the ability to support innovative delivery system while waiving many of the legal restrictions on new payment models. Note this waiver is for Medicare only. The legal framework will have to be revised to allow the payment model to change. The AMA has already been in discussions with Secretary Sebelius and the Federal Trade Commission to work with them to develop safe harbors.

### ***Accountable Care Organization Model*** ***Gregory Reicks, DO, Mesa County Physician's IPA***

Mesa County was highlighted in an often cited New Yorker article, *the Cost Conundrum*. The group [called the Rocky Mountain Health Plan, has 265 members, 40 percent of whom are primary care physicians, and one large hospital. Ninety percent of physicians in the county are members of the IPA. Thirty percent of the members serve on a IPA committee and receive an hourly rate for their service. Most IPA members contract with outside payers, but can only use the IPA agreement for their interaction with RMHP. It provides no incentives to patients

The IPA is a non-profit (but is not tax-exempt) with a \$650,000 annual budget. It is funded with a 0.5 percent administrative withhold from all RMHP claims, a monthly stipend from RMHP and a one-time membership fee.

There two programs of incentives for participants. The first is a withhold which is returned when an agreed-upon budget is met. There is a second individual performance withhold, which is earned based on quality and cost metrics. A separate physician performance incentive fund is used to support individual incentive payments. When determining how to structure an incentive program, one must consider the level of trust among member physicians. The size of the incentive is not the driving factor. The incentive is that physicians' peers will have knowledge of the performance data. Physicians are ranked in terms of the IPA and their practice. The IPA uses cost data to develop individual performance metrics.

The IPA utilizes health information exchange. Clinical results are routed from the data source in an electronic form to the physician office. IRMHP is in the process of developing a bidirectional interface with an EMR.

In the future, the IPA will have to gather more data and develop more quality measures. The main concern about programs like this is that upfront investments are needed to make meaningful changes. Physicians' offices do not have an upfront investment in this model. This is low-risk for the payer, but high-risk for the provider.

### ***Physician-Hospital Bundling Model*** ***David Fox, MD***

The Acute Care Episode (ACE) Demonstration Project, which is run by CMS, went live at the Baptist Health System in San Antonio, TX on January 1, 2009. Fox, who is Vice Chairman of the program, thought this would

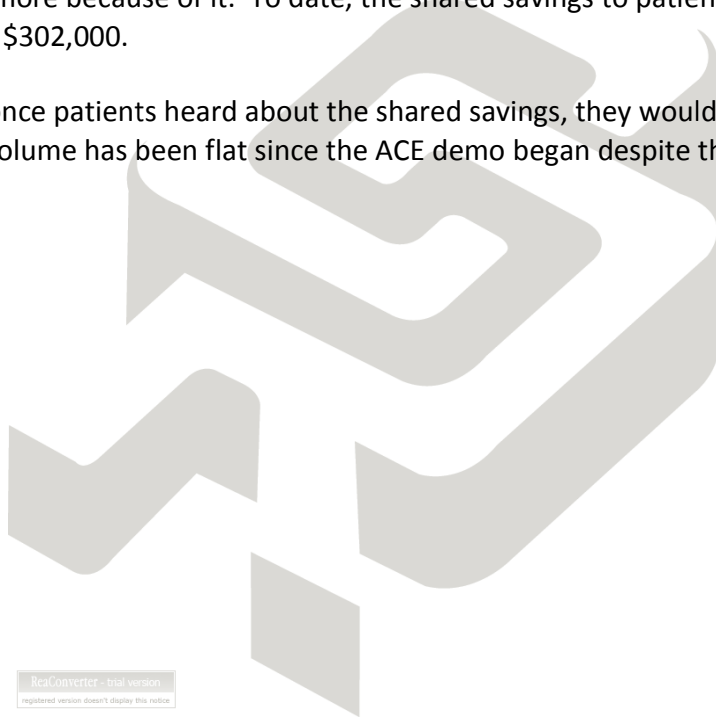
provide a windfall to physicians. The demonstration strives to enhance quality by tying financial incentives between doctors and hospitals together to improve quality and reduce costs.

The ACE demo consists of 28 Cardiac and 9 Ortho DRGs, and includes competitive bidding, a bundled payment, gainsharing, and a beneficiary incentive

The hospital used the previous three years of data on DRG payment for the five hospitals in the system to develop a global payment. The price to CMS was reduced between one and nine percent, depending on the DRG. Up to one half of the CMS savings was given back to the patient. That payment is made regardless of the quality of services. A total of 22 quality metrics are tracked for orthopedic and cardiac services and are submitted quarterly to CMS. A subset of these metrics is used as criteria for the gainsharing.

There have been dramatic improvements in all five orthopedic quality gainsharing metrics. Physicians are making up to 25 percent more because of it. To date, the shared savings to patient has totaled \$237,000 and the gainshare has totaled \$302,000.

Physicians believed that once patients heard about the shared savings, they would be overrun with new business. However, the volume has been flat since the ACE demo began despite the reimbursement and new marketing efforts.



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