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Provider Payment Reform

An Accountable Care Approach to Alignment of Health Care Goals and Incentives

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Introduction

While most people would agree that quality of care, efficiency, and cost effectiveness are desirable traits for a health care system, the dominant modes of provider payment conflict with these traits. Traditional capitated arrangements incentivize doctors to provide the least amount of care as possible and often lead to patient dissatisfaction. The downfall of many HMO-style health plans in the 1990s clearly demonstrated that most Americans are not willing to trade choice and quality for cost savings. Traditional fee-for-service (FFS) arrangements have the opposite problem. These arrangements incentivize providers to perform as many services as possible, even when less costly alternatives are available. FFS arrangements have contributed to double-digit medical trends, resulting in unreasonable premium rate increases. These rate increases coupled with the recent economic recession have made health insurance unaffordable for many individuals and employers. This environment spurred the passage of the health care reform legislation earlier this year.

While the purpose of the new legislation is to provide affordable health care for all Americans, most of the provisions will actually make health care more expensive in the near term. These provisions include dependent coverage up to age 26, the elimination of member cost sharing on preventive care services, and the elimination of annual and lifetime benefit limits. While most in the actuarial community would agree that restructuring the provider payment system is a crucial aspect of health care reform, there likely are as many opinions on how to achieve this reform as there are actuaries. It is clear that without a dramatic change to the provider payment system, the goals of health care quality, access, and affordability will remain out of reach and the legislative efforts towards health care reform will prove fruitless.

I am proposing a system that returns to a more capitated form of provider payment that capitalizes on some of the changes brought about by PPACA and HCERA. An overnight across-the-board change in provider payment policy would be both undesirable and unachievable. Rather, this system must be industry-driven, not imposed by state or federal government. The ideal implementation approach would consist of a pilot program whereby a carrier forges a partnership with the dominant physician group in one particular community. This would allow the carrier to limit its risk during the evaluation stage, and would also allow the carrier to compare the experience in the pilot community to the rest of its block of business to determine if health outcomes were improved and costs contained.

A 'Twist' on Cap: The Accountable Care Organization

An effective provider payment system must be financially sound and create appropriate incentives which align with the goals of quality, efficiency, and cost effectiveness. One of the chief complaints in the provider community with regard to capitation is a lack of equity. Two physicians may each be responsible for 100 patients and thus receive the same income, but one physician may be fortunate enough to treat mostly young, healthy individuals while the other sees primarily elderly, chronically ill patients. In order for a capitated system to work, the payments must be risk-adjusted. I propose that higher capitation rates be paid for the elderly and for individuals with chronic disease. This system ensures that the providers are adequately compensated for caring for people of all ages and health statuses.

In addition to paying capitation fees to the physician group, the carrier will set aside funds to cover hospital costs. The amount of money in the fund should be equal to the expected hospital costs for the population. A stop-loss arrangement will be included to prevent one or two shock claims from exhausting the hospital fund. Most capitation arrangements include some form of a bonus program. The bonus program for this system will be based on several criteria:

(1) The maximum bonus payment is a percentage of the amount remaining in the hospitalization fund at the end of the year. The insurer will retain the other portion of the savings.

(2) Bonus payment will be contingent on achieving a certain level of compliance with services recommended by the U.S. Preventive Services Task Force as outlined in PPACA.
(3) Bonus payment will also be contingent on improved health care outcomes and overall provider performance.

Item #1 is fairly straightforward and typical of a capitation arrangement, as it gives the physician incentive to treat in a way that emphasizes preventive care in order to avoid expensive hospitalization. It is an equitable system because it allows the physician group to share in the cost savings with the insurer.

Item #2 capitalizes on the efforts of PPACA to encourage wellness and preventive medicine. Under PPACA, all benefit plans sold after Sept. 23, 2010 will provide preventive care services at no cost to the policyholder. This clearly incentivizes the patient to seek preventive care services with no cost sharing now and avoid potentially costly treatment later. Current fee-for-service provider payment conflicts with this incentive, whereas this new payment system effectively aligns the incentives of the insurer, the providers, and the patients.

Item #3 ensures that cost savings is not achieved at the expense of quality. Several different quality measures could be used, but it is important that they be easily understood by the insurer and the physician group. The important concept is that the bonus payment will be contingent on adherence to nationally recognized standards of care and on achievement of positive health outcomes. Patient satisfaction is an important measure of the performance of the system, and should be factored into the bonus payment calculation.

Items 2 and 3 should lead to new outreach mechanisms initiated by the provider group. In order to receive the bonus, the physician group will have to more actively manage its patients to ensure they are complying with the prescribed treatment and current on all recommended preventive care services. Attaining buy-in from the provider community is a critical ingredient to shifting the emphasis from treatment to prevention.

The bonus program should not be an "all-or-nothing" arrangement. Rather, a minimum level of performance should be required for payout, and then the amount of the bonus should increase depending on the actual level of performance. In addition, as a community-based system, bonuses should be paid based on the level of performance for the entire organization, not that of the individual physician. This will encourage better coordination of care and should also encourage "best practices" to emerge as physicians challenge each other to improve the performance of the organization as a whole.

This model falls under the accountable care organization (ACO) family, in that the group of physicians has the collective responsibility of caring for patients and achieving cost savings. This particular form of the ACO relies on the physician group to make appropriate decisions on hospitalization, and the financial incentives should steer physicians away from unnecessary surgery and hospitalization while encouraging wellness and preventive medicine. Ideally, this new provider payment system will result in immediate savings and also reduce the increase in costs year to year. The emphasis on prevention and wellness should help curb the inflationary tendencies of the cost associated with medical technology and expensive treatment.

The Ideal Case Study

The ideal pilot community for this program will need to possess several important traits. First, the community must contain a physician group that can provide comprehensive care. Most specialty care must remain inside the participating physician group in order for cost containment to be effective. A physician group which refers a substantive number of cases to outside clinics would not realize the potential cost savings.

Secondly, the insurer must have a good relationship with the physician group. A project of this magnitude can only succeed through the cooperation and motivation of all parties. Without a good long-term relationship with the carrier, the physician group would not be motivated to enter into a potentially risky arrangement.

Finally, the insurer must have good contracts with the major area hospitals. While the goal of the project is to emphasize preventive care and limit hospitalization, the insurer must have competitive contracts in order to achieve cost savings. One advantage of this system is that the cost and quality of hospital care directly impacts

the reimbursement to the physician. The primary care physician will be incentivized to direct his/her patient to the hospital that provides the best care at the lowest cost. This is obviously favorable to the insurer and patient as well. The price sensitivity of the referring physician should be helpful to the insurer negotiating reimbursement rates with area hospitals, as hospitals will be competing for referrals from the physician group.

The patients involved in the pilot program will be those who are using one of the physicians in the group as their primary care physician. This helps limit member disruption and dissatisfaction. Insurers who do not have their members formally designate a primary care physician (PCP) will need to perform a claim data analysis in order to identify the members who have effectively chosen a doctor in the group as their PCP.

The Role of Government

The recommended implementation plan may seem conservative, but a gradual rollout is essential to limit the risk faced by insurers and provider groups. This payment system is a radical change for most carriers, and it involves a fair amount of financial and operational risk. As such, the carrier, not the government, should determine the best course of implementation. If the expected cost savings are realized, the insurer will naturally implement the system in more communities.

I do believe the government must be involved, but through incentive rather than mandate. The government could offer tax breaks to provider groups and insurers who implement this prevention and wellness-based payment system. This encourages carriers to proactively implement the system but does not penalize carriers for exercising caution through a gradual rollout. A pilot program allows carriers and providers to evaluate the effectiveness and financial impact of the new system without a significant increase in risk. The new financial arrangement is certain to require refinement; having this system in place in a single community allows necessary adjustments to be made easily and efficiently.

Challenges

One of the greatest challenges facing this proposed model is overcoming the negative perception of capitated payment arrangements. If patients perceive that care is being withheld in order to increase profits, the system will likely suffer the same fate as the HMO model of the 1990s. In order to succeed, the insurer and the provider group must work together to educate the patient about the merits of the system, particularly the focus on improvement of quality and health outcomes. For this reason, the compatibility of the insurer and the pilot physician group is of the utmost importance. A successful pilot can pave the way for a large-scale launch of the ACO system.

The physician group will find it challenging to balance cost savings with patient satisfaction. This is a challenge for both the providers and the insurer, because the insurer must develop the right formula for the bonus program. The size of the bonus fund must be significant enough to create change in physician behavior and yet not so large that the physician group is at risk of financial ruin if it does not receive the bonus. The goal of the insurer is to achieve cost savings through more efficient and effective care, not through short-changing the providers.

Summary

The proposed ACO model provider payment system combines the waste-cutting ideals of capitation with a bonus program that encourages preventive care and rewards providers for quality care. The bonus program achieves balance by incentivizing physicians to avoid unnecessary hospitalization and treatment while not withholding needed care. This new provider payment system can best be achieved through a pilot program in a single community to allow for evaluation and refinement of the system with a manageable level of financial risk. The proposed ACO model capitalizes on the preventive care provision of the new health care reform bill to align the incentives of the insurer, the providers, and the patients. ■

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