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Health Care Payment Reform: A Look Ahead

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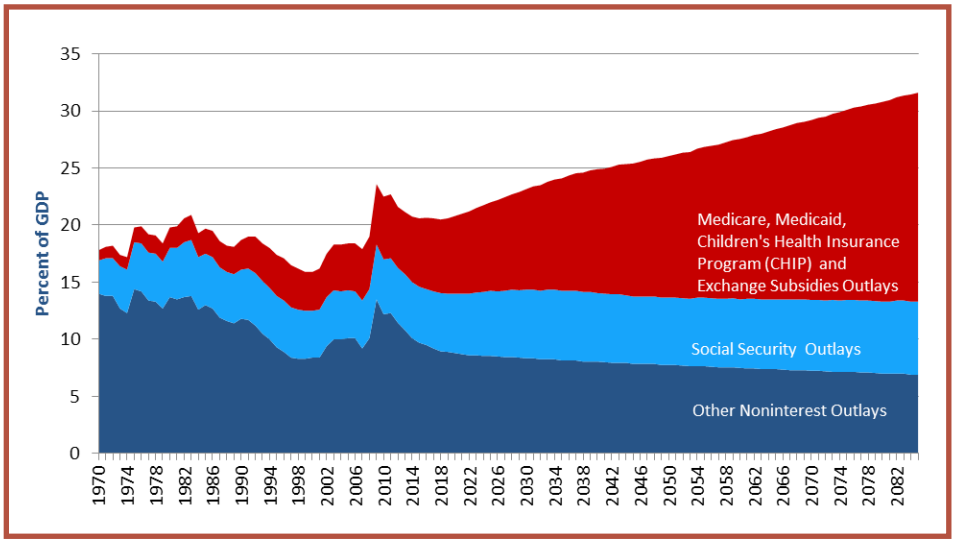
Health Care Payment Reform: A Look Ahead

By Cary Sennett, MD, PhD

The public debate about raising the federal debt limit—and Standard and Poor's downgrading the rating of federal bonds—have contributed to a growing consensus that controlling federal spending should be an urgent national priority. Controlling federal spending on health care must be a central part of that.

Figure 1 lays out the issue visually: the Congressional Budget Office projections for federal spending (as a percentage of gross domestic product) show inexorable growth to levels that are clearly unacceptable. But, when the spending is broken down into its components, we see that the projected growth is driven entirely by outlays for health care; specifically Medicare, Medicaid, the state Children's Health Insurance Program, and projected subsidies for the Health Insurance Exchanges created by the Affordable Care Act (ACA). The problem of rising health care costs is not merely a threat to health care; it is a very real threat to the sustainability of the American economy.

Figure 1. Actual and projected federal outlays as a percentage of Gross Domestic Product (GDP).



Source: *CBO's 2011 Long-Term Budget Outlook*. Washington, DC: Congressional Budget Office; June 22, 2011.
CBO=Congressional Budget Office, CHIP=Children's Health Insurance Program

Long-term control of health care costs—or, more desirably, long-term improvements in the value of health care—will require fundamental reform of our health care system and, in particular, fundamental change in the organization and operation of health care delivery systems across the country. Given the indispensable role of physicians in delivering health care and shaping the processes through which it is delivered, it is inconceivable that necessary changes can take place without the active and willing participation of those who practice medicine. And therein lies the concern; many physicians are neither active nor willing partners in effecting the process changes that must accompany health care reform.

Health care reform is seen by some as a threat to physician income. The new law is, after all, the Patient Protection and *Affordable* Care Act, and *affordability* can translate into pressure on the incomes of all health care providers. More often though, health care reform is equated with *accountability;* indeed, many people think that "ACA" stands for the

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Accountable Care Act. For physicians, accountability has come to mean public reporting, compliance, and the considerable costs associated with them. It should come as no surprise that, as they are understood by physicians, *affordability* and *accountability* offer little to make health care reform an appealing and attractive proposition.

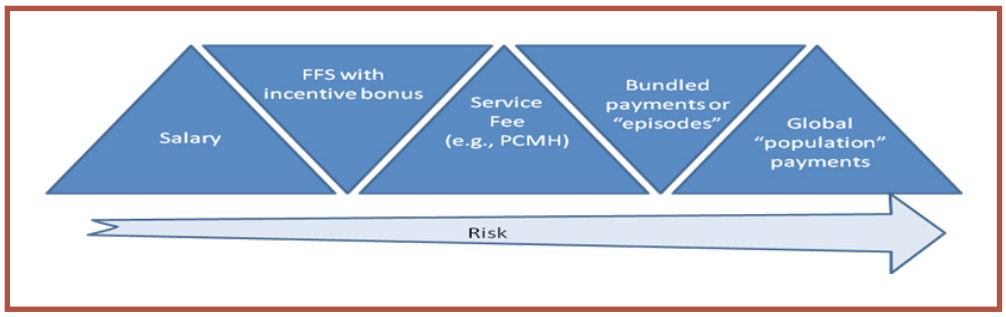
Solving the Problem: The Central Role of Payment Reform

Although improving the value of health care will require movement on several fronts, new ways of paying for care are likely to be central to efforts. Clearly, delivery system reconfiguration is the "end game" but, as Donald M. Berwick, MD put it, "Every system is perfectly designed to achieve exactly the results it gets."[1] Fee-for-service (FFS) payment for health care services drives service volume and intensity. If we want a delivery system that drives value, we must change the way we pay for health care.

If there is any good news, it is that the political will to take on the issue of payment reform appears to have reached a tipping point. On one hand, the budgetary issues that have driven federal debt have intensified pressure to act. On the other hand, there is growing acceptance of the premise that the current formula for Medicare adjustments to physician payments—the "Sustainable Growth Rate"—is not "fixable" and that some other methodology must replace it. In fact, the Medicare Payment Advisory Commission has issued recommendations to move away "from the Sustainable Growth Rate System," to "shift Medicare payment policies away from FFS," and to "make FFS less attractive."[2]

There are several alternatives that could "shift Medicare payment policies away from FFS"—alternatives that vary substantially with respect to the performance risk they create for providers.

Figure 2. Payment Strategies as a function of Provider Risk



FFS=fee for service, PCMH=patient-centered medical home

At one end of the risk spectrum is "salary." Salaried physicians have income predictability, but very little upside (and virtually no downside) risk to that income. At the other end of the spectrum are "bundled" or "episode-based" payments, and global or "population-based" payments. Under these systems, physician income may have considerable upside potential but there often is considerable downside risk. Figure 2 is a brief, high-level summary of alternative payment strategies plotted along a risk continuum. Of course, variation is possible in each of these payment themes and the strategies for combining them.

Which strategy/strategies are "best" for achieving the optimal results? The evidence is still accumulating. It seems likely, though, that almost any strategy can work in some settings—and that almost none can work in all settings. So, the challenge will be to understand what type of payment model works best in a particular context or setting.

Physicians and Financial Risk

Given the importance of risk as a motivator of change—and the variation in risk implicit in different payment models—it is necessary to consider how physicians respond to risk. Historically, physicians have not managed risk well, and many have been inclined to avoid it to the extent possible. At the limit, avoiding risk is best achieved through salaried employment, and we have seen more and more physicians embracing that model. But there are strategies to mitigate risk as opposed to avoiding it completely.

One such strategy is affiliating with an entity that is better prepared to accept and to manage risk. Physicians and medical groups are motivated to affiliate with larger, better capitalized (hence more risk-tolerant) organizations such as integrated delivery systems, physician-hospital organizations, and larger medical groups or Independent Practice Associations, which function as large, virtual medical groups. As part of these larger entities, physicians are insulated from some of the risk that attends more advanced payment models.

At the other end of the spectrum, some physicians and medical groups have prepared (or are preparing) themselves to understand and accept financial risk, and are seeking to be paid in ways that offer significant upside opportunity. To manage risk, these groups had to acquire new actuarial and care management skills and invest in the information, knowledge, and care management infrastructure required to understand and respond to clinical risk. These investments require size and scale as well as considerable capital.

Where Are We Headed?

We are in the early stages of a period of rapid change. The specific shape of that change is difficult to predict and, almost certainly, the course will be one marked by frequent correction. That said, I

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believe that there are certain givens or, at the very least, likely outcomes:

- *There will be progressive expansion of the number and intensity of risk-based payment options*

We are already seeing some experimentation, and I expect that promising models for replacing FFS will be scaled rapidly. Much of the experimentation is occurring in the private sector where pressure for change is intense, but regulatory constraints on innovation may be less binding. It is very important to note that the Center for Medicare and Medicaid Innovation ("the Innovation Center" at the Centers for Medicare and Medicaid Services [CMS]) has recently announced a Bundled Payment for Care Improvement initiative,[3] which complements CMS's Acute Care Episode demonstration.[4] Together, and with the construction of a Medicare-specific Episode Grouper (Section 3003 of the ACA requires that the Secretary develop a Medicare-specific episode grouper by January 1, 2012),[5] these strategies suggest that Medicare may be able – and inclined - to introduce bundled payments into the mainstream of Medicare in the foreseeable future.

- *Vertical integration in health care will continue…*

Although the response to the Medicare Shared Savings Program (MSSP) may be limited, the marketplace clearly understands the inevitability of "accountable care," and is responding in a variety of ways to create entities that are better able to coordinate care and manage risk. Although these responses are quite pleomorphic, many appear to be steps on a path toward structural integration: in particular, "clinical integration" achieved through the acquisition of physician practices by hospitals.

…but there will be more and more virtual *integration*

Structural integration is a vehicle to accomplish the coordination of care necessary to achieve better clinical and financial outcomes; however, it is only one way in which hospitals, physicians, and other providers can achieve those ends. Although they offer certain advantages, it is important to note that truly integrated systems (eg, Geisinger) are not built quickly and more nimble, virtual structures are likely to continue to emerge. Some of the models being developed in the private sector[6] may be in response to the MSSP, and to the Innovation Center's Bundled Payment Initiative.

- *There will be many bumps in the road*

Although there is a path forward, the direction is clearer than the topography. At a time when there is intense pressure to respond, there will be some missteps. "Nimbleness" will be a critical success factor.

One of the central challenges that will need to be addressed—and one that can be anticipated and managed affirmatively—is potential resistance among practicing physicians. Physician resistance to change in payment and delivery system organization will, at a minimum, create inertia and friction. At the limit, they could cause gridlock.

Physician resistance is not inevitable but, for the reasons outlined earlier, is probable. In general, health care reform represents a threat to physicians who may perceive the cornerstones of reform—"affordability" and "accountability"—as forces that exert pressure on their income and autonomy. A recent survey by the Massachusetts Medical Society suggests that the majority of physicians, for example, would not participate in a voluntary bundled payment program, and only about half would participate in a voluntary Accountable Care Organization.[7] At the same time, many physicians are dissatisfied with the current health care system, and many would welcome change if that change would allow them to practice medicine as the professionals they are.

So, among the critical requirements for making the necessary changes in the payment and delivery systems are:

1. An understanding of what physicians perceive as a better way to deliver care, and

2. Recognition that the tools and additional supports needed by physicians to reconfigure their practices must be made available in parallel with – or in advance of - the policy changes that will force the reconfiguration.

Transforming health care means changing the way physicians practice. For success under the new set of rules that will guide the transformation, we must ensure that physicians are equipped with the knowledge and tools they need.

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