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Payment & Delivery

Analyzing Shifts In Economic Risks To Providers In Proposed Payment And Delivery System Reforms

Jeff Goldsmith¹

¹ Jeff Goldsmith (trcoyote@gmail.com) is president of Health Futures, in Charlottesville, Virginia, and an associate professor of public health sciences at the University of Virginia, in Charlottesville.

Abstract

A key consideration in implementing the Patient Protection and Affordable Care Act of 2010 will be changing Medicare payments to providers to slow the growth in

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costs and spur improvements in health care delivery. In addition to the technical feasibility of new payment models, a crucial issue will be the capacity of the health care system to assume more economic risk. This article analyzes some of the major models under consideration and assesses how feasible their implementation would be.

Key Words: Health Reform • Medicare • Organization and Delivery of Care • Hospitals • Physicians

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The issue of who bears the economic risk of medical costs has important effects on providers, patients, and payers. The way that providers are paid has implications not only for how that risk is allocated, but for patients' well-being. For example, as is well known, in traditional fee-for-service medicine, providers are paid by insurers for each service they render to patients at rates defined in advance. A physician caring for a patient may order unnecessary tests, procedures, or treatments—some for economic rather than medical reasons—and still expect to be paid a fee for each of them. In this case, the insurer has open-ended economic risk because there is no limit on the number of services that the physician deems necessary to treat a patient for a specific condition.

Under capitated payment systems, physicians are given a fixed amount of money for each patient under their care. If patients receive services whose cost exceeds the payment, physicians must absorb the overage as lost income. But if patients receive services that cost less than the payment, physicians keep the difference. In this case, physicians share the risk with insurers and have incentives to economize on treatment, which limits the potential growth in costs.

These examples illustrate the trade-off between cost control and physicians' degree of involvement in economic risk. The two different forms of payment produce different economic incentives in managing patients' care. In a fee-for-service system, more services mean more money for providers, putting upward pressure on costs and possibly exposing patients to the clinical risks associated with overtreatment. Under capitation, because providers may lose money if they provide too many services, providers may be inclined not to order even necessary services, possibly exposing patients to the clinical risks of undertreatment.

Other forms of payment present still different risk profiles. One of the key challenges to Medicare under the Patient Protection and Affordable Care Act of 2010 will be to test and develop payment systems that encourage both disciplined spending and the right level of care for patients. So which parties bear the economic risk, and how much of it, are important questions to consider as new payment schemes are designed and tested under health reform.

A Legacy Of Fragmentation

Medicare has traditionally separated hospital payments from physician payments and has paid for individual services à la carte, with no economic risk to providers. The fact that physicians were paid individually, separately from hospitals, contributed to a fragmented care process. Physicians and other care decision makers were free to proceed independently and without others' knowledge, thereby exposing patients to needless risks, such as having multiple drugs prescribed for the same condition. The fact that providers made more by doing more encouraged them to provide unnecessary care, subjecting patients to potential clinical risks and increasing the overall cost of care.

In attempting both to rein in the inflationary pressure of health care costs and to reduce the fragmentation of care, during the past twenty-five years Medicare policy has been consistently shifting risk toward providers of care through consolidating payment transactions, either within defined episodes of care or within defined time periods. The purpose of

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this consolidation was to place limits on payment for specific episodes or time periods, forcing providers to economize by doing better at managing resources and coordinating their activities.

Methods Of Shifting Risk Medicare has used two different models in shifting risk. In the first, treating the hospital as the fiduciary, hospitals were held economically responsible for the costs of each episode and paid for a consolidated bundle of clinical activity around that episode, such as a hospital admission. In the second, treating the health plan as the fiduciary, health plans were paid a lump sum per capita for all health services provided to a defined population of government-funded subscribers for a specified time period. The health plans, in turn, managed the messy business of assembling provider networks and negotiating payment terms for the care of Medicare beneficiaries so that providers were compelled to economize.

Common to both methods is that Medicare wrote a single check to someone for the specific care episode or time period. For a brief period, in the late 1990s, it looked as if the health-plan-as-fiduciary model would triumph, and Medicare might stop paying providers directly.¹ However, political and policy fashions have moved away from private health plans as managers of economic risk and toward changing Medicare's policy of provider payment.

A History Of Risk Shifting The history of Medicare's shifting risk to providers was best detailed by Rick Mayes and Robert A. Berenson in *Medicare Prospective Payment and the Shaping of U.S. Health Care*, which discusses not only the financial pressures that forced policy change, but also the response of the provider community.²(chaps 2-3) Medicare's 1984 switch to payment by diagnosis-related group (DRG) for inpatient hospital services placed hospitals at risk of bearing the cost of an episode of hospitalization, instead of paying for each service inside that episode without any limit.

This was a considerable expansion of risk for the hospital because the hospital could lose money if it did not control episode costs and keep them under the DRG payment. Hospitals that were able to shorten patients' lengths-of-stay and manage resource consumption more efficiently could keep the difference between their actual costs and the DRG payment.

Of course, hospitals did not make the clinical decisions that affected Medicare's episode costs; those were made by the medical staff. But because hospital managers and their physicians together worked out how to contain per admission expenses, the conversion to DRGs was a success and stabilized Medicare costs.²(chaps 2-2) Crucial to the success of DRGs was that their use did not require structural changes either in hospitals or in their economic relationships to their physicians.

Dealing With Fragmentation And Cost Under Health Reform

The Patient Protection and Affordable Care Act created a new Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid Services (CMS). Its purpose is to test new payment models designed to "bend the curve" of health care costs and improve the coordination of care for Medicare patients.³ Although many experiments have already been proposed with new payment models mandated by the health reform law, several important ones follow this Medicare pattern of expanding provider economic risk. They include involving the hospital in postacute care management, bundling care around acute episodes, chronic care models, and communitywide cost management.

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Involving The Hospital In Postacute Management

Traditionally, the end point of a hospital's financial responsibility for a patient has come when the patient is discharged from the hospital. Hospital discharge planning has focused on freeing up beds and making sure the patient has a ride home. As a result, a depressing one-fifth of Medicare patients return to the hospital within thirty days, half of them never having had any follow-up care in the interval.⁴

This number could certainly be reduced. A recent Medicare Payment Advisory Commission (MedPAC) analysis indicated that 13 percent of readmissions within thirty days could be considered avoidable, but it also cited instances where 45 percent or more of potential readmissions were avoided by careful follow-up management.⁵ As a consequence of its analysis, MedPAC recommended penalizing hospitals with "excessive" readmissions by reducing their Medicare payment for those readmissions.

Extending Payment Before And After Discharge A more appealing alternative is the idea of extending the DRG payment to cover the period from three days before discharge to thirty days after it. That would force hospitals to take responsibility for the period after discharge for all beneficiaries, instead of defining an arbitrary percentage of admissions as avoidable.

It also would force all hospitals, not just those with high readmission rates, to take more responsibility for the coordination of care after discharge. Hospitals already have infrastructure that could facilitate this enhanced role, such as discharge planning operations in their social services departments. An increasing number of hospitals have hired primary care physicians and could refer patients to the practices of those physicians for follow-up care. And many hospitals have home health care and rehabilitation services—both part of the so-called continuum of care—that could provide follow-up care as part of the extended period of care.

Obstacles To Implementation Some obstacles to the implementation of this reform include the fact that many hospitals lack the ability to track postacute service costs and the care management protocols to guide such care. However, health systems that operate their own Medicare Advantage plans already contract for postacute services for their enrolled populations. They could provide both actuarial and network management guidance to their peers lacking in Medicare Advantage experience.

There are also turf issues about who "owns" the postacute patient, because with "ownership" comes the prospect of economic gain. Further, "free choice" provisions in Medicare regulations give patients the right to select care providers who meet their needs, which might limit hospitals' ability to coordinate care. Medicare's managers can expect a big fight from independent postacute providers of rehabilitation services and home care, for example, who will try to avoid having their incomes subsumed under global payments managed by hospitals.

Nonetheless, postacute care bundling seems to be a highly promising avenue for reducing costs and improving outcomes, and it would require minimal structural changes on the part of hospitals and health systems.

Acute Episode Bundling

A different approach to extending risk is packaging together all hospital and physician costs related to an episode of illness requiring hospitalization, an approach known as acute episode bundling. This method of bundling—less ambitious than the thirty-day extension of postacute care discussed above—places the hospital at financial risk not only for its costs directly related to hospitalization, which is what the DRG now includes, but also the physician care provided in that episode, now paid separately to each physician involved under Medicare Part B.

Bundling Services This concept has a lengthy pedigree, having been the subject of three CMS demonstrations: the so-

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called Center of Excellence demonstrations in 1991, 1996, and 2001. It is being investigated yet again in the CMS Acute Care Episode demonstration that began in 2008 and will last three years.⁶ Despite the previous demonstrations' promising outcomes, in terms of both lower costs and higher quality, intense hospital opposition to changes in Medicare that might have forced some hospitals to close lucrative surgical services prevented the CMS from incorporating episode bundling into Medicare policy.⁷

The basic principle of acute episode bundling is to pay a fixed amount that includes all hospital and physician care for a defined clinical intervention, such as bypass surgery or joint replacement. The core event inside the bundle is a hospital-based procedure. Successful demonstrations could help establish best-practice benchmarks that, in turn, could form the basis for new acute care payment bundles, adjusted for the severity of the case.

Example Of Episode Bundling Episode-based coordination of care that is sufficiently reliable to support a "warranty" against any additional costs was the basis for Geisinger Health System's ProvenCare product.⁸ Developing ProvenCare required Geisinger to convene physician and nonphysician clinical stakeholders and work with them to change clinical processes to minimize avoidable complications associated with coronary artery bypass graft (CABG) surgery. The approach could be extended to other clinical services, such as hip replacement, bariatric surgery, and treatment for lower back pain.

An important structural change in physician staffing in hospitals could facilitate a transition to bundled payments—namely, the widespread hospital adoption of hospitalist coverage for inpatient care management.⁹ Hospitalists are physicians who are responsible for managing a patient's care during a hospital stay. They are the logical people to implement standard protocols for care management of inpatient cases, as well as to resolve communications problems and oversee care handoffs and other factors that may affect an episode's cost. Hospitalists are also the logical people to manage consultation expenses, an important component of that cost.

Integrated care systems such as Geisinger also have salaried physician practices, which permits negotiation of the crucial income splits with practitioners and determining who provides what services within a given episode. In addition to hiring hospitalists, a number of hospitals throughout the country are adding formerly independent specialist physicians to their staffs as they seek a greater degree of integration.

Challenges To Episode Bundling This process is still in flux, however. Hospitals' progress in developing the organizational infrastructure needed to manage care more comprehensively will vary from institution to institution and from market to market.

A complex and politically fraught challenge awaits providers who continue to rely primarily upon "voluntary" attending physicians—that is, independent physicians in private practices that are not owned by the other provider. One challenge will be to create an appropriate division of labor among specialists who now compete for patients with a given clinical condition—for example, neurosurgeons and orthopedic surgeons in the case of lower back pain. Another challenge will be to negotiate satisfactory fee arrangements with the voluntary physicians as well as controlling the cost of specialty consultations.

Reducing unnecessary consultations is crucial to containing episode costs. Those consultations not only generate fee income for independent practitioners, but they also generate follow-up testing in which those physicians might have an ownership interest. The variation in the number and intensity of consultations was identified as a major source of variation in Medicare costs in the most recent *Dartmouth Atlas of Health Care*.¹⁰

Interim Steps There is a potential interim step toward episode-based payment that does not rely on hospitals' completing the evolution to a closed, salaried staff model. This would be folding a standard amount for specialty consultations into the DRG for inpatient care and letting hospital administrators and clinical managers sort out how to contain costs.

An alternative interim step would be to bundle all hospital-based physician fees for pathology, radiology, and anesthesiology services into the DRG. The Physician Payment Review Commission (a predecessor to MedPAC) considered that

proposal in 1988, but physician groups killed the idea through intense lobbying of Congress. [2\(chap 2\)](#) This approach would leave surgical and medical management fees outside the bundle, presumably to be controlled by the present Medicare Part B physician fee schedule.

Chronic Care Models

One consequence of the health-plan-as-fiduciary model discussed above was the emergence of disease management companies that managed specific clinical problems for health insurers on a per member per month basis. These focused on major problem areas such as mental health, drug expense, and—more recently—imaging. The underlying thesis was that because fee-for-service payment encouraged the overuse of care, costs had to be contained by imposing an externally managed system of prior authorization.

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The recent Medicare Health Support demonstration exploring the comprehensive application of third-party disease management to Medicare patients had some disappointing results: The savings realized were less than the cost of the external control systems. [11](#)

However, the idea of third-party disease managers raises an important question: Could providers do a better job of managing the avoidable costs of chronic illnesses if they were paid to do so? Episode-based bundled payments may work for routine, high-cost, hospital-based procedures, but with most chronic diseases, the concept of an episode is meaningless. What, for example, is an episode of diabetes, or congestive heart failure? Once diagnosed, patients typically have these conditions for the rest of their lives.

Patient-Centered Medical Home Exploring this thesis is the rationale for a new strain of innovation that attempts to enhance primary care services and payment: the patient-centered medical home. [12](#) Projects to test this approach for both Medicare and Medicaid patients are mandated in the health reform law. The medical home strengthens primary care to focus on clinical risks, rather than on visits. For instance, primary care for the chronically ill person should seek to avert medical problems through medication, changes in behavior, and other preventive measures. This provides an alternative to excessive diagnostic testing to enable primary care physicians to earn a living wage.

For this model to work, primary care must be enabled by information technology that can predict and track identifiable health risks. It must also include nonphysician services, such as patient education, that can help patients who are at risk for expensive medical problems to manage their own health more effectively.

There have been numerous public and private experiments with this model. A major concern, discussed by Robert Berenson and his colleagues, [12](#) is whether the medical home concept is becoming so logistically complex that only large group practices or hospital systems can afford the requisite information technology systems and overhead.

The intention is not and should not be to place the medical home at risk for downstream medical costs. Here, enhanced payment does not convey economic risk to providers; rather, it is intended to support a more-comprehensive and better-orchestrated care model. Although that model may well produce savings, they are not to be achieved by rationing specialty care but by reducing the need for care, through avoiding acute illness associated with chronic conditions.

Other Solutions However, the medical home should not be viewed as the only solution for the looming shortage of primary care physicians, as baby boomers flood into Medicare while the baby-boom generation of primary care physicians retires. [13](#) The Patient Protection and Affordable Care Act granted primary care physicians a temporary 10 percent Medicare fee increase for evaluation and management services, as well as temporarily bringing Medicaid primary care fees to parity with Medicare rates. Although helpful, these increases are just a start. Medicare needs to dramatically increase payments for traditional primary care, to encourage more physicians to provide that care.

Communitywide Cost Management

In the 1990s, hospitals and medical communities experimented with a wide variety of models for assuming economic risk for entire populations, either by establishing their own health plans or by creating subsidiaries to contract with health plans on a per capita basis. The result was a new generation of health maintenance organizations that included associations of independent practices, as well as preferred provider organizations, at-risk organizations of physicians and hospitals, and a host of other arrangements.

Although some of these organizational efforts succeeded—in communities as diverse as Grand Junction, Colorado; Sioux Falls, South Dakota; and Canton, Ohio—the broader national experience with provider risk sharing was an expensive failure.¹⁴ Many of the new organizations were not able to control the use of care or to align their incentives with those of high-earning specialists such as cardiologists, orthopedic surgeons, and oncologists, who organized into single-specialty, communitywide monopolies to resist the incursions of managed care.

Many insurers also turned away from delegated risk models in the late 1990s, preferring to manage care through their own programs. This left many new provider risk-sharing entities without customers.

Accountable Care Organizations Despite this experience, policy makers now see accountable care organizations (ACOs) as a way to control the rate of cost increases for Medicare patients within hospital service areas, through what might be termed "shadow capitation." The name reflects the fact that patients are not enrolled in physician panels under the plan. Rather, costs are statistically reconstructed after the fact for all Medicare patients who live in the area that the hospital serves.

The original idea,¹⁵ advanced by Elliott Fisher, now director of the Center for Health Policy Research at Dartmouth Medical School, was to apply cost caps to Medicare spending in hospital service areas and to encourage hospitals and their medical staffs to form collaborations to manage care and thus reduce cost growth.

Although it is conceptually easy to understand how this approach would work in a medium-size community with one hospital, it is not clear what would happen in cities where two or more hospitals compete in overlapping service areas. It is also not clear what role academic health centers, with their vast service areas and quasi-competitive relationships with community hospitals, would play in this model.

Broadening The Concept As the exponents of accountable care organizations have encountered real-world constraints on the adoption of the model, they have broadened the concept—initially focused on hospitals—to include regional group practices, independent practice associations, and other modes of care organization. These presumably serve geographic catchment areas that could be used for measuring the population's Medicare costs.¹⁶

Some hospital systems and group practices already have the information technology and medical management infrastructure in place from earlier operations involving health plans or independent practice associations. These organizations will find it easy to make the accountable care model work. And, as mentioned earlier, many hospitals are hiring increasing numbers of physicians as salaried employees.

However, in many other communities, specialist physicians own their own clinical services and will actively resist reductions in their income from managed care in any form. In these communities, hospitals will have limited influence over Medicare expenses incurred outside the boundaries of their care systems.

Whether the savings from better care coordination for Medicare patients will be offset by much higher costs to private insurers of a seemingly inevitable further wave of provider consolidation remains to be seen. In the past, trying to manage Medicare costs through entities such as accountable care organizations has often had the collateral effect of helping hospitals and physicians obtain increases in payments from private health plans.¹⁷

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Barriers To The Model Many communities face high logistical and market-structure barriers that will make it hard to scale this approach up to the national level, to that it could replace the Sustainable Growth Rate (SGR) caps—limits now placed upon growth in payments for Medicare’s Part B physician services. Replacing fee-for-service Medicare itself would be even more difficult.

Conclusion

These innovative payment methods all share the assumption of broader responsibility—either formally or informally—by hospitals or physicians for reducing Medicare expense through better coordination and management of care. Sadly, these diverse approaches do not appear to fit together seamlessly to encompass the entire continuum of health care.

Policy makers are unlikely to find a single "silver bullet" they can use to replace Medicare fee-for-service payment. They might have to tolerate multiple, overlapping, and partial solutions, and substantial regional variation in the mechanisms that are feasible.

Nonetheless, for better or worse, hospitals are going to play a much larger role in organizing or reorganizing care in their communities. The most promising innovations are those that build on hospitals’ existing information technology and organizational infrastructure. The key to successful innovation will be extending risk assumption to follow suit.

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