Preparing for Payment Reform:
A Whole New Ball Game?

As of this writing, confusion continues to surround virtually every component of the 2010 Patient Protection and Affordable Care Act (PPACA). With the March 31 release of preliminary regulations, some specific provisions and timing of healthcare reform have been clarified, but the comment period is under way, and there are still many issues to be resolved. The imperative to reduce healthcare costs has emerged as perhaps the only point of agreement among policy wonks, politicians, and industry leaders. The trajectory of healthcare cost increases is simply not sustainable for either public or private payors, and your organization can expect significant changes in how it is paid, regardless of what happens with healthcare reform legislation and regulation.

Hospitals, health systems, and medical groups must understand that big changes are coming in how revenue is generated. This Insight:
• Explains the types of payment reform that are being considered.
• Shares our perspective on how healthcare organizations will be paid in the future.
• Offers what we see as the critical steps to prosper in the post-reform era.

Fundamentals of Payment Reform

CMS has long been aware of the need for fundamental change and has used reimbursement levels as a blunt instrument to promote physician/hospital integration and foster demonstration projects to test alternatives.
to the current system. Value-driven provider payments have gained considerable traction as an apparently effective way to improve quality while controlling aggregate costs. Medicare is clearly on a track to reduce spending while making providers accountable for quality and efficiency. Further, it would be naïve to think that payment reform will be limited to Medicare patients. Medicaid programs and commercial payors are likely to follow the lead of Medicare in most markets, and these payors will have the opportunity to adopt the most effective Medicare initiatives, as well as to develop new products/payment methodologies that are most appropriate in each market.

Government and private payors are experimenting extensively with provider reimbursement methodologies that can increase the efficiency and effectiveness of medical care. Healthcare leaders must understand the major forms of value-based payment in order to determine which model, or models, will help them meet their strategic objectives in both the near and longer term. Currently, there are four basic payment models that are being broadly tested and promoted:

1. **Pay for Performance**

   Pay for performance (P4P) is intended to promote evidence-based medicine (EBM) and reduce the incentives to perform unnecessary services. Measures of performance vary from program to program. Most use a combination that includes:
   - Clinical quality and effectiveness.
   - Utilization and cost management.
   - Patient satisfaction.
   - Administrative involvement.
   - Patient safety.

   Hospitals and physicians are paid a bonus for meeting objective standards in selected categories. Initial P4P projects were launched over 10 years ago and had a limited impact. Recently, there has been a significant increase in P4P activity, primarily generated by CMS’s promotion of the Physician Quality Reporting Initiative (PQRI) and reports of significant payouts to physicians under the program. While P4P has been helped by improved quality and performance standards, there are many obstacles hindering widespread implementation. These include:

   - **Lack of Consensus and Consistency of Standards**
     Agreement on the benchmarks is difficult to achieve, and performance measures vary from program to program and from payor to payor.
   - **Complex and Expensive Administration**
     Measurements need to be updated frequently, and the administrative requirements of gathering and reporting data and securing payment are substantial.
   - **Performance Incentives That May Not Be Adequate to Change Behavior**
     In a 2009 survey conducted by ECG Management Consultants, Inc., we found that performance incentives averaged just 5 percent of total reimbursement for 89 percent of participating organizations.

2. **Bundled Payments**

   The term “bundled” has been used broadly to describe payments that encompass more than discrete patient encounters and specific patient services. A bundled payment can cover particular conditions (e.g., congestive heart failure) or episodes of care (e.g., knee replacement, including postoperative rehab) and generally applies to hospital, physician, ancillary, and all other related services for a specific time period. If demonstration and pilot projects are successful, the Medicare program could implement bundled payments for a range of services within 5 years.

   Bundled payments are receiving considerable attention from private payors as well as the government. Interest from the payor perspective is not surprising, because this methodology can save money on complex and expensive services that have been difficult to control under fee-for-service (FFS) payments. For providers, it is critical that you understand your cost structure and ensure the “bundle” is adequate to compensate each of the participants involved.

   The use of bundled payments is likely to expand in the near term because it is easy to understand and has significant cost-saving potential for select conditions and service types. In the longer term, we see a limited future for bundled payments primarily because this approach:
• Is applicable to a relatively small portion of healthcare services.
• Is complex to administer.
• Provides near-term savings, with limited long-term opportunity.
• Can make it difficult to secure needed provider commitment, especially regarding compensation.

3. Patient-Centered Medical Homes

The patient-centered medical home (PCMH) model creates a team of providers led by a primary care physician who is responsible for coordinating all medical services to a defined population. Under current models, providers are paid on an FFS basis, with an additional monthly payment for care management and a share of any savings realized. This model is thought to be most effective for treating chronic illnesses and patients with multiple problems, such as the elderly. A comparison of the current care model and PCMH is shown below.

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<th>THE COLLABORATIVE CONTRAST</th>
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<tr>
<td><strong>Traditional Gatekeeper Model</strong></td>
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<td>Care is episodic and based on illness and patient complaints.</td>
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<td>Providers operate in silos with limited communication.</td>
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<td>The patient is a passive participant with limited say in treatment.</td>
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<td>Practice patterns vary widely according to physician preference.</td>
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<td>Payment is procedure-based, and volume is rewarded.</td>
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Primary care physicians and physician organizations are providing leadership for the development of PCMHs, and the concept appears to be gaining traction. There are laws governing medical homes in 44 states, as reported by the Patient-Centered Primary Care Collaborative. From the perspective of long-term viability, major issues include requirements for:
• A significant investment both in personnel and information systems.
• Complex compensation protocols.
• Cross-practice and hospital coordination/cooperation.

4. Shared-Risk Models and Accountable Care Organizations

There is a broad array of models that allow risk sharing among payors, providers, and facilities. The PPACA identified the characteristics required of provider organizations that choose to be accountable for the quality, cost, and overall care for a designated group of Medicare beneficiaries. This officially defined the accountable care organization (ACO) as the model intended to bring hospitals, doctors, and other providers together to better coordinate care and reduce costs.

It is important to understand the difference between shared-risk arrangements and organizational structures that facilitate shared-risk arrangements. Pilot programs include two payment approaches: shared savings programs (SSPs) and population-based payment (PBP).

• **SSPs** – Providers are paid on an FFS basis for specified patients or services, and if payments are less than expected, they receive a portion of the savings. A variation can utilize withholding a portion of FFS payments that would be distributed only if cost and quality targets are met.

• **PBP** – Providers are paid based on a capitation system in which they receive a global payment for each covered patient, as long as quality standards are met.

These payment models reward successful clinical integration and care coordination. The ACO is simply the legal structure needed to participate in the payment models currently being evaluated. Over the next several months, CMS will be issuing standards for ACO designation, and both the Department of Justice and the Federal Trade Commission (FTC) will be providing guidance that will clear the way for the next generation of shared-risk payment arrangements.

The move toward PBP is reminiscent of the surge of health maintenance organizations (HMOs) and capitation payments to providers that occurred in the late 1980s and 1990s. ACOs are in fact intended to accept and manage financial risk for medical services, whether we call it global payment, PBP, or capitation. The previous movement to risk contracting fizzled largely due to a perceived lack of consumer choice and resistance within both the insurance and provider communities. Important lessons were learned, however, and it is clear that with today’s economic pressures and changes in the political climate, the transfer of risk away from the government and payors and toward providers and consumers is likely to gather momentum.

The significant barriers to shared-risk models include:

• Current legal and regulatory standards make formation of a qualified network a long, complex, expensive, and risky undertaking.

• Challenges in creating effective clinical collaboration, including care delivery and performance metrics, are substantial. To be effective, provider organizations will require a degree of integration that few healthcare delivery systems currently achieve.

• The culture of many organizations is firmly entrenched in FFS, even if the stated strategy includes moving toward payments based on shared risk and population. As previously noted, there are significant functional differences between FFS and at-risk payment models. Right or wrong, culture trumps strategy, and unless the culture is changed, attempts to promote coordinated care will be stymied.

### How Will Providers Be Paid in the Future?

Given the variety of ideas being explored for payment reform, it is easy to understand why healthcare providers are confused about how to proceed and are uncertain about where all this will lead. Based on past attempts at payment reform, it is tempting to conclude that there will be improvements to the current system but no major overhaul. However, if we look at the objectives of politicians, the government, and payors instead of the details of each plan, several indicators point to major changes in payment methodology, rather than continued tinkering with the existing FFS system.

The bottom line? We believe that population-based compensation will expand to become a major source of provider payment within the next 5 years. Here’s why:

**The Cost Imperative**

The fallout from our country’s Great Recession has focused attention on the costs of healthcare. Specifically, there is broad understanding that both the current spending on healthcare and the rate of cost increase are simply unsustainable. Cost is the “burning platform” forcing us to leap to a new model for provider organization/compensation. Continuing to pay providers based on volume maintains the contradictory incentive to do more, rather than to do better.

The government has also become more direct in encouraging changes in organization and compensation of providers. A recent joint statement by the FTC and Department of Justice defines clinical integration as “the implementation of an active and ongoing program to evaluate and modify practice patterns by the network’s physician participants and create a high degree of interdependence and cooperation among the physicians to control cost and ensure quality.” Regulators now recognize that cost control and quality assurance require collaboration that the FFS regulations do not permit.

Although not widely publicized, CMS has been

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promoting integration by using changes in Medicare reimbursement as a tool. Reimbursement has dropped for procedures done in freestanding facilities, while the same procedures done in hospitals have received significant increases. Many specialties have been impacted by these changes. This is most clear in cardiology, which, during a 7 year span, has experienced reductions in compensation for office-based procedures of 11 percent, while the same procedures done under the hospital license have been increased by 18 percent.4 It is not surprising that the result has been a surge in hospital acquisitions of freestanding cardiology practices.

Reducing the costs of healthcare is the dominant objective of payment reform. Reduction in payments to providers is ostensibly the only cost control possible with FFS, and there is agreement that while this approach might be used in the near term, it is unlikely to produce sustainable results. The value-based systems under consideration move away from FFS to promote efficiency and demonstrate effectiveness of patient care.

Progress in Healthcare Delivery
Healthcare has been described as the last “cottage industry,” characterized by large numbers of independent providers and facilities that all operate as separate businesses. FFS was essentially the only way to compensate a provider in a time when the physician’s office was the site of virtually all medical services, and the hospital served as the “doctor’s workshop.”

However, with the steady growth in the number and type of medical specialties, ancillary providers, imaging modalities, diagnostic procedures, and specialized facilities, FFS reimbursement is increasingly cumbersome and expensive. As healthcare depends more on collaboration between and among providers, the FFS payment system provides little or no incentive to collaborate, and it reinforces the cottage industry rather than promoting collaboration, quality, and efficiency. It is increasingly apparent that the value-based options offer significant advantages over FFS in today’s delivery system.

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Provider Integration
To be effective, value-based payment demands clinical coordination. Clinical coordination, then, demands some form of integration of providers and services. A significant barrier to payment reform has been the lack of integration among healthcare providers. Efforts to encourage consolidation/integration are under way by the government (ACOs) as well as the private sector (PHOs, acquisitions, medical group expansions). While not widely recognized, we have already achieved a significant degree of provider integration, and the pace is accelerating. The primary vehicle for integration has become hospitals purchasing practices and employing physicians, as shown in the following chart:

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The end of the cottage industry will come with the economic integration of providers, and, to date, hospitals and health systems, along with a few large medical groups, have led the way in moving toward clinical coordination. Hospital domination of provider integration activity is a direct result of hospital access to management and capital, two key resources for integration. There are only a handful of ecumenically integrated medical groups that have the size, specialty mix, management depth, or financial resources to serve as the integrator of providers in their communities. It may be that physicians, when faced with employment by

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a hospital as their only option, will be willing to create and sustain large, disciplined, and well-financed medical groups. If so, these medical groups will be powerful community forces. Unfortunately, we have yet to see a significant rise in group formation or in physicians joining freestanding medical groups.

A major question remains regarding the role of preferred provider organizations (PPOs), independent practice associations (IPAs), and similar structures that bring independent providers together into contracting networks while retaining economic independence. These entities are widespread and popular with providers, and they have the potential to play a major role in a population-based reimbursement world. However, too often the dominant concerns of physician members are to (1) maximize personal compensation and (2) preserve and protect their private practice models. Achieving the requisite level of clinical coordination and economic integration for shared savings or population-based reimbursement will be a major challenge for these organizations unless they are able to adapt their objectives to marketplace requirements.

Our View of the Future
In this Insight, we have reviewed a few of the many factors that will result in payors working with providers to ultimately move away from traditional FFS arrangements and toward value-based alternatives. For the near term, the shared savings alternatives will be most common because they retain an FFS base and have significant cost-reduction potential.

Over time, however, we expect to see continuing successes in PCMH projects as well as in other PBP initiatives, including Medicare Advantage and innovations similar to the Alternative Quality Contract initiative in Massachusetts. During the next few years, hospital-led integration and ACO formation activity will increase, creating many more organizations that are capable of accepting and managing PBPs. These provider organizations will initially seek PBPs through Medicare and Medicaid programs and will later serve as the provider network for HMO or self-funded products. In the future, the SSP payments will be subsumed under more widely utilized PBP for well-organized provider networks.

While hospital-owned networks are likely to be the dominant structure, we also see hospital partnerships with physician groups, and in some instances, independent medical groups will serve as the “integrator” of services in their communities. In our judgment, PBPs will gain traction in the next 5 years and will be the major source of reimbursement within 10 years.

The To-Do List for Payment Reform
Given the uncertainty and complexity surrounding payment reform, it may be tempting to hide and watch for the next year or two. Letting the issues be sorted out and lessons be learned (by others) before making any commitments has considerable appeal. Unfortunately, the other providers and payors in your market are not likely to take the same time-out, and they will be busy with building relationships and finding worthy initiatives. As a result, you may be late to the market for provider networks, insurance products, clinical coordination, and other attributes needed by payment reform – whichever version emerges. We believe three actions should be completed in the near term:

1. Understand Your Payor Market
It is likely that you have an adequate understanding of the hospital market and even the physician market in your immediate area. It is less likely that you understand the payor market in terms of how you measure up as a component of their provider networks, new products under development, data-management capabilities, and strategic priorities. Meet with, and learn from, the insurance companies’ senior managers.

2. Assess Your Organization’s Role
Before defining your role and developing a detailed strategy for coping with payment reform, you’ll need to take a realistic look at the culture and capabilities of your organization as they relate to value-based payment. By realistic, we mean an objective evaluation of the operational, financial, political, and competitive capabilities of your organization as they relate to value-based payments. It is not what you want to accomplish, but rather what your organization is able and willing to accomplish that must be identified.
Given this assessment, you’ll be able to identify which of the following basic roles is most appropriate:

A. **Be the Integrator** – If your assessment shows that you have both the capability and commitment, you should acquire the provider network, provide required capital, negotiate contracts with payors, and manage all clinical and administrative services. Examples include the following:
   - Hospital/health system with a large employed physician network.
   - Multispecialty medical group with comanagement responsibility for inpatient services.

B. **Be a Partner** – If you are missing one or more key capabilities or lack adequate market strength, you should seek opportunities to participate in the governance and management of a contracting entity, provide some of the capital required, share financial risk for performance of the contracting entity, and retain operational and financial autonomy. An example would be one or two hospitals and local medical groups that form a contracting entity (ACO), owned by the participants. Each retains its independent corporate status.

C. **Be a Vendor** – If your organization has significant limitations, your role may be to provide clinical services under contract to one or more contracting entities and assume financial risk only for services supplied under contract. Have an advisory role only in governance of the prime contracting entity. Examples include the following:
   - A hospital contracts with one or more ACOs for inpatient services.
   - An orthopedic group contracts with a PCMH to provide specified services.

It isn’t surprising that most hospitals, many medical groups, some PHOs, and a few provider contracting entities (IPAs) are operating under the assumption that they will be the integrator in their community. Our experience suggests that this assumption is based on organizational hubris rather than careful planning. We believe that the combination of skills and perspective required in value-based payment will limit the number of organizations that can, on their own, be successful integrators in a given region. The partner role will likely grow in importance as alliances are put together in response to payment reform. The vendor role will remain critical in most areas because many organizations lack the resources and/or the interest to be a more active player.

3. **Develop an Explicit Strategy**

After considering the role for your organization, the selection of objectives and specific initiatives is much easier, and a payment reform strategy should be prepared that is limited to three categories:
- Clinical coordination.
- Provider collaboration.
- Cost control.

Too often hospitals focus on creating the structure and governance of a contracting entity such as an ACO while paying scant attention to the functional requirements of coordinated care. Start with initiatives aimed at the above goals, and the organizational structure will emerge as part of the process. Another concern arises when considering that measurement of quality and documentation of outcomes receive most of the attention. Providers also need to understand their current costs and pricing structure as well as how they compare to others across the portfolio of services. Both in the short and longer term, rationalizing payment structures can indeed result in gains.

**The New Ball Game**

We will, in fact, have a new healthcare ball game as the reality of how providers are paid goes through the process of change. Few would argue that FFS should remain our basis of compensation, and those providers who cling to the old rules will find a downward revenue spiral and loss of third-party contracts. We have made our case for the future growth of value-based payment and PBP. The encouraging reality is that it will take a number of years for the changes to have full impact, and this gives providers adequate time to respond.

The first order of business is to understand your costs and capabilities. Next, align your contracting priorities with your organizational strategy. Finally, and most difficult of all, focus on changing the culture of your organization to match the requirements of the new value-based system.
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