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ISSUE: HEALTH CARE PAYMENTS March 28, 2016

Health Care Payments

By Deborah Abrams Kaplan

Can billing based on "value" save money and improve care?

Executive Summary

Health care spending continues to rise in the United States, consuming nearly 18 percent of gross domestic product in 2014—a trajectory that many experts warn is unsustainable. Some say the traditional "fee-for-service" system of reimbursing doctors and hospitals for each service rendered wastes money and even harms patients because it lacks adequate incentives to ensure quality care. A growing number of insurers and employers agree. Led by the federal Medicare program, they are aggressively pursuing alternative models designed to rein in spending and improve care by basing payment partly on "value" and "quality." In 2014 Medicare made 20 percent of its payments using alternative payment models, up from zero in 2011, and it wants to increase that to 50 percent in 2018. Defenders of the fee-for-service approach, however, question whether payment based on value is workable and cost-effective. Among the issues under debate: Can health care providers operate profitably under new payment systems? Do new systems reward quality care better than fee for service? Can hospitals and doctors measure what matters?

Overview

Critics of the “fee-for-service” payment model say doctors should be compensated based on the quality of their patient care. (Jahi Chikwendiu/The Washington Post via Getty Images)

When Oregon officials overhauled the state's Medicaid payment system in 2012, they promised to save the state and federal governments $11 billion over a decade while improving care for the program's low-income and disabled patients. To achieve that goal, Oregon changed the way Medicaid paid doctors and hospitals for their services.

Under the old system, payments were based on the traditional fee-for-service model, in which health care providers received money for each service rendered during a patient's visit. Under the new system, participating provider groups—doctors, health care clinics and sometimes hospitals—receive a bonus and other financial incentives for meeting quality-of-service goals, such as following up after a patient is hospitalized for mental illness, performing developmental screenings on newborns within 36 hours of birth and providing depression screenings and follow-up plans.

Oregon's new system uses a number of alternative payment plans, including the “global payment” model, in which a doctor or clinic is paid one fee for each patient's care, including office visits, hospitalization and even dental care. The state also uses a pay-for-performance model, providing bonuses to doctors and hospitals that meet quality goals.[1]

The goal is for doctors and health care systems to make positive changes in patient care by offering incentives, like extra financial payments, says Chris DeMars, director of system innovation at the Oregon Health Authority Transformation Center.

The center provides support for the state's 16 newly created Coordinated Care Organizations (CCO), which oversee Medicaid patients' medical, oral and mental health needs. “Alternative payment models are providing more flexibility and ways to be innovative,” says DeMars.

Oregon's approach exemplifies a shift from “volume” to “value” in U.S. health care, in which part of doctors' and hospitals' fees are tied to how well they perform and not simply on whether they render a service. In 2014 Medicare—the federal health care program for the elderly—made

20 percent of its payments using alternative payment models, up from zero in 2011, and it wants to increase that to 50 percent in 2018.[2]

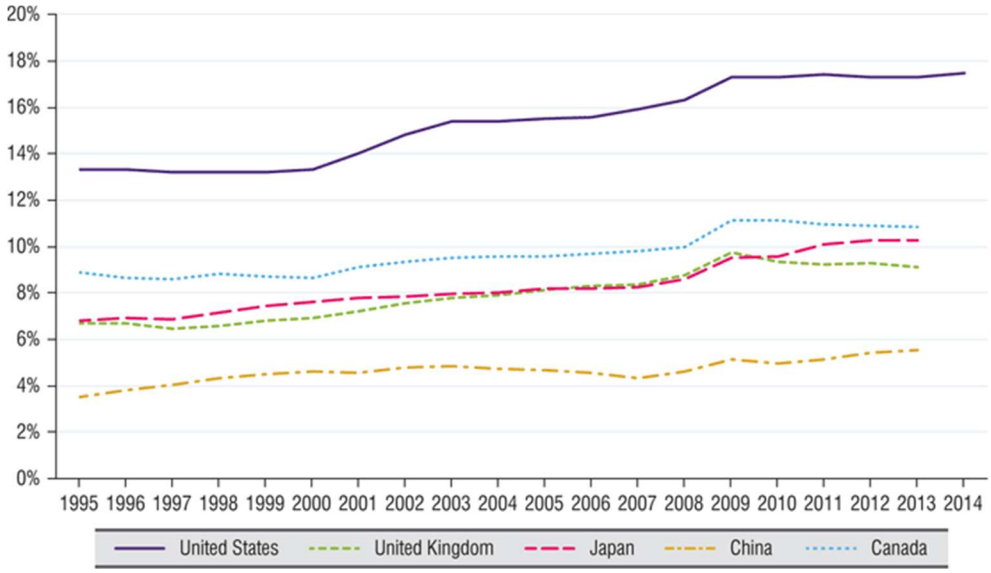
Critics, however, question the growing use of alternative payments, wondering how Medicare and others can accurately measure "value," and they warn that health providers are taking on too much financial risk without fully understanding the consequences. Paying doctors and hospitals based on "value" and awarding them bonuses for meeting certain "quality" measures carries downsides, the critics also argue. Physicians might focus more on earning bonuses than on providing the most effective treatment, and hospitals could shy away from treating the most ill or could rely more on "observational" care, where instead of readmitting patients, the hospitals observe them before sending them home—a practice that can leave patients with big bills because insurers don't always fully cover such care.

Experts note that most of these supposed innovations have been tried in one form or another since the 1980s, with inconclusive results. But the alternative payment movement has new momentum because of continuing increases in health care costs, growing demographic pressures from an aging population and new opportunities to quantify "quality" and "value" as data technology advances.

The high cost of health care in the United States is a key driver in the renewed effort to find cheaper, and better, ways to pay for medical care. In 2014, health care spending accounted for nearly 18 percent of gross domestic product (GDP)—a measure of the country's total economic output. That was up from about 14 percent in 2001.[3] The United States spent $3 trillion on health care in 2014, up 5.3 percent from the year before.

U.S. Health Care Spending Soars

Annual outlays as a percentage of GDP, by country, 1995–2014



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Note: Data for the United States are from U.S. National Health Expenditure Accounts estimates. Data for all other countries are from the World Bank and are unavailable for 2014.

Sources: “NHE Summary including share of GDP, CY 1960-2014,” U.S. Centers for Medicare and Medicaid Services, updated Dec. 3, 2015, downloaded from http://tinyurl.com/opcgw48; “Health expenditure, total (% of GDP),” World DataBank, the World Bank, accessed March 8, 2016,http://tinyurl.com/2vmh66c

Health care spending in the United States increased from 13 percent of gross domestic product (GDP) in 1995 to nearly 18 percent in in 2014. Spending also rose in China and Japan from 1995 to 2013, the latest year for which data are available, but to far lower levels. Spending as a share of GDP fell slightly in recent years in Canada and the United Kingdom. Long Description (graph)

Experts say spending at this level isn't sustainable. “We don't believe the country can continue on this path with fee-for-service medicine. It's an economic threat to the nation,” says Jeff Micklos, executive director of the Health Care Transformation Task Force, a consortium of private health insurance companies, group health care insurance purchasers, providers and patients working to transform the U.S. health care system.

The more money that is spent on health care, the less that is available for education, infrastructure and other needs, and the cost affects job creation because many employers can't afford employee health insurance premiums, according to one study.[4]

Numerous factors are driving up health care costs, including the increasing cost of medical technology and services, the large number of uninsured and the expense of meeting government regulatory requirements—the latter a major concern of conservative critics of government.

In addition, the massive Baby Boom Generation, born between 1946 and 1964, is retiring and is enrolling in Medicare at a rapid pace. That generation's departure from the workforce means fewer workers are left to fund Medicare, at a time when more people are using it. In 2010, the 65-plus age group was 13 percent of the U.S. population; it will be more than 20 percent in 2030, when all Baby Boomers will have reached 65, according to the U.S. Census Bureau.[5] Plus, as people age, they have more health problems and need more care.

With health care costs increasing and the ranks of the uninsured growing, President Obama and the then Democratic-controlled Congress enacted the Affordable Care Act (ACA) in 2010. An important goal was to improve the quality and safety of patient care, while financially penalizing doctors and hospitals that don't meet quality goals. The ACA also authorized new payment and health care delivery models to slow the growth of health care costs and improve services.[6]

Medicare is leading the shift toward alternative payment systems. By the end of 2016, 30 percent of Medicare payments will be linked to payment models other than fee-for-service. The payments will increasingly be tied to quality and value metrics, such as requiring hospitals to decrease post-surgery infections rates and patient readmissions after discharge.[7]

Alternative payment programs take many forms. In bundled care, a health insurance company pays one fee for a medical procedure such as a knee replacement. The fee is divided between the hospital (covering the surgery suite, hospital room, nursing care, medical supplies and anesthesia) and physicians (orthopedic surgeon, anesthesiologist and radiologist). It covers complications within a certain time frame, too. The traditional fee-for-service method generates a detailed bill, including each physician's services, operating and recovery room costs and lab tests, that is typically higher than bundled care.

When Medicare announced its payment goals, it said seven of the 10 largest private insurers agreed with them. Medicare and many private insurers are working together on the value-based models, because most doctors and hospitals treat both Medicare and privately insured patients, says Micklos. It's easier for medical providers to work under similar payment systems. More than 50 percent of state governments agreed to do this as well for Medicaid.[8]

In some alternative payment systems, doctors and hospitals could lose money if they don't meet targets for quality. For example, out of 2,723 hospitals that received value-based payments from Medicare in fiscal 2014, 54 percent of them lost money when they were penalized after failing to meet goals set by the agency. (See "Most Hospitals Lost Money from Medicare Incentives in 2014.") The alternative payment systems also might mean that doctors and hospitals have to add staff to coordinate patient care, with physicians and others working in teams to monitor patients' health care needs, especially for patients with chronic diseases.

To control costs, some insurers and employers are developing their own payment and quality programs, with the aim of curbing unnecessary procedures and holding down their premium costs, says David Lansky, CEO of Pacific Business Group on Health, a group that includes 60 large companies and city governments working to lower health care costs and improve delivery. "As stewards of the company's money, [employers] have to take action and bring rationality to the way the health care system performs," Lansky says.

In the past few years, companies in Lansky's group have tried to implement change by offering financial incentives to patients and doctors, he says. If a doctor or clinic can make the care process more efficient, it saves everyone money, Lansky says.

With patients, Lansky says, the idea is to teach "wellness" strategies and ways to make good medical decisions so that they will need less treatment.

Developing metrics to measure quality and value is burdensome and controversial because hospitals with multiple insurance contracts have to track different quality metrics to report to insurers, says Micklos. "Is it good for the system to implement six different measure sets because that's what's negotiated in the contract?" he asks. Making data collection consistent would be more efficient and make the metrics easier to analyze, he says.

Other experts say measuring doctors' performance is misguided. Robert Berenson, a physician and a fellow with the Urban Institute, a Washington, D.C., think tank, says that 20 years ago, reformers wanting to improve health care focused on finding the 5 percent of doctors who weren't good doctors. But today's reformers want to evaluate the good ones as well as the bad, he says. "Our argument is that it's not up to the government to move to the middle, to distinguish a good physician from a little-better-than-good physician. That's not possible," Berenson says. Government's role should be to protect patients from the bad physicians, he says.

Supporters of the Affordable Care Act rally outside the Supreme Court last year. Critics say the law raises health care costs and should be repealed. (Al Drago/CQ Roll Call)

Some conservatives want less government involvement in medicine, warning that the ACA could turn into a government-funded model similar to the health care payment system used in the United Kingdom and Canada. “People can't resist the notion that if only you have more central planning, more controls, things will get better,” says Linda Gorman, director of the Health Care Policy Institute at the Independence Institute, a think tank in Colorado. She adds, “You need to get rid of the federal controls and let the market do its thing.”

There is no agreement, however, on which payment system—fee-for-service or its many alternatives—is the most effective. “All payment systems have advantages and drawbacks,” says Martin Roland, a professor of health services research at the University of Cambridge in England. Fee-for-service requires doing more for patients than needed, which is expensive, he says. “Capitation,” in which doctors receive a set fee per patient, is good for managing a large number of patients but provides no incentive for physicians to spend time with each individual. Paying doctors a salary doesn't give them an incentive to see more patients, or strive for quality, he says.

“All methods provide basic income for doctors and staff,” Roland says. Many health care systems are looking to a blended payment system, taking the best of each approach.

As alternative payment systems take root, here are some of the questions policymakers are debating:

Weighing the Issues

Can health care providers operate profitably under alternative payment systems?

With payment systems changing and goals to cut the growth in spending proliferating, savings have to come from somewhere—and someone is going to lose, experts say. Either a patient will pay more, or a doctor, hospital or medical supplier will earn less. Some doctors and hospitals even worry they could face bankruptcy.

While innovation represents an opportunity for everyone, “there will be winners and losers,” says Micklos of the Health Care Transformation Task Force. “It's logical in any market that there will be those who won't be able to answer the bell. Any time there's a ratcheting down of the [reimbursement] rate, you have to assess what it does to your program.”

To succeed, doctors and hospitals are working with other provider groups to share the risk of the downward pressure on reimbursement rates. Others are merging to form larger organizations that can better withstand the financial pressures and can influence market rates.

Lansky of the Pacific Business Group says he isn't concerned that some health care organizations might go under. “I'm sure there are individual organizations that will struggle through that process,” he says. However, “employers and taxpayers have been paying way too much for far too long.” High medical payments have come at the expense of the rest of society, Lansky says, with some workers not getting wage increases because of rapidly rising health care costs. “I don't think protecting the health care system is something we should worry about.”

Jeff Micklos: Changes will produce “winners and losers.”

Any time someone proposes changing the payment system, those affected get defensive, Lansky says. “There's a very strong tendency toward self-protection, and every major initiative in the past 10 to 20 years gets met with a self-protective impulse to slow it down or change it,” he says. Undoubtedly the changes will reduce the income of some working in the health care system. “But there's another part of society that urgently needs this transition to take place,” Lansky says.

Many physicians would rather shift to an alternative pay system than be stuck trying to make two incompatible forms of billing work, says Lansky. Combining risk-based contracts, in which providers can lose money if they fail to meet goals, and fee-for-service payments is difficult for a medical practice, he says, because they are radically different ways to earn money. The fee-for-service model encourages doctors to order more tests and examinations, while risk-based

contracts give them a financial stake in coordinating the patient's care and providing only what's needed. Lansky says he encourages a rapid shift to alternative payments to eliminate this problem.

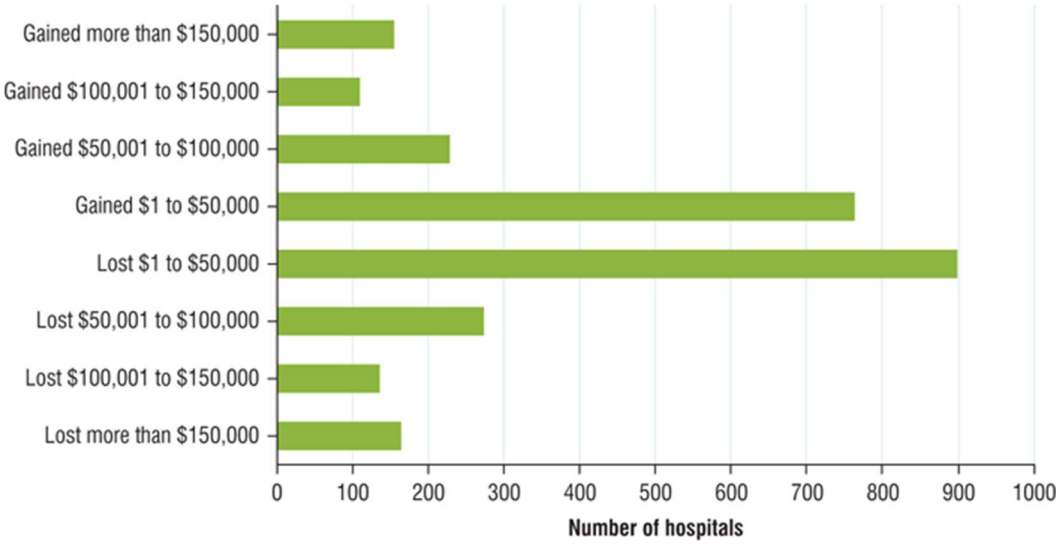
Many doctors and hospitals are nervous about the changes coming and fear losing income, says R. Adams Dudley, director of the University of California-San Francisco's Center for Healthcare Value, a university-based organization seeking new ways lower health care costs. Doctors' salaries averaged about $189,000 for pediatricians and $421,000 for orthopedic surgeons in 2014.[9] Those figures are up from 2010, when pediatricians averaged $148,000 and orthopedic surgeons $350,000.[10] Provider organizations are doing equally well, he says. Some doctors and hospitals, as a result, are resisting changes to the payment system while others are trying to make the changes palatable, according to Dudley.

Some smaller medical practices are consolidating or getting bought by hospital systems because they fear failing financially under the new payment systems, says Berenson of the Urban Institute. They may not have the money to upgrade their information technology to better track the required data, or they may not be large enough to negotiate higher reimbursement rates with insurance carriers. Hospitals are also buying up other hospitals and medical practices for the same reason. Dudley says he sees a downside to these consolidations. The hospitals want to form monopolies and oligopolies so that they will have sufficient size to control prices.

Hospitals and other providers who are most successful at staying profitable are making real changes in care delivery, says Mark Friedberg, a practicing physician in Boston and a senior natural scientist at the RAND Corp. think tank. In a 2015 study, he found that when physicians lost money, it was due to volatility in revenues resulting from the unpredictability of patients' health needs.[11] “If you don't think about how volatile costs will be year-to-year, which is outside your control, you could easily lose a lot of money,” he says.

Most Hospitals Lost Money from Medicare Incentives in 2014

Net payments for hospitals participating in Medicare value-based incentive payments, fiscal 2014



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Note: Medicare initially withholds a percentage of payment for hospitals participating in the agency's value-based payments system. Hospitals can earn back money, with bonuses, for meeting or exceeding value goals, or they can lose money through penalties if they fail to meet these goals. Hospitals with negative balances lost more from initial withholding than they made in incentives and bonus payments.

Source: "Net Change in Base Operating DRG Amount," U.S. Centers for Medicare and Medicaid Services, undated, http://tinyurl.com/zswb9bw

Nearly 1,500 hospitals that received value-based payments from Medicare in fiscal 2014 lost money after factoring in penalties for failing to meet goals set by the agency. A total of 164 of those hospitals lost more than $150,000. Among the 1,253 hospitals that earned money from Medicare value-based incentives, 762 made between $1 and $50,000, 228 made between $50,000 and $100,000 and 263 made $100,000 or more. Long Description (link to graph)

Hospitals and physicians may well continue making money under the new payment plans, Lansky says, but with consequences: Medical practices will change dramatically, with more mergers and fewer independents. More hospitals, meanwhile, will employ physicians directly.[12] The changes in payment systems are here whether the providers like them or not, he says. "They're going to have to figure this out."

Do the new systems reward quality care better than fee-for-service?

The idea that value-based care can produce better results than the fee-for-service model may make sense in theory. But the evidence is mixed on whether the theory works in practice, because some of these improvements prove to be only temporary, some experts say. One advantage of fee-for-service is that it makes measuring doctor productivity easier. But this doesn't necessarily help patient care, say advocates of alternative payments.

Lansky says he's unsure whether alternative payments produce more value. "There have been models of managed care and prepayment and bundled payment for a long time. Every one of them has risk. It's not always a higher value," he says. What's missing, he says, is a good way to measure the quality of outcomes and show which payment models are more successful.

"I'm not the biggest fan of pay-for-performance," says Aaron E. Carroll, a pediatrician and director of the Center for Health Policy and Professionalism Research at the Indiana University School of Medicine. "Too often we define quality by what we *can* measure, rather than by what we *should be* measuring."

Studies sometimes show a benefit when a system rewards quality, but the benefit tends to be short term, Carroll says.[13] That's because everyone tends to get on board when an incentivized metric first appears, Carroll says. But when the money is pegged to another metric, the doctors follow. Changing behavior is complex, he says. "If it was easy we would have fixed it by now. It's a lot more difficult than policy experts would believe."

Quality is better improved on the local level, Carroll says. Hospitals can look at what isn't working well for them and fix it. "It just isn't done with national arbitrary metrics," Carroll says. One-size-fits-all programs don't work, especially because each health care provider has different types of patients and quality challenges. "It depends on what the problem is or what you're trying to fix," he says. That might mean too many infections in a hospital, or lack of follow-up at discharge. Nationally standardized metrics aren't measuring the same thing at each provider

because some might have sicker patients, for example. Providers can get penalized under a pay-for-performance system even when problems are outside their control.

Charles N. Kahn III, president and CEO of the Federation of American Hospitals, which represents more than 1,000 for-profit hospitals in the United States, agrees that it's difficult to compare hospitals because some treat lower-income patients who have less access to the medical system and therefore are sicker than more well-off patients. While money incentivizes doctors to change how they practice, they also have other motivations, such as doing a good job and wanting their patients to do well, say Carroll and other experts.

“Pushing money only may backfire,” Carroll says. “It's not as simple as, ‘Offer me a dollar and I'll be a better doctor.’” Some doctors complain that their hospitals don't have enough resources, such as social workers to help with case management. Hiring another staff member can be an effective reward, he says.

One way that rewarding quality can work is to give patients a choice and a financial incentive to use certain providers, says Lansky. Walmart employees needing knee- or hip-replacement surgery can go to one of four high quality facilities chosen by Walmart, with no out-of-pocket cost, including travel.[14] “The employer will pay more of the cost, but that's because it's better for the employee and it's cheaper for everyone. There's a low rate of reoperation,” says Lansky. “It's win-win.” The message to health care facilities is to “up their game” if they want to provide health care to Walmart employees. “It saves the employees and company money, ultimately signaling to the market that employers are not going to passively accept mediocre care,” Lansky says.

Another way to encourage quality is to compile and share in-house performance reports comparing doctors within a particular medical system, says Berenson of the Urban Institute. But there's a big difference between sharing reports with the doctors for self-improvement and publishing them publicly. “If it's publicly reported, it has to be right. You're dealing with reputation. I'm all for the confidential feedback of reports,” he says.

Incentives also are effective if they get doctors to work together as a group, says Friedberg of RAND. Doctors in a group practice shouldn't be rewarded through individual billing, he says. Instead, bonuses should depend on the group's performance, including each doctor's performance on quality measures. This encourages doctors to work for the betterment of the patient and the group, reducing the cost overruns involved with fee-for-service, Friedberg says.

Friedberg cites the savings produced when a practice changed its approach to treating diabetes. In shared savings programs, the doctor and the insurance carrier share the money saved when the cost of care is lowered. In this situation, doctors found that some of their diabetic patients also had untreated mental illness. By referring them to psychiatrists who treated the mental illness, the patients were better able to control their diabetes. The group ultimately got financial bonuses for quality performance. It saved money on diabetes complications and patients got better care, with fewer hospitalizations. “The provider made quite a bit of money,” Friedberg says.

Can providers measure what matters?

While many experts think it's possible to measure key aspects of health care, others say quality and patient outcomes aren't easy to pinpoint.

Metrics came a long way in the last decade, Dudley says. Some early metrics measured activities that were routinely done by almost all clinicians, such as measuring the oxygen level in a patient with pneumonia, he says. If performance starts out close to 100 percent, incentives don't work because people are already doing that task.

But, says Micklos of the Health Care Transformation Task Force, the number of metrics has multiplied as more insurers develop their own set of measurements. “The volume of metrics is a concern,” he says. “We believe there needs to be consistency across payers, and we need to find the most effective measures.”

For example, Oregon's new Medicaid program asks providers to meet 18 metrics, ranging from adolescent checkups to treating diabetes. “I've heard the frustration,” says Summer Boslaugh, transformation analyst at the Oregon Health Authority Transformation Center. “It's only 18 metrics, but that's a lot. How do you prioritize even with that relatively small number?” But Oregon providers are actually responsible for more than 100 metrics when all insurers, not just Medicaid, are considered.

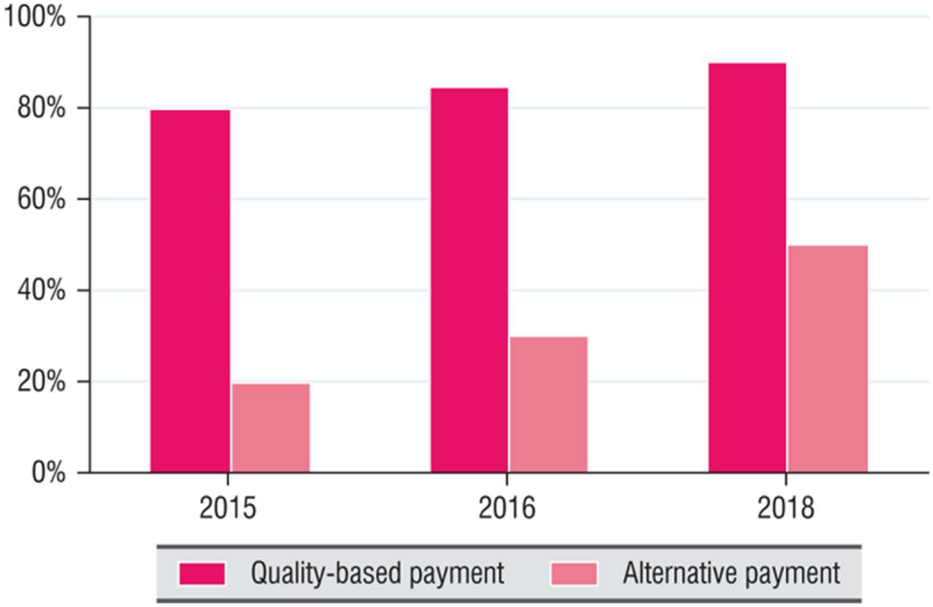
Sharing quality-of-care data between the government and private payers is one option, but a stumbling block is who would require doctors and hospitals to collect and share certain data, says Friedberg. “Government is reluctant to do that. It's considered government intrusion to mandate those data requirements,” he says. Other stumbling blocks are the fragmentation of the private market and the mobility of patients between insurance carriers, making data consistency difficult.

Sometimes providers do a great job of measuring activities affecting patient care, but collecting this data ends for other reasons, says Dudley. One example, he says, is a California study in which hospitals collected intensive care unit (ICU) data to measure the risk of ICU patients dying in the hospital.[15] “The hospitals lowered their mortality rates, and it seemed like it was working great,” he says. Around that time, Medicare instituted its own quality measures but didn't include ICU metrics. So they could gather the Medicare data, the hospitals stopped collecting the ICU metrics even though they were clinically important, Dudley says, adding that the ICU data were expensive to collect and analyze.

Cost and ease of data collection play a big role in what's measured, even if the information collected is not the most needed. “We keep picking things we can measure administratively,” such as billing data, says Carroll of the Center for Health Policy and Professionalism Research. Those data aren't always the most helpful. “Quality is sometimes hard to measure. It requires people and processes that might be expensive,” he says.

Medicare Seeks to Expand Alternative Payment Programs

Percentage of Medicare payments linked to quality-based and alternative payment programs, 2015, 2016 and 2018



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Note: Figures for 2016 and 2018 are goals for the Centers for Medicare and Medicaid Services.

Source: "Healthcare's alternative payment landscape," PricewaterhouseCoopers, 2015, p. 2, http://tinyurl.com/zumckgn

The Centers for Medicare and Medicaid Services intends to tie 30 percent of Medicare payments to alternative payment plans, such as the "accountable care organizations" and "bundled-payments" programs, by 2016 and half of payments to such programs by 2018, up from 20 percent in 2015. The agency also aims to raise the percentage of Medicare payments linked to quality-based programs, such as rating systems for quality of care, from 80 percent in 2015 to 85 percent in 2016 and 90 percent by 2018. Long Description (link to graph)

A concern with current metrics is that researchers cannot tell whether a doctor made a correct diagnosis, says Berenson of the Urban Institute. "There's nothing on the claim form that tells you if the procedure they referred the patient for was appropriate for the patient's clinical condition. You'd have to go into the medical records to find that. It's prohibitively expensive," he says. "You can't measure the accuracy of the diagnosis."

Surveying patients about their care experience is one required metric in pay-for-performance systems, but experts disagree as to whether these reports are helpful.

When patients and loved ones are asked whether they would recommend a certain hospital to friends or family for treatment, informal reports about their medical experiences correlate to formal surveys about care quality, says Dudley. While formal surveys are typically used, Dudley looked at Yelp star ratings and commentary and compared them with results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS), a popular survey tool designed with federal backing and testing. "We learned that a lot of people besides patients have passionate

opinions about hospital care," he says. Hospitals don't survey family or friends, just the patients, even if the patient is too ill to fill out the survey, Dudley says. But on Yelp, friends or family are the ones often commenting. He saw correlations between the Yelp star ratings and CAHPS scores.[16]

While there are many types of patient health care surveys, Friedberg says CAHPS is the best way to monitor provider performance from a patient perspective because it's not a customer-satisfaction survey. "These are valid and reliable for comparing providers against each other. Something meaningful is being asked," he says. For example, the outpatient CAHPS survey might ask whether a patient who had an urgent health problem at night could get help from a doctor or hospital in a timely fashion. "It distinguished practices that just say 'call 911' to better ones with a 24/7 call system where someone [who] has access to your records can give you guidance."

Background

Paying Out of Pocket

In the early 1800s, Americans paid for health care out of pocket. Hospitalization was rare, usually reserved for the poor, as wealthier people were cared for at home because they considered it safer and cleaner than the hospital. Medical care remained primitive in the 19th century, and physicians typically lacked effective medications or treatments for most illnesses.

By the late 1800s and early 1900s, more people began staying at hospitals when ill. As antiseptic techniques improved, and anesthesia was discovered and used, treatments improved. The number of hospitals rose, from 178 in 1873 to 4,359 in 1909.[17] Reformers pushed for health insurance so that patients could afford these medical advances but they encountered opposition from doctors, who feared that insurance companies would negatively influence the care given to patients.[18]Some people had sickness insurance through mutual benefit associations, such as fraternal organizations.[19]

A doctor prepares for an operation at St. Luke's Hospital in New York City in the 1890s. Hospitals grew slowly in the 19th century because of questions about their safety. (PhotoQuest/Getty Images)

The Great Depression of the 1930s, with its high unemployment and steep wage cuts, harmed patients' ability to pay for health care and hurt hospitals' ability to survive. “Hospital revenues went through the floor,” says Gorman of the Health Care Policy Institute. “Health care is really a discretionary expense in some respects.” She says the community hospitals banded together to form Blue Cross, the first hospital health insurance company, in 1929, based on prepaid health care; when someone was hospitalized, the policy covered all costs. “They picked a payment system that maximized their revenue. That's why we now have pricing per bandage,” Gorman says. Hospitals started accepting these prepaid Blue Cross hospital health plans in the 1930s.

During the 1930s and 1940s, more companies offered health care insurance to their employees to attract workers.[20] And in 1946, prepaid physician service plans consolidated under the name Blue Shield. During these post-World War II years, the modern insurance system emerged: Employers provided health care coverage to their employees, or people bought insurance policies on their own, and insurers paid as service was rendered.

Government funding of Medicare and Medicaid became law in 1965. They used the same fee-for-service payment as Blue Cross and Blue Shield. In the mid-1960s through the early 1970s, health insurance took off nationally, says Gorman. More employers bought insurance for their employees. By 1970, 86 percent of the population had hospital insurance, up from 12 percent in 1941.[21] In the 1970s, medical costs increased quickly because of inflation and the price of improved technology.[22]

With health costs growing, reformers passed the HMO (health maintenance organization) Act in 1973 to rein in costs. Employers who had 25 employees or more were required to offer an HMO option, in which insurance companies gave health care providers a set payment per patient to take care of all their medical needs. Primary-care doctors were "gatekeepers," needing to approve visits to specialists. But in the 1980s and '90s, health care costs continued rising, and newly created managed care and capitation plans became more popular as cost-savings measures. In capitation, providers received a set amount of money per patient for all their care, regardless of whether care was needed or provided. Managed care grew out of the HMO movement, encouraging providers to discount rates, do only necessary treatments and shorten hospital stays.

Managed care was popular in the 1990s, when the Pacific Business Group on Health and other consortiums focused on the quality and efficiency of care. Pacific Business Group "was formed in the same mind-set at the time, with what was happening with managed care and capitation," Lansky says. "These issues have been on the minds of these companies for 20-plus years."

The 2000s saw a shift toward consumer-directed health care, which had bigger financial consequences for patient decisions, Lansky says. In consumer-directed health care, patients had insurance with high deductibles, meaning they had to pay a large portion of their health care costs before insurance kicked in. This was paired with health savings accounts, in which people could put aside pretax money for health care. Consumers had more control over their health care payments and more incentive to control costs. It wasn't completely successful in slowing health care cost growth, however, Lansky says. "It was a blunt instrument that didn't achieve the goal."

Medicare/Medicaid Cost Controls

Starting in 1998, Medicare tried to control costs with the Sustainable Growth Rate (SGR), a financial payment rate calculated to keep Medicare's growth rate per patient below GDP growth. A key component was to control the cost of payments to doctors treating Medicare patients; their reimbursement would be cut if overall physician costs exceeded the expenditures target.[23]

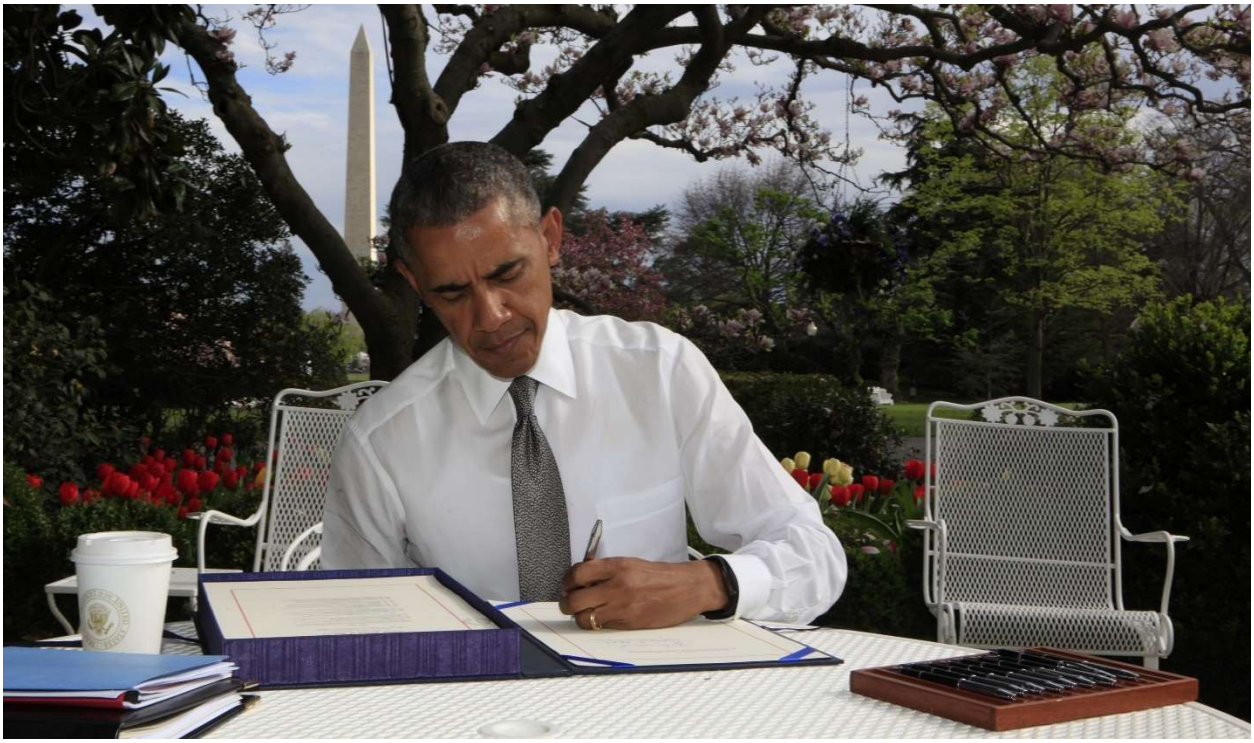
In the early 2000s, Medicaid instituted a mandatory preferred drug list, to combat the high cost of medications and to discourage doctors from prescribing expensive drugs that may not have offered the best value. Medicaid outpatient drug costs had been increasing 18 percent a year between 1999 and 2002, at the same time overall Medicaid costs were rising 10 percent.[24]

In 2006, Medicare enacted the Physician Quality Reporting System (PQRS), which gave medical providers a bonus for sending Medicare data on metrics seeking to measure quality.[25]

In 2010, Congress passed the ACA, championed by President Obama and widely known as Obamacare. The ACA further increased alternative payment systems by requiring doctors and other providers to report on metrics measuring quality and financially penalizing those who don't report or meet quality goals. Pay-for-reporting thus became pay-for-performance, where reimbursement was linked to the quality of treatment.

The ACA also authorized new payment and health care delivery models, ushering in the "value" concept to slow the growth of health care costs and improve services.[26] The ACA expanded eligibility for Medicaid and required all Americans to get health care coverage, with some financial assistance available.

Republicans, however, derided the ACA as unworkable and a major drag on the economy. The changes, they said, will not lower health care costs but increase them. Congressional Republicans further complained about the annual regulatory burden; several House committees in 2013 compiled an "Obamacare Burden Tracker," which said meeting the ACA's provisions requires almost 190 million hours of work annually.[27] When Republicans regained control of Congress in the 2010 midterm elections, they began voting yearly to rescind the ACA. Their efforts so far have failed.



President Obama signs the Medicare Access CHIP Reauthorization Act on April 16, 2015. The law amends the payment formula for doctors treating Medicare patients.

(Dennis Brack/Pool/Getty Images)

In 2011, almost no Medicare payments used alternative payment models. By the end of 2014, 20 percent of Medicare payments used them.[28] The SGR was long unpopular with physicians, however, because the formula called for cuts in the amount they were reimbursed for treating Medicare patients. In a nearly annual ritual shortly after SGR's implementation, lobbyists for

physicians' groups told Congress that doctors would not treat Medicare patients unless they were fairly compensated. Seventeen times between 2003 and 2014, Congress agreed not to cut their Medicare rates, passing an emergency, end-of the-session bill that became known as the "doc fix."[29]

Current Situation

New Payment Models

As alternative payment models take hold, private and government insurers are looking at ways to improve them.

One of the more popular new programs is the Accountable Care Organization (ACO), offered by Medicare and some private insurers, that features shared savings. Hospitals, physician groups and other providers band together to share records and data electronically, coordinate patient care and measure the quality with various metrics. If they save money providing quality care, the ACO and insurer split the savings.

But some ACO programs carry risk, because the medical group can lose money if it doesn't meet savings and quality targets. Medicare currently has more than 400 ACO shared-savings programs, which have saved the agency $417 million, although some ACOs have lost money.[30]

Cigna, a private insurer, has an ACO called Cigna Collaborative Care. A care coordinator works with higher-risk patients with chronic health problems. For the patient, this means better oversight and easier access to medical care, says Cigna.[31] Providers have an incentive to keep patients healthy, and to work as a team to minimize unneeded testing and spending, according to Cigna.

Another new model is the patient-centered medical home, organized within a primary-care practice. Medicare and Medicaid have programs for patients with chronic illnesses, using a team approach to coordinate care, prevent other illnesses and help patients make medical decisions. Someone oversees the patient's care so he or she gets what's needed.[32]

The bundled-payment model is sometimes voluntary, sometimes mandatory. Research by Blue Cross Blue Shield of North Carolina, according to The Wall Street Journal, compared the fee-for-service prices with the bundled payment prices at five hospitals for knee and hip replacement for patients covered by Blue Cross in North Carolina. The fee typically included hospital admission, one to three nights' stay, surgery, anesthesia, physician fees, medical devices, facility fees, lab tests, 90-day post-discharge care, physical therapy, home health care, skilled nursing and a care coordinator. With fee-for-service, the cost was $25,000 to $43,000. With bundled payment, it was $22,000 to $30,000.[33]

Private insurer Cigna has implemented Cigna Collaborative Care, in which a care coordinator works with patients with chronic health problems to lower medical costs.

(Ron Antonelli/Bloomberg via Getty Images)

Medicare is rolling out mandatory bundled payments for hip and knee replacements in 67 geographic areas starting in April.[34] It is offering bonuses to doctors who achieve savings and meet quality measures—and penalties for those who fail to reach benchmarks. Insurance companies save money on this system, advocates say; providers need to work together to minimize complications and keep patients on the path to recovery.

To further cut Medicare costs, the Obama administration announced in early March that it will test ways to reduce spending on prescription drugs by changing the payment formula to doctors. Currently, administration officials said, doctors have little incentive to choose lower-cost drugs and treatments. One possible idea is to set a payment rate for similar drugs.[35]

When deciding which alternative payment models to use, doctors and hospitals should look at their patient populations and specialties, says Micklos of the Health Care Transformation Task Force. “In urban areas with academic medical centers that focus on specialty care, bundled pay is in vogue now,” he says. “Regional or national health systems have a piece of all the different health models. It allows them to test and learn how to operate those.”

Provider Consolidation

An unforeseen consequence of payment reform and pay-for-performance is provider consolidation: Hospital consolidations rose 14 percent in 2014 from the previous year due to the ACA, according to Knowledge@Wharton, an online business journal.[36] Physician practices are also merging to create larger medical groups. Advocates argue integration “would allow you to cut across silos and manage patients better,” says Dudley of the Center for Healthcare Value,

with physicians working more as a team. But it wasn't until payment reform arrived that consolidation started in earnest so that providers would be in a better position to negotiate prices and make money, Dudley says.

“If payment reform is going to create incentives for the provider, that statement assumes the provider can be incentivized,” Dudley says. “There's a threat that if they don't do it, they won't get paid or they'll go somewhere else.” With monopolies, the threat carries less force, he says.

As an example, Dudley cites the San Francisco Bay Area, which has an oligopoly despite being one of the biggest metropolitan areas. Sutter Health is one of the most powerful providers, Dudley says—it is a medical system with 26 hospitals in Sacramento, the San Francisco Bay Area and the Central Valley, plus urgent care clinics, home health services, imaging facilities, surgery centers and independent practices. Sutter “has power because they're the dominant force” with the ability to set prices in both Sacramento and San Francisco, Dudley says.

Purchasers of commercial health insurance sued Sutter several years ago, alleging it used its power to charge above-market prices. The federal District Court of Northern California, however, dismissed the suit, ruling that the plaintiffs failed to prove their case.[37]

Adams Dudley: Oligopoly makes change hard.

Monopolies and oligopolies put the health care payment system in a tough place, Dudley says, similar to the situation in the utility sector: Everyone needs electricity, but there's no true competition in the market, he says.

To keep competition alive and make alternative payment systems work, some insurance companies are giving doctors and other providers data or money to invest in data management, so they don't feel the need to join larger medical systems to survive. “If providers consolidate, it's much tougher negotiating” for the insurers, Friedberg of RAND says. Forward-thinking insurers that change payment systems give a lot of support to doctors and other providers to make the switch successful. “They give data, coaching, hire consultants to help them, give them startup money or credit for data infrastructure,” he says. While that sounds expensive, Friedberg says it

can return huge dividends. “It doesn't take much of a health care spend to earn that back in a few years.”

Some experts note that size can be an advantage, especially in Medicare's case. As the biggest payer around, Medicare is moving to control costs. “Roughly 50 percent of hospital business comes from Medicare,” says Gorman of the Health Care Policy Institute.

Medicare can set the rules because it has more power, says Berenson of the Urban Institute. “The new [enhanced fee-for-service merit-based incentive] Medicare program will apply to physicians starting in 2019. By 2023, physicians can lose as much as 9 percent of their revenue, or gain as much as 27 percent, based on their performance [on] a relatively small number of performance metrics,” Berenson says. Private insurers, by contrast lack the power to impose such requirements.

In 2015, Congress repealed the Sustainable Growth Rate, the 1998 program that sought to control Medicare spending by limiting physicians' fees if program expenditures exceeded a target. The approach, critics said, unfairly punished doctors because it mandated across-the-board cuts in their Medicare fees. Congress replaced the approach with the merit-based incentives that reward high-performing doctors.[38]

Medicare, Medicaid and insurance companies are starting to work together to standardize payment and quality measurements. The Healthcare Learning and Action Network run through Medicare is bringing groups together to share ideas on how to develop programs and metrics.[39]

Micklos of the Health Care Transformation Task Force says private insurers are learning a lot from Medicare programs, such as the ACO shared savings programs. They are particularly paying attention to evaluations and reasons of those who leave it. “It's a challenging model to do,” he says. They'll tweak private programs based on what they learn.

Not all metrics can be coordinated between private and public insurers. “Medicare is covering a population that private is not,” says Carroll of the Center for Health Policy and Professionalism Research. “The metrics we'd consider measuring in the 65-plus population is not the same as [for those] under 65.” An example is maternity, labor and delivery. “They're treating totally different people with totally different goals.”

There is some overlap, though. Lansky says the Medicare bundled payment program for joint replacement uses some of the same quality and payment measures that his group uses. “Where appropriate, we use the same quality measures or definitions [as Medicare] for what's in the service.”

Lansky of the Pacific Business Group says his group developed a commercial insurance program for chronically ill people but realized it would also work well for Medicare. Medicare then supported a demonstration project for Medicare beneficiaries. “Providers who have difficult, complex patients don't want to have different care models for someone who is 66 versus 61, with Aetna paying for one and Medicare paying for the others,” he says.

Alternative Payments

Providers, whether it's the hospital staff, doctor or social worker, are increasingly coordinating patient care with these new systems. “They're getting interdisciplinary teams together to see how they'll deliver that care,” says Micklos.

In some cases, employers are going directly to doctors, hospitals and other providers to change how care is delivered to their workers. “In the last few years, we've worked directly with provider organizations and delivery systems to change things on the front line,” says Lansky. For example, Intel worked with a provider to improve the ways it handled spinal cases, to lower costs and improve care for Intel employees.

Insurers need to support providers with the right data and tools, says Friedberg. “If you just change the payment model, it may not go very well,” he says. Those changing from fee-for-service to other models need data at their fingertips, to know who their high-cost patients are, what those care needs are and where they can find savings. “Practices don't normally have this data,” he says. It's a huge investment most small practices can't afford.

Medicare is also providing support to doctors and others through Practice Transformation Networks. The Great Lakes region is one of 29 networks helping providers transition to alternative care payments by 2019. They're helping providers choose the best metrics for their practice and teaching doctors how to manage patient populations, time and staffing, says Nadia Adams, network director of the Great Lakes Practice Transformation Network.

Looking Ahead

More Experimentation

When deciding where to go next, advocates of alternative payment systems have a couple of choices. One route is to analyze where growth and spending are headed. The other is to examine how well new systems are lowering costs and increasing quality, and whether the transition is proving successful for doctors, patients and the health care system itself.

The government estimates that from 2012 to 2022, health care spending will grow 5.8 percent annually. And while the health spending portion of GDP is already 17.5 percent, the government expects it to rise to 19.9 percent by 2022.[40]

Many experts say the United States needs to do more to reduce health care spending, noting that the United States still spends more than any other country per capita and by GDP percentage. Not everyone agrees that the level of spending is a problem, though. “No one knows how much we should be spending,” says Gorman of the Health Care Policy Institute.

To demonstrate the nation is overpaying, “you have to be saying the U.S. is wasting more money on health care than other countries. There's no evidence of that,” Gorman says, noting that the United States has a higher life expectancy than many other nations and superior care. “We have evidence we're getting something for the medical spending.”

Partly through alternative payment programs, Medicare is trying to slow spending growth. But even with these programs it projects that from 2015 to 2022, Medicare costs will grow 7.4

percent annually. That's due in part to higher enrollment and use, plus sicker patients because of the aging population. Combining private and public payers, the Centers for Medicare and Medicaid Services, the government organization that runs Medicare and Medicaid, anticipates 6.2 percent average annual growth, as the ACA continues its rollout and the population ages.[41]

David Lansky: Expanding trial payment programs is difficult.

As for alternative payment programs, “the next five to 10 years will be a combination of experimentation, systematic learning and spread of technology, learning how to replicate good ideas across the country more rapidly,” says Lansky of the Pacific Business Group. Medicare and Medicaid can expand successful regional demonstration projects across the country. However, scaling up a demonstration project takes time. After a trial ends, researchers could need two years to compile, evaluate and publish the data required, before the program can be rolled out nationally.

“There are hundreds of really good demos operating around the country. They all have the same concern,” Lansky says. “There's not a rapid enough ability to see positive impact and shift changes in Medicare payments.” It's not an easy problem to solve, he adds. Medicare needs to be careful as it proceeds because it could make payment mistakes or invite fraudulent charges. “But [the process is] too slow,” Lansky says.

As changes to Medicare continue in the next decade, the commercial sector will follow suit, says Friedberg of RAND. “Alternate payment models will become more common. This can lead to more consolidation [of health care providers] or not,” he says, depending on whether private insurance companies invest in technology to help them. “The reliance on health information technology will only increase,” Friedberg says. With proper financial incentives to use technology to provide better patient care, vendors can build better technology products.

The demise of fee-for-service has been predicted many times, says Friedberg. “It's certainly possible we'll look back in 10 years and we're back to fee-for-service in the 2020s,” he says. That's because many doctors may well prefer being paid the old-fashioned way—for each service rendered.

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ISSUE: HEALTH CARE PAYMENTS March 28, 2016

U.K., Canada Employ Variety of Approaches

By Deborah Abrams Kaplan

Experiments on doctors' pay achieve mixed results

Executive Summary

The British have sought to address relatively low incomes for primary-care physicians, while Canadians are adding payments for rural doctors. Both places are implementing more alternative payment systems.

Full Article

The United States spends more per capita on health care than any other country and wants that to change. But many other nations are also seeking better ways to pay for care.[1] The United Kingdom and Canada both have alternative payment models. Britain's pay-for-performance approach is the "most comprehensive" in the world, according to an analysis in the British Medical Journal.[2] And Canada allows each province and territory to take its own approach to health care administration and negotiation of physician fees.[3] The results in both the U.K. and Canada are mixed, however, and patients wanting to see a specialist often face long waits.

United Kingdom

Medical care in the U.K., which comprises England, Scotland, Wales and Northern Ireland, is funded through the National Health Service (NHS), and every citizen is registered with a family practitioner, says Martin Roland, a physician and professor of Health Services Research at the University of Cambridge.

In 2004, the U.K. started the Quality and Outcomes Framework, a pay-for-performance system that rewards doctors who meet the program's quality goals. Many of the goals focus more on the process of providing care than on the outcome, with metrics seeking to encourage more careful monitoring of a patient's condition, such as ensuring that a caregiver's contact information is in the records of someone with dementia and documenting that a person receiving epilepsy drug treatment hasn't had a seizure in the past year.[4]

Doctors earn points for meeting clinical indicators for 22 chronic conditions, and for achieving benchmarks such as managing medication guidelines. The program pays bonuses based on how many points a doctor accumulates.[5] The system seeks to boost the incomes of primary-care physicians, who are underpaid compared with specialists.[6]

Until recently, the bonus payments could increase doctors' income by up to 25 percent. A year into the program, doctors across the U.K. earned 90 percent of the allowed points and received close to the maximum bonus payments.[7]

But the NHS in 2014 cut the maximum bonus payment to 15 percent of income, although it did raise pay for the average practice by about 37,000 pounds ($53,000).[8] And because most physicians were qualifying for nearly the maximum payment, the NHS increased the number of quality indicators to 154 from the original 136 indicators for 2015–16, says Roland.

The Quality and Outcomes Framework has had mixed success improving the quality of care, according to Roland. Quality has increased somewhat, he says, but it is unclear how much of the improvement can be attributed to the framework because the government already had a separate quality initiative in place.

For conditions without incentivized benchmarks, quality rose slightly initially and then declined.[9]

In addition to pay-for-performance, the U.K.'s other alternative-payment model is “capitation,” in which family doctors receive a monthly fee for each patient in their care. Hospitals' payments to specialists, by contrast, are mostly fee-for-service, in which these doctors are paid for each office visit, test or procedure.

With bonuses dropping and quality metrics rising, family doctors are increasingly unhappy with the alternative payment system, according to Roland. Physicians don't like getting fewer rewards while having to meet more quality measures, he says. Scotland is ditching the pay-for-performance system in 2016, in an effort to reduce physicians' workloads.[10]

Canada

In 2015, Canada's health care spending per person was half that of the United States.[11] The Canadian system is entirely government-funded, financed by personal and corporate taxes. Doctors' pay is based mostly on a fee-for-service model, according to the Canadian Institute for Health Information, an independent organization that focuses on health issues. As of 2011–12, the most recent years for which statistics were available, alternative models made up 29 percent of payments nationally, up from 11 percent a decade earlier.[12]

The ministries in Canada's 10 provinces and three territories handle health care payments. Like the U.K., Canada is adding alternative payments to the mix for some family physicians to give them financial stability, especially in rural communities. One method is capitation; others include paying bonuses to doctors who use electronic medical records and meet quality targets.[13]

Different provinces handle alternative payments in different ways. British Columbia's alternative funding budget increased over the last decade and is now about 20 percent of the money available for physician services.[14] In 2012, the most recent year for which statistics were available, Ontario was paying $1 billion of its $11 billion budget to physicians who used a combination of payment

programs. About half of specialists received some type of alternative payment.[15]In Alberta, some 14 percent of payments were based on alternative systems, while the figure was 47 percent in Nova Scotia.[16]

The U.S. system has one big advantage over its government-run and -funded counterparts: convenience, says Linda Gorman, director of the Health Care Policy Institute at the Independence Institute, a research organization in Colorado.

While most U.K. and Canadian citizens are pleased to have the government pay for their care, Gorman says, they often have trouble getting appointments because of shortages in staffing, facilities and equipment due to inadequate funding. In Canada in 2015, patients waited an average of 18.3 weeks to see a specialist after a physician's referral; in the U.K., the goal is for 90 percent of patients to get treatment from a specialist within 18 weeks of the referral.[17]

Americans “don't have large waiting lines,” Gorman says, because the U.S. market is willing to pay more to avoid those lines.

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ISSUE: HEALTH CARE PAYMENTS March 28, 2016

Three States Try Alternative Payment Systems

By Deborah Abrams Kaplan

“Now it's in the hospital's financial interest to avoid unnecessary hospitalizations”

Executive Summary

Massachusetts, Maryland and Oregon are among those converting to new models for health care services, but critics question the use of metrics.

Full Article

While Medicare is leading the charge on alternative payment models for health care services, some states and private insurers also are trying new systems. Supporters say these programs save money while improving quality. Critics, however, say the quality metrics aren't meaningful or useful. Here is what three states are doing.

Massachusetts

In 2009, Blue Cross Blue Shield of Massachusetts started the Alternative Quality Contract, which seeks to slow spending growth while improving care. A key component is the “global budget payment,” in which physicians' practices and hospitals receive a set budget per patient that covers all costs, including inpatient and outpatient care as well as prescriptions. Eighty-five percent of Blue Cross' HMO providers are participating in the program; successful participants receive bonuses.[1]

The program seems to be working so far, according to Blue Cross and a major study published in the New England Journal of Medicine. The study, led by Harvard physician and economist Zirui Song, shows that from 2009 to 2012, the global payments' growth rate was 6.8 percent less than that of the control group, which used a fee-for-service system.[2] The doctors given a set fee also better managed chronic diseases, including diabetes, and more successfully controlled high cholesterol and blood pressure.

Blue Cross rewards doctors and hospitals for meeting the highest quality level according to 64 predefined metrics, such as controlling high blood pressure, providing breast cancer screening, performing neuropathy testing on patients with diabetes and giving proper discharge instructions after treatment for heart failure.[3] The incentives give “provider organizations an opportunity to receive significant rewards for focusing on clinical services that are deemed high value, such as preventative care, well-child visits and managing chronic care,” says Song.

Blue Cross controls about 40 percent of the state's commercial insurance market, and it was able to induce a high number of physicians and other providers to participate, according to Song. “They have an opportunity to negotiate with multiple provider organizations and align incentives among them,” he says. Because Blue Cross is pleased with the program, it is expanding it, but Song says the outlook for spending growth remains uncertain.

Critics of the Alternate Quality Contract say the metrics don't properly assess good health outcomes, and that some medical staffs are gaming the system to meet the bonus thresholds. Others, including some doctors and administrators, worry that practitioners are taking on financial risks they are not prepared to handle. They point out that while the quality contract is supposed to save money, Blue Cross' spending growth exceeded the state benchmark for 2009 to 2011, which Blue Cross agreed happened the first few years of the program.[4]

Maryland

For 40 years, the state Health Services Cost Review Commission set all rates paid to hospitals—by government, private insurers and individuals without insurance—rather than have each hospital negotiate independently. The system needed modernizing to focus on quality, not just cost, says Carmela Coyle, president and CEO of the Maryland Hospital Association, which represents more than 50 hospitals.

In 2014, the state instituted a global budget system for hospitals, with Medicare and other insurers, allocating a specific amount to be paid to each hospital for inpatient care. In return, the hospitals must meet certain conditions, including:

- The amount paid for each person in the global budget can't rise more than 3.58 percent each year.
- Hospitals must save Medicare $330 million over five years.
- They must meet quality targets, such as reducing readmission rates.

The change to global payment is huge, Coyle says. “Now it's in the hospital's financial interest to avoid unnecessary hospitalizations,” she says. Hospitals are paid a lump sum and keep any profit. Other care partners, such as outpatient providers, aren't under the same restrictions.

But to keep readmission rates low, it's also in the hospital's interest to ensure that patients receive their medications and understand discharge instructions when they leave, Coyle says. The hospital won't meet one of its quality targets if patients are readmitted for any reason within 30 days.

A challenge for hospitals is their agreeing to limit the growth rate in total care cost, including outpatient costs. “We'll be held accountable for what happens in the non-hospital setting,” says Coyle.

The system appears to be working so far, according to Coyle and a study in the New England Journal of Medicine. The first year it saved Medicare $119 million of the $330 million in savings that had been promised over five years, the study said. The 2013–14 per capita growth rate in hospital costs in Maryland was 1.47 percent, far lower than the goal of 3.58 percent. And, in the system's first year, the rate by which patients developed 65 preventable conditions fell 26 percent.[5] These are conditions that patients can contract while in the hospital, such as pulmonary emboli, bed sores and infections from central venous catheters.

“While we're proud of our first-year performance, we need to find out if the model is successful and sustainable over the long term,” Coyle says. The program faces several challenges. Accessing outpatient data would be helpful, she says. “It's difficult to manage total cost of care if the only data you have is hospital data.” Also, the new system will work only if reformers can build behavioral and social supports like Meals on Wheels programs, to keep residents healthy. “But not all the infrastructure can be built on the backs of the hospitals,” she says.

Oregon

Oregon's revamped Medicaid program, the Oregon Health Plan, rose from the ashes of an experimental program mired in controversy.

From 2008 to 2010, Oregon compared the health outcomes of the state's Medicaid enrollees against those who were eligible but not enrolled. The experiment came about because Oregon had a limited number of spots available for its Medicaid expansion. It followed about 10,000 new enrollees selected randomly by lottery, as well as an equal number who weren't chosen, to study whether insurance coverage affected their health two years later. The finding: The health of those in the experimental program showed no significant improvements versus the unenrolled.[6]

After Medicaid expanded under the Affordable Care Act, Oregon made changes in 2012. It assigned the state's Medicaid enrollees to one of 16 Coordinate Care Organizations (CCO), with each CCO receiving a global budget for all physical, mental and oral health care.[7]

Under the plan, a small percentage of the Medicaid budget is held in a “quality” pool (the amount is 4 percent in 2016), which later can be awarded to CCOs that meet 17 metrics, such as controlling blood pressure, providing children with dental sealants to prevent tooth decay and adopting electronic health records.[8] “The incentive metrics have driven so much behavior change, it's surprised people,” says Chris DeMars, director of systems innovation at the Oregon Health Authority Transformation Center, the state's support system for CCOs.

As part of the Medicaid deal to limit the global budget growth each year, Oregon agreed to keep its increase to 3.4 percent annually, lower than its recent 5.4 percent annual increases. In exchange, Oregon received $1.9 billion to fill a budget gap from its previous Medicaid program, says DeMars.

Each CCO is independent and is overseen by a local governance board and community advisory panel that is required to have at least half of its members on Medicaid. “None of the CCOs are the same,” says Summer Boslaugh, transformation analyst at the Transformation Center. While each

CCO adopted at least one alternative payment model, the organizations are looking at ways to incentivize doctors and hospitals to move away from the fee-for-service payments to new payment models.

Last year, the Oregon Health Plan led to a 23 percent decrease in emergency room visits and a 32 percent drop in short-term hospitalizations due to adult diabetes. The CCOs didn't succeed in all metrics. For example, they were 50 percent below the benchmark for adolescents and young adults having at least one checkup during the year. The rate of dental sealants placed on adolescents was also lower than expected.[9]

Notes

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ISSUE: HEALTH CARE PAYMENTS March 28, 2016

Q&A: Charles N. Kahn III on Pay-for-Performance

By Deborah Abrams Kaplan

"The data show that on most of the metrics, we've seen real improvement"

Charles N. Kahn III

Charles N. Kahn III is president and CEO of the Washington, D.C.-based Federation of American Hospitals, which represents more than 1,000 U.S. investor-owned hospitals and health care systems. He discusses with SAGE Business Researcher correspondent Deborah Abrams Kaplan how pay-for-performance systems and Medicare's quality-improvement programs are affecting patient care and hospitals' finances. This is an edited transcript of their conversation.

Have the three core Medicare quality-improvement payment programs—the Hospital Readmissions Reduction Program, the Value-Based Purchasing Program and the Hospital-Acquired Condition Reduction Program—improved care?

The combination of these efforts have become central to hospital care for Medicare beneficiaries and all patients, because private insurers are pressing on the quality measures and pay-for-performance side, too. The data show that on most of the metrics, we've seen real improvement. Following the patient post-hospitalization can only be a plus for the patient, and hopefully it gets a better track record for the hospital as far as readmissions rates.

Has the Hospital Readmissions Reduction Program been effective?

The data have shown there's been a reduction in readmissions. Part of it is real, and part is that patients are coming to the hospital and being put on observation rather than being readmitted, [so the hospital will] avoid the readmissions penalty. The patient is still getting hospital care either way. But there are cases where patients who would have been readmitted in the past are now put in observation when brought to the emergency room.

What impact do pay-for-performance programs have on hospital finances?

I don't think the [bonuses and penalties] reflect the total cost of these programs, because you have to spend a lot more on designing them and on the staff that oversees or focuses on the post-hospital period for up to 30 days to avoid patient readmissions. You need someone on the phone checking to see if the patients filled their prescriptions, or checking electronically. We always do discharge planning, but now it has to be a lot more honed. Improving quality isn't free. I don't think the penalties reflect everything that's being spent on quality. There's a lot of moving parts, so it's hard to figure out the economic effect.

What are the problems with the programs?

The issues I have with the programs are not whether it's the right thing to have them, but that they were put together quickly, with the vagaries of the legal process. There are also many questions about whether these are the right metrics—with readmissions, for example. [The programs don't] account for patient acuity [the level of nursing care a patient needs] or, more importantly, a patient's socioeconomic status.

Statistically, if you're coming from certain neighborhoods with lower income, … you may not have the support at home or the ability to get high-quality home health or to go to a skilled nursing facility post-hospitalization. So those patients… may end up back in the hospital because they don't have a caregiver to get their prescriptions. There are a lot of factors that can affect care that are outside the control of the hospital. Yet the hospital will be penalized one way or the other.

Why is it a problem that the legal system created these programs?

There are concerns when we look at penalties for hospital-acquired conditions [such as infections that patients picked up while in the hospital for an unrelated reason, sometimes due to hospital staff not properly sanitizing equipment or washing their hands]. The way the law is written, the bottom 25 percent of hospitals will get penalized if they don't meet the standards. That's true today; it's true five years from now unless the law changes.

That's an arbitrary amount. We know from experience that as hospitals improve in these metrics, there are going to be a lot of hospitals very close to the penalization line. For a year or two, that's fine. But if this is how it will be in perpetuity, that's a problem. This isn't a dynamic program. It needs to evolve as hospitals continue to improve. These programs aren't suited to do that. It's one of the problems when you take a program and put it into the law. It doesn't give the regulators the ability to be flexible, to let a program evolve.

What's the impact of the payments and penalties on hospital profitability?

I don't think we know yet. We're in the early years of these programs. If you're right below whatever the metric threshold is year after year on hospital-acquired conditions, that can be very painful to your bottom line—especially when it's been shown that Medicare already pays below cost.

Chronology

1800s–1930s	**Health insurance coverage emerges.**
1800s	Patients who could afford to get care at home avoid the hospitalbecause of unsanitary conditions; most hospital patients were poor, and medical expenses were paid out of pocket.
1873	The number of U.S. hospitals reaches 178, with 35,064 beds, as sanitary conditions improve.
1901	American Medical Association (AMA), which was founded in 1847, reorganizes and forms local medical societies and recruits more physician members. Within the decade, the AMA represents half of the country's physicians, giving the organization power to influence payment policies.
1909	The number of hospitals reaches 4,359, with 421,065 beds.
1929	Texas' Baylor Hospital starts prepaid hospitalization for teachers in a plan that grows into Blue Cross.
1930s	Hospitals struggling to stave off bankruptcy during the Depression begin accepting patients covered by Blue Cross prepaid health care.
1935	The Social Security Act creates retirement benefits and provides health care grants to mothers and children in distressed areas.
1940s–1970s	**Companies offer benefits to attract workers, leading to employer-sponsored health care.**
1945	President Harry S. Truman proposes mandatory health care coverage, but the AMA and others criticize the idea as socialized medicine and it fails to advance in Congress.
1946	Prepaid physician-service plans consolidate into Blue Shield.
1965	President Lyndon B. Johnson establishes Medicare for those 65 or older and Medicaid for those with low incomes or disabilities.
1973	President Richard M. Nixon signs a bill requiring companies with more than 25 employees to offer a health maintenance organization (HMO) option if they also offer traditional health coverage. To contain costs, the HMO model

	requires patients seeking a specialist to get a referral from their primary-care physician.
1980s–1990s	**Managed-care programs emerge.**
1993	First lady Hillary Clinton heads a task force on national health care reform, leading to legislation requiring universal health insurance coverage. The proposal fails to advance in Congress.
1995	U.S. health care spending reaches 13.2 percent of grossdomestic product, a measure of total national economic output, spurring additional calls for reforms to rein in health costs. Health care spending was only 4.5 percent of GDP in 1950.
1997	As part of the Balanced Budget Act of 1997, Congress includes the Sustainable Growth Rate, a formula to control growth in Medicare Part B, or non-hospital, spending.
2000–Present	**Affordable Care Act overhauls health insurance system.**
2003	President George W. Bush signs the Health Savings Account bill, allowing people with high deductibles to use pretax money for health care expenses. As part of the bill, Medicare patients receive access to prescription drug coverage.
2006	Massachusetts Republican Gov. Mitt Romney guides into law a measure providing health coverage to all state residents; the plan is held up as a model for the federal Affordable Care Act (ACA) championed by Democratic President Obama.
2010	The ACA becomes law, with numerous health insurance reforms, including funding for Medicare to develop new payment models.
2012	Medicare's Shared Savings Program begins, allowing doctors and hospitals to split the savings with Medicare when meeting quality goals and keeping medical costs below budget.
2015	Health and Human Services Secretary Sylvia Burwell announces goals for transitioning from fee-for-service to pay-for-performance systems. (January) … Congress passes the Medicare Access and CHIP Reauthorization Act, which repeals the Sustainable Growth Rate formula and establishes a program with value-based payments that will begin in 2019. (March and April)
2016	By year-end, 30 percent of Medicare payments will be linked to alternative payment models and 85 percent of Medicare fee-for-service payments will

be linked to quality metrics.… Obama administration announces it will test new ways to pay for prescription drugs under Medicare Part B. (March)

Resources

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Organizations

Center for Healthcare Value
3333 California St., Suite 265, Box 0936, San Francisco, CA 94118
415-476-4921
http://healthvalue.ucsf.edu/
A University of California, San Francisco, program that researches health delivery systems and health policy; also trains physicians how to create value.

Center for Medicare and Medicaid Innovation
7500 Security Blvd., Baltimore, MD 21244
https://innovation.cms.gov/
Federal agency working with providers on new payment and delivery models for Medicare and Medicaid.

Health Care Payment Learning and Action Network
7500 Security Blvd., Baltimore, MD 21244
https://hcp-lan.org/
A group begun by the Department of Health and Human Services that brings together private, public and nonprofit sectors to explore how to move to value-based care and alternative payment models.

Health Care Transformation Task Force
601 New Jersey Ave., N.W., Suite 450, Washington, DC 20001
202-774-1405

http://www.hcttf.org/
Industry consortium formed in 2015 with large payers, patients, providers and purchasing groups that has committed to 75 percent value-based purchasing by 2020.

Oregon Health Transformation Center
421 SW Oak St., Suite 775, Portland, OR 97204
971-673-3363
http://www.oregon.gov/oha/Transformation-Center/pages/index.aspx
A branch of the Oregon Health Authority working with Coordinated Care Organizations to lower costs and increase quality for Oregon's Medicaid recipients.

Pacific Business Group on Health
575 Market St., Suite 600, San Francisco, CA 94105
415-281-8660
http://www.pbgh.org/
Not-for-profit group representing 60 large health care purchasers, whose members share ideas as well as work on innovations in the payment and delivery processes for their employees.

About the Author

Deborah Abrams Kaplan covers medical and health care topics for publications such as Diagnostic Imaging, Memorial Sloan Kettering Cancer Center, Doctor's Digest, Fierce Health Payer, Modern Healthcare and Atlantic Health Systems. Her other consumer writing appears in Bankrate.com, the Los Angeles Times, Chicago Tribune, Miami Herald and various magazines. Her work is at www.kaplaninkmedical.com and www.kaplanink.com.