



Coherent and Transparent Health Care Payment: Sending the Right Signals in the Marketplace

By Karen Davis



The market for health care is not like markets for other goods and services. Information on prices is not typically available, decisions about where to get life-saving care are often made in an emergency, and patients lack knowledge about the value of diagnostic and treatment services and the comparative effectiveness of alternative therapies,

or where to go for the best care with the best prospects for full recovery, functioning, and quality of life.

However, there are ways we can improve the functioning of the health care market and increase the value of what we pay for care. The Affordable Care Act includes important provisions to increase access to information on the quality of physician and hospital care and establish multi-payer databases that will provide a more comprehensive picture of patterns of care across providers. It also begins to address the imbalance between primary and specialty care by increasing primary care payment rates under Medicare and Medicaid.

Moreover, the law creates a Center for Medicare and Medicaid Innovation to pilot new ways of paying for and delivering health care, including “bundled” methods of payment to encourage providers to work together across health care settings to treat their patients and approaches that reward those who offer appropriate, high-quality, and efficient care. These initiatives represent a move away from the current fee-for-service system, under which providers are paid for individual services—regardless of appropriateness and quality—and are responsible for only a portion of

their patients’ overall care. They also can help improve transitions in care from one provider to another and one care setting to another. Many errors occur during these hand-offs and patients often experience frustrations due to inadequate communication among providers involved in their care.

These initiatives are one important step in the evolution of a new payment system that will provide incentives to achieve the best results—rather than provide the most services—and in doing so achieve savings from the elimination of wasteful, duplicative, or avoidable treatment.

But changing the method of payment is only one part of the solution. To make it work, new health care organizations that are accountable for both patient outcomes and the resources devoted to care will need to be formed. These organizations will need better information, tools, and technical assistance to ensure that essential services are provided efficiently while quality, innovation, productivity, and prevention are enhanced. Safeguards will also be needed against potential under-provision of care or exercise of undue market power.

And, ultimately, the U.S. will have to decide whether to combine its leverage in paying for health care through public programs and private insurance plans to ensure fair prices. This could take many forms, including: competitive bidding; reference pricing (paying the lowest offered price with patients paying any extra charge); multi-payer price negotiations; or state- or federally established multi-payer payment systems.

In this first essay in a series about how U.S. health system financing could be more coherent and transparent, I will look at options for paying for coordinated care.

Paying for Coordinated Care Rather Than Individual Services

Global Fees. The current fee-for-service payment system rewards physicians for providing a greater volume of more costly services rather than for getting the best results for patients. An alternative is to pay each provider organization a global fee for all care—a fixed, per-person payment based on the patient’s health condition or a risk-adjusted capitation rate.

Real-life—and very successful—examples of global payments exist. Staff-model health maintenance organizations such as Kaiser Permanente are well known for this approach. In the case of integrated delivery systems with their own health insurance plans, like HealthPartners in Minnesota and Intermountain Healthcare in Utah, patients enroll in the insurance plan and get their care through that health system of hospitals and physicians. (At both HealthPartners and Intermountain, patients can also choose to get their care from other hospitals and physicians in the network.) The health system is effectively paid a global fee per patient, with some cost-sharing payments by patients for individual services. But if HealthPartners manages patients’ diabetes well and those patients don’t end up in the hospital, or Intermountain begins using lower-cost imaging tests, those savings flow to the health plan and can be invested in improved care or distributed to the health care providers who share in the savings. Patients certainly benefit from better outcomes and avoiding hospitalization or unnecessary tests, and may also share in the savings in the form of lower premiums.

This approach requires careful monitoring to ensure patients receive accessible, high-quality care. But available—and constantly improving—measures of quality, access, and outcomes should make it possible to monitor these aspects of care, and tying rewards to performance on these measures can help to ensure this outcome.

Bundled Acute Case Rates. Another approach is to pay a bundled acute case rate with a warranty for a given procedure, such as hip replacement surgery or heart bypass surgery. Everything is included in one fee, including the hospital bill (and any complications that arise that cause the patient to be readmitted to the hospital), the surgeon’s fee, the

anesthesiologist’s fee, the rehabilitation facility fee, and the fees for the many other providers that are typically involved in such a complex procedure and recovery. The Geisinger Health System in Pennsylvania, on whose board of directors I am pleased to serve, offers such a global fee for a number of procedures, including coronary artery bypass graft surgery, total hip replacement, and perinatal care. The rise of “medical tourism” in countries like India has also given rise to quoting a single fee for surgery and rehabilitation—perhaps even including some tourist attractions!

A bundled acute case rate for a surgical, medical, or obstetrical procedure has many advantages. The patient knows in advance what the total bill will be. It’s even better if the patient knows in advance the hospital or doctor’s record on infections, complications, recovery time, long-term functioning, and long-term survival. If the procedure is covered by insurance, the insurer can base what it will pay on the lowest fee available for hospitals and doctors that get the best result. Some patients may be willing to travel—if not to India, then to Johns Hopkins in Baltimore or Mayo in Rochester, Minnesota—to get the best care at no extra cost.

Primary Care Medical Home Fees. The concept of a “patient-centered medical home,” which receives either a primary care fee for all primary care or a blended payment of part fee-for-service and part monthly medical home fees, is beginning to take hold. The medical home is attracting interest from primary care physicians, who are drawn to its team approach, and patients, who appreciate getting prompt attention to medical issues as they arise and ongoing care and support for chronic conditions.

Health systems like Group Health Cooperative in Seattle have found that this medical home model has many advantages. Primary care physicians using a team approach involving nurses and medical assistants are encouraged to care for patients in new ways. This includes longer visits for sicker patients as well as phone and e-mail access, and support of patients in their homes for complex medication, nutritional, or counseling needs to manage conditions and avoid complications. As a result, physician burnout goes down, costs go down, and patients appreciate the time it saves them and the better attention and assistance they get from the entire team.

Shared Savings. One approach that has been combined with fee-for-service payment is a shared-savings model for physician group practices. In a recently completed five-year Medicare demonstration, 10 large multi-specialty physician group practices demonstrated that they could better manage the total care of patients, achieve high-quality results, save the Medicare program money, and share in the savings as well. Under this demonstration, the organizations were chosen for their capacity to engage in system redesign. A wide array of organizational models was represented, including two physician groups with no formal affiliation with a hospital, five integrated delivery systems, two practices affiliated with a major academic medical center, and one network physician organization. Practices received extra payments from Medicare if they met quality standards and reduced spending by more than a cumulative two percentage points, compared with Medicare spending on similar patients in the same area.

By the third year, all 10 physician group practices had achieved benchmark performance levels on at least 28 of 32 chronic care and prevention quality measures, and two had achieved benchmark levels on all measures. Five practices received extra payments of \$25 million for achieving over \$32 million in total Medicare savings. Strategies used by the practices to improve quality and reduce costs included use of the patient-centered medical home system of primary care, better management of patients with chronic conditions using nurse care coordinators, follow-up care post-discharge, and improved information systems.

Applying the Payment Models

All of these payment models show considerable promise. The central question in any switch to a global fee, bundled acute case rate, medical home fee, or shared savings system of payment, however, is who will receive the payment. Only about 10 percent of U.S. health care is currently organized into integrated delivery systems such as Kaiser Permanente, HealthPartners, Intermountain, Geisinger, or Group Health Cooperative. Most physicians still practice on their own or in very small group practices of fewer than 10 physicians.

Some payment models would work in independent or small-group settings. In the case of patient-centered medical homes, a primary care fee or blend of payments could be made to the primary care physician practice or group

practice. In the case of bundled acute case rates for a hospital surgery and post-acute care, payment might be made to the hospital and then allocated to that institution as well as the physicians, nursing homes, rehabilitation facilities, and home health services, but this process could be quite complex if these providers are not employed or owned by the hospital.

But the most complex case is when a single global fee (or risk-adjusted capitation payment) is made for all of the care a patient needs—including preventive care, basic primary care, specialty care, emergency care, hospitalization, and post-acute care that is provided by numerous independent providers over a period of time. In that case, where should the payment go? If savings across the entire continuum of care are to be shared with providers, how should those savings be distributed?

One solution is to create a new organizational entity that includes physicians and other providers who agree to be accountable for the total care of patients, their outcomes, and the resources used in providing it. This solves the basic question of “to whom should I write the check” and leaves it up to the organization to decide how best to compensate providers for their contribution. The physician group practices that participated in the Medicare demonstration are leading candidates for conversion to such “accountable care organizations,” which under the Affordable Care Act will be eligible for Medicare payment with shared savings. The Center for Medicare and Medicaid Innovation is charged with developing alternative payment approaches that maximize the potential of these new organizations to achieve better and more efficient care. Other organizations, including hospitals employing physicians as well as partnerships or joint venture arrangements between hospitals and physicians and other health professionals, will also likely seek to become accountable care organizations.

Future essays will explore the promise and pitfalls of these new models of care. Certainly some of the country’s previous experience with capitated payment arrangements—notably those under some managed care plans in the 1990s—has been negative. But as the examples above illustrate, this need not be the case: global and bundled payment initiatives hold tremendous potential for moving the U.S. health system toward more integrated models of care delivery,

encouraging care coordination among providers, and reducing waste. Fortunately, many of the global and bundled payment programs included in the Affordable Care Act are conditioned on new provider performance standards, transparency initiatives, and quality reporting requirements that will encourage good outcomes and discourage provider groups from “skimming” the healthiest patients or “skimping” on the provision of care to those who need it. Much will depend on the nature of participating organizations and their commitment to quality and patient care.

This essay series will also consider the kinds of strategies that have been shown to be effective in achieving savings. Such strategies could include reducing hospital

readmissions, reducing emergency room use, reducing administrative overhead and waste, operating more leanly, or improving productivity. We will address concerns that such organizations may restrict access to essential care and discuss how to safeguard against that. We will also look at the concern that as health systems grow larger, they may be less responsive to patients and perhaps exert undue market power to charge higher prices, and we will explore what remedies are appropriate in such cases. And finally the series will consider whether a more coherent and transparent payment system across public programs and private insurers would create more powerful incentives for improved care and lower costs.

A handwritten signature in black ink, reading "Karen Davis". The signature is written in a cursive, flowing style.