



Beyond Pay for Performance — Emerging Models of Provider-Payment Reform

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Escalating costs and the growing imbalance between primary and specialty care have increased the urgency of calls for fundamental reform of the health care payment system. At the

core of the problem is the fact that the dominant fee-for-service model rewards volume and intensity rather than value. But although the faults in the way we currently pay for health care are obvious, it is much less clear what feasible approach would yield better results.

Earlier this decade, pay for performance took center stage as a tactic for realigning payment with value. Payers' experiences during this period, as well as several major studies, clarified the limitations of this approach — characterized by some as putting lipstick on a pig. Both the enthusiastic adoption and somewhat lackluster early results of pay for performance have given rise to a

broader payment-reform movement, with proposals and pilots emerging from a wide variety of stakeholders and policy leaders (see table).

The contours of proposed reforms of the health care payment system follow the fault lines of current reimbursement models — either undoing perverse incentives in existing payment approaches or augmenting the incentives for providing high-value care. A number of incremental payment-reform models that have gained traction over the past several years address individual issues; more ambitious reform proposals attempt to correct multiple shortcomings.

Among the incrementalist approaches embraced by many pay-

ers is enhancement of existing pay-for-performance programs through changes in scope, performance measures, and magnitude of funding. The changes appear to be focused on two perceived shortcomings of earlier efforts: too little impact on provider behavior and not enough focus on demonstrable benefit — including both health outcomes and spending — as opposed to process-of-care measures. At the same time, nonpayment for treatment of preventable complications has emerged as the mirror image of pay for performance. Early adopters of this approach, including HealthPartners in Minnesota, refuse to pay for “never events” (rare and preventable errors or complications); the Centers for Medicare and Medicaid Services (CMS) has cast a somewhat broader net, aided in part by new “present-on-admission” diagnostic codes.

Emerging Models of Payment Reform.*		
Source or Model	Description	Stage of Development
Incremental reforms: nonpayment for avoidable complications		
HealthPartners, CMS	Nonpayment for “never events” (e.g., surgery performed on the wrong body part, HealthPartners) and other preventable inpatient complications (e.g., catheter-associated urinary tract infections, CMS)	Implemented by HealthPartners Jan. 1, 2005, and by CMS Oct. 1, 2008
Primary care payment reform		
American Academy of Family Physicians, American College of Physicians, American Osteopathic Association, American Academy of Pediatrics	Tiered case-management fees (in addition to fee for service) paid per member per month to practices that demonstrate structural characteristics of a medical home, such as maintenance of disease registries and patient-education capabilities; performance incentives typically included	Pilots under development or in place include individual health plans, Medicare, Medicaid, and involved coalitions; specific examples include Group Health Incorporated and the Health Insurance Plan of New York as well as the Chronic Care Sustainability Initiative (multipayer initiative in Rhode Island that includes Medicaid)
Comprehensive Primary Care Payment and the Massachusetts Coalition for Primary Care Reform†	Primary care capitation with performance incentives; per-member, per-month payment rate based on accounting for costs of medical home, including, for instance, a \$250,000 salary for the primary care physician; the salaries of a part-time nutritionist, part-time social worker, nurse, nurse practitioner, and medical assistant; office expenses; and the costs of setting up electronic health records and employing a data manager	Pilot under development
Episode-based payment		
Prometheus	Episode-based payment model that defines global case rates for given conditions (e.g., acute myocardial infarction, diabetes, and knee replacement); payment amounts informed by cost of adhering to clinical standards of care; risk stratification and complication allowance; performance incentives based on comprehensive score card	Pilot under development
Geisinger Health System, ProvenCare	Episode-based payment for elective coronary-artery bypass grafting; 90-day global fee paired with high-reliability process improvements to achieve 40 best-practice standards	In use; expanding to other conditions and types of acute episodes
Shared savings		
Medicare Physician Group Practice Demonstration	Large, integrated groups may earn bonuses for demonstrating slower growth in spending for patient care relative to peers; any savings above 2 percentage points are shared with CMS, with up to 80% for the physician group; quality of performance affects share of savings (no quality bonus without savings)	Began in 2005; intended to last 3 years
Alabama Medicaid	Primary care physicians are eligible to share in savings according to their performance on use of generics, emergency department visits, office visits, and an index of actual-versus-expected total of allowed charges	Launched in 2004; payments began in 2007

* CMS denotes Centers for Medicare and Medicaid Services.

† See Goroll et al.¹

The downward spiral of the primary care profession in terms of compensation, professional satisfaction, and numbers of new entrants to the field has sparked

a payment-reform movement specifically focused on primary care. Prominent among these efforts has been a set of proposals wrapped around the notion of a “medical

home” (sometimes called the “patient-centered” or “advanced” medical home). The medical home is a set of philosophical and structural elements designed to ensure

that a physician practice (usually in primary care) takes responsibility for providing and coordinating timely and appropriate care for its patients.² The medical-home payment model typically includes a case-management fee, tiered according to the extent and sophistication of office systems and other practice capabilities attained, and pay for performance to support the delivery of optimal preventive and chronic-disease care.

An alternative vision for primary care payment that acknowledges the functions encapsulated in the medical-home concept goes further by replacing fee-for-service payment with primary care capitation.¹ This “comprehensive” payment model advocates payments computed (over a typical patient-panel size) to cover salaries for a multidisciplinary clinical team, infrastructure costs (e.g., the cost of implementing electronic health records), and other practice expenses that are deemed necessary for building a functioning medical home. Although primary care physicians would not pay for downstream costs such as referrals, the model includes substantial performance incentives for quality and cost efficiency (amounting to 15 to 25% of total payments).

Outside the primary care arena, some groups are turning to episode-based payment systems such as Prometheus Payment, developed by a panel of experts and stakeholders. Global case-payment rates for a given condition are developed on the basis of clinical standards for appropriate care rather than solely through examination of current patterns of care, which reflect high rates of underuse, misuse, and overuse. Calculation of payments includes risk

adjustment and a warranty for care in the event of related complications. Performance incentives (equal to 10 to 20% of the case-payment rate) related to clinical quality, patient experience, and cost efficiency are also part of the model.

Geisinger Health System’s ProvenCare payment concept is also based on clinical quality standards as applied to a defined episode of treatment.³ For elective coronary-artery bypass surgery, for example, the ProvenCare payment includes preoperative care, all services associated with the surgery and inpatient stay, plus 90 days of follow-up care. The episode price set by the health system is based on the cost of routine services plus an amount equal to half the average cost of complications.

Meanwhile, the Medicare Physician Group Practice Demonstration program is a leading example of the shared savings model of payment reform, which resembles the soft capitation contracts of the 1990s. In this program, participating group practices agree to manage the care of a population of Medicare patients with the prospect of sharing in savings that accrue to Medicare. Savings are calculated as the difference between actual spending and the risk-adjusted spending trend in a given market. Once this difference surpasses 2 percentage points, savings are shared with the integrated physician groups involved, which can receive up to 80% of these savings by performing well on cost-efficiency and quality measures.

Similarly, in late 2004, the State of Alabama instituted a program whereby 50% of any documented savings associated with primary care physicians in

the state’s primary care case-management program is shared with those physicians. Shared savings are allocated according to a point system that takes into account physicians’ scores on three risk-adjusted measures of performance (use of generic medications, emergency department use, and number of office visits) and an index of their actual-versus-expected total of allowed charges.

Although these approaches to payment reform span a wide range of models, a number of common themes emerge. The first is value-based payment: although cost control is a major goal of most reforms, clinical guidelines and quality measures play important supporting roles. For example, both the episode-based and comprehensive primary care payment models require payment levels to cover the costs of explicitly defined “best practices.”

The second theme reflects a lesson from earlier iterations of capitation-payment systems: the need to distinguish random variation in outcomes and patient mix from variation in practices and avoidable complications. The new CMS hospital payment rule is the most obvious example of an attempt to make such distinctions, but both the episode-based payment models and shared-savings approaches involve this type of accounting.

Finally, many of the payment approaches are inseparable from specific care delivery and organizational models. The medical homes are the most explicit examples of this trend, but it is also noteworthy that Medicare’s shared-savings model was piloted only in large, integrated health care systems. Policy developments in new models of accountability

share this view that aligning provider incentives with payer goals will require organizational forms that can coordinate care more effectively than the fragmented current system.⁴

There are, fundamentally, no “new” methods of health care payment. Novel approaches such as those described here are new combinations of old ideas, with updated features such as improved risk adjustment. Economic theory, as others have long noted, suggests that such mixed payment models will function better than any single approach.⁵ Which recipe will yield the best balance of meaningful incentives for cost control and quality improvement, risk protection for providers, and

selection incentives remains to be seen. The prospects for payment reform, however, hinge more on politics than on economics. Given that the two major goals of reform are to constrain spending growth and to move money from more intensive to less intensive settings — from doctors who carry endoscopes and scalpels to primary care physicians, for example — there will be substantial resistance to even the best-designed plans.

Dr. Rosenthal reports having an unpaid role in the design and testing of the Prometheus Payment system. No other potential conflict of interest relevant to this article was reported.

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No Place Like Home — Testing a New Model of Care Delivery

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Seeking ways to slow the growth of Medicare spending and to better coordinate the health care it finances, the federal government is preparing to test the concept of the “medical home” in the Medicare program. In response to a mandate in the Tax Relief and Health Care Act of 2006, the staff at the Centers for Medicare and Medicaid Services (CMS) is developing a demonstration program that will operate for 3 years in rural, urban, and underserved areas in up to eight states. Congress has directed the agency to use the program to “redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high-need populations.” Reluctant to constrain the freedom of bene-

ficiaries currently covered under the traditional fee-for-service model, however, Congress placed no limits on patients’ freedom to seek treatment, without a referral, from physicians not affiliated with their medical home and made virtually all practices eligible to participate in the demonstration program.

There is no consensus definition of the term “patient-centered medical home,” a concept that was introduced by the American Academy of Pediatrics (AAP) in 1967 with the aim of improving health care for children with special needs. Over the years, the AAP, the World Health Organization, the Institute of Medicine, the American Academy of Family Physicians (AAFP), Dr. Edward Wagner (director of the W.A.

MacColl Institute for Healthcare Innovation at the Center for Health Studies in Seattle), and others have honed this model, expanding its scope and placing more emphasis on adults with chronic conditions. In 2007, the AAFP, the AAP, the American College of Physicians, and the American Osteopathic Association issued principles defining their vision of a patient-centered medical home.¹ The core features include a physician-directed medical practice; a personal doctor for every patient; the capacity to coordinate high-quality, accessible care; and payments that recognize a medical home’s added value for patients. With the possible exception of some multispecialty group practices, this model remains largely an aspiration — a type of care