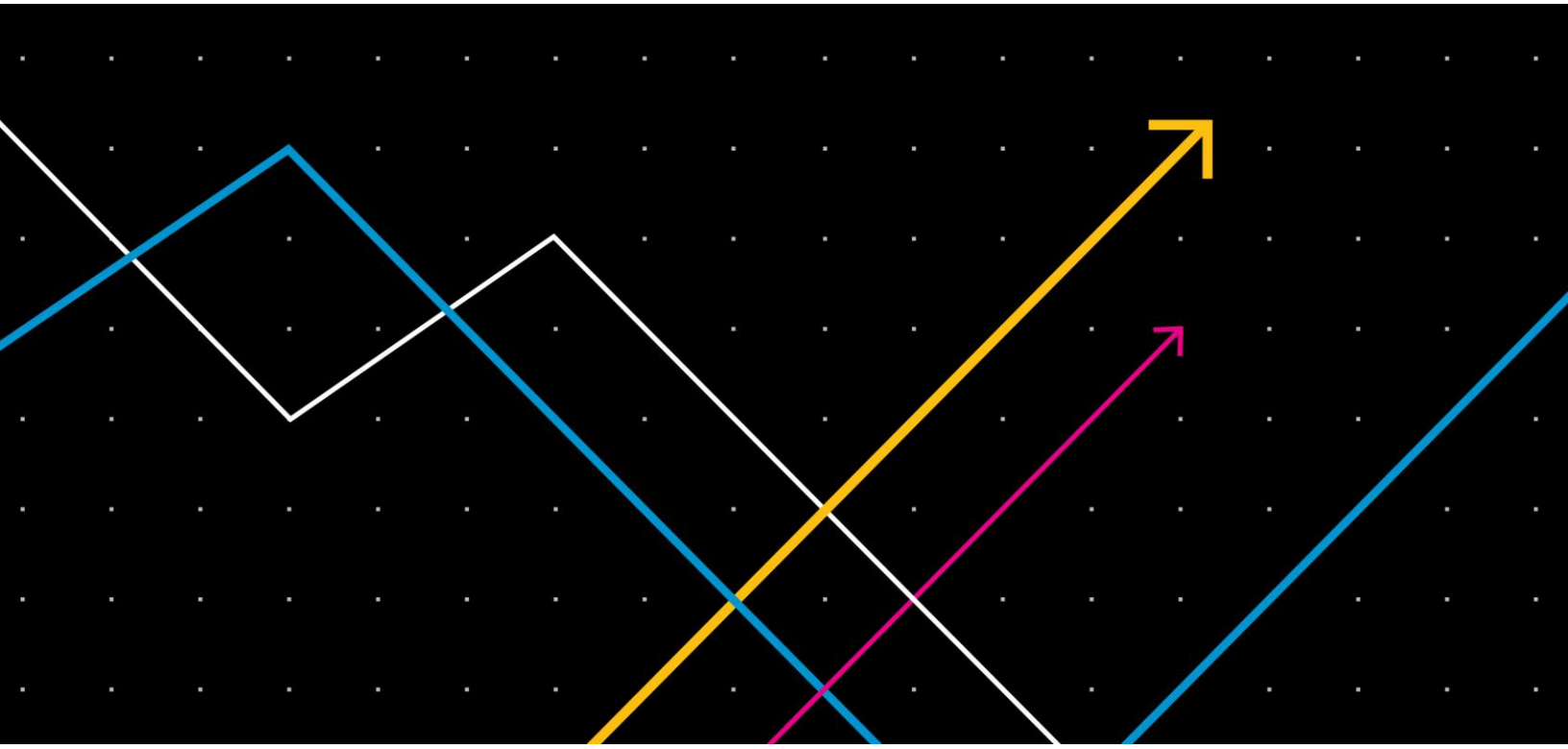

RESEARCH REPORT

Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care

Accountable Care Organizations—Integrated Delivery Systems

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OUR HEALTH CARE SYSTEM NEEDS CPR

CATALYST FOR PAYMENT REFORM

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Payment reform promises to substitute value for volume. Yet, value- and volume-based approaches typically are implemented together. All payment methods have strengths and weaknesses, and how they affect the behavior of health care providers depends on their operational design features and, crucially, on how they interact with benefit design. Those seeking greater value for their health care dollar are also turning to innovation in benefit design, which also typically involves the implementation of more than one approach at a time—each with its own strengths, weaknesses, and effect on consumer health care behavior. Although payment and benefit design each has received significant attention independently, the intersection between the two has received little if any. The Urban Institute partnered with Catalyst for Payment Reform to explore how established and proposed payment methods and benefit design options work on their own and together. We also examined how payment and benefit design can be blended to improve health care delivery. This chapter is one of the three pairs of interactions between payment methods and benefit designs discussed in the report *Matching Payment Methods with Benefit Designs to Support Delivery Reforms*. All reports and chapters can be found on our project page: Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care.

Accountable Care Organizations—Integrated Delivery Systems

Accountable care organizations (ACOs) are groups of physicians and hospitals that share financial and medical responsibility for providing coordinated care, with financial incentives to provide high-quality care and to limit avoidable, unnecessary spending. This concept was promoted by the Affordable Care Act and has since expanded across the public and private sectors. ACOs can be staffed by a hospital or groups of physicians receiving payment for coordinating care across a population of patients. Typically, the ACO's constituent members—physicians and other health professionals, or hospitals for hospital-based ACOs—receive standard payments for services rendered. Payments are made through fee schedules for physicians and per diems or DRGs for hospitals. The ACO itself is typically under either a shared savings or a shared risk arrangement, and savings or overspending are calculated against a target. Some ACOs are paid on per capita basis, such as with capitation.

The Medicare Shared Savings Program (MSSP) ACO, which pays provider groups under a fee-for-service shared savings arrangement, does not incentivize or require that patients seek care from

providers within the ACO. This can make it more difficult for providers to take on the financial responsibility associated with the population attributed to them. However, in the commercial market, employers and other payers can use benefit designs to create incentives for consumers to seek care from the ACO. This supports the ACO's incentive to coordinate care and improve patient outcomes. For ACOs that take on financial risk, in the form of a shared risk arrangement or capitation, a narrow network benefit design might best drive consumers to seek care from ACO providers and those providers only. This makes it easier for the ACO to manage and coordinate its patients' care. Value-based insurance design can also encourage consumers to seek clinically beneficial services, thereby improving patient outcomes and helping ACO providers meet quality standards and become eligible for sharing in any savings. Last, alternative, less expensive sites of care can help ACOs deliver care more cost-effectively and reduce the likelihood that consumers will seek care at a level they do not need (e.g., emergency services). All these components can better support the delivery of integrated patient care.

Introduction

ACOs are networks of physicians and hospitals that share financial and medical responsibility for providing patients with coordinated care, along with financial incentives to limit avoidable, unnecessary spending. Typically, ACOs, whether organized and managed primarily by a hospital system or a medical group practice, have a strong base of primary care. The participating providers are collectively accountable for both the quality and the full cost of care for a population of patients who, in various ways, are assigned to the ACO to make providers accountable. A core objective is to reduce the trend in costs; however, the ACO is typically required to achieve targets of performance on quality measures to be eligible to share savings from any reduction in costs.

The ACO concept is recent and was first promoted by specifications in the ACA. However, commercial insurers have long supported ACO-like organizations with payment and benefit design approaches that support the goals of improved quality and, especially, reduced costs. Organizational structures consistent with the ACO delivery concept include multispecialty group practices, integrated delivery networks, and independent practice associations. In contrast to Medicare, which does not modify its standard benefit structure with prescribed beneficiary cost-sharing obligations, private payers typically develop benefit design approaches that provide consumers with financial incentives to seek care from ACO providers.

Basic Payment Approaches

The ACA prescribed Medicare's approach to ACO development with a specific payment approach along with the standard Medicare benefits package. In general, the various approaches to paying ACOs are referred to as population health methods, because the base or incremental payment is based on the number and characteristics of the individuals assigned to the ACO, without regard to the specific services they receive. Shared savings, the most common payment method established for ACOs, maintains legacy approaches to the constituent providers based on service activity and provides incremental bonuses based on spending for the assigned population as compared against a target spending amount. Shared risk builds on this approach, creating penalties for overspending as well and usually awarding greater amounts for savings. Alternatively, various forms of capitation alter the base payment method to per capita spending rather than use the legacy volume-based payment approaches.

MSSP relies on a payment method called shared savings, under which ACOs receive financial bonuses if their assigned beneficiaries' health care costs are below a projected target amount, which is based on the ACO providers' historic spending. (This approach is sometimes referred to as "upside-only" shared savings.) In this approach, the provider members of the ACO receive their usual fee schedule or diagnosis-related group payments; the ACO entity itself is eligible for shared savings if it reduces spending to a minimum savings threshold (to account for normal variations in health care spending), contingent on its performance on quality measures. MSSP ACOs can choose to participate in two-sided, shared risk arrangements—in addition to receiving bonuses, ACOs with expenditures at or above a minimum loss threshold have to repay excessive spending. Similarly, Pioneer ACOs, which are Medicare demonstrations, can be paid using a variety of population-based methods, including partial or global capitation (i.e., per capita payments per month).

Commercial ACOs are often paid shared savings based on historic costs trended forward, although there is variation. An increasing number of commercial ACOs are being established with shared risk arrangements or are entering into contracts that migrate the payment method to shared risk over three years.

Complementary Payment Approaches

One challenge for shared savings and shared risk ACOs is that the constituent providers continue to face volume-enhancing payment incentives through standard payment methods, such as physician fee schedules and DRGs for inpatient care. Indeed, two-sided risk is similar to global capitation in how it

penalizes the ACO for unnecessary spending. Yet, the legacy payment methods that represent constituent providers' cash flow may overwhelm ACOs' incremental shared savings incentives for more prudent spending. It is for that reason that some consider shared risk an "on-ramp" to prepayment through capitation.

Capitation provides front-end capital to the ACO, permitting the entity to employ payment methods for its constituent providers that deviate from standard payment, with greater incentives for reduced spending. That is, the capitated ACO can use primary care and specialty capitation to distribute the revenues it receives from payers to providers in the ACO. Similarly, the capitated ACO may be in a better position than a more removed third party to pay based on procedure- or condition-based bundles, as it can better prevent potential unintended behavioral responses. For example, given the concern that procedure-based bundled episode payment remains volume based (i.e., providers still have incentives to do more bundled episodes), the ACO can assure that providers follow evidence-based guidelines for appropriate care. Similarly, the ACO is in a better position than the insurer to guarantee that condition-specific episodes of care meet the clinical criteria required to be eligible for a bundled payment.

Commercial insurers have increasingly adopted DRGs as the payment method of choice for inpatient care, to be consistent with Medicare and to transfer risk for an entire hospital stay, rather than each day, to the hospital (except for outlier cases). However, under population-based payment methods that place ACOs at risk for the individuals assigned to them, the ACO might actually prefer to maintain the risk itself rather than pass it on to the hospital: it can actively manage whether the patient gets admitted, and it can better assure a high-quality, "early" discharge that includes follow-up when the patient returns to the community or to a postacute care facility. In short, using per diems can benefit an at-risk ACO with regard to early discharge, rather than using DRGs to give the hospital the savings.

This example emphasizes that hospital-based ACOs and physician-based ACOs may have different perspectives on which payment methods to employ, if they can receive capitated payments and then pay participating providers. In particular, assuming a reasonably competitive market for hospital services, a physician-based ACO may be in a position to exert negotiating leverage with competing hospitals, achieving more favorable prices and better terms and conditions than a hospital-based ACO committed to its own hospital and other facilities.

Complementary Benefits Designs

ACOs, whether receiving base capitation payments or incremental shared savings or shared risk, would be supported by narrow and tiered network benefit designs. The objective would be for favorable cost-sharing to encourage consumers to use ACO providers. Presumably, the payer has achieved some price concessions from the ACO constituent providers in exchange for increased volume. Further, if selection into the favored tier or narrow network is determined by performance-based quality and service-use benchmarks, the ACO would improve its value of care by channeling patients to its providers through differential patient-cost-sharing.

From the ACOs perspective, a narrow network design would be preferable to a tiered network: ACO providers would have more control over clinical care decisions, including referral preferences, because patients have more limited choice of providers in the narrow network. Providers in a tiered network would likely be less willing to assume risk, because their patients still have access to providers in all tiers. However, a shared savings (upside-only) arrangement, could work well with a tiered network by aligning patients' outcomes to providers' performance and eligible savings.

HDHPs may create a mixed set of interactions with population-based payment methods in which providers bear financial risk. On one hand, because providers are bearing risk, their patients face a high deductible; this has the direct effect of influencing patients to seek less care, which reduces spending to the ACO's benefit. On the other hand, ACOs, typically based on primary care practices, seek more management control over patient care; therefore, financial barriers to care (through a high deductible) can interfere with patients' acceptance of ACO providers' judgment. ACOs need to meet quality standards and, for that reason alone, would want to see lowered barriers to care. Otherwise, adverse outcomes will occur when patients choose to disregard their physicians' advice. HDHPs typically provide first-dollar coverage for primary preventive services, which eases the tension between patients' incentives and providers' directions. However, secondary preventive services and other clinical services that might affect more serious conditions and complications are subject to the full impact of the high deductible, for good and bad.

Similar to the impact of waving cost-sharing for primary prevention inside a HDHP, value-based insurance design complements to population-based payment in how it can encourage consumers to seek preventive services. V-BID reduces financial barriers to seeking care and can identify services of high value, such as maintenance medications for chronic conditions. This adds an additional demand-side tool to the delivery-side population-based payment approach. V-BID could lower consumer cost-sharing for secondary preventive or other clinical services subject to a deductible. But for an HDHP

with a health savings account, according to IRS standards, all services must be subject to the deductible regardless of other incentive designs. V-BID could encourage nuanced fee-for-service payment, so that providers performing clinically beneficial procedures receive regular payments and those providing unnecessary services do not.

Both HDHPs and V-BID were designed to complement standard methods for paying health professionals and hospitals. As a result, they are both readily compatible with a shared savings or shared risk approach to population-based payment, as these approaches rely directly on usual fee schedule and per diem or DRG hospital payments. The retrospective determination of shared savings or losses does not affect patients' cost-sharing obligations or any impact cost-sharing might have on their care-seeking behavior. HDHPs are not readily compatible with professional or global capitation because they do not include the usual fee-for-service claims on which a patient's cost-sharing is calculated. Traditionally, co-payments, rather than co-insurance or deductibles, have been applied when payment to the integrated provider entity is made by capitation. Therefore, V-BID can be compatible with capitation if co-payments are the cost-sharing mechanism used to encourage certain care-seeking behavior. In addition, HDHPs could function with capitation if the plan administers deductibles based on each patient encounter, though this is operationally difficult to do.

Finally, benefit designs that encourage consumers to seek care from alternative sites have potential strengths and weaknesses in a non-risk-bearing, fee-for-service environment. Telehealth might be susceptible to overuse if the providers employing it are not sharing any risk. However, risk-bearing ACOs would have strong interest in preventing frivolous or otherwise inappropriate use of alternative sites of care, including telehealth. Similarly, a risk-bearing ACO might wish to contract with, manage, or own retail or workplace clinics as well as telehealth services, as a way to facilitate care in environments with lower cost than emergency rooms. In this way, promoting alternative sites of care and population-based payments are complementary.

Environmental Factors

A fundamental factor in commercial insurers' expanding the use of global payment approaches to support ACOs lies in how states regulate risk-bearing entities. Today, most state regulations only allow the various forms of capitation, ranging from primary care capitation to full global capitation, to take place in licensed HMOs and not PPOs or other unlicensed products. The theory is that HMO requirements and oversight provide both needed protection against stinting on care and the ability to

take on insurance risk. With current trends continuing to move away from HMOs toward PPOs, fostered by the growth of self-funded, employer sponsored insurance not subject to state regulation, prepaid capitation may have less potential as a payment model for ACOs.

Less clear is the degree to which shared risk will be permitted on a PPO commercial insurance platform. While Medicare payment methods are not subject to state regulation, states might regulate how commercial payers set up both shared risk payment arrangements and provider networks. States may only tolerate shared risk up to a certain limit or allow providers to apply losses to future management fees rather than to out-of-pocket payments to the insurance entity. States may apply regulations similar to those for capitation arrangements that require significant insurance risk by an unlicensed entity.

Conclusion

With a successful combination of incentives for consumers and health care providers, integrated care delivery could deliver better health care and create healthier populations. On the supply side, potential payment methods could encourage providers to coordinate care by offering incremental bonuses or penalties for care that meets both cost and quality targets, perhaps as a transitional payment method leading to population-based payment methods like capitation. On the demand side, benefit designs, such as narrow networks, can encourage consumers to seek care from providers in an ACO. Value-based insurance design can encourage consumers to follow clinical guidelines and seek evidence-based care that can lead to positive outcomes and therefore, savings for providers. And alternative sites of care can help providers operating under shared risk payment arrangements provide cheaper, more convenient care to consumers who do not need care in traditional settings. All of these components can better support the delivery of integrated patient care.

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