

Overview of Alternative Payment Models

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Blended Capitation Rates

Description

Blended capitation rate programs are payment models where capitation is combined with other payment models such as fee-for-service or pay-for-performance programs. Under capitation, physicians are paid a monthly fee for each patient under their care to cover a set of services regardless of the amount of services provided. Blended models where capitation is combined with pay-for-performance programs aim to address some of the weaknesses of current payment methods by rewarding physicians with additional payment for providing high-quality care.¹

Many health plans also offer physicians bonuses for efficiency--either for following 'utilization management' guidelines (which try to keep the use of health care services within certain parameters on the part of patients and doctors), or through some other mechanism. Physicians believe that these bonus programs add additional potential for ethical conflict of interest since they usually reward physicians who make conservative decisions on what care they give to patients. However, generalizing about these arrangements is difficult due to the variation in compensation across managed care plans.¹

Blended models are widely used by physician groups in California that reimburse specialists and primary care physicians using blends of capitation and fee-for-service. Payers can design blended systems to achieve specific policy objectives— for example, combining capitation incentives for spending within budget targets with fee-for-service for promoting preventive services such as mammography, and bonus payments for encouraging physicians to meet quality and patient satisfaction targets. Importantly, blended models can be designed to limit physicians' financial risk by making certain aspects of care beyond their control are fee-for-service based.¹

An example of a blended capitation model is the Blue Cross Blue Shield (BCBS) Alternative Quality Contract (AQC) model where the company will pay physicians and hospitals a flat sum per year, adjusted for age and sickness, plus a bonus if physicians improve care.² The BCBS AQC model is structured as a five-year contract. In year one, payment is a global rate based on the regional network average adjusted for patient health status, plus a performance-based payment based upon a set of pre-defined measures (including outcomes, process, and patient experience measures). Each year, the global payment is increased by an inflation factor and adjusted for changes in health status. Provider organizations can earn up to 10% in incentive payments by reaching the highest level of performance.^{1,3}

Another example of blended capitation is the New Century Health Quality Alliance Inc., a multispecialty IPA in the greater Kansas City area. This group's primary care physicians receive capitation, but they also receive fee-for-service payments for "excluded" procedures like immunizations, colonoscopies and echocardiograms.³

Additional Information

Capitation: Capitation in healthcare financing consists of risk transfers from insurers to physicians for cost and utilization of services via fixed prepayment.⁴ Under capitation, physicians are paid a monthly fee for each patient under their care to cover a set of services regardless of the amount of services provided. Capitation creates financial risk for the physician to the extent that the cost of the actual services provided may exceed those covered by the payment. The

physician retains the excess payment when the reverse is true and payment exceeds cost of care.⁵

Capitation was designed to improve efficiency, cost control, and preventive care because the physician, hospital or health system is responsible for the enrolled member's health regardless of cost. In theory, capitation motivates the health care provider to provide health screenings and other preventive care to enrolled members, and to focus on keeping the member healthy through good primary care thus relying less heavily on costly medical specialists.⁶

Global- or Full-Risk Capitation: There are essentially two kinds of capitation, with many variations. The first is called 'global capitation,' in which whole networks of hospitals and physicians band together to receive single fixed monthly payments for enrolled health plan members; under global capitation, the physicians sign a single contract with a health plan to cover the total cost of care of groups of members, and then must determine a method of dividing up the total capitation payment among themselves. The second type of capitation is simply capitated payment contracted to a specific provider group: a physician group, or a hospital, individually.⁶

According to Elliot Fisher, MD, one of the underlying causes of rising cost and poor quality is a payment system that rewards more care, increased capacity, high margin treatments and entrepreneurial behavior. In order to implement payment reform, there needs to be a fostering accountability for capacity through capitation or global shared savings. His research demonstrates the problems with the fee-for-service system and the need to move toward "capitation" or shared savings models that support the transformation of care. He said that this must be done in ways that ensure that risk is successfully managed, either by leaving most of the management of risk in the hands of those who are good at it (insurers) or building that capacity and infrastructure into the integrated systems themselves (a la Kaiser). Timely good and accurate data is essential for success.⁷

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Episodes-of-care payments

Description

Episode-of-care payment, a subset of bundled payments, involves one fixed payment for the treatment of a specific illness. This payment covers all or a portion of the services by all physicians for an entire course of treatment over a specified period of time. The fixed payments may be adjusted for severity of illness and/or the extent to which evidence-based services are provided or clinical outcomes are achieved.¹

The most recent models of episode-of-care payment include the Prometheus Payment program and Geisinger's ProvenCare system. The Prometheus payment system is unique because of its exclusive reliance on Clinical Practice Guidelines (CPGs), which clearly state what science should be brought to bear to treat a patient with specific clinical profiles. From the CPGs, an evaluation is made that takes into account all resources needed to provide the care the diagnosis necessitates – including everything from clinicians time to lab expenses, from medical equipment to rehabilitation. Based upon that evaluation, an Evidence-informed Care Rate (ECR) is calculated, summing all of the costs necessary to provide the patient with the necessary resources and services. In this model, risk is shared by both insurers and physicians.²

Since PROMETHEUS is applicable to all provider settings—whether large integrated networks, multi-specialty groups, single specialty groups, hospitals, nursing homes, or individual physicians—each ECR also has to be parsed to reflect the portion that is allocable to a principal physician, consultants, a pharmacy, a hospital or any other provider that cares for the patient. Physicians negotiate with the plan for that part of the ECR which they will provide for patients with that condition. They can bargain for defined steps on the CPG, rendered solely by them or they can join with other physicians to provide a broad array of the services in the CPG. They can negotiate to be paid separately or together.³

Geisinger's ProvenCare System is an episode-based payment for elective coronary-artery bypass grafting. It includes a ninety-day global fee paired with high-reliability process improvements to achieve forty best-practice standards. 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.

Geisinger plans to expand its ProvenCare system to include hip replacement, cataract surgery, PCI/ angioplasty and Erythropoietin.⁴

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Medical home models

Description

The basic tenets of the Medical Home plan are the voluntary certification of primary care and specialty practices providing patient-centered care based on the principals of the Chronic Care Model:

1. Use of evidence based guidelines.
2. Use and application of Health Information Technology (HIT)
3. Use of “best practices” to meet the needs of patients and be accountable for the quality and value of care provided.

Primary care physicians are crucial to this model. They are responsible for implementing an infrastructure that allows them to have more continuous contact with patients, coordinate care better across the entire health system and use more evidence-based medicine to guide clinical decision-making, among other responsibilities⁹. In the advanced medical home model, patients will have a personal physician working with a team of healthcare professionals in a practice that is organized according to the principles of the advanced medical home. For most patients the personal physician would most appropriately be a primary care physician, but it could be a specialist or sub-specialist for patients requiring ongoing care for certain conditions (e.g., severe asthma, complex diabetes, complicated cardiovascular disease, rheumatologic disorders, and malignancies). Primary care physicians are defined as physicians who are trained to provide first contact, continuous, and comprehensive care³. Enhanced patient access is available through open scheduling, expanded hours and new communication options among patients, their personal physicians and medical home staff⁹.

Current options for payment under the medical home model are generally some form of blended payment, the most common framework consisting of a global payment for primary care services, including all coordination of care, and fee-for service payment for services falling outside the established primary care domain⁸. Additional payments are available for medical homes that achieve measurable and continuous quality improvements⁹. Medical home payments reflect the value of care-management work conducted by physicians and staff beyond face-to-face visits. Payment is available for use of health information technology as well as secure e-mail and telephone consultations. Physicians share in the savings from reduced hospitalizations.

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Global Budgets

Description

Effective cost containment requires that payers of health services adopt expenditure controls: that is, a limitation on the total amount of money available for health care services. Expenditure controls, while highly controversial, are effective. One mechanism of expenditure control is global budgets.¹

Under a global-budget health care system, hospitals and government authorities negotiate an annual budget based on past budgets, clinical performance, and projected changes in services and input costs. Hospitals receive periodic lump-sum payments. Individual physicians are free to allocate the mix of resources and services provided. Caps or targets establish a ceiling for all physicians of a specific service.¹ In Canada, physicians are paid mainly through fee-for-service payment models with some alternative payment models in place.^{2,3}

In a globally budgeted health care system, expenditures for all services within the budget are set in advance. The budgets may set an overall figure or may specify expenditure limits on different components of a health institution or health system. The National Health Service of the United Kingdom is a globally budgeted system. Canada pays hospitals, but not physician services or pharmaceutical products, by global budgets. In the United States, the Veterans Affairs hospitals are paid through global budgets. Although the amount of a global budget could be unilaterally set by payers, most global budgets in Canada and Europe are negotiated between payers and physicians.¹ The Veteran's Affairs budget is appropriated by Congress as a global budget and distributed to its networks via a form of capitation.⁴

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Pay-for-Performance Programs

Description

Pay for performance is an emerging movement in health insurance. Under this arrangement, physicians are rewarded for meeting pre-established targets for delivery of healthcare services or sometimes improving care by meeting established standards.⁶ This is usually geared toward primary care but moving to include specialists.

Also known as "P4P" or "value-based purchasing", this payment model rewards physicians, hospitals, medical groups, and other healthcare providers for meeting pre-established targets on specific performance measures for quality and efficiency. The rapidly aging population and rising health care costs have recently brought P4P to the forefront of health policy discussions.^{1,3} State of Minnesota Health Economist, Scott Leitz, M.A, has asked the question: Does increased spending to meet P4P measures outweigh the cost?⁹ At the root of this question are the physician's increased costs of patient treatment which are necessary to meet the targeted measurements of pay for performance programs.

Physicians hope that insurers will come to understand that rather than unsuccessfully attempting to identify and reward the best practitioners, the most productive use of pay-for-performance programs is promoting behavioral change for a small set of carefully selected measures for which there is ample evidence of need for improvement. Organizing the professional community around a specific set of behaviors that are known to have a direct impact on outcomes creates incentive to improve. Although there is concern about incentives diverting attention from non-selected activities, if the measures chosen are of significant benefit, the time focused on them would be well spent.⁶

Bridges to Excellence (BTE) is a non-profit coalition-based organization created to encourage significant leaps in the quality of care by recognizing and rewarding physicians who demonstrate that they deliver safe, timely, effective, and patient-centered care. BTE works with large employers, health plans, physicians and a wide range of organizations that have a shared goal of improving quality and patient outcomes.

Through participation in three of BTE's programs – Physician Office Link, Diabetes Care Link and Cardiac Care Link – Massachusetts' employers, physicians, coalitions and quality improvement organizations are working together to improve care processes and systems of care – directly impacting and improving the quality of health care delivered to patients in Massachusetts.¹⁰

Medicare has implemented a Provider Quality Reporting Initiative (PQRI) program. The foundation of effective pay-for-performance initiatives is collaboration with physicians and other stakeholders, to ensure that valid quality measures are used, that physicians are not being pulled in conflicting directions, and that physicians have support for achieving actual improvement. Consequently, to develop and implement these initiatives, CMS is collaborating with a wide range of other public agencies and private organizations who have a common goal of improving quality and avoiding unnecessary health care costs, including the National Quality Forum (NQF), the Joint Commission of the Accreditation of Health Care Organizations (JCAHO), the National Committee for Quality Assurance (NCQA), the Agency for Health Care Research and Quality (AHRQ), the American Medical Association (AMA), and many other organizations. CMS is also providing technical assistance to a wide range of health care physicians through its Quality Improvement Organizations (QIOs).¹¹

Medicare has also implemented an e-Prescribing measure in 2009. The inclusion of electronic prescribing in the Medicare Modernization Act (MMA) of 2003 gave momentum to the movement, and the July 2006 Institute of Medicine report on the role of e-prescribing in reducing medication errors has received widespread publicity, helping to build awareness of e-prescribing's role in

enhancing patient safety. Developing the standards that will facilitate e-prescribing is one of the key action items in the governments plan to expedite the adoption of electronic medical records and build a national electronic health information infrastructure in the United States.¹¹

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Tiering of Physicians

Description

Physician tiering can be defined as when a health plan analyzes claims data in two ways: to assess network physicians on the basis of efficiency (e.g. costs per episode of care) and to assess physicians on measures of quality (e.g., blood tests for diabetic patients). Health plans locally and nationally have begun ranking physicians on certain quality and efficiency measures, thus placing each individual physician and sometimes groups of physicians into a specified tier linked to a higher or lower co-payment for patients.^{1,3}

Tiered networks attempt to utilize two mechanisms for controlling cost. The first mechanism is to encourage patients to switch from lower-value to higher-value physicians by offering lower co-pays for higher-value physicians or higher co-pays for lower-value physicians. The second mechanism is to encourage physicians to become more cost efficient in order to avoid the negative outcomes of being advertised as a lower-tier physician, with an attendant loss of patients.⁶ Although designed to encourage physicians to deliver quality, cost-effective care, physicians may be placed in a lower tier due to quality and/or cost issues beyond their control. For example, being included in a pool of exceptional physicians where most are offering high quality, cost-effective care, some physicians will be placed in lower tiers due to the sheer number of those in the highest tier.

The Massachusetts Group Insurance Commission (GIC), covering state employees, retirees, and their dependents, launched the Clinical Performance Improvement initiative (CPI) in 2003. CPI requires health plans under contract with the GIC to incorporate provider "tiering" -differential payment based on value-into their GIC product. After early data delays, group tiering began in the third year of the contract, and individual physician tiering began in the fourth year.⁷

An example of the GIC Tiering includes:⁵

- Tier 1 (excellent) lowest copay
- Tier 2 (good) - middle copay
- Tier 3 (standard)-highest copay

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Evidence-based purchasing strategies

Description

Evidence-based purchasing strategies look to purchase services from physicians that demonstrate the best possible outcomes on patients. Implementation of this strategy has been hampered by the lack of available consistent, actionable, quality outcomes data.

A related strategy is value-based purchasing, where the goal is to obtain the most effective and efficient service possible on behalf of the patient at the lowest possible cost. Efficiency and effectiveness are evaluated as cost control measures, and may not be related to outcomes or quality of care.

An example of this type of strategy is incorporated in the Prometheus payment model. In the Prometheus payment model, value-based purchasing strategies rely on Clinical Practice Guidelines. These guidelines indicate what science should be brought to bear on treatment for any specific patient with a specific clinical profile. This forms the “Evidence Informed Case rate” which sums all the costs necessary to provide the patient with the necessary care.⁶

Clinicians or groups bid on that portion of the care they are willing and able to provide. This model has an inherent shared risk factor between physicians and insurers. If physicians over-utilize resources, they will exceed the budget. Insurers can rely on certain budgeted amounts to contain costs⁶. Where Prometheus varies from value based purchasing is the consideration of patient outcomes. A percentage of reimbursement is withheld and paid out after that provider's patient outcomes are evaluated. This entire process is thought to encourage better communication among physicians through the referral process, e.g. referrals to higher quality physicians.^{6, 8}

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