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Payment and Delivery System Reform: It's Only a Matter of Time

BY DOUGLAS A. HASTINGS

Sen. Kent Conrad (D-N.D.) complained last week that the press had done a disservice to the country by virtually ignoring in its coverage of the health care reform bills the important payment and delivery system reform provisions. Now that the fate of comprehensive federal reform is uncertain, health care providers should not make the same mistake. Indeed, the loss of momentum at the federal level reinforces the need for the private sector to move forward in innovative ways and to share best practices.

The Problems Are Still There

The underlying problems that led to the consensus in the policy community, in both houses of Congress and in both parties—that health care must become much more integrated, coordinated and cost-efficient—have not changed. The fragmentation, unsafe and uneven practices, and runaway costs are no less threatening than they were prior to the Jan. 19 special election in Massachusetts.[1] It is important to keep in mind that the federal reform package would not have resulted in immediate, wholesale changes in the way health care is paid for and delivered. Incentives for quality-related care improvements, accountable care organizations (ACOs), bundled payments and so on were to be phased in over time, and there were no new built-in legal protections for providers engaging in more coordinated care. Accordingly, whether or not there is a comprehensive federal bill, delivery system reform is still likely to take place in various piecemeal steps through regular Medicare/Medicaid legislation and regulation, through the budgetary process, through state actions and through private sector initiatives.

Thus, health care providers and payers should continue to push ahead, notwithstanding the obstacles. Indeed, what we have learned over the last 20 years in efforts at aligning hospitals, physicians and other providers through various contractual arrangements, networks, acquisitions and employment provides a lot of ''do's'' and ''don'ts'' that should help guide providers in their current efforts. So does experience gained with various efforts at risk-based contracting between payers and providers. We also have some guidance—of course, not enough—from regulators as to what kinds of clinically-integrated relationships will not be challenged and what features will create better legal defenses.

[1] Most of the press and public focus during the reform debate has been on increasing access and how pay for it. As Massachusetts has learned, it is likely that the only real way to pay for increased access in the long run is payment and delivery system reform that drives down cost through better quality and greater cost-efficiency in service delivery.

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The 10 questions I posed in early January[2] are still fully relevant:

- How will developing an ACO benefit the community you serve?
- Do you have the right provider components in place?
- Do you have an organizational and contracting structure that will create the necessary ownership, employment, joint venture and/or network relationships—and sufficient clinical integration—to succeed?
- Does your current board have the right mix of individuals to provide oversight in the accountable care era?
- What is your level of experience with measuring and reporting on quality, cost and outcomes?
- Do you have sufficient IT infrastructure?
- Have you considered the level of capital and reserves that may be required to manage the financial risk of bundled payments?
- Have you assessed existing or planned provider-payer linkages (through ownership or contract) that might facilitate the integration of payment and delivery and the acceptance of bundled payments?
- Have you explored existing pilot programs or demonstration project opportunities with CMS, state governments or private payers?
- Do you have access to timely information about developments on the Hill, at CMS and at the state level to benefit from opportunities?

Not only will providers need to continue to look at their current internal processes to improve quality and cost efficiency, but they also will need to look at new structures and relationships to get to the size and scale necessary to succeed in the accountable care era. This will mean more consolidation, formation of new systems and entities, vertical and horizontal integration, formation of clinically integrated contractual/virtual networks, partnerships and new forms of payment arrangement with payers, and more. Providers should be looking at current federal, state and private pilots and demonstrations as well as thinking up innovative projects and programs and seeking partners (including payers) and potential sources of funding.

All health care is local, and each institution needs to figure out the best course for itself. Sitting still is not a good strategy. The cost pressures along with our aging population over the next few years will expedite the drive toward accountable care, and away from high cost fee-for-service, both in public and private payment systems. Providers and payers need to be positioning themselves by planning, changing and structuring accordingly.

New Directions in Payment—From P4P to Bundling

As has been widely discussed in recent years, the fee-for-service based payment system in the United States rewards volume, not value.[3] Among many other implications, this method of payment incentivizes providers to emphasize high cost procedures in high volume and disincentivizes care coordination and prevention. Accountable care means, at the most basic level, a payment system that pays for outcomes and efficiency. Or, stated in another way, in the accountable care era, payment will reward providers who deliver care in a way that meets, as determined by evidence-based measures, the six aims of quality set forth in *Crossing the Quality Chasm* — care that is safe, effective, efficient, patient-centered, equitable and timely.

While pay-for-performance, penalties for readmissions and other such tools to drive more coordinated care within a fee-for-services system have merit, and are being implemented in various public sector and private sector pilots, more meaningful in the long run are a set of evolving bundled payment approaches.[4] These include inpatient bundling (a single payment to cover the physician and hospital costs of a single hospitalization), episode of care bundling (global DRG case rate, including pre-acute and 90 days post-acute care), per enrollee bundling on a shared savings basis (capitation framework, but fees not capped) and full patient population capitation (providers fully at risk).

Capitation, of course, is not new and was a buzzword in the 1990s. There are those who joke about what went on in the 1990s and what they refer to as the capitation ''false alarm.'' I would suggest that developments in evidence-based measures, information technology, clinical integration (especially by leaders in integrated delivery), continued exploding costs and the widespread acceptance of the need for payment changes in the policy and business communities all will lead to ''volume to value'' payment reforms in the years ahead. We may not know the exact timing today, but we know that it is only a matter of time. We are in the early stages of the accountable care era, and providers ignore these coming payment changes at their peril.

Implementing ACOs—Timing, Structures, and Legal Issues

At the same time, current payment methodologies punish care coordination. There are no payments for the act of coordination itself.[5] One of the key results of more coordinated care—reduced inpatient admissions—contributes to overall cost efficiency, but under current reimbursement can be harmful to hospitals. This is a dilemma no doubt. But, again, even under

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[2] Douglas A. Hastings, ''Is Your Organization Ready to Become an Accountable Care Organization? Here are 10 Questions to Ask,'' *BNA's Health Law Reporter*, Vol. 19, No. 1, Jan. 7, 2010 (19 HLR 47, 1/7/10).

[3] *See, e.g.*, Elliott S. Fisher, Mark B. McClellan, John Bertko, Steven M. Lieberman, Julie J. Lee, Julie L. Lewis, Jonathan S. Skinner, ''Fostering Accountable Health Care: Moving Forward in Medicare,'' *Health Affairs* Web Exclusive, Jan. 27, 2009; Atul Gawande, ''The Cost Conundrum,'' *The New Yorker*, June 1, 2009; Commonwealth of Massachusetts, Recommendations of the Special Commission on the Health Care Payment System, July 16, 2009 (*available at*: http://www.mass.gov/dhcfp/paymentcommission); Institute of Medicine, ''Rewarding Provider Performance: Aligning Incentives in Medicare'' (Washington: National Academies Press, 2006) (*available at*: http://www.nap.edu/catalog.php?record_id=11723).

[4] *See, e.g.*, Brookings-Dartmouth ACO Pilot Project; Robert Wood Johnson Foundation Prometheus Payment Model; CMS/Premier Hospital Quality Incentive Demonstration; CMS Acute Care Episode Demonstration; and CMS Physician Group Practice Demonstration.

[5] The ability to better coordinate care among providers, however, is a positive factor in satisfying the ''meaningful use'' requirement for electronic health records incentives under the American Recovery and Reinvestment Act of 2009.

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the federal reform bills now stalled, ACOs, bundled payments and other innovations were to be phased in over the next decade. Providers will need to be careful as to the financial impact and timing of implementation—and seek to participate in pilots and demonstrations as much as possible to prepare—but they should so prepare.

From a structural perspective, there are three broad categories of approaches to integration: contractual models, partial or virtual integration models and fully integrated models. I believe that all three remain relevant and can be used, depending on the particular circumstances, to create the kinds of delivery systems with the size, scope and level of clinical integration necessary to be successful in the accountable care era—*i.e.*, ACOs .

Clearly, consolidated entities under common ownership with physicians and other key health care professions in employment relationships (fully integrated models) have operational and legal advantages. Nevertheless, the need to expand the base of services and to coordinate them to meet bundled payment models will require new provider linkages, many of which necessarily will be virtual and/or contractual, at least at the outset. It is reasonable to expect, for example, that today's large integrated delivery systems will need to continue to expand the physicians they relate to, including many by contract. These systems also are likely to want to build relationships with long-term care providers, primary care providers and community-based service providers such as Federally Qualified Health Centers (FQHCs). Well-established medical groups may find it advantageous to link contractually or virtually to hospitals or other providers in addition to merging or acquiring to form ACOs. For all the joking about the building and taking apart of physician-hospital organizations (PHOs) in the 1990s, that contractual model of integration, now with more antitrust guidance on clinical integration requirements, is making a comeback. And any effective ACO will need a strong primary care or medical home component.

Each ACO will need to be structured to meet local needs and particular payer arrangements as these evolve over time. A federal framework would be a helpful but not necessary component of new private payer bundled payment arrangements with ACOs. The degree to which providers developing ACOs can find cooperative payers to work with is as significant a factor in ultimate success as the degree of clinical integration achieved at the operational level.

The antitrust, Stark, antikickback, CMP and other legal issues that create obstacles to aligning incentives and coordinating care among providers remain. This creates a potential train wreck as ACOs and bundled payments continue to pick up steam. During the last months of the development of the pending Senate reform bill, several freshman Democratic senators had proposed a formal GAO study of these obstacles, but such study did not make it into the proposed legislation. I have elsewhere proposed a legislative solution[6] that has received some attention on the Hill but no formal recognition yet.

The challenge for the enforcement community will be to prosecute improper activity while not discouraging appropriate and necessary activity as the health care system changes. Given that the goal of health system reform is more coordinated care and the inclusion of incentives to better coordinate and cooperate among providers, regulators will have to be able to distinguish the ''good'' coordination from the ''bad.''

What is a ''good'' incentive between a hospital and physician to encourage proper use? What is a kickback disguised as a proper incentive? Which hospital mergers and joint ventures promote sufficient clinical quality and cost efficiency, even if they reduce competition, to be allowed to proceed? Which do not? What measures are to be used to determine good from bad, legal from illegal?

The government, as purchaser, wants more cost effective health care delivered for those patients it covers and wants providers to collaborate to bring that result about. The government, as regulator, wants to make sure that such collaboration involves neither payments for referrals or agreements to restrain trade. Enforcing against fraudulent behavior or monopolistic activity by an individual or single entity is broadly supported and raises few concerns as a general concept. However, getting the balance right when judging ''good'' collaborative behavior from ''bad'' as between independent parties in this era of health care reform is tough. If evidence-based medicine can define proper use, perhaps evolving consensus-approved quality and cost-efficiency measures can assist the enforcement community in finding the right balance.

Conclusion

As I write this, the president has just announced the format for the Feb. 25 health care summit. With or without comprehensive federal reform this year, the clock is ticking on today's current fee-for-service, siloed health care system. Every provider has challenging choices to make. No action is not a good choice.

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[6] Douglas A. Hastings, ''Addressing the Legal Issues in Achieving Quality and Cost Efficiency: The Need for a Rebuttable Presumption,'' *BNA's Health Law Reporter*, Vol. 18 No. 22, June 4, 2009 (18 HLR 740, 6/4/09).