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Provider Payment Reform:
Incentives to Improve Care
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As the Accountable Care Act is deployed by the Federal government there is more and more anxiety about whether there will be enough primary care providers to take care of all of the new people who will have insurance. Regrettably, the problem may be less severe than previously thought because it now appears that there will be tens of millions who will still be without insurance. One of the solutions to the primary care dilemma is seen in reforming the way physicians are paid.

In March, 2013, The Commonwealth Fund published a brief entitled, "*Paying for Value: Replacing Medicare's Sustainable Growth Rate Formula with Incentives to Improve Care*." The Sustainable Growth Rate (SGR) is the policy which has been in place for the past forty years to control excessive increases in cost of Medicare. The SGR is also what has resulted in the need for the "doc fix." The SGR is the accumulated required decreases in Medicare reimbursement which have been postponed for years. "To fix" the SGR problem there has been a threat of a one-time over 20% decrease in physician payments for treating Medicare beneficiaries. In that the SGR has not worked to control cost and in that such a decrease in reimbursement would make it virtually impossible for Medicare beneficiaries to find care, new methods for controlling cost and maintaining quality have been sought.

On April 16th, in SETMA's providers' monthly training-and-care-improvement meeting the content of the Commonwealth's brief was discussed. The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy.

For 48 years, which is how long Medicare has existed, there have been different payment rules for different providers in different settings. For 30 years, Medicare has "bundled" payments – paid a predetermined lump sum for the treatment of a specific condition regardless of how much it actually cost to treat an individual patient -- for inpatient hospital care with the introduction of diagnosis-related groups (DRGs). Payments have tended to be tied to the volume and intensity

of services provided, with little effort to hold care systems accountable for patients' outcomes or care experiences, much less the total cost of care.

One of the solutions to our health care problem is that for several years, across the nation and particularly with SETMA, there have been efforts to achieve greater transparency in terms of:

- health care quality
- outcomes
- developing value-based purchasing approaches

SETMA's transparency can be reviewed at www.jameslhollymd.com under Public Reporting where SETMA reports by provider name on over 300 quality metrics.

The Commonwealth's March brief elaborated on recommendations made by their Commission on a High Performance Health System in the report entitled, *Confronting Costs: Stabilizing U.S. Health Spending While Moving Toward a High Performance Health Care System.* That report focused on improving provider payment by:

- Strengthening primary care
- Providing incentives for physicians to participate in innovative delivery systems
- Requiring accountability for population outcomes and total costs of care
- Rewarding the adoption of best practices.

The expectation is that these policies would:

- Repeal the Medicare SGR immediately
- Direct all future increases in physician payments to those participating in innovative delivery reforms such as **accountable care organizations**, **patient-centered medical homes**, or similar approaches.
- Recalibrate payment rates for overvalued, or undervalued, services.
- Establish a new way of paying for primary care and care teams that are able to provide high-value, patient-centered care for high-cost beneficiaries across care systems.
- Institute a new bundled payment approach for hospital episodes that includes both hospital and physician services during the initial hospital stay; any related hospital readmissions for 30 days after discharge; and, for selected conditions and procedures, post acute care as well.

New Payments for Primary Care, Health Care Teams, and Innovative Health Care Delivery

The brief recommends that Medicare payment rates would be maintained at their 2012 level (including the 10 percent increase for primary care applied under a provision of the Affordable Care Act) from 2013 through 2023, but additional policies would seek to strengthen primary care and encourage the availability and use of high-cost care management teams, including:

- A modest additional payment per patient per month for primary care providers to deliver services to Medicare beneficiaries who designate those providers as their regular source of care.

- A somewhat larger additional payment per patient per month for providers who qualify as medical homes, with the potential for further bonus payments for high performance on measures of quality and efficiency.

To provide broad-based support to primary care and provider teams, the federal government would encourage states to use similar payment approaches for their Medicaid programs, or Medicare could join state initiatives to adopt innovative payment methods for their Medicaid programs. For physician practices caring for disabled or seriously mentally ill patients, both Medicare and Medicaid could enhance payments in recognition of the need for a multidisciplinary approach and community-based services. The cost of the enhanced payments would likely be offset by reductions in readmissions and the use of hospital emergency departments.

For other physician services, Medicare payment rates would be maintained at their 2012 level from 2013 through 2023, with eligibility for additional payment if practices participate in

- a high-value accountable care organization,
- bundled payment arrangement, or
- other innovative model of health care delivery

that shows promise of encouraging high-value care. As with the primary care policies described above, this policy would be coordinated across Medicare, Medicaid, and private plans participating in the health insurance marketplaces.

Bundled Payment for Hospital Episodes

The following policies would accelerate the application of bundled payment approaches, building on initiatives under way in Medicare and the private sector:

- Bundling all physician services performed at the hospital during the inpatient stay with the hospital DRG payment. This would be a first step to a more comprehensive bundling policy, building on current Medicare demonstrations.
- Including related readmissions in the bundle, building on initiatives already taking place to reduce preventable readmissions.
- Applying this bundled payment approach for hospital episodes to Medicare, Medicaid, and private plans participating in the health insurance marketplaces.
- Payment would be designed to reduce the variation in costs across similar episodes and to provide incentives for providers to adopt best practices and take responsibility for the effectiveness and efficiency of resources used during the episode of care.

Policies designed to strengthen primary care and provide incentives for physicians to participate in innovative models of health care delivery would apply to Medicare and Medicaid as well as to private plans participating in the health insurance marketplaces. If these policies were implemented quickly and effectively, and spread rapidly across the public and private sectors, they have the potential to yield $496 billion in savings from 2013 through 2023, with $345 billion accruing to the federal government, $88 billion to state and local governments, $14 billion to private employers, and $49 billion to households (Exhibit 1).

Instituting the bundled payment policy described above for Medicare, Medicaid, and private plans could generate a cumulative $620 billion in savings in national health spending, with the federal government saving $296 billion, state and local governments $64 billion, private employers $66 billion, and households $194 billion (Exhibit 1).

The potential savings to the federal government from this set of provider payment reforms would be more than enough to completely offset the estimated cost of forgoing the across-the-board cuts required under the SGR formula. These policies not only would reduce Medicare spending but also would address the most important needs of beneficiaries, as well as improve health care and reduce cost growth throughout the health care system.

SETMA endorses the Commonwealth's proposal. In the review of these proposals at SETMA's monthly provider meeting, it was pointed out that the growth and development at SETMA over the past 18 years have prepared SETMA's providers to be read to provide primary care in a medical home setting with high performance on measures of quality and efficiency. With publicly displayed transparency since 2009, SETMA is prepared for this future and can reassure Southeast Texas, that they will always have access to high quality, progressive healthcare.