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Three Emerging Challenges for Sustained Payment and Delivery System Reform

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Introduction

In October 2014, the Robert Wood Johnson Foundation (RWJF) convened grantees and a diverse group of faculty to continue exploration of payment reform design and implementation issues. The grantees and national experts focused on two different topics: best practices in payment reform and new areas of payment reform development that push current boundaries. This brief summarizes three emerging challenges identified during the meeting that will need to be addressed to assure the long-term success of payment and delivery system reform:

- aligning value-based payments to providers with the compensation approaches used by providers with their employed and contracted clinicians;
- addressing social determinants of health in payment reform models; and
- strategically repurposing hospital resources in the face of declining inpatient admissions.

This brief explores each of these issues, providing examples of current activity in each area and identifying issues for future exploration and strategy development.

Readers may access the presentations made throughout the **conference**.

#1 Aligning Alternative Payment with Clinician Compensation

The topic of payment reform has typically been oriented toward the contractual arrangements between payers and providers. As payers and providers increasingly establish financial relationships that create new incentives for quality and efficiency, provider organizations must consider how they translate these incentives to their employees—including both clinicians and non-clinicians. Should provider organizations fail to do so, they run the risk of misaligning incentives and jeopardizing performance under alternative payment models. For example, if a health system enters a shared risk arrangement with a health plan that rewards the system for managing total cost of care and meeting quality outcome targets, but then compensates providers based on the number of units of service that they bill, the system will be rewarding behaviors that diminish its ability to succeed relative to its shared risk arrangement.

RWJF supports several grants testing health care payment reforms, which are managed by AcademyHealth.

AcademyHealth

The impact of compensation on provider behavior has been long studied. For example, in a meta-analysis of 23 U.S. and international studies that reviewed the impact of salary on physician behavior, authors found some evidence that salary is associated with the lowest ordering of tests and referrals compared to fee-for-service and capitation. Salary was also associated with longer consultations and more preventive care.[1]

The methods by which provider organizations compensate their employed and contracted providers were the focus of presentations by Dr. John Walker, Chief Health Enablement Officer of Cornerstone Health Enablement Strategic Solutions; Dr. Dean Gruner, President and CEO of ThedaCare; and Dr. Wells Shoemaker, former Medical Director of the California Association of Physician Groups.

Cornerstone Health

Cornerstone Health is a 240-physician multi-specialty practice located in North Carolina. Operating in a state with little alternative payment model penetration, Cornerstone's physician compensation model is primarily productivity-based. Dr. Walker defined the objectives of Cornerstone's physician compensation model to be:

- reward physicians for their hard work;
- incentivize appropriate productivity goals;
- encourage physicians to engage in behaviors that promote value-based health care;
- reward physicians who care for complex patients;
- reward physicians for quality; and
- reward physicians for controlling the cost of care.

He expressed how difficult it is to achieve such aims, noting several specific challenges. These challenges included the differences among individual clinicians in terms of what motivates them and the high level of emotion that often accompanies the topic of compensation. A third challenge he identified is how to attribute performance for individual patients and panels of physicians—especially as it relates to cost—to individual clinicians.

Cornerstone compensates its primary care physicians with a contractual salary that accounts for 90 percent of their earnings, and then uses a value-based algorithm to distribute organizational fee-for-service revenue that accounts for the remaining 10 percent. Of the funds available for distribution, 70 percent is distributed based on each practice site's contribution to overall organizational profitability. Of the remaining 30 percent (or 3 percent of total fee-for-service revenue), 60 percent (or 1.8 percent of the total FFS revenue) is made available to primary care clinicians serving adults, and 40 percent (or 1.2 percent of the total FFS revenue) is made available to specialists and pediatricians. Cornerstone uses the following formula for distributing these "value" payments to adult primary care practices:

Overall		Detail
Quality	≤40%	Clinical quality measures
Patient Satisfaction:	≤20%	Clinician performance based on Press Ganey survey
Acceptance of New Medicare Patients	≤20%	
Access	≤20%	• Same-day appointments • Emergency room call • Extended office hours

ThedaCare

ThedaCare is a Wisconsin health system with a national reputation for excellence. Dr. Gruner explained that ThedaCare's traditional approach is to mimic the compensation designs used in private practices, focusing on incentives for productivity and profitability, but also introducing a small incentive for quality. Over time, ThedaCare has reoriented the model toward a broader conceptualization of the value that physicians produce. This approach has been introduced with primary care physicians and is being contemplated for specialist physicians. Dr. Gruner shared the design of a potential ThedaCare primary care physician compensation plan for 2015:

Overall		Detail
Production	70%	
Quality	≤20%	≤ 15% clinical quality measures
		≤ 5% patient experience measures
Margin	≤20%	≤ 15% division performance
		≤ 5% system performance
Panel Management	≤10%	• Use of EHR • 100% charts closed within 48 hours • Meeting participation • Minimum panel size or open practice

Under the above model, a physician can generate income worth up to 120 percent of the compensation earned by other physicians in the region. Dr. Gruner explained that ThedaCare was striving for an "ideal state" that balances the inflationary incentives of production-based compensation with the efficiency incentive of total cost of care-based payment. Dr. Gruner advised organizations interested in adopting a value-based compensation to make gradual changes and learn as experience accumulates.

California IPAs and Medical Groups

Dr. Shoemaker shared lessons from 20 years of compensation experimentation in California. He advised that an effective compensation model can't be simple. Like Dr. Gruner, he counseled that the challenge is to find a model that mitigates the shortcomings of volume-based and budget-based compensation models.

Dr. Shoemaker focused on a different type of payment alignment—one between Independent Practice Associations (IPAs) or accountable care organizations and their network providers. Because many IPAs and medical groups in California are capitated, and because many medical groups have contracted networks for their risk contracts, the IPAs and medical groups need to have methods for compensating non-employed direct service providers. In that context, he suggested the following strategies:

Service Type	Recommended Payment Model
Prevention services	Fee-for-service For capitated physicians, a P4P bonus for performance
Chronic care	Capitation
Acute care outpatient	Fee-for-service
Acute inpatient	Capitation to group-contracted hospitalists and/or episode-based payment
Palliative and end-of-life	Episode-based payment

Dr. Shoemaker noted that compensation models for complex care patients—the small percentage who consume a disproportionate share of resources—deserve special attention as care is delivered by specialized teams[2] and may need to incorporate multiple strategies.

While bringing three unique perspectives to the topic, Drs. Walker, Gruner, and Shoemaker demonstrated the increasing focus on harmonizing financial performance incentives as they cascade from payer to provider organization to practitioner. Because insurers and Medicaid programs are implementing alternatives to traditional fee-for-service payment at a measured pace in most states, providers will be reluctant to move their compensation models away from productivity-based models as long as fee-for-service motivates them to increase service volume. As long as providers have a divided focus, changes will move slowly and incrementally.

It also remains to be seen how provider organizations will balance compensation strategies with non-financial strategies to motivate employed physician behavior. There is a body of literature that argues that financial incentives can be detrimental to strong performance, and that intrinsic motivators are much more powerful, particularly for professionals.[3] Some health systems place heavy emphasis on such strategies.[4]

It is anticipated that payment and compensation models will continue to vary by provider type and/or service. It also seems clear that the payment incentives will seek to balance multiple dimensions of performance. While it is expected they will typically consider quality and cost, it is likely the other dimensions will vary in substantive ways. Finally, as all of the presenters noted, successful design and implementation requires active clinician participation throughout the process.

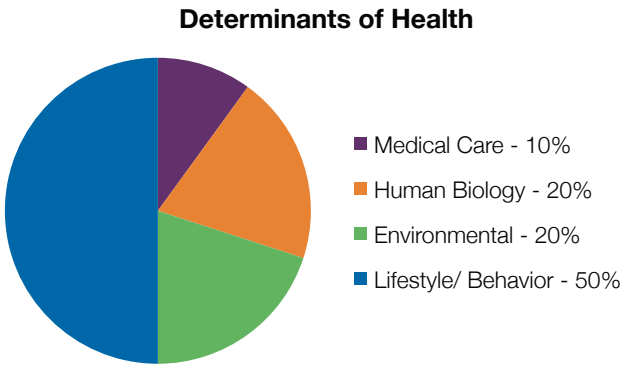
#2 Considering Social Determinants of Health in Payment Reform Models

While the impact of social determinants on health has been long-recognized, there is increasing discussion as payment reform and delivery system initiatives focus on improved connections between the drivers of poor health (socioeconomic disparities), current social needs, health care, and health outcomes. This trend was quite apparent during the course of the October 2014 payment reform meeting. Several speakers focused on the impact of social determinants of health and how they may be addressed within payment reform, including in plenary sessions (Dr. Dana Safran from Blue Cross Blue Shield of Massachusetts and Dr. Karen Hacker from the Allegheny County Health Department) and in multiple breakout sessions (most of these presentations are available here).

The Impact of Social Determinants on Health Status

Throughout the sessions, speakers noted that the relative impact of medical care on health status is rather small. Instead, as shown in Figure 1, health status is impacted mostly by lifestyle/behavior and the environment.

Figure 1: Relative Impact of Factors Determining Health Status in the United States[5]



With this context, it is clear that as states, payers, and providers implement payment reform activities aimed at improving health care outcomes and status while reducing costs, it is essential to consider the impact these social determinants have on health status and to consider how they may be addressed to enable individuals to better engage in their own care.

Access to Health Care and Social Services

Social determinants play an important role across all parts of the health care delivery system, beginning with enrollment. New businesses are emerging to help patients gain access to benefits and services that address these social determinants. A few of these new ventures presented at the meeting.

The session "Treating the Whole Patient: Addressing Social Determinants of Health" focused on models that assist individuals in accessing benefits. There are a number of barriers to accessing benefits, including lack of knowledge, difficulty in completing an application for benefits (cumbersome process, navigation difficulty, mobility and other health-related barriers), and stigma of applying for public benefits. **Benefits Data Trust** (BDT) works with five states to identify individuals who may be eligible for public benefits and help them to submit applications. BDT assists individuals applying for health coverage and for programs such as the Supplemental Nutrition Assistance Program. In Maryland, BDT also helps individuals apply for the Maryland Energy Assistance Program. Their model recognizes that having health coverage is not enough—individuals also need, for example, funding for food which can lead to reduced health care expenses and better health by reducing hypertension, diabetes and cardiovascular risk factors.

Healthify (HTY) is a year-old start-up organization focused on helping care providers and health plan staff address social determinants. For these groups, the difficulty patients experience in obtaining food, childcare, employment, housing, and mental health services can dramatically increase their costs, impede improved outcomes, and reduce case management efficiency. HTY creates a database of validated community-based organizations and services that can be beneficial to staff who are making referrals for individuals they are managing. They also provide a screening and referral system, which captures information on social determinants and automatically matches individuals to appropriate services and benefits. HTY then follows up with texting outreach and reports related to successful referrals. HTY is currently active in New York, Maryland, Florida, and the District of Columbia. They are set to expand to six more states by February 2015.

Medical-Legal Partnership (MLP) brings together practitioners and experts in the disciplines of medicine, public health, and law to identify health-harming legal needs, provide legal care, transform clinical practices, advocate health policies, and improve population health. MLP supports vulnerable and underserved people with legal issues related to income, insurance, housing, education, employment, legal status, end-of-life decisions, intimate partner violence, and family law.[6] There are more than 262 organizations contributing to the MLP movement across the country. James Teufel, MPH, PhD, of Mercyhurst University, noted that MLPs have shown positive social and financial returns on investment and are a scalable and sustainable approach to address health and social inequities.

Risk Adjustment for the Impact of Socioeconomic Variables on Payment and Quality

As payers move to alternative payment methodologies that reward or penalize providers for improving health outcomes, there are a number of questions about whether or not new approaches to payment are needed to enable providers to help serve patients with social and economic barriers to better health, and whether or not (and, if so, how) measurement strategies should be adjusted for the socioeconomic status of patients.

During a session focused on appropriately risk-adjusting payment, moderator Harold Miller noted that cost and quality may well be affected by differences in the *health status* of individual patients. In other words, some individuals require more services than others to attain better health status. Risk adjusters should provide states, payers, and providers with confidence that budgets and payments are appropriate for a particular individual. Two risk adjusters were highlighted during the session: 3M Health Information Systems' proprietary Clinical Risk Groups (CRGs), which provides for specific risk adjustment based on detailed and refined clinical categories, and CMS's publicly-available hierarchical condition categories, administered by RTI, which take into account clinical differences in a general way. While the CRG model utilizes currently available claims information including diagnoses and functional status/social support (e.g., from the Home Health prospective payment data collection), neither model fully accounts for social determinants of health. While long discussed and advocated for among safety net providers, in fact, there is no current widely accepted methodology to risk-adjust payment or quality measures based on socioeconomic variables.

Laura Sisulak and Laurie Francis of the Oregon Primary Care Association provided an overview of how the Federally Qualified Health Centers (FQHCs) in Oregon are piloting an alternative payment advanced care model that will try to incorporate socioeconomic factors. A primary care capitation payment delinks FQHC revenue from face-to-face visits.[7] This frees FQHCs to design and deliver care in new ways. Part of the Primary Care Association's pilot involves designing and testing a socioeconomic risk adjustment methodology.

In addition to the challenges associated with making socioeconomic adjustment to payments, there is disagreement nationally on whether quality measures should be adjusted based on socioeconomic status. Those supporting the notion have argued that providers and health plans serving poor populations are unfairly judged on their quality since socioeconomic factors influence care seeking and health behaviors. Those opposing the idea have contended that, as a nation, we should not accept that low-income populations should reasonably be expected to receive poorer quality health care.

At the RWJF meeting, Dr. Safran argued for same targets regardless of population. Under its Alternative Quality Contract, Blue Cross and Blue Shield of Massachusetts reported that certain providers serving disadvantaged populations have achieved the most improved and highest quality scores. Meeting participants also noted that the National Quality Forum (NQF) has historically rejected the concept of adjustment of quality measures based on socioeconomic status, but an NQF advisory panel recently voted to

endorse adjustments to quality measures in certain circumstances to account for socioeconomic status and other sociodemographic factors. The NQF panel recommended a measure-by-measure determination of the appropriateness of sociodemographic adjustment based on two criteria:

- conceptual relationship between one or more sociodemographic factors and an outcome or process of care reflected in the particular measure; and
- empirical evidence that sociodemographic factors affect a measure.

The panel also developed guidelines for adjustment that require use of some principles for determining if sociodemographic adjustment of specific measures is appropriate. The panel reasoned that confounding will occur whether by clinical factors or socioeconomic factors and that adjustment for socioeconomic-related factors generally doesn't mask poor quality performance for services provided to disadvantaged individuals. In addition, the panel recommended additional steps be taken to minimize unintended consequences—particularly the risk that this adjustment will allow for acceptable lower standards for socially disadvantaged patients. For that reason, the panel recommended that measures be reported both with and without the sociodemographic adjustment.

Next Steps

There is likely to be an increased and ongoing focus on social determinants of health and how addressing those socioeconomic factors can improve health outcomes and reduce health care costs. As new payment models encourage providers to take on increased accountability for the health outcomes of their patients, they will have increased incentive to understand the whole person, including barriers impairing health status that lay outside of the health care delivery system. Health care providers will be motivated to innovate in ways that improve access to non-health care programs and services, adjust payments to reflect variation in socioeconomic status, and ensure that quality measurement fairly and appropriately recognizes the socioeconomic status of their patient populations.

#3 Repurposing Hospital Resources

Health care is increasingly delivered in outpatient, home and other community-based care settings. Payment reform activity across the United States is accelerating this trend, as these new payment models motivate providers to generate savings, in part, by reducing avoidable inpatient hospital and emergency department utilization.

During the meeting, Dr. Safran spoke about how health system providers that have entered risk-based contracts with Blue Cross and Blue Shield of Massachusetts have begun to "repurpose" their facilities. This phenomenon is not specific to Massachusetts. Acute care hospitals are facing increasing pressure to think differently about their service configuration and use of "bricks and mortar" facilities, due to the effects of payment reform and other independent variables. In fact, payment reform is bringing into light a commonly discussed, but seldom-addressed phenomenon: health care services in the United States are often not aligned with population need. There are frequent shortages of some services (e.g., primary care clinicians, child psychiatrists) and excess supply of others (e.g., acute care beds, some medical specialties).

> **"Part of our cost problem is that we have too much."[8]**

In many cases, dropping inpatient volume has caused smaller community and rural hospitals to close or transform. Some hospitals have been converted to other medical uses, such as an urgent care center or office space while, in other cases, the hospital closes entirely. Former hospital competitors often purchase the facility and use it to develop non-inpatient services. For example, St. Joseph's Hospital in Stamford, Connecticut was acquired and closed in the 1990s. The Stamford Health System created a new wellness, outpatient diagnostic, and outpatient surgery center on the old St. Joseph's Hospital site. In other instances, real estate developers renovate the space and use it for non-inpatient medical services, including doctors' offices, dialysis centers and urgent care centers, as well as for non-medical services.[9] Finally, former hospitals are sometimes converted to non-health care uses entirely. In Rogers, Arkansas, St. Mary's Hospital became a center for nonprofits. At Virginia Commonwealth University, a former hospital was converted to student housing.[10]

As services move into outpatient and community-based settings, hospitals are diversifying their delivery systems by moving into the post-acute care delivery continuum to provide services such as home health, hospice and palliative care, and to reposition their inpatient facilities into skilled nursing, rehabilitation, step-down units and transitional care units.[11] Hospitals are also changing their inpatient service offerings to better serve the populations that are covered by risk agreements. For many hospitals, the question is how to reposition resources to remain viable. The stakes are high—the numbers of shuttered hospitals give testimony to the price of failure.

To understand how hospitals can strategically and successfully navigate this changing environment, Kathryn Burke, Vice President of Contracting and Business Development at Mount Auburn Hospital in Cambridge, Massachusetts, offered several insights during an interview following the RWJF meeting. With most of her hospital's revenue at risk or contingent on achieving performance targets, the hospital's view of its mission has changed over time from a place for providing episodic, discrete care with a focus on filling beds to one of being part of a health care delivery

system responsible for caring for a patient population. Knowing that inpatient admissions could drop significantly under risk and value-based contracts, one change Mount Auburn knew it had to address was how to right-size its facilities and to offer the appropriate services to keep populations healthy, while providing necessary services in the most effective settings. To navigate these changes successfully, the hospital has implemented several key steps that others can model:

Create a Shared Leadership Vision: At Mount Auburn Hospital, both the hospital and physician leaders share a similar vision of how to care for communities and are deeply committed to realizing this vision together. This commitment is strengthened by their partnership to develop win-win strategies, such as right-sizing inpatient units even to the point of closing beds, if utilization falls. A collaborative approach to decision-making is part of the hospital's affiliated IPA's culture. For example, the IPA has an active committee structure that enables physicians to participate in decision making.

Know the Data: In order to be successful under risk-based contracts and value-based contracts, the hospital must know very specifically where the opportunities for cost reductions exist by thoroughly understanding the data. Hospitals must ask and answer key questions such as: Where is there overutilization that could be reduced? At what level? What is the plan to reduce the utilization and how likely is it to succeed? What services do patients need that the hospital is not now providing that can reduce costs and improve the health of the patients? Where can we improve quality performance in order to meet quality targets? Is there service leakage to outside providers that should stay within the provider community participating in the risk contract? Why is this occurring and can plans be developed to decrease or eliminate the leakage? What are the metrics of success to measure leakage reduction? In developing the hospital's annual operating budget, the financial staff at Mount Auburn includes expected revenue from all of the hospital's risk contracts and value-based purchasing contracts. To achieve those revenue and quality targets, carefully designed and executed programmatic initiatives to better manage each patient's care are essential.

Build the Repositioning Strategy Based on Hospital Opportunities: Once the hospital understands its opportunities, it can develop a repositioning strategy. Hospitals are generally pursuing two key strategies to address declining admissions: a) growing market share by growing covered lives and/or entering into new partnerships; or b) repurposing excess capacity through offering new services or lower-cost services and closing units.[12] These two strategies may be pursued in combination.

For example, Mercy Gilbert Medical Center in Phoenix closed its pediatric unit, as part of a consolidation of pediatric services among Catholic Healthcare West hospitals with plans to repurpose the area into a short-stay unit for adults and adolescents.[13] Successful repositioning strategies could also include offering new services to optimize savings opportunities under risk contracts. For example, in addition to offering more post-acute services, Mt. Auburn developed a bariatric surgery program because its data indicated that there was a high demand for bariatric surgery, which was going to other hospitals. By keeping the service within the hospital, costs were reduced and post-acute care was closely managed to reduce complications.

The repositioning options must be assessed within the context of the community and the hospital's competitive environment. A hospital in an urban setting in a very competitive environment may have different responses than a hospital that is in a rural area. Moreover, hospitals must take into consideration the sentiments of the community, which may want to block the closure of the hospital.

During 2012, MaineHealth announced it would close a 25-bed hospital and its emergency department (ED) in Boothbay Harbor, Maine. The hospital's ED was seeing an average of 12 patients a day, only 2 of whom needed emergency care. Community opposition was strong and evoked much anger,[14] eventually leading the state to require the hospital ED to be maintained long past the intended closure date.

Invest in Primary Care: Mount Auburn has partnered with its IPA to build primary care capacity and the necessary infrastructure to implement and manage population-based care. The hospital and IPA partner with each other when negotiating contracts with payers so that their strategies and incentives are aligned and mutually supportive. The hospital works very closely with the IPA to understand where costs can be reduced and to assure that initiatives to realize those reductions are in place in the hospital and in providers' practices. Both the hospital and the IPA closely monitor the impact of these initiatives throughout the term of each contract.

The commitment of the provider community to a population-based vision is reinforced when the risk-based contracts generate surplus that is distributed to the provider community. This sends a clear message to the providers that the population-based approach to providing care can be more efficient, less costly, of high quality, and successful.

Successful repurposing of hospital resources must be part of a broader strategy focusing on effective delivery of care. When the strategy is jointly embraced by hospitals and affiliated providers, both can benefit while improving the care delivered to all patients.

Conclusion

Each of these three issues describes the challenges of navigating toward a population-based, whole person-focused delivery system while continuing to receive a significant percentage of payment under a volume-based fee-for-service system. Provider organizations are redesigning their payment models for employed and

contracted providers to break the fee-for-service, volume-based incentives at the delivery level, while retaining sufficient production incentives to assure adequate provider payments. Efforts to include socioeconomic factors in payment models (to either adjust payment levels or quality targets) is a clear recognition that to achieve successful health care reform, health care can no longer be limited to the four walls of provider offices and health care facilities. Finally, delivery system reform is requiring a reallocation of physical resources, which will necessarily have winners and losers. The challenge for hospital leaders is to adopt a strategic approach to repositioning resources that benefits not only the hospital, but broader reform efforts.

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