



# Moving Beyond Fee-for-Service: A Path to Payment Reform From Community Health Plans

*This report highlights how seven ACHP member health plans have established physician payment models that promote value rather than volume. These examples provide a practical guide to payment reform that incorporates quality metrics, shared savings, care coordination and additional desired objectives while reducing reliance on fee-for-service payment. The report also highlights implications for Medicare payment reform.*

## Executive Summary

### The Issue

Much has been written about the myriad challenges inherent in the U.S. health care system, namely that we spend more on care than the majority of developed nations, and yet our population health outcomes lag behind those of other countries. The current payment system for physicians is often cited as a key contributor to the high cost of care<sup>1</sup>, with several factors highlighted as driving the high level of expenditures. These include a reliance on fee-for-service (FFS) reimbursement; reliance on technology and expensive care; and a lack of meaningful data on cost and quality, provided to physicians in a way that allows them to take action.

Meanwhile, the Medicare sustainable growth rate (SGR) formula that was enacted in 1997 has failed to restrain volume growth and has called for negative updates to physician payments in Medicare every year since 2002. Though Congress has provided short-term overrides of those reductions every year since 2003, this has led to a situation where in 2014 the SGR formula will call for a cut of approximately 25 percent to physician payment. There is an increasing awareness that the current payment system is not adequate to meet the demand for affordable cost combined with high-quality care. Committees of jurisdiction in both the House and Senate are now poised to take action, and have reached out to the physician and policy communities to develop alternative approaches.

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<sup>1</sup> Report of the National Commission on Physician Payment Reform, March 2013.

An electronic copy of this report and other resources on ACHP member plan innovations are available at [www.achp.org](http://www.achp.org) or by emailing [innovations@achp.org](mailto:innovations@achp.org).

### *Health Plan Innovations in Payment Reform*

Members of the Alliance of Community Health Plans (ACHP) have been leaders in restructuring physician payment and moving away from FFS for many years. Our health plans have adopted payment reforms in order to align the goals of payers and physicians in keeping people healthy and providing care that is of the highest quality and value. As innovators in different areas of the country, ACHP organizations have developed physician incentive programs that meet the needs of practices and patients in their communities – whether physicians are delivering care as sole proprietors, multispecialty clinics or integrated health systems. One unifying characteristic is the simultaneous focus on quality, efficiency and patient satisfaction.

This brief examines the actions undertaken by seven ACHP member plans to move from FFS payment to payment based on patient-oriented results. All of the plans featured in this brief implemented a thoughtfully planned transition from FFS by working in partnership with the physicians in their communities. This transition includes attention to the infrastructure necessary to successfully implement reform, with transparent information on quality, use, costs and patient characteristics presented in an actionable manner. Building on that infrastructure, payment reform focuses initially on the centrality of primary care.

### *Future Steps*

Based on ACHP plans' experience, we recommend that Medicare physician payment reform follow a clearly phased transition beginning with primary care that incorporates thoughtful attention to the infrastructure needed to support physicians' ability to share accountability for the health and cost of care for their patient populations. As primary care is put in place, specialty care reforms can be developed.

We also recommend that Medicare work to provide transparent, actionable data to physicians. This transition begins with a gradual move away from payment dominated by FFS to payment that incorporates monthly fees (such as care management fees) and performance-based incentives.

## Introduction

The current efforts in both the House and Senate to rectify the structural financing problems in the Medicare sustainable growth rate (SGR)<sup>2</sup> provide a unique opportunity to address the need for more fundamental reform in Medicare physician payments, shifting away from 100 percent fee-for-service (FFS) and toward incentives for quality and value.

Members of the Alliance of Community Health Plans (ACHP) have practical experience in managing comparable reforms. That experience spans a range of models, including prepaid, multispecialty groups as well as broadly

<sup>2</sup> Medicare's sustainable growth rate (SGR) formula was put in place by the Balanced Budget Act of 1997 to limit the growth of Medicare physician-related spending per beneficiary. It was implemented without making needed changes in the underlying fee-for-service payment model. As a result, the formula has failed to restrain growth in spending per beneficiary and the statute has called for negative updates to physician payments every year since 2002. In every year since 2003, Congress has provided short-term overrides of those reductions, most recently for 2013. Since the underlying formula remains in place, those short-term overrides result in larger required payment reductions in future years. For 2014, the formula would call for a cut of approximately 25 percent.

**The Alliance of Community Health Plans (ACHP)** is a national leadership organization bringing together innovative health plans and provider groups that are among America's best at delivering affordable, high-quality coverage and care.

The community-based and regional health plans and provider organizations that make up ACHP's membership provide coverage and care for approximately 16 million Americans. These 22 organizations focus on improving the health of the communities they serve and are on the leading edge of innovations in affordability and quality of care.

To learn more about ACHP, visit us at [www.achp.org](http://www.achp.org).

based networks in which the member plans developed new relationships and payment approaches with physicians who have traditionally operated in the FFS environment – changes similar to what Medicare is confronting today. These models are working at scale and reflect care delivered to millions of members in multiple markets. Our experience, focusing on the “how-to” of implementation, is that payment reform must be phased-in and linked to efforts to create a higher degree of integration and collaboration among payers and physicians.

We recommend that Medicare physician payment reform follow a clearly phased transition incorporating several key elements that build the capacity, trust and incentives for reform:

- Infrastructure and transparency: Reform begins with attention to the capacity to incorporate and use information to implement reform successfully. Information on quality, use, costs and patients should be captured and presented in a manner that is transparent, trusted and actionable by practitioners and useful for patients in making decisions.
- Phased transition, starting with primary care: Building on that infrastructure, reform focuses initially on the centrality of primary care, with a carefully phased transition of payments from the current FFS system to new payment models that increase flexibility, reward better outcomes on critical measures and diminish the incentives to increase volume of services. As primary care reform is put in place, specialty care payment and population-based reforms should follow closely behind.

This brief outlines specific approaches that seven ACHP member plans have undertaken to incorporate these key elements. It is meant to serve as an illustrative guide for policymakers and others looking to implement physician payment reform.

### I. Infrastructure and Transparency

Members of the Alliance of Community Health Plans (ACHP) have determined through experience that change is successful only when the capacity to incorporate and use actionable information is in place in both the private and public sectors.

- Reform requires commitment to developing metrics on quality, use and costs that are meaningful to patients and physicians.
- Reform requires extensive physician involvement from the beginning, on everything from measure selection to data aggregation and attribution. Payment change will not work if buy-in and trust are not established.
- Comparison of performance drives change, and its accuracy and credibility for physicians depends on appropriate risk adjustment.

A commitment to transparency is necessary for practitioners, patients and communities.

- Transparency begins with the process of developing measures and associated payment changes in partnership with physicians. Executing this process is critical to the success and sustainability of resulting measurement sets and reforms.
- Transparency requires that the resulting information is presented in ways that are meaningful for all involved.
- Relevant and credible data are necessary but not sufficient. The critical step is to develop mechanisms to turn the data into useful and actionable information, with valid comparisons and identification of improvement opportunities.

## I. Infrastructure and Transparency

In the context of efforts to deliver high performance at a lower cost, patients and communities have a right to expect information on physician performance to make more informed decisions about care.

The information must include metrics on the total cost of care and use of resources, with appropriate comparisons, so that use and costs can be assessed and acted on at the same time as quality, service and health outcomes.

The importance of building relationships with physicians over time cannot be overstated. Physician buy-in to new payment arrangements that are aligned with outcomes measures is an essential component of payment reform. Such buy-in includes on-the-ground work with physicians to explain and benchmark performance, along with participation from other community stakeholders to ensure broad support and buy-in to the metrics used for incentives. Absent the hard work of developing those relationships – providing the information needed to promote success and align incentives between payer and provider – payment reform is not likely to be successful. These connections have been a successful means of drawing a credible connection between aligned payment models, measures of clinical quality, patient experience and the ideal of professionalism held by the great majority of physicians.

One way to engender trust is to acknowledge and solicit the leadership of physicians in identifying clinical needs for the community and developing the programs to address these needs. Economic alignment should proceed in parallel with clinical alignment.

The plan profiles that follow provide specific examples of how to build the appropriate infrastructure and transparency needed for success, the centrality of primary care in the payment transition and models for a phased transition from FFS to results-oriented payment.

### *Lessons on Infrastructure and Transparency*

**Priority Health** (Grand Rapids, Michigan) provides a comparative, provider organization-level dashboard report that details the provider organization's risk-adjusted assessments of the total cost of care, a series of cost of utilization measures and the total quality index, which is shared across the participating practices. The dashboard shown in Figure 1 rank-orders the practices by the risk-adjusted total cost of care<sup>3</sup>, and allows the plan and individual groups to understand and act on the information. For example, network groups S and O, at the bottom of the chart, are informed that they have the worst total cost of care rankings – and where those shortfalls lie – as well as poor quality scores, and should be directed to several of the better-performing groups to learn best practices in these areas. Network group J, at the top of the chart, has the best total cost of care ranking but does not report quality scores, meriting a special review. Most network groups have areas of both high and low performance. Group T, for example, does well on the total cost of care measure but has problems with readmissions, providing an appropriate area of focus.

<sup>3</sup> Total Cost of Care is the sum of total medical claims, total pharmacy claims, provider incentive payments and physician organization administrative fees. Claims include all paid, withhold and member liability dollars.

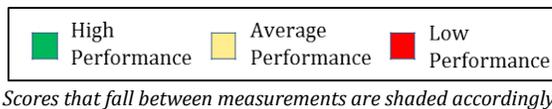
“ I understand the wariness and skepticism that some physicians have about value-based payment because I once shared it. I have come to understand, however, that **value-based** payment systems – if built thoughtfully and properly – can be not only workable but **desirable** for physicians and an accelerant of **improved health, better experiences and improved affordability** for patients. ”

**Patrick Courneya, M.D.**  
Medical Director, HealthPartners  
Testimony before Congress, May 2013

**FIGURE 1: PRIORITY HEALTH TOTAL COST OF CARE DASHBOARD REPORT**

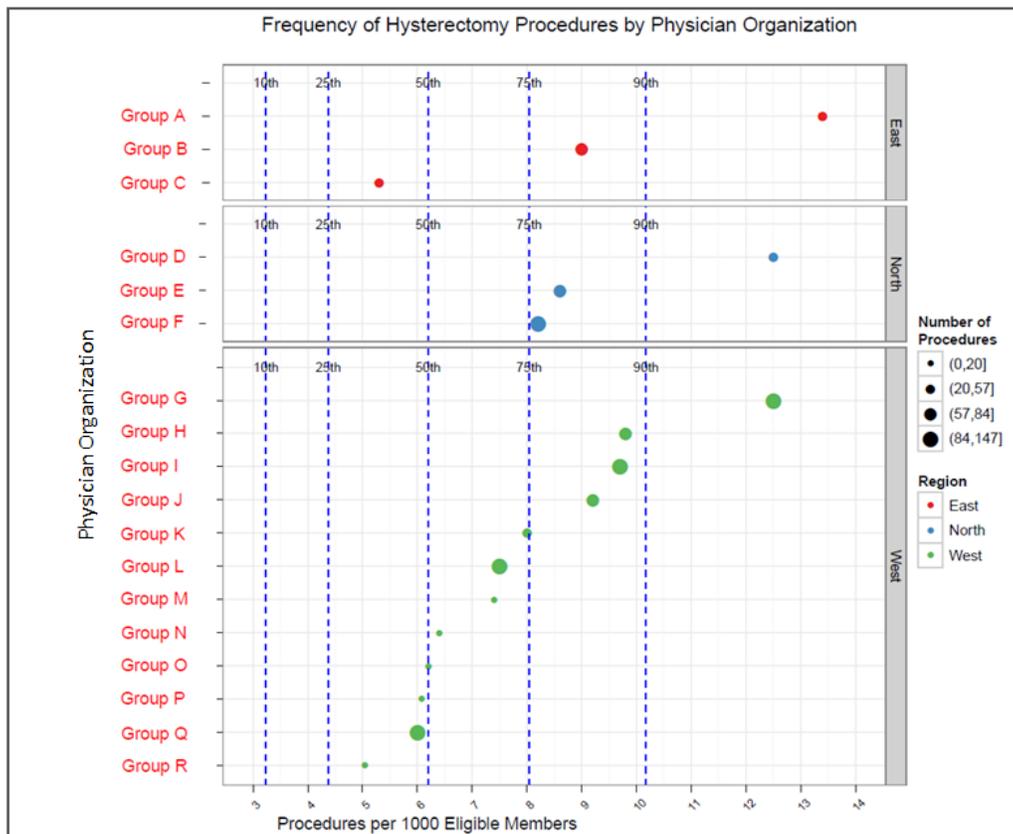
Accountable Care Network	Risk Score	Total Cost of Care	Adm / 1000	Cost per Adm	Readm Rate	OP Fac Cost PMPM	OP Surg Cost PMPM	OP Lab Cost PMPM	ER Visit / 1000	Spec Cost PMPM	2011 Quality Index
Group J	1.25	0.89	0.92	0.98	1.02	0.73	0.82	0.9	0.74	0.94	
Group I	1.27	0.91	0.94	0.91	0.71	0.86	0.87	0.56	1.03	0.96	0.96
Group T	1.76	0.91	0.89	1.06	1.18	0.85	0.89	0.53	0.79	0.92	0.93
Group B	0.96	0.91	1.18	0.83	0.68	0.83	0.87	0.73	1.04	0.87	1
Group G	1.22	0.94	0.82	1	0.74	1.01	1.07	1.19	1.08	0.98	1.02
Group D	1.02	0.98	1.12	0.91	0.77	0.86	0.85	0.95	0.87	0.97	1.03
Group H	1.18	0.99	0.88	1.07	0.75	0.9	1.07	0.85	0.98	1.18	0.85
Group N	1.13	1.03	1.22	1	0.89	0.92	0.81	1.15	0.96	0.94	1
Group S	1.06	1.28	0.98	1.18	0.88	1.74	1.29	2.32	1.17	1.14	0.8
Group O	0.86	1.39	1.09	1.17	0.88	1.64	1.45	2.43	1.44	1.46	0.36

\*Chart does not include full set of Priority Health network groups.



Priority Health couples this information with reports about performance on specific clinical procedures, allowing each organization to understand its care patterns in comparison with similar organizations in the community and region. An example is provided for hysterectomies in Figure 2, allowing the physicians in groups H, I and J in the western region to learn why their frequency of hysterectomies is so much higher than that of group R.

**FIGURE 2: VARIATION IN CLINICAL PERFORMANCE: PRIORITY HEALTH FREQUENCY OF HYSTERECTOMY PROCEDURES**



**HealthPartners** (Minneapolis, Minnesota) helped found Minnesota Community Measurement (MNCM) in 2000 to foster a community-wide collaboration on development and implementation of quality metrics. Patients, plans and providers now benefit from comprehensive comparative metrics on performance that are shared publicly. Provider groups can use this information to identify opportunities for improvement. For example, in reviewing Figure 3, HealthPartners medical group and clinics could work to understand why they meet all of the high performance standards except the colorectal cancer screening measure and focus on improving that screening. Consumers can observe the rankings for each group as they select plans and providers.

**FIGURE 3: MINNESOTA COMMUNITY MEASURES  
HIGH-PERFORMING MEDICAL GROUPS IN 2011 - PRIMARY CARE**

Measure	HealthPartners Clinics 13 out of 15	CentraCare Health Systems 10 out of 15	Health East Clinics 9 out of 15	Park Nicollet Health Services 9 out of 15	Affiliated Community Medical Centers 8 out of 15	HealthPartners Central MN Clinics 8 out of 15	Allina Medical Clinic 7 out of 15	Family Health Services of Minnesota 7 out of 15
ADHD	●	●		●	●	●	●	
Breast Cancer Screening	●							●
Bronchitis	●	●	●	●	●	●		
Cervical Cancer Screening	●	●			●			
Childhood Immunization Status (Combo 3)	●	●	●	●		●	●	●
Chlamydia Screening	●	●	●	●	●	●		●
Colorectal Cancer Screening			●	●	●	●	●	●
Controlling High Blood Pressure	●			●				
COPD	●	●	●	●		●	●	
Pharyngitis	●	●	●					
Optimal Asthma Care- Children	●	●	●					●
Optimal Asthma Care- Adults	●	●	●	●	●		●	●
Optimal Diabetes Care	●		●	●	●	●	●	●
Optimal Vascular Care	●	●			●	●	●	
URI								

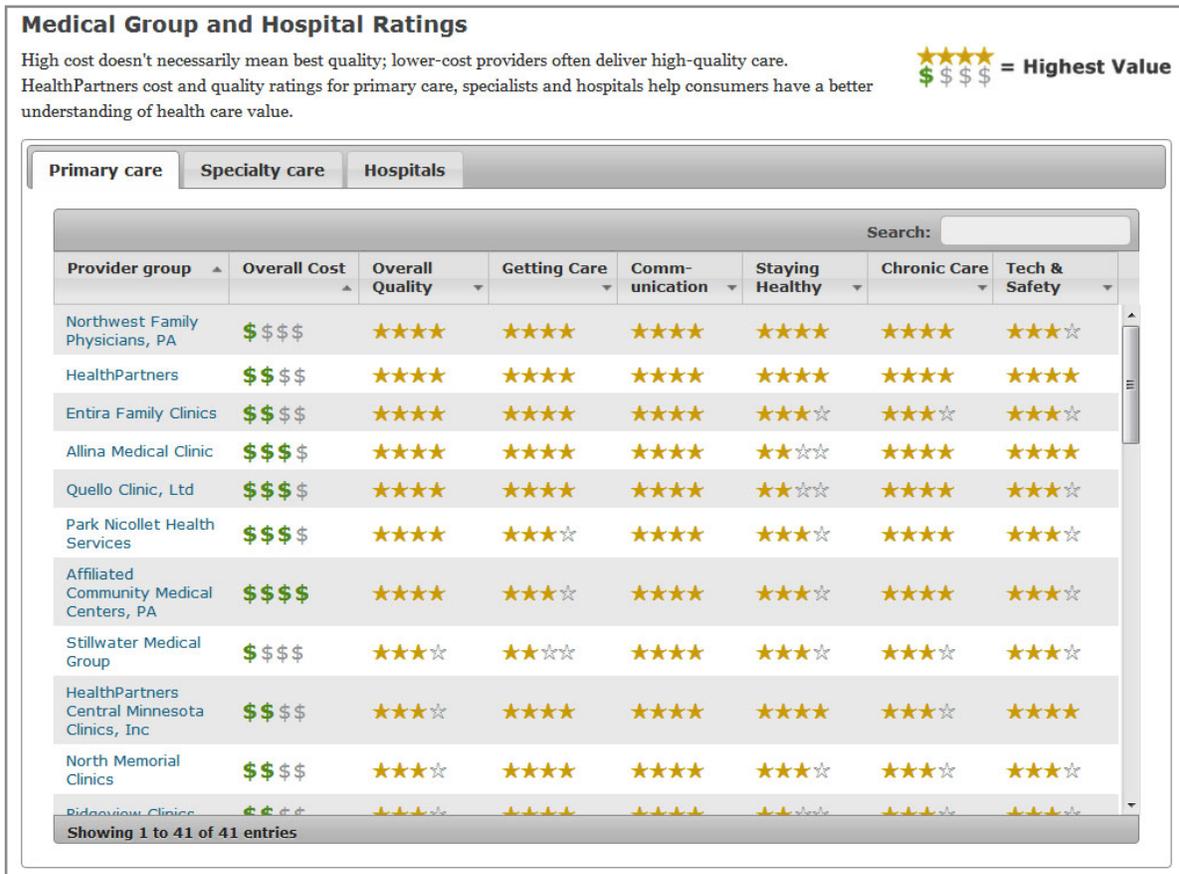
HealthPartners pioneered the development of a Total Cost Index and Resource Use Index<sup>4</sup>. On its website, HealthPartners posts group and hospital-specific quality, cost and service ratings for primary care, selected specialty services and hospital care<sup>5</sup>.

In 2012, the National Quality Forum endorsed this population-based Total Cost of Care measure and the companion Resource Use Measure. MNCM, a multi-stakeholder collaborative, has adopted the total cost of care measurement approach and is currently in the process of piloting data collection with the health plans with the goal of reporting in 2014. An example for primary care is provided in Figure 4. The information makes clear for consumers and providers that Northwest Family Physicians performs best on the overall cost metric and performs well on quality and service measures.

4 HealthPartners®, *Total Cost of Care and Resources Use (TCOC)*, <http://www.healthpartners.com/public/tcoc> (September 2013).

5 HealthPartners®, *Cost and quality ratings*, <http://www.healthpartners.com/public/cost-and-quality/index.html> (September 2013).

**FIGURE 4: HEALTHPARTNERS TOTAL COST INDEX AND RESOURCE USE INDEX**



HealthPartners then provides each medical group with more detailed, actionable information on the group's specific care patterns, as well as the patterns for providers within the group.

Within each group, the measures are available to each individual practitioner so that individual and professional colleagues can work to understand and act on the variations, as shown in Figure 5 for provider X.

**FIGURE 5: HEALTHPARTNERS UTILIZATION MEASURES**

		Utilization Measures			
	Acuity Index	E&M Count Index (Total)	E&M Count Index (Primary Care)	E&M Count Index (Specialty Care)	Lab/PathCount Index
Provider X	1.03	0.97	0.92	1.01	1.07
State Average	1.00	1.00	1.00	1.00	1.00

High Cost Utilization Measures			
	Admit Count Index	ER Count Index	High Tech Radiology Services Count Index (non-ER)
Provider X	1.00	0.92	1.07
State Average	1.00	1.00	1.00

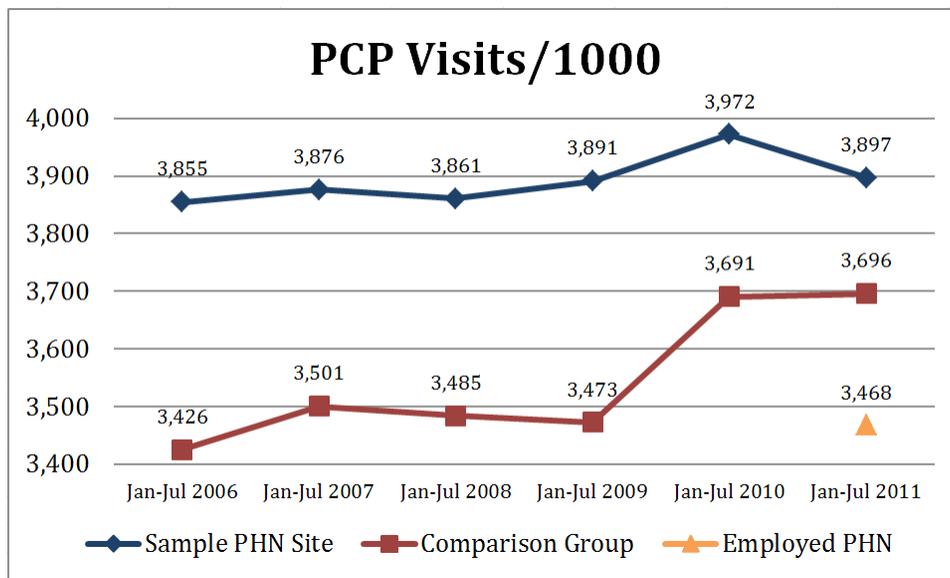
## I. Infrastructure and Transparency

Beginning in 2009, HealthPartners introduced new shared savings payment agreements, using the HealthPartners total cost of care measures as the foundation. The shared savings approach requires providers to maintain or improve quality and experience performance while improving costs. Quality measures are preferentially sourced from MNM and augmented with other HealthPartners measures. In the first year, HealthPartners included only physician groups judged to be the most advanced and most likely to succeed with this new model. Each year since, more groups have joined this payment structure and now over 80 percent of HealthPartners' members seek care at clinics paid in this new way.

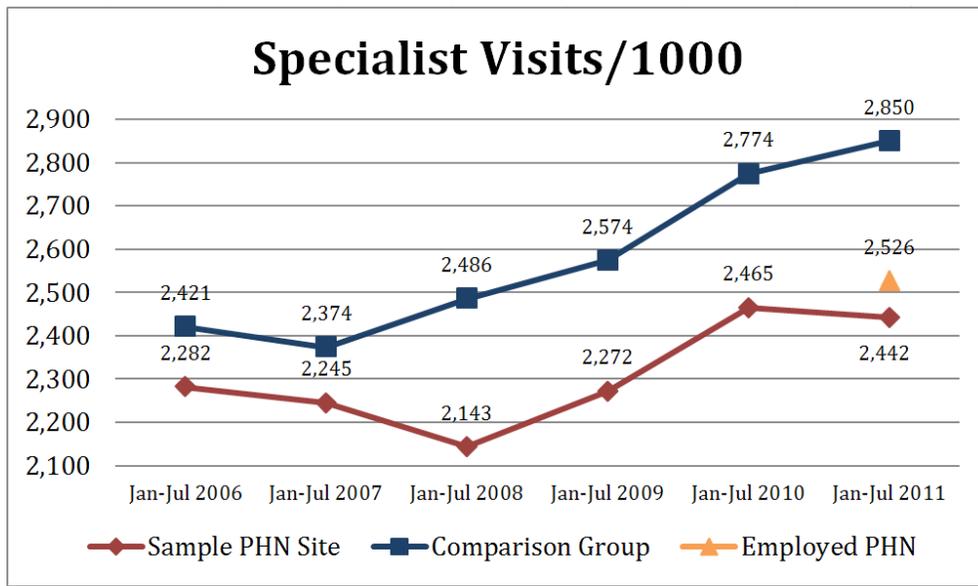
Success depends on a partnership model that includes analytics support and collaboration on clinical and operational work that gives physicians information and tools they can use to perform well financially while they continue to deliver results on the clinical and experience dimensions. Groups included in the model range from large multispecialty hospital-affiliated groups with over 1,500 physicians to much smaller, single-specialty unaffiliated primary care groups. Testing of the measure over time indicates that patient populations as small as 600 produce results reliable enough to serve as a foundation for this type of agreement. Current agreements have kept patient populations to a minimum of 1,000.

**Geisinger Health Plan's** (Danville, Pennsylvania) ProvenHealth Navigator® (PHN) approach provides comparative information on trends for each care site, illustrating that site's trends as well as the trends from its comparison group. The reports cover a comprehensive range of information on use and per member per month (PMPM) costs for admissions, and different types of physician visits and pharmacy data attributed to that care site's provider group. An example of the reports on primary care physician and specialist visits per 1000 is shown in Figure 6, allowing the plan and this primary care site to understand both its primary care and specialty visit rates and trends related to a comparison group.

**FIGURE 6: GEISINGER PRIMARY CARE VISITS AND SPECIALTY VISIT REPORTS**



**FIGURE 6: GEISINGER PRIMARY CARE VISITS AND SPECIALTY VISIT REPORTS**



In all of these examples, representatives from the health plan commit to meeting regularly with physician groups to review these reports, both to ensure the groups understand the information and to support them in developing action plans for improvement. It is not enough to simply provide the data – payers also need to work with physicians to help them translate the data into actionable information.

## II. Phased Transition, Starting With Primary Care

Because the primary care physician should be at the center of a system that is responsible for the health of a defined total population, members of the Alliance of Community Health Plans (ACHP) have focused initially on the transformation of primary care.

- It is important to first provide credible, comparative information that allows practices to understand and act on their quality and cost performance and respond to the evolving incentives.
- Revised payment approaches are phased in over a number of years, building from and typically retaining an element of fee-for-service (FFS) payment. The models then pay a growing share of overall costs with various blends of payments, including care management fees; per member per month (PMPM) payments; risk-adjusted performance payments based on quality, service and total cost of care, using measures of the type noted in the previous section; and in some circumstances, a withhold of payment until certain results are achieved.
- While details vary from market to market, all the ACHP plans’ models operate on the principle of diminishing share of payment depending on FFS and a growing share based on performance across cost, experience and clinical quality metrics.
- A key element is financing and investment that motivates the practice to build practice management infrastructure, including nurse management and other skilled staff as caregivers and managers.

As primary care reform is more fully implemented with additional providers, leading plans are turning to pilots and tests of payment reform approaches for specialty care and the total care provided for a population.

## II. Phased Transition, Starting with Primary Care

### *Lessons on Phased Transition, Starting With Primary Care*

**Independent Health** (Buffalo, New York) has spent a great deal of time building a coalition of respected, high-performing primary care physicians who work collaboratively with each other, specialty physicians and other providers to improve the health of the population. This coalition and its approach to health care delivery is known as Primary Connections<sup>SM</sup>. It is a physician-led, physician-driven initiative, with the health plan as facilitator and collaborator, that has phased in a hybrid reimbursement model for primary care practices, combining three elements:

- FFS for preventive services, in-office procedures and lab tests and immunizations.
- Prepaid, risk-adjusted monthly care coordination fee to include additional FFS services (e.g. Evaluation & Management services directed toward the management of acute and chronic conditions, revisits) other than those above, and enhanced to help capitalize practices' investment in the development of new care systems and skilled ancillary staffing.
- The potential to share in savings based on meeting quality thresholds and total cost of care savings targets for attributed patients.

Independent Health phased in the model in three stages starting in 2011. The first phase included continuation of the traditional FFS reimbursement model for primary care physicians, with an added and enhanced component of pay-for-performance based upon quality. In the second phase, FFS was retained only for those services for which enhanced utilization was encouraged (e.g. preventive health visits, immunizations, in-office lab tests and minor procedures), with the remaining balance of FFS revenue converted to a monthly, risk-adjusted, population-based care management fee; the previously mentioned quality incentive was maintained. In the third phase of the program, a shared savings opportunity (upside risk only) was added.

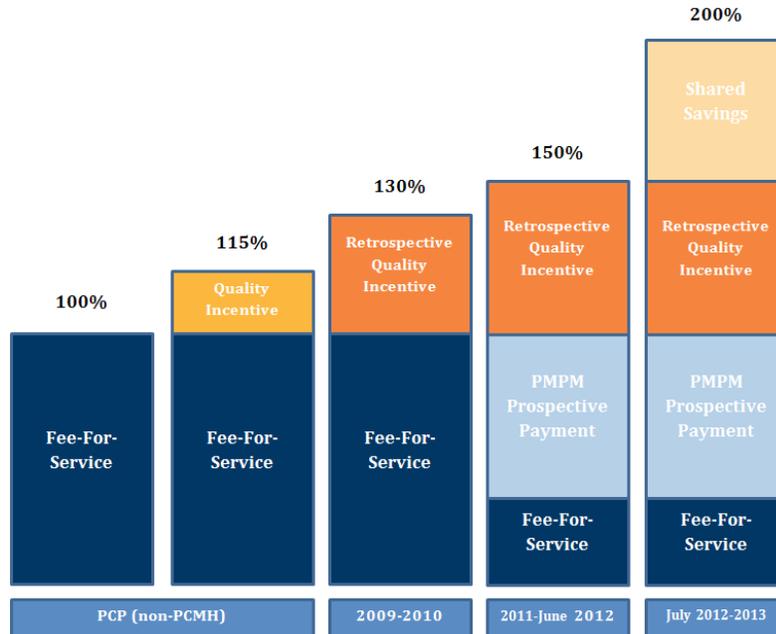
Throughout each of these phases, overall reimbursement opportunity for primary care physicians was increased. By the final phase of the program, a primary care physician's maximum reimbursement opportunity is nearly twice that of what had existed under a traditional FFS system alone. The model is portrayed in Figure 7. Of note are the ripple effects that have been seen in the Buffalo physicians as a result of the work of Primary Connections<sup>SM</sup>.

The development of the shared savings model has had a dramatic effect on the interaction of primary care practices with one another, as well as generating meaningful engagement with specialists. Since shared savings opportunities are dependent upon the performance of specialists, collaborative efforts with cardiology, gastroenterology, neurology, radiology and orthopedics with the referring primary care physician have emerged. This engagement has included efficiency and quality data reporting of specialty practices with primary care practices, as well as complete transparency among and within the specialty community. Specialty practices have now begun to compete for primary care referrals based upon published efficiency and effectiveness scores, work within their practices to eliminate non value-added procedures and tests, and work to address avoidable hospital admissions and readmissions, reduce duplicative services and testing, prescribe generic medications where appropriate, and enhance service attributes, care coordination and communication with referring primary care physicians<sup>6</sup>.

The impact of these improvement efforts is now evident across the region's competing hospital systems as well. Since differences within negotiated hospital contract rates directly influence those specialties that are heavily hospital-based, high-cost facilities risk disenfranchisement by specialties eager to improve their published efficiency indexes and willing to relocate their facility-based procedures and admissions to other more cost-effective hospitals.

<sup>6</sup> Thomas J. Foels, M.D., "Hearing on Reforming SGR: Prioritizing Quality in a Modernized Physician Payment System," Committee on Energy and Commerce Subcommittee on Health, United States House of Representatives, 5 June 2013.

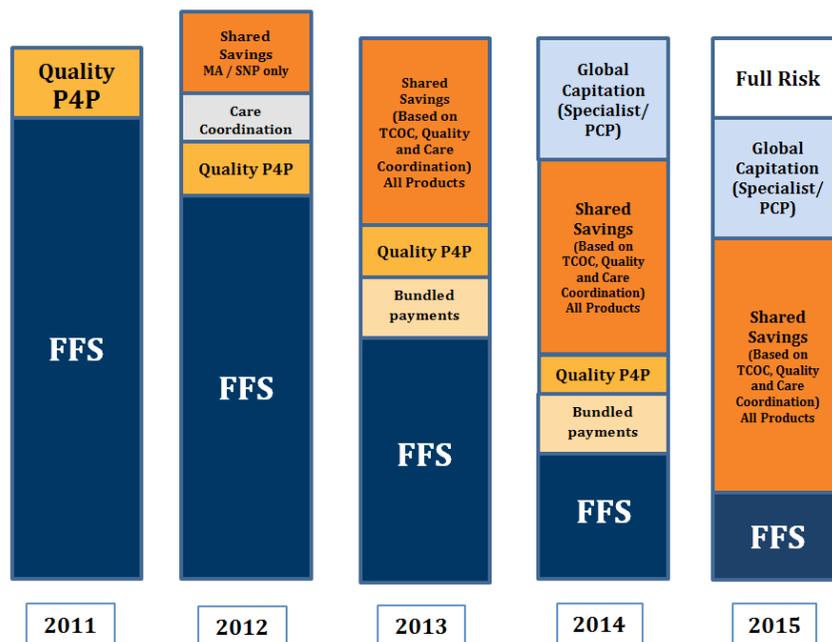
**FIGURE 7: INDEPENDENT HEALTH PHASED TRANSITION TO PAYMENT REFORM**



**UPMC Health Plan** (Pittsburgh, Pennsylvania) is also phasing in a reformed payment strategy for primary care. UPMC’s payment reform strategy was initiated in 2006 with the addition of a quality-based payment for performance bonus on top of FFS payments. Since 2011, UPMC added both a management fee and a shared savings opportunity for improved care coordination and care management. With initial improvement in the total cost of care, quality results and care coordination in 2012, implementation of shared savings was advanced to all products in 2013. In addition, high-quality scores must now be maintained to share in any financial opportunity model.

UPMC envisions a reduced reimbursement portion for FFS payments, while increasing shared savings models and instituting fixed payment models (bundled payments, risk and capitation) over the next two to three years. UPMC’s payment transition over five years is portrayed in Figure 8.

**FIGURE 8: UPMC PHASED TRANSITION TO PAYMENT REFORM**



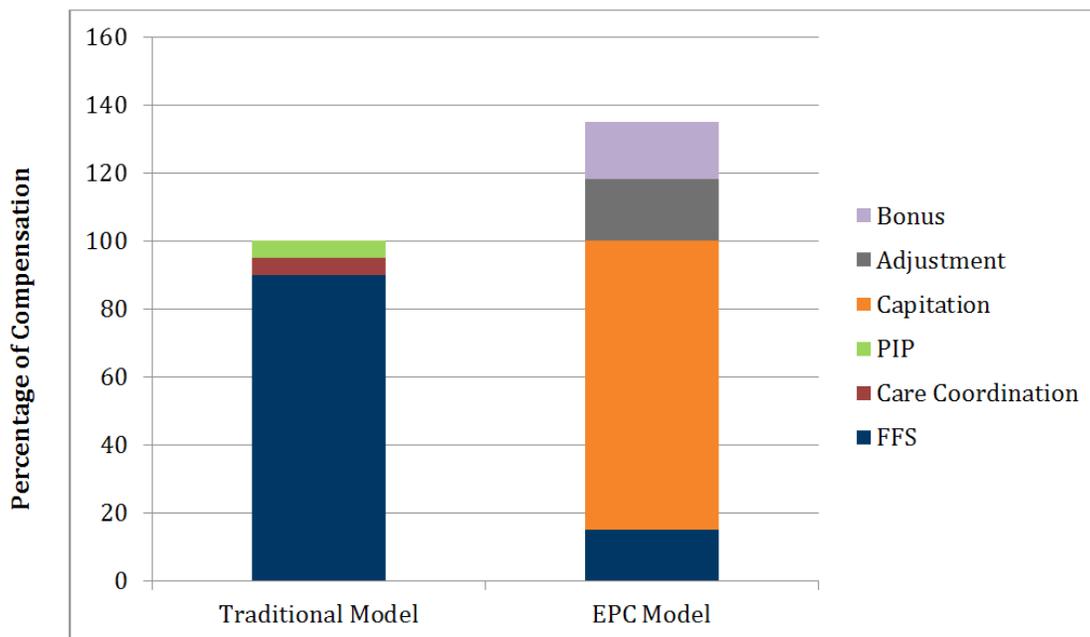
## II. Phased Transition, Starting with Primary Care

**Capital District Physicians' Health Plan (CDPHP)** (Albany, New York): Starting in 2008, CDPHP invested over \$10 million assisting practices with transformation to a patient-centered medical home model of care, later called Enhanced Primary Care (EPC), the acquisition of electronic medical records and its achievement of meaningful use. CDPHP also deployed on a selective basis its nurse care managers, pharmacists and behavioral health workers directly into EPC practices.

The plan began with an initial pilot of three practices, and over a two-year period of time was able to demonstrate an improvement in 14 of 18 specific quality metrics, a 15 percent reduction in hospital utilization, a 9 percent reduction in emergency department usage and a 7 percent reduction in the use of advanced imaging. All of this resulted in an \$8 PPM savings in total health care costs.

On the strength of these early data, CDPHP expanded its EPC program by establishing training programs for selected practices lasting 12 months and requiring significant commitment of time and effort as they learned the basics of EPC. Once the practices complete this program they are eligible for an enhanced payment from CDPHP that provides them an opportunity to enhance their income up to 35 percent, on average. As shown in Figure 9, this payment model features a substantial shift, first to small care coordination and performance-based payments, and then to a substantial decline in the portion paid through FFS with risk adjusted capitation and pay-for-performance bonuses providing the bulk of the new financing. There are currently 200 practices representing 850 providers and 212,000 members in CDPHP's EPC program.

**FIGURE 9: CDPHP EPC MODEL VS. TRADITIONAL MODEL**



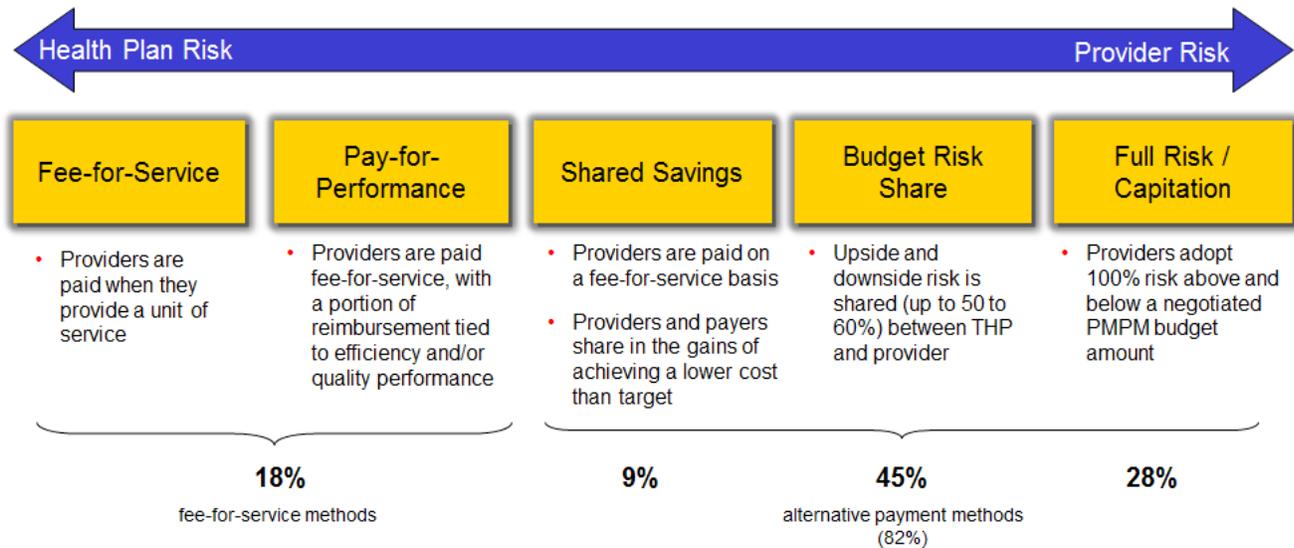
**Tufts Health Plan's** (Watertown, Massachusetts) value-based global payment strategy is based on a systematic approach that engages both providers and patients in health care decisions. The Coordinated Care Model is a three-pronged approach that focuses on the alignment of behavior through provider engagement, product design and care management. Provider engagement creates a collaborative alignment around an appropriate level of financial risk – shared vs. full – based on a group's readiness to assume risk.

Tufts Health Plan assesses each group's readiness to assume risk along several attributes. Groups must possess appropriate levels of physician leadership, system integration and cultural alignment and internal provider

incentive structures. The plan also looks at organizational infrastructure related to primary care access, referral management approaches, care management capabilities and data and analytic capacities. Appropriate risk motivation and alignment along these attributes are used as determinants of likely success under a risk-based contract. This construct informs the plan’s decision on the appropriate level of initial risk and the progressive increases in risk shared by the provider.

Figure 10 displays the continuum of shared risk, and its alignment with physician payment at Tufts Health Plan.

**FIGURE 10: TUFTS HEALTH PLAN VALUE-BASED GLOBAL PAYMENT STRATEGY**



*Phased Transition - Beyond Primary Care to Specialty Care*

Following closely on the heels of transition in primary care are payment innovations in specialty care. ACHP plans are currently actively engaged in developing new models for payment to specialists, in partnership with specialty physicians in their communities. We briefly profile two below.

**Priority Health** built on its pioneering work in payment reform and is now testing an **oncology medical home** model with three elements:

- Payment reforms, including a standard care management fee independent of cancer type, stage or treatment in exchange for payment for drugs at acquisition costs.
- An enhanced \$1,500 per physician per year infrastructure development fee; payments for treatment planning, genetic counseling and advance care planning; and shared savings for reductions in emergency department visits and hospitalizations.
- Care reforms including adherence to preferred regimens for breast, lung and colon cancer; implementation of advance care planning within 60 days of initiation of chemotherapy for metastatic disease; and redesign of triage and enhanced triage protocols.

Priority Health has piloted this model with five practices, and early results are encouraging. Both patients and oncologists are more satisfied, advance care planning has been successfully implemented and initial cost savings resulting from a 24 percent reduction in emergency department visits have been shared with the practices. Priority

## Conclusion

Health plans to continue the pilot for another year before expanding it to additional oncology practices.

**Geisinger Health Plan** is implementing pilot programs to integrate specialty care with its primary care medical home. It is testing different approaches to selected problems in four specialty areas: **endocrinology, nephrology, rheumatology** and **pulmonology**.

One approach in these models is the development of “triggers and pathways” to identify populations at various levels of risk, and the appropriate care pathway and accountability for those at different levels of risk. Geisinger is piloting this approach with endocrinologists for diabetes and nephrologists for hypertension. For example, in the case of diabetes, the protocol assigns:

- Continuing accountability for the patient to the primary care provider in the case of individuals at low risk for diabetes;
- Accountability for the patient to the health manager (nurse practitioner) in the practice for those at moderate risk; and
- Accountability for the patient to endocrinologists for those at the highest risk.

Geisinger is also developing protocols for enhancing communications and models of care with rheumatology and pulmonary medicine.

## Conclusion

These models reflect seven Alliance of Community Health Plans (ACHP) member organizations. Many other ACHP members are also implementing alternative models to fee-for-service (FFS) for both primary care and specialty physicians. All of our members recognize the importance of linking payment to meaningful measures, involving physicians in the design of new models and ensuring quality patient care is a key driver behind all payment innovation.

Given the on-the-ground experience of many of our members, ACHP recommends that any approach to Medicare physician payment reform include the following:

- Infrastructure and transparency: Reform begins with attention to the capacity to incorporate and use information to implement reform successfully, with transparent information on quality, use, costs and patient characteristics presented in a manner that is trusted and actionable.
- Phased transition, starting with primary care: Building on that infrastructure, reform should focus initially on primary care, with a carefully phased transition of payments from the current FFS system to incorporate monthly fees and performance-based incentives. As primary care reform is put in place, specialty care payment reforms can be developed.

As Medicare and other payers consider physician payment reform, there are several additional implications from the examples reviewed in this brief:

- Prospective, risk-adjusted, population-based care coordination fees (distributed on a per member per month basis) give practices the freedom to tailor their care services to member needs and free them from dependency upon face-to-face interactions.
- Virtual high-performing networks have the potential to emerge organically under the influence of properly designed alternative payment systems. Novel reimbursement programs focused on greater

responsibility of the primary care team can have important ripple effects across the broader delivery system. Shared savings programs, even when limited to primary care practices, can have a dramatic impact on the engagement of other important segments of the provider community (specialists and hospitals) and help communities move toward greater efficiency and effectiveness of health care delivery.

- FFS remains a valuable mechanism to promote utilization of important and potentially underutilized services, including preventive services.

No singular payment system is sufficient to simultaneously promote quality, efficiency and effectiveness. A hybrid approach that balances the best attributes of various payment systems, based upon operational ease and transparent methodologies, is most likely to be effective at aligning incentives with performance.

The existing models of care delivery and reimbursement featured in this brief are potentially scalable and transferable to other settings. Payment reform that truly changes the trajectory of health care costs in the U.S. is dependent on changes made at a national level, as well as at the community level. We hope that the recommendations and examples provided in this brief can serve as important catalysts for change at both levels in the coming years.

### ACHP MEMBER ORGANIZATIONS

<p><b>Capital District Physicians' Health Plan</b> Albany, New York - <a href="http://www.cdphp.com">www.cdphp.com</a></p>		<p><b>Martin's Point Health Care</b> Portland, Maine - <a href="http://www.martinspoint.org">www.martinspoint.org</a></p>	
<p><b>Capital Health Plan</b> Tallahassee, Florida - <a href="http://www.capitalhealth.com">www.capitalhealth.com</a></p>		<p><b>New West Health Services</b> Helena, Montana - <a href="http://www.newwesthealth.com">www.newwesthealth.com</a></p>	
<p><b>CareOregon</b> Portland, Oregon - <a href="http://www.careoregon.org">www.careoregon.org</a></p>		<p><b>Presbyterian Health Plan</b> Albuquerque, New Mexico <a href="http://www.phs.org/phs/healthplans">www.phs.org/phs/healthplans</a></p>	
<p><b>Fallon Community Health Plan</b> Worcester, Massachusetts - <a href="http://www.fchp.org">www.fchp.org</a></p>		<p><b>Priority Health</b> Grand Rapids, Michigan - <a href="http://www.priorityhealth.com">www.priorityhealth.com</a></p>	
<p><b>Geisinger Health Plan</b> Danville, Pennsylvania - <a href="http://www.thehealthplan.com">www.thehealthplan.com</a></p>		<p><b>Rocky Mountain Health Plans</b> Grand Junction, Colorado - <a href="http://www.rmhp.org">www.rmhp.org</a></p>	
<p><b>Group Health Cooperative</b> Seattle, Washington - <a href="http://www.ghc.org">www.ghc.org</a></p>		<p><b>Scott &amp; White Health Plan</b> Temple, Texas - <a href="http://www.swhp.org">www.swhp.org</a></p>	
<p><b>Group Health Cooperative of South Central Wisconsin</b> Madison, Wisconsin - <a href="http://www.ghcscw.org">www.ghcscw.org</a></p>		<p><b>Security Health Plan</b> Marshfield, Wisconsin - <a href="http://www.securityhealth.org">www.securityhealth.org</a></p>	
<p><b>HealthPartners</b> Minneapolis, Minnesota - <a href="http://www.healthpartners.com">www.healthpartners.com</a></p>		<p><b>SelectHealth</b> Murray, Utah - <a href="http://www.selecthealth.org">www.selecthealth.org</a></p>	
<p><b>Independent Health</b> Buffalo, New York - <a href="http://www.independenthealth.com">www.independenthealth.com</a></p>		<p><b>Tufts Health Plan</b> Watertown, Massachusetts - <a href="http://www.tufts-health.com">www.tufts-health.com</a></p>	
<p><b>Kaiser Foundation Health Plan, Inc. and The Permanente Federation</b> Oakland, California - <a href="http://www.kaiserpermanente.org">www.kaiserpermanente.org</a></p>		<p><b>UCare</b> Minneapolis, Minnesota - <a href="http://www.ucare.org">www.ucare.org</a></p>	
		<p><b>UPMC Health Plan</b> Pittsburgh, Pennsylvania - <a href="http://www.upmchealthplan.com">www.upmchealthplan.com</a></p>	