Payment reform and the changing landscape in medical practice

Implications for neurologists

Laura Powers, MD, FAAN

Katie M. Shepard

Karolina Craft, MA

Summary

The growth in health care spending in the United States, though slowed in the last few years, remains unsustainable. Since higher health care spending does not correlate with most measures of improved patient outcome, there are new attempts to define “value” in health care as the ratio of quality to cost. This article reviews newer proposed models for provider payment and organization and their possible effects on neurologic practice.

The Resource-Based Relative Value Scale (RBRVS) is a systematized method for recommending reimbursement for a particular service based on a combination of the relative value of other services and the cost of the resources used. As the RBRVS system has developed, physicians often are paid more to perform procedures than to give cognitive care, and care coordination face-to-face patient management is not adequately compensated. As a result, overutilization of procedural services and fragmented care drives up US health care costs while in some areas of the country increased spending is not necessarily associated with better outcomes.¹

Physicians’ decisions about the quantity and type of rendered services are one of the largest determinants of overall medical spending.² To improve outcomes and lower health care costs, delivery and policy experts are re-engineering payment and delivery systems by realigning incentives intended to change physician behavior.³ The new policies are expected to reduce spending, particularly for the most expensive patients.⁴ New models encourage collaboration among providers by incentivizing both cost savings achieved by the entire medical care organization and quality of care.^{5,6}

American Academy of Neurology, St. Paul, MN.

Correspondence to: kshepard@aan.com

Although the traditional fee for service (FFS) payment system encourages overutilization of procedural services, some newer payment models use FFS as modified by quality measures and financial incentives to reduce costs.

The present and future of quality reporting

New payment models require new definitions of quality of care. It is difficult to define some important metrics, such as quantifying adverse medication effects on cognition, and it is difficult to measure others, such as 5-year risk of recurrent stroke. As quality definitions are being developed, quality may be defined by the consistency of care, such as how often stroke patients are offered antiplatelet therapy, or by process measurements, such as how often headache patients get MRI scans. The rigorous, evidence-based, and highly regarded quality measures developed by the American Academy of Neurology (AAN) to date have been process based.^{7,8} The next generation of quality measures may be based on patient-reported outcomes (PRO). These measures will be developed and validated based on objective outcomes adjusted for disease severity and comorbidities. Payers will use outcome measures to define each provider's quality of care and will likely base all or partial payment on these measures.

Reform in payment

Although the traditional fee for service (FFS) payment system encourages overutilization of procedural services, some newer payment models use FFS as modified by quality measures and financial incentives to reduce costs.

In an episode payment model, physicians may still be paid based on FFS but the payment includes incentives to perform fewer redundant services. In this model, providers (usually physician and hospital) are paid a predetermined amount for a given episode of care, which includes all agreed-upon services related to a particular procedure or illness and rendered within a specific timeframe. All or a portion of the services included in the episode may be performed depending on the patient's individual need. Participating providers then distribute the bundled payment among themselves according to their own governance. When payments to hospitals and other providers are bundled, the payer more easily negotiates with fewer providers, more easily adjudicates costs, and better predicts future costs.

In a "global" payment model the insurer pays for all care of a patient in a given period of time across many episodes. This is similar to older per-member-per-month "capitation" payments made by health maintenance organizations (HMOs) 2 decades ago, but newer models adjust the payments for the health care risk of a specific patient population. Accurate risk-adjusting could promote fair payment for care provided to the sickest patients while still maintaining incentives to keep patients well.

Whether payment is made for each service, for each episode, or globally across episodes, future payments probably will be modified by standards of "quality" and performance applied to each provider. Medicare's Physician Quality Reporting System is designed to modify FFS payments based on quality measures as early as 2015 (based on 2013 data), though the program is currently in effect as a pay-for-reporting program only. Financial incentives for preventative care and coordination of care may also modify physician payments.

Figure Joining new payment and organizational models in practice

Reforms in Payment	Reforms in Organization
1. Risk-adjusted fee for service (FFS)	1. Single specialty or multispecialty group or solo practice
2. Episode payments and bundled payments	2. Independent Practice Association (IPA)
3. Population based global payments (risk-adjusted)	3. Physician-Hospital Organization (PHO)
4. Payment adjustments superimposed on any of the above, in the form of: <ul style="list-style-type: none"> • Payment for preventive care and coordination of care (partial capitation) • Pay-for-performance (quality) • Shared savings (after quality standards are met) 	4. Hospital + employed physicians
	5. Vertically integrated health system
	6. Accountable Care Organization (ACO) = any of the above plus accountability for the health and quality for a given population

Demonstration/Pilot	Payment Reform(s) Used	Organizational Reform(s) Used
Original Health Maintenance Organizations (HMO's)	Non-risk adjusted global payment	Any organizational structure
Patient Centered Medical Home (PCMH)	Partial capitation to cover coordination of care and preventative care	Any organizational structure
Medicare Acute Care Episode (ACE) Demonstration	Episode payments plus shared savings	PHO
Medicare Physician Group Practice Demonstration	FFS and shared savings after quality standards met	ACO
Medicare Shared Savings Program	FFS and shared savings after quality standards met	ACO
Medicare Pioneer ACO's	Fee for service, then population based payment with shared savings based on outcome	ACO
Medicare Bundled Payments for Care Improvement Initiative	Four different bundled payment models	Any organizational structure

Finally, in a “shared savings” program, the physician or organization may be paid more if health care costs for the population are below a targeted level while care quality is maintained. This payment incentive encourages individual providers to work together in larger health management coalitions for cost efficiency. In some current models the risk of financial loss is also shared by payer and provider.

Reform in organization

Since fragmentation may lead to duplication of care and contribute to less favorable outcomes, reform also modifies the organization of patients and providers to increase the coordination of care.⁹

Although small single-specialty practices might find it financially challenging to comply with all reforms, the single-specialty group and multispecialty group are likely to remain viable options in future health care delivery. For example, single- and multispecialty groups may band together (within specific legal antitrust limits) and form an Independent Practice Association (IPA) to negotiate with payers while maintaining most of their financial independence from each other.

Furthermore, a group of physicians (often already organized into IPAs) may join with a hospital in a care and payment consortium, again within specific legal antitrust limits, to form

Whether payment is made for each service, for each episode, or globally across episodes, future payments probably will be modified by standards of “quality” and performance applied to each provider.

a physician-hospital organization (PHO). Over the last decade, more hospitals are employing physicians within a PHO structure.

Finally, in a “vertically integrated” health system, all providers for a population join together, including doctors, hospitals, pharmacists, therapists, home health providers, durable medical equipment providers, and others.

All 3 organizational models—IPAs, PHOs, and vertically integrated health systems—may serve as a base for a new model of health care delivery system, the Accountable Care Organization (ACO). An ACO assumes “accountability” for care, quality, and cost for a given population of patients. The mutual agreements among ACO participants are designed to promote coordinated and cost-efficient care. The ACO receives bundled payments or targeted FFS payments, and may then reimburse individual providers according to FFS, episode, or global agreements.

Joining payment and organizational models in practice

Payment models can be complementary or additive. Often one delivery model will use multiple payment tactics to answer various organizational problems (figure). In the patient-centered medical home (PCMH), the organizational structure between primary care and other providers did not change, but practice costs increased to facilitate better communication and care coordination. To cover higher practice costs, providers in PCMHs may be reimbursed with supplemental payments for non-face-to-face activities, enhanced payments for evaluation and management services, or for additional services performed to facilitate transitions among various health care settings.¹⁰

In the acute care episode (ACE) demonstration by the Centers for Medicare and Medicaid Services (CMS), a PHO negotiated for a discounted payment for both the global hospital payment (diagnosis-related group or “DRG”) and the FFS physician payment for a hospitalization for specific conditions (an episode of care payment). In turn, any further savings produced by reducing costs within the hospitalization could be shared by the PHO if they met certain quality standards.

The Medicare Shared Savings Program (MSSP) uses traditional FFS payment structure with an ACO organizational structure and superimposes shared savings payments based on a risk-adjusted targeted total health care expenditure if quality standards are met. Participants in CMS’s Pioneer ACOs, on the other hand, are designed to test a risk-adjusted, per-beneficiary per month payment amount that is intended to replace some or all of the ACO’s FFS reimbursement.¹¹

In the CMS Innovation Center’s Bundled Payments for Care Improvement Initiative, payments to all providers who rendered services during a given episode of care are included in one bundled payment. There are 4 payment models within the initiative, each defining a specific part of the episode combining services rendered in various health care settings (e.g., acute inpatient hospital stay or post-acute care setting). The first 3 bundled payment models are retrospective, which means that providers are paid the traditional FFS first and the total episode payment is later reconciled against the agreed-upon targeted amount. Only the last bundled payment model is prospective, meaning that a single payment is made to cover all services rendered by multiple providers instead of the traditional fee for each service.¹²

Although small single-specialty practices might find it financially challenging to comply with all reforms, the single-specialty group and multispecialty group are likely to remain viable options in future health care delivery.

Initial evidence of the effectiveness of reforms

Policy experts argue for the improved care coordination activities, electronic health record use, and quality measure adherence, updates to payments, and structural reorganization of the practice. Yet, evidence does not always support that one or a combination of the above will lead to reduced costs, improved patient outcomes, or ultimately solve the problems of the US health care system.

Under its current shared savings program, CMS estimates that the median net Federal savings during the first 3-year cycle will be \$470 million.¹³ This number, however, represents only about 0.1% of the expected increase in US health care expenditures during that same period.¹⁴ Thus, it appears that even with this major step in health care reform, this model does not appear to be a short-term solution to curb increasing health care costs.

Furthermore, the Congressional Budget Office (CBO) analyzed value-based payment reforms tried in Medicare demonstration projects.¹⁵ The CBO saw no decrease in Medicare spending with the Physician Group Practice Demonstration, which tested an ACO model that used FFS payments. Alternatively, CBO did see savings in the heart bypass bundled payment demonstration. Thus, in the future we will likely see a trend toward global payment models rather than FFS.

The future of specialists

In general, specialists are viewed as “expensive” factors contributing to high health care expenditures, notably within patient hospitalizations. Many models place barriers to overutilization of procedural services with quality measures. These models also aim to reduce utilization of specialists by avoiding patient hospitalizations and preventing major illnesses where possible. Primary care providers in PCMHs are assuming more of the follow-up care for chronic diseases with only phone or other non-face-to-face advice from specialists.

Neurologists must now justify their role in caring for patients with acute and chronic neurologic disease. Though some evidence-based research exists to demonstrate the value of neurologists, more is needed for the future.^{16,17} Individual practice cost/quality data can assist neurologists to prove value within their community until evidence for improved outcomes as a result of intervention by neurologists is more widely available.

Physicians are voicing legitimate concerns that their small single-specialty practices will not be able to find the financial capital required to acquire an EHR, gather and analyze data, report on quality measures, and comply with other aspects of health care reform. Alliances with larger organizations may be necessary for survival, and neurologists will need to weigh carefully the pros and cons of either remaining independent while allied to a large organization, or being fully employed by the larger organization.

Neurologists still have some time to decide if joining a larger organizational model is right for them, because the current MSSP ACOs allow patients to see specialists outside the ACO. In addition, the small number of current ACOs and their limitation on market share means less effect on independently practicing neurologists in many communities. In the meantime, neurologists should actively seek opportunities within their practices

to improve outcomes and reduce costs in anticipation of future universally applied payment reform.

DISCUSSION

Health care organizations and physicians face substantial work to create care delivery collaborations and reporting methodologies which improve patient outcomes and reduce costs while maintaining quality standards.

Neurologists who coordinate and provide the majority of care for long-term, degenerative neurologic diseases need to take a leadership role in developing and testing new reform models that benefit this specialty so that patients continue to have access to the appropriate neurologic services.

This time of upheaval is also one of opportunity for our specialty. Physician leaders in neurology have the opportunity to create the future of neurologic care as they would choose to deliver it; the opportunity to collaborate among other specialists and share responsibilities for the care of patients with neurologic disease; the opportunity to make the system more cost-effective and therefore assure patient access to all needed neurologic care; and the opportunity to provide high-quality neurologic care and improved outcomes for patients.

REFERENCES

1. Fisher ES, Wennberg DE, Stukel TA, Gottlieb DJ, Lucas FL, Pinder EL. The implications of regional variations in Medicare spending: part 1: the content, quality, and accessibility of care. *Ann Intern Med* 2003;138:273–287.
2. Fuchs VR. *Who Shall Live? Health, Economics and Social Choice*, 2nd ed. Hackensack: World Scientific; 2011:57.
3. Medicare Payment Advisory Commission. Report to the Congress: improving incentives in the Medicare program. In: MedPAC [online]. Washington: MedPAC; 2009. Available at: <http://www.medpac.gov/>. Accessed April 2012.
4. Stanton MW, Rutherford MK. The High Concentration of US Health Care Expenditures. Rockville: Agency for Healthcare Research and Quality; 2005. Research in Action Issue 19. AHRQ Pub. No. 06–0060. Available at: <http://www.ahrq.gov/research/ria19/pendria.htm#diff4>. Accessed June 6, 2012.
5. Miller HD. Pathways for physician success under healthcare payment and delivery reforms. In: American Medical Association [online]. Available at: http://chapteraffairs.acc.org/BOGUpdate/Documents/Payment-pathways_HMiller.pdf. Accessed March 13, 2012.
6. McClellan M. Reforming payment to healthcare providers: the key to slowing healthcare cost growth while improving quality? *J Econ Perspect* 2011;25:69–92.
7. Cheng EM, Tonn S, Swain-Eng R, et al. Quality improvement in neurology: AAN Parkinson disease quality measures: REPORT of the Quality Measurement and Reporting Subcommittee of the American Academy of Neurology. *Neurology* 2010;75:2021–2027.
8. Fountain NB, Van Ness PC, Swain-Eng R, et al. Quality improvement in neurology: AAN epilepsy quality measures: Report of the Quality Measurement and Reporting Subcommittee of the American Academy of Neurology. *Neurology* 2011;76:94–99.
9. Enthoven AC. Integrated delivery systems: the cure for fragmentation. *Am J Manag Care* 2009;15:284–290.
10. Merrell K, Berenson RA. Structuring payment for medical homes. *Health Affairs* 2010;29:852–858.
11. Centers for Medicare & Medicaid Services. Pioneer accountable care organization model: general Fact Sheet. Available at: <http://innovations.cms.gov/Files/fact-sheet/Pioneer-ACO-General-Fact-Sheet.pdf>. Accessed April 12, 2012.
12. Center for Medicare & Medicaid Innovation. Bundled payments for care improvement initiative. Request for application. Available at: <http://innovations.cms.gov/Files/x/Bundled-Payments-for-Care-Improvement-Request-for-Applications.pdf>. Accessed April 10, 2012.
13. VHA Inc. Summary of Medicare shared savings program—accountable care organizations—final rule CMS 1345 F. Available at: <https://www.vha.com/Issues/Documents/CMS1345FMedicareSharedSavingsFinalRule.pdf>. Accessed April 10, 2012.
14. Centers for Medicare and Medicaid Services. Updated and extended national health expenditure projections, 2010–2019. Available at: <http://www.cms.hhs.gov/Research-Statistics-Data-and-Systems/>

Statistics-Trends-and-Reports/NationalHealthExpendData/downloads//NHE_Extended_Projections.pdf. Accessed April 10, 2012.

15. Congressional Budget Office. Issue brief: lessons from Medicare's demonstration projects on disease management, care coordination, and value-based payment. January 2012. Available at: <http://www.cbo.gov/sites/default/files/cbofiles/attachments/01-18-12-MedicareDemoBrief.pdf>. Accessed April 10, 2012.
16. Roberts N, Costelloe D, Hutchinson M, et al. What difference does a neurologist make in a general hospital? Estimating the impact of neurology consultations on in-patient care. *Ir J Med Sci* 2007;176:211–214.
17. Gillum LA, Johnston SC. Influence of physician specialty on outcomes after acute ischemic stroke. *J Hosp Med* 2008;3:184–192.

ACKNOWLEDGMENT

The authors acknowledge Marc Raphaelson, MD, FAAN; Joel M. Kaufman, MD, FAAN; William S. Henderson, FACMPE; Rebecca Swain-Eng, MS, Senior Manager, Measurement & Implementation (AAN); and AAN Medical Economics and Management Committee (MEM).

DISCLOSURES

L. Powers is an Associate Editor for *Neurology: Clinical Practice*. K. Shepard is a full-time employee of the AAN. K. Craft is a full-time employee of the AAN. Go to Neurology.org/cp for full disclosures.

Related articles from other AAN physician and patient resources

Neurology® ● www.neurology.org

Resident and Fellow Section Emerging Subspecialties in Neurology: Public policy fellowships
October 11, 2011; 77:e85–e87.

Invited Article: Threats to physician autonomy in a performance-based reimbursement system
June 10, 2008; 70:2338–2342.

Neurology Today® ● www.neurotodayonline.com

Policy Watch: Will a New Reimbursement Model be Coming to Your Area? Massachusetts Program Gains Traction
November 3, 2011; 11:50, 52.

Policy Watch: Why Neurologists are Protesting the New Federal Pay Proposal
October 20, 2011; 11:42–44.