A Closer Look at Alternative Payment Models
A PART OF THE FASTERCURES VALUE AND COVERAGE ISSUE BRIEF SERIES

This issue brief, the second in a series prepared by Breakaway Policy Strategies for FasterCures, discusses four of the most common alternative health care payment models (APMs) and how these models are gradually shifting our nation’s health care delivery and payment systems away from the traditional fee-for-service (FFS) model of reimbursement to one that seeks to reward higher quality and lower cost care. The APMs examined in this brief include accountable care organizations, bundled payment arrangements, pay-for-performance initiatives, and primary care medical homes. This brief also discusses public and private sector initiatives, recent studies on program outcomes, and key challenges with implementation.

Introduction

National health care spending continues to grow, pushing public and private health care payers, providers, and other stakeholders to find innovative and lower cost ways of providing quality care. In 2012, U.S. health care spending increased by 3.7 percent to $2.8 trillion or $8,915 per person, composing 17.2 percent of the nation’s Gross Domestic Product (GDP). The Centers for Medicare and Medicaid Services (CMS) projects that by 2022, U.S. health care spending will reach approximately $5 trillion, amounting to 19.9 percent of GDP.

One primary driver of rising health care costs is our system’s reliance on a model of reimbursement, which often compensates providers for each service they provide. As the most common payment model among public and private sector payers, Fee for Service (FFS; See Index of Acronyms) can create incentives for providers to increase the volume (and cost) of care they deliver—through additional tests, procedures, inpatient stays and outpatient visits—rather than focusing on the value of care provided to patients. In addition, by paying each provider separately for their services regardless of the quality of care or patient outcome, FFS can encourage fragmented and uncoordinated care that further increases health care costs and care inefficiencies.

Increasingly, these concerns associated with FFS reimbursements have motivated private payers and providers to experiment with Alternative Payment Models (APMs). In addition, in 2010, the Patient Protection and Affordable Care Act (ACA) mandated several changes in existing compensation programs and established the CMS Innovation Center to develop and test payment and service delivery models, helping to steer the focus of provider payment systems from volume-based to value-based care.

Over the past few years, the number of APMs and individuals receiving care through APMs has grown rapidly. The expansion of APMs has been fueled in large part by a desire among providers, payers, policymakers, and consumers to develop integrated payment and delivery systems that provide higher quality and more cost-effective care. One sign that APMs will likely play a prominent role in the future delivery of health care is the bipartisan embrace of these models in recent, high-profile Congressional proposals to repeal the Sustainable Growth Rate (SGR)—a formula enacted by Congress in 1997 in order to limit growth in spending for physician services—and reform the Medicare’s physician payment system. These proposals (including the February 2014 bipartisan, bicameral SGR replacement bill), in part, would provide financial and other incentives to encourage health professionals to participate in APMs in place of the traditional volume-based Medicare FFS structure.

Types of Alternative Payment Models

There are several different types of APMs, some of which evolved in the private sector, others which were established by
the ACA. The following section provides a brief description of the features of some of the most prevalent APMs.

**Accountable Care Organizations**

Accountable care organizations (ACOs) are networks of doctors, hospitals, and other health care providers that share responsibility for coordinating care and meeting health care quality and cost metrics for a defined patient population.

**ACOs are a product of the growing movement to realign financial incentives in health care with the primary objectives of:**

1) **promoting more coordinated care,**

2) **improving quality,** and

3) **reigning in health care spending.**

Although ACO-like delivery and payment arrangements gradually evolved among private health care providers and insurers over the last decade, the ACO movement is strongly associated with the Medicare program. The ACA codified the ACO model into law, creating the Medicare Shared Savings Program (MSSP), to assess whether this new framework could offer higher quality care at a lower cost. The private sector has also implemented several ACO variations. As of January 2014, there were 606 public and private ACOs—with more than 360 of them offered through Medicare.

Participation in Medicare ACO programs is voluntary. ACOs must accept responsibility for at least 5,000 Medicare FFS patients and participate for at least three years. Medicare ACOs use some variation of a shared savings model with CMS, which financially rewards providers that improve quality on certain metrics while decreasing spending. To earn shared savings, participating ACOs must meet 33 quality measures related to patient and caregiver experience, care coordination, patient safety, preventive health, and at-risk populations. ACOs also must have annual per-beneficiary Medicare expenditures below the CMS-established benchmark for their defined beneficiaries. In some cases, Medicare ACOs financially penalize providers who fail to meet quality and cost metrics.

In January of this year, CMS released findings on the cost savings achieved by the 114 ACOs in the MSSP that launched in 2012. According to the study, during their first 12 months of operations, nearly half of the ACOs spent less than the benchmark projections and roughly a quarter achieved shared savings—a total of $254 million, with $126 million in provider savings and $128 million for the Medicare Trust Fund. Some, however, have interpreted these findings as less than favorable. In the first year, ACOs were required to report data but were not evaluated based on performance. So, the results of the study do not show whether the ACOs actually improved care quality while achieving shared savings. In addition, only about a quarter of ACOs actually achieved shared savings. Accordingly, it is difficult to accurately assess the overall success of the MSSP.

**Table 1: Breakdown of ACO Measures for Each Domain**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Number of Individual Measures</th>
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<tbody>
<tr>
<td>Patient/Caregiver Experience</td>
<td>7</td>
</tr>
<tr>
<td>Care Coordination/Patient Safety</td>
<td>6</td>
</tr>
<tr>
<td>Preventive Health</td>
<td>8</td>
</tr>
<tr>
<td>At-Risk Population</td>
<td>12</td>
</tr>
<tr>
<td>Total in all Domains</td>
<td>33</td>
</tr>
</tbody>
</table>

*Source: Centers for Medicaid and Medicare Services.*

While many private sector ACOs incorporate aspects of a shared savings model, they are more likely to experiment with ACO variations and include other APMs. Most private ACOs offer financial incentives tied to established quality measures, consist of three-to-five year programs, and institute shared responsibility for 5,000 or more individuals. Types of private ACO contracts include: 1) the Shared Savings Contracts (One-Sided Model), which rewards providers with bonuses for meeting quality measures and reducing health spending, but does not penalize them if they fail to achieve savings; 2) the Shared Risk Payment Model (Two-Sided Model), which holds providers accountable for both bonuses and penalties; and 3) Partial Capitation, which allows providers experienced in coordinated care to transition towards population-based alternative payment systems. Most private sector ACOs operate within the one-sided risk framework.

Private sector ACOs tend to differ from Medicare ACOs. For example, they: 1) are more likely to experiment with other APMs, such as bundled payments, retainer agreements, in-kind services, and payer subsidies; 2) have contracts that tend to offer greater flexibility and customization for the providers' and payers' respective patient population; 3) are more willing to experiment with greater risk in their payment models; and 4) sometimes enter into contracts that provide incentives for patients to seek care exclusively within the ACO network. Some private sector ACOs report that they have successfully reduced hospital admissions and medical costs, facilitated...
closer provider-patient relationships, and encouraged investments in health information technology (HIT).

Several important issues may need to be addressed as the ACO model evolves. For example, Medicare ACOs do not provide patients with incentives to reward healthy behavior or stay within the ACO network for their care. **Given the critical role that patients play in determining their own health outcomes, some stakeholders argue that the failure to engage patients directly could be ACOs’ biggest weakness.** In addition, within the MSSP, ACOs do not include Medicare Part D prescription drug costs within the shared savings calculations. This exclusion may affect how providers in Medicare ACOs utilize Part B services and Part D therapies in striving to improve their shared savings. CMS raised this issue in its recent Request for Information on the Evolution of ACO Initiatives, seeking stakeholder comments on the potential benefits and barriers of integrating Part D expenditures within the Medicare ACO structure. If the MSSP expands to include Medicare Part D prescription drug costs in the future, providers may have increased incentive to reduce the utilization of expensive drugs in favor of cheaper generic drugs. As a result, biopharmaceutical companies may face greater pressures to demonstrate the cost-savings and/or quality gains of new therapies for patients in ACOs.

**Box 1: Outpatient Prescription Drug Coverage—Medicare Part B vs. Part D**

Outpatient prescription drugs generally are covered under either Medicare Part B or Part D. Medicare Part B, which pays for outpatient medical care, such as doctor visits, home health services, and some laboratory tests and medical equipment, generally pays for prescription drugs and biologics that are not usually self-administered; and are furnished and administered as part of a physician service. Medicare Part B also covers a limited number of other drugs including immunosuppressive drugs for patients who have had Medicare covered transplants, hemophilia clotting factors, and certain vaccines and oral anti-cancer drugs. Outpatient prescription drugs not covered under Part B are often covered under a Part D Medicare Prescription Drug Plan. Some conditions, such as cancer, may be treatable by drugs covered under either Part B or Part D. Since an ACO participant’s Part D drug costs will not be part of the “shared savings” calculations, ACOs may have an incentive to switch patients to Part D therapies and away from appropriate treatments or procedures that are reimbursed through Medicare Part B.

**Bundled Payments**

Under a bundled payment arrangement, payers compensate providers with a single payment for an episode of care, which is defined as a set of services delivered to a patient over a specific time period. This model aims to incentivize providers to improve care coordination, limit costly and unnecessary services, and reduce variations in care not tied to patient care quality and outcomes. By providing one single payment for various providers, bundled payments seek to promote a team-based approach to care. **Though bundled payments differ based on the patients’ illnesses and conditions, and tend to reflect the average costs of the treatments involved in an episode of care, they do not typically vary with the explicit number or mix of services provided to any individual patient.**

In most models, participating providers share in savings if their actual expenditures are below the bundled payment amount.

Both Medicare and private payers have utilized bundled payment arrangements with providers for narrow sets of services, including, for example:

- The PROMETHEUS Payment model—launched in 2006 with four initial pilots—has grown to cover 21 episodes of care bundles, including heart attacks, hip and knee replacements, diabetes, asthma, congestive heart failure, and hypertension.
- The Medicare Acute Care Episode Demonstration, where CMS provided bundled payments to providers at five health systems for all Part A and B services relating to three joint replacement and five cardiovascular procedure episodes of care.

The most prominent Medicare initiative is the Medicare Bundled Payments for Care Improvement (BPCI) initiative, established by the CMS Innovation Center. The three-year project involves four different models of care and payment for participating providers. On January 30, 2013, CMS announced that 464 health care organizations would participate. Depending on the results of the initiative, which are not yet available, CMS and Congress may consider implementing bundled payments on a broader basis in Medicare.

As with all APMs, there are some issues with bundled payment arrangements. The financial incentives associated with an episode-based bundled payment model may have broader impacts on provider utilization and patient outcomes than anticipated. As with FFS payments, bundled payments only
compensate providers for treating the sick, with no incentive for providing preventive care. Current measures of care quality in bundled payment models are limited, focusing mostly on processes of care and less on actual health outcomes—such as improvements in health or avoidance of new medical problems. In addition, bundling requires provider integration and communication to ensure optimal resource use without repeat or unnecessary utilization. Coordinating care, tracking the quality of care, and maintaining accountability for costs across providers can be difficult, especially if there is not a single health system or hospital organizing a patient’s care. Improving connectivity and building effective communication channels among providers will be critical to the success of bundled payment arrangements moving forward.

**Pay For Performance**

“Pay-for-performance” (P4P) is a term used to refer to those payment models aimed at improving the quality, efficiency and the overall value of health care. In P4P arrangements, providers are reimbursed based on whether they achieve a pre-determined set of quality measures.

**Table 2: Four P4P arrangement categories:**

<table>
<thead>
<tr>
<th>Quality Measures</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process</td>
<td>Process measures look at improvement and assess the performance of activities shown to contribute to positive health outcomes for patients.</td>
</tr>
<tr>
<td>Outcome</td>
<td>Outcome measures look at the effects that care had on patients. These measures can be controversial since social or clinical factors unrelated to the treatment received may affect outcomes.</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>Patient experience measures assess patients’ satisfaction with the quality of care they receive and their overall health care experience.</td>
</tr>
<tr>
<td>Structure</td>
<td>Structure measures look at the facilities, personnel, and equipment used in treatment.</td>
</tr>
</tbody>
</table>

The most common form of financial incentive in a P4P program is a bonus payment—an amount paid to a provider in addition to his or her usual fee for a particular service once that provider meets certain quality goals. Other financial incentives may include withholds, penalties, fee schedule adjustments, per-member payments, payments for the provision of a particular service, lack of payment for poor performance, shared savings, quality grants or loans, or payment for participation in certain activities or for reporting on certain activities, such as reporting of outcome measures for hospitals.

There are numerous P4P initiatives, both in the private and public sectors. One well-known private sector program is the BCBS of Massachusetts’ Alternative Quality Contract. The program, implemented in 2009, compensates providers based on a global budget with a quality incentive. In the public sector, the Medicare Premier Hospital Quality Incentive Demonstration project, run by both CMS and the Premier hospital system, tested the extent to which financial bonuses would improve the quality of care for Medicare patients with certain illnesses. States also have experimented with P4P in Medicaid. In Massachusetts, a hospital-based P4P program paid hospitals incentive payments based on scores for a set of quality indicators related to care for Medicaid patients with pneumonia.

Some have criticized early P4P initiatives for focusing too narrowly on “quality” with very little consideration of cost. Studies have shown that incentive amounts can sometimes be too low to make an impact on quality.

As the P4P model evolves, programs may have to address overall value by looking not only at quality, but at cost as well. The ACA explicitly steers CMS in this direction by providing for demonstrations and incentives for value-based purchasing, physician quality reporting, and Medicare Advantage plan bonuses.

**Box 2: Assessing the Performance of APMs**

In February 2014, the RAND Corporation released a study commissioned by the Department of Health and Human Services (HHS) which examined value-based initiatives over the past decade that might help inform policymaking, including P4P programs, ACOs, and bundled payment initiatives. One issue noted in the study was that the absence of quantifiable goals for many of the programs made it difficult to determine whether the programs were successful in meeting their goals. Of the published studies evaluating improvement in performance from the impact of P4P programs, improvements, where observed, were typically modest. In addition, ACOs and bundled payment programs using clinical quality measures have only recently emerged and are just now being tested and evaluated—meaning there is little evidence regarding the impact of these programs and whether they can be successfully implemented. However, because these programs are relatively new, experimentation at the private-sector level will be beneficial in testing programs through trial and error so that lessons can be learned for public and private initiatives going forward.
**Patient Centered Medical Homes**

The patient centered medical home (PCMH) model facilitates the coordination of care through a patient’s primary care physician. The PCMH model integrates mental health and specialty services, and involves a team-based approach consisting of physicians, nurses and medical assistants, pharmacists, nutritionists, social workers and care coordinators. Stating the exact definition of a PCMH is difficult as the model is continually evolving. Four major primary care societies, however, have endorsed the description provided in the *Joint Principles of the Patient-Centered Medical Home*, which outlines the general characteristics of a PCMH as: personal physician care, physician-directed medical practice, whole person orientation, coordinated and/or integrated care, high quality and safety in care, enhanced access to care, and payment that supports enhanced services.\(^{41}\)

Payments to PCMHs differ from those under the traditional FFS system in several ways. PCMH programs typically use a combination of the following care coordinating and performance-based payments on top of existing FFS payments:

1. enhanced FFS evaluation and management payments;
2. additional codes for medical home activities within FFS payments;
3. per member per month medical home activities within FFS payments; and
4. risk-adjusted, comprehensive per member per month payments.\(^{42}\)

**Reforms to the payment system are critical to the success of the PCMH model since the traditional FFS system does not account for the additional work physicians and other providers perform in order to coordinate a patient’s care**—including additional support services, patient education, communications among providers, and interactions with patients outside the clinical setting. An effective transition to this model also requires significant cooperation among and communication between providers, which may require additional investment in health information technology.

**The success of APMs like P4P and PCMHs is due, in part, to the effective use of health information technology (HIT) to coordinate care and facilitate communication among providers.**

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**Box 3: HIT: Coordinates Care and Facilitates Communication**

As defined by the HHS Office of the National Coordinator for Health IT (ONC), HIT is, “the application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of health information, data, and knowledge for communication and decision making.” Electronic health records (EHRs)—digital or computerized versions of patients’ paper charts—are an essential part of the HIT framework, providing real-time patient-centered records that make information available instantly across more than one health care organization. In addition, today, more than 40 percent of all permissible prescriptions are transmitted electronically using certified EHR technology—a process known as e-prescribing (eRx)—allowing information to be automatically stored in the patient’s record for easy review during follow-up visits or for transitions between providers.

There are several private-sector PCMH initiatives. Community Care of North Carolina focused its PCMH program on care coordination and primary care, and was able to decrease preventable hospitalizations for asthma by 40 percent and lower emergency visits by 16 percent.\(^{43}\) The Group Health Cooperative of Puget Sound reduced emergency visits by 29 percent and hospital admissions by 6 percent,\(^{44}\) while the Geisinger Health Plan program reduced hospital admission rates by 18 percent and readmissions by 36 percent per year.\(^{45}\)

The ACA promotes the use of the PCMH model by supporting nationwide medical home demonstration projects administered by the CMS Innovation Center. Some public-sector PCMH initiatives led by the CMS Innovation Center include the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration,\(^{46}\) and the Comprehensive Primary Care (CPC) Initiative.\(^{47}\) Both initiatives implement payment models that facilitate the transformation of primary care practices into “medical homes.” The goal of both initiatives is to encourage practices to use a team-based approach to care, with the patient at the center, emphasizing prevention, HIT, care coordination and shared decision making among patients and their providers.

In January 2014, the Patient-Centered Primary Care Collaborative (PCPCC) and the Milbank Memorial Fund issued an annual report highlighting recently published clinical, quality and financial outcomes of PCMH initiatives.\(^{48}\)
Key findings include:

1) that PCMH studies have demonstrated some improvements in cost, utilization, population health, prevention, access to care, and patient satisfaction, while a gap still exists in reporting impact on clinician satisfaction; and

2) that the PCMH continues to play a role in strengthening the larger health care system, specifically ACOs.

A February 2014 study from The Journal of the American Medical Association, however—believed to be the first multi-payer pilot to report results over three years—has found that the PCMH model did not, in fact, reduce hospitalizations, emergency department use, ambulatory services, or costs.49

There are other broader concerns worth noting regarding the PCMH model:

- For the model to work, providers must receive adequate compensation for the additional time and effort involved in coordinating care across the various care settings. Some primary care practices may not have the financial stability to invest in the transformation to a PCMH without assistance to cover initial costs, such as those involving HIT.
- Another concern involves the adequacy of the health care workforce to form an effective medical home, particularly in areas with shortages of primary care providers.

Key Challenges

Payers and providers will likely face challenges in implementing APMs. Perhaps the most significant is that the financial incentives for providers in APMs to reduce hospital costs, readmissions, specialty care, and excessive utilization make it more challenging for providers to maintain the level of compensation they receive under traditional FFS arrangements.50

Given that most providers continue to receive at least some of their reimbursements through FFS, APM success may be limited until a more widespread transition away from FFS becomes viable.

In addition, care coordination within APMs depends on robust data analytics and HIT infrastructure to work effectively. Health systems with more advanced integration and available capital are in a better position to make these necessary investments and increase their success within the new APM frameworks. For providers with limited coordinated care infrastructure, acquiring expensive HIT systems can be especially difficult.51

The limitations with current quality measures and the focus on reducing overall costs within some types of APMs may discourage providers from utilizing the most recent advances in medicine, including new prescription drugs and medical devices. In addition, providers may face cost pressures to reduce the uptake of medical innovations that are: 1) more costly upfront during the measurement period of an APM, despite potentially representing significant health advances and/or cost-savings in the long-term; 2) not yet incorporated into an APM’s quality measures, potentially causing providers to receive reduced quality scores and even financial penalties; and 3) primarily designed to treat health conditions that affect only a narrow set of patients within an APM’s defined population.

Conclusion

Physicians, medical societies, payers (public and private), and patient groups—such as the PCPCC—are continually working to develop payment models that are specifically designed to improve patient care and save taxpayers money. Both the public and private sectors will continue to play a vital role in motivating providers to reform their practices across the health care system through the use of APMs. The rapid growth over the last few years in Medicare APM programs suggests that there is long-term, widespread interest in the APM framework. Private sector innovation will also be essential in developing new APMs and furthering the movement to reorient our health care payment system. As private sector payers and providers continue to experiment with different types of APMs and risk arrangements, this innovation has the potential to shape future Medicare initiatives as well.
Index of Acronyms

ACO  Accountable care organization
APM  Alternative payment models
CMS  The Centers for Medicare and Medicaid Services
CPC  Comprehensive primary care
eRx  Electronic prescribing or e-prescribing
FFS  Fee-for-service
GDP  Gross domestic product
HHS  The Department of Health and Human Services
HIT  Health information technology
MAPCP  Multi-Payer Advanced Primary Care Practice
ONC  Office of the National Coordinator for Health Information Technology
P4P  Pay-for-performance
PCMH  Patient centered medical home
PCPCC  Patient-Centered Primary Care Collaborative
SGR  Sustainable growth rate

5 Bendix, Jeffrey. "Private payers re-examining reimbursement." Medical Economics. 25 Feb 2013.
7 "Senate, House Leaders Introduce SGR Replacement Bill." United States Senate Committee on Finance. n.p. 06 Feb 2014.


Werner, Rachel and Dudley, R. “Medicare’s New Hospital Value-Based Purchasing Program is Likely to Have Only a Small Impact on Hospital Payments,” Health Affairs. 31.9 (2012): 1932-40.


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