Alternative Payment Models and Competition

There is a whole spectrum of payment models ranging from traditional fee for service up to global capitation. As you move up the spectrum of alternative models, the alignment of payment incentives for an organized provider system, and/or incentives related to outcomes, efficiency, and access lead to improvements in value for purchasers and patients.

Bundled payments provide for a global payment covering a discrete set of services, usually around a specific procedure. This creates alignment between the various providers and facility involved in the bundle to optimize efficiency. Global capitation in essence becomes a bundled payment covering a specific population of patients over a period of time. Again, it leads to alignment within an organized system of care to provide the most efficient care that leads to a quality outcome.

Alternative payment models allow organized systems of care to invest in services that enhance outcomes but may not be covered in traditional fee for service models, or where reimbursement is inadequate to provide a return on investment. Examples of this include the use of telemedicine to improve access, care managers as part of a multidisciplinary care team, transition coaches when patients do not meet traditional criteria for home care services, and rounding in post-acute facilities to minimize emergency department visits and readmissions. The list of creative use of resources in alternative payment models goes on and on. In a high acuity population with many polychronic patients, specialized clinics with multidisciplinary teams such have been set up by CareMore and others have been shown to significantly decrease costs while enhancing patient access and satisfaction.

Alternative payment models create incentives to provide care in the most cost effective setting. This leads to a focus on improving office access, decreasing expensive low acuity emergency department visits, moving ambulatory surgeries to lower cost free standing surgicenters, and providing services at home to minimize use of skilled nursing facilities and reduce readmissions.

Alternative payment models create alignment and incentives for an organized system of care, but the incentive for a payer to offer such models is that it will reduce the overall cost of care and allow it to provide more value to purchasers in the marketplace. Our experience at Advocate Health Care has been that as we have moved to global capitation so that there was better alignment between physicians and the hospitals the payers have insisted that the capitation payments be less than the overall market spend on a per member per month basis. The rationale for this is that if it does not reduce costs for the payer, why should they offer this alignment. This then puts more pressure on competing organizations to reduce their total cost of care.

Advocate Health Care has experience with a variety of alternative payment models. In four full years of a commercial shared savings arrangement with the largest payer in the market (covering approximately 200,000 lives) Advocate has demonstrated fewer complications and fewer readmissions, while reducing the overall total cost of care. Advocate went from being a high cost delivery system based on unit prices in a fee for service paradigm, to having costs that are below the market median. This was in spite of a broad PPO with virtually every physician and all hospitals in the market as part of the network. This resulted in about 50% of the care occurring outside of Advocate. This illustrates the additional potential value of benefit plan design that incents patients to utilize the network that is aligned to provide the most efficient high quality care.

Advocate's experience with Medicare Shared Savings (120,000 lives) has shown similar trends. Despite not having any meaningful data to use to manage care until fourteen months of the initial eighteen month performance period had passed, Advocate's overall cost of care was 0.2% below the benchmark while showing high performance on the quality metrics. Without benefit plan alignment for Medicare beneficiaries in the shared savings program, about 40% of the care occurred outside of the Advocate network. A significant improvement was the creation of a post-acute network consisting of 37 skilled nursing facilities across metro Chicago. Only 2 of these were owned and managed by Advocate. At all of them, Advocate provided advanced practice nurses who round daily with back up from physicians. This led to a decrease in readmissions and emergency department visits as well as a shorter length of stay that reduced the cost of care for patients transitioned to a skilled nursing facility by approximately $2000 per

case. These investments would not have been compensated adequately in a fee for service environment.

Another opportunity relates to behavioral health services. Review of Advocate's data shows that approximately 1/3 of medical/surgical inpatients have a comorbid behavioral health diagnosis and these patients have longer lengths of stay and higher overall costs of care for their inpatient episode. As a result, we are integrating behavioral health with the inpatient care team so that patients are assessed in real time and behavioral health professionals participate in the treatment plan. The reimbursement in a fee for service environment does not justify this type of integrated approach, but in an alternative payment model the savings from a reduced stay more than offset the additional investment in resources.

With the evolution of the public and private exchanges, there is more price sensitivity than in the past. Alternative payment models have the ability to bend, if not break, the cost curve, and allow an organized system to price care at a lower price point. This produces pressure on competing organizations to reduce costs or there will be a shift in market share. The data from public exchanges in the first two enrollment periods supports that most individual purchasers are very price sensitive.

In the traditional fee for service model, competition between health plans generally is focused on the price of their networks. Physicians and hospitals are pushed to yield lower prices but there can be unintended consequences. Medicare has found over the years that when the fee schedule is reduced, volumes increase and there is a new increase in spending. Fee for service incents volumes, and higher utilization, whether it is of diagnostic testing, procedures, or imaging generally leads to higher costs. There is no financial incentive to focus on waste and inefficiency.

When there are alternative payment models provided to organized systems of care, it is an opportunity for providers to compete with each other on price, service and outcomes. Just as in other sectors of the economy, patients make decisions that are appropriate for them in selecting a provider network. This type of competition will enhance price efficiency, as well as improve service and

outcomes. Much of this is driven by coordination of care. Care coordination can be enhanced with information systems, embedded care managers, telephonic care managers, disease management for specific conditions, and polychronic clinics. None of these things provide a reasonable return on investment in a fee for service world, but in an alternative payment model the cost avoidance that remains with or shared with the provider supports such investments.

To succeed in an alternative payment environment, a provider will need adequate scale, capital for investment, intellectual property among its clinicians, an enterprise data warehouse, and organizational infrastructure and governance that allows it to change the way it does business.

There has always been a fear that alternative payment models will reduce access to necessary care or by skimping on care lead to poor outcomes. The growing sophistication of both process and outcomes measures should enable payers and individual patients to not be victimized as happened with capitation in the 1990's. With pharma expense consuming a growing portion of the health care premium, creating alignment between providers and prescription drug cost should yield additional cost reductions. Our experience at Advocate Health Care has been that aligned incentives can be liberating. It may make sense to use a higher cost drug if the patient will have a better outcome, or a drug that more effectively prevents a hospitalization.

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