Fed up with the status quo, many employers, health plans and the federal government have been on a steady march to change how healthcare is paid for, moving away from paying for care based on volume to paying for value.

For example, the Department of Health and Human Services announced in early 2015 it wants to shift 50% of Medicare payments out of fee-for-service and into alternative payment models that reward quality or value by the end of 2018.

“The movement reflects growing frustration with traditional fee-for-service. Fee-for-service means we pay providers for many of the services they deliver regardless of necessity or outcome, and don’t pay for other services that would improve care but are not recognized as eligible for payment,” says Suzanne F. Delbanco, executive director of Catalyst for Payment Reform (CPR), an independent, non-profit employer coalition pushing for better value in U.S. healthcare.

While there are many different definitions of payment reform, CPR defines payment reform as payment methods that “reflect or support provider performance, especially the quality and safety of care” and “are designed to spur provider efficiency and reduce unnecessary spending.”

Most of the alternative payment methods fall into one of three categories based on how much financial risk providers assume:

1. ”Upside risk”: In this arrangement healthcare providers are compensated for services with no added financial risk. Common examples include pay-for-performance bonuses or care-coordination fees for physicians serving as medical homes.
2. “Downside only risk”: Providers are at risk in the event that they have to care for a patient in situations where additional care could have been avoided, such as non-payment for preventable hospital-acquired conditions or penalties for excessive hospital readmissions.
3. “Two-sided risk”: Under these arrangements providers’ compensation can increase or decrease based on the services rendered and the quality of care delivered. One example of this is risk-sharing payment arrangement is Accountable Care Organizations (ACOs), where providers can share in savings, but also get penalized for not meeting budget or quality targets. ACOs have become a common service model for providers that accept Medicare reimbursements and will become the norm going forward based on a recent announcement by CMS.

What follows is an overview of some leading models.

**Pay for Performance (P4P)**

A P4P model provides financial incentives to providers to improve the quality of the care they deliver and reduce costs. The model gives healthcare providers the chance for a financial upside – such as a bonus — but no added financial risk, or downside. Pay-for-performance may also be one of the first available options for reform where fee-for-service is the underlying payment model, or with providers who are unwilling to accept new forms of payment, especially those that put them at potential financial risk for their performance. Implementing an upside-only payment model can ease implementation in markets where payment reform historically has been difficult and unsuccessful.

**Payment for Non-Visit Functions and the Medical Home**

Another upside-only model, typically used to support care coordination and patient centered medical homes (PCMH), is a model CPR calls “payment for non-visit” functions. In its simplest form, this model is a ‘per member per month’ (PMPM) payment, layered on top of another form of payment like fee-for-service. Providers typically receive this PMPM payment to help them manage their patients’ care and coordinate their care with other providers in the “medical home.”

**Bundled Payment**

Bundled payment is a single payment to providers or healthcare facilities (or jointly to both) for all services to treat a given condition or provide a given treatment. Bundled payment asks providers to assume financial risk for the cost of services for a particular treatment or condition, as well as costs associated with preventable complications. Payments are made to the provider on the basis of expected costs for clinically defined episodes that may involve several practitioner types, settings of care, and services or procedures over time.

**Accountable Care Organizations: Shared Savings and or Shared-Risk**

An ACO organizes doctors, hospitals and other providers to assume joint responsibility for all of the healthcare and related expenditures for a defined population of patients. Medicare launched its ACO program in 2012 and a growing number of commercial health plans and large employers are piloting or implementing ACOs. In some cases, large employers are contracting directly with provider systems. ACOs are typically paid under a shared-savings or shared-risk arrangement or by global payment. A shared-savings arrangement provides an upside-only financial incentive for providers or provider entities to reduce unnecessary healthcare spending for a defined population of patients, or for an episode of care, by offering providers a percentage of any realized net savings. It may also include arrangements in which providers may share in savings only after meeting specified quality targets. In shared-risk arrangements, providers accept some financial liability for not meeting specified financial targets. It may also include arrangements in which providers accept some financial liability for not meeting specified quality targets.

**Non-Payment**

Some purchasers actually withhold payment to try to prevent providers from providing care that is not clinically warranted or a result of preventable complications, like hospital-acquired infections or early elective deliveries. South Carolina Medicaid, for example, has had great success using this downside risk policy to improve maternal and infant health outcomes.

 *Using Education, Collaboration, and Payment Reform to Reduce Early Elective Deliveries: A Case Study of South Carolina’s Birth Outcomes Initiative*. Case Study. Catalyst for Payment Reform, 2013. Print.

# **Payment Reform 101**

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Source: National Association of Health Underwriters Education Foundation