

INNOVATIONS IN HEALTH CARE | A TOOLKIT FOR STATE LEGISLATORS

Overview

As health care costs continue to rise, so do state interests in innovative ideas to improve quality and reduce costs. While a companion brief in this toolkit addresses innovative state approaches to Medicaid payment models, this brief addresses alternative payment models in private insurance plans and provides potential actions policymakers may consider.

Under the traditional payment system, known as a fee-for-service model, insurers and individuals pay for each service they receive from a health care provider. While this model provides some simplicity in understanding what a patient is paying for, it can create challenges in accounting for the quality or outcome of the care provided. Prescribing the wrong medication for a misdiagnosed patient, for instance, will result in that patient and his or her insurer making a second payment to a physician or emergency room and a second prescription.

Several alternative payment models seek to shift health care providers' incentives from a system that rewards volume to a system that rewards better health outcomes. In doing this, policymakers will face several challenges, including the scarcity of conclusive data that any single new approach will produce actual cost savings and continuing discussion about how to measure the "quality" or "value" associated with specific services and health outcomes.

Alternative Payment Models

■ **Accountable Care Organizations (ACOs).** ACOs focus on creating cost savings by coordinating care among cross-disciplinary providers who have agreed to share responsibility for the cost and quality of their patients' care. While many ACOs still rely on a fee-for-service model, payers measure the actual cost of care against a predetermined target. When costs exceed that target, providers may pay financial penalties. When costs come in below the target, the payers reward the providers with some of the cost savings. This payment model recognizes that overlapping care and redundant or excessive tests can increase costs and coordination can increase the quality of patient care.

Although ACOs are most commonly associated with Medicare and other public programs, privately managed ACOs have grown to be a significant part of the health care industry. In 2016, the Commonwealth Fund reported that some 28 million Americans relied on



more than 800 ACOs nationwide for coverage.¹ The Leavitt Partners, a health care consulting firm, found that 488 ACOs operated in 2013, half of them outside the Medicare market.² NCSL's brief "[Accountable Care Organizations \(ACOs\) - Health Cost Containment](#)" provides examples of state attempts to manage both private and Medicaid costs using ACOs.

■ **Bundled Payments.** Under a bundled payment model, insurers and other payers agree to provide a lump sum for a single "episode of care," such as a hip replacement or maternity care. When providers receive the payment, insurers withhold a fraction, usually from 2 percent to 3 percent of the agreed upon amount. This incentivizes providers to keep the cost of care below the resulting 97 percent to 98 percent payment, as they will keep any cost savings. As an illustration, if an insurer agreed to pay \$1,000 for a full episode of care, which includes a patient's surgery and recovery, it would withhold \$20. If the care provider keeps the cost below \$980, both the care providers and the insurer reap a financial reward through cost savings.³ This model shifts most of the financial risk away from patients and payers and onto care providers, who have additional incentive to avoid superfluous or redundant treatment and to prioritize comprehensive care that prevents complications. NCSL maintains a "[Episode of Care and Bundled Payments—Health Cost Containment](#)" brief with information about bundled payments as well as other forms of episodic care, such as capitation payments.



■ **Capitation Payments.** Capitation payments, common in managed care plans, are similar to bundled payments but are made at a population level, rather than at an individual level. Instead of reimbursing care providers for episodes of care, payers pay a fee for each patient each month. This fee broadly reflects cost of care in the region and patient risks. Care providers are responsible for keeping cumulative costs below the cumulative payment. Because this payment model shifts significant financial risks to care providers, it works best for those who serve a large and diverse group of patients with many healthy members.^{4,5}

■ **Health Management Organizations (HMOs).** HMOs are one prevalent example of capitated payments. This payment approach most often is based on a single health insurance plan that usually limits coverage to care from doctors and practitioners who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require enrollees to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

■ **Patient-Centered Medical Homes.** Patient-centered medical homes use coordinated teams of providers, such as physicians, nurse practitioners, social workers, nutritionists and perhaps specialists, to provide a range of needed services, which is especially effective for high-risk and high-needs patients. Such intensive services increase the primary care costs but can save money by reducing emergency room visits and hospital stays.⁶ NCSL has more information available on patient-centered medical homes on our [medical homes webpage](#).

■ **Clinical Pathways.** This payment model, most useful in intensive and high-cost health care environments, has gained the most traction in oncology care. Clinical pathway payment models provide a system of choices and decision-making tools to prioritize the patient's needs and the lowest cost option. For instance, where two treatments exist of equal effectiveness and quality, providers would

be equipped with the tools and incentives to prescribe the lower cost option. One way of doing this is to use a database of hundreds of common medical problems, including information about the severity or progression of the medical issue at hand. Physicians can consult this database to find effective treatments while taking into account the unique circumstances of each patient's condition. Long-term and with broad-scale application, these savings could add up for payers.

State Examples

■ **Vermont: All-Payer ACO Model.** Vermont, with the support of the Centers for Medicare & Medicaid Services (CMS), formally adopted its innovative all-payer ACO approach in 2016, with its first year of full implementation for Medicare and Medicaid in 2017. The model incentivizes health care providers and payers, including commercial health care payers, Medicare and Medicaid, to prioritize health care value and quality with a focus on health outcomes.

The model allows ACO providers to participate in both a Medicare and Medicaid ACO agreement in which the ACO receives capitated monthly payments. Providers receive a monthly payment to cover all costs of their covered patients. The highly coordinated structure inherent to ACOs allows for cost savings by closely aligning patient care among various providers, and the capitated payment structure incentivizes further savings by rewarding efficiency.

Initial positive results from the transition are highlighted in the Commonwealth Fund's [report](#). It found that Medicaid beneficiaries attributed to the ACO were making greater use of primary care and behavioral health services, as well as pharmacy benefits, and made fewer emergency room visits compared with other beneficiaries.⁷ By 2022, Vermont aims to have nearly 70 percent of its 624,000 residents attributed to an ACO. Commercial insurers began implementing the model in 2018 and initial findings are expected in 2019.⁸

■ **Arkansas: Multi-payer Bundled Payments.** The Arkansas Health Care Payment Improvement Initiative, begun in 2012, includes most of the state’s largest payment providers—including Medicaid, private insurers and some of the state’s largest employers, such as Walmart. The initiative uses bundled payments that cover specific episodes of care instead of individual services. The initiative also implemented a new patient-centered medical home model to allow for better treatment of chronic conditions.

Several early metrics suggest the model helps save costs. Blue Cross Blue Shield reports that the average hospital stay for patients experiencing congestive heart failure shrank by 17 percent from 2014 to 2015. In addition, a report by the National Bureau of Economic Research found that the state’s perinatal episode of care reduced spending by 3.8 percent relative to other states.⁹

■ **Massachusetts: Patient-Centered Medical Home Initiative.** From 2012 to 2014, Massachusetts implemented the Patient-Centered Medical Home Initiative. This encouraged health plans, through incentives and penalties, to contract with providers on a global payment basis instead of the standard fee-for-service method. The Massachusetts cost-control legislation included benchmarks intended to encourage providers in the state Medicaid program and other programs to move toward ACOs. The initiative also limited total health spending within Massachusetts to the rate of inflation and provided for annual reporting to assess success of this provision, as well as to examine cost drivers. The law builds on the momentum in the private market by developing processes for certifying organizations as ACOs and patient-centered medical homes. In addition, the law provided the Health Policy Commission with the authority to create a program through which organizations can be designated as “Model ACOs.” Only ACOs that have demonstrated best practices for quality improvement, cost containment and patient protections can earn this distinction. The law required state insurance providers, like the state’s Medicaid program and Health Connector (Massachusetts’ health insurance exchange that connects consumers to private and public insurance), to prioritize these ACOs to deliver publicly funded health care.¹⁰

The Massachusetts Executive Office of Health and Human Services (EOHHS) set the goal for all primary care practices in Massachusetts to become patient-centered medical homes by the year 2015. The Massachusetts PCMH Initiative (PCMHI) is intended to address a series of challenges, including: fragmented care that harms patient health status and increases costs; increasing prevalence of chronic disease, and suboptimal management of chronic disease among patients with such illness; and a growing shortage of primary care providers. Early evaluations of the program have found statistically sig-

Alternative Payment Options: State Policy Options and Considerations

- Explore payment policies that offer incentives for quality and efficiency and/or disincentives for ineffective care or uncontrolled costs.
- Remember that no single model examined above will likely solve all your state’s payment problems or reduce costs immediately. Consider how various payment models work within the broader health care system or what incremental steps, like changing the payment model of the state employee insurance plan or altering incentives for payers, your state can take.
- Consider inviting stakeholders from across the health care system to weigh in on challenges to reducing costs, increasing efficiency and improving health outcomes and what payment models have proved successful or unsuccessful in your state.

nificant improvements in chronic disease management, prevention and care coordination in participating providers. Researchers believe this will translate into cost savings down the road.¹¹

■ **New England States:** The Primary Care Investments Workgroup, launched in 2017, includes representatives from four states—Connecticut, Massachusetts, Rhode Island and Vermont. The group’s main goal was to explore opportunities for improving primary care by comparing each state’s strategies and activities. During meetings over the past year, the group engaged in discussions about each state’s approach to primary care investments, including their policy environments and data capabilities, and potential opportunities for collaboration. Their report issued in October 2018 compares spending across major payers, with primary care making up just 8 percent of overall care costs.¹²

Conclusion

No single document or initiative can provide a comprehensive menu of every policy option available to legislators searching for solutions to rising health care costs. The U.S. health care system remains tremendously complex and prescriptions for improved health outcomes and cost savings will naturally vary from state to state, depending on local challenges and opportunities. Any long-term approach to cost-containment, balanced with quality care, will likely use multiple approaches tailored to fit each state.

Notes

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3. Darshak Sanghavi et al., “The Beginners Guide to New Payment Models,” USC-Brookings Schaeffer on Health Policy (blog), July 23, 2014.
4. Vera Gruessner, “Are Bundled Payment Models or Capitation the Better Choice?” Healthpayer Intelligence (blog), Jan. 30, 2017.
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6. Sanghavi et al., “The Beginners Guide to New Payment Models.”
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