

# New Approaches to Paying for Health Care

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*Implications for Quality Improvement  
and Cost Containment in Colorado*

July 2012

*A joint project of Center for Improving Value in Health Care  
and the Colorado Health Institute*



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## About CIVHC

The Center for Improving Value in Health Care (CIVHC) is a nonprofit organization committed to identifying and advancing initiatives across Colorado that enhance consumers' health care experiences, contain costs and improve the health of Coloradans by creating an efficient, high quality and transparent health care system. For more information about CIVHC, please visit [www.CIVHC.org](http://www.CIVHC.org).

## About CHI

The Colorado Health Institute is a trusted source of independent and objective health information, data and analysis for the state's health care leaders. CHI, celebrating its tenth anniversary in 2012, is funded by the Caring for Colorado Foundation, Rose Community Foundation, The Colorado Trust and The Colorado Health Foundation. For more information about CHI, please visit [www.coloradohealthinstitute.org](http://www.coloradohealthinstitute.org).

## With Gratitude

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*Colorado cannot sustain the ever-increasing costs of health care.*

*The steep upward spending trajectory of recent years has profound implications for the state's economy, its ability to attract and retain jobs and the quality of life for all Coloradans.*

The rising price of insurance limits employers' abilities to invest in current or new businesses, increase wages or hire more workers. As employers shift more costs to their employees, those employees have less money to spend on other things. And state government finds itself paying a larger portion of the general fund for public health programs such as Medicaid and Child Health Plan *Plus* (CHP+).

Meanwhile, an aging population is expected to create additional demand for health care services that will send spending even higher.

The end result: In too many instances, health care costs have become barriers to care, barriers that directly affect lives.

There is broad agreement that one underlying cause of the rise in health care costs is how we pay for health care.<sup>1</sup> The fee-for-service (FFS) payment method, which represents the majority of health care reimbursement in Colorado and across the nation, results in a pay-for-piecework system that rewards providers for volume of care and not for quality. It is a flawed system that inflates health care spending by its very design.

Consequently, it has become clear that health care

spending in our state won't be controlled without an overhaul of the payment system. This transformation is taking shape as part of efforts to achieve the linked goals of improved population health, improved patient experience of care and reduced per capita health care costs, known as the Triple Aim.<sup>2</sup>

Through extensive statewide dialogue documented in its *Framework for Transforming the Health Care Payment System in Colorado*<sup>3</sup>, the Center for Improving Value in Health Care (CIVHC) found consensus among stakeholders that achieving the Triple Aim in Colorado requires reforming health care payment - moving from a fee-for-service/ pay-for-outputs model to approaches that reward coordination of care and hold providers accountable for patient outcomes.

But how is that done? What models should be pursued? The available research often provides greater insights into what does not work than what does. Current findings suggest that payment methods that improve coordination of care show promise for controlling health care costs. However, some models are only just beginning to be tested, while others seem to show mixed results. Yet, one finding is certain: the current fee-for-service payment

system supports neither quality improvement nor cost containment.<sup>4</sup>

The work of evaluating new models involves not only examining academic studies but tracking leading market indicators of transformative change. Growing evidence points to coordinated care delivery and global payment as holding great promise. Kaiser Permanente Colorado is expanding its statewide market share through an integrated system that operates mainly outside the fee-for-service system. Denver Health also is demonstrating capacity to cost-effectively manage complex patient populations under a similar payment mechanism.

Nationally, there is significant investment by the private equity and capital markets in those organizations demonstrating the ability to manage populations with high quality and at a lower cost, all outside the traditional fee-for-service system. Lastly,

nearly every major national insurer is investing heavily in the technology and programmatic initiatives that reward value rather than volume. It is anticipated that this trend will only accelerate.

Faced with the urgency of the health care spending crisis, thoughtful leaders across Colorado are examining the evidence, moving forward with payment reform experiments and adding to the body of work by piloting reforms tailored to the needs of Colorado's citizens and communities.

This report is intended to serve as a resource for those working on this important health policy issue. It outlines reforms targeting the current fee-for-service payment system; Colorado's public and private sector efforts in deploying and testing new models; the available research on their effectiveness; and key insights and recommendations to advance payment reform in Colorado.

## Working Together

This publication represents a joint effort of the Center for Improving Value in Health Care and the Colorado Health Institute. Both organizations share the goal of providing information to help guide the discussion related to payment reform for Colorado. Our shared vision is to examine models of reform and identify areas of opportunity to advance evidence-based solutions.

# Payment Reform: *Moving from Volume to Value*

The fee-for-service (FFS) system is the most common payment method for health care services in Colorado and across the nation. FFS rewards providers for delivering more care by paying a predetermined amount for each discrete service. This tends to create “perverse incentives”<sup>5</sup> that encourage the delivery of more care. Often, it is more expensive care.<sup>6</sup> Under traditional FFS, providers receive payment for face-to-face visits but not phone or email consultations.

FFS does not compensate providers for coordinating care with other providers. Each provider is paid for his or her services, with no clinician responsible for managing quality or held accountable for costs. Today’s fragmented health care delivery system generates an estimated 30 percent of unnecessary, duplicative health spending.<sup>7</sup>

One opportunity for slowing the growth in health care costs is changing from FFS payment, which rewards for volume, to payment methods and strategies that reward for value.<sup>8</sup> Instead of paying for the quantity of services, the new models link payment to patient outcomes and cost-effective care. This is intended to create incentives for clinicians, hospitals and other providers to improve communication and coordination and share accountability for the cost and quality of their services.

Figure 1 shows the progression of payment reform models from paying for volume, usually with little accountability for cost or quality of care, to paying for value and outcomes. Providers on the path along this continuum assume greater financial accountability, or financial risk (see “Risky Business”), as they move away from FFS (see Figure 2).

## Risky Business

*Some new payment methods transfer financial risk and accountability for the cost of care to providers, creating stronger incentives for controlling costs, improving outcomes and promoting healthy behaviors. The level and amount of at-risk payment depends on the model. Sharing financial risk is generally more feasible for larger medical groups than it is for individual or small group practices because the systems needed to monitor and manage care, outcomes and costs are expensive.*

*In setting up risk-sharing arrangements, it is critical to distinguish between clinical risk and insurance risk. Effective risk-sharing payment strategies hold the provider accountable for the services provided to patients. This is clinical risk. The payer, meanwhile, is responsible for the risk associated with things over which the provider has no control, such as the health status of the patients who come to them. This is insurance risk.*

*“Risk adjustment” is the process of adjusting payments to minimize the provider’s exposure to insurance risk.<sup>9</sup> Some patients are considered riskier than others because they are more expensive to insure. For instance, they may be older or have a chronic medical condition. Adjusting for risk means that providers with sicker patients receive larger budgets to manage care. Appropriate risk adjustment is critical to ensure that providers have adequate resources to care for high-risk patients and that patients get the care they need.*

**Figure 1: The Progression of Payment Reform Models**

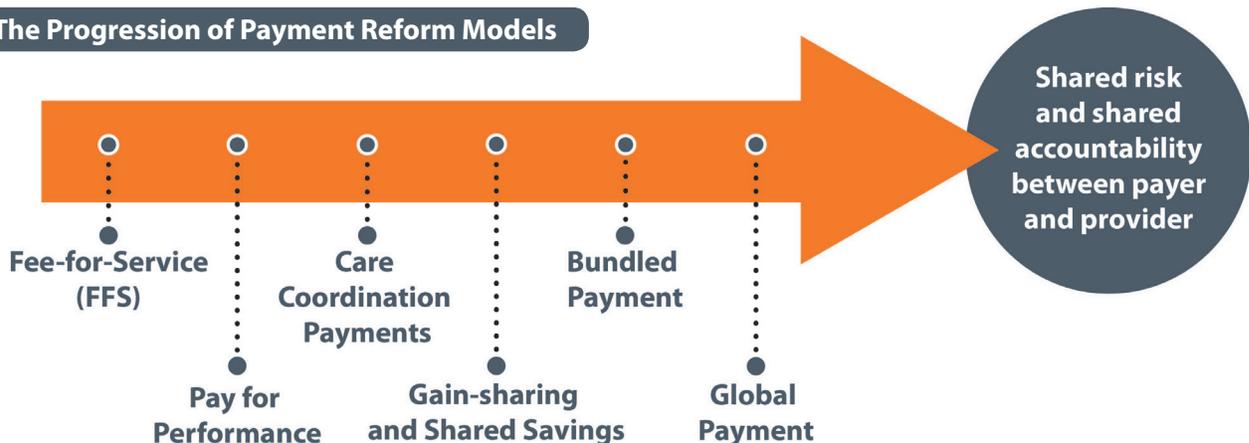
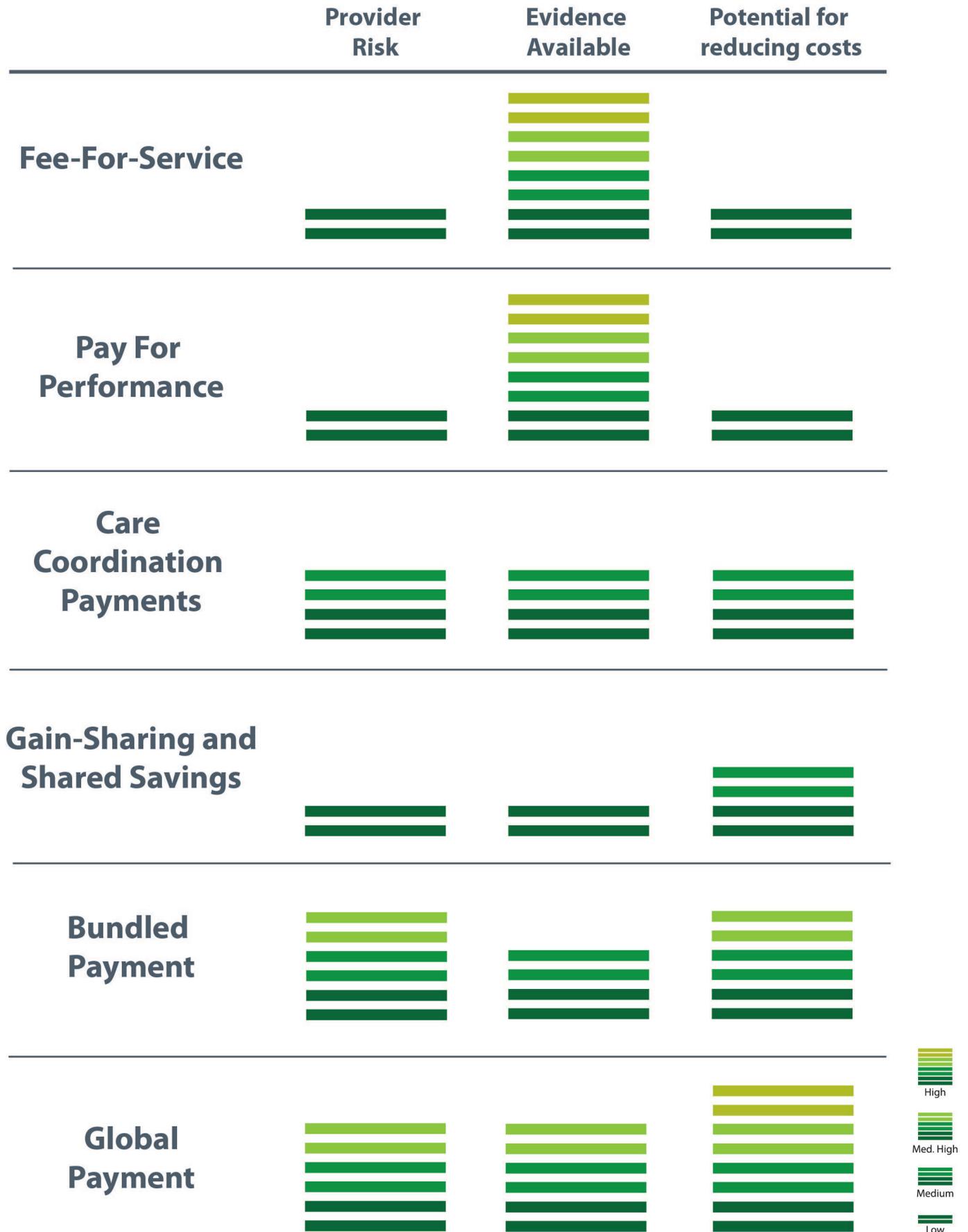


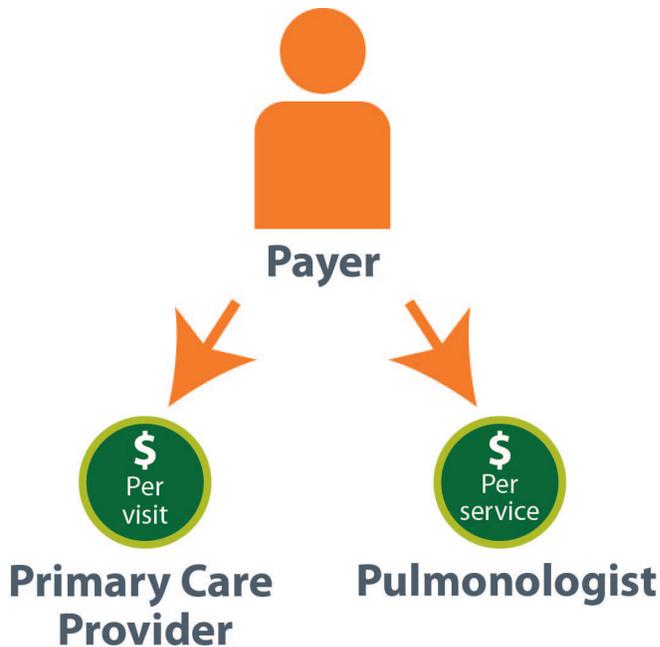
Figure 2: New Models of Payment Reform: Risk, Evidence, Effectiveness



# Overview of Payment Methods

## Fee-For-Service (FFS)

Patient = 40-year-old woman with asthma



### Overview

Under FFS, providers are paid a predetermined amount for each discrete service. They bill using a long-standing coding system that categorizes each service, whether a blood test, checkup or open heart surgery, according to narrowly prescribed parameters. Providers submit itemized claims to commercial insurers and public payers detailing the services provided during an encounter and tie them to billing codes. Providers are paid for in-person encounters but not for phone or email consultations or other work that does not have a billing code. The quality of care or its outcome for the patient does not make a difference in how much the provider is paid.<sup>10</sup>

### In Colorado

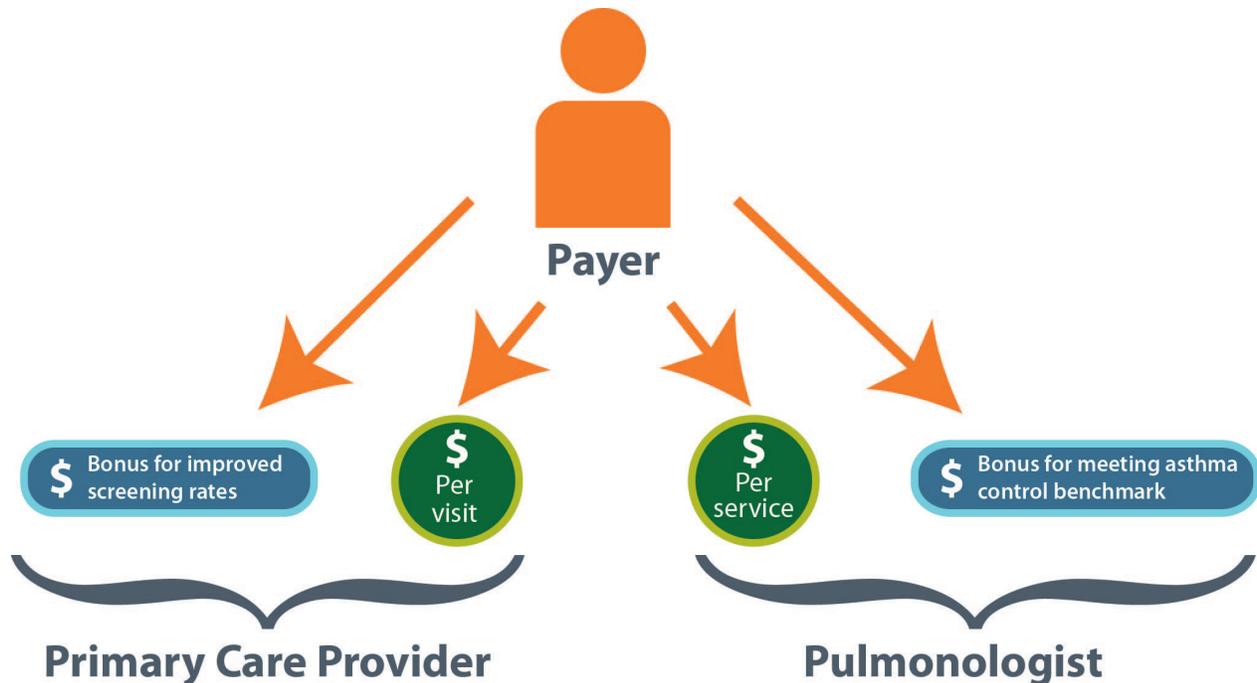
This is the most common payment method, in both commercial insurance and public programs such as Medicare and Medicaid.

### The Evidence

Providers bear no financial accountability for the quality of their care and receive greater rewards for providing more services. This arrangement creates financial incentives to provide more care and contributes to health care inflation.<sup>11</sup> While there are many factors influencing the continued climb in health care spending in the United States - an increase of nearly 3.5 times from 5.2 percent of Gross Domestic Product in 1960 to 17.9 percent in 2010<sup>12</sup> - FFS plays an important role.<sup>13</sup>

# Pay For Performance (P4P)

Patient = 40-year-old woman with asthma



## Overview

P4P rewards providers for meeting or exceeding pre-established benchmarks for care processes and patient health outcomes. For example, a pediatrician may receive a bonus if a majority of patients receive recommended immunizations. Similarly, hospitals that score well on quality-of-care measures such as surgical complications or mortality may receive rewards.

## In Colorado

Medicare is launching a P4P program, *Hospital Value-Based Purchasing*, in October 2012. More than 3,000 hospitals across the country, including Colorado hospitals, will receive incentive payments for high quality care or quality improvement on several measures. Payments will be reduced for hospitals that do not meet performance benchmarks.<sup>14</sup>

Commercial payers including Anthem, Rocky Mountain Health Plans and United Healthcare have incorporated P4P measures into their FFS provider payment models for many years and also feature them as part of their transitions to new payment approaches.

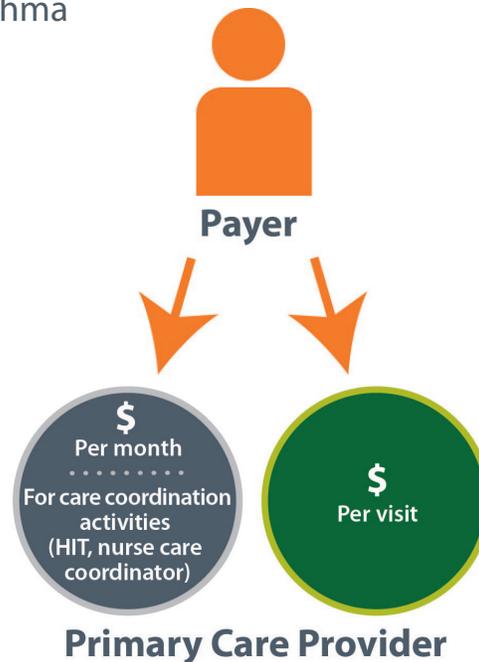
*Bridges to Excellence* is a P4P initiative administered by the Colorado Business Group on Health (Colorado's employer purchasing coalition), which pays per-patient bonuses to physicians who meet national standards for screening and effectively managing the care of patient with diabetes or cardiac disease.

## The Evidence

Evidence is mixed. While some studies suggest that P4P can improve care quality for certain conditions such as diabetes and increase the use of preventive services such as colonoscopy screenings, its impact on controlling health care costs is limited.<sup>15</sup> A study released by the Congressional Budget Office (CBO) in January 2012 evaluated the results of three Medicare P4P demonstrations. These demonstrations were conducted in different settings - physician group practices, hospitals and home health agencies - and linked P4P incentive payments to quality and spending benchmarks. The CBO evaluation found little to no effect on cost, citing the difficulties in achieving cost savings with payment methods that do not change the underlying FFS system.<sup>16</sup>

# Care Coordination Payments

Patient = 40-year-old woman with asthma



## Overview

In the care coordination payments model, health care providers receive monthly payments (in addition to their standard FFS reimbursements) to pay for the infrastructure needed to enable care coordination - costs that are not reimbursable under the FFS model. Examples include health information technologies such as electronic medical records and disease registries to help providers track and manage patients' care, and additional staff including nurses, medical assistants and other professionals. These staff may provide a range of care coordination and patient support services, including following up with patients between visits, staffing 24/7 patient call lines, providing education and self-care techniques, and serving as a communications hub among a patient's health care providers.<sup>17</sup>

Care coordination payments are most often found in the context of medical homes. Medical homes are delivery innovations designed to improve the continuity of care in the primary care setting, and to improve coordination among primary care providers and specialists, oral health and behavioral health providers, hospitals and long term services and supports providers.

## In Colorado

Both public and private payers have embraced the notion of care coordination payments and the medical home.

Colorado is the site of several medical home programs, including:

- The **Colorado Children's Health Access Program (CCHAP)**, which supports more than 240 primary care practices and 750 primary care providers as medical homes for nearly 276,000 children in Medicaid and CHP+.
- The **Safety Net Medical Home Initiative**, sponsored by The Commonwealth Fund, Qualis Health and the MacColl Center for Health Care Innovation at the Group Health Research Institute, which launched in 2008.<sup>18</sup> This five-year demonstration project is assisting 14 primary care safety net clinics to become medical homes.
- The **Multi-Payer Patient Centered Medical Home Pilot**, which ran from 2009 through April 2012, brought together five commercial payers (Aetna, Anthem, Cigna, Humana and United Healthcare) as well as Medicaid and CoverColorado (the state's high-risk pool) to provide care coordination payments to 16 Colorado primary care practices.
- The **Comprehensive Primary Care (CPC) Initiative**, sponsored by the Center for Medicare and Medicaid Innovation (see "A New Opportunity"), is just launching.

## The Evidence

A small but increasing number of studies suggest that care coordination payments in the context of medical home models, when designed for and targeted to appropriate populations, can lower health care costs.<sup>19</sup> Evidence from programs including Geisinger Health Systems in Pennsylvania, Group Health Cooperative in Washington and HealthPartners in Minnesota cite reductions in emergency room visits as well as hospital admissions and readmissions among patients with medical homes, resulting in cost savings.

Studies examining the potential of care coordination programs to reduce hospital admissions and re-admissions found that successful programs used team-based care models, maintained high levels of engagement and collaboration among physicians and care coordinators and had timely information about patient transitions between care settings.<sup>20, 21, 22</sup>

Colorado's medical home efforts are yielding small but positive results. Children in practices that participated in CCHAP had lower median Medicaid costs and fewer emergency department visits than those not in a CCHAP practice, according to the Department of Health Care Policy and Financing.<sup>23</sup>

Because the multi-payer pilot has just concluded, final data will not be available for some time. However, some preliminary results are available. Anthem reported that its pilot practices reduced hospital admissions by 18 percent (while control practices showed an 18 percent increase) and lowered emergency department utilization by 15 percent (compared with a four percent increase in the control group).<sup>24</sup> Preliminary analysis of quality impacts across all payers for the first two years of the pilot shows

## A New Opportunity

*Colorado is one of seven regions selected to participate in the Comprehensive Primary Care Initiative, a four-year program beginning in late 2012. The program aims to strengthen primary care using the medical home model by combining care coordination payments from Medicare with those of commercial payers.*

*In Colorado, the participating payers are Anthem Blue Cross Blue Shield, Cigna, Colorado Access, Humana, Rocky Mountain Health Plan, San Luis Valley HMO/Colorado Choice Health Plans, Teamsters Multi-Employer Taft Harley Funds, United Healthcare and Medicaid.*

*Medicare will select up to 75 primary care practices to test the potential of using significant care coordination payments to improve quality and lower costs by supporting primary care transformation. These practices will receive risk-adjusted per member per month payments from Medicare, Medicaid and the participating commercial payers to help pay for investments in infrastructure and personnel. They will also be eligible to share in a percentage of cost savings in the later years of the initiative if they meet quality improvement and cost reduction benchmarks.*

an overall reduction in emergency department visits by approximately 13 percent and a reduction in ambulatory care-sensitive inpatient admissions for patients with multiple comorbidities of approximately one-third. At this time, no cost impacts across all payers are available.<sup>25</sup>

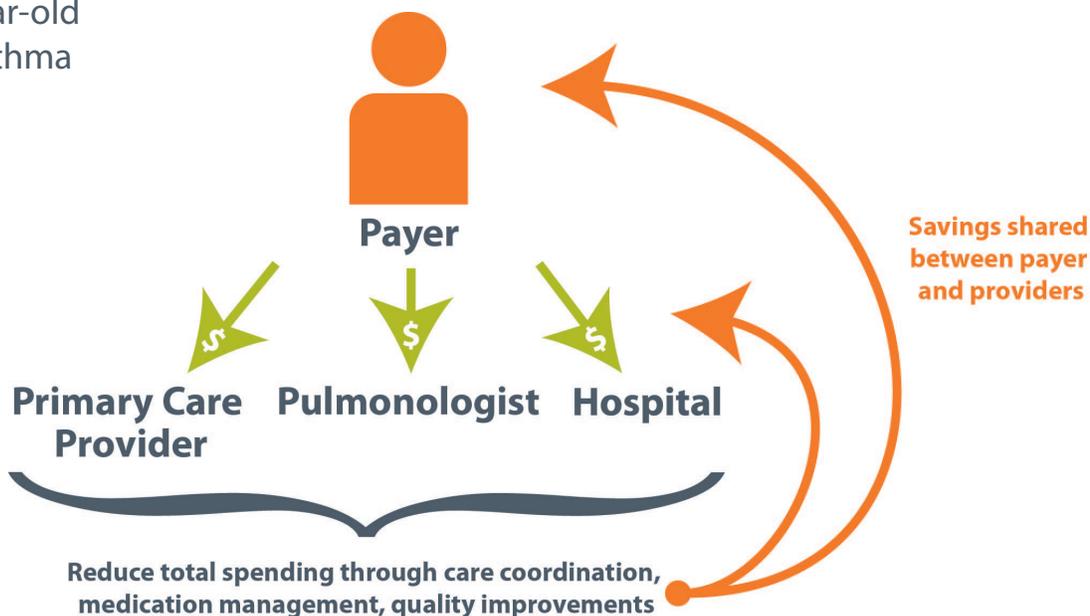
## What is a Patient-Centered Medical Home?

A patient-centered medical home is a model for delivering enhanced patient-centered health care that structures care delivery around patients' needs. Office hours are extended and there is greater use of phone calls and emails, as well as active coordination with other providers to manage all aspects of a patient's care. Practices that serve as medical homes frequently use a team-based staffing model, with a diverse set of medical professionals providing different skills and

services. Team-based care that includes lower-cost providers allows practices to deliver cost-effective care and use their workforce efficiently. Medical homes rely on information technology, including electronic health records and patient registries, to track and manage patient care and outcomes. Several national accreditation organizations have established functional areas in which practices must be competent to be recognized as a patient-centered medical home.

# Gain-Sharing and Shared Savings

Patient = 40-year-old woman with asthma



## Overview

This model offers providers a percentage of net savings resulting from their efforts to reduce health spending for a defined population. Alternatively, providers may earn bonuses for keeping costs below established benchmarks. Gain-sharing and shared savings models may be used by individual providers or small group practices as well as larger networks of providers.

Under a hypothetical shared savings arrangement, a provider who reduces the average annual total health care costs for her patients below a target, based on the previous expense of those patients and anticipated costs based on the patients' demographics and risk factors, may be eligible to receive a percentage of savings.

## In Colorado

Both commercial payers and those operating in the Medicaid arena - Anthem, Cigna, Colorado Access, Denver Health and Rocky Mountain Health Plans - are incorporating shared savings approaches into their payment structures. Anthem is including shared savings payments into its patient-centered primary care program. The CPC Initiative (see "A New Opportunity") also provides shared savings opportunities.

## The Evidence

Gain sharing/shared savings is often incorporated into

## What's an ACO?

*Accountable Care Organizations, or ACOs, are networks of physicians and other providers who are held accountable for the cost and quality of the care delivered to a group of patients.<sup>28</sup> ACOs provide an overarching structure for joining health care delivery system reforms, such as medical homes, and provider payment models, such as shared savings or global payment.<sup>29</sup> Medicare launched the Medicare Shared Savings Program (MSSP) in 2012 to encourage the voluntary development of ACOs, with approximately 150 ACOs participating nationwide. ACOs in MSSP can elect either shared savings arrangements or shared savings/shared loss arrangements. No Colorado ACOs have been created for MSSP, although Medicare is continuing to accept applications.<sup>30</sup>*

other payment models such as care coordination. As a result, few pilots and demonstrations that test the stand-alone cost-saving potential of gain-sharing/shared savings have been conducted.<sup>26</sup> An evaluation of an earlier Medicare shared savings demonstration, the Physician Group Practice Pilot, found that little to no money was saved. But this finding was influenced by the underlying FFS payment system upon which the shared savings model was built.<sup>27</sup>

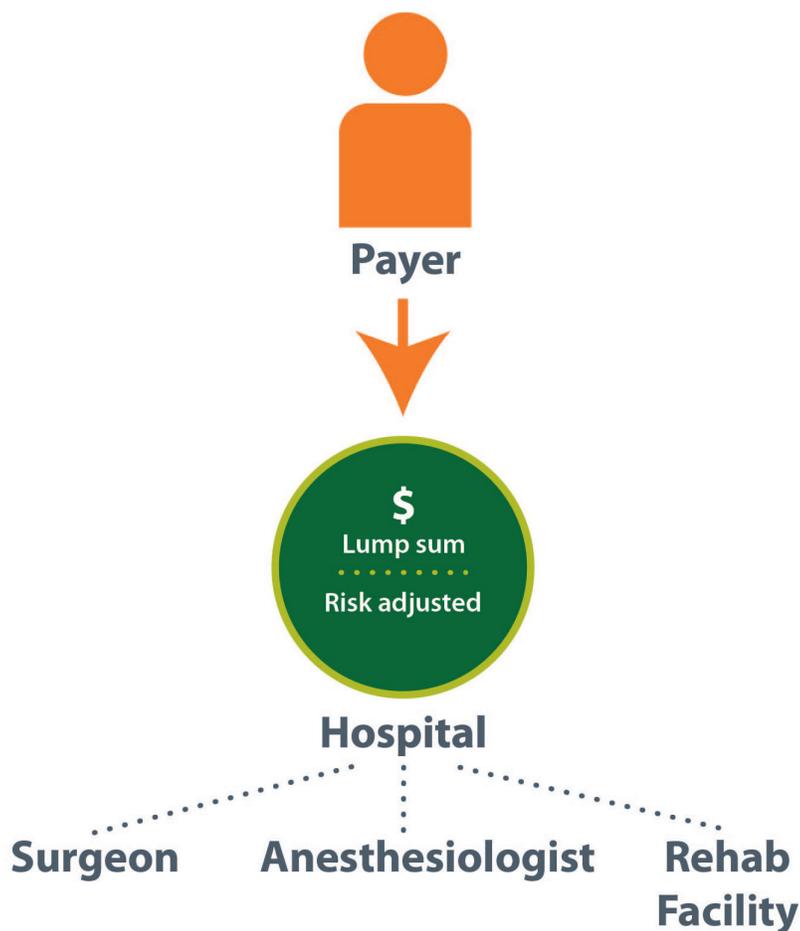
## Bundled Payment

Patient = 40-year-old woman with asthma



**Primary Care Provider**

Patient = 60-year-old woman needing knee replacement



### Overview

Bundled payment is a model that provides a single payment to a provider, or a group of providers, for all health care services associated with a defined episode of care. The episode may be for a specific condition (diabetes, for example), event (heart attack) or medical procedure (hip replacement). Most episodes of care have a reasonably well-defined beginning and end, but for management of chronic conditions, episodes are defined as all of the condition-related services in a certain period of time (for example, 12 months). Payment bundles can be adjusted to reflect the risk or severity of patients' conditions.<sup>31</sup> The goal of bundled payment is to control costs and improve outcomes by reducing or eliminating unnecessary or inefficient care and spending, and giving providers an incentive to work together to accomplish these goals.

For example, a bundled payment for joint replacement would cover a defined span of time (from hospital admission through a certain number of weeks of rehabilitation after the patient leaves the hospital) and a defined array of providers and services (surgeon, anesthesia team, rehab team, all hospital services and rehab care within the timeframe). Quality expectations and benchmarks are built into the bundle. For example, if the patient must be readmitted to the hospital for a potentially avoidable complication, the hospital/clinicians must cover that cost.

Savings are shared with providers when total expenditures for the episode of care are less than they would have been under FFS.<sup>32</sup> This is intended to provide incentives for providers participating in the bundle to work together to identify potential up-front cost savings such as negotiating lower prices for surgical

supplies and devices like implants. It is also designed to provide an incentive for providers to coordinate with one another in ways that they may not have previously. For example, the surgeons in a bundled arrangement may decide they need to check on their patient's progress at the rehab facility on a regular basis, something they receive no payment or incentive to do under the FFS model.

## In Colorado

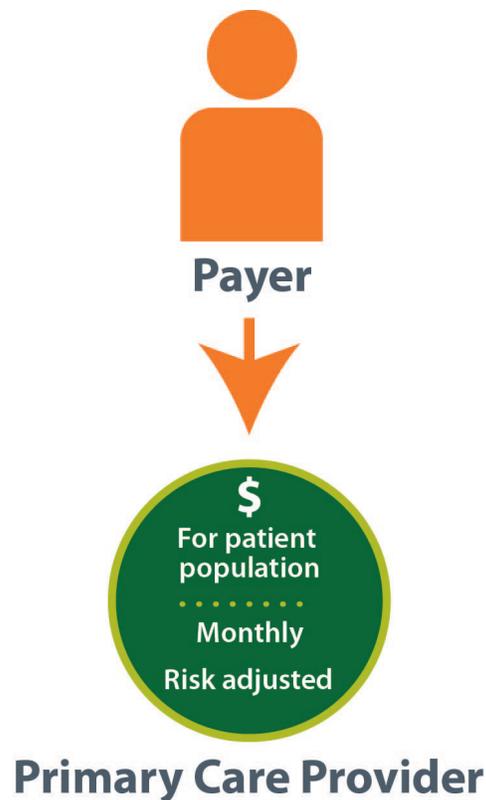
Two efforts to test bundled payment are underway. Exempla Saint Joseph Hospital is participating in the **Medicare Acute Care Episode** bundling demonstration for cardiac surgery. The Colorado Business Group on Health (CBGH) is overseeing the second pilot, **PROMETHEUS**, in Alamosa, Boulder and Colorado Springs with eight employers and engaging commercial payers in discussions about participation. The pilot will bundle payment for six chronic conditions: asthma, chronic obstructive pulmonary disease, coronary artery disease, diabetes, gastroesophageal reflux disease and hypertension.

## The Evidence

A 2009 study by RAND Corporation that modeled 12 options for controlling costs in Massachusetts found that bundled payment showed the greatest promise

for reducing health care expenditures relative to other approaches.<sup>33</sup> It is important to note that this study examined a variety of different interventions, not just payment reforms, and did not examine some of the reimbursement approaches, such as global payment, that this paper discusses. Studies that evaluated actual provider experiences with bundled payment have found some evidence of cost savings for specific conditions. For example, a study of Medicare's bundled payment pilot for heart bypass in the mid-1990s showed a 10 percent decline in spending and a reduced average length of stay among pilot program hospitals.<sup>34</sup> In the same time frame, Geisinger Health Plan in Pennsylvania reported a 21 percent reduction in complications and a 44 percent reduction in readmissions in its ProvenCare bundled payment pilot for heart bypass surgery in Medicare patients, leading to a five percent reduction in hospital costs.<sup>35</sup>

The PROMETHEUS pilots are in the early stages and do not yet have results. Implementing the complex PROMETHEUS model has been challenging for participating sites to incorporate into existing systems and requires time- and resource-intensive changes. However, participating sites report that, even before full implementation, the model is a valuable tool for quality measurement and stimulating care coordination activities.<sup>36</sup>



## Overview

Under global payment, providers are prospectively compensated for all or most of the care that their patients may require over a contract period, such as a month or a year. This is sometimes referred to as population-based payments, risk-based capitation or comprehensive care payments.<sup>37</sup> Bundled payments made for chronic conditions such as diabetes can also be thought of as disease-specific global payments. Like bundles, global payments are adjusted to reflect the health status of the patient. This risk adjustment protects providers from potentially significant financial losses associated with caring for patients with higher than average health care costs.

Global payment differs from the capitated payment model under managed care in the 1990s in some important ways. Although, like old-school capitation, global payment represents a fixed dollar payment per patient to a provider for care, it includes incentives, such as quality bonuses, to discourage under-treatment and to maintain or improve patient access to services. In addition, the data management systems available to health care providers today are better suited to the

information challenges associated with global payment. Recent pilot programs have provided technical assistance to participants to help address associated data and information management challenges.

Global payment provides financial incentives to deliver coordinated, efficient care and to promote preventive and health maintenance activities among patients because providers bear at least some financial risk for the cost and outcomes of patient care. Under a full risk model, providers retain any savings when the total cost of care is below the global payment amount. They are also responsible for paying any cost overages. Under a shared risk model, the provider and payer share any retained savings as well as take joint responsibility for paying costs above the budgeted amounts.

## In Colorado

Rocky Mountain Health Plans is planning to launch a global payment model on the Western Slope. Physician Health Partners' Pioneer ACO (see "Colorado's Pioneer") begins with shared savings but will transition to monthly global payments during the final year of the three-year pilot program with Medicare.

## The Evidence

Research indicates that global payment can reduce spending on health care services. Results from the first two years of Blue Cross Blue Shield of Massachusetts' multi-year initiative with global payment contracting found a steady slowing of health spending, including reduced hospital readmissions and savings in procedures and imaging, coupled with similar quality gains in chronic care management, adult preventive care and pediatric care (see "The Alternative Quality Contract").<sup>38,39</sup> Additional studies suggest that global and capitated payment result in lower use of unnecessary services and, with appropriate provider incentives, can be implemented in ways that maintain or improve quality and patient outcomes.<sup>40,41</sup>

### Colorado's Pioneer — Physician Health Partners

In January 2012, Colorado's Physician Health Partners (PHP), a management services organization that provides care management, data analysis and quality improvement services for primary care practices in metro Denver, was named one of 32 Pioneer Accountable Care Organizations by the Center for Medicare and Medicaid Innovation. The Pioneer ACOs are established networks of clinicians that will be held accountable for the cost and quality of care delivered to their Medicare patients. In the first two years of the five-year pilot, Pioneer practices will participate in shared savings with Medicare. As practices' ability to manage risk matures and they meet savings and quality benchmarks, they will transition to global payments that will entail the potential for "downside" risk as well, meaning they will share in spending overages as well as savings. Approximately 250 PHP physicians are participating in this pilot, providing care to nearly 28,000 Medicare recipients.

## The Alternative Quality Contract (AQC)

*Launched by Blue Cross Blue Shield of Massachusetts (BCBSMA) in January 2009, this modified global payment system is designed to promote care quality and significantly reduce the annual rate of growth in health care spending. Providers can either assume all of the financial risk or opt to share risk with BCBSMA. Payments are linked to achieving specific quality, performance and outcome benchmarks over a five-year period, with quality incentive payments of up to 10 percent of the monthly per patient global rate. Results of detailed claims and data analysis from the first two years of the AQC found positive cost savings and quality improvements, with the pace increasing in year two. The increased slowing of spending growth from year one to year two suggests that global budgets may be an effective tool to use in helping control health care spending, but also that organizations need time to implement changes.<sup>42</sup>*

*Per-member spending in year one among participating providers was between two and six percent less than at non-participating groups. BCBSMA reports that all groups met budget targets in the first year. In addition, participating groups realized reduced hospital readmissions accounting for about \$18 million in avoided costs and fewer non-emergency ED visits accounting for approximately \$300,000 in avoided costs relative to non-participants, largely due to a shift in referral patterns toward lower-cost specialists. While the magnitude of initial savings is modest, results suggest that quality can be maintained or improved under the global payment model. Total spending in the first year increased due to additional payments made to providers for quality bonuses and infrastructure investments. However, the focus of the AQC was to slow the growth of spending, rather than to demonstrate actual savings.<sup>43</sup>*

# What's Happening in Medicaid?

*Colorado's Medicaid program has seen a steep rise in enrollment resulting from the economic downturn. The corresponding increase in costs, coupled with the fact that an estimated 85 percent of all beneficiaries were in an unmanaged FFS model, led Colorado to launch the Medicaid Accountable Care Collaborative (ACC) in 2011.*

The goal of the ACC is to contain costs and improve health outcomes through a Care Coordination model. The ACC divides the state into seven regions managed by Regional Care Collaborative Organizations (RCCOs). RCCOs affiliate with local primary care providers, who receive traditional FFS payments with per member per month supplements to support care coordination for patients within their regions. RCCOs and primary care providers that reduce emergency department visits, hospital readmissions and outpatient imaging can be rewarded with incentive payments. House Bill 12-1281, passed in 2012, allows state Medicaid contractors to propose alternative payment arrangements, including global payments, to achieve greater savings.

In addition to the ACC, Colorado Medicaid is implementing a gain-sharing payment system with behavioral health organizations, federally qualified health centers and rural health clinics, allowing these providers to share in a percentage of any savings in Medicaid spending. Denver Health offers a managed care program, *MedicaidChoice*, which provides

a comprehensive, risk-adjusted payment via a capitated per member, per month rate. MedicaidChoice encourages primary care-oriented care for its enrolled Medicaid members and provides care within its integrated health delivery system.

## The Evidence

As a safety net program for some of Colorado's most vulnerable residents, Medicaid is only sustainable if the program implements mechanisms to improve care while controlling costs. To date, limited information has been made available on recent reform efforts. MedicaidChoice reports higher quality and utilization metrics for its members over those in FFS.<sup>44</sup> The Medicaid gain-sharing program has not been implemented and findings from the ACC have not been released. Understanding the efficacy of different efforts and identifying the most effective strategies in the current Medicaid system will be important as additional models and initiatives authorized through recent legislation (HB 12-1281) take shape.

# Implementation: Challenges and Options

*Research shows that payment reforms that continue to operate within the FFS framework are unlikely to achieve significant results. Yet, shifting from FFS to payment models that provide incentives for care coordination, quality outcomes and cost savings is challenging and time-consuming. Even as the opportunities within these new payment structures are spotlighted here, it is important to recognize ongoing challenges and develop strategies to address them. Experiences from the pilot projects cited in this paper provide helpful insights.*

## Aligning Payers

**Challenge:** Each payer assesses outcomes slightly differently. For example, while a provider will be asked to manage their diabetic patients' blood sugar levels, the reportable measurement or clinical value may differ by payer. A clinician who accepts many different types of insurance is being asked to meet many different goals. The administrative and clinical complexity is significant, and can undermine a provider's ability to meet care improvement goals.

**Options:** Aligning payers, both commercial insurers and public programs, around common measurements of care processes and health outcomes will minimize frustration and ease the burden on providers, facilitating wider take-up of outcomes-based payments. The CPC Initiative may help. All participating payers will have to measure practices according to Medicare's quality benchmarks. While there is the opportunity for payers to add other metrics to that core list, it is critical that all the participating commercial payers use the same ones. Organizations such as CIVHC, which operate as neutral conveners across interest groups, are well-positioned to broker such agreements.

## Engaging Patients

**Challenge:** New payment models that emphasize quality and patient outcomes require greater levels of patient engagement. While such engagement can enhance how a patient experiences care, not all patients will

understand these new models. Many may fear that, by emphasizing cost savings, new payment models will limit their access to the care and providers they want.

**Options:** Education is a sure way to minimize fears of the unknown. Educating patients about how the current payment system increases their costs and does not assure quality is critical. It must be accompanied with easy-to-understand information about how new payment approaches will affect their health care experience. Clinicians, especially nurses, are trusted messengers and can play a key role, as can consumer advocacy organizations.

## Engaging Employers

**Challenge:** Employers in the private and public sectors account for a significant portion of health care spending through premiums and the benefits included in the health plans they purchase for their employees. Still, few Colorado employers request their insurance carriers move toward payment models designed to improve quality and lower costs. In addition, some models, such as care coordination payments, may require additional investment in the early stages in order to demonstrate longer-term savings and a positive return on investment. Such messages may be difficult for employers faced with immediate cost concerns.

**Options:** Education, once again, is key. Employers must understand how FFS payment contributes to their costs, and how new payment models can help bend

that curve while improving the quality of care for their employees. With this knowledge, employers may begin to require their insurance carriers to switch models. It is also critical that employers understand the need for initial investments in new payment models that can yield long-term savings. CBGH, Colorado's coalition of employer health care purchasers, is an important messenger. Its Bridges to Excellence P4P and PROMETHEUS bundling pilot are designed to demonstrate the value of new payment models to the employer community. Colorado's All Payer Claims Database (APCD) - a database that will use insurance claims to illustrate health care spending and utilization statewide - is designed to help employers and their employees see prices and outcomes. (CIVHC is the state-designated administrator for the APCD.) This information can then be used to make informed choices about where to spend health care dollars.

## Supporting Providers

**Challenge:** Shifting from FFS may affect providers in different ways. Primary care clinicians typically receive low reimbursements under FFS compared to their specialist counterparts. Most cannot currently afford to make the investments required to support care coordination, including electronic health records and care management.<sup>45</sup> Many primary care clinicians will welcome any shift away from FFS. Specialists and hospitals, meanwhile, may view some new payment models with greater concern.

**Options:** Payment that encourages coordination and emphasizes outcomes can align incentives among primary and specialist clinicians and hospitals, keeping them working toward common goals. Phasing in reforms, beginning with shared savings and gradually moving toward bundled or global payment, may also assist providers in modifying their practices. While models that shift from FFS are developed and built, setting realistic expectations, measurements and time frames for success will be important.

## Supporting the Safety Net

**Challenge:** Colorado's safety net providers serve vulnerable populations with limited resources. While these providers often use efficient care models, their lean

operating budgets may not support the investments - robust health information technology, secure health information exchange platforms and nurse care coordinators - needed to implement reforms.

**Options:** Safety net providers are already engaged in Medicaid payment reform initiatives, including the Medicaid gain-sharing pilot with federally qualified health centers, rural health clinics and behavioral health organizations and care coordination in the ACC. New models that may be proposed as a result of House Bill 12-1281 are likely to involve safety net providers. These opportunities can be structured to give additional support and assistance for safety net providers.

## Measuring Progress

**Challenge:** Understanding the programs and interventions that successfully control health care spending and improve quality is difficult but essential. Data that show how much is paid for health care services across all payers, commercial and public, and what outcomes result from that payment, are currently unavailable.

**Options:** Evaluation needs to be integrated into reform efforts throughout the duration of the programs. In addition to examining the outcomes, evaluations that ask why and how programs work generate useful information for future programs.<sup>46</sup> Broad dissemination of findings enables replication and scaling up of successful interventions but also requires transparency regarding what is - and is not - working. Colorado's private sector - including foundations and neutral, non-profit organizations like the Colorado Health Institute (CHI) - can create opportunities for stakeholders to share lessons learned and best practices in safe, facilitated environments.

**Options:** The APCD will facilitate evaluation of new payment models. Its utility will be enhanced as its data grows. APCD data collection is beginning in 2012, first with the majority of claims for the fully insured market and Medicaid. Medicare will follow and self-insured employers will be asked to work with their third-party administrators to submit their data. Lastly, any statutes limiting payers' abilities to submit data to the APCD will be carefully examined with an eye toward modification.

## Conclusion

*A new urgency marks the work of patients, providers, employers, health plans and policymakers from across Colorado who have come together to solve the problem of ever-increasing health care spending – and the flawed payment system that is a key component of that growth.*

These stakeholders have started pilot projects, begun to test programs and hatched new ideas to address the complex problem of paying for health care in a way that best rewards value and results.

It has become increasingly clear that the current system is not sustainable. Rising health care spending limits future growth and investments in Colorado's businesses and communities.

Shifting from paying for volume to paying for value is a key strategy for changing this dynamic, for controlling costs, improving care for patients and improving the health of our communities.

Growing evidence points to care coordination payments, bundling and global payments as promising new pay-

ment models. This paper has outlined a variety of ways to make that shift and reported on the dedicated Coloradans testing these models.

Colorado's leaders in policy, practice and philanthropy can use this evidence to inform future approaches for the testing and take-up of the best new health care payment models.

This is a complex and ingrained problem. Solving it will take political will and continued allocation of resources and time. But Colorado's health care community is known nationwide for its spirit of collaboration and its forward-looking solutions to health care issues.

Harnessing this creativity, spirit of collaboration and energy can move Colorado forward.

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