

WHITEPAPER

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Navigating Payment Reform: Thriving Through the Changes to Come



5 Essentials for Surviving and Thriving as an Independent Practice

Executive Summary

Payment reform has long been discussed in health care, as escalating costs have spurred calls for changes to the dominant fee-for-service model. But the calls for rapid acceleration of reform have become louder and more urgent in recent years as the burden of health care costs reaches new, precarious heights and as a broad consensus has emerged that we're getting poor value for our money. Government health care spending costs have risen since 1980 and are projected to rise dramatically until 2050, unless something is done to stem the tide.

The federal government is pushing for improved quality, better population health, and reduced health care costs through legislative and regulatory activity, as well as much-needed collaboration with the private sector. Its initiatives include Shared Savings programs; reporting on quality measures; incenting practices to achieve Meaningful Use of electronic medical records; encouraging Patient-Centered Medical Home and Accountable Care models; and establishing the CMS Innovation Center to experiment with various forms of reimbursement. Private payers are also trying a variety of new approaches to payment.

With so many payment models in play, how can you prepare your practice for the changes to come?

There is a set of capabilities that you can develop that will not only help position your practice to respond to any of the payment reform models likely to occur in the future, but can also make your practice more successful now. The capabilities you will need to succeed fall into these categories:

1. Patient relationship management.
2. Influencing clinical protocols.
3. Referral management.
4. Connectivity and data exchange.
5. Counseling patients about medical costs.

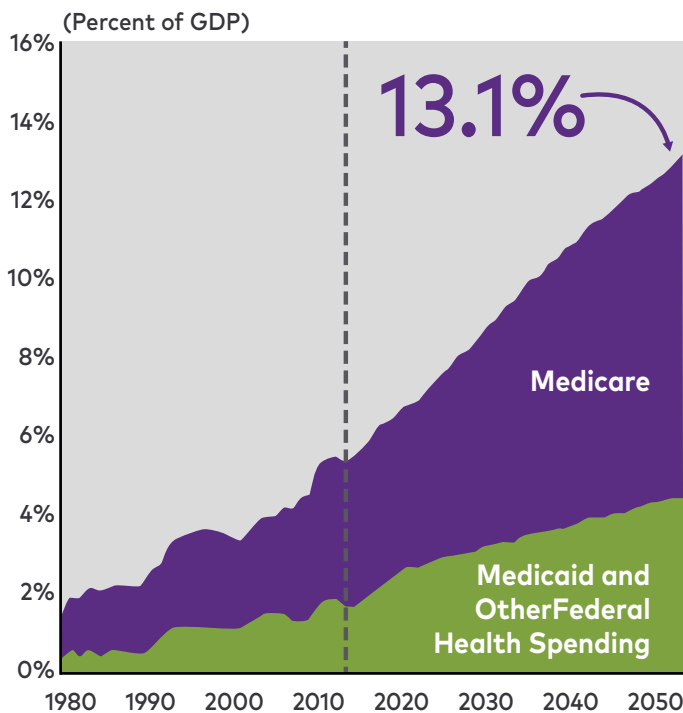
This whitepaper examines each of these categories and discusses the capabilities within them that can prepare your practice for the future of payment reform while offering immediate clinical and financial benefits.

Where We've Been, Where We Are Now

Payment reform has long been discussed in health care, as escalating costs have spurred calls for changes to the dominant fee-for-service model. But the calls for rapid acceleration of reform have become louder and more urgent in recent years as the burden of health care costs reaches new, precarious heights and as a broad consensus has emerged that we're getting poor value for our money.

Just how heavy is the burden of health care costs? Figure 1 provides a visual representation of how dramatically government health care spending costs have risen since 1980 and how they are projected to rise until 2050, unless something is done to stem the tide.

Figure 1. Medicare, Medicaid, and other federal health care spending as a percent of GDP 1980-2050



Source: CBO Long-Term Budget Outlook. June 2011.

Note: CBO: An alternative fiscal scenario: reflects gross spending on Medicare, Medicaid, CHIP, and outlays for health insurance subsidies through exchanges.

The escalating cost of health care puts tremendous pressure on an already teetering system in which the threat of reduced Medicare reimbursement to address over-spending against the Sustainable Growth Rate (SGR) continues to loom large. The SGR was established by the Centers for Medicare and Medicaid (CMS) to set a budget trajectory for Medicare expenditures each year. That spending

trajectory has been surpassed every year since 2002 without Congressional action, resulting in substantial debts under the SGR.

An American Medical Association letter to Congress in September 2011 summed up the situation this way: "Continued delay in replacing the SGR has escalated the cost of permanent payment reform, from \$48 billion in 2005 to nearly \$300 billion today. We estimate additional short-term interventions will double the cost to approximately \$600 billion by 2016."²

The need for health reform is driven not just by a broken financial system, however, but also by the need to replace payment models that don't promote and incent value-based care. Neither the government nor providers can afford to operate under the status quo. As Jeremy Lazarus, President-elect of the American Medical Association, wrote in a letter to the New York Times in February 2012:

"We agree that Congress must pass a permanent solution to the broken physician payment problem that plagues Medicare with frequently scheduled cuts, but eliminating this problem by putting in place other physician cuts rather than true payment reforms will only continue to threaten patients' access to care.

Medicare physician payments have already been nearly frozen for a decade, while the cost of caring for patients has increased by more than 20 percent. A 32 percent cut is now scheduled on Jan. 1, 2013.

More cuts are not the answer. They would compromise physicians' ability to participate in new models of care delivery..."³

Under the current fee-for-service model, payment is not aligned with value. Rather than motivating care coordination, patient engagement, and quality, the fee-for-service construct rewards volume alone. As a result, there is no market for good outcomes and cost-effective health care—only one for tests and procedures. Unless the market shifts, costs for medical services will continue to rise and as they do, all actors—government, payers, employers, and patients—will pay more for less.

The situation is untenable. Payment reform must accelerate, and all stakeholders must step up to change the system. As Senate Budget Committee Chairman Kent Conrad said at the Health Care Spending Hearing in February, 2012, "Now what is absolutely imperative for all of us, for the private sector, for the federal government, for state government, for local government, for our families, is that we don't let this trend line continue."⁴

Previous attempts to cut costs through payment reform have met with mixed results. For example, diagnosis-related groups (DRGs) was a classification system developed in the early 1980s that attempted to group hospital procedures into discrete units of activity to which prices could be assigned, thereby influencing physician behavior to contain associated costs. While DRGs have achieved some success, they have also created incentives to discharge patients too quickly, since outpatient and readmission costs were separately reimbursed. Group capitation was another cost-saving approach introduced in the 1990s, but it has also failed in many places due to factors such as inadequate

risk adjustment, “cherry picking” of procedures, under-utilization of routine care, and failure to take into account the activities expected of physicians under managed care.

With payment reform having such a mixed record to date, you might ask: why should this time be any different? For one, reform is now regarded as unavoidable, with a strong consensus emerging in support of broad systemic change. As importantly, we now have the technology, data, and tools to share information necessary for value-based models, making the widespread adoption of new payment models possible for the first time.

What the Government Is Doing about Payment Reform

The federal government is pushing for improved quality, better population health, and reduced health care costs through legislative and regulatory activity, as well as much-needed collaboration with the private sector.

Its initiatives include: Shared Savings programs under the Affordable Care Act (ACA); reporting on how doctors are doing on quality measures; providing incentives to practices that achieve Meaningful Use of electronic medical record technology under the HITECH Act; encouraging Patient Centered Medical Homes (PCMHs) and accountable care organizations (ACOs); and establishing the CMS Innovation Center to experiment with various forms of reimbursement.

In recent years, government programs have rewarded providers for quality measurement and reporting. While initiatives, such as the Physician Quality Reporting System (PQRS) and the Meaningful Use federal incentive program, represent a step in the right direction, quality is only one variable in the health reform equation. Cost control and outcomes measurement are notably missing from these penalty- or bonus-based programs.

However, the introduction of the ACO model marks the next step in the evolution of government reimbursement. While the model still relies on fee-for-service at its core, the inclusion of a risk basis for payment and a focus on patients and care coordination brings us closer to value-based payment.

An ACO is a system of inpatient, ambulatory, and ancillary care providers that assumes responsibility (becomes accountable) for the quality and cost of health care of a defined population of patients and shares in resulting savings. The initial round of applications for the ACO Shared Savings Program was submitted in January 2012, and 27 organizations were chosen to launch in April. The cost and complexity of establishing ACOs, however, ensure that the model will not be the solution for all providers and many have questioned its chances for success.

In order to identify, develop, support, and evaluate additional models of payment and care service delivery, the government instituted the CMS Innovation Center. Some of the payment reform provisions developed by the Center that will have an impact on providers over the next four years are:

- Medicare bonus payments to physicians who participate in quality reporting (2011 through 2014).
- Reduced Medicare payments to hospitals with high readmission rates (2012).
- Bundled payment pilot program with four models of payment (2013).
- Hospital value-based purchasing program, with payments based in part on quality (2013).
- Higher federal Medicaid matching payments for states that pay for care coordination services (90% match for 2013 and 2014 only).
- “Value index” based on quality and cost added to Medicare physician payment methodology; reduced Medicare payment rates for physicians not participating in Physician Quality Reporting Incentive program; and reduced Medicare payment rates for hospitals with high rates of hospital-acquired conditions (2015).
- Finally, in 2016, Medicare will launch a pay-for-performance pilot program.

While the government foots the bill for a substantial portion of health care spending, payment reform in the private sector is also imperative. With more flexibility and speed to innovate, providers and private payers can play a critical role in driving reform to achieve system-wide goals.

What the Private Sector Is Doing about Payment Reform

Private payers are also highly motivated to cut health care costs, of course, since they are responsible for treatment costs not covered by government programs or paid directly by patients. So, they are trying a variety of payment reforms—none of which are likely to emerge as the dominant model but which serve, nevertheless, as steps along the way to the ultimate shape of payment reform. For example, more than 25 health plans now incorporate PCMH recognition into their own programs, and many will offer financial incentives to practices that adopt the model.

A 2011 Commonwealth Fund paper, “Promising Payment Reform: Risk-Sharing with Accountable Care Organizations,” provides examples of new payment models that have been developed by private payers.

The models described in the paper often include multiple payment forms, such as bundled payments for some services, shared savings payments based on performance, penalties for declines in performance metrics, payment differential based on budget surplus or deficit, bonuses based on clinical quality metrics, and so on.⁵

By way of example, one program described in the paper is the Blue Cross Blue Shield of Massachusetts Alternative Quality contract, which Blue Cross describes as “an innovative global payment model that uses a budget based methodology, which combines a fixed per-patient payment (adjusted annually for health status and inflation) with substantial performance incentive payments (tied to the latest nationally accepted measures of quality, effectiveness, and patient experience). The goal of this restructured model is to enable the delivery system to give the patient the best result from the most appropriate treatment (e.g. based on the best medical evidence), by the right kind of provider (e.g. specialist, family doctor, nurse), at the right time (when intervention is most appropriate), and in the most appropriate setting (e.g. hospital, physician office, independent laboratory, home).”⁶

Pay-for-Performance (P4P) programs are also becoming an important part of the reimbursement environment, though physician adoption remains slow. The 2012 Physician Sentiment IndexSM survey conducted by athenahealth found that 57% of physicians are still not participating in any P4P programs. Payments available from P4P programs can average 7% of physician compensation, though they can be as high as 30%.⁸ One example of a P4P program is Bridges to Excellence (BTE), a private non-profit organization that works with insurance companies to facilitate quality improvement and incentives. To be eligible for recognition through BTE, a physician must achieve minimum thresholds for quality care assessed through both process and outcome measures. Where applicable, clinicians can establish eligibility for pay-for-performance bonuses, differential reimbursement, or other incentives from payers and health plans.⁷

What to Expect in the Future

It could take a decade or more for health care to shift entirely away from fee-for-service, but, with a debt crisis looming, we have reached a point where payment reform should be regarded as inevitable. While no one knows exactly how payment reform will evolve over time, which programs will succeed and which will fail, there are a number of common threads in the proposed solutions.

In addition to the models discussed above, some form of traditional fee-for-service is likely to remain in the mix, and patients are likely to continue to foot an increasing proportion of health care costs. We will see a great deal of experimentation with payment models with the situation growing more complex for physicians before it gets simpler. In order to encourage participation in these experimental payment programs, the models put forth by both the public and private sector will have to be financially incremental, with limited risk at the outset and growing risk over time, and they will combine outcome and process requirements.

While the reimbursement future remains murky, some trends stand out crystal clear: markets are aligning around value-based health care; major initiatives are focused on changing provider and patient behavior; and quality measures are taking hold as the path to success.

What It Takes to Thrive Today...and Under Payment Reform

With so many models in play, how can you possibly prepare your practice for all of them? No medical practice can afford to adjust care models and financial systems, investing staff time and resources, without a clear sense of strategy and focus. There is, however, a core set of capabilities that you can develop that will make your practice thrive now and help position you to succeed under any of the payment reform models likely to occur in the future.

Those capabilities fall into five categories:

1. Patient relationship management
2. Influencing clinical protocols
3. Referral management
4. Connectivity and data exchange
5. Counseling patients about medical costs

In the following sections, we will examine each of these categories and discuss the specific capabilities that can prepare your practice to thrive under future reimbursement models while allowing you to reap immediate benefits in the current fee-for-service structure.

1. Patient relationship management

Patient relationship management entails understanding your patients' health care needs and communicating effectively with them in order to deliver the right care at the right time. It requires the ability to:

- Mine your patient data to identify patients with gaps in care and patients who need to come into your office at regularly scheduled intervals or more frequently in order to receive the care they need.
- Reach those patients through phone, text, and email in order to inform them of their health care needs and get them into the office for treatment.
- Enable two-way communication with these patients, in order to keep them on track while efficiently answering questions they have about their care.
- Track third-party outside orders for these patients and follow up on them to ensure completion—and then communicate results to patients in order to guide their behavior.

Benefit in payment reform future: One of the ways the health care industry needs to reduce costs is by reducing hospitalizations through interventions that keep patients healthier and away from more expensive procedures. An ounce of prevention is worth a pound of cure. It's never been more true, and providers who excel at identifying which patient needs which prevention at what time—and getting it to them—will be the low cost, high quality providers who thrive under health care reform.

Benefit today: Patient relationship management will enable you to fill open slots in your schedule with patients who truly need additional care, minimizing your downtime and boosting schedule density and revenue.

2. Influencing clinical protocols

Influencing clinical protocols involves the ability to define what needs to happen when a patient is being treated and consistently execute on the required tasks. You should be able to:

- Standardize clinical protocols to provide the best and most efficient care.
- Ensure that clinical tasks are delegated to the most appropriate person on staff.
- Capture quality data in order to analyze the success of standardization and delegation.

Benefit in payment reform future: The ability to influence clinical protocols will enable you to meet the care thresholds and quality criteria required with some payment reform models; ensure timely, appropriate care to avoid hospital readmissions—penalized under some models; lower staff costs through delegation; and avoid malpractice and long-term costs by ensuring that correct preventative measures are taken. Under some models of payment reform, it will be necessary to follow proven clinical protocols for certain conditions and diseases. Virtually any kind of payment reform will require practices to document their workflow with patients, and the Meaningful Use federal incentive program already requires that this be done via an EHR.

Benefit today: The ability to influence clinical protocols can enable you to provide and bill for all essential services, improve quality, and reduce malpractice risks by ensuring that proper procedures are being followed and documented and by giving your providers feedback on their success at using them.

3. Referral management

Managing your referrals enables you to ensure that your patients get the best care at the most reasonable cost. In order to do this effectively you need to:

- Have access to data about the location, capabilities, quality, and cost of third-party health care service providers, both inside and outside your network.
- Make this information conveniently accessible to your providers and patients.

Benefit in payment reform future: In approaches that involve global or bundled payments, the division of a set amount of funds among a group of providers will require each provider to work as efficiently as possible in order to prosper. Managing your referrals will enable you to achieve better care coordination at lower cost, because data will be easily accessible to providers and their patients and results can be tied back to orders. Practices will benefit from keeping care within the network of health care providers that manage a patient's care, because that network is sharing the cost of providing care.

Benefit today: Managing your referrals will make patients more aware of the high quality of care you offer within your network and encourage patient loyalty.

4. Connectivity and data exchange

Connecting your practice with other health care providers and services and exchanging data with them can enable you to both improve care and lower costs. In order to do this you must:

- Establish reliable, efficient electronic connections with payers, hospitals, labs, imaging centers, state registries, and so on.
- Work with an EHR system that enables you to exchange data easily, accurately, and securely with all of these entities.

Benefit in payment reform future: One of the driving forces in health care reform—and the motivation behind the PCMH movement and the federal government's championing of ACOs—is the lack of coordination among providers. One study mentioned in a *New England Journal of Medicine* article found that in 49% of referrals the receiving physician was given no information and in 55% of referrals the ordering physician got no information back from the receiving physician.⁹ Connectivity and data exchange can enable you to meet foundational payment reform requirements, cut costs for duplicate testing and redundant care, and ensure that you have the data you need at the point of care to help you achieve the quality care goals some payment reforms will set.

Benefit today: Connectivity and data exchange can enable you to reduce costs through efficient, accurate communication with other health care providers and services, providing you with better data for decision-making and helping you improve your quality scores.

5. Counseling patients about medical costs

Counseling your patients about their medical costs can benefit them and benefit your practice: it prepares patients for the expense of care and provides them with options while enhancing your relationships with them and making it more likely they will pay in a timely manner. For effective financial counseling you need to:

- Set expectations for likely costs.
- Present options for high-quality, lower-cost treatments.
- Provide payment arrangements that meet patient needs.

Benefit in payment reform future: One of the keystones of payment reform is better management of costs. This will require providers to discuss costs with patients, enlisting their involvement to ensure that treatments occur in the most cost-effective way that serves patients' needs. Financial counseling will enable you to direct patients to lower-cost procedures and help them avoid unnecessary care—both of which will be required under many forms of payment reform.

Benefit today: Effective financial counseling and communication can help remove stress from patient billing discussions by addressing the subject in a straightforward manner. It can also improve the collection of the patient responsibility portion of treatment charges.

Now is the Time to Prepare for Change

There is no reason to wait to find out which kinds of payment reform will be enacted over the coming years—nor is waiting wise. Selectively building the capabilities described above can improve your practice's bottom line and the quality of the care you deliver today, while readying your practice for future forms of reimbursement still emerging.

athenahealth: A Partner to Help You Thrive Through Change

athenahealth's cloud-based services for practice management, electronic health records, and care coordination are uniquely capable of responding to changing reimbursement models anticipated under payment reform.

We continuously monitor and track the latest industry trends and adapt our solutions to ensure our clients stay profitable and compliant through all the changes to come.

- **Patient relationship management**—athenaClinicals® enables you to mine patient data and identify groups with gaps in care, while athenaCommunicator® enables you to communicate with those groups via phone, email, and text to encourage them to come in for treatment. One client used these tools to contact 83% of its patients about flu shots, announcing a flu shot clinic that brought in 869 patients and \$13,000 in additional revenue.
- **Influencing clinical protocols**—athenaClinicals enables you to delegate tasks to the appropriate person and document its execution. It also documents your clinical protocols and tracks each provider's success at using them, providing them with feedback via a real-time dashboard view. You can see, at any given moment, how well each provider and staff member is progressing toward satisfying the measures for which they are responsible. Meaningful Use attestation success serves as a good yardstick for how well this capability has been achieved. An industry-leading 85% of eligible athenahealth clients attested and got paid in 2011.
- **Referral management**—athenaCoordinatorSM enables you to spend less time managing outbound orders, obtaining pre-certifications, scheduling patients, and following up with clinical documentation. It also provides you with much greater visibility into the status of the patients you have sent to other facilities. athenahealth's order management service allows receivers of orders to get clean patient demographic, insurance, and clinical data. Spending less time on these tasks frees up your providers to focus their efforts on patient care.
- **Connectivity and data exchange**—athenaNet® connects more than 33,000 providers to the largest network of payers and labs in the nation. athenahealth has sought out and connected with 36 registries in 33 states, making them instantly available to all clients in those states. All but one of athenahealth's providers have been able to either satisfy the Meaningful Use connectivity measure or claim exemption from it.
- **Counseling patients about medical costs**—athenaCoordinator provides facilities with the ability to inform patients ahead of time about potential costs, facilitating easier discussions with patients. athenaCoordinator services include pre-registration, during which patients are given a clear picture of what the third-party treatments you have ordered for them will cost and what payment options are available.

athenahealth provides the tools to help you achieve the tasks, and capture, measure, and report on the metrics, that will determine your practice's ability to deliver cost-effective care in the years to come.

Endnotes

1. Transcript of remarks by Senate Budget Committee Chairman Kent Conrad (D-ND) at hearing on Putting Health Care Spending on a Sustainable Path, February 29, 2012, [click "view charts" in summary paragraph] http://budget.senate.gov/democratic/index.cfm/speeches-and-remarks?ContentRecord_id=06bafd63-95b9-477a-9898-b13f363dc240&ContentType_id=d9d7aad4-81c5-463a-a3e8-9a4c4d7eb824&27f11e11-fcf1-4df1-a902-5227eb9c6a67&Group_id=c7a5c4c3-6dec-49be-9e36-7d6e11d4873f.
2. AMA-sponsored letter to Jeb Hensarling, Co-Chair Joint U.S. House of Representatives Select Committee on Deficit Reduction, September 20, 2011, <http://www.ama-assn.org/resources/doc/washington/sgr-repeal-sign-on-letter-hensarling-20sept2011.pdf>, pg 1.
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4. Conrad, *supra*.
5. "Promising Payment Reform: Risk-Sharing with Accountable Care Organizations," Commonwealth Fund, July 2011, pgs vi-20, <http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2011/Jul/1530Delbancopromisingpaymentreformrisksharing%202.pdf>.
6. "Blue Cross Blue Shield of Massachusetts, The Alternative QUALITY Contract," May 2010, <http://www.bluecrossma.com/visitor/pdf/alternative-quality-contract.pdf>, pg 2.
7. 2012 Physician Sentiment IndexSM. Annual survey conducted by athenahealth.
8. Med-Vantage/Leapfrog press release, "Med-Vantage and Leapfrog Present Early Results From 4th National P4P Survey," March 9, 2009.
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Notes

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we connect care™

A leading provider of cloud-based services and mobile tools for medical groups and health systems. Our mission is to be the most trusted service to health care providers, helping them do well by doing the right thing.

 **athenahealth**