By Paul B. Ginsburg

DOI: 10.1377/hlthaff.2012.1007
HEALTH AFFAIRS 32,
NO. 5 (2013): 929–934

ANALYSIS & COMMENTARY

Achieving Health Care Cost Containment Through Provider Payment Reform That Engages Patients And Providers

Paul B. Ginsburg (pginsburg@hschange.org) is president of the Center for Studying Health System Change, in Washington, D.C.

ABSTRACT **The best opportunity to pursue cost containment in the next five to ten years is through reforming provider payment to gradually diminish the role of fee-for-service reimbursement. Public and private payers have launched many promising payment reform pilots aimed at blending fee-for-service with payment approaches based on broader units of care, such as an episode or patients' total needs over a period of time, a crucial first step. But meaningful cost containment from payment reform will not be achieved until Medicare and Medicaid establish stronger incentives for providers to contract in this way, with discouragement of nonparticipation increasing over time. In addition, the models need to evolve to engage beneficiaries, perhaps through incentives for patients to enroll in an accountable care organization and to seek care within that organization's network of providers.**

For many years the US approach to controlling health care costs has centered on public payers' lowering providers' payment rates, while private payers increased patients' cost sharing and required prior authorizations for hospitalizations and some tests and procedures. However, provider and consumer push back, the latter fostered in part by continued large tax subsidies for those who obtain comprehensive health insurance through their employers, have limited the success of these approaches.

Yet as cost containment becomes increasingly urgent, these tools are being used more often. Under the Affordable Care Act, for instance, reimbursement pressure on providers has increased. And employers who provide health insurance are imposing larger increases in deductibles and copayments than in the past.

Public- and private-sector health care leaders' attitudes about cost containment are changing amid an emerging consensus that health care spending trends are unsustainable and traditional cost-control approaches are reaching the limits of acceptability. Health care spending continues to consume a growing share of the gross domestic product—almost doubling in the past three decades, from 9.2 percent in 1980 to 17.9 percent in 2011. An increasing number of Americans cannot afford health insurance because increases in premiums are outpacing income growth.

Meanwhile greater portions of federal and state budgets are needed to support health coverage for elderly, disabled, and lower-income Americans. In addition, spending on Medicaid expansions and insurance premium credits under the Affordable Care Act will leave federal and state budgets even more vulnerable to health care cost trends than in the past.

Indeed, the prospect that health spending will continue to grow more rapidly than the national income is the basis for the alarming projections that the federal debt will rapidly increase in

relation to the gross domestic product.[1] Controlling health care spending will be a critical element in long-term deficit reduction.

Providers' perspectives on cost containment are changing as well. Many providers are already working to further constrain operating costs as they prepare for sharp cuts in Medicare payment rates under the Affordable Care Act. And private insurers may have begun responding to purchasers' growing resistance to premium increases by negotiating more aggressively with providers to hold down payment rate increases.[2,3]

To address spiraling health care costs, hospital and physician leaders increasingly talk of reengineering the delivery system. Changes are likely to include additional coordination across care settings and providers, more effective management of chronic disease by both providers and patients, and a larger role for primary care.[4]

This article begins with a description of approaches to payment reform designed to contain costs. It outlines the important role of Medicare and Medicaid in this process and discusses the pilot programs authorized and funded by the Affordable Care Act. It argues that for this approach to cost containment to really bear fruit, Medicare will have to move beyond pilots and impose increasingly strong disincentives on those providers not participating in these payment approaches. The Medicare model in these pilots will also need to evolve so as to encourage beneficiaries through financial incentives to enroll in accountable care organizations and use providers in their networks.

Payment Reform To Control Costs

The best opportunity for cost containment is through provider payment reform that moves away from fee-for-service payment, which rewards greater volume and does nothing to support care coordination or chronic disease management, and toward models that engage and reward providers and patients for reducing costs and increasing quality. New payment methods are needed to motivate providers to pursue new care delivery approaches and to support those who succeed in reducing the unnecessary use of services. More efficient care delivery should involve providing some services, such as care coordination and patient education, that are not currently reimbursed under fee-for-service but have the potential to reduce the need for other services, including inpatient care.

Many private health plans and health systems are experimenting with new payment methods. These are primarily shared savings arrangements, which allow providers to share a percentage of the savings achieved when they deliver care at lower cost than budgeted. Examples include Blue Cross Blue Shield of Massachusetts's Alternative Quality Contract and the Total Cost of Care contracts between Minnesota Blue Cross Blue Shield and health systems in the Twin Cities area.[5,6] Accountable care organizations, authorized under the Affordable Care Act, are similar approaches.

A Key Role For Medicare And Medicaid In Payment Reform

These private initiatives hold promise, but their potential will be limited unless Medicare and Medicaid also aggressively pursue consistent provider payment approaches. In 2011, 38 percent of health consumption expenditures came from these public payers, with the proportion of hospital spending probably even higher.[7] Additional efforts within Medicare and Medicaid could provide the critical mass to achieve meaningful payment reform.

Delivery reform is a risky endeavor for providers, because success in reducing costs through care coordination and other initiatives applied to all patients may lower margins for patients whose care is paid for through traditional fee-for-service payments. Unless public and private payers adopt similar reforms, there may not be enough patients to ensure that providers that improve efficiency do not suffer financially. For example, if a reimbursement contract that rewards efficiency, such as a shared savings contract, covers only 20 percent of patients, the lower returns for the remaining 80 percent of patients who remain under fee-for-service could outweigh the rewards.

The Centers for Medicare and Medicaid Services (CMS) is already taking steps to motivate providers and payers to seek contracts that are consistent across payers. For example, contracts with Pioneer Accountable Care Organizations, discussed below, require the organizations to contract with private payers in a consistent manner. In addition, CMS's Comprehensive Primary Care initiative, a patient-centered medical home approach, is limited to areas in which the Medicaid program and leading private payers have agreed to use the same approach.[8]

Accountable Care Organizations And Bundled Payment In Pilots

The Affordable Care Act jump-started public-sector payment reform efforts. For example, it authorized accountable care organization contracts between CMS and provider organizations, making providers that meet quality standards eligible to share savings with Medicare.

The act also created the Center for Medicare and Medicaid Innovation, which has the authority to conduct pilots of a wide range of payment innovations, including a type of accountable care organization contract involving greater risks and rewards for the provider organizations—the Pioneer Accountable Care Organizations—and bundled payment models for selected inpatient admissions, in the Bundled Payments for Care Improvement initiative. Past demonstration projects have often been small and of a fixed duration. But these pilots will involve many provider organizations, and successful pilots are likely to be continued and expanded.

Providers' interest in the pilots has been encouraging. The Medicare Shared Savings Program, which contracts with accountable care organizations, met with a lukewarm reception when the proposed rule was announced in early 2011. However, the final rule, posted in late 2011, has sparked interest in the provider community.

CMS now has contracts with 250 accountable care organizations, covering four million Medicare beneficiaries.[9] Most of the contracts offer only upside risk to providers, meaning that providers will be rewarded if they succeed in lowering costs below targeted projections but not penalized if they fail to do so.

In addition, CMS recently announced that more than 500 organizations will be negotiating bundled payment contracts.[10] These contracts will encourage hospitals, physicians, and post-acute care facilities to work together to improve health outcomes and lower costs for episodes of care for certain conditions involving an inpatient admission, such as hip or knee replacements.

Substantial resources will be devoted to evaluating these pilots, and the results will inform the next steps in provider payment reform. Given the support for these payment approaches from providers and payers and the lack of sustainability of the status quo fee-for-service model, any initial unfavorable results are more likely to lead to changes in the model than to abandoning the strategy. And favorable results will spur policy makers under pressure to constrain Medicare spending growth to look more aggressively for ways to transition from pilots to more broadly applicable reform.

Moving Beyond Pilots

Despite the enthusiastic take-up, the pilot initiatives face important limitations. The most serious limitation is that because these programs are voluntary, the benchmark performance targets for an accountable care organization's spending—the basis of the shared savings calculations—must be based on the actual recent payment experience of each accountable care organization or organization accepting bundled payments. If regional or national benchmarks were set for participating accountable care organizations, but the programs remained voluntary, the pilots would probably attract only providers with spending already below the benchmark, which would be sure to receive the shared savings bonus payments.

Consider a hypothetical example of a region where Medicare spending per beneficiary—including Medicare payments and patients' cost sharing—is $10,000 per year. Spending for beneficiaries attributed to different accountable care organizations, however, ranges from $6,000 to $14,000. If all providers in the region were members of accountable care organizations, Medicare might offer shared savings to each organization based on a benchmark of, say, $9,800 per beneficiary. Under a voluntary pilot, those accountable care organizations with per beneficiary spending well above $10,000 would not participate, but many of the organizations with spending under that amount would.

The result of such a selection process would be a large transfer of Medicare resources to lower-cost providers and little participation by higher-cost providers. Furthermore, the lower-cost providers would not have to deliver care any differently to profit from their contract, although some might attempt to increase their efficiency to increase profits.

CMS thus bases the spending benchmark for each accountable care organization on what Medicare paid for beneficiaries attributed to the organization's providers in recent years. For organizations to succeed in the pilot, they have to improve their own performance, thus motivating everyone to improve. In theory, success will be easier for providers with higher costs, who may have more "low-hanging fruit" when it comes to improving efficiency, making participation more attractive to them.[11]

However, setting shared savings goals based on the accountable care organization providers' past performance cannot continue over the long term. After an initial three-year Medicare accountable care organization contract, the question becomes how, if at all, cost benchmarks should be adjusted during contract renewal. Does Medicare raise the bar for the provider, to reflect the provider's experience during the pilot? Or does it continue to use the old data and reward the provider if it maintains the progress achieved during the initial contract?

Choosing the former option would substantially undermine providers' incentives, since the rewards for their initial success would be at risk from the more challenging benchmark

for the subsequent period. But continuing a benchmark based on an accountable care organization's costs in the distant past could create a perpetual reward for those beginning with the lowest efficiency and a perpetual struggle for those starting as relatively efficient.

Indeed, consultants have been pointing out the lack of an upside in Medicare's accountable care organization contracts with providers, advising their clients that the main reason to participate is to start learning how to manage as part of accountable care organizations—even if near-term rewards are limited—in anticipation that payment reform efforts will continue to move in this direction. However, some health systems that believe they are already relatively efficient have begun to consider an alternative: creating a provider-sponsored Medicare Advantage plan, where their payments would be based not on their historical spending but on risk-adjusted per capita spending in the region.

Private payers face similar challenges in encouraging providers to enter contracts with innovative payment arrangements. Blue Cross Blue Shield of Massachusetts's Alternative Quality Contract currently bases rates on each provider's historical experience, and it remains to be seen how negotiations for subsequent contracts will proceed. Presumably, providers' expectations that reformed payment contracting of some type will become the norm have outweighed the unattractive short-term financial proposition.

Transitioning From Pilots To Long-Term Programs

Nonetheless, voluntary pilots are an appropriate first phase of payment reform, during which contracting approaches are refined and providers prepare for stronger incentives to increase efficiency. Evaluations of the pilots will help further refine the payment approaches.

But after the initial adjustment period—in, let's say, three to five years—it will be time to transition from pilots to more inclusive payment policies that either apply to all providers or assess mounting reimbursement penalties on nonparticipants. The transition will not be simple. Requiring all providers to participate in new payment arrangements such as accountable care organizations might not be politically feasible for quite some time. However, providing smaller payment rate updates for services for providers not contracting under reformed payment might be.

For example, annual updates in payment rates for nonparticipants could be two percentage points less than the updates that participants would receive. Such an approach could be incorporated into a broad package of measures designed to reduce Medicare spending, a process that could follow adoption of a congressional budget resolution later in 2013. The approach could also include a permanent "fix" to the Sustainable Growth Rate formula, which CMS uses to calculate annual changes in Medicare physician payment rates.[12] As differences in payment rates between participants and nonparticipants increased, most providers would probably transition into the reformed payment system.

Once most providers had opted into that system, the basis for spending benchmarks could then transition from each accountable care organization's prior spending experience to regional spending experience. For example, regional spending could begin with a weight of 20 percent and increase 20 percentage points each year until reaching 100 percent.[13]

A transition from voluntary to quasi-mandatory participation in Medicare payment reforms would aid private payers seeking to create similar contract arrangements. Indeed, coordination in payment methods among public and private payers is critical for providers' transitioning to more efficient care delivery. To this end, efforts to standardize contracts between providers and private payers, and changing Medicare methods in the state to be consistent with them—as discussed in Massachusetts shortly after enactment of that state's health insurance expansion, but not yet pursued—could have merit.[14]

Engaging Patients

A striking contrast between how private insurers and Medicare pursue provider payment reforms concerns the degree to which patients are engaged. An approach gaining traction in private insurance is to provide incentives for patients to choose providers who offer better "value," a composite of efficiency and quality. For example, an enrollee seeking knee replacement surgery could be offered lower cost sharing if he or she selects a participating orthopedic group and a hospital that accept a bundled payment for the procedure—or a group or hospital with a lower bundled rate than that of other organizations.

Engaging patients through incentives can lower spending in two ways: by directing patients to more efficient providers and by motivating providers to improve efficiency to increase or retain their market share. If reforms involve incentives for beneficiaries, the provider has the potential for higher margins through shared savings and for increased patient volume at the expense of competitors.

In contrast, Medicare has rarely used incentives to direct beneficiaries to more efficient providers. Hospital deductibles—a form of cost sharing—are uniform nationwide. Coinsurance amounts vary only slightly across providers, although there is greater variation across provider types—such as hospital outpatient, ambulatory surgical center, and physician office—where different payment systems lead to differences in payment rates and coinsurance amounts. Few beneficiaries perceive the differences in coinsurance, however, because widespread use of supplemental coverage protects them from these costs.[15]

Similarly, Medicare does not currently provide incentives to beneficiaries to choose primary care physicians who participate in accountable care organizations or to use surgeons and hospitals that participate in such organizations or bundled payment pilots. As a result, Medicare lacks levers to shift volume to lower-cost providers, and there is no opportunity for providers to gain volume through greater efficiency.

Failing to engage beneficiaries also exposes payment reforms to the risk of political backlash. With no direct stake in reforms, such as rewards for using more efficient providers, beneficiaries may suspect that a policy has negative implications, such as the rationing or withholding of care, without perceiving the positive ones.

A more promising way to engage Medicare beneficiaries is to create an accountable care organization model in which beneficiaries enroll in a specific organization, as proposed by Steven Lieberman, in contrast to the current approach in which beneficiaries are attributed to accountable care organizations.[12,16] Under this scenario, beneficiaries could be offered lower Medicare Part B premiums and lower patient cost sharing for using providers in the accountable care organization's network—and they would pay higher premiums if they did not enroll and higher cost sharing if they did enroll but used providers outside of the network. As an added incentive to enroll, beneficiaries could even be offered a share of the accountable care organization's savings as a premium rebate.

Enrollment would also address the problem of attributing beneficiaries to accountable care organizations—an imperfect process. Attribution is done on the basis of which primary care physician a beneficiary uses most, but many claims histories lead to incorrect attributions. With an enrolled population, accountable care organizations could encourage beneficiaries to participate in disease prevention activities, healthy behaviors, and care management for chronic diseases.

To ensure that enrollment or other beneficiary incentives are effective, however, Congress would have to address issues related to excessive supplemental coverage. Because of an implicit subsidy from Medicare, premiums for supplemental coverage do not reflect the full costs of enrollment in such coverage.[17] The result has been the high market share of products that remove all cost sharing at the point of service, a major obstacle to offering incentives to use providers linked to an accountable care organization.

Conclusion

The Medicare program has the potential to be an important catalyst for provider payment reform that encourages greater coordination of care, quality of care, and overall efficiency. The right Medicare initiatives can support the ongoing efforts of many private payers and Medicaid programs that are already pursuing consistent approaches. However, without a stick to back up the carrot of the existing pilot payment reforms, what Medicare can accomplish will be limited.

Ending fee-for-service payment in favor of accountable care organizations and bundled payment once and for all is unlikely to be feasible for quite some time, but gradually increasing disincentives for providers that do not participate in reformed payment approaches is a practical way to move forward. Reformed payment models will also need to increasingly engage beneficiaries, in both the public and the private sectors, to drive patients to providers that are more efficient and deliver higher quality care. ■

An earlier version of this article was presented at the Alliance for Health Reform's invitational conference, "Health Care Costs: What Can be Done," Washington, D.C., June 12, 2012. The author is grateful to the Alliance for Health Reform and the National Institute of Health Care Reform for financial support for writing this article.

NOTES

1 Congressional Budget Office. The 2012 long-term budget outlook [Internet]. Washington (DC): CBO; 2012 Jun 5 [cited 2013 Mar 25]. Available from: http://cbo.gov/publication/43288

2 See the recent studies by the Center for Studying Health System Change, available at California HealthCare Foundation. California health care almanac: regional markets [Internet]. Sacramento (CA): The Foundation; [cited 2013 Mar 29]. Available for download from: http://www.chcf.org/almanac/regional-

markets
3 Shedden M. Area leaders frustrated by Baycare, UnitedHealthcare dispute. TBO: The Tampa Tribune [serial on the Internet]. 2012 Dec 7 [cited 2013 Mar 29]. Available from: http://www2.tbo.com/lifestyles/health-4-you/2012/dec/07/2/area-leaders-frustrated-by-baycare-unitedhealthcar-ar-580013/
4 Cosgrove DM, Fisher M, Gabow P, Gottlieb G, Halvorson GC, James BC, et al. Ten strategies to lower costs, improve quality, and engage patients: the view from leading health system CEOs. Health Aff (Millwood). 2013;32(2):321–7.
5 Song Z, Safran DG, Landon BE, Landrum MB, He Y, Mechanic RE, et al. The "Alternative Quality Contract," based on a global budget, lowered medical spending and improved quality. Health Aff (Millwood). 2012;31(8):1885–94.
6 Governor's Health Care Reform Task Force. Total cost of care contracting in Minnesota: current activity [Internet]. St. Paul (MN): Health Reform Minnesota; 2012 Apr 2 [cited 2013 Feb 25]. Available from: http://mn.gov/health-reform/images/Task-Force-2012-04-02-Total-Cost-of-Care-Contracting%20in%20MN.pdf
7 Hartman M, Martin AB, Benson J, Catlin A, the National Health Expenditure Accounts Team. National health spending in 2011: overall growth remains low, but some payers and services show signs of acceleration. Health Aff (Millwood). 2013;32(1):87–99. Exhibit 3, National Health Expenditures (NHE), amounts and average annual growth from previous year shown, by source of funds, selected calendar years 1990–2011.
8 Center for Medicare and Medicaid Innovation. Comprehensive Primary Care initiative [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; [cited 2013 Feb 25]. Available from: http://www.innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/
9 Department of Health and Human Services [Internet]. Washington (DC): HHS. News release, More doctors, hospitals partner to coordinate care for people with Medicare: providers form 106 new accountable care organizations; [last revised 2013 Jan 14; cited 2013 Mar 29]. Available from: http://www.hhs.gov/news/press/2013pres/01/20130110a.html
10 CMS.gov. Bundled Payments for Care Improvement (BPCI) Initiative: general information [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; 2013 Jan 31 [cited 2013 Apr 17]. Available from: http://innovation.cms.gov/initiatives/bundled-payments/
11 This issue does not apply to the Comprehensive Primary Care initiative, which continues to make fee-for-service payments to primary care physicians but adds a uniform capitated amount for coordination services.
12 Such an approach was outlined in Bipartisan Policy Center. A bipartisan Rx for patient-centered care and system-wide cost containment [Internet]. Washington (DC): The Center; 2013 Apr [cited 2013 Apr 18]. Available from: http://bipartisanpolicy.org/library/report/health-care-cost-containment. Legislation along these lines was recently reintroduced by Representatives Allyson Schwartz (D-PA) and Joe Heck (R-NV) (Medicare Physician Payment Innovation Act of 2012, H.R. 5707).
13 This approach would be similar to the transition to the Medicare Inpatient Prospective Payment System in the mid-1980s, when hospital-specific payment rates and national payment rates per diagnosis-related group (adjusted for each area's input prices) were blended over a period of four years.
14 Massachusetts Health Care Quality and Cost Council. Roadmap to cost containment: Massachusetts Health Care Quality and Cost Council final report [Internet]. Boston (MA): HQCC; 2009 Oct 21 [cited 2013 Mar 29]. Available from: http://www.mass.gov/hqcc/docs/roadmap-to-cost-containment-nov-2009.pdf
15 See Huang JT, Jacobson GA, Neuman T, Desmond KA, Rice T. Medigap: spotlight on enrollment, premiums, and recent trends [Internet]. Menlo Park (CA): Kaiser Family Foundation; 2013 Feb [cited 2013 Mar 29]. Available from: http://www.kff.org/medicare/upload/8412.pdf
16 Lieberman S. Reforming Medicare through "version 2" of accountable care, 2013. Unpublished paper.
17 Medicare Payment Advisory Commission. Report to the Congress: Medicare and the health care delivery system [Internet]. Washington (DC): MedPAC; 2012 Jun [cited 2013 Mar 29]. Available from: http://www.medpac.gov/documents/Jun12_EntireReport.pdf

ABOUT THE AUTHOR: PAUL B. GINSBURG

Paul B. Ginsburg is president of the Center for Studying Health System Change.

In this month's *Health Affairs*, Paul Ginsburg explores the possibilities in the next five to ten years of reforming provider payment to gradually diminish the role of fee-for-service reimbursement.

Ginsburg is president of the Center for Studying Health System Change, an organization that conducts research on local and national changes in health care delivery and finance and their impacts on people. His research interests include health care costs, consumer-driven care, provider payment, the future of employer-based health insurance, and competition in health care.

Before founding the Center for Studying Health System Change, Ginsburg was the founding executive director of the Physician Payment Review Commission, a precursor to the Medicare Payment Advisory Commission. During his tenure the commission developed the Medicare physician payment reform proposal that was enacted by Congress in 1989. He is a member of the *Health Affairs* editorial board and has written numerous articles for the journal. He earned a doctorate in economics from Harvard University.