CHEST Topics in Practice Management

Using Risk Contracting to Reduce Service Use, Improve Quality, and Strengthen Primary Care

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The high costs of American health care, the related problem of the uninsured, and the grim fiscal prognosis of Medicare and Medicaid are among the most pressing challenges facing the United States today. A solution to the cost problem that does not reduce access or quality is sought by those at all points on the political spectrum. This article discusses the experience of an independent practice association that has collaborated with a related business partner and a health plan to improve the quality of care of 16,000 Medicare Advantage beneficiaries while substantially reducing hospitalization rates and overall service use. The capacity to reduce service use frees funds that are used to support the infrastructure for high-value care and to reward those who provide it. Higher performing primary care, supported by changes in payment, has driven a sustainable business model that preserves the option of independent practice for physicians. We are now testing competencies developed for Medicare Advantage in the Pioneer Accountable Care Organization program, which preserves the broad patient choice that is an important feature of traditional Medicare. ***CHEST 2013; 144(4):1368–1375***

Abbreviations: ACO = Accountable Care Organization; CMS = Centers for Medicare & Medicaid Services; EHR = electronic health record; FFS = fee for service; IPA = independent practice association; PCP = primary care physician; PHP = Physician Health Partners; PPP = Primary Physician Partners

In the 1990s, health maintenance organizations were touted as the solution to the health-care cost/quality conundrum. By focusing on both the price and especially the volume of health-care services, managed-care programs were able to moderate cost growth for a time. But Americans bristled at the restrictions of the plans, which were at times heavy handed. The ensuing patient and provider backlash prevented the wholesale conversion to managed care that many had predicted. Nevertheless, Medicare managed care, now called Medicare Advantage, remains a significant feature of the health-care landscape, and has served in some cases as a laboratory for innovation.

Although services provided directly by primary care physicians (PCPs) account for a small fraction of health-care payments, the referrals and decisions PCPs make are powerful drivers of overall costs. Managed-care organizations understood this relationship and structured care delivery around the "gatekeeper" model whereby patients were required to choose a PCP, who could influence utilization. In return, some payers promised to reward quality and cost effectiveness, a scenario that had significant appeal for PCPs disenchanted with payment under the resource-based relative value scale.

Our experience with Medicare Advantage leads us to believe that substantial savings can be realized through the reduction of avoidable and low-value care, even without the referral requirements and closed network structure typically encountered in managed-care programs. Medicare's Accountable Care Organization (ACO) program offers the opportunity to test competencies developed through engagement with Medicare Advantage, in a "kinder, gentler" framework in which patients enjoy the same freedom of choice as they do in traditional Medicare.

An Independent Practice Association Model of Coordinated Care

In the mid-1990s, a change in leadership led to the demise of a nascent physician-hospital organization when the hospital partner withdrew. With the support of a health plan, two related organizations emerged from that failure, for the purpose of risk contracting.

Primary Physician Partners (PPP), a nonexclusive independent practice association (IPA) of PCPs, now includes 180 PCPs in 71 different practices. They are family physicians, general internists, and geriatricians. Since PPP is nonprofit, its physician members hold no individual ownership interest. This has promoted a focus on group success over individual financial gain.

Physician Health Partners (PHP) is an IPA management and services company that provides business, information, and clinical support and expertise for IPA risk contracting. It is owned in part by PPP, in part by other physicians, and in part by its management.

In 1996, these entities began to collaborate on performance-based risk contracts for Medicare managed-care business. PPP entered into participation agreements with PCPs and contracted with PHP for management support on their behalf. PHP represented PPP in contact negotiations and was delegated responsibility for utilization and quality functions by the health plan. Patients covered by the health plan selected one of the IPA's member physicians. The partners worked together to build a comprehensive specialty and hospital network including about 600 specialty physicians and two hospital systems. This three-way partnership defined clinical, management, and financial responsibilities, as well as the division of the pooled, risk-adjusted capitation payments received by the health plan from the government, on a "percentage of premium" basis.

Over time, and with increasing experience, the partners experimented with various performance-based payment incentives, including a "bed-day incentive" fund, pay for performance, pooled professional risk, and a budget model for high-impact specialty services, and others. Data analysis and reporting, managerial capabilities, and clinical enhancements were developed synchronously, allowing the assumption of more financial risk. We now operate under global capitation, under which PPP bears financial responsibility for all Medicare-covered services for 16,000 Medicare Advantage patients. PPP (not the individual physician) is paid a percentage of the monthly risk-adjusted global capitation fee using the Centers for Medicare & Medicaid Services (CMS)-Hierarchical Coexisting Category methodology[1] for each of the enrolled patients served by its member physicians. The global capitation fee excludes transplants, behavioral health, and part D benefits.

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In late 2011, PHP, with PPP and a second affiliated IPA, was selected by CMS's Center for Medicare and Medicaid Innovation to participate in its Pioneer ACO program. The combined entity now serves >50,000 Medicare recipients (evenly divided between Medicare Advantage and the Pioneer ACO) in accountable care/risk arrangements.

Changing Payment

Primary care in the United States is undergoing a major transformation that is intended to strengthen its effectiveness and increase health-care value. Our work is informed by the "Joint Principles of the Patient-Centered Medical Home"[2] and the chronic-care model.[3] Each requires payment reform and delivery system reform. Risk contracting is a vehicle that can be used in the simultaneous pursuit of both.

Risk Contracting

In a risk contract, an organization agrees to provide and/or arrange for specified care for a defined population for a specified time period for an amount negotiated in advance. The organization takes the risk that its costs will exceed the payment; thus, there is an incentive to control costs. If care is provided for less than the negotiated amount, the residual might be shared with a payer, used for building reserves or infrastructure, or for rewarding quality and cost-effectiveness among its providers. The potential permutations of risk contracting are numerous.[4-6] The essential characteristic is that the ultimate financial result is linked substantially to performance on measures of cost and quality.

Risk contracting is not gambling; it should be undertaken only when there is sufficient administrative capacity, including the ability to obtain and analyze data about financial and clinical performance, to negotiate appropriate terms, and to manage all the legal, business, and financial requirements. Even most large physician-group practices will not have such capabilities,[7] but by combining in an IPA arrangement, physician practices large and small can remain independent businesses while achieving the scale that can make such capacity affordable.

Physicians are constrained by antitrust law, which, in most circumstances, views them as competitors who are prohibited from negotiating collectively. Sharing substantial financial risk among members of an IPA offers a safe harbor for physicians who wish to contract together while they continue to operate as independent businesses. Other available safe harbors include a single tax-identification group-practice structure

(complete financial integration), and clinical integration, an arrangement where physicians work together to produce substantial and demonstrable quality improvements that cannot be accomplished without collective arrangements with payers.[8,9] It is likely that the law in this area will evolve as it adapts to multiple new organizational and payment models being tested as part of health-care reform.

Risk contracting depends upon the ability to forecast future medical spending. Individual patient costs will vary greatly, but if a sufficiently large population is assembled, its future costs can be predicted accurately. Some patients will cost more than average and some less. Pooling risk across a large population affords actuarial protection as the effect of interindividual variation is dampened, allowing an average cost or rate to be computed.

If a single, flat capitation rate is paid for each patient, case mix will become a principle determinant of financial success. If the case mix is skewed toward patients who are more costly than average (adverse selection), it will be difficult to achieve financial viability, whereas a healthier-than-average population (favorable selection) will make profitability unreasonably easy. Such deviations from "average" should be expected when numbers are small. Also, knowledge of patient characteristics (eg, the presence of diabetes) provides insight into future costs and can be used by payers or providers to gain an advantage by assembling a population in which favorable characteristics are overrepresented.

Risk adjustment (also called case-mix adjustment) uses demographic and clinical characteristics to pay more for sick patients and less for healthy ones, reducing the incentive for "cherry picking." It is a second major pillar of fair payment in a risk contract.

Risk-adjustment methods focus on predicting the cost of a population, not the cost of individual patients. No method can predict a single individual's future costs with much precision. The CMS-Hierarchical Coexisting Category system can accurately determine the expected costs of a large population of beneficiaries but explains (ie, goodness of fit) only 12% of interindividual variation among them.[10] Nevertheless, it pays much more accurately for groups of patients (eg, those with heart failure), and by paying more for each sick patient and less for each healthy one, it mitigates a serious problem of perverse incentives.

An early version of capitation illustrates the importance of careful consideration of incentives. A health maintenance organization paid a PCP a flat monthly fee for each enrolled member in her practice, in exchange for which she provided primary care. This average amount is too high for healthy patients, and too low for sick ones. No physician had enough patients to enjoy actuarial protection. Variation in case mix, either random or manipulated, was a major determinant of winners and losers. The best financial strategy was to build a large panel of healthy patients who would need little care but avoid those who were sick. A payment system that discourages a focus on costly patients cannot foster cost-effectiveness.

Paying Physicians and Hospitals

To enjoy actuarial protection and the benefits of risk adjustment, only an organization that can assemble a sufficiently large population (5,000 Medicare patients is often cited) should accept major risk through capitation. But what happens after capitation? How should individual clinicians be paid by the organization? Particularly for primary care, the still-common practice of simply paying providers the old fee-for-service (FFS) way does nothing to promote value-driven change in care delivery.

The best approach will balance incentives, drive improvement, and minimize gaming opportunities.[11] Reflecting that belief, compensation methodology for our PCPs includes four elements:

1. FFS. PCPs submit claims and are paid at a rate slightly higher than Medicare's fee schedule. This facilitates reliable practice cash flow and partially bridges the gap between Medicare and commercial rates. FFS rewards work effort (but not quality or cost-effectiveness).
2. Panel size. This encourages serious engagement, rewarding the decision to make this a substantial part of the physician's practice.
3. Quality scores. This commands attention to process improvement and the embrace of evidence-based medicine, which the organization needs to demonstrate to external stakeholders.
4. Cost-effectiveness. When, as in our case, risk-adjusted revenue and the actual expenses incurred by every patient are known, part of PCP compensation can be based on the ability of a practice to manage its panel of patients (not individual patients) within the funds allocated for their care.

Using checks and balances, we try to provide incentive for the right mix of work effort, care quality, and stewardship of resources needed to produce excellent care in a sustainable business. Performance-based compensation has added significantly to the overall financial result, helping to make this easily the best payer with whom our PCPs do business.

For many specialists, especially those who are procedurally oriented, the FFS system is a reasonable approach to compensation. A focus on reducing the number of inappropriate referrals can reduce overall costs without reducing fees. Engaged specialists who provide excellent care will find themselves the

recipients of a steady stream of quality referrals. As they always have, specialists compete on the basis of clinical excellence, and good communication and service to patients, but now data can be used to compare performance and drive improvement. As relationships mature and confidence grows, compensation enhancements can be tied to mutually agreeable improvement and performance measures.

Specialists in high-cost, high-volume fields like cardiology can engage differently. Here there is sufficient patient volume and economic impact to make a form of risk contracting a prudent and reasonable strategy. In the "shared savings" approach, a budget target is established. Physicians are paid on a FFS basis but share in savings if costs are less than budget, and are paid less for additional services after the budget is exceeded. Good stewardship of resources is rewarded. If quality is carefully monitored and targets are realistic, the result is higher value and lower total costs but maintained or improved compensation for the specialist.

Hospitals in our Medicare Advantage program have been paid by diagnosis-related group, promoting a focus on reducing length of stay. The hospital is not rewarded financially if the number of admissions decreases. Many hospitals are beginning their own difficult transition to value-based care under circumstances in which their financial incentives are decidedly mixed.

Hospitalists are crucial intermediaries between the PCP and the hospital. They can help prevent unnecessary admissions, reduce readmissions through good discharge planning, and make thoughtful, rather than reflexive, referral to postacute services. Many receive financial support from the hospital and, thus, may find themselves attempting to serve two masters with poorly aligned financial incentives. Our hospitalists provide excellent inpatient care to the patients, but optimizing their decision making and priorities while they are influenced by conflicting incentives continues to be a challenge.

Changing Care Delivery

In a risk environment, controlling the volume of services provided is a primary mechanism for controlling costs. While there may be some opportunities to negotiate lower prices, market realities limit the application of this "zero-sum" approach. Creating new value and sharing the financial benefits are far superior to fighting over the division of a steadily shrinking pie. Reducing the volume of services requires changes in care delivery.

Avoidable hospital admissions have negative clinical and financial consequences. Each hospital admission results in additional specialty-physician costs and often drives costs for subacute services such as home health care and skilled nursing facility care. If the circumstances that resulted in admission can be prevented, the potential savings far exceed the payment to the hospital itself.

A shift is needed away from the reactive "tyranny of the urgent" to a proactive approach that identifies and prevents crises and exacerbations of chronic disease. Hospital admissions are avoided by improving access to and quality and coordination of care for those with chronic conditions and by helping patients care for themselves more effectively through coaching and education. Substantial reductions in hospital admissions are the most important single driver of value creation (Figs 1, 2[12]).

Medicare patients experience a high rate of readmission after discharge from an inpatient facility. We have used the Care Transitions Intervention,[13] a coaching and skills-transfer model that empowers patients to embrace responsibility for their own care, to produce a steady reduction in readmissions in the last 5 years (Fig 3).

PCPs can improve the quality of their decisions to refer for specialty care and to send patients for high-cost imaging and procedures. The goal is to get the right patient to the right specialist or test at the right time. Referrals that are unnecessary and those that are necessary but too late are undesirable and costly.

Establishing a preferred network of specialists facilitates improved communication and performance but must also assure adequate access for patients. Building long-term partnerships between PCPs and specialists is vital strategy. A PCP-specialist compact outlines mutual aspirational goals to guide such partnership (e-Fig 1).

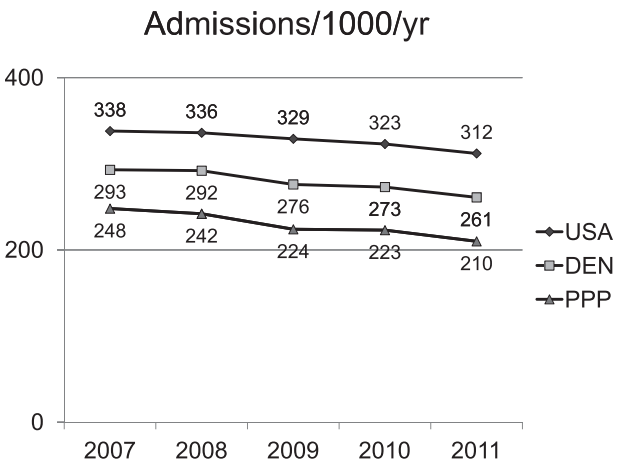

Figure 1. Hospital in-patient admissions per thousand per year. PPP Medicare Advantage beneficiaries vs Medicare fee-for-service beneficiaries (United States and DEN), 2007 to 2011. Data from Health Indicators Warehouse,[12] Physician Health Partners (PHP) data warehouse. DEN = Denver Hospital referral region; PPP = Primary Physician Partners.

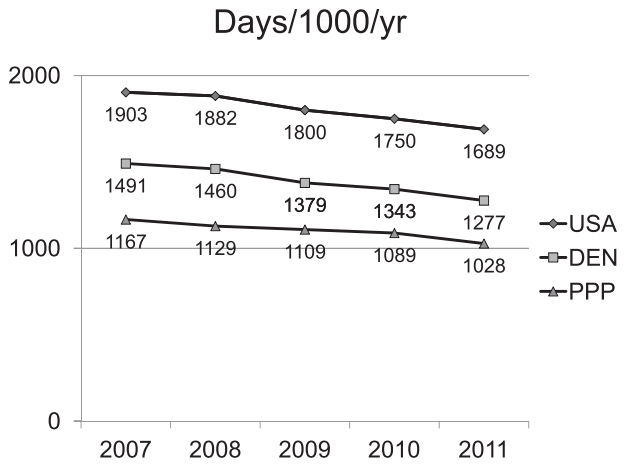

FIGURE 2. Hospital in-patient days per thousand per year. PPP Medicare Advantage beneficiaries vs Medicare fee-for-service beneficiaries (United States and DEN). 2007 to 2011. Data from Health Indicators Warehouse,[12] PHP data warehouse. See Figure 1 legend for expansion of abbreviations.

Requiring prior authorization for referrals and procedures is a common feature of managed-care programs. Evidence-based prior authorization has large sentinel effects in that physicians learn and internalize better practice patterns. Over time, in our experience, the percentage of referral requests that are denied has become vanishingly small. Prior authorization also provides real-time utilization information, facilitating early detection of anomalies and trends.

Care Management

Health-care spending in Medicare is highly skewed. In 2008, 10% of beneficiaries used 55% of each dollar, while the less costly half of beneficiaries used only 5%.[14] Human and financial costs of sickness in the coming year will be highly concentrated. Disease burden, self-care ability, cognition, mental health, socioeconomic factors, and even payment policy all influence use patterns. Targeting extra resources to patients who are likely to incur high costs is essential to making the business case for care management.

Many patients experience avoidable health problems because of poor coordination of care and suboptimal management of chronic conditions. Some resort to the ER and acute hospital as default solutions. The volume-driven FFS system leaves most PCPs with neither the time nor the resources to deal comprehensively with the complex web of medical, social, financial, and psychological issues that drives utilization. IPA risk contracting makes it possible for care-management professionals to work as a team with PCPs, providing more effective and comprehensive care.

Care management generates better patient experience and cost savings by substituting more valued and often less costly services for those that might otherwise be used.[15] Services of care managers include evidence-based patient education and coaching, planning, navigation, and connecting to community resources. In our IPA, each PCP has access to both a social worker and a nurse care manager for help with high-risk patients. Where the density of high-risk patients is sufficient, these professionals are embedded in practices. Care management is most effective when there is frequent face-to-face contact between patients and physicians, evidence-based patient teaching, and strong medication management.[16]

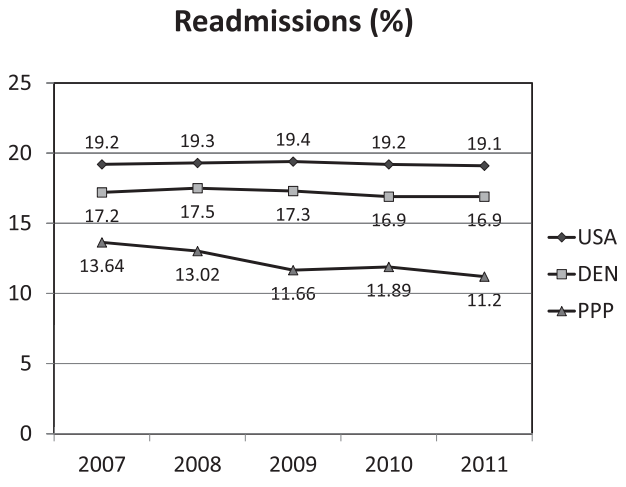

FIGURE 3. Thirty-day all-cause readmission rate (percent). PPP Medicare Advantage beneficiaries vs Medicare fee for service beneficiaries (United States and DEN), 2007 to 2011. Data from Health Indicators Warehouse,[12] PHP data warehouse. See Figure 1 legend for expansion of abbreviations.

Measuring and Reporting Quality

Despite substantial progress, measuring the quality of medical care remains challenging.[17] Most available quality measures for PCPs focus on the process of care, generally for single diseases, and are only indirectly attached to better outcomes. Quality measures are most confidently applied to straightforward patients with a single disease such as diabetes. Conversely, patients with multiple chronic diseases cannot be managed by summing the recommended interventions for each of their several problems.[18] Yet patients with multiple chronic diseases are precisely those who sustain high costs and must be the focus of cost-control efforts. Thus, while both are important, cost-control efforts and quality reporting are, in large part, different enterprises targeting different patients.

Achieving excellence on measures of quality requires identifying and communicating what is to be measured, helping practices to collect and document the designated metrics, and retrieve, collate, and report

the information. Both changes in practice work flow and information management are necessary. The lack of interoperability among different electronic health record (EHR) platforms makes a single shared platform very desirable. A strategic commitment to a regional health information organization, which offers the capacity to share information across multiple EHR platforms, is a rational approach when using a common platform is not feasible.

PHP's Quality and Clinical Standards Committee reviews and selects evidence-based guidelines and measures for improvement activities and reporting. Information is disseminated through electronic communication, educational forums and lectures, and on-the-ground assistance by practice coaches. Practices receive feedback, delivered by peers, regarding their own performance on a regular basis. The focus is on supporting improvement, but financial penalties are sometimes assessed when improvement opportunities are not embraced (Fig 4).

Promoting Practice Change

For primary care, the transition from volume to value requires extensive redesign of practice work flow and staff responsibilities. This requires a cultural transformation, an evolution from a disconnected assortment of individual PCPs toward an integrated network with shared processes and standards, and a population focus. Practices need assistance that requires resources not ordinarily at their disposal.

PHP practice coaches support efforts like patient-centered medical home transformation/certification, data acquisition and documentation, and EHR selection and implementation. PPP offers financial support to its physicians targeted to EHR costs, while PHP provides technical assistance as part of the government's Regional Extension Center program.

PHP conducts continuous, multidimensional reviews of the performance of its practices. Physician leaders analyze this information and conduct peer-to-peer meetings with each practice to recognize strong performance, identify areas needing improvement, and develop individual action plans in response.

Physician Engagement and Leadership

Effective practice change cannot be achieved unless physicians are engaged. No matter the physician's business arrangement (employment by a hospital, single- or multispecialty group practice, or IPA of independent practices), issuing memos and instructions does not suffice. Better alignment of financial incentives makes change possible, but does not guarantee it. Buy-in

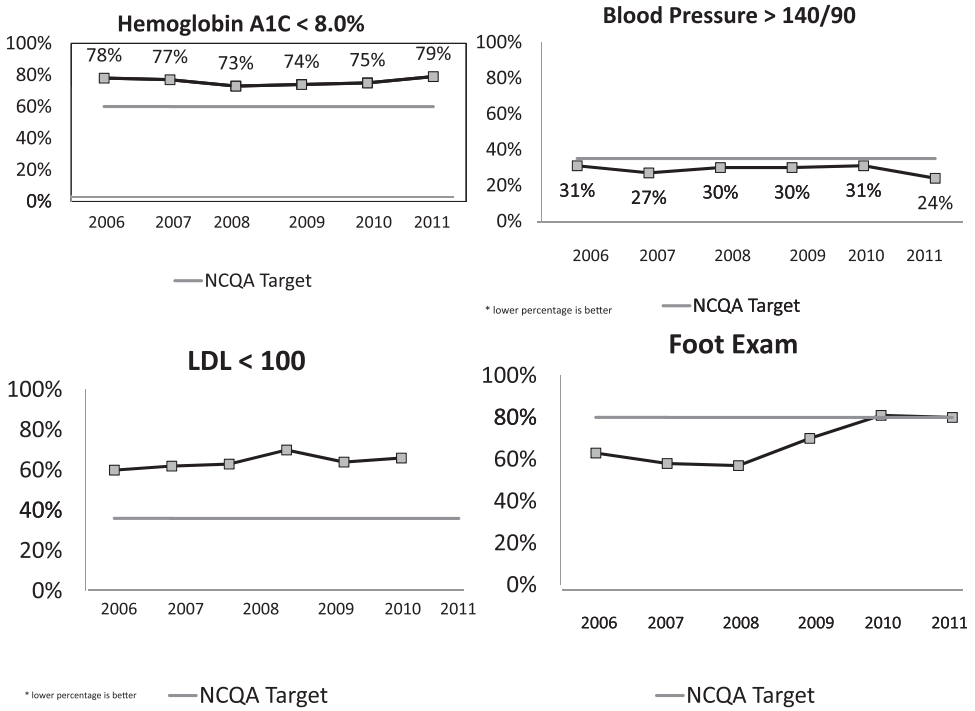

Figure 4. Representative independent practice association-wide quality measures, PPP. Several diabetes measures are shown. Results for many other measures are similar. LDL = low-density lipoprotein; NCQA = National Committee for Quality Assurance. See Figure 1 legend for expansion of other abbreviation.

is promoted by imagining and articulating a better shared future, building relationships with allies and partners, and embracing mutual expectations among peers.[19] Drivers include positive perceptions of the change, and attention to the characteristics of those involved and to the local context.[20] We have achieved buy-in incrementally, building upon small successes that showcase collective capability, gradually increasing expectations (and opportunities) as improved clinical and financial performance can be demonstrated.

Physician engagement is stronger when a substantial proportion of practice patients are cared for under risk. Creating such conditions is a strategic objective. PHP and the member physicians of its affiliated IPAs now participate in risk contracts in various states of evolution covering Medicare Advantage, Pioneer ACO (Medicare), Medicaid, and commercially insured patients.

Committed and sometimes tenacious physician leadership is essential. We enjoy broad participation by member physicians on boards and committees. With PHP business leadership and administrative support, physician board members are involved in all strategic and many operational decisions. Physicians populate committees that address quality, finance, physician education, and contracting. All are in active practice and must themselves live with the expectations they establish. PHP and its affiliated IPAs pay physicians for all board and committee work.

Conclusion

Our experience demonstrates that it is possible for an organization built around PCPs, in collaboration with talented business partners, to operate successfully in a risk environment and produce improved patient care. PCPs have enjoyed better compensation than under Medicare FFS, while maintaining the ability to operate as independent businesses. Reducing the volume of low-value services frees funds that are used to help practices improve their performance and to reward them for doing so.

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Other contributions: The e-Figure can be found in the "Supplemental Materials" area of the online article.

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