Can Provider Risk Cure High Medical Costs?

written by Theresa Hush | May 23, 2019

Fee-for-Service (FFS) has been on a slow march toward risk-based reimbursement for two decades. But FFS has proven to be remarkably resilient—until now. In the last six months, Medicare has doubled down on creating new provider risk models for ACOs, specialists and primary care physicians. All of them have methods to ensure that providers are held accountable for medical expenditure targets.

Wait. Haven't we been here before?

What's different between now and the 1980s, when HMOs and provider risk first prevailed in the market—and then were purged as both ineffective and unpopular? Is provider risk a cure for high medical costs, or is it unfair to physicians? Will it drive physicians from participation in Medicare and commercial risk—or induce them to adopt it, then dump sicker patients and reduce access for consumers? Let's examine provider risk, its reasons and how providers are likely to react.

Why Now? Surging Health Care Costs Create New Urgency

We should look at provider risk reimbursement for what it is—a cap on medical expenses driven by services that physicians order or perform. These caps predominate in governmental programs because beneficiaries have open choice of providers, thus excluding options that are available to commercial health plans and employers, namely, narrow provider networks that limit choice.

After a period of low growth in Medicare costs, especially compared to commercial health plans, there is a projected surge coming. Significantly, the highest cost increase is expected in Medicare Part B, professional costs.

With only two percent of total Medicare spending attributed to direct primary care services, we should expect CMS to use models that control referrals and costs of specialty care. New downside risk provisions in ACOs and new primary care models affirm the concept of using gatekeeper models, as in the past, to control access to specialists. Since ACOs have had a difficult time proving successful in controlling referrals, CMS is betting that downside risk will create the internal leverage needed for ACOs to take these steps.

The use of risk reimbursement in multiple forms—ACOs, direct contracting, primary care risk and reward, Bundled Payment pilots and Medicare Advantage—allows CMS to test different organizational and reimbursement models that all include expenditure targets. These models also either totally or partially eliminate FFS and its incentives for generating higher costs, which is the intended effect. In addition, they will surely affect income for some providers, and probably specialists.

Further, by using models that involve providers themselves as the guardian of costs, CMS avoids a political war over a simple change in the reimbursement system from FFS to something else.

The hesitancy to quickly change reimbursement is obvious with respect to bundled payments for specialty procedures. Despite the introduction of the Bundled Payment for Care Initiatives (BPCI) in 2013, Medicare tread slowly and carefully in implementing bundled payments based on time- and procedure-defined episodes of care. In fact, Medicare pulled back from mandatory bundled joint replacement procedures in the past few years in favor of voluntary measures, and scaled back testing of numerous specialty episodes. Now it is moving more deliberately forward with field-tested models that group payments together, but the models are still voluntary.

Good and Bad Incentives Exist in All Payment Methods

The positive aspect of FFS is that it directly relates to how many services physicians provide to patients. That same relationship, however, makes volume the primary indicator of productivity and value, and leaves the system vulnerable to excessive procedures motivated by physician-versus-patient decisions.

A system where physicians and not patients still govern choices of treatment creates incentives for physicians to game FFS by performing unnecessary or borderline procedures rather than more conservative therapies. While such physician volume-boosting occurs, however, the larger problem now is that the newly consolidated health systems pressure physician, now employees, to meet higher volume goals and make more internal referrals. Those incentives are embedded in compensation plans as well as soft benefits like leadership appointments, access to operating room time and good space.

Capitation and bundled payments also have incentives, and these can also harm patients and de-activate cost control incentives. Under fixed cost models, these incentives can include:

> "Dumping" patients, especially patients with more restrictive coverage like Medicare and Medicaid;
> Delaying patient therapies where there are more questions about symptoms or efficacies, most likely to occur for patients with autoimmune diseases or where diagnoses and treatments are less clear-cut. Women and people of color, who have higher risk for these conditions, may be more vulnerable;
> Limiting scope of services or not referring patients for them; e.g., physical therapy, rehabilitation or home care, imaging and laboratory testing and other exclusions from the fixed fee. The more all-inclusive reimbursement models are designed to counter such incentives.

HMO history should have taught us that, although it is somewhat possible to control or lower the increase in costs, this approach can come at a high price: patient outrage and dissatisfaction.

What's Different Now That Could Make Provider Risk Work for Providers and Patients?

Is it possible to put providers at risk successfully for both providers and their patients? That depends on the actions that providers take as payers implement these plans, as well as how transparent the changes are for patients. Four factors make it less likely for a transition to

provider risk reimbursements to implode and to harm patients:

> Health care has become a political issue, and consumers are more aware and energized about health care than ever before. The constraints on Medicare and the safeguard of provider choice stems from political advocacy for beneficiaries. The ACA debate has seeded other groups. That political advocacy will need to mature beyond insurance, but it is easy to envision how health care access could become a larger consumer movement. Social media and journalism are highly focused on health care, and reporting on inequities and problems in health care is a common theme. There will be consumer and journalistic watchdogs on health care that can help popularize issues and push them into the political environment.
> Data is more available to identify problems in health care services, and there is more ability to obtain patient responses. What is not available now are good measures of quality. The system of quality reporting created by Medicare did not evolve, as industry experts hoped, into real measures of patient health and outcomes.
> Patients know they have options and are more educated about health. Spurred by health care providers, a growing alternative health care industry, and wearable devices, consumers are no longer waiting for providers to make decisions. The fact that patients want more involvement in choosing for themselves—and are also financially motivated to do so—will make them less likely to tolerate care that doesn't succeed (on their terms).

Physicians can protect themselves from undue risk in providing patient services and have many options for services to help them with population health, measuring cost and outcomes, and testing strategies. We have reported options for shadow testing of bundled payments and for navigating ACO arrangements, and have suggested how ACOs can create systems to select specialists.

This decade in health care is not the 1980s. Science is moving forward faster, and health care is more sophisticated. Both providers and patients need not feel helpless in a system that is changing and holding everyone more accountable. More technology focused on measuring patient outcomes and costs, better data, and transparency will all be required to accomplish a significant change in health care.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

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