Health Care Delivery and Payment Reform

A Primer on the Better Care, Lower Cost Act of 2014

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Health care providers have experienced significant changes in recent years. From patients who are in medical homes to value-based purchasing to accountable care organizations (ACOs), these programs and the changes involved appear to always focus on the goals of promoting and improving quality and controlling and reducing costs. For many reasons, critics often claim that these goals are difficult to achieve in any one program. All too often the discussion defaults back to costs and the no-win decision of either reducing benefits to patients or paying providers less.

Enter the Better Care, Lower Cost Act of 2014. This recently proposed bipartisan legislation aims to tackle the issue head-on by building upon previously successful reform activities. The program that comes from the Act is being compared to ACOs, although its characteristics touch on many other concepts.

Even if all goes as planned though, the Act does not take effect until 2017. That will certainly not stop health care providers from talking about the Act and asking questions. If the past is any indication of the future, health care providers and their attorneys that stay out in front of the Act will position themselves to capitalize on the benefits.

Integrated Care Networks with Managed Care Attributes

The Act essentially creates highly focused, integrated care networks for Medicare beneficiaries with significant financial characteristics of a managed care organization. The Act refers to these networks as Better Care Programs (BCPs), which can involve the participation of multiple stakeholders. BCPs can be structured to include providers only (i.e., physicians, other professionals, hospitals, health centers, etc.) or as a collaboration between health care providers and payers.

BCPs must fulfill two significant requirements: (1) maintain the capacity to manage the full continuum of care for their enrollees (including medical care, skilled nursing care, home health services, behavioral care and social services) at a high level of Medicare customer satisfaction; and (2) assume the financial risk for the cost of health care for their enrollees. Initially, BCPs will be limited in number. The Act calls for initial enrollment of only 250 BCPs during the first five years of the program.

BCPs are designed to target certain beneficiaries. The healthy need not apply. The Act indicates that BCPs will be automatically assigned only high-risk beneficiaries. BCPs will provide care to beneficiaries who are considered medically complex as the result of the prevalence of chronic disease that actively and persistently affects health status and causes enhanced risk for hospitalization, limitation of daily activities or other significant health outcomes. To further meet this requirement, at least 50% of all BCPs must serve a geographic region where the prevalence of the most costly chronic conditions exceeds the national average by at least 125%.

The care delivery model of BCPs is similar to that found in patient-centered medical home arrangements and ACOs. The focus is on care coordination and patient engagement. BCPs are required to provide enrollees annual comprehensive risk assessments, individualized patient-centered chronic care plans, and access to the resources and technology necessary to effectively manage care.

The financial model of BCPs is simple — capitation. BCPs receive a per-member, per-month (PMPM) payment for each enrollee. The PMPM payment is initially based on the total cost of care for a random control group of Medicare beneficiaries who have similar health risk characteristics and have sought care in a geographically similar territory. The PMPM payment is further adjusted on an individualized basis to account for any health risks of the individual. For the most part, BCPs assume all the risks of gain or loss under the model except, in limited circumstances, BCPs may be eligible for marginal downside

protection. BCPs are also eligible to receive bonuses for achieving certain benchmarks that focus on quality measurement and improvement, delivering patient-centered care, and practicing in an integrated care delivery environment.

BCPs – ACOs 2.0

The concept, design, and focus of BCPs may appear shockingly similar to ACOs. While this is no coincidence since the Act is modeled after several successful pioneer ACOs, there are several differences between BCPs and ACOs. These differences are significant and intended to further the ultimate goal of the Act.

ACOs are built on a complex patient attribution model that does not account for health risk factors. ACOs consist of a broad spectrum of patients, from those who experience the most at-risk health conditions to patients who are perfectly healthy. BCPs will not include healthy patients. The attribution model for BCPs directly accounts for health risk by only including chronically ill beneficiaries.

Unlike ACO participants, providers in BCPs will not continue to receive traditional fee-for-service payments. The PMPM payment process will be similar to the system in place for Medicare Advantage plans. This will permit BCPs to capture all of the financial benefits of success. BCPs will retain all savings and will not share these amounts with the government. The potential for quality bonuses, in addition to any savings from the PMPM fees, is another differentiator that distinguishes BCPs from ACOs.

ACOs must rely on patient engagement, education and relationship building to ensure that patients are following treatment plans and electing to receive care from the most appropriate providers — in most cases, ACO participants. BCPs will be permitted to supplement these activities with financial penalties. For example, BCPs will be able to choose to implement value-based insurance features that reward beneficiaries for seeking care and treatment from BCP providers.

Many Questions

When ACOs were first proposed, numerous legal and business issues arose. Among other issues, the effect of the antitrust laws and the fraud and abuse rules were hot topics. Funding also was, and still is to some extent, a significant challenge in ACO development. These issues will certainly exist for BCPs, as well. Nevertheless, the government should be able to use the general regulatory framework for ACOs as the initial model for BCPs. Applying the relevant ACO guidance on anti-trust matters and the anti-kickback/Stark waivers to BCPs should not require extensive modification. As for funding, BCPs could also reasonably expect to participate in some form of advanced payment model, which would more than likely borrow significantly from the ACO advanced payment model.

Another major issue will focus on the details of the PMPM payments. The Act requires a two-step approach to setting the PMPM payments. Providers will likely question and challenge this approach. Hence, the data and information used in this approach must be accurate and verifiable by BCPs and their providers. Any minor deviation in the data and information, especially with respect to the second step in the process involving individualized risk scoring, could have enormous financial impact on BCPs.

Even more important than any legal, business, or payment concerns, however is the fact that BCPs, just like ACOs, will succeed or fail based on the level of commitment from providers to further transform the culture of medicine. This means there will be an ongoing need to push for care delivery models and payment reforms that promote high-quality, cost-efficient health care. This commitment does not come easily or quickly, because the focus is often not about the business of medicine. As a result, preparing for BCPs, or any other delivery or payment reform initiative, requires providers to take, or keep taking, proactive steps towards implementing currently available options, such as participation in patient center medical home programs, ACOs, or other clinically integrated arrangements.

Even though the Act is nothing more than a proposal at this point (although there is some talk that the new "doctor payment fix" legislation will include the Act), BCPs are clearly viewed as another wave in the reforms around health care delivery and payment. Only time will tell what happens, but keeping abreast of the Act is certainly beneficial. BCPs, or some other similar reform initiative, will be here before you know it.

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