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Overcoming challenges to US payment reform: could a place-based approach help?

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Accountable care organizations (ACOs) cover more than 32 million individuals in the U.S.[1] However, despite improvements in patient experience, financial savings have been limited and the effect of ACOs on health outcomes remains unclear. Several countries, including England, Sweden, and New Zealand, have adopted 'place-based' approaches to organizing health services aimed at integrating care, improving population health, and controlling costs. 'Place-based' approaches are defined as giving health care organizations or systems some degree of responsibility for the health or care of all people living in a specific 'place': a geographically defined area such as a county, hospital referral region, or state. As the US moves away from mandatory participation in payment reform, the current 'place-based' reforms in England offer useful insights for US policy makers.

In the US, barriers remain to the success of ACOs and other value-based payment models. Large numbers of patients are still covered by fee-for-service payments,[2] and weak incentives with narrowly focused outcome measures limit the motivation of ACO leaders to meaningfully change clinical practice. Furthermore, despite ongoing reform efforts, overall health care costs continue to rise and health care organizations do little to collaborate or to address the social, economic, and behavioral factors, such as food insecurity and poor housing, that profoundly influence health and the need for health care.[3]

England's National Health Service (NHS) has been promoting ACO-like reforms and recently moved from testing voluntary local change to implementing mandatory regional reforms. Although a single-payer system, there are longstanding divisions in funding and service provision between NHS organizations, such as between primary care and hospitals, and between the NHS and local government (responsible for public health, social services, and long-term care). In 2014, the NHS launched a voluntary "Vanguard" program, explicitly drawing on the experience of ACO initiatives in the U.S., to try to integrate care, improve

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health, and manage costs.[4] Under the scheme, 50 groups of NHS organizations tested various new care models including hospital-led ‘primary and acute care systems’, aiming to integrate primary and secondary care, and primary care-led ‘multispecialty community providers’. Both models aim to achieve better integration between organizations working across specialties and sites of care, including in the community. Some of these groups developed pooled budgets for services and new contracts to align incentives across organizations.

More recently, national NHS leaders in England mandated the creation of 44 sustainability and transformation partnerships (STPs) covering the entire country. STPs are referred to as ‘place-based’ partnerships because they are responsible for improving care and managing costs for geographically-defined populations. They involve coalitions of all NHS organizations and local government departments that purchase and provide health and long-term care services for people living in their area, serving an average population of 1.2 million (for example, London is divided into five STPs).

The implementation of STPs is in progress and their effect is as yet unknown. However, such a mandatory and regional focus offers insights that could help policymakers overcome some of the challenges facing US reforms (supplement, table).

First, mixed payment models in the US mean that within the same health care organization, some patients receive health care coverage through fee-for-service contracts and others through capitated contracts. This creates conflicting financial incentives for both clinicians and organizations that can be a barrier to care redesign[2] and encourages cost-shifting between payer-types. A place-based global payment system could help address these issues. For example, the all-payer ACO in Vermont incentivizes physicians and health care organizations to work under a single payment model across all payers (including trialing primary care capitation). This helps to shift funding toward primary care and preventive care, and encourages coordination of care within regions of the state and with the two major academic medical centers, all while providing stable financing over a number of years within a global budget. Although states cannot regulate all employer health plans, Oregon’s place-based Coordinated Care Organizations are currently exploring how their care model could spread beyond Medicaid to include private insurers. States can also regulate total hospital budgets (Maryland and Vermont do so) and have the authority to extend this to physician spending, which could be used to create an additional incentive to join ACO-like alternative payment models (although no states are currently doing this).

Second, current US performance measures are problematic in several ways. Importantly, they are generally limited to clinical performance. Shifting to performance measures that focus on health outcomes or that reflect the social, behavioral, and environmental determinants of health (such as using a composite measure of modifiable behavioral and socioeconomic health risks) would encourage health care organizations to consider non-clinical community-based interventions best implemented through collaborations with community-based organizations (CBOs). Effective management of asthma, for example, may require housing-related interventions. Reducing cardiovascular risk could be achieved by working with local governments to create walkable environments and to improve access

to healthy foods. Although such collaborations (and their evaluations) are in their infancy,[5] they may lead to better outcomes than health care organizations pursuing narrowly focused clinical interventions or novel place-based strategies in isolation.[6]

Current performance measures also focus only on the population covered by each health plan. Adding community-level measures to current ACO accountability frameworks would encourage the kinds of collaboration discussed above. Equally important is accountability for community-level health care costs: under current ACO payment models, health care organizations can earn bonuses for reducing costs among ACO patients while continuing to raise costs for others, whether by simply raising prices or by leveraging any reduced utilization on the part of ACO patients to fill beds or operating rooms with better paying patients. Using performance and cost measurements focused on all residents of the community or region would penalize such behavior and would allow policy makers to reward organizations that are improving regional population health and slowing overall cost growth. Regional withholds related to slowing cost growth could be readily implemented for Medicaid and Medicare patients, and perhaps could also be used at the state level to manage physician fees; these would likely be more effective and fairer than simple payment cuts.[7]

Third, stronger collaborations between the health care organizations and CBOs that jointly serve a population within a given geography will necessitate both new ways of sharing resources and new governance structures. A virtual budget, whereby funding is not formally merged but organizations agree to use their resources to deliver shared outcomes, and place-based health boards involving all relevant stakeholders (including patients and the public) could both help. An example from England is in Greater Manchester, where a $6bn regional budget is governed in partnership by specialist, primary, and community health organizations, as well as local government. There are also increasing numbers of regional multisector partnerships in the US and although their governance can be fragile and poorly coordinated,[5] a notable exception is Rochester NY, which has a more than 30 year history of strong regional collaboration and has among the lowest per-capita costs for both Medicare and private payers.[8]

In addition, if alternative payment models result in improved performance, allowing these to remain as voluntary programs will widen variations and, as in the case of ACOs, may exacerbate inequalities.[9] By making STPs a mandatory national program (while allowing flexibility to fit local context), the NHS may mitigate these risks. Encouraging states to pursue federal waivers that support mandatory place-based comprehensive payment and delivery reforms would, by reducing selection effects, help ensure that the benefits of improved performance are available to all.

The challenges to systematically implementing place-based approaches to reform should not be underestimated. Sweeping reforms at the federal level are not on the legislative agenda and headline-grabbing single-payer plans at the state level have been rejected in both Vermont and California. However, Oregon, Maryland, and Vermont demonstrate that more nuanced approaches that incorporate key elements of place-based approaches to reform are both politically possible within the current state-legislative framework and have the potential to overcome the limitations of current US payment reforms.

The current place-based approach adopted in England – STPs – still faces major challenges: [10] budgets remain poorly coordinated; initial outcomes measures are, as in the US, too clinically focused; many STPs have failed to adequately engage community organizations and patients; and reductions in social service and public health budgets have undermined STPs' ambitions to prioritize prevention. Systematic evaluation will be needed on both sides of the Atlantic as the health systems in the US and in England strive to achieve the goals of better health, improved care, and lower costs.

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Table

Challenges for US health care and how elements of place-based reform could help

Challenge	Underlying Problem	General Approach to the Problem	Specific Policies to Help
Fragmented payment systems	Mixed payment models, (e.g. global payments and fee-for-service) and multiple payers limit opportunity for care transformation and enable cost-shifting, leading to continued cost growth.	Establish a single payment model for all patients served by a given type of health care organization and establish mechanisms to control overall cost growth for all patients.	All-payer or single payer ACO for all residents within a region. Use state authority to regulate hospital and physician spending. Capitate primary care and incentivize total cost of care management for all residents within a region.
Narrowly focused performance measures	Performance measures focused on health care organizations' clinical outcomes leave important domains less visible (e.g. health, social determinants, and community-level costs) and unaddressed. Neither health care organizations nor policy makers can be held accountable for improving regional health and costs.	Measure and report key domains – health status, social and behavioral risk factors, experience and total per-capita costs – at both the organization and the community level.	Implement patient-level and population-wide health outcome and total cost of care measures. Augment current payment models with incentives to improve patient and population-level performance. Track, publish, and compare organization and regional health system performance.
Limited inter-organizational collaboration	Health care organizations have little incentive to collaborate with each other or with community based organizations to address important determinants of health and costs.	Augment current payment systems with incentives focused on regional level performance; establish inter-organizational governance structures.	Form place-based health boards to coordinate cross-organizational collaboration. Establish regional virtual budgets including health and social care services, to enable collaborative planning and resource shifting.
Voluntary participation	Voluntary programs may widen variation in performance and exacerbate socioeconomic disparities.	Require all health care organizations to participate in initiatives focused on improving population-level performance.	Encourage state level comprehensive reforms to provide an alternative to voluntary models.