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A Comparative Analysis of Primary Care Practice Payment Models: Practice and System Level Implications

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Capstone

A Comparative Analysis of Primary Care Practice Payment Models: Practice and System Level Implications

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Graduate Program in Public Health

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EXECUTIVE SUMMARY

The purpose of this capstone was to (1) assess the likely effects of various primary care practice reimbursement models on quality of care and costs, (2) assess each reimbursement model's applicability relative to practice size, and (3) analyze each model's practice and system level implications. This was done through the conduction of a comparative analysis of current practice reimbursement models. The questions addressed in this analysis include:

- What are the primary, practice reimbursement models currently being used?
- What are the implications of these models on quality and costs?
- Are these reimbursement models applicable in all practice types (e.g. large-small, health system based versus independent)?
- What are the practice and system level implications for each reimbursement model?

Comparative analysis of current reimbursement models with respect to multiple practice considerations illuminated a variety of implications that vary depending on the implementing organization. Practice size, quality of care and improvement strategies, cost containment and system efficiency, and the promotion of population health are vital considerations when evaluating each reimbursement model's design and potential practice and system-level implications.

Practice size – The size of the practice and system in which it functions positively correlates to its ability to take on financial risk. Each model involves some amount of risk, thus the size of the practice should inform the procurer of the most appropriate level of risk. The Shared Savings and Comprehensive Care models include a high amount of risk on the part of the practice and are therefore, more appropriate for larger organizations. The Pay-For-Performance model also requires the provider to assume great risk, but this can be mitigated through efficient implementation strategies and subtle design manipulations, making this model appropriate for both large and mid-sized practices. Direct Primary Care is designed to support smaller practices, particularly those wishing to remain autonomous and includes a variety of methods to reduce any associated risk.

Quality – Improvements in the quality of the care provided by a practice are ongoing and, in most cases, continuously measured. Most reimbursement models require some level of quality measurement as a component of its design which makes it a paramount consideration for practices. The Pay-For-Performance and Shared Savings models both require a practice to achieve pre-determined performance and quality goals for reimbursement. Both function to improve system performance in a variety of ways, however, Shared Savings goes a step further by promoting the development of particular quality improvement strategies related to decreasing costs and waste. Like these models, Comprehensive Care has some requirement

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for capable data-gathering technologies, but these data are not always tied to metrics and may not play a direct role in reimbursement. Direct Primary Care practices have no related requirements but are still capable of maintaining a high quality of care through other mechanisms like increased time spent per visit, elevated levels of patient engagement, and an increased focus on overall patient satisfaction and experience.

Cost – Strategies for improving system efficiency and cost containment are key considerations for practices but must be weighed against deficiencies in quality that may result. Substantial contemplation of these factors is vital when determining an appropriate equilibrium, particularly when reimbursement is attached to quality metrics. The Pay-For-Performance, Shared Savings, and Comprehensive Care models all typically require a substantial initial investment to purchase and implement capable technologies; a significant burden for many organizations. Also, for Shared Savings, is a consideration of the level of financial risk that a practice is willing to assume. Abundant cost savings can result in a big reward, although there's no certainty any cost savings will be realized. The Comprehensive Care model involves a pre-negotiated payment to the practice, allowing for the development of an appropriate strategy for increasing efficiency and cutting costs, mitigating any adverse effects on quality. Direct Primary Care is based on cost cutting through the reduction of overhead expenses, a decrease in panel size, and the establishment of a sustainable delivery system. However, such a large diminution of costs and traditional processes typically shifts this burden onto the patients.

Population Health – A focus on health improvement of the entire population served by a practice is another vital consideration. Providing multidisciplinary services, equitable care, and appropriate access can result in a reduction of expensive interventions and improved health outcomes. The Pay-For-Performance and Shared Savings models can promote population health improvement if some performance requirements are associated with increasing access to and the enhancement of offered services as well as a focus on health outcomes. Unfortunately, these models can also inadvertently incentivize enlistment of healthier, lower-risk patients to avoid poor results on performance indicators, leading to decreased equity and access. The single payment for all services rendered involved in the Comprehensive Care model incentivizes the maximization of the population's health to grow revenue, thus promoting improved health for all patients. Direct Primary Care functions to improve access to care and equity, innately promoting the overall health of the population served.

Through analysis of important organizational considerations and implications, it became clear that although each model has a defining framework, variabilities in practice structure and desired outcomes results in complexities that inform the individual organization's model selection. Therefore, more than one payment model can be an appropriate fit for a practice and is directly dependent upon organizational goals. It is important to note that all

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considerations and implications are intertwined in complex and multifaceted ways. Although each payment model can have a significant effect on the organization and the system, both positively and negatively, understanding the mechanisms that produce these impacts is especially valuable for an organization's leaders to recognize.

INTRODUCTION

Currently, the United States healthcare system is unsustainable and in need of tremendous change. The cost of healthcare services is rising at a rate that will outpace anyone's ability to pay, further burdening individuals and employers with higher deductibles and decreased access to care. A second, contributing problem is that primary care practice in its current form is markedly unsustainable. Medical students entering practice are not choosing to work in primary care due to a variety of challenges and frustrations associated with the practice. Some of these barriers include insufficient third-party reimbursements and subsequent low pay, high overhead costs to run an independent practice, increasing capital requirements to implement necessary changes like electronic health records and meaningful use metrics, and the fines and penalties practices are subjected to as a result of non-compliance of the former. Reconstituting the primary care infrastructure is one of the core strategies for addressing this problem. Arguably, the most important and difficult step toward achieving this goal is improving medical practice payment models.

Presently, the United States healthcare system operates under a fee-for-service (FFS) model, where providers are paid for each individual service they provide (What is Fee-For-Service, 2019). This payment method incentivizes providers to do more to get paid more, producing tremendous waste and inefficient care without incentives for improving quality or health outcomes. The financial burden associated with this model falls on the payers and the system itself, contributing to rising national healthcare costs.

Various innovative practice payment models have been proposed to support improvement. The models showing the most promise are value-based, referring to the incorporation of incentives that focus on improving the quality of services while simultaneously reducing related costs. This approach aligns with that of the national movement toward the improvement of the healthcare system as a whole. Four value-based models have gained significant momentum in the healthcare environment for practice payment improvement; Pay-For-Performance (P4P), P4P - Shared Savings, Comprehensive Care, and Direct Primary Care (DPC).

BACKGROUND

Payment models have particular attributes that appear to improve aspects of the broken system, but include various implications, both negative and positive, that make them most effective under certain conditions or/and in particular environments. Each model has the

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objective of positively affecting the cost and quality issues of the current system; however, they attempt to do this through different strategies and incentive methods.

The traditional payment model used in the U.S., *Fee-For-Service (FFS)*, involves a particular reimbursement attached to each individual healthcare service or piece of equipment provided by an organization to a single patient. This primary characteristic incentivizes an increase in the volume of services above all else; the more services rendered, the more money paid to the organization or provider of these services. FFS incentivizes increased productivity, promotes the maximization of service delivery and patient visits, and can be utilized by practices of any size, in any environment. Unfortunately, these qualities come with a steep cost to the system as a whole.

FFS does not include any limitations on services or incentives related to efficiency or decreasing wasteful practices. This allows providers to simply order as many tests as they choose without containment. FFS doesn't have any mechanism for assuring the provision of high quality care and discourages the use of care coordination and email/phone management of ailments. These characteristics allow providers and organizations to remain unaccountable for the services they provide, the health outcomes of the patients they see, and the containment of costs related to alternative communication methods. In addition to the failures of the model, FFS is constrained by coding rules and guidelines that determine what can be billed for and include many system complexities. These attributes make it difficult for many patients to understand and navigate the healthcare system and improve their engagement in their own care.

The *Pay-For-Performance model (P4P)* can be defined as "a payment or financial incentive [model] associated with achieving defined and measurable goals related to care processes and outcomes, patient experience, resource use, and other factors" (Silversmith, 2011). Clearly, this model is goals-driven and relies on the health organization's focus on the particular metrics involved. These metrics are usually predetermined and negotiated with the payer prior to implementation. Choosing appropriate metrics that are true indicators of the performance of the organization and/or physician can be difficult and come with its own set of implications. The P4P model attempts to address the quality and cost issues in the current health system by incentivizing organizations to alter current care processes for increased efficiency and implement quality improvement initiatives that will aide in the achievement of the goals (Rosenthal, 2007). This is different from traditional FFS in that it drives down the need for increased volume of services rendered and instead, strengthens the focus on value. Other implications related to the implementation of this model include: the initial Health Information Technology (HIT) investment required, access to necessary resources, the size and environment of the practice, and the model's effect on population health.

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The Shared Savings Model is a variation of P4P and can fluctuate slightly in its composition, however; the model's structure involves a group of physicians joining to form an ACO (Accountable Care Organization). As Ritchie et al. (2014) note, the ACO contracts with a payer that will provide negotiated reimbursement for the care of a patient population. In turn, the ACO must meet certain quality and cost benchmarks for that population over a predetermined time period. This payment strategy incentivizes physicians to reduce healthcare spending for their patient population by rewarding them with a percentage of the savings attained by the group. However, if the organization fails to achieve these savings, the resulting financial loss is also shared ("Is "Shared Savings" the Way to Reform Payment", 2015). Since Shared Savings is a subset of P4P, many of the considerations related to implementing this strategy are the same. Sustainability of this model is questionable and should be considered as it relates to a particular organization. The most significant consideration for the provider, organization, and the system is how much risk they are all willing to assume. Depending of the contracted terms with the payer, risk can fluctuate significantly from one party to the other.

The Comprehensive Care Model, as described by the Center for Healthcare Quality and Payment Reform (Transitioning to Comprehensive Care Payment, 2015), involves the provision of a single payment by a payer for all of the health care services needed by a particular group of people over a specific time period. The objective of a Comprehensive Care Payment is to incentivize the healthcare provider to improve health outcomes and reduce costly hospitalizations as well as to avoid unnecessary services during any occurrence of care (Quinn, 2015). Like the models previously outlined, implementation of this model requires a substantial investment in HIT that can support data interpretation and reporting. Also, the health of the population the organization or provider treats should be another consideration as this model can affect how and which patients are treated. Unlike the current volume-based FFS model, the Comprehensive Care Model focuses on improving quality through cost saving mechanisms, creating yet more potential positive and negative implications.

In the *The Direct Primary Care (DPC) model* primary care physicians provide all or most primary care services including clinical, laboratory, consultative services, care coordination and comprehensive care management for a retainer or reoccurring fee, independent of a third-party payer. DPC "rewards family physicians for caring for the whole person while reducing the overhead and negative incentives associated with fee-for-service, third-party-payer billing" (Direct Primary Care: An Alternative Practice Model to the Fee-For-Service Framework, 2015). Unlike the other models discussed DPC works to improve the patient and physician experience by lowering costs of services and increasing the time spent per office visit. DPC also strives to utilize other communication improvements like online portals and phone screens. However, the lack of large, integrated HIT systems and third-party payer sources can affect the range of services a practice can offer and it's networking capabilities. Lastly, the size of the practice,

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health outcome accountability, and patient health insurance requirements are also important considerations of DPC implementation.

METHODS

Literature Review: I conducted a comprehensive literature review to identify the key issues associated with practice payment reform and to delineate what we know about their impact on the cost and quality of healthcare services. I used OneSearch, MEDLINE, PubMed, and Google to conduct this search and review relevant literature. These search engines were used to (1) provide a comprehensive review of scholarly and peer-reviewed journal articles, (2) obtain related quantitative data, and (3) locate governmental and health organization sites. All search engines and search terms were recorded in order to maintain documentation of vital inquiries.

Data Collection, Data Analysis, and Participants: Data for this paper includes (1) secondary data sources such as scholarly and/or governmental literature in order to ensure the information is the most current available and (2) interviews with key informants to better understand traditional and innovative healthcare reimbursement methods and how each reimbursement method relates to the needs of practices of various sizes. Specifically, I conducted semi-structured interviews with professionals with extensive knowledge about practice reimbursement models; Dr. Michael Ciampi, MD of Ciampi Family Practice, Dr. Lisa Letourneau, MD, MPH of Maine Quality Counts, and Dr. Brian Pierce of Megunticook Family Medicine. Qualitative data collection and analysis was informal and noninvasive. All primary objectives and questions were approved by the interviewees prior to performance of the interviews and presentation in the final capstone deliverables.

The IRB review process was completed shortly after the presentation of the Capstone proposal and was determined not to be human subject related research as of May 26, 2015.

THE IMPLICATIONS OF PAYMENT MODELS FOR PRIMARY CARE PRACTICES AND THE HEALTH SYSTEM

Each of the four payment models discussed here has multiple practice and system level implications, some positive and some negative. Each model has its own unique core attributes that tend to be static as well as a set of variable characteristics that allow for subtle manipulations, ensuring an adequate fit into a preexisting framework. These variations not only accommodate the practice utilizing the model, but also provide the system within which the practice functions, yet another unique building block that could become the foundation for a very efficient, effective payment model.

With every innovative strategy employed by the individual practice, come related implications that affect the overall function and outcomes within the system. In order for new

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model implementation to be effective, there must be careful consideration of the variable factors being utilized and potential repercussions involved, prior to proceeding. Also, there must be mechanisms for assessment and room for reconsideration of at least the variable aspects of the model. Failure to address these preliminary considerations could result in significant detriment to the practice and subsequently, the system.

The implications discussed below are important for the provider and the organization to consider before choosing a payment model, as each is paramount to the function of the system. Consideration of practice size can help distinguish between models that are appropriate for the organization's needs and services and those that are too complex. The strength of a model's focus on quality of care or cost containment can be important characteristics to an organization as well. Each model varies in its emphasis on these attributes and each can directly affect care processes, efficiency of services, and eventual health outcomes. The promotion of improved population health is also a crucial consideration since the demographics and the needs of the population will determine the types of services that will be utilized. Understanding these population influences will help the organization to align the chosen model appropriately. Each implication appears discrete; however, they are integral and central to a well-functioning system and should be carefully considered together prior to implementation.

PRACTICE SIZE

Although there are many considerations, the practice's and the system's size are central to choosing an appropriate model. The size of the practice and system directly relate to the ability to take on financial risk. Each payment model is accompanied by a particular amount of risk; some models require the provider to take on enormous risk, others have nearly zero risk, and the rest have some level of risk that lies somewhere in between. The size of the practice and system is more complex than simply the square footage or the number of buildings; the size can be interpreted as the number of providers it contains, the patient panel it services, the number of payers it contracts with, and the amount of services it offers. This vital contemplation is paramount when determining which model to implement into a practice and therefore, a system. Generally, the greater the "size," the more risk it can absorb and therefore, the more appropriate one model will be than the others.

Pay-For-Performance (P4P): This model is somewhat limited to larger, multiservice providers. However, mid-sized organizations can function very well in this environment, provided the appropriate manipulations are made. Since this model requires a significant initial investment, it may be difficult for mid-sized organizations to implement (Pierce, 2015). To combat this barrier, these practices should implement this model in stages, over time (Brown, 2016). Also, providers are incentivized based upon efficiency, quality, and process metrics; therefore, even mid-sized practices can improve significantly and do very well within the confines of previously

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contracted, specific metrics. The P4P model inherently shifts much of the risk from the payer, onto the organization. These entities are held accountable for achieving these goals and failure to do so can result in a loss of revenue and reimbursement.

P4P - Shared Savings Model: Since this model is basically another form of P4P, it too functions best in larger practices. The related risk to a practice under this model is substantial and would most likely be too much of a burden for a mid-sized organization. Not only is the initial investment generally very high, the cost to a practice that doesn't succeed in achieving necessary savings can be incredibly destructive.

Comprehensive Care Model: This model is somewhat limited to larger, integrated practices that offer a greater range of services, because it involves a single payment for treatments that may require multiple areas of care. The majority of risk is absorbed by the provider of services, which requires users of this model to be in nearly full control of all services rendered to their population.

Direct Primary Care Model (DPC): This model is designed to support smaller, independent and even rural practices that wish not to function under any traditional, third party payer system. This model allows for complete autonomy for the provider with nearly zero overhead or burden. Even though all risk is fully attributed to the provider, this exception to the rule is only risky if the practice's costs substantially outweigh the income. Fortunately for the provider, this model can be manipulated at his or her discretion and may include only a few services, function within limited hours, not involve any health information technology, use only basic diagnostic and treatment tools, and service a small patient panel. Adjusting these aspects of the practice up or down allows the provider to control costs as well as income efficiently and effectively.

QUALITY

Another priority consideration of model implementation is the quality of care and quality improvement strategy implications. With national movement toward increasing the quality of the healthcare system, organizations and providers are under a microscope when it comes to measuring health outcomes and care processes. As Harold Miller explains in his article, "The Building Blocks of Successful Payment Reform: Designing Payment Systems that Support Higher-value Health Care," the majority of value-based payment models include requirements and incentives related to the improvement of quality and are measured through predetermined metrics to ensure accountability on behalf of the organization and individual provider (Miller, 2015). Also, effective communication between providers and specialty organizations should be considered mechanisms for increasing quality. Literature shows, effective communication throughout the healthcare system leads to better health outcomes

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and patient experiences. Health systems and the organizations within them must be cognizant of these considerations and the implications they may have.

Pay-For-Performance (P4P): Inherent in this model are requirements for organizations to meet pre-negotiated goals related to performance and quality. Often, it can be difficult to develop appropriate, comprehensive indicators that are valid assessments of the state of the organization. An inappropriate choice of indicators can reflect poorly upon the organization and provide a false representation of quality and performance. Adoption of applicable metrics allows for effective evaluation and subsequently, improvement of services and processes. Also, P4P encourages collaboration and the improvement of communication between physicians and other healthcare providers. This is accomplished by incentivizing them to achieve particular scores on metrics that require improved communication and successful collaboration. These metrics increase the accountability of the provider as well by holding them responsible for their own individual performance. Development of representative indicators effectively promotes the quality improvement of care services.

P4P – Shared Savings Model: Since this model is a type of P4P and includes similar quality and performance indicators, much of its effect on quality is the same. Where the shared savings model differs slightly from classic P4P, is the built-in incentive to decrease costs and waste through quality improvement mechanisms. By improving the quality of care and services, a reduction in costly hospitalizations and preventable ailments will be realized. This method should reduce excess costs to the system, increasing the likelihood the organization will achieve savings.

Comprehensive Care Model: Like the previous models discussed, the Comprehensive Care Model requires certain technologies for analyzing, interpreting, and reporting various data types. However, the data are not always tied to particular metrics and may not play a direct role in reimbursement. These requirements are primarily used to track specific processes and outcomes in order to develop unique strategies to improve quality and reduce related costs. By doing so, organizations can work to utilize fewer resources while simultaneously enhancing health outcomes. This model allows for greater flexibility and innovation of care delivery methods as a result of not being required to report every tool and test. Finally, there is an intrinsic incentive to communicate and collaborate with other providers serving the same population in order to reduce costs and increase positive health outcomes, thus improving the quality of care.

Direct Primary Care (DPC): DPC does not require practices to obtain data analysis software, to invest in large communications systems, or to work with third party payers. However, it is inherently difficult to be held accountable for standards of information sharing, quality reporting, and population health program participation without a claims-based billing system.

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The absence of these capabilities decreases transparency and discourages the implementation of quality improvement strategies. Also, effective communication and networking with other providers throughout the healthcare system is substantially diminished. This inability can compromise the quality of the care provided by preventing physicians from obtaining necessary specialty consults in a timely fashion, learning and utilizing current evidence-based practices, and accessing appropriate laboratory and radiology resources. Since the DPC model usually involves a smaller patient panel, more time is typically available for office visits. This increase in time allows the physician to look more closely at individual health issues and research health problems while the patient is present, increasing patient engagement and general satisfaction.

COST

Effective cost containment mechanisms and system efficiency are other vital considerations when choosing a payment model. For some models, the initial investment required to begin implementation is tremendous and should be carefully considered. The cost to maintain such a system, particularly one that has the capacity to analyze and interpret data, can also come with a steep price. Though many payment models have been designed with cost containment in mind, sometimes costs are simply shifted to other areas of a process or to other entities, like the patient. Also, organizations should be wary of some cost cutting mechanisms, as increases in efficiency can result in deficiencies elsewhere. For example, a strong focus on efficiency can sometimes create an incentive to treat less and rush through patient interactions, potentially leading to poor health outcomes and low patient satisfaction, thus lowering quality. Special attention should be paid to the payment model's strategy for achieving increased efficiency and lower costs since the strategy itself could provide insight into possible problems for the organization and the system. Preemptive identification of these issues could allow for the prevention of poor organizational outcomes.

Pay-For-Performance (P4P): In the framework of the P4P model, reimbursement is directly tied to an organization's achievement of a variety of performance indicators. Generally, these indicators are based upon quality improvement, cost reduction, and increases in process efficiency. Failure to perform well enough could mean substantially less reimbursement for services provided. The required investment in systems capable of performing necessary tasks for the organization can be large and may include Health Information Technology (HIT), metric-related software, tools and devices, additional services or personnel, and improvement programs. Many organizations lack the resources to make an initial investment of this magnitude and to maintain such systems, particularly those in low socioeconomic areas. The organizations and health systems that can afford to absorb this level of cost will inevitably perform better on many indicators and receive full reimbursement. Implementing the P4P

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model in an organization or health system in low socioeconomic regions can result in financial detriment, further increasing disparities in health care.

P4P – Shared Savings Model: Since the Shared Savings Model functions off of the same basic framework as P4P, it must contend with the same obstacles described above. The primary implication specific to this model is the level of financial risk the organization is willing to assume. The underlying incentive is to take on greater risk in order to reap higher rewards through cost savings; however, there is no guarantee any savings will be realized. Also, if any additional investments are required, like HIT and personnel, there is no assurance the savings will be enough to cover these costs.

When a multi-provider organization chooses to implement the Shared Savings Model, a variant of the “Prisoner’s Dilemma” can ensue. This phenomenon can occur if one of the providers in the organization invests to improve care and the others do not. The savings realized may not be enough to cover the individual provider’s costs, resulting in a financial loss for that provider. The opposite is also possible if most of the providers in the organization choose to invest and one does not. The dissident provider can increase his profits by sharing in the savings without making the initial investment, without taking on financial risk (“Is “Shared Savings” the Way to Reform Payment”, 2015).

The Shared Savings Model can further increase payment system inequities by rewarding high spending practices instead of high performing ones. Savings are generated by the amount of improvement over a fixed period of time; therefore, organizations that produce the most waste and have the highest costs have the most to gain through improvement. Since savings is usually measured in comparison to the historical performance of the practice, there is abundant savings to be had by making even the simplest improvements. Current high-performing organizations are already saving money and may not be able to drastically improve without making significant investments in even more capable systems. Even so, savings may not be enough to cover associated costs. The Shared Savings Model is unsustainable, because even if savings are achieved now, eventually there will be no more room for improvements significant enough to generate adequate savings and increases in reimbursements will cease.

Comprehensive Care Model: Like the previous models, the Comprehensive Care Model requires a substantial investment in sophisticated data and information systems capable of analyzing, interpreting, and reporting various types of data. If an organization is not already equipped with these systems, the cost can be difficult to absorb. Generally, payment for the practice’s patient population is made up front, allowing the organization time to develop a care strategy around a predetermined sum. The organization can then better appropriate funds and focus on continuous improvement.

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Since a single payment is made for the treatment of their entire patient population, organizations have an incentive to deliver care as efficiently as possible. Inherent in this strategy is a disincentive to take on high-risk and noncompliant patients to avoid overspending on any one individual. If these complex, risky patients are accepted by the practice, the result could be the under-treatment of some patients in order to accommodate these more costly individuals.

Direct Primary Care (DPC): The Direct Primary Care Model is independent of any third-party payers and therefore, does not require any substantial investment in complex systems or other technologies. DPC involves the reduction of overhead costs, a decrease in panel size, and an exceptionally sustainable delivery system; however, this global diminution of expenses and traditional processes reallocates costs onto the patient. The patient pays a generally small, recurring sum to the practice in exchange for most primary care-related services, but the requirement remains for health insurance that covers specialty services, emergency interventions, and hospitalizations (Chase, 2013). The retainer fee, in conjunction with the insurance premium can be a far greater expense than an inclusive premium alone.

POPULATION HEALTH

The promotion of population health is another critical consideration that can lead to a reduction in costly hospitalizations, improved health outcomes, and increased health equity. Some payment models can inadvertently incentivize providers and organizations to avoid complex, high-cost patients to improve scores on metrics or to reduce related expenses. This phenomenon can result in more expensive, preventable hospitalizations for these individuals, in turn costing the organization far more to treat (Pope, 2011). Improvement of the health outcomes of individuals will lead to a healthier population as a whole, continuously promoting population health ideals. Improving access to care is another aspect of health promotion that, in conjunction with a strong focus on the population, can result in equitable healthcare. These considerations are essential when choosing a model since appropriate dispersion of services in a population can tremendously improve the health of its constituents, thus improving quality and reducing costs.

Pay-For-Performance (P4P): The P4P Model can inadvertently incentivize providers to take on lower-risk patients to avoid performing poorly on quality and outcome metrics. Clearly, this occurrence excludes those in the population that require expensive treatments or hospitalizations, resulting in an inequitable healthcare system and a significant decrease in access to care. The same performance indicators can emphasize health outcomes and incentivize the global improvement of care services. Finding equilibrium between the exclusion of individuals in the patient population and the improvement of care services is essential for an effective system that promotes population health.

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P4P – Shared Savings Model: Like traditional P4P, the Shared Savings Model's basic structure revolves around performance metrics and therefore, includes the same implications.

Comprehensive Care Model: Since the Comprehensive Care Model involves a single payment for the provision of all primary care services, there is an incentive to maximize the health of the population to increase revenue. Along with a strong focus on population health, come metrics that further promote the improvement overall health outcomes. Still, a disincentive exists in this model to undertreat some patients in order to financially account for the expensive, more complex cases.

Direct Primary Care (DPC): The primary way DPC promotes population health is through increasing access to members of the practice. Wu et al. (2010) note, patients experience increased opportunities for visits with their physicians and far more time per visit. However, due to a decrease in panel size relative to a traditional practice, overall healthcare access for the population in the region is diminished. DPC, with its smaller panel size and improved patient experiences, has also been developed as a mechanism for attracting new physicians to primary care and decreasing turnover rates of existing primary care doctors (Wu, 2010). Unfortunately, an increase in the number of small-panel practices might actually further exacerbate the shortage of available primary care physicians, resulting in more of a reduction in care access.

CONCLUSION

The value-based payment models discussed have been developed to combat the inequities and inconsistencies in the current FFS system and include attributes and innovative strategies for improving the function of the healthcare system overall. Each model is most appropriate for a practice of a particular size, corresponding to the amount of risk that can be assumed. Large, multi-physician organizations are more capable of accepting greater risk and absorbing more financial loss. These organizations may benefit from a more complex model; a model with bigger risks and bigger rewards. A smaller, independent practice can more reasonably be paired with a model that eliminates additional costs, particularly sizeable upfront investments.

With a national movement toward increasing the quality of care throughout the healthcare system, particularly in relation to health outcomes, quality implications and quality indicators should be very important concerns for procurers of a model. Choosing a model that will aide in the transition to a more quality-focused organization through the improvement of communication mechanisms and increased provider accountability, is essential when evaluating current practice framework.

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Assessing costs and cost containment mechanisms involved with a model is another vital consideration. Since most value-based models require substantial investment in systems capable of analyzing and interpreting data, recording and communicating metrics, and improving process efficiency, procurers must consider all related implications for the organization and the system it functions in. Without financial stability, improving quality and health outcomes is near impossible and may involve greater investments in the future. Also, implications related to cost shifting and changes in efficiency should be another focus of consideration, as these influences can affect users of the healthcare system, both positively and negatively.

The manner in which a payment model can be utilized to affect the promotion of population health is a final subject of consideration. Models that function to reduce costly hospitalizations, improve health outcomes, and increase health equity can have positive effects on the overall health of the population, further supporting cost containment and quality improvement strategy within the system. Lastly, impacts on healthcare access and related implications should be considered as mechanisms for promoting population health.

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COURSE CONTRIBUTIONS

MPH 565: Social and Behavioral Health – Literature review skills, and knowledge of multiple aspects of health disparities and public health theory.

MPH 525: American Health System – Knowledge about how health systems work and current issues plaguing our world today (i.e. healthcare costs and quality).

MPH 545: Applied Biostatistical Analysis – Data analysis skills and identifying data trends.

MPH 535: Introduction to Epidemiological Research – Research design skills, analysis of research studies, data collection methods.

MPH 640: Health Finance I – Financial analysis skills related to the comprehension of financial reports.

MPH 645: Health Finance II – Healthcare finance development, physician compensation, and related financial decision-making.

MPH 575: Health Systems Organization and Management – Methods of exploring innovative strategies and/or models to address public health issues.

MPH 670: Quality Improvement – Healthcare quality issues, the quality improvement movement, and quality improvement tool and strategies.

MPH 698: Field Experience – During this field experience I was introduced to various innovative practice reimbursement models, many of which seemed to have the potential for addressing global healthcare associated issues. I studied these models in depth during the four months of this field experience while attending lectures, meetings, and a conference that involved dozens of physicians and many other individuals in various public health roles practicing in Maine and throughout the nation. I was fortunate to have these interactions and experiences, all contributing greatly to my interest in this project.

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