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Shifting Away From Fee-For-Service: Alternative Approaches to Payment in Gastroenterology

Kavita Patel, Elise Presser, Meaghan George, and Mark McClellan

Center for Health Policy, Brookings Institution, Washington, District of Columbia

Fee-for-service payments encourage high-volume services rather than high-quality care. Alternative payment models (APMs) aim to realign financing to support high-value services. The 2 main components of gastroenterologic care, procedures and chronic care management, call for a range of APMs. The first step for gastroenterologists is to identify the most important conditions and opportunities to improve care and reduce waste that do not require financial support. We describe examples of delivery reforms and emerging APMs to accomplish these care improvements. A bundled payment for an episode of care, in which a provider is given a lump sum payment to cover the cost of services provided during the defined episode, can support better care for a discrete procedure such as a colonoscopy. Improved management of chronic conditions can be supported through a per-member, per-month (PMPM) payment to offer extended services and care coordination. For complex chronic conditions such as inflammatory bowel disease, in which the gastroenterologist is the principal care coordinator, the PMPM payment could be given to a gastroenterology medical home. For conditions in which the gastroenterologist acts primarily as a consultant for primary care, such as noncomplex gastroesophageal reflux or hepatitis C, a PMPM payment can support effective care coordination in a medical neighborhood delivery model. Each APM can be supplemented with a shared savings component. Gastroenterologists must engage with and be early leaders of these redesign discussions to be prepared for a time when APMs may be more prevalent and no longer voluntary.

Keywords: Bundled Payments; Per-Member, Per-Month; Medical Home; Health Care Reform.

High-value gastroenterology care is critical in improving quality and reducing health care costs as part of health reform. The National Institutes of Health estimate that 60 to 70 million people are affected by digestive diseases in the United States, costing $141.8 billion in 2004.[1] Medicare Part B spending for gastroenterology is $1.52 billion annually, approximately 2% of Part B fee-for-service (FFS) spending.[2] This figure is much higher when ancillary services related to gastroenterologic diseases, influenced by gastroenterologists but not coded under gastroenterology, are taken into account. For example, colorectal cancer (CRC) treatment cost Medicare $14.14 billion in 2010.[3]

Gastroenterology costs are driven by a few main procedures and conditions. Endoscopic procedures account for a large proportion of gastroenterologic services. In 2009, 18.6 million endoscopic procedures were performed in the United States, amounting to $32.4 billion in outpatient costs.[4] CRC screening is the most common screening test in America and can vary greatly in cost based on geography and setting.[5] Medicare beneficiaries underwent more than 3.3 million colonoscopies in 2010. Half of all colonoscopies were performed for CRC screening and surveillance.[4] Chronic conditions such as inflammatory bowel disease (IBD) and gastroesophageal reflux disease (GERD) also are major cost drivers in gastroenterology. IBD, which includes Crohn's disease and ulcerative colitis, affects more than 1 million people in the United States and is responsible for $1.8 billion in direct costs.[6,7] Crohn's disease is responsible for the majority of IBD costs and represents $1.07 billion in direct annual medical costs.[8] GERD, which is the leading gastroenterology-related diagnosis during outpatient visits, is responsible for $12.1 billion in direct costs and affects 20% of Americans.[8,9] Although not one of the top cost drivers in the past, hepatitis C, which affects approximately 3 to 4 million Americans and is the leading cause of liver transplants in the United States, will become increasingly relevant for costs because of the high expense of improved drug therapies, which alone accounted for $1.1 billion in direct costs.[7,8,10–12]

With gastrointestinal (GI)-related disorders and costs increasing, opportunities to improve care and avoid unnecessary spending have become more critical. Such opportunities include more effective use of CRC screening, reducing significant variations in upper GI endoscopy rates and management patterns for conditions such as reflux esophagitis, variations across sites and providers in

Abbreviations used in this paper: **ACO, Accountable Care Organization; AGA, American Gastroenterological Association; APM, alternative payment model; ASC, ambulatory surgical center; BPCI, Bundled Payments for Care Improvement; CRC, colorectal cancer; ECHO, Extension for Community Healthcare Outcomes; FFS, fee-for-service; GERD, gastroesophageal reflux disease; GI, gastrointestinal; IBD, inflammatory bowel disease; MAC, monitored anesthesia care; PCMH, patient-centered medical home; PCP, primary care provider; PMPM, per-member, per-month.**

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complication rates, and preventable complications from hepatitis and IBD.[13–15] Moreover, opportunities exist for better coordination of care with primary care providers (PCP) (eg, informal consults and guidance that could head off more costly but unneeded formal consultations and procedures for patients with mild reflux), for performing procedures in less costly but appropriate settings (eg, ambulatory vs outpatient department CRC screening), and for using electronic communications (eg, e-mail or telemedicine) to manage their patients more efficiently and conveniently when feasible.

Similar to US health care in general, the gastroenterology FFS payment structure provides little or no support for these opportunities to improve care, instead encouraging high-cost, procedure-based services without respect to patient outcomes. In a FFS model, providers are penalized financially for reducing the use of unnecessary services, in addition to not being reimbursed for low-cost, high-impact interventions such as care coordination and non–face-to-face services. Simply adding additional paid services to FFS cannot address this problem efficiently because many important aspects of care are not easily broken into discrete services and simply adding on more payments would provide little encouragement to avoid low-value procedures.

Many stakeholders are exploring ways to support better care and lower costs through payment and delivery reforms. Alternative payment models (APMs) aim to correct the issues described earlier by shifting payments away from FFS to allow more resources to be used for supporting appropriate services while instituting new accountability for keeping overall costs down.[14,16] Recognizing this need to move away from volume-based reimbursement toward value- and quality-based reimbursement, in January 2015 the Department of Health and Human Services announced a goal of tying 30% of traditional Medicare payments to APMs by the close of 2016, moving to 50% by the close of 2018.[17] This goal was reinforced by Congress with the passage of the Medicare Access and CHIP Reauthorization Act of 2015, which repealed the sustainable growth rate formula for physician payments, instead linking payments to performance measures and providing incentives for participation in APMs.[18] With payment reform implementation accelerating, gastroenterologists have an opportunity to influence how these reforms develop, with important implications for gastroenterology practice. In this article, we provide the framework to help gastroenterologists move forward with this challenge.

Implementing Alternative Payment Models in Gastroenterology

APMs in gastroenterology, similar to all APMs, aim to realign provider financial incentives to support high-quality care by delinking payments from volume. A spectrum of APMs exist that transition away from traditional FFS through aggregation of payments at the individual provider level or across multiple providers, as summarized in Table 1. We describe how these APMs could be used to support care reforms in the 2 main components of gastroenterologic practice, procedures, and management of chronic conditions. We note that because GI practice is complex and varied, the specific reforms best suited to each practice will depend on the patient and service mix and that payment reform can be implemented in a stepwise fashion. In addition, although the main focus is on individual and group practices, the themes remain relevant for gastroenterologists practicing in academic settings and large health systems because large components of their payment remain directly or indirectly linked to volume. Many such systems already are moving to alternate payment and delivery models such as Accountable Care Organizations (ACOs) and bundled payments and the reforms described here can complement and inform those initiatives.

APMs relevant to each major component of a GI practice are described in detail. A bundled payment model is most relevant for discrete procedures, such as screening and surveillance colonoscopies, which are common in gastroenterological practice. In a fully implemented bundled payment model, a lump sum payment replaces the FFS payments to cover a specific set of services provided during an episode of care. For the treatment of chronic conditions such as IBD, we suggest a per-member, per-month (PMPM) payment to support the types of care coordination and expanded services that are necessary for patients with these conditions—these payments are best grounded in a gastroenterology medical home. For chronic conditions that require occasional specialty involvement but generally can be handled in a primary care setting, such as uncomplicated GERD or management of stable chronic hepatitis, we suggest a PMPM in conjunction with a primary medical home. The overall PMPM would be shared between the PCP, who acts as the clinical lead, and the gastroenterologist, who would have better support to provide consultation and assistance to the PCP. This version of a medical neighborhood model can be viewed as a variant of the medical home model in which specialist payment is better aligned with the goals of the medical home.[19] These models can be implemented on a limited basis (ie, only replacing a small portion of FFS payments), or a more comprehensive basis (ie, as a more complete fixed payment for the episode or for all services provided during the month). Each model can be implemented in conjunction with a shared savings component for the nonbundled or noncapitated services, in which the providers share in any cost reductions in these remaining services that result from the improved quality of care. Shared savings support improvements in the health of the total population of patients for whom a provider is responsible, and requires identifying that patient population and tracking patient level outcomes and costs.