The JAMA Forum

Financial Stability as a Goal of Payment Reform—A Lesson From COVID-19

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Over the last decade, the US health care system embarked on a journey toward value-based care. The Centers for Medicare & Medicaid Services (CMS) designed and implemented a range of value-based payments through the rollout of alternative payment models, such as accountable care organizations (ACOs). The goal of these efforts was to increase value by improving quality and reducing costs. To date, however, alternative payment models have had modest effects on health outcomes or spending.

In the next decade, the difficult work of payment innovation should continue, using lessons learned from prior efforts. However, the goals of payment reform also must be updated—along with the mechanisms used to achieve those goals—based on the lessons learned from the coronavirus disease 2019 (COVID-19) pandemic. Increased financial stability should become an explicit objective for policy makers. Reorienting efforts to include the pursuit of stability may protect access, preserve independence, and advance value-based care.

Disrupting an Unstable Foundation

Approximately 95% of health care payments in 2018—including many through alternative payment models—were built on fee-for-service care delivery, which has long been criticized for incentivizing overuse of medical services and contributing to waste. But COVID-19 laid bare another important drawback of fee-for-service: it provides an unstable basis of financing, making it exceptionally vulnerable to shocks that reduce demand for in-person care.

During the COVID-19 pandemic, the quantity of medical care delivered to US patients decreased precipitously, especially in the early months. Emergency department visits declined, elective procedures were deferred, and inpatient admissions slowed. Outpatient visits decreased almost 60% by early April, with a cumulative visit deficit of 37% between March 15, 2020, and June 20, 2020. These reductions in medical care caused reductions in revenue for hospitals and physician practices, contributing to the 18% decline in national health spending during the first quarter of 2020 and to the layoffs of 1.4 million health care workers in April.

In addition to contributing to unemployment and the contraction in GDP, these unexpected declines in revenue had 2 other important consequences. First, they threatened access to care for patients. Because surgical admissions account for almost half of hospital revenue, the deferral of procedures was particularly devastating for hospitals, which saw significant declines in operating margins. Some hospitals—especially large nonprofit teaching hospitals—can weather such losses in the near term, but many small rural hospitals are more financially vulnerable due to less cash reserves. As a result, several rural hospitals closed during the pandemic despite receiving federal relief funds, accelerating a preexisting trend and leaving rural patients with significantly longer travel times to the nearest medical center.

Second, although the financial duress on physician practices also led to closures, it has another, more insidious effect as well. In a recent survey in Massachusetts, 30% of independent primary care practices—which may provide more cost-effective care than hospital-owned practices—reported they were considering consolidation with a hospital or health system. Even though this type of consolidation is often purported to facilitate care coordination, it usually leads to increased prices for commercial insurers that drive up spending. One-third of independent primary care practices also reported considering selling their practice, creating an opening for private equity firms and other buyers that may emphasize profit over other goals, raising concerns about patient welfare and health equity.

Stability as a Goal of Payment Reform

These consequences underscore the risks that the fee-for-service care model poses to access, cost, and quality because of its unstable financial foundation. In contrast, financing methods such as prospective population-based payments are more resilient in the face of shocks like COVID-19, protecting access to care when it is most needed. Such financing methods may also protect against further consolidation by preserving the financial independence of physician practices. And they can enable, as 6 former CMS administrators noted in a recent letter to Congress, more versatile care models, including proactive outreach to high-risk patients, home-based care, and integration of medical and social services, all of which are important during and outside a pandemic.

How can the goal of increased stability in health care financing be accomplished? For physician practices, one avenue is fully capitated payments. Drawing on past experiences, including the ACO Investment Model of the CMS and Hawaii's experience with population-based payments for primary care, and looking to emerging examples, like the Blue Cross Blue Shield of North Carolina Accelerate to Value program or the Blue Cross Blue Shield of Massachusetts pilot for independent primary care practices, can help speed implementation. For hospitals, adopting global budgets (building on the experience of the CMS partnership with the state of Maryland), can help foster health care financing stability. For both physician practices and hospitals, 2019 revenue can serve as an anchoring point for these population-based payments, with limits on future growth but also enhancements for preparedness and

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select high-value services (such as integrated behavioral health). To facilitate this transition, the CMS should provide ample technical support and offer special pathways that limit downside risk for small practices, which often have fewer levers to manage total cost of care compared with large physician groups and hospitals.

These payment methods, which are rarely used today, would provide a financial lifeline for hospitals and primary care practices during the COVID-19 pandemic and provide greater stability beyond the pandemic. In addition, by tying spending growth to a benchmark over multiple years, capitation and global budgets incentivize financial stewardship by constraining annual expenditures and year-over-year spending growth. This incentive may help seize this once-in-a-generation opportunity to eliminate waste by encouraging clinicians to resume necessary services and let unnecessary ones remain foregone as society transitions into a new normal. Evidence-based guidelines and international standards can inform this process, especially for cancer care and supply-sensitive surgeries like spinal fusion. Prospective payments also offer increased flexibility for the delivery system—to invest in prevention and other upstream services, to devote more attention and resources to the sickest patients, and to deliver care through whatever modality makes the most sense for a given patient.

Moreover, these models provide a foundation for sorely needed redistributions of dollars in the health system. By abandoning the fee-for-service reimbursements that disproportionately reward specialist and procedural care, true population-based payments at the organizational level may stimulate redistribution of resources from specialists toward primary care, improving population health. By gradually titrating those payments based on need, agnostic of payer mix, they could also drive redistribution of dollars from wealthier systems to safety net institutions that—despite caring for the most vulnerable patients—are systematically disadvantaged by existing payment structures.

In this way, adding financial stability as a goal of payment reform would provide a platform to make progress on other priorities, including cost containment, prevention, and health equity. Value was—and still is—a worthy objective. But, as COVID-19 teaches us, stability is often a precondition for access to high-value care. ■

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Conflict of Interest Disclosures: Mr Gondi reported being an advisor at 8VC and was recently employed at Commonwealth Care Alliance. Dr Chokshi reported receiving personal fees from the Institute for Healthcare Improvement, Aspen Institute, RubiconMD, and ASAPP Inc; and being a board member of the nonprofit Primary Care Development Corporation.

Note: Source references are available through embedded hyperlinks in the article text online.

Previous Publication: This article was previously published in *JAMA Health Forum* at jamahealthforum.com.