



# ACOG COMMITTEE OPINION

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## Committee on Health Economics and Coding

*This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Health Economics and Coding in collaboration with committee member John P. Geisler, MD, and Karen E. George, MD.*

## Value-Based Payments in Obstetrics and Gynecology

**ABSTRACT:** Unsustainable health care costs combined with suboptimal patient outcomes have led health policy experts and payers to consider value-based payment or alternative payment models. Replacing fee-for-service reimbursement, these models link payment to value by rewarding efforts to enhance the quality of care at similar or reduced costs. Although many of the models employed to date have focused on primary care, management of chronic disease in the Medicare population, and episodes of care for common procedures, models for primary and specialty care of women are in the early stages of development. As specialists in women's health, obstetrician–gynecologists need to be actively engaged in this fundamental shift in the payment and delivery system.

### Recommendations

The American College of Obstetricians and Gynecologists makes the following recommendations:

- Obstetrician–gynecologists (ob-gyns) must understand how a change from fee-for-service to value-based payments will affect the way health care providers practice and the health and well-being of the patients served.
- Because ob-gyns are providers of primary care with care coordination responsibilities and specialists in women's health, value-based payment models should prioritize and reward ob-gyns with payments that account for the full value of the service provided.
- Ob-gyns must be fully engaged in this transition by defining quality and value within the specialty.
- As advocates for women's health, ob-gyns must promote patient engagement and recognize the essential role that patients play in bringing value to their health care.

### Background

Health care spending comprises an increasingly large portion of the U.S. economy. In 1950, health expendi-

tures accounted for only 4.6% of the gross domestic product, but current projections estimate that by 2022, health care expenditures will compose 20% of the gross domestic product (1, 2). To many economists, this growth rate is unsustainable and represents one of the “greatest fiscal policy challenges facing the United States” (1). Despite spending more on health care than any other country, people in the United States experience higher rates of disease and injury and die earlier than their counterparts in all other high-income countries (3). Although the root causes of these differences are multifactorial, the National Academy of Medicine (previously known as the Institute of Medicine) identified several drivers of lackluster outcomes, including a weaker foundation in primary care, lack of access to affordable care, poor coordination of care across the system, and a population with greater propensity for unhealthy behaviors (3). Health care reform, including the Patient Protection and Affordable Care Act, has sought to change the trajectory of health care costs and improve the quality of care by improving access to care, providing preventive services without cost-sharing, and tying reimbursements to value. Unsustainable health care costs combined with suboptimal patient outcomes have led health policy experts and payers to consider value-based payment or alternative payment models.

Replacing fee-for-service reimbursement, these models link payment to value by rewarding efforts to

enhance the quality of care at similar or reduced costs. Value in health care often is defined as quality over cost. Much has been written in the past two decades about value in health care, and there is ongoing debate about how to best achieve it. Politicians and policymakers on both sides of the national debate agree in principle with the importance of achieving a health care system that provides the highest quality at the most affordable costs (4). In 2008, the Institute for Healthcare Improvement proposed a new framework, known as “The Triple Aim,” to optimize health system performance that incorporates three equally important goals: 1) to enhance the experience of care, including quality, access, and reliability; 2) to improve the health of populations; and 3) to control and reduce the per capita costs of health care (5). Achieving the goals of The Triple Aim requires a new paradigm for health care delivery that fosters an interdisciplinary team focused on coordinated, standardized care that incorporates patient preferences and avoids redundancy and waste. With this paradigm change in delivery, there are also major changes to the way in which health care services are reimbursed.

Critics of the long-standing fee-for-service model contend that it encourages health care professionals to provide unnecessary or less efficient services because they are incentivized to provide more services, including services that are more expensive. Further, it does not incorporate patient outcomes or experience (6). It also may discourage health care providers from engaging in activities that improve patients’ health, such as counseling about healthy behaviors and prevention, watchful waiting, or communicating with patients in nontraditional yet more convenient methods, such as telephonic communication, because these activities often are not reimbursable.

In contrast to fee-for-service, alternative payment models (APMs) are strategies used by payers to incentivize the provision and coordination of high-value care, services, products, and medications. High-value payment systems emphasize quality over quantity, process improvement and efficiency, and elimination of unwarranted variation in care delivery using best practices. Although fee-for-service reimbursement rewards the health care provider for the individual visit or procedure, value-based payment models aggregate services into more complex units of payment, such as a bundled payment for an episode of care or a set amount for care for one or more patients over a specified amount of time, with ties to quality and performance measurement (7). These value-based payments shift some of the financial risk from insurers to health care providers and incentivize physicians to provide high-quality care at reduced costs.

Alternative payment models are currently being deployed across the health care landscape, and there has been considerable collaboration across stakeholder

groups in the transition. Although many of the models employed to date have focused on primary care, management of chronic disease in the Medicare population, and episodes of care for common procedures, models for primary and specialty care of women are in the early stages of development. Alternative payment models are used in conjunction with different delivery system reforms (see Box 1).

### Box 1. Common Alternative Delivery Models

Delivery models that use value-based payment models include Patient-Centered Medical Homes and Accountable Care Organizations. **Patient-Centered Medical Homes (PCMHs)** are medical practices that provide ongoing, team-based, coordinated care for the health maintenance and acute and chronic health care needs of a panel of patients. The focus of this delivery model is on patient engagement in self-management, collaboration with community supports, and population health management. Patient-centered medical homes operate in a variety of practice models, including multispecialty group practices, integrated health care systems, and community practice centers but, in general are led by a primary care physician team (1). Patient-centered medical homes also utilize a variety of payment models, including fee-for-service with supplemental payment to allay costs of care coordination, payment for reporting of quality measures, shared savings models, and various levels of capitation with certain quality metrics that must be met to ensure appropriate care is provided (2).

**Accountable Care Organizations (ACOs)** are integrated systems of health care providers and organizations under a formal agreement with a commercial or public payer that voluntarily assume the responsibility of care for a defined population and are accountable for health care quality, cost, and outcomes of their population (3). The accountability incentivizes participating health care providers and health organizations within an ACO to deliver coordinated, high-quality care to patients, particularly those with chronic conditions (1). Accountable care organizations are not reimbursed in a set way, and payments incorporate varying levels of financial incentives. Accountable care organizations may receive upside-only reimbursement for achieving savings and attaining certain quality standards, or they may have downside risk if they fail to meet cost or quality measures.

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In 2015, Sylvia Burwell, then Secretary of the Department of Health and Human Services, announced the department's goal of moving away from fee-for-service to value-based reimbursement models for Medicare and the entire health care system by tying 30% of traditional Medicare payments to quality or value through APMs by the end of 2016, and 50% of payments by the end of 2018. In the same year, Congress repealed the sustainable growth rate formula for Medicare payments to physicians and replaced it with the Medicare Access and CHIP Reauthorization Act of 2015 Quality Payment Program (8). This legislation represented bipartisan support for linking payments to quality and value. Physicians caring for Medicare patients have the option of two value-based reimbursement tracks: the Merit-based Incentive Payment System or participation in an Advanced APM. The Medicare Access and CHIP Reauthorization Act also created the Physician-focused Payment Model Technical Advisory Committee in order to facilitate the Centers for Medicare and Medicaid Services' (CMS) adoption of APMs in Medicare that improve quality and cost.

Commercial payers also are creating and testing value-based schemes for payments. The Health Care Transformation Task Force, a private sector alliance of patients, payers, health care providers, and purchasers, similarly pledged a shift away from fee-for-service payments with a goal that by 2020, 75% of overall payments will be value-based reimbursements (9). Additionally, there have been publicly-funded collaborations between private and public payers to co-develop APM models that streamline administrative processes, align outcome measures with evidenced-based practices, and reduce the reporting burden for health care providers. One such effort, the Health Care Payment Learning and Action Network, is sponsored by the CMS Alliance to Modernize Healthcare. The goal of this collaborative is to bring a variety of stakeholders, including health care providers, public and private payers, and patient advocacy groups, together to drive alignment in payment reform across private and public sectors and accelerate adoption of APMs. As part of this collaboration, frameworks for three clinical episode payment models were developed, including one for maternity care (10).

## **Determining What Is High-Quality Care**

Quality measures are an integral component of APMs and collectively assure payers and the public that cost savings do not come at the expense of reductions in quality or rationing care. There are several types of quality measures employed by payers, including structural, process, outcome, and patient experience measures. Structural measures describe the context in which care is delivered and focus on the capacity of an organization such as the physical facility, human resources, financing, and equipment. Examples of structural measures include patient-to-staff ratios, capacity of

a hospital to perform vaginal birth after cesarean delivery, or the ability of an office to prescribe electronically. Outcome measures are considered the gold standard as they are most directly linked to care provided and are meant to measure changes in health or quality of life. Examples include changes in health status, such as readmission rates, morbidity, or mortality. Because of the difficulty of measuring the effects of care on health and the rare nature of many of these events, process measures often are used as proxies for outcome measures. These include the technical aspects of how care is delivered and include measures of steps known to improve health such as immunizations or screening for a certain condition (eg, chlamydial infection or depression). Process measures are ideally backed by evidence that directly links the process measured with improved or desired outcomes (9, 11). Patient experience measures are increasingly seen by payers and reporting agencies as trusted measures of the quality of care that patients receive (9). Patient experience measures are collected through survey tools such as the Consumer Assessment of Healthcare Providers and Systems survey, which are administered after care is delivered.

Quality measures are developed and disseminated from several sources, including government agencies such as CMS and the Agency for Healthcare Research and Quality, private non-profit agencies such as The Joint Commission and the National Committee for Quality Assurance, and for-profit companies such as Healthgrades and Leapfrog (9, 11). Measures often go through an endorsement process spearheaded by the National Quality Forum, which vets measures for reliability, validity, usability, and feasibility in a consensus-driven process.

Quality measures should be based on scientific research that links a process, structure, or outcome with an improvement in patient care or experience. Because of their growing importance to performance measurement and reimbursement, it is crucial that quality measures be developed with input from provider organizations like the American College of Obstetricians and Gynecologists and follow "SMART" (specific, measurable, achievable, relevant, and timely) criteria. Current measures employed sometimes have limitations in their sensitivity to detect quality, are not always in alignment across payers and reporting organizations, and can create a reporting burden for health care providers and organizations.

Data for quality measures are extracted from many sources. The most commonly used source is administrative or claims data as it is the most easily accessible through coding and billing. The emphasis placed on this data source for measuring quality underscores the need for comprehensive and correct billing practices for physician groups. Another source of data for quality measures is abstracted data from patient charts, which are accessed either through a review of individual charts or electronic record query. Because these data capture

clinical information beyond what is submitted in claims, they often give more detail about the quality of the care provided. Patient registries are another source of outcome data arising across industry and specialty societies. Data are either manually entered into the registry or abstracted from the electronic health record automatically and sent to the registry (9). Increasingly, there also are quality measures that are designed based on electronic health record data. These often are referred to as “electronic clinical quality measures.” When health care providers move towards reimbursements by APMs, they will need to develop Health Insurance Portability and Accountability Act-compliant systems for coding and data collection to capture quality measures and document practice-wide improvements that enhance the value of the care provided.

Quality measures also are designed to measure the care delivered at a variety of levels, such as the individual health care provider level, the practice level, the facility level, the health plan level, and the regional level. Although some quality measures can be specified at multiple levels, others are limited to a certain level. For example, there is a measure of moderate and most-effective contraception use that is only specified to the facility level, health plan level, and the population level in order to assess whether there is sufficient access to contraceptive methods. The measure does not drill down to the individual health care provider to measure contraceptive use because of concerns that ob-gyns and other health care providers would be incentivized to steer patients to certain methods. Because ob-gyns increasingly practice in interdisciplinary teams, the American College of Obstetricians and Gynecologists recommends that measures should reflect the quality of care delivered by the practice as a team and not focus on individuals.

### **Payment Incentives for High-Value Care**

Payers use several different strategies to reward high-value care. Alternative payment models are often created with one or several of the following four strategies (12).

**1. Incentives for Improving Processes of Care.** One way in which payers incentivize high-value care is to provide enhanced payments for select services or processes leading to higher quality, or reduced costs, or both. Health care providers under this scheme might receive annual bonuses in addition to fee-for-service reimbursements for meeting a predetermined percentage of quality measures for a population of patients, or might be given extra payment to help defer the cost of care coordination for high-risk patients. For example, the Pregnancy Medical Home program developed in North Carolina’s Medicaid primary care case management program provides extra reimbursement to health care providers for a high-quality, comprehensive postpartum visit between 14 days and 42 days to ensure that

patients receive all recommended components of care and are transitioned to the appropriate primary care setting (13). Health care providers in some settings are reimbursed for the use of shared medical decision-making tools or patient decision aids (14). This rewards health care providers for recognizing the importance of patients’ values, goals, and preferences in the medical decision process and addresses the patient experience component of the Triple Aim.

**2. Penalties for Unwanted Outcomes.** Another way of incentivizing value in health care is to decrease payments or refuse payment for unwanted outcomes or unnecessary services. This strategy has been used more commonly in hospital reimbursements. For example, in 2015, CMS implemented the Hospital-Acquired Condition Reduction Program through which the agency reduces Medicare payments to hospitals scoring in the worst performing quartile with respect to hospital-acquired condition quality measures (15). Similarly, the Hospital Readmission Reduction Program, established in 2013 by the Patient Protection and Affordable Care Act, requires Medicare to reduce payments to hospitals with relatively high readmission rates. Readmission rates are calculated over 3 years and risk-adjusted for demographics of the patients being readmitted and each hospital’s patient population. The Centers for Medicare and Medicaid Services then calculates a rate of excess readmission and reduces payments to hospitals that exceed that threshold (16). Both Medicare programs disincentivize low-value care and motivate hospitals to engage in quality improvement measures.

**3. Payment Methods That Share Accountability.** To incentivize high-value care, most of the APMs currently being developed and tested share accountability for outcomes and cost between payers and health care providers. These models shift some financial risk from payers to health care providers but also may provide financial rewards for high-value care. The APMs with the most influence in the field of obstetrics and gynecology are episode payments or bundled payments.

In an episode payment system, health care providers are paid for the care of a patient’s medical condition across a discrete episode of care, such as a procedure or treatment for a particular condition. When the payment covers the services provided by multiple health care providers, including hospitals and different specialties, the term “bundled” payment is used (17).

Bundled payments include one lump payment usually based on historical prices for all the care,

procedures, tests, drugs, and even devices used during the episode. Bundled payments are being developed for several common surgical procedures to include hospital, surgical and anesthesiology professional fees, and preoperative and postoperative care for a defined period of time. If quality health care is provided at lower cost, the health care providers, or hospitals, or both, can keep the savings. Likewise, if costs are higher across an episode, health care providers will face the financial risk of not getting the full payment or possibly being required to pay a penalty. Bundled payments, particularly in joint replacement procedures, have been associated with better outcomes for patients at lower costs to Medicare with better compensation to hospitals and surgeons (18).

Condition-focused episodes are also in development. Although more complex to create and implement because of the lack of concrete beginning and end points, condition-focused episodes seek to reduce costs by incentivizing the most appropriate care. Pregnancy—a time-limited, but common event—is seen by payers as an ideal condition for episode payments. A review of three state Medicaid programs' trials of episode-based payment models for obstetric care found that all employed risk-sharing for accountable ob-gyns and other health care providers, meaning that payments to health care providers are adjusted for outcomes and costs (19). Challenges to implementation of a maternity bundle include assignment of the accountable health care provider (because there are often many involved in a pregnancy episode) and agreement about quality or outcome measures. Another challenge is that the measures being used are limited and possibly unlikely to improve care or outcomes (19).

Other considerations in creating episode payment include delineation of the covered ancillary services linked to quality within an episode, determination of the beneficiaries (some obstetric models include newborn care), and determination of the episode budget. To avoid taking on too much financial risk, there are some mitigation strategies that can be employed, such as “carve-outs” for services that are not included in bundles and risk adjustment based on clinical and socio-demographic factors. These predetermined exceptions prevent health care providers from cherry-picking patients and from withholding necessary care to patients within a bundle or episode. As experts in obstetric care, ob-gyns should continue to be involved actively in the development of maternity episode-based payment models.

Population-based reimbursement, through capitation or a global budget, is a fixed payment given to cover a population of patients over a predetermined

period of time. A health care provider, group, or network of health care providers receives a fixed, predetermined amount to care for a panel of patients regardless of the amount of care sought by the patients; however, there is usually some adjustment made for the clinical complexity of given patients within the panel. For example, an ob-gyn would receive a higher capitation payment to care for a woman with human immunodeficiency virus (HIV) than for a woman with type II diabetes. These models encourage health care providers to take a proactive approach to care, emphasizing prevention, efficiency, and patient-centered coordination of care for chronic illness to avoid hospitalization and preventable future costs. These models often incorporate a bonus (upside risk) for health care provider groups for shared savings and achievement of population outcomes as determined by quality measures, but also may have a penalty (downside risk) for more expensive care and poor outcomes (20). As population-based models evolve, ob-gyns must be actively involved in health system leadership contract negotiations and determination of the quality measures linked to payment.

Frequently, shared accountability models employ risk adjustment, which is a tool used to equitably compare health care providers to one another. Risk adjusting for social and clinical factors is meant to ensure that assessment is based on health care providers' performance rather than patient-level factors that health care providers are unable to control. Risk adjustment can be used when measuring quality or making value-based payments. The appropriateness of using risk adjustment depends on whether the outcomes being measured are related to the relevant risk factors, and, if so, whether the factors are directly related to the outcome or whether there are mediating factors. If there are other outside factors, it is necessary to assess whether they are within health care providers' control (21).

**4. Consumer-Directed Models.** In addition to methods that are focused on changing health care providers' practice patterns and behavior, there are also models aimed directly at health care consumers to drive value in health care. These demand-side interventions, including value-based insurance design programs and value-based pricing for medication, align benefits to demonstrated value of treatment and diagnostics. Value-based insurance benefits are designed to incentivize consumers to seek out higher-value care over lower-value services, generally by lowering cost-sharing for enrollees who select higher-value health care providers or medications, or participating in services that have been shown to

improve health outcomes such as smoking cessation or disease-management programs (22).

Tiered health care provider networks are used by employers and commercial insurers to steer patients towards health care providers and hospitals with demonstrated high quality at lower costs compared with other health care providers seeing similar patients. Enrollees in tiered networks pay lower cost-sharing for care with health care providers and hospitals with a preferred-tier ranking. An analysis of total health care spending across the inpatient, outpatient, and radiology outpatient services showed modest decreases in spending for nonelderly adult patients enrolled in tiered networks (23). As ob-gyns are contracting with health plans, it is important that they understand how practice data are collected and used to create scoring systems that dictate the network tiers. These systems can be based on quality measures, coding practices, medications prescribed, tests ordered, and hospital use.

Another example of value-based benefit design are tiered formularies. Medication pricing and formulary position among pharmacy benefit managers, insurance plans, and manufacturers are proprietary. Value-based pricing for medication is employed by payers in tiered approaches. For example, if drug A costs less than the new drug B, but drug B is far more effective, in a value-based formulary, drug B will be on a lower and better tier than drug A. Hence, patients will have lower cost-sharing to acquire the medication. Although most health plans place medications in tiers based solely on cost, one plan in the state of Washington has a value-based formulary that bases co-payments for medications on their value in quality-adjusted life years (24). Each tier assigns an incremental cost-effectiveness ratio and all of the drugs that fall into that tier's threshold have the same flat co-payment. This type of pricing allows patients to access high-value medications that previously would have been cost prohibitive. Indication-specific pricing is another attempt at value-based pricing for medications. In this model, medications are valued by how they work for each specific indication. For instance, a GnRH analog currently has the same price for all indications. With indication-specific pricing, each indication will have different prices (eg, GnRH analogs for in vitro fertilization would have different prices than GnRH analogs used for shrinking leiomyomata or treating prostate cancer).

A key aspect of value-based methods targeting patients is the important role that ob-gyns and other health care providers play in engaging patients in their own treatment decisions. Incorporating patient preferences into treatment plans through the use of shared decision-making tools has been shown to decrease costs in several settings, especially when treating preference-sensitive conditions (14). Teaching patients about the value of

recommended treatments also decreases health expenditures. Researchers have demonstrated that even with increasingly expensive medications, proper patient use leads to overall lower health care costs because of fewer hospitalizations and less use of emergency services (25).

## Conclusion

Specialists in women's health, obstetrician-gynecologists need to be actively engaged in this fundamental shift in the payment and delivery system. As APMs evolve and are adopted in public and private markets, ob-gyns will need to make adjustments to increase efficiency and reduce waste in care processes and develop systems to demonstrate and document quality in the work performed. Alternative payment models must appropriately compensate ob-gyns as health care providers of primary care and specialty care with payment that accounts for the full spectrum of the services provided. It is vitally important for ob-gyns to be involved in determining measures of quality informed by the best evidence. These measures should be harmonized across payers to decrease the reporting burden. Obstetrician-gynecologists also must support the voice of our patients to ensure that our health system delivers what matters most to them. Finally, it is important to continue to be vigilant that any cost-savings do not come at the expense of quality, especially for the most vulnerable members of the populations served.

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