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WORKING DRAFT –
FOR DISCUSSION AND COMMENT ONLY

FROM CONCEPT TO REALITY:
IMPLEMENTING FUNDAMENTAL REFORMS IN HEALTH CARE PAYMENT SYSTEMS TO SUPPORT VALUE-DRIVEN HEALTH CARE

Issues for Discussion and Resolution at the 2008 NRHI Healthcare Payment Reform Summit

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The concepts in Section II are based on a previous framing paper that was prepared for NRHI's 2007 Summit and on the recommendations that emerged from that Summit. The 2007 framing paper, *Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform*, was published by the Commonwealth Fund in September 2007. The recommendations from the Summit were published by the Jewish Healthcare Foundation in a report entitled *Incentives for Excellence: Rebuilding the Healthcare Payment System from the Ground Up*. Both documents are available on the NRHI website at www.nrhi.org/summit.html. Financial support and guidance for the 2007 Summit were provided by the California HealthCare Foundation, The Commonwealth Fund, and the Jewish Healthcare Foundation.

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EXECUTIVE SUMMARY

A major cause of the quality and cost problems in healthcare today is that payment systems encourage *volume-driven* healthcare, rather than *value-driven* healthcare. Under current payment systems, physicians, hospitals, and other healthcare providers receive strong financial incentives to deliver more services to more people, but are often financially penalized for providing better services and improving health.

Fortunately, there are better ways to pay for health care – ways that give healthcare providers more responsibility for increasing quality and controlling costs, without putting them at risk for how sick or well their patients are. Systems called "episode-of-care payment" and "condition-specific capitation" involve paying a single price (a "case rate") for all of the services needed by a patient for their condition, regardless of which providers are involved, instead of multiple fees for each of the specific services provided. These types of systems have been used at various times and locations around the country, in some cases for specific types of patients or providers, in other cases across an entire community, with generally positive results in terms of both quality improvement and cost control. Section II provides the background needed to understand the basic structure of these systems.

Implementing these kinds of improvements in payment systems more broadly holds significant promise for improving the quality and reducing the cost of health care. But there are a number of important issues that need to be addressed, and a variety of challenges which need to be overcome, in order to move them from concept to reality.

Organizational Structures to Support Fundamental Payment Reforms

If a large number of providers can and will accept and manage the payments effectively, then the new payment system can be successful. But if few or no providers can do so, then, as a practical matter, the payment system cannot be implemented or will likely not achieve the desired improvements in value. Section III identifies the specific issues associated with efforts to improve primary care and to improve major acute care:

- Payment Systems and Organizational Structures Needed to Implement the Patient-Centered Medical Home
  - What organizations should be eligible to participate in payment systems designed to support medical homes and improved primary care?
  - What kinds of changes in payment systems should be used to encourage the creation of medical homes and improvements in primary care?
- Provider Organizational Structures Needed to Manage Bundled Payments and Warranties in Major Acute Episodes
  - What organizational structures should be eligible to receive bundled payments and warranties?
  - What intermediate steps should be taken to facilitate the transition to bundled payments and warranties?
  - What restrictions, if any, should be placed on the way bundled payments are divided among individual providers?

Ensuring Quality and Controlling Costs

How should the use of high-value providers and services be encouraged? What protections are needed to ensure appropriate quality for patients? The issues associated with patient choice, patient protection, and provider competition are explored in Section IV of the Framing Paper:

- Encouraging Use of Higher-Value Providers and Services
  - How should the use of higher-value providers and care systems be encouraged?
  - How should the use of higher-value treatments/services for preference-sensitive care be encouraged and the use of unnecessary care be reduced?
  - How can lower costs be encouraged in consolidated or underserved markets?
- Protecting Patients in Restructured Payment Systems
  - How should patients be protected against inappropriate under-provision of services?
  - How should providers be discouraged from dropping or avoiding patients with higher-than-average utilization of expensive services?
  - How should payment systems balance consumer choice and continuity of care?

Implementing New Payment Systems Successfully

Section V of the Framing Paper discusses a number of key issues related to implementation:

- Piloting New Payment Systems
  - What should be the goals of pilot projects?
  - What types of patients/conditions should be the initial targets for pilot projects?
  - How many providers should be included in a pilot project?
  - To what extent should pilot projects be "budget neutral?"
- Achieving Sufficient Alignment of Payers
  - How many payers must be aligned to enable providers to implement necessary care improvements?
  - What aspects of payment systems are most important to align across multiple payers?
  - What mechanisms can be used to encourage or assist payers to align their payment structures?
- Encouraging Payers and Providers to Support New Payment Systems
  - How should payers be encouraged to take on the significant costs and challenges of retooling payment systems and running current and new payment systems in parallel during pilot projects and phase-in periods?
  - How should hospitals and other providers which are likely to lose revenues under new payment systems be encouraged to support (or not oppose) the changes?
  - What efforts should be made to help small physician practices succeed under new payment systems and care delivery models?
- Community-Wide Structures to Support Payment Reform
  - What information, standards, systems, and assistance should be provided collectively at the regional, state, or national levels, rather than by individual payers or providers, and at which level should these be provided?

- How can consumers and patients be encouraged and assisted to support the creation of new payment systems and efforts to encourage the use of higher-value providers and services?
- What mechanisms should be established to ensure that payment systems achieve goals for improved value in health care and that progress is maintained over the long period of time likely needed for success?

Moving From Concept to Reality

In most cases, definitive answers to these questions do not exist today, and there are debates in many areas about which approach is best. Each of the sections of the Framing Paper presents a range of options for each issue to help facilitate consensus-building about which options and combinations of options have the greatest likelihood of success.

However, there is unlikely to be a single, one-size-fits-all approach to payment reform that will work equally well in all parts of the country. Every region of the country is different in terms of the number, types, and relationships of health care purchasers, payers, and providers. Just as experimentation and evaluation are hallmarks of evidence-based medicine, experimentation and evaluation will also likely be needed in order to develop the most effective cure for the ills of the payment system.

I. Introduction: Moving from Volume to Value

The serious problems with the quality and cost of today's healthcare system have been well-documented. A major cause of these problems is that current healthcare payment systems encourage *volume-driven* healthcare, rather than *value-driven* healthcare. Under current payment systems, physicians, hospitals and other healthcare providers gain increased revenues and profits by delivering *more services* to *more people*, which in turn fuels inflation in health care costs.

But what is even more troubling is that these payment systems often financially *penalize* health care providers for providing *better quality* services. Providers frequently lose revenues and profits if they keep people healthy, reduce errors and complications, and avoid unnecessary care. This not only leads to many of the problems in healthcare quality which exist today, but impedes efforts to improve quality, by forcing a tradeoff between a healthcare provider's financial well-being and the quality of their services.

This has led to the creation of a variety of pay-for-performance ("P4P") programs, which add a new layer of rewards and incentives for quality improvement and cost containment on top of the existing payment systems. While well-intended, there is a growing recognition that most current pay-for-performance initiatives won't by themselves solve the fundamental problems and disincentives that are built into the underlying payment systems.

On March 29, 2007, the Network for Regional Healthcare Improvement (NRHI) convened a national Summit on *Creating Payment Systems to Accelerate Value-Driven Health Care* to accelerate thinking about how healthcare payment systems can be redesigned to reward, rather than penalize, improved quality and lower costs. The participants at the NRHI Summit – major healthcare payers, health plans, regional coalitions, researchers, and other thought leaders – agreed that fundamental changes to payment systems, rather than just pay-for-performance add-ons, were essential, and they developed specific recommendations regarding the changes needed.

There has been considerable discussion around the nation regarding payment reform since the 2007 NRHI Summit, and some payment reform demonstrations have gotten underway or are in the planning stages. These efforts have helped to identify a number of important barriers to implementing payment reforms, even on a pilot or demonstration basis, and to highlight a range of important issues that need to be resolved in designing new payment systems.

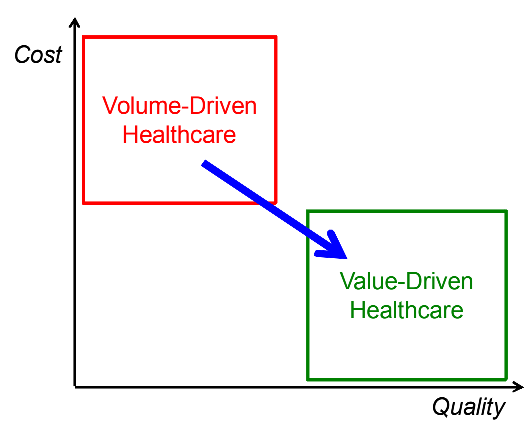

Figure 1

The attendees at the 2007 NRHI Summit recommended that NRHI hold another summit on health care payment reform in 2008 to review progress on the recommendations from the 2007 Summit and to address key issues that emerge through implementation efforts. The goals of the 2008 NRHI Summit are to develop:

- Recommendations for actions by regional payers, providers, and coalitions that will support fundamental payment reforms;
- Recommendations for actions to advance fundamental payment reform through state and national policies; and
- Agreement on key elements needed for pilot payment reform projects.

This Framing Paper was prepared to provide background information on a number of key issues involving payment system design and implementation, as well as a number of options for addressing them, in order to facilitate discussions and recommendations by the participants in the 2008 NRHI Summit, as well as discussions by leaders in regions around the country who want to develop improved payment systems. Section II provides background on payment reform concepts and summarizes the recommendations for new payment changes that were developed at the 2007 Summit. Sections III, IV, and V discuss 25 distinct, but inter-related issues that need to be addressed in designing and implementing payment reforms, as well as dozens of potential options for addressing them. The issues and options presented in the paper are by no means exhaustive, and readers are encouraged to propose additional options and combinations of options for consideration, as well as to make recommendations for the most desirable options to pursue.

Many readers may be surprised or distressed that this paper does not explicitly discuss the growing problem of the uninsured. This should not in any fashion be interpreted as a belief that insurance coverage issues are unimportant, but rather that there are extensive discussions underway in many different forums, from Congress to state legislatures to local communities, about this problem, and there are a growing number of specific initiatives planned or underway to address it.

In contrast, there has been relatively little opportunity for purchasers, payers, providers, policy-makers, consumers, and civic leaders to understand and discuss the issues related to fundamental payment reform. The goal of the 2008 NRHI Summit and this Framing Paper is to provide such an opportunity. Moreover, since the growing problem of the uninsured is due in substantial part to the rapid escalation of healthcare costs, using payment reform to control costs and improve quality should help to address the root causes of inadequate insurance coverage as well as make insurance coverage solutions more affordable.

II. A Framework for Understanding Alternative Payment Systems

A. Focusing on Value, Not Volume

There is widespread agreement that the health care system today does not provide good value, where "value" is defined as the combination of both quality and cost. A variety of studies have demonstrated that there are serious problems with the *quality* of health care, ranging from failure of many patients to receive services of proven value, to unacceptably high rates of medical errors, adverse events, iatrogenic illness, etc. At the same time, the *cost* of health care has reached unaffordable levels, which is a major cause of high rates of uninsurance across the country. As noted in the Introduction, health care systems have strong incentives to focus on *volume*, not *value*.

One of the fundamental impediments to improving value in health care is that efforts to improve quality and reduce cost in health care are often perceived as being at odds with each other:

- Patients often believe that lower cost means lower quality, and that efforts to reduce cost will require "rationing" or restrictions on their ability to receive needed care.
- Payers often believe that higher quality means higher cost, and providers often request higher payments to support initiatives to improve the quality of care delivery. (See Appendix A for a definition of terms like "patients," "payers," and "providers" as they are used in this paper.)

Yet in industries other than health care, consumers routinely reap the benefits of higher value from both improved quality and lower cost. In health care, there are easily identified examples where improvements in quality and cost are possible. For example,

- **Healthcare-Acquired Infections and Other Adverse Events.** Numerous studies have shown that unnecessarily high rates of preventable adverse events occur within hospitals and other health care settings. In most cases, payers pay more when these events occur, and patients suffer from them, often seriously. Clearly, reducing these adverse events would be a win-win for both quality and cost.
- **Hospital Admissions and Readmissions.** Numerous studies have also shown that a large number of hospitalizations are preventable, particularly among patients who have what are known as "ambulatory sensitive conditions," such as asthma, chronic obstructive pulmonary disease, congestive heart failure, diabetes, etc. In addition, a high proportion of people who are hospitalized are readmitted within 30 days, frequently for the same condition that they were admitted for or for a complication or infection resulting from that initial admission. Again, payers pay more when these admissions and readmissions occur, and patients

suffer from them. And again, reducing admissions and readmissions represents a win-win for both quality and cost.

The problematic incentives in current healthcare payment systems are increasingly recognized as one of the major barriers to addressing these kinds of problems. Although not all quality and cost problems are caused by payment systems, and not all quality and cost problems can be resolved by changes in payment systems, it is clear that in many cases, payment reform is at least a necessary element of efforts to increase the value provided by the nation's health care system.

B. The Health Care Cost Equation

Understanding how current health care payment systems work against value requires understanding the factors that drive health care costs.

In any economic sector, total expenditures on a good or service are the product of two factors: (1) the quantity of the good or service that is consumed, and (2) the price or cost of the good or service.

Similarly, health care expenditures are a function of two distinct factors: utilization and unit cost/price. As shown in Figure 2, the rate of health care expenditures (i.e., "cost") per person will increase if more people have conditions needing care, or if the cost of caring for an individual condition increases, or both. In the example shown, health care expenditures will rise if more people have heart disease, if the cost of treating an individual case of heart disease increases, or both.

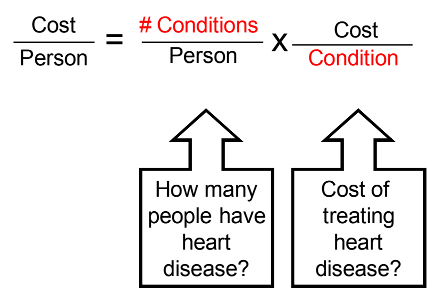

Figure 2

But this is too simplistic an analysis for understanding health care payment, because each of these two factors, particularly "cost per condition," is itself a function of other factors, each of which can be affected differently by different systems of paying for healthcare.

Figure 3 shows the same equation with a more detailed breakdown of "cost per condition." This shows that total cost is driven by the number of "episodes of care" per condition (e.g., how many heart attacks does the person with heart disease have?), how many and what types of health care services do they receive in each episode (e.g., when they have a heart attack, do they get coronary artery bypass graft surgery, a stent, angioplasty, or simply medical management?), how many and what types of processes, devices, drugs, etc. are involved in each service (e.g., what type of stent does the heart attack patient receive, what procedures are followed to prevent infections, etc.?), and finally, the costs/prices of each of those individual processes, devices, drugs, etc.

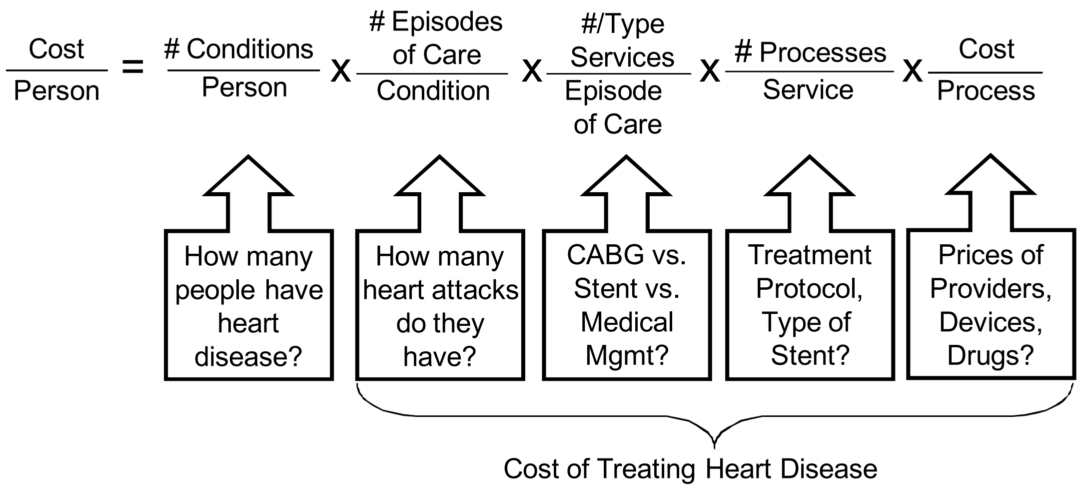

Figure 3

The "number of conditions per person" is also affected by other factors, some of which can be influenced by the health care system and by the patient, and some of which cannot be (at least with current knowledge and technologies.) For example, as shown in Figure 4, the rate at which people develop heart disease can be reduced through improved health care and healthier lifestyles, although it may not be possible to completely eliminate heart disease even with best efforts by both health care providers and patients.

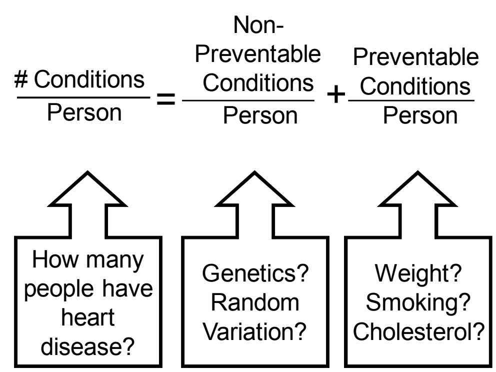

Figure 4

C. The Causes of Health Care Cost Inflation

To understand the sources of health care cost inflation and the reasons why current payment systems have been unsuccessful in controlling it, one can think of the health care cost equation as a balloon, as shown in Figure 5.

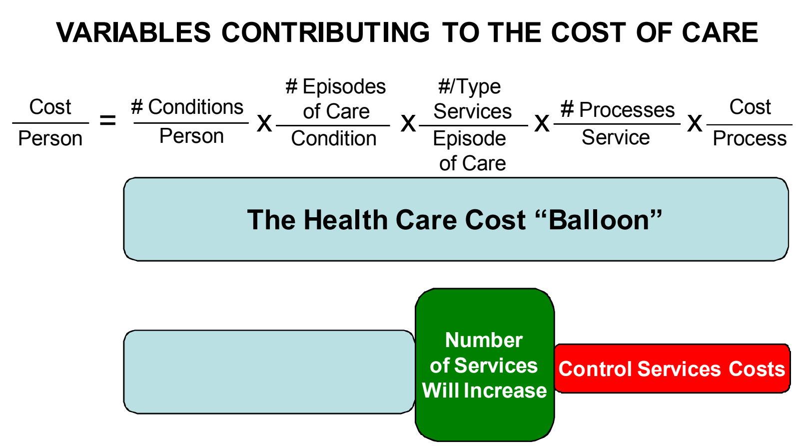

Figure 5

If one "squeezes the balloon" by trying to control the costs of individual processes or services alone, the costs may well "pop out somewhere else," e.g., through an increase in the number of services provided. And if one tries to control the number of services within a particular episode of care, the result may simply be more episodes of care (for example, placing arbitrary limits on the costs of hospital stays may result in patients coming back more frequently through readmissions).

D. How Payment Systems Address the Health Care Cost Equation

The most common way of paying for health care services today is the fee-for-service system. Physicians and other health care providers get paid a fixed fee for each discrete service they provide, in most cases with no pre-defined limits on the number of services that can be provided. In the framework of the health care cost equation, fee for service puts the provider *at risk for the number and cost of processes* within each service covered by a separate fee, but *nothing else*.

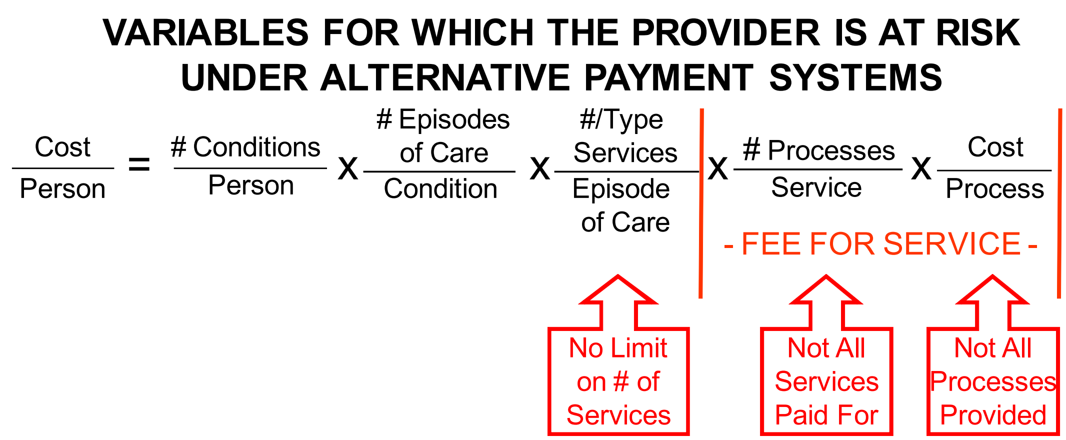

Figure 6

As shown in Figure 6, this results in some of the problems in health care quality and costs today:

- **It Rewards Volume:** There is no limit on the number of services, and drawing on the balloon analogy again, if one tries to limit the fees for services too much, providers will be encouraged to increase the number of services they provide in order to maintain their incomes;
- **It Does Not Penalize Poor Quality:** Efforts to limit fee levels may also result in providers eliminating desirable processes as part of a service, either in an intentional effort to reduce costs, or simply because they don't feel they have as much time to follow all of the processes which would be desirable;
- **It Focuses on the Short-Term, Not the Long-Term:** Efforts to control overall service expenditures encourage payers to resist paying for some services, even if they might have long-term value in improving health or otherwise reducing the need for services in the future .

E. Band-Aids on a Broken System

A variety of efforts have been made to try and address these problems. Two of the most common are:

- **Utilization Controls.** In order to restrain the natural incentive for providers to generate more volume, payers have instituted a variety of systems to "squeeze the balloon harder" and discourage provision of unnecessary services. For example, two common approaches are to require providers to obtain pre-authorization from a payer before a service can be delivered, and to create detailed criteria defining the circumstances when services will be paid for and when they will not.
- **Pay-for-Performance.** In order to counter the tendency for providers to eliminate or "forget" to deliver desirable processes as part of a particular service, a growing number of payers have established pay-for-performance, or "P4P" systems. These systems provide bonus or incentive payments (or more rarely, penalties) for providers based on the rate at which they actually perform the specific processes viewed as desirable. For example, in the case of heart attack patients, there are pay-for-performance systems which give payment rewards to hospitals based on whether heart attack patients are given aspirin when they arrive at the hospital. In the case of diabetes, since many physicians "forget" to do checks of hemoglobin A1c levels on diabetic patients (perhaps because the fees they are paid for patient visits allow too little time to do everything a patient needs), a number of P4P systems pay the physicians more for successfully remembering to do those checks.

These systems can lead to a level of micromanagement of providers by payers that is not only undesirable, but inefficient. For example, most P4P systems focus on rewarding processes, rather than outcomes, which may (a) reward providers with poorer outcomes, and (b) unintentionally deter innovation and experimentation with new processes that achieve better outcomes. Since measures are only available for a subset of the processes that are important to good outcomes, rewarding only a subset of processes may divert attention from other important processes.

Moreover, the amount of performance bonuses and penalties in most P4P systems is relatively small, reducing the likelihood that they can offset the powerful incentives for volume in the underlying payment system. In fact, the reductions in a provider's net revenues from implementing a quality improvement initiative may exceed the payment incentives provided through a pay for performance system for that initiative.

F. The Strengths and Weaknesses of Capitation

During the 1990s, a dramatically different solution called *capitation* was developed to address the problems of the fee-for-service system. Capitation means paying a provider (typically a primary care physician or a health care system) a fixed amount per patient to provide care for all of the patient's conditions. Under capitation, the amount paid per patient is the same for all patients cared for by the provider, regardless of how well or sick the individual was or how many services were provided.

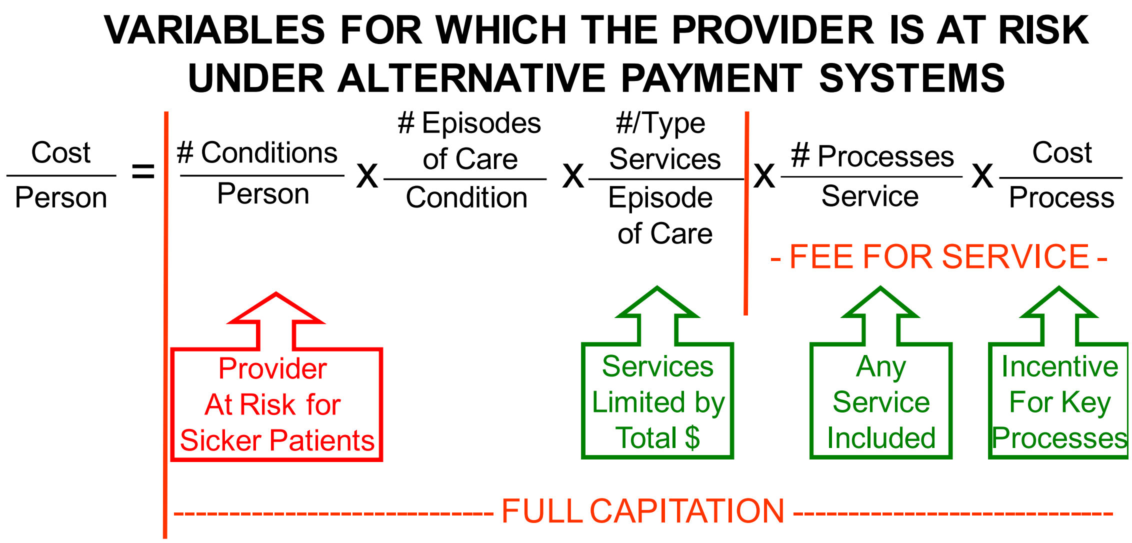

Figure 7

As shown in Figure 7, the capitation system "solves" (or at least reduces) the problems caused by the fee-for-service system, in the following ways:

- **Controls Volume.** Because the provider is paid the same amount regardless of the number of services provided, there is no longer an incentive to provide more services simply to increase revenues.
- **Avoids Micromanagement.** At the same time, there are no restrictions on which services will be paid for, and so the provider is compensated regardless of which combination of services they choose to deliver.
- **Penalizes Poor Quality.** The provider has an incentive to ensure that key processes of care are delivered, because the provider will be responsible (with no added compensation) for providing any remedial services that are needed.

However, in trying to address these problems, capitation (at least as it was most commonly implemented) went too far in the other direction, incorporating every factor in the health care cost equation into a single payment. Most importantly, capitation put providers *at risk for how sick or well their patients were*, when the providers had little or no ability to control that. This created a strong and undesirable incentive for providers to avoid patients who had multiple or expensive-to-treat conditions, and a number of providers experienced significant financial difficulties or bankruptcies if they took on patients regardless of their needs.

G. Distinguishing Insurance vs. Performance Risk

In effect, what capitation contracts did was transfer *all* cost risk to the provider. But a portion of that risk – the risk of whether a patient has an illness or other condition requiring care – is really what *insurance* is all about. In contrast, once a patient has an illness or condition requiring care, it is appropriate for health care providers to take responsibility for their *performance* in delivering services to address that illness or condition in a high-quality and efficient manner. As shown in Figure 8, payers (health insurance plans, self-insured employers, or government programs providing health benefits) should take responsibility for insurance risk, and providers should take responsibility for performance risk. (Other authors have labeled the two types of risk "probability risk" and "technical risk." For a comprehensive discussion of the different kinds of risk and the roles of insurers and providers in managing them, see Douglas Emery, *Customer-Directed Healthcare Reform with Episode Pricing*, Thomson, 2006.)

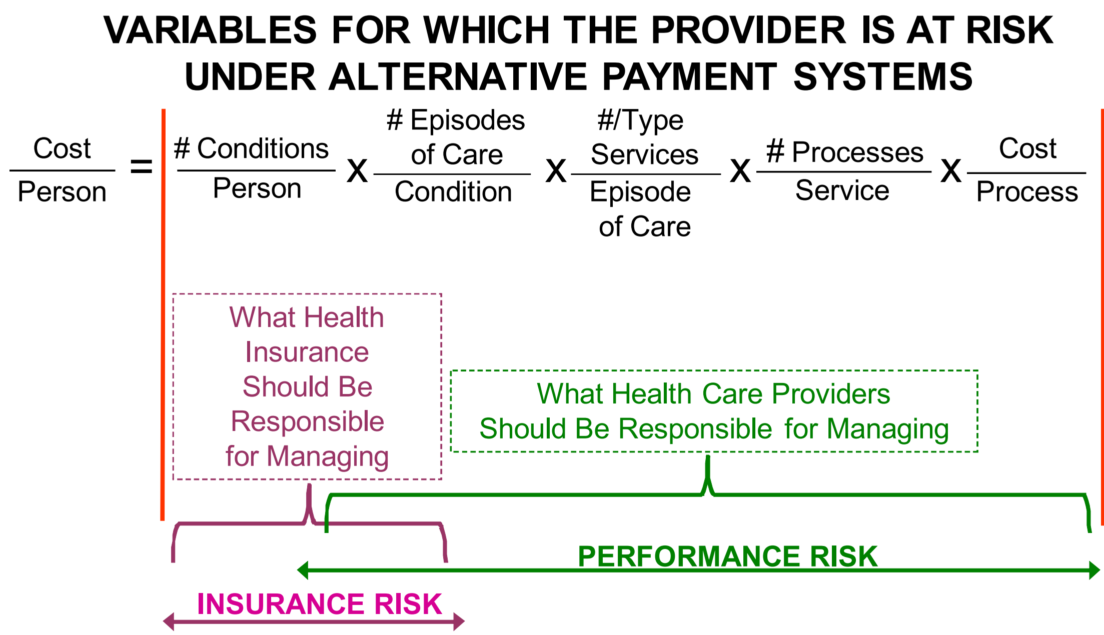

Figure 8

There is no hard line distinguishing where insurance risk ends and performance risk begins. One patient may be harder to treat than another for the same condition or may have adverse reactions to treatment due to unmeasurable factors that are outside the control of a physician, making it difficult to say how much of the higher costs of treatment are an insurance risk vs. a performance risk. But it is clear that not all of the costs of health care should be considered pure performance risk (as traditional capitation systems would imply), and fewer health care costs are insurance risk than fee-for-service systems implicitly give insurers responsibility for.

H. New and Better Payment Models

Fortunately, there is a middle ground between fee-for-service and traditional capitation that can strike a better balance between insurance risk and performance risk than either of those approaches do, while still moving away from the volume-driven healthcare system engendered by fee-for-service payment systems.

One model is “**episode-of-care payment**,” which means paying a single price for all of the services needed by a patient for an entire episode of care. This kind of payment approach is most appropriate to isolated acute care episodes with a reasonably clear beginning and a reasonably clear endpoint. So, for example, once a patient has a heart attack, a single payment would be made to a provider for all of the care needed by that patient for the heart attack. This single payment is also frequently called a “case rate,” i.e., there is a *single* payment for the *case*, rather than *multiple fees* for each of the specific services provided within that case.

For many patients, however, their condition does not end in a fixed period of time; they may need care over an extended period of time. For example, people with chronic diseases such as asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and diabetes will generally live with those conditions for the rest of their lives. Many of them are hospitalized multiple times with no fundamental change in their underlying condition. But the rates at which they are hospitalized can be significantly affected by the type of care they receive outside the hospital.

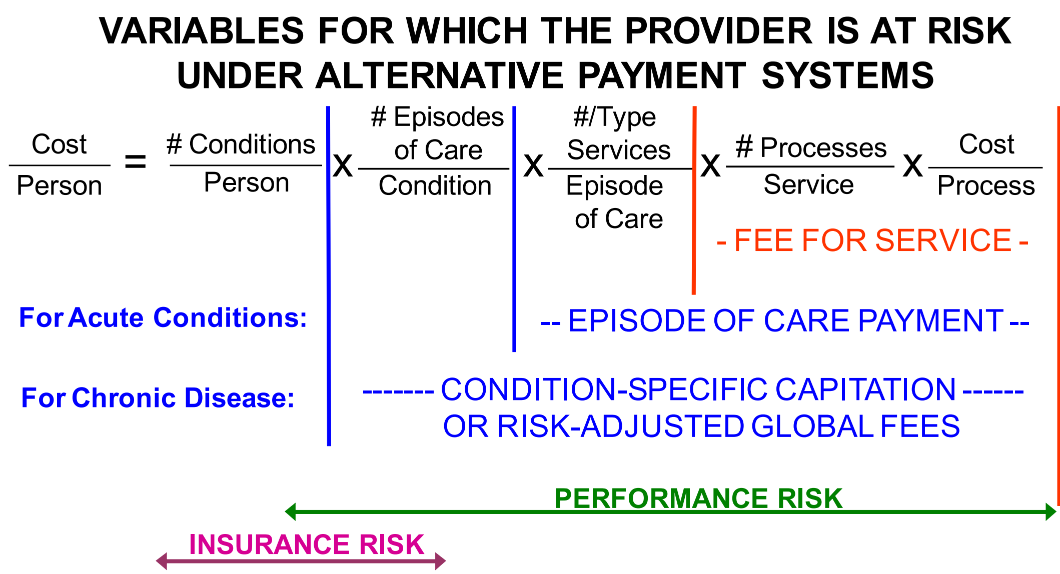

Figure 9

For these patients, paying for each hospitalization on an episode-of-care basis may help to control the costs of each hospitalization, but it does nothing to control the number of episodes (hospitalizations) that the person experiences. (Moreover, there will likely not be a clear endpoint to each episode, making the definition of the payment for the episode particularly challenging.) Instead, it makes sense to pay providers for all of the care that the patient needs over a *fixed period of time*, including as many or few episodes as are needed during that period of time. This approach can be called “**condition-specific capitation**” or “**risk-adjusted global fees.**” “Condition-specific” capitation means that while there is a single payment for a patient, the amount of that payment varies depending on the specific condition(s) that the patient has, unlike traditional capitation. The term “global,” although it sounds like it might mean “world-wide," is intended merely to indicate that *all providers* and *all services* are covered by a single fee or payment. (Better names are needed, since neither of these are either easily remembered or readily understandable, unfortunately.) Regardless of the name, the idea is that the provider is paid a "case rate" rather than individual service fees. In contrast to episode-of-care payment, though, the case rate is for an inherently arbitrary period of time (e.g., a calendar year), rather than being defined by a resolution to the patient's condition.

A key aspect of both episode-of-care payment and condition-specific capitation systems is that the amount of the payment would vary based on the precise nature of the patient's condition, particularly those aspects of the patient's condition which are outside of the provider's control. In contrast, a traditional capitation system pays the same amount regardless of the patient's condition. Clearly, a provider *should* be paid more for caring for a congestive heart failure patient who also has diabetes or other co-morbidities than for a patient who has congestive heart failure and no other co-morbidities. A provider *should* be paid more for caring for a heart attack patient with significant artery blockage than one with minimal blockage. Although this reflects the fact that one patient will likely need more expensive care than the other, it is up to the provider to determine exactly what is needed, rather than having an incentive to provide more expensive services to a patient than are actually needed, as is the case under the fee-for-service system. (It should be noted that "condition-specific capitation" is very different than "contact capitation," a variant of capitation that was used in the 1990s. Contact capitation paid a particular specialist or group of specialists a fixed amount per patient for each patient who came to them for service, regardless of the exact conditions those patients had, whereas condition-specific capitation pays a provider a fixed amount based on the patient's condition, regardless of which specialist or services they use.)

I. Price-Setting as Well As Payment Structure

In either of these different payment models, there is still the challenge of price-setting. (The term "price" here is intended to mean the "cost to the payer.") Even though the relative incentives created by either episode-of-care payment or condition-specific capitation would be better than what exists today, if the price of an episode or a case is set too low, providers may still be forced to either under-provide care or to suffer financially. If the price is set too high, the pressure for efficiency will be less and costs will inherently increase.

There are three basic approaches to determining prices, which could be applied to either episode-of-care payment or to condition-specific capitation:

- **Price-Setting by the Payer.** This is the approach that Congress and Medicare use to establish the rates paid to hospitals under DRGs and the fees paid to physicians under the Resource Based Relative Value Scale (RBRVS) system;
- **Negotiation Between the Payer and Provider.** This is the method commercial health plans typically use in determining the amounts they will pay providers.

- **Price-Setting by the Provider.** Although this model is used in most other economic sectors, it has been less frequently used in the world of health care, other than for services where consumers pay all or most of the cost of the service.

Although there is considerable interest in trying to increase the use of the third approach – price setting by providers – the challenge in health care is that because prices are actually *paid* by third-party payers, rather than by the consumers of the services, the incentives for consumers to choose lower-cost providers, and the incentives for providers to reduce their prices to attract consumers, are weak or non-existent. A variety of methods of creating greater price-sensitivity for consumers have been proposed or attempted, many of which are generally referred to as "Consumer-Directed Health Plans." Section IV-A explores these issues in greater detail.

J. What an Episode-of-Care Payment System Might Look Like

Participants at the 2007 NRHI Payment Reform Summit recommended the creation of an episode-of-care payment structure for major acute episodes, and outlined many of the key elements that should be included:

- A single, "bundled" Episode of Care Payment would be paid to a group of providers to cover all of the services needed by the patient during the episode of care. (Combining the payments for multiple providers into a single payment is generally referred to as "bundling" payment.) This "case rate" would be paid instead of individual fees or DRG payments.
- The group of providers would include all of the hospitals, physicians, home health care agencies, etc. involved in the patient's care for that episode. The providers would be encouraged to create joint arrangements for accepting and dividing up the Episode of Care Payment among themselves.
- The amount of the Episode of Care Payment would vary based on the patient's diagnosis and other patient-specific factors. However, there would be no increase in payment to cover preventable adverse events (errors, infections, etc.).
- The amount of the Episode of Care Payment would be prospectively defined (i.e., it would be established *before* the care actually took place), but would include a retrospective adjustment based on the level of outcomes achieved by the provider group (e.g., if the provider group had an unusually high mortality rate, even after adjusting for patient severity and risk, its payment would be reduced). There would be some adjustments in payment made for cases requiring unusually high levels of services, but only if improved outcomes were achieved through those higher levels of service.
- A Regional Collaborative Organization would estimate the cost of providing good quality care for each type of patient, but provider groups would bid and negotiate the amount of the actual Episode of Care Payment they would receive for each type of patient and condition.

- Patients would receive incentives to use higher-quality/lower-cost providers, and they would also receive incentives to adhere to care processes jointly developed by the patients and providers.

An example of how this system might work for an individual patient is described in the sidebar. (More details on the recommendations for payment for major acute episodes from the 2007 NRHI Summit are available in the report *Incentives for Excellence: Rebuilding the Healthcare Payment System from the Ground Up*, published by the Jewish Healthcare Foundation, and available at www.nrhi.org/summit.html.)

Why would this be better than current payment systems?

- Hospitals would have an incentive to prevent adverse events, prevent readmissions, and use the right combination of in-patient and post-acute care;
- Physicians would no longer be paid more for longer hospital stays, more procedures, or adverse events;
- Physicians and hospitals would have an incentive to cooperate in optimizing care quality and cost;
- Providers would have the funding flexibility to use the best combination of facilities and services for maximum value; and
- Patients would have an incentive to choose the facility and services that provide the best value (i.e., better quality and/or lower cost).

Have episode-of-care systems ever been tried, and do they work? Yes – in fact, partial versions have been used nationally for decades, and full versions have been tested in demonstration projects with successful results; for example:

- Medicare's prospective payment system (DRGs) has paid hospitals on an episode-of-care basis for 25 years. Although this

How Episode-of-Care Payment Would Work in a Hypothetical Case

Ms. Brown falls and breaks her hip and goes into the hospital for surgery to implant a prosthetic hip. Each of the hospitals in the community has defined a price that it will charge Ms. Brown's insurance company for performing the surgery and providing all of the post-operative care for a woman of Ms. Brown's age and health status. That price will cover Ms. Brown's hospital care, her surgeon's fees, the cost of her prosthetic hip, her care by any other physicians who are involved (e.g., anesthesiologists, intensivists, etc.), her post-hospital rehabilitation, and any home care she may need to make sure she can return home safely. The hospital will be responsible for dividing up the payment among all of those providers. If Ms. Brown develops an infection in the hospital following surgery, the hospital and its physicians will be responsible for treating that infection at no additional charge.

The insurance company measures the outcomes (e.g., mortality rate, complication rate, infection rate, range of motion following rehab, etc.) that the hospital achieves for hip replacements on patients similar to Ms. Brown, and it adjusts the payment to her hospital up or down by a certain percentage based on whether the hospital's outcomes are above or below a standard established by the insurance company.

Ms. Brown will be responsible for paying for a portion of her care. The amount she pays will be lower if Ms. Brown selects a hospital that charges a price lower than the average of other hospitals in the area and/or with quality ratings above the average for the region for patients similar to Ms. Brown.

Ms. Brown receives a small rebate on her share of the costs of her care if she achieves the rehabilitation goals and complies with the post-discharge plan that she develops jointly with her physicians.

system does not go as far as "bundling" physician payments or post-acute care payments into the same payment as the hospital receives, it represented a major transformation from the previous cost-based reimbursement system for hospitals, and it resulted in significant improvements in both cost and quality for patient care.

- In 1987, an orthopedic surgeon in Lansing, Michigan collaborated with his principal hospital, Ingham Medical Center, to offer a fixed total price for surgical services for shoulder and knee problems. The price included a warranty for any subsequent services needed for a 2-year period, including repeat visits, imaging, rehospitalization, and additional surgery. A study found that the payer paid 40% less than it would have expected to otherwise, while the surgeon received over 80% more in payment than he would have otherwise expected. The savings for the payer were achieved by reducing unnecessary auxiliary services, such as radiography and physical therapy, by reducing the length of stay in the hospital, and reducing complications and readmissions. The hospital actually received 13% more in payment for the cases it cared for than it would have otherwise, but the number of hospitalizations decreased. (See "An Alternative Health-Care Reimbursement System – Application of Arthroscopy and Financial Warranty: Results of a 2-Year Pilot Study," by Lanny L. Johnson, M.D. and Ruth L. Becker, L.P.N., *Arthroscopy*, Vol. 10 , No. 4, 1994, pp. 462-470.)
- In the 1990s, Medicare's Participating Heart Bypass Center Demonstration selected four hospitals in Ann Arbor, Atlanta, Boston, and Columbus to receive a single payment covering both Part A (hospital) and Part B (physician) services for coronary artery bypass graft surgery. No outlier payments were permitted, and the amount of the combined payment was negotiated to be below current payment levels by between 10% and 37%, depending on the city. The hospital and physicians were free to split the combined payment however they chose. An evaluation of the demonstration showed that the providers, patients, and Medicare all benefited: physicians identified ways to reduce length of stay and unnecessary hospital costs; costs decreased by 2% -23% in nominal terms in 3 of 4 hospitals; even though post-acute care was not included, post-discharge outpatient expenses actually decreased; and patients preferred the single copay. (See "Cost Savings and Physician Responses to Global Bundled Payments for Medicare Heart Bypass Surgery," by Jerry Cromwell, Debra A. Dayhoff, and Armen H. Thoumaian, *Health Care Financing Review*, Vol 9(1), pp. 41-57, Fall 1997.)
- Geisinger Health System in Pennsylvania, through its ProvenCare^{SM} system, provides a "warranty" that covers any follow-up care needed for avoidable complications within 90 days at no additional charge. The system currently is used for coronary artery bypass graft surgery, and there are plans to expand it to hip replacement, cataract surgery, angioplasty, and other areas. (See, for example, "ProvenCare: A Provider-Driven Pay-for-Performance Program for Acute Episodic Cardiac Surgical Care," by Alfred S. Casale, MD *et al*, Annals of Surgery, Volume 246, Number 4, October 2007, pp. 613-623.)

There are also some efforts today to implement more episode-of-care payment systems, including:

- **Medicare's Acute Care Episode Demonstration.** The Centers for Medicare and Medicaid Services has announced a demonstration, to begin in 2009, called the Acute Care Episode (ACE) Demonstration. Under the demonstration, Medicare will pay a single amount to cover both hospital and physician services for either or both of two sets of services: cardiac care (CABGs, valves, defibrillators, pacemakers, etc.) and orthopedic care (hip and knee replacements). One hospital/care system will be selected in each market based on the price it bids and the quality approach it uses. Patients will receive lower copayments, and the selected hospital/care system will be expected to promote its selection and the opportunity for lower costs to patients in order to attract more patients. The demonstration is only open to hospitals and care systems in Texas, Oklahoma, New Mexico, and Colorado. (See the "Medicare Demonstrations" section at www.cms.hhs.gov for more details.)
- **PROMETHEUS.** PROMETHEUS Payment, Inc. is currently developing an episode-of-care payment system that will cover the full episode of care and all providers for a variety of conditions. The amount of the payment will be based on a combination of historical actual costs and the estimated cost of delivering evidence-based care, with payment adjustments based on quality performance. The acute conditions being focused on initially include acute myocardial infarction (heart attack), hip and knee replacements, coronary artery bypass graft surgery (CABG), coronary revascularization, bariatric surgery, and hernias. (See "Evidence-Informed Case Rates: Paying for Safer, More Reliable Care," by Francois de Brantes, M.S., M.B.A. and Amita Rastogi, M.D., M.H.A., The Commonwealth Fund, June 2008, and www.prometheuspayment.org for more details.)

K. What a Condition-Specific Capitation System Might Look Like

Participants at the 2007 NRHI Summit recommended the creation of a form of condition-specific capitation payment for care of chronic disease patients, and outlined many of the key elements that should be included:

- A periodic (e.g., monthly or quarterly) Comprehensive Care Payment would be paid to a group of providers to cover all of the care management, preventive care, and minor acute services associated with the patient's chronic illness(es), in place of all current fees for those services. (Major acute care and long-term care would be paid separately.)
- The amount of the Comprehensive Care Payment would vary based on the patient's characteristics – both the specific chronic illness(es) they have and other factors affecting the level of health care services they will need.
- The set of services to be covered by the Comprehensive Care Payment would be determined by a Regional Collaborative Organization. The Regional

Collaborative Organization would also estimate the cost of providing those services for each type of patient, but provider groups would bid and negotiate the actual Comprehensive Care Payment they would receive.

- The provider group would receive payment bonuses or penalties based on (a) health outcomes for patients, (b) patient satisfaction levels, and (c) patient utilization of major acute care services.
- Patients would receive incentives to use higher-quality/lower-cost providers, and they would also receive incentives to adhere to care processes jointly developed by the patients and providers.

An example of how this system might work for an individual patient is described in the sidebar. (More details on the recommendations for payment for patients with chronic diseases from the 2007 NRHI Summit are available in the report *Incentives for Excellence: Rebuilding the Healthcare Payment System from the Ground Up*, published by the Jewish Healthcare Foundation, and available at www.nrhi.org/summit.html.)

Why would such a system be better?

- Physicians would no longer be restricted by fee codes and amounts as to what services they can provide and be paid for;
- Physicians would have an incentive to maintain or improve a patient's health,

How Condition-Specific Capitation Would Work in a Hypothetical Case

Mr. Jones has diabetes. His insurance company pays his primary care provider a monthly Comprehensive Care Payment to help him manage his diabetes and to address some of the complications which might arise from his diabetes.

His primary care provider has physicians, nurse practitioners, and other staff working as a team to help Mr. Jones. In addition, they have relationships with other health care providers that will need to provide some aspects of Mr. Jones's care, such as laboratories and ophthalmologists. Mr. Jones's primary care provider works with him to develop a plan of care that defines the actions that he can and will take (e.g., exercising; managing his diet; taking medications; etc.) as well as the actions that the provider will take (e.g., contacting him regularly by phone to see how he is doing; seeing him periodically to check his blood glucose and hemoglobin levels; checking his feet at every visit; etc.) in order to successfully manage his diabetes. Mr. Jones understands that he does not need to see a doctor each time he comes to the office for checkups, since a nurse practitioner can perform all of the necessary checks and call in a physician when needed.

The costs of blood tests and any visits to specialists that Mr. Jones needs, such as periodic eye examinations by an ophthalmologist, are all paid by his primary care provider from the monthly Comprehensive Care Payment.

Mr. Jones pays no co-payments for his regular checkups or routine testing. Mr. Jones receives a small cash payment from his insurance company if he meets the goals established in his care plan as measured by objective test results, such as hemoglobin A1c levels. His primary care provider also receives a financial bonus from the insurance company if Mr. Jones meets the goals in the care plan.

The insurance company measures the number of hospitalizations that occur related to diabetes for Mr. Jones and other patients like him that are under the care of the primary care provider. If the rate of hospitalizations is below a pre-determined target level, the primary care provider receives a financial bonus, since it has saved the insurer money.

Mr. Jones is free at any time to switch to another primary care provider if he isn't happy with the care he is receiving. However, if he switches to a provider which has significantly poorer outcomes, rates of hospitalizations, and/or higher prices for care, his insurance company will require him to pay more in order to use that provider.

prevent hospital admissions, and coordinate care among multiple providers;

- Physicians would have the funding flexibility to use the best combination of providers and services for maximum value; and
- Patients would have an incentive to choose providers and services that provide the best value (i.e., better quality and/or lower cost) and to adhere to recommended care.

A variation of this model has existed in Minnesota for over a decade through the Patient Choice system, which was first created under the auspices of the Buyers Health Care Action Group (BHCAG). (See www.patientchoicehealthcare.com.)

Under the Patient Choice model:

- "care systems" (groups of providers including both hospitals and physicians) bid on the risk-adjusted (total) cost of caring for a population of patients;
- the care systems are divided into cost/quality tiers based on their relative bids;
- consumers pay the difference in the bid price to select a care system in a higher cost tier;
- providers continue to bill based on fee for service codes (with addition of new codes to cover previously unpaid services), but the fee levels that are actually paid are adjusted to keep total payments within a budget. The budget is based on the provider's bid, but it is adjusted upward or downward based on the relative illness and other characteristics of the patients that the provider actually cares for. This prevents the provider from assuming insurance risk, and makes them liable only for the performance risk component of their bid.

This system has encouraged patients to select more cost-effective providers, and has encouraged providers to reduce their costs while maintaining or improving quality in order to attract more consumers.

There are also some efforts today to implement condition-specific capitation systems, including:

- **The Alternative Quality Contract.** Blue Cross Blue Shield of Massachusetts (www.bluecrossma.com) has developed an optional contract for providers called the Alternative Quality Contract (AQC). It makes a fixed payment per patient, adjusted by the health of the patients, to cover all care services delivered to the patient, as well as substantial performance incentives tied to the latest nationally accepted measures of quality, effectiveness, and patient experience of care.
- **PROMETHEUS.** As noted earlier, PROMETHEUS Payment, Inc. is currently developing a new payment system designed to cover all care delivered by all providers for a particular condition. In addition to acute conditions, the PROMETHEUS payment model is being developed for chronic conditions, including diabetes, congestive heart failure, chronic obstructive pulmonary

disease (COPD), asthma, coronary artery disease, and hypertension. (See www.prometheuspayment.org for more details.)

L. Issues Involved in Moving from Volume-Driven to Value-Driven Healthcare

Although these improved payment systems hold significant promise for improving the quality and cost of health care, there are a number of important issues that need to be addressed and a variety of challenges which need to be overcome in order to move them from concept to reality. Many of these issues and challenges stem from the number, diversity, and complexity of organizations involved in health care. There are multiple payers, each with different payment methods and benefit structures, and a wide range of types of providers, all interacting in complex ways to deliver health care services to patients, as shown in Figure 10.

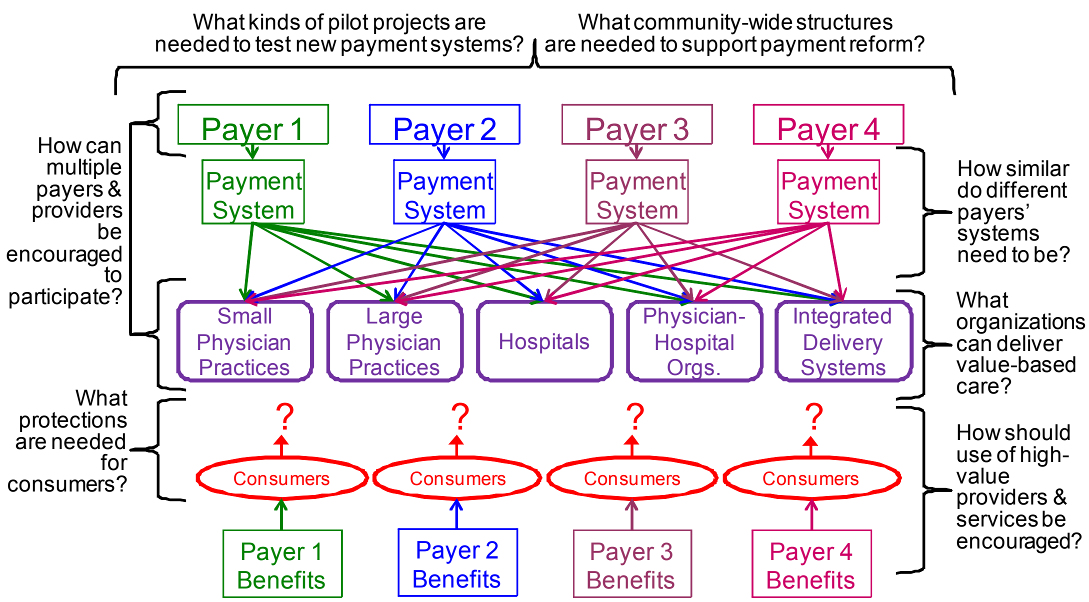

Figure 10

As suggested by Figure 10, there are a number of key questions which must be addressed in designing and implementing new payment systems:

- **Which health care providers, if any, are able and willing to accept new payment structures?** If a large number of providers can and will accept and manage the payments effectively, then the new payment system can be successful. But if few or no providers can do so, then, as a practical matter, the payment system cannot be implemented or will likely not achieve the desired improvements in value. Section III of this Framing Paper explores these issues in more detail.
- **How should the use of high-value providers and services be encouraged? What protections are needed to ensure appropriate quality for patients?** The

issues associated with patient choice, patient protection, and provider competition are explored in Section IV of the Framing Paper.

- **What actions should be taken to support and encourage payment reform initiatives?** Section V of the Framing Paper discusses a number of key issues related to this question, such as how pilot projects should be designed, how much alignment of payers is necessary, how payers and providers can be encouraged to participate in new payment systems, and what community-wide structures are needed to support payment reform.

In most cases, definitive answers to these questions do not exist today, and there are debates in many areas about which approach is best. Different approaches may well be better in different regions of the country. Consequently, each of the subsequent sections presents a range of options related to these issues for consideration.

III. Organizational Structures to Support Fundamental Payment Reforms

The goal of the new payment systems described in Section II is to enable and encourage health care providers to go beyond just delivering narrowly-defined services in return for fees, and to have them take on significantly greater responsibilities for managing the overall quality and cost of a patient's care.

- In the case of episode-of-care payment, a single payment is made for a full episode of care for a particular condition (typically an isolated acute condition). The provider receiving the payment is responsible for arranging for any and all appropriate services needed within the episode of care, for achieving good outcomes for the patient, and for covering the costs of the services within the payment.
- In the case of condition-specific capitation, a single payment is made for care related to a condition during a defined period of time (typically a chronic condition that does not have a short-term endpoint). The provider receiving the payment is responsible for arranging for any and all appropriate services needed for care of the condition during that time period, for achieving good outcomes for the patient, and for covering the costs of the services within the payment.

Although theoretically desirable, implementing these payment systems raises a fundamental question: ***which health care providers, if any, are able and willing to accept such payments?*** If a large number of providers can and will accept and manage the payments effectively, then the new payment system can be successful. But if few or no providers can do so, then, as a practical matter, the payment system cannot be implemented or will likely not achieve the desired improvements in value.

Is Bigger Better?

Some have suggested that only large integrated health delivery systems or large multi-specialty group physician practices have the ability to accept and effectively manage true episode-of-care or condition-specific capitation payments. Moreover, since a number of studies have indicated that larger physician group practices and more integrated delivery systems provide better quality of care for patients, it has been suggested that having more global payment methods that encourage the creation and expansion of these kinds of organizational structures would be good for patient care.

Others have expressed concern that encouraging the creation and expansion of large group practices and integrated systems would also mean greater consolidation of providers, which in turn would lead to less competition and higher prices. Indeed, in many cases, a major reason why providers have consolidated to date is to more effectively negotiate contract prices with large payers, not to provide better care for patients.

So, the challenge for new payment systems is how to encourage and support provider structures that both maintain or improve quality while maintaining or reducing costs, i.e., a value-driven healthcare system.

Key Elements That Providers Need to Participate in New Payment Systems

There are three key factors that affect whether a provider can effectively participate in a payment system such as episode-of-care or condition-specific capitation that uses case rates rather than individual service fees: (1) the provider's ability to ensure each patient receives the full range of care encompassed by the case rate payment, (2) the provider's skills in designing care processes to achieve quality outcomes while maintaining or reducing costs, and (3) whether the provider is caring for an adequate volume of patients.

Range of Care

A case rate payment presumes that the provider receiving the payment can either (a) directly deliver all of the services needed for the care covered by the payment or (b) arrange for and coordinate the delivery of those services by other providers. Although larger providers and more integrated providers are frequently able to deliver more services, fragmentation and lack of coordination occur frequently even within large integrated delivery systems, so larger size or greater integration do not necessarily guarantee more coordination of care.

A provider can have the ability to ensure patients receive the full range of services they need without the provider having to provide all of those services itself. Indeed, in other economic sectors, businesses routinely subcontract with multiple suppliers and service providers in order to deliver a complete product or service to their customers. Their customers leave it to the business from which they are purchasing to make those arrangements, and the customers rarely know or concern themselves with whether the business is performing a particular function in-house or through a sub-contractor. These "make or buy" decisions enable smaller firms to achieve excellence in particular specialty area without having to produce an entire product or service themselves. Ideally, health care payment systems should similarly allow health care providers the flexibility to structure themselves in whatever way delivers the best value, without being overly prescriptive about the organizational arrangements that a provider uses to deliver that value.

For example, a large integrated health system that employs physicians in a wide range of specialties, has its own diagnostic facilities, and provides both inpatient and outpatient care is presumably well-positioned to accept bundled episode-of-care payments for care that involves all of those practitioners and facilities. But an individual hospital or physician group can develop working relationships with other, independent providers so that it can accept such bundled payments as well. For example, there are already many Physician-Hospital Organizations (PHOs) around the country that were formed to respond to capitation contracts, and those might serve as a foundation for managing episode-of-care payments as well.

Similarly, a large multi-specialty physician group may be well-positioned to accept condition-specific capitation payments that cover the full range of primary care and specialty care for chronic disease patients. But a small primary care physician practice could establish formal contracts and coordination agreements with separate specialty physicians, laboratories, etc. in order to also accept such payments.

Skills in Quality and Cost Management

In any industry, the skills that are most highly developed are those that are most valued under the incentives that exist in that industry. In health care, current payment systems primarily reward volume, not quality or efficiency, so it's likely that skills in designing and managing care processes to improve quality and control costs will be in short supply until the incentives change.

Although as noted earlier, some studies have shown that larger physician group practices and more integrated delivery systems provide better quality of care for patients, these studies are, by definition, correlational studies, not controlled trials. No study has said that small providers *cannot* provide good quality care, nor that all large providers universally deliver good quality care. In fact, there are many examples of relatively small providers delivering exceptional value in chronic disease management, acute care delivery, etc., and there are certainly examples of large systems that provide low value – either very high costs or unacceptably low quality. Moreover, a variety of training programs and consulting practices exist around the country that are designed to help physicians, hospitals, and other health care providers of all sizes identify ways to improve quality and efficiency.

In addition to quality management skills, providers will need strong financial management skills to survive and thrive under global payment structures. These are not fundamentally different skills from what businesses in other industries routinely use to manage cash flows when customers pay for end products rather than intermediate products, but since fee-for-service systems enable health care providers to be paid for intermediate products, these skills have not been routinely required.

Number of Patients

For the purposes of payment reform, a provider's size (as measured by the number of patients the provider cares for) does matter, for (at least) three reasons:

1. to the extent that the payment to the provider is based, at least in part, on outcomes, the provider needs to care for a large enough number of patients (all of whom are paid for under the new payment system) to enable statistically valid quality measurement;
2. to the extent that the provider is responsible for using the payment to cover low-probability, but high cost events (e.g., if a primary care practice is responsible for

covering the costs of hospitalizations for chronic disease patients under a condition-specific capitation payment), a provider with a small number of patients will experience larger swings in cash flow when those low-probability events occur; and

3. to the extent that the provider needs to increase its fixed costs to adequately manage patient care or manage its own finances (e.g., purchasing an electronic health record system, hiring a nurse care manager, etc.), it may not be able to fully recover those costs without an adequate number of patients. (The calculation of this will depend on the exact structure of the payment system and the cost item involved.)

By definition, larger providers have more patients, and are thereby more likely to meet these criteria than small providers. However, there are ways that small providers can join together to address these issues without having to formally merge into larger organizations. For example, Blue Cross Blue Shield of Michigan, through its Physician Group Incentive Program (www.bcbsm.com/provider/value_partnerships/pgip/index.shtml), has been encouraging small physician practices to participate in multi-practice organizational structures that are explicitly focused on quality measurement and quality improvement, and these organizational structures are also being used to enable physician practices to share important quality improvement resources (such as nurse care managers) that they could not individually afford to support.

Willingness vs. Ability

Clearly, some providers will already have some or all of the characteristics needed to participate in more global payment structures, while others will have to develop them. How much of a transitional period is needed to allow providers to fill in any gaps, and what is the role of payment systems, if any, in facilitating this process?

This is, in effect, a classic "chicken and egg" problem. The payer wants a provider which is fully capable of accepting and managing a payment before paying the provider on that basis, but the provider may need to begin receiving the payments first in order to make the changes needed to develop the capability the payer expects.

Many pay-for-performance systems fail to distinguish whether the impediment to greater capability on the part of providers is a lack of *ability* or a lack of *willingness*. For example, although the use of nurse care managers for patient education and support has been demonstrated to improve outcomes and reduce costs for chronic disease patients, hiring a nurse care manager costs money, and a physician practice will not be able to pay for that cost under most fee-for-service systems because what the nurse care manager does is not a billable service. A payment system that gives small rewards to practices with better outcomes will not overcome this problem if the rewards are lower than the cost of the care manager, in contrast to a payment system which enables the practice to bill directly (and at an adequate rate) for the cost of the nurse care manager (or which pays a case rate for patient care and leaves it to the practice to decide what type of staffing is best).

On the other hand, even if a payment system gives providers the *ability* to make the changes needed for better care, some providers may be *unwilling* to implement them, either because they prefer the current structure or because they fear the inherent uncertainty of a new system (i.e., "the devil you know may be better than the devil you don't"). In this case, incentives and rewards may (or may not) be appropriate to encourage participation.

The Dangers of Over-Specification

Finally, it is important to decide whether certain provider capabilities or organizational structures are *essential* to success, or whether they are merely *desirable.* The more narrowly that a payment system defines the types of providers that are eligible to receive payment, the fewer providers there will be which can participate in the payment system (at least in the short run), and the less competitive pressure there will be for improvements in quality and efficiency. Moreover, the more restrictive the requirements are, the more likely they are to inhibit innovations by providers that could increase value.

For example, it may be the case that, on average, physician practices which have electronic health records provide better quality care than those which do not. But this does not necessarily mean that having an electronic health record (EHR) is essential for quality care or that it guarantees quality care (indeed, a practice can certainly have an EHR and still deliver poor quality care). If a payment system *requires* that a physician practice have an EHR in order to participate, it will potentially exclude some practices that provide high quality care but do not, at least yet, have an EHR. Moreover, it may force physician practices to devote disproportionate time and resources to installing EHRs rather than implementing other types of care improvements that could provide a bigger impact on quality and costs in the short run. Instead, it might be preferable for a payer to define the priority patient care outcomes it wishes to achieve, and then allow the physician practice to determine whether and when an EHR is necessary to achieve those outcomes.

A. Payment Systems & Organizational Structures Needed to Implement the Patient-Centered Medical Home

All of the issues above are applicable to the concept of the "patient-centered medical home." Efforts are underway all across the country to improve the quality of primary care delivery by encouraging the creation and use of medical homes, both broadly and for specific categories of patients. There are multiple goals for doing this, including improving patients' health, reducing preventable hospital admissions, etc.

What is a Medical Home?

The American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA) have issued joint principles (www.medicalhomeinfo.org/Joint%20Statement.pdf) to describe what they believe are the key characteristics of a patient-centered medical home. These principles are:

- ***Personal physician*** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- ***Physician directed medical practice*** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- ***Whole person orientation*** – the personal physician is responsible for providing for all of the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life: acute care; chronic care; preventive services; and end of life care.
- ***Care is coordinated and/or integrated*** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes, etc.) and the patient's community (e.g., family, public and private community-based services, etc.). Care is facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
- ***Quality and safety*** are hallmarks of the medical home:
  - Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family;
  - Evidence-based medicine and clinical decision-support tools guide decision making;
  - Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement;
  - Patients actively participate in decision-making, and feedback is sought to ensure patients' expectations are being met;
  - Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication;
  - Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model; and
  - Patients and families participate in quality improvement activities at the practice level.
- ***Enhanced access*** to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
- ***Payment*** appropriately recognizes the added value provided to patients who have a patient-centered medical home.

- It should reflect the value of physician and non-physician staff conducting patient-centered care management work that falls outside of the face-to-face visit;
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources;
- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation;
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology;
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits);
- It should recognize case mix differences in the patient population being treated within the practice.

Many of these principles are stated as philosophies or outcomes, rather than easily observable and measurable processes or features. This has naturally raised the question: "How does a payer or a patient know if a provider is, in fact, a 'medical home?'"

In an effort to address this, the National Committee for Quality Assurance (NCQA) has established detailed standards for patient-centered medical homes (http://www.ncqa.org/tabid/631/Default.aspx). There are nine standards, with a total of 30 elements within those standards, and 170 separate items on which a provider is to be scored to determine whether they meet the standards. There are three different levels of certification that a provider can achieve depending on how many of the items they meet. Many payers are considering use of these standards to determine which providers should be eligible to receive payments designed to support medical homes.

Chronic Care Model

The "patient-centered medical home" is not the only approach to improving primary care; many communities are also pursuing efforts to implement the "Chronic Care Model," a concept developed by Edward Wagner of the MacColl Institute for Healthcare Innovation in Seattle to improve outcomes for patients with chronic diseases. There are six key components envisioned as part of the Chronic Care Model (see, for example, the American Academy of Family Physicians' "Guide to Implementing the Chronic Care Model" www.aafp.org and www.improvingchroniccare.org):

- **Community Linkages** – mobilizing community resources to meet needs of patients;
- **Health Care Organization** – creating a culture, organization, and mechanisms that promote safe, high quality health care;
- **Self-Management Support** – empowering and preparing patients to manage their health and health care;
- **Delivery System Design** – assuring the delivery of effective, efficient clinical care and self-management support;

- **Decision Support** – promoting clinical care that is consistent with scientific evidence and patient preferences; and
- **Clinical Information Systems** – organizing patient and population data to facilitate efficient and effective care.

Although the Patient-Centered Medical Home and the Chronic Care Model have much in common, there are clearly differences in emphasis and focus. For example, the Chronic Care Model has a strong emphasis on self-management support and the creation/use of community resources outside the physician practice. A provider could conceivably be viewed as meeting the criteria for a medical home, but not be viewed as a successful implementer of the Chronic Care Model, and vice versa.

Ideal Medical Practices

A third approach for improving primary care has been developed by Gordon Moore and John Wasson. Called "Ideal Medical Practices," it addresses goals similar to those of the patient-centered medical home and the chronic care model, but stresses the critical importance of "collaborative interaction" between patients and their physicians and other care providers. It uses tools and techniques that are low cost and practical for small physician practices to implement.

Key elements of the Ideal Medical Practices approach are:

- A strong focus on patient interaction, using structured tools, to identify what matters to patients;
- Design of office operations to provide convenient access for patients, provider continuity, and efficiency;
- Minimization of overhead to enable more time for patients and services such as email, group visits, and phone coaching;
- Creation of office processes to ensure that patient needs and desires are addressed, using techniques such as reminder systems to ensure that patients receive periodic preventive care, are monitored for status changes, etc., and providing focused attention to those patients who are not doing well or are not confident in self-management of their conditions; and
- Measurement of patient outcomes and use of patient self-reports to identify in real time where improvements are needed.

Moore and Wasson's research has indicated that the quality of patient care and patient satisfaction are significantly higher in physician practices which follow this approach. (See "The Ideal Medical Practice Model: Maximizing Efficiency, Quality, and the Doctor-Patient Relationship," *Family Practice Management*, September 2007, pp. 20-24.)

ISSUE 1.1: What Organizations Should Be Eligible to Participate in Payment Systems Designed to Support Medical Homes and Improvements in Primary Care Delivery?

As noted in the introduction to this section, there are some specific capabilities that are highly desirable, if not essential, for providers to have in order to effectively manage under payment structures designed to provide better quality and lower cost patient care, and so there is a natural desire by payers to ensure that only providers which have those capabilities can receive the payments. However, as also noted there, there are risks of imposing too many specific requirements on providers as a condition of participation or of too narrowly specifying the types of providers that can participate. The concepts of the "medical home," the "chronic care model," and "ideal medical practices" could either be viewed as *general guidelines* for the types of capabilities needed to provide effective primary care and to manage under improved payment systems, or they could be viewed as *strict criteria* for a provider's eligibility to participate in a new payment system.

Since payers and payment systems depend on organizations to actually deliver health care, and health care provider organizations depend on payment systems to adequately and appropriately support the care they wish to deliver, it is desirable to reach consensus as to which kinds of organizations would be appropriate to participate in payment structures designed to improve primary care and which would not, and what specific conditions, if any, would be applicable. The options described below are not exhaustive, nor are they mutually exclusive.

OPTION 1.1.1: Any primary care (or appropriate specialist) physician practice with (a) a commitment to the principles of a medical home, the chronic care model, ideal medical practices, or another model, and (b) which have good patient outcomes or a commitment to improve outcomes.

Under this option, the Patient-Centered Medical Home and Chronic Care Model are viewed as general guidelines for physician practices to follow, but the focus is on the organization's outcomes, rather than the specific methods it uses to get there. Concepts such as Ideal Medical Practices can be used to improve the quality and reduce the cost of care in ways that are feasible for small physician practices to implement.

Many chronic disease patients who routinely see a specialist (e.g., cardiologists for patients with congestive heart failure, pulmonologists for patients with chronic obstructive pulmonary disease, etc.) may, for both convenience and cost savings, wish to have their specialist play the role of their primary care physician, which could require providing the opportunity for specialty practices to participate as well.

OPTION 1.1.2: A primary care (or appropriate specialist) physician practice that meets standards for a medical home (e.g., the standards developed by NCQA).

In contrast , this option establishes strict criteria for what a physician practice must have or do in order to participate in new payment systems, particularly since the outcomes sought may not occur until well into the future.

OPTION 1.1.3: **A primary care (or appropriate specialist) physician practice of sufficient size and patient volume to support care management resources, quality measurement and improvement activities, etc. (even if those resources and activities are not yet in place).**

This option focuses on the size of the practice, rather than its capabilities *per se*. As noted earlier, several aspects of both the payment system and the expected care delivery mechanisms are difficult or impossible to implement with small patient volumes.

OPTION 1.1.4: **A multi-specialty group practice of sufficient size and patient volume to support care management resources.**

Since the most expensive and challenging patients will likely require consultations or care from specialists, it would be desirable to have close integration between primary care physicians and those specialists.

OPTION 1.1.5: **A primary care (or appropriate specialist) physician practice that is part of an independent practice association (IPA) or other organizational structure that has mechanisms for shared staff resources, quality measurement and improvement, etc. across multiple small physician practices.**

Since the majority of physician practices in most regions are very small (1-5 physicians), the only practical way to improve care for the majority of patients but still achieve sufficient patient volumes needed to implement new payment structures may be through collaborative arrangements among those practices.

OPTION 1.1.6: **Any type of physician organization (whether it is an individual practice, an IPA, , a management services organization (MSO), or a new structure) that creates an organized system of care with accountability for patient outcomes and costs.**

If the goal of payment reform is to empower and assist physicians to improve outcomes and control costs, what may be needed is a physician organization structure that is explicitly designed to accept accountability for using payments to achieve that goal.

It will be important to ensure that such organizations truly represent more integrated approaches to care delivery, otherwise they may raise antitrust concerns with the Federal Trade Commission (FTC).

OPTION 1.1.7: **An "accountable care organization" consisting of all the physicians who admit patients to a particular hospital.**

Elliott Fisher and his colleagues have proposed treating a hospital and the physicians who admit patients to that hospital as "an accountable care organization." (See "Creating Accountable Care Organizations: The Extended Hospital Medical Staff," by Elliott S. Fisher, Douglas O. Staiger, Julie P.W. Bynum, and Daniel J. Gottlieb, *Health Affairs* Vol. 26, No. 1, pp. w44–w57, January/February 2007.) Quality measurement and payment incentives would be applied to this collection of providers as if they were a single provider (treating it, in a sense, as a *virtual* organization), and encouraging them to jointly create the care systems needed to improve quality and manage within the payment structure.

OPTION 1.1.8: **An integrated delivery system that includes both outpatient and inpatient services.**

Given the desirability of managing the full array of clinical services (both inpatient and outpatient) that patients may require, an integrated delivery system may be in the best position to manage a bundled condition-specific capitation payment system for complex primary care patients such as people with chronic disease.

ISSUE 1.2: What Kinds of Changes in Payment Systems Should Be Used to Encourage the Creation of Medical Homes and Improvements in Primary Care?

The "chicken and egg" problem referenced earlier is particularly applicable here. Proponents of the medical home clearly expect that not only will payment for medical home services be made *differently* than the way primary care is paid for today, but that the amounts of those payments will be *more* than they are today. For example, a commonly proposed payment model for supporting the medical home is to pay a physician practice an additional fixed amount per patient, on top of fee-for-service reimbursements, to cover the costs of all of the new or additional services and activities that are provided as part of a medical home (for simplicity, this will be referred to in this section as "enhanced fee-for-service").

Payers, however, are understandably reluctant to pay *more* without assurances that outcomes will be *better* and that costs will be saved elsewhere (e.g., through reductions in preventable hospitalizations). Moreover, even if there are assurances of net savings in the long run, if the cost savings will occur *in the future*, but the increased costs occur *now*, it may be difficult for current payers to justify making the initial investments. The conundrum is that the ability of medical homes to reduce overall costs cannot be proven until they are put in place, yet most physician practices probably cannot meet all of the principles or standards for becoming a medical home unless the structure and amount of payment are changed.

Condition-specific capitation payment is intended to address part of this concern, by establishing a pre-defined total "price" for all medical home services (both those currently paid for under fee for service and those not paid in that way) and by providing performance incentives that link directly to reductions in other health care expenditures. Although this kind of global payment is not inconsistent with the AAFP/AAP/ACP/AOA joint principles, the principles do not require the level of accountability or skill needed to successfully manage these types of case rate payments.

Thus, it is possible that (a) some providers will be able to meet standards for being a medical home, but not have the capacity or skills to manage a case rate payment, while (b) other providers may well be able to manage a case rate payment, deliver quality care, and maintain or reduce overall health care spending for their patients, but not meet the standards for being a medical home.

So the challenge is how both payment systems and provider structures should evolve to achieve the goals of the medical home while also maintaining or reducing overall health care costs.

As indicated in Figure 11, more limited fee-for-service reforms may be needed initially where providers do not have the capability to function as medical homes with full accountability for outcomes and costs; true condition-specific capitation systems could then be phased in when and where providers have the capability to manage them. However, as suggested in Figure 11, a provider that already has full medical home capabilities today may find the continued burdens and incentives of even an enhanced fee-for-service payment system counterproductive.

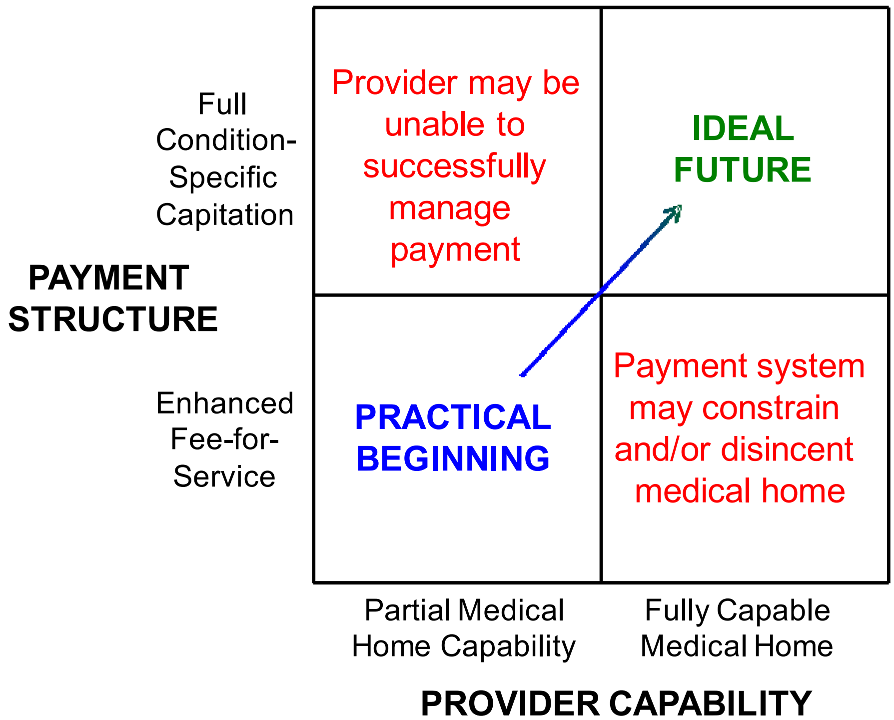

Figure 11

A wide range of different payment options can be considered to encourage the creation of improved primary care and to provide ongoing support for these improvements during the transition to longer-run payment structures. The options described below are not exhaustive, nor are they mutually exclusive. Some options may only be appropriate for providers with certain structures, as defined in Issue 1.1.

OPTION 1.2.1: **Provide financial rewards within the current fee-for-service system (e.g., annual bonuses or higher fees) for practices that achieve medical home or other comparable standards.**

As noted earlier, reward systems presume that the principal impediment to improved care is lack of *willingness*, rather than lack of *ability*, on the part of providers. Moreover, given that the fee-for-service system creates significant undesirable incentives, the rewards have to be large enough to at least neutralize, if not dominate, the incentives within the underlying fee-for-service system.

OPTION 1.2.2: **Provide up-front financial assistance (grants, loans, etc.) to enable practices to install needed infrastructure, redesign care processes, etc.**

Some of the capabilities envisioned as part of the medical home or chronic care model may require up-front investments by physician practices. In particular, implementation of electronic health record systems and patient registries may require significant one-time expenditures on hardware, software, and consulting support. Although these costs may be recoverable by a physician practice under new payment systems over a period of time, there will likely be no *guarantee* of that, and the physician practice may need a source of financing in order to assemble the upfront capital needed to make the investment.

For example, Highmark Blue Cross Blue Shield is providing $29 million to physician practices in the Pittsburgh area to cover up to 75 percent of the costs of electronic health records, up to a maximum of $7,000 per physician's office.

OPTION 1.2.3: Provide short-term transitional funding to providers to offset losses in revenue during the process of restructuring care delivery.

Providers may experience a variety of short-term costs that are simply due to the transition to new ways of doing things. For example, to the extent that physicians spend time redesigning their care processes, participating in quality improvement collaboratives, obtaining training in new information systems, etc. they will not be able to see patients and their practice will lose revenue.

For example, as part of Pennsylvania's initiative to implement the Chronic Care Model, payments are being made to physicians to help cover the time they spend participating in quality improvement collaborative.

OPTION 1.2.4: Add fees/billing codes to cover new services needed for medical home capabilities (e.g., nurse care managers, phone contacts with patients, etc.).

One of the serious limitations of current fee-for-service systems is that they generally pay only for face-to-face visits between physicians and patients, not for other services and methods of helping patients.

For example, as part of its Patient Centered Medical Home initiative, Blue Cross Blue Shield of Michigan is reimbursing physician practices for care management & self-management training services provided by RNs, dietitians, diabetes educators, social workers, clinical pharmacists, and respiratory therapists.

OPTION 1.2.5: Provide bonuses/penalties/shared savings to providers based on the number of hospitalizations, ER visits, readmissions, etc. for ambulatory-sensitive conditions.

It is possible that providers could receive any or all of the fee-for-service enhancements listed in the options above, and that total health care spending for their patients will increase as fast or faster than in the past. Payers will likely look more favorably on payment enhancements if there are explicit incentives or other mechanisms to encourage reduction in costs elsewhere in the system, such as through reduced hospitalizations.

For example, under the Medicare Physician Group Practice Demonstration, the total level of Medicare expenditures for participating patients is compared to what projections indicate they would have been without care improvements. If the actual expenditures are lower than projections, a portion of the savings is shared with the physicians who are providing the care for those patients.

OPTION 1.2.6: Pay a single additional fee (on top of existing fees) to cover the additional costs of services and processes associated with improving primary care or becoming a medical home.

Rather than creating an array of new billing codes as envisioned in Option 1.2.4 (which may or may not include all of the creative approaches a physician practice may wish to use to help patients manage their conditions) and trying to determine an appropriate fee level for each of them, it may make more sense to simply provide a single payment that a physician practice can use flexibly for all services and approaches that are not currently billable.

For example, the Rhode Island Chronic Care Sustainability Initiative has asked payers to provide a single payment per patient to physician practices to cover the additional costs of all improved services, ranging from case management to electronic health records.

OPTION 1.2.7: Pay a single amount for each patient visit based on their specific conditions.

Instead of having physicians bill for a variety of individual visit and billing codes, a single payment could be defined for the patient's care during a physician visit, similar to what is done now with DRGs for hospital stays.

For example, Norbert Goldfield and colleagues have proposed using Ambulatory Patient Groups (APGs), which are currently used by Medicare for outpatient services, to replace the E&M (evaluation and management) codes under the CPT coding system for the purposes of paying physicians. The APGs would enable higher amounts to be paid for patients who need more care. (See "Reforming the Primary Care Payment System," *Journal of Ambulatory Care Management*, Vol. 31, No. 1, pp. 24-31.)

OPTION 1.2.8: Make a single, severity-adjusted comprehensive payment to a physician practice for outpatient care (completely replacing the current fee structure), with rewards/shared savings given to providers based on the extent to which reduced hospitalizations, etc. have been achieved for patients with ambulatory-sensitive conditions.

Rather than adding new fees on top of the existing fee-for-service structure and retaining the undesirable incentives built into the existing structure, an alternative would be to move towards a condition-specific capitation structure by paying the physician practice a single per-patient amount that would be used to cover the costs of all services and processes delivered to the patient by the practice.

For example, Allan Goroll, Robert Berenson, Stephen Schoenbaum, and Laurence Gardner have proposed a risk/needs-adjusted payment for the comprehensive care of each patient, with the amount designed to cover all of the costs needed for a practice to qualify as a medical home, and with a portion of the payment based on performance/outcomes. (See "Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care," *Journal of General Internal Medicine*, 2007, 22:410-415.)

OPTION 1.2.9: Make a single, severity-adjusted comprehensive payment for both outpatient care and inpatient care for patients with ambulatory sensitive conditions.

This option represents a condition-specific capitation payment system, including not only the costs of the physician practice (as in Option 1.2.8), but all inpatient and outpatient services as well. However, it would be limited to those patients with conditions where rates of hospitalization can be significantly reduced through improved primary care.

OPTION 1.2.10: Pay providers using a condition-specific capitation system (i.e., one severity-adjusted amount to cover all of a patient's care).

Under this system, a physician practice or other provider would receive a single payment per patient (paid monthly or quarterly) to cover all of the costs of caring for that patient, with the payment amount varying based on the severity and complexity of the patient's needs.

B. Provider Organizational Structures Needed to Manage Bundled Payments and Warranties in Major Acute Episodes

Payment on an episode or case-rate basis as described in Section II, rather than a fee-for-service basis, is not a new concept for many providers. For example, for 25 years, hospitals have been paid by Medicare and many other payers on the basis of Diagnosis Related Groups (DRGs), rather than based on costs or individual service fees. A DRG is basically a single payment for all of the hospital's costs (but not for the physicians' fees) associated with a single hospitalization episode. Some physicians are also already paid on an episode basis: surgeons are routinely paid a single fee for all of their services and care associated with a single surgical episode, and nephrologists are paid a single fee by

Medicare for caring for end-stage renal disease. Medicare now pays for home health services and other post-acute care services on an episode of care basis.

The Problems With Unbundled Payments

What does *not* routinely happen is for the services of *different* providers to be "bundled" together into a *single* episode payment, even if all of those services are integral parts of a single patient's total episode of care. As illustrated in Figure 12, if a patient requires hospitalization for a particular condition, some of the providers delivering services during various stages of that patient's episode of care will be paid on an episode or case-rate basis, but others will not, and even those providers which are paid on a case-rate basis will be paid *separately*, not *jointly*.

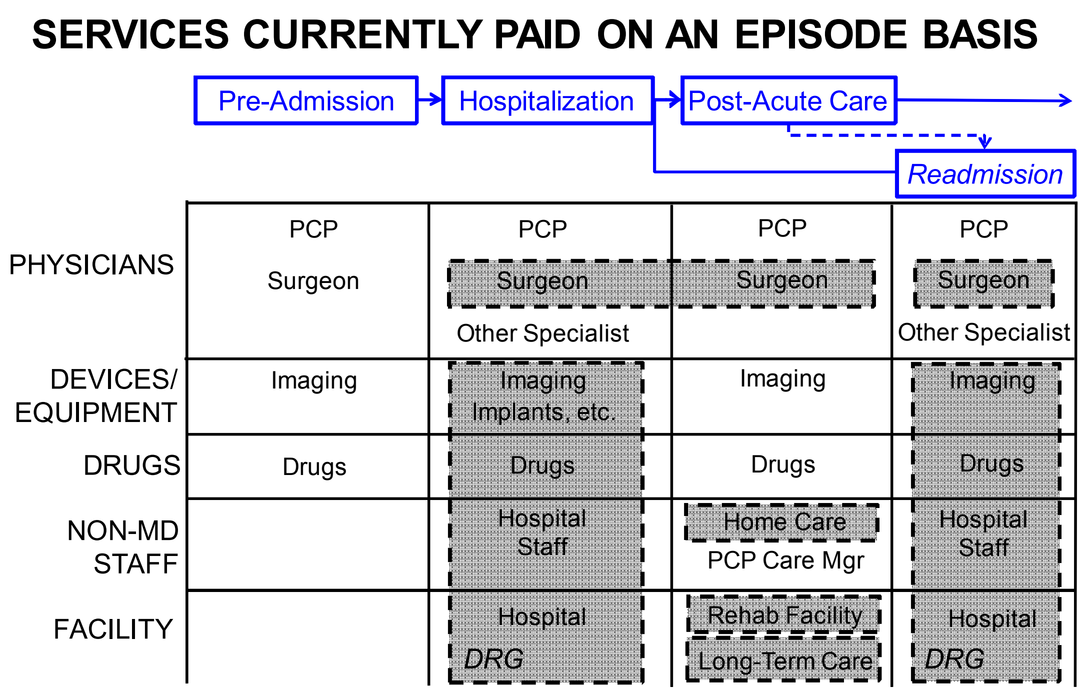

Figure 12

As a result, some of the providers within the patient's overall episode will be subject to the undesirable incentives and limitations of the fee-for-service system, while others will face a very different set of incentives under a case-rate payment. Moreover, even those providers who *are* paid on a case-rate basis are only paid for a *portion* of the entire episode of care. This leads to (at least) two different types of problems:

- There is no financial incentive for multiple providers involved in the same portion of a patient's overall episode of care to coordinate their activities in a value-maximizing way. For example, even though the *hospital* is responsible for paying for the costs of devices, drugs, staffing, etc. using its episode of care payment (the DRG), it is the *physicians* who fundamentally control what drugs are prescribed, what devices are used, etc., and there is no financial incentive built into the physicians' payments to encourage them to help the hospital manage those costs and stay within the hospital's case rate budget (i.e., the DRG).

- There is a financial incentive for each provider to shift costs onto other providers involved in separately-paid portions of the patient's overall episode of care. For example, a hospital may benefit by discharging patients earlier and having care that could have otherwise been provided during the hospital stay covered through home care or even through a later hospital readmission.

A solution to these problems is to "bundle" all of the providers into a single, comprehensive episode of care payment that covers *all* of the services involved in the patient's *complete* episode of care. For example, as illustrated in Figure 13, in the case of a major acute episode, a single payment would be made that covers all of the physician services, all of the hospital services, and all of the post-acute care services, including any hospital readmissions that are directly related to the initial hospitalization. (True long-term care, e.g., long-term nursing home care, as opposed to short-term rehabilitative care which might occur in a nursing home, would likely not be covered in this single payment unless the need for long-term care is a direct result of avoidable complications that occur during the hospital stay.)

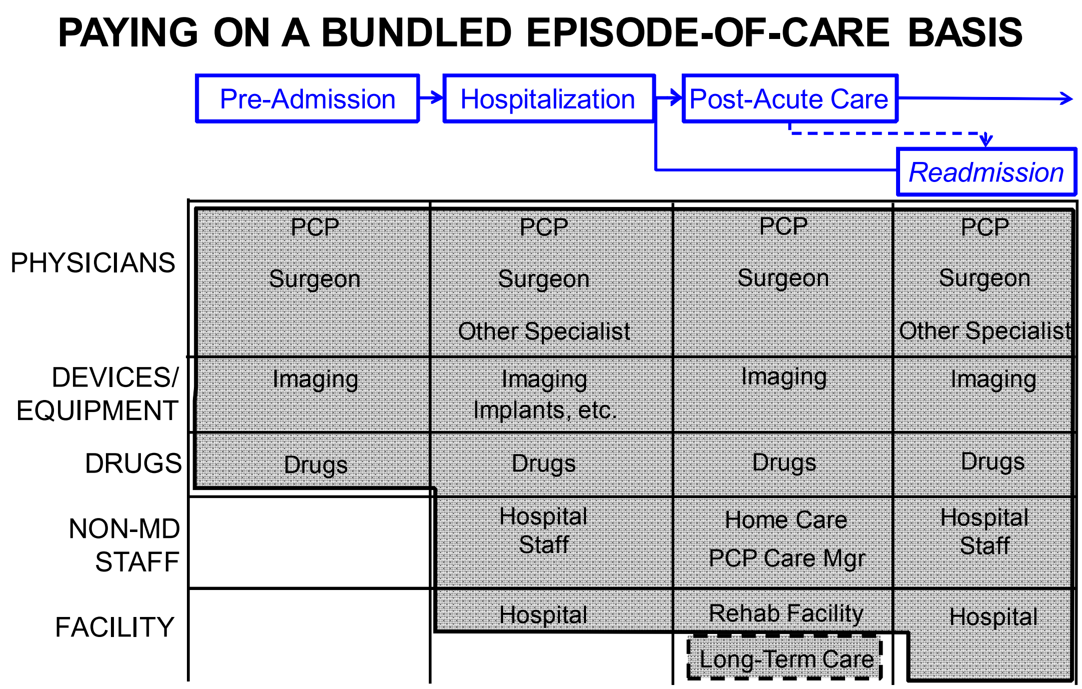

Figure 13

ISSUE 2.1: What Organizational Structures Should Be Eligible to Receive Bundled Payments and Warranties?

Bundling the services of hospitals, physicians, and post-acute care providers into a single payment presumes the existence of an organizational entity that can (a) serve as the recipient of the single payment and (b) divide that payment among the individual providers in a manner acceptable to those providers. An integrated health care delivery system, if it employs physicians and operates both hospitals and post-acute care services, might seem best positioned to accept such payments. But most patients are not cared for by integrated health delivery systems.

Defining a Payment Recipient

Outside of an integrated delivery system, selecting one provider to receive payment on behalf of other providers raises thorny political issues. If the hospital receives payment on behalf of otherwise independent physicians, does that put the hospital in the position of controlling the way the physicians practice? If a physician receives payment to cover both physician and hospital services, does that put the hospital at risk of physicians creating their own specialty hospitals to provide specific types of services? And if a physician were to receive the payment, which physician, of the many involved in a patient's care, would it be?

This suggests that special organizational mechanisms, which have shared "control" by all involved providers, may be needed to receive bundled payments. For example, in the Acute Care Episode (ACE) Demonstration for cardiac and orthopedic surgery announced in 2008 by the Centers for Medicare and Medicaid Services (CMS), CMS is requiring that physician-hospital organizations (PHOs), with at least one physician group and at least one hospital that routinely provide the services covered under the demonstration, be the applicants for the demonstration and receive the bundled payments. However, there is no requirement that all of the physicians who provide those services at the hospital need to be part of the PHO applicant, which means that some physicians may see their payments being determined by an organization in which they have no direct voice.

Defining a Payment Allocation Process

The challenge is far more complicated than just finding or creating an appropriate organization to receive the payment. The presumption in making a bundled payment is that it will be divided up among the individual providers in a different way than it is today. This requires creating a process for determining what that division will be. Even for integrated systems, receiving a bundled payment could well require a significant change in internal procedures and physician compensation structures in order to respond to the different incentives created by a bundled payment.

For example, to the extent that the bundled episode-of-care payment incorporates a "warranty" (i.e., that the costs of treating preventable complications, readmissions, and other adverse events will be covered from that single, bundled payment), a determination will have to be made as to how each provider's individual payment will be affected if one of these adverse events occurs. Will everyone share proportionately in the increased costs/lower margin that results, or will there be some process for attributing responsibility for the adverse event to a subset of providers and having them disproportionately bear the burden of the higher costs?

The nature of the mechanisms for utilizing bundled payments may determine whether the organizational structures created to receive them will raise antitrust concerns with the Federal Trade Commission (FTC). For example, although

Physician-Hospital Organizations represent an organizational mechanism for hospitals and physicians to jointly accept bundled payments (see Option B.1.3 below), the FTC has brought cases against a number of Physician-Hospital Organizations for anti-competitive behavior for agreeing on common prices without also agreeing to change their operations in ways that achieve significant clinical integration. (See, for example, Susan A. Creighton, "Diagnosing Physician-Hospital Organizations," Federal Trade Commission, January 22, 2004.)

Challenges for Payers

In addition to the challenges on the provider side, there are significant challenges on the part of payers, as well. For example, if only a portion of payments to providers are made on a bundled basis, then the payer has to have a mechanism for filtering claims from providers to determine whether any are associated with a bundled payment (and therefore should not be paid separately). Even the process of determining a reasonable amount for the bundled payment is challenging, because there is generally no mechanism today for accumulating all of the many services from multiple providers and the costs associated with those services into patient-specific episodes of care, in order to determine the total cost of these episodes. And since complete episodes of care may extend for several months, providers delivering services early in an episode may face long delays in payment unless payers and the recipients of the payment establish mechanisms for partial payment and reconciliation.

A variety of existing and new organizational structures might be considered to receive bundled payments. It is desirable to begin determining now which kinds of organizations would be appropriate for bundled payments and which would not, and what specific conditions would be applicable, so that efforts can be made to put the organizational structures in place in advance of the actual implementation of bundled payments. Some of the options for organizational structures to receive bundled payments are described in more detail below.

OPTION 2.1.1: An individual physician or group practice with the capacity and expertise to manage the full episode of care.

As noted in Section II, there have been cases where individual physicians have taken responsibility for accepting and managing bundled payments to all of the involved providers.

OPTION 2.1.2: A multi-specialty physician group practice with the capacity and expertise to manage the full episode of care.

The multi-specialty physician group would be likely to include all or most of the primary care and specialty physicians involved in a patient's episode of care (except for some hospital-focused specialties such as anesthesiology), and might also have ancillary services such as laboratories and outpatient clinics. However, hospital services, home health services, etc. would still be delivered by separate providers, requiring inter-organizational agreements for division of payments with them.

OPTION 2.1.3: A hospital medical staff organization.

Each hospital is, as a practical matter, in a partnership with the physicians who admit and care for patients there. However, since payment structures and fees are ordinarily defined by payers, these organizational structures generally do not currently take any role in determining payment levels.

OPTION 2.1.4: A physician-hospital organization.

Physician-hospital organizations (PHOs) were established specifically in order to manage capitation and similar managed care contracts. These organizations are designed to achieve alignment between hospitals and physicians on payment issues without otherwise affecting their autonomy. However, in many cases, inter-organizational agreements will still be needed for services delivered by home health care providers and other post-acute care providers.

OPTION 2.1.5: A specific agreement for the division of payments between a hospital and the physicians involved in the care of patients covered by episode-of-care payment (as well as with any other providers involved in delivering care).

Since episode-of-care payments may, particularly in the short run, only involve a subset of physicians, a traditional PHO may not be necessary if a hospital and the affected physicians can work out an appropriate agreement for dividing payments. More limited arrangements, sometimes called "Provider Specialty Alliances" (PSAs), could provide the more limited arrangements needed.

OPTION 2.1.6: A new intermediary organization, with representation from physicians, hospitals, and other providers included in the bundled payment, created specifically to manage bundled payments.

Physician-hospital organizations only cover a subset of providers – the hospital and physicians – that are involved in a full episode of care (and possibly not all of the physicians). Dealing with fully-bundled payments may require the creation of new intermediary organizations that have representation from the full range of providers involved (or potentially involved) in episodes.

OPTION 2.1.7: An integrated delivery system that includes the full range of services and providers included in the bundled payment.

As noted earlier, while this might seem to be the ideal recipient of a bundled payment, only a small proportion of patients use such systems. Moreover, even in an integrated system, changes in existing compensation systems might still be needed to reflect the incentives provided under the new, bundled payment system.

OPTION 2.1.8: Any organization that is willing to accept accountability for delivery of the complete range of services needed in an episode of care in return for a bundled payment.

The creation of bundled episode-of-care payments may create opportunities for entrepreneurs to form new organizational structures to package and market services provided by multiple providers.

ISSUE 2.2: What Intermediate Steps Should Be Taken to Facilitate the Transition to Bundled Payments and Warranties?

Although bundled payment is viewed by many as a desirable goal, even its own supporters see it as such a dramatic change from current payment systems and current processes for interaction among providers that transitional strategies may be needed.

For example, MedPAC (the Medicare Payment Advisory Commission), in its June 2008 *Report to the Congress: Reforming the Delivery System*, discussed the issues around bundled payment for hospitalizations at length (see Chapter 4, "A path to bundled payment around a hospitalization," www.medpac.gov/chapters/Jun08_Ch04.pdf). In its findings, the Commission said "bundling Medicare payment to cover all services associated with an episode of care has the potential to improve incentives for providers to deliver the right mix of services at the right time." But the Commission went on to say, "Although this approach holds great potential, the Commission recognizes the complexity associated with bundled payment," and then recommended an incremental approach involving (1) reporting readmission rates to both hospitals and physicians; (2) reducing payments to hospitals with high readmission rates, allowing shared accountability between physicians and hospitals, and exploring "virtual bundling" (i.e., paying providers separately, but including rewards or penalties based on the aggregate spending of all providers in a complete episode); and (3) establishing pilot programs to test the feasibility of bundled payment.

Figures 10 and 11 suggest that there are implicitly a series of discrete steps and tasks that must be taken to create a fully bundled episode-of-care payment:

1. Creating a case rate (i.e., a single fee for all services provided during the episode) for *each provider* in each phase of an episode of care, e.g., paying *each* physician a single fee for a patient's hospital stay, not just surgeons;
2. Including a *warranty* in each provider's case rate, e.g., including the hospital costs of any related hospital readmissions in the hospital's DRG payment, including the physician fees for a hospital readmission in the physician's case rate, etc.;
3. *Bundling* case rates for all providers in a particular *phase* of an episode of care, e.g., paying a single fee to both the hospital and physicians managing the hospital stay;
4. Combining the case rates for *all phases* of an episode, e.g., paying a single fee for both inpatient and post-acute care.

Each of these steps involves a number of important tasks; a partial list of these tasks is shown in Figure 14. For example, an effective case rate system for any individual provider requires having an appropriate severity/complexity adjustment system, since a patient with a more serious condition and/or complicating factors will require more time, effort, and/or expense from that provider.

STEP	TASKS TO BE PERFORMED
Creating a Case Rate for a Single Provider	• Establishing an appropriate case rate for a type of patient • Defining a severity/complexity adjustment system • Providing protections against inappropriate under-utilization • Making adjustments for low-volume, special cost providers • Discouraging cost-shifting to/from other providers • Establishing a stop-loss system for unusually high-service cases
Adding a Limited Warranty to a Provider's Case Rate	• Defining the limits of the warranty • Determining the achievable rate of errors and adverse events • Determining the cost of errors and adverse events
Bundling Case Rates for Multiple Providers in the Same Phase	• Determining the recipient of the bundled payment • Establishing a system for dividing the payment among providers • Providing protections against under-service
Creating a Combined Case Rate For All Phases of an Episode	• Determining the recipient of the combined payment • Establishing a system for dividing the payment among providers in different phases

Figure 14

Although all of these steps and tasks are needed to implement a fully bundled episode-of-care payment structure, each of the steps individually addresses a portion of the problems with the current unbundled, mixed fee/episode-of-care payment structure. Consequently, it may make sense to pursue the steps individually as a transitional process for getting from the current payment structure to a fully-bundled structure.

The following are potential options for intermediate steps along the path to fully bundled payment structures.

OPTION 2.2.1: Pay non-surgeon physicians in hospitals on a case rate basis for patients in major DRGs.

Paying physicians on an episode of care or case rate basis is not a new concept for all physicians. Surgeons are routinely paid this way, and nephrologists are paid this way by Medicare for care of End-Stage Renal Disease (ESRD) patients. Most other physicians are not paid this way, however. Episode payments could be established for other physicians for hospital-based medical procedures.

OPTION 2.2.2: Establish financial rewards for hospitals and physicians that reduce hospital readmissions (or penalties for those that do not).

From a patient's perspective, an important negative aspect of their overall episode of care is a need to return to the hospital for additional care related to the condition that led them to be hospitalized in the first place. In most cases, these readmissions generate additional payments to both hospitals and physicians. One way to introduce the notion of a "warranty" is for hospitals and physicians to accept some or all of the financial responsibility for readmissions. (Since readmissions may be due to factors that are controlled by both hospitals and physicians, this may set the stage for creating a "bundled warranty.")

OPTION 2.2.3: Remove restrictions on gain-sharing between hospitals and physicians for efforts to improve efficiencies in hospital care.

There is little practical difference between (a) a hospital and physicians jointly accepting a bundled payment and having arrangements for dividing it, and (b) a hospital and physicians accepting separate payments but having arrangements for sharing portions of those payments with each other. In this light, gain-sharing arrangements represent a potential step toward arrangements for dividing bundled payments.

Currently, there are tight federal restrictions on gain-sharing arrangements involving Medicare or Medicaid patients, so these restrictions will also affect the ability to do bundled payments. The Civil Money Penalty provisions of the federal law governing Physician Incentive Plans prohibit a hospital from knowingly making a payment to a physician as an inducement to reduce or limit services to Medicare or Medicaid beneficiaries. The Office of Inspector General (OIG) has approved waivers under the law on a case-by-case basis for programs that meet a number of criteria, particularly those where the specific cost saving expected will have no adverse effect on patient care (e.g., an agreement by all surgeons to use a particular medical device). In addition, the Stark Law prohibits a physician from making referrals for health services paid by Medicare or Medicaid to entities where the physician has a financial relationship.

Rather than forcing each bundled payment arrangement to seek special approval from the OIG and CMS to ensure that the providers will not be vulnerable under these laws, changes could be made in the laws to create explicit authorizations for bundled payment arrangements that meet specific tests (e.g., avoiding more narrowly defined situations for undesirable payment division arrangements, such as those discussed under Issue 2.3 below).

OPTION 2.2.4: Give preference to providers that provide warranties on their care.

Geisinger Health System in Pennsylvania has received national attention for its ProvenCare system that provides a warranty on certain kinds of procedures (see the earlier discussion in Section II). Payers and patients could give preference to hospitals, physicians, and other providers that offer such warranties, by using them more frequently or giving favorable payment arrangements.

OPTION 2.2.5: Provide rewards and/or penalties to all providers involved in an episode of care, based on the total cost of the episode relative to regional or national averages.

Under a bundled episode-of-care payment structure, all providers involved in an episode are jointly at risk if their collective costs exceed the amount of the payment for the episode, which in turn provides an incentive for them to jointly find ways to control those collective costs. This incentive can be simulated without actually providing a bundled payment if the payer computes the total billings of all of the providers and then issues rewards or imposes penalties on each the providers based on the extent to which the total billings were lower or higher than a target amount for total payment. (For example, a simple version of this would be to reduce or increase each provider's fees in the episode by the percentage that their collective billings exceeded a target amount, thereby limiting the payer's total payment to the target amount.) This "virtual bundling" avoids the need to define a separate organization to receive a single payment and divide the payment among the providers, but it also eliminates the ability for the providers to define their own, customized approach to that division.

OPTION 2.2.6: Bundle hospital and surgeon payments for surgical procedures.

Since both hospitals and surgeons are already paid on a case rate/episode of care basis, surgical procedures are "closer" to a fully bundled case rate payment structure than medical procedures are. This is likely why most past and current bundled-payment demonstrations have focused on surgical procedures.

OPTION 2.2.7: Bundle hospital and post-acute care payments for major DRGs.

Similarly, Medicare currently pays both hospitals and post-acute care providers separately on an episode-of-care basis, so both sets of providers are already experienced in managing case-rate payments. A next step could be to combine both payments into a single bundled payment.

ISSUE 2.3: What Restrictions, If Any, Should Be Placed on the Way Bundled Payments Are Divided Among Individual Providers?

The goal of bundled payments is to encourage better quality care, more coordinated care, and more efficient care by removing the undesirable incentives of current payment systems and creating a payment structure that encourages those goals. However, the flexibility to divide up payments could also potentially incentivize undesirable behaviors by the providers involved. For example, MedPAC's June 2008 *Report to Congress* identified several undesirable responses which might result from bundled payments for hospitalization episodes:

- Hospitals might choose to reward physicians who initiate hospital admissions, particularly for conditions that are relatively generously reimbursed. (As noted in Section II, while condition-specific capitation payments provide incentives to control the number of episodes of care a patient experiences, episode-of-care payments only provide incentives to control costs within an episode, and so under an episode-of-care payment structure (bundled or not) a provider will still have incentives to increase the number of episodes of care it provides.)

- Financially stronger hospitals might provide more generous sharing arrangements with physicians, making it more difficult for other hospitals to retain top-quality physicians.
- Either physicians or hospitals might choose to provide inappropriately low levels of services in order to reduce costs and increase their profits, or to avoid patients with high service needs within a severity-adjustment category.

Potential options for discouraging these undesirable behaviors include:

OPTION 2.3.1: **Prohibit bundled-payment recipients from rewarding physicians based on the rate of admissions to the hospital or facility involved in the bundled payment.**

OPTION 2.3.2: **Limit the ability for providers to divide bundled payments in ways that result in unusually high or low payments to some providers, or that result in some providers being paid below accepted estimates of minimum costs for quality care.**

OPTION 2.3.3: **Establish penalties for recipients of bundled payments which have unusually high rates of utilization of services.**

OPTION 2.3.4: **Establish quality monitoring and incentive programs to discourage limiting services.**

See Section IV-B for a more detailed discussion of protecting patients against inappropriate reductions in services.

OPTION 2.3.5: **No restrictions should be placed on the way payments are divided.**

It may be desirable to require reporting on the way payments are divided, so that if unusual payment divisions are detected, they can be examined and a determination made as to whether new restrictions should be established.

IV. Ensuring Quality and Controlling Costs

As described in Sections I and II, current healthcare payment systems have a number of problems that discourage high quality, efficient care for patients. Some of the most important of these problems include:

- Fee for service payment systems reward providers for providing more services, even if they are unnecessary or of low value, or if they are needed because of adverse events caused by the provider. Indeed, fee for service payment systems usually financially penalize providers for keeping patients healthy.
- Current fee for service systems generally do not pay adequately (or at all) for many elements of primary care and preventive care, particularly for the more complex care issues associated with the elderly and other people with chronic conditions.
- Payment systems reinforce fragmentation of care by paying multiple providers for elements of the same episode of care for the same patient, regardless of whether the care is coordinated or duplicative.

The episode-of-care and condition-specific capitation payment systems described in Section II are intended to solve these problems by giving providers the flexibility to determine what services are needed and the most effective, efficient way of delivering them, by reducing the rewards for providing more services and increasing the rewards for keeping patients healthy, and by providing the ability and incentive for providers to coordinate their care.

However, while a better payment system *structure* may be *necessary* for delivering improved value in health care, it will not be *sufficient*, for at least three reasons.

Price-Setting

First, as noted in Section II, the episode-of-care and condition-specific capitation payment structures define *what* is paid for and *how* it is paid for, but not *how much* is paid. If that payment amount is higher than necessary to deliver quality care, then (a) costs will be higher than necessary, and (b) the incentives for value in the payment structure will be less powerful, since there is "room" in the high payment level to accommodate inefficiency. If the payment level is too low, it may force providers to reduce care below minimum levels.

As described in Section II, the traditional methods for price-setting have been either regulation (the approach used by Medicare for hospitals, physicians, and other providers) or negotiation (the approach typically used by commercial payers). These methods can still be used in conjunction with new payment structures, but doing so will also likely perpetuate problems that exist under current payment structures, including:

- Payment rates may be set at levels which are far below or far above the costs that the most efficient, effective providers can achieve. Payment rates that are too low can result in problems accessing care (e.g., the current shortage of primary care providers is likely due in part to the low payment rates for primary care physicians relative to specialists), and payment rates that are too high can encourage over-provision of services.

- Underpayment by one payer can result in cost-shifting to other payers, particularly those payers with the smallest market share. Uninsured individuals can be particularly harmed by having to pay "full charges" rather than the discounted rates available to larger payers.

There is considerable interest in using more market-based approaches to price-setting (i.e., determining the common amount that the provider expects to receive and the payer will pay), and particularly in engaging consumers more directly in choosing providers and services based on value. These approaches would appear to be facilitated by having prices defined at the episode or condition level, rather than at the narrow service level. But in addition, improved mechanisms will be needed for making consumers sensitive to price differences between providers and services, and helping them make good choices among providers and services based on value, not just price.

Utilization Control

As described in Section II, health care spending is a function of both utilization and prices. Even if one successfully encourages lower prices and higher value for individual services, if the utilization of those services increases unnecessarily, health care spending will increase, and overall value will decrease. The current struggles in Congress with the Sustainable Growth Rate formula for physician payment under Medicare are a reflection of what happens if one tries to control spending through pricing alone.

Episode-of-care payment and condition-specific capitation provide much stronger incentives for providers to control utilization than do current payment systems. But utilization is determined not just by providers, but by patients. For many conditions, there is no absolute "right way" to provide care, and for these "preference-sensitive conditions," patient preferences as well as provider expertise will determine what is actually delivered. The failure of many past managed care programs was due in significant part to both patients' and providers' objections to having health care providers serve as cost-driven gatekeepers.

Moreover, in many cases, the existence or severity of a patient's condition is not a purely random, uncontrollable event (the type for which insurance is really designed), but is influenced significantly by the patient's own behaviors (and a health care provider's ability to educate and convince a patient to choose those behaviors wisely). Even the effectiveness of treatment for a condition, once it is manifested, can depend significantly on the patient's own behavior as well as on the skills of the health care provider delivering care.

Patient Protection and Assistance

Although episode-of-care and condition-specific capitation payment structures provide much better incentives to reduce overuse and misuse of health care, they may increase the incentives for underuse of care. One of the major objections to traditional capitation systems has been that they encourage providers to “deliver as little care as possible to as many patients as possible.” Although the use of severity-adjustment systems and the focus on specific conditions or episodes reduces these incentives, they are still greater than under current fee-for-service payment structures.

In addition, many patients may need assistance in making appropriate choices about their lifestyles and health care in order to improve their health. Although there is a rapidly growing array of information resources available to assist patients, some patients, such as those with language barriers, cultural differences, learning disabilities, income limitations, etc. will have greater difficulty than others in accessing and utilizing these resources.

A number of specific issues associated with patient choice, patient protection, and provider competition are explored in more detail in the following subsections.

A. Encouraging Use of Higher-Value Providers and Services

It seems clear that in order for payment systems to be successful in controlling utilization and encouraging competitive pricing, patients need to play a more central role than they do today. There are at least three major issues that need to be addressed:

1. **Choosing higher-value providers for a particular service.** In some ways, the simplest scenario is when it is clear that a patient needs a particular type of care, and there are multiple providers who can provide that care. To the extent that those providers differ in value, it would be desirable to have patients receiving their care from the higher-value providers rather than the lower-value providers. How can this best be accomplished?
2. **Choosing higher-value services.** For many conditions, though, there are choices as to which type of care is selected, and the alternatives differ in terms of their effectiveness and their cost. It would be desirable to have patients receiving higher-value alternatives rather than lower-value alternatives (as well as selecting the higher value providers of the higher-value alternatives). How can this best be accomplished?
3. **Dealing with limited choices in local markets.** Even if there are strong incentives for choosing higher-value providers and services, the impact of those incentives will be more limited in regions with fewer health care providers, since patients there will have fewer choices than do patients in regions with more health care providers. What can be done in regions with limited choices?

ISSUE 3.1: How Should the Use Higher-Value Providers and Care Systems Be Encouraged?

A variety of mechanisms have been used to encourage the use of higher-value providers and care systems. These generally fall into three categories:

1. **Inclusion/Exclusion:** Selection of a subset of providers to be part of a health insurer's "network," and making it easier or cheaper for patients to use those providers.
2. **Information:** Publishing information about the relative quality, cost, or both of different providers.
3. **Financial Incentives:** Creating financial incentives for consumers to use higher-value providers.

The first is the most common approach that has been used by payers, but it represents a very crude approach, since a provider has to be either "in" or "out," even if they may differ in value from other providers by a small amount, and even if they adjust their prices or quality to improve their value within the current year. Moreover, the ability to use this approach can be affected by "any-willing-provider" (AWP) laws and "freedom-of-choice" (FOC) laws in different states. AWP laws require health insurance plans to accept any qualified provider who is willing to accept the terms and conditions of the health insurance plan, and FOC laws require health insurance plans to pay for services even if consumers choose providers that have not contracted with the health insurance plan (see, for example, Fred J. Hellinger, "Any-Willing-Provider and Freedom-of-Choice Laws, *Health Affairs*, Volume 14, Number 4, 1995; Michael A. Morrisey and Robert Ohsfeldt, "Do 'Any Willing Provider' and 'Freedom of Choice' Laws Affect HMO Share," *Inquiry*, Winter 2003/2004, pp. 362-374).

The ability to use the second and third categories depends, among other things, on the availability of good information about the value delivered by providers. Since "value" is the combination of both quality and cost, this in turn depends on having good information on both of those factors. In addition, appropriate mechanisms are needed to encourage consumers to use the providers that are shown to be of higher value.

Information on Cost/Price

In an effort to encourage use of lower-cost providers, some systems have compared providers based on their overall average cost of services, with the averaging done across the full range of patients they care for and the full range of services they provide, and then given incentives to patients to use providers with lower averages. Even if these averages are adjusted to reflect differences in the types of patients each provider cares for, any provider may deliver low value in one set of services and high value in another set of services, so encouraging patients to choose providers based on these kinds of overall averages may or may not encourage use of the highest value providers for a particular condition.

Consequently, it makes more sense to compare the relative value of alternative providers in delivering care to address a *specific condition*. However, under current payment systems, most providers do not have a clear, single "price" for all of the care associated with a particular episode for a patient. They may have prices for individual *services*, but not for the entire episode of care (in the case of acute episodes) or for all of the care over a particular period of time (in the case of chronic diseases).

Although prices can be imputed retrospectively using episode grouping software and other techniques and then reported publicly, these methods inherently report on value *in the past*, rather than in the present; a provider which has lowered its costs subsequent to the period measured in the retrospective analysis will not be able to easily signal that fact to the market, while a provider which had low costs in the past could raise its prices in order to reap windfall profits from consumers who choose that provider in the mistaken belief that it still has higher value today.

Episode-of-care payment and condition-specific capitation payment systems can solve this by having providers establish a single, prospectively-defined price for the full set of care that a patient needs for a condition, making it easier for consumers/patients to compare providers on that dimension.

An important challenge that arises in comparing providers on cost or price is that some providers may have higher costs for socially desirable reasons that are unrelated to the costs of caring for individual patients. For example, academic medical centers and other teaching hospitals incur greater costs than community or non-teaching hospitals simply due to the additional personnel and time associated with teaching. Even if quality is the same, a teaching facility will be more expensive than a non-teaching facility, and if patients are encouraged to use lower-cost facilities, it could jeopardize the ability of teaching hospitals to train new generations of physicians and other health care professionals. Medicare explicitly computes the portions of its hospital DRG payments that are attributable to medical education, but commercial payers generally do not. Some states, such as Minnesota, have established a separate community-wide mechanism for paying for medical education, but other states have not. Similar issues arise with rural hospitals, inner-city providers, etc. that must incur higher costs for serving low patient volumes, providing greater security, caring for more uninsured patients, etc.

Information on Quality

The measurement of the quality component of value has a different set of challenges. First, there generally is no single measure of "quality" for an episode of care. Second, the ability to measure quality is affected by the size and number of providers involved in the episode of care. For measurement purposes, the ideal is to have a single provider caring for a large number of patients with similar conditions throughout their full episode of care, since (a) the provider will have a large enough volume of cases to avoid small-sample statistical variations, (b) the quality measures can be obtained from a single source, and (c) the outcomes can be attributed to that single provider. As a result, the ability to measure quality will depend on the size and organizational structure of the providers participating. (See the issues and options in Section III regarding the size and organizational structure of providers.)

Many payers have recently come under attack for systems that they have created to compare physicians, and a number of states have taken action, either administratively or legislatively, to control the ways that providers are compared. To address this, the Consumer-Purchaser Disclosure Project (www.healthcaredisclosure.org) developed a comprehensive national agreement with leading physician groups and health insurers called the *Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs* that establishes principles to guide how health plans measure doctors' performance and report the information to consumers.

An important concern about quality measurement systems is whether they create unintentional incentives for providers to avoid certain types of patients who are more difficult to care for and may have a higher probability of high costs and/or poor outcomes. Although severity/risk adjustment systems are intended to address this problem by controlling for differences in the types of patients that providers care for, these systems may not control for all relevant factors.

Ranking and Tiering

If information on the relative cost and quality of different providers is available, how should it be reported in a form that is most usable for consumers? A simple ranking of providers from "highest value" to "lowest value" requires combining the cost and quality information into a single measure of value, and there is no generally accepted methodology for doing that. (Although many people often glibly refer to measuring value by "dividing quality by cost," this presumes that quality is measured on a scale that is comparable to dollars. For example, if one provider has twice the mortality rate as another, but charges half as much, not everyone would agree that they have identical value.)

In addition, if there are a large number of providers to choose from, there may be relatively small differences in the cost and/or quality measures between any two of them, and the differences in the quality measures may be due to random statistical variations, rather than genuine differences in the quality that an individual patient will experience, particularly on a prospective basis.

This has led to the use of systems for "tiering" providers, i.e., grouping providers together with similar, but not identical, quality and/or cost. The smaller the number of tiers, the more variation in quality and/or cost that is allowed to exist inside of a tier with no formal recognition of the difference. This means that providers who have the lowest cost or highest quality within a tier may not be rewarded for being better than the providers who have the highest cost or lowest quality within the same tier. This, in turn, likely creates an incentive for each provider to stay "just inside" the tier, which in turn means they will deliver lower quality and/or higher costs than they are capable of producing.

Consumer Cost-Sharing

Once information on quality and price is collected and made available to consumers in a usable form, how should consumers be encouraged to use the higher value providers?

Co-payments for services (i.e., flat amounts that a patient pays for a service) do not provide any incentive for consumers to use higher-value providers over lower-value providers, since the co-payment is the same regardless of which provider is used. Indeed, to the extent that patients perceive that higher price implies higher quality (even if the quality data indicate otherwise), co-payments could actually encourage use of higher-cost providers.

Co-insurance for services (i.e., where the patient pays a percentage of the price of the service) do provide an incentive for consumers to use lower-cost providers, since their outlay will be higher if they use a higher-cost provider. However, the strength of the incentive depends on the magnitude of the co-insurance percentage and also on the difference in the price of alternative providers relative to the price of the lowest cost provider. If the co-insurance percentage is small, then the incentive for the consumer to use the lower-price provider is also small, since the insurer is still paying for the vast majority of the difference.

Although raising the co-insurance percentage significantly does increase the incentive to use the lower-price provider, it also means that the consumer will be paying much more to use the service, even from the lower-price provider. This may deter the consumer from using the service at all, which may not be the desired outcome.

Co-payments and co-insurance levels can be made to vary for different providers if the payer has a mechanism for classifying providers into tiers. (A simple version of this approach is used routinely in Preferred Provider Organization (PPO) plans, which require patients to pay higher co-payments and/or co-insurance levels for care received from out-of-network providers than from in-network providers.) Although this increases the incentive for consumers to use the providers eligible for the lower co-payment/co-insurance levels, the choice of those different levels is inherently arbitrary.

Deductibles also provide an incentive for consumers to use lower-cost providers, at least for services that have relatively low prices. With a deductible, the patient must pay the full cost of services until their total spending reaches the deductible amount, then their insurance begins to cover all or a portion of the cost of services after that point. Before the consumer reaches the deductible, they have an incentive to use a lower-price provider if the provider's price is less than the deductible. But for any service that costs, in total, more than the deductible amount, the consumer will pay the same amount regardless of any difference in price between two providers, which eliminates the incentive to use the lower-price provider. (For example, suppose a consumer has a $10,000 deductible and needs hospital care. Two providers are available, one of which charges $15,000 for the care and another charges $20,000. The consumer pays $10,000 regardless of which provider is chosen, and any further difference will depend on whether the consumer is required to pay co-insurance on the total amount.) A variation on this option is the "high deductible health plan" with a "personal care account." Although the individual has a high deductible amount, he or she also receives a fixed amount of money that can be used to pay for services. Once that account is exhausted, then he or she pays for the total cost of services out of their own pocket until the deductible is reached.

All of these three options – copayments, co-insurance, and deductibles – require the consumer to pay all or a portion of the “first dollar” that the provider charges. In contrast, a fourth option is to make the consumer explicitly responsible for all or a portion of the “last dollar,” i.e., the *difference in prices between higher-cost and lower-cost providers*. For example, as shown in Figure 15, in addition to any normal co-payment or co-insurance amount that the consumer would pay (“Consumer Share #1), they could be charged a second amount based on the

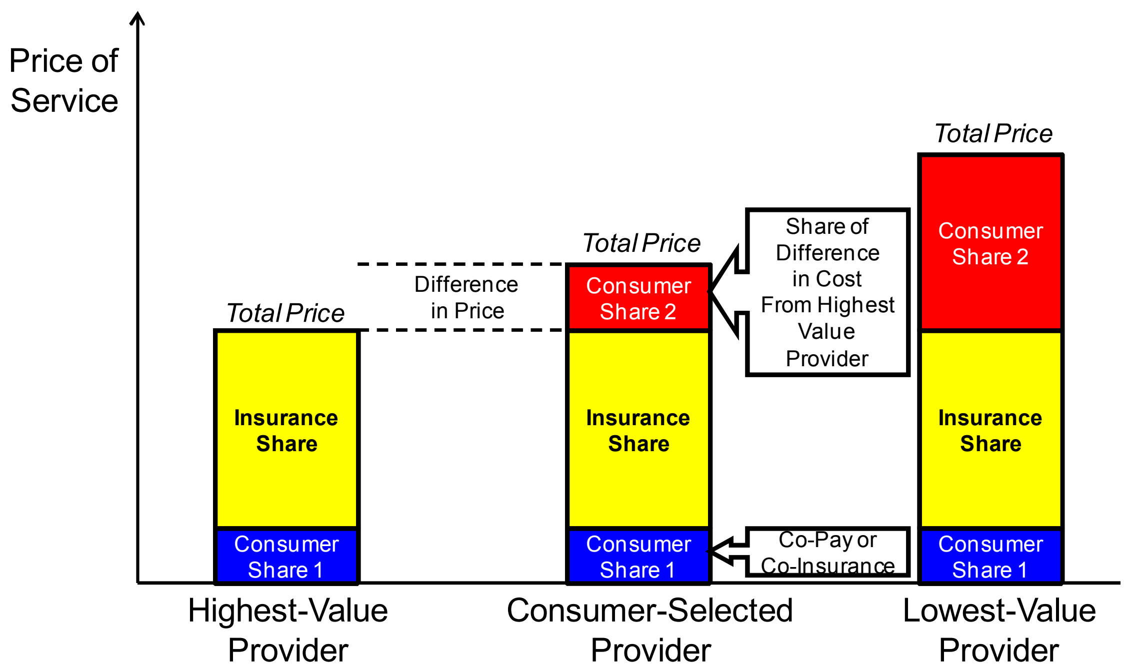

Figure 15

difference in price between the provider they select and the lowest-price provider (Consumer Share #2).

Although Figure 15 shows the consumer being responsible for the *full* amount of the difference in price between their selected provider and the highest-value provider, they could be made responsible for only a *proportion* of the difference.

This approach allows the two different consumer-share amounts to be set based on the goals each is best able to influence:

- Consumer Share #1 (the co-payment or co-insurance amount) can be set based on the necessity or value of the underlying service, regardless of who provides it. For example, a preventive service that has a high return on investment in terms of avoiding more expensive services later can be given a low or zero co-payment or co-insurance amount, without affecting the incentive provided by Consumer Share #2 to use higher-value providers or services.
- Consumer Share #2 (the proportion of the difference in price from the highest-value providers) can be set based on (a) the clarity of the information about quality and (b) the capacity/availability of high-value providers. If there are believed to be differences in the quality of providers that are not captured in

the published quality data, then it may be viewed as unfair to charge patients the full difference in price between two providers, when some of that price difference could reflect unmeasured differences in quality. Similarly, if there are a limited number of providers available that charge the lowest prices, it might be viewed as unfair to charge patients for the full difference in price when they may not be able to actually get access to the lowest-price providers.

The fourth option can be used with or without tiering providers. However, if tiers are not used, it may be appropriate to set the "floor" for the computation of Consumer Share #2 at a price that is reasonably available to a large number of consumers, rather than an unusually low price offered by a single provider with limited capacity.

All of these various factors must be considered in evaluating the following options for addressing Issue 3.1. These options are neither exhaustive nor mutually exclusive; for example, the choice about the number of tiers (Options 3.1.4 and 3.1.5) can made separately from the choice about the magnitude of consumer cost-sharing (Options 3.1.6 and 3.1.7).

OPTION 3.1.1: Provide better information to consumers on the relative value (quality and cost) of different providers for equivalent services.

There is some evidence that merely publishing information on the quality and cost of providers encourages providers to improve their quality and encourages consumers to use higher-quality providers. There has been relatively little public information on the comparative costs of providers, so the impact of publicizing this information is unclear, but unless consumers are given more responsibility for paying the differences in costs, the impact of information alone is likely to be limited.

OPTION 3.1.2: Group providers into cost/quality tiers and inform consumers about the tiers that providers are in, but do not vary consumers' costs based on which provider they choose.

Whereas Option 3.1.1 provides a lot of flexibility about how much information is presented, Option 3.1.2 explicitly contemplates creation of a ranking/tiering system.

OPTION 3.1.3: Exclude low-value providers from insurance coverage or require consumers to pay the full cost for using the lowest-value providers.

This approach is similar to the traditional "network inclusion" decision by health plans, but it could be more explicitly made based on quality and cost measures. Although conceptually identical, excluding providers may be perceived by consumers as "limiting choice," whereas allowing consumers to use a provider but making them pay full price might not.

OPTION 3.1.4: Group providers into a *small number* of broad cost/quality tiers, and require consumers to pay a portion of the difference in cost for using a provider in a higher-cost tier.

OPTION 3.1.5: Group providers into a *large number* of cost/quality tiers, and require consumers to pay a portion of the difference in cost for using a provider in a higher-cost tier.

As noted above, the fewer the tiers, the less reward there is for providers to exceed the minimum value in a particular tier.

If consumer cost-sharing is in the form of co-insurance (i.e., a percentage of the cost of the care) vs. co-payment (i.e., a fixed amount), then providers are, in effect, automatically tiered on the basis of cost, since a consumer will pay more if a provider charges more, even if the difference in cost is small or if the provider is in the same tier as a lower-cost provider.

OPTION 3.1.6: **Require consumers to pay a *small portion* of the difference in cost for using a provider in a higher-cost tier.**

OPTION 3.1.7: **Require consumers to pay *all or most of the difference* in cost for using a provider in a higher-cost tier.**

As noted above, if there are believed to be differences in the quality of providers that are not captured in the published quality data, then it may be viewed as unfair to charge patients the full difference in price between two providers, when some of that price difference could reflect unmeasured differences in quality. Similarly, if there are a limited number of providers available that charge the lowest prices, it might be viewed as unfair to charge patients for the full difference in price when they may not be able to actually get access to the lowest-price providers.

OPTION 3.1.8: **Tier all types of providers together, and create separate methods of paying providers for special costs that may be unrelated to the cost of caring for individuals, e.g., the additional costs of medical education, the additional costs of providing service in low-income or rural areas, etc.**

OPTION 3.1.9: **Tier different categories of providers separately, e.g., tier academic medical centers separately from community hospitals.**

OPTION 3.1.10: **Require individual providers to join comprehensive systems of care, group the systems of care into tiers, and require consumers to pay a portion of the difference in cost for using a higher-cost system of care.**

Options 3.1.1 and 3.1.2 presume that providers have sufficient size to be measured accurately on quality and that they have the skill and capacity to accurately price individual services. As discussed in Section III, current providers may not meet these criteria. Option 3.1.10 contemplates the creation of organizational structures that can be more appropriately tiered for consumer choice.

ISSUE 3.2: How Should the Use of Higher-Value Treatments/Services for Preference-Sensitive Care be Encouraged, and the Use of Unnecessary Care Be Reduced?

The opportunities and challenges for encouraging use of higher-value treatments/services and for reducing use of unnecessary services are similar in many ways to those associated with encouraging use of higher-value providers. Conceptually, there are four types of approaches which can be used:

1. **Inclusion/Exclusion:** Exclusion of some types of treatment or services from coverage under a health insurer's plan.
2. **Information:** Publishing information about the relative quality, cost, or both of different treatments/services, and/or publishing information about a providers' utilization of services relative to other providers.
3. **Financial Incentives for Consumers:** Creating financial incentives for consumers to use higher-value treatments/services and to reduce use of unnecessary or low-value services.

4. **Financial Incentives for Providers:** Creating financial incentives for *providers* to use higher-value treatments/services. The way in which this fourth approach is structured depends on the way n which the payment to the provider varies depending on which treatment/service is used. Some approaches to severity adjustment will place a patient in different payment categories depending on which treatment approach is used; others may not. For example, does a provider get paid the same amount for childbirth regardless of whether vaginal delivery or caesarian section is used, or does the choice of caesarian section move the patient into a higher payment level? The former incorporates a natural incentive for the provider to limit unnecessary use of caesarian sections, while the latter does not.

Value-Based Benefit Design

The recent interest in "value based benefit design" has derived from the recognition that patient cost sharing, if indiscriminately applied, may reduce expenditures in one area or in a short term timeframe, but increase expenditures in another area or in the long run. For example, if patients are discouraged by high copayments or coinsurance from using pharmaceuticals that can prevent hospitalization, the total costs of care may increase, even though the payer outlays for the pharmaceuticals alone will be lower. (It is important to note, though, that even if the cost of the pharmaceutical is lower than the cost of a hospitalization for the patient who is hospitalized, when the rate of hospitalization is low and the cost of the drug is high, increased spending on drugs across an entire patient population may not be offset by reduced expenditures on hospitalizations.)

Measuring and Evaluating Relative Value

As with the choices of providers, the ability to encourage the use of higher-value treatments and services depends on the availability of good information about the relative value associated with the alternative. Since "value" is the combination of both quality and price, this in turn depends on having good information on both of those factors.

The most common use to date of incentives to encourage use of higher-value treatments has been with generic drugs. Health plan benefit structures routinely charge consumers more for non-generic drugs than for generic drugs, and some pay-for-performance systems reward doctors if their patients have higher rates of using generic drugs. These initiatives have generally resulted in significant shifts toward use of generic drugs and significant savings for payers.

However, generic drug incentive programs are premised on the fact that generic drugs have been officially determined to have "equivalent quality" to their brand-name counterparts, so the relative value of a generic vs. brand-name drug is easy to compute based on the relative price. In contrast, for most types of drugs, devices, and services, there will be differences in the quality or effectiveness as well as differences in cost, making the value tradeoffs more complex. (Even for generic drugs, perceived and actual differences in the quality of production and method of action cause concerns that the difference in value is lower than the difference in price alone would indicate, and indeed, few payers either prohibit the use of non-generic drugs or require consumers to pay the full difference in cost between generics and their brand-name equivalents.)

If information on relative value is to be used more widely, more extensive efforts to generate that information will be needed.

Patient Education and Shared Decision-Making

Because of the complexity of the tradeoffs between quality and cost, many patients will not be willing or able to make the choice about which treatment or service to use (or whether to have treatment at all) without significant education and assistance, including the input of a physician or other health care provider. Studies have shown that when health care providers inform patients about the alternatives and tradeoffs in preference-sensitive care, they are more likely to use more cost-effective alternatives. However, this requires extra time and skill on the part of the provider to engage in this process; this time may not be compensated adequately under the current fee-for-service system, and even under an episode-of-care payment structure, there will not be a financial incentive for the provider to engage in this discussion if the provider's payment changes in proportion to the service or treatment chosen.

Aligning Provider and Patient Incentives

Shared decision-making between providers and patients will likely be more effective if the financial incentives for both are aligned. If a provider has an incentive to provide more or higher cost services, as exists today under the fee-for-service system, then the information given by that provider to patients may be biased. But even if the payment structure is changed so that the provider has a financial incentive to pursue lower-cost treatment options, if the patient does not have similar incentives, then the patient will inherently be suspicious if the provider recommends a lower cost treatment. Similarly, even if providers are given financial incentives to encourage the use of preventive care, provide patient education, etc., their ability to achieve success will be lower if patients do not have comparable incentives to adhere to the provider's recommendations.

All of these various factors must be considered in evaluating the following options for addressing Issue 3.2. These options are neither exhaustive nor mutually exclusive.

OPTION 3.2.1: Provide better information to consumers and providers on the relative value (quality, cost, and satisfaction) of alternative treatments/services.

Although most providers and consumers are routinely exposed to information on the *clinical* effectiveness of treatments and services, they are less likely to be given information about the relative *values* (i.e., cost-effectiveness) of alternative treatments and services.

OPTION 3.2.2: Require consumers to pay a *portion* of the difference in cost of alternative treatments/services that have *differing* effectiveness.

Charging consumers for the *full* difference in cost between alternatives with differing effectiveness implies that the lowest-cost alternative has the highest value, when it could be that the lowest-cost alternative also has the lowest effectiveness. In contrast, charging consumers *nothing* for the difference in costs implies that they all have the same value, when some may provide little additional value for their higher cost.

OPTION 3.2.3: Require consumers to pay the *full* difference in cost between alternative treatments/services of *equivalent* effectiveness.

In those cases where there is strong evidence that two alternatives are equivalent in effectiveness, the difference in value between the two is identical to the difference in cost.

OPTION 3.2.4: Reduce or eliminate consumer cost-sharing for treatments/services demonstrated to significantly reduce hospitalizations or use of other high-cost services.

OPTION 3.2.5: Provide financial support or incentives to providers for involving patients in shared decision-making processes about treatments and services.

OPTION 3.2.6: Provide incentives to both patients and providers to use shared decision-making tools.

OPTION 3.2.7: Provide financial incentives to consumers for improving their health status (through whatever means, not just services from health care providers).

Rather than providing incentives on a treatment-by-treatment basis, an alternative would be to incentivize consumers based on overall outcomes, i.e., their overall health status. A variety of mechanisms have been proposed or used for encouraging consumers to maintain or improve their health. (See, for example, *Consumer Financial Incentives: A Decision Guide for Purchasers*, Agency for Healthcare Research and Quality, November 2007.)

ISSUE 3.3: How Can Lower Costs Be Encouraged in Consolidated Or Underserved Markets?

The options discussed previously presume that there are, in fact, choices of providers and/or services available to consumers in their local market. However, this may not be so. At least two distinct types of situations can lead to limited choice in a particular market:

- A market may be too small to support multiple providers or it may have other characteristics that make it unattractive for providers. For example, a rural area may simply have too few patients to support multiple providers or certain kinds of services, and an inner-city area may be viewed as too dangerous by many providers.
- Even if the market is large enough and desirable enough to support multiple providers, those providers may have consolidated into a small number of corporate entities, limiting the actual choice for payers and consumers.

In either case, the market will likely take on the economic characteristics typically associated with a monopoly or oligopoly – more limited choices about services, and higher prices for the services that do exist. There may be no alternative providers to rank or tier under Issue 3.1, and some high-value services may not exist at all or may be priced higher than in other, more competitive markets.

What, if anything, can be done in regions with these situations? The following are some potential options for encouraging greater value for payers and consumers in these kinds of regions:

OPTION 3.3.1: Provide information to consumers and purchasers on the costs of equivalent services in other markets.

One way to demonstrate the limited variation in a particular market is to provide comparable information on other markets, even if consumers cannot, as a practical matter, use the services in those other markets. For example, the Dartmouth Atlas Project has stimulated discussions around the country about the cost and quality of services through its data that show the tremendous variation in costs and utilization of services in different regions with no corresponding differences in quality.

OPTION 3.3.2: Establish target payment levels for services based on the costs of equivalent services in other markets and/or based on a study of the reasonable costs of delivering care consistent with clinical practice guidelines, and require consumers to pay all or a portion of the difference between the target payment and the local provider's price.

In a consolidated market, health care payers may have little leverage to force providers to lower their prices, even if strong information is available to suggest that prices are inflated. But purchasers could refuse to provide full coverage for the higher prices, thereby encouraging reduced utilization by consumers and generate greater community pressure on providers to reduce prices. This could also encourage new providers to enter the market.

OPTION 3.3.3: Establish payment levels through regulation (based on either the costs of equivalent services in other markets or a study of reasonable costs).

If a health care market takes on monopoly characteristics, then since health care services are generally viewed as a necessity, prices could be regulated by a state agency, similar to the regulation of public utilities.

OPTION 3.3.4: Facilitate "medical tourism" by consumers willing and able to travel to other regions where providers deliver quality services at lower costs.

OPTION 3.3.5: Take legal actions under anti-trust and similar laws to prevent consolidation or encourage greater competition among providers.

OPTION 3.3.6: Provide financial incentives to encourage additional providers to enter consolidated markets, such as startup financing, multi-year contracts for services, etc.

B. Protecting Patients in Restructured Payment Systems

The greater the responsibility a payment system gives a provider for managing the overall costs of care, the greater the incentive the provider has to inappropriately stint or skimp on services (particularly those whose preventive value will manifest many years in the future) or to refuse to care for patients who appear likely to have poor outcomes (within a severity-adjusted category). In addition, patients may prefer not to follow a provider's advice or to change providers if they don't like the way their care is being managed. How should patients be protected against under-provision of needed care? What kinds of education and support do patients need, particularly patients from disadvantaged populations? How should the ability of patients to choose providers and services be preserved, while encouraging increased value in health care delivery?

ISSUE 4.1: How Should Patients Be Protected Against Inappropriate Under-Provision of Services?

In discussing options for protecting against under-provision of services in episode-of-care payment systems, it is appropriate to begin by noting that fee-for-service payment has not protected patients against this problem. Numerous studies by the Institute of Medicine, RAND, and others have shown that a significant proportion of patients do not receive care that has been shown to be effective. Moreover, studies by John Wennberg, Elliott Fisher and others have shown that in communities where patients receive more services, outcomes are generally not better, and may actually be worse (particularly since many services carry their own risks of poor outcomes).

Conversely, although there is theoretically a risk of stinting and under-delivery of services under case-rate systems like episode-of-care payment and condition-specific capitation, the experience with episode-of-care payment to date does not suggest significant risks. Hospitals have been paid on an episode-of-care basis (DRGs) for 25 years, and there are a variety of systems in place to discourage premature discharge of patients and more recently to encourage delivery of quality of care. As described in Section II, the evaluation of Medicare's demonstration of bundled episode-of-care payment in the 1990s found that quality was maintained or improved and patient satisfaction actually increased.

In fact, a well-designed episode-of-care payment system actually creates stronger disincentives for providers to stint on some kinds of care than exist in a fee-for service system: if a service is necessary for good outcomes within the episode of care, then the provider will be penalized for failure to provide that service either through poorer outcomes, higher expenditures (to rectify the problems caused by the failure to provide the service), or both, whereas under fee-for-service payment, the provider may actually get paid *more* to correct problems later than to prevent them now.

This does not mean that there is no risk of stinting or under-service or that it should be ignored, merely that it is not a new problem. To the extent that an incentive to stint on services exists, it is presumably strongest for preventive care – services which, if provided now, will reduce the likelihood of poor outcomes many years in the future. Because condition-specific capitation payments would not ordinarily cover periods of that length, and many patients may have changed providers or payers or both before the implications of undertreatment are manifested the failure of providers to deliver preventive care services will likely affect future time periods, or even different providers. For example, under fee-for-service, a physician gets paid more for providing preventive services to diabetics that reduce the chances of complications in the distant future, but under a condition-specific capitation system, the payment would be the same whether those services are provided or not, and the physician may no longer be caring for the patient when the complications appear.

A significant body of experience has been developing around the country with P4P systems and other methods to deal with the problems of under-provision of services in current payment systems. To the extent that protections are needed for new payment models, these existing systems can be examined and adapted if appropriate before trying to develop entirely new systems from scratch. However, the concerns noted in Section II about process-based P4P systems should serve as a balancing caution here.

Also, it should be noted that pay-for-performance systems generally rely on fee-for-service billings as a way of monitoring whether services are provided. Although episode-of-care and condition-specific capitation payment structures offer the potential for simplifying billing structures, the need to monitor quality (and to adjust payments for differences in patient severity) may force continuation of at least some aspects of current procedure-based billing systems in order to provide the data needed for quality monitoring. As electronic health records become more widely used, it should be possible to obtain an even richer array of quality data than are available through billing records. This may enable discontinuation of complex billing systems once they are no longer needed for actual payment.

Special focus may be needed to ensure that minority and disadvantaged populations receive appropriate care. Even if a provider has good overall quality ratings across their patient population, they may have poor quality ratings on particular subpopulations. For example, the Robert Wood Johnson Foundation has pointed out the significant disparities between African Americans and whites on quality measures such as rates of leg amputation, screening mammography, testing for diabetes, etc. (See www.rwjf.org/qualityequality for more information.)

The following are some potential options for protecting patients from under-service under new payment systems; the options are not exhaustive, nor are they intended to be mutually exclusive (i.e., it may be appropriate to combine two or more options in order to provide appropriate protections).

OPTION 4.1.1: Require that processes and services viewed as *essential* be provided to a patient in order for a provider to receive payment.

For example, where clinical practice guidelines exist that clearly indicate a certain treatment or process is appropriate and of high value, providers could be denied payment if they fail to provide that treatment or process, unless there is clear documentation that the treatment or process is contra-indicated for the patient or if the patient is participating in a formal clinical trial of alternative treatments.

OPTION 4.1.2: Collect and report data publicly on the quality of care delivered by providers, with particular emphasis on underuse of evidence-based care processes and on the care of minority and disadvantaged populations.

A growing number of state and regional programs are being created around the country to publicly report on the quality of care delivered by individual providers. This is a key element of the Robert Wood Johnson Foundation's Aligning Forces for Quality (AQF) initiative and of the U.S. Department of Health and Human Services' Chartered Value Exchange (CVE) initiative.

OPTION 4.1.3: Provide bonus payments or penalties to providers based not only on patient outcomes (both short-term and long-term) but also on the extent to which evidence-based care processes are used.

Although it is generally preferable to evaluate providers based on outcomes rather than processes, the fact that many outcomes are difficult to measure (particularly with current information systems) and are longer-term in nature means that there will be lags in determining whether providers have stinted on care to particular patients.

A large number of pay-for-performance (P4P) systems have been developed around the country for hospitals, physicians, and other providers to encourage them to provide evidence-based care to their patients. These systems could be adapted to measure the extent to which providers are undertreating certain groups of patients, triggering either bonus or penalty payments in response.

OPTION 4.1.4: Provide independent education, assistance, and advocacy support for patients so they understand what kinds of services are appropriate for care of their conditions.

ISSUE 4.2: How Should Providers Be Discouraged From Dropping or Avoiding Patients With Higher-Than-Average Utilization of Expensive Services (And Discourage Care Systems from Dropping Providers Who Serve Such Patients)?

An additional issue arises with respect to *patients*, not just individual *services*. Theoretically, under episode-of-care and condition-specific capitation payments, a provider has an incentive to drop or refuse to serve patients who require an unusually high level of services. This incentive may increase if efforts are made, as described in Issue 4.1, to discourage providers from underserving high-cost patients – rather than facing a Hobson's choice of being penalized in quality terms for providing fewer services to the patient than appropriate or being penalized in financial terms for providing more services than the payment is sufficient to cover, the provider may prefer to simply not accept the patient for care at all.

The use of a severity adjustment system to ensure that providers receive higher payments for patients who have greater needs will mitigate this problem compared to traditional capitation systems. But no matter how detailed the severity adjustment system is, there will inherently be some variation in patient needs and costs within any severity adjustment category.

So the precise problem to be addressed is – what protections, if any, are needed to discourage providers from dropping or avoiding patients who have higher costs within a severity category? In order for a provider to effectively avoid these patients before knowing for sure that their needs are high, the provider would need to be able to accurately predict who they are, and if the provider can systematically do that better than the severity adjustment system does, it suggests that the severity adjustment system can be improved. But this does not prevent a provider from dropping a patient once the provider has first-hand information indicating that the patient will have unusually expensive needs.

A separate, but related issue is that patients who fail to adhere to appropriate care may require more care and more expensive care than otherwise, and to the extent that a provider is responsible for the costs of that care and can identify which patients are going to be least compliant, they have an incentive to drop them. Consequently, in addition to creating mechanisms for discouraging providers to drop such patients, it may be desirable to encourage these patients to *change* the characteristics that may make providers *wish* to drop them.

Finally, to the extent that larger organizations are accountable for payments, as discussed in Section III, those organizations' quality ratings and costs will be affected by whether they have individual providers (e.g., physicians) who care for patients who are likely to have poor outcomes and/or high costs. To the extent that all of the providers within the organization are collectively affected by their combined outcome or cost ratings, they may have an incentive to avoid including those providers in their organizations who serve the most difficult-to-care-for patients. For example, if inner-city health care providers care for patients with more health problems, greater adherence problems, and higher costs, they may be less likely to be invited to join organizations populated by physicians dealing with less challenging populations. Again, although severity adjustment systems will mitigate this problem, they may not completely eliminate it.

The following are some potential options for helping ensure that high-cost patients retain access to care under new payment systems. The options are not exhaustive, nor are they intended to be mutually exclusive (i.e., it may be appropriate to combine two or more options in order to provide appropriate protections).

OPTION 4.2.1: Make outlier payments to providers for patients requiring unusually-high amounts of care.

It is impossible for any severity/risk-adjustment system to identify patients with unique needs, and so a system of outlier payments or stop-loss arrangements may be needed to assure providers that they will not be financially penalized for caring for these patients. This could be part of the payer's payment system, or it could be arranged by the providers through reinsurance or a group self-insurance program.

OPTION 4.2.2: Ensure that severity/risk-adjustment systems adequately account for factors leading to higher utilization.

To the extent that providers can identify groups of patients whose needs significantly exceed those of others in a particular severity-adjusted category, then it may be appropriate to modify the severity/risk-adjustment system to classify those groups separately.

OPTION 4.2.3: Require providers to retain partial responsibility for the costs of services used by patients after leaving the provider's care.

As noted in the discussion under Issue 4.1, if a service is necessary for good outcomes within an episode-of-care or across the period of time covered by condition-specific capitation, the provider will inherently be penalized for failure to provide that service, either through poorer outcomes, higher total expenditures, or both. However, this assumes that the provider continues to have responsibility for the patient throughout the period of time until the patient experiences the poor outcome. If a provider determines that a patient is going to have higher costs in the future (either due to undertreatment by the provider, patient adherence factors, or both), the provider could cut its losses by dropping the patient (or encouraging the patient to change providers). This type of behavior could be discouraged by holding providers responsible for some portion of the costs that patients incur for a period of time after they leave the provider's care.

OPTION 4.2.4: Require providers to accept new patients on a first-come, first-served basis as capacity is available.

At the other end of the spectrum, providers could be required to accept patients on a first-come, first-served basis, rather than being able to cherry-pick those patients who are expected to have the best outcomes and lowest costs.

OPTION 4.2.5: Provide incentives to patients to adhere to care processes that improve outcomes.

OPTION 4.2.6: Provide financial incentives to patients to improve their health status.

Providers could well argue that it is inappropriate to penalize them for caring or failing to care for those patients who are unwilling to adhere to recommendations for care that will improve their health and reduce treatment costs. As noted in the discussion of Issue 3.2 above, it would be desirable to align incentives for both providers and patients in order to encourage better outcomes and lower costs.

OPTION 4.2.7: Provide incentives to patients to use providers who serve patients from a broad range of severity/risk profiles.

In addition to discouraging providers from avoiding high-cost patients, it might be desirable to encourage low-cost patients to seek care from providers who also serve high-cost patients.

ISSUE 4.3: How Should Payment Systems Balance Consumer Choice and Continuity of Care?

One of the goals of new payment systems is to facilitate and encourage greater coordination of care compared to the current system of fragmented care delivery. The presumption is that a provider who charges a single price for providing or arranging all of the services needed for a particular episode of care and who has the flexibility to provide services in the most cost-effective way will deliver greater value. In particular, the concept of a medical home (see Section III-A) explicitly calls for patients to have "an ongoing relationship with a personal physician trained to provide first contact, continuous, and comprehensive care."

But what if no single provider is, in fact, in a position to coordinate all of the services needed for a patient's care over a complete episode or that a patient does not select or retain a medical home? Many consumers do not currently use a single provider for their care, and many may not wish to be limited to using a single provider, medical home or not. (For example, research has shown that among Medicare beneficiaries, the average patient saw two primary care physicians and five specialists, working in a median of four practices, over the course of a year. Patients with chronic conditions saw a larger number of physicians and physician practices. See "Care Patterns in Medicare and Their Implications for Pay for Performance," by Hoangmai H. Pham, Deborah Schrag, Ann S. O'Malley, Beny Wu, and Peter B. Bach, *The New England Journal of Medicine*, 356:11, pp. 1130-1139, 2007.)

So in addition to considering how to encourage patients to change to higher-value providers as discussed in Section IV-A, it is important to consider whether and how to encourage patients to stay with a particular provider once that choice is made (unless the provider's quality of care is sufficiently poor to justify the patient making a switch). Some options include:

OPTION 4.3.1: **Provide education for consumers on the value of selecting and consistently utilizing a primary care provider (or appropriate specialist) as a medical home.**

OPTION 4.3.2: **Reduce copayments and co-insurance for patients utilizing a primary care provider (or appropriate specialist) as a medical home.**

OPTION 4.3.3: **Require consumers to pay a one-time fee for switching primary care providers unless there are appropriate justifications (e.g., a change in the consumer's residence or the provider's location, poor quality ratings of the provider, etc.)**

OPTION 4.3.4: **Require consumers to accept a greater share of the financial risk for their care (e.g., through higher cost-sharing for hospitalizations for ambulatory-care-sensitive conditions) if they do not select a medical home or otherwise use a consistent provider for their care.**

OPTION 4.3.5: **Require providers to establish "carve-out credits" for consumers if the consumers choose to use services other than those provided or recommended by the provider within a bundled price.**

A patient may be willing to use a consistent provider for their primary care and some portion of the services they need, but they may want the flexibility to use some services other than those recommended by their provider, or they may want to obtain some of the recommended services from other providers. To the extent that those services are included in the bundled payment to the patient's primary provider, a mechanism is needed to enable the patient to obtain them from other providers without penalizing the primary provider or restricting the patient's options. (For example, if lab testing is included in the case rate for the patient's care, a patient might find it more convenient to have their lab tests done at a lab near to them, even though that lab will charge more than the cost at which the patient's provider can do the testing.) This can be facilitated if providers pre-define the "credits" that patients will receive from the bundled payment if they use alternative providers for a particular service. The primary provider would agree to pay the alternative provider the amount of the credit, and the patient would be responsible for paying the remainder of the alternative provider's price.

V. Implementing New Payment Systems Successfully

Despite the promise of better quality and lower costs, healthcare providers, payers, purchasers, and patients may be understandably reluctant to invest time, energy, and money in implementing new payment systems until the operational details are resolved, the unintended consequences are identified and addressed, and there is hard evidence that the promised benefits will materialize. Although there are good *theoretical reasons* for believing that moving towards episode of care structures and bundled payments will improve quality and reduce costs, there is only limited *evidence* to prove that this will, in fact, occur, since there have been relatively few cases across the nation where significantly different payment systems have been attempted, and even fewer where thorough evaluations have been conducted.

How much testing is needed before a new payment system can or should be placed into widespread operations? How narrowly can a pilot project be defined and still provide useful information? How many payers have to agree to a new payment system to make it feasible for providers to participate? What can be done if key players resist changing from the current payment system to the new system? What kinds of community-wide structures are needed to support payment reform efforts?

A. Piloting New Payment Systems

In addition to resolving the kinds of important design details described in the previous section, there are many practical issues to be resolved in getting new payment systems from the design stage into actual operations. In some cases, there may simply be insufficient knowledge or experience as to how providers or patients will respond under different options in order to comfortably make a decision about which options should be used until they are tested. There will also likely be unintended consequences and unexpected difficulties which will need to be identified and rectified before broader implementation is warranted.

There is also unlikely to be a one-size-fits-all payment system that will work in every region due to the significant differences in the number and type of providers and the nature of existing payment systems across regions.

Medicare has a long tradition of using demonstration projects and pilot projects to test changes before they are implemented on a broad scale. “Demonstration projects” are the most experimental, trying a new approach to learn what works and what doesn’t in order to provide input to more detailed design work and decisions about policy changes. “Pilot projects” are more explicitly intermediate steps toward full implementation, with the expectation that if the pilot projects are successful, they will be implemented on a broad scale.

The overwhelming majority of the participants at the 2007 NRHI Summit agreed that regional demonstrations and pilot projects were needed to advance payment reform.

ISSUE 5.1: What Should Be The Goals of Pilot Projects?

Changes in payment systems are not ends in themselves, but means to support more effective health care delivery in order to improve quality and lower costs. Moreover, as discussed in Section IV, there may also be significant changes in the way consumers/patients will select and utilize health care providers and services as a result of both the payment and delivery system changes.

This means that as many as three completely different streams of activity must take place to fully demonstrate the effectiveness of a revised payment system: (1) the payment changes themselves, i.e., the way that providers charge for and are paid for services; (2) the changes in the health care delivery system, potentially including changes in organizational structure (as discussed in Section III) as well as changes in the way individual health care personnel provide care; and (3) the changes in the way consumers make choices about health and health care, including evaluation of information about quality and cost, policies about consumers' cost-sharing, shared decision-making processes with health care providers, etc.

Each of these separate areas has many details to be resolved and the potential for unintended consequences, and each therefore may merit being piloted before moving to full-scale implementation. Attempting to pilot all three areas simultaneously will be very challenging, so it may be easier to pilot each area separately, but because all three areas are interdependent, it may not be feasible to separate them. For example, there is much to be learned about how to implement the medical home concept in the diverse range of physician practices that exist in most regions, but a pilot test of the care changes alone will be difficult or impossible without a source of funding to pay for them.

Another way to look at the question of goals is to ask: What most needs to be tested or proven? For example, if there is skepticism about whether the payment changes can be implemented as designed or if there are concerns about unintended consequences, then the pilot project may need to focus on the operational aspects of the changes. On the other hand, if there is skepticism about whether the payment changes will achieve the quality and cost improvements that are envisioned, then the goal of the pilot may need to be a demonstration that improvements in quality and/or cost can be achieved. Depending on the nature of the payment change and the patient population involved (see Issue 5.2 below), it may take years to fully realize the benefits of the changes in terms of improved outcomes or reduced costs.

Consequently, it is essential that clear goals be established as part of any demonstration and that they be supported by all of the participants. Which types of goals should be priorities for regions that want to move forward on payment reform? Options include:

OPTION 5.1.1: To demonstrate that costs will be reduced (or that cost increases will be slowed).

OPTION 5.1.2: To demonstrate that quality will be improved.

If the case for making the changes needs to be established, it may be desirable to select quality measures for which improvements can be seen quickly rather than longer-term outcomes.

OPTION 5.1.3: **To gain experience with the *billing and payment systems* to be used to support the payment changes, and to identify and develop solutions to problems and unintended consequences.**

OPTION 5.1.4: **To gain experience with the *care improvements* to be supported through the payment changes, and to identify and develop solutions to problems and unintended consequences.**

OPTION 5.1.5: **To gain experience with changes in *patient information and incentives* that will accompany the payment changes, and to identify and develop solutions to problems and unintended consequences.**

OPTION 5.1.6: **To test alternative options for specific elements of the program where there is insufficient evidence to make a decision about the best approach.**

For example, as discussed at length in Section III, imposing strict standards on the types of providers that can participate in a payment effort may simplify the complexity of the program, but it may also undesirably limit the number of providers who can participate. A pilot program could test the ability of providers who do not meet standards to participate effectively.

OPTION 5.1.7: **To enable administrative systems to be developed and tested.**

Extensive and potentially expensive new administrative systems will likely be needed by both payers and providers to manage under new payment systems. Pilot projects could facilitate the development and testing of such systems on a smaller scale so that they can be ready if and when full-scale implementation begins.

OPTION 5.1.8: **To begin building any new provider organizational structures needed to accept and manage the new payment structure.**

To the extent that new organizational structures are needed to manage new payment structures (as discussed in detail in Section III), pilot projects could focus on creating such organizations.

ISSUE 5.2: What Types of Patients/Conditions Should Be the Initial Targets for Pilot Projects?

Regardless of the precise goals selected, the opportunities for impact and the challenges of implementation will likely vary significantly depending on the group of patients and conditions selected as the targets for a pilot project.

Options for the patient/conditions that could be selected as targets, which are not mutually exclusive, include:

OPTION 5.2.1: **All of the patients being served by the providers participating in the pilot project.**

Some providers, particularly small providers, may find it financially impossible to make the investments or care changes needed (e.g., installing electronic health record systems or patient registries, or hiring nurse care managers) unless all of their patients are supported by a new payment system. They may also find it too confusing to try and manage two different sets of payment systems and their associated quality measures simultaneously.

OPTION 5.2.2: A particular population of patients, e.g., all of an employer's employees, all of the patients with a particular type of insurance, all patients of a particular age, etc.

Some key aspects of new payment structures, such as severity/risk adjustment for patients, may only be able to be tested meaningfully if they are applied to a population of patients with a diverse range of characteristics. In addition, purchasers or payers may be unwilling to participate if they need to manage two different payment systems for different subsets of their members.

OPTION 5.2.3: Patients/conditions where there is the strongest evidence of overuse, underuse, or misuse of care driven by inappropriate payment incentives.

Since a primary goal of payment reforms is to reduce overuse, underuse, and misuse of care, it would make sense to focus pilot projects on patients or conditions where those problems are known to exist.

OPTION 5.2.4: Patients/conditions involving large amounts of expenditures.

If the goal of the pilot project is to save money, or at least to generate enough savings to offset the costs of the project (see Issue 5.4 below), it would make sense to target patients or conditions involving significant costs.

OPTION 5.2.5: Patients/conditions for whom there are agreed-upon new care models that will be implemented in conjunction with the new payment structure.

If providers already know what changes in care they would make if payment systems would support them, impacts on quality and cost will occur more quickly than if providers need to study care processes to determine what changes should be made.

OPTION 5.2.6: Patients with the most common chronic conditions or ambulatory-sensitive conditions.

The largest impact from payment changes designed to support the patient-centered medical home and/or the chronic care model (see Section II-A) will likely be achieved by focusing attention on patients with common chronic conditions and on patients with ambulatory-sensitive conditions (i.e., conditions for which the rate of hospitalizations can be reduced with the right kind of community health care).

OPTION 5.2.7: Patients with the types of acute episodes that have high rates of hospital-acquired infections, hospital readmissions, etc.

Episode of care payments for major acute episodes may be able to achieve their greatest impacts on both quality and cost for patients who have experience high rates of preventable adverse events and readmissions as part of their episodes of care.

OPTION 5.2.8: Patients whose conditions do not significantly overlap with patients who will not be covered by the payment system.

To the extent that a pilot project is narrowly focused on particular conditions or episodes, it would be desirable to ensure that the patients with those conditions or episodes are reasonably distinct from patients who will be paid for under current payment methods. Otherwise, more time and energy may be spent sorting out the complexities of which patients should be paid under what method than in actually using the flexibility of the payment system to improve care. For example, it may be hard to focus too narrowly on a particular chronic disease such as congestive heart failure or diabetes, since so many patients have multiple chronic conditions.

OPTION 5.2.9: Patients/conditions for whom the majority of payers will participate in the new payment structure.

It is difficult for a provider to change the way it provides patient care if payment changes only apply to the subset of the provider's patients covered by a particular payer. See Section V-B below for a more detailed discussion of issues associated with getting multiple payers involved.

ISSUE 5.3: How Many Providers Should be Included in a Pilot Project?

Paying some providers under a new payment system but not others may create competitive advantages or disadvantages for each group. However, in a region with a large number of providers, particularly small physician practices, the sheer volume of effort involved implementing changes for all providers could overwhelm a pilot project.

OPTION 5.3.1: The proposed payment structure should be tested with all providers who serve the patients defined as targets for the pilot project within a specific geographic area.

OPTION 5.3.2: The proposed payment structure should be tested with a few providers who are willing and able to manage the new structure.

Testing the payment changes will be facilitated if they are implemented with providers who are already well-positioned to utilize them, e.g., physician practices that already meet the standards for a medical home.

Although this approach would facilitate implementation of the pilot project, it may give a biased impression of the kinds of challenges which will be faced when implementing the payment changes with the full range of providers.

OPTION 5.3.3: The proposed payment structure should be tested with a diverse set of providers, including types of providers where there are concerns or uncertainties about their ability to participate effectively.

ISSUE 5.4: To What Extent Should Pilot Projects Be "Budget-Neutral?"

In an environment of intense concern about the high and growing cost of health care, there will likely be resistance, if not opposition, to implementing payment system changes on a pilot basis if they will increase costs. However, there are many reasons why new payment systems will increase costs in the short run, even if they promote savings in the long run; for example:

- New billing and payment software systems need to be put in place by providers and payers, at considerable expense;
- New infrastructure and personnel need to be put in place by primary care providers to implement the medical home and chronic care models;
- Consumers/patients need to be educated about how the new payment systems and new care delivery mechanisms will affect them and the protections that will be in place to ensure quality of care.

This presents a challenge to the designers of pilot projects – how to be "budget neutral" when there are short-term costs that will need to be incurred? Options for addressing this challenge include:

OPTION 5.4.1: Pilot projects should be focused on patients/conditions and care changes that are expected to maintain or reduce costs over current levels within the first year.

Several of the categories identified under Issue 5.2 hold the potential of reducing costs within the first year of operations, including patients with ambulatory care sensitive conditions and hospital patients with high rates of readmissions.

OPTION 5.4.2: Pilot projects should be expected to provide cost savings within 2-3 years of implementation, but will likely require higher expenditures initially.

Although purchasers and payers will likely be unwilling to wait many years to see returns on investments, they may be willing to support projects which can establish a business case for savings within 2-3 years.

OPTION 5.4.3: Pilot projects that increase costs in the short run should be combined with other projects that will achieve short-run savings in order to maintain or reduce total spending throughout the demonstration period.

Another approach would be to combine a payment reform pilot with an initiative designed to achieve short-run savings, such as an initiative to reduce utilization of high-cost services.

OPTION 5.4.4: Special funding should be obtained to cover one-time and transitional costs for pilot projects.

For example, foundation grants could be requested to cover startup costs during the "learning phase" of implementation.

ISSUE 5.5: How Many Payers Need to Participate in a Pilot Project?

Section V-B below discusses the issues associated with payer alignment in detail. A pilot project may or may not require the same degree of payer alignment as would be desirable in full-scale implementation.

B. Achieving Sufficient Alignment of Payers

It is difficult for a provider to change the way it provides patient care, particularly when new staff or infrastructure are required, if only a portion of the provider's patients are paid for under a new payment system. For example, a key element of the chronic care model is to have a non-physician care manager provide patient education, monitoring and assistance. (Typically the care manager would be a nurse, but pharmacists, respiratory therapists, certified diabetes educators, etc. may also be used with specific patient populations.) A physician practice may have enough patients who can benefit from care management to justify hiring a full-time care manager, but if only a subset of those patients have coverage from payers who will reimburse for or otherwise support the cost of the care manager, the physician practice may lose money by hiring such an individual.

In addition, even if all or most payers use payment systems based on the same principles, if the details differ significantly, it may be difficult for a provider to implement changes in care. For example, continuing the previous illustration, if each payer agrees to pay for a non-physician care manager, but each focuses on a different patient population (one payer supports care management only for diabetes patients, while another supports it for anyone who has been hospitalized at least once), the payments may not "add up" to enough to support the costs of the care manager, and may also inappropriately fragment care.

Moreover, the challenges of compliance with multiple rules and systems can increase administrative costs for providers significantly. For example, many providers are currently complaining about the challenges of responding to pay-for-performance systems when different payers require different quality measures to be reported in different ways on otherwise similar patients.

How much alignment among payers is necessary for payment reform to succeed, and how can that alignment be accomplished?

ISSUE 6.1: How Many Payers Must Be Aligned to Enable Providers to Implement Care Improvements?

There is likely no single answer to this issue, because the number and types of payers differ dramatically from region to region. Some regions have one or two dominant commercial health insurance companies; others have many companies with similar shares of the market. In some regions, locally-headquartered insurance plans provide the majority of the insurance coverage, while in others, national insurance companies provide the majority. In some regions, many people receive health care coverage through companies and organizations that are self-insured; the headquarters and decision-making authority for these self-insured companies and organizations may be local, or they may be in other regions or states. In older regions, Medicare plays a more dominant role than in other areas, and in urban areas, Medicaid will typically pay for a greater share of health services.

Because of this, the gap between how much alignment is *desirable* and how much is *feasible* will differ significantly across regions. In some places, one payer could single-handedly change the payment structure for a majority of patients in the region, whereas in others, multiple payers would have to adopt payment changes to affect the same proportion of patients. For that reason, it is important to think carefully about what the absolute minimum level of alignment is in order for payment changes to achieve their purpose.

The following are options for how many and which payers need to participate in payment reform (either on a pilot or full-implementation basis) in order for providers to be successful in implementing the care improvements needed to achieve the goals of the payment reform:

OPTION 6.1.1: The payers who are collectively responsible for all or most of the patients who would be affected by the new payment system, so

providers can change their care processes for all patients without regard to which payer they use.

OPTION 6.1.2: **A group of payers whose payments will collectively be sufficient to cover the costs of new staff or infrastructure that providers would need to provide improved care for the patients who would be affected by the new payment system.**

OPTION 6.1.3: **At least one large payer with sufficient volume to significantly change the revenues and profitability of the providers who would be affected by the new payment system.**

The widespread use of P4P systems over the past several years has prompted many researchers to try and determine how large an incentive needs to be in order to be meaningful to providers. Similarly, the goal of payer alignment could be to affect a minimum percentage of a provider's revenue or profits.

OPTION 6.1.4: **All of the payers that have sufficient volume to significantly change the revenues and profitability of the providers who would be affected by the new payment system.**

Even if one payer has sufficient volume to affect the incentives for providers, if another payer also has sufficient volume but is using a payment system that provides very different incentives, then the incentives created by the first payer may be neutralized.

OPTION 6.1.5: **All or most commercial payers in the regional market.**

Even if a subset of payers could provide sufficient volume to enable providers to implement care changes, the complexity of administering multiple systems from participating and non-participating payers may be a significant deterrent to provider participation or success.

OPTION 6.1.6: **All or most locally-based payers (both public and private).**

It may be easier to get locally-based payers to agree on payment changes, rather than national health insurance companies or multi-state self-insured companies that would need to implement different payment systems in different regions.

OPTION 6.1.7: **For conditions involving seniors, payment changes should not be implemented unless Medicare is participating.**

ISSUE 6.2: What Aspects of Payment Systems Are Most Important to Align Across Multiple Payers?

Although having multiple payers use an identical payment system would probably be the ideal from a provider's perspective (assuming the provider likes the payment system!), there will be a variety of impediments to getting multiple payers to implement completely identical systems:

- Antitrust laws and policies at both the federal and state levels will limit the ability of multiple payers to discuss and agree on changes in payment systems. (There may also be limitations on the ability of multiple providers to agree on the changes they would like to see made in payment systems.)
- Even if antitrust restrictions were not a factor, payers may view payment system innovations as a basis for competing for consumers and/or providers, and thereby be unwilling to only use payment systems that other payers are also using.

- Depending on the individual market, a significant proportion of payers may be national or multi-state in scope (i.e., national insurance companies and self-insured companies with multi-state operations) versus locally focused. National payers may be unwilling to implement completely different payment systems in one market than in others.
- Building new payment systems "on top of" existing systems can reduce the cost and time needed for implementation, particularly where the new payment structures will only apply to a subset of patients or providers. For example, episode-of-care and condition-specific capitation systems can be designed to allow providers to continue billing under existing systems, but have their claims paid in a different way. But if each payer has a different system to build on, then each may need to adapt the new payment structure in a different way.

Given the challenges of aligning any aspect of payers' systems, it will be helpful to have consensus on which aspects of payment systems are most important to align. The options include:

OPTION 6.2.1: **The *incentives* implicit in the payment systems should be similar.**

Some have suggested that since the motivation for changing payment systems is to correct the undesirable incentives in current payment systems, the minimum goal should be to have as many different payers as possible use payment systems which have incentives that are similar in direction, even if they are different in specifics. For example, having some patients paid for on a case rate basis while others are paid for on a fee-for-service basis creates two conflicting sets of incentives for physicians, so even if it is impossible to get all payers using a case rate system, it could be helpful if payers using fee-for-service would also use pay-for-performance systems that create disincentives for high utilization, hospital admissions/readmissions, etc.

OPTION 6.2.2: **The *definitions of the patients/conditions* to which particular payment systems will apply should be identical, or as similar as possible.**

Since the goal of revised payment systems is to enable and encourage improvements in care, providers should be able to make care changes for all similarly-situated patients (rather than just those paid for by a particular insurer).

OPTION 6.2.3: **The *quality/performance standards* for which providers will be held accountable should be identical, or as similar as possible.**

OPTION 6.2.4: **The *quality/cost/value measures*, the methodologies for collecting/reporting them, and any categories to which providers are assigned should be identical, or as similar as possible.**

OPTION 6.2.5: **The definitions of the *services or processes that will be included and excluded* from coverage under the payment system should be identical, or as similar as possible.**

OPTION 6.2.6: **The *types of organizations or care systems* that will be eligible for payment and the standards they will need to meet should be identical, or as similar as possible.**

OPTION 6.2.7: **The *payment levels* for the services under the payment system should be identical, or as similar as possible.**

ISSUE 6.3: What Mechanisms Can Be Used to Encourage or Assist Payers to Align Their Payment Structures?

Even if payers agree that their payment systems should be changed, it may be easier for one payer to change their payment system in one way (due to the particular way that payer's billing and payment systems are structured, its contracts are written, etc.), but easier for another payer to change their system in a different way. Moreover, because of anti-trust concerns, even if payers might be willing to agree on a common payment structure, it will be difficult or impossible for them to have direct discussions to achieve that agreement.

The following are some of the options that can be considered for facilitating alignment of payers:

OPTION 6.3.1: A regional collaborative, state agency, university, or other entity that is independent of any individual payer or provider should develop a recommended payment structure that all payers can adopt.

For example, in Minnesota, the Institute for Clinical Systems Improvement worked with payers to develop multi-payer support for the DIAMOND initiative to improve the quality of care for patients with depression. In Pennsylvania, the Governor's Office of Health Care Reform worked with payers to develop a multi-payer demonstration of the chronic care model in the southeastern corner of the state. In Rhode Island, Quality Partners of Rhode Island worked with payers to develop a multi-payer initiative to implement the advanced medical home and chronic care model.

OPTION 6.3.2: A large purchaser or group of purchasers should define the payment system which it wishes to see used for care of its employees, and then it should only select third-party administrators or indemnity plans that will utilize this payment system.

OPTION 6.3.3: A provider association (e.g., a medical association or hospital association) should define the payment structure that it believes will best support the delivery of high-quality, affordable health care by its members.

Although gaining support from providers is often an important concern for payers, there will likely be anti-trust issues raised when a provider association defines a common payment structure.

OPTION 6.3.4: State law should require the use of a common payment mechanism by all commercial payers in a regional market.

The necessary powers to do this may already exist under state insurance law, or the law may need to be amended to establish or clarify those powers.

OPTION 6.3.5: Amendments to anti-trust laws should be passed at the federal and state levels to explicitly allow payers to discuss and agree on some or all details of new *methods* of paying providers, while retaining prohibitions on discussions/agreements about the *amounts* of payment (or the prices charged to purchasers).

These anti-trust exemptions could be focused on one or more of the specific aspects of payment systems described under Issue 6.2.

OPTION 6.3.6: Federal law should require participation of Medicare in any payment structure being used by a majority of commercial payers in a regional market.

In many markets, the size of the Medicare program makes it difficult to affect the payment structure for the majority of adult patients unless Medicare is participating. Moreover, many payers are concerned that if they implement payment changes before Medicare does, and then Medicare pursues a different approach, the local payers will ultimately be forced to redo their payment systems again to match what Medicare has done.

OPTION 6.3.7: State laws should require participation of Medicaid in any payment structure being used by a majority of commercial payers in a regional market.

OPTION 6.3.8: State laws should prohibit providers from charging different payers different prices (or charging them in different ways) in a regional market.

For example, in order to facilitate transparency on cost and quality and to avoid inappropriate cost-shifting through differing discount rates, the State of Minnesota recently enacted legislation that (a) authorizes providers to establish bundled episode-of-care prices and (b) prohibits charging different prices for the same episode to different payers.

C. Encouraging Payers and Providers to Support New Payment Systems

Although there is growing agreement that fundamental reforms in payment systems are needed to solve the problems that exist in health care today, payers, providers, purchasers, and patients will all likely worry about the cost, effort, and potential negative consequences to them in transitioning to new payment systems and care delivery models. How can or should these concerns be mitigated? How can the inertia of existing systems be overcome? And if new payment systems achieve savings, who will gain and who will lose?

ISSUE 7.1: How Should Payers Be Encouraged to Take on the Significant Costs and Challenges of Retooling Payment Systems and of Running Current and New Payment Systems in Parallel During Pilot Projects and Phase-In Periods?

A considerable infrastructure is needed to support any type of payment system, including establishing definitions of patients/conditions to be paid for, methods for providers to submit claims and be paid; systems for measuring quality; rules and processes for resolving ambiguities, disputes, and errors; etc. Even with a detailed conceptual design for how a payment system should work, extensive effort is needed to resolve all of the details, program and test new computer systems, print manuals and forms, train staff, educate providers and patients, and many other steps. This work is expensive, particularly since the development work must be done in parallel with continued operation of the current payment system. Moreover, not just the *design*, but even the *operations* of the new payment system may also need to proceed in parallel with the current payment system, since not all patients or providers may be participating in the new system, at least in the short run. Payers may feel that the benefits of new payment systems will accrue to purchasers and patients, making it difficult to create an internal business case supporting the changes.

Payers may be particularly reluctant to participate in pilot projects, since they may need to incur all or most of the same costs that would be associated with full-scale implementation, yet the returns will be more limited, and there is the chance that the pilot will end with a decision not to proceed to full implementation.

The following are some potential options for overcoming these barriers to payer participation:

OPTION 7.1.1: Purchasers (i.e., self-insured businesses, governments supporting public programs, and those paying premiums for health insurance policies) should acknowledge that payers will incur significant short-run costs to transition to new payment systems, and reach agreement with payers on short-term rate increases to cover these costs.

OPTION 7.1.2: Payers should jointly support work by national, state, or regional organizations to develop billing systems, measurement systems, etc. that all payers can use, rather than duplicating development efforts.

As a practical matter, this may require payers to agree on a common payment structure (see Section V-B) in order for these other organizations to develop systems that all payers can use.

OPTION 7.1.3: New payment systems should be designed in a way that minimizes transition costs for payers, e.g., by utilizing existing quality information, billing codes and systems, etc. to the maximum extent possible; by limiting eligibility for new payments to large multi-physician organizations rather than individual physician practices; etc.

Although these compromises may be viewed as less than ideal, it may increase the likelihood and speed of getting the basic elements of payment reform in place.

OPTION 7.1.4: Phase-in strategies should be designed for new payment systems that enable payers to spread implementation costs over multiple years.

OPTION 7.1.5: Purchasers should give preference to payers that implement new payment systems, and encourage payers to compete on how quickly and efficiently they can implement system changes.

To be effective, this will likely require either large purchasers or groups of purchasers to define the standards that new payment systems should meet.

OPTION 7.1.6: Medicare should develop the payment systems so that other payers can use them.

The hospital prospective payment system (DRGs) and the resource-based relative value scale (RBRVS) for physician payment that were developed by Medicare in the 1980s and 1990s have been adopted by many payers.

ISSUE 7.2: How Should Hospitals and Other Providers Which Are Likely to Lose Revenues Under New Payment Systems be Encouraged to Support (or Not Oppose) the Changes?

As concerns increase about the magnitude and growth in health care costs, purchasers will gravitate toward payment systems and changes in care delivery that have the prospect of reducing health care spending, or at least reducing the rate of *growth* in spending.

Reductions or slowdowns in spending will not occur uniformly across all providers; some providers may lose revenues, while others may gain. In particular, there are widespread expectations that primary care physicians should receive more revenues under payment changes. The providers most likely to lose revenues are hospitals, particularly given the increasing focus on payment changes designed to reduce or eliminate payments for preventable adverse events and readmissions and to reduce admissions for ambulatory sensitive conditions. Reductions in hospitalizations may also result in reduced revenues for some specialty physicians.

Although on the surface, this appears to set up an undesirable win/lose scenario, reductions in revenues do not necessarily translate directly into reductions in profits or operating margins for providers. If a hospital can find ways to deliver care more efficiently or to reduce its costs, it may be able to offset some or all of the reduction in revenues. For example, a number of initiatives based on the Toyota Production System and lean manufacturing principles (e.g., the Pittsburgh Regional Health Initiative's Perfecting Patient Care℠ techniques, in-house projects conducted by hospitals such as Virginia Mason in Seattle and ThedaCare in Wisconsin, etc.) have shown significant results in reducing costs as well as improving quality.

A particular challenge for providers such as hospitals and specialists with large investments in equipment and facilities is how to cover fixed costs with smaller numbers of patients. For example, the "cost" of an x-ray or other diagnostic image is partly based on the capital cost of the imaging equipment divided by the number of patients who are imaged. If fewer patients are imaged, the capital cost per patient increases. Even some "variable" costs such as personnel are only variable with large changes in patient volume; for example, the staffing costs to operate the imaging equipment may not change within a wide range of utilization. Similarly, a small reduction in the number of patients on a hospital unit may not be sufficient to justify a reduction in nursing staff levels on the unit, increasing the cost per patient even though the total spending by the hospital has not changed.

As a result, the cost savings to the *provider* from the lower utilization is not proportional to the reduction in utilization, even though the cost savings to the *payer* is proportional (assuming the payer pays the same amount for each patient). This means that providers will be more likely to support an approach that (1) reduces their revenues by an amount similar to their marginal costs rather than their average costs and (2) recognizes that investments in existing fixed assets were based on the incentives implicit in the existing payment system, and that those costs cannot be reduced instantaneously.

Some of the options for addressing this issue include:

OPTION 7.2.1: **Technical assistance should be made available to providers to help them eliminate waste and increase efficiency, so that reductions in revenue will be accompanied by reductions in costs.**

Although solutions for successfully adapting to lower revenues may exist, it will take time and resources for providers to find them, and it will be less efficient if every provider needs to develop the same solutions independently.

OPTION 7.2.2: Payment systems or other methods should be used to encourage physicians and hospitals to collaborate in finding ways to reduce costs.

For example, demonstrations of bundled episode-of-care payments for surgeries have shown that they provide significant incentives for surgeons to reduce costs for hospitals. Although bundling of payments presents some of the greatest challenges for payment reform (see Section II-B), the incentives provided by bundling may be some of the most important ways to enable providers to adapt to reduced revenues.

OPTION 7.2.3: Payers should seek to reduce administrative costs and unnecessary regulations imposed on providers, in order to help offset reductions in revenues.

In addition to avoiding or eliminating unnecessary requirements, payers can reduce costs for providers by using the same (or similar) requirements in their payment systems. See Issue 6.2 for examples of areas where payers can align their requirements.

OPTION 7.2.4: Payers should acknowledge that with reduced utilization, current fixed costs of hospitals and other providers will need to be spread over a smaller number of cases, and agree to pay higher prices for those cases so that providers can cover those fixed costs.

Increasing prices per patient does not necessarily mean that purchasers and payers will not achieve savings. If utilization is reduced by more than the prices are increased, payers may still pay less in aggregate. For example, most people expect to pay slightly more for a product or service that carries a warranty, so if health care providers begin offering limited warranties on their care (as Geisinger Health System has done with its ProvenCare system), it may well be appropriate to pay them slightly more for that care in return for not being charged for errors and avoidable complications.

OPTION 7.2.5: Payers should "share savings" that are achieved through reduced utilization with the providers which will experience lower patient volume, in order to mitigate the providers' loss of revenue.

For example, Medicare's Physician Group Practice Demonstration program included provisions for giving participating providers a portion of the savings from improved care, with savings calculated as the difference in actual total Medicare spending on the participating patients compared to the spending amount projected to occur in the absence of the care improvements.

OPTION 7.2.6: Payment changes should be phased in slowly to allow providers time to reduce costs and adapt.

As noted earlier, if payments are reduced in the short run by amounts comparable to a provider's marginal costs, there will still be some savings for payers without causing net losses for providers until they can make the changes needed to reduce fixed costs.

OPTION 7.2.7: Payment changes designed to reduce hospitalizations should be applied to large numbers of patients, so that hospitals have the ability to close units and significantly reduce fixed costs.

OPTION 7.2.8: Payers and purchasers should provide transitional financial support to providers which will lose revenues in order to help them adapt to lower revenues and to avoid significant financial hardships.

OPTION 7.2.9: Providers should be expected to plan and adapt to new payment systems without any special support.

ISSUE 7.3: What Efforts Should be Made to Help Small Physician Practices Succeed Under New Payment Systems and Care Delivery Models?

Although many people hope or expect that new payment models for chronic disease management and preventive services will increase the compensation to primary care physicians for the time they spend with patients, these payment models also presume or require that primary care physicians will change the way they provide care for patients. Many of the specific issues were discussed earlier in conjunction with the patient centered medical home (see Section III-A). In general, however, the challenges that will need to be addressed if small physician practices are to participate in new payment systems and change the way they care for patients fall into the following major categories:

- A significant amount of time and skill will be needed to retool the operations of physician practices to meet the goals of new care delivery models such as the medical home. Physicians and their staff may not have sufficient time to devote to this retooling (or if they devote the time, they may lose revenues temporarily due to seeing fewer patients), and they may not have the necessary skills or training to analyze and reinvent care processes;
- Similarly, a significant amount of time and skill will be needed to design or select and implement new billing, cash flow management, and other systems that physician practices need to participate in the new payment structure;
- The physician practice may need to invest significant funds up front to acquire new fixed assets such as equipment or IT systems, but the higher revenues to cover those costs will begin later and come in over a longer period of time;
- The physician practice may need to utilize non-physician staff, such as nurse care managers, in order to improve care for patients, but may not have sufficient patient volume to support a dedicated staff person in their own practice;
- The physician practice will need the ability to collect and analyze quality data in order to demonstrate that minimum standards are being met and to qualify for incentive payments, but may not have the personnel or systems with the appropriate capability to do so.

The following are some options for addressing these challenges:

OPTION 7.3.1: Provide technical assistance to small physician practices in understanding how to manage care and finances under new payment models.

OPTION 7.3.2: Provide grants to small physician practices to cover all or part of the costs of installing new infrastructure and transitioning to new care models.

OPTION 7.3.3: Arrange for long-term loans (to help finance infrastructure such as electronic health records), short-term loans (to help manage cash flow), insurance/reinsurance (to cover costs of unusually expensive

patients), and other financial mechanisms to enable small physician practices to manage global fees.

OPTION 7.3.4: Encourage/assist small physician practices to join together in organizational structures such as independent practice associations that can facilitate quality improvement, create mechanisms for sharing resources, etc.

OPTION 7.3.5: Encourage/assist small physician practices to form or join organizational structures that can accept accountability for overall patient outcomes and costs.

As discussed in more detail in Section III-A, it may be necessary for small physician practices to be part of a larger organizational structure in order to effectively participate in new payment structures and care delivery models.

OPTION 7.3.6: Provide supports through hospitals to the physician practices that admit to the hospital.

For example, many hospitals have well-trained quality improvement staff that could expand their roles to include assisting physician practices in reinventing care processes and management systems, and the hospital could hire a nurse care manager to work with all of the physician practices that are too small to support such a position on their own.

OPTION 7.3.7: Modify proposed payment systems to ensure that physician practices of all sizes can participate.

As noted in Section III, the more narrowly a payment system defines the providers that can participate, the fewer providers will be able to participate, and this may limit the ability of the payment system to achieve the goals of improved quality and reduced costs.

OPTION 7.3.8: Do nothing special, and leave it to physician practices to find ways to develop the skills and capacity needed to participate in new payment models.

D. Community-Wide Structures to Support Payment Reform

Markets other than health care have a variety of structures to facilitate and regulate transactions among market participants and to protect consumers, e.g., stock exchanges, the Securities and Exchange Commission, credit rating systems, consumer protection bureaus, etc. These structures and systems are independent of individual buyers and sellers, but are designed to support them in their dealings in the marketplace.

Similarly, a variety of structures and activities will be needed to facilitate the transition to new payment systems; many of these are not specific to any one payer or provider, and could be facilitated through regional, state, or national organizations other than payers and providers.

States and regions vary tremendously in the types of organizations available to (1) encourage and support improvements in care and management processes for health care providers, and (2) to develop and report measures of quality and cost for use in quality improvement efforts and payment incentive programs. Some states and regions, such as Minnesota and Pittsburgh, have had such organizations in place for many years. Others, such as Oregon and Seattle, have created such organizations relatively recently. And many other regions have no such organizations or are just in the process of trying to create them.

A variety of national organizations have been working to play similar roles, either by supporting state and regional efforts or by working nationwide. For example, the Robert Wood Johnson Foundation's Aligning Forces for Quality (AF4Q) initiative is providing significant financial and technical assistance to organizations working to improve health care quality in 14 regions across the nation (with more regions expected to be added), and the U.S. Department of Health and Human Services has designated 14 community-based multistakeholder collaboratives across the country as Chartered Value Exchanges (CVEs), based on their efforts to transform the quality and cost of health care. Organizations such as the Institute for Healthcare Improvement (IHI) provide training and technical assistance to individual healthcare providers to help them improve quality and cost.

However, the diversity of these efforts creates the risk of gaps, overlaps, and conflicts. One effort to address this is the Quality Alliance Steering Committee (QASC), which was formed in 2006 as a voluntary, multi-stakeholder collaboration to provide national coordination for activities designed to enable value-driven health care (www.brookings.edu/projects/qasc.aspx).

ISSUE 8.1: What Information, Standards, Systems, and Assistance Should be Provided Collectively at the Regional, State, or National Levels Rather Than by Individual Payers or Providers, and at Which Level Should These be Provided?

As discussed under Issue 6.2, there are a number of aspects of payment systems that would be desirable to have aligned across payers. Not only are there anti-trust challenges to having payers agreeing on the details of these elements of payment systems, it is inefficient for them to separately develop and implement those details. Similarly, as discussed in Issues 7.2 and 7.3, providers of all types could benefit from information and assistance on how to make the changes in care delivery, cash flow management, billing, etc. needed to respond to new payment systems.

As regions and states move forward with pilot projects and other planning for new payment systems, it will be helpful to reach agreement on which of these aspects of new payment systems and care improvements should be provided *collectively*, rather than being left to individual payers or providers. In addition, it would be desirable to agree on whether each of these items *should* be done at the regional, state, or national levels, and whether they can be done at each of these levels. For example, although it may be desirable to have something done at the national level to achieve the greatest economies of scale, if no action (or insufficiently rapid action) is taken at the national level, it may be necessary to consider taking the necessary action at the state or regional level.

Some of the options include:

OPTION 8.1.1: Severity/risk-adjustment systems to determine which patients appropriately will cost more than others to care for.

OPTION 8.1.2: Outcome and process measures used for quality measurement and performance incentives.

OPTION 8.1.3: Common definitions of services, episodes of care, etc. to be used in defining new payment systems.

OPTION 8.1.4: Clinical practice guidelines to guide effective care delivery and on which to base quality standards.

OPTION 8.1.5: Assessments of the effectiveness and relative value of healthcare services.

OPTION 8.1.6: Data on the quality levels of individual providers.

OPTION 8.1.7: Data on patient satisfaction with individual providers.

OPTION 8.1.8: Data on the costs of individual providers for episodes of care.

To the extent that providers are not establishing prices on a case-rate basis, but payers wish to encourage competition and/or patient choice on the basis of relative costs, a system may be needed for collecting data from providers, computing the costs for episodes of care (or total per-patient costs), and publishing that information.

OPTION 8.1.9: Estimated/recommended prices for care.

Many providers may not have the cost accounting or other information systems needed to determine an appropriate price for care on an episode or case-rate basis. Moreover, to the extent that entirely new modes of care delivery are envisioned (such as the patient-centered medical home or chronic care model), historical cost information may be only partially helpful in establishing prices. For example, Prometheus, Inc. is working to establish recommended payment levels for various episodes of care.

OPTION 8.1.10: Methods for providers to advertise their prices for services.

If providers do define bundled prices for episodes of care or for care of individuals with chronic disease, and patients have incentives to select higher-value providers, the providers will need a mechanism to advertise their prices and quality to consumers. This is different than current efforts to report on quality and cost of providers, since it is *prospective* rather than *retrospective*. One option is for each health payer to make the information available to their members, but this requires each provider to maintain information with multiple payers. An alternative would be for a community wide marketplace to be established. For example, Carol, Inc. (www.carol.com) has been developing a internet-based software system to enable providers to post prices for care packages, allow consumers to compare providers on quality and price, and even allow consumers to directly schedule care with the providers they select.

OPTION 8.1.11: Billing and payment software to be used by payers and providers.

As noted in earlier sections, sophisticated software systems will likely be needed to enable payers to process claims under new payment models, particularly if the new payment models are being operated in parallel with existing payment systems or are being built on existing billing systems. For example, Prometheus, Inc. is developing a suite of software to enable this to be done for episode-of-care payment systems.

Similarly, providers will likely need to have new software systems with which to submit bills, monitor their costs, etc. Although private vendors will likely develop products once it is clear that there will be a significant market for those products, there may be a need for joint development of an "entry" software system to help providers, particularly small providers, in the early years of payment reform, and to establish standards that private vendors' systems should meet.

OPTION 8.1.12: Use of electronic health record (EHR) systems and registries.

If payers want providers to use information in electronic health record systems (as opposed to billing systems) to report quality of care, if patients and payers want providers to use EHRs and registries to improve management of care, and if providers want to use EHRs to enable closer integration of services under bundled payment arrangements, it is in a community's interest to proactively ensure that all providers have such systems and that they are appropriately interoperable.

OPTION 8.1.13: Patient education materials about payment systems.

See Issue 8.2 below for a more detailed discussion of this option.

ISSUE 8.2: How Can Consumers and Patients be Encouraged and Assisted to Support the Creation of New Payment Systems and Efforts to Encourage the Use of Higher-Value Providers and Services?

Although the issues in designing and implementing payment reforms are understandably focused on providers and payers, the fundamental goal of payment reforms is to improve the quality and affordability of care for consumers and patients. It is quite conceivable that a new payment and care delivery structure could be developed that is perfectly satisfactory from the perspectives of payers and providers, but unacceptable to a significant number of consumers and patients, either because of the actual problems it creates for them, or because of the problems they *perceive* it will create for them. The history of managed care systems in the U.S. demonstrates that consumer acceptance of payment and care delivery systems can be critically important.

Consequently, in addition to addressing all of the issues discussed in earlier sections, it will likely be important for those supporting payment reforms to be proactive about creating and maintaining consumer support for the many changes that they will experience in care delivery, in the way they evaluate providers and services, in the amounts they pay for care, etc.

Some options for addressing this are outlined below:

OPTION 8.2.1: Create materials and communication campaigns to educate consumers about the way new payment systems and care delivery processes will work.

OPTION 8.2.2: Identify the types of patients/conditions that might be negatively impacted by new payment systems and/or care delivery processes and develop solutions to those problems.

Even though there are well-documented problems in patient care under *current* payment systems, efforts to provide solutions to those problems through new payment and care systems will likely come under particularly intense scrutiny. Even a few examples of people who have serious negative experiences with new payment systems or care delivery models could represent serious setbacks for implementation efforts. As with adverse events, hospital-acquired infections, etc., even 99.9% success in implementation may not be good enough. Consequently, proactive efforts to identify patient populations which could have the most difficulties with new payment and care delivery systems and to plan methods of preventing or addressing those problems would be desirable.

OPTION 8.2.3: Create systems for educating consumers about healthcare issues and healthcare payment systems, for helping consumers select providers and services, and for advocating for consumers who are having difficulty receiving care, particularly consumers from disadvantaged populations.

OPTION 8.2.4: **Establish methods for resolving consumer complaints and problems with new care models and payment systems.**

OPTION 8.2.5: **Create mechanisms for involving consumers in the design and evaluation of payment systems.**

OPTION 8.2.6: **Collect and disseminate information on consumer satisfaction with new payment systems and care delivery processes where they already exist.**

One of the challenges in convincing consumers that new payment systems and care models will be better than existing structures is that there are relatively few examples where the new systems have been tried. As experience develops through pilot projects, positive patient experiences can be used to help with consumer education in regions contemplating similar efforts.

ISSUE 8.3: What Mechanisms Should be Established to Ensure that Payment Systems Achieve Goals for Improved Value in Health Care and That Progress is Maintained Over the Long Period of Time Likely Needed for Success?

In many fields, it has been observed that "today's problems were yesterday's solutions." Although there is widespread agreement that the current healthcare payment system is highly problematic, there are those who express concerns that despite the best efforts to develop new payment systems that are better, the cure could turn out to be worse than the disease. This concern is exacerbated by the diversity of health care payment and delivery structures around the country and the wide range of cost and quality both across regions and within regions, which makes it difficult to anticipate how new payment models will interact with each region's unique environment.

The fact that nobody (person or organization) is "in charge" of all aspects of health care payment and delivery not only makes it difficult to get new payment systems in place, it also makes it difficult to ensure that multi-stage transition plans are not diverted from their long-term goals, or to assure stakeholders that unintended consequences of those systems will be quickly and effectively addressed.

The following are some options for providing overall coordination and oversight of payment reform efforts:

OPTION 8.3.1: **Establish regional collaboratives or state quality improvement agencies (or use collaboratives and agencies that already exist) to measure and report on how quality, cost, and access have changed across the entire community under new payment systems.**

OPTION 8.3.2: **Establish mechanisms (or utilize mechanisms that already exist) to bring all key stakeholders (purchasers, payers, providers, and consumers) together to discuss and achieve consensus on how to resolve problems with new payment systems and care delivery processes.**

OPTION 8.3.3: **Facilitate exchange of information among regions and states in different parts of the country to identify what works and how to resolve problems with new payment systems.**

OPTION 8.3.4: **Establish a national evaluation team to evaluate payment systems and pilots in a consistent, objective way.**

VI. Moving from Concept to Reality

There is unlikely to be a single, one-size-fits-all approach to payment reform that will work equally well in all parts of the country. Every region of the country is different in terms of the number, types, and relationships of health care purchasers, payers, and providers. Just as experimentation and evaluation are hallmarks of evidence-based medicine, experimentation and evaluation will also likely be needed in order to develop the most effective cure for the ills of the payment system.

The issues identified in the previous sections are clearly some of the most important to address in order to make progress on payment reform, but they are by no means an exhaustive list. Not only is it impossible to identify in advance every potential issue that may arise in implementation of payment systems, it is unreasonable to expect that every issue *should* be identified and resolved before a payment reform initiative, particularly a pilot project, can begin. Although every effort should obviously be made to resolve reasonable concerns and issues as quickly as possible, it is also important to recognize the urgency of moving forward quickly on payment reform because of the serious cost and quality problems that current payment systems create.

Similarly, while every effort should be made to find win-win solutions for both payers and providers, it is unreasonable to expect that everyone can be protected against losses in revenues or profits, particularly during the transition process. Ultimately, what is best for patients and what is affordable for communities and the nation will have to take precedence. Many other sectors have gone through significant restructuring in order to survive and thrive in the global economy, and the current value crisis in health care will likely require significant restructuring of health care organizations as well.

The extensive and enthusiastic participation of payers, providers, and purchasers from across the country in the Payment Reform Summits organized by NRHI is a cause for optimism that the kind of support and interest needed for true reform of healthcare payment systems may now be in place.

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Appendix: Definitions of Terms

For simplicity, the term "**payer**" is used throughout this paper to refer to organizations or individuals paying health care providers for services they render. Payers can include health insurance plans, self-insured organizations (directly or through third-party administrators), government agencies paying for health care (such as Medicare and state Medicaid agencies), or self-pay individuals.

The term "**purchaser**" refers to an organization or individual that purchases a health insurance policy or otherwise uses a payer to pay a provider for care delivered either to themselves or an individual they represent (e.g., an employer may purchase a health insurance policy to pay for health care for its employees).

The term "**provider**" is used to refer to organizations and individuals providing health care to patients. Providers include hospitals, physicians, clinics, nursing homes, diagnostic labs, etc. Technically, providers can include patients themselves, through self-care regimes.

The term "**patient**" is used to refer to an individual receiving health care services, including healthy individuals receiving preventive care.

The term "**consumer**" is used to refer to an individual or family who is selecting a health care provider or considering the use of health care services (either prevention or treatment).

The term "**care**" refers to services and processes involving patients that are designed to improve their health or prevent it from worsening.

The term "**care system**" is used to refer to the full set of providers which provide care to a particular individual, either for a specific condition or for the full range of conditions that they have.

An "**episode of care**" refers to the complete set of services provided to deal with a time-limited acute condition from the time it is diagnosed until the condition is resolved. The term has also been adapted to apply to chronic conditions (which have no resolution), in which case it refers to all of the services provided during a fixed period of time (e.g., a year) for the chronic condition.

The term "**major acute episodes**" refers to conditions such as heart attack, stroke, premature delivery, newly diagnosed invasive cancer, or major trauma, and is characterized by the patient needing a complex mix of often-expensive interventions within a relatively brief period of time.

The term "**chronic condition**" refers to conditions such as asthma, diabetes, congestive heart failure, etc. that are rarely, if ever "cured" or completely resolved and which continue to require care or attention in some fashion through a person's life.

The term "**preventive care**" includes immunizations, screening tests, counseling, etc. designed to prevent chronic conditions and some acute episodes.

The terms "**cost**" and "**price**" are used to refer to the amount paid by a payer to a provider for a specific health care service or group of services. The amount paid by the ultimate purchaser (e.g., an employer or an individual who has purchased a health insurance policy or contracted with a third-party administrator) may be very different from the amount paid to the provider by the entity that they use as the direct payer (e.g., the health plan or third-party administrator), but this is a function of the structure of the contract between the purchaser and the payer, and will not be addressed in this paper.

A "**payment system**" is the methodology that a payer uses to compensate one or more providers for the care provided to a patient. This includes definitions of what will be compensated and what will not be compensated, the general way that compensation will vary depending on characteristics of the patient or the care provided, which providers and/or costs will be covered under a single payment, etc.

The term "**value**" will be used to refer to the combination of the quality of health care and the cost of that care. More quality for the same cost represents higher value, and the same quality for lower cost is also higher value. Comparing the value between providers or services that differ on both quality and cost, however, is much more subjective.

The term "**value-based payment system**" means that in some fashion, payment to a provider is based on the value of care delivered.

The term "**outlier payment**" refers to a mechanism used in case-rate payment systems such as Medicare's inpatient hospital payment system whereby a provider receives a higher-than-normal payment for a particular patient if the patient received an unusually large number of services (i.e., if the patient was an outlier in the distribution of the number of services received by patients with similar diagnoses or conditions). A similar concept is the "stop-loss," which limits the maximum difference between the payment a provider receives for a patient and the costs they incur to care for that patient.

The term "**marginal cost**" refers to the additional spending that a health care provider (or any other business) incurs in order to produce an additional product or service. For example, if an x-ray machine has already been purchased, the staff to operate the machine have already been hired, and there is time in the day to perform an additional x-ray, the marginal cost of an additional x-ray will consist only of the cost of x-ray film (if film is used), the electricity to do that x-ray, etc., but will not include any portion of the cost of the machine or the salaries of the staff. (The *average* cost of an x-ray would, however, incorporate the expenditure made on the machine and the salaries of the staff.)

The term "**regional collaborative organization**" refers to an organization in a region or state which includes payers, providers, purchasers, patients, and/or civic leaders and which works to improve the quality and/or reduce the cost of health care.