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Network for
Regional Healthcare
Improvement

Payment Reform

ACCELERATING THE IMPLEMENTATION OF VALUE-BASED CARE AND PAYMENT

Recommendations from the
2016 National Payment Reform Summit



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EXECUTIVE SUMMARY

There is widespread agreement that there are serious weaknesses in the current payment systems used by Medicare and most health plans to pay physicians, hospitals, and other providers, and there is agreement that payment reforms are needed to correct these weaknesses in order to enable and encourage healthcare providers to deliver care in higher-quality, lower-cost ways. However, stakeholders who are working to develop Alternative Payment Models (APMs) are facing a number of significant barriers and challenges, and those who would implement APMs or receive care supported by them have expressed a number of serious concerns about the way APMs are currently being designed and about potential negative consequences poorly-constructed APMs may have on patients, providers, payers, and communities. Failing to address these problems in a proactive and effective way will slow progress in improving the quality and affordability of healthcare and make it difficult to build support for implementing more effective payment models.

Recommendations for addressing eight of these barriers and challenges were developed by the participants at the 2016 National Payment Reform Summit. The Summit was convened by the Network for Regional Healthcare Improvement with assistance from the Center for Healthcare Quality and Payment Reform and with generous financial support from the Robert Wood Johnson Foundation. Over 80 national and local health care leaders from 33 states and Washington, DC helped develop the recommendations, including physicians from 16 different specialties;

executives of national and regional self-insured businesses; leaders of employer purchasing coalitions; representatives of hospital and medical associations; health plan executives; foundation leaders; directors of Regional Health Improvement Collaboratives; federal and state government officials; executives of health care Quality Improvement Organizations; consumers and representatives of labor organizations; and others with expertise and experience in efforts to design and implement better payment systems.

Supporting Coordinated Team-Based Approaches to Care and Compensating Individual Providers Inside Bundled Payment Models

Recommendation 1.1: Each patient should have the opportunity to have a clinician who takes responsibility for coordinating the services the patient receives from other providers who are involved with the patient's care. This clinician may delegate all or part of this role to one or more other healthcare professionals, and the members of this team should be compensated adequately for performing this comprehensive management role. In many cases, a primary care practice should play the comprehensive management role, but for some patients, a specialty physician practice should play that role, and in either case, other clinicians may serve as the coordinator for specific procedures or management of individual conditions. The appropriate amount of compensation for each of these coordination and management services should be based on the complexity of the work involved.

Recommendation 1.2: When a patient needs care for a specific health condition or needs to receive a particular procedure, a prospectively defined payment or budget should be established for all of the care needed for that condition or procedural episode, and each clinician or provider involved in delivering services as part of the care or procedure should be compensated for those services as a share of the overall payment/budget. Those providers should determine how best to distribute the payment/budget among them, and they should have the flexibility to redesign the way the care is delivered and the way the payment/budget is allocated as technology and evidence change over time. Payment/budget amounts should be risk-adjusted and additional amounts (outlier payments) should be paid for those patients who

have needs for large numbers of services. Information on the quality and cost of services for the condition or procedure should be made publicly available.

Recommendation 1.3: If a group of providers is receiving a global payment or budget designed to cover the total cost of care for all of the needs of a population of patients, that budget should be divided into prospective condition-based budgets and procedure-based episode budgets, and each clinician or other provider should be compensated for their services as shares of the budgets for the conditions and procedural episodes in which they were involved.

Protecting Providers from Excessive Financial Risk and Protecting Patients from Under-Treatment and Loss of Access to Care

Recommendation 2.1: In alternative payment models in which providers take accountability for delivering a range of services needed by patients within a fixed payment or budget amount, the amount of the payment or budget should be adequate to support the delivery of care that is consistent with the best evidence available. If the costs of delivering care are higher in a geographic region because the cost of labor and locally-sourced goods are higher, payment amounts should be proportionally higher. The payment to the provider should also be adequate to maintain financial reserves or to purchase reinsurance needed to ensure there is sufficient funding to cover the costs of addressing differences in patient needs.

Recommendation 2.2: The amount of payment in an alternative payment model should be stratified based on patient characteristics if (a) there are characteristics (including both clinical and non-clinical characteristics) that are outside the control of the clinicians and have a substantial effect on the cost of the services patients need and (b) there is a cost-effective way of collecting information on those characteristics and adjusting payment levels based on them.

Recommendation 2.3: Limits should be placed on providers' financial risk for services or aspects of service costs that they cannot control or influence.

Recommendation 2.4: Where evidence-based guidelines exist regarding appropriate treatment for a patient's condition or effective delivery of a procedure, providers participating in an alternative payment model should be required to document (a)

that the guidelines have been followed or (b) the reasons for deviation and the patient's involvement in the decision.

Recommendation 2.5: Alternative payment models should support the collection and reporting of data on patient-reported outcomes.

Designing Payment Systems to Support Prevention and Long-Term Improvements in Health

Recommendation 3.1: Population-based payment models should use outcome-based population health measures and risk adjustment systems that are designed to support population-specific and community-specific priorities for prevention and health promotion.

Recommendation 3.2: If a payment model is based on measures of value that use annual measures of spending, high-value preventive services with multi-year benefits should be paid for through a separate payment mechanism or budget in order to facilitate patient access to the services, to protect against underuse of services, and to enable flexibility in the way preventive services are delivered.

Supporting Adequate and Appropriate Care for Patients Facing Non-Medical Challenges

Recommendation 4: Payments to clinicians and other healthcare providers should allow flexibility for the provider to use the payments to purchase or deliver non-medical services for a patient with non-medical challenges in addition to or instead of medical services if the provider believes the non-medical services will enable better outcomes for the patient without increasing overall spending for payers than the delivery of medical services alone. For patients with non-medical challenges, outcomes should be measured over multi-year periods and impacts on outcomes other than health, such as reducing unemployment, homelessness, etc., should be considered.

Providing Adequate Support for Hospitals' Essential Services and Medical Education Costs

Recommendation 5: The amount of financial support provided to a graduate medical education program should not be based on the number or costs of hospital inpatient admissions, discharges, or days.

Changes in Patient Benefit Designs Needed to Support Successful Payment Reform

Recommendation 6.1: A clinician or other healthcare provider who is taking accountability under an alternative payment model for improving the quality of care for a patient and for controlling the cost of the patient's care should have the flexibility to design or redesign cost-sharing requirements for the patient where necessary to enable and encourage the patient to adhere to a care plan developed through a shared decision-making process.

Recommendation 6.2: Providers should be transparent about the quality of care they deliver so that patients can be assured that they are receiving high-quality care under value-based payment systems and benefit designs.

Data and Analyses Needed to Develop and Implement Successful Payment Models

Recommendation 7.1: Data on all of the important clinical and non-clinical factors that can have a significant impact on patient needs and outcomes must be accessible in order to support development and use of valid and reliable risk stratification methodologies in performance measures and alternative payment models.

Recommendation 7.2: Linkages must be developed between the information in claims data, the information in electronic health records and registries, and information on patient-reported outcomes in order to provide the analyses needed to improve care and measure performance. Funding should be provided to enable Qualified Entities (which have multi-payer claims data), Qualified Clinical Data Registries (which collect clinical information relating to patient care), and Patient-

Reported Outcome databases to link their data for specific uses that will benefit patients, payers, and providers and that incorporate appropriate protections to ensure responsible use.

Recommendation 7.3: All Electronic Health Record systems should be required to support (a) the creation of custom fields and (b) data retrieval and analysis. Incentives should be created to encourage the development of infrastructure for linking data and there should be penalties for vendors that block data.

Recommendation 7.4: Payers and provider organizations should be required to give clinicians access to information on the amounts payers and patients pay for services.

Facilitating the Transition to Improved Payment Systems

Recommendation 8.1: Alternative payment models should be implemented using multi-year contracts and/or multi-year performance measures that allow for a short-term period in which costs can increase or quality measures can remain stable before decreases in costs or improvements in quality are expected.

Recommendation 8.2: New service/billing codes should be created so that providers and payers can more easily implement alternative payment models within existing billing and claims payment systems.

Recommendation 8.3: A payer should align the incentives and measures it uses for payment of different types of providers.

Recommendation 8.4: Changes should be made to statutes and regulations that were designed to prevent or mitigate problems under current payment systems when those regulations are impeding the transition to higher-value care delivery under alternative payment models.

Recommendation 8.5: Providers designing and/or implementing alternative payment models should be able to obtain claims data on the services received by their patients and the amounts paid for those services, at low cost or no cost to the provider for obtaining the data. In addition, small providers should be able to obtain basic analytic and data-merging tools and/or technical assistance & benchmarks in

order to help them utilize claims data in designing and implementing alternative payment models.

Recommendation 8.6: Providers need to have the ability to link and analyze all clinical data for each of their patients in order to successfully implement alternative payment models.

Recommendation 8.7: Alternative payment models will need to support the costs of modifying electronic health record systems to calculate and report quality measures used in those payment models.

Introduction

There is widespread agreement that there are serious weaknesses in the current payment systems used by Medicare and most health plans to pay clinicians and other providers. For example, there is no payment at all for many high-value services, and payments based solely on the number and costs of services can penalize healthcare providers for keeping patients healthy and can encourage the delivery of unnecessary services, thereby increasing spending for payers and out-of-pocket costs for patients.

There is also broad agreement that payment reforms are needed to correct these weaknesses in order to enable and encourage healthcare providers to deliver care in higher-quality, lower-cost ways. In general, “pay for performance” (P4P) systems have failed to significantly improve quality or control costs because they do not really correct weaknesses in current fee-for-service payment systems. This has led to considerable interest in developing “Alternative Payment Models” (APMs) that would more directly address these weaknesses. A number of APMs have been implemented or are being tested by the Centers for Medicare and Medicaid Services (CMS), the Center for Medicare and Medicaid Innovation (CMMI), state Medicaid agencies, and private health plans, but to date, relatively few healthcare providers are participating in APMs, and the results to date of many of the APMs have been disappointing.

The Medicare Access and CHIP Reauthorization Act of 2015, commonly known as “MACRA,” was specifically designed to accelerate development

and implementation of Alternative Payment Models. In addition to repealing the Sustainable Growth Rate (SGR) formula and creating a new Merit-Based Incentive Payment System (MIPS) that replaces existing Medicare P4P programs for clinicians, MACRA specifically encourages physicians to participate in Alternative Payment Models both for their Medicare patients and their other patients. Under MACRA, physicians who achieve a minimum level of participation in qualified APMs can be exempted from the requirements of MIPS, receive a 5% lump sum bonus each year for up to 6 years, and then receive a higher annual increase in the Medicare payments for their services than other physicians would receive. Moreover, MACRA specifically encourages the development of “physician-focused payment models,” including payment models for specialist physicians.

Although the incentives created by Congress are significant, they are not the only reason for physicians to participate in APMs and they likely will not be the most important reason. Well-designed APMs can give physicians the ability to achieve far greater improvements in the quality and affordability of care for their patients than under MIPS, because APMs have the potential to overcome the barriers to better care that exist in the current payment system in ways that MIPS cannot. Moreover, good APMs can also help other healthcare providers – hospitals, post-acute care providers, laboratories and imaging centers, surgery centers, birth centers, etc. – to deliver better care at a more affordable cost in a way that is financially viable for the providers.

Efforts to develop Alternative Payment Models have accelerated over the past year in response to MACRA. Many organizations, including CMS, healthcare providers, private payers, provider associations, communities, the CMS-sponsored Health Care Learning and Action Network, think tanks, academic researchers, and others have developed, are developing, or are exploring the possibility of developing Alternative Payment Models. These efforts are focusing on a wide range of different types of patients, health conditions, procedures, and services, and they are using a variety of different payment concepts, such as bundled payments, condition-based payments, episode payments, and global payments.

However, stakeholders who are working to develop APMs are facing a number of significant barriers and challenges, and those who would implement APMs or receive care supported by them have expressed a number of serious concerns about the way

the APMs are currently being designed and about potential negative consequences poorly-constructed APMs may have on patients, providers, payers, and communities. Failing to address these problems in a proactive and effective way will slow progress in improving the quality and affordability of healthcare and make it difficult to build support for implementing more effective payment models.

Eight of these barriers and challenges, and recommendations for addressing each of them, are described in this report. The recommendations were developed by the participants at the 2016 National Payment Reform Summit on June 17, 2016. The Summit was convened by the Network for Regional Healthcare Improvement with assistance from the Center for Healthcare Quality and Payment Reform and with generous financial support from the Robert Wood Johnson Foundation. Over 80 national and local health care leaders from 33 states and Washington, DC helped develop the recommendations. The participants included physicians from 16 different specialties; executives of national and regional self-insured businesses; leaders of employer purchasing coalitions; representatives of hospital and medical associations; health plan executives; foundation leaders; directors of Regional Health Improvement Collaboratives; federal and state government officials; executives of health care Quality Improvement Organizations; consumers and representatives of labor organizations; and others with expertise and experience in efforts to design and implement better payment systems. (The Appendix includes a list of the participants.)

For each of the eight issue areas, a multi-stakeholder subgroup of the Summit participants was formed based on the interests and expertise of the participants. This subgroup reviewed and discussed a series of options for addressing the issue area, then the subgroup developed draft recommendations for addressing the barriers and challenges in that area. All of the Summit participants then collectively discussed the subgroups' draft recommendations and suggested refinements. The recommendations described in this report were those for which the majority of Summit participants expressed support. (It is important to note that all of the participants attended as individuals, not as representatives of organizations, so the participants' support for the recommendations does not imply endorsement by the organizations for which they work.)

Not surprisingly, given the diversity of the attendees, there was not unanimity about how to address some of the most complex and challenging issues facing payment reform efforts. However, the fact that an overwhelming majority of the diverse participants expressed support for each of the recommendations described in this report suggests that they deserve priority attention by all stakeholders.

1. Supporting Coordinated Team-Based Approaches to Care and Compensating Individual Providers Inside Bundled Payment Models

Description of the Issues

Most people would agree that if two or more clinicians or other providers (e.g., physicians, hospitals, home health agencies, etc.) are providing care to the same patient, it would be desirable for them to adequately coordinate their efforts in order to avoid delivering or ordering conflicting services or duplicative services, to avoid any gaps in services, and to address the patient's health conditions in the most efficient and effective way possible. However, this kind of care coordination can be difficult for many reasons, including:

- Patients obtain services from multiple clinicians and other providers without informing each provider of the other services they are receiving;
- Lack of interoperability among electronic health record systems prevents providers from learning about other services the patient has received;
- Health plan-defined networks may not include all of the clinicians and providers who work together as a team to deliver coordinated care;
- Fee-for-service payment systems pay each provider separately for the services they deliver regardless of whether they conflict with or duplicate services delivered by other providers.

- There is no explicit payment in most fee-for-service (FFS) payment systems to support the time and effort required for clinicians and other providers to coordinate their services. Clinicians are not paid for time spent discussing how to coordinate services for individual patients, and clinicians who play the role of a team leader are not compensated for the time involved in doing so.

Although fee-for-service payment is not the only reason that patients can receive uncoordinated care, payment models that effectively support coordinated or team-based care could potentially lead to solutions to the other problems described above. For example, more flexible payments could support telephone-based information sharing among teams of providers until more comprehensive electronic interoperability solutions are developed, and bundled payments could allow providers to form coordinated teams that health plans could use to define their networks.

It is important to recognize that patients will vary significantly in their need for coordination and in the benefits they will receive from greater coordination among healthcare providers:

- At one extreme, many individuals have only one health problem and it can be treated efficiently and effectively by a single clinician or other provider, so coordination among multiple providers is not even an issue. Other patients may have two or more health conditions that require treatment by different clinicians but where each condition, and the treatment for that condition, has little or no effect on the other conditions and treatments.
- At the other extreme, there are many individuals with multiple serious or complex health problems that require services from dozens of different clinicians and other providers, and the ability to successfully treat any one of their problems may depend heavily on how all of the other problems are treated.

In between these two extremes are a range of situations that require different types of care coordination:

- A patient may receive a treatment or other service that requires the simultaneous participation of two or more clinicians or other

providers. For example, a patient undergoing major surgery requires the simultaneous services of both a surgeon and an anesthesiologist.

- Effective treatment for the patient’s health problem may require the sequential use of two or more separate services that are delivered by different clinicians or other providers. For example, a patient with cancer might require both chemotherapy from a medical oncologist and radiation therapy from a radiation oncologist.
- A patient may have two different health problems that require services from two different clinicians or other providers, and the way one health problem is treated has a significant impact on the other health problem or the effectiveness of the treatment for it.

The benefits of a particular alternative payment model will depend not only on how effectively it supports each type of care coordination but also on the extent to which situations requiring those types of coordination exist in the patient population for which the payment model will be used.

It is also important to recognize that many of the problems with the quality and cost of health care today are not due to lack of coordination or the lack of payment models that explicitly encourage coordination. For example, a patient may receive unnecessary tests and procedures even when only one clinician is involved in their care, and a patient may be infected during a hospital stay even though the hospital receives a single payment for that stay. Coordination alone will not achieve high-quality, efficient care if individual clinicians or other providers are delivering poor quality, inefficient care to the patient.

Consequently, the benefit of a payment model will also depend not only on how well it supports coordination of care, but also on how well it supports quality and efficiency in the individual services that are being coordinated. For example, if two or more providers are paid through a single “bundled” payment in order to support and encourage coordination of care, a decision still has to be made about how each individual clinician or other provider will be compensated for what they do (i.e., what share of the bundled payment each will receive) and whether their compensation enables and encourages them to deliver their individual services in the highest

quality, most efficient way. Who makes this decision, and the options they can choose from, depends on the methodology the payer uses to implement the bundled payment:

- In a *prospective payment* methodology, the individual providers no longer bill the payer for their individual services; instead, some entity (either one of the providers or a partnership among the providers) receives the bundled payment and then allocates it among the individual providers as compensation for their individual services. For example, some physician groups, independent practice associations (IPAs), and health systems accept capitation or global payments and then compensate individual clinicians with a salary, while others continue to compensate individual clinicians based on “relative value units” that parallel fee-for-service payments.
- In a *retrospective reconciliation* methodology, the bundled or global “payment” is really just a budget or target for spending. Each individual provider continues to bill the payer and to receive payment using standard fee-for-service methods; the payer tabulates the total amount of the payments made for the services included in the bundle, and then some entity (either one of the providers or a partnership among the providers) receives any surplus (if the accumulated payments are less than the budget/target amount) or is responsible for repaying any deficit (if the accumulated payments exceed the budget/target amount). Here, the compensation for an individual clinician or other provider is the combination of (1) the fee-for-service payments the provider receives from the payer and (2) the provider’s share of any bonus payments received (when surpluses exist) or assessments paid (in order to cover deficits) by the entity responsible for keeping spending within the budget/target amount.

Under the same *payment* methodology, different *compensation* systems for the individual providers can either enable and encourage individual providers to deliver services in the highest-value way and to coordinate services with others, or they can prevent or discourage them from doing so.

Recommendations

Recommendation 1.1

Each patient should have the opportunity to have a clinician who takes responsibility for coordinating the services the patient receives from other providers who are involved with the patient's care. This clinician may delegate all or part of this role to one or more other healthcare professionals, and the members of this team should be compensated adequately for performing this comprehensive management role. In many cases, a primary care practice should play the comprehensive management role, but for some patients, a specialty physician practice should play that role, and in either case, other clinicians may serve as the coordinator for specific procedures or management of individual conditions. The appropriate amount of compensation for each of these coordination and management services should be based on the complexity of the work involved.

It is difficult for clinicians and other providers to work as a team without someone playing the role of "coordinator," but there currently is no payment to compensate clinicians for the time they spend or the extra staff they employ to fulfill this role. Many patients will need "teams within teams" (e.g., a team to manage care during and immediately following a surgical procedure for a particular health problem, and a broader team to coordinate the care for that health problem and the care for the patient's other health problems), and different individuals may be appropriate to coordinate these smaller and larger teams. These coordination roles are important and need to be compensated in order for clinicians and other healthcare professionals to be able to devote adequate time and resources to perform them effectively. Although it would be desirable to have a primary care clinician provide comprehensive management and coordination services for most patients, there are many patients for whom it would be more efficient and effective for a specialist to play that role, particularly if the patient has one dominant, serious health problem.

Recommendation 1.2

When a patient needs care for a specific health condition or needs to receive a particular procedure, a prospectively defined payment or budget should be established for all of the care needed for that condition or procedural episode, and each clinician or provider involved in delivering services as part of the care or procedure should be compensated for those services as a share of the overall payment/budget. Those providers should determine how best to distribute the payment/budget among them, and they should have the flexibility to redesign the way the care is delivered and the way the payment/budget is allocated as technology and evidence change over time. Payment/budget amounts should be risk-adjusted and additional amounts (outlier payments) should be paid for those patients who have needs for large numbers of services. Information on the quality and cost of services for the condition or procedure should be made publicly available.

In addition to adequately compensating the coordination role, the payment system needs to pay the entire team in a way that rewards both coordination and the delivery of high-value care. Under the current payment system, individual clinicians and other providers receive payments for each individual service they deliver regardless of how many services they deliver, how effective those services are, or how well coordinated the services are. Instead, the payment system should be designed to compensate teams rather than individual providers, and payments should be designed to reward high quality and affordable cost for all of the services needed for care of a condition or for a procedural episode, rather than merely to reward quality and efficiency of individual services.

In order to achieve the maximum benefit in terms of quality and savings, it is important that providers have the flexibility to redesign the way they deliver care for a condition or for a procedural episode and to make corresponding adjustments in the amounts individual providers are compensated for their redesigned care. To accomplish this, payment systems that use current fee-for-service billing codes and retrospective reconciliations must ensure that the budget is prospectively defined and the providers have flexibility to distribute the reconciliation payments or repayment obligations among themselves differently than would be possible under fee-for-service payment.

Recommendation 1.3

If a group of providers is receiving a global payment or budget designed to cover the total cost of care for all of the needs of a population of patients, that budget should be divided into prospective condition-based budgets and procedure-based episode budgets, and each clinician or other provider should be compensated for their services as shares of the budgets for the conditions and procedural episodes in which they were involved.

Paying for management of individual conditions or procedures rewards quality and efficiency of care within those conditions and procedures but does not discourage overuse of procedural episodes or encourage coordination of care across multiple conditions. Paying a group of providers based on the total cost of care for a population of patients avoids these problems, but the providers then need to have a way of allocating the overall budget that is different from traditional fee-for-service. This can be accomplished by defining condition-based budgets and procedural episode budgets, and using those budgets as a way to allocate the overall total cost of care budget among the teams of providers involved with each condition or procedure. Then the providers involved could divide the condition or procedure budget among themselves as compensation for their individual services, taking into consideration the quality/outcomes of the services delivered.

2. Protecting Providers from Excessive Financial Risk and Protecting Patients from Under-Treatment and Loss of Access to Care

Description of the Issues

To date, many of the payment reforms that Medicare and other payers have been implementing have produced disappointing results in terms of the amount of savings generated. Although this is most likely due to the fact that shared savings programs and similar payment models did not actually change the underlying fee-for-service payment system or remove the barriers it creates to delivering higher-value care, many have been attributing the poor results to clinicians having insufficient “financial risk” under the payment models. In response, Medicare and other payers have been trying to encourage or require physicians and other providers to participate in more “risk-based payment” models. In the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress required that in order for physicians participating in Alternative Payment Models (APMs) to be exempt from the Merit-Based Incentive Payment System (MIPS), the entity participating in an APM must bear “financial risk for monetary losses...that are in excess of a nominal amount.”

In an alternative payment model, the amount of financial risk from the perspective of a provider organization will differ from the amount of risk for the payer. For example, Medicare spends about five times as much on all aspects of a patient’s care than it pays to the physicians involved in the patient’s care simply because of the much higher amounts paid to hospitals, skilled nursing facilities, etc. For some physicians, total Medicare

spending for their patients can be more than ten times as much as the physician receives. This means that if a physician practice is at risk for 5% of Medicare spending, the physician practice could lose 25-50% or more of their revenues under such a payment model, which could easily force the practice out of business.

Also, the amount of financial risk from the perspective of a provider organization will differ from the amount of risk for the payer if some of the services that will be delivered by the provider organization are not separately paid for by the payer. For example, hiring a nurse care manager to provide education and self-management support to chronic disease patients can reduce avoidable hospitalizations, but the care manager is not a billable service in most fee-for-service payment systems. If a provider participating in an alternative payment model hires a nurse care manager, that will cause the provider's costs to increase but it will not cause the payer's spending to increase if the payment model does not explicitly pay for the nurse care manager. If the care manager does not reduce hospitalizations, the payer's spending on hospitalizations will not change, but there may be no additional payment to the provider to cover its added costs. In this example, the risk of loss to the provider would be greater than the risk of loss to the payer.

In addition, requiring physician practices or other providers to accept a particular *amount* of financial risk without defining the type of risk involved can be dangerous for both the providers and patients. The physician practice or other provider will be much better able to manage a given amount of financial risk if the risk is primarily associated with types of expenditures that the provider can control or influence than if it is associated with expenditures that the provider cannot control. For example, a clinician can control the number and types of medications prescribed for a patient but not the price of those medications. If physicians are placed at financial risk for spending on medications for their patients, they could be unable to succeed at a time when pharmaceutical companies are rapidly increasing prices, and patients would be understandably concerned that clinicians might avoid prescribing drugs they needed because the clinicians would be responsible for paying the higher prices themselves.

Similarly, a clinician can control what kinds of services they deliver or order for their patients, but they cannot control what health problems their patients have. These two different aspects to risk are often described as "insurance risk" (the risk

that a patient will have a health condition) and “performance risk” (the risk that unnecessarily expensive services will be used to treat a health condition once it appears). Under typical fee-for-service payment systems, payers incur both insurance risk and performance risk because providers will be paid more if they deliver or order more services, even if fewer services could have adequately treated the health condition. However, if a payment system pays providers the same amount to treat patients regardless of the number or severity of health problems they have, the payer has shifted insurance risk as well as performance risk to the providers, and the providers may be forced to respond by avoiding higher-need patients. Consequently, a well-designed alternative payment model should shift appropriate performance risk to providers while leaving all or most insurance risk with the payer.

A common approach that is used to try and protect healthcare providers from assuming insurance risk is “risk adjust” payment amounts, i.e., to make higher payment amounts for patients who are determined to have a higher risk score based on some type of risk adjustment formula. Unfortunately, the risk adjustment formulas that Medicare and other payers are using today for both resource use measurement and payment have many serious weaknesses that can inappropriately penalize providers who care for sicker patients and reward clinicians who do not. There are many reasons for this, including:

- Most risk adjustment systems are designed to predict *current spending* on patient care, not adjust for differences in patient *needs*. This can reinforce inappropriate spending, penalize efforts to reduce underuse, and cause providers to focus spending reduction efforts on the wrong patients.
- Most risk adjustment systems use *historical* information on patient characteristics, not the most current information on health problems that affect the services patients need. This can penalize providers who care for patients with many current acute healthcare problems.
- The patient characteristics used to calculate the risk score are given the same weight regardless of the specific type of health problem being treated, even though *different characteristics will have different levels of impact on the services of different providers*.

- Most risk adjustment systems only use diagnosis information currently recorded in claims data that does not completely or accurately measure *differences in the severity of patient health problems*.
- Most risk adjustment systems give little or no consideration to factors *other than health status* that can affect patient needs. For example, patients who have functional limitations are more likely to require higher spending on post-acute care services following discharge from a hospital, but measures of functional limitations are not included in typical risk adjustment systems.

Another aspect of risk is simply random variation. In any group of patients, some patients will need more services or more expensive services and others will need fewer or less expensive services, and in any year there will be more patients in one category than the other. This means that there can be increases and decreases in spending from year to year due purely to random variation, not because the provider caring for those patients has become more or less efficient. Over time these variations would be expected to average out, but in any given year, they could be significant. For providers with large groups of patients, the variations may be small relative to total spending, but for small physician practices, small hospitals, and other providers with small numbers of patients, random variation can have a significant impact on spending when measured over a short period of time. Unless appropriate adjustments are made for this, small providers will be unable to participate in alternative payment models or they could be bankrupted if they do.

Failure to adequately define and control risk for providers not only harms the providers but can also harm patients. If too much risk is shifted to clinicians and other providers, patients would be at risk of under-treatment because the payments made to the provider are not sufficient to cover the cost of all of the services.

Recommendations

Recommendation 2.1

In alternative payment models in which providers take accountability for delivering a range of services needed by patients within a fixed payment or budget amount, the amount of the payment or budget should be adequate to support the delivery

of care that is consistent with the best evidence available. If the costs of delivering care are higher in a geographic region because the cost of labor and locally-sourced goods are higher, payment amounts should be proportionally higher. The payment to the provider should also be adequate to maintain financial reserves or to purchase reinsurance needed to ensure there is sufficient funding to cover the costs of addressing variations in patient needs.

It is unreasonable to expect healthcare providers to deliver high-quality care to patients unless the payments they receive are adequate to cover the costs of that care. In many aspects of healthcare, there is not clear evidence as to the most efficient and effective way to deliver services, but in areas where evidence does exist, it should be used in setting appropriate payment rates.

In many cases, healthcare providers will need to make investments in facilities, equipment, personnel, and software that will support the delivery of services over multiple years. Participants at the Summit felt that it was important that payment amounts be sufficient to enable providers to make necessary investments in infrastructure, but that payments should not subsidize over-investment in infrastructure nor preserve more service capacity in a community than is necessary to support adequate services and choice for patients.

Certain types of equipment and personnel needed for the delivery of care are purchased in national markets and those portions of care delivery costs can be appropriately supported by a single national payment rate. Geographic adjustments should focus on the specific types of costs that are higher in specific geographic areas, such as regions where a high cost of living requires higher wage rates and rural communities that face higher costs for recruiting and retention of personnel.

In order for healthcare providers to be at risk when variations in patient needs can cause healthcare costs to exceed payment amounts, they will need to receive payments that are adequate to enable them to maintain financial reserves or to purchase appropriate levels of reinsurance. Smaller providers will need to spend proportionally more on reserves or reinsurance than larger providers because of the bigger percentage impact of individual high-cost patients.

Recommendation 2.2

The amount of payment in an alternative payment model should be stratified based on patient characteristics if (a) there are characteristics (including both clinical and non-clinical characteristics) that are outside the control of the clinicians and have a substantial effect on the cost of the services patients need and (b) there is a cost-effective way of collecting information on those characteristics and adjusting payment levels based on them.

Since some patients will need substantially more expensive services than others, it is important that the payment system make higher payments for those patients in order to avoid financially penalizing providers for caring for those patients and to ensure the patients can access necessary care. However, many current risk adjustment systems fail to adjust payments based on factors that are known to have large effects (such as severity of disease and patient functional status) because data on these factors are not readily available in healthcare claims data.

An effective risk stratification system should focus on factors that have a *causal relationship* with a patient's need for services, not just factors that happen to be available in claims data and are correlated with spending. In addition, in order to properly separate insurance and performance risk in an alternative payment model, risk stratification should be based on factors that are outside of the control of the clinicians caring for the patient, so that when clinicians help patients lower their risk factors, the clinicians will not be financially penalized with lower payments. However, because there is a cost to collecting information about patient characteristics for risk stratification and risk adjustment, this cost needs to be weighed against the benefit the additional information will have in improving the accuracy and fairness of payment.

Recommendation 2.3

Limits should be placed on providers' financial risk for services or aspects of service costs that they cannot control or influence.

There is greater risk associated with spending on a service when the provider cannot control or influence the utilization of the service, the cost of the service, or both. To avoid putting providers at risk for aspects of spending they cannot control, payments

and measures of spending should be adjusted in two ways: (1) they should exclude specific types of services that the provider organization cannot control or that occur rarely with high costs (e.g., organ transplants), and (2) they should be adjusted to account for price changes that the provider cannot control (e.g., an increase in the price of a drug for which there is no substitute) and for high prices in situations in which there are limited options for obtaining a service (e.g., a test that is only available from one high-cost provider in a community), while continuing to hold the provider accountable for reducing avoidable utilization of that service. This “Division of Financial Responsibility” (DOFR) between utilization and prices could be different for different providers in different markets depending on the nature of the services they deliver and the availability of lower-cost options in their community for the services they order.

Recommendation 2.4

Where evidence-based guidelines exist regarding appropriate treatment for a patient’s condition or effective delivery of a procedure, providers participating in an alternative payment model should be required to document (a) that the guidelines have been followed or (b) the reasons for deviation and the patient’s involvement in the decision.

If a provider does not receive an additional payment when an additional service is delivered, there is the risk to patients that the provider will fail to deliver the service to patients who need it. In order to ensure that the financial incentives in a bundled payment do not result in underuse of important services, providers could be required to use evidence-based guidelines to determine the appropriate use of services if such guidelines exist. The provider should not be required to *always* follow the guidelines, since (1) “guidelines” are intended as a guide, not a mandate; (2) most guidelines are not intended to cover every possible situation; and (3) evidence-based guidelines may not reflect the most current best practices due to lags in completing and publishing the results of clinical trials. However, when the guidelines are not followed, the provider should document the reason for deviation and document that the decision was discussed with the patient. The documentation for deviations can serve as an important data source to help improve guidelines, and there should be a way for those who develop and maintain guidelines to obtain and use these data for that purpose. Since current guidelines will likely be based on use of the kinds

of services that are supported by current payment systems, more deviations may occur when payment system give the flexibility to use different approaches. Also, there need to be mechanisms for developing additional guidelines and for keeping guidelines updated as evidence about effective care evolves so that providers are not being locked into outdated modes of practice.

Recommendation 2.5

Alternative payment models should support the collection and reporting of data on patient-reported outcomes.

One of the reasons for developing alternative payment models is that they can give healthcare providers the flexibility to redesign services in ways that will either achieve better outcomes for patients at similar costs or reduce costs while maintaining equivalent outcomes. Assessing the quality of care based on the provider's compliance with specific processes of care can inappropriately limit this flexibility. To address this, providers should be assessed based on patient-reported outcomes whenever possible, and payments under alternative payment models should be adequate to cover the cost of collecting and reporting patient-reported outcome measures.

3. Designing Payment Systems to Support Prevention and Long-Term Improvements in Health

Description of the Issues

In many cases, the healthcare services that a patient receives today will affect the types and cost of services they need in the future. For example, an immunization can prevent an individual from contracting a serious illness; a screening test (such as mammography or colonoscopy) can identify and treat a disease before it progresses to a more advanced state when treatment costs are higher and outcomes are worse; and individuals who stop smoking, lose weight, etc. can avoid developing health problems, slow the progression of existing conditions, or improve the effectiveness of treatments for the conditions they have.

However, there is a cost to delivering healthcare services such as immunizations, screening tests, weight loss clinics, etc. In some cases, the individual cost of the preventive service is relatively small, but when applied to a large number of individuals who are potentially at risk, the total spending can be significant. In other cases, the individual cost of the preventive service can be very large, and even though a relatively small number of people could benefit from the service, it will still result in very high short-term spending.

Even though spending on preventive services might result in savings from avoiding more expensive treatments, the savings will frequently occur one or more years after the costs of the preventive services were

incurred. Since patients who have health insurance frequently change insurers from year to year; the insurer that would pay for the preventive care will often not be the same insurer that would have paid for the future services. Consequently, an insurer may be reluctant to pay more for services today that result in savings in the future because the insurer will only be able to capture a portion of those savings, and insurance premiums will need to be higher if the insurer does pay more for preventive services.

This problem – costs and savings occurring in different years – will often be transferred to clinicians and other healthcare providers under alternative payment models. If the alternative payment model holds a physician practice, hospital, health system, or other healthcare provider accountable for the total cost of care for a patient during the *current year*, that provider will be penalized for delivering additional services today that might reduce total spending in the future.

The principal mechanism used today to address these problems in both pay-for-performance and bundled payment systems is to define a quality measure around the delivery of specific preventive services and to financially reward or penalize a clinician or other provider based on the proportion of patients who received the preventive service. However, the weaknesses with this approach include: (1) there is not a quality measure for every service that might have preventive value for individual patients, and (2) the amount of the bonus or penalty may not offset the cost of delivering the service (which means the provider could be better off being penalized on the quality measure than being penalized for the increase in spending resulting from delivering the additional preventive services). For example, in many “shared savings” payment models, savings must first be achieved, and then the share of the savings is reduced based on performance on quality measures. Under this structure, effective delivery of preventive care could reduce the amount of short-term savings generated, whereas failure to deliver preventive care could reduce the share of the savings given to the provider. This penalizes the provider either way.

Three further complexities also deserve mention:

- When previously-uninsured or under-insured individuals first obtain adequate health insurance, they often need to “make up” for services they have avoided

or delayed because of lack of adequate insurance coverage in the past. A provider who begins caring for these individuals and delivers the services they need will experience a short-term increase in resource use (if the provider is paid individually for each service delivered) or will experience a short-term drop in their operating margins (if the provider delivers services within a fixed per-patient payment amount).

- Something that is not a “healthcare” service may be better at preventing future healthcare needs than healthcare services. Access to healthy foods, places to walk or exercise, clean water, etc. can improve health, but they are not covered services under health insurance and are not paid for under healthcare payment systems tied to current fee-for-service structures. (See Recommendation 4 for more specifics on how payment models can address non-medical needs.)
- A healthcare service may successfully prevent or mitigate a future health problem, but it may not be cost-effective in terms of *healthcare spending*, i.e., the cost of delivering the preventive service (to those who could potentially incur the future health problem) is higher than the total amount of future savings from the healthcare services that would be prevented. This does not mean that the preventive service is of low value, since it could save lives, improve individuals’ quality of life, enable individuals to work productively, etc. However, those benefits would not be reflected in healthcare spending.
- It is very difficult, if not impossible, to develop evidence about what works if there is no way to pay for promising preventive services so the impact on outcomes can be evaluated.

The problems are not caused solely by the way payers pay healthcare providers. For patients who do not have health insurance, the patient may not be able to afford the preventive care, and even if the patient has health insurance, the patient may not be able to afford the cost-sharing required for that preventive care, even though it could mean they would not face the need to pay for an even less affordable treatment in the future. The Affordable Care Act required that certain types of preventive services be covered by insurers without requiring cost-sharing by patients, but this does not address other types of services that might result in lower future spending, and it does

not address the problem for uninsured patients. Reducing patient cost-sharing but paying providers the same amount for preventive service means that total spending will increase even more for providers who deliver more preventive services.

Recommendations

Recommendation 3.1

Population-based payment models should use outcome-based population health measures and risk adjustment systems that are designed to support population-specific and community-specific priorities for prevention and health promotion.

Rather than specifying what services should be delivered or rewarding the delivery of specific services, population-based payment models should use outcome-based measures wherever possible. For example, the clinicians managing a population of patients should be measured based on outcomes such as the rate of influenza and reductions in the rate at which patients are diagnosed with late stage breast or colon cancer (for which treatment is more expensive and less likely to be successful), rather than merely measuring the proportion of patients who receive a flu shot, a colonoscopy, or a mammogram. Different subgroups of patients will derive different levels of benefit from a preventive service, and there are higher rates of false positive results from screening low-risk populations, so a clinician might achieve better outcomes by targeting prevention services on the patients who are at highest risk even though a smaller proportion of the total eligible population received the preventive service.

This outcome-based approach requires several things:

- Outcomes and spending must be measured over a multi-year period, because the improved outcomes and associated savings may occur in a different time period than the period in which the costs are incurred (e.g., a significant proportion of the savings from fewer influenza cases may occur the year after flu shots are administered, and the savings from treating fewer late-stage cancer diagnoses will be achieved multiple years after cancer screenings are performed).
- Payment amounts and outcome measures must be appropriately risk-adjusted based on factors that affect the costs of delivering preventive care services

and factors that affect outcomes. These factors will likely include both medical characteristics of patients and non-medical factors such as the patient's ability to easily access standard sources of care or the availability of caregivers at the patient's home.

- The outcome measures used should be appropriate for the types of patients who are being managed under the alternative payment model. For example, the benefits of preventive services differ between elderly patients and younger populations and differ between patients who are healthy and those who have existing health problems. There may also be different risk factors in different communities that justify the use of different outcome measures and different factors in risk adjustment systems. Ideally, issues and priorities specific to population groups and communities would be identified by multi-stakeholder groups involving patients, purchasers, and clinicians and other providers.

Recommendation 3.2

If a payment model is based on measures of value that use annual measures of spending, high-value preventive services with multi-year benefits should be paid for through a separate payment mechanism or budget in order to facilitate patient access to the services, to protect against underuse of services, and to enable flexibility in the way preventive services are delivered.

Although payment models that measure value based on multi-year spending and outcomes are preferable, most current value-based payment models use annual measures of spending and quality measures based on processes or short-term outcomes because many patients change health plans each year. For patient populations where multi-year outcome and spending measures cannot be used, a separate payment mechanism or a separate pool of resources should be created that is dedicated to the services expected to have benefits over a longer period of time. In the examples cited above, payments for influenza immunizations and cancer screening services could be made differently or separately from payments for other types of services. For example, immunizations and cancer screening services could continue to be paid for on a fee-for-service basis, or providers could be given a risk-adjusted budget or pool of funding that could only be used for these preventive services but would allow flexibility to target the services to higher-risk patients.

In some cases, it may be more efficient and effective for preventive services to be delivered through community organizations or shared-service arrangements among multiple clinician practices rather than as traditional office-based medical services, and more flexible payment models could facilitate those approaches.

4. Supporting Adequate and Appropriate Care for Patients Facing Non-Medical Challenges

Description of the Issues

There is growing recognition that both the effectiveness of healthcare services in addressing an individual's health problems or in preventing future health problems and the cost of those services depend on characteristics of the patient other than their medical conditions. Moreover, for many patients, medical services alone may not be the most effective approach to treating or preventing health problems. For example:

- A hospital with a high proportion of low-income patients may have a higher readmission rate than other hospitals because many of the low-income patients do not have access to a primary care clinician (e.g., because there are no primary care clinicians located close to where the patients live and the patients do not have affordable transportation).
- The average total cost for joint replacement surgery may be higher for a surgeon or hospital with a high proportion of patients who live alone or have functional limitations, because those patients will likely require more expensive post-acute care following surgery.
- Low-income children may have persistent asthma problems because of environmental conditions in their home (e.g., dust, smoking, etc.),

and a greater reduction in asthma exacerbations may result from correcting those environmental triggers than by prescribing more powerful asthma medications.

- Patients who cannot drive may have difficulty coming to a clinician's office for care that might avoid an emergency room visit, but health insurance does not pay for transportation to see a clinician (although it will pay for an ambulance trip to an emergency department).

Recent efforts to address this issue have focused on whether and how to adjust measures of the quality and cost of healthcare services. Health care providers have advocated for risk adjusting or stratifying performance measures based on demographic and socioeconomic characteristics of patients in order to ensure the providers are not penalized financially when they provide care for patients who have such characteristics. In contrast, purchasers and patient advocates have been concerned that adjusting measures based on such characteristics implicitly condones the delivery of lower-quality or lower-efficiency care to individuals who have those characteristics.

Adjusting performance measures can be problematic when the characteristic being used for adjustment is merely a proxy or correlate for the factor that is truly affecting performance. For example, hospital readmission rates will likely be higher for many low-income patients not because of their low income *per se*, but because low income patients are less likely to have insurance or access to primary care and other services that could help reduce hospitalizations. Income may be easier to measure than access to care, but adjusting measures based on income can lead to a problematic measure of performance, since improvements in access to primary care would not be reflected in the income measures being used for adjustment.

Adjusting performance measures for the specific non-medical challenges patients face solve these problems, but it would not increase the providers' ability to help their patients overcome the challenges. Using a non-medical service to address a patient's non-medical needs could potentially result in improvements in their health status or enable medical services to be more effective. However, these non-medical services are generally not covered by health insurance and there is no financial support for either healthcare providers or other service providers to deliver them,

even if the savings in healthcare costs would be greater than the cost of the non-medical services.

Alternative payment models may or may not address these barriers, depending on how the payment model is structured. For example, it can be difficult to address non-medical barriers for low-income patients in a shared savings payment model for several reasons:

- Delivery of non-medical services that are not directly reimbursable could require a provider to incur significant costs with no revenues to support them until a shared savings payment is received.
- Helping an individual on Medicaid to avoid the need for an emergency room visit, a hospitalization, or other service may produce a smaller dollar amount of savings than it would for a Medicare beneficiary or a member of a commercial health plan because Medicaid may pay less for those services than Medicare or a commercial health plan. Even if low-income patients have higher rates of avoidable utilization, an initiative that successfully reduces utilization may not generate enough savings to cover the cost of the non-medical services because of low payment rates for the avoided services.
- It may take longer to achieve savings because of the time needed to fully resolve non-medical challenges and the need to “catch up” on the healthcare services patients have missed due to inadequate access.
- There may be greater benefits from improved care than are reflected in healthcare spending. For example, individuals who can successfully address their health problems may be better able to find work, retain a job, and earn more.

Recommendations

Recommendation 4

Payments to clinicians and other healthcare providers should allow flexibility for the provider to use the payments to purchase or deliver non-medical services for a patient with non-medical challenges in addition to or instead of medical services if the provider believes the non-medical services will enable better outcomes for the

patient without increasing overall spending for payers than the delivery of medical services alone. For patients with non-medical challenges, outcomes should be measured over multi-year periods and the impacts on outcomes other than health, such as reducing unemployment, homelessness, etc., should be considered.

Although one of the goals of bundled payments and many other alternative payment models is to provide greater flexibility to a physician practice or health system to deliver services in different ways, in many cases the payments are required to be used only for medical services or the payment amounts are adjusted over time based only on the medical services that are delivered. For patients who face non-medical challenges to improving their health, such as lack of transportation to health services or sources of fresh foods, payers should permit providers to use the payments to deliver or purchase non-medical services as well as medical services as long as this does not increase the total payments made and as long as it maintains or improves patient outcomes. For example, paying a physician practice using a monthly per-patient payment rather than payments tied to physician office visits or medical procedures would give the practice the flexibility to provide or arrange for transportation to help a patient visit the physician practice in order to receive needed preventive care, or to pay for small modifications to the patient's home (e.g., a ramp or carpet repairs) that would improve the patient's mobility and avoid injuries.

Since clinicians and other providers of medical services may not be the most efficient or effective entities to deliver non-medical services, it is important that providers have the flexibility to use payments to purchase services from other entities. However, in order to ensure that those services are used in ways that support reductions in total healthcare spending, it is important that the healthcare providers determine when healthcare funds should be used for non-medical services. It will also be important to ensure that non-medical services are used to address genuine barriers to improving patients' health, rather than being used as inducements for patients to choose particular healthcare providers.

It should not be assumed that merely providing *flexibility* to use payments for non-medical services will enable non-medical challenges to be successfully addressed if the total amount of payment is not sufficient. If payments are stratified such that payment amounts are larger for higher-need patients, then providing the flexibility

to use the higher payments for non-medical services can enable better outcomes to be achieved for the same amount of payment or to enable similar outcomes to be achieved at lower cost than if only medical services could be used.

In addition, measuring costs, savings, and quality within one-year periods can penalize providers for delivering services to patients with non-medical challenges or for implementing programs to help such patients that require more than one year to achieve results. For patients with significant non-medical challenges, performance measures should calculate costs, savings, and quality for these patients over a multi-year period. Also, when the amounts of payments are updated over time to ensure they are adequate to cover costs, the costs of both the medical services and non-medical services need to be considered.

The value of addressing non-medical challenges can extend beyond improvements in health status to include outcomes such as reducing unemployment or homelessness. Although it is unreasonable to expect that spending intended to address patients' healthcare needs can or should be adequate to fully address these kinds of significant, ongoing social needs, improvements in patient outcomes other than health status could be considered when assessing provider performance in a budget-neutral payment change.

It would likely be desirable to first implement more flexible payment approaches in pilot projects in order to determine the most efficient ways to deliver the non-medical services and how best to target those services to individual patients in ways that would improve patient outcomes without increasing total spending.

Options Meriting Further Development and Discussion

Option Requiring Further Analysis: Create “community based health collaboratives” that would assume responsibility for addressing both healthcare needs and the social determinants of health in a more integrated way.

Some participants at the Summit felt that it could be more efficient or effective to make payments directly to a non-medical provider rather than a medical provider for delivery of services to address non-medical challenges. However, there were concerns about whether this would fragment care delivery and there were questions

about the nature of the accountability for health outcomes that a non-medical provider could accept.

To address this, the participants discussed a proposal to create “community based health collaboratives” that would assume responsibility for addressing both healthcare needs and the social determinants of health in a more integrated way. These entities would not be expected to accept insurance risk (i.e., they would need to receive higher payments from payers for individuals with more health problems), but they would be expected to take accountability for achieving better outcomes for individuals than could be achieved through either medical care alone or through social services alone. This would require new payment and service delivery arrangements between health plans, healthcare providers, social service agencies, and other entities. Although many participants felt this concept was worth pursuing, there was not sufficient time at the Summit for participants to adequately define how the concept could be implemented and to assess its advantages and disadvantages.

5. Providing Adequate Support for Hospitals' Essential Services and Medical Education Costs

Description of the Issues

The methodologies used by Medicare and most payers to pay hospitals for their services create financial rewards and penalties for hospitals that conflict with efforts to reduce avoidable admissions and readmissions, unnecessary testing and imaging, etc. For example, although the case rate (DRG) structure used by Medicare and many other payers encourages hospitals to deliver care during each hospital stay as efficiently as possible, it creates large financial penalties for a hospital when admissions decline, and it can create excessive financial rewards when admissions increase. This is because the majority of costs in a hospital are fixed, at least in the short run, and the payments are much larger than the hospital's marginal cost for the services. Even if the DRG payment amounts to the hospital match the average cost per case at the hospital's current volume of patients, the same DRG payment amounts will create a large profit for the hospital when it has more admissions and large losses when the hospital has fewer admissions. Similarly, payments that are made for outpatient services may be higher or lower than a hospital's costs depending on the volume of services, creating financial rewards for the hospital when the volume of services increases and penalties when volume decreases.

Hospitals are both required by law and expected by their communities to have certain essential services available to residents and visitors in the

community. Community residents need 24/7 access to an emergency department, a cardiac catheterization center, imaging and laboratory services, a surgical suite, etc. in order to avoid preventable deaths and complications from accidents, heart attacks, strokes, etc. However, Medicare and other payers do not provide direct support for the costs associated with maintaining these “standby services.” Instead, hospitals must support those costs using the revenue derived from payments for actual emergency room visits, cardiac catheterizations, CT scans, surgeries, and unrelated procedures and services. Consequently, when there are fewer ED visits, tests, procedures, and admissions, payers will spend less, but the hospital will have a more difficult time maintaining its essential standby services. Under the structure of the current payment system, improving the affordability of care has the potential to decrease timely access to essential services for patients.

Teaching hospitals are doubly penalized by the structure of the current hospital payment system, because they rely on revenues from admissions not only to pay for their standby services (the costs of which may be higher than in a community hospital because of the unique, specialized standby services delivered by an academic medical center) but also to pay for their medical education and research costs. Although Medicare pays teaching hospitals more than other hospitals to cover the costs of their teaching functions, these payments are explicitly tied to the number and types of admissions to the hospital. Most commercial payers do not explicitly support teaching costs through a direct payment, but many do so implicitly by making higher payments to teaching hospitals for an admission or service than they do to other hospitals, so as a practical matter, all of the teaching hospital’s payments for teaching and research are tied to the number of patients it treats. These explicit and implicit ties between patient admissions and teaching/research revenues mean that admitting fewer patients to an academic medical center jeopardizes the hospital’s ability to pay for teaching and research as well as its ability to sustain its standby services.

The smallest hospitals in the most rural communities in the country are classified as Critical Access Hospitals and are paid by Medicare through a “cost-based reimbursement system” rather than the case rates and service payments under the Inpatient and Outpatient Prospective Payment Systems. A much higher proportion of these hospitals’ budgets are used to support essential standby services for their

communities such as emergency rooms, because the hospitals are too small to support more advanced services and because the volumes of patients using the emergency room are lower than in urban areas. Although it would seem on the surface that cost-based reimbursement would better support a high proportion of standby service costs and avoid the problems of payments being higher or lower than costs as patient volumes change, this would only be true if a hospital were paid for *all* of its patients based on its costs. Because Medicare's cost-based payment system for Critical Access Hospitals only pays the hospital based on its costs for *Medicare* patients, the hospital cannot generate an adequate operating margin to cover the costs of services delivered to uninsured patients. Moreover, every non-Medicare patient the hospital treats reduces the Medicare payments the hospital receives to cover its fixed costs, because Medicare only pays for the proportion of the hospital's costs that is allocated to Medicare beneficiaries.

Under Congressional budget sequestration rules, Medicare currently only pays Critical Access Hospitals 99% of their actual costs allocated to Medicare beneficiaries, not 101% of their costs as it did in the past. In other words, today, if a Critical Access Hospital only treated Medicare beneficiaries, it would go bankrupt because the law requires that the hospital receive less revenue than its costs, no matter how low those costs are. However, even if sequestration were not in effect for Critical Access Hospitals, a 1% margin would likely not be sufficient to allow the hospital to cover the costs of treating uninsured patients, to make capital investments in equipment and facilities, etc. This payment system creates significant pressures for a Critical Access Hospital (CAH) to treat or admit commercially-insured patients and it creates financial penalties for a CAH if it supports efforts to reduce avoidable admissions and readmissions for Medicare beneficiaries.

Recommendations

Recommendation 5

The amount of financial support provided to a graduate medical education program should not be based on the number or costs of hospital inpatient admissions, discharges, or days.

Medicare currently calculates Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) payments to teaching hospitals based on the Medicare share of inpatient days and the payments for Medicare patients discharged from the hospital. Instead, Medicare could deliver the same amounts of money to each hospital using a formula that does not penalize the hospital for reducing inpatient admissions or reward it for increasing them. The DGME and IME payments for a hospital could still be calculated using a formula based on a measure of teaching intensity at that hospital.

Commercial health plans could be permitted or required to contribute funds to a federal or state fund to support teaching costs at hospitals, and then the plans could reduce their payments to teaching hospitals for individual admissions by a corresponding amount. This would result in no increase in spending by the health plan and no reduction in revenue to the medical education program, but it would eliminate the financial penalty faced by the medical education program when hospital utilization decreases.

Since the majority of healthcare services are not delivered during inpatient hospital stays, medical education should not be limited to inpatient hospital-based programs. Separating the payments for medical education from payments for hospital admissions creates the opportunity to support new approaches to medical education. It also provides the opportunity to allocate medical education funds based on the type of medical education a teaching program offers, rather than based on the types of inpatient admissions a hospital has.

Options Meriting Further Development and Discussion

Participants at the Summit discussed a number of options for how payment systems could be changed to provide adequate support for hospitals' essential services in conjunction with efforts to reduce avoidable hospital admissions and outpatient services. There was not sufficient time at the Summit to reach consensus on a desirable approach, but two options were identified that many participants felt merited further development and analysis:

Option Requiring Further Analysis: Create a new category of hospital facility that offers a less extensive range of services than current hospitals and that would be eligible for a different type of Medicare payment.

In small and rural communities, there may not be a sufficient volume of patients or an adequate ability to recruit clinicians to enable a hospital to deliver the full range of services offered by larger hospitals, but the hospital may feel compelled to do so by regulatory requirements or by the need to obtain sufficient revenues to cover its fixed costs. These communities need a financially viable way to retain an emergency department and right-size their hospital inpatient and outpatient services. One approach could be to define a new category of hospital with different regulatory requirements and payment amounts.

Option Requiring Further Analysis: Create community-based mechanisms to encourage and legally enable competing facilities and providers to cooperatively design a more efficient and effective approach to delivering clinically integrated care.

Many communities have multiple hospitals, each of which made investments in the capacity to deliver services based on assumptions about the types and volume of services needed in the community that are no longer valid. This has resulted in hospital overcapacity in the community in aggregate, even though no individual hospital may have more capacity than the community needs. Under the current payment system, any hospital that reduces its service volume could harm itself financially while other hospitals could increase their volume and improve their finances, and an effort by the hospitals to divide services among them would be seen as a violation of antitrust law. Consequently, a mechanism is needed to encourage and facilitate competing facilities to develop a “right-sized” competitive environment. This would likely need to be implemented through a community-based multi-stakeholder process, with assistance from national guidelines on the number and types of services needed for a community based on the size and characteristics of its population.

6. Changes in Patient Benefit Designs Needed to Support Successful Payment Reform

Description of the Issues

In general, “alternative payment models” are defined in terms of changes in the way that a payer pays a provider for delivering services to patients. However, the structure of the patient’s insurance benefits can also affect the type of healthcare services they receive and it can affect a provider’s ability to deliver higher-quality, lower-cost care under the alternative payment model. For example:

- If the cost sharing amount the patient is required to pay for a service is too high, the patient may be unwilling or unable to use that service, even if the service might avoid the need for other, more expensive services.
- If a high-value service is not a covered benefit for the patient, the patient may be unable to obtain the service even though it might avoid the need for other, more expensive services.
- If the highest-quality or lowest-cost provider of a service the patient needs isn’t included in the health plan’s network or if the patient is required to pay a high cost-sharing amount to use that provider, the patient’s clinician may be unable to achieve the best outcomes for the patient at the most affordable cost.

- Low-cost sharing for low-value services may encourage patients to use those services, increasing overall costs of care without corresponding improvements in outcomes.
- A patient's freedom of choice regarding providers in Medicare and in most commercial PPO plans may result in a patient choosing to use providers other than those who are members of a coordinated team.
- Even if the cost-sharing for a bundled payment is lower than the sum of the cost-sharing payments the patient would have made for each of the individual services included in the bundle, a patient may perceive the single cost-sharing to be higher and resist obtaining the services from the providers participating in the bundled payment.

Despite the potential impact of benefit design on the success of payment and care delivery reforms, changes in benefit designs are often not even considered in developing alternative payment models because of barriers to making the changes. For example:

- Many aspects of benefit structures are established by law and cannot be changed without Congressional or state legislative action.
- Changes in the benefit design for a health insurance plan may require approval from the state insurance official(s) in the state(s) where the plan operates.
- Benefit structures may be based on compensation agreements negotiated between employers and unions, so changes can only be made through a new round of collective bargaining.
- Benefit structures for pharmaceutical insurance may be determined by a completely different entity (i.e., in Medicare, a Part D insurance plan rather than CMS, or in commercial insurance, a pharmacy benefit manager rather than the medical benefits administrator).

In some cases, an alternative payment model can indirectly overcome a limitation in a patient's benefit design. For example, a healthcare provider could choose to use

the revenues from a flexible payment to deliver a service to a patient that the payer would not pay for separately. If the provider feels that the cost-sharing for a service is too high, the provider might make a payment to the patient to offset their cost-sharing amount. If the provider feels the cost-sharing for a low-value service is too low to discourage patients from using it (e.g., for patients on a Medicaid plan with zero or low cost-sharing for all services), the provider might make a payment to the patient if they use a high-value service instead of the low-value service.

However, there are legal barriers to using payment models to solve problems with benefit designs. For example, under the federal Civil Monetary Penalties law, a healthcare provider is liable for penalties for offering “inducements” to Medicare beneficiaries, including waivers of cost-sharing, that may influence them to use particular providers. The Centers for Medicare and Medicaid Services (CMS) and the Office of Inspector General (OIG) have used authority under the Affordable Care Act to waive these penalties for services offered by Accountable Care Organizations participating in the Medicare Shared Savings Program and for participants in a number of the payment demonstrations operated by the Centers for Medicare and Medicaid Services, but the waivers are limited to providers participating in specific programs and are not automatically available to any provider who wants or needs such a waiver.

Recommendations

Recommendation 6.1

A clinician or other healthcare provider who is taking accountability under an alternative payment model for improving the quality of care for a patient and for controlling the cost of the patient’s care should have the flexibility to design or redesign cost-sharing requirements for the patient where necessary to enable and encourage the patient to adhere to a care plan developed through a shared decision-making process.

Even if an alternative payment model provides the flexibility and resources a clinician or other provider needs to deliver better care to patients, the provider’s ability to achieve the desired outcomes for a patient may be limited if the benefit design in the patient’s health plan creates financial barriers that make it difficult for the patient to obtain the necessary services. Consequently, providers that are participating in

alternative payment models (APMs) should have the ability to reduce cost-sharing requirements for services that they believe are essential to better outcomes, and to modify cost-sharing requirements in ways that encourage the use of higher-value providers and services and discourage use of lower-value providers and services. In some cases, cost-sharing might be reduced for providers or services that are nominally more expensive but that enable the overall costs of care for the patient to be lower.

While reducing cost sharing on a service for *all* patients would likely increase payer spending on that service and potentially lead to overuse of the service, cost-sharing reductions that are limited to the patients participating in an alternative payment model would not have that same impact because the provider in the APM is taking accountability for controlling costs and quality and can take steps to ensure that patients do not overuse services when cost-sharing is reduced.

Similarly, the factors that led to a provider being excluded from a health plan network may not be applicable or relevant to the specific service that the patient needs for successful management of their health condition(s) under the APM. If the clinician who is managing the patient's condition under the APM is accountable for the cost and quality of the patient's care, then the clinician would only refer patients to the out-of-network provider in situations in which that provider would be expected to deliver better outcomes at lower costs than in-network providers. This, in effect, allows the clinicians and other providers who are participating in an alternative payment model to partially define their own networks for their patients.

If cost-sharing amounts cannot easily be reduced directly for the patients in an alternative payment model, then payments to the providers could be increased so that they can make payments to the patient that offset cost-sharing requirements. This would need to be accompanied by changes to or waivers of laws that prohibit or restrict such payments, while continuing to restrict the use of such payments purely as inducements for patients to seek unnecessary care.

In order to ensure that benefit design changes are used to support use of things that will help patients, providers and patients should engage in shared-decision making processes to establish patient care plans that patients support, and then the benefit

design changes should be structured in ways that will enable patients to adhere to those care plans.

Recommendation 6.2

Providers should be transparent about the quality of care they deliver so that patients can be assured that they are receiving high-quality care under value-based payment systems and benefit designs.

Patients need to be assured that changes in benefit designs that encourage the use of specific providers or services will maintain or improve the quality of the patient's care, not simply reduce its cost. A key part of that assurance is providing patients with meaningful, complete, understandable information about the quality of the providers and services they are being encouraged to use.

Information on the quality of care should be collected and reported by healthcare providers using valid measures. Measures should be risk-adjusted or risk-stratified as well as possible in order to ensure providers are not penalized for caring for sicker patients and to enable patients to make apples-to-apples comparisons of provider performance. (See Recommendations 2.2 and 7.1 for further recommendations regarding the development and use of risk stratification systems in alternative payment models.)

7. Data and Analyses Needed to Develop and Implement Successful Payment Models

Description of the Issues

Successful implementation of truly innovative care delivery models could result in significant changes in the types of services patients receive and the costs of delivering those services. Implementation of payment models that will support these kinds of care delivery changes could result in significant changes in how much is spent on particular patients and types of care, in the revenues received by different kinds of healthcare providers, and in the administrative costs of both providers and payers. The Institute of Medicine estimated that 30% of current healthcare spending goes to unnecessary services, inefficiently delivered services, excess administrative costs, prices that are too high, missed prevention opportunities, and fraud.

It is unrealistic to expect healthcare providers to make changes in care delivery that would improve quality or reduce total spending if the payment system does not provide sufficient revenues to cover their costs. It is also unrealistic to expect that purchasers and patients will pay more or differently for services without assurances that quality will be improved, spending will be lower, or both. Both providers and payers need to be assured that there is a business case for them to implement a new payment model and a new approach to care delivery.

However, both providers and payers often have difficulty determining whether there is a business case for a proposed change in the payment system or in the care delivery structure because they do not have access to all of the data needed to analyze the cost and revenue impacts of the change. Moreover, providers or payers who want to develop an alternative payment model often have great difficulty doing so because the necessary data and analyses cannot be obtained. Some of the most important gaps in data and analyses include:

- **Difficulty of Obtaining Medicare Data.** It is difficult and expensive for clinicians, hospitals, and other providers to obtain and analyze Medicare claims data related to their services and patients in order to develop alternative payment models or to assess how a particular model might impact them. CMS has been providing “Quality and Resource Use Reports” (QRURs) to physician practices for several years, but the reports are focused specifically on the quality measures and resource use measures that CMS has developed, and there is no flexibility for clinicians to look at different aspects of care delivery or to disaggregate the data more finely. Although CMS has been making more of its claims data publicly available, each individual data release represents only one narrow view and cannot be connected to other types of data. For example, CMS has released data on Part B billings by individual physicians, but there is no way to connect the Part B services to any associated Part A services or Part D medications even though those may represent far greater amounts of spending, bigger opportunities for improvement, or bigger risks under an alternative payment model. Even participants in CMS-sponsored alternative payment models have had difficulty getting timely access to the kind of complete and accurate Medicare claims data they need to successfully manage care for the patients in the alternative payment model.
- **Lack of Funding for Qualified Entities.** The Affordable Care Act authorized the formation of Qualified Entities (QE) to receive detailed Medicare claims data for the purpose of public reporting of quality measures, and the Medicare Access and CHIP Reauthorization Act (MACRA) expanded the authorization so that QEs could provide analyses of Medicare data to physician and provider organizations, including for purposes of developing alternative payment models. However, most states and regions do not have a Qualified Entity, and there is no federal funding to support the creation of QEs or to cover their operating costs.

- **Limited Availability of All-Payer Claims Data.** Health problems and healthcare services are different for commercially-insured patients and Medicaid patients than Medicare beneficiaries, so claims data from those other payers are needed to analyze or develop payment models related to their patients. Moreover, Qualified Entities can only receive Medicare data if they are already receiving and analyzing healthcare claims data from other payers. In a few states and regions, the majority of payers are providing claims data to a QE or to an all-payer claims database; in other states and regions, a subset of payers do so; but in many states and regions, there is no way that providers or members of the public can gain access to claims data or obtain analyses of healthcare utilization and spending.
- **Secrecy About Prices.** In some cases, commercial health plans have made claims data available but with the payment amounts (the “allowed amounts”) suppressed. This makes it impossible for providers to determine what would be saved by using less of a particular type of service and what it would cost to use more of another service.
- **Claims data has limited information on key clinical characteristics of patients.** Key pieces of clinical information about patients that can be essential to designing payment models and analyzing their impacts are not recorded in health care claims forms. These data may be stored in electronic health records, but many electronic health record systems are not designed to allow data to be queried in customized ways by healthcare providers. In some cases, the EHR is not designed to store the relevant information in a structured data field, which makes retrieval and analysis even more difficult.
- **Clinical data is provider-specific not patient-focused.** Even if electronic health record data can be queried, the data in an individual EHR will generally only contain information relevant to the health problems treated by that provider organization, and it will not contain information on health problems treated by other clinicians or providers. Conversely, health plans and other payers may have information on all of the billable services a patient received from all providers through their claims data, but they will not have access to the clinical information in EHR data that fills in the gaps in claims data. Getting all of the necessary

information requires combining clinical information from EHRs and service and payment information from claims data.

- Claims data only contain information on services that are eligible for payment. Physician practices typically perform a variety of services for patients that are not directly billable and that are supported indirectly by the revenues from services that are billable. A new approach to care delivery may require an increase in the use of the non-billable services (e.g., more phone calls with patients to proactively identify and resolve health problems before they escalate) and may result in a reduction in the use of billable services (e.g., fewer office visits with clinicians). Data from claims forms would not accurately reflect the new mix of services and could make it appear that fewer services in total were being provided.
- Payment rates are not the same as a provider's costs, particularly when the volume of services changes. Most services delivered by a physician practice, hospital, or other healthcare provider involve some combination of fixed costs and variable costs. This means that when the number of services delivered increases, the average cost per service will decrease, and vice versa. Beginning a new service may require a significant investment upfront, which will result in higher costs initially than later. Most providers do not have the necessary cost data or the ability to analyze the impacts on costs that will result from changes in the volume or types of services delivered. Cost accounting systems may provide useful information about how costs are allocated today, but they are generally not designed to simulate the impacts of significant changes in services.
- Shortage of Skilled Analysts. Even when claims, clinical, and/or cost data are available, skilled analysts are needed to turn those data into actionable information. Most organizations that are trying to analyze healthcare data have difficulty finding and retaining individuals with the right combination of statistical skills and clinical knowledge to do this work.

Recommendations

Recommendation 7.1

Data on all of the important clinical and non-clinical factors that can have a significant impact on patient needs and outcomes must be accessible in order to support development and use of valid and reliable risk stratification methodologies in performance measures and alternative payment models.

Effective risk stratification methods are essential to both performance measurement and alternative payment models. If providers who treat higher-need patients do not receive adequate payment to address those needs and if performance measures do not recognize the greater challenges those providers face in achieving good patient outcomes, higher-need patients will have greater difficulty finding providers willing and able to treat them.

The variables used in most current risk adjustment methodologies do not include many important clinical and non-clinical factors that affect patients' need for services. As a result, the predictive ability of these models is low and clinicians do not see them as valid measures of the important differences in patients. Efforts to improve access to data should focus on the types of information that could enable significant improvements in risk adjustment methodologies. (See Recommendation 2.2 for more details on defining appropriate risk stratification methods.)

Although it would be desirable to have an approach to improved risk adjustment/stratification that could be used for a wide range of patients and conditions, the factors that affect costs and outcomes differ from condition to condition and they can even vary from community to community, and the validity and reliability of risk adjustment/stratification should not be sacrificed for the sake of standardization.

Recommendation 7.2

Linkages must be developed between the information in claims data, the information in electronic health records and registries, and information on patient-reported outcomes in order to provide the analyses needed to improve care and measure performance. Funding should be provided to enable Qualified Entities (which have multi-payer claims data), Qualified Clinical Data Registries (which collect clinical

information relating to patient care), and Patient-Reported Outcome databases to link their data for specific uses that will benefit patients, payers, and providers and that incorporate appropriate protections to ensure responsible use.

Quality measures, resource use measures, and risk stratification methodologies require three different types of data – data on services delivered to patients and the amounts paid for those services, data on the characteristics of the patients that can affect their needs and outcomes, and data on the outcomes experienced by patients following treatment. There is no one source for these three types of data, so linkages are needed among the data sources in order to properly measure and analyze healthcare performance. The organizations that currently collect and report the individual components of data struggle to find the resources needed to carry out their own work, so additional resources will be needed to enable them to also link their data together.

It is important that public resources invested in creating these linkages produce the kinds of information that will benefit patients, payers, and providers, that there be appropriate protections to ensure that connected data systems are used responsibly, and that there be adequate mechanisms to validate the accuracy of the linked data.

Recommendation 7.3

All Electronic Health Record systems should be required to support (a) the creation of custom fields and (b) data retrieval and analysis. Incentives should be created to encourage the development of infrastructure for linking data and there should be penalties for vendors that block data.

As a result of the tremendous investments made in Electronic Health Records in recent years, an unprecedented amount of clinical data is now stored in digital formats. Unfortunately, many providers have found it impossible or prohibitively expensive to create and store custom data fields in their EHR or to retrieve data from EHR systems in ways that would facilitate quality improvement, population health management, and/or resource use analysis. Moreover, barriers to data exchange between EHRs have severely limited providers' ability to use EHRs for care coordination purposes. Because all of these functions are essential for achieving higher-quality, more affordable healthcare, EHR vendors should be required to include all of these functions in their EHR systems at an affordable cost for providers.

Recommendation 7.4

Payers and provider organizations should be required to give clinicians access to information on the amounts payers and patients pay for services.

It is impossible for clinicians to take accountability for the total costs of the care, to make value-based decisions about the services they should order for their patients, or to recommend other providers to their patients if they do not know how much those providers and services cost as well as the quality of those services and the outcomes they achieve. (See Recommendation 8.5 for additional detail on the types of information that healthcare providers need to implement alternative payment models.)

Options Meriting Further Development and Discussion

Option Requiring Further Analysis: Require external validation/audit of quality and cost measures for all reporting entities.

Measures of quality and resource use are only of value if they are based on accurate and complete data. Many participants at the Summit felt that in order to assure the accuracy of measures, some mechanism for external validation or audit of the data used to create the measures is needed. However, other participants were concerned about the burden that such a validation/audit system might create for providers, particularly small providers, and whether additional resources devoted to data validation would reduce the time and resources that could be devoted to innovations that would result in improvements in the measures.

8. Facilitating the Transition to Improved Payment Systems

Description of the Issues

Although there is widespread agreement that significant changes are needed in current fee-for-service payment systems in order to enable and encourage the delivery of higher-value care, the current care delivery systems, billing systems, claims payment systems, etc. used by both providers and payers are optimized around the current payment system. For example, physician practices have organized themselves with a focus on filling clinicians' schedules with office visits and procedures, because those are the only services for which clinicians are paid and payments for physician services are the principal source of revenue for the practices. Health insurance plans, third party administrators, and Medicare contractors have organized themselves to process and pay millions of claims for individual services from clinicians, hospitals, and other providers as efficiently and accurately as possible because that is how the current payment system is structured.

Changing all of this is difficult, expensive, and risky, for a variety of reasons:

- Many physician practices, hospitals, and other providers have made significant investments in facilities, equipment, and personnel premised on a continuation of the current mix of services and current methods of payment for those services. Changes to the types of

services and the methods of payment could mean that these providers have no way to recoup the investments they have made.

- There is not a clear business case for health plans to incur significant costs to implement new payment systems. In communities dominated by one health plan, the plan will incur additional administrative costs whereas most of any savings on healthcare services will go to self-insured purchasers. In communities with multiple plans, if one health plan implements a new payment model and providers respond by changing care, the changes in care will likely affect all of their patients for all payers, which means the other health plans in the market will have received savings without incurring the associated costs of a new payment system (i.e., the other plans will be “free riders”). The other plans may then be able to offer lower rates to employers and individual purchasers, penalizing the plan that implemented the payment model that led to improvements in care delivery. If one plan implements a payment model and the providers do not change care in response (because most of their payments are still based on fee-for-service models being used by the other payers), then the plan will have incurred costs without creating any benefit for its patients or purchaser customers or any reduction in its own spending on healthcare services.
- There is not a clear business case for providers to implement new billing systems to participate in new payment models, since there may be no way for them to recoup these costs, particularly if they are using any additional revenues under a new payment model to implement new care management systems that enable them to achieve the accountability for costs and quality required under the new payment model.
- It is not clear exactly what kinds of changes in billing and payment systems providers and payers should make, since many different payment models are currently being “tested” with no commitment by Medicare or other payers to continue any of them in the long run.
- It is not clear what changes in care delivery will enable success under new payment models. Many providers have been struggling to succeed under shared savings models and other current alternative payment models, and payers have

not achieved the kinds of results they had hoped. This is likely due to the fact that current alternative payment models have made very limited changes in payment, which in turn has limited the ability of providers to change the way they deliver care. As a result, however, current evidence about appropriate medical care is based on current approaches to delivering that care, and it may not be possible to generate evidence about whether different approaches will work until there is greater flexibility to actually change care delivery.

- It can be difficult to accurately project the costs of a new approach to delivering care until experience is gained in using that approach. Moreover, there will likely be temporary inefficiencies as providers transition from an approach they are familiar with to an approach they are unfamiliar with. For example, many primary care practices have reported that they incur significant transition costs as well as temporary losses in revenues as they move from purely reactive, visit-based care to proactive population management.
- Changes in care delivery that will ultimately improve quality or reduce costs may result in quality problems in the short run. Clinicians and other providers who know how to achieve quality results using current techniques may experience temporary problems with quality as they learn to use new approaches. For example, a surgeon who has developed a high degree of skill in performing surgeries using a particular set of instruments and medical devices may temporarily experience worse outcomes after switching to different instruments or devices that are lower cost. This can result in financial penalties under current pay-for-performance programs as well as under an alternative payment model.
- At least in the near future, it seems likely that only a portion of services will be paid through new payment models and not all payers will participate in new payment models, meaning that both providers and payers will need to continue operating under current fee-for-service structures as well as new payment and delivery models. Running parallel systems increases costs and reduces the return on new investment.

Trying to transition to alternative payment models while continuing to deliver services under the current system has been analogized to “repairing an airplane

in midair.” Consequently, it would be desirable to find ways to facilitate the transition to better payment and delivery models.

Recommendations

Recommendation 8.1

Alternative payment models should be implemented using multi-year contracts and/or multi-year performance measures that allow for a short-term period in which costs can increase or quality measures can remain stable before decreases in costs or improvements in quality are expected.

Providers may be reluctant to enter into alternative payment models if they are expected to instantaneously transition to new care delivery approaches and achieve higher performance on new accountability measures. Year-by-year payment contracts and annual measures of quality and spending can penalize providers who need time to redesign care delivery, since there may be temporary increases in costs before quality improvements and cost reductions are achieved, and there may even be short-term drops in quality during the transition period. This could be addressed by averaging cost and quality performance measures over a period of time or by using a multi-year contract that phases in higher quality and cost performance standards over time.

Multi-year contracts are challenging for payers with high turnover of insured members from year to year, but Medicare and large health plans with stable membership/beneficiaries should be able to implement this approach.

Recommendation 8.2

New service/billing codes should be created so that providers and payers can more easily implement alternative payment models within existing billing and claims payment systems.

In some cases, an alternative payment model could be implemented using existing coding and billing systems; however, for many models, new service/billing codes are needed. For example, if clinicians could submit a claim form with a code indicating that they are managing care for a patient’s condition, then there would not be a need for complex patient attribution rules to make that determination. If clinicians,

hospitals, or teams of providers could submit a claim form with a code requesting payment for a bundled payment instead of individual service codes, a health plan could simply issue payment for that bundled payment claim rather than having to try and group procedure-based claims into bundles or episodes and make providers wait for reconciliation payments.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires that three new sets of billing codes be created and included on claims forms beginning in 2018. These “Care Episode Group” codes, “Patient Condition Category” codes, and “Patient Relationship Category” codes could potentially avoid the need for complex episode grouper, risk adjustment, and attribution systems and facilitate a faster and more successful transition to alternative payment models.

Recommendation 8.3

A payer should align the incentives and measures it uses for payment of different types of providers.

In many aspects of healthcare, no one provider delivers all of the care a patient needs, and each of those providers may be paid under different payment systems by the patient’s payer. Changing the payment system for only one of those providers can create conflicting incentives, e.g., a clinician in an alternative payment model may be rewarded for reducing utilization of hospital services, but the hospital may be financially penalized for lower utilization because it is still being paid under a traditional fee-for-service system.

One solution is to create bundled payments that include all of the involved providers in a coordinated payment arrangement. An alternative approach is for the payer to modify the separate payment systems for each of the involved providers in order to create compatible incentive structures.

Recommendation 8.4

Changes should be made to statutes and regulations that were designed to prevent or mitigate problems under current payment systems when those regulations are impeding the transition to higher-value care delivery under alternative payment models.

A variety of laws and regulations have been created to prevent or mitigate overuse of services or to ensure quality of care based on the incentives created by current payment systems, including federal fraud and abuse laws (such as the Stark laws), conditions of participation and minimum standards of service, and restrictions on payment for certain services and providers. When alternative payment systems are created that change current incentives, these existing rules can not only create unnecessary administrative burdens but they can also limit providers' flexibility to redesign care. There should be a rapid, flexible process for providers to obtain waivers of regulations and statutes from all government agencies in situations in which the rules are no longer relevant or necessary.

Recommendation 8.5

Providers designing and/or implementing alternative payment models should be able to obtain claims data on the services received by their patients and the amounts paid for those services, at low cost or no cost to the provider for obtaining the data. In addition, small providers should be able to obtain basic analytic and data-merging tools and/or technical assistance & benchmarks in order to help them utilize claims data in designing and implementing alternative payment models.

It is extremely difficult for healthcare providers to design or implement alternative payment models without actionable data on the full range of services their patients are receiving. Although there is a cost to Medicare and other payers to assemble and transmit these data to providers, if providers can use the data effectively to redesign care, the savings to the payers could far exceed these costs. Moreover, since providers will typically need to incur significant costs to combine and analyze any data they can obtain, charging providers for access to the data makes it even less affordable for them and can discourage them from designing alternative payment models and make them less likely to be successful in implementing APMs.

Even if data are available at no cost, the cost of purchasing statistical analysis software and hiring staff with the skills to use it or engaging consultants with those capabilities will likely be unaffordable for small providers. Affordable basic analytic tools that are designed to work with claims data should be developed and made available to these providers.

Recommendation 8.6

Providers need to have the ability to link and analyze all clinical data for each of their patients in order to successfully implement alternative payment models.

Providers' ability to coordinate their patients' care depends on their ability to see the full range of care the patients are receiving and to communicate efficiently and effectively with other providers. This requires that providers have both interoperable Electronic Health Record systems and effective tools that can utilize that interoperability to link all of the data for an individual patient and provide actionable information to the provider. Most current EHR systems do not have adequate interoperability or analytic capabilities. Significant improvements in EHRs will be needed to enable clinicians and other providers to participate in alternative payment models that require them to take accountability for the cost and quality of healthcare services other than those they directly deliver. (See Recommendations 7.2 and 7.3 for more detail on the needs for linking data for developing and implementing alternative payment models.)

Recommendation 8.7

Alternative payment models will need to support the costs of modifying electronic health record systems to calculate and report quality measures used in those payment models.

Providers spend significant amounts of time and resources today collecting and reporting quality measures. Automating quality measurement would enable more time to be spent on care to patients and quality improvement initiatives and facilitate successful implementation of alternative payment models. When payers change quality metrics, they should cover the costs providers incur in order to update EHR systems to report those metrics.

Issues Meriting Further Discussion

Participants at the Summit indicated that an important current issue in payment reform that was not discussed at the Summit was the differences and conflicts in the payment systems and performance measures being implemented by different payers. It is difficult and expensive for a healthcare provider to implement a new

payment system and to make the changes in care delivery needed to succeed under a new payment system while also needing to continue delivering care for a subset of patients under the current payment system. It is even more difficult and expensive if the provider has to implement multiple new payment systems and try to achieve high performance on multiple, different measures that only apply to a subset of patients. Encouraging all payers to use the same alternative payment models could reduce implementation costs and enable providers to more rapidly deliver higher-value care.

IMPLEMENTATION AND OTHER ISSUES

Encouraging Implementation of Recommendations

Participants agreed that the recommendations developed at the Summit should be broadly distributed and that educational materials should be developed to explain the recommendations and their rationale. However, the Summit participants felt that dissemination and education alone were not sufficient to achieve widespread implementation, and that several additional implementation strategies should also be pursued:

- **Incorporate recommendations in MACRA and other CMS regulations.** Medicare is one of the largest payers for most providers, and many private payers implement the approaches that Medicare uses. Consequently, it would be particularly important to encourage the Centers for Medicare and Medicaid Services (CMS) to incorporate the recommendations into Medicare payment regulations, particularly the regulations implementing the Medicare Access and CHIP Reauthorization Act (MACRA).
- **Hold state/regional summits to develop implementation strategies.** Although changes in federal laws, regulations, and payment policies will be important for implementing many of the Summit recommendations, successful implementation will also require coordinated actions by individual purchasers/payers and providers in individual states and regions. To address this, local multi-stakeholder summits could be convened to focus on two types of issues:

- Translating the national recommendations into more detailed implementation steps for particular types of health conditions where local data suggest opportunities for improvement and where there is clinical leadership.
- Resolving specific implementation issues or barriers that exist in that state or region. For example, a community where most physicians are still in small, independent practices might look specifically at how to help those physicians implement alternative payment models, and a community with many competing health plans might discuss how to have all health plans move to new payment models in a way that preserves competition but avoids free-rider problems, aligns incentives, minimizes administrative burdens and costs, and allows new entrants to the market.
- **Organize pilot projects in several regions.** Although the Summit participants agreed that the recommendations developed at the Summit should be implemented, many details need to be resolved. One way to do this would be to organize pilot projects in which willing providers and supportive payers would collaboratively develop the details and test those approaches in their community before efforts are made to implement the approaches nationally.

Addressing Additional and Future Issues

Summit participants unanimously agreed that similar National Payment Summits should continue to be held in the future to address other issues that could not be covered in the 2016 Summit and to address new issues as they arise.

Appendix

Attendees at the 2016 National Payment Reform Summit

All of the participants at the 2016 National Payment Reform Summit attended as individuals, not as representatives of organizations. Their participation in developing the recommendations described in the report does not imply endorsement of those recommendations by the organizations for which they work nor by any of the organizations with which they are affiliated.

Name	Professional Roles
Michael Abecassis, MD	Founding Director, Comprehensive Transplant Center, Northwestern University Feinberg School of Medicine; Former President, American Society of Transplant Surgeons
Joseph Angelelli	Senior Advisor, Alternative Payment Models, UPMC Health Plan
Amy Bassano	Deputy Director, Center for Medicare and Medicaid Innovation
Howard Beckman, MD	Senior Consultant, Finger Lakes Health Systems Agency; Chief Medical Officer, Eagle Dream Health
Marc Bennett	President and CEO, HealthInsight; Past President, American Health Quality Association
Jane Brock, MD	Medical Director, Telligen; Clinical Director, QIN-QIO National Coordinating Center; President, American Health Quality Association

Name	Professional Roles
Paul Casale, MD	Executive Director, New York Quality Care ACO; Member, Board of Trustees, American College of Cardiology; Member, Physician-Focused Payment Model Technical Advisory Committee
James Chase	President, Minnesota Community Measurement
Fowad Choudhry	CEO, North Texas Specialty Physicians
Mylia Christensen	Executive Director, Oregon Health Care Quality Corporation
James Costlow, MD	Director of Value-Based Care, Premier Medical Associates
Betsy Critchfield	Operations Specialist, Network for Regional Healthcare Improvement
Thomas Curtis	State Innovation Models Specialist, Michigan Department of Health and Human Services
Francois DeBrantes	Executive Director, Healthcare Incentives Improvement Institute
Cheryl DeMars	President and CEO, The Alliance; Member, Board of Governors, National Business Coalition on Health
Susan Elster	Consultant, Jewish Healthcare Foundation and Pittsburgh Regional Health Initiatives
Karen Wolk Feinstein	President and CEO, Pittsburgh Regional Health Initiative; CEO, Jewish Healthcare Foundation
Ellen Gagnon	Senior Project and Operations Director, Network for Regional Healthcare Improvement
Clif Gaus	President and CEO, National Association of Accountable Care Organizations
James Gera	Senior Vice President for Business Development, Signature Medical Group

Name	Professional Roles
Deidre Gifford, MD	Director of State Policy and Programs, National Association of Medicaid Directors; Former Medical Director, Rhode Island Executive Office of Health and Human Services; Co-Founder and Project Director, Rhode Island Multi-Payer Advanced Primary Care Project
Nancy Giunto	Executive Director, Washington Health Alliance
William Golden, MD	Medical Director, Arkansas Medicaid; Chair, Medicaid Medical Director Network
Neil Goldfarb	President and CEO, Greater Philadelphia Business Coalition on Health; Member, Board of Governors, National Business Coalition on Health
Allan Goroll, MD	Primary Care Physician, Massachusetts General Hospital; Professor of Medicine, Harvard University
Stephen Grubbs, MD	Vice President for Clinical Affairs, American Society of Clinical Oncology; Former Managing Partner, Medical Oncology Hematology Consultants, Delaware
Diana Han, MD	Medical Director, Appliance Division, General Electric
Dianne Hasselman	Deputy Director, Network for Regional Healthcare Improvement
Hilary Heishman	Program Officer, Robert Wood Johnson Foundation
Heather Howard	Director, State Health and Value Strategies Program, Princeton University; Former Commissioner, New Jersey Department of Health and Senior Services
Nathan Johnson	Chief Policy Officer, Washington State Health Care Authority
Joel M. Kaufman, MD	Neurologist, Rhode Island Hospital; Clinical Professor of Neurology, The Warren Alpert Medical School of Brown University; Chair, American Academy of Neurology Payment Alternatives Team

Name	Professional Roles
David Kendrick, MD	CEO, MyHealth Access Network; Chair of Medical Informatics, University of Oklahoma School of Community Medicine
Donna Kinzer	Executive Director, Maryland Health Services Cost Review Commission
Kate Kohn-Parrott	President and CEO, Greater Detroit Area Health Council; President and Owner, KKP Consulting, LLC
Lawrence R. Kosinski, MD	Managing Partner, Illinois Gastroenterology Group; Community Private Practice Councillor, AGA Governing Board; President, SonarMD, LLC
Ivana Krajcinovic	Senior Director, Healthcare Delivery, Unite Here Health
Robert Kropp, MD	Robert M. Kropp Consultants; Former Regional Medical Director, Aetna
Mary Beth Kuderik	Chief Strategic and Financial Officer, United Auto Workers Retiree Medical Benefits Trust
Todd Leri	Regional President, Remedy Partners, Inc.
Sandra Lewis, MD	Cardiologist, Northwest Cardiovascular Institute; Clinical Affiliate Professor of Medicine, Oregon Health and Science University; Past Member, Board of Governors, American College of Cardiology
Danielle Lloyd	Vice President for Policy and Advocacy, Premier, Inc.
Martin Love	CEO, Humboldt Independent Practice Association
Harold Luft	Director, Palo Alto Medical Foundation Research Institute; Professor Emeritus of Health Policy and Health Economics, University of California San Francisco
Constantine Mantz, MD	Chief Medical Officer, 21st Century Oncology
Sandy Marks	Assistant Director of Federal Affairs, American Medical Association

Name	Professional Roles
Heather Marshall, MD	Associate Regional Medical Director, Island Medical Management; Member, American College of Emergency Physicians Alternative Payment Models Task Force
Enrique Martinez-Vidal	Vice President, State Policy and Technical Assistance, AcademyHealth
Barbara McAneny, MD	CEO, New Mexico Cancer Center; CEO, Innovative Oncology Business Solutions, Inc.; Member and Immediate Past Chair, Board of Directors, American Medical Association
J. Allen Meadows, MD	Chairman of the Advocacy Council of the American College of Allergy Asthma and Immunology; Member, American College of Allergy, Asthma, and Immunology Payment Reform Subcommittee
Harold D. Miller	President and CEO, Center for Healthcare Quality and Payment Reform; Member, Physician-Focused Payment Model Technical Advisory Committee
Elizabeth Mitchell	President and CEO, Network for Regional Healthcare Improvement; Vice Chair, Physician-Focused Payment Model Technical Advisory Committee
Patricia Montoya	Executive Director, New Mexico Coalition for Healthcare Value, HealthInsight (Government Relations – New Mexico); Former Secretary, New Mexico Department of Health
Cindy Munn	CEO, Louisiana Health Care Quality Forum
Len Nichols	Director, Center for Health Policy, Research, and Ethics, George Mason University; Member Physician-Focused Payment Model Technical Advisory Committee
Tara Oakman	Senior Program Officer, Robert Wood Johnson Foundation
Frank Opelka, MD	Chairman, Surgical Quality Alliance, American College of Surgeons; Former Executive Vice President, LSU

Name	Professional Roles
Carolyn Pare	President and CEO, Minnesota Health Action Group; Vice Chair, Consensus Standards Approval Committee, National Quality Forum; Past Chair, National Business Coalition on Health
Ray Peters	Vice President, Human Resources and Marketing, RoyOMartin
Stuart Pickell, MD	Medical Director for CMS Risk Adjustment, North Texas Specialty Physicians; Chairman, Texas MOST Coalition
Laurel Pickering	President and CEO, Northeast Business Group on Health; Member, Board of Governors, National Business Coalition on Health
Louise Probst	Executive Director, St. Louis Area Business Health Coalition
Christopher Queram	President and CEO, Wisconsin Collaborative for Healthcare Quality
Ralph Reeder, MD	Neurosurgeon, Center for Neurosciences, Orthopaedics & Spine, Dunes Surgical Hospital/Mercy Health Network
Jerry Reeves, MD	Senior Vice President of Medical Affairs, HealthInsight Nevada
Neil Resnick, MD	Chief, Division of Geriatric Medicine and Gerontology, University of Pittsburgh Medical Center
William Riley	Director, National Safety Net Advancement Center; Professor, Arizona State University School for the Science of Health Care Delivery
Jolie Ritzo	Program Manager, Network for Regional Healthcare Improvement
Ann Robinow	President, Robinow Healthcare Consulting; Former President, Patient Choice Healthcare; Former Executive Director of Care Systems and Finance, Buyers Health Care Action Group

Name	Professional Roles
Phillip Rodgers, MD	Departments of Family Medicine and Internal Medicine, University of Michigan Medical School; Co-Chair, Public Policy Committee, American Association of Hospice and Palliative Medicine
Ted Rooney	Board Member, Maine Area Agencies on Aging; Advisor, Maine Health Management Coalition; Staff, Maine Health Action Roundtable; Former Manager, Employee Health Management, L.L. Bean
Valinda Rutledge	Vice President, Public Payor Health Strategy, Greenville Health System; Former Director, Patient Care Model Group, Center for Medicare and Medicaid Innovation; Former President and CEO, CaroMont Health
Shawn Ryan, MD	President and Chief Medical Officer, Brightview Health; Assistant Professor, Department of Emergency Medicine, University of Cincinnati; Member, Payer Relations Committee, American Society of Addiction Medicine
Linda Schwimmer	President and CEO, New Jersey Health Care Quality Institute; Former Director, Strategic Relationships and External Affairs, Horizon Blue Cross Blue Shield of New Jersey; Former Director of Legislation and Policy, New Jersey Department of Banking and Insurance
Wells Shoemaker, MD	Former Medical Director, California Association of Physician Groups; Former Co-Chair, California Quality Collaborative
Alan M. Speir, MD	Cardiothoracic Surgeon, Inova Health System; Chairman, Virginia Cardiac Surgery Quality Initiative; Chair, Society of Thoracic Surgeons Workforce on Health Policy, Reform, and Advocacy
Barbara Spivak, MD	President, Mount Auburn Cambridge Independent Practice Association; Vice-Chair, Board of Directors, Massachusetts Health Quality Partners
Bruce Steinwald	President, Bruce Steinwald Consulting; Member, Physician-Focused Payment Model Technical Advisory Committee

Name	Professional Roles
Diane Stewart	Senior Director, Pacific Business Group on Health
Edith Coakley Stowe	Senior Manager, Manatt, Phelps & Phillips; Former Team Lead, Comprehensive Primary Care Initiative, Center for Medicare and Medicaid Innovation
Timothy Swan, MD	Cardiovascular and Interventional Radiologist, Marshfield Clinic; Vice Speaker, American College of Radiology Council
Grace Terrell, MD	Founder and Strategist, CHES; Member, Board of Directors, American Medical Group Association; Member, Physician-Focused Payment Model Technical Advisory Committee
Meredith Roberts Tomasi	Program Director, Oregon Health Care Quality Corporation
Susan Turney, MD	CEO, Marshfield Clinic Health System; Former CEO, Medical Group Management Association
Karen van Caulil	President and CEO, Florida Health Care Coalition; Chair, Board of Governors, National Business Coalition on Health
Jay Want, MD	Chief Medical Officer, Center for Improving Value in Health Care; Principal, Want Healthcare LLC; Former CEO, Physician Health Partners
Sarah Woolsey, MD	Medical Director, HealthInsight Utah