
Transitioning to Accountable Care



INCREMENTAL PAYMENT REFORMS
TO SUPPORT HIGHER QUALITY,
MORE AFFORDABLE HEALTH CARE

ABOUT THE AUTHOR

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TRANSITIONING TO ACCOUNTABLE CARE:

Incremental Payment Reforms to Support Higher Quality, More Affordable Health Care

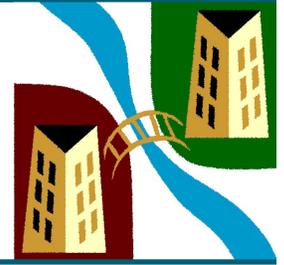
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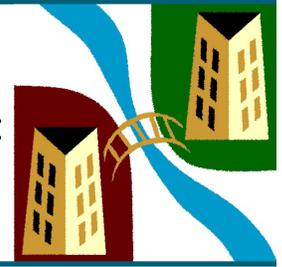
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EXECUTIVE SUMMARY

TRANSITIONING TO ACCOUNTABLE CARE: INCREMENTAL PAYMENT REFORMS TO SUPPORT HIGHER QUALITY, MORE AFFORDABLE HEALTH CARE



There is growing agreement that many of the cost and quality problems in health care today are either caused or exacerbated by the way we pay for health care services. Although a variety of payment reforms have been proposed to address these gaps, many of them are seen either as doing too little to address the problems caused by current payment systems or as changing payment too radically for providers to easily implement.

There is a need for “middle-ground” options – payment reforms that provide greater flexibility and accountability for care than typical pay-for-performance, shared savings, and medical home programs, but which avoid forcing providers to take on more financial risk than they can manage or to take accountability for services they cannot effectively control (as traditional capitation systems or full episode-of-care payment systems can require). These middle-ground changes can be viewed as *transitional payment reforms*, i.e., they enable healthcare providers to deliver some improvements in cost and quality for payers and patients as the providers build the capacity to transition to more comprehensive payment reforms in a way that is feasible for them.

PAYMENT REFORMS TO SUPPORT ACCOUNTABLE ACUTE CARE

There are at least seven different types of payment reforms that could be used by providers and payers to transition toward more episode-oriented payment structures for major acute care:

- **Paying hospitals on a case rate basis for all patients**, i.e., using DRG-type payments in place of per diem and charge-based payments for all patients;
- **Paying all physicians on a case rate basis for acute care episodes**, i.e., making a single payment to a physician for all services during an entire patient stay, similar to the way surgeons and obstetricians are currently paid;
- **Bundling payments to hospitals and physicians**, i.e., making a single payment for both hospital and physician services instead of separate payments;
- **Providing an inpatient warranty**, i.e., having hospitals and/or physicians agree not to charge more for services to correct errors, infections, and other hospital-acquired complications;
- **Bundling payments for inpatient and post-acute care**, i.e., paying a single amount to cover both inpatient care and services after discharge such as inpatient rehabilitation and home health care;
- **Providing a warranty for post-discharge complications and readmissions**, i.e., having hospitals and/or physicians agree not to charge more for preventable readmissions to the hospital; and
- **Paying based on diagnosis instead of treatment**, i.e., defining DRGs and physician case rates based on patient diagnoses, rather than on the specific procedures or treatments performed.

These transitional payment reforms need not be pursued in any particular sequence, and different approaches can be used with different types of patients and conditions. The goal should be to change the payment structure in the most targeted way possible to enable specific problems with care to be solved or specific goals to be achieved. For example, if there are inefficiencies in the way care is delivered, bundling payments could be the best approach for solving that, whereas if infection rates are high, a warranty would be a more appropriate approach.

PAYMENT REFORMS TO SUPPORT ACCOUNTABLE MEDICAL HOMES AND SPECIALTY CARE

Three payment changes that could help primary care and specialty physician practices transition toward more global payment structures are:

- **Paying Primary Care Practices with Care Management Payments and Utilization-Based Performance Incentives.** This would involve adding three new components to fee-for-service payments for primary care:
 - ♦ A Care Management Payment would be paid to the primary care practice for each patient (in addition to current fees for individual services) to support better patient education and self-management support, access to physicians by telephone, etc.;

- ◆ Specific targets for reducing utilization of healthcare services outside of the practice (e.g., non-urgent emergency room visits, ambulatory care sensitive hospitalizations, and/or high-tech diagnostic imaging) would be established that would result in savings greater than the cost of the Care Management Payment; and
- ◆ Bonuses/penalties would be paid to the practice based on its performance against the targets.
- **Paying Specialists with Care Management Payments and Utilization-Based Performance Incentives.** Similar to the payment model above for primary care practices, specialists would be paid more to better manage and coordinate patient care, but with specific targets for reducing utilization of expensive services such as hospital care.
- **Paying Physician Practices with Condition-Specific Partial Comprehensive Care Payments.** A physician practice or group of providers would be paid a single amount for most or all of the services that a patient will need from more or all providers for one or more of the patient's health conditions over a fixed period of time (e.g., a year). This would replace separate fees currently paid for the individual services that are covered by the payment.

SETTING PRICES, MANAGING RISK, AND ENSURING QUALITY

For any of the transitional payment reform steps, as well as for full episode or global payment, three additional issues must be addressed:

- **Establishing an appropriate payment amount (i.e., a price) for each patient or group of patients.** Even if the payment method provides the right incentives for better care, if the payment level is too low (i.e., below the minimum feasible cost of providing care), providers will be unable to provide quality care, and if the payment level is too high, there will be no real incentive for efficiency. A major challenge here is getting adequate data to enable both providers and payers to determine what appropriate prices are for new payment systems.
- **Limiting the financial risk associated with unusually expensive patients or with costs that the provider cannot control.** Four methods could be used to do this:
 - ◆ **Condition/Severity Adjustment**, i.e., paying a provider different amounts depending on the type and severity of the patient's health conditions;
 - ◆ **Outlier Payments/Adjustments**, i.e., paying a provider more when the cost of caring for a patient exceeds a certain threshold, or not holding the provider accountable for the total cost or quality of care for patients with unusual conditions;
 - ◆ **Risk Corridors**, i.e., limiting the extent to which the cost of actual service delivery for a group of patients can differ from the payment amount; and
 - ◆ **Exclusions and Risk-Sharing With Other Providers**, i.e., excluding the costs of services delivered by some outside providers from the payment, or having two providers each accepting accountability for different portions of the total costs of caring for a group of patients.
- **Ensuring that the quality of care to patients is maintained or improved as incentives to control costs are introduced.** The types of explicit quality incentives needed will depend on the specific payment model used, but it is likely that current efforts to measure the quality of preventive care will be a critical complement to all new payment models.

DEVELOPING A TRANSITION STRATEGY

Ideally, a community should start by focusing transitional payment reforms on areas where significant cost savings can be achieved quickly. The following four criteria can help identify where the likelihood of significant, short-term success is highest:

- Conditions which affect a large number of patients;
- Services where there is evidence of overutilization or inefficiency involving relatively large amounts of spending;
- Changes in care that have been proven to reduce overutilization or inefficiency, that are relatively simple or low-cost to implement, that can achieve significant results within a relatively short time period, ideally a year, and that are viewed favorably by patients; and
- Services, conditions, and care changes where there is strong clinical leadership in the community.

When developing a transitional payment strategy, it is important to try and define not only the *initial* incremental steps, but also the desired *end point* (i.e., the payment system that is ultimately to be used) and as many of the intermediate steps as possible, so that both providers and payers understand how investments made today will pay returns in the future.

The transitional payment models can also serve as important building blocks for Accountable Care Organizations (ACOs). The most important factors in the success of ACOs will be (1) their ability to identify specific opportunities for improving the way care is delivered to patients that can reduce costs and improve quality, and (2) their ability to provide

the resources and supports that individual healthcare practitioners need to enable and encourage them to make those improvements. An ACO cannot control *total* costs and quality if it cannot control the costs and quality of individual episodes of care and the number of episodes for groups of patients, and it cannot control those things if the individual practitioners who deliver the care are still being paid based on volume rather than value. Even if the ACO is accepting a global payment for the total costs of care for a patient population, it will need to break that payment down and use it to make the equivalent of episode payments and comprehensive care payments to the individual physician groups and other providers involved in delivering the care.

OBTAINING SUPPORT FROM PAYERS

Since providers need better payment systems in order to deliver higher-value care, it will be essential to have payers offer a range of transitional payment options in order to allow all of the providers in a community to transform their care. Although it might seem much easier and cheaper to try and choose one “best” payment system and stick to it over a long period of time, any one-size-fits-all payment change would mean that (1) those providers who could accept greater accountability than permitted by the payment change would be unable to deliver all of the improvements in value they could offer, and (2) those providers without sufficient skills to participate in the payment model that is chosen would be unable to make even the small improvements in value they could offer if given the opportunity to participate in a more incremental payment reform. Consequently, multiple payment models will likely need to be available in many communities to support providers with different capabilities.

In addition, as many payers in a community as possible need to implement the *same* payment reforms. It is in both payers’ and providers’ interests for all payers to adopt a new payment arrangement, since this would enable a healthcare provider to change its care processes for all of its patients without being financially penalized for any of them, while also avoiding creating a competitive disadvantage for an individual payer which makes payment changes if the other payers do not. However, achieving alignment of all payers in a market is very challenging because of antitrust concerns and the fact that it is costly for national payers to implement different payment systems in different communities. Some approaches that could be used to achieve a critical mass of multi-payer alignment for providers include:

- Use state government or a non-profit Regional Health Improvement Collaborative to facilitate agreement on a common payment methodology.
- Reach agreement on a common approach to payment reforms first among payers who exclusively or primarily pay for patients living in the local market.
- Restructure payment for types of patients and conditions for which there are fewer payers or payers who are more willing to change their payment systems.
- Implement payment reforms with providers who accept payment from a more narrow range of payers.
- Implement payment reforms initially with providers which have their own health plan.
- Define the most critical aspects of payment systems that need to be aligned, rather than trying to get all payers to implement identical payment systems.

Because of its size, participation by the Medicare program is extremely important. Fortunately, the federal Patient Protection and Affordable Care Act (PPACA) has given the Centers for Medicare and Medicaid Services the power to offer the full range of transitional payment reforms described above if it wishes to do so. The two principal sections of the law that provide this capability are:

- **Shared Savings Program/Accountable Care Organizations (ACOs).** Although titled the “Shared Savings Program,” Section 3022 of PPACA (Section 1899 of the Social Security Act) provides the Secretary of Health and Human Services with the power to establish “other payment models” for Accountable Care Organizations that the Secretary determines “will improve the quality and efficiency” of healthcare, as long as payments do not result in spending more “than would otherwise be expended ... if the model were not implemented, as estimated by the Secretary.” Each of the transitional payment reform models described above can be structured in a way that maintains or reduces spending for the services encompassed by the payment. Moreover, the law does not require that ACOs provide or control provision of all services, merely that an ACO must “be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it;” this could easily include organizations that are willing to transition over time to broad accountability but need more narrowly defined initial payment reforms to enable them to get started.
- **Center for Medicare and Medicaid Innovation.** Section 3021 of the law creates this new entity and gives it the power and duty “to test innovative payment and service delivery models to reduce program expenditures ... while preserving or enhancing the quality of care...” This will also allow Medicare to participate in unique payment models developed in individual communities to help their providers transition to more accountable care.

I.

THE NEED FOR TRANSITIONAL PAYMENT REFORMS



A. THE BARRIERS TO HIGH QUALITY, AFFORDABLE CARE POSED BY CURRENT PAYMENT SYSTEMS

There is growing agreement that many of the cost and quality problems in health care today are either caused or exacerbated by the way health care services are paid for. Under most current healthcare payment systems:

- Physicians, hospitals, and other healthcare providers receive more revenue for delivering more services, not for delivering higher quality services or services which are more effective in improving a patient's health, i.e., providers are paid for doing *more*, not *better*.
- Healthcare providers may actually be financially penalized for improving the quality of their services. For example, reducing errors and complications can not only reduce providers' revenues, but also reduce their profits and ability to remain financially viable.¹ Moreover, under most payment systems, health care providers make less money if a patient stays healthy.
- Separate payments are made to each physician, hospital, and other healthcare provider involved in a patient's care, which can result in duplication of tests and services for the same patient², with no incentive for separate providers to coordinate their services.
- Many valuable preventive care and care coordination services are not paid for adequately (or at all)³, which can result in unnecessary illnesses and treatments. In addition, low payment levels are believed to be discouraging physicians from entering primary care, contributing to shortages of primary care physicians in many areas.

B. THE PROBLEMS WITH MANY PAYMENT REFORM PROPOSALS

Although a variety of payment reforms have been proposed to address these gaps, the major proposals either do too little to address the problems caused by current payment systems or change payment systems too radically for many providers to easily implement. For example:

- **Pay-for-Performance Programs.** Many health plans are using pay-for-performance (P4P) programs to reward physicians and hospitals for achieving better performance, and the federal Patient Protection and Affordable Care Act has authorized Medicare to implement such programs. However, these programs typically do nothing to change the problems and undesirable incentives in the underlying payment system, and if they provide bonuses on top of existing payments, they require payers to spend more than they are spending today. As a result, the amount of funding involved is relatively small relative to the overall revenues that a provider will receive, creating relatively little incentive for improvement, particularly since the underlying fee-for-service incentives remain in place.⁴
- **Shared Savings Programs.** "Shared savings" programs are intended to address some of the weaknesses with traditional P4P systems by paying a bonus to providers that is explicitly connected to the amount by which they reduce the total cost of care for their patients compared to expected levels. Because the provider's bonus payment is directly related to the payer's savings, a shared savings program avoids directly increasing costs, and gives a provider the potential for receiving significant bonuses. However, like other P4P programs, a shared savings program does not provide any higher payment up front or any greater flexibility in the basic payment system to enable providers to change the way they deliver services. Most physician practices do not have sufficient financial reserves or access to working capital to enable them to afford to hire the staff, install the information technology, etc. needed to significantly reduce costs elsewhere in the healthcare system, particularly based on the uncertain prospect of a shared savings payment that will only arrive a year or more after the expenses are incurred. In addition, because total costs must decrease (or increase more slowly than projected) in order for bonuses to be paid, it may be impossible for an individ-

ual provider to receive a shared savings bonus, even if it is controlling or reducing the portions of costs it can control, if other providers in the system are not behaving similarly (e.g., a primary care practice might receive no reward for a successful program to reduce hospitalizations of chronic disease patients if the local hospital is simultaneously working to encourage specialists to increase admissions for elective procedures). Because there is no change in the underlying payment system, all of the existing weaknesses of the current payment system remain, and even though shared savings payments could be higher than the bonuses under many P4P programs, it is still unlikely that they can overcome the problematic incentives built into the current system.⁵

“*SHARED SAVINGS*” IS
MERELY A NEW FORM OF
PAY-FOR-PERFORMANCE
THAT LEAVES ALL OF THE
WEAKNESSES OF THE
FEE-FOR-SERVICE
SYSTEM IN PLACE

- **Medical Home Payment Programs.** A number of programs have been created to provide additional payments to primary care practices so they can restructure their services to be consistent with the principles of the Patient-Centered Medical Home (PCMH).⁶ However, many payers have been reluctant to make payments of any significant size to medical homes merely for meeting accreditation standards as a PCMH without evidence that the practice will actually reduce the costs of other services not delivered by the physician practice, such as preventable hospitalizations and emergency room visits.⁷ Consequently, the payment levels for medical home services may be lower than needed to significantly change the way care is delivered.

At the other extreme, some payment systems are viewed as being too radically different from fee-for-service for many providers to participate in, at least in the near term. For example:

- **Capitation/Global Payment.** Traditional “full risk” capitation and global payment systems provide considerable flexibility for providers to change the way services are delivered, but they also require the provider to be able to control or manage the costs of all aspects of a patient’s care, and they put the provider at financial risk for having patients who are sicker than average or have rare or unusually complex conditions. Most small providers do not have the size, scope, or financial capacity to manage such payment systems without outside assistance.
- **Episode-of-Care Payment.** “Episode-of-Care Payments” have been proposed that would define a single payment for all of the services associated with a hospitalization or other episode of acute care, including both inpatient and post-acute care and any services needed to treat errors or adverse events during the patient’s care. However, successfully managing these payments requires controlling the actions of a number of independent healthcare providers (hospitals, physicians, post-acute care providers, etc.), and because of the variability in the number and types of services from episode to episode, determining a fair price for such episodes is very challenging.

C. THE NEED FOR TRANSITIONAL PAYMENT REFORMS

Clearly, there is a need for “middle-ground” options – payment reforms that provide greater flexibility and accountability for care than typical pay-for-performance, shared savings, and medical home programs, but which avoid forcing providers to take on more financial risk than they can manage or to take accountability for services they do not have effective mechanisms for controlling (the way traditional capitation systems or full episode-of-care payment systems would require). These middle-ground changes can be viewed as *transitional payment reforms*, i.e., they enable healthcare providers to deliver some improvements in cost and quality for payers and patients as the providers build the capacity to transition to more comprehensive payment reforms, such as capitation or episode-of-care payment, in a way that is feasible for them.

In most communities in the nation, the majority of primary care physicians, specialists, and hospitals are relatively small, independent entities, not large integrated systems. Consequently, transitional payment reforms are particularly important so that these providers can immediately begin to take accountability for the subset of costs they can realistically expect to control today, while building the capacity to control a greater share of costs in the future.

Section II will examine transitional payment reforms which enable and encourage hospitals and specialists to reduce the costs and improve the quality of major acute care episodes, e.g., treating a serious injury, replacing an arthritic hip or knee, facilitating childbirth, responding to a heart attack, or treating a curable cancer. There is considerable evidence that the costs of many acute care episodes can be reduced while maintaining or improving quality, e.g., by increasing co-

operation among hospitals, physicians, and other providers, by using lower cost treatment options, by reducing adverse events (such as complications and infections), and by reducing preventable readmissions, if payment systems can be structured in a way to support the necessary changes in care delivery.

Section III will examine transitional payment reforms which enable and encourage primary care practitioners and specialists to reduce the costs and improve the quality of care for a wide range of patients. There is evidence that both short-run and long-run healthcare costs can be reduced for many types of patients, e.g., by improving prevention and early diagnosis, by reducing unnecessary testing, referrals and medications, and by reducing preventable emergency room visits and ambulatory care-sensitive hospitalizations, if primary care practitioners, specialty physicians, and other providers can be paid in ways that support the necessary changes in care delivery.

Some important aspects of transitional payment reforms, such as pricing, risk limits, and quality assurance are common to both payments for major acute care, primary care, and specialty care, and these will be addressed in Section IV. Section V will discuss how multi-step transition processes could be developed that match the specific opportunities and capabilities of different providers and communities, and how these transitional payment reforms can serve as the building blocks for “Accountable Care Organizations.” Finally, Section VI will examine the importance of having a range of payment changes made in a consistent fashion by all payers in a community.

*APPROPRIATELY STRUCTURED
TRANSITIONAL PAYMENT REFORMS
CAN ENABLE SMALL PROVIDERS TO
IMMEDIATELY TAKE
ACCOUNTABILITY FOR THE
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CONTROL TODAY,
WHILE BUILDING THE CAPACITY
TO CONTROL A GREATER
SHARE OF COSTS IN THE FUTURE*

II. PAYMENT REFORMS TO SUPPORT ACCOUNTABLE ACUTE CARE



There has been considerable interest in payment reforms for major acute care (e.g., treating a serious injury, replacing an arthritic hip or knee, facilitating childbirth, responding to a heart attack, or treating a curable cancer), partly because so much of healthcare spending is devoted to hospital and post-acute care, and partly because so many opportunities have been identified for both improving the quality and reducing the costs of such care, such as reducing infections, complications, and readmissions and improving the efficiency and coordination of care. Episode-of-Care Payment is designed to help address these opportunities by defining a single payment for all of the services from all providers associated with a hospitalization or other episode of acute care, including any services needed to treat errors or adverse events during the patient's care.⁸

A full episode-of-care payment makes three key types of changes from current payment systems:

- It combines payments for two or more services delivered during the episode which are currently paid for separately (e.g., multiple visits by a single physician) into a single payment;
- It combines payments for two or more providers involved in the episode who are currently paid separately (e.g., hospitals, doctors, and post-acute care providers) into a single payment;
- It may combine payments for treatment of two or more related patient conditions or diagnoses which are currently paid for separately (e.g., the condition that led to the hospitalization and complications which arise during the hospitalization) into a single payment.

A major reason why such a payment is viewed as challenging for both payers and providers is it makes these three significant types of changes at once, affecting many providers and many services in complex ways.

However, although all of these types of changes may be desirable, it is not essential that they all be made at the same time; indeed, one approach to transitioning to a full episode-of-care payment system would be to make one or more of these changes without the others. Moreover, a single change may enable significant improvements in cost and quality, and it may be possible to achieve savings more quickly by taking incremental steps than by trying to implement a complete episode-of-care payment system all at once.

There are at least seven different types of steps that could be taken by providers and payers to transition towards more episode-oriented payment structures for major acute care:

- Paying hospitals on a case rate basis for all patients;
- Paying all physicians on a case rate basis for acute care episodes;
- Bundling payments to hospitals and physicians;
- Providing an inpatient warranty;
- Bundling payments for inpatient and post-acute care;
- Providing a warranty for post-discharge complications and readmissions; and
- Paying based on diagnosis instead of treatment.

A. PAYING HOSPITALS ON A CASE RATE BASIS FOR ALL PATIENTS

In 1983, Medicare took a major step toward episode payment for major acute care by creating the Inpatient Prospective Payment System, commonly known as DRG (Diagnosis Related Group) payment. Previously, all hospitals were paid based on their incurred costs, which provided little incentive to control costs. Under the DRG system, hospitals receive a single “case rate” payment for a patient stay, which gives the hospital a strong economic incentive to control its costs so that they are less than the payment amount.⁹

Although Medicare instituted the DRG payment system nearly 30 years ago, and although many private health plans and Medicaid programs followed in Medicare’s footsteps, a number of private health plans and Medicaid programs across the country still pay large hospitals on a per diem basis (i.e., the hospital is paid an additional amount for each day the patient is in the hospital) or on a percent-of-charges basis (i.e., the hospital is paid more for each individual service delivered to the patient). These systems create far less incentive for hospitals to control their costs than the DRG system, and for many hospitals, it appears that rather than reducing costs to stay within Medicare payment levels, they merely shift costs to other payers who use non case-rate payment systems.

Consequently, one obvious transitional step is for hospitals to be paid on a case rate basis, such as the DRG system, for *all* of their patients, including self-pay patients. This could not only generate savings for the payers who make the switch, but could create more consistent incentives across the hospital’s entire patient population and reduce the hospital’s administrative costs needed to manage multiple payment systems. For example, the State of Maryland requires that hospitals be paid on a DRG-type basis for all of their patients, regardless of payer.¹⁰ Recent refinements to the DRG system (e.g., the MS-DRG system used by Medicare, and the APR-DRG system used by many commercial payers) have improved the ability of this payment system to match differences in patient needs.

B. PAYING ALL PHYSICIANS ON A CASE RATE BASIS FOR ACUTE CARE EPISODES

Even when hospitals are paid a single amount for all of the hospital services associated with a patient’s hospital stay, Medicare and other payers typically pay most physicians on a fee-for-service basis for the care they deliver during that same hospital stay, i.e., the physician gets an additional payment for each additional service that he or she provides to the patient in the hospital. The more services provided, the more payment the physician receives, and the longer the patient stays in the hospital, the more opportunity there is for physicians to provide additional services, even if it is merely a daily visit to see how the patient is doing.

Some physicians, however, are paid in a fashion similar to the way hospitals are paid under DRGs. Surgeons typically receive a “case rate” or “global fee,” i.e., they receive a single payment to cover all of their services to a particular patient for a specific episode of care. Similarly, obstetricians are typically paid this way for maternity care – they receive a single payment that covers prenatal care, labor and delivery, and post-partum care for a mother’s pregnancy.

The case rate approach could be expanded to other physicians. For example, when a patient is admitted to the hospital for treatment of pneumonia, the physician managing the patient’s care (either a primary care physician or a hospitalist or another specialist) could be paid a single amount for the patient’s treatment, similar to the single DRG payment the hospital will receive for the patient’s treatment from Medicare and many other payers.

This can have advantages for both payers and physicians:

- From a payer’s perspective, it creates an incentive for the individual physician to eliminate unnecessary services, since the payment remains the same regardless of how many individual services are delivered during the episode of care or period of time for which the combined payment is being made.
- From the physician’s perspective, a case rate payment provides more flexibility to customize services to what a patient needs without regard to the impact of delivering more or fewer services on the physician’s revenue and the patient’s cost-sharing. In addition, it may reduce or eliminate the need to bill for each individual service provided, and

it can provide greater predictability of revenues for the physician (since payment will not vary based on the exact number of services a patient happens to need).

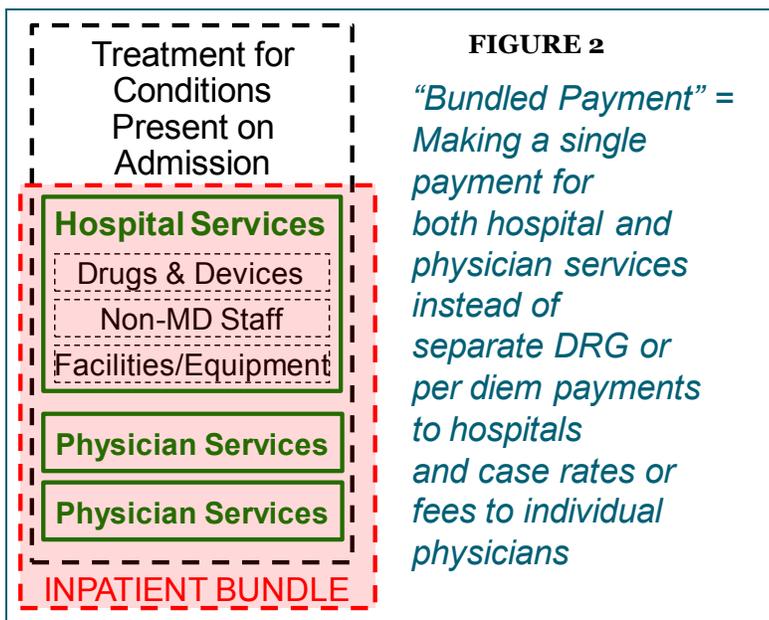
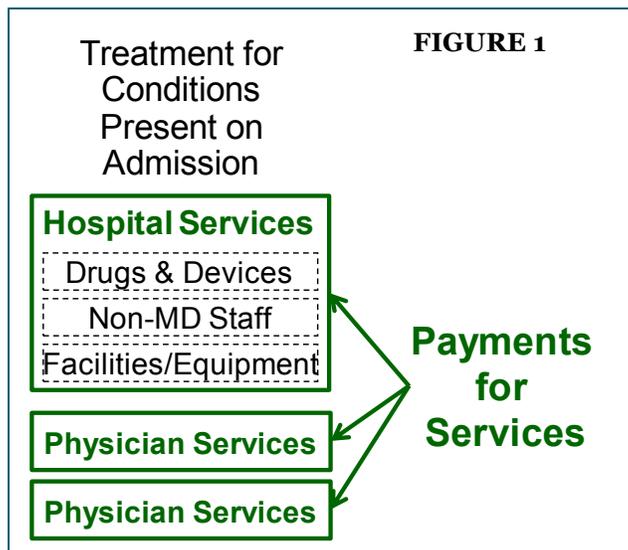
C. BUNDLING PAYMENTS TO HOSPITALS AND PHYSICIANS

Today, when a patient is hospitalized, at least two separate payments are made for the costs of their hospitalization – one to the hospital, and one to the physician who treated them in the hospital. (See Figure 1.) In many cases, more than one physician will be involved in the patient’s care, which means that more than two separate payments will be made.

This structure creates three major types of problems:

- Even though the hospital and the physician(s) are each clearly dependent on each other for the patient’s care, there is no financial incentive for the physicians to help find ways to lower the hospital’s costs, because the physicians are not responsible for paying for those costs. Lowering the hospital’s costs (e.g., by reducing the number or costs of drugs or devices used for patient treatment) improves the hospital’s profit margin, but it does nothing to improve the physician’s own profit margin, since the physician’s costs and fees remain the same. In some cases, reducing the hospital’s costs could reduce the physician’s revenues, e.g., if the patient is discharged from the hospital earlier and thereby receives fewer visits from the physician. (The current payment system also gives the hospital no financial incentive to help the physicians lower *their* costs; however, because hospital costs and payments for treating a patient are generally so much larger than the payments and costs for a physician, the biggest lost opportunities are likely on the hospital side.)
- There is no financial incentive for multiple physicians to better coordinate their activities; indeed, finding a way to reduce the number of physicians involved in a patient’s care, or reducing the frequency with which they see the patient, would merely reduce revenues for one or more of them with no increase in payment to the remaining physicians, and could potentially cause more work for one or more of them with no increase in compensation.
- It is impossible for consumers and payers to determine the total cost of care in any hospital or to compare costs across hospitals. Even if the consumer or payer knows in advance what fees the hospital and physicians charge for their individual services, they will not know the total cost of the hospitalization in advance, since that will depend on how long the patient was in the hospital and how many physicians were involved during their stay.

These problems can be solved or mitigated by “bundling” the payments to the hospital and physicians into a single payment covering all services provided in the hospital, whether those services are delivered by hospital staff or by the physicians. (See Figure 2.) For example, if a patient has hip replacement surgery, rather than having one payment to the hospital, a second payment to the surgeon, a third payment to the anesthesiologist, and potentially additional payments to other consulting physicians, Medicare, Medicaid, or a health insurance plan would make a single “bundled” payment for all of these services, and it would be up to the hospital, surgeon, anesthesiologist, etc. to determine how to



divide that payment among themselves. Under bundled payment, the surgeon and the anesthesiologist both have an incentive to help the hospital lower its costs, because they would have the ability to share in the hospital's savings, which they do not today.¹¹

It is easier to bundle a hospital's and physician's payments if the hospital and physician are already each being paid a single case rate for the patient's stay (e.g., for surgery where the hospital is paid on a DRG basis and the surgeon is paid a global fee) than if the hospital is being paid on a per diem basis and/or the physician is being paid fees for individual services. (This is why most payment bundling projects to date have been focused on surgery.) Consequently, bundling would be facilitated if the transitional steps in Sections II-A and II-B had already been taken.

A challenge in implementing bundled payments is reaching agreement on which entity will receive the combined payment. Physicians who are not employed by hospitals will likely resist having hospitals accept bundled payments and then pay the physicians their share; hospitals will likely be equally reluctant to have physicians accepting the bundled payments and paying hospitals their share. One solution to this is for the physicians and hospitals to create a joint Physician-Hospital Organization (PHO), controlled equally by the hospital and the physicians participating in the bundled payment; the PHO would accept the payment for the bundled services, and then allocate it between the hospital and physicians based on mutually agreeable rules. An alternative solution is what is known as "virtual bundling." In a virtual bundled payment, no one actually receives the combined payment; it is treated as a budget, and a payer divides it between the hospitals and physicians according to predetermined rules or an allocation agreed to by the hospital and physicians.

There is evidence that bundling of hospital and physician payments can be done successfully and produce better quality, lower cost care. For example, in the 1990s, Medicare's Participating Heart Bypass Center Demonstration selected four hospitals in Ann Arbor, Atlanta, Boston, and Columbus to receive a single payment covering both Part A (hospital) and Part B (physician) services for coronary artery bypass graft surgery. No outlier payments were permitted, and the amount of the combined payment was negotiated to be below current payment levels. The hospital and physicians were free to split the combined payment however they chose. An evaluation of the demonstration showed that the providers, patients, and Medicare all benefited: physicians identified ways to reduce length of stay and unnecessary hospital costs; costs decreased in nominal terms in 3 of 4 hospitals; and patients preferred the single copayment.¹² Beginning in 2009, Medicare began testing bundled payment on a broader range of conditions in its Acute Care Episode Demonstration, and preliminary indications are that the program has reduced costs for Medicare, improved margins for hospitals and physicians, and improved quality for patients.¹³

D. PROVIDING AN INPATIENT WARRANTY

Today, under most current payment systems, both hospitals and physicians are paid extra to deal with errors or complications they themselves cause. For example, if a patient hospitalized for a medical condition develops an infection which leads to a longer stay in the hospital, the physician managing the case will likely be paid more than if the infection had not occurred, and the hospital will also likely be paid more, particularly if the infection causes significant complications.

Although it may sound desirable to pay for services patients need to address complications they experience in the hospital, this payment structure has the perverse effect of financially penalizing hospitals and physicians for efforts to prevent infections and complications in the hospital.

Medicare and other payers have tried to solve this by reducing or prohibiting additional payment for services associated with treating preventable errors or infections.¹⁴ However, this approach only denies payment for treatment of the *error or infection itself*, not for any additional *complications* which may be caused by the error or infection, and the complications frequently result in far greater costs than the infection. Moreover, non-payment for a particular error or infection implicitly requires a judgment that that error or infection was fully preventable (otherwise, the provider is being penalized for a problem it could not control), which limits the number of errors and infections for which denial of payment is appropriate.

A better solution is for hospitals or physicians to offer a "limited warranty" as part of their care, i.e., they would commit that they would not charge more for addressing errors, infections, complications, etc. that occur during the patient's

care. The hospital and/or physicians offering the warranty would have to determine two things: (1) how broad the warranty would be, i.e., how many types of adverse events would be included, and (2) how much to charge for such a warranty. This flexibility is what distinguishes this approach from the more simplistic approach of non-payment for complications described in the previous paragraph – rather than a choice of either receiving full payment or no payment for costs associated with a specific complication, the hospital and physicians could define a price based on the extent to which they believe they can reduce such complications.

More importantly, they then have an economic incentive to reduce the rate of complications even further.

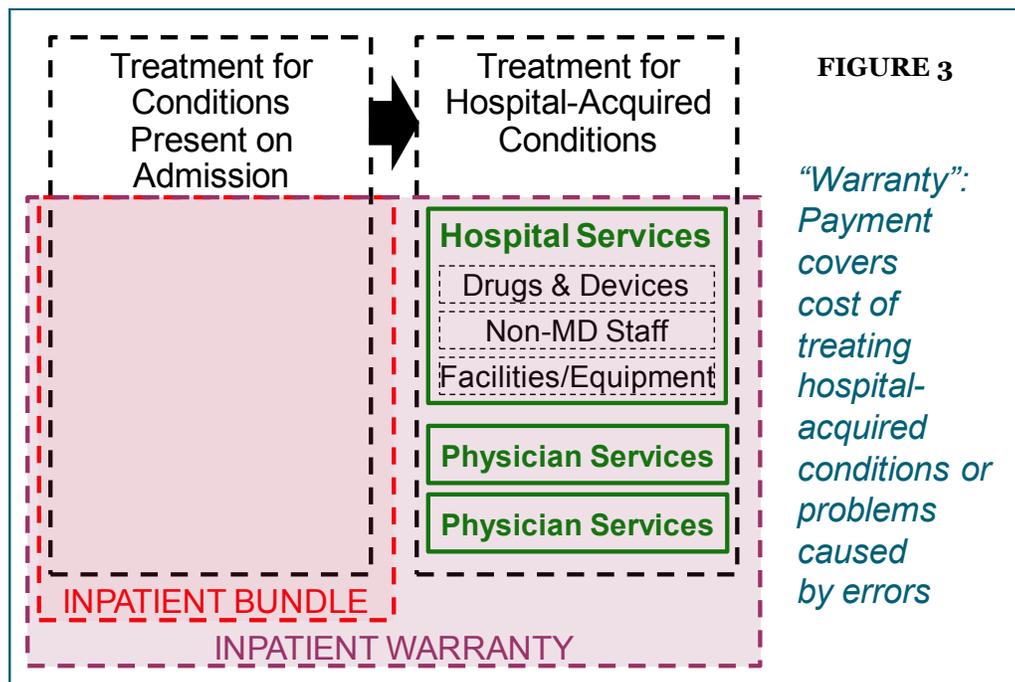


FIGURE 3

*“Warranty”:
Payment covers cost of treating hospital-acquired conditions or problems caused by errors*

An example will help to illustrate this point. Suppose that today, a hospital is paid \$10,000 for a certain procedure, but 5% of the time, patients get infections during their hospital stay; when an infection occurs, the additional payment for treating the complications is \$20,000. The hospital believes it can reduce the rate of infections to at least 4%, so it begins offering the procedure with a warranty for infections, and it charges \$10,800 for the warranted procedure. Although this price appears to be higher than the current payment of \$10,000 for the procedure, it actually represents a savings for the payer, because the payer is currently paying an average of \$11,000 for patients’ care, given the current 5% infection rate ($\$11,000 = \$10,000 + 5\% \times \$20,000$). If the hospital is able to reduce the infection rate to 3%, then it is still paid \$10,800, but its costs are now below \$10,600 ($\$10,000 + 3\% \times \$20,000$), so it is actually making more money. This approach is preferable to telling the hospital that it will not be paid any extra money for *any* of the infection cases, in which case the hospital would only be paid \$10,000 for all cases and potentially lose money even if it reduced the infection rate significantly.

The pricing of warranted payments may initially be confusing for many purchasers and payers, who will ask why they are paying *more* (\$10,800 instead of \$10,000 in the example above) for care when they are trying to save money. The answer is that they are not really paying the nominal price today; they are actually paying more per patient on average (\$11,000 vs. \$10,000 in the example above), but the additional payments are hidden in the costs of treating the errors and infections, and so paying more for care with a warranty will actually cost them less than paying lower prices multiple times. Outside of healthcare, people expect to pay more for products and services which have warranties than for those which do not.

Because there is a wide range of different types of infections and complications that occur in hospitals, and because there are varying degrees of knowledge about how to prevent them, it may initially be desirable to allow hospitals to compete on the breadth of their warranties, rather than trying to develop a uniform definition of a warranty. A disadvantage of this is that differences in the definitions of warranties make comparisons among providers more difficult, but this is similar to products and services in other industries which have warranties with varying lengths and exclusions. Over time, the definitions will likely converge as techniques for reducing infections and complications become more broadly implemented.

A hospital and its physicians could each separately offer such a warranty on their individual payments without having to bundle their payments together, i.e., this transitional step could be taken without taking the step described in Section II-C. However, it would likely be more challenging to successfully implement the warranties if the hospital and physicians were not both implementing them simultaneously so that their mutual incentives were aligned.

Although warranties sound like a radical idea, the Geisinger Health System in Pennsylvania, through its Proven-CareSM system, has been providing a “warranty” on care for several years. The system was started for coronary artery bypass graft surgery, and has been expanded to hip replacement, cataract surgery, angioplasty, bariatrics, low back pain, perinatal care, and other areas.¹⁵ Offering the warranty led to significant changes in the processes used to deliver care, and Geisinger has reported dramatic improvements on quality measures and outcomes.¹⁶

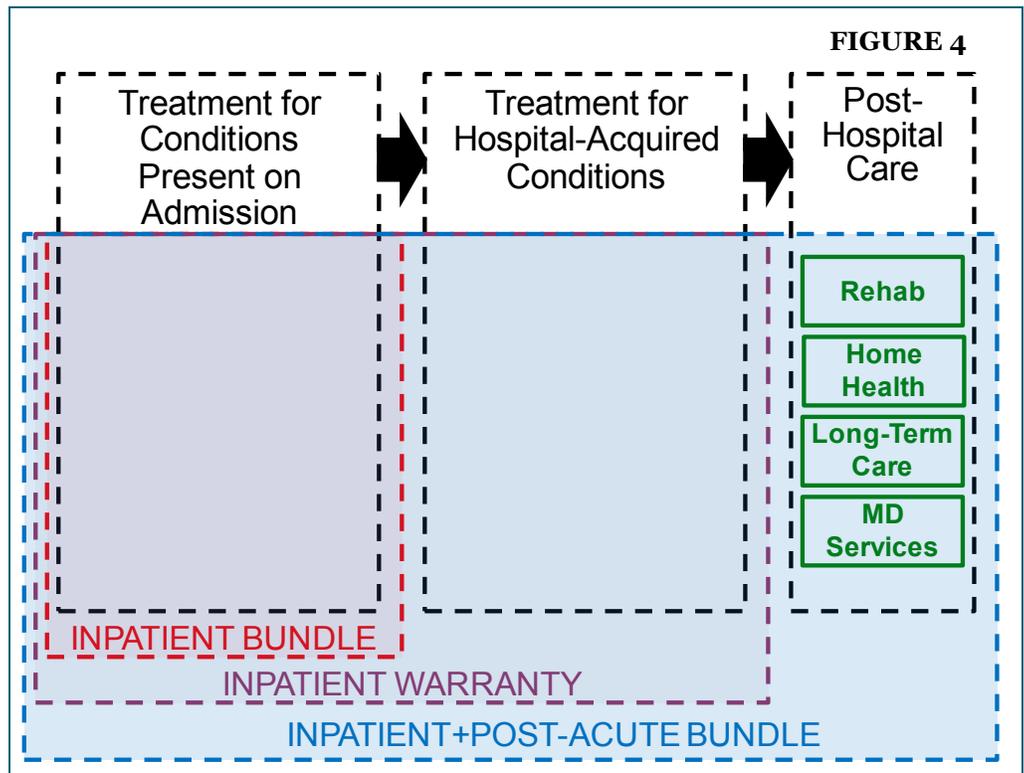
However, it is important to note that the ability to create warranted payments is not limited to large health systems such as Geisinger. For example, in 1987, an orthopedic surgeon in Lansing, Michigan collaborated with his hospital to offer a fixed total price for surgical services for shoulder and knee problems, including a warranty for any subsequent services needed for a 2-year period, including repeat visits, imaging, rehospitalization, and additional surgery. A study found that the payer paid less and the surgeon received more revenue by reducing unnecessary services such as radiography and physical therapy and reducing complications and readmissions.¹⁷

E. BUNDLING PAYMENTS FOR INPATIENT AND POST-ACUTE CARE

“Bundles” can be defined more broadly than just combining the hospital and physician payments for the services they provide during the inpatient stay. Many patients receive post-acute care services (e.g., home health care, rehabilitation services, etc.) after they are discharged from the hospital, and these are frequently delivered by providers unrelated to the hospital and physicians and are typically paid for separately. The fragmentation of payment can result in overuse or underuse of the post-acute care services as well as lack of coordination among all of the providers involved. One solution to this is to create a single, bundled payment for inpatient care and post-acute care services. (See Figure 4.)

Although many of the advantages and challenges of creating a single, bundled payment for inpatient and post-acute care services are similar to those described earlier in conjunction with bundling of hospital and physician services, a key difference here is that not all patients need post-acute care or need the same types of post-acute care. One patient may need physical therapy after a hospital stay, while another may not; one patient may have family members to help them recuperate following discharge and need no professional healthcare services, while another may need home health services or a temporary stay in a nursing facility to play that same role. Consequently, the price of the bundled payment cannot simply be the sum of the payment for an inpatient stay and the price of a post-acute rehabilitation stay or home health care. This means pricing the bundled payment has challenges similar to pricing a warranty – the provider accepting the bundle needs to estimate how frequently the various types of post-acute care will be needed, and then establish a price designed to cover post-acute care services at the necessary frequency.

There are other challenges to bundling inpatient and post-acute care besides pricing. In most communities, inpatient and post-acute care services are delivered by different organizations. Even if the health system that operates the hospital also provides post-acute care services, they are likely not the sole source of such services, and patients will want to have a choice



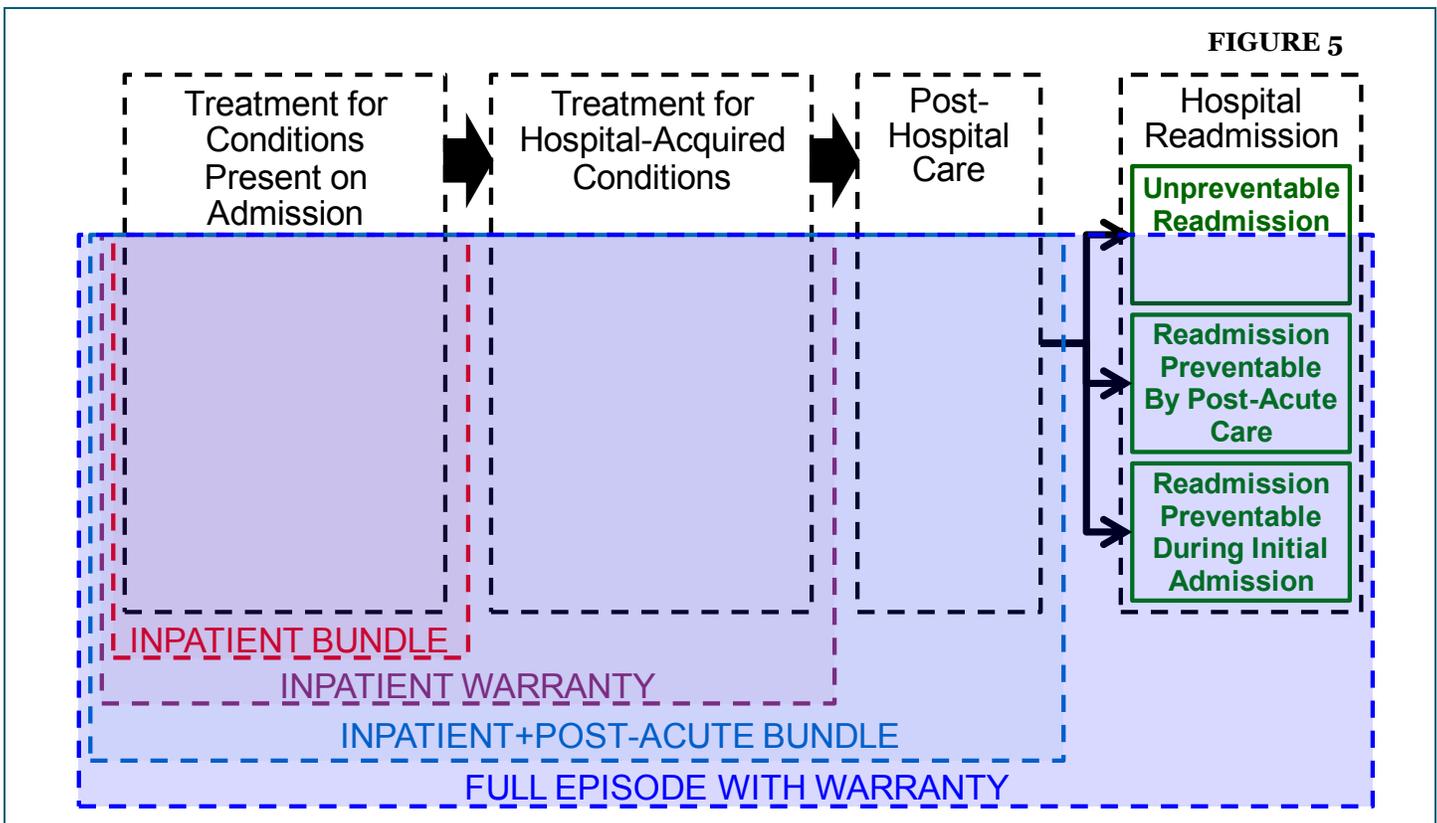
of which post-acute care provider they will use or they will be required by the payer to be given such a choice. In some cases, a patient may receive post-acute care services in a completely different community.

F. PROVIDING A WARRANTY FOR POST-DISCHARGE COMPLICATIONS AND READMISSIONS

The warranty concept described in Section II-D for complications and adverse events that occur during the patient’s hospital stay can also be applied to events that occur after discharge. In particular, there is growing concern about the high cost associated with patients who are readmitted to hospitals after discharge for treatment of conditions related to their initial admission.

Although a commonly-discussed approach is to reduce or prohibit additional payment to hospitals for services associated with readmissions, this approach requires making a judgment about which readmissions are fully preventable. If some readmissions are not preventable, then denying payment for them means denying payment for services that patients need, putting providers in the position of either refusing to provide the care or delivering the care without appropriate compensation. This is particularly a problem if a patient goes to a different hospital or physician for care during the readmission than the original admission.

A better solution is for the hospital and physicians to offer a warranty for post-discharge complications and readmissions. (See Figure 5.) As with the inpatient warranty, rather than giving the payer the simplistic choice of either making full payment or no payment for costs associated with a specific readmission, the hospital could define a price based on an expectation of reducing, but not necessarily eliminating, all of the readmissions. This allows the payer to pay less than it does today without penalizing the hospital for readmissions it cannot prevent, but retains an economic incentive for the hospital to continue working to reduce the rate of readmissions even further. Having the services of both hospitals and physicians included in the warranted payment, particularly the physicians who will provide post-discharge care, is highly desirable because readmissions can be affected both by care in the hospital and care provided after discharge.



G. PAYING BASED ON DIAGNOSIS INSTEAD OF TREATMENT

Today, even where case rates or bundled episode payments exist, they are frequently associated with a particular *procedure*. Although the hospital payment system used by Medicare and many other payers is based on what are called “Diagnosis” Related Groups, in reality, many of them are really “Treatment” Related Groups. For example, while MS-DRG 176 is defined in terms of a diagnosis of “pulmonary embolism without major complications,” MS-DRG 234 is defined in terms of a specific procedure, “coronary bypass surgery with cardiac catheterization without major complications,” rather than in term of the level of coronary artery blockage the patient is experiencing (i.e., the diagnosis).

On the surface, paying by procedure sounds like a fair way to compensate hospitals and physicians for the different costs of different types of procedures needed by two patients with the same diagnosis. The problem is that in situations where there are two alternative procedures which could be used to treat a patient with a particular condition, and where one of those procedures is paid at a significantly higher rate than the other, the hospital and physicians may make more money doing the more expensive procedure than the less expensive procedure. Conversely, if the hospital and physicians choose the less expensive procedure, it might save the payer money with no adverse effect on patient outcomes, but the hospital and physicians would see their revenues and profit margins decrease.

For example, one-third of pregnant women in the U.S. currently deliver by Cesarean section rather than vaginally, a rate which is widely believed to be much higher than necessary and which can result in poorer outcomes for both mothers and babies. Typically, payers pay two different amounts for vaginal delivery and Cesarean sections, with the latter payment being twice as high for hospitals and somewhat higher for physicians than the former; this creates undesirable financial penalties for hospitals and physicians which reduce the use of Cesarean sections.¹⁸

A solution to this is to move away from payments defined in terms of procedures to payments defined in terms of diagnoses. In the example above, creating a single payment for “labor and delivery of uncomplicated pregnancies,” regardless of the delivery method used, would reverse the current financial penalty for reducing Cesarean sections and create a financial incentive as well as quality incentive to increase the rate of vaginal deliveries.

H. TARGETING PAYMENT REFORMS TO FACILITATE THE TRANSITION

The transitional payment reforms described above need not be pursued in any particular sequence, as might be implied in Figures 1 through 5. For example, a hospital and physicians might choose to offer a warranty for post-discharge complications before they try to offer a warranty on inpatient complications, and a hospital might choose to define a bundled payment for inpatient and post-acute care services before it tries to define a bundled payment with its physicians. Moreover, different approaches can be used with different types of patients and conditions.

Indeed, one way to decide which transitional payment reform to use is to determine where the greatest opportunity exists for improving value. For example, as shown in Figure 6, if a hospital believes there are significant opportunities to reduce hospital-acquired infections or other inpatient complications, then it could work with payers to create an inpatient warranty so that it would no longer be penalized financially for reducing those infections or complications. It would not necessarily have to create a bundled payment with its physicians to do this, although doing so would provide an incentive for the hospital and physicians to collaborate on the strategy because both would be able to benefit financially from success.

However, what Figures 1 through 5 demonstrate is that once most or all of these changes are made for a particular procedure, the provider is then able to accept a complete Episode-of-Care payment for that procedure, i.e., a single payment that covers hospital services (Section II-A), all physician services (Sections II-B and II-C), all post-acute care (Section II-E), and any adverse events that occur during the inpatient stay (Section II-D) or after discharge (Section II-F). If these elements are combined for a particular diagnosis (Section II-G), then the provider is also able to accept a Condition-Specific Comprehensive Care Payment for that diagnosis (see Section III-D).

FIGURE 6

SELECTING A TRANSITIONAL PAYMENT APPROACH FOR MAJOR ACUTE CARE	
IF THE GOAL IS TO:	USE THIS PAYMENT REFORM:
Eliminate inpatient inefficiencies	Create case rates for hospital costs and for physician costs during inpatient stays (Sections II-A and II-B); Bundle hospital and physician payments during inpatient stays (Section II-C)
Reduce adverse events during inpatient care	Create an inpatient warranty, either for hospital costs or physician costs or both (Section II-D)
Encourage more efficient combinations of inpatient and post-acute care	Bundle inpatient and post-acute care payments (Section II-E)
Reduce readmissions and other post-discharge problems	Create a warranty for readmissions and post-discharge complications (Section II-F)
Shift treatment to lower-cost options	Define payments based on diagnosis rather than treatment (Section II-G)

III. PAYMENT REFORMS TO SUPPORT ACCOUNTABLE MEDICAL HOMES AND SPECIALTY CARE



Although episode-of-care payment and the transitional steps described in the previous section have considerable promise for reducing costs and improving quality *within* major acute episodes, the major weakness of episode-of-care payments is that they do nothing to reduce the *number* of episodes. For many patients, such as individuals with chronic disease, the primary goal should not be to make their hospital stays better or cheaper, but to prevent hospital stays from being necessary in the first place.

Capitation payment or “global” payment systems attempt to address this problem by defining a single price for all services needed to care for a patient or a group of patients during a particular period of time, regardless of how many episodes of major acute care they receive.¹⁹ A capitation/global payment makes several major changes from current payment systems:

- It combines payments for many services which are currently paid for separately into a single payment; and
- It makes one provider responsible for the costs of services delivered by a wide range of other providers, or makes a group of providers collectively responsible for the costs of the services they each deliver and for which they are currently paid separately;
- It makes the provider responsible for managing all of a patient’s conditions, rather than just a subset.

Capitation/global payment is viewed as very challenging and risky for healthcare providers because it makes all of these changes at once, affecting many providers and many services in complex ways. However, as with episode-of-care payment, although all of these types of changes may be desirable, it is not essential that they all be made at the same time; indeed, one approach to transitioning to a full global payment system would be to make one or more of these changes without the others or to focus the changes on a subset of patients.

Three steps that could be taken by providers and payers to transition physician practices towards more global payment structures are:

- Paying primary care practices Care Management Payments combined with utilization-based performance incentives;
- Paying specialists Care Management Payments combined with utilization-based performance incentives; and
- Paying physician practices or health systems Condition-Specific Partial Comprehensive Care Payments.

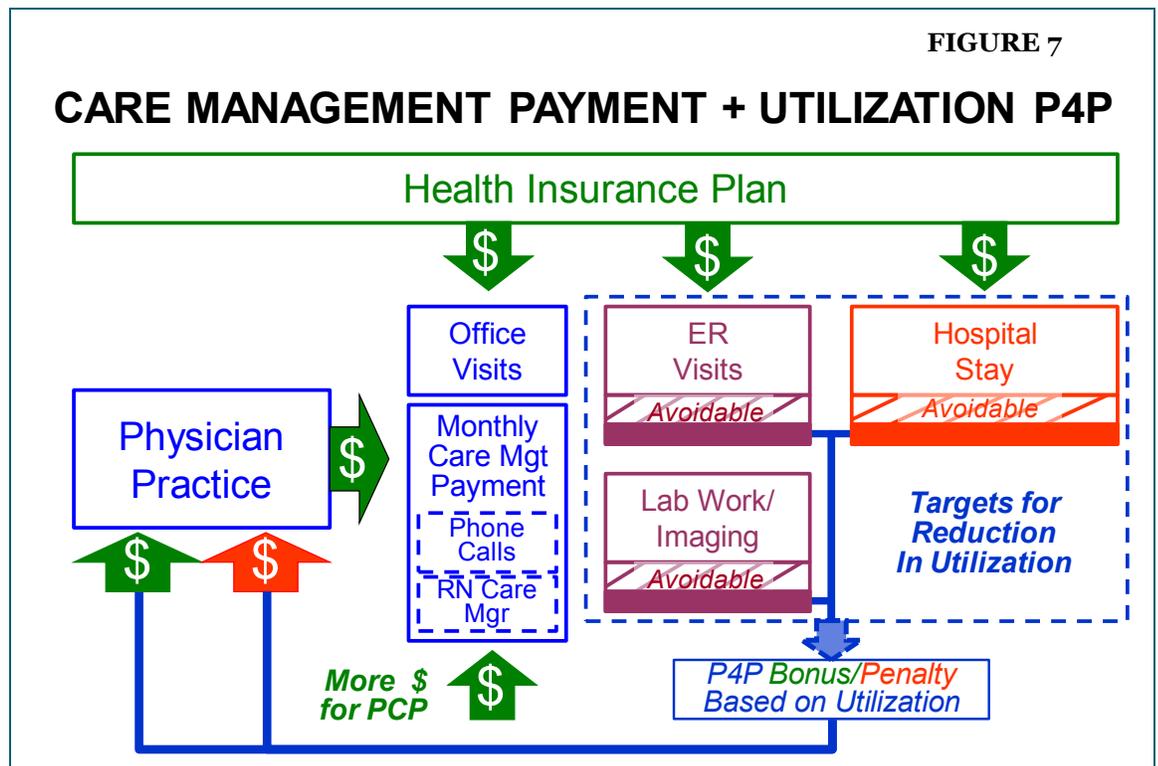
A. CARE MANAGEMENT PAYMENTS AND UTILIZATION-BASED PERFORMANCE INCENTIVES FOR PRIMARY CARE

As noted in Section I-B, a weakness of most current medical home payment models is that they increase payments to primary care practices to improve the way they deliver care without the practice accepting any accountability for ensuring that the improved care actually results in fewer preventable hospitalizations, fewer referrals to specialists, etc. A weakness of the shared savings payment model is that even though it rewards physician practices that reduce hospitalizations, it doesn’t provide any upfront resources to enable the physician practices to improve the way they deliver care in order to reduce hospitalizations.

Rather than trying to choose between these two payment models, each with its own significant weaknesses, they could be viewed as complementary components that can be used as part of an incrementally better payment system for primary care practices. This would work as follows:

- **Component 1: Care Management Payment.** The primary care practice would continue to be paid at current fee levels for each individual service the practice delivers to any patient it sees, but in addition, a new Care Management Payment would be added to pay the practice for care management services (e.g., patient education and self-management support delivered by a nurse practitioner, access to physicians by telephone, etc.) to a group of patients (either all of the primary care practice’s patients or a subset of patients who have specific diseases). The payment would be made on a per-patient basis, i.e., the practice would receive the payment regardless of what specific services it provides, or how many services are provided to any individual patient.²⁰
- **Component 2: Targets for Utilization Reduction.** The physician practice would also agree to improve the way care is delivered to its patients so that the rates of utilization of specific healthcare services outside of the practice (e.g., non-urgent emergency room visits, ambulatory care sensitive hospitalizations, or high-tech diagnostic imaging) are below specific target levels. The target levels would be lower than current utilization rates, such that the reduction in utilization, multiplied by the amounts the payers pay for the services being reduced, would result in aggregate savings that are greater than the aggregate amount of payment made under Component 1.
- **Component 3: Bonuses/Penalties for Performance Against Targets.** A third component would be a pay-for-performance type of payment that would reward the practice for doing better than the targets and penalize it for failing to achieve the targets. The physician practice could receive a fixed bonus or “shared savings” payment for reducing utilization below the target level, but it would be required to refund all or a portion of the upfront care management payment if it failed to achieve the target level (with the amount of the refund being proportional to how far above the target the actual utilization for the patients was).

For example, suppose a four-physician primary care practice manages a total of 5,000 commercially-insured patients. These patients make 450 visits to emergency rooms each year for non-urgent reasons, at an average cost to their health insurance plan of \$1000 per visit. The health plan agrees to give the practice a \$2.00 monthly Care Management Payment for each patient to enable the practice to improve access to the practice for patients



(e.g., longer office hours, weekend hours, and improved phone support). This represents \$120,000 in additional revenues to the practice. The practice agrees that in return for the Care Management Payment, it will take accountability for reducing the rate of non-urgent ER visits by 30%. If it succeeds in doing this, the health plan will save more on ER visits (\$135,000 = 30% x 450 x \$1000) than the cost of the Care Management Payments. If the practice reduces non-urgent ER visits by more than 30%, the practice would receive a bonus payment from the health plan equal to one-half of the cost of the additional prevented ER visits, but if it fails to meet the 30% target reduction, it would be required to pay back a portion of the Care Management Payment equivalent to the cost of the extra ER visits.

A payment system with the above three components would be preferable to the current fee-for-service system, where the primary care practice receives no resources to help reduce emergency room visits, hospitalizations, etc., receives no financial penalty if they remain constant or increase, and receives no reward if ER visits or hospitalizations are reduced. But it would also be easier for a small practice to accept than a traditional capitation structure that would simply pay the

practice a fixed amount per patient, because even though such a payment would give the practice both the ability and incentive to reduce the rate of ER visits and hospitalizations, the practice would suffer a serious financial penalty if there was an unexpected increase in the rate of hospitalizations or the costs of hospitalizations for non-preventable reasons.

This middle-ground approach simulates the flexibility and accountability inherent in a capitation or global payment system, but limits both flexibility and accountability in ways that make it a more practical step for both the primary care practice and the payer. The Care Management Payment is both flexible and predictable, as a full global payment would be, and the utilization targets and bonuses/penalties give the practice incentives to manage utilization similar to what providers need to do to succeed under global payment arrangements.

The Care Management Payment in Component 1 is similar to the care management payments that many health plans are currently paying to primary care practices to help them become certified as “patient-centered medical homes.”²¹ However, most of these programs do not require that the medical homes accept any explicit accountability for reducing utilization of other services. They typically require that the medical home meet accreditation standards which are believed to increase the probability of reducing utilization, but which do not guarantee it. Consequently, many payers have been unwilling to pay a Care Management Payment of significant size because of the concern that this could simply increase the total cost of care. Components 2 and 3 address this concern by directly tying the increased payment to savings elsewhere.

A payer might understandably be concerned that basing targets and rewards/penalties solely on *specific services*, such as the rate of hospitalizations, rather than on *all services* to the patient runs the risk for the payer that the practice will utilize some other expensive services (e.g., increasing referrals to specialists) to reduce hospitalizations. However, if the primary care practice understands that this is a *transitional* payment system, and that targets for additional aspects of utilization will be phased in over time, then it would be undesirable for the practice to significantly increase the utilization of services that are unmeasured this year, only to have a bigger challenge of reducing them next year when those additional services are also being measured. In the meantime, giving the practice an easily understood and measured target to focus on initially would facilitate its ability to move toward more accountable care.

Setting targets based on *utilization of services*, rather than *total cost*, is also important, since it is reasonable to expect that a primary care practice can help manage patients’ conditions in ways that avoid ER visits and hospitalizations, but it is not reasonable to expect that PCPs can control what happens once the patient is hospitalized, particularly when the hospital care is being managed by hospitalists or other physicians. Focusing on utilization avoids putting the practice at risk for the cost of hospital-acquired infections or price changes by hospitals or other providers that could wipe out any savings from reduced utilization.

B. CARE MANAGEMENT PAYMENTS FOR SPECIALISTS

As with most current medical home payment programs, the above option only makes changes in payments and incentives for the primary care practice, not for the “medical neighborhood,” i.e., the specialists and other providers who may also be providing services to the same patients. The Care Management Payment would provide flexible resources that could be used to compensate the primary care practice for contacting specialists to coordinate a patient’s care, but it would do nothing to compensate the specialists for answering the primary care practice’s call or for proactively contacting the PCP to coordinate a treatment plan.

To address this, a payment structure focused on specialists could be created with 3 components similar to those in Section III-A:

- **Component 1:** The specialty provider would receive a fee for consulting with a primary care practice about a patient’s care (rather than only being paid for an office visit with the patient)²²;
- **Component 2:** The specialty provider would make a commitment to work with the primary care practice to achieve specific targets for reduction of avoidable hospitalizations and ER visits, duplicative testing, etc.; and
- **Component 3:** A bonus/penalty payment would be established so that the specialist would be rewarded if the joint effort with the primary care practice beat the targets in Component 2, but the specialist would have to refund a portion of the new fees if the targets were not met.

Here again, this transitional approach simulates the flexibility and accountability of a global payment system, since under a global payment system, a specialty provider can be paid more or differently if they are helping to reduce overall costs.

C. CONDITION-SPECIFIC PARTIAL COMPREHENSIVE CARE PAYMENT

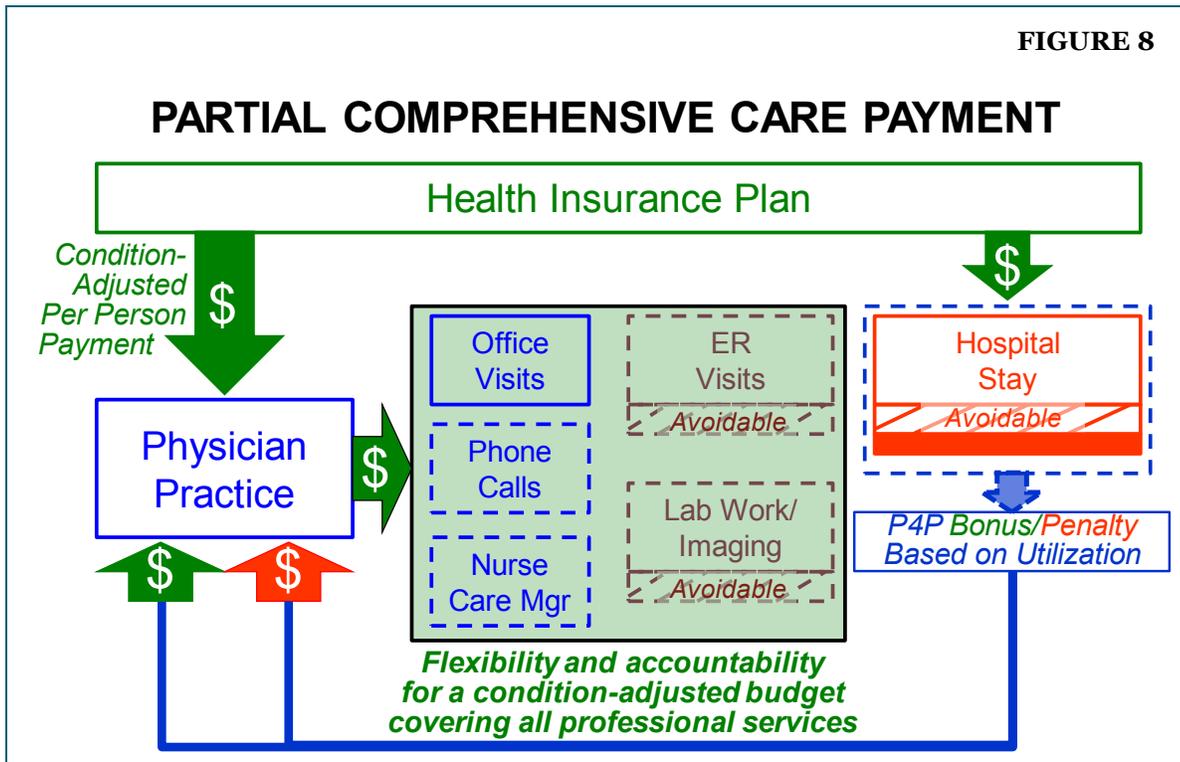
A third transitional approach is to pay a physician practice, an Independent Practice Association, a health system, or other provider or group of providers a single amount for most or all of the services that a patient will need from most or all providers for one or more of the patient’s health conditions over a fixed period of time (e.g., a year). This “Condition-Specific Partial Comprehensive Care Payment” would replace separate fees currently paid for the services that are covered by the payment.

1. SERVICES TO BE INCLUDED IN THE PAYMENT

A range of different types of services could be included in such a payment depending on the provider’s willingness and ability to take responsibility for those services:

- The Provider’s Own Services.** At one extreme, the services could be limited only to those which are currently delivered by the provider receiving the payment. For example, a primary care practice might receive a single payment to cover the costs of all of the services it currently provides to its patients (in place of the fees it is receiving today), but not for any costs delivered by other providers (i.e., specialists, hospitals, etc. would still be paid as they are today). A version of this approach that has been used by some payers is “practice capitation,” in which the physician practice receives a single per-patient (“per capita”) payment to cover all of the services the practice provides to the patient, but services delivered outside of the practice are still paid separately. A growing number of primary care practices, particularly those describing themselves as “concierge” practices, have instituted a similar approach in the form of prepaid annual fees for self-pay consumers.

This type of payment gives the provider complete flexibility about what services to offer and how to target services to the patients who need them the most. However, unless there are other cost and quality incentives included in the payment structure, this approach can also diminish the provider’s incentive to deliver services at all, since the provider is paid regardless of how many services it provides to the patients, as long as the patients remain associated with that provider, and it has a financial incentive to refer patients to other providers to receive services (since they would still be paid separately for delivering those services) rather than having the provider

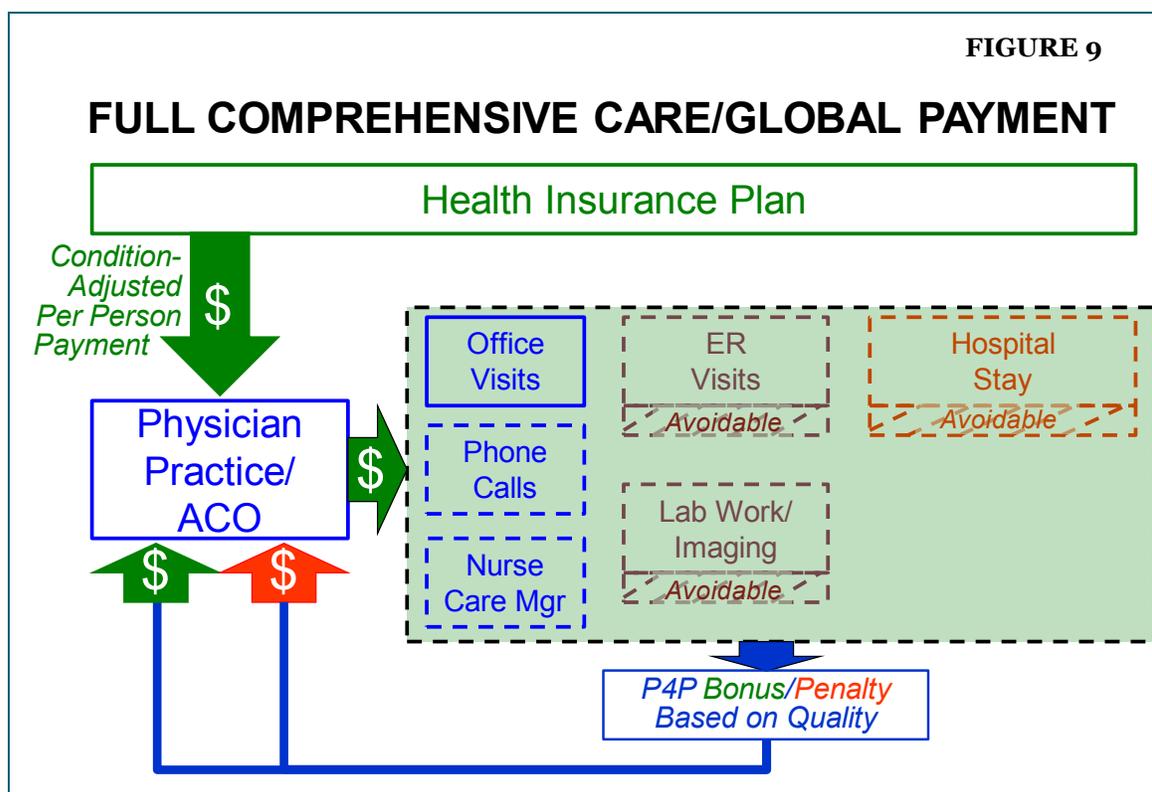


receiving the Comprehensive Care Payment delivering those services directly. (This could be addressed by adding utilization targets and quality payment bonuses/penalties, similar to Components 1 and 2 that are described in Section III-A.²³)

- Some Services Offered by Other Providers.** A more advanced option is to include in the payment to a provider the costs of *some* services that *other* providers deliver; these should be costs that the provider who receives the payment can influence or control. For example, a primary care practice might receive a payment that covers not only the services it delivers, but also the costs of diagnostic imaging services or emergency room visits for its patients. This would create an incentive for the primary care practice to limit excessive use of the imaging services or emergency room, since it could keep any savings, and it would also give the practice the flexibility to substitute other services (e.g., using physical therapy instead of an MRI for a patient with back pain, holding weekend office hours to deal with urgent issues rather than sending patients to the ER, etc.). However, it would also require the practice to actively manage the patients, since it would be liable for the costs of the included services any time the patient received them.

A version of this approach that payers in some parts of the country use to pay physician practices is known as “professional services capitation,” i.e., a single payment that covers the costs of all services delivered by physicians and other healthcare professionals, but not hospital costs. This provides great flexibility to determine exactly what services a patient needs, and a significant incentive to reduce unnecessary referrals and services, including hospitalizations (since a hospitalization will involve considerable professional services fees), without putting the physician practice at risk for the large total costs of hospitalizations. (A pay-for-performance component could also be included based on the utilization of the hospital.)

- Most Services Offered by Other Providers.** The most advanced option would be to include in a single payment most or all of the costs of most or all services that all providers would deliver, including most hospitalizations. This would be similar to traditional full capitation contracts, except that the payments would be risk-adjusted and risk-limited in specific ways (see Section IV). A narrow set of specific services might still be excluded, particularly those that occur infrequently and involve large costs, since these are least likely to be controlled by a provider who does not directly offer the services. In addition, limits on the total amount of costs that the provider would be responsible for, either on a per patient or per case basis, would help to avoid providers taking on too much risk for all services (ways to limit provider risk are described in more detail in Section IV-B).²⁴



2. PATIENT CONDITIONS TO BE COVERED BY THE PAYMENT

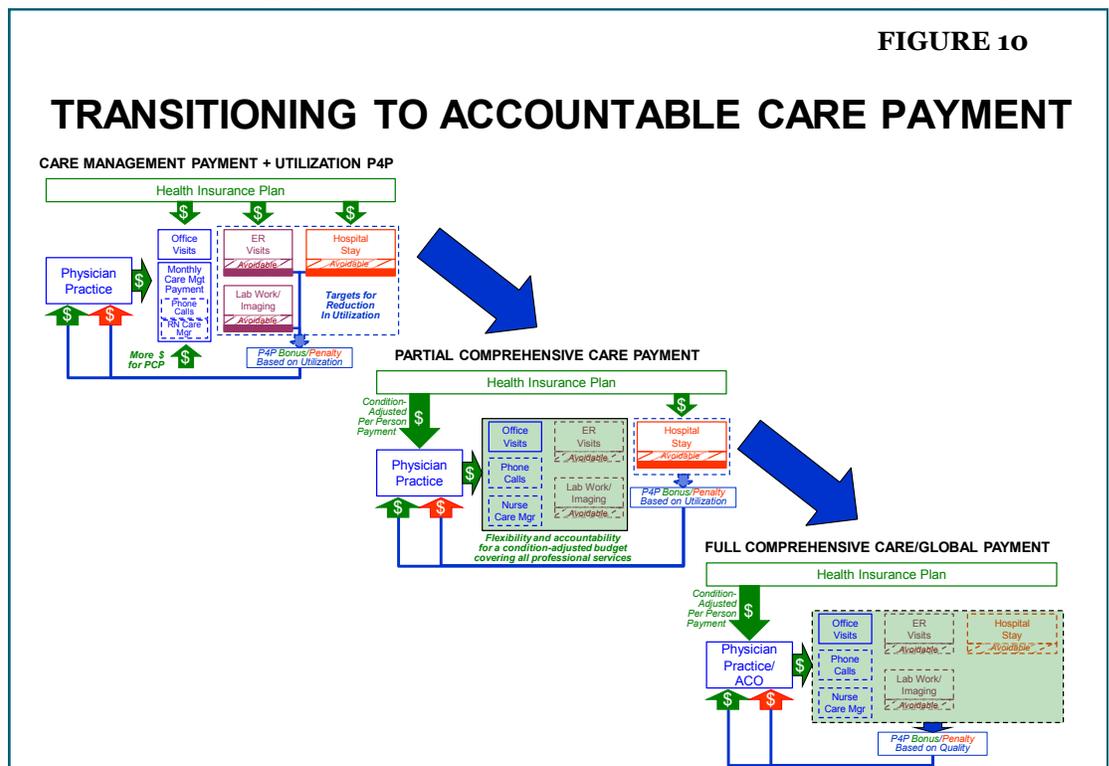
A key difference between Condition-Specific Partial Comprehensive Care Payment and full capitation or global payment is that the Condition-Specific Partial Comprehensive Care Payment would be targeted to specific types of patients or a subset of their conditions. For example, suppose a physician practice felt that it could manage the overall costs of treating diabetics for their diabetes-related problems, but it was not yet prepared to do so for any other patient population or for issues unrelated to the diabetes. It could agree to accept a Condition-Specific Comprehensive Care Payment for patients with diabetes, but continue to receive traditional fee-for-service payments for all other patients, and also for other unrelated conditions or problems the diabetic patients experience (treating injuries from an accident, for example).²⁵

For example, the PROMETHEUS payment system has defined a risk-adjusted payment amount to cover all of the care needed during the course of a year by a patient with a specific chronic disease. The payment is intended to give providers adequate resources to manage the care of the patient in a high-quality way, as well as a financial incentive to reduce preventable hospitalizations and other avoidable complications. This payment model is being tested in several pilot sites.²⁶

D. MOVING FROM CONDITION-SPECIFIC PAYMENT TO GLOBAL PAYMENT

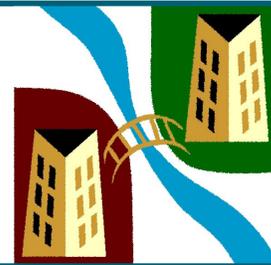
Although Condition-Specific Comprehensive Care Payments may sound far more narrow and feasible to manage than a full capitation or global payment system, a global payment system that is risk-adjusted can be thought of as simply the aggregation of a series of condition-specific payments. For example, if a provider receives a global payment to manage a group of patients, some of whom have diabetes, some of whom have congestive heart failure, and some of whom have both conditions, and if the global payment amount is adjusted up or down based on the number of patients in each category, then this “condition-adjusted payment” is technically equivalent to the provider receiving a condition-specific payment for the patients with diabetes, a separate condition-specific payment (with a different price) for the patients with congestive heart failure, a third condition-specific payment (with yet a different price) for the patients with both diabetes and congestive heart failure, and a fourth condition-specific payment for the patients with neither condition.

This means that providers can use condition-specific payments to make the transition to condition-adjusted global payments, focusing initially on individual types of patients with particular combinations of conditions, learning how to manage the costs and quality for certain services for those patients, and then adding new services and new groups of patients over time until the full range of patients and the services they need can be managed effectively, at which point the provider is capable of accepting a condition-adjusted global payment in place of the collection of individual condition-specific payments.



IV.

SETTING PRICES, MANAGING RISK, AND ENSURING QUALITY



For any of the transitional payment reform steps defined in previous sections, as well as for full global payment or episode-of-care payment systems, three additional issues must be addressed:

- Establishing an appropriate payment amount (i.e., a price) for each patient or group of patients;
- Limiting the financial risk associated with unusually expensive patients or with costs that the provider cannot control; and
- Ensuring that the quality of care to patients is maintained or improved as incentives to control costs are introduced.

A. SETTING PRICES

Sections II and III focused on how to change the *method* of payment for providers in order to improve their ability and incentive to reduce overall costs and improve the quality of healthcare. However, under any payment method, the payment *level* is also critical. Even if the payment method provides the right incentives, if the payment level is too low (i.e., below the minimum feasible cost of providing care), providers will be unable to provide quality care, and if the payment level is too high, there will be no real incentive for efficiency.

WHY PRICE-SETTING IS DIFFICULT

There are three principal reasons why it will be difficult, particularly initially, to set appropriate prices for care under new payment methods:

1. Bundled payments and payments with warranties require substituting a single payment for what were previously separate payments for a varying number of services. In certain cases (e.g., surgery), where there is already a single payment for one set of services (those delivered by the hospital) and a single payment for another set of services (those delivered by the surgeon), and where *all* patients receive *both* sets of services, it is a simple matter to add the two payments together to define the single combined payment. In most cases, however, there is significant variation in the number of services provided, the number of different providers involved, etc., and so defining a single payment for a particular type of patient or procedure requires determining what the appropriate “average” level of services should be. Although some of the current variation in the types and frequency of services is likely to be inappropriate, some of the variation reflects legitimate differences in patient needs, and so the challenge will be determining the proper balance. Having a good condition/severity adjustment system (see Section IV-B) will help, because there should be less variation for more homogeneous groups of patients.
2. It is widely recognized that current prices for many individual services differ significantly from the costs of delivering those services.²⁷ This means that even if one can determine the “right” combination and frequency of services within a bundle or the feasible level of errors, complications, etc. for a warranty, the price of the bundle or warranty will still be wrong if it is based on the current prices of the services being bundled or warranted. Even prices which are “right” today may not accurately reflect what costs will be in the future for many services which will be utilized less frequently, since a provider’s fixed costs will have to be spread over a smaller volume of services. This will be an issue particularly for providers like hospitals with high levels of fixed costs that have long amortization periods (e.g., facilities and major equipment).²⁸
3. In many cases, the actual prices paid for services are a closely guarded secret, and so it is difficult for a provider to determine the actual prices for services delivered by other providers if both are to be included in a new, combined payment amount. Moreover, the prices paid for services vary significantly from provider to provider, so in addition to the variation in the number and types of services similar patients receive today (as described in #1, above), there will be variation in prices depending on which other providers are used, both variations based on genuine differences in the costs of delivery and variations driven solely by the relative negotiating power of the providers and payers.

It is important to note that having “bundled” payment systems will not eliminate the need to have accurate prices for individual providers and services. As long as there are separately incorporated providers involved in the delivery of care, some mechanism of dividing up the episode or comprehensive care payment among them will be needed, and that will require prices (or the equivalent of prices) for each of the providers’ individual contributions as well as for the combined package of services. However, these internal prices will only be used by the providers themselves to allocate their costs, and there will be no need for either payers or patients to know what they are or how they are determined.

THE NEED FOR DATA TO SET PRICES

In order to address the above challenges, it is critical to have current data on utilization and costs of services. For example:

- setting a price for a bundled payment of care requires knowing what services are currently being delivered during such episodes by which providers at what price, and gaining support for the bundled price from the participating providers requires showing them how their share of the bundled payment is going to compare to the payments they currently receive.
- pricing a warranty requires knowing the frequency with which adverse events (such as infections, complications, re-admissions, etc.) occur.
- defining comprehensive care payments requires knowing the rate at which patients receive services from providers which are not part of the organization that will be managing the payment (i.e., “out-of-network” providers) and the payment amounts for those services.

In general, these data are not readily available to providers today, particularly those which are not part of a large, integrated delivery system. Indeed, to a significant extent, many of the quality and cost problems in healthcare today exist because healthcare providers do not have access to the kinds of information that will tell them whether or not problems exist, if the problems are improving or worsening, or even if the solutions are being implemented as intended.

Unfortunately, the large investments currently being made in installing Electronic Health Records (EHRs) will likely do little to solve this. EHRs are primarily designed to retrieve information about individual patients, not to analyze patterns of care across multiple patients. Moreover, an EHR will only contain information about the services delivered by the providers who use that particular EHR; information about services delivered by other providers will only be available if they have a compatible EHR and a mechanism for sharing data between the two.

The most likely source of information to help providers establish appropriate prices will be multi-payer databases that have been established by states and by Regional Health Improvement Collaboratives.²⁹ Although most of these databases are currently being used primarily to produce measures of the quality of physicians’ and hospitals’ care, they can increasingly serve as a powerful tool for helping providers identify cost-saving opportunities and develop the business case for care changes to capture those opportunities.

ALTERNATIVE APPROACHES TO PRICE-SETTING

The way the decision is made about the actual payment level and who makes that decision will depend on the overall mechanism used for price-setting for specific payers in a particular healthcare market. There are four different approaches to price-setting used in healthcare today:

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HEALTHCARE TODAY EXIST
BECAUSE HEALTHCARE
PROVIDERS DO NOT HAVE
ACCESS TO INFORMATION
THAT WILL TELL THEM
WHETHER OR NOT
PROBLEMS EXIST OR IF THE
PROBLEMS ARE IMPROVING
OR WORSENING*

-
- **Regulation**, i.e., the government defines the price that a provider can charge or be paid. For example, the Maryland Health Services Cost Review Commission sets all-payer prices for hospital services in Maryland.
 - **Price-Setting by Large Payers**, i.e., large payers define the amounts they will pay specific types of providers in a particular market. For example, Congress and the Centers for Medicare and Medicaid Services (CMS) establish detailed rules defining the rates that Medicare will pay providers.
 - **Negotiation**, i.e., individual payers negotiate with individual providers to determine prices. This is the most common way of setting the prices paid to providers by commercial health insurance plans in most markets, and the outcome depends on the relative bargaining power of the payers and providers.
 - **Competition by Providers**, i.e., providers set prices themselves and patients choose providers based on price as well as quality. The ability to do this depends on whether the benefit design in the patients' health plan makes them responsible for paying for differences in prices, as well as the availability of multiple providers for patients to choose among.

At one extreme, where prices are set by regulation or by a payer that has little or no competition (such as Medicare), it is likely that the same price will be used for all providers, or that differences will be based on objective factors for differences in costs that are unrelated to practice variations (for example, Medicare pays providers more only if they are teaching facilities, located in higher cost-of-living regions, etc.) This puts the burden on the regulator or large payer to determine what price is appropriate, and providers have a strong incentive to push for higher prices rather than to lower costs.

Where prices are negotiated, it is common for different prices to be paid to different providers for the same services based on the relative market power of the providers as well as objective reasons for differences in cost. This creates incentives for providers to consolidate, which can create greater inefficiencies as well as enable demands for higher prices.

In cases where patients pay all or part of the differences in prices between providers, providers can set different prices themselves and let the market determine whether there is sufficient difference in quality to justify a difference in price. However, the ability to do this depends on having multiple providers offering similar services and having the capacity to accept additional patients, and it also depends on having easy-to-understand information on the quality of services so that patients' choices are made on value (i.e., quality and costs) rather than costs alone.

B. LIMITING FINANCIAL RISK FOR PROVIDERS

Even with the best data, the challenges described in the previous section mean that it will likely be impossible to get the prices under any new payment methods exactly "right," particularly during the transition process. Providers will get better at accurately pricing bundles and warranties once they have more experience implementing them, but in the short run, there will be financial risk for a provider if prices are set too low and financial risk for payers if prices are set too high. In order to avoid having this risk deter implementation, transitional payment systems will need to have ways of limiting this risk.

1. CONDITION/SEVERITY ADJUSTMENT

Healthcare providers generally have little or no control over whether a patient will have serious or major health conditions such as cancer, head trauma, pregnancy, etc. The fact that some patients need more services, and therefore incur higher healthcare costs, because they have more health conditions or more severe conditions is known as "insurance risk." Conversely, once a patient has a particular set of health conditions, healthcare providers have the ability to control how many and what types of services the patient will receive to treat those conditions, and therefore providers (not payers) have the most direct influence on the quality and cost of care for any given combination of conditions. Consequently, a good payment system will keep as much insurance risk (the risk of whether a patient has an illness or other condition requiring care) as possible with the payer (Medicare, Medicaid, or an insurance company), and transfer as much "performance risk" (the risk of whether a condition can be treated successfully for a specific amount of money) as possible to physicians and other providers.³⁰

A key method for separating insurance risk and performance risk is the use of a condition/severity-adjustment system.³¹ If one patient has more health conditions or more severe conditions than another, the amount the provider is paid

for delivering any particular combination or bundle of services to the first patient is “condition/severity-adjusted” to be higher than the amount paid for the same combination or bundle of services to the healthier patient. Defining a more homogeneous group of patients for which a single payment is made also makes it easier to establish an appropriate price for the services needed to treat the patients with those characteristics.

Similarly, if the payment system includes a bonus or penalty structure, then it is important that a provider’s bonus or penalty be based on its performance on factors it can control, not on differences in the types and severity of conditions that the provider’s patients have, so condition/severity adjustment is important here, too. In addition, adjustments may be needed for factors other than health conditions; for example, patients with language barriers, low income, or other socio-economic challenges can require more intensive and expensive assistance in managing their health conditions.

In theory, the more condition adjustment factors that are used, the more providers can be protected from insurance risk, and the more precisely payment can be matched to the actual cost of services.³² However, there is no hard line distinguishing where insurance risk ends and performance risk begins. One patient may be harder to treat than another for the same condition or may have adverse reactions to treatment due to unmeasurable factors that are outside the control of a physician, making it difficult to say how much of the higher costs of treatment are due to insurance risk vs. performance risk. Similarly, through good preventive care, a healthcare provider can reduce the likelihood that patients will develop conditions or can identify conditions in an earlier stage where treatment costs are lower, so providers can impact what otherwise would be considered insurance risk.³³

Condition/severity-adjustment systems can evolve over time as a better understanding is developed of the factors affecting the need for services. For example, beginning in October, 2007, the federal Medicare program changed the condition/severity-adjustment system used in its hospital DRG payment system to ensure that hospital payments more appropriately reflected differences in patients’ needs for services.³⁴ Similarly, Medicare added a condition/severity adjustment system to the way it paid Medicare Advantage plans in 2000, and then introduced a new and improved system beginning in 2004.

2. OUTLIER ADJUSTMENTS AND RISK CORRIDORS

Because of the inherent limitations on condition/severity-adjustment systems, when the provider accepts a fixed payment for a group of patients, even if it is adjusted based on their actual health conditions, that provider still incurs a risk that one or more patients will need many more services or unusually expensive services than the payment covers, without a sufficient number of patients needing fewer services or lower-cost services to offset the higher-cost patients. The risk is much lower than if there were no condition/severity-adjustment at all, but it cannot be eliminated completely.³⁵ The problem is exacerbated for small providers, since a single unusually expensive patient will represent a much larger proportion of the provider’s overall costs of caring for the group of patients. To mitigate this, payment systems can incorporate provisions designed to protect providers (and also payers) against such situations.

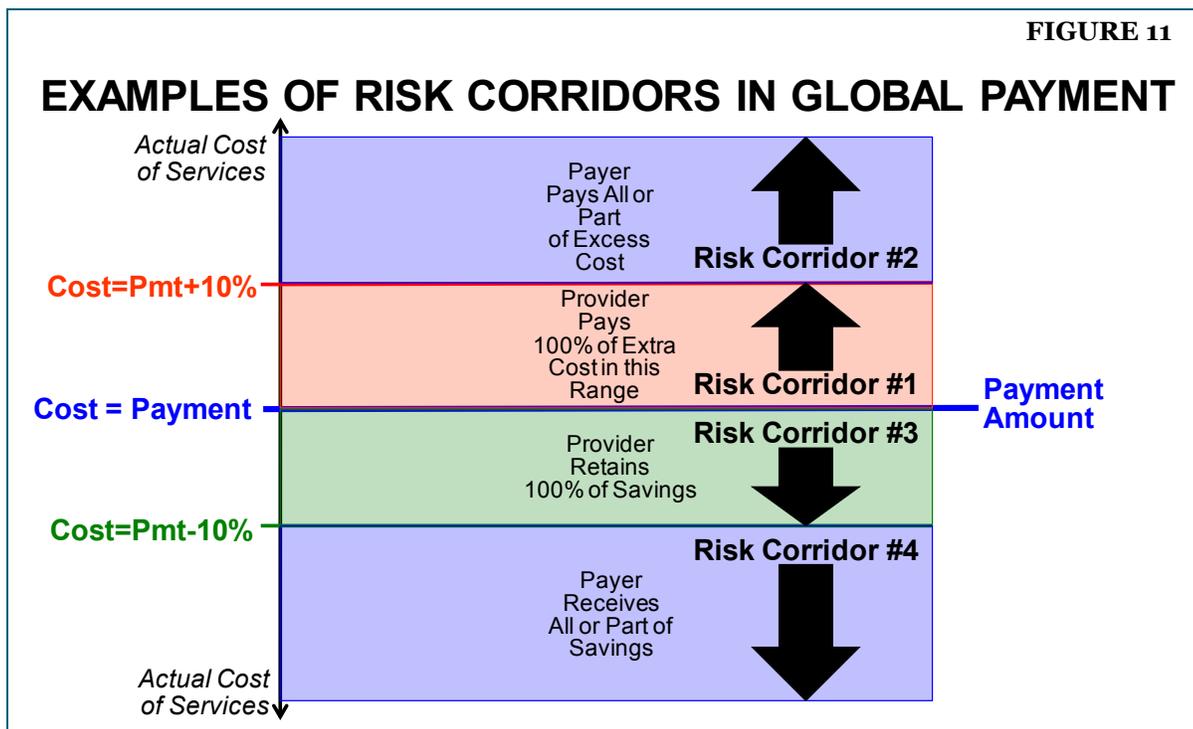
OUTLIER ADJUSTMENTS/REINSURANCE

One commonly used approach is to make an additional payment or some other form of payment adjustment (e.g., an adjustment to the calculation of a bonus payment or penalty) to a physician for a patient who has rare or unexpected problems that require an unusually large number of services or unusually expensive services, or who poses unusual challenges to the physician’s ability to meet quality performance standards. Since these patients are “outliers” in the typical distribution of services and costs, the adjustment is known as an “outlier payment” or (in the case of bonus/penalty calculations) “outlier adjustment.” Typically, an outlier payment is made when the total costs of services exceed some threshold or multiple of the payment level.³⁶ An alternative to making outlier payments is to require the provider to purchase reinsurance, i.e., an insurance policy that pays the provider if a patient’s care is unusually expensive. Outlier adjustments typically involve excluding the unusual patient from calculations of total cost or quality performance when determining bonus or penalty payments, or limiting the total amount of cost that such a patient will contribute to a calculation of costs or savings.

RISK CORRIDORS

Another approach is to measure the extent to which actual costs exceed payment levels for a *group* of patients. Instead of or in addition to making an outlier payment for an *individual* patient if the cost of services for that one patient

exceeds a certain threshold, a payer could make an additional payment if the average costs of all similar cases exceed a predetermined threshold. For example, if the average cost of treating all patients who have pneumonia exceeded 110% of the amount the provider is paid for treatment of pneumonia patients, the provider might be expected to cover



the excess cost up to 10% of the total payment amount (i.e., to spend 110% of the payment amount to care for the patients) and then be given an extra payment to cover all or part of the portion of the costs beyond 110% of the total payment for all of the patients treated. This is known as a “risk corridor;” in this example, when costs are between 100% and 110% of the payment amount (i.e., they are in “risk corridor #1”), the provider takes full responsibility (i.e., accepts full risk) for paying those costs even though they are greater than the payment amount, but when actual costs are above 110% of the payment amount (i.e., in risk corridor #2), the payer accepts a portion of that risk and pays an additional amount to cover all or part of the costs that exceed 110% of the base payment. The advantage for a payer of using risk corridors is that it avoids having to pay more for one unusually expensive case if the provider has managed to keep its costs for other patients well below the payment level and could offset the extra costs itself.

Risk corridors can be defined in the other direction as well, i.e., if it turns out that a provider can treat a group of patients at significantly *lower* cost than the payment amount, the payer may want to share in those savings. So, for example, if costs are between 90% and 100% of the payment amount (i.e., in risk corridor #3), the provider might keep the full savings (i.e., bear the full “risk” of achieving savings), but if the costs are below 90% of the payment amount (in risk corridor #4), the payer could require that it receive a rebate of all or a portion of the difference between the actual costs and 90% of the payment.

The potential magnitude of the risk depends on the nature of the services that the provider has accepted accountability for. If the services are individually very low cost, then even if the provider has patients who need an unusually large number of services, the cost impact will be much lower than if some of the services are very high cost and the provider has patients who need an unusually large number of the high-cost services. For example, if a physician practice has agreed to provide as many *practice-based* services as a group of diabetic patients need for their diabetes in return for a fixed payment, the practice could have a patient that requires many visits, or extra-long visits, but the cost of those extra services to the practice would be relatively small. On the other hand, if the practice has agreed to provide or arrange for *any* services that the diabetic patients need for their diabetes in return for a fixed payment, the practice could experience a very high cost if several of the diabetic patients require (for example) amputations as a result of their diabetes.

Since most current payment systems give very little risk in either the insurance or performance risk categories to providers, even if all insurance risk is retained by the payer, many providers will not be prepared to accept full performance risk immediately, particularly for a broad range of patients and services, and particularly for high-cost services such as hospitalizations. Consequently, it would be desirable to phase in risk corridors over time; e.g., initially, a provider might only be liable for costs that exceed payments by 5% and only eligible to keep savings up to 5% of the payment

amount, but later, the provider might accept liability for costs that exceed payments by 10% or 15%, and in turn have the ability to keep an even larger share of savings.³⁷ Similarly, different risk corridors can be defined for providers of different sizes, so that small providers could receive greater protection against unexpected expenses, particularly in the early stages of their transition to accepting greater accountability for costs.

3. EXCLUSIONS AND RISK-SHARING

Healthcare providers are far more likely to be willing to accept responsibility for the utilization and cost of services they deliver themselves than those delivered by other providers, particularly if they do not have a good working relationship with those other providers or if they believe the other provider is not committed to controlling costs or improving quality. Although many people believe that the solution to this is to have a full range of providers owned by the same corporate entity, corporate integration does not guarantee clinical integration, and moreover, unless the integrated provider is the *only* provider in the community, there is no guarantee that a patient who uses one service from that integrated system will obtain *all* of their services from that system. Indeed, the Medicare fee-for-service program and the majority of commercial health plans do not restrict patients to a single provider or group of providers. In most communities, certain services will only be obtainable from a single provider in the community (e.g., there may be only one hospital which does major organ transplants), and other providers may be reluctant to accept responsibility for the utilization or costs of services delivered by that provider when a patient needs them. There will also be situations in which a patient is unable to receive any services from the accountable provider for some period of time; for example, individuals who spend part of the year living in a different part of the country, or who develop health problems while traveling will have to receive their healthcare services from other providers during those times.

EXCLUDING CERTAIN SERVICES OR COST DRIVERS FROM A BUNDLED OR COMPREHENSIVE CARE PAYMENT

The techniques of risk adjustment, outlier payments, and risk corridors described in the previous sections do not effectively address this issue. The provider may be willing to take full accountability/risk for all of the services that it delivers directly, but no accountability or only partial accountability for the services delivered by certain other providers. Consequently, the payment model can be designed to exclude or “carve out” certain services, e.g., the payer would continue to pay for the excluded services on a fee-for-service basis, while paying for non-excluded services through a bundled or comprehensive care payment. In some cases, a provider may be willing to take accountability for whether a patient uses a service delivered by an outside provider, but not for the price of those services if the outside provider is in a position to negotiate high prices or increases in prices; this can be addressed by making the accountable provider responsible for increases in the *utilization* of the outside provider, but not for increases in the *price* of that other provider’s services.

The challenge is to define the exclusions in a way that preclude or limit the potential for the accountable provider to inappropriately shift patient care to the excluded categories, particularly in cases where the patient would have higher-than-average costs if they received care from the accountable provider.

SHARING RISK AMONG PROVIDERS

An alternative option for limiting a provider’s financial risk for the costs of services delivered by another provider is to formally transfer accountability to the other provider through a formal contract between the providers. The second provider might be asked to agree to provide a specific group of services for a fixed price per patient (which makes the first provider responsible for controlling how *often* the second provider is utilized, but not for how *many* services the second provider delivers when it is utilized for a particular case), or to make that group of services available to all of the first provider’s patients for a fixed budget based on the total number of patients the first provider is managing (regardless of how many of the patients actually use the second provider or how often they use them).³⁸ For example, a physician practice would likely be more willing to accept a full Comprehensive Care Payment (as described in Section III) if the local hospitals were all offering warrantied, bundled payments (using the techniques described in Section II) for the major categories of hospitalizations; this would enable the physician practice to focus on managing patient care so that their patients are hospitalized less frequently, while knowing with certainty how much it would cost if the patients were hospitalized, and the hospital and specialists could focus on how to ensure that the hospitalizations that do occur have the lowest cost and highest quality possible.

C. ENSURING THE QUALITY OF CARE

A common concern about payment reforms that are designed to increase incentives for providers to *control costs* is that they will also create incentives for providers to *withhold care* that patients need or to deliver *lower-quality care* in order to reduce costs. For example, capitation payment systems have been criticized because the provider is paid the same amount regardless of how much care a patient receives, which gives the provider a financial incentive to deliver no care at all.

It is important to recognize, however, that even fee-for-service payment, with its inherent incentives to deliver more services to patients, does not guarantee the delivery of higher quality care, as evidenced by the proliferation of quality-based pay-for-performance components in commercial fee-for-service payment systems. Indeed, in fee-for-service payment, the incentive swings too far in the other direction, since a provider receives more revenue for treating infections, complications, and other conditions that might have been prevented with better quality care.

The fact is that no payment system will, in and of itself, *guarantee* higher quality care unless higher quality care is explicitly rewarded and/or lower quality care is explicitly penalized in the payment system. In order to achieve higher-quality, lower-cost healthcare, the payment system must explicitly enable and reward both types of outcomes. (In addition to using the payment system to encourage higher-quality, lower-cost care, it is also important that the design of a patient's health benefit plan should give the patient incentives to choose higher quality, lower-cost providers and services.)

However, since different payment systems create different kinds of quality incentives and disincentives, no single set of quality measures and payment adjustments will be appropriate for all payment reforms. For example, if a provider accepts a payment with a warranty for errors, infections, or complications occurring during treatment, there is no need to have a separate quality bonus/penalty for such errors, infections, and complications, because there is a built-in penalty for the provider if such events occur, namely, it has to correct the problems with no additional compensation. In the absence of such a warranty, however, a separate bonus/penalty component would need to be added to the payment system to provide similar incentives.

As payment reforms along the lines described in Sections II and III are developed and implemented, they will need to be accompanied by *appropriate* quality incentives to address three principal categories of quality problems:

- Poor quality in a service that results in patient problems requiring treatment that is not included within the overall scope of services covered by the payment for that service. In the example above, if treatment for an infection that occurs during a procedure is *not included* in the payment for that procedure, then a separate system would be needed to reward or penalize the providers delivering that procedure based on the rate at which infections occur. However, if treatment for the infection is *included* in the payment, there is *no need* for a separate reward or penalty. (Patients and payers may still want to know how often infections occur, but reporting quality measures does not mean that payment needs to be explicitly tied to them.)
- Poor quality in a service that results in patient problems occurring outside the timeframe covered by the payment for that service. To continue the above example, if the provider gives a warranty for infections occurring *within* 7 days of a procedure, it may be necessary to have an additional bonus/penalty system based on the rate of infections that occur *after* 7 days.
- Poor quality of service that results in a patient developing preventable conditions that increase the provider's payment level for services to those patients. For example, if the provider is receiving a condition-adjusted payment for primary care which increases the payment amount for patients who are obese, then it may be necessary to have a bonus/penalty system based on the rate at which patients become obese while under the provider's care.

SINCE DIFFERENT PAYMENT SYSTEMS CREATE DIFFERENT KINDS OF INCENTIVES AND DISINCENTIVES, NO SINGLE SET OF QUALITY MEASURES AND PAYMENT ADJUSTMENTS WILL BE APPROPRIATE FOR ALL PAYMENT REFORMS

The further that payment reforms move toward a total episode-of-care or global payment structure, the less need there will be for quality adjustments in the first category, because more and more of the corrective services will be covered by the payment itself, thereby internalizing the incentive to maintain quality. The need for quality adjustments in the second category will depend on the length of warranties and the length of provider contracts. For example, if a provider has a five-year payment contract with a payer, they will be accountable for the costs of addressing quality problems that manifest themselves within the five-year term of the contract (e.g., a failure to perform preventive cancer screening where a missed malignancy could significantly worsen within five years), but not for problems that occur more than five years in the future.³⁹

Because of this, it seems likely that quality measurement focused on *preventive care* – where problems will often not manifest themselves until many years in the future – will take on enhanced importance for both explicit payment incentives and public reporting under more global payment structures. Fortunately, this is the area where most community-based public reporting programs now focus their efforts.⁴⁰

This does not mean that other types of measures will not be needed; indeed, they will become even more important. However, the primary customers of the measures will no longer be payers, but the healthcare providers themselves, who will need effective ways of measuring and monitoring their performance since *they* will now be financially responsible for the problems poor performance causes, rather than payers. Moreover, rather than having outside entities imposing requirements for public reporting of these measures on the providers, the providers with the best performance will have a strong incentive to advertise their good performance to the public in order to attract more patients, and they should, in principle, welcome the existence of a community reporting program which can certify their good performance to the public.

D. SPECIAL CHALLENGES FOR SMALL PROVIDERS

Pricing, limiting risk, and ensuring quality are more challenging for providers who care for a small number of patients, such as small physician practices and small hospitals. For example, if a small physician practice has taken accountability for the rate of hospitalizations for chronic disease patients, or if a small hospital has offered a warranty for infection rates, it is more likely that the rates of hospitalizations and infections for that practice and hospital will vary significantly from year to year solely due to random variations in the characteristics of patients and unique events than would be the case for larger physician practices and hospitals. Condition-adjustment systems can compensate for systematic variations, but they cannot compensate for the large impact caused when one or two patients turn out to be unusually expensive for reasons that could not have been anticipated in advance. Outlier payments or reinsurance can compensate for unusually expensive patients, but even the outlier limit or reinsurance threshold represents a higher proportion of total revenues for a smaller provider than for a large provider.

A similar problem arises with quality measurement. It is frequently impossible to generate statistically meaningful and reliable measures of the quality of care delivered to a small number of patients, since a single patient can dramatically change the success or failure rate in meeting a particular quality goal.⁴¹ For example, suppose that patients get infections 1 out of 1,000 times after a particular procedure is performed. If a provider who performs the procedure on 1,000 patients has one patient who gets an infection, its measured infection rate would be 1 out of 1,000, which is the expected level. However, if a provider who performs the procedure on 10 patients has a patient who gets an infection, it would be impossible to tell whether the provider's "true" infection rate was 1 out of 1,000 or 1 out of 10, with the latter being 100 times higher than expected.

In short, when a provider is small, it is difficult for the provider itself to accurately determine whether it is improving cost and quality outcomes and even harder for any payer to do so, since the payer will only be concerned about its own subset of the provider's patients. Moreover, small providers may not have either the information systems or staff with the time and expertise to analyze data in a meaningful way.

*PAYMENT REFORMS NEED TO
BE CUSTOMIZED TO HELP
SMALL PROVIDERS PARTICIPATE,
PARTICULARLY DURING THE
TRANSITIONAL PHASES*

The solution is not to limit the payment reforms to large physician groups and hospitals, because this would preclude the majority of physicians and hospitals in the country from participating (e.g., over 80% of the physician practices in the country have only 1 or 2 physicians) or result in consolidations of providers that then discourage price-based competition. Instead, payment reforms need to be customized to help small providers participate, particularly during the transitional phases. Several possible techniques for doing this are:

- **Focus payment reforms on larger patient populations and/or on cost/quality targets that occur frequently.** The challenges in measuring costs and quality described above are a function of both the number of patients involved and the frequency with which the measured processes or outcomes occur. It is difficult to accurately measure a provider's performance on an adverse event that occurs rarely if the patient population is small, but it is less difficult to do measurement for processes or outcomes that occur more frequently and for types of patients that the provider sees more of.
- **Use different risk corridors or quality categories for different sizes of providers.** Rather than establishing a single risk or quality threshold that is independent of the number of patients cared for, a more flexible standard could be established that varies based on the number of patients that a provider cares for. For example, a 2% risk corridor might be established for a smaller provider (i.e., the provider would only be responsible for costs up to 102% of the payment amount), but a 4% risk corridor could be used for larger providers, since there would be a much higher probability that a 2% higher cost could occur by chance for the smaller provider than for the larger provider. Conversely, bonus payments for the smaller provider might be limited to situations where costs were at least 4% below expected levels, whereas the larger provider might be rewarded when costs were only 2% below expected levels, because there would be less likelihood that a 2% cost reduction for a large provider was due purely to chance. In other words, a smaller provider would need to achieve a bigger impact on outcomes (higher quality, lower cost, or both) to achieve rewards than would a larger provider, but the smaller provider would also have greater protection against uncontrollable increases in costs. This would provide an *incentive* to the smaller provider to join with other providers to form a larger organization such as an Independent Practice Association (thereby allowing it to receive "credit" for smaller outcome improvements) without *requiring* it to do so. At the same time, it would allow a high-performing small provider to remain small and still be rewarded for its high performance.
- **Use measures and standards applicable to individual patients, rather than those applicable to groups of patients, or define measures in terms of broader categories of patients.** For example, if bonuses or penalties are defined in terms of individual patients (e.g., a physician practice is only paid for a visit with a diabetic patient if a hemoglobin A1c test is performed) rather than a group of patients (e.g., a physician practice is paid a bonus if its rate of HbA1c testing is above average), then the size of the provider's patient population is irrelevant. If a composite measure is used that is applicable to all patients (e.g., a measure of whether "all preventive measures are up to date") instead of individual measures only applicable to specific types of patients (e.g., a measure of whether "mammograms are given to women in a particular age group"), then the provider's performance can be measured more accurately because it is calculated over all of its patients.
- **Measure performance across all of a provider's patients, not just those associated with an individual payer.** This cannot be done effectively by any payer alone, particularly in regions where there are many different payers, but it is being done in many communities by Regional Health Improvement Collaboratives which pool quality data from multiple payers to measure the performance of small providers more accurately and comprehensively.⁴² Although payers naturally will want to ensure that their own patients are not getting care from the provider that is worse than average among the provider's patients, it is unlikely that the provider will even know at the point of care which payer is responsible for payment, so the chances of systematic differences in care quality are low. Moreover, a growing number of Regional Health Improvement Collaboratives are measuring disparities in the quality of care across different patient populations.

V.

DEVELOPING A TRANSITION STRATEGY



A. CHOOSING A STARTING POINT

With so many options for designing payment reforms, where should a community start? In choosing initial incremental steps in payment reform, the overarching goal should be to design steps that can be successful, quickly, from the perspectives of all major stakeholders:

- **For Providers:** The payment change should require manageable changes in care processes and affordable investments by providers, without putting them at significant risk of large financial losses;
- **For Purchasers and Payers:** The payment change and associated changes in healthcare delivery should produce financial savings to purchasers and payers in a relatively short time period and require modest changes in claims processing and other information systems. Ideally, the time period for receiving some financial return should be less than one year, since many purchasers must manage annual healthcare spending budgets, and health plan premiums are often adjusted annually. This is particularly important for state Medicaid programs, which need to achieve savings during the same fiscal year in which any enhanced payments are made.
- **For Consumers/Patients:** The changes in healthcare delivery made in response to the payment reform should improve the quality or affordability of healthcare services from consumers/patients' perspective, such as by reducing undesirable outcomes, improving access to desirable services, etc.

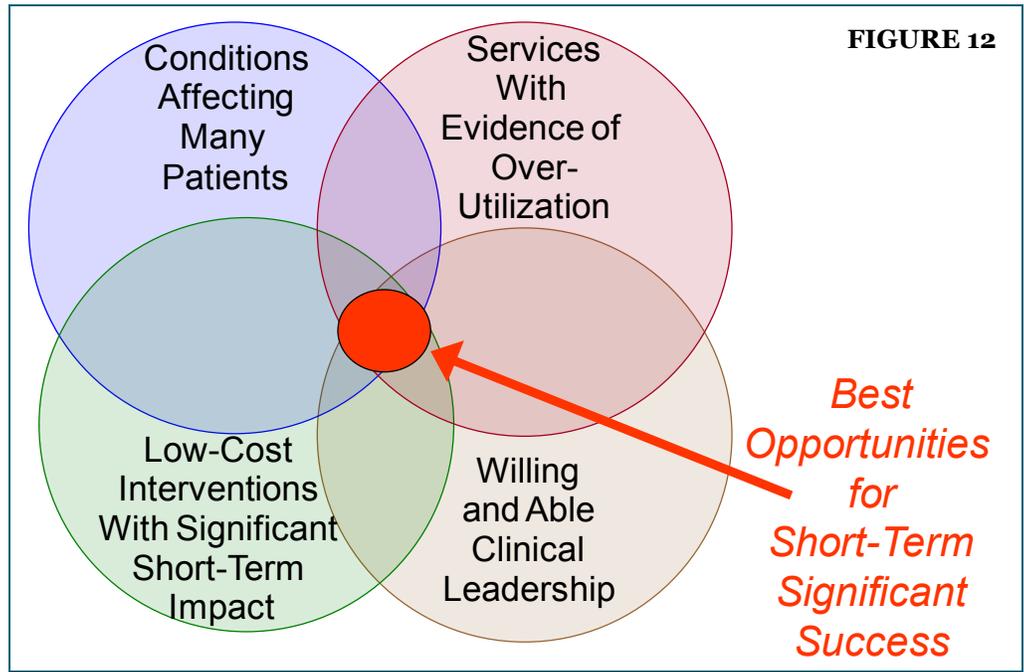
From a provider's perspective, it makes sense to start with patients and conditions for which most of the patient's needs can be met by services that the provider delivers itself, since it is easier for a provider to take accountability for its own services than for those delivered by other providers. For example, patients with mild and moderate stages of chronic disease are much more likely to be manageable primarily through the services that a primary care practice offers, whereas patients with more advanced stages of the disease are more likely to need a consultation with a specialist. The primary care practice could begin its transition to payment accountability by taking full risk for its own services and partial risk for specialist services and hospital stays for the mild/moderate stage chronic disease patients. Then, as it develops closer working relationships with specialists and hospitals, it could both expand the types of patients it takes accountability for and expand the level of risk it takes for services delivered by other providers until it reaches full accountability for all services and all patients.

This means that some providers will be able to accept more accountability more quickly than others. A multi-specialty group practice or IPA will be able to accept more accountability for more services and more types of patients because it delivers specialty services itself which in turn gives it more direct control over hospitalizations. An integrated healthcare system which operates hospitals and employs both primary care physicians and other specialists should be able to accept full or almost full accountability for all services and all patients. However, since these large systems deliver only a small proportion of healthcare in the U.S., if new payment systems are only designed for them, there will be little impact on the nation's overall costs and quality.

From the perspective of purchasers and payers, the following are four basic criteria for choosing an initial step that will help to maximize the likelihood of significant, short-term success:

- **Focus on conditions which affect a large number of patients.** Even small improvements in efficiency or effectiveness can have a significant aggregate impact when applied to conditions affecting large numbers of patients. Moreover, even small providers are likely to be able to participate in payment and care delivery changes affecting common conditions. For example, a large proportion of most providers' patients have chronic diseases, so payment reforms focused on chronic diseases will likely provide an opportunity for broad participation by providers and the potential for large amounts of savings. For commercial and Medicaid populations, pregnancy and newborn care represent a relatively large share of patients and costs.

- Focus on services where there is evidence of overutilization or inefficiency involving relatively large amounts of spending.** Even small reductions in overutilization or improvements in efficiency can generate significant savings when applied to expensive services. For example, a large proportion of spending on patients with chronic disease is used for potentially preventable hospitalizations, and a large proportion of spending on maternity care goes to avoidable Cesarean sections, avoidable elective pre-term inductions, preventable low birthweight babies, etc.



There is evidence of significant overutilization of many kinds of surgery (particularly cardiac surgery and orthopedic surgery, which involve many patients), high-technology diagnostic imaging, etc.

- Focus on changes in care that have been proven to reduce overutilization or inefficiency, that are relatively simple or low-cost to implement, that can achieve significant results within a relatively short time period, ideally a year, and that are viewed favorably by patients.** For example, relatively low-cost programs that provide better patient self-management support and better discharge transitions have been demonstrated to quickly reduce preventable hospitalizations and rehospitalizations. Clinical guidelines defining the appropriate conditions for use of Cesarean sections, pre-term elective inductions, high-technology diagnostic imaging, etc. have been demonstrated to reduce overutilization of these services and can reduce costs and improve outcomes from the patient’s perspective. Shared decision-making between clinicians and patients has been demonstrated to reduce rates of surgery and other expensive interventions in ways that patients view as desirable.⁴³
- Focus on services, conditions, and care changes where there is strong clinical leadership in the community.** Even if there is evidence of overutilization or inefficiency and evidence from other communities that this can be reduced, the changes must be made by the physicians, nurses, and other healthcare practitioners who actually deliver the care. Faster progress and greater success is likely to occur if they are enthusiastic participants than if they are unwilling or even resistant to making the changes.

As suggested in Figure 12, the best opportunities will exist where all four of these criteria are met, but even opportunities that meet two or three of the criteria will have good chances of success.

B. KEEPING THE END IN SIGHT

When developing a transitional payment strategy, it is important to try and define not only the initial incremental steps, but also the desired end point (i.e., the payment system that is ultimately to be used) and as many of the intermediate steps as possible. There are two important reasons for this:

- From a provider’s perspective, this helps strengthen the case for making significant investments in infrastructure, personnel, and processes of care if these investments would not pay off under the initial, incremental reforms but would be worthwhile under later transitional stages. For example, if there were a desire to have physician practices accept risk for hospitalizations of their patients, an initial step might be to have them take responsibility for a small portion of their patients’ hospital costs; although the small share would limit their downside risk, it would also provide relatively little incentive for them to make significant investments in systems that would reduce hospitalizations. However, if they knew that the level of risk-sharing would increase in future transitional steps (e.g., through wider risk corridors, as described in Section IV-B-2), they would be more likely to make those investments to better position themselves for that future arrangement.

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- From a payer’s perspective, this could mitigate any concerns about providers “gaming” more limited payment reforms. For example, if there were a desire to have hospitals accept greater accountability for the full costs of episodes of care, an initial step might be to have them accept a single payment that includes the costs of readmissions, but not post-acute care costs. This could create an incentive for a hospital to significantly increase the use of home health care for discharged patients, but if it knew that a future transitional step would also bundle home health care into the single payment, then the hospital would have an incentive to ensure that home health care was not being overutilized when lower-cost ways to reduce readmissions were available.

The lack of a clear transition strategy is likely one of the reasons that many pay-for-performance systems have had limited impact on the delivery of care. The amount of money involved in most such systems represents only a very small percentage of revenues for most providers, and there is no indication as to whether or how much the P4P incentives will increase in the future, so providers may not see a significant return for making major investments in quality improvement. On the other hand, if it were clear that the share of payment devoted to quality incentives would be increased in the future, more providers would see the initial steps as an opportunity to restructure their processes in order to take maximum advantage of the larger incentives when they are implemented.

Similarly, a problem with payment reform “demonstrations,” i.e., time-limited changes in payment systems wherein payment reverts back to the current system at the end of the demonstration, is that there may be little incentive for a provider to make significant investments in infrastructure, personnel, or new processes of care to enable success under the new payment model if it has no assurance that the revised payment incentives will continue after the end of the demonstration.⁴⁴ A better approach is what the Medicare program refers to as “pilots,” which can be automatically continued if the initial experience with the payment reform is positive, but even pilot projects can create too much uncertainty for providers about how aggressively to pursue major changes in the way they deliver care.

This does not mean that either a precise timetable for the transition or the exact structure of all intermediate steps has to be locked in. For example, it may not be possible up front to determine just how quickly providers will develop the ability to accept greater accountability for the costs and quality of care for various types of patients and conditions. If the transformation of the delivery system occurs more rapidly than expected, then the transition timetable could be shortened and/or some incremental steps could be skipped. Conversely, if the transformation happens more slowly, the timetable could be extended and additional intermediate steps added. The key is for everyone to have a good sense of “what’s coming next” and the timeframe in which transformation needs to occur.

C. EXAMPLES OF MULTI-STEP TRANSITIONS

HOW A HOSPITAL COULD TRANSITION TO ACCOUNTABLE PAYMENT

Suppose that a hospital and the physicians who practice there wanted to move to being paid using full episode-of-care payment, but had no experience with such systems. A multi-step transitional payment approach might be structured as follows:

- **Step 1:** The hospital decides to start by focusing on one of its highest volume groups of surgery patients, such as orthopedic surgery, where it believes there is an opportunity to reduce costs and improve the quality of care. It reaches an agreement with its orthopedic surgeons to accept a single bundled payment for each major type of orthopedic surgery (e.g., hip replacements) that will cover both the hospital services and the surgeon’s fee. The combined payment is set at a level slightly below the sum of the previous DRG payment to the hospital and the case rate to the surgeon, based on an expectation by the hospital and the surgeons that by working together, they can deliver more efficient care with equal or better quality (e.g., by reducing the number of different brands of orthopedic implants used by multiple surgeons, by redesigning the flow through the operating rooms to make them more efficient, etc.). A Physician-Hospital Organization is created as a joint venture between the hospital and the orthopedic surgeons to receive the bundled payments and divide them between the hospital and physicians in ways that reward each for successful efforts to reduce costs. Payments for all other types of patients in the hospital would continue to be made on the same basis as in the past.
- **Step 2:** The hospital and surgeons expand the single payment to include the fees paid to all other consulting physicians on the orthopedic surgery cases. The combined payment is set at a level that is slightly below the average aggregate level of payments to the hospital and all physicians over the past year. The hospital, surgeons, and other physicians work together to define and implement guidelines for how all physicians should participate in these cases.

Other physicians, such as anesthesiologists, now have an incentive to help identify additional ways to reduce the cost and improve the quality of care.

- **Step 3:** The hospital and physicians expand the single payment to include the costs of any complications that occur during the hospital stay. For example, if the patient gets an infection during surgery or during recovery and develops additional preventable conditions, the hospital and physicians would agree not to charge extra for treating those conditions. In return for providing this “limited warranty,” the payment amount would be higher than under Step 2, but it would be lower than the average amount the payer paid for the care of similar patients in the past (including the additional payments that were made for treating preventable complications). The hospital and physicians now will be financially rewarded if they reduce infections, rather than being penalized.
- **Step 4:** The hospital and other types of surgeons define similar warranted, bundled payments for other types of surgery, based on the successful experience of the orthopedic surgeons.
- **Step 5:** The hospital and physicians other than surgeons work together to define a bundled, warranted payment for certain types of *medical* admissions. For these types of cases, *all* physicians have been paid in the past on a fee basis, but a similar two-step process might be used – first creating a combined payment just for the hospital and the physicians in the specialty that typically manages such admissions, and then adding in payments for consulting physicians.
- **Step 6:** The hospital reaches agreements with a number of post-acute care providers, such as home health care agencies and inpatient rehabilitation facilities, to create a bundled payment for one or more types of admissions that includes both the costs of hospitalizations and post-acute care services. The amount of the combined payment is set at a level slightly below the average amount that would otherwise have been paid based on the historical rate and cost of post-acute care for the types of admissions for which the payment is being changed.
- **Step 7:** The hospital expands the inpatient bundled payments for one or more types of admissions to include not only the costs of the initial hospital stay and post-acute care, but also any hospital readmissions that are related to the initial stay. Initially, only readmissions that occur within 15 days of discharge might be included, but the payment could then be expanded to include readmissions that occur within 30, 60, and ultimately 90 days after discharge. The amount of the payment is set slightly below the total amount that would otherwise have been paid for both admissions and readmissions based on the historical rate and cost of such readmissions, since the hospital and physicians believe that they can reduce the number of readmissions through better care in the hospital and during the discharge process.

The hospital and the physicians who work there are now accepting bundled, warranted, full-episode payments for the conditions representing the majority of their revenues, and they are able to deliver significant savings to payers and better outcomes for patients with healthier financial statements for all involved.

HOW A PRIMARY CARE PRACTICE COULD TRANSITION TO ACCOUNTABLE PAYMENT

Suppose that a primary care practice that is currently paid entirely through fee-for-service payments wanted to accept greater accountability for the total cost of care for its patients in return for having greater flexibility and control over the services that its patients receive. Ultimately, it hopes to be able to accept some form of global payment arrangement for managing its patients, but it does not have the skills or experience to do that immediately. A series of transitional payment reforms could be structured to enable the practice to accept greater accountability in increments as it builds its capacity. The following is just one example of how a transitional payment reform might be structured:

- **Step 1:** The primary care practice decides it wants to start by focusing on a subset of its chronic disease patients (e.g., the patients with congestive heart failure or chronic obstructive pulmonary disease) and working to reduce the rate at which those patients are hospitalized (or readmitted) for preventable exacerbations of those conditions. Payers agree to add a new Care Management Payment component to their payments to the practice so the practice can hire a nurse care manager to provide patient education and self-management support to these patients, to install a patient registry, etc. A pay-for-performance component is also included based on the practice’s success in reducing hospitalizations. If the practice is unsuccessful in reducing hospitalizations, the most it can lose is the cost of the nurse care manager and the registry software; if it is successful, it will receive not only sufficient new revenue to cover those costs, but also revenue enabling it to increase its profit margins and pay higher salaries to the physicians and staff of the practice.

- **Step 2:** The physician practice has success in reducing hospitalizations for the initial subset of chronic disease patients, and it expands the program defined in Step 1 to include additional types of chronic disease patients, e.g., those with asthma, diabetes, etc.
- **Step 3:** The physician practice recognizes that some of the most complex patients are still being hospitalized frequently, and it feels that greater involvement of specialists and coordination of care with them could help improve patient outcomes. The practice works out a cooperative arrangement with several specialty physician groups to jointly take accountability for the hospitalization rate of these complex patients, and the payers agree to pay the specialty groups for consultations with the primary care practice, but with rewards/penalties based on the success in reducing hospitalizations for these patients.
- **Step 4:** The primary care practice is sufficiently comfortable with its ability to manage the rate of hospitalizations for patients with certain chronic diseases that it agrees to accept a condition-specific comprehensive care payment for those patients. Instead of separate fees for office visits and other practice services, and in place of the new payment component added in Step 1, the payer(s) would make a single monthly payment to the physician practice for each of the patients with the relevant conditions. The amount of this payment would be adjusted based on the severity of each patient's conditions and other factors that could affect the cost of caring for them. Some patients with unusually complex combinations of conditions may be excluded from this payment and continue to be paid for under the current fee-for-service system, as would the practice's patients who do not have chronic diseases. The payment would be expected to cover the costs of all services those patients need related to their chronic disease, including specialists' fees and a portion of the costs of hospitalizations. The practice would not be expected to directly pay claims for hospitalizations or services delivered by specialists (unless it wished to); the payer would still process and pay claims, and it would treat the condition-specific comprehensive care payment amount as a budget against which the cost of all of the claims would be tabulated. The costs of the specialty consults defined in Step 3 would be covered by this payment.
- **Step 5:** The physician practice accepts similar condition-specific comprehensive care payments for patients with other chronic diseases, with partial responsibility for the costs of hospitalizations.
- **Step 6:** The physician practice is now managing condition-specific comprehensive care payments for so many different types of chronic diseases that it can comfortably agree to accept a condition-adjusted global payment for all of its chronic disease patients (or potentially all of its patients, regardless of whether they have chronic disease).

DIFFERENT TRANSITIONS FOR DIFFERENT PROVIDERS AND COMMUNITIES

These steps are merely illustrative. Some hospitals and physician practices may require more steps to make the transition, while others may require fewer steps or may be able to jump immediately to an intermediate step. Moreover, although the transitional approaches described above for physician practices and hospitals could be pursued independently of each other, there are also potential synergies between them. For example, once the local hospitals are able to offer a bundled, warrantied, full-episode payment for admissions for chronic disease exacerbations, physician practices will be more comfortable taking accountability for the total costs of care for their chronic disease patients, including hospitalizations, because they only have to worry about the rate at which admissions occur, and not about what those admissions will cost. Similarly, a hospital should be more willing to accept a single payment that covers the costs of hospital readmissions for chronic disease patients if the physician practices in the community are actively working to reduce preventable admissions for their patients who have chronic diseases and taking accountability for doing so.⁴⁵

D. CREATING SUCCESSFUL ACCOUNTABLE CARE ORGANIZATIONS

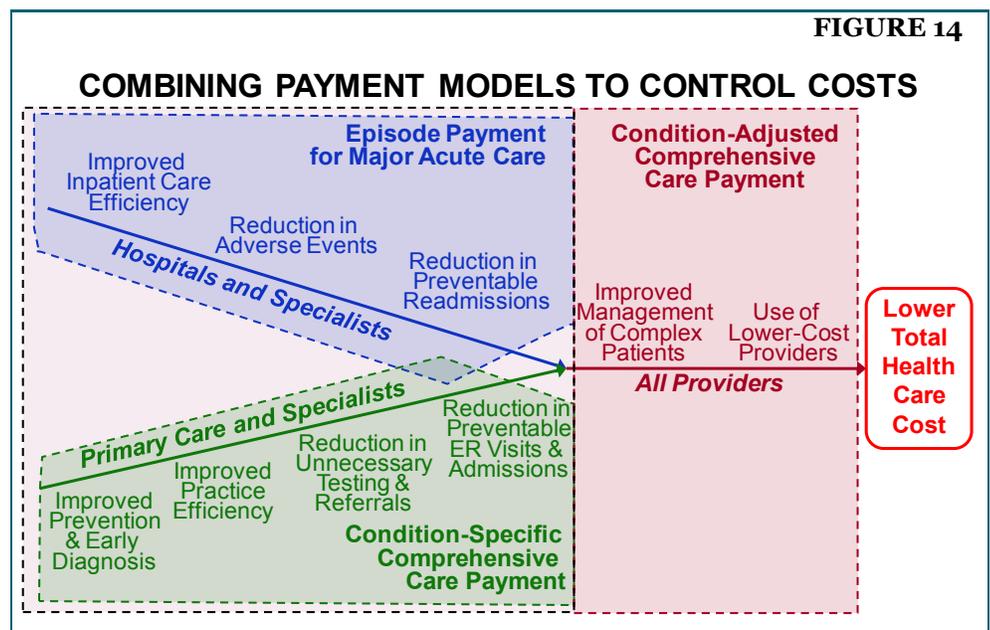
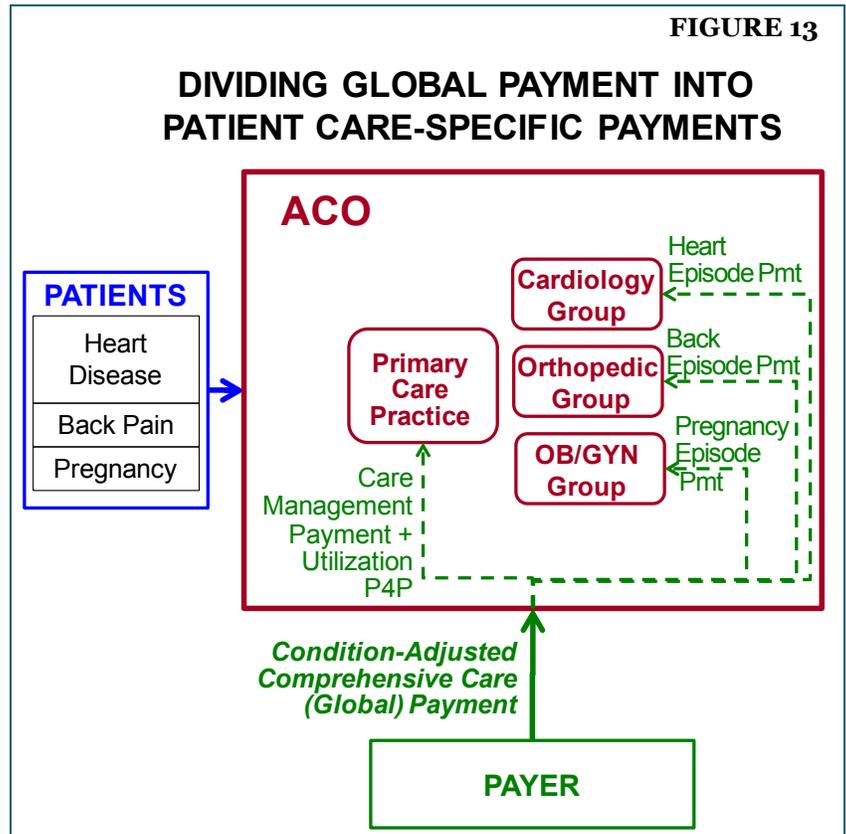
An “Accountable Care Organization” or “ACO” is a provider or group of providers which takes accountability for controlling the total cost of care for a population of patients. Although many authors have discussed in great detail the technicalities of such issues as patient attribution, the statistical formulas for reliably declaring that savings have been achieved, and the legal issues associated with organizational consolidation, there has been almost no attention to what is a far more important question – how exactly will an ACO change the way healthcare is delivered in order to reduce costs and improve quality? While many providers are busy creating new organizational structures to manage the finances associated with payments to ACOs, new organizational structures do not directly translate into better care for patients or

greater efficiencies in the delivery of that care.

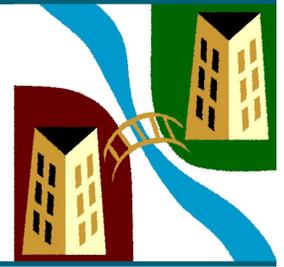
The most important factors in the success of ACOs will likely be (1) their ability to identify specific opportunities for improving the way care is delivered to patients that can reduce costs and improve quality, and (2) their ability to provide the resources and supports that individual healthcare practitioners need to enable and encourage them to make those improvements. Even if the ACO is accepting a global payment for the total costs of care for a patient population, in order to successfully provide high-quality care at a cost less than or equal to the payment amount, it will need to break that payment budget down into sub-units and ask individual teams of healthcare practitioners to manage the care they deliver within those sub-units.

For example, as illustrated in Figure 13, in order to improve the total costs and quality of care for a group of patients with conditions such as heart disease, back pain, and pregnancy, the ACO will need to have cardiac care teams improving the cost and quality of care for patients' heart disease, orthopedic groups improving the way back pain is managed, maternity care teams improving the cost and quality of care for pregnant women, and teams of primary care physicians, specialists, nurses, and others improving the cost and quality of care for patients with chronic disease. An ACO cannot control *total* costs and quality if it cannot control both the cost and quality of individual episodes of care and the number of episodes of care for groups of patients, and it cannot control these things if the individual practitioners that are delivering the care are still being paid based on volume rather than value. So the ACO will need to make the equivalent of episode payments and care management payments to the individual physician groups and other providers involved in delivering the care.

As explained in more detail in *Creating Accountable Care Organizations*⁴⁶, many opportunities for reducing costs can be addressed primarily through the actions of primary care practices; others can be achieved primarily through the actions of hospitals and specialists; and some will require efforts by a broad range of providers in the community acting in concert. In order to maximize the impact on total costs, each of these providers will need to be paid in ways that support their efforts using the kinds of approaches described in Sections II and III, with the individual payment components adding up to the overall global payment.



VI. OBTAINING SUPPORT FROM PAYERS



A. THE MYTH OF THE ONE-SIZE-FITS-ALL PAYMENT REFORM

An implication of the preceding sections is that multiple new payment models need to be available in each community for providers with different capabilities, that different combinations of models will likely be needed in different communities, and that these payment models should evolve over a multi-year period as providers transition toward greater accountability.

Although it might seem much easier and cheaper to try and choose one “best” payment system and stick to it over a long period of time, doing so would serve as a major barrier to achieving the better value in healthcare that the nation desperately needs. Given the diversity of provider capabilities across the country, any one-size-fits-all payment change would mean that (1) those providers which could accept greater accountability than permitted by the payment change would be unable to deliver all of the improvements in value they could offer, and (2) those providers without sufficient skills to participate in the payment model that is chosen would be unable to make even the small improvements in value they could offer if given the opportunity to participate in a more incremental payment reform.

Although offering multiple new types of payment may sound very complex and expensive, it is difficult to imagine that the payment systems described in Sections II and III, even with multiple options to facilitate the transition, could be any more complex than current payment systems. For example:

- Medicare currently has not one, but four different methods of paying general acute care hospitals –one system for Critical Access Hospitals, a different system for Sole Community Hospitals, yet a different system for Medicare Dependent Hospitals, and finally the Inpatient Prospective Payment System (IPPS) for all other hospitals, and the IPPS system has further modifications for Rural Referral Centers, Disproportionate Share Hospitals, and teaching hospitals. Under the IPPS, Medicare pays hospitals separate prices for over 700 different MS-DRGs.
- Physicians are paid for over 8,000 different types of activities and procedures classified under the CPT code system, and Medicare determines fees for each of these separate codes based on three separate relative value units (RVUs) – work RVUs, practice expense RVUs, and the malpractice expense RVU – each of which is in turn modified by separate Geographic Practice Cost Indexes.
- Most providers are paid using a variety of different payment systems, some superficially similar but with many specific differences (e.g., different P4P standards from different payers), and others significantly different (e.g., many hospitals are paid using DRGs for some patients, per diem payments for others, and percent-of-charges for still others).

The transitional payment models described in Sections II and III could actually help to simplify many of the payment structures that are currently in place.

B. ALIGNING THE PAYMENT SYSTEMS OF MULTIPLE PAYERS

Most healthcare providers receive payment for their patients’ care from multiple payers, including:

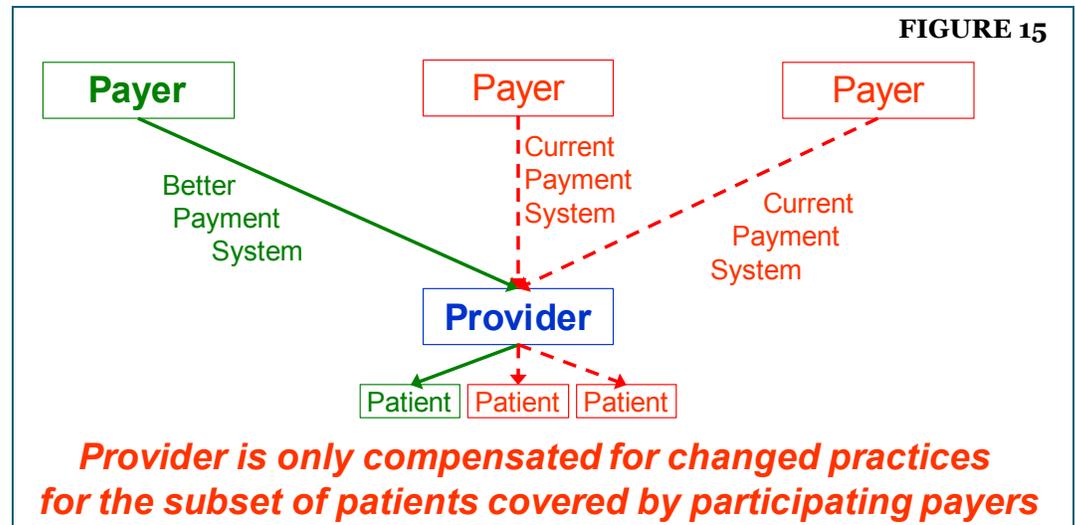
- The federal Medicare program;
- The state Medicaid program and other public programs;

- National or multi-state commercial insurance companies (including Medicare Advantage plans);
- Local commercial insurance companies (including Medicare Advantage plans);
- Self-insured companies and organizations (including governments, for-profit businesses, and non-profit organizations), which typically use a national or local health plan to process and pay claims; and
- Self-pay patients.

WHY PROVIDERS NEED ALIGNMENT OF PAYERS

Even if one payer is willing to implement desirable payment reforms, it is difficult and may even be inappropriate for a provider to change the way it delivers care for only that payer's patients. Consequently, if other payers do not also implement similar reforms, the provider faces an undesirable choice between:

- improving the way it delivers care for *all* of its patients, and being financially penalized for those patients still paid for under the payment systems that have *not* been changed;
- continuing to provide care for all patients the same way as in the past, and either refusing to participate in the new payment system or, if refusal is not an option, losing money for the patients paid for under the new system.



WHY PAYERS NEED ALIGNMENT OF PAYERS

Payers may also be deterred from implementing a new payment system if they believe that other payers will not implement the same payment approach. If the payer contemplating the payment change does not have a large enough number of patients to ensure that providers will change the way they deliver care, then that payer would incur the costs of making the payment change with no corresponding savings in care delivery costs. Conversely, if that payer does have a large enough number of patients to convince a provider to change the way it delivers care, the provider will likely also generate savings for other payers without them having to incur the costs of making the payment change. In either case, the payer making the change is placed at a competitive disadvantage compared to other payers who do not make the change.

OVERCOMING THE BARRIERS TO ALIGNMENT

This means that it is in both payers' and providers' interest (as well as in the interest of patients) for all payers to adopt a new payment arrangement, since this would enable a healthcare provider to change its care processes for all of its patients without being financially penalized for any of them, while also avoiding creating a competitive advantage for any individual payer.

Despite this, achieving alignment of all payers in a market is very challenging, for at least two reasons:

- Concerns about antitrust law violations make it difficult for payers to discuss or reach agreement on a common approach to payment.
- Many payers pay for patients located in multiple geographic markets, and in some cases nationally, and they find it more efficient to use the same payment system in all of their markets, rather than having different payment systems

in each market that align with other payers in that market. This is true of Medicare itself, national and multi-state health insurance firms, and even large self-insured employers.

Although alignment of all payers would be ideal, many providers have indicated that having at least 50% of their patients covered under a better payment system would likely provide sufficient critical mass to enable them to implement different care processes.

It is unclear to what extent effective payer alignment should mean having payers adopt *identical* payment systems or merely that all payers need use to payment systems that provide *similar flexibility and incentives* to providers. The answer will likely depend on the extent of the administrative burden imposed on providers for complying with different payment systems. For example, many providers complain today about the enormous variation in pay-for-performance bonus programs among commercial health plans. Although at the most general level, one could say that two payers are aligned if they each have a P4P program that rewards high quality performance for a particular type of patient, different measures of what constitutes “high quality performance” in each payer’s system mean the provider has to devote a higher level of administrative attention to being able to measure and report quality in multiple ways.

Some approaches that could be used to achieve a critical mass of multi-payer alignment for providers include:

- Use state government or a non-profit Regional Health Improvement Collaborative to facilitate agreement on a common payment methodology. Antitrust prohibitions focus primarily on payers agreeing on a common price for services, not necessarily on a common *method* of payment.⁴⁷ However, the risk of running afoul of antitrust laws will likely deter payers from discussing and agreeing on payment methodology changes without help from a neutral outside entity. One approach is for states to supervise the development of a common payment methodology, using the state action exemption under federal antitrust law. Another approach is for a neutral entity, such as a non-profit multi-stakeholder Regional Health Improvement Collaborative, to develop a common payment methodology and convince multiple payers to use it. For example, in a number of communities, non-profit Regional Health Improvement Collaboratives have developed agreement among multiple payers on a common payment methodology to support innovative care delivery programs or on a common set of quality measures that all of the payers will use in their pay-for-performance programs.⁴⁸
- Reach initial agreement on a common approach to payment reforms among payers who exclusively or primarily pay for patients living in the local market. This could include:
 - ◆ the State Medicaid program.
 - ◆ locally-based self-insured employers. In many communities, the largest self-insured employers are health care systems, so these providers could actually take the lead in implementing the payment systems they want to see implemented more broadly.
 - ◆ local commercial health plans, including Medicare Advantage plans (Medicare Advantage plans are not limited to paying providers on the same basis as the traditional Medicare fee-for-service system).
- Restructure payment for types of patients and conditions for which there are fewer payers or who have payers that are more willing to change their payment systems. For example, there is no need to be concerned about participation by Medicare in order to change payments for maternity care; conversely, a major impact could likely be made on end-of-life care through changes in Medicare payment alone.
- Implement payment reforms with providers which accept payment from a more narrow range of payers (assuming those payers are willing to implement the payment reforms).
- Implement payment reforms initially with providers which have their own health plan. Providers which are integrated in this way will have greater flexibility in designing and evolving payment systems, since all revenues and costs for the patients in the health plan stay within the overall system.
- Define the most critical aspects of payment systems that need to be aligned, rather than trying to get all payers to implement the identical payment systems. The key issues for providers are that the incentives and disincentives in different payment systems be similar (e.g., the provider is not rewarded for more volume in one system and penalized for it in another) and that the administrative burden of complying with different systems not be high. It may be easier for different payers to implement similar incentives in different ways because of the unique structure of their information systems, the payment systems they use in other markets, etc.

C. HOW MEDICARE CAN PARTICIPATE

Given its size, it is very important that the Medicare program participate in new payment models for most types of providers. Fortunately, the federal Patient Protection and Affordable Care Act (PPACA)⁴⁹ has given the Centers for Medicare and Medicaid Services (CMS) the power to offer the full range of transitional payment reforms described in Sections II, III, and IV if it wishes to do so. The two principal sections of the law that provide this capability are:

1. SHARED SAVINGS PROGRAM/ACCOUNTABLE CARE ORGANIZATIONS

Section 3022 of PPACA added Section 1899 to Title XVIII of the Social Security Act to support the creation of “Accountable Care Organizations (ACOs).” Although titled the “Shared Savings Program,” subsection 1899(i) provides the Secretary of Health and Human Services with the power to establish “other payment models” for ACOs that the Secretary determines “will improve the quality and efficiency” of healthcare, as long as payments do not result in spending more “than would otherwise be expended ... if the model were not implemented, as estimated by the Secretary.”

Each of the transitional payment reform models described in Sections II and III above can be structured in a way that maintains or reduces spending for the services encompassed by the payment. For example, the Care Management Payment and Utilization-Based Performance Incentive for primary care described in Section III-A can be structured in a way that ensures that the increased spending for the Care Management Payments is offset by reduced spending on emergency room visits, hospitalizations, etc. Consequently, any of these transitional payment reforms could be implemented under Section 1899.

Although the “other payment models” can only be used by ACOs, the law defines ACOs quite broadly; physicians in group practices and Independent Practice Associations can qualify as well as hospitals employing physicians. Although it is generally perceived that only providers which deliver or control a full range of services would be able to qualify, the law says only that an ACO must “be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.” This could easily include organizations that are willing to transition over time to broad accountability but need more narrowly defined initial payment reforms to enable them to get started, similar to the sample transitional strategies outlined in Section V-C.

*THE AFFORDABLE CARE ACT
GIVES MEDICARE THE
ABILITY TO PARTICIPATE IN
THE FULL RANGE OF
TRANSITIONAL
PAYMENT REFORMS*

2. CENTER FOR MEDICARE AND MEDICAID INNOVATION

The Shared Savings/ACO section of PPACA is not the only area where broad authority for payment reforms is granted; Section 3021 of the law added Section 1115A to Title XI of the Social Security Act, establishing the Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare and Medicaid Services. The purpose of CMMI is “to test innovative payment and service delivery models to reduce program expenditures ... while preserving or enhancing the quality of care...” The law gives CMMI the power and/or duty to:

- test models focused on “a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures” (Section 1115A(b)(2)(A)), which allows targeting payment reforms on specific types of patients or health conditions where there are opportunities for savings, as suggested in Section V above;
- “limit testing of models to certain geographic areas” (Section 1115A(a)(5)), which allows different transitional payment reforms to be used in different areas as needed to match the capabilities of providers there; and
- focus on models “expected to reduce program costs...while preserving or enhancing the quality of care” (Section 1115A(b)(2)(A)), but not to require that the model is budget neutral initially (Section 1115(b)(3)(A)); this allows use of payment reforms which will achieve reductions in cost over a multi-year period.

This can allow Medicare to participate in unique payment models developed in individual communities to help their providers transition to more accountable care.

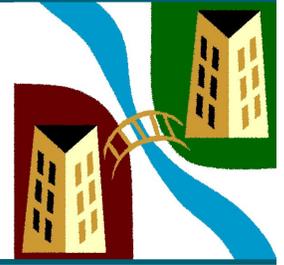
3. MAKING MEDICARE CLAIMS DATA AVAILABLE

As described in Section IV-A, it is very difficult to set prices without access to data on current utilization patterns. It is also difficult to identify where opportunities for cost reduction exist or how to capitalize on them without access to such data. Healthcare providers need information on current utilization patterns and analyses of the likely impact of interventions in order to construct a feasible business case for the investment of resources in new care processes, and they will also need continuously updated data in order to monitor the success of these changes in care. Although many communities have multi-payer databases that can assist with this, these databases typically do not contain data on Medicare patients, which makes it impossible for providers to identify care improvement opportunities for Medicare beneficiaries or to design changes in care that will improve quality and reduce costs for the Medicare program.

It is critical that the Centers for Medicare and Medicaid Services make current Medicare claims data available quickly so that healthcare providers can begin planning successful strategies to take accountability for the costs and quality of care for their patients. An ideal approach is to use multi-stakeholder Regional Health Improvement Collaboratives as recipients of the data, protecting the confidentiality of the information while helping providers in their communities to analyze the data and plan appropriate changes in the way they deliver care.

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ENDNOTES



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7. Network for Regional Healthcare Improvement. *Pay for Innovation or Pay for Standardization? How to Best Support the Patient-Centered Medical Home*. February 2009. Available at <http://www.nrhi.org/downloads/NRHI-HowtoSupporttheMedicalHome.pdf>.
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 20. Instead of a Care Management Payment, new fees could be paid for specific services that are not currently compensated, such as phone calls or emails with patients, home visits or calls by a nurse care manager, etc. However, if the ultimate goal is to move to a payment structure that gives the physician more flexibility to determine the right mix of services for individual patients, then paying for currently-uncompensated services through a single per-patient payment would be preferable to creating a series of new fees that would each have to be individually priced and adjudicated for payment.
 21. A list of medical home payment and technical assistance programs is available at the website of the Patient-Centered Primary Care Collaborative (<http://www.pcpcc.net/pcpcc-pilot-projects>). Also, the majority of state Medicaid programs pay at least some of their primary care practices a Primary Care Case Management payment, in addition to fees for service, to enable and encourage the primary care practice to improve the quality and reduce the cost of care to Medicaid beneficiaries.
 22. For example, in the DIAMOND Initiative created by the Institute for Clinical Systems Improvement in Minnesota, psychiatrists are paid fees not just for seeing patients in the office, but also for consulting with primary care physicians and their care managers on how to better manage patients with depression. See www.ICSI.org.
 23. The Massachusetts Coalition for Primary Care Reform is testing a comprehensive primary care payment model under which primary care practices receive a risk-adjusted comprehensive payment plus a risk-adjusted bonus for implementing medical home services and achieving desired outcomes. The concept is described more fully in Goroll AH, Berenson RA, Schoenbaum SC, Gardner LB. Fundamental reform of payment for adult primary care: comprehensive payment for comprehensive care. *J Gen Intern Med.* 2007 Mar;22(3):410-5.
 24. For example, the Alternative Quality Contract implemented by Blue Cross Blue Shield of Massachusetts in 2009 makes a fixed payment to a healthcare provider for each patient to cover all care services delivered to the patient (including hospital care, physician services, pharmacy costs, etc.), with the payment amount adjusted by the health status of the patients. The provider can earn up to a 10% bonus payment for achieving high performance on clinical process, outcome, and patient experience measures. The amount of the payment is based on historical costs for caring for a similar population of patients and is increased annually based on inflation. Outlier payments are made for patients with unusually high needs and expenses, and limits are placed on the total amount of financial risk the providers accept. Chernew ME, Mechanic RE, Landon BE, Safran DG Private-payer innovation in Massachusetts: The 'alternative quality contract.' *Health Aff (Millwood).* 2011 Jan; 30:151-161.
 25. The condition-specific payment for diabetics might still be *condition/severity-adjusted* based on the comorbidities that the diabetic patients have (for example, the payment to the practice for its diabetic patients could be higher if their diabetes was more severe), or the conditions for which the payment is made could be defined in a way which excludes some particularly complex patients (e.g., a diabetic patient with three or more other major comorbidities could be excluded from the group of patients covered by the condition-specific payment, and services for that patient could continue to be paid using fee-for-service), or both. See Section IV-B for more discussion of this point.
 26. More information on PROMETHEUS is available at <http://www.prometheuspayment.org/>.
 27. See, for example, Ginsburg P. When the price isn't right: How inadvertent payment incentives drive medical care. *Health Aff (Millwood).* 2005 Jul-Dec;Suppl Web Exclusives:W5-376-84.
 28. See Miller HD. Creating accountable care organizations in Massachusetts. Massachusetts Hospital Association, November 2009. Available at: <http://www.mhalink.org/AM/Template.cfm?Section=Newsroom&Template=/CM/ContentDisplay.cfm&ContentID=9056>.
 29. Examples include the California Cooperative Healthcare Reporting Initiative (www.cchri.org), the Greater Detroit Area Health Council (www.gdahc.org), the Maine Health Management Coalition (www.mehmc.org), Massachusetts Healthcare Quality Partners (www.mhqp.org), Minnesota Community Measurement (www.mncm.org), the Oregon Health Care Quality Corporation (www.q-corp.org), the Puget Sound Health Alliance (www.pugetsoundhealthalliance.org), Quality Quest for Health of Illinois (www.qualityquest.org), and the Wisconsin Collaborative for Healthcare Quality (www.wchq.org).
 30. Miller, HD. From volume to value: Better ways to pay for health care. *Health Aff (Millwood).* 2009 Sept-Oct;28(5):1418-28.
 31. "Condition/severity-adjustment" is the same basic concept as "risk adjustment," but since the payment is being adjusted based on the patient's current status, not just on their risk of future needs, and since most risk-adjustment

systems are based primarily on the conditions the patient has, it seems clearer to refer to this as condition/severity-adjustment.

32. Risk-adjustment formulas are commonly evaluated based on what proportion of the variation in costs among patients they can explain/predict. However, this evaluation criterion is inappropriate, since a risk-adjustment formula cannot explain/predict something that has no logical underlying rationality – if different physicians treat patients differently purely based on the personal preferences of the physicians (or the patients), then no model based on clinical characteristics of patients will ever be able to explain or predict those differences. This is not a flaw with the models; in fact, the goal of having a condition/severity-adjusted payment system would be to pay physicians more for a patient who has more conditions that justify more services, but not more for a patient who is essentially identical to another patient but where the physician simply chooses to deliver unnecessary services.
33. Ultimately, condition/severity-adjustment systems will need to be modified to measure how patient conditions improve or worsen over time under the care of a particular provider; a provider could inadvertently be penalized financially for helping patients lose weight, stop smoking, etc. because the condition-adjustment would reduce payment when the patients improve, and the provider could be rewarded for their patients developing poorer health habits. See Miller HD. Making reform a reality: Ways to facilitate better healthcare payment and delivery systems and lower healthcare costs. Robert Wood Johnson Foundation, June 2010. Available at <http://www.rwjf.org/files/research/64970.pdf>.
34. CMS replaced the previous 538 Diagnosis Related Groups (DRGs) with 745 “Medicare-Severity DRGs” (MSDRGs).
35. It is worth noting that this problem exists even in the fee-for-service system, because fee levels are fixed for specific services. For example, if a physician’s patients routinely require much more than the assumed amount of time for an office visit, the physician will lose money because he or she will be able to see fewer patients during the day than needed to cover their costs. Alternatively, compressing the visits to fit within the assumed time can result in failure to address all of the patient’s needs appropriately, resulting in poorer quality of care and poorer outcomes.
36. For example, the Medicare DRG payment system for hospitals pays hospitals a fixed amount per case but includes a provision to pay an outlier payment to the hospital if a patient’s costs significantly exceed the base payment amount.
37. For example, Medicare uses symmetric risk corridors in paying health plans for pharmaceutical costs incurred under the Medicare Part D prescription drug benefit. If a Part D plan incurs costs between 95% and 105% of a defined target amount, the plan is responsible for covering those costs with no additional payment from Medicare. However, if a plan incurs costs between 105% and 110% of the target, it is only responsible for 50% of those costs, and Medicare pays the remaining 50%; if costs exceed 110% of the target, the plan is responsible for only 20% of the costs, and Medicare pays an additional amount sufficient to cover the remaining 80%. If the plan incurs costs between 90% and 95% of the target, the plan refunds 50% of the savings in that range to Medicare, and if the plan’s costs are below 90% of the target, it refunds 80% of the costs below 90% of the target to Medicare. The risk corridors were originally narrower in order to encourage private health plans to participate at a point where there was limited information about exactly how drug usage by Medicare beneficiaries might change in respond to the new program.
38. In capitation payment systems, this process of accepting risk and then contracting out portions of that risk on a similar basis is known as “subcapitation.” Paying a hospital or specialty provider a specific amount for each patient who is referred to them, rather than a specific amount for all patients in a broader population group, is called “contact capitation,” i.e., the payment is only made if the provider has contact with that patient, whereas in a traditional capitation system, a provider is paid the capitation payment even if a particular individual does not use any services from the practice.
39. Arguably, this also depends on the frequency with which patients change health plans, because the provider will not reap the savings from preventive care nor incur the penalties of failure to deliver such care to patients who move to a different health plan or provider. However, this would require the provider to predict which patients would switch and systematically deny care to those patients.
40. Links to measures of the quality of preventive services in various communities can be found on the website of the Network for Regional Healthcare Improvement (www.NRHI.org).
41. See, for example, Scholle SH et al. Benchmarking Physician Performance: Reliability of Individual and Composite Measures. *Am J Manag Care*. 2008; 14(12):829-838.
42. More information on Regional Health Improvement Collaboratives is available from the Network for Regional Healthcare Improvement at <http://www.NRHI.org>.
43. See, for example, O’Connor AM, Llewellyn-Thomas HA, Barry Flood A. Modifying unwarranted variations in health care: shared decision making using patient decision aids. *Health Aff (Millwood)*. 2004;63(1), and Bottles K, Vinz C.

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44. Network for Regional Healthcare Improvement. From Volume to Value: Transforming Healthcare Payment and Delivery Systems to Improve Quality and Reduce Costs. Network for Regional Healthcare Improvement, Pittsburgh Regional Health Initiative, and Robert Wood Johnson Foundation, November 2008. Available at: <http://www.nrhi.org/downloads/NRHI2008PaymentReformRecommendations.pdf>.
45. The Pittsburgh Regional Health Initiative has developed a comprehensive approach for reducing readmissions that involves changes in care processes both in the hospital and in primary care practices. Pittsburgh Regional Health Initiative. PRHI readmission reduction guide: A manual for preventing hospitalizations. January 2011. Available at: http://prhi.org/docs/Readmission_Reduction_Guide_1-10-11.pdf.
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47. Burke T, Cartwright-Smith L, Pereira E, Rosenbaum S. Health System Reform and Antitrust Law: The Antitrust Aspects of Health Information Sharing by Public and Private Health Insurers. Robert Wood Johnson Foundation Aligning Force for Quality Program, July 2009.
48. Examples of multi-payer initiatives coordinated by Regional Health Improvement Collaboratives can be found at: <http://www.nrhi.org/paymentdeliveryreform.html> .
49. P.L. 111-148 and 111-152.



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